POLAC INTERNATIONAL JOURNAL OF ECONS & MGT SCIENCE (PIJEMS)
DEPARTMENT OF ECONOMICS & MANAGEMENT SCIENCE
NIGERIA POLICE ACADEMY, WUDIL-KANO

INCIDENCE AND PREVALENCE OF HIV/AIDS IN ANAMBRA STATE, NIGERIA

Obi Sixtus Chibuzor Department of Sociology, Nasarawa State University, Keffi -Nigeria

John Obioma Ukawuilulu, PhD Department of Sociology, Nasarawa State University, Keffi -Nigeria

Ambrose W. Ogidi PhD Department of Sociology, Nasarawa State University, Keffi –Nigeria

Abstract

Anambra is rated fifth in Nigeria's HIV prevalence and first in the South East Zone with a 2.4 prevalence rate, which is above the 1.4 National prevalence. Anambra state is the fifth highest in Nigeria in terms of HIV transmission among people between 15 to 49 years. The pattern of transmission of the disease has made prevention a bit difficult in the state. The objective of this paper is to examine the incidence and prevalence of HIV/AIDS in Anambra state and its drivers. The study employed the Action Frame of Reference theory to explain the nature and drivers of HIV/AIDS in Anambra State. Literature and past studies on HIV incidence and prevalence in Anambra were reviewed and analyzed using content analysis and in-depth summary. The findings revealed that the high incidence of HIV/AIDS in Anambra was due to low level of knowledge about the disease, wrong cultural belief and the wrong perception of HIV/AIDS as a disease that afflicts only immoral people. Only a few saw the disease as a disease that could afflict anybody. In addition, many of them believe that AIDS is real but show a low level of knowledge about the mode of transmission. Furthermore, educational level, sex, occupation, and income was identified as factors that influence the perception and reactions to HIV treatment and prevention. High prevalence and incidence were because of people's low level of knowledge about HIV and cultural belief systems, which see it as a strange illness that is a punishment from God for disobedience. It was also an indication that government HIV/AIDS awareness programs were not effective. The study therefore recommends that strategies for effective culture-based HIV educational programs should be sought and carried out in Anambra state. In addition, every HIV intervention program in the state should be through the traditional institution and stakeholders. Cultural and community-based intervention programs have the power to change the high incidence of HIV by changing people's negative perceptions and close low levels of knowledge of HIV/AIDS gaps, thereby curtailing the HIV prevalence and incidence rate in the State.

Keywords: Prevalence, Incidence, HIV, AIDS, Anambra State

Introduction

Human Immunodeficiency Virus (HIV), the virus that causes AIDS (acquired immunodeficiency syndrome), is one of the world's most serious health and development challenges. According to UNAIDS (2022), the Global HIV Statistic 2022 fact sheet revealed that 38.4 million people were living with HIV in 2021, up from 30.8 million in 2010, the result of continuing new infections and people living longer with HIV, and tens of millions of people have died of AIDS-related causes since the beginning of the epidemic. Furthermore, UNAIDS (2022) Global AIDS Update; In Danger, shows that many people living with HIV or at risk for HIV infection do not have access to prevention, treatment, and care, and there is still no scientific cure.

Results released by the Government of Nigeria in 2021 indicate a national HIV prevalence in Nigeria of 1.4%. UNAIDS and the National Agency for the Control of AIDS (2019), estimate in the national HIV/AIDS Strategic Framework, that Nigeria ranks 4th in global HIV with estimated 1.9 million people still living with HIV. According to NACA (2021), Anambra State has an HIV prevalence of 2.4%. In 2020, less than 30% of pregnant women were tested for HIV and less than a quarter of pregnant women living with HIV accessed

antiretroviral therapy, even though more than 90% of pregnant women attended a health facility for antenatal care in Anambra. There was a 73% increase in the estimated number of new HIV infections among children in the state from 2015 to 2020. Given its HIV prevalence and the increase in new HIV infections among children, Anambra was recently supported to develop an operational plan for the elimination of vertical transmission of HIV in 2016.

The Executive Director, of Anambra State Aids Control Agency (ANSACA), in the Punch newspaper (September 19 2022) revealed that Anambra state is the fifth highest in Nigeria in terms of HIV transmission among people between 15 to 49 years. He lamented the situation saying that "The agency is working tirelessly to ensure its reduction or elimination by promoting behavioural change in both low and high population, increase awareness and sensitisation among the general population". The state Commissioner for Health, on his part, called for more efforts to reduce HIV transmission in the state. He stated that the pattern of transmission of the disease has made prevention a bit difficult in the state but Governor Chukwuma Soludo's administration is determined to give residents quality healthcare service delivery.

Statement of the Problem

According to NACA (2021), Anambra State has an HIV prevalence of 2.4%, which is higher than the national prevalence rate of 1.4. With this prevalence rating, Anambra is rated fifth in Nigeria and first in South East Nigeria in HIV prevalence rating. Many studies on HIV/AIDS in Anambra have focused on attitudes, stigma, and care and support. Likewise, on high-risk groups – sex workers, male clients of sex workers, and intravenous drug users, and biomedical perspectives (hospital care, and health workers). However, none has critically considered the connection between Low-level knowledge of HIV, Cultural beliefs, negative perception of HIV and high prevalence and incidence of HIV/AIDS in the state. This study closed this gap by carefully x-raying the crucial connection between Knowledge, perception, socio-cultural variables, and the incidence of HIV/AIDS in Anambra State. Caldwell (1999), captured the effect of culture and negative perception in his report when he said that people prefer not to talk about AIDS partly because it was an unusual disease with mysterious symptoms perhaps related to the occult and partly because it was associated with sexual behaviour in a society that finds it difficult to talk about sex publicly and across generational boundaries. It is this perception of the disease that influences the attitude of the public toward PLHIV, which invariably increases the incident rate.

The practical aspect of this study highlights how negative perceptions, low levels of knowledge of the disease, and cultural beliefs influence HIV prevalence in Anambra State. The findings showed the people's perception of HIV/AIDS as a punishment from God and as a disease of immoral people, this was a product of the people's cultural and religious beliefs. This assertion was supported by a study of South Western Nigeria by Olubuloye, Caldwell and Caldwell (1993) found that three-quarters of Christian and Moslem clergy in Nigeria believed that AIDS was a divine punishment from God and the proportion was not likely to be lower in East and Southern Nigeria or among the laity of the congregations. These perceptions influenced how the people of Anambra State responded to HIV preventive campaigns. This study recommends that public health officials and policymakers in the state should focus more on culture-based awareness campaigns in the state to enlighten people on HIV/AIDS and how it is contracted and transmitted. This would increase the level of knowledge of the disease and change their negative perception.

The scientific aspect of this study revealed the consequences of low-level knowledge, negative culture and perception of HIV. This negative perception was shown in Alubo, Zwandor, Jolayemi, and Omudu (2002) in a study of the stigmatization of PLHIV in Benue State, which found that at the community level, AIDS was perceived as a 'just reward' for immorality, according to them, 'the mouth that eats pepper feels the bitterness'. This negative perception influences the incidence and prevalence of HIV in the state. Anambra State Commissioner for Health reiterated that a low level of knowledge of the disease has been indicated as one of the problems

associated with HIV perception and misconceptions in Anambra state. This study therefore proposed that any intervention on HIV/AIDs in Anambra should be community-based and focused on the traditional institution to achieve the desired outcome.

Objectives of the Study

The objective of this study is to examine the prevalence and incidence of HIV/AIDS and its drivers in Anambra State, Nigeria.

Conceptual and Theoretical Framework

Prevalence Rate

According to the World Health Organization WHO (2022), HIV Prevalence is the percentage of people living with HIV. HIV prevalence (per 1000 population (%)). Prevalence measures the frequency of existing disease in a defined population at a specific time. Numerator: Total number of infections. Denominator: Total population. Although prevalence does not indicate how long a person has had a disease, it can be used to estimate the probability that a person selected at random from a population will have the disease.

HIV incidence

HIV incidence is expressed as the estimated number of persons newly infected with HIV during a specified period (e.g., a year), or as a rate calculated by dividing the estimated number of persons newly infected with HIV during a specified period by the number of persons at risk for HIV infection, USAID (2023) Global HIV & AIDS statistics — Fact sheet:

Theoretical Framework

The theoretical framework for this study was the Action Frame of Reference (Max Weber 1960; Parsons 1937), which posited that the action of an individual towards an issue or object is determined or influenced by the definition of the situation. The action frame of reference is associated with the name of Talcott Parsons, whose theory starts with a systematic analysis of action which sees the social actor as choosing between different means and ends, in an environment that limits choice from both physical and social. This sociological perspective focuses on the acting individual and the acting group. The action frame of reference gives a complete and comprehensive picture of the interaction between the actor and the environment in which the actor operates. As explained by Weber (1960), an explanation of social action must arise from the definitions of the situation and purposes of the actors. In action, it included all human behaviour when and insofar as the acting individual attaches a subjective meaning to it. Action in this sense may be overt or purely inward or subjective.

Weber postulated that cultural values circumscribe and direct social action and as such, another main defining agency is the community. Owing to Weber's overt emphasis on individual meaning, Talcott Parsons's Voluntarist Social Action Theory was employed to strengthen the shared meaning aspect of human action, which is the main force in individual behaviour. Parson's Voluntarist Action Theory is a variant of the functionalist perspective. This theory emphasizes the constraint of individuals within particular customs and values. This helps to explain human behaviour with regard to socio-cultural factors and their influence on perceptions and attitudes. Much like Weber's action theory, which asserts the primacy of society over the individual (Giddens 2000), it argues that societies exert social constraint over the actions of individuals.

This perspective focuses on the course of action as determined by the conditions of the cultural, physical and social environment; society influences the end which the actor seeks and the means he/she will use in attaining them. Parsons' theory like that of Weber states that action can be explained in the context of the subjective meaning, given to it by the actor and that actions are always directed at the attainment of goals with the choice of the most appropriate method by the actors. Applying action theory to the study of the incidence and prevalence of HIV/AIDS in Anambra, the assumption is that social action (in this case; perceptions) must arise from the definition of the situation, which is to a great extent culturally defined. That is to say that how people define (perceive) the HIV/AIDS disease and the people living with it, is determined by the cultural beliefs and the level of knowledge of the people. This definition of the situation also influences the incidence and prevalence of HIV/AIDS in the state.

Literature Review

Incidence and High HIV Prevalence

A low level of knowledge of HIV was indicated as one of the causes of high HIV incident and prevalence. In a study of Barbing saloon operators in Sokoto, Nigeria, Ibrahim, Opara and Tanimomo (2007) found that there is a very low level of knowledge of the risk of transmission of HIV infection through unsterilized equipment in barbing saloons. Chng, Eke-Huber, Eaddy and Collins (2005) in a study of the perception of HIV/AIDS in selected Tertiary institutions in Southern Nigeria found that many of the respondents believed that antibiotics could cure HIV/AIDS. In the same vein, the Kaiser Family Foundation (2006) found that there were misconceptions about HIV transmission in all segments of the American population which 37% believed that it might be transmitted through kissing, 22% through sharing a drinking glass, 16% through touching a toilet seat and that at least 43% adult population hold at least one of these misconceptions.

This low level of knowledge of the disease is a big factor fuelling the problem of stigmatization, which quickens the spread of the disease. For instance, UNAIDS (2003) described the Nigerian public as a people who know little about HIV/AIDS and who discriminate against PLHIV with little or no sympathy. Despite the disease's impact in Nigeria, the historical lack of both private and public efforts around disease prevention has resulted in a public that is largely uninformed and unconcerned about the epidemic. In a study of knowledge, perception and acceptability of microbicides among non-healthcare workers in Lagos, Nigeria. Smith, Adeiga and Agomo (2008) found that those at high risk of HIV acquisition like the hairdressers and truck drivers' spouses and partners were not willing to use the microbicide because they did not see any need for it as they did not see how contracting HIV concerns them.

In addition, Odu and Akanle (2008) in a study of youth in South Western Nigeria found that there had been misconceptions; that most of the youth engaged in high-risk sexual behaviour with the belief that antibiotics can cure the disease. According to a study on the Perception of HIV/AIDS among the Igbos of Anambra State published in the National Institutes of Health by Sahara (2013) One in 10 care providers reported refusing to care for HIV-positive patients, 10% reported refusing admission to a hospital, 65% reported seeing other healthcare workers refusing to care for an HIV or AIDS patient. Some 20% felt that many people living with HIV had behaved immorally and deserved to be infected. This perception was influenced by a lack of sympathy for others, a lack of knowledge about the disease, and traditional belief systems. According to the Centers for Disease Control (2021) Fact about HIV Stigma: The lack of information and awareness combined with outdated beliefs lead people to fear getting HIV.

Additionally, many people think of HIV as a disease that only certain groups get. This leads to negative value judgments about people who are living with HIV. The perception of HIV/AIDS has been a big problem owing to its central place in the discrimination, stigmatization, and attitudes towards people living with HIV/AIDS (PLHIV) throughout the world. Sabatier (1988) noted that due to the initial misconceptions and negative reactions to the disease, people affected with HIV/AIDS have been blamed, stigmatized, and isolated. Owing to the fact that HIV/AIDS is to some extent a behavioural disease, PLHIV has been perceived by many as immoral people. Caldwell (1999) captured this in his report when he said that people prefer not to talk about AIDS partly because it was an unusual disease with mysterious symptoms perhaps related to the occult and partly because it was associated with sexual behavior in a society that finds it difficult to talk about sex publicly and across generational boundaries. It is this perception of the disease that influences the attitude of the public to PLHIV, which have contributed to high incidence of HIV/AIDS.

Even religious bodies are not left out of this perception. A study of South Western Nigeria by Olubuloye, Caldwell and Caldwell (1993) found that three-quarters of Christian and Moslem clergy in Nigeria believed that AIDS was a divine punishment from God and the proportion was not likely to be lower in East and Southern Nigeria or among the laity of the congregations. In the same vein, Aniebue (2006)

also found that Nigerian clergy attributed HIV/AIDS to a divine punishment from God and activities of demonic and spiritual forces. These misconceptions had also been part of the problem of HIV/AIDS in the sense that it had serious implications for preventive efforts and care for PLHIV. Traditional society believes that non-marital sex should be surreptitious and that public revelation or being caught out often results in punishing illnesses and other disasters. Bleek (1981) noted that this can be associated with an older sense of shame, that is, fear of bringing disaster to the community because suffering from an unusual or previously unknown disease can be related to sin which must have been committed by the infected individual but which would, nevertheless, bring punishment on the whole society.

One of the reactions of relatives when this occurs is to distance themselves from the shame and ridicule brought by a member of the family or corporate clan. Bleek (1981), therefore, maintained that it is within this context that people react to HIV/AIDS infection, which have contributed to high HIV prevalence rate. Alubo, Zwandor, Jolayemi and Omudu (2002) in a study of the stigmatization of PLHIV in Benue State found that at the community level, AIDS was perceived as a 'just reward' for immorality, according to them, 'the mouth that eats pepper feels the bitterness'. In spite of the fact that the whole family was often labelled 'AIDS family', the children of the PLHIV were often taunted as having AIDS mama or papa; there was thus the possibility that these reactions might jeopardize the chances of the infected person coming out to take treatment and curtail the risk of spreading the diseases in the community.

There is general inaction on the part of the government, individuals, community, and other groups. Malungo (2000) observed that no one blamed the government for inaction, even in countries where over one-quarter of adults are currently seropositive and where most of the population will die of AIDS. This general perception has portrayed PLHIV as untouchables and this has equally raised the level of stigma. Another problem with these misconceptions was that many people did not view themselves as being at risk of contracting HIV. According to UNAIDS and the World Health Organization (2001), the healthcare sector has generally been the most conspicuous context for HIV-related discrimination. Negative attitudes from healthcare staff have generated anxiety among PLHIV. This was corroborated by UNAIDS (2004) epidemic update research in four Nigerian states which found discriminatory and unethical AIDS-related behaviour among doctors, nurses and midwives – denial of care, testing without consent, and breaches of confidentiality. This unethical AIDS-related behaviour has made a lot of aids patient to resort to self-help and revenge mission, so that they will not be only one that will be discriminated. This practise has contributed to the high incident and prevalence of HIV/AIDS.

Methodology

Research Design applied for the study is the survey research design. The researcher reviewed the relevant literature on the incidence and prevalence rate of HIV/AIDS and past studies on the subject matter. The study location was Anambra State. The State is located in the South-eastern part of Nigeria, founded on August 27, 1991. The State is bounded by Delta to the west, Imo to the south, Enugu to the east and Kogi to the north. According to the 2022 Census report, the population is over 9 million residents in the state. Anambra is rated fifth with 2.4 prevalence rate in Nigeria states with the highest number of HIV/AIDS Patients with over 92,078 said to be living with HIV/AIDS in the state (NACA 2022) fact sheet on HIV/AIDS. The study reviewed the relevant literature and past studies on HIV/AIDS incidence and prevalence. Purposive sampling techniques were used to identify the relevant literature and past studies that were reviewed and analyzed. The data was analysed using an in-depth summary and content analysis

Findings

The findings revealed that Culture, low level of knowledge and negative perception of HIV/AIDS on the PLHIV were perceived to be the major drivers of HIV/AIDS in Anambra State. The findings further showed that many of the HIV & AIDS interventions in Anambra State have been on awareness creation, building institutional capacities to cope with the epidemic, the treatment of opportunistic infections and administration of Antiretroviral (ARV) drugs. Very little attention is paid to mitigating the effects of the negative perception of HIV/AIDS in the State. This is

because there is no known study assessing the impacts in the State. The effect of low levels of knowledge and negative perception of the disease is inferred largely from studies conducted in other places with similar socio-economic and cultural conditions. These inferences are complemented by a study on the perception of HIV among the Igbo people of Anambra by Sahara (2013) in Idemmili North and Oyi local Government areas of Anambra state. The subsequent discussion will rely heavily on the findings from these studies.

The findings from the study carried out by (Sahara 2013 March) on the Perception of HIV/AIDS among the Igbo of Anambra State, Nigeria revealed that the majority of respondents agreed that AIDS is real. On how it is contracted, 92.0% said that it is contracted through sexual intercourse while, 11.5% indicated that it is contracted through the hospital, and 1.8% through shaking of hands. Meanwhile, 22% of the respondents indicated that they use condoms in order to protect themselves, 51.0% abstain from sex, 3.0% use medicine and 24.0% do nothing to protect themselves. Insight from this study showed that most people have heard about HIV/AIDS. They knew some of the sources through which it can be contracted and the majority indicated that everybody was at risk. However, there were still others who showed a low level of knowledge of the disease by indicating that they used medicine to protect themselves against the disease. There were also those who said that AIDS is contracted through shaking hands.

Furthermore, In-depth interviews from that study showed that many people in the study area did not know much about the disease. For instance, a male informant said that the disease is so strange that they feel that someone can contract it through the air. This fear of contracting the infection means that many of the people would not want to come near or have anything to do with PLHIV. This low level of knowledge affects perception and inhibits how PLHIV copes with the disease and other preventive measures. Also during an interview session as reported from the same study, an opinion leader said that he did not believe that AIDS is real. To him, it was the white man's propaganda to curb men's libido. He maintained that he had not seen anybody who said he/she had AIDS. These responses showed a lack of knowledge of the disease, which was likely to affect the people's perception and application of proper measures to protect themselves against the disease. 34.3% of the respondents from the study indicated that AIDS afflicts immoral people, 20.6% saw it as caused by a germ, 25.9% saw AIDS as a punishment from God, 4.3% saw it as a disease that can afflict anybody while 14.9% did not know. The fact that almost 15% of the respondents indicated that they did not know how to define HIV/AIDS was a sign of a low level of knowledge of the disease and could have implications for the prevention of HIV/AIDS. The study revealed that 54.1% of the respondents would care for PLHIV, while 21.7% would confine them and keep it a secret and 24.2% did not know what they would do in such a situation. The majority of the respondents were ready to care for relations suffering from HIV/AIDS.

According to a male informant from the study: In most cases, the family of PLHIV keeps him/her in one room and takes care of the person by providing his/her needs as much as possible. They accompany him to the herbalist or hospital and they tell outsiders that the person travelled or that he/she is suffering from typhoid fever or poison. No family ever mentions that their family member is living with HIV/AIDS because the shame would be on the entire family. This kind of practise jeopardise the spread of the disease. A male respondent during one of the interview sessions from the study indicated, ‘If my relation is HIV positive, I can only contribute money for his care but cannot go near him/her because I would not like the sight.’ A female opinion leader also indicated that it is difficult to even come near PLHIV, let alone try to help them. If my family members were living with HIV/AIDS, I would never mention it to anybody outside the family. This is because it is a big shame for all the members of the family. According to her, it is a big shame for the family that one of their own is suffering from a disease of immoral people meaning that the entire family members are likely to be immoral people. The practise of keeping this disease as a secret from other community members, make it impossible for them to apply some preventive measures, thereby spreading the disease among the community members.

Discussion of Findings

The revealed literature showed that the majority of the people saw HIV/AIDS as a punishment from God. This finding corroborates Olubuloye (1993) in a Nigerian study of the clergy's view of HIV/AIDS in which they found that a majority of the clergy saw the disease as a divine punishment from God. This Perception accounts for the people attitudes towards preventive measures, which have contributed to the high prevalence rate of HIV in the state. This perception is attributed to the definition of HIV/AIDS, which corroborates the study's theoretical position that the definition of the situation determines the actions of the people. These findings could be ascribed to the culture of the people because culturally, the people define strange illnesses (illnesses without cure) as a punishment from God, confirming Bleek's (1981) assertion that people attribute unknown illnesses to wrongs done to the gods by the sick person, which had attracted punishment in the form of a disease.

In addition, HIV/AIDS was seen as a disease that afflicts immoral people. This perception could be attributed to the fact that many of the respondents saw sexual intercourse as the only way through which HIV/AIDS could be contracted. This is because promiscuity is frowned at in the study area and as such, there is no pity for a person suffering from any disease that is sexually transmitted in nature. This negative perception of the disease has contributed to the kind of response towards HIV/AIDS. This agrees with Caldwell (1999) and Alubo (2002) in a study in Benue State, Nigeria in which they found that there was no pity for PLHIV and that the respondents said that it is the person who eats pepper that should feel the bitterness. This means that PLHIV should bear the consequences of their action. According to Bleek (1981), it is within this context that people's negative perceptions of HIV/AIDS are formed. The low-level knowledge of HIV/AIDS equally influences the spread of the disease, the more people know about HIV/AIDS, the less they would see it as a disease of immoral people and seek proper medical attention.

The analysis of the findings indicated that many people in Anambra know that HIV is real, but their level of knowledge of the disease was quite shallow considering that many of them did not feel that everybody was at risk and many also indicated that HIV is contracted through shaking of hands and some even indicated that they were using medicine to protect themselves. This implies a low level of knowledge, which influences the incident of the disease in the state. This upholds Ibrahim (2007) and UNAIDS (2003) that there was a generally low level of knowledge among the members of the public. For instance, a person who feels that HIV is transmitted through shaking hands would definitely see PLHIV as an outcast who should not mingle with the public at all and will not uphold the proper preventive measures. The cause of this low level of knowledge could be a low level of education in the area. It could also be the absence of culture-based government HIV-intervention programs in the area. This supported Kaiser (2006) that at least 46% of adult Americans hold a misconception. In addition, the reviewed literature showed that marital status, educational level, income, sex and occupation of the people had significant relationships with the perception and incidence of HIV/AIDS. The reason for the influence of marital status could be the fact that in the study area, the marriage bond is very strong. The influence of sex could be a result of the fact that women have always been very sympathetic to sick relations. Furthermore, the educational level influences the perception of HIV/AIDS, which could result in the fact that education enables people to have greater awareness about HIV/AIDS. The influence of income in the perception of HIV/AIDS could be because people with higher income levels were likely to be people with a higher level of education, which helped them to view the disease differently.

The Summary of the findings revealed that the people's knowledge of HIV/AIDS influenced their perception which relatively affects the incident and prevalence of HIV/AIDS to a large extent. The findings showed that the majority of the people saw HIV/AIDS as a punishment from God. This Perception accounts for the attitudes towards preventive measures, PLHIV and their families. For effective HIV intervention, behavioural analysis and intervention points of entry into a community should focus more on culture rather than on individual behaviours.

Conclusion

In conclusion, it was revealed that negative perception, low level of knowledge of HIV/AIDs and wrong

cultural believe are the major drivers of high incidence and prevalence of HIV/AIDS in Anambra State. The findings showed that the people's perception of HIV/AIDS as a punishment from God and as a disease of immoral people was a product of the people's cultural and religious beliefs. These perceptions influenced how the people response to HIV/AIDS preventive campaign and measures. It also influenced the behaviour of PLHIV, thereby discouraging them from seeking proper medical care and support. The people's perception of HIV as a punishment from God and a disease of immoral people had the serious implications of making the people to ignore proper preventive measures. This also meant that PLHIV in the area hardly got adequate help and support. It, therefore, followed that PLHIV in the study area would degenerate quickly from HIV to AIDS as they did not have much support. Furthermore, the uniform negative perception is an indication that the people react alike to the issue irrespective of their social status. This was a sign that changing this negative perception to reduce HIV incidents in the state without involving the traditional institutions is likely to be a difficult task that would constitute a hindrance towards the containment of the pandemic.

Recommendations

To ameliorate the high HIV prevalence and incidence rate in Anambra, the Health workers have to implement several community culture-oriented awareness campaigns and programs to make PLHIV and their families more acceptable to their communities and to disabuse the minds of the people of their negative perception of the disease. Other recommendations are-

i. Interventions on HIV/AIDS in Anambra should be Community-based through the Traditional Institutions and key stakeholders. The backing of the key stakeholders and the traditional institutions is vital for the acceptance of intervention programs.
ii. Religious bodies should be fully involved in the campaign on HIV/AIDS and encouraged to educate their congregation that HIV/AIDS is not a punishment from God for immoral acts, that it can be contracted through means other than sexual immorality. They also need to apply their religious teaching to encourage empathy on PLHIV.
iii. Policymakers and other Social workers should come up with policies that will discourage discrimination, especially among health workers. The health care workers need to be properly educated on preventive measures and support the people affected by HIV.
iv. There should be a continuous awareness on the means of contraction and transmission of HIV especially among the active population to bridge the knowledge gap.

References

Alubo O., Zwandor A., Jolayemi T., Omudu E. (2002). Acceptance and stigmatisation of PLWA in Nigeria. AIDS Care. 2002; 14(1):117–126. [PubMed]

Anarfi J. (1092). Report on a Pilot Study on the Coping Strategies of Households with AIDS Sufferers. Legon: Institute of Statistical, Social and Economic Research, University of Ghana; 1992.

Aniebue P. (2006). Perception of Nigerian clergy about HIV/AIDS and their involvement in HIV/AIDS prevention and supportive care. *Journal of College of Medicine. 2006; 11(1):59–64.*

Awusabo-Asare K. (1995). Living with AIDS: perceptions, attitudes and post- diagnosis behaviour of HIV/AIDS patients in Ghana. Department of Geography, University of Cape Coast, Cape Coast Ghana Reprinted from HealthTransition Review; 1995. pp. 265–285. Supplement to Volume 5.

Awusabo-Asare K., Ntozi J., Orubuloye I., (1995). Resistances to Behavioural Change to Reduce HIV/AIDS Infection in Predominantly Heterosexual Epidemics in Third World Countries. Canberra, Australia: National University; 1993.pp.93–104.

Bleek W. (1981). Avoiding shame. Anthropological Quarterly. 1981; 54(4):203–209.

Berer M., Ray S. (1993). Women and HIV/AIDS. London: HarperCollins; 1993.

Chng C., Eke-Huber E., Eaddy S., Collins J. (2005). Nigerian college students' HIV knowledge, perceived susceptibility for HIV and sexual behaviours. College Student Family Journal. 2005;39(1):1–8.

Caldwell J., Caldwell P., Anarfi J., Awusabo-Asare K., Ntozi J., Orubuloye I., (1919). Resistances to Behavioural Change to Reduce HIV/AIDS Infection in Predominantly Heterosexual Epidemics in Third World Countries. Canberra, Australia: National University; 1999

Centers for Disease Control and Prevention (ngov.) (CDC) (2022) Terms, Definitions, and Calculations Used in CDC HIV Surveillance Publications.

Centers for Disease Control (2021) Fact about HIV Stigma:Health International, (2001). Rapid Assessment on Anambra State. 2001.

Federal Ministry of Health. (2011). HIV Seroprevalence Sentinel Survey. Nigeria: Abuja; 2011.Four African Countries" *International Journal for the Advancement of Counseling 24, page 193-203*

Giddens A. (2000). Sociology. 3rd ed. Oxford: Polity Press; 2000.

Giddens A and Duneier M., (2006). Introduction of Sociology, New York: W.W. Norton

Ibrahim M., Opara W., Tanimomo T. (2007). Knowledge of HIV/AIDS, infection prevention, practices and accidental skin cuts in barbing saloons in Sokoto, Nigeria. Nigerian Medical Practitioner. 2007;51(6):123–127.

Kaiser Family Foundation. (2006). Public's Knowledge and Perception about HIV/AIDS. Kaiser Family Foundation's Survey of Americans on HIV/AIDS

Lindsay P., Norman D. (1977). Human Information Processing: An Introduction to Psychology, New York, Academic Press. 1977.

Malungo R. (2000). Towards the containment of AIDS. Health Transition Review, Supplementary copy 2000, 129–141. Canberra: National Centre for Epidemiology and Population Health, Australian National University; 1998. Health seeking behaviour among STD patients and institutional responses to Zambia.

NACA (2022). Fact sheet on HIV/AIDS

NACA (2021). National HIV/AIDS Strategic Framework, State HIV/AIDS prevalence rate. HIV/AIDS care.

Nigeria's HIV/AIDS Indicator and Impact Survey (2019). National Fact Sheet, HIV Prevalence by state

Odu K., Akanle F. (2008). Knowledge of HIV/AIDS and sexual behaviour among the youths in south west, Nigeria. *Journal of Humanities and Social Science. 2008;3(1):81–88.*

Olubuloye I., Caldwell J., Caldwell P. (1993). The role of religious leaders in changing sexual behaviour in southwest Nigeria in an era of AIDS.

Parsons T. (1937). The Structure of Social Action. New York: McGraw Hill; 1937.

Peltzer K. (2002). "Attitude towards HIV Antibody Testing Among University Student in Punch Newspaper (2022). Anambra state is the fifth highest in Nigeria in terms of HIV transmission among people between 15 to 49 years, on 9th September

Revised National HIV/AIDS Strategic Framework (2019-2021). National Agency for the Control of AIDS (NACA)

Sahara J. (2013). A study on the Perception of HIV/AIDS among the Igbos of Anambra State published in the National Institutes of Health.

Sabatier R. Blaming Others, (1988). Prejudice, Race and World-Wide AIDS. Washington, DC: Panos; 1988.

Smith S., Adeiga A., Agomo C. (2008). Knowledge, perception and acceptability of microbicides among non-health care workers in Lagos, Nigeria. *Journal of Public Health. 2008;16(3):191–194.*

UNAIDS (United Nations Programme on AIDS) (2003). Report on the Global AIDS Epidemic.

UNAID (2004). Report on the Global AIDS Epidemic. 2004.

UNAIDS (2022). HIV Statistics 2022 fact sheet, July 2022.

UNAIDS, (2022). Global AIDS Update: In Danger; July 2022. United Nations, Reinvigorating

UNAIDS and the National Agency for the Control of AIDS (2019). National HIV/AIDS Strategic Framework

United Nations reform (2017). The AIDS response to catalyze sustainable development: Report of the Secretary-General; June 2017

UNDP Human Development Report (2007/2008). Fighting Climate Change Human Solidarity in a divided world

UNAIDS & World Health Organization (2001). AIDS Epidemic Update 2001, in Population, Reports. 2001; XXIX (3) fall 2001 Series L, Number 12.

USAID (2023) Global HIV & AIDS statistics — Fact sheet.

Weber M. (1960). The Theory of Social and Economic Organization. New York: Free Press; 1960.

World Health Organization (2022). HIV Prevalence, percentage of people living with HIV.