UNIVERSITY OF EDUCATION, WINNEBA

HUMAN RIGHTS ABUSE OF PEOPLE LIVING WITH HIV/AIDS IN THE TEMA METROPOLIS OF THE GREATER ACCRA REGION OF GHANA

SAMUEL ROBERTS AHORKLUI

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A THESIS IN THE DEPARTMENT OF SOCIAL STUDIES EDUCATION,
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DECLARATION

Student's Declaration

I, Samuel Roberts Ahorklui, hereby declare that this thesis, with the exception of quotations and references contained in published works which have all been identified and duly acknowledged, is entirely my own original work, and it has not been submitted, either in part or whole, for another degree elsewhere.

SIGNATURE ……………………………………………

DATE …………………………...........................

Supervisor's Declaration

I hereby declare that the preparation and presentation of this thesis were done in accordance with the guidelines for supervision of thesis as laid down by the University of Education, Winneba.

NAME OF SUPERVISOR: DR.. G. Y. DAKE

SIGNATURE: …………………………………………..

DATE: …………………………..…………..

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DEDICATION

To my family, especially my mother, Anna Kuma Kludze, my aunties Gladys Afi Adzimah and Agnes Adjovi Ahadji for their loving heart, kindness, tolerance and everlasting support throughout my studies.

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GLOSSARY

AIDS	-	Acquired Immuno - Deficiency Syndrome
CDD-Ghana	-	Center for Democratic Development
CHRAJ	-	Commission for Human Rights and Administrative Justice
CSOs	-	Civil Society Organisations
FHI360	-	Family Health International
FIDA	-	International Federation of Women Lawyers
GAC	-	Ghana Aids Commission
GHANET	-	Ghana HIV And AIDS Network
HCW	-	Health Care Workers
HIV	-	Human Immuno Deficiency Virus
HRAC	-	Human Rights Advocacy Center
KAPs	-	Key Affected Populations
KPs	-	Key Persons
LHRC	-	Legal and Human Rights Centre
MARPS	-	Most at Risk Populations
MDG	-	Millennium Development Goals
NAP+ Ghana	-	Network Of Persons Living With HIV, Ghana
NGO	-	Non-Governmental Organization
PEPFAR	-	Partnering to Achieve Epidemic Control in Ghana
PLWHA	-	People Living With HIV/AIDS
PLWHIV	-	People Living With HIV
S&D	-	Stigma and Discrimination
SHARPER	-	Strengthening HIV/AIDS Response Partnership
SWAA-Ghana	-	Society for Women and AIDS in Africa
UNAIDS	-	The Joint United Nations Programme on HIV/AIDS
WAPCAS	-	West Africa Project to Combat Aids And Stigma
WHO	-	World Health Organization
WTO	-	World Trade Organization

ABSTRACT

Since the beginning of the HIV/AIDS epidemic, the epidemic of stigma, discrimination and denial have been recognised to fuel the transmission of the disease and have greatly increased the negative impact associated with it. HIV-related stigma, discrimination and denial according to the WHO Global Programme on AIDS continue to be manifest in every country over the world, creating major barriers to preventing further infection, alleviating impact and providing adequate care, support and treatment. It has resultantly silenced open discussion, both of its causes and of appropriate responses. Meanwhile, visibility and openness about AIDS are prerequisites for the successful mobilization of government, communities and individuals to respond to the epidemic. The stigma, discrimination and denial associated with the disease are ostensible violations of the human rights which affect the well-being of people living with HIV/AIDS (PLWHA) in fundamental ways. The present study, therefore, sought to examine how the human rights of PLWHA were abused. Interviews were held with ten (10) participants in the Tema Municipality of the Greater-Accra Region of Ghana, and thematic content analysis of the qualitative or interview data confirmed clear cases of abuses of human rights of victims. The abuses were in the form of discrimination, stigma, rejection and violation of privacy. For instance, their rights to privacy were violated by health professionals, family members, friends and other close confidants who disclose their status without their consent. Some indicated having been laid off or denied employment as a result of their serostatus, violently ejected from residence by house owners (Landlords) and insulted and shamed in public. Worse of all was the finding that access and distribution of the anti-retroviral drugs were delayed over months and victims had to buy them over-the-counter sometimes. Also, the drugs were also suspected to be faked and all these caused fear and panic among the victims. Indeed, these abuses are against the fundamental principles and practices of human rights enshrined in the economic and social rights of the 1992 constitution of Ghana. It is recommended that more intensive public awareness on the HIV/AIDS epidemic be embarked upon.

CHAPTER ONE

INTRODUCTION

1.1 Background to the study

The past three decades have seen HIV infection as undoubtedly the disease that has captured more political and scientific mobilization than any other disease. The latest data from the World Health Organization reveal that over 40 million people live with HIV virus worldwide with almost 90% of the infected living in developing countries (WHO, 2009). Despite medical advances and widespread availability of medication, HIV/AIDS remains a significant public health issue. In Ghana, lack of understanding of the illness, misconceptions about how HIV is transmitted, lack of access to treatment, irresponsible media reporting on the epidemic, the incurability of AIDS are challenges to an effective prevention programmes. Negative or discriminatory attitudes towards those infected by HIV/AIDS are pervasive throughout the world and constitute a major element in the spread of the epidemics.

In 1987, the late Jonathan Mann, then director of the WHO Global Programme on AIDS, identified three phases of the HIV/AIDS epidemic: the epidemic of HIV, the epidemic of AIDS, and the epidemic of stigma, discrimination, and denial. He noted that the third phase is “as central to the global AIDS challenge as the disease itself” (Mann, 1987). Despite international efforts to tackle HIV/AIDS since then, stigma and discrimination (S&D) remain among the most poorly understood aspects of the epidemic. Peter Piot, Executive Director of UNAIDS, identified stigma as a “continuing challenge” that prevents concerted action at community, national, and global levels (Piot, 2000).

Stigma is associated with conditions or diseases that have harmful and incurable outcomes, particularly when the means of transmission are perceived to be under the control of individual behaviour. Stigma is also common in diseases that are perceived to be the result from the transgression of the social norms (Gilmore & Somerville, 1994 cited in Perrin, 2010). HIV/AIDS can lead to various forms of discrimination and ill-treatment that can negatively affect the well-being of infected patients. Many human rights activists have raised growing concerns about stigmatization and discrimination in HIV/AIDS infected populations. Amnesty International (2006) outlined in a special report that people living with HIV/AIDS have to deal not only with the disease itself, but also with society's response which is often characterized by fear and discrimination.

In most parts of the world, people living with HIV are stigmatised and go through some form of discrimination in one way or another. For instance, in South Africa a large number of incidences of this nature happen. A case in point is that of Lorna Mlofane of South Africa, who was raped and later murdered after her three rapists had learned that she was HIV positive (Huisman, 2004). There are many of such instances across the continent of Africa such as Ghana, Tanzania etc. where HIV/AIDS victims are dehumanised.

Nowell and Van der in 2003 described stigma as irrational responses directed towards people living with HIV/AIDS. Some of these responses include being shunned by family members, being discriminated against in work places, medical treatment at hospitals, and funerals. In recent times HIV/AIDS related stigma has been more specifically conceptualised and defined as a real or perceived negative response to a person or persons by individuals, communities or societies. It is characterised by rejection, denial, prejudice, discounting, discrediting and discrimination (Herek, 1999).

There is a general consensus that HIV/AIDS is a public health concern. Victims need our support in any form; be it physical, psychological or legal. The apparent widespread discrimination, stigma, and rejection of people living with HIV/AIDS (PLWHA) is fuelling the spread of the disease (UNAIDS, 2004). It is against this background that, the UNAIDS advocates for a human rights-based approach to the epidemic. Knowledge and behaviour affect an individual's risk of acquiring HIV infection. HIV transmission is dependent on a number of behavioural and physical factors which include the number and nature of unprotected sex acts, and the number of sexual partners. Individuals who have multiple partners concurrently or sequentially have a higher risk of HIV transmission than individuals who have fewer links to a wider sexual network.

UNAIDS (2003) theorises that HIV/AIDS related stigma is a process of devaluation which in-turn leads to the violation of human rights for people living with the disease. Even though there are normative laws and policies that protect the human rights of all Ghanaians, the human rights of key affected populations (KAPs) and PLWHIV are often violated or abused by others. Many CSOs have been spearheading the fight to protect the human rights of KAPs and PLWHIV including their right to access HIV and AIDS services: these include NAP+ Ghana, GHANET, SWAA-Ghana, FIDA, WAPCAS, HRAC, FHI360, CDD-Ghana, Maritime Life Precious Foundation, and Action Aid Ghana. To reduce stigma and discrimination, some implementing partners, including CDD-Ghana, HRAC, and the SHARPER project with funding support from PEPFAR and the UN system have jointly and severally built the capacity of CHRAJ, the criminal justice system, and the police among many others to better understand HIV- related stigma and discrimination in the hope that PLWHIV and KAPs whose human and legal rights are abused or violated can have access to justice. GAC, CDD-Ghana, and other stakeholders have held sensitization and advocacy meetings and interactions with senior government officials and parliamentarians on key HIV and AIDS issues, including the need for HIV-specific legislation (GSS & ORC Macro, 2014).

Stigmatization of people living with HIV remains a global challenge both in the church and the secular world. Anecdotal evidence suggests that in the church some of the clergy and some church members have continued to reject and isolate people living with HIV AIDS. This has led many PLWHA and their families to suffer emotional pain. This study, therefore seeks to examine the human rights abuses of PLWHA and how it could be mitigated if not eliminated completely in consonance with the millennium development goals.

1.2 Statement of the problem

There is the problem of stigmatization and discrimination against people living with HIV/AIDS in the Tema Metropolis of the Greater Accra region of Ghana. In recent times, government, NGOs and other stakeholders have put in place a number of measures to minimize the stigmatization against people living with HIV/AIDS. Some of the measures are making available HIV/AIDS services to victims, building capacity of the Ghana AIDS Commission, CHRAJ, the police and the judiciary to be able to give justice and protection to victims and to uphold their rights. Additionally, sensitization and advocacy workshops have been held with key government officials towards specific HIV legislation.

Despite these measures, HIV/AIDS patients are shunned, dehumanised and discriminated against in the area of study. Their rights have been violated, abused and trampled upon in various ways. Specifically, stigmatization remains the greatest threat to disclosure which is likely to affect the attainment of MDG 6A and B which is to combat the spread of HIV/AIDS.

This is because such HIV victims face divorce, physical violence, rejection and accusation of infidelity. Indeed, the result of such discrimination and isolation has the potential of further spreading the disease because victims are not willing to disclose to others their status for fear of being stigmatized. This study, therefore, aims at identifying the extent and form of human rights abuses of the victims in the study area in the form of discrimination, denials and abuse.

1.3 Objectives of the study

This study is purposed to examine the human rights abuses of people living with HIV/AIDS. It will also attempt to show the form these abuses take, context, and types of HIV/AIDS related abuses.

Specifically the study seeks to:

a. identify the extent of human rights abuses of PLWHA.
b. determine the form of HIV/AIDS related abuses take.
c. examine the group of people who mostly abuse PLWHA.

1.4 Research questions

a. To what extent are the rights of PLWHA abused.
b. What forms do human rights abuses of PLWHA take?

c. Who are the main abusers of the rights of PLWHA?

1.5 Significance of the study

In Ghana, empirical research on HIV/AIDS stigmatization and abuses are limited leading to limited disclosure. Socio-cultural factors influence the presence of high risk populations in certain geographical areas and this is particularly true for populations found along the main transport corridors. This study focused on the behavioural aspects of PLWHA in Tema. The findings of this study will provide evidence to guide HIV interventions for PLWHA in Ghana. Thus, this study is significant for two reasons:

a. It will create awareness, especially in communities where there is much abuse of human rights of victims of HIV/AIDS.

b. It will benefit major stakeholders such as Ghana Aids Commission, Local NGO's and International NGO's to enhance their policy formulations towards PLWHA and other related abuses.

1.6 Delimitations of the study

Due to time and cost constraints, data collection was restricted to PLWHIV in the Tema Metropolis. If more of the respondents were covered, advanced statistical inferences could have offered more robust outcomes. Therefore, the conclusions made were based on the findings of the in-depth interviews made with 10 PLWHA who lived and work in the selected area. As a result, there could be problems generalizing the findings to all PLWHA in general. Diligence was however taken while selecting respondents to make sure that it covered range of experiences of the study population as much as possible, but there is no claim that this sample is statistically representative.

1.7 Operational definitions of terms

Human rights

Basic entitlement due to human persons or basic standards that relate to the dignity of a human being usually recognised by law in a state, including politics, economic, cultural, children's, women's individual and group rights. Some of the rights which are guaranteed PLWHA by the constitution of Ghana and other human rights instruments are:

Right to proper medical care

The 1948 Universal Declaration of Human Rights also mentioned health as part of the right to an adequate standard of living (Art. 25). The right to health was again recognized as a human right in the 1966 International Covenant on Economic, Social and Cultural Rights. Article 12 of the ICESCR explicitly sets out a right to health and defines the steps that states should take to "realize progressively".

Right to live or associate with anyone.

The Ghanaian constitution in Article 21 (1) stated clearly that all persons shall have the rights to; (d) freedom of assembly including freedom to take part in processions and demonstrations; (e) freedom of association, which shall include freedom to form or join trade unions or other associations, national and international, for the protection of their interests.

Article 22 of The United Nations International Covenant on Civil and Political Rights which Ghana is a signatory to also stated that everyone shall have the right to freedom of association with others, including the right to form and join trade unions for the protection of his interests.

Right to marry and make a family

Article 16 of the United Nations Declaration of Human Rights stated that men and women of full age, without any limitation due to race, nationality or religion, have the right to marry and to found a family. They are entitled to equal rights as to marriage, during marriage and at its dissolution.

Right to employment

Article 23 of the UDHR guarantees everyone "the right to work, to free employment, to just and favourable conditions of work and to protection against unemployment." The ICESCR provides in article 6(1) for the "right to work, which includes the right of everyone to the opportunity to gain his living by work." It also says, in article 6(2) that "the full realization of this right shall include technical and vocational guidance and training programmes." Under article 1(2) of ILO Convention No. 122 each member shall ensure that "there is work for all who are available for and seeking work." It is therefore unacceptable to deny people living with HIV/AIDS the right to work.

Right to legal redress if abused

United Nations General Assembly resolution 60/147 of 16 December 2005 (VII) 11. stated clearly that violations of international human rights law and serious violations of international humanitarian law include the victim's right to the following as provided for under international law: Equal and effective access to justice; Adequate, effective and prompt reparation for harm suffered; Access to relevant information concerning violations and reparation mechanisms.

Right to have sex

The right to have sex or sexuality and freedom from discrimination is based on the universality of human rights and the inalienable nature of rights belonging to every person by virtue of being human. No right to sexuality exists explicitly in international human rights law; rather, it is found in a number of international human rights instruments including the Universal Declaration of Human Rights, the International Covenant on Civil and Political Rights and the International Covenant on Economic, Social and Cultural Rights.

Human rights abuse

Denial and /or disrespect for one’s rights whether political, economic, or cultural or environment.

Stigmatization

Any attribute that is deeply discrediting and results in the reduction of a person or group "from a whole and usual person to a tainted, discounted one" (Goffman, 1963).

Discrimination

A negative thought which leads people or institution take, or omits to take, action that treats a person unfairly and unjustly on the basis of their presumed or actual HIV/AIDS status.

1.8 Organization of study

This thesis was made up of five (5) chapters. Chapter one provided an introduction which covered the background to the study; problem statement, research questions, objectives of the study; significance of the study, limitations and delimitations of the study and lastly, the chapter disposition of the study. Chapter two was a review of related literature of the empirical and theoretical perspectives. This chapter puts the research into an academic context by reviewing some of the main contributions made by other renowned scholars on the variables in connection with HIV/AIDS and Human Rights. The chapter began with the theoretical basis of how attitudes are formed and changed with regards to PLWHA. To put this in perspective of Ghana, the history of the HIV/AIDS epidemic in Ghana and the current situation were vividly analysed. Stigma and HIV status disclosure challenges, perceived consequences of disclosure, socio-cultural beliefs about disclosure and finally the legal perspectives on HIV/AIDS were considered in the review of the literature. The third chapter contained and in-depth description of the methods of investigation of the issue. It consisted of the research design, study population, sampling techniques and procedures, sources of data, instrumentation, ethical principles and method of data analysis. Chapter four presented the research findings and discussions. Chapter five presented the summary, conclusions and recommendations.

CHAPTER TWO

LITERATURE REVIEW

2.1 Introduction

This chapter reviews the related literature on the subject matter of the study. It first focuses on the theoretical framework on which the study hinges. It then traces the trajectory of HIV/AIDS in Ghana, and review of HIV/AIDS stigma related cases. Finally the rights and legal structures that support PLWHA in Ghana and in international realms are explored.

2.2 Theoretical framework

This study hinges on the basis of human bahaviour in social settings under the discipline of Social Psychology; known as attitudes. How much we like or dislike something has much to do with determining our behaviour toward that. We tend to approach, seek out or be associated with things we like. We also avoid, shun or reject things we do not like. Attitudes therefore are simply expressions of how much we like or dislike a thing(s) or project(s). They represent our evaluation of a wide variety of attitudinal objects (Morgan, King, Schillz & Wesz, 1985). According to Sdorow (1995), attitudes are evaluations of ideas (such as insanity defence), events (such as surprise parties). Objects (such as abstract art) or people (such as senior members). Drever (2008) defines attitude as a more or less stable set or disposition of opinion, interest or purpose involving expectance of a certain kind of experience and readiness with an appropriate response.

It is sometimes used in a wider sense but rather less definitely as in aesthetic attitude in the sense of a tendency to appreciate or produce artistic result or social attitude in the sense of being sensitive to social relations, social duties or social opinions. Other psychologists have also described the attitude to mean different things. Among these scholars are Kretch and Cruthfield (2002) who define attitude as an enduring organization of motivational, emotional, perceptual and cognitive process with respect to individual's world. Bartleet (2002) has reduced the phenomena of perception, judgment, memory, learning and thought largely to operations of attitudes. This explanation tends to recognize that the way one perceives, judges, learns is a function of one's attitude. According to Green (1992), attitude as a concept does not refer to any specific act or response but is an abstraction from a large number of related acts or response is sufficient to determine an individual's attitude rather it involves many related responses o acts. Allport (1973) while broadly identifying attitude asserted that an attitude is a mental and neutral state of readiness organized through experience exerting a directive or dynamic influence upon the individual's responses to all objects and situation with which it is related.

Thurston (2000) defines attitude as either the effect for or against a psychological object implying that attitude can refer to effective reaction of an object. Fishbein (2003) sees attitudes as a person's evaluation of an act or behaviour towards specific act and is proposed to be a function of acts, perceived consequences, and their value to that person. The underlining factor here is that attitude towards a particular object or event is influenced by the personal experience of the individual. In summary, an attitude is a learned predisposition to respond consistently in a positive or negative way to any person, object or situation (Petty, Ostrom & Brock, 2001).

In this study, the researcher adopted the aforementioned definitions of the concept of attitude because attitude clearly depicts an individual’s response to stimulus (stigma, social opinion, mental image). Also, the choice of this concept is based on the fact that social psychology explains how the thoughts, feelings and behaviour of individuals are influenced by the actual, imagined or implied presence of others. Baron, Byrne and Johnson (1998) defined social psychology as “the scientific field that seeks to understand the nature and causes of individual behaviour and thought in social situations”. According to Halonen and Davis(2001) social psychological research has been traditionally divided into three general topic areas, based on whether the emphasis is on the internal factors for the individual or broader social processes. Fan et al. (2004) role and cognitive theories that are particularly relevant to the understanding of the human and societal dimensions of HIV/AIDS. In social psychology, stigma is understood as an attitude consisting of emotional, cognitive and behavioural components. Petty (1995) defined an attitude as the general evaluation that people hold of themselves, other people, objects and issues. It is a challenge to change this attitude because it often functions as schemas, or cognitive frameworks that hold and organize information about specific concepts, situations or events (Wyer & Srull, 1994). Petty (1995) mentioned that beliefs, emotions and behaviours can all contribute separately to people’s attitudes. Millar and Tesser (1986) also stressed that attitudes may be based on only one or two of these components.

2.2.1 Theories of attitude formation

Some theories such as the balanced theory, cognitive dissonance theory, congruity theory, learning and cognitive theories have been propounded to explain how attitudes are formed. Thus, many theories have been postulated by numerous scholars, but the learning and cognitive theories of attitude formation were discussed for the purpose of convenience.

According to the learning theory, attitudes are acquired in the same way as other types of behaviour (McGuire, 2005). They emphasize the importance of factors in the formation of attitudes. The learning theories, believes more importantly, that attitudes are acquired in the same ways as facts, concepts, ideologies, habits, and ways of thinking are acquired. We learn facts, we also lean emotions that go with them. It is the pairing of facts with emotions that result in the development of attitudes. This can be done through classical conditioning, operant condition or modelling (observational learning).

Emotional response can be elicited by numerous environmental stimuli. A new stimulus is able to elicit the same emotional responses as the old stimulus if the new stimulus becomes associated with the old one. Thus if an individual experiences unpleasant feelings when he is exposed simultaneously to a loud noise and electric shock, then, the words that are repeatedly will be associated with the noise and the shock will also elicit an unpleased emotional response. Stoats and Crawford (2002), for example, stated that individuals who were subjected to loud noise or electric shock every time they hear the word "large" developed a negative attitude towards the word. Along the same line, Zanna, Kiester and Pilkonis (2000) conducted another experiment using the word "light" and "dark" and obtained similar results. Hence, an attitude may develop indirectly from an emotional association with another attitude. Research indicated that food preferences are, in fact, influenced by classical conditioning (Rozinard, 2005). In operant conditioning, Insko (2005) showed that Hawaii undergraduate University students who were reinforced developed wether positive or negative attitude toward an object. Social learning theories, on the other hand, has shown how observing others, particularly parents, peers and characters on television can change our attitude (Bandura & Walters, 1985).

Linking the theory with attitude towards PLWHA, one could say that negative attitude towards PLWHA could be attributed to the fact that most people pair HIV with promiscuity. Though HIV can be contracted through other means such as blood transfusion, mother to child, etc., it is believed that the commonest means is through unprotected sexual intercourse with an infected person. Borrowing from this theory, pairing of HIV with immoral act (promiscuous) breeds a negative attitude towards those infected with the virus. Also because of these issues surrounding the virus many people hold different attitudes towards the virus.

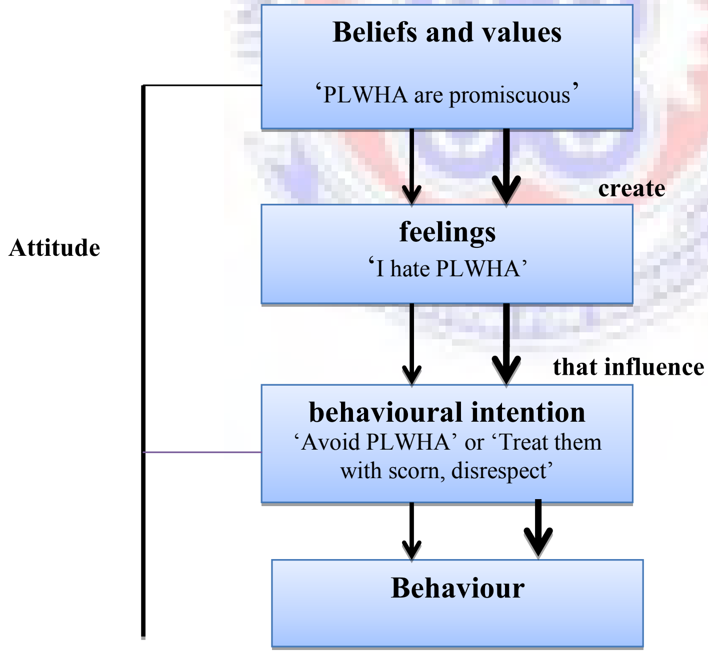
The cognitive theories of attitude believe that we form our attitude based on internal thought and reasoning. According to Daryl Berns (2002), self-perception theory, people do not always know how they think or feel about all issues. As a result they sometimes infer attitudes from observing their own behaviour. The cognitive consistency theory asserts that people have a strong need to feel that their attitudes match and are in harmony with one another.

In line with this statement, most people develop negative attitude towards PLWHA because most people share the same reasoning and perception towards people living with HIV/AIDS. Heider (1958) developed the balanced theory of attitude formation while Festinger (1957) developed the cognitive dissonance theory which states that we feel tension whenever one discovers that he/she has inconsistent thoughts or cognition. The congruity theory is related to Heider's balance theory and it was postulated by Osgood & Tantenbaum (1995). According to these investigators, the principle of congruity governs all human thinking. This principle stated that changes in evaluation or attitude always occur in the direction of increased congruity with the existing frame of reference (Osgood & Tannebann, 1995). In other words, our attitudes change so that the inconsistency is reduced or eliminated and is achieved.

Congruity theory is basically concerned with the ways an individual evaluation of an object affects another person's attitudes. For instance, different people in a society have different attitudes towards certain kinds of behaviour such as rape, armed robbery or murder and HIV/AIDS.

2.2.2 The three-component-attitude model

Attitudes determine the behaviour of persons, and they provide a framework for responding in a particular fashion. The attitudes may be positive or negative. The positive attitudes yield favourable behaviour and the negative attitudes yield unfavourable behaviour. The persons having positive attitudes towards PLWHA may contribute their best to their welfare. On the other hand, values provide a basic foundation for understanding a person's attitude, perception and personality. It contains a judgmental element of right, wrong, good, and bad. The individuals having a high value system may be involved in constructive activities and refrained to the destructive activities. Therefore, in combating abuse of the human rights of PLWHA, we must inculcate a high value system in people. Cognitive components of attitude refers to the opinion or belief part of the attitude. When one form an opinion or judgment on the basis of available information and decides whether to have a favourable or unfavourable opinion on that, it is the cognitive part of attitude. An affective component of attitude refers to the emotional aspect of attitude. This is perhaps the most often referred part of attitude and decides mostly the desirable or undesirable aspect of attitude. A behavioural component of attitude refers to the behavioural part of the attitude. If one has a positive attitude to a particular object, it is likely to be translated into a particular type of behaviour, such as avoiding that object (see Figure 2.1 below).



Source: Murray, Poole and Jones (2006).

Figure 2.1: Components of attitude.

From the Figure above, the cognitive component of an attitude consists of the values or beliefs that an individual has concerning the attitude object. These values and beliefs have an important influence on how people feel about their PLWHA. The affective component refers to the individual's positive or negative feelings concerning the attitude object. The behavioural component of an attitude refers to the intention to behave in a certain way based on specific feelings. It does not necessarily refer to the actual behaviour; it is the predisposition to act in a particular way. The behavioural predisposition is determined to a large extent by the cognitive and the affective components. For example, someone who believes that PLWHA are promiscuous (the cognitive aspect) states that being close with or relating with PLWHA is distasteful to him/her (the emotional component) and consequently, says that he/she is going to avoid them (the behavioural predisposition).

In terms of prejudice and discrimination against PLWHA, Baron and Byrne (2003) defined prejudice as an attitude toward the members of some group, based solely on their membership in that group. Discrimination refers to negative behaviors or actions directed toward members of social groups who are the object of prejudice. Stigma is a real or perceived negative response to a person or persons by individuals, communities or society. It is usually characterized by rejection, denial, discrediting, disregarding, underrating and social distance which often leads to discrimination (Ragimana, 2006)

In the cognitive and emotional point of view, stigma towards PLWHV is shown by anger and negative feelings towards them. There used to be the belief that those with HIV/AIDS deserve to be ignored and ostracized because the disease is incurable. Invariably the stigma to PLWHIV is strongly linked to the fact that it is sexually transmitted and the external debilitating features the patients develop as the disease develops. Many people believe that AIDS is the result of deviant behavior and promiscuity.

The social psychology approach seeks to understand the causes of social behavior and thought of individuals on their actions, feelings, beliefs, memories and inferences with respect to other persons. HIV/AIDS stigma is conceptualized as a psychological attitude or as a facet of public opinion. Herek and Capitanio (1997) states that HIV/AIDS related attitudes have been conceptualized in multiple ways such as affective reactions to people with AIDS, attributions of blame, avoidance of interpersonal contact with PLWHA and support for various public policies related to AIDS. Green (1995) stressed that ignoring the needs of a person infected with the disease can harm or stigmatize them psychologically, physically and emotionally. Failure to address stigma can discourage individuals from seeking voluntary counselling and testing for HIV and proper medical care.

2.2.3 The theory of instrumental functions of attitude

The severity of the HIV epidemic in the early 1980s has contributed to the emergence of stigmatizing attitudes towards the infected individuals. Previous researchers in the HIV sphere have used the theories by Katz (1960) and Smith et al (1956) on functional attitude theories to conceive that the attitudes towards people living with HIV (PLWHIV) reflect one's personal interests. Herek (1986) and Pryor et al. (1989) were among the few who investigated the role of the instrumental functions in the expression of attitudes towards those infected by HIV. Herek (1986) identified two broad functions for attitudes: expressive and evaluative. Expressive functions are primarily played by symbolically based attitudes whereas evaluative functions are primarily played by instrumentally based attitudes. Herek explained that negative reactions toward HIV/AIDS might originate from a fear of transmission of the disease (serving an evaluative function) or might be a reaction to the social meanings of the disease (serving an expressive function). In relation to HIV/ AIDS stigma, attitudes that perform primarily an expressive function are likely to be based on deeply held values regarding the metaphorical social meanings attached to this disease. HIV/AIDS is often used as a symbol of moral decadence (Herek, 1991). It is also often used to symbolize homosexual promiscuity because of the relationship between its transmission and homosexuality (Brandt, 1988; Pryor et al., 1989). In contrast, attitudes underpinning HIV/AIDS stigma that perform an evaluative function arise from a psychological need to protect oneself from HIV/ AIDS, a disease that is potentially fatal.

In the presence of a serious disease like HIV/AIDS, the attitudes of the individuals towards people living with the virus are based fundamentally on the fear to contract the disease. Crandall et al. (1997) provided a comprehensive framework for a better understanding of the attitudes of the people towards those infected by HIV. The authors demonstrated through their study that the HIV-related stigmatization is related to both instrumental and symbolic concerns. According to this model, the apprehension of contracting the disease influences the development of negative attitudes. Connors and Hely (2007) conducted a study in order to define the significant predictors of attitudes towards people living with HIV/AIDS. The results of this study involving 220 young Australian men and women revealed that the fear of contracting HIV (instrumental function) and homophobia (symbolic attitude) greatly contributed to the intolerance towards people living with HIV.

2.3 The history of HIV/AIDS epidemic in Ghana

A report by the International Organization for Migration, Ghana (2012) on HIV morbidity indicated that about 34 million people were living with HIV worldwide and 2.7 million new infections occurred in the sub-Saharan Africa as of end of 2010. It is estimated that 32% of new infections in Ghana are associated with sex work.

Ghana's population stands at 24.6million. The HIV epidemic in Ghana is generalized with a prevalence of more than 1% in the general population . In 2011 the national HIV prevalence was estimated at 1.5%. According to Sueve, Dzokoto et al. (2002) studies have shown that in Ghana there exist some links between HIV and mobility. The HIV epidemic in Ghana may have been accelerated by the migration of women from the Manya Krobo districts in Eastern Region of Ghana to Côte d'Ivoire after the construction of the Akosombo dam in the 1960s. This dam flooded the Volta River Basin and formed Lake Volta (the largest man-made lake in Africa) which led to a population displacement. While in the Ivory Coast, these women may have been infected with HIV through sex work and upon return home, facilitated local transmission of HIV through sex work, which in turn led to a gradual spread of HIV in Ghana.

A 1991 socio behavioural study conducted in Ghana showed that migrants had regular sexual partners as well as casual partners and that international migration was associated with higher number of sexual partners. Anarfi et al. in their 1995 study among female itinerant traders (women who move around trading in goods) in Ghana, found that female traders, because of their difficult working conditions, were vulnerable to sexual exploitation by men with whom they came into contact with while on the road and at trading centres(Anarfi, Appiaha & Awusabo-Asare,1997b).

A study conducted by the United Nations Population Fund (UNFPA) in 2008 among "Kayayei" or porters, indicated that Kayayei could be vulnerable to HIV infection. The studied participants had very low knowledge about HIV in general and none knew their HIV status. 32% were sexually active and 4.4% had experienced forced sex by acquaintances.

The National Population Council (NPC) in 2011 conducted a study on tourism, sexual violence and HIV and AIDS among five communities in Central and Greater Accra regions, and found that 18.2% of all female respondents had had sexual relations with tourists. Among the female respondents who had sex with tourists, only 16.3% and 5% used condoms in the Greater Accra and Central regions respectively. Transport corridors are known to have many hot spots (economic hubs, ports, mining fields, and border towns) where mobile people, female sex workers and resident populations interact and risky sexual practices take place. Long Distance Drivers (LDD), a highly mobile population, are known to have multiple sexual partners, often but not always.

In West Africa, the prevalence of HIV among truck drivers ranges between 3% and 32 %. However, a study in Accra and Tema Metropolitan areas found HIV prevalence among commercial drivers not to be significantly higher than that of all men in Ghana or men in the Greater Accra area. In its 2011 and 2015 strategy, UNAIDS has set forward three strategic visions for a renewed global HIV response: zero new infections, zero AIDS related deaths and zero discriminations. The goal of the vision, zero new infection, is to reduce by half, sexual transmission of HIV including among young people, men who have sex with men and transmission in the context of sex work.

The Ghana National Strategic Plan for Most at Risk Populations (MARPs) 2011 and 2015 has articulated the goal of reaching 80% of all identified MARPs by 2015 with a comprehensive and evidence based package of HIV prevention, protection, treatment, care and support. Vulnerability not only stems from individual knowledge and behaviour but also from a range of environmental factors specific to a place including the relationship dynamic between mobile and sedentary populations, IOM advocates "spaces of vulnerability" approach in HIV programming.

2.4 HIV/AIDS disclosure and related challenges

Studies have found that disclosure to significant others would provide emotional and psychological support to PLWHA whereas disclosure to sexual partners could lead to the partners also undertaking HIV counselling and testing (Mathews, Kuhn, Fransman, Hussey & Dikweni, 1999; Farquhar, Ngacha, Bosire, Nduati, Kreiss & John, 2000). Since disclosure creates the awareness of HIV risk to untested sexual partners, it subsequently leads to greater uptake of HIV counselling and testing. Furthermore, disclosure to sexual partners enables couples to make informed reproductive health choices that may ultimately lower the number of unintended pregnancies among HIV positive couples, and even reduce the risk of HIV transmission from the mother to child (Kebede, Wassie & Yismaw, 2005; Medley, Garcia-Moreno, McGill & Maman, 2004; Anderson & Doyal, 2002). Not only does disclosure motivate people to reduce risky sexual behaviours thereby decreasing the transmission of HIV, but it is also associated with improved access to HIV prevention and treatment programmes and with better treatment outcomes via improving adherence to ART.

Despite the important implications of disclosure of HIV status for the spread of the HIV epidemic and the health of individuals who are HIV positive, HIV infected individuals often have difficulties telling others about their status because of fear of stigma and discrimination,

The disclosure of HIV positive status has potential risks such as blame, divorce, abandonment, physical and emotional abuse, discrimination and stigma, as well as loss of custody of children and property especially for women. In developed countries, HIV status disclosure rates among antenatal care women ranges from 42%-100% compared to 16.7% - 32% for developing countries (Braddock, 2008). However, previous studies by Medley et al. (2004) and Kairania et al. (2010) report that the rates of disclosure in developing countries as ranging from 16.7% to 86%. The disclosure of HIV positive status among HIV discordant couples in Sub-Saharan Africa is generally low. HIV transmission among discordant couples is quite substantial, ranging from 5.0 to 16.7 per 100 person years, which is 5 to 17 times higher than the incidence among HIV concordant negative couples. Thus, they considerably contribute to the HIV epidemic (Kairania et al., 2010). According to Mayfield Arnold, Rice, Flannery and Rotheram-Borus (2008), disclosure is higher among women than men, among Latino and white compared to African-American families, and among younger compared to older HIV-positive adults in the USA. Again, they noted that PLWHA disclose to their sexual partners and family members, yet there is a significant minority who do not disclose.

So for disclosure to happen, it depends on several factors which include age, socio-economic status, level of education, marital status, social relations, knowledge, cultural factors and acquaintance on the importance of HIV disclosure. Research from many different countries in Africa and elsewhere have reported the influence of various factors affecting the magnitude of HIV status disclosure among PLWHA attending CTC. A study in Uganda by Kadowa and Nuwaha (2009) revealed that people who had good interpersonal communication skills and those who are on ART are more likely to disclose their HIV positive status. Furthermore, a study done in Ethiopia shows that disclosure of HIV status to sexual partners is associated with knowing the partner's HIV status, advanced disease stage, low negative self-image, residing in the same house with partner, and discussion about HIV testing prior to seeking services.

The process of disclosing HIV status differs from one person to another. It involves decisions about timing, to whom, how and under what conditions (Makin et al., 2008). Some disclose their status soon after receiving HIV test results, others give the information after a short period of time (months), some take longer to disclose (years) as some do not disclose anything to anyone, fearing the consequences if their status became widely known. Most PLWHA tend to disclose their status to people whom they are closely related, and who they truly trust, mostly family members such as spouses, parents, siblings, children, aunts and uncles.

Comment [BB1]: Use et al. for 6 or more in APA in-text citation

Anglewicz and Chintsanya (2011), note that disclosure of HIV status after voluntary counseling and testing has important implications for the spread of the HIV epidemic and the health of individuals who are HIV positive. They used individual and couples level data for married respondents from an ongoing longitudinal study in rural Malawi and found that disclosure of HIV status is relatively common among rural Malawians, where most have shared their status with a spouse, and many disclose to others in the community. However, there are significant differences in disclosure patterns by HIV status and gender. Factors associated with non-disclosure are also gendered, where women who perceive greater HIV/AIDS stigma and HIV positive are less likely to disclose HIV status to a spouse, and men who are worried about HIV infection from extramarital partners are less likely to disclose their HIV status to a spouse.

However, Lgalla,Yoder, Sigalla and Madihi (2011) were of the opinion that, some PLWHA disclose their status to friends, neighbours, and even members of the public PLWHA tend to share their status with family members due to the social ties they have and the psychosocial support they expect from them. However, this might not always be the case, as some people do not trust their family members as they do trust their friends. Previous study by Bouillon et al. (2007) reports that friends appear to be closest confidants than immediate family members among gay men. He further explains that relatives may be chosen over spouses.

As earlier explained in the definition of disclosure in the context of HIV/AIDS, it may also refer to the fact that such information has been personally transmitted, or by a third party, with or without their consent. In China, a health care provider has the choice to disclose HIV status of the HIV infected person to the person himself/herself or to family members taking into consideration the circumstances surrounding the infected person. Li, Lin, Wu, Lord and Wu (2008) opined that health care providers should honestly inform the patient or his or her family member(s) about the condition of the disease. In this study, 49% of health care providers who responded were of opinion that family members (mainly spouses and children) should be the first to be informed on a patient's HIV status by the provider.

Finally, Greeff et al. (2008) used a qualitative research design to explore the experience of HIV/AIDS stigma of people living with HIV or AIDS and nurses involved in their care in Africa. Focus group discussions were held with respondents. They asked them to relate incidents that they themselves observed, and those that they themselves experienced in the community and in families. Thirty-nine focus groups were conducted in five countries in both urban and rural settings. They came up with themes of disclosure which were experiences before the disclosure, the process of disclosure, and responses during and after disclosure.

Comment [BB2]: Use et al. for 6 or more in APA in-text citation

2.4.1 Perceived consequences of HIV disclosure

There are number of factors which promote HIV status disclosure. HIV counselling promotes disclosure of one's HIV status. Counselling encourages the HIV infected persons to disclose their HIV positive status to others. Counselling can be done during pre-test and post-test counselling sessions or during the routinely clinic visit for care and treatment programmes. According to Kadowa and Nuwaha (2009), clients who received on-going counselling at every clinic visit are more likely to disclose. A study by Antelman et al. (2001) reports that counselling indeed has influence on disclosure.

However, majority of HIV/AIDS infected persons are afraid of disclosing their status to others for many reasons. Fear of stigma and discrimination remains the main reason for non-disclosure among PLWHA. Most HIV infected individuals are scared of widespread information of their HIV status, which might lead to stigma and discrimination, as pointed out by Antelman et al. (2001) who reported that counselling indeed has influence on disclosure. Antelman et al. (2001) further reported that 5 out of 11 respondents did not disclose their HIV status to anyone, fearing of discrimination. It was also revealed that HIV positive status disclosure may expose a woman to stigmatization, discrimination and rejection from relatives, friends and health care providers which may cause social withdrawal, psychological stress and depression (Antelman et al., 2001). However, HIV status disclosure may reduce depression due to the fact that a woman may no longer have to keep her secret status and hence minimize psychological stress.

Comment [BB3]: 6 & more names, but not cited

Many global studies have documented the negative consequences of disclosure which include fear of stigma, discrimination, abandonment, divorce, physical violence, accusation of infidelity, rumour mongering, feelings of shame, fear of loss of economic support, loss of custody of children and property especially for women (Maman & Medley, 2004; Kebede, Wassie & Yismaw, 2005). A study done in China by Li, Lin, Wu, Lord and Wu (2008) also reports that discrimination occurs within the family after HIV status disclosure by the patient to family members.

In the USA, Derlega, Winstead, Greene, Serovich, and Elwood (2002) examined how perceived HIV-related stigma influences disclosure and self-reports of HIV disclosure to a friend, intimate partner and a parent. The research participants were 145 men and women living with HIV. They were asked to recall when they first learned about their HIV diagnosis. Then they indicated how much specific reasons might have influenced disclosing or not disclosing about the HIV diagnosis to a friend, intimate partner and a parent. Findings, based on the total sample, indicated that perceived HIV-related stigma was associated with the endorsement of various reasons against disclosing to a friend and a parent, including concerns about self-blame, fear of rejection, communication difficulties and a desire to protect the other person. Self-disclosure is based on the type of relationship with the potential recipient.

In addition, Parsons, VanOra, Missildine, Purcell and Gómez (2004) examined HIV status disclosure in an ethnically diverse sample of HIV-seropositive injection drug users (IDUs) from New York City and San Francisco. Qualitative interviews were conducted with 158 participants. Analyses revealed a number of negative and positive consequences of disclosing serostatus to sexual partners. Negative consequences included stigma, rejection by sexual partners and others, loss of intimacy, and threats to personal well-being. Positive rewards resulting from disclosure included increased social support and intimacy with partners, reaffirmation of one's sense of self, and the opportunity to share personal experiences and feelings with sexual partners. The role of responsibility in impacting disclosure and nondisclosure revealed varied patterns in terms of how this construct impacts disclosure and resulting behaviors with sexual partners. Some participants used particular strategies, such as getting involved in seroconcordant relationships or minimizing intimacy in relationships, in order to combat potential negative outcomes of disclosure. For others, positive rewards were viewed as important enough to risk negative consequences.

Stigmatization and discrimination against PLWHA have been recognized as one of the hallmarks of the global HIV/AIDS pandemic (Cohen, 2004; USAID, 2005). Stigmatization could lead to delays and failures in seeking treatment by PLWHA and delays in diagnosis of high risk patients. This may contribute towards the continuous spread of the disease within the community, impact on healthcare services in general and derail the curtailment of the global HIV-AIDS pandemic (Roehr, 2012). Discrimination may be described as a form of ‘enacted stigma’ or the negative acts that result from stigma which serve to devalue and reduce the life chances of the stigmatized. Such discriminatory acts against PWLHA could lead to denial of rights to health, education, and employment. This is evidenced by legal cases such as the Nigerian case of *Georgina Ahamefule v. Imperial Medical Centre* (Georgina Ahamefule v. Imperial Medical Centre, 2012. (Suit No. ID/1627/2000). Here, a health care worker (HCW) with suspected AIDs-related opportunistic infection was tested for HIV without informed consent, and without counselling. When she tested positive, she was promptly fired by the employer. She subsequently suffered severe psychological and emotional trauma and miscarriage of pregnancy. The patient claimed "humiliation, stigmatization and discrimination" because of the doctors refusal to offer her appropriate treatment following her miscarriage because of her HIV status. In judgment, Idowu J of the Lagos High Court held that the termination of the HCW's employment was illegal, unlawful, and based on malice and bad faith. The Court also held that the employer's action in subjecting the claimant to HIV testing without informed consent constituted unlawful battery, and that not affording the claimant pre or post-test counselling for HIV testing constituted professional negligence. Finally, denying the claimant medical care on grounds of her HIV-positive status constituted violation of the right to health guaranteed under article 16 of the African Charter on Human and People's Rights (African Union: ACHPR, 2004) and the international covenant on economic, social and cultural rights (United Nations, ICESCR, 1976). Similarly, in the South African case of *Jansen van Vuuren v. Kruger* (1993), the Supreme Court of Appeal held that disclosure of a patient's HIV status without consent constituted a breach of doctor-patient confidentiality (Jansen van Vuuren and another v. Kruger 1993. (4) SA 842 (A)). In this case a doctor diagnosed a patient with HIV and shared this information with other medical colleagues, not involved in the patient's care, while playing a game of golf-a behaviour which may be described as 'gossip'.

It has been averred that stigmatization can be overt and may constitute libel, slander, or defamation of persons who are stigmatized (Omosanya et al., 2013). From the foregoing it is evident that the practice of stigmatization and discrimination of PLWHA by health care workers has been occurring in healthcare practice in Africa and elsewhere since the advent of the HIV/AIDs pandemic. It has also been suggested that reduction of HIV/AIDS-related stigma and discrimination amongst HCW would be helpful not only for PLWHA, but also for healthcare professionals who often show reluctance and delay in accessing healthcare services because of the fear of stigma and discrimination (Feyissa, Abebe, Girman & Woldie, 2012).

Most HIV infected persons have negative attitudes towards disclosure of their status because they fear that the community shall discover their tragic status. Denue et al. (2012) revealed in Nigeria that HIV positive patients fear negative outcomes of disclosure, and rejection due to stigma, discrimination, social withdrawal, and being disgraced by their families. More so the study by Zou et al. (2009) again reported that religious beliefs on HIV help to shape attitudes towards HIV status disclosure. Religious teachings which state that HIV/AIDS is a punishment from God make a person feel guilty, hence less likely to disclose their status for fear of being blamed of unfaithfulness and adultery.

2.4.2 Socio-cultural beliefs on disclosure

Socio-cultural beliefs of varied societies determine the rightful perspective on truthful disclosure. Braddock (2008) revealed that some people in some cultures hold the belief that mere hearing about possible risks of treatment amounted to inviting the mishaps. Such beliefs make people withhold truthful information about their HIV status for fear of inviting harmful effect. Mbonu, Borne and De Vries (2009), on stigma of people with HIV/AIDS in Sub-Saharan Africa, suggested that some societies associate specific signs with HIV/AIDS disease, thus if HIV infected persons do not manifest any signs generally associated with HIV/AIDS such as weight loss, the community does not believe that they have been infected even when they disclose their status. Moreover, some societies associate HIV/AIDS with witchcraft, a tendency which affects the disclosure. A study undertaken in Zimbabwe reveals that traditional healers told people that HIV was not a virus, but a misfortune caused by unhappy spirits (Duffy, 2005). Therefore, the diagnosis of unhappy ancestors or bewitching leads to non-disclosure of the true health status of a person.

Religious belief, being one of the cultural aspects, has important role to play in HIV status disclosure. Religion shapes individual outlooks on living with HIV. It is also used as a coping strategy among PLWHA by providing a sense of peace and hope through prayers and faith in God. A study done among HIV positive pregnant women in Kinshasa(Maman and Cathcart, 2009) reveals that faith in God and or religious leaders does influence women's disclosure and coping strategy. The study by Lugala et al. (2011) also revealed that there are some cultural rules that discourage the disclosure of mischief conduct. However, a study done in Tanzania by Zou, Tamanaka, John , Watt , Ostermann and Thielman (2009) reports that respondent's intentions of disclosing their status to the religious community if they become HIV infected is primarily associated with non-religious factors. This concurs with the findings of another study Denue, Jacks, Bello, Akawu, Hussaini and Adebayo (2012) reports that there was no relationship between HIV status disclosure and religion.

Parker and Aggelton (2003), Ogden and Nyblade (2005) mentioned that much of the rhetoric and literature have cited the complexity of HIV/AIDS stigma and its diversity in different cultural settings as the primary reasons for the limited response to the pervasive phenomenon. To Mahajan, and colleagues (2008), the complexity of the phenomenon has led to difficulties and disagreement about how to define HIV/AIDS stigma and sometimes, to an erroneous conflation of stigma with its related concept of discrimination. The manifestation of HIV/AIDS stigma not only varies by cultural/national setting, but also by whether one is considering intrapersonal versus societal levels of stigma. The variability in manifestations of stigma by setting and level has led to difficulty in measuring the extent of stigma, assessing the impact of stigma on the effectiveness of HIV prevention/treatment programs, and devising interventions to reduce stigma. These four challenges – defining, measuring, assessing impact of, and reducing stigma – among others have hampered local and global efforts to address HIV/AIDS stigma.

2.5 Legal protection of PLWHA against stigma and discrimination

Several legislative provisions claim the right of any individual to equality and prohibit discrimination at the international, the regional and the national levels. The South African Constitutional Court interpreted the right to equality as implying the right not to be discriminated against and as being closely related to the right to human dignity. Human History showed many instances where violation of the fundamental right to equality yielded to dramatic consequences on those who have been denied this right. In general, anti-discrimination provisions list prohibited grounds of discrimination. However, although HIV positive persons experience serious patterns of discrimination, HIV status is not an explicit ground of prohibited discrimination in these provisions.

2.5.1 The international and regional legal instruments prohibiting discrimination on grounds of HIV status

None of the international human rights conventions specifically prohibits unfair discrimination on the basis of HIV status because the problem of HIV/AIDS had not yet arisen at the time they were drafted. However, much could have been done since the epidemic took global proportions. Articles 51 of the *International Covenant on Civil and Political Rights*, 1966, and 68 of the *African Charter on Human and Peoples' Rights*, 1981, give room for amendment. However, no text providing legal protection to the human rights of persons suffering from HIV/AIDS, as vulnerable group on its own, has ever been adopted neither at the international nor at the regional levels. HIV positive persons are simply protected under the general anti-discrimination provisions that might be interpreted to include HIV status as a prohibited ground.

The International Covenant on Civil and Political Rights (ICCPR) prohibits discrimination in articles 2(1) and 26. Neither article mentions HIV status as a prohibited ground but it could be read in the term 'other status'. The Committee on Human Rights established under the ICCPR is also silent about the issue of discrimination on the grounds of HIV/AIDS status.

***International Covenant on Economic and Socio-Cultural Rights* (ICESCR), 1966,** which Ghana has signed and ratified, takes the same stand and refers to the term 'other status'. The ICESCR is not legally binding on South Africa but judges may take inspiration from its provisions when interpreting domestic laws. However, the United Nations (UN) Commission on Human Rights reiterates in its Resolution 2001/517 that discrimination on the basis of HIV or AIDS status, actual or presumed, is prohibited by existing international human rights standards, and that the term 'other status' in non-discrimination provisions in international human rights texts should be interpreted to cover health status, including HIV/AIDS status.

In the absence of international instruments that deal specifically with HIV/AIDS, the ***International Guidelines on HIV/AIDS and Human Rights (International Guidelines)*** are an important indication of the view taken by the United Nations on the rights of people living with HIV/AIDS. The *International guidelines* was adopted in Geneva in September 1997. Guideline 5, in particular, deals with 'anti-discrimination and protective laws' and provides that states should enact or strengthen anti-discrimination and protective laws that protect vulnerable groups, such as people living with HIV/AIDS and people with disabilities from discrimination in both the public and private sector. In the insurance sector in particular, 'exemptions from superannuation and life insurance should only relate to reasonable actuarial data, so that HIV/AIDS is not treated differently from analogous medical conditions.' The *International Guidelines* are internal documents of the UN and therefore concern all Member states of the UN. However, the International Guidelines do not have legally binding force, they are not treaties. Lobbying efforts from international nongovernmental organisations (NGOs) and advocacy on the part of

UNAIDS resulted in the Guidelines being enhanced at the level of international legal standards for the protection of the rights of persons living with HIV/AIDS.

The non-discrimination clause of the *African Charter on Human and Peoples' Rights (ACHPR)* is specifically in article 2. This article is very similar to article 26 of the ICCPR, but it gives more emphasis to the grounds of race, ethnic group and colour because of the history of slavery, and apartheid. Like article 26, article 2 does not mention HIV/AIDS status as a ground on its own, but it is implied in the term 'other status'. The African Commission on Human and Peoples' Rights (the African Commission), which is the main body of the ACHPR, acknowledges the HIV/AIDS pandemic as a threat to human rights and humanity. However, the African Commission refers to the issue of non-discrimination only in connection with the right to health and to access to antiretroviral drugs. Moreover, the African Commission's jurisprudence on issues related to discrimination on the basis of HIV/AIDS status is non-existent. The ACHPR is overdue; amendment in favour of a better protection of the human rights of persons infected and affected by HIV/AIDS should be undertaken. The ACHPR needs to be updated according to the current scourges affecting the continent, among which is the pandemic of HIV/AIDS.

Ghana has no laws that specifically protect PLWHA and KPs from discrimination and address violations of their human and legal rights. However, there are aspects of key normative legal and policy frameworks that protect the general population including PLWHA and KPs against stigma and discrimination. The 1992 Constitution protects all Ghanaians against discrimination and upholds their fundamental human and legal rights. Specifically, Article 17 enshrines that "All persons shall be equal before the law. A person shall not be discriminated against on the grounds of gender, race, ethnic origin, religion, creed or social economic status". The Commission for Human Rights and Administrative Justice (CHRAJ) is charged with the general protection of the rights of all Ghanaians and has powers to investigate the violations of these rights. The National HIV and AIDS Policy objectives include reducing stigma and discrimination and respecting the rights of PLWHA whilst many institutions have HIV/AID Workplace Policies that prohibit stigma and discrimination and disclosure of confidential information. This notwithstanding, Ghana has laws that hinder effective delivery of HIV and AIDS prevention, treatment, care and support services for sex workers, MSM, and PWIDs who are key drivers of the HIV epidemic in the country. The specific laws are: Criminal Code 1960 (Act 29) section 276, which criminalizes prostitution and soliciting for sex and Criminal Code 1960-97 Chapter 6, Sexual Offences Article 105, which criminalizes homosexuality and lesbianism. These laws criminalize sex work and MSM thus making it more challenging to organize HIV prevention information and services for these groups. There is no progress in reviewing the laws that hinder access to HIV prevention information and services for KPs despite efforts to do for some time now. Sex workers and MSM have often been at the receiving end of human rights abuses and discrimination from law enforcement agencies many activities were implemented by a cross section of stakeholders to protect the human and legal rights of all groups in Ghana including KPs and PLWHA in efforts to ensure unhindered access to HIV and AIDS services for all Ghanaians.

2.5.2 Development of the HIV legislation

In 1996, an international expert consultative group convened by UNAIDS and the Office of the High Commissioner for Human Rights, representatives of national AIDS programmes, people living with HIV/AIDS, and nongovernmental organizations, prepared guidelines for states on the application of international human rights law in the context of HIV/AIDS. The guidelines (consisting of twelve succinct paragraphs) were included in the report of the consultative group at the 53rd session of the Commission on Human Rights in 1997. The Commission welcomed the report and invited states to consider the guidelines (now known as the ‘‘International Guidelines on HIV/AIDS and Human Rights’’. Subsequent resolutions in 1999 and 2001 asked states to report on measures taken, where appropriate, to promote and implement these guidelines and tools that have been prepared to help specific groups implement the guidelines in their areas of responsibility.

The commentary that accompanies the guidelines addresses complex issues in areas such as confidentiality and disclosure of HIV status by applying international legal principles to these dilemmas. The guidelines note that the international law of human rights allows states to impose limitations on certain personal freedoms, such as the right to liberty of movement, but only where the state can establish that the restriction is:

– provided for and carried out in accordance with the law, i.e. according to specific legislation that is accessible, clear and precise, so that it is reasonably foreseeable that individuals will regulate their conduct accordingly;

– based on a legitimate interest, as defined in the provisions guaranteeing the rights;

– proportional to that interest and constituting the least intrusive and least restrictive measure available and actually achieving that interest in a democratic society, i.e. established in a decision-making process consistent with the rule of law.

For example, the guidelines envisage circumstances in which public health legislation might legitimately authorize health care professionals to inform their patients' sexual partners of the HIV status of the patients. By requiring strict legal processes for any limitations on the rights of people infected, however, the guidelines reflect the ‘‘public health rationale’’ for preventing discrimination against people living with HIV/AIDS. In 2002, the High Commission for Human Rights and UNAIDS held another international consultation to revise the sixth guideline, which addresses access to prevention, treatment, care and support. The revised guidelines recommend that domestic legislation incorporates safeguards and flexibilities in international agreements, such as intellectual property agreements, to promote and ensure access to HIV/AIDS prevention, treatment, care and support for all.

In 1999, UNAIDS and the Inter-Parliamentary Union jointly published the Handbook for Legislators on HIV/AIDS, Law and Human Rights. In September 2001, the 106th Inter-Parliamentary Conference in Ouagadougou, Burkina Faso, called on all parliamentarians ‘‘to step up their national efforts to establish effective national and international AIDS policies and programmes including the use of condoms, measures to counter discrimination and the provision of care to affected persons, including orphans. The resolution urged governments to give human rights precedence over trade rights, and it urged pharmaceutical companies to reduce the prices of medicines ‘‘above all in developing countries.

The Human Rights Advocacy centre on HIV/AIDS, the legal Audit of Ghana Laws and Policies (2011), and GAC have been providing leadership in mobilizing the collective efforts of all HIV and AIDS stakeholders to develop an HIV bill and advocate for its passage by Parliament. A draft HIV bill has been developed and provides for the protection of the human rights and legal rights of PLWHA and key affected populations that will enable them to have unhindered access to HIV and AIDS prevention, treatment, care, and support services. The draft bill has been discussed at various public forums. Sensitization about and capacity building meetings on the HIV bill have been held with a number of Parliamentary Committees including the Committees on Constitutional, Legal, and Parliamentary Affairs; Health; Gender; and the Employment, Social Welfare and State Enterprises. Intense advocacy efforts are continuing with key constituents including advocacy with lawmakers on the need for protecting the human rights of PLWHA and KPs and the passage of the draft HIV legislation bill into law.

2.5.3 Protecting the rights of KPs and PLWHA in Ghana

According to the Country AIDS response report Ghana (March, 2014), between February and June 2013, certain designated individuals dubbed M-Friends and M-Watchers handled more than 98 cases of Sexual and Gender Based Violence (SGBV) and other human rights abuses against KPs and PLWHA. The network has become an important mechanism for identifying and responding to human rights abuses and violations of PLWHA and KPs. To this end, key stakeholders whose work includes addressing the human and legal rights violations of KPs and PLWHA include the following: CHRAJ and Legal Aid Scheme, Ghana police service, judicial service and a number of civil society organizations.

CHRAJ is an independent body that assists people to seek redress in issues of unfair treatment and human rights abuses. Though not set up for HIV and AIDS specifically, CHRAJ provides a forum for addressing violations and abuses of the human rights of PLWHA and KPs in relation to the national HIV and AIDS response. Similar to CHRAJ, the Legal AIDS Scheme was established by Act 542 of 1997 of Parliament to provide legal assistance at a minimal cost to enable the poor to defend and prosecute human and legal rights violations so that all citizens can go about their economic, social and political activities in freedom and with a sense of security. Staffs from CHRAJ and the Legal AID Scheme have received training on HIV and KPs related stigma and discrimination to assist in the prudent discharge of their duties.

CHRAJ and the Legal AID Scheme have not reported cases of HIV and KPs related discrimination during the period covered by the MTE. Meanwhile, NAP+ Ghana and GHANET report that their members complain of suffering stigma and discrimination, but are afraid to report it to the authorities, as they believe no action will be taken and they will be stigmatized even further.

The absence of reported cases from CHRAJ and the Legal Aid Scheme may be more a reflection that PLWHA and KPs are unaware of or unwilling to seek redress for violation of their human and legal rights than its lack of occurrence in the larger society. It may also reflect reporting challenges within the two institutions. The SHARPER Project has worked with CHRAJ to prepare for a training of local CHRAJ representatives with the aim of improving reporting and documentation of human rights abuses against female sex workers (FSW), MSM, PLWHA and others.

With regard to Ghana Police Service, The USAID-funded FHI360 SHARPER Project in partnership with John Hopkins University has assisted the Ghana Police Service to develop a HIV pre-service training curriculum and complementary video that includes stigma and discrimination for new recruits. The training curriculum focuses on HIV prevention in general and rights and responsibilities of police towards key affected populations. Graduates from this training program will join the ranks of officers already trained by other stakeholders (e.g. CDD-Ghana) to better handle violations of the human and legal rights of KPs and PLWHA. To ensure the human rights of sex workers are not violated, senior police officers are expected to supervise police swoops on sex workers with instructions to officers to avoid arresting women who possess condoms as evidence of engaging in 'soliciting'.

In respect of judicial service involvement in combating HIV related crime and stigma; the Judicial service has received tremendous support. Since August 2010, the Judicial Training Institute of Ghana has 88 initiated HIV and AIDS related stigma and discrimination training program for newly appointed magistrates and judges and provides regular sensitization on the rights of PLWHA and KPs for Magistrates and Circuit Court Judges. This is expected to improve the understanding and handling of cases that violate the rights of KPs and PLWHA.

A number of civil society organizations (CSOs) in Ghana provides legal support and related services for PLWHA and KPs and addressing their human rights violations and abuses. The key organizations include the International Federation of Women Lawyers (FIDA), Centre for Demographic Development Ghana (CDD-Ghana), Human Rights and Advocacy Centre (HRAC), and the Ark Foundation.

2.6 What is being done to support PLWHA in Ghana?

A review of social support systems for PLWHA revealed that a lot is being done to ensure that many of the abuses of their rights are curtailed. The Ghana AIDS Commission has involved PLWHA in all aspects of HIV policy and programme design and implementation. PLWHA are represented on the Ghana AIDS Commission, Technical task teams, and the Global Fund Country Coordination Mechanism. In 2009, National Association of Positive Persons (NAP+) inaugurated a nine member board. The board continues to play an executive and advisory role to guide and direct the affairs of the organisation. Funding was provided for NAP+ by the Ghana AIDS Commission to strengthen their institutional capacity at national and sub-national levels to effectively and efficiently coordinate and manage the activities of the associations and to empower PLWHA to be more involved in the national response. The support was based on the gaps identified following an organizational assessment done in 2008.

According to Ghana AIDS commission, half year report (2009), the ongoing nationwide stigma reduction campaign through the mass media is an impetus to support PLWHA. The inauguration of the Heart to Heart campaign has encouraged PLWHA to come out into full public disclosure of their status. Despite this HIV related stigma is still high as is the growing level of homophobia, which makes it difficult to work openly with sexual minorities. The DHS of 2008 indicated that stigma and discrimination against persons living with or affected by HIV was still an important issue.

Other intensive and innovative efforts were made by the SHARPER Project, to provide hard to reach PLWHAs and KPs with HIV and AIDS services. Many HIV program reports point to fear of stigma and discrimination, real or perceived, as one of the greatest deterrent to PLWHA and KPs accessing HIV and AIDS prevention, treatment, care, and support services. HIV positive status and the judgmental attitudes of and the penchant to leak confidential information by some service providers are some of the key stigmatizing situations PLWHA and KPs complain about.

CSOs providing services to KPs indicate that stigma and discrimination have essentially made many PLWHA and KPs “hard to reach” with HIV prevention, treatment, care and support services through conventional methods. They conclude that services for these hard to reach PLWHAs and KPs need to be provided in environments that are as stigma-free as possible. Leading implementing partners at the forefront of providing HIV and AIDS services for hard to reach PLWHA and KPs include the SHARPER Project, WAPCAS, and Maritime Life Precious Foundation. Key behavioural interventions that are designed and implemented by these “hard to reach” PLWHA and KPs who do not or cannot utilize the services because of stigma and discrimination include intensified peer education, targeted hotspot outreach and condom and lubricant sales. In addition to these interventions, the SHARPER project is using innovative interpersonal communication technology approaches including; Helpline Counselling, SMS Healthy Living, Life Line, and MSM.net to seek and reach out to the hard-to-reach PLWHA and KPs in the project areas.

In response to the complex and changing environment of the HIV epidemic in Ghana illustrated by results from the 2011 FSW and MSM integrated behavioural and biological surveillance studies (IBBSS) and the persisting high levels of stigma and discrimination, the SHARPER Project is pioneering a set of new interventions to improve reach of the most at risk among KPs. Other social interventions such s models of Hope, drop in centers, interpersonal communications strategies have all been established and promoted to guard against discrimination and foster quick disclosure.

For instance, models of hope are community-based PLWHA volunteers who assist at the ART clinics – performing simple non-medical task, such as organizing patients, registering patients and providing psychosocial support, adherence counselling, positive prevention and healthy living to clinic attendees. They also trace patients who are lost to follow-up. The Models of Hope project reduces stigma and discrimination associated with ART clinics, as ART clinic attendees, are much more comfortable in dealing with Models of Hope members who are also living with HIV and who are not judgmental. This popular support group network has been scaled-up to all the regions and now operates at all 164 ART sites in the country. Drop-in centers are particularly ideal for reducing HIV related stigma and discrimination associated with providing HIV prevention information and services at conventional clinics. Drop-in clinics are located within communities, are often innocuous, and managed by trained PLWHA and KPs friendly professionals in an open drop-in format with little or no appointments. Drop-in centers provide HIV prevention information and services including sale of condoms and lubricants, HTC, STI screening, and assessment of SGBV support. An increasing number of PLWHA and KPs are using these centres, as they are more convenient and less stigmatizing. The SHARPER project currently supports 38 DICs (12 MSM, 19 FSW and 6 PLWHA) in nine regions of Ghana. Statistics on the number of PLWHA and KPs who have accessed the HIV and AIDS services in these Drop-in Centres over the last 2 years are not yet available.

The SHARPER Project is using M-Health strategies to target PLWHA and KPs with HIV and AIDS prevention, treatment, care, and support services using three Information and Communication Technology (ICT)-based interpersonal communication strategies. These interpersonal behavioural interventions reduce stigma and discrimination associated with face-to face communication systems. The 3 ICT-based behavioural interventions are: *Mobile phone*: Helpline Counselling Services (Text Me! Flash Me! Call Me!) – This is a toll-free phone service that gives easy access of KPs, PLWHA, and others to HIV-friendly service providers. Clients are provided with HIV prevention and care information, receive psychosocial Counselling and referred for HTC and other services. *Bulk SMS Messaging*: These are bulk SMS messages that SHARPER sends out regularly to PLWHA and KPs. Healthy Living provides advice to KPs and PLWHA on healthy lifestyles, and Lifeline provides reminders to ART clients about medication adherence and clinic appointments. In 2012, about thousands of people were reached with Helpline Counselling Services. *Internet:* - Social Media Outreach in which MSM Community Liaison Officers (CLO) reach out to MSM (not reached through tradition peer education approaches) on social media including Facebook, Whatsapp, Foursquare, and Badoo and educate them HIV and AIDS and healthy lifestyles. Those who do not know their HIV status are encouraged to go for testing and counselling. Records at SHARPER project indicate the prevalence of HIV among the hard-to reach subgroup of MSM is 27%, much higher than the 15% for the general MSM population reported in the IBBSS 2011. Between October 2012 and March 2014, a total of 19,490 hard to reach KPs have received HIV and AIDS prevention information and services provided through the social media outreach approach (Country AIDS response press report, 2014, page 82).

Whilst these interventions reviewed intended to curtail human right abuses of people living with HIV and AIDS are commendable, the mind-boggling question is whether these programs actually reach those they are intended to reach and to what extent they have changed the perception of PLWHA as well as the general public.

2.7 Empirical reviews

2.7.1 Attitude toward PLWHA

All over the world, especially in developing countries where the epidemic is detrimental, stigma and discrimination are the major identified attitudes against PLWHA. These have multiple consequences within numerous contexts that affect the conditions of them. Various studies have been conducted in relation to attitude towards HIV/AIDS and people living with HIV/AIDS. According to Barunji, Kaluma, Burkilya and Kosajo (2002), family members play an important role in providing care and support to people living with HIV/AIDS. In this endeavor they are faced with psychological problems and their attitude toward the people living with HIV/AIDS fluctuates. This increases stigma an lowers the quality of support the people living with HIV/AIDS receive. In carrying this study, 40 “families’ 30 of which has people infected with HIV and 10 of patients with full blown AIDS, (five died during the course of study) were studied for a period of 18 months. The study was done by observation, questionnaires and interviews which addressed factual issues about HIV/AIDS especially transmission, care and support, feelings towards patients, their sexual partners and children, the role of the counselor in providing psychological support. Issues on how the present situation could be improved were also addressed. The questionnaires and interviews were administrated to family members, relatives and any other care providers. Findings revealed that most of the family members believed that AIDS is still secret issue, a taboo family members should not discuss openly. Their psychological reactions range from blaming, bewilderment, anger, confusion and resentment towards patients. This culminates into self-blame among family members, stigmatization, poor understanding, acceptance and support of the PLWHA. The negative reaction increases as the disease advances. The counselor's supportive role is paramount but not adequate. They highlighted the need for more care focused on community initiated interventions and intensive education programs to supplement the counselors role in reducing psychosocial problems and stigma.

In a similar study, Niemic, Preeelawska and Chagan (2006) gathered information about the attitude of polish women toward HIV/AIDS and determine if there was relationship between social-demographic variables, altitudes and opinions expressed. One thousand and three hundred and eighty five women in reproductive age (N = 1385; 15-49 years) from three different religion of Poland were interviewed regarding their attitudes towards PLWHA, perceived risk for HIV/AIDS prevention and AIDS-related knowledge. The participants demonstrated a hostile attitude towards HIV infected peoples, especially to women, and had low level of AIDS knowledge. However, there was little evidence of avoidance of high-risk sexual behaviours. Overall, polish women had reactively liberal views about people with HIV although majority felt freedom. Finding suggests that there is no close match between what is epidemiologically accepted as risk behaviour and what respondents regarded as risk behaviour. Age, marital status, educational status and locality appeared to be significant determinant of altitudes towards people living with HIV/ AIDS, while religion and income were not. In conclusion findings indicate the need for a comprehensive AIDS education programme to improve the knowledge and change of attitude toward PLWHA in Poland.

In Haiti, there are very few reports about stigmatization and discrimination issues. One of the rare publications about the concept was released in 2005 by Castro and Farmer. The authors provided an explanation about the development of discriminatory attitudes in rural Haiti. They argued that stigma and discrimination are part of complex systems of beliefs about illness and disease. They stated that HIV-related stigma is connected with the quality of services and care available. According to the article, stigma and discrimination could be reduced by comprehensive programs that target education, information about access to care and treatment.

Genberg et al. (2009) extensively discussed in their article the impact of HIV/AIDS – related stigma and discrimination on people living with the virus. They compared the perceived acts of discrimination towards people living with HIV/AIDS in 4 countries (Tanzania, Zimbabwe, South Africa and Thailand). The results of the comprehensive survey demonstrated more negative attitudes and higher perceived discrimination towards patients living with HIV in areas where the support system and educational programs were lacking. The study emphasized as well on the link between HIV knowledge and the attitudes toward HIV infected people.

To show that HIV/AIDS – related stigma has persisted world-wide for decades, studies on the linkage between stigmatizing attitudes towards PLWHA and misconceptions about HIV transmission routes in the general population, especially among youth in China was carried (Zhang, Li, Mao, Stanton, Zhao, Wang & Mahur, 2008). Cross sectional data from 1,839 students from 19 colleges were collected by trained interviewers using a structural questionnaire in Yiangusu province of China. The study reveals that there is a high proportion of college students having both stigmatizing attitude towards AIDS and PLWHA and misconceptions about HIV transmission routes. Analyses show that having stigmatizing attitudes towards AIDS and PLWHA is positively associated with having misconceptions about HIV transmission. The study recommend that HIV/AIDS education should be strengthened among the general population especially among youth to reduce stigmatizing attitudes towards PLWHA and the AIDS virus.

A study was conducted in Iran by Tavoosi et al. (2002) and published in 2004. The comprehensive survey involving 4,641 students and utilizing a cluster sampling design revealed a high level of intolerant attitudes among participants towards HIV positive individuals. One-third of the participants were not willing to sit near an infected student. About 15% of the female participants and 18% of the male participants expressed feelings of hatred towards those infected with HIV.

In a related study, a survey among 383 female college students in Japan assessed the attitudes and the beliefs of the participants regarding HIV positive patients (Maswanya et al., 2000). The study demonstrated a high level of negative attitudes among the respondents. Half of the participants stated that they would feel uncomfortable and burdened to live if sharing a home with a person infected by the virus. Similarly, more than two-thirds of the respondents were not willing to take care of PLWHA. Compared to Japan, the situation appears to be worst in China where the level of discriminatory attitudes towards those living with HIV/AIDS has drastically increased from 1994 to 2000. A survey of the general population consisting in 20 items that assessed HIV-related attitudes (Lau & Tsui, 2005) examined the attitudes of 800 participants in a cross-sectional telephone survey in Hong Kong. 42% of the survey respondents affirmed that they would avoid contact with a HIV positive individual among the 20 items assessing the HIV-related attitudes. Approximately 40% of the female respondents and 34 % of males believed that a person infected with HIV could not appear healthy. In general, younger people and respondents with a higher level of education expressed more positive feelings towards the HIV positive people.

In an intervention study on reducing discriminatory attitudes towards AIDS and PLWHA in Hong Kong, Lau, Tsui and Chan (2005) presented a paper on the development and evaluation of an intervention programme aimed at reducing adolescents discriminatory altitudes towards PLWHA. The intervention programme integrates components of virtual interaction with PLWHA (watching a documentary), knowledge enhancement and a simple cognitive exercise. To evaluate its effectiveness, the programme was implemented to about 600 from 3 – 4 (grade 9 – 10) students of three secondary schools in Hong Kong. Using a structured questionnaire, the level of discriminatory attitudes towards PLWHA, and knowledge about HIV/AIDS was found after the implementation of the programme. Negative perceptions about PLWHA also reduced substantially. For instance, before the programme, over-third (35.7%) of all respondents believed that the majority of PLWHA were promiscuous; the figure dropped to 15.8% after exposure to the programme. With an observation on gender difference, female respondents tended to have a less discriminatory attitude towards PLWHA and responded more favourable to the programme than their male counterparts.

A study conducted in Nigeria by Ogunjuyigbe et al. (2009) assessed the attitudes of the citizens of Lagos State towards PLWHA. The study enrolled HIV positive and negative participants. People living with HIV were asked to share their experiences related to stigma and discrimination during in-depth interviews. The study revealed that approximately 65% of HIV negative male and 55% of HIV negative female participants would not shake hands with patients living with HIV/AIDS. Furthermore, 70% of the HIV negative male sample and 58% of the females would not eat together with HIV infected people. 63 % of the HIV negative male and 80% of the HIV negative female believed that PLWHA should not hold public offices. The main reason provided for those attitudes is the fear of being infected by interacting with people living with the virus. The study also revealed that a great majority of the HIV infected participants have felt stigmatized at least once in their life because of their HIV status and that stigmatization led to depression, shame, or even suicide thoughts among this population. The results of this study highlighted great concerns in Nigeria regarding HIV-related stigma, and the need for appropriate HIV education programs targeting the issue. The reliability of the previous study has been confirmed by another Nigerian study (Nwanna, 2005) that assessed the level of HIV-related stigma and discrimination in the workplace in Nigeria. The sample of the study was comprised of 150 HIV positive participants who responded to a structured interview related to the attitudes of people regarding their status. The study showed that of the people living with HIV/AIDS who had worked, 48% have lost their jobs and more women than men reported stigmatizing and discriminating acts.

In Nepal, key attitudes and beliefs related to stigma and discrimination towards PLWHA were explored by Family Health International (FHI) in 2003. Even though the majority of the survey respondents approved of social interactions with HIV infected people, one-third of the respondents expressed their desire to separate individuals living with HIV from the general population. Respondents expressed concerns and fears that HIV infection could be transmitted through casual contact with infected people. In addition, nearly three-fourths of the respondents thought that contracting HIV/AIDS was a punishment for immoral behaviour. The same proportion of the respondents said they would discourage someone from marrying the child of an infected person. These findings suggest urgent needs for aggressive awareness campaigns to educate the population in Nepal about the means of transmission of HIV. According to FHI, the negative attitudes and beliefs could be reduced and even eradicated by a greater depth of knowledge of the nature of the disease.

In another study in China, Lau and Tsui (2007) examined discriminatory attitude towards people living with HIV/AIDS and associated factors. The aim of the study was to examine the level of discriminatory attitudes towards PLWHA and factors in association with such attitudes. A population based sectional telephone survey was conducted. A total of 800 Hong Chinese aged 18 – 50 randomly selected from the general population participated in the study. Findings revealed that respondents exhibited discriminatory attitudes in at least five out of the 20 relevant items. For instance, about 42% could avoid making physical contact with PLWHA, believed that all infected medical staff should be dismissed and about 47% would agree with enacting a law to prohibit PLWHA from visiting Hong Kong. A sizable proportion of the respondent also hold negative perceptions about PLWHA (for example, 43.7% agreed that the majority of PLWHA are promiscuous, 20.7% thought that PLWHA are merely receiving the punishment they deserve, etc). Regression analysis found that age, HIV related knowledge, the above mentioned negative perception about PLWHA, fear related to AIDS, and exposure to HIV related information were independent predictors of discriminatory attitudes towards PLWHA. About 30% would give PLWHA the lowest priority in resource allocation among five groups of patients with chronic disease.

Similarly, the level of stigma and discrimination towards people living with HIV was also found to be very high in a study conducted in India by Sudha, Vijay and Lakshmi (2005). According to the survey involving 800 individuals in the city of Hyderabad, only 18% of the participants were willing to care for an HIV positive family member. Furthermore, 41% of the survey respondents stated that HIV infected students should not be allowed to attend schools, and about the same percentage reported that they would not buy things from a retailer suspected of being infected with HIV. More than 80% of the participants stated that they believed it to be inappropriate for people to tell others about their HIV status. The extent of the negative attitudes towards people living with HIV in this large city was further demonstrated by the fact that 51% of the respondents wanted a public list of the people infected with HIV in order to avoid them. The results of the study also showed that illiterate participants were more likely to exhibit discriminatory attitudes.

A notable study in Barbados (Massiah et al., 2004) assessed the attitudes of 273 physicians towards their patients. Because physicians are more knowledgeable about HIV, one might expect that they would have more favorable attitudes towards PLWHA. However, the results of the survey confirmed that some physicians (20%) were uncomfortable having HIV/AIDS clients and would test a patient without consent. The analysis of the results also demonstrated that the attitudes of the physicians were

Comment [BB4]: Names 6 & above

associated with their level of knowledge about the disease. Physicians with a higher level of knowledge about HIV infection tended to have more positive attitudes towards the patients living with HIV/AIDS, while physicians with a lower knowledge expressed more negative attitudes and were more likely to provide inappropriate care and services to their patients.

A survey conducted in 2004 among young populations, revealed that approximately 23% of the participants argued that people living with HIV/AIDS should be quarantined. Amnesty International also drew attention to discrimination faced by people living with HIV/AIDS in the workplace and provided testimonials from those infected with HIV infected people facing daily discrimination. For instance, an HIV-infected Guyanese woman testified that she has been repeatedly denied jobs because of her HIV status (Amnesty International, 2006).

Jamaica, another country severely affected by the HIV/AIDS epidemic in the Caribbean region, is also faced with the negative effects of prejudicial attitudes towards people living with the virus. In 2005, the Jamaican Ministry of Health expressed true concerns about ongoing stigmatization and discrimination against HIV infected people. A cross-sectional study of 252 students in Jamaica (Norman et al., 2006) revealed that the participants have the tendency to associate the disease with homosexuality and sex work. Interestingly, the findings suggest more positive attitudes towards children infected through perinatal transmission or people infected during a blood transfusion. Additionally, another study conducted in rural Jamaica (Mahdi et al., 2004) revealed that individuals less than 30 years of age were less likely to stigmatize people living with

HIV/AIDS when compared to people aged 30 years old and more. The latter study also showed that women were more tolerant towards PLWHA.

Conorsy and Helly (2003) carried a similar study in Italy. This study examined attitudes towards PLWHA within a sample of 20 young men and women. As predicted, multiple regression analysis revealed that the fear of contracting HIV/AIDS through casual contact was significant predictor of both men's and women's unwillingness to interact with people living with HIV/AIDS. Attitudes towards homosexuality were also a significant predictor of negative attitudes towards PLWHA among women who generally have a low risk of contracting the disease in Western societies. These results indicate that attitudes towards people with a serious illness may be strongly related to the perceived risk of contracting the disease.

In Nigeria, Ogunjujugbe, Olugbemga & Obiyan (2007) surveyed attitudes towards people living with HIV / AIDS in Lagos state. Data for the study were obtained from a survey. It was study revealed that many of those infected and affected by HIV/AIDS have been stigmatized and there is tendency for them to hide their HIV/AIDS identity. The results therefore highlighted the need for open education on stigma and discriminatory regarding HIV/AIDS and people living with HIV/AIDS. Apart from targeting people who are not infected with the virus in order to prevent them from becoming infected alone, people living with HIV/AIDS also need to be exposed to information and education on how to access medical services and drug provision and on how to find appropriate emotional and practical support and help.

By 2010, Botswana was said to have highest prevalence of HIV in the world and discriminatory attitudes are expected to be very common in this southern African country. For that reason, the Botswana AIDS Impact Survey conducted in 2001 had several questions that were used to assess the stigmatizing attitudes among the survey respondents (Letamo, 2003). The findings of this study showed mixed results. For instance, most of the respondents were willing to care for a family member with HIV/AIDS, but a large majority (60%) of the respondents in this study reported that they would not buy vegetables from a vendor infected with HIV. Interestingly, women were found to be more tolerant than men, perhaps because women are the principal caregivers in the households in developing countries. As a final point, most people who expressed discriminatory attitudes were young people which indicated a need for targeted educational programs.

The concept of stigma and discrimination is also an issue in developed countries. In the United States, negative attitudes towards PLWHA still exist and are sometimes related to the misconceptions about the disease. Herek et al. (2002) performed telephone surveys to assess the prevalence of negative feelings and attitudes about HIV infected people. The samples were obtained according to a random procedure. The results of the findings showed that 20% of the samples supported a quarantine action for the PLWHA. In addition, 30% of the participants stated that they would avoid shopping in a grocery store if the owner was found to be HIV positive. Approximately one-fourth of the respondents thought that the people who got AIDS have gotten what they deserve.

In Canada, the HIV/AIDS Attitudinal Tracking Survey conducted by EKOS Research Associates (2006) showed some patterns of stigmatization towards people with

HIV/AIDS in the general population. Although 81% of the survey respondents did not believe that the HIV positive people should be quarantined, approximately 25% believed that people with HIV infection should not be allowed to provide some public services (hairstylists, dentists, food vendors). Survey results also outlined that Canadian women were more likely to have positive attitudes, while senior citizens were less likely to support the rights of those infected by the virus.

In France, the attitudes toward people living with HIV/AIDS were assessed by a national cross-sectional survey that recruited 4,963 HIV-infected individuals. Among the responding participants, 12% reported experiences of stigmatization from the close family and 24% of respondents felt discriminated by their social environment. In addition, a higher percentage of participants (27%) reported stigmatizing attitudes from their healthcare providers (Peretti-Watel et al., 2007).

An epidemiological study about HIV knowledge, attitudes and misconceptions was conducted in Turkey and supported some findings previously reported. The results of the study demonstrated that women, people living in the city and well educated participants expressed more positive attitudes towards people living with HIV/AIDS (Ayranci, 2005). Furthermore, this study revealed that misconceptions about HIV/AIDS are related to stigmatizing attitudes and recommends that accurate knowledge about the disease should be addressed by educational programs.

In May 2005, 2,400 people were surveyed in order to assess, among other issues the attitudes and stereotypes related to HIV infected individuals in Russia (Popova, 2007). The study participants included students in high schools and professional schools, teachers and parents of students. The findings from the survey showed that a vast majority of the respondents did not blame people with HIV/AIDS for their condition. However, nearly half of the participants did believe that being in close proximity with HIV infected people should be avoided. Interestingly, the students were found to be more tolerant towards people who are infected with HIV compared to teachers and parents.

From the literature reviewed, it is obvious that stigmatization and discrimination against PLWHA is a global problem. Several studies attributed this stigma to poor knowledge about HIV/AIDS. Studies from Africa, the Americas, Europe and Asia revealed that people living with HIV/AIDS suffer stigma from all factors including members of their family, friends and society. Literature review showed that governments of various countries are yet to control stigma against people living with HIV/AIDS. Above all, stigma and discriminatory attitude towards PLWHA retards the war against the spread of the virus.

2.7.2 HIV/AIDS and human rights abuse

As indicated earlier the inception of HIV/AIDS epidemic has given rise to stigma and discrimination against PLWHA as disturbing factors that not only infringe on the rights of infected individuals but has thwarted the progress in fighting the prevention of the spread of the disease. HIV-related stigma and discrimination exists across the globe and accounts for serious discrimination and violations of the rights of people living with the infection.

Statistics released by the UNAIDS and WHO (2007) indicate that although sub-Saharan Africa has approximately 10% of the world’s population, it is home to more than 60% of all people living with HIV/AIDS in the world. According to this publication, by the end of 2005, an estimated 3.2 million people in the region became newly infected with HIV. UNAIDS (2006) suggests that HIV/AIDS have profound effects on the human resources of organizations and companies due to increased absenteeism, financial costs related to training or recruiting new staff, loss of institutional capacity and loss of productivity. HIV/AIDS related stigma and discrimination, therefore lead to PLWHA to be reluctant in disclosing their status and to a low uptake of HIV/AIDS-related services made available at workplaces.

It has been pointed out that HIV/AIDS provides fertile ground for a stigma to take root, and the latter increases where there is ignorance as to how HIV is transmitted, leading individuals and communities to discriminate with a resultant violation of the fundamental human rights of persons living with HIV/AIDS. Studies have shown that peoples' rights i.e. PLWHA are violated in so many ways such as denial of employment, refusal/delaying of health care services, rejection by colleagues, families and community, insults and so on.

HDN and Global Network of People Living with HIV/AIDS (2004) as cited in USAID (2007) defined stigma as "a real or perceived negative response to a person or persons by individuals, community or society that is characterized by rejection, denial, discrediting, disregarding, underrating and social distance" This definition builds on definitions by others who suggest that stigmatized individuals are believed to possess an attribute that conveys an inferior social identity, which, once obtained, immediately diminishes the individual's worth (Stafford & Scott 1986 as cited in USAID, 2007). The study states that stigma is often associated with diseases that have severe and incurable outcomes, frequently in cases where acquisition of the disease is perceived to have been a consequence of the behavior of the infected individual. Once enacted, stigma against PLWH results in discrimination, which, as defined by the UNAIDS Protocol for Identification of Discrimination against People Living with HIV, refers to “any measure entailing any arbitrary distinction among persons depending on their confirmed or suspected HIV serostatus or state of health” (UNAIDS, 2000).

Stewart, Pulerwitz and Esu-Williams (2002), in their study on addressing HIV/AIDS stigma and discrimination in a workplace programme defined stigma as a social process that marginalizes and labels those who are different, and discrimination as the negative practices that stem from stigma, or “enacted” stigma. They found out that employees of Eskom suffer from HIV-related stigma from their co-workers and supervisors, such as social isolation and ridicule, or experience discriminatory practices, such as being fired from their jobs. The violation of their fundamental human rights from colleagues and employers discourages workers from undergoing voluntary counselling and testing (VCT) and seeking available prevention and care services. Employees expressed their concern they would be fired if the company learns that they are HIV-positive.

The fundamental human right which is infringed by the acts of discrimination was described by UNICEF/UNAIDS (2002) as freedom from discrimination founded on principles of natural justice that are universal and perpetual. Thus, the principle of non-discrimination is central to the human rights thinking and practice. Again, it was found that HIV/AIDS-related stigma and discrimination and human rights violations are interlinked, hence, creating, reinforcing and legitimizing each other. They form a vicious circle whereby due to the stigma associated with HIV/AIDS, the act of discrimination follows, leading to the violation of rights of employees living and affected with HIV/AIDS together with their families. It was suggested that this violation of the fundamental rights increases the negative impact of the epidemic seen at different levels. For example, at the level of the individual, it causes undue anxiety and distress; at the level of the community and family, it causes people to feel ashamed, to conceal their links with the epidemic, and to withdraw from participating in more positive social responses; and at the level of the society as a whole, discriminating against PLWHA reinforces the mistaken belief that such action is acceptable and that those infected with HIV/AIDS should be ostracized and blamed (Ogunjiofor, 2011). Pan American Health organisations (2003) highlight that HIV/AIDS and human rights can have serious health consequences. Therefore, it states that the abuse of human rights leads to vulnerability to HIV/AIDS which is seen when people living with HIV/AIDS are denied the right to appropriate health information and care, and are enveloped to a non-exercise or non-enjoyment of human rights due to various acts of discrimination which they suffer such as rejection; isolation; refusal of medical help; physical abuse, breach of confidentiality and among others.

In the paper of ILO (2004), it was revealed that several fundamental rights are threatened in the context of HIV/AIDS. This includes the right to non-discrimination, the right to privacy, the right to appropriate protection in social security and the right to work. There was an in depth emphasis that the protection of fundamental human right must constitute an integral part of the response to the epidemic because failure to do this increases the risk of transmission of the disease and magnifies other tragic impacts the disease has on their lives, vis-à-vis stigma and discrimination associated with HIV/AIDS. Interestingly, in the context of employment the paper highlighted that the breeches of fundamental rights emanating from HIV/AIDS-related stigma and discrimination includes mandatory testing of employees and job applicants, discrimination in access, terms and conditions of employment, termination of employment on the basis of HIV infection regardless of medical fitness to work, breaches of confidentiality with regard to medical information, stigmatisation of workers living, or presumed to be living with HIV/AIDS; denial of access for people infected or affected by HIV to care and support services, including social security coverage. Therefore, the protection of human rights in the context of HIV/AIDS according to ILO is essential not only on account of the very nature of the rights themselves, which exist to preserve the human dignity of infected persons, but also because the protection of those rights is a necessary part of the fight against the epidemic.

Also, in the context of HIV/AIDS-related stigma and discrimination and human rights violation, UNAIDS (2005) highlighted that stigmatisation associated with AIDS is underpinned by many factors which includes the lack of understanding of the illness, misconceptions about how HIV is transmitted, lack of access to treatment, the incurability of AIDS, and prejudice and fears relating to a number of socially sensitive issues including sexuality, disease and death, and drug use. According to the UNAIDS the act of stigmatisation is believed to lead to discrimination and other violations of human rights which affect the wellbeing of persons living with the dreaded disease in fundamental ways. This necessitated the Global consensus on the importance of tackling AIDS-related stigma and discrimination via the Declaration of Commitment adopted by the United Nations General Assembly Special Session on HIV/AIDS in June 2001. It states that confronting stigma and discrimination is a prerequisite for effective prevention and care, and reaffirms that discrimination on the grounds of one's HIV status is a violation of human rights.

USAID (2007) stipulates that persons living with HIV/AIDS face not only medical problems, but also social problems associated with the disease. Stigma as one of the social problems, acts as a barrier to reaching those who are at risk or infected with HIV/AIDS and through discriminatory act leads to the infringement of the fundamental rights of infected persons. It enhances secrecy and denial, which are catalysts for the transmission of HIV. It also noted that it is being increasingly acknowledged that effective treatment and care strategies require an understanding of the cultural context in which stigma and discrimination exists.

Human Rights Watch's research (2005; 2006) found that efforts to fight HIV/AIDS are being undermined by widespread human rights abuses against drug users, sex workers, and PLWHA in the workplace and society. It noted that the abuse of PLWHA violates fundamental human rights protections against torture and other forms of stigma and discrimination. The study showed that HIV/AIDS is as much about social phenomena as they are about biological and medical concerns. There have been widespread discrimination and violation of the rights of PLWHA in the workplace, such as in the health system where infected persons are denied medical treatment, and face violations of their privacy by health care providers who disclose confidential information about their HIV status.

In 2006, Amnesty International provided an update of the situation in the Caribbean region particularly in the Dominican Republic and in Guyana. The report highlighted growing concerns about the situation in the Dominican Republic especially for vulnerable groups such as women and Haitian descendants. Despite existing laws which supposed to protect HIV/AIDS people against prejudice, discriminatory attitudes in the workplace, in the healthcare facilities and in the communities have continued to be significant problems. In Guyana, one of the Caribbean countries most affected by HIV/AIDS, Amnesty International expressed some concerns about human rights violations against people living with HIV/AIDS.

According to Aggleton, Wood, Malcolm, and Parker (2005), stigma and discrimination have fuelled the transmission of HIV and have greatly increased the negative impact associated with the epidemic. HIV-related stigma and discrimination continue to be manifest in every country and region of the world, creating major barriers to preventing further infection, alleviating impact and providing adequate care, support and treatment. The stigma associated with AIDS has silenced open discussion, both of its causes and of appropriate responses. Visibility and openness about AIDS are prerequisites for the successful mobilization of government, communities and individuals to respond to the epidemic. Concealment encourages denial that there is a problem and delays urgent action. It causes people living with HIV to be seen as a 'problem', rather than as a solution to containing and managing the epidemic. Stigmatization associated with AIDS is underpinned by many factors, including lack of understanding of the illness, misconceptions about how HIV is transmitted, lack of access to treatment, irresponsible media reporting on the epidemic, the incurability of AIDS, and prejudice and fears relating to a number of socially sensitive issues including sexuality, disease and death, and drug use. Stigma can lead to discrimination and other violations of human rights which affect the well-being of people living with HIV in fundamental ways. In countries all over the world, including Ghana, there are well-documented cases of PLWHA being denied the right to healthcare, work, education, and freedom of movement, among others.

In related study, Kohi et al. (2006) explored the HIV/AIDS stigma situation and human rights of PLWHA through focus groups in five African countries (Lesotho, Malawi, South Africa, Swaziland and Tanzania) using a descriptive qualitative research design was used. The 251 informants were people living with HIV and AIDS, and nurse managers and nurse clinicians from urban and rural settings. They identified specific incidents related to human rights, which were compared with the Universal Declaration of Human Rights. The findings revealed that the human rights of people living with HIV and AIDS were violated in a variety of ways, including denial of access to adequate or no health care/services, and denial of home care, termination or refusal of employment, and denial of the right to earn an income, produce food or obtain loans. The informants living with HIV and AIDS were also abused verbally and physically. The recommended that country governments and health professionals need to address these issues to ensure the human rights of all people.

2.8 Summary of literature review

Indeed, HIV/AIDS as one of the most serious public health concern globally, has received enormous attention from all kinds of professionals. The literature consistently supported the increasing prevalence of stigma and discrimination against PLWHA; creating major barriers to preventing further infection, alleviating impact and providing adequate care, support and treatment. The apparent stigma and discriminations resulting in denial of access to adequate or no health care/services, and denial of home care, termination or refusal of employment, and denial of the right to earn an income, produce food or obtain loans are but a few ways by which the human rights of PLWHA are violated. Due to this, some feel rejected and isolated while others feel like committing suicide. While it is refreshing to note that PLWHA have a wide range of areas with which they get social support as well as seek redress in times of abuses on their rights, it is obvious that a lot more efforts are needed to better the lots of PLWHA.

This chapter began with examining the components of attitudes as a social psychological theory which breeds people's attitudes and behaviours such as stigmatization, discrimination, and rejection towards PLWHA. The prevalence context within Ghana was also explored and how issues such as socio-cultural factors lead to disclosure and nondisclosure with their accompanying consequences. In addition, the kinds of social support available for PLWHA in Ghana were examined. Finally, the previous empirical findings on attitude towards PLWHA and the link between HIV/AIDS and Human Rights abuses in the global arena were explored.

CHAPTER THREE

METHODOLOGY

3.1 Introduction

This chapter is a presentation of the various research approaches, methods and techniques used in undertaking the study. It captures a brief presentation of the research design and outlook of the study, the approach and philosophy adopted by the researcher and a justification of the data gathering technique adopted, with emphasis on the form of data gathering. Furthermore, it contains explanations and justifications for the sampling technique employed for the study. Again, this chapter also provides an in-depth detail on the analytical tools employed to enable the researcher arrive at valid and reliable conclusions.

3.2 Research philosophy

A research philosophy is a paradigm and manner in which data on a phenomenon would be collected, analysed and presented. The term epistemology is used to describe what is true and doxology is used to describe what is believed to be true (Bryman, 2012). Western tradition of science identifies two major philosophies namely, positivism (scientific) and interpretivitism (anti-positivist).

3.2.1 Positivism

Positivists are of the conviction that through real time events, it is possible to conduct a study from an objective viewpoint free from any interference by the researcher (Levin et al., 1997). However, positivists contend the need for repeated observation of a phenomenon to justify the outcome of a research as scientific. As a result, predictions are deduced based on explained realities and inter-relationships from previous studies.

Comment [BB5]: 6 names

Hirschheim (1985: 33) states, "Positivism has a long and rich historical tradition. It is so embedded in our society that knowledge claims not grounded in positivist thought are simply dismissed as unscientific and therefore invalid". Notwithstanding, there is the debate whether the positivist paradigm is appropriate for social sciences or not (Hirschheim, 1985).

3.2.2 Interpretivism

Interpretivist (or naturalist) philosophy argues that the study of the phenomena must be in a natural environment, bearing in mind that the knowledge that researchers already have, affect those phenomena they study (Galliers & Huang, 2012; Gorard, 2010). In addition, interpretivists (or naturalists) contend that the elaborate understanding of real events is through intervention and individual interpretation (Galliers et al., 2012). Interpretivists accept the fact that there are diverse interpretations on reality, but maintain that those diverse interpretations of reality form part of scientific knowledge being studied (Hirschheim, 1985).

The research adopted an interpretive philosophy as it seeks to explain for clearer understanding, how the human rights of people living with HIV/AIDS (PLWHA) are abused within a social context. Here, the researcher sought to gain insights through discovering by improving his comprehension of the whole issue. The objective was to explore the richness, depth, and complexity of the phenomena under study, which makes interpretivism a better option than other research philosophies.

3.3 Research design

Research design is a detailed blueprint on how the objectives of a research would be met (Saunders, Saunders, Lewis & Thornhill, 2011). Bell (2014) described research design as an investigative plan to steer a research project. In addition, it provides further information on the priority attached to the study and helps minimise the influence on statistical sampling (Bryman & Bell 2007). Saunders et al. (2011) assert that three main types of research designs exist: exploratory, descriptive and explorative explanatory. Adopting the use of exploratory or inductive research has high uncertainty and concentrates on broader theories as opposed to specific theories (Saunders et al., 2012).

This study however makes use of a descriptive research design to enable the researcher draw conclusions based on logical reasoning (Bryman & Bell, 2007). According Collis and Hussy (2013) descriptive research involves the use of statistical tools such as frequency tables, regression and correlation analysis to provide information on variables and elements contained in the research objectives.

The analysis of data gathered, provides the researcher the opportunity to take a neutral stance while taking into account the outcome of events and situations (Bell, 2010; Bryman, 2012). The thesis is descriptive and relies on the use of both primary and secondary data to help reduce cost and enhance time efficiency as it provides a narrower focus for analysis.

3.3.1 Qualitative study

The qualitative research methodologies are employed by researchers to seek answers to human behavior and opinion, which can be difficult to detect or find answers to when undertaking quantitative research (Bell, 2010; Teddlie & Tashakkori, 2009). According to Lichtman (2013: 1), “Qualitative research involves any research that uses data that do not indicate ordinal values.” Qualitative research is not merely the opposite of quantitative research but rather provides answers, which quantitative research methods cannot access. There are several forms of qualitative research; these include participant observations, case studies, interviews, cross sectional studies etc. (Bell, 2010; Teddlie & Tashakkori, 2009).

This study employed interviews to obtain empirical evidence that could be used to inform intervention programmes and policy. It involves trying to understand the essence of a phenomenon by examining the views of people who have experienced that phenomenon. As a phenomenological study, it is interested in the lived experiences of people. According to Creswell (1998), about 10 cases are enough to reach saturation for a phenomenological qualitative study using interviews.

3.4 Target population

According to O'Leary (2004), population is the total membership of a defined class of people, objects, or events. In research, population means all the members, individuals or cases of target of the study. This target is normally determined by the purpose of the study. By this definition, with HIV/AIDS 3.5% prevalence rate for 2012 (GAC, 2012) in the study setting, the population for this study consisted of 60 PLWHAs aged 18 years and above.

3.5 Sampling technique and sample size

Sampling is the process of selecting units from a population of interest so that one may fairly generalize results back to the population from which they were chosen (Trochim, 2006). Similarly Fink (1995) admits that a sample is the proportion of the population, a slice of it, a part of it and all its characteristics. A sample is a scientifically drawn group that actually possesses the same characteristics as the population. It is impossible to select all members of the population to take part in the research. Hence, purposive sampling technique was employed to identify the respondents.

According to Schwardt (2007), purposive sampling targets a particular group of people. Purposive sampling is appropriate when the desired population for the study is rare or very difficult to locate and recruit for a study, Again the researcher used some level of tact in identifying population members who might give the desired or accurate information. According to Alhassan (2006), the objective of the investigation decides the sample members as it selects only those variables that relate to the objective of the study. The objective of this research is to present the views of PLWHA on the nature, and the form of abuses. Thus, only places that the PLWHA were located were purposively chosen to reflect the study.

The snowball sampling strategy was adopted to select respondents. This method also known as judgmental involves the selection of a group from the population on the basis of available information presumed to adequately represent the total population (Alhassan, 2006). In other words, one Person Living with HIV/AIDS directed the researcher to other People Living with HIV/AIDS in the various localities for the research work to be conducted. This technique has been preferred because other methods like the simple or systematic random are not practical when it is difficult to identify all the PLWHA in Tema. HIV/AIDS is also a secretive disease. Since people do not want to associate themselves with PLWHA it was difficult to use other methods like the simple and systematic sampling techniques.

In all, a sample size of 10 respondents was sampled from the target population for an in-depth interview. The reason for choosing this sample size was because of apparent ease of data collection in presenting the views of the respondents. The researcher identified one or two persons Living with HIV/AIDS who linked him to the other respondents. The two people were contacted during a conference held for PLWHA by on … (personal communication) Whilst it was difficult to access enough respondents as they feared being exposed as having HIV/AIDS, confidentiality was assured them.

3.6 Sources of data

Data collection is an essential component to conducting research. Data collection is a complicated and hard task. O'Leary (2004:150) remarks "collecting credible data is a tough task and it is worth remembering that one method of data collection is not inherently better than another". Therefore, the data collection method to use depends on the research goals and the advantages and disadvantages of each method? The quality of a research may be influenced by the types and sources of evidence used. Various sources and types of evidence abound and could be used for the work. Data for this study was obtained from both primary and secondary sources.

3.6.1 Secondary data

Secondary data are processed information that is readily available to be utilized. The researcher in this study made use of literature search of books, journals and various articles of scholars and practitioners, books, and other scholarly databases such as google scholar, science direct and emerald as guidance towards answering the research questions.

3.6.2 Primary data

Primary data provide first-hand information on any subject under study. The primary data was collected from respondents through the use of a structured and unstructured interviews which were administered to the respondents on one-on-one basis.

3.7 Instrumentation

The data for the study was collected using an interview guide. The interview guide was structured in three sections. Section one collected personal information such as age, gender, marital status, level of education, employment and place of residence. In section two, questions are related to frequency of contact with other HIV patients, frequency of talk about HIV in the community, families, church, and community leaders and relationship with family members and friends. Section three assessed the form of human rights abuse related to patients in the community, the level of participation of HIV related programs, level of association with family, friends, church, community, work. It also identified the type of stigma that is often meted out in the community.

3.8 Validity and reliability of instruments

In any systematic enquiry into the human behaviour, it is important to establish the true value of the study. The study must be judged against certain criteria so as to ensure that the findings are a true reflection of the participants or reality (De Vos, 2002). Through criteria such as validity and reliability, the accurateness and completeness of a study can be ascertained.

In order to ensure the validity and reliability of the research instrument, the interview schedule was designed to reflect on the research questions. The instrument was given to the research supervisor for scrutiny as well as expert judgment to ensure its appropriateness before it was pilot-tested. A pilot study is the most effective strategy to minimize problems in the actual conduct of the study (Muijs, 2004). Suggestions received from the research supervisor helped the researcher to refine and shape the contents of the instrument to make it more valid and reliable for the study.

To ensure reliability of the research instrument, it was pre-tested on 2 PLWHA victims at Accra. In the following week, the test-retest technique was used to determine the reliability of the instrument. The same 2 people were asked to answer the same questions. This yielded similar responses.

3.8.1 Trustworthiness

Lincoln and Guba (1985), cited in De Vos (2002), call trustworthiness the true value of the study. To ensure that the data for the study is trustworthy, the researcher relied on a tape recording of the interview, field notes and personal observations as well as respondents' validation. To ensure validation, the recorded interviews were played to respondents for them to authenticate the responses.

Robson (2002) further states that the aim of a piece of research is to have a measure that is reliable and valid. In dealing with these problems, the researcher clarified the questions for the interviewees, and the researcher acquainted himself with possible problems. Verbatim tape transcriptions were availed to the participants as soon as possible after the interviews. Holstein and Gubrium (1985) cited in Greeff (2002) points out that this allows the information to be clarified and elaborated.

3.8.2 Dependability

To give credence to the reliability or trustworthiness for this study, the researcher ensures dependability. Lincoln and Guba (1985) assert that there could be no credibility without dependability in qualitative research. They suggest that dependability can be established through the establishment of appropriate enquiry decision, review of interviewer bias to resist early closure, establishment of categorical schemes and exploration of all areas, resistance to practical pressures and findings of both positive and negative data triangulation.

Information obtained from the literature review were helpful in the development of the questions that elicit responses to the research questions that are formulated to direct this study. This ensures the appropriateness of the questions that the respondents were asked. Besides, the interview format helped to develop categories and themes in the findings. Furthermore, both the positive and the negative responses were listed.

To deal with the issue of bias in the study, the researcher sought clarification for answers that were not clearly stated during the interview. In this way, issues of unclear data that were obtained were resolved. Care was taken about the duration of the interview to avoid early closure and at the same time to prevent the provision of unreliable data following boredom on the part of respondents as a result of the prolonged interview session.

3.8.3 Credibility

To establish the reliability, the data for this study must be credible. According to Creswell (2002), respondent validation is where the result of the research is submitted to the respondents for confirmation as a means of establishing credibility. Bryman (2001) observes that the establishment of credibility of findings demands that, the research is carried out according to good practice and by submitting it to the social world that studies it for confirmation and that the researcher understands that social order correctly.

In this study, the researcher interacted with the subjects over a period of not less than two weeks in order to develop an acquaintance with them. This was done through casual visits to the respondents in their homes and telephone conversations. This enabled the researcher to develop a relationship with them. In this way, the researcher was able to build trust between himself and each respondent. This trust made it possible for the respondents to readily open up for discussions of all sensitive issues that were covered by the interview for the study.

3.9 Data collection procedure

Data for this research was collected using semi-structured in-depth interviews to collect data from respondents. The semi-structured interview guide provided a clear set of instructions for interviewer and also provided reliable and comparable qualitative data. The interview is preferred because the information needed could not be directly observed. It was a great challenge to obtain the data for the entire population living with HIV in the metropolis. However, having identified three leaders of the AIDS Ambassadors of the Ghana AIDS Commission has led to identifying other respondents within the Tema Municipality.

Only PLWHA registered as patients at the major AIDS centres, including the Tema General Hospital aged 18 years and above and who were willing to give informed consent were included in the study. Patients who were too sick or unwilling to participate were excluded.

3.10 Data analysis

The data sets for the study were essentially qualitative and hence the data collected were analyzed by summarizing key themes on the key issues, factors and determinants of HIV/AIDS related abuses. Data was subsequently triangulated and interpreted to draw conclusions using thematic analysis, and descriptive statistics in the form of frequency counts and percentages which captured in tables and charts where applicable. Thus, data were presented in a convenient, usable and understandable form. Thus, information was provided in a table form to give a clear picture of the data. Responses to open-ended question were analysed using a thematic content analysis approach (Neuman, 1997). The experiences of community perceptions of stigma and discrimination situations affecting PLWHA were presented in themes.

3.11 Ethical considerations

Ethical matters or considerations are very important for every research adventure or study and especially due to the sensitive nature of the issues involving PLWHA, ethical considerations were painstakingly adhered. As a researcher, it is an obligation to respect the rights, needs, values and desires of research participants. In lieu of this, confidentiality of information gathered from participants was held in high esteem. In addition, their informed consent was appropriately sought in respect of all information they provided. Respondents were also informed that the work is purely for academic purposes and not for any other purpose and that it could help in ensuring their welfare as it was purposed to inform policy and intervention programmes. In addition, all documents used and sites visited for the literature review were properly acknowledged and documented to avoid issues of plagiarism.

CHAPTER FOUR

RESULTS AND DISCUSSION

4.1 Introduction

This Chapter is the presentation of the findings gathered from the field. The presentation concentrates on the results of the in-depth interview and focus group discussions conducted with People Living with HIV/AIDS in the Tema Metropolis of the Greater Accra Region of Ghana. The recorded audio was transcribed verbatim and organized according to the stated objectives.

4.2 Demographic characteristics of respondents

The study examined the human rights abuses of people living with HIV/AIDS. To this end, all the respondents were HIV/AIDS patients. In all, ten (10) individuals living with HIV/AIDS were interviewed. There were three males and seven women representing 30% and 70% of the respondents.

The average age of the respondents is 44.2 years. All of them were Christians and often attend church services. Six (6) of them representing 60% were single whilst 40% were married. Whiles only 10% had tertiary education, 80% had completed school below Senior High School and the remaining 10% had no education. The minimum and maximum number of years respondents had lived with the disease was 2 and 15 years respectively with an average period of 8.3years. This implies that respondents had rich experience on the issues examined by the study. It was gathered from the interviews that only one interviewee had other relations with HIV/AIDS. Aku, a 26 year old respondent, indicated that her sister who was 11 years old was positive and no other member of the family knew of their status. This case is intriguing in that that the 11 year old child attends school and may put other pupils at risk whiles as an extended family home other family relations are at risk of contracting the virus.

4.3 Research objectives

The study was set out to identify the extent of human right abuses of people living with HIV/AIDS, to determine the form of abuses and to determine the group of people who mostly abuse these individuals and to find out from the perspective of PLWHA what can be done to improve their living conditions. The findings in respect to these objectives are presented in the next section.

4.3.1 Identify the extent of human rights abuses of PLWHA

To achieve this objective series of questions were posed to the respondents. The first was to find out whether as persons living with HIV/AIDS they know their rights. All the ten respondents answered 'yes'. To find out to what extent they know these rights, respondents were asked to mention some of the rights they know. Some of the rights mentioned are provided below;

a. Right to free medical care.
b. Right to live or associate with anyone.
c. Right to marry and make a family.
d. Right to employment.
e. Right to legal redress for abuse.
f. Right to have sex.

According to them, knowledge of these rights did not permit them to exercise it for fear of being exposed to the general public. Those who were working were sacked from their jobs, their status were disclosed to friends and cotenants. Right to freely associate with everyone was violated once their status was disclosed.

The next was to find out how often they exercised the rights they mentioned. The responses given are stated below.

Table 1: How often do you exercise your rights as mentioned?

Statement	SA	A	D	SD
Obtaining antiretroviral medical care	1	2	3	4
People easily associate with me	2	4	2	3
I am married with children	4	2	1	3
I am currently employed	1	2	5	2
I take action against people who abuse me	0	1	4	5
I have sex normally,regularly	1	4	3	2

Source: Fieldwork data (2015).

Key: SA = Strongly Agree; **A** = Agree; **D** = Disagree; **SD** = Strongly Disagree.

From Table 4.1 above, it could be observed that not many interviewees very often exercise the aforementioned rights. In each of the cases of 'Right to free medical care', 'Right to employment' and 'Right to have sex'. Only one (1) respondent was found to have exercised those rights very often. As regards the 'Right to marry and make a family' and the 'Right to live or associate with anyone' were found to be often exercised by 4 out of the 10 respondents and 3 out of the 10 respondents respectively. More of respondents, however were of the view that they would exercise all those rights should the situation demands it. In all, majority of the respondents felt that they hardly or never tried exercising these rights given the fact that in most cases, the abuses were done on their blind side hence it was difficult to exercise these rights legally.

As a follow up, respondents were asked to adduce whether they were denied of any of the rights mentioned by those who know their status and to what extent. The responses are presented in figure 2 below.

Table 2: Results of declaration of status

Relationship with those who knew my status	Frequency
Normal	2
Very bad	5
Bad	2
Non response	1
Total	**10**

Source: Fieldwork data (2015).

From the responses above, it could be seen that 2 out of the 10 respondents said they were treated normal whilst about 7 out of the 10 respondemts said they were treated badly. When asked the extent of which they were abused of their rights, 7 out of the 10 respondents said very often whilst 3 out of the 10 respondents indicated as when they needed to exercise their right they encounter such treatments. Surprisingly, one person said no one knows about her status. According to them, they judge them all the time and call them opportunist. Below is the statement of a male respondent who is an ambassador of HIV/AIDS:

> Neighbors knew about this, but they didn't believe it because what they believed was that HIV infected person should be skinny, hairless, with his shoulders pulled up. He went further by telling me that I should not pronounce that I was HIV positive. It was not good to do so because they knew how HIV infected people look like. (42 year old male respondent).

The outcome that PLWHA were treated badly that constituted a human rights abuse. The result of this study revealed that 7 out of the 10 respondents were denied of their fundamental human rights as citizens of the republic of Ghana through denial of their status, losing jobs as a result of one's status, and not associating with infected people.

The next section examined the form of the abuses and the place of perpetuation or kinds of people who often abuse; that is whether the church, family, community, work place, hospital, the court, the market or friends.

4.2.2 Form and places of abuse and major abusers of PLWHA

This section is the results to achieve Objectives two and three of the study. PLWHA are often abused almost everywhere they come into contact with other people who knew their status. The following table presents a summary of the findings on this.

Table 3: Form and place of major abuses of PLWHA

(n = 10)

	Form of Abuse			
Place	**Discrimination Freq.**	**Stigma Freq.**	**Rejection Freq.**	**Violation of privacy Freq.**
Home	2	3	2	3
Community	2	2	3	3
Church	2	2	2	4
Workplace	4	3	2	1
Market	4	4	1	1
Hospital	3	1	3	3

Source: Fieldwork data (2015).

Table 4: Major abusers of PLWHA

(n = 10)

	Form of Abuse			
People	**Discrimination Freq.**	**Stigma Freq.**	**Rejection Freq.**	**Violation of privacy Freq.**
Family members	2	1	4	3
Friends	3	4	2	1
Church members	3	2	2	3
Association/club members	2	3	3	2
Health workers	2	1	2	5

Source: Fieldwork data (2015).

From the table above, it is clear more PLWHA happened to have suffered abuses in the home by family members. It must be noted that not all respondents indicated that these various abuses were meted out to them. The findings of this study established that 7 out of the 10 the respondents suffered discrimination, stigma, and rejection while 3 out the 10 respondents suffered violation of privacy in the home. This is as a result of the fact that it is often the immediate or the extended family members who first get to know of the status of a patient. For instance, Akweley who lives in a compound house with other family members recalled how her sister insulted her in the presence of other cotenants about her HIV status.

> My sister constantly calls me names, says I am a prostitute that is why I contracted the disease. My pain is that she insults me in the presence of other tenants. I am always excluded from family meetings because of my status. Anytime, I used the bathhouse, the next family member who is next uses disinfectant to clean the place before taking his or her turn (37 year old female respondent)

The outcome that it is rather the family that more often abuse respondents supports Lgalla et al. (2011) opinion that some PLWHA disclose their status to friends rather than family because they do not trust their family members as they do trust their friends. Quite sadly, friends disclose their status to the public. During the interviews, it was discovered that the major form of abuse comes from friends who disclosed interviewees' status to other friends, and other family members without their consent. In support, a report on the HIV/AIDS, human rights in Tanzania revealed similar results that the greatest source of human rights violation emanated from family and friends (LHRC, 2005).

According to the respondents, sometimes due to the cost of health care, family members and children do abuse them. The findings also revealed a lack of timely supply of medication or antiretroviral drugs, and proliferation of fake drugs on the market. This is likely to affect their health care, and willingness to disclose their status. This conjecture supports Denue (2012) who revealed that HIV positive patients decline to declare status due to rejection, stigma, discrimination, social withdrawal and being disgraced by families. Zou et al. (2009) indicated that religious teachings that state that HIV/AIDS is a punishment from God make a person feel guilty, hence less likely to disclose their status for fear of being branded and blamed for unfaithfulness and adultery. The beliefs and attitude of these individuals corroborate what Herek and Capitanio (1997) put out that, HIV/AIDS related attitudes have been conceptualized in multiple ways, such as effective reactions to people with HIV/AIDS, attributions of blame, avoidance of interpersonal contact with PLWHA and lack of support for various public policies related to AIDS. Green (1995) further stressed that ignoring the needs of a person infected with the disease can harm or stigmatize them psychologically, physically, and socially. Failure to address the stigma can discourage individuals from seeking voluntary mediation, counselling and testing that could lead to the further spread of the disease.

Not seeking the consent of an HIV/AIDS patient before disclosure is a direct violation of their fundamental human rights. Guideline one of the United Nations International Guidelines (2006) stated that Privacy is a fundamental right and key to treating people with autonomy, dignity and respect. Guideline 3 states that public health legislation should ensure that information on the HIV status of an individual is protected from unauthorized collection or disclosure. Guideline 10 calls on states to ensure that government and the private sector develop codes of professional responsibility and practice in line with human rights principles, with accompanying mechanisms for enforcement and implementation of these codes. One of the abuses highly reported by the respondents was violation of privacy. To the respondents, their right to privacy has on occasions been curtailed even by close confidants. One male respondent (Alex) noted that he has been lugubriously ejected or expelled from his room by his Landlord when he (the Landlord) got to know of his HIV status.

> My landlord heard about my status, I can't tell who told him, but he has become aware of it. Even though I had 8 months more for my rent to expire, he walked into my hall one day and demanded I move out in a weeks' time. When the time came and he realized I was still occupying the room, he forcibly evicted me. (38 years old male respondent)

Another form of abuse was the increased abuse in the form of discrimination, rejection and violation of privacy in the hospitals. According to the interviewees, there was so much discrimination in access to healthcare and distribution of ARV drugs. This confirms the observation by Ruiz-Torres, Cintrón-Bou and Varas-Díaz (2007), Ogunjiofor (2011), Famoroti, Fernandes and Chima (2013) who have associated HIV/AIDS to fear among health workers to all patients, and this has culminated in instances of overly caution and negative attitude towards patients with HIV/AIDS in particular termed as AIDS.

To some of them, the health personnel tell them in the face that: It is God who takes care of us.

To some, it is this statement which encouraged them to believe that the drug is not that efficient as has been claimed. A male interviewee described their experiences as follows:

> Sometimes for five months, we have not got the medicine that we require to maintain ourselves. We are also denied of employment. Those who are traders, their goods are not sold because others pass their back and spread information about their status. We are treated as if we were going to die anyway (36 year old male respondent)

It is not surprising that in the other social domains where only few might know of their status, there is no or few scores of abuses. It must be noted that all the respondents were on the ART hence it is difficult to know their status by look. However, generally, studies have confirmed that PLWHA suffer different forms of Human Rights violations, ranging from discrimination, unequal treatment, lack of support from partners, mistreatment in the hospitals/heath centres, disrespect from the family, friends and society in general and alienation by them as well.

The right to privacy simply means freedom from interference i.e. the right to disclose one's HIV status without interference. Issues related to one's health are personal and are entitled to privacy unless by express consent of an individual concerned. But unfortunately, most of the respondents have indicated often violation of this right.

One main explanation of these abuses on PLWHA might be that the level of education in these places is still low, hence their disregard for such patients especially at the hospital. Majority of the respondents agreed that the activities of Ghana AIDS commission, NGOs and the various media campaigns have helped in reducing the stigma and discrimination. Nonetheless, about 80% of the respondents indicated that through such campaigns, they are aware of the laws that protect PLWHA which include the right to seek legal redress, but according to the interviews, they barely exercise such rights for fear of further societal oppression. Thus the study sought to identify human rights abuses of people living with HIV. It is clear that these abusers are ignorant of what HIV/AIDS is and the rights of PLWHA.

According to the respondents though the rights are known they hardly exercised them due to the encumbrances and maneuvers that come with it. For instance, the right to obtain the proper medical care is well understood, but if fake drugs are issued, the respondents find it difficult to seek legal redress. Again, sometimes due to lack of adequate supply of the anti-retroviral drugs, the medical practitioners discriminate. This means that the right to medical care is trampled upon by authorities, but the frustration that may come with the process is what many of the respondents are concerned about. This is what Akua had to say with regards to the shortage or unavailability of ART.

> We have been told as PLWHA that we have the right to free medical care, especially the ART but sometimes we don't get these services. The medical officers frown at us sometimes and say abusing words to us. They sometimes

> demand money before giving the drug to us. We wish to seek legal redress, but we don't want the whole world to know that we have HIV for fear of more abuses. (26 year old respondent)

Besides, another abuse, the study identified was the abuse of employees living with HIV and lack of employment. It was found that some respondents who were working before diagnosed with the virus were sacked from their job after employers knew of their status. For others, they were denied access to employment when they were requested to medical examinations and it was found that they were HIV positive.

One respondent said:

> I was about to be enlisted into the Immigration Service and when my status was found out through a medical examination I was dismissed. Ithink this was a a blatant violation of my rights to employment. (34 years old female respondent).

Clearly, it is these forms of abuses by all kinds of people in the social milieu that has brought the issue of disclosure to the HIV/AIDS management literature. Studies conducted on HIV status disclosure have revealed very low rates, especially in developing countries (Greeff et al., 2008; Kairania et al., 2010; Lgalla et al., 2011). A study in Uganda, Mityana district revealed that only 43% of people attending post-test care had disclosed their status to partners and other people (Kadowa & Nuwaha, 2009). A study conducted in Malawi on HIV status disclosure between spouses revealed that women who perceive HIV stigma in the community are less likely to disclose HIV status. It is for these human rights abuses that HIV patients find it arduous to disclose their status (Anglewicz & Chintsanya, 2011).

Added to the above is the socially constructed belief that HIV/AIDS is a reflection of one's degree of promiscuity, therefore acquiring social label. The basis for stigmatization may be the underlying social attitudes.

According to one female respondent:

> Friends and church members see me as a prostitute, which to them is the reason why I contracted the disease in the first place and that associating themselves with me may cause them to have the disease as well. (32 year old respondent)

In effect, individuals such as cotenants, landlords, friends and family members who identify them during their support meetings and know their status have been the major catalyst of abuse and it is the estrangement or separation from these circles that has resulted in the low disclosure rate.

It is, however refreshing to discover that the degree of abuse and discrimination which to some used to be very bad has reduced to some level. To buttress, a case was reported of an infected lady who once went to the boyfriend who knew of her status and accosted her that she has HIV and she did not tell him. The boyfriend even threatened that he was going to kill her if his test result was positive. It came out that after series of tests at different centers, the boyfriend was negative, even though they had had unprotected sex on several occasions. The fact is that the antiretroviral drugs that the woman took regularly protected her from infecting the boyfriend and for that matter any other man that has sex with her. The two are said to be happily married, having gone through education and counseling.

4.2.3 What can be done to improve wellbeing of PLWHA?

The next important objective of the study was to be able to outline ways to improve the status quo of the people living with HIV/AIDS through advocacy of their human rights. The researcher asked the respondents to indicate the things they thought could be done to enhance their living conditions to minimize discrimination and stigma.

According to the respondents, they need the following to be able to cope with their status:

I. Financial assistance

Financial support was found to be one of the most important issues when it comes to increasing the wellbeing of PLWHA. The respondents want financial support to be able to get the Anti-drugs, drugs regularly. Even though the drugs were supposed to be given for free some health centers sell them. For instance Akosua notes that: *When I run out of drugs, I had to buy myself even though it is supposed to be free.* (40year old respondent)

This implies that there is so much inequity in the access and distribution of the ARTs. This also reflects the inequity in the general healthcare system in the country.

II Fake anti-retroviral drugs

Another issue has to do with the extent of proliferation of fake ARTs in the country. Some of the respondents claimed that there was massive importation of fake anti-retroviral drugs into the country and this is causing complications in patients. Their humble was directed at government to institute control mechanisms to stop the canker. *There are fake drugs in the system so my greatest fear now is that I don't even know if the medicine I am taking is fake or not. Government must do something about it*. (28 year old female respondent).

III Love and care

The respondents were of the opinion that as a means of coping with their condition, individuals, family members and community members and religious groups should accept, love and care for them. Also, these people should not treat them as outcasts. They also felt that it should be easy for them to integrate into the family, community or any social groups without fear or discrimination in any form since they are also human beings like them. Some of them believe that it is rather the stigma, discrimination and rejection which has resulted in their feeling hopeless and helpless that is sending HIV/AIDS patients into early grave.

IV Education

The PLWHA respondents noted that lack of education is the reason for the perpetuation of the abuses meted out to them. They are therefore calling for a more exclusive public education on HIV/AIDS. Studies have found that education plays a vital role in reducing stigmatization and discrimination because all over the world, there continues to be a great deal of fear and stigmatization of people living with HIV/AIDS fuelled by misunderstanding and misinformation (Vandemoortele & Delamonica, 2000; Duflo, Dupas, Kremer & Sinei, 2006). Important to this research is the education on the rights of people living with HIV/AIDS. People should be made aware that PLWHA are not dangerous to the community, but people who have the same human rights as anybody else in the community. Education must be delivered in our schools, churches, workplaces, markets and hospital posts. Respondents indicated that education be targeted at these groups of individuals in the communities where they usually live. Unfortunately, a lot more people do not know that the ART prevents the spread from one person to another which is why an infected pregnant woman does not infect her baby with the diseases, with proper health care, and counselling.

V Access to legal redress

Respondents plead with government to enact laws to protect and promote the rights of people living with HIV/AIDS. They want existing laws simplified so that HIV patients could exercise their right without fear of further bewilderment.

> If the laws are simplified and made known to the general public that the rights of PLWHA must be respected, protected and promoted, this, when done, will help. It is because there are no specific laws protecting the rights of PLWHA that's why our rights continues to be abused. (25year old female respondent)

It is worth noting that CHRAJ is set up to assist people seeking redress in issues of unfair treatment and human rights abuses. Though not set up for HIV and AIDS specifically, CHRAJ provides a forum for addressing violations and abuses of the human rights of PLWHA. The Legal AIDS Scheme was established by Act 542 of 1997 by Parliament to provide legal assistance at a minimal cost to enable the poor to defend and prosecute human and legal rights violations so that all citizens can go about their economic, social and political activities in freedom and with a sense of security. It is however difficult for some of the respondents to take the challenge, the view is that the minimum cost is relative as they are incapacitated to some extent to work and acquire the needed resources.

VI Employment

Young people living with HIV are finding it hard to find employment, even though they have the necessary competence and skills. The practice of mandatory HIV testing remains common. Job applicants are often denied employment if they are found to be HIV- positive. In the words of one of the young respondents:

> It’s already hard to find a decent job and if you’re a young person living with HIV, it becomes twice as hard, I had successfully completed my apprenticeship with the company and I was about to be hired when I was told that I was not ‘medically suitable’ for the job. (26 year old female respondents)

Respondents are therefore pleading with all stakeholders to make it possible for them to get decent jobs to do since they have the right to employment.

CHAPTER FIVE

SUMMARY, CONCLUSIONS AND RECOMMENDATIONS

5.1 Introduction

This section is the concluding part of the research report which is made up of summary of the major findings, conclusions of the issues discussed and recommendations for policy and research. It also outlines the limitations and suggestions for future research.

5.2 Summary of findings

Owing to the backdrop of the high levels of stigmatization and discrimination against people living with HIV/AIDS despite the proliferation of HIV campaigns in the media and other public forums, the study sought to explore the issue in Tema metropolis of the Greater Accra Region with a focus on the abuses of the human rights of such groups. The objectives of the study were, among other things, to determine the extent to which human rights abuses of people living with HIV/AIDS (PLWHA) were rife, examine the form or nature of abuse and identify the architect of the abuse or the abusers for such individuals. Questionnaires and audio recorders were used in collecting the data. The data was analyzed using both quantitative and thematic content analyses. Below is the summary of findings:

5.2.1 Extent of Abuse of PLWHA

It was discovered that the rights of people living with HIV/AIDS are abused most of the time. In particular, more than 5 out of the 10 the respondents indicated that the right to be employed, the right to proper and timely medical care, the right to marry and have children and the right to engage in any productive venture even if the status is disclosed and the right to privacy were trampled upon.

5.2.2 The nature of abuse of PLWHA

The abuses were often in the forms of discrimination, stigma, rejection and violation of privacy in the home, the community, the Church, the workplace, the marketplace and the hospital. An example of the abuses was lack of medical supplies leading to discrimination among caregivers. There were also unnecessary delays in access to appropriate medication that is supposed to be free supplied or sold to them. Simply, the drugs supplied were either contaminated or delayed; thus, causing panic among victims.

Also, employers who knew of the statuses of the victims either sacked them or were unwilling to employ them. Individuals and sometimes medical health care givers disclose status to friends and family members without recourse to their consent. The abuses also take the form of insults, by friends, co-tenants and even children and even being ejected from rented apartments by landlords.

5.2.3 The main abusers of the rights of PLWHA

Victims were usually abused by friends and family members who knew about their status. The abusers normally disassociated themselves from them. About 5 out of the respondents revealed that medical practitioners divulged information about them (the victims) to friends, hence causing them embarrassment.

It was, however, noted that the extent of stigmatization and discrimination from family members and other members of the public were on the decline due to education in the media and the activities HIV campaigners.

One interesting finding was that most of the female victims kept more than one sexual partner for financial reasons. But because they were on the ART, they were less likely to infect their sexual partners. Besides, they added that they always asked their partners to protect themselves.

5.3 Conclusions

The study has found out that there were abuses of human rights of PLWHA in the Tema Metropolis of the Greater Accra Region. The abuses were in the form of discrimination, stigma, rejection and violation of privacy. It is also significant to note that the family, which is the basic unit of social integration, was rather highly perpetuating the abuses because they were often the first to have been disclosed about the status of a victim. The socio-economic statuses of victims were also worsened by them being avoided and sacked from their places of employment. In addition, PLWHA refused to disclose their identity due to fear of abuse, denial and rejection, yet their status often gets disclosed by health professionals, family members, friends and other close confidants without their consent. Additionally, the victims' access to anti-retroviral drugs was indicated to be poor and distribution was also delayed over months. The drugs were also suspected to be fake, and all these caused fear and panic among patients.

These abuses are against the fundamental principles and practices of Human Rights enshrined in the economic and social rights of the 1992 constitution of Ghana. While the respondents acknowledged that there has been some level of decline in the levels of discrimination and stigma against them, there was a call for more intensive public awareness on the issue.

5.4 Recommendations

Based on the major findings of the study, the following recommendations were suggested for policy directions.

Since victims were abused by people close to them, there should be education. People should be educated about the situation. This can be in the form of rallies, preaching in Churches, Mosques, and other social Government in conjunction with the gatherings since over 90% of Ghanaians are said to be religious and attend some form of religious gathering. The education can also be in peer education and rights education. Thus, education and sensitization of the disease must be increased to bring the discrimination and stigmatization to the barest minimum. Special emphasis should be made to increase the coverage of provision of education and counseling on disclosure after receiving HIV positive results. This should be an effective, on-going practice which will result in changes in attitudes towards disclosure. In order to avoid further spread, victims should be advised or educated not to keep multiple sexual partners.

There should also be more education and discussion of the subject on how to provide sustainable and gainful employment to the PLWHA since majority are youths in order to foster disclosure. It is further recommended that the victims who are mostly the youth be integrated into the National Youth Employment Programme or the Youth Enterprise Scheme. The government should directly support formed groups of PLWHAs by training and establishing them to be self sufficient.

Laws on non-discrimination should be enforced; those who abused respondents should be punished, and compensation paid to the affected individual.

The Government of Ghana in conjunction with the Food and Drugs Authority should be encouraged to take steps to manage supplies and also see to it that the right drugs are purchased.

5.5 Limitations of the study

The study was limited in several ways. It was difficult getting the respondents for fear of publicity. The issues uncovered by the study are very sensitive and so a lot of the respondents who were intended to be interviewed declined. The ethical considerations of the study also limited the use of robust research methods that could have increased the internal and external validity of the study. The study also faced financial constraints as all the interviewees needed to be compensated. The study has wished to cover several of them in various districts, but time constraints could not allow. Responses could only be obtained from 10 individuals in the Tema metropolis and this limits the generalization of the findings to Ghana. The findings could however be extrapolated due to its in-depth nature.

5.6 Suggestions for future research

Based on the findings of the study, it is suggested for consideration by future researchers, policy makers and human rights activists who are interested on issues of PLWHA to:

a. identify how children living with HIV/AIDS got infected.

b. find out the kind of jobs PLWHA do for living.

c. determine the efficacy of anti-retroviral drug for PLWHA as people can now live without it for over five months when it is medically advised to be taken daily.

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APPENDICES

APPENDIX A: Interview guide

The aim of this study is to identify the human right abuse of PLWHA hampering their living standards. At the end of this study, the findings will contribute to the existing knowledge and enable suggestions for proper intervention measures for promoting disclosure and healthy living in the community which in turn will reduce the spreading and transmission of the disease.

Time: Start of interview___________ End of interview__________

Section 1

1. Gender ___male ___female
2. Age _____________________
3. Do you attend church regularly? ____Yes ___No
4. Marital status _________________
5. Educational level________________
6. How long have you lived with the disease?_________

Section 2

7. Do you have friends who are HIV/AIDS negative? ____Yes ___No

8. Do these friends know about your current status?____Yes ___No

9. Were they your friends before you discovered your status? ____Yes ___No

10. What is your relationship with

them?____

11. Those who know about your status how do they treat

you?____

____

____

12. Does any of your family relation know about your status? ____Yes ___No

13. If yes which of

them?____

14. How do they treat

you?____

15.How often do people you know talk about HIV/AIDS? ___Weekly __monthly, __less than monthly, ____never

16. How often do you participate in the activities organized for PLWHA ___Weekly __monthly, __less than monthly, ____never

17.Why do you participate or why not

____

____

____

____

18. Does any of your church members know about your status?____Yes ___No

19. If yes what was the reaction when your church friends first heared of your conditions?____

____

20. Has your relationship with the church members changed____Yes ___No

Section 3

21. As a person living with HIV do you know your rights ____Yes ___No

22. Mention some of the rights you know____

____

____

23. How often do you exercise these rights?

24. How often are you abused or insulted or dehumanised or discriminated against etc?

25. Which category of people do they usually abuse you?

26. Are you aware of any law that protect PLWHA?____Yes ___No

27. If yes, can you mention some of these laws ____

____

28. Have you ever been discriminated in any form?____Yes ___No

29. Where did that abuse took place? School/home/church/hospital

30. Mention some of the things you think your community can do to enhance your living to minimize stigma and discrimination against PLWHA?

____

____

____

____

31. Do you think activities organized by Ghana AIDS commission, NGOs and media campaigns etc has reduced the stigma and discrimination of PLWHA ____Yes ___No

32. If yes in what form, if no why?____

____

____

____