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Psychological Impacts and Treatment of HIV/AIDS among Nigerian Women: New Perspective toward Cultural Implications and Gender Equality

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Abstract

Nigeria is a heavily populated country in West Africa and highly enriched with natural resources, a country that is very much encoded with high cultural values and appears to severely constrain women to attain their potentials. Too often, women (young and old) tend to bear the heavy cost of caring for family members with certain illnesses. Worst still, Nigerian women very often are automatically sentenced to social isolation when infected with HIV/AIDS, for instance. This article extensively reviewed some of national, continental and global studies conducted in the past related to prevalence, causation and treatment of HIV/AIDS among Nigerian women. While exploring these variables in the Nigerian context, this extensive literature review demonstrated the high-risk vulnerability of Nigerian women as against their male counterpart in regards to the causation and cultural attitude toward individuals struggling with HIV/AIDS. Such level of vulnerability is also psychological as they struggle with HIV/AIDS illness and automatic cultural and social isolation.

Keywords: HIV/AIDS; Psychological impacts; Gender inequality; Cultural and treatment implications.

Introduction

In the global context, it has been suggested that women have the highest prevalence of HIV/AIDS. This means that women appear to be more vulnerable to the infection of HIV/AIDs than men are. Thus, some African scholars have suggested that despite the biological vulnerability of women to the disease, women have been bearing the highest burden of HIV/AIDS by being caregivers of HIV/AIDS family members. This is also true with Nigerian women, who tend to have a greater risk than men toward being infected by HIV/AIDS disease. That is why some scholars have identified HIV/AIDS as bearing the "female face" [1,2]. Most importantly, the cultural and traditional environment in Nigeria has thus put Nigerian women in a position of bearing the highest level of burden of this disease. For instance, the cultural and traditional environment has placed caring for any form of illness in the hands of female population. This traditional role has made it possible for women to leave work, school, and social engagement in order to take care of male family members suffering from the disease. This is in addition to other forms of traditional role place on women such as, childbearing/caring, homemakers and home keepers [3,4]. Such an environment has continued to enhance the high increase of impacts of HIV/AIDS among Nigerian women.

Furthermore, extensive existing data from different studies have suggested that Nigeria has shown the second burdened country with HIV in the world and that Nigeria has the highest rate of new HIV/AIDS citizens in the Sub-Sahara Africa. Being a country

highly populated, it has been estimated that 3.6 million Nigerians have HIV/AIDS [5]. In addition, other studies have suggested that about 240,000 adolescents [6-15] in Nigeria are living with HIV/AIDS. This number accounted for about 7% of the total population of individuals living with HIV/AIDS in Nigeria [16]. This is an alarming number for the growing population in Nigeria. However, it is suggested that the prevalence of adolescents living with HIV/AIDS in Nigeria differs according to regions, and states. For instance, the south/south region has 4.3% of this population [11-15] living with HIV/AIDS; southeast 1.3% [17] and it has also been reported that young women tend to have the highest rate of adolescents living with HIV/AIDS in Nigeria. Thus, most recent literature suggests that young women are more at risk to be infected with HIV/AIDS than their male counterpart is. Most studies have also suggested that young women are at high risk to be infected by HIV/AIDS because these young women tend to have sex with men who are far older than their age (CIPHER (2018) [18].

However, it is very much suggested that Nigerian adolescents are at risk of being infected with HIV due to the following reasons: lack of appropriate knowledge on healthy sexual behavior; prevalence of mythology around the transmission of HIV/AIDS; early engagement in sexual behavior and inter-generational sexual behaviors [19]. Although studies tend not to have a common agreement on the vulnerability factors for this population, almost all studies agree on the fact that prevalence of HIV/AIDS is more among young women than young men [9].

In another instance, it has been suggested that most adult Nigerians are completely unaware that they have HIV/AIDS symptoms. Thus, they continue to engage in unprotected sexual behavior and thereby continue to spread the disease. In another study, it has also been suggested that some other Nigerians who are aware of having the disease, appear not to be concerned about treatment due to some social stigma associated with the illness. These factors appear to have contributed toward the high prevalence of the disease among Nigerian adults. Particularly, women have been shown to be at high risk toward being infected with HIV/AIDS than their male counterpart is. Although studies have estimated that 58% of Nigerian population living with HIV are women, scholars have identified different factors that put women at high risk with HIV [16,19]. Thus, some African scholars have suggested that the following at risk factors are responsible for the high-risk condition of Nigerian women: anatomy of women; female genital cutting; sexual interaction with their infected significant others; sexual violence, sexual abuse; and poor sexual negations. Other studies have suggested that divorced/widowed women are more likely to be infected than married or single women are [20,21]. In addition, studies have also identified limited education, employment opportunities, limited economic independence; socio-cultural status of women in Nigerian society and many more other cultural practices such as early marriage and arranged marriage practices [22,23]. Other scholars have identified other factors to be responsible for the high prevalence of HIV/AIDS among Nigerian women such as poverty, cultural masculinity and femininity norms, disabilities, "harmful traditional rites as well as human rights, legal and political factors" [24,25].

From the above data and data analysis, studies have suggested that the prevalence of HIV/AIDS in Nigeria is higher among females in contrast to their male counterparts are. This means that women (young and old) are at high risk of being infected in Nigeria when compared with their male counterpart. Moreover, other scholars have identified some variations of prevalence even among women themselves across age; socioeconomic and cultural status [20,24]. Nevertheless, the overall agreement among studies is that women are more susceptible to HIV/AIDS infections than their male counterparts are. More also, it all depends on other factors such as the geographical location or region to which the women belong. Although there are no consensuses concerning the role of geographical location on the prevalence of HIV/AIDS among Nigerian women, recent studies have identified some of the causes of this high rate of susceptibility of women to HIV/AIDS infection [26,27].

Objectives of the Study

The general objective of this study is to assess the disparity in the impacts of HIV/AIDS among Nigerian women and men, while specific objectives are:

1. To investigate the prevalence of HIV/AIDS disease in Nigeria.
2. To analyse the gender disparity on the impacts of HIV/AIDS on Nigerian Women and men.
3. To assess the cultural and social implications of HIV/AIDS on Nigerian Women.
4. To proffer a way forward on treatment and cultural implications of HIV/AIDS.

Conceptual Clarifications

HIV/AIDS

Human Immunodeficiency Virus (HIV) infection and AIDS remain a major public health crisis in Nigeria that harbors more people living with HIV than any other country in the world, except South Africa and India [27]. Stigma and discrimination is a significant challenge to the success of achieving universal access to HIV prevention, treatment, care and support. According to UNAIDS, Nigeria has about 3.8 million people living with HIV, the second largest globally. Stigma and discrimination are major barriers to testing, treatment uptake, and adherence [2,28].

In addition, UNAIDS has noted that recent statistics shows 36.9 million persons were living with HIV as of the end of 2017 [29]. Out of this, 21.7 million people were accessing antiretroviral therapy in 2017, 1.8 million people became newly infected with HIV in 2017, while 940 000 people died from AIDS-related illnesses in 2017. In another study, it has been reported that 36.7 million people were living with HIV/AIDS of which about 46% have access to treatment [25]. Of these, Nigeria has the second highest number, 3.8 million

with adult prevalence of 3.1%. About 44% of adults and children living with HIV have access to ART based on the eligibility criteria of CD4 count of 350 cells/mm [30]. HIV epidemiology in Nigeria indicates that infections are higher among women while prevalence varied across the six geopolitical regions. One of the main factors driving the infection in Nigeria includes low risk perception, concurrent sexual partnerships, and inadequate access to quality healthcare services [25]. At the center of these factors is the challenge of HIV-stigma and discrimination which are a major barrier militating against the national response to the epidemic.

Epidemiological studies throughout the world have reported only three main modes of HIV transmission. One is through sexual intercourse with an infected person; second, through exposure to blood, blood products or transplanted organs or tissues; and third, from an infected mother to her fetus or infant before, during or shortly after birth. Casual contacts such as touching, hugging and kissing an infected person with HIV/AIDS do not result in HIV transmission [31-33].

Stigma and discrimination

Some scholars have defined stigma as an undesirable or discrediting attribute that an individual possesses, thus reducing that individual's status in the eyes of society. Stigma can stem from a particular characteristic, such as a physical deformity, or from negative attitudes towards a group, such as homosexuals or prostitutes. Under Goffman's definition, society labels an individual or group as different or deviant [27]. Another study defined stigma as an attribute that links a person to undesirable characteristics [34]. In a further explanation, other scholars have indicated that stigmatized individuals are believed to possess some attributes or characteristics that convey a social identity that is devalued in a particular social context [8]. Others have defined stigma as societal processes that are linked to societal power structures [35]. Stigmatization can lead to prejudicial thoughts, behaviors, and actions on the part of governments, communities, employers, health care providers, coworkers, friends, and families [6,36,37].

Discrimination is an aspect of stigma defined as a form of exclusion, or restriction of expression, marginalization, or prevention from access to something or services. Thus, discrimination is normally expressed by force, from avoidance to life threats, lynching and death [38].

Stigma has been classified by several authors. Some divide stigma into felt, or perceived stigma and enacted stigma [15,39,40]. AIDS stigma by association with someone who is HIV positive is classified as secondary stigma or "courtesy stigma" which can affect family and friends of PLWHAs, as well as health care workers [41,42]. Other classifications identify stigma and discrimination as operating at three levels; personal, community and institutional [38].

HIV/AIDS related stigma and the resulting discriminatory attitudes creates an environment that fuels the epidemic. This is often times because of inadequate knowledge about the disease in the general population, even among health care professionals. Several studies [43-45] among nurses, physicians and laboratory scientist in Nigeria showed that these groups of caregivers still lack knowledge about the disease, thus enhancing their negative attitudes and often times refusal to treat and care for PLWHAs.

HIV/AIDS and women/gender equity

Gender equity means fairness of treatment for both women and men according to their respective needs. If equality is the end goal, equity is the means of getting there [13]. According to one of the reports titled "WOMEN, GIRLS, GENDER EQUALITY AND HIV IN NIGERIA: FACT SHEET 2016," [46,47], gender is an inextricable part of the HIV/AIDS equation; and young women are disproportionately vulnerable to infection; elderly women and young girls are also disproportionately affected by the burden of care giving in the epidemic's wake.

The NACA-produced report according to The Guardian Features Online, (2016, 3.09 am):

"Globally, females make up to 50 per cent of People Living with HIV (PLHIV) while in sub-Saharan Africa, 60 per cent of PLHIV are females. In low and middle- income countries worldwide, HIV is the leading cause of death and diseases in women of reproductive age. Men and boys are affected by gender expectations that may encourage risk-taking behavior, discourage accessing health care services and narrowly define their roles as partners and family members. Rates of HIV testing and treatment tend to be lower among men compared to women. Gender inequality and poor respect for the human rights of women of women and girls are key factors in the HIV/AIDS epidemic: both from the point of view of effectiveness and from the call of social justice" [7].

Other studies referred to WHO report that women in sub-Saharan Africa are ahead of men in the number of those living with HIV and that several factors are responsible for the variation. These include gender norms related to masculinity can encourage men to have more sexual partners and older men to have sexual relations with much younger women, raising the risk of more infection against women; Violence against women (physical, sexual and emotional), which is experienced by 10 to 60% of women (ages 15-49 years) worldwide, increases their vulnerability to HIV; and Forced sex can also contribute to HIV transmission due to tears and lacerations resulting from the use of force [26].

Furthermore, another study has shown that every week, around 7000 young women aged 15–24 years become infected with HIV. In sub-Saharan Africa, three in four new infections are among girls aged 15–19 years and young women aged 15–24 years are twice more likely to be living with HIV than men. More than one third (35%) of women around the world have experienced physical and/or sexual violence at some time in their lives. In some regions, women who experience violence are one and a half times more likely to become infected with HIV [29].

In another study, scholars have suggested that 60 percent of about 3.5 million Nigerians living with the virus, are women, meaning that men account for the remaining 40 percent [26]. In addition, it has been suggested that violence against women and girls is a key driver of HIV [7]. Studies have demonstrated strong links between gender-based violence (GBV) and HIV infection with violence as a risk factor for HIV as well as a consequence of being HIV positive. About 35.6 percent of women across the world have experienced either non-partner sexual violence or physical or sexual violence by an intimate partner or both. Gender-based violence and gender inequality are increasingly cited as important determinants of women's HIV risk. Forced sex increases the risk of HIV transmission among women due to lacerations. Women dreading or experiencing violence, are less likely to negotiate for safe sex, go for HIV testing, share their HIV status and access treatment [26]. For example, in Nigeria, women and girls abducted by the insurgency groups are forced to marry, convert and endure physical and psychological abuse, forced labor, and rape in captivity. More than 500 Nigerian women and girls have been abducted since 2009 [26].

Various studies in Nigeria identified the following as factors that make women and girls more vulnerable to HIV, viz: most women and girls lack power to control key aspects of their lives including marriage and sexual negotiation in and out of marriage; most women and girls also lack social and economic power to control the impact of the epidemic in their lives (about 70% of Nigerian women live below the $1 a day threshold emphasizing the feminization of poverty in Nigeria); women and girls lack access to education at all levels, economic empowerment largely tied to property rights (10% of women in Nigeria own land); in Nigeria, 60–79% of the rural workforce is women but men are five times more likely to own land; Weak political commitment to domesticate and implement international and regional treaties and national laws that aim to address gender inequalities among others, remain a challenge for empowering women across board in Nigeria [26].

In another study, it has been noted that masculinity norms impress on men to have more than one sexual partner and it is common for older men to have unprotected sexual relationship with much younger women, it stated that:

" . . . gender inequality has been identified as a key driver influencing the vulnerability of women and girls to HIV infection. This is evident in the current HIV prevalence among the general population in Nigeria of which women constitute 58 per cent. The rate among young women between the ages of 15 and 24 years is estimated to be three times higher than among men of the same age" [26].

Meanwhile, the National Policy on HIV and the National Strategic Framework and Plan over the years elucidate the strong commitment of the national response to promoting gender equality and upholding human rights of all Nigerians. Furthermore, another study has noted that: "This guiding principle is a clear indication of due recognition of the place of gender equality in the national HIV response". Within the ambits of the policies and legal frameworks, participation and involvement of women, girls, men, boys and the marginalized groups including key populations is encouraged. The federal nature of the country also allows each State to enact its own laws and develop its own policies [26].

There is however, a clear gap between rhetoric and reality. Available data continues to point to the fact that women, girls, men and boys are disproportionately affected. Women and girls vulnerability to HIV is deeply rooted in their biological make up and this is exacerbated by a complex mix of societal norms and value systems which not only affect women and girls but also men and boys. Gaps however exist both in implementation and provision of some of the laws that mitigate its efficiency. Punitive laws may reverse the gains in the HIV prevention achieved over the years especially among key vulnerable populations. Efforts are however being scaled up to make gender equality and human rights response a reality.

Causes of HIV/AIDS among Nigerian Women

Unprotected sexual intercourse

In studying some of the causes of HIV/AIDS among Nigerian women, some Nigerian and global scholars have suggested that the engagement into unprotected sexual intercourse and relationship as number one cause [7,12,14]. This has accounted for about 80% of the cause of the illness [25] very much referred to heterosexual intercourse relationship between male and female without intention of pregnancy. However, research has not been able to establish the rate of HIV/AIDS connected to unprotected sexual behaviors among heterosexuals in Nigeria. Nevertheless, it has been established that this act is a very risky behavior practiced among heterosexual men and women. The consequences of such a risky behavior can be measured by the high rate of unwanted pregnancy and infection of sexual transmitted disease such as HIV/AIDS**.** Studies have also suggested that most Nigerian women tend to engage in unprotected sexual behavior due to lack or limited power to negotiate the need to use protective techniques such as condoms [9,12]. Sometimes poverty and low access to capital some prevent women from protective sex [20,21,48].

Patriarchy society

Nigeria as a patriarchy society gives validation to the interest of men and women live subject to their dictates and interest most time. With this background, women lack power to negotiate their sex partners or methods of intercourse. Such limited and lack of power of negotiation has its root in the paternal nature of Nigerian society. It is a society where women have less power to negotiate their health [3,7].

Ignorance

In addition, Nigerian women tend to engage in unsafe sexual behaviors because of limited or lack of knowledge related to the use and effectiveness of safe sex tools; inconvenience of the use of condoms and cost [12].

Feel of sexual pleasure

Studies have suggested that the cause of HIV/AIDS disease could be attributed to the fact that some Nigerian women tend to abandon the use of condoms in order to have that physical and emotional closeness attributed to sexual behavior. That, a lot of Nigerian women abandon protective sexual behavior in order to enjoy sexual pleasure; demonstrate love to their male counterpart; enhance mood and sometimes to please their partners; heighten sexual pleasure; strengthen romantic relationships and possibly the urgency to feel close or very connected to their male counterparts [12,14,49]. Thus, it has been suggested that the rate of condom use among some Nigerian women is very low because of the above-mentioned variables.

Disempowerment

Some national, continental, and global scholars have also suggested that one of the major causes and spread of this disease among Nigerian women rests on the several disempowerment experienced by Nigerian women. Thus, this form of risk factor ranges to areas of their lives, which include cultural, social, education and financial disempowerments. Such disempowerments tend to put Nigerian women in a vulnerable position of sexual exploitations. In addition, most recent national, continental, and global studies have suggested that formally married women are at higher risk than current married women regarding several forms of disempowerments among women [6,12].

Prevalence of tuberculosis (TB)

In another sphere, scholars have suggested and identified the prevalence of TB (Tuberculosis) among Nigerian women to have some links to HIV/AIDS. It is important to note that Nigeria has been reported to have fourth highest prevalence of TB globally. Unfortunately, Nigerian government has not been able to provide comprehensive prevention and treatment strategies to combat the high level of prevalence associated with TB. In addition, most Nigerian women with TB have not been able to either complete their treatment regime or made use of the limited resources available to prevent or treat TB as it has been shown to be linked to HIV/AIDS disease [2,50].

Sharing of needles and syringes

In most recent studies associated with addiction and substance abuse, it has been suggested that addicts who engage in injecting drugs and sharing of needles and syringes are also vulnerable to been infected with HIV/AIDS disease. Thus, it has been demonstrated that 14% of women have been infected through this means. Other studies have also suggested that every year, 9% of Nigerians have been infected with this disease through sharing of needles and syringes [2,25]. Overall, though there has been reduction at the rate of infection through sharing of needles and syringes, the rate is still high in Nigeria. This is very much among Nigerian women [25].

Spread of HIV/AIDS

Environmental, social, cultural & religious beliefs

It has been established through research on the national, continental, and international ground that Nigeria has the second highest record of HIV/AIDS globally [7,26,50]. Unfortunately, very much many of Nigerians living with HIV/AIDS are either ignorant of their HIV/AIDS status or have decided not to seek treatment in order to prevent continuous spread of the disease. However, the question here is all about some of the causes of HIV/AIDS in Nigeria, especially among Nigerian women [7].

Cultural attitudes toward HIV/AIDS

According to Suleiman [51], the African conception of health assumes a holistic perception, which asserts that the state of health includes political, social, economic and "religious" well-being of individuals and communities. It suggests that health is a general well-being. HIV/AIDS has impact not only on the biological well-being, but also on the general well-being of individuals and that of the community.

Poverty and forced prostitution

Poverty affects fertility and sexual activity [52]. African women bear the higher brunt of poverty because they have low access to capital [21]. In traditional economy, they do not have access to cattle and land, while in modern economy they are discouraged from higher education and the labor market. They also face unequal opportunities in access to household resources [53]. Consequently, women do not have access to the few available jobs and sufficient income- earning. Since women have to live, some women depend on marriage and sex to access resources. Among many young and unmarried women, sex is the instrument with which they get jobs, qualify for higher education and even fulfill their requirements for award of certificate, especially when they migrate to urban communities.

Poverty also makes it difficult for the people to use condoms to protect themselves against the infection. Because of poverty, when infected with sexually transmitted diseases they lack resources to visit clinics [51]. In Nigeria, primary health care does not provide reproductive health care services freely. In addition, due to stigmatization, the victims of sexually transmitted diseases prefer treating their ailment secretly. They therefore depend on medical quacks and self-medication.

HIV/AIDS as sexual immorality

In a study, it was found that HIV/AIDS in some traditional communities is referred to as "akoatosi" (virulent gonorrhea). Sexually Transmitted Diseases are regarded as diseases caused by sexual immorality. Consequently, its victims cannot disclose as they would be treated with ridicule and embarrassed. The victims therefore only seek treatment secretly. Underlying that conception is the belief that HIV/AIDS is similarly a disease caused by immoral conduct, thus its victims should be made to serve the punishment for their indiscipline. This position is in contrast with western

perceptions of HIV/AIDS. Because of these opposing views, many PLWAs do not have confidence in modern hospitals until the disease becomes advanced [51].

Reluctance to protective sex

Some people believe that using condoms is indirect sex, and it is not pleasurable and enjoyable, hence they are reluctant to use condoms. Thus, studies have noted that the reluctance to the use of condom is also supported by the perception that since World Health Organization (WHO) is busy promoting traditional methods of health caring [2,53], and then local contraceptives should be encouraged. People believe that many of the local contraceptives are better than condom, but the local contraceptives are not promoted and that if there is need to protect illicit and unfaithful sex, why not use local contraceptives, which are affordable in cost, and accessibility [51].

Notion that HIV/AIDS is incurable

The Yoruba people believe that HIV/AIDS is an incurable and fatal disease and that no amount of care given to PLWAs will avert death through AIDS [51]. The knowledge of Anti Retro-viral drug is very low among people. Even in the institutions caring for PLWAs, the use of ARVs is affected by some cultural factors. These include the side effect of the drugs. The PLWAs always complained that it makes them dizzy, and make them to lose their hair. ARVs are also affected by irregular supply to those who want to use the drug. There are also many PLWAs who could not afford the cost of ARVs. In the context of all the above, the belief is that it is needless to care for the victims, because according to a respondent in a study conducted among the Yoruba people of South-West Nigeria:

Caring for an HIV/AIDS patient is a sheer waste of both money and time.

Vulnerability of Women to HIV/AIDS

Unequal treatment given to women compared to men in the Yoruba society forms the basis of women being more vulnerable to HIV/AIDS than men are. The fact that women do not have equal access to society's resources such as capital, land and other social needs like their male counterparts exposes women to finding means of access to such resources [51]. For many women, the available means is sexuality, which becomes an indiscriminate tool of access to resources. Such women are exposed to illicit pre-marital sexuality and after marriage they are exposed to extra-marital sex. While engaged in this practice, they are not usually mindful of the health conditions of their sex partners. Generally, among the Yoruba, and indeed in many sub-Saharan Africa, women are betrothed for marriage upon payment of marriage goods or dowry by their prospective husbands, thus selling out their sexual rights to men. Women then bequeath their sex rights to their husbands. Even if the husband is known to have health problems, in so far those problems have not impaired his manhood. Women do not have 'cultural' right to refuse sex. In many circumstances, the combined effect of the gender inequality is sexually related problems in women [51].

Furthermore, it is very important we understand that not all Nigerian women are equally vulnerable to this disease at the same level/rate. Thus, other determinants position most Nigerian women to be categorized as the most vulnerable population. These determinants include but not limited to the following: educational level; location; marital status; economic power; and age. These can be labeled key determinants that tend to significantly increase the vulnerability of any Nigerian women in general. The point is that some Nigerian women are more vulnerable than the rest of the well-placed Nigerian women who are highly educated; with high economic power; well experienced with life (age); married, etc.

Social Attitudes toward HIV/AIDS Patients

HIV/AIDS is a complex disease associated with social, political and economic disabilities of the societies affected. It is not only a biological infection, but also political, social, economic and psychological [54]. The pattern of spread, its prevalence, and the care and support in AIDS show that there are many interlocking variables contributing to the epidemic. These variables include gender inequity economic imbalance, and misplacement of priorities in government policies [54].

In a study aimed at determining the impact of public beliefs and perceptions about HIV/AIDS and the quality of their attitude toward PLWHA, conducted in Iran, the prevalence rate of discriminatory attitudes toward PLWHA in this study was very high and most of participants had discriminatory and negative attitudes toward PLWHA. It shows that PLWHA are extremely stigmatized in Iran. It was found that negative and discriminatory attitudes towards people living with HIV/AIDS (PLWHA) are one of the biggest experienced challenges by people suffering from HIV, and these attitudes have been regarded as a serious threat to the fundamental rights of all infected people who are affected or associated with this disease in Iran [55].

In a study conducted to examine the knowledge, beliefs and attitudes of nurses and laboratory technologists towards people living with HIV/AIDS (PLWA) and the factors responsible for these attitudes [20]. This study found that the fear of being infected at workplaces, educational institutions and in the community has led to irrational and discriminatory treatment of people living with HIV/AIDS (PLWA). Their rights to employment, housing, education and even health and nursing care are being violated because of their HIV status. This practice unfortunately exists despite strong evidence from research that has revealed that non-sexual contact with HIV positive individuals carries little or no risk. This is even more so if careful precautions with blood products are taken, as this further protects people from contracting the infection. The resultant effects of such negative attitudes include poor patient management, with people being denied most needed treatment, care and support. This in turn could affect their morale, self-esteem and self-determination to live quality lives devoid of stigma, fear, repression and discrimination [20].

According to the study, though, most of the respondents (96.0%) knew the causative agent of AIDS to be a virus and the main modes of transmission to be sexual intercourse, blood transfusion, sharing sharp objects and perinatal transmission, yet. There were also erroneous beliefs by the majority of the respondents that the HIV could be transmitted through insect bites (84.3%), touching and hugging (90.6%), sharing of toilet facilities with infected persons (90.6%), and poor levels of health and nutrition (92.9%). The fear of contracting HIV through accidental inoculation of infected blood has assumed alarming proportions, affecting not only the career choices of young people and discriminatory practices towards PLWAs, but it has also compromised the quality of care provided for them. Lack of confidence of health workers arising from the lack of knowledge and skills to provide AIDS counselling and advice has been identified as another factor that can explain the negative attitudes exhibited [10,31,56,57].

Thus, it can be said that the spread of HIV/AIDS in Nigeria has social, cultural, and economic attributes. These variables tend to leave Nigerian women very much vulnerable and at high risk. This has nothing to do with the womanhood; rather, it has to do with the way women are treated in Nigerian society in all these spheres of the society's life. At this point, one would wonder, what are some of the psychological impacts of this disease on Nigerian women?

Psychological Impacts of HIV/AIDS on Nigerian Women

Research and studies that have produced sufficient data have suggested that there are causes, population vulnerability, and of course rates of this disease. Such studies and research tend to run through ages, psychological development, gender, and sexual orientations. However, this portion of this paper will review and analyze data regarding some of the psychological impacts of HIV/AIDS among Nigerian women. Other studies have suggested that these psychological impacts include direct victims of the disease and indirect victims (children, partners, family members, caretakers, etc).

In light of direct victims of the disease, recent studies have suggested that Nigerian women tend to display some symptoms of depression resulting from their mood whenever they learned of their diagnosis of HIV/AIDS disease [51,54]. In addition, some of other recent studies have demonstrate that the prevalence of depressive symptoms are higher among women who are not educated, unemployed and disempowered women within the Nigerian society [3,7]. This is in addition that most Nigerian women experiencing depressive symptoms due to this disease also display severe physical symptoms associated with depression [20,58]. Other studies suggested that psychotropic medications and psychological intervention would go a long way to help these women not only managed their HIV/AIDS, but also, their depressive symptoms [11,32,45].

Regarding social/cultural stigmatization of HIV/ADIS patients, most recent studies have suggested that victims of the disease tend to display symptoms of stigmatization associated with the cultural and gender role in the Nigerian society. This is because "Stigmatized persons lose social status, they are discounted and discredited—reduced in the minds of others from being whole and acceptable individuals to those whose identities are spoiled and tainted" [11,58]. Such an impact could affect their social, emotional, self-worth, self-perception and self-esteem, which tend to affect their employment, family, and social responsibilities. The impact tends to be extremely negative due to the societal perception of HIV/AIDS; and the way it was transmitted. Thus, Nigerian women are held responsible personally, blamed and judged for the disease [11,58].

All these psychological impacts and more are very much on the increase as there are no consistent monitoring of the spread of this disease among Nigerians in general and women in particular. In addition, most of the women inflected by the disease have not been able to either have access to or seek psychological services in order to manage these psychological impacts. Though there have been some efforts by few to combat these psychological effects, HIV/AIDS in Nigeria has been evolving overtime. This evolutionary movement of the disease also involves evolutionary movements of the effects to all Nigerians and to particular vulnerable population-Nigerian women [58].

Thus, the Nigerian government and the society in general need to reposition their attitude toward Nigerian women. More also, there is need for planning, developing, implementing, monitoring and evaluation of evidence based treatment for individuals with HIV/AIDS in general and Nigerian women in particular.

Available Treatment Modalities (Traditional & Western approaches)

It will be incomplete to discuss treatment of HIV/AIDS among Nigerian women without first attempting to discuss issues around prevention. Prevention as a strategy has been highly supported by many professionals, government agencies (state, national and global) as one of the most effective strategy toward combating HIV/AIDS among the most vulnerable population. Thus, prevention strategies should be identified as a priority for all including women themselves. In light of this assertion, most scholars and studies have identified three levels of prevention-primary, secondary and tertiary levels [54,59]. These levels of prevention can come in the form of psycho education on the rate, risks factors, treatment availability, assessing treatment services, adherence toward treatment recommendation, management of stigma, etc.

In addition, there is need and urgency for the Nigerian government and agencies to develop prevention strategies that are very much contextualized and evidence based. In this sense, women and other sub-groups among women's' needs should be included while preventionists develop any form of prevention program. In other words, these prevention

programs need to be specific to the women and/or sub-group among women (racial, ethnic, young women, low socioeconomic, uneducated, former married women, etc). Moreover, at the same time, these programs will have to be theory driven in their planning, development, implementation and monitoring stages.

This form of prevention and treatment modalities are very western oriented and they can be helpful toward the reduction of risk factors and enhancement of the protective factors among this population. These are treatments and prevention modalities that are theory-driven; evidence based. This means that they have been tested and proven to be effective and efficient. In addition, they have been shown to be very handy for many health professionals in Nigeria. Most of these professionals have been trained on the application and contextualization of these western-based prevention and treatment modalities. Although there may be some challenges in the application and contextualization of these western-oriented approaches, it has been recognized and accepted as effective, efficient and evidence based by Nigerian health workers. These health workers have been well positioned to make these approaches available and accessible to most women.

Although the Nigerian government, Nigerian health professionals and the Nigerian society have been proactive and progressive in harnessing, implementing and contextualizing these wester-oriented approaches, they seem to lack in the understanding of the effectiveness and efficiency of the traditional method of prevention and treatment [60]. Thus, some studies have echoed the fact that biomedical methods only cannot provide comprehensive prevention and treatment for individuals infected with the disease in Nigeria [59]. It all implies that other forms of treatment and prevention approaches can really be effective if used appropriately in combination with biomedical forms. However, some studies have objected to the benefits of traditional health practitioners (THP) toward prevention and treatment of HIV/AIDS. Therefore, there appears to be no consensus on whether THP is beneficial or not.

Opponents of THP assert that it is illogical and unscientific in its application and contextualization. In addition, other studies have suggested that THP does not have the capability of diagnosis and treatment [19,61,62] thus, rendering judgement that THP is non-evidence based. Nonetheless, THP practices can be used in a combined activity with the biomedical approaches. In reality, THP can play a supportive role such as psychoeducation, encouraging safe sex behavior, and providing community-based prevention and treatment. Thus, it is important to recognize the role of THP and biomedical methods in developing a prevention and treatment programs in Nigeria for Nigerian women.

Conclusion

This study concludes that Nigerian women living with HIV/AIDS are susceptible not only to stigma and to discrimination, but also to cultural and social outcast. These women are vulnerable than their men counterparts as they are unable to choose their sex partners, negotiate safer sex with their men, nor avoid domestic violence. Poverty resulting into devising means of survival like forced prostitution, and inability to afford good treatment or engage in protective sex are issues that portend to gender inequality of HIV/AIDS in Nigeria. The fact that some cultural beliefs lie in the notion that HIV/AIDS is incurable, and that it stems from immorality, coupled with the fact that sex partners want the flesh to flesh actual feelings during intercourse, aggravate stigma and discrimination against PLWHAs and expand the spread of the disease. Also, inadequate sex education in schools and sensitization to the public and especially the health care providers on HIV/AIDS deepens concern of stigmatization against PLWHAs, especially the female gender.

Recommendations

The study recommended gender responsive budgeting to ensure milestone in HIV/AIDS programming. Main streaming of gender into all policy-related and programming activities and structures will ensure that all interventions and programs are gender-sensitive and gender-responsive to appropriately meet the unique needs of females and males [5].

The government at all level should ensure economic empowerment for the stigmatized group, like the PLWHAs and the commercial sex workers as well as their involvement in the design and implementation of prevention programs in the country. This will reduce poverty level and improve their economic status to access ATR drugs.

To reduce stigma and discrimination against HIV/AIDS patients, there is a need for AIDS-education/intervention studies aimed at students and health care givers and continuous and population based AIDS education program that will significantly increase knowledge and public awareness. This can be done through the news media-like home videos, radio jingles etc, to produce de-stigmatization programs in schools, hospitals, religious centers; integrated into the curriculum of teaching in the country from primary to university level. Closely related to this is a need for health education campaigns, which should integrate a change from fear to caring for PLWHAs, as this is particularly important for the health care personnel.

Furthermore, since more people reside in rural communities, more prevention activities should be situated in rural and remote areas than in urban locations, as it is currently in Nigeria. It is most appropriate to concentrate these programs where the majority of the population resides. This translates to more emphasis on primary care.

Moreover, only handful cultural impacts study are available in literature, for broader knowledge of diverse cultural impacts, there is a need for more research to study the role of culture, religion and social structures and their relationship to stigmatizing attitudes in the various ethnic communities that make up the about 200 million people in Nigeria.

Above all, prevention is the utmost for HIV/AIDS rather than palative treatment or cure. Thus, de-stigmatization should be a major component of the Abstinence, Be faithful and Condom (ABC) approach in prevention strategies.

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