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Stigmatisation and Discrimination against People Living with HIV and AIDS in Agona Swedru and Coping Strategies

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Abstract:
The study aimed at exploring the personal views and experiences of People Living with HIV and AIDS at AgonaSwedru and coping strategies. The study was a qualitative research which employed a case study design. A semi structured interview guide was used for data collection. A sample size of 10 people living with HIV and AIDS was used for the study. Purposive and convenient sampling techniques were used. The findings revealed the nature of stigmatisation and discrimination to visible, invisible and self-imposed. It was also found out that People Living with HIV and AIDS go through psychological experiences. People living with HIV and AIDS feel self-guilty once their HIV positive status is revealed to them and begin to live lifestyles that they think will prevent people from knowing their HIV status. Another finding is that people living with HIV and AIDS adopt engagement coping, disengagement coping and selective disclosure strategies to help them cope with their situation. It emerged from the study upon voluntary testing and counselling that not only irresponsible behaviours like promiscuous life and heterosexual behaviour that contract HIV and AIDS. The study concludes that it is significant to note that the family, which is the basic protective institution, should stigmatise and discriminate against their members that have HIV and AIDS; and discrimination, some People Living with HIV and AIDS have found a way of coping with their condition. The research recommends that the participants should engage in information, education and communication, community mobilisation, and advocacy.

Keywords: Stigmatisation, discrimination, HIV and AIDS, coping, strategies

1. Introduction

It seems many people avoid having anything to do with people living with the Human Immuno-deficiency Virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS). As a result, some infected persons conceal their HIV-positive conditions because of the stigmatisation associated with the virus. Some of them continue to have unprotected sex, thereby infecting more people with the dangerous virus (Ohene-Sakyi, Adoo-Adeku, Aggor, Benneh, Anibra, &Obeng, 2010).

Discrimination against people living with HIV and AIDS in the areas of employment, education, individual liberties, access to healthcare, social security, access to bank loan, insurance is observed in various settings (Guzmán, 2014). The respect of the rights of the HIV-infected person is one of the fundamental rights of every individual, which nearly all countries in Africa and the world have enshrined in their constitutions. These include socio-economic rights, educational rights, cultural rights and practices. These rights are infringed with impunity. Pregnant women go through mandatory testing as part of the prenatal care. Some employers demand HIV testing before recruitment or communication of the results of HIV diagnosis or test. In their daily life, people living with HIV and AIDS are often indexed and, in some countries, they go into hiding and avoid revealing their status and getting involved in AIDS control activities (UNAIDS Ghana, 2017).

Chijioke, Preko, Baidoo, Bayard, Ehiri, Jolly and Jolly (2005) in their book - 'HIV and AIDS-related Stigma in Kumasi, (Ghana), state that, "in Ghana and many other countries in sub-Saharan Africa, HIV transmission occurs primarily through heterosexual intercourse". In these countries, HIV and AIDS are widely seen as a consequence of sexual immorality or immoral behaviours, thus, infected individuals are considered responsible for acquiring the virus. In some cases, the infection is perceived as a punishment given by God to perpetrators of sins like prostitution, promiscuity, drug use or homosexuality (Ayranci, 2005).

In the particular case of Ghana, HIV prevention and treatment programmes have been established to combat the AIDS epidemic. Reports from the United Nations Integrated Regional Information Networks on Africa indicate that the Ghanaian government's AIDS programme is in danger of failure due to primarily stigmatisation and a failing health system (Ghana AIDS Commission, 2014). Since the beginning of the epidemic, much progress has been made preventing new HIV infections and in delaying progression of the disease. However, very little has been done to halt the effects of stigmatisation and discrimination (Pilot, 2006).

In 1988, a panel convened by the Institute of Medicine in the United States of America concluded that, *"The fear of discrimination is a major constraint to the wide acceptance of many potentially effective public health measures"* (Guzmán, 2014). Now, more than twenty-five years after the emergence of the epidemic, the stigma and discrimination of AIDS is

still a hindrance in the fight against the disease. The stigmatisation and discrimination of HIV and AIDS hampers the effective AIDS response, deters people from knowing their status, prevents high risk individuals from receiving needed services, prevents condom use and creates non-compliance with breastfeeding recommendations for HIV positive mothers (UNAIDS, 2017). In respect of preventing the condom use, people living with HIV and AIDS who decide to buy condom to prevent re-infection perceive people will identify them as having HIV and that is why they want to use the condom. Halting the epidemic will involve changing the perceptions of individuals in the community toward HIV and AIDS, and people living with HIV and AIDS. International documents report nothing on HIV transmission by homosexual or bisexual groups in Ghana (UNAIDS, 2015). The criminal code of 1960 (Act 29) of Ghana makes "sexual intercourse with a person in an unnatural manner" a crime (Attipoe, 2008). However, HIV is transmitted through both homosexual and heterosexual relationships but much has not been done by government agencies and other organisations to educate homosexuals on how to prevent HIV. They cannot even be identified. This is a draw back to the programme on HIV prevention (Ghana AIDS Commission, 2014).

In Ghana, HIV positive persons hide their HIV-seropositive status to reduce HIV and AIDS-related stigmatisation and discrimination and to retain the care and support of family members (Mills, 2003). People who feel stigmatised or discriminated against are more likely to have poor health outcomes, socio-psychological problems and suicidal thoughts (Katz &Nevid, 2005).

At the community level, the fear of stigmatisation and discrimination can lead to the refusal of voluntary counselling and testing for HIV, increased gender-based violence and marginalisation of high-risk individuals (Meiberg, Bos, Onya, &Schaalma, 2008). Community members may not seek VCT because of the fear of discovering that they are HIV positive and fearing of the resulting stigmatisation and discrimination. Thus, HIV and AIDS-related stigma and discrimination may have a profound impact on the disclosure of HIV status and the subsequent care, support or treatment that HIV positive persons receive by society at large (Than, Tran, Nguyen, Truong, Thai, Latkin, Ho & Ho, 2019).

Again, family members are considered ultimately responsible for the behaviour of each household member and the family is blamed or praised for the behaviour of its members (Hintz, 1997). An individual is linked to a long chain of living and deceased members in his or her family and in his or her town or village. Thus, family members of a person who dies from or lives with HIV and AIDS are also stigmatised. Family members may encourage relatives with HIV and AIDS to remain silent about their HIV status to prevent gossip, social rejection and HIV-related stigmatisation. In some cases, family members isolate relatives with HIV to minimise social contact and/or prevent infection (Hintz, 1997). The stigma continues from there.

Article 1 of the Universal Declaration of Human Rights states that, *"All human beings are born free and equal in dignity and rights. They are endowed with reason and consonance and should act towards one another in a spirit of brotherhood"*. The preamble of the declaration asserts that:

Whereas recognition of the innate dignity and of the equal and absolute rights of all membership of the human family is the basis of freedom, justice and peace in the world, whereas contempt and disregard for human rights have given rise to barbarous acts which have irritated the conscience of mankind (UNAIDS, 2015).

This has culminated in the formation of the United Nations' declaration. Article 7 of the same declaration notes *"All are equal before the law and are entitled without any discrimination to equal protection of the law"*. Unfortunately, by shear ignorance of the law or non-adherence of the law, People Living with HIV and AIDS are stigmatised and discriminated against in society by people (UNAIDS, 2015).

The African Charter of Human and People's Rights, has article 2 claiming that "Every individual shall be entitled to the enjoyment of the rights and freedoms recognized and guaranteed in the present charter without distinction of any kind such as race, ethnic, social origin, fortune, birth or order or status". Article 28 of the same charter says that, all people shall have the duty to respect and consider their fellow beings without discrimination, and to maintain relationship meant to promote, safeguard and reinforce mutual respect and tolerance. The status in the document includes socio-economic status and has HIV elements as part of the social status (UNAIDS, 2010).

Article 17 of the 1992 Constitution of Ghana prohibits discrimination on the grounds of gender, race, colour, ethnic origin, religion, creed or social or economic status. The gender here includes both male and female people living with HIV and AIDS as well as those without HIV and AIDS. people living with HIV and AIDS are not allowed to mingle in society proper: the moment their status is known by others and are not allowed to enjoy their basic rights and freedoms such as healthcare, education, work, and movement in the community among others. Some institutions and organisations compel their potential employees and subjects to undergo compulsory HIV and AIDS test. Consequently, they stigmatise and discriminate against them when they test positive. We see people living with HIV and AIDS as victims of the virus and the subsequent stigmatisation and discrimination (UNAIDS, 2010).

Article 23 of the declaration postulates that everyone has the right to work or free choice of employment, without any discrimination, has the right to equal pay for equal work, remuneration and join trade unions; but according to Ohene-Sakyi*et al*. (2010), many of the people living with HIV and AIDS, are either sacked from their jobs or have their job description changed by their employers and superiors after their status has been known. The employers action implies that, their continuous stay at the job places, where they mingle with people, would contribute to the infection of others at those places. Due to this mistreatment, people living with HIV and AIDS cope/deal with their conditions differently.

Some use constructive means and others use destructive means. Some people living with HIV and AIDS conceal their status and infect others as vengeance on the society that infected them. Constructively, other people living with HIV and AIDS engage in more positive or productive ways of educating other people on the virus. However, we are not aware of the real-life situation people living with HIV and AIDS go through. The study therefore seeks to unravel the

stigmatisation and discrimination against People Living with HIV and AIDS at AgonaSwedru in the Central Region of Ghana and how they cope with such experiences.

The following research questions were formulated to guide the study based on the views raised.

- Explore how People Living with HIV and AIDS feel about the stigmatisation and discrimination against them.
- Highlight how People Living with HIV and AIDS cope and respond to such stigmatisation and discrimination.
- Identify possible ways of minimizing the stigmatisation from People Living with HIV and AIDS.

2. Methodology

The research design for the study is a qualitative design, using the case study approach to describe in-depth the stigmatisation and discrimination against people living with HIV and AIDS in AgonaSwedru and coping strategies. Qualitative research focuses on understandings and meanings through verbal narratives, observation and artifacts (Adentwi&Amartei, 2009).

For the purpose of this study, the researcher chose to base his philosophy on Interpretivist/Constructivist position. This position is defined by Hatch and Cunliffe (2006) as anti-positivist and by Creswell (2012) as post-positivist since it is opposed that there is a fundamental difference between the subject matters of social and natural sciences. The close nature of the researcher and the study in this paradigm, and the risk that any interpretation is framed inside the mind of the researcher means that steps must be introduced to sidestep bias.

The focus of this study is people living with HIV and AIDS in the Agona West Municipality, particularly AgonaSwedru the municipal capital. It was necessary to focus on only few people living with HIV and AIDS so as to be able to get an in-depth understanding of their lives. AgonaSwedru was chosen because of its central business activities which has drawn people from all walks of life to carry out business there; making the place choke of human traffic.

The population for the study consisted of 6 females and 4 males; making a total of 10 people living with HIV and AIDS in AgonaSwedru. Purposive and Convenient sampling techniques were used for this study. Convenience sampling technique was useful for the piloting stage of this study – perhaps to build up a picture of which questions might be included in the questionnaire or to test out the questions in terms of their clarity or meaning (Creswell 2012). Therefore, it was chosen for this particular study because the questions were tested before the studies begun.

Purposive sampling technique was chosen because it is less costly and less time consuming, ensures proper representation of the universe, and gives better results; except that there other is no equal chance for the entire items of the universe being involved in the sample.

Further, the Convenience Sampling (also known as accidental, incidental or grab sampling) technique of the non-probability sampling was used to identify the participants for the research work to be conducted.

Semi structured interview was used to collect data for the study. The interview guide was flexible, with a given set of questions covered with varying levels of standardisation. The questions were open-ended, yet directed at obtaining particular information. Due to the sensitive nature of the study, in some cases, closed-ended style of questions was used, and probing was done to get the participant to expand upon their answer, give more details, and add additional perspectives. Semi structured interviews were used because it starts with the assumption that flexibility is needed in order that participants are not restricted by standardized questions and closed-ended structured answering formats.

3. Data Presentation, Analysis and Discussion

The data presented were obtained using interviews discussed earlier. The researcher undertook the study with the intention of unraveling the realities and perceptions of stigmatisation from the perspectives of people living with HIV and AIDS and to find out their coping strategies.

Assessment of the data in this research suggests that HIV and AIDS is a highly stigmatised and discriminated disease. Comments from people living with HIV and AIDS saw them as people who are immoral, dangerous and should be isolated. Local name sought to give HIV and AIDS a bad name generally, tagging it as morally resonant and disgraceful disease. These negative attitudes held true regardless of the gender of the people living with HIV and AIDS. There remains an unacceptable high level of stigmatisation and discrimination against people living with HIV and AIDS in Swedru, largely due to continued misconception about the HIV and AIDS epidemic.

In all, ten people living with HIV and AIDS were interviewed for this study. They included six females and four males each from the Swedru Township. The data highlighted several issues concerning stigmatisation and discrimination of people living with HIV and AIDS and how they cope with them. These are presented under the following themes:

- The nature of the stigmatisation and discrimination people living with HIV and AIDS experience.
- How people living with HIV and AIDS feel about the stigmatisation and discrimination against them.
- Coping strategies people living with HIV and AIDS employ to cope with the stigmatisation and discrimination.

3.1. Research Questions 1: What Is The Nature of the Stigmatisation and Discrimination Experienced by People Living with HIV and AIDS in AgonaSwedru?

The data revealed that there are different forms of stigmatisation and discrimination against people living with HIV and AIDS. The forms of discrimination range frominstitutional stigmatisation and discrimination;community stigmatisation and discrimination; family stigmatisation and discrimination andindividual and personal stigmatisation and discrimination.

Two forms of stigmatisation and discrimination that were noted are those from religious organisations and employment sector. It can also be deduced that at some health facilities there are wards reserved especially for HIV and AIDS patients.   Anybody who enters that place would be stigmatised and discriminated against.

Also, the fact that one of them was made to identify himself in public was stigmatising enough because the disease did not leave the body and other people who had been there and seen him and other HIV patients ended up not associating themselves with her for fear of contagion of the disease. It also confirms that people link HIV and AIDS to immorality especially when the participant claims that other church members used the bible to judge her with immorality.

It was seen clearly in the data that the various communities also discriminated against people living with HIV and AIDS. The stigmatisation and discrimination took in the form of lose of respect and the identity as a result of being HIV-positive; and also, a marked reduction in interactions with family and friends.

It also came to light that people who spread the news of the participants' health did it to stigmatise and discriminate against them. Gossip, shunning, avoidance and isolation led to non-disclosure of one's status. Also, people will not eat food prepared by others suspected to be living with the virus for this. people living with HIV and AIDS will prefer to conceal their status in order to be recognised and associated with the community rather than make it known and be rejected. For example, some studies show that women will not disclose their HIV status to avoid being isolated from participating in the socio-cultural aspect of food preparation since food is regarded as an expression to support and acceptance, or refuse to buy food from people living with HIV and AIDS (Panos, 1990).

The study showed that most families shun their members who are perceived to be HIV-positive for fear of infection of the disease. The behaviour of these families may force some people living with HIV and AIDS to conceal their status to avoid stigmatisation and discrimination. The behaviour of some parents who rejected their biological children because they have been infected with HIV and AIDS is contrary to the situation where families might shield affected members from the community by keeping them within the house or by protecting them from questioning (Panos, 1990). It can also be deduced that women are mostly treated badly when it comes to HIV and AIDS stigmatisation and discrimination confirming the fact that women are reported to be more badly treated than children and men (World Bank, 1997; Bharat &Aggleton, 1999).

It was also seen from the data that people living with HIV and AIDS stigmatised themselves. Individuals who were already marginalised are fearful of negative or hostile reaction from others. In her own words a female research participant said, "*I don't want to go to any social gathering for anyone to tell me nonsense. The way my husband is behaving I don't want to believe he has not spread me around. I just want to keep my cool and think about myself*". It can be seen from the data that the participants themselves do not want to associate themselves for fear of stigmatisation and discrimination which could lead to internalized stigmatisation. This is in line with the assertion that fears of HIV and AIDS related stigmatisation and discrimination may cause individuals to isolate themselves to the extent that they no longer feel part of civil society and are unable to gain access to the services and support they need (Daniel & Parker, 1993).

Another area that saw stigmatisation and discrimination is traditional healers. The study revealed thatpeople living with HIV and AIDS are desperate and accept anything purported to have powers to heal them; especially within the early stages of knowing their status. It can be seen that due to this, herbalists deceive unsuspecting public that are infected and affected by the virus. This is directly incongruence with the misconception that herbalists are at the grass-roots level with sufferers and can provide psychological support (Campbell, 2005).

3.2. Research Questions 2: How People Living with HIV and AIDS Feel About the Stigmatisation and Discrimination against Them

The interview gathered revealed several ways that people living with HIV and AIDS feel. People living with HIV and AIDS in this study feel rejected at work, home, school, and in the health care centers. They felt shameful, guilty, hopeless and useless. This led to withdrawal, depression, and concealing and failure to disclose HIV status.

The study revealed that some of the participants went through psychological experiences. Female participant 1(F1) revealed her feelings when giving personal experiences. In her own words she said:

My once loving and caring husband, whom I trusted and confided, has disappointed me. Initially, I had wanted to pack out of my matrimonial home but the nursing officer had advised me against that as 'every marriage is full of ups and downs'. Pastors and church elders had advised me against that even though I have not told them the reason for my husband's behavior. I am feeling ashamed of myself and do not want to go to social gatherings since I am afraid my husband may broadcast my status to people.

This response seems to suggest that once it is confirmed that an individual has HIV and AIDS virus the fellow naturally feels self-guilt. It also suggests that victims begin to change their ways of life and begin to live life styles that will safeguard what they think will not expose them for fear of stigmatisation. This means that people living with HIV and AIDS feel guilty of themselves and stigmatise themselves even before others stigmatise against them. This is in line with Miller and Kaiser's assertion that the stigmatised individual changes the way he or she thinks about stigmatisation and discrimination and those who stigmatise, (Miller & Kaiser, 2001). Black and Miles (2002) also reported thatHIV-related stigmatisation and discrimination can also be felt indirectly when people living with HIV and AIDS hear others talk negatively about HIV.

Also, the responses of some participants indicate that the family which is the first point of support one can call has rejected them. They therefore rely on God solely for healing through prayers. This confirms the fact that infected individuals often experience stigmatisation and discrimination in the home, (Bharat &Aggleton, 1999). However, this is directly opposite what Warwick (1998; 1999), Aggleton and World Bank report (1997) reported that the family is the

main source of care and support for PLHA in most developing countries.Another contrast here is that lovers or couples were more likely to become angry and withdraw after disclosure than family members. (Stempel, 1995).

From the data it appears some participants wished their condition remained a secret. It can be seen from the data that the major barriers of HIV-positive status disclosure among people living with HIV and AIDS are: fear of rejection/discrimination/stigmatisation, fear of accusation of unfaithfulness by partners, fear of withdrawal of support, fear of abandonment, fear of upsetting family members, fear of lack of confidentiality, denial, difficulty in initiating the process of disclosure, fear of suspicion by partner(s) of infecting him/her, and shame/disgrace. This confirms what Goffman (1963) said, that in some cases, disclosure is not a choice and people living with HIV and AIDS are not in a position to reveal their status. Some narrations from the participants agrees with what Ohene-Sakyi*et al.* (2010) said that, many of the people living with HIV and AIDS, are either sacked from their jobs or have their job description changed by their employers and superiors after their status has been known.

It emerged from the data that some participants felt like committing suicide because they have nothing doing than continuously thinking about their situation. This confirms what research has demonstrated that unemployed individuals generally report more depression, anxiety, social isolation, and low self-esteem than employed individuals (WHO, 2000). Kelly Raphael, Judd, Perdices, Kernutt, and Burnett, (1998) also found that because of stigmatisation and discrimination unemployment was one of the several factors associated with suicidal ideation in HIV-positive patients corroborating the unemployed and suicidal thoughts.

3.3. Research Questions 3: Coping Strategies People Living with HIV and AIDS Employto Cope with the Stigmatisationand Discrimination

People living with HIV and AIDS can attempt to mitigate the negative psychological and social impact of HIV-related stigmatisation and discrimination by employing coping strategies that will help them cope withstigmatisation and discrimination. In transcribing and coding the collated data, other sub-themes that emerged strongly in addressing the coping strategies people living with HIV and AIDS adopt are engagement coping; disengagement coping; selective disclosure; counselling, care and support by counsellors; finding support with Non-Governmental Organisations and going public.

Engagement copingis geared to either increase primary or secondary control over stressful circumstances which the victims go through. An individual that engages in problem solving to gain primary control over stigmatisation and discrimination would likely seek to change the perceptions held by stigmatising individuals through, for instance, social skillfulness or by displaying stereotype disconfirming behaviors (Miller & Kaiser, 2001).

All the participants said through the counselling they receive at the voluntary counselling and testing centre, they were now aware that not only irresponsible, promiscuous or heterosexual people contracted HIV. In fact, they said they were aware that even though sex forms about 85% of HIV transmission, the 15% was through other modes like using unsterilised syringes and unscreened blood and its products. This was a consolation for them not to feel down hearted about the stigmatisation and lose hope. Anytime someone asked them about their infection they would mention other modes of transmission due to the stigmatisation. To them, getting infected through sexual contact meant that they were promiscuous.

Some people living with HIV and AIDS use control copingstrategies by using distraction - that is by focusing on others rather than on their own negative experiences, whilst others sought comfort in their faith.Inference from the data suggests that people living with HIV and AIDS adopt secondary control coping strategies to deal with their situation. The various views of the participants point to the fact that people living with HIV and AIDS resort to various emotion-focused coping strategies that can regulate negative emotions and help cope with their situation. This means that people living with HIV and AIDS find various places to seek support to help them live if not normal life, improved life by constantly attached or feeling to be in constant touch with people or places of worship. This claim is in line with the fact that, Christian people living with HIV and AIDS engage in prayers to help them overcome their 'storm' when there is stigmatisation and discrimination against them (Abudu, 2007).

Disengagement copingis by using avoidance. That is by disengaging from people who stigmatised them and that people living with HIV and AIDS purposely avoid situations in which they expected stigmatising reactions to their HIV status to occur. Upon a careful analysis of the data, it emerged that some participants disengage from the situation to cope with the stigmatisation and discrimination. This means that people living with HIV and AIDS feel better when they are left alone. Due to stigmatisation, they will always want to be in isolation and be left alone exhibiting voluntary avoidance. This justifies the assertion that voluntary avoidance is very common among people living with HIV and AIDS (Abudu, 2007). This does not agree with Miller and Kaiser (2001), when they said engagement coping increases control over stressful circumstances.

Some participants also use selective disclosure to cope with the stigmatisation and discrimination. This means that there are many other people living with HIV and AIDS who have refused to disclose their status due to stigmatisation and discrimination. It can be seen that people living with HIV and AIDS do not trust anyone any longer, even religious leaders. This finding confirms with Makinwa and O'Grady, (2010) where they posit that promiscuity is common even amongst church leadership and that church going people were as sexually active and as engaged in risky sexual behavior as non-churchgoing youth, hence people living with HIV and AIDS are circumspect in whom they disclose their status to.

Counselling, care and support strategy by counsellors includes interventions towards empowerment aimed at the infected or affected individual or group. These interventions reduced stress and anxiety and increased disclosure of

one's positive status and improved community attitudes. All the participants benefitted in counselling, care and support from counsellors to cope with the stigmatisation and discrimination.

The counselling services provided at the health facility has helped some people living with HIV and AIDS to cope positively with the stigmatisation and discrimination. The data revealed that counsellors give care and support to people living with HIV and AIDS. This suggests that counselling plays a major role in the bid to reduce the effects of stigmatisation and discrimination. Literature shares this view indicating thatcounselling, care and support strategy used by counsellors help people living with HIV and AIDS cope with stigmatisation, (Abudu, 2007).

It emerged from the data that the people living with HIV and AIDS also find support from Non-Governmental Organisations. Some people living with HIV and AIDS are stigmatised and discriminated against and hence they are unemployed. They are favoured by some NGOs who support them to survive. This confirms what Abudu (2007) indicated that support from civil society groups and NGOs for people living with HIV and AIDS help them tremendously in decreasing or minimizing stigmatisation and discrimination.

Another coping strategy used by the people living with HIV and AIDS is that some of them decide to go public with regards to creating awareness or educating the general public. Analysis from the data suggests that some people living with HIV and AIDS become fed up in the course of the stigmatisation and discrimination and decide not to care about whatever is said about them. They therefore agree with NGOs combating HIV and AIDS and are used as 'living testimonies. people living with HIV and AIDS have often been in the forefront of advocacy efforts, and that voice has been enormously helpful in ensuring that resources are available and that programs are appropriate and useful", (Naidoo, 2009). This is however in contrast with the assertion that stigmatised persons seek to actively lessen the stress of stigmatisation by either changing the situation and denying or avoiding association with others. It is clear that the very disclosure that can generate social support can also yield stigmatisation, (Miller & Kaiser, 2001).

The focus of this study was to explore the stigmatisation and discrimination against people living with HIV and AIDS in AgonaSwedru and coping strategies. According to the data, it appears that there are varied ways by which the people living with HIV and AIDS perceive themselves. That is to say they sometimes regard themselves as social outcasts, alienated, and promiscuous, and this is largely attributed to some psychological and emotional feelings. The data reveals that even though some laws associated with human rights are there on paper, they really do not work as purported to be working. The data also revealed that people living with HIV and AIDS prefer to conceal their status instead of making it known for fear of stigmatisation and discrimination. The next chapter focuses on the key findings of the study, conclusions, recommendations and suggestions for further research.

4. Recommendations and Conclusions

The following conclusions were drawn grounding on the findings. The research recommends thatpeople living with HIV and AIDS engage in community mobilisation to reduce stigmatisation and discrimination against them. A community mobilisation is when a group of people become aware of a shared or common concern or need and decide to come together to take action in order to create shared benefit. people living with HIV and AIDS should be engaged in Information, Education and Communication (IEC) and this can improve their lives. Advocacy can be encouraged since it has a role to play in every intervention that needs to change attitudes, behaviour and perceptions of people. The study also recommends that HIV programs should be organised to address multiple aspects of HIV and AIDS stigmatisation including personal, cultural, institutional and structural factors.

Despite the stigma and discrimination, some people living with HIV and AIDS have found a way of coping with their condition. In all these, the Ghana AIDS Commission which has been setup to deal exclusively with HIV and AIDS issues should provide support to organisations and health personnel to provide counselling services to people living with HIV and AIDS.

5. References

i. Abudu, F. G. (2007). Stigma and discrimination against People Living with HIV/AIDS: A case study of some districts in the BrongAhafo region. Master's Thesis. (Unpublished).

ii. Adentwi, I. K. and Amartei, M. A. (2012). A Practical Approach to doing Educational Research, Kumasi: Ebens Printing Press

iii. Attipoe, D., (2008). Literature review; Looking at Ghana in view of AIDS epicenters elsewhere. The Gully Online Magazine. Retrieved from http://www.thegully.com/essays/gaymundo/040623_gay_life_ghana.html on 24/03/2020).

iv. Ayranci, U., (2005). AIDS knowledge and attitudes in a Turkish population: An epidemiological study. Beijing. BMC Public Health, 5, 95-103.

v. Bharat, S., &Aggleton, P., (1999). Facing the challenge: Household responses to AIDS in India. AIDS Care. Bangalore: Danita production.

vi. Black, B. P., & Miles, M. S., (2002). Calculating the risks and benefits of disclosure in African-American women who have HIV. Journal of Obsteric, Gynecologic & Neonatal Nursing. Harvard: Harvard Press, 31(6), 688-697.

vii. Campbell, A. (2005). Understanding HIV/AIDS Stigma; a theoretical and methodological analysis. Cape Town: Human and Rousseau.

viii. Chijioke, U.; Preko, P.; Baidoo, J; Bayard, B.; Ehiri, E.; Jolly, C.; Jolly, P., (2005). HIV/AIDS-related Stigma in Kumasi (Ghana). Kumasi: Adom Publication.

ix. Country factsheets: Vietnam 2017 HIV and AIDS estimates [http://www. unaids.org/en/regionscountries/countries/vietnam].

x. Creswell, J. W. (2012). Education research. Berkeley: Carisle Communications Limited.

xi. Daniel, H., & Parker, R., (1993). Sexuality, Politics and AIDS in Brazil. London: Falmer Press.

xii. Ghana AIDS Commission, (2014). National HIV/AIDS Strategic Plan 2011-2015; Towards Achieving Universal Access to Comprehensive HIV Services. Accra: Assembly Press.

xiii. Goffman, E. (1963). Stigma: Notes on the management of spoiled identity. Harmondsworth: Penguin publication.

xiv. Guzmán M. D. (2014). From Middle Class Guatemalan to U.S. Gay Latino Activist: Roland Palencia and Queer Oral History. MA thesis, California State University, Northridge. Retrieved June 5, 2020 from http://scholarworks.csun.edu/bitstream/handle/10211.3/122147/Guzman-David-thesis - 2014.pdf?sequence=9.

xv. Herek, G. M. (1998). Confronting AIDS; Public priorities in a global epidemic. London: Oxford University Press Inc.

xvi. Hintz, M., (1997). Living in the tropics. A cultural Geography. Franklin Watts, New York. Influencing Factors, 2008. The Gully online magazine. Available from:<http://www.thegully.com/esseays/gaymundo/0403_gaymen_hiv_ghana/msm_ghana_findings.html (accessed 24/02/19).

xvii. Katz, S. &Nevid, J. S. (2005). Risk factors associated with posttraumatic stress disorder symptomatology in HIV –infected women: AIDS patients care and STDs. 19, 110-120. New York: University Press.

xviii. Kelly et al (1998). Suicide ideation, suicide attempts and HIV infection. Psychosomatics, 39, 405-15.

xix. Makinwa, M., & O'Grady, J., (2010). Working with the church, Rutgers: Rutgers University Press.

xx. Meiberg, Bos, Onya, &Schaalma (2008).Fear of stigmatization as barrier to voluntary HIV counselling and testing in South Africa. East African Journal of Public Health (V5) 2. Retrieved from http://www.bioline.org.br/pdf?lp08011/2019.

xxi. Miller, C. T. & Kaiser, C. R. (2001). A theoretical Perspective on coping with stigma. Journal of social issues. 57(1), 73-92.

xxii. Mills, J. E., (2003). Shrouded in secrecy: breaking the news of HIV infection to Ghanaian women. Journal of Tran cultural Nursing. 14, 6-16.

xxiii. Naidoo, S., (2009). The sense of coherence and coping resources of adult family caregivers of HIV/AIDS patients in the Kwazakhele area of Port Elizabeth. Master's Thesis. Nebraska Symposium on Motivation, vol.15, pp.192238, Lincoln, University ofNebraska Press.

xxiv. Oheneba-Sakyi, Y., Adoo-Adeku, K., Tagoe, M., Aggor, R. A., Benneh, C., Anibra, N., &Obeng, S., (2010). Reducing HIV Stigma through Education. Institute of Continuing and Distance Education, Legon: ICDE Press. April, 2010.

xxv. Panos., (1990). The 3rd Epidemic: Repercussions of the fear of AIDs. London: Panos institute.

xxvi. Pilot, D. F., &Hungler, B. (2006). Nursing research (5th Ed.). Philadelphia: JB Lippincott Company.

xxvii. Stempel, R.R., Moulton, J.M. and A. Moss (1995). Self-disclosure of HIV-1 antibody test results: the San Francisco General Hospital Cohort. AIDS Education and Prevention, 1995; 7:116-23.

xxviii. Than et al. (2019). Stigma against patients with HIV/AIDS in the rapid expansion of antiretroviral treatment in large drug injection-driven HIV epidemics of Vietnam.Harm Reduction Journal 16:6

xxix. UNAIDS Ghana (2010). A report submitted by the united nations programme on HIV/AIDS (UNAIDS) to the office of the Human Rights Council on the universal periodic review.

xxx. UNAIDS, (2015). On the fast-track to end AIDS by 2030: focus on location and population.

xxxi. UNAIDS, (2017). Reducing HIV stigma and discrimination: A critical part of national AIDS programmes. Geneva: Joint United Nations Programme on HIV/AIDS.

xxxii. WHO., (2004)? World AIDS day Advocacy kit. www.who.org.2002, 2004

xxxiii. World Bank. (1997). Confronting AIDS: Public Priorities in a Global Epidemic. New York: Oxford University Press.