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ATTITUDES OF MOSLEMS ON HIV AND AIDS RELATED STIGMA AND DISCRIMINATION IN UPPER WEST REGION, GHANA

BY

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DECLARATION

Candidate's Declaration

I hereby declare that this thesis is the result of my own original research and that no part of it has been presented for another degree in this University or elsewhere.

…… ……..

Abudu Sakara **Date**

(Candidate)

Supervisors' Declaration

We hereby declare that the preparation and presentation of the thesis were supervised in accordance with the guidelines on supervision of thesis laid down by the University of Ghana.

…… ……..

Dr. Samuel Kofi Badu-Nyarko **Date**

(Principal Supervisor)

…… ……..

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(Co-Supervisor)

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DEDICATION

I dedicate this work to my dear wife Niamatu Abdulai, and my lovely children, Nafisah Sakara, Hamdia Mwindingu Sakara, Abdul Hamid Tuurosung Sakara and Abdul Hamad Yelsung Sakara for their patience, understanding and prayers throughout my academic journey.

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ABSTRACT

HIV and AIDS is one of the most widespread and devastating epidemic with global public health implications in the 21st century and Ghana as a nation, is not an exception. Several studies in Ghana suggest that HIV and AIDS related stigma and discrimination has been the bane of fighting the reduction and elimination of HIV and AIDS.

Such issues like nondisclosure, public outcry, and social exclusion constitute a basic problem so far as the disease is concerned. This study therefore tends to look into stigma and discrimination and for that matter, the influence of the beliefs and practices and socio-demographic characteristics of the Moslems on their attitudes towards PLWHAs within this catchment area.

To achieve its objective, the study employed the cross sectional survey research design. With the aid of structured interview schedules as well as the multi stage, incidental and purposive sampling techniques, the primary data was gathered from 300 (178 males and 122 females) Moslem respondents from three sampled districts namely Wa Municipality, Wa West and Sissala East. Pearson correlation co efficient and the chi square test statistics as well as descriptive statistics (mean scores, standard deviation, frequency counts, percentages and cross tables) were also employed to check and analyse significance, the extent of relationship and or influence.

The major findings of the study were that Moslems' attitude towards PLWHAs was positive and to a large extent influenced by their beliefs and practices as enshrined in the Quran and Hadith. Among the four constructs of religious, social, economic and political, the most discriminatory was that of social engagement ($\bar{x}$ = 3.60; sd= 1.13).

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There was also a significant relationship between the socio-demographic or personal characteristics (sex, age and educational background) of the Moslems and their attitudes towards PLWHAs in relation to religious, social, economic and political engagement. The Moslems in the Upper West region will not disclose their HIV and AIDS status ($\bar{x}$ = 2.79; sd= 1.33) despite their religious beliefs and practices for fear of discrimination and stigma.

To help minimise the negative impact of HIV and AIDS related stigma and discrimination, the study recommended that Moslem leaders' teachings should be centered on what Islam espouses on attitudes towards the sick and vulnerable, especially PLWHAs. Another recommendation of the study was that adult education institutions (National Commission on Civic Education, Institute of Local Government Studies, Department of Adult Education of the University of Ghana and the District Assemblies) should organise training programmes to educate and sensitise religious leaders, tutors and students of Islamic educational institutions to enable them accept the sick, especially PLWHAs. It is also recommended by the study that Moslem leaders, National Commission on Civic Education and District assemblies should organise education and training programmes for Moslem communities to help reduce HIV and AIDS related stigma and discrimination.

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CHAPTER ONE
INTRODUCTION

1.1 Background to the Study

Stigma and Discrimination, in any form the world over is considered as one of the obstacles towards the reduction and elimination of some chronic health conditions or diseases, particularly HIV and AIDS. HIV and AIDS is one of the most widespread and devastating epidemic in the 21st century. The disease has not only brought untold hardships and its impact felt in all aspects of life but it has also affected different people of diverse status and background putting them at risk. It is, therefore, not surprising that it has emerged as a global public health concern that merits a multidimensional response. As it were, it has direct implications on the health of the economy, the social and political lives of affected countries.

There is evidence to suggest that the overall level of new HIV infection is still high. Worldwide, 36.9 million persons were affected by the disease with two (2) million newly infected persons and 1.2 million deaths associated with the disease (UNICEF, 2014). The year 2015, however, recorded a decrease in the number of persons living with the disease, which stood at 36.7 million and AIDS related deaths at 1.1 million but unfortunately, there was an increase in the number of newly infected persons, which was 2.1 million (UNICEF, 2014; UNAIDS, 2016).

Also, sub-Saharan Africa was not spared the scourge of the disease because it had 1.4 million newly infected persons with approximately 800,000 HIV and AIDS related deaths in 2014. For the year 2015, 25.6 million persons living with the disease were

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found in the region and that accounted for 2/3 of the global total of HIV infections (WHO, 2015).

Ghana is not an exception as far as the HIV and AIDS epidemic is concerned. There has not been any remarkable improvement in terms of the reduction of the prevalence rate of infections and deaths despite numerous interventions by government and non-governmental organisations, agencies and bodies. Available data show that ever since the first case of the disease was detected in 1986, everybody has been at risk in Ghana. In 2012, the number of persons who were living with the disease was 235,982. Persons who were infected within that year totalled 7,991 and 11,655 as AIDS related deaths (UNAIDS 2013). The Ghana AIDS Commission (2013) stated that an estimated 224,488 people were living with the disease and that 7,812 had become infected in 2013. In the same year, the number of people who died due to AIDS related causes was 10,074.

The 2014 National HIV and AIDS estimates showed that Ghana had 250,232 persons living with the disease and out of that number 229,009 were adults with 21,223 children. New HIV infections stood at 11,356 and AIDS related deaths recorded in 2014 were 9,248 (Ghana AIDS Commission 2014). Also, UNAIDS (2016) established that in 2015, 274,600 persons were living with the disease and that 13, 000 AIDS related deaths were also recorded in the same year.

HIV prevalence rate in Ghana as at 2010 stood at 1.5% and remained same in 2011. There was a drop in 2012 to 1.4% and further dropped to 1.3% in 2013. However, the prevalence rate witnessed an increase to 1.5% in 2014 and a minimum decline in 2015 to

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1.4. As at 2012, the rate had come down to 1.4% and further slowed down to 1.3 in 2013 (HIV Sentinel Survey Reports, 2013).

This implies that the reduction or improvement in the prevalence rate is not steady. This could probably be due to certain factors that have not been effectively addressed by the many and different interventions by government and other related bodies. Some of these Government of Ghana interventions were the establishment of the National Advisory Commission on AIDS (NACA) in 1985, National AIDS/STI Control Programme (NACP) in 1987 and the Ghana AIDS Commission in 2000 to plan, co-ordinate, prevent, manage and control HIV in the country. Others included the Ministry of Education and Social Welfare and Employment respective introduction of School and workplace HIV and AIDS counseling services.

The government's commitment was also evidenced by being a signatory to many continental and international treaties, conventions and declarations on HIV and AIDS. The focus of all these instruments was on the rights and protection of persons living with HIV and AIDS, (PLWHA) from discrimination. Since 2001, about fifteen percent (15%) of the annual health budget of Ghana has been assigned for HIV and AIDS activities. Government Ministries were also required to have budget lines for HIV/AIDS related activities (Anarfi & Appiah, 2004). These interventions have created increased awareness and knowledge of the methods of acquiring the disease as well as the 'hows' to prevent and to treat it. According to the National HIV and AIDS Strategic Plan, Ghana: 2011-2015, issues of stigma and discrimination associated with the disease have been the greatest challenge to curtail the spread and new infections.

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Stigma and discrimination has been the biggest challenge or bane in the control and elimination of many health chronic conditions including leprosy, tuberculosis, (TB) epilepsy, mental illness and of course, HIV and AIDS, which seem to have common characteristics or attributes (Van Brakel, 2006). This is because they are considered and believed to be highly contagious, infectious and incurable, may cause disability to victims and disaffection to families and friends. HIV and AIDS is usually occasioned by fear, ignorance, lack of knowledge, misconceptions and rumors, as well as placing blame and accusation of moral wrong doing (ICRW, 2002; Ogden and Nyblade, 2005; Adoo-Adeku et al, 2010).

In most instances, derogatory terms and jargons used to describe the disease such as 'curse', 'demoniac', 'a form of mental illness or madness', 'a disease that can kill' and 'a walking skeleton' contribute to the fears associated with the disease. Moreover, poverty further exacerbates the situation and thus makes it more difficult for the interventions to overcome the epidemic. All these contribute to PLWHAs' relations and families' negative social perception and image towards PLWHAs, which invariably re-inforce the latter's denial and refusal to disclose their status; a situation that provides a fertile conduit for the spread of the disease.

This assertion by the National HIV and AIDS Strategic Plan (2010) statement that HIV and AIDS related stigma and discrimination has been the most vibrant factor that promotes the continuous spread as well as the barrier for preventing and controlling the spread of HIV and AIDS cannot be overlooked. Some studies undertaken in Ghana revealed that addressing HIV and AIDS related stigma and discrimination were critical in addressing the planning management and control of the disease. For example, a study

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conducted by Mills (2003) revealed that most HIV-Sero women felt the need not to disclose their status based on perceived shame and disgrace surrounding the HIV infection. Similarly, Mwinituo and Mills (2006) found out that even caregivers experienced widespread stigma and discrimination from close neighbours, family members and health workers not to talk of the victims. Studies undertaken by Adoo-Adeku, Badu-Nyarko, Kwashie and Benneh (2010) on HIV /AIDS education on Stigmatization and Discrimination specifically in four regions including the Upper West Region concluded that tackling HIV and AIDS related stigma and discrimination were critical in the management and control of the spread of the disease in Ghana.

1.2 Statement of the Problem

Several studies, Mwinituo & Mills (2006) Adoo-Adeku et al (2010) and Ayiworoh (2016) on HIV and AIDS related stigma and discrimination in Ghana have not done much on the extent to which the beliefs and practices of religious sects have influenced the attitudes of their members or individuals towards PLWHAs. In Ghana, religion plays a very important role in the lives of all Ghanaians. More than 90% are either Christians, Moslems or traditional believers. As regards the Upper West Region, which is the study area, over 95% of the population are adherents of the three major religions namely Christianity (44.2%), Islam (38.1%) and traditional religion (2010 Population and Housing Census).

In this regard, one can confidently say that Ghanaians particularly are curiously religious and are not only seen to be peaceful, hospitable but also loving, caring and tolerant to fellow human beings, especially with respect to the sick and their fundamental human rights in the society. These are in fulfilment of the existing tenets and beliefs systems of

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their various religious sects including Islam, which in particular admonishes its followers to be loving and caring towards fellow human beings.

As narrated by Abu Hurayra in Saheeh Bukhari, the Prophet (PBUH) said

> "There are five duties that the Moslem owes to his brother", one of which is visiting the sick". Another version states that "The rights of one Moslem over another are visiting the sick´' and "Feed the hungry, visit the sick and free the captives".

God himself stressed the significance and reward of visiting the sick and afflicted as narrated by the Prophet:

> "On the day of Resurrection, God the Almighty and Majestic will say: "O child of Adam! I became sick and you did not visit me!' The person will say, 'O Lord, how can I visit you and you are the Lord of all that Exists! ''…Did you not know that if you visited him, you would have found me with him?'' (Saheeh Muslim)

Also, as captured in Saheeh Al Bukhari: 13, which states

> "None of you will have faith until he loves for his brother what he loves for himself".

The Holy Quran chapter 5:8 also states the following in relation to hatred and love

> "... And do not let the hatred of a people prevent you from being just. Be just; that is nearer to righteousness…'

> "God does not forbid you to be kind and equitable to those who have never fought against your faith nor driven you out of your homes. In fact God loves the equitable'' (Quran 60.8)

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> 'The parable of the believers in their affection, mercy and love for each other is that of a body. When any limb aches, the whole body reacts with sleeplessness and fever' (Bukhari 5665).

All these verses show the level of non-stigmatisation and non- discrimination based on religious beliefs and practices.

This notwithstanding, little evidence exist on the extent of how the beliefs and practices of Islam have influenced the attitudes of practising adult Moslems towards PLWHAs in the Upper West region despite many and varied research and studies on HIV and AIDS related stigma and discrimination in Ghana.

In the light of the above, this study therefore sought to find out: "To what extent do the beliefs and practices and socio-demographic characteristics of Moslems influence their attitudes towards persons living with HIV and AIDS in the Upper West Region in Ghana?"

1:3 Purpose of the Study

The purpose of the study is to determine and assess how practising Moslems' religious, social, economic and political relations with PLWHAs have been influenced by the beliefs and practices as well as their socio demographic characteristics such as age, sex and education in the Upper West Region have implications for adult education

1:4 Main Objective

The study's main objective is to establish the extent to which the beliefs and practices and socio-demographic characteristics in terms of sex, age and educational level of Moslems in the Upper West Region have influenced their attitudes towards people living with HIV and AIDS regarding their religious, social, economic and political engagement.

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1.4.1 Specific Objectives of the Study

In order to operationalise the main objective, the following specific objectives were formulated.

1 To find out the extent to which the attitudes of Moslems in the Upper West Region towards PLWHAs have been influenced by their beliefs and practices in religious, social, economic and political relations.

2 To assess the extent to which the socio-demographic characteristics (sex, age and educational level) influence the attitudes of Moslems in the Upper West Region towards PLWHAs in religious, social, economic and political engagements.

3 To identify the teachings of Islam that influence the attitudes of Moslem respondents in the Upper West region towards PLWHAS

4 To determine how disclosure of HIV and AIDS status influences attitudes towards stigma and discrimination of PLWHAs

5 To find out the effects of stigma and discriminatory attitudes on PLWHAs and their relatives.

6. To determine Moslems' views in reducing stigma and discrimination against PLWHAs

1.5 Research Questions

To achieve the study objectives, the following research questions were addressed.

1. To what extent do Moslems beliefs and practices influence their attitudes towards PLWHAs in terms of religious, social, economic and political relations?

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2 To what extent do the socio demographic characteristics (age, sex and educational level) of Moslems in the Upper West Region influence their attitudes towards PLWHAs in religious, social, economic and political engagements?

3 What teachings in Islam influence Moslem respondents' attitudes towards PLWHAs?

4 In what ways does disclosure influence Moslems attitude towards stigma and discrimination of PLWHAs?

5 What are the effects of stigma and discriminatory attitudes on Moslems who are HIV positive?

6. In what ways can stigma and discrimination towards PLWHAs be reduced?

1.6 Significance of the Study

It is a fact that stigma and discrimination has become an issue of national concern and both government and non-governmental institutions have initiated several policies and initiatives to focus on this phenomenon. Thus, the outcome of this study, which is the influence of religious beliefs and practices of Moslems on their attitudes towards PLWHAs, will serve as additional literature in the area of religion and health.

Against the background of paucity of material or literature on Moslems beliefs and practices in relation to stigma and discrimination, this study is significant to adult education practice and theory as a guide for designing and planning management of effective education programmes as a tool to reducing HIV and AIDS related stigma. In this light, the study will fill in this void.

There are several adult education institutions such as the Department Adult Education and Human Resource studies of the University of Ghana, Non-Formal Education

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Division of Ministry of Education, Institute of Local Government Studies (ILGS), District Assemblies and other Non-governmental organisations which are involved not only in the propagating and disseminating information on developmental issues but also in the training of communities. However, one important void is the incorporation of HIV and AIDS related stigma from the Islamic perspective in such training manuals. Thus, the findings of this study can therefore serve as a valuable resource in the teaching, learning and training manuals for such institutions.

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1.7 Scope and delimitation of the Study

The study is limited to only three districts of the Upper West Region where Islam is predominant and to 300 adult practising Moslems on their attitudes towards PLWHAs. The reliability of the study largely depends on how frank and candid the subjects of the study responded to the questions posed. Generalization of the findings may be limited to the study area because of regional disparities in the awareness level and beliefs.

1.8 Definitions of Terms

Throughout the study, the under listed terms or words will have the meanings attached to them as stated below unless otherwise stated:

Stigma: It is an attribute, characteristic or diagnosis, which is deeply discrediting and conveys a diminished social identity and reduced worth of the individual or group of individuals. People are therefore stigmatised as a result of their belonging to a particular group or possession of certain traits, which can lead to their exclusion from all the important aspects of life such as religious, social, economic and political.

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Discrimination: It refers to the unfair or unjustifiable behaviour or actions directed at individuals or group of persons due to their sexual orientation race, socio-economic or health status. Discrimination may lead not only to the exclusion or marginalization of people but also deprive them of their civil rights.

Attitude: This refers to a relatively enduring organization of emotions, beliefs and behaviours, which result from experience, social roles or norms and learning towards a particular object, person, thing or event

Practising Adult Moslem: This refers to the adherents of the Islamic faith who are eighteen (18) years and above.

1.9 Organisation of the Thesis

The study is organized into six chapters as indicated. The Chapter One covers the introduction to the study. The major identified areas were the statement of the problem, the purpose of the study, the objectives and the research questions and finally the significance and delimitations of the study.

Chapter Two is concerned with the attribution –affect –action theory of Bernard Weiner and a review of related literature on HIV and AIDS related stigma and discrimination, its causes and effects; religious beliefs and practices, and Islamic religious beliefs and practices vis a vis HIV and AIDS related stigma and discrimination.

The Chapter Three deals with the research methodology, which includes the research design, the population and sampling techniques of the study; data collection and analysis.

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Chapter Four contains the presentation and analysis of primary data on the Moslems' perception of HIV and AIDS related stigma and discrimination, the assessment of their opinions on the extent to which their beliefs and practices as well as their socio demographic characteristics influence their attitudes towards PLWHAs in religious, social, economic and political relation; the beliefs and teachings of Islam that support and influence Moslems attitudes towards PLWHAs, Moslems' views on disclosure of HIV and AIDS status and the effects of stigma and discrimination on PLWHAs, their families and community. The chapter also presents Moslems views on reducing and possibly eliminating stigma and discrimination among PLWHAs in their communities.

Chapter Five discusses the findings of the study while the last chapter concerns itself with the summary, the conclusion and the recommendations for institutional and knowledge development and other research areas for further studies.

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CHAPTER TWO

THEORETICAL FRAMEWORK AND REVIEW OF RELATED LITERATURE

2.1 Introduction

The chapter deals with Bernard Weiner's theory of attribution, specifically the attribution-affect-action relating to stigma and discrimination against Persons Living with HIV and AIDS (PLWHAs) as the framework employed for the study. It also deals with a review of literature on the concepts of stigma and discrimination and reviewed empirical studies on the perceptions of society towards PLWHAs, HIV and AIDS related stigma and discrimination particularly religious beliefs and practices and in particular those of Islam and finally strategies for reducing HIV and AIDS related stigma and discrimination.

Some theories on Stigma and Discrimination

The labeling theory, which was propounded by Scheff (1996; cited in Corrigan, 2005) asserts that the label 'ill' results in society to treat the label-led person as abnormal. The label may be put by health professionals or through observation by noticing people who visit the hospital. Society's response to the labeled may include fear and disgust, which results in a social distancing to avoid any contact with the 'labeled person'. The resultant prejudice and discrimination cause the person labeled with mental illness to continue with the same behaviour and consequently fit the label of 'illness'. In other words, negative social reactions (negative stereotypes) are part of the etiology of the mental disorder, in this case, HIV/AIDS menace. The theory has been criticised on the basis that the abnormal behaviour, which is a product of the mental illness and not the label on it was the source of the prejudice. In this respect, the reason why people distance themselves from the mentally ill is not the 'label of mental ill' but the person with the

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illness who behaved in a bizarre way. Secondly, the effects of stereotypes on the mentally ill is only a temporary one, which also results to only a minor and short term problem for the affected person (Gove,1980).

Modified Labelling Theory

In view of the criticism leveled against the labelling theory, Link, Cullen, Struening, Shrout & Dohrenwend (1989) propounded a modified theory, referred to as Modified labelling theory, which states that labeled persons are not only rejected when they behave inappropriately but even when their behaviour is not abnormal. They also indicated that though negative labelling can worsen existing illness, it does not result in illness as shown in the labelling theory.

Link et al (1989) as well showed how stigma exists notwithstanding mental health diagnosis and stigma variables acted as important predictors of social support network in patients. Psychiatric labels are linked to negative societal reactions that worsen the situation of the illness. This is not different from PLWHAs in our societies.

Link and Phelan (2001) emphasise the importance of these labels in the stigmatising process, when the stigmatising group or person is in a more dominant social situation than the stigmatised group. Thus, according to this theory, the core ingredients of stigma are 'labelling, stereotyping, separating, status loss and discrimination, which exist in a power situation that allows these ingredients of stigma to unfold' (Link & Phelan, 2001, p367). It is in view of the shortcomings of the above theories in explaining HIV and AIDS related stigma and discrimination that the attribution theory is adopted.

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2.2 Attribution Theory

The Attribution theory has been one theoretical framework popularly employed for assessing societal reactions towards PLWHAs (Anderson, 1992; Cobb & De Charbert, 2002; Dooley, 1995, Greene & Rademan, 1997; Steins & Weiner, 1999; Weiner, Perry, & Magnusson 1998). The importance of this theory cannot be over-emphasised as far as understanding societal attitudes towards the sick and for that matter, PLWHAs is concerned. The theory has served as an explanatory tool for anticipating peoples' immediate emotional and behavioural responses towards PLWHAs supported the specified interconnections between attribution types (internal versus external) and emotional and behavioural responses (anger versus sympathy and helping behaviour) as stated in Weiner's Attribution. The theory also tested whether personal/environmental characteristics surrounding a target (person) illness (sexual orientation, seriousness of the illness, perceived personality) serve to influence perceivers' emotional and behavioral responses towards the target (the sick). One factor that has been shown to moderate persons' attitude towards the target is sexual orientation of the target with more negative emotional and behavioural responses toward homosexuals and PLWHAs.

The attribution theory of Bernard Weiner (1974) simply states that when people assign the causes of an event to controllable internal factors other than to uncontrollable external factors, their pity and sympathy towards the affected person will be greatly minimised. On the other hand, if the causes are attributable to uncontrollable, external factors, people's pity and sympathy towards the target person will increase.

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2.2.1 Attribution-Affect-Action Theory

The attribution-affect-action theory, which constitutes an aspect of the attribution theory, is a viewpoint that brings together causal attribution, emotion and behaviour and theorizes about their interconnections. The theory recognises three aspects of causality namely locus, which deals with whether the cause is attributable to internal or external factors, stability, which considers the cause as either stable or unstable and finally, controllability, whether the cause is something that is within the control of the person or beyond his control.

One distinguishing feature of the theory is its differentiation between outcome-dependent affects and attribution-related affects. The outcome-dependent affects are general like happiness, which results from desirable outcomes and sadness due to negative outcomes. These are experienced independently notwithstanding the perceptions of the causes. The attribution-related affects on the other hand, are motivated by individuals, causal attribution. Thus, results, which are considered as unexpected, significant or undesirable influence, people to undertake a causal search to find out the reasons for the outcome.

Varied emotions are exhibited based on the type of causal attribution one makes. The type of one's behavior or attitude towards the target of attribution is, therefore, influenced by the emotions. Hence, one's anger and sympathy determines the type of attitude whether in support or rejection of the target of attribution.

This theory therefore propounds that if the cause of the 'need' is viewed as controllable or attributable to the person's own responsibility, it is expected that more anger and less sympathy will be exhibited and by extension less support offered to the affected person. In contrast, when the cause is considered to be uncontrollable and not the responsibility

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of the person, sympathy will be experienced and for that matter, more support to the affected person.

This study therefore employs this theory in view of the several studies on HIV and AIDS, (Weiner,1986; Reiserzein,1986; Eiser.C; Eiser,J.R; Lang 1989) which have revealed that PLWHAs who are seen as being responsible for their infection elicit anger and therefore receive no assistance and consequently negative reactions from the public; while those whose infections are not attributable to their responsibility, however elicit sympathy and support and, consequently positive response from the public.

Several studies (Weiner, 1986; Reiserzein, 1986; Eiser.C; Eiser, J.R; Lang 1989) on HIV and AIDS related stigma and discrimination reveal that the degree and effects of stigma towards PLWHAs tend to change based on social factors. Prominent among them are the means of infection and social attribution, which significantly influence the assignment of blame and responsibility, and consequently attitude towards PLWHAs.

As it relates to the present study, this theory has been employed to determine whether peoples' attitudes towards PLWHAs are being influenced by their religious beliefs and practices, their demographic and personal characteristics or dependent on the causal attribution one makes as regards the infection. That is whether the infection is due to controllable internal factors such as immoral behaviours like prostitution, adultery, gay sex and drugs, which are condemned by the teachings of Islam and the society as a whole or attributable to uncontrollable external factors such as mother to child, blood transfusion or contaminated sharp objects.

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Apart from applying the theory to HIV and AIDS, Peters, de Boer, Kok & Schaalma (1994) also used it on other diseases like syphilis, lung cancer and tuberculosis. It is also important to add that the theory has been applied in the field of marketing (De Carlo, 2005; Fang, Evans & Landry, 2005).

This study conceptualises that Moslems attitude towards PLWHAs will be modified on whether the cause of the infection was due to controllable internal factors or uncontrollable external factors. This is in view of the fact that stigma that arises from medical condition is very strong, when that condition is related to deviant behaviour or viewed as the responsibility of the individual. This becomes very strong if the illness is associated with religious beliefs and considered to be contracted through immorally unsanctionable behaviour.

2.3 Review of Related Literature

This section of the chapter deals with reviewed literature on the concepts of stigma and discrimination, HIV and AIDS related stigma and discrimination as well as the causes and effects of HIV and AIDS related Stigma and discrimination. It also reviewed empirical studies on the perception of society towards PLWHAs, HIV and AIDS related stigma and discrimination. Again, religious beliefs and practices in particular those of Islam was addressed.

2.3.1 Concept of Stigma

Stigma is multi-dimensional concept of which it significantly focuses on deviance or departure from an accepted standard or convention. It has gained a lot of attention especially in many health perspectives. The aftermath of Goffman's (1963) definition as

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an undesirable or discrediting attribute, reducing an individual's status in the eyes of society, the concept of stigma has been defined severally.

According to Crawford (1996), the term stigma has its roots from the Greek language and refers to a tattoo mark branded on the skin of an individual as a result of some incriminating action, identifying the person as someone to be avoided. Generally, it has two meanings. One is derived from Christianity and denotes bodily marks which resemble those of the crucifixion of Jesus Christ; attributed to divine favour. The second meaning is secular, namely marks of disgrace, discredit, or infamy (Gilmore & Somerville, 1994). Today, the term "stigma" is applied more to social disgrace than to any bodily signs (Hardon, Boonmonkon& Streefland, et al, 1995).

Goffman (1963) defined stigma as "an attribute that is deeply discrediting, which reduces the bearer from a whole and usual person to a tainted, discounted one". Stigma can result from a particular characteristic, such as a physical deformity or from negative attitudes towards a group such as prostitutes or homosexuals. From this definition, society labels an individual or a group as different or deviant. It is for this reason that a respected person such as a wealthy person, a chief, an Imam, manageress or queen mother will immediately lose their status and become an object of ridicule immediately they have tested HIV positive.

Stigma is also relational in nature and a process that is described by Link and Phelan (2001) as occurring in the context of power when four interrelated components – distinguishing and labeling differences; associating human differences with negative attributes; separating "us" from "them"; and status loss and discrimination-converge in the context of social, economic and political power. According to Link and Phelan

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(2006), stigma is a process that begins when a particular trait or characteristic of an individual or group is identified as being undesirable or disvalued. The stigmatized individual often internalizes this sense of disvalue and adopts a set of self-regarding attitudes about the marked characteristic including shame, disgust and guilt. These attitudes produce a set of behaviours that include hiding the stigmatized trait, withdrawing from interpersonal relationship or increasing risky behaviour (Smith, Rossetto & Peterson 2008).It is against this background that most PLWHAs, lepers, tuberculosis and epileptic patients respectively always strive to hide their conditions by avoiding the public such as staying indoors the whole day or moving to places where people might not know their status if the symptoms are not visible.

In the view of Heijnders and Van DerMeij (2006) stigma, which is shaped and promulgated by institutional and community norms and interpersonal attitudes, is a social determinant of health. It is not coincidental that most of the conditions that elicit stigmatising attitudes from the community have to do with health conditions such as HIV and AIDS, tuberculosis, leprosy, epilepsy and mental illness. What is also important to note is that people exhibit such stigmatising attitudes based on what institutions and communities prescribe as acceptable and unacceptable actions and norms.

Stigma generally refers to any attribute that marks the bearer as culturally unacceptable or inferior due to a physical condition or disfigurement, a moral blemish, membership in a despised social group or simply ‘different’. The affected person is cast out of the society and is made to feel of little value. As a result, people who are stigmatized, experience guilt, shame, rejection, feelings they may accept with fatalism that stops them seeking assistance or try to change things (Gillian Paterson.Undated) (https//scholar.sun.ac.za/bitstream/handle/100.19/)

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From this perspective, people with tuberculosis, leprosy, mental illness and HIV and AIDS are seen as sub-humans and valueless for the mere fact that they have some form of illness which conveys or elicits stigma. This creates some level of distancing between them and those who do not have these illnesses.

It is equally important to state that stigmatization is not only the expression of individual attitudes but also involves social processes based on social, economic and political power. Power is required to be able to introduce stigma and to remove power from the stigmatized person (Link & Phelan, 2002). According to Parker et al (2002), stigmatization and discrimination as social processes, are employed to create and maintain social control and to produce and reproduce social inequality. Stigma contributes to the creation of social hierarchy in a community and then in turn legitimizes and perpetuates social inequality. Thus, stigma does not only mark the boundaries a society creates between 'normals' and 'outsiders', between 'us' and 'those' but it is also a social process in which people out of fear of the disease want to maintain social control by contrasting those who are normal with those who are different.

The fact is that once someone is HIV positive, they are condemned in relation to HIV and AIDS related stigma and discrimination. The emphasis is that if one is HIV and AIDS positive, they are regarded as outcast and shunned by those who consider themselves as uninfected. The creation of a boundary is meant to protect those who consider themselves as not affected from those who are seen to be affected.

In lending support to the above definitions, Bos, Reeder & Sutterheim (2013) stated that in modern times, stigma does not only refer to a physical mark but also an attribute that is characterized by widespread social disapproval- a discrediting social difference that

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yields a "spoiled social identity"(Goffmans,1963). Hebl and Dovidio (2005) also emphasise that stigma occurs in social interaction. In this regard, stigma is not considered to reside in the person but rather in the social context. It is however, important to also state that apart from social interactions, stigma is also manifested in religious, economic and political engagements. Thus, persons who are stigmatized due to their conditions especially HIV and AIDS are seen not as part of the community. Such persons are excluded from participating in social or communal activities by the larger community; those who see themselves as uninfected. They do not eat or share cooking or eating utensils or sleep with others in the same room, take part in family deliberations, and participate in religious activities and other activities.

Persons affected by HIV and AIDS are stigmatized based on their physical condition, which is one of depreciation and leanness and on the basis of moral blemish (Kafuko, 2009). It is believed though erroneously that once affected by AIDS, it is either through promiscuity or immoral sexual activities or that the person belongs to a group of prostitutes, gay or drug injectors who are already stigmatized.

2.3.2 Concept of Discrimination

Discrimination arises from stigma and occurs when a distinction is made of a person based on their real or perceived HIV and AIDS status and results in them being treated unfairly and unjustly. The Encarta Dictionary defines discrimination as:

> "…. Any situation in which a group or individual is treated differently based on something other than individual reason, usually their membership in a socially distinct group or category. Such categories would include ethnicity, sex, religion, age or disability. Discrimination can be viewed as favourable or unfavourable,

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> depending on whether a person receives favours or opportunities, or is denied them. However, in modern usage, 'discrimination' is usually considered unfavourable (Microsoft ®Encarta Encyclopedia 2016).

In this regard, discrimination can be defined as any action or measure that results in a person being treated unfairly because they belong or are perceived to belong to a particular group (National AIDS Trust, 2016). Thus, when persons, because of their HIV status are denied health care, employment, admission into educational institutions, residential accommodation because of their conditions, then a clear case of discrimination arises.

Discrimination is a behavioural reaction, which in terms of stigma results from HIV and AIDS. It may include avoidance of associating with PLWHAs, which in turn reduces opportunities for employment, education and recreation. It may take the form of exclusion, segregation, withdrawal behaviours or withdrawal of assistance, which may be medical services. Another important aspect of discrimination is segregation or treatment of persons with HIV and AIDS in custodial or less restrictive health care facilities.

Discrimination can be on the interpersonal or structural level (Link & Phelan, 2001). Interpersonal discrimination is excluding PLWHAs and cither persons suffering from terminal illness from social engagements while structural discrimination deals with excluding such people from public life through legal, economic, social and institutional methods. Apart from instances where supervisors blocked the promotion of staff and others losing their jobs or reassigned to lower positions within their organization due to their HIV positive status; HIV-positive are also excluded by family members from

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discussions and decision making due to the belief that PLWHAs were incapable of making any important contributions (Kafuko, 2009).

Discrimination is a result of stigma. It consists of actions or omissions that derive from stigma and is directed towards those individuals who experience stigma. Discrimination is any form of arbitrary distinction, exclusion, or restriction affecting a person, usually but not only by virtue of an inherent personal characteristic or perceived to belong to a particular group (Mukasa, 2008). It includes actions that negatively impact the rights and entitlements of others based on prejudiced viewpoints or positions and ensue when a distinction is made against a person. The result is unfair or unjust treatment based on their HIV sero-status or risk status (UAC 2007).

Discrimination may arise from social disapproval of the infection and its implied behaviours or from fears due to lack of knowledge about how HIV and AIDS can or cannot be transmitted. Because the HIV pandemic emerged so suddenly and progressed so quickly, in many countries discrimination could result from people's belief "…that not enough time remains to weigh carefully the strengths and weaknesses of various alternative solutions to an AIDS-related problem" (Herek and Ghant, 1988:888) and the reaction is thus to err on the side of caution, even at the expense of individual rights. In this case, it refers to negative behaviour towards someone based on any grounds or qualities such as class, race, ethnicity, HIV and AIDS status, gender, sexual orientation and age.

Discrimination, therefore, arises when people are treated with less respect or worth than they deserve due to any of the above mentioned characteristics. Thus, it can involve the distinction, exclusion, or preference of a person. In this regard, there are instances of

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PLWHA being allowed to work only for half of the required working hours, given light working schedule, assigned a separate examination room, and excluded from family discussion. Thus, persons living with HIV and AIDS, tuberculosis, leprosy and mental illness are discriminated against because they are seen by those who discriminate against them as belonging to particular or different groups and for that matter, such groups are treated in an unfair or unjustifiable manner.

It is, therefore, common to see persons living with HIV or AIDS being ejected from their family homes, served with different and specific eating plates and drinking cups, sleeping in separate rooms, admitted in separate hospital wards called in some circles as isolation wards, wares and goods not being patronized at market and traders refusal to sell to them if they know their status to being refused employment or even sacked if such a person is already employed.

From the discussion so far, one can therefore conclude that while stigma reflects an attitude, discrimination on the other hand as an act or behavior.

2.3.3 HIV and AIDS related- Stigma

Stigma and discrimination, which is termed as the hidden burden of disease is not only to quantify but also added on to the burden of disease which can be measured (WHO fs218, 2001). Stigma and discrimination is a phenomenon associated with many chronic health conditions including HIV and AIDS, leprosy, tuberculosis and mental illness. Simply put, HIV and AIDS related stigma and discrimination refers to prejudice, negative attitudes and abuse directed at people living with HIV and AIDS. UNAIDS (2002) refers

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to HIV and AIDS related stigma as a process of devaluation of people either living with or associated with HIV due to sex and intravenous drug use.

In associating with this view, Seale (2004) defines it as a real or perceived negative response to persons by individuals, communities or societies, which is characterized by rejection, denial, discrediting, disregarding; underrating as well as social distance. Badahdah (2010) considers HIV and AIDS related stigma as unfavourable evaluation, treatment and discrimination of people living with HIV and AIDS. Stigma may also affect the people associated with the person living with HIV and AIDS. According to AVERT (2015), a global online information and advice on HIV and AIDS cited in Ayiworoh (2015), HIV and AIDS related stigma includes negative attitudes and prejudice directed at people living with HIV and AIDS.

2 .3.4 Causes of HIV and AIDS related Stigma

The International Centre for Research on Women (ICRW) (2002) states that the AIDS epidemic, since its early stages, has been characterized by fear, ignorance and denial leading to stigma and discrimination against PLWHA and their family members, which has accounted for the reasons why people do not want to find their sero-status, change their unsafe sexual lives and take care of PLWHA. Stigmatisation and discrimination associated with HIV and AIDS are underpinned by many factors including lack of understanding of the illness, treatment, irresponsible media reporting on the epidemic, the incurability of AIDS and prejudice and fears relating to a number of sexually sensitive issues including sexuality, disease and death, and drug use.

Studies conducted by Tee and Huang (2009) and Herek (1999) have shown that HIV and AIDS related stigma and discrimination exist due to people's limited knowledge about

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the causes of HIV and AIDS, in addition to existing treatment. In their view, Zeelen, Wijbenga, Vintges & de Jong (2010), assert that stigma exist because there is confusion about how the disease is contracted and how it can be prevented.

In support of the above, Adoo-Adeku, Badu-Nyarko, Kwashie and Benneh (2010) study on HIV and AIDS Education on Stigmatization and Discrimination in Ghana, revealed that misconceptions about the causes, the myth and fear caused by earlier interventions regarding the disease constitute some of the main causes of stigma and discrimination. These are basically due to general perceptions that link the disease to immorality and socially unacceptable behaviours. The belief among many Ghanaians is that those infected lack good morals. It is important to remark here that against the background of wrong perceptions and erroneous beliefs of the disease, people have advocated for the urgent need for relevant programme implementors to promote and sustain their educational campaigns on the disease.

Messages on HIV and AIDS Campaigns

Fear-based messages, which portray negative attitudes about HIV and AIDS, have contributed significantly to people trying to avoid any situation that might pose a potential transmission risk. Fear-based messages about the disease and the messages in health campaigns, which focused heavily not only on death as the outcome of HIV but also on the depiction of a painful, disfiguring, and sometimes shameful death by linking HIV to socially unacceptable behaviours all play a role in stigmatization. These have negative implications that invariably increase stigmatisation on infected persons.

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Based on their experiences in Vietnam, Hong et al (2004) remarked: “Many posters use highly emotive symbols such as human skulls, bleeding syringes, and coffins, or they contrast images of sick and dying drug users with images of robust, healthy people”.(p.15). These kinds of messages heighten the anxiety and magnify the fear of contracting HIV. This fear then elicits stigmatizing behaviour such as isolation of people living with HIV and AIDS.

A study in Ethiopia reveals that people do not want to associate with PLWHAs because of fear due to its horrible nature as captured by a female respondent “The reason people isolate a person living with HIV and AIDS is because they fear HIV and AIDS. The reason they fear HIV and AIDS is because they hear from different mass media, i.e. radio and TV, how horrible the disease is and how it is widespread in the country (Ogden and Nyblade 2005).

The reference to the skull and crossed bones as a symbol of the disease, which by implication means that once an individual gets infected, the person will turn into skeletal bones as stated by Amankwaa (2008) make people avoid the company of infected people representing the idea of fear as one of the causes of stigma.

Likewise, de Bryun as well as Mbonu, Van Den Borne & De Vries (2011) mentioned the life-threatening and contagious nature of the disease and assignment of guilt as a result of the assertion that PLWHAs are solely responsible for the disease due to their involvement in immoral and deviant behaviours such as promiscuity or deviant sex that deserves punishment.

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Fear, Ignorance, Social Judgement and Control:

It might therefore be said that HIV and AIDS related stigma and discrimination arises from fear, ignorance, social judgement and control; and more importantly, the marginalization and exclusion of individuals from interaction has possibly originated as a defence mechanism to protect the community from infection. Visser, Makin, and Lehobye (2006), propound that apart from the fact that the disease is being stigmatised, it is also associated with fear and discrimination; and that it elicits stigma because people are not only afraid of contracting it but also due to negative assumptions about PLWHAs since HIV and AIDS is a life threatening disease. In lending support to this, Bollinger (2002) in Policy Project (2002) and Deacon et al (2005) state that PLWHA are stigmatized not only due to the perception that they have a fatal disease, which elicits fear of infection and often characterized by behaviour which is already stigmatized, but is also considered as the result of the individual's own responsibility as well as punishment for deviant behaviours.

In support of the above statements, Ogden and Nyblade (2005) in studies conducted in Ethiopia, Tanzania and Vietnam on stigma cited in Nkansa-Kyeremateng and Attua (2013) stated fear of infection from casual transmission of the disease due to inaccurate understanding and knowledge of how HIV is transmitted and the attribution of blame and accusation of moral wrongdoing on those infected as the causes of stigma.

The fact that AIDS, as an illness is not only characterized by several attributes that elicit stigma but also seen as the outcome of immoral or deviant behaviour attributable to the person infected, makes people vulnerable. It is perceived as a threat to the community

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due to its contagious nature and viewed as a degenerative disease, whose outcome is death, are in the main, reasons PLWHAs are being discriminated against. .

UNAIDS (2000), also, views HIV and AIDS as a life-threatening illness that people are afraid of contracting. They state that the various metaphors associated with AIDS have also contributed to the perception of HIV and AIDS as a disease that affects 'others' especially those who are already stigmatized because of their sexual behaviour, gender, race, or socio-economic status and have enabled some people to deny that they personally could be at risk or affected.

HIV and AIDS Similes

Another area that has contributed to discrimination concerns the vocabulary used to describe the disease. For example, the early similes that were attached to AIDS such as 'death', 'horror','punishment','guilt', 'shame', and others have exacerbated these fears, reinforcing and legitimizing stigma and discrimination. It is therefore not surprising that people living with HIV and AIDS are considered variously as: "Living dead bodies", "Dangerous people", "People beset with misfortunes", "People who should be isolated from society", "People who would soon die because their days are numbered" (Amankwaa,2s08; Adoo-Adeku et al 2010; Appiah, Afrane and Price 2002).

In support of the above, Campbell et al (2007) assert that in many societies, HIV and AIDS is associated with stigma against the backdrop that not only does it carry many symbolic association with danger but it also conveys attribution of contagiousness, incurability, immorality, and punishment for sinful acts.

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Some studies in Ghana have also indicated the association of HIV and AIDS with danger. Thus, a study by Mill in 1999 on the manner of informing Ghanaian women about their HIV and AIDS was done in a very indirect way as captured in the following statements:

"You have acquired an illness which cannot be cured", "You have the same 'bad disease' that killed your husband".

Similarly, Adoo-Adeku et al (2010) study revealed that persons living with HIV and AIDS are variously perceived as: "ghosts", "People who are at the end of their lives", "Patients who would die soon because their days are numbered and their lives are almost ended'

As regards its contagious nature, the story is not different in Ghana. In the same study by Adoo-Adeku et al (2010), the respondents stated fear of also being infected by persons living with HIV and AIDS as a reason to "avoid them", ''shun their company", and "do not go near them'. Respondents from the study adduced reasons for their actions not likely to take care of people living with HIV and AIDS such as: "Fear of transmission', 'Afraid of contracting the opportunistic and chronic diseases because the patient could intentionally infect me', 'It is very dangerous and does not have any cure', 'they should be kept in isolation', 'It is risky'. The respondents considered people living with HIV and AIDS as 'dangerous people' and a 'threat to other people's lives', and as such, should be isolated from the society".

In view of the above, people will therefore go to every extent to ensure that such persons are avoided for fear of being infected. This brings into sharp focus the issue of lack of

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understanding or better still detailed information as regards the causes of HIV and AIDS. It is an acknowledged fact that the illness is not caused by casual contact but by other factors, which include contaminated blood, direct sexual contact with an infected person without protection among others. This, therefore, calls for intensified and comprehensive education by relevant institutions, both governmental and non-governmental organisations that are engaged in HIV and AIDS activities to correct these unfounded beliefs. The situation also calls for change of attitudes by the public.

Also, Busza's (2001) study in South East Asia on stigma shows that PLWHA were stigmatized through isolating both the infected and affected due to fear of casual contact, restrictions on participation in local events, refusal to allow infected children in local schools, lack of support for affected bereaved family members (including orphans), violation of confidentiality in the health sector and denial of religious rituals such as funeral practices.

Immorality

The linkage of HIV and morality might be explained by the reason that affliction or any suffering is an indication of moral transgression. This is not coincidental in view of the fact that in some African societies, certain specific illnesses or sets of symptoms are traceable to breaking one or more social prohibitions. In the same vein, Judeo-Christian societies believe that illness is a punishment for one's sins. Thus, the tendency to associate illness with immoral impropriety is a significant contributory factor to HIV and AIDS related stigma. This stigma is exacerbated by the seriousness of the illness, its mysterious nature and its association with behaviours that are either illegal or socially sensitive.

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Assumptions are made about the moral integrity of PLWHA; hence blame is apportioned as being morally improper and "guilty'' of transgressions, resulting in shame felt by PLWHA. The perception is that HIV infection is the product of one's personal choice of engaging in social evils, and thus it is a punishment for disobedience to God's laws. When dealing with a PLWHA, the emphasis is on "guilty" versus "innocence" with regard to how the person became infected, and this informs the degree of stigmatization the person will experience.

It is also significant to state that AIDS stigma is often targeted at individuals and groups in society who are already stigmatized. In North America, the groups that are stigmatised are gay men and intravenous drug users whereas in Ghana, AIDS stigmatization is compounded by its association with prostitution (Mill 2001). Thus, an individual who is already marginalized and suffers from HIV illness may experience a double burden or layering of stigma.

In supporting these views, Herek, Capitanio and Widaman (2002) affirm that people tend to reject PLWHAs because they feel they have been sexually immoral and therefore deserve 'to die'. The said rejection extends to the social groups to which PLWHAs belong as well as to their care givers (Van Dyk, 2008). In confirmation to this statement, Patterson (2005) states that HIV infection is viewed as a deserved punishment or retribution for violating the community norms. As such, the stigmatized person is held accountable for any real or imagined ills that affect the community, which can only be cleansed by the expulsion or isolation of the polluting influence. Their continued presence can become a threat to the survival of the whole group. It is thus against this that exclusion, victimization and 'scapegoating' follow. Further justification is

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established by the belief that those who are 'different' are sub-human, and do not feel things like 'normal people do'.

This is applicable not only to people living with HIV and AIDS but other stigmatized persons such as tuberculosis patients and lepers. In Ghana, the description of TB wards as 'isolation wards' and' "cured lepers" home, which are often separated from the mainstream community all confirm the issue of exclusion and stigmatization. There are also cases of landlords and even family members who eject their tenants or family members based on their HIV and AIDS status. These actions are undertaken to protect the alleged normal people from being contaminated by the "not normal people".

Similarly, Abraham's (2006) study on perceptions of HIV /AIDS related stigma among Moslems in a Cape Town community in South Africa reveals that Moslems do not associate with people living with HIV and AIDS (PLWHAs) based on their belief that the creator could punish all of them though it might be one person who commits the sin. From this perspective, they regard PLWHA as 'sinners' and therefore would want to avoid doing anything with them for fear of their creator's anticipated wrath against the entire family. Closely linked up with this is the shame associated with pre-marital and extra-marital sexual relations which would result in a family being ostracized by the community because of its association with a sinner.

Definitions, Representations and Metaphors:

The definitions, representations and metaphors associated with HIV and AIDS have also been responsible for people disassociating with PLWHAs. The early definitions, which associated it with sexually transmitted disease and not a viral communicable disease has

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had an implication on the social definition of AIDS (Altman, 1994; Gilman, 1988). The sexual transmission of this disease denotes, for many, a manner of infection that is self-induced (Sontag, 1989). Women have been particularly vulnerable to AIDS stigma by being positioned as 'dirty', 'diseased' and 'undeserving' (Lawless, Kippax & Crawford, 1996).These issues become critical when viewed against the backdrop that this study is targeting Moslem, and will therefore be interested in determining whether the issues raised are also applicable to them.

Witchcraft and Supernatural Forces:

As far as witchcraft or supernatural forces are concerned, Shisana and Simbayi (2002) assert that there is a belief in many traditional cultures that witchcraft or supernatural forces can cause HIV and AIDS and hence, the reason why people in South Africa shun the company of PLWHAs.

Similarly, Kalichman and Simbayi (2004) study in South Africa on the traditional beliefs and causes of stigma indicates a high level of stigma among those who believe that AIDS was caused by supernatural forces and spirits than those who did not hold the same belief. Again, Senah (1997) and Wyllie (1983) studies on the traditional healing system in Ghana reveal that diseases, which lead to deformity or is contagious, whose source the victim is unaware of and characterized by seriousness and stress attributable to the violation of a cultural norm, qualifies such a disease to be the result of supernatural forces or spirits. From these characteristics, there is the tendency for HIV illness to be regarded as supernatural and in reality assigned a supernatural explanation by Ghanaians (Awusabo-Asare & Anarfi, 1997). Thus, the linkage of HIV illness with supernatural forces contributes to its stigmatization.

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2.3.5 Effects of AIDS and HIV Stigma and Discrimination

The effects of HIV and AIDS related stigma and discrimination do not only lead to isolation, deprivation of human rights but also worsens the impact of infection as stated by Van Dyk (2008). It is also instructive to state that in view of stigma and discrimination, PLWHAs do not disclose their status, fail to attend voluntary counseling and testing (VCT) and also do not seek treatment. More importantly is the fact that there is no open discussion about the disease in view of stigma and discrimination as noted by Herek, 1999; Ogunjigbe, Adeyime & Obiya (2005). The net effect of all these contribute in no small measure to creating barriers in HIV and AIDS prevention programmes.

The effects of HIV and AIDS related stigma and discrimination are felt in every aspect of life of PLWHAs, their families and associates as well as the society as a whole. The non-disclosure of their HIV positive status to their partners, family members and health providers as a result of fear of stigmatisation does not only contribute in no small measure to the spread of the disease but also the quality of health care PLWHAs receive. It also leads to social isolation of PLWHAs where they are denied participation in family and community events, which lead to their loss of power and respect. Due to this, some PLWHAs are left on their own with no care and support, which eventually leads to their death.

Another significant consequence of stigma and discrimination is the shame and guilt, which most PLWHAs face with its consequential effects of adverse psychosocial disorders such as distress, depression and in extreme cases, suicidal tendencies and death. Stigma and discrimination also affects the human capital development of the region in view of the fact that PLWHAs are denied the space to make available their

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talents and skills in the economic, political and social arenas. The views and concerns of PLWHAs are therefore not being represented at the appropriate decision making and implementation agencies or departments.

From the discussions on the causes of HIV and AIDS related stigma, it is evident that the fear of contagion, the linkage of the disease with life-threatening conditions associated with death, its association with behaviours that people disapprove may explain why people exhibit stigmatic attitudes towards PLWHA. Also, people show unfavourable attitudes to HIV and AIDS infected persons as a result of the misconception that HIV is transmitted through only sex, which borders on immorality and the issue of personal irresponsibility. The notion that once infected with HIV, it is due to moral fault which deserves to be punished. Furthermore, inaccurate information as regards how the disease is transmitted, creating irrational behaviour and misperceptions of personal risk, all constitute in the main, factors that fuel stigma and discrimination.

2.3.5 Attitudes towards Persons Living with HIV and AIDS

In as much as the HIV and AID is not only about sociological but biological and medical issue, it is also a disease that has elicited both negative and positive responses from society. Globally, just as the AIDS pandemic has not only generated responses of compassion, love, solidarity and support from people, families and communities, it has also nevertheless witnessed behaviours associated with stigma, ostracism, maltreatment and discrimination since PLWHAs or persons believed to be affected by HIV have been rejected by their families, their loved ones and their communities in both the developed and developing countries (Kwashie, 2014).

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Phiri's (2012) study on HIV /AIDS knowledge levels and attitudes towards PLWHAs in South Africa by members of the Pretoria South LIONS Club shows high levels of knowledge of HIV and AIDS and positive attitudes towards PLWHAs by the members. Another study by Tee and Huang (2009|) on the knowledge of HIV and AIDS and attitudes towards PLWHAs among the general staff of a public university reveals a positive attitude towards PLWHAs, though some felt uncomfortable relating with the latter.

Similarly, Visser's (2007) study on stigmatising attitudes towards PLWHAs shows that most of the respondents (80%) felt uncomfortable relating with PLWHAs though they also believe that their human rights should be protected. The results also indicate that notwithstanding the sound knowledge of HIV and AIDS by the respondents, they are still uneasy about physical contact with them such as buying food or sharing utensils with PLWHAs.

Al-Owaish, Moussa, Anvar, Al-Shoumer & Sharma (1999) study in Kuwait to assess the attitudes of the people towards PLWHA, also reveals that while 80 per cent of them believed that PLWHA should not be left freely in the community, 34 percent of them stated that those infected should be ostracized to prevent the HIV chain of transmission. The study also found that females, younger ages and single respondents were more likely to express negative attitudes towards PLWHA. Thus, indicating that socio-demographic characteristics of an individual may affect their attitude towards PLWHA. The argument may be that these categories of the population, namely females, the youth and unmarried expression of negative attitudes borders on insufficient or lack of relevant information on HIV and AIDS. This suggests the urgent need for the appropriate institutions both government and non-governmental as well as religious organisations to undertake

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sensitization and educational programmes for these categories of the population to equip them with the relevant knowledge and positive attitudes.

Another study in India by Sudha, Vijay & Lakshmi (2005) reveals that there is a high level of stigma and discrimination among the people towards PLWHAs. While 18 per cent of the participants were willing to take care of HIV- positive family members, 41 percent were against HIV infected students attending schools and buying things from a PLWHA retailer respectively. The degree of the negative attitude towards PLWHA in this community was exemplified by the fact that 51 per cent of the participants wanted a public list of people infected with the disease so as to avoid them. The study further indicated that illiterates and the poor were more likely to show discriminatory attitudes, which is also an indication of the role socio-demographic characteristics play in determining one's attitude towards PLWHA.

Findings from a study by Mahdi, Nnedu, Ogunowo and Jolly (2004) in rural Jamaica found that persons below 30 years were less tolerant to PLWHA as against those 30 and above years. Furthermore, the study establishes that women in the same study were more tolerant than men to PLWHAs. This is an indication that socio-demographic characteristics of people may influence their attitudes towards PLWHA.

An epidemiological study in Turkey on HIV knowledge, attitude and misconception by Ayaranci (2005) showed that women, married participants, people living in cities, well-educated and rich participants showed positive attitudes towards PLWHAs. This suggests that socio-demographic characteristics of a person may determine their attitude towards PLWHA. Another significant finding was that misconception about HIV and

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AIDS also influences stigmatising attitudes resulting in the need for education programmes to focus on accurate and detailed knowledge about the disease.

Telephone surveys conducted by Herek, Capitanio and Widaman (2002) in United States on the prevalence of negative feelings and attitudes towards PLWHAs indicate that while 20 per cent of the respondents support a quarantine action for PLWHA and 30 per cent will avoid shopping in a PLWHA grocery shop, one-fourth of them attributed the PLWHAs situation to what they deserve. This, however, contrasts with Adeku et al (2010) findings in Ghana where respondents from both rural and urban communities were divided on whether or not to purchase cooked food from PLWHAs while about 80% supported institutional confinement of PLWHAs, their negative attitudes could be attributed to the misconceptions held about the disease by the respondents.

Besides, EKOS Research Associates (2006) in Canada on HIV and AIDS Attitudinal Tracking Survey revealed some patterns of stigmatisation towards PLWHA in the general population. In the said study, about 25 per cent of the respondents believed that PLWHA should not be allowed to be hairstylists, dentists and food vendors. The result also indicated that Canadian women were more likely to show positive attitudes, while senior citizens were less likely to support the rights of PLWHA, thus suggesting a relationship between socio-demographic characteristics of a person and his/her attitude towards a PLWHA.

Research by Genberg et al (2009) on the impact of HIV and AIDS related stigma and discrimination in four countries namely Tanzania, Zimbabwe, South Africa and Thailand indicated more negative attitudes and higher perceived discrimination towards PLWHA

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especially in areas which lack support system and educational programmes. What is significant is the relationship between HIV knowledge and attitudes towards PLWHA.

Letamo (2003) in an AIDS Impact Survey in 2001 in Botswana to assess stigmatising attitudes of respondents towards PLWHA found women to be more tolerant than men possibly due to the fact that women were the main caregivers in households in developing countries. The findings also showed that most of the respondents who expressed discriminating attitudes were young people and hence, the need for targeted educational programmes. The study findings may also give credence to the belief that one's socio-demographic characteristics influence their attitude towards PLWHA.

In another study by Letamo (2004) in Botswana, the results showed that sex, age and education were positively associated with attitudes towards PLWHA. Respondents who were young and those who were of low educational level were more likely to stigmatise PLWHA than older and those with higher educational level emphasizing that one's demographic characteristics also has an influencing role to play when it comes to attitudes towards PLWHA.

Furthermore, Ogunjuyigbe, Adeyime and Obiyan (2009) in Nigeria assessed the attitudes of citizens of Lagos towards PLWHA. It was revealed that more than half HIV negative participants would not shake hands (55%) and eat together (66.5%) with PLWHA. Again, 71.5% of the participants believed that PLWHAs should not hold public offices. The results invariably reflect a high degree of stigmatisation towards PLWHA.

It must also be emphasized that in relation to Ghana, the issue of negative attitudes towards PLWHAs is not different from what is found in other places. For instance,

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Awusabo-Asare and Marfo (1997) studies in Cape Coast on HIV and AIDS stigma established that there was general fear of infection .and hence stigmatising attitudes among health workers towards PLWHA. Mills (2003) reporting on the experiences of HIV sero- positive women in Accra and Agomanya showed that many of the women, for fear of shame and disgrace, which ultimately will lead to stigmatisation did not reveal their status.

As cited in Nkansa-Kyerematenge and Attua (2013), Ghana Statistical Service, GHS, IFC Macro, 2009, all found stigma and discrimination of PLWHA as relatively high as evidenced in the 2008 Ghana Demographic and Health Survey where only 11 percent of adult females and 19 percent of adult males exhibit accepting attitude towards PLWHA. Such attitudes found expression at all levels, which include individuals, homes, workplaces, institutions and the communities.

A study conducted by Kwashie (2014) on determining people's attitudes towards PLWHA in Ghana concluded that major explanatory factors such as sex, education, marital status and comprehensive knowledge contributed to attitudes towards PLWHA. It also revealed that age, religious affiliation, occupation, and place of residence constituted important factors in understanding the people's attitude towards PLWHAs.

Ayiworoh's (2016) study on stigma in Wa in the Upper West Region of Ghana reveals widespread stigma among the respondents towards PLWHAs. In this study, people who are uninfected with the AIDS virus and have family members living with the disease employ efforts to distance themselves from PLWHAs. The results of the study also stated impending death and physical deterioration of PLWHA, HIV as a product of

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punishment and sin, outcome of prostitution, infidelity and above all misinformation as the causes of stigma.

2.3.6 HIV and AIDS related Stigma and Discrimination and Religious Beliefs and Practices

Based on one's religious affiliation, a person's response to HIV and AIDS is likely to change due to their underlying religious belief system. It is as a result of this that certain people hold the opinion that the religious response to AIDS has often been ambiguous and contradictory. A victim-blaming orientation is likely to stem from what Pargament, McCarthy, Shah, Ano, Tarakeshwar, Wachholtz, et al (2004) refer to as 'negative religious coping', which involves seeing God as punitive. This is in contrast to 'positive religious coping' which views God as loving and caring to probably lead to a more tolerant orientation. In this way, religion has the potential to mould followers' attitudes about the illness. It can influence thinking around what causes illness, what treatment is indicated and how society should view and support sufferers.

Otolok-Tanga, Atuyambe, Murphy, Ringheim and Woldehanna (2007) study in Uganda reveals that faith-based organisations in the past were seen as those that promoted HIV and AIDS related stigma due to inadequate knowledge, morality and fear associated with sensitive issues in relation to sexuality and death. However, due to increased awareness about HIV status among the clergy and congregants and the leadership of PLWHA, their stance has now changed to a more positive one. This stance will definitely have an impact on the beliefs system of the congregants in relation to their attitudes towards PLWHAs. This is because Africans are so religious that they will readily accept whatever their religious leaders say as regards the religion. The implication is that once

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the people have adequate information and knowledge about HIV and AIDS, they will surely exhibit positive attitudes towards PLWHAs.

In South Africa, Keikelame, Murphy, Ringheim and Woldehanna (2010) established that notwithstanding the perceptions that faith-based organisations are committed to tackling the issue of stigma and discrimination, on the contrary, they are seen as promoting them in view of their association of sexuality issues, morality with HIV and AIDS with sin. This is attributed to lack of information and self -stigmatisation which prevents PLWHA from revealing their status.

Li, Lee, Thammawijaya, Jiraphongsa and Rotheram-Borus (2009) work on stigma, social support, and depression among people living with HIV in Thailand, revealed that HIV related stigma has a negative impact on the psychological wellbeing of PLWHA in Thailand since depression was significantly associated with stigma. Thus, there is the need for emotional and social support to be provided as a protective effect for the mental health of PLWHA.

According to Okunna and Dunu (2006) cited in Oluduru (2010), the linkage of HIV and AIDS epidemic with punishment from God for sexual transgression or divine curse due to an immoral act has made some religious leaders to believe erroneously that any association with PLWHAs is an endorsement of the affected person's act or supporting the afflicted person's acts. The fact that religious leaders view PLWHAs as 'sinners' or equate the epidemic with a 'curse' instead of showing compassion and care contributes significantly to the stigma, discrimination, guilt and shame suffered by PLWHA. This is unfortunate when one comes to realize the fact that people become infected through other means such as mothers getting infected through caring of their children,

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contaminated blood transfusions to innocent persons, faithful partners infected through unfaithful partners and innocent females infected through rape and others.

Studies abound which support the importance of religious beliefs and practices in dealing with HIV and AIDS, particularly in reducing HIV symptoms and improving quality of life of PLWHAs and their families (Coleman &Holzemer,1999; Green, 2003; Woodard & Sowell, 2001). Green (2003) found that in regions with high HIV prevalence, faith-based organisations (FBOs) have contributed in no small measure to stigma especially towards PLWHAs. In support of this, Parry (2003| asserts that religious entities have become avenues of exclusion for PLWHAs rather than places of shelter and comfort.

A study conducted by Muturi and Soontae (2010) on HIV /AIDS stigma and religiosity among African American women reveals that persons who display high religiosity significantly exhibit high level of stigma towards PLWHA associating the disease with a curse or punishment from God. This view is supported by Madru (2003) who also observe that HIV infection is as a result of sinful acts and immorality and AIDS as an outcome of such behaviour. UNAIDS (2002) on the same issue, asserts that religious and moral values account for some people to conclude that AIDS is due to moral fault like promiscuity or 'deviant sex' and hence deserved punishment. These perceptions are further given credence by the Biblical teachings captured in the following verses: 'Wages of sin is death' (Romans, 6:23) 'Likewise, Sodom and Gomorrah…committed sexual sins and engage in homosexual activities, serve as an example of the punishment of eternal fire' (Jude, 1:7) and "for all have sinned and come short of the glory of God" (Romans 3:23). These teachings to a great extent, have accounted for the stigmatisation against PLWHAs by most people especially, the religious.

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Religious beliefs and practices influence the behaviours and attitudes of people towards PLWHAs. Dilger (2007) in a study in Dar.Es Salaam established the role of religious organisations in both spiritual matters and material needs. Apart from the fact that they can give PLWHAs spiritual counseling, prayers for healing, hope for spiritual salvation, social and material support, they can also provide care and assurance of burial after death. Likewise in Tanzania, Zou, Yamanaka, John, Watt, Ostermann and Thielman (2009 found that most of the respondents believed that PLWHAs have disobeyed the word of God and are therefore being punished accordingly. They however, believe that they could be cured through prayers. The study also revealed that people who hold such beliefs exhibit high level of stigma towards PLWHAs.

Another study by Varas-Diaz, Neilands, Malave-Riveral and Betancourt on religion and HIV and AIDS stigma in Puerto Rico establishes that Nursing students who were greatly involved in religious activities exhibit higher levels of HIV and AIDS related stigma. Also, Andrewin and Chien (2007) studying stigmatisation of patients among doctors and nurses in Belize stated that health care professionals who identified themselves as religious exhibited high level of stigma as compared to those not considered religious.

Again, Rader and Campbell (2002) asserted that religious groups are noted for responding to issues of HIV and AIDS in negative terms, which breeds stigma and discrimination. They stated that judgmental comments from religious leaders and debate about condoms have been responsible for such a situation. This is attributable to the unwillingness of the religious sector to engage in any way that could imply dilution of moral standards, hence PLWHAs experience of rejection by religious people.

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It is important to state that this is not a good practice since religion is expected to assuage human suffering, show love, care and compassion and above all provide a supportive environment for the excluded and rejected. The essence of religion will be lost to its adherents if religious leaders engage in activities that suggest rejection, isolation and above all stigma for the mere fact that such persons have contracted a disease, HIV and AIDS. Religious leaders should rather lead their lost flock to salvation instead of condemning them.

Nyblade et al (2003) in Mukasa (2008) declared that in Ethiopia and Zambia, there is a strong linkage among sex, religion and stigma in view of the belief that HIV is a deserved punishment from God for sexual sins committed by individuals and communities. Religious institutions are reported to play a contradictory role towards people living with HIV and AIDS. Mukasa (2008) reports that a number of studies show religious leaders as active proponents of stigma towards PLWHAs.

As noted by Braithwaite & Genrich (2005), there is the possibility of the church to be turned into a stigmatizing environment for PLWHAs in view of the association of sexual and moral connotations with HIV transmission. The perceived stigma towards PLWHAs may be traceable to their perceptions that the disease was contracted through such immoral ways like pre-marital sex, infidelity and prostitution, which are all considered as sinful. Thus, the actions of the religious leaders and congregations are therefore meant to protect them from the sinners. This, however, should not be the situation because the church and mosque are supposed to be havens for those who might have committed sins and need redemption or salvation. It is also important to state that people may get infected through other ways other than immoral ways, which may not be their fault. They also emphasise that religious beliefs significantly shape individuals' outlooks on living

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with HIV since faith practices and beliefs do not only provide a sense of peace and hope but also assist people to prepare for and accept death. It is against this background that people often turn to religion to make sense and come to terms with being HIV-infected.

The employment of prayers, meditation and faith in God and other forms provide solace to the infected. This is evidenced in studies in Tanzania and other African countries (Makoe, Greef, Phetlhu, Uys, Naidoo, Kohi, Dlamini, Chirwa Holzemer, 2008).

It is significant to mention that as part of its contradictory role, just as religious faith and beliefs are seen as an avenue for providing solace and hope for PLWHA, they on the contrary promote fatalistic attitudes and passive resignations, which obstruct participation in treatment. This is supported by McKinney & Hess (2007) study in Mali, where those who believed that AIDS was a punishment from God had fatalistic attitudes than those who did not. In the same vein, there is the tendency for PLWHA to discontinue their treatment because of their belief that their pastors' prayers can cure them of HIV. The implication of the statement is that once God is the source of the disease, no matter what treatment the PLWHAs engages in will not yield any positive results. Such a person will surely die and there will not be the need to waste time and resources in undergoing any treatment. It is important to state that such a stance will affect the uptake of antiretroviral drugs and possibly lead to the spread of the disease and for that matter, the fight against stigmatisation towards PLWHAs.

In a study conducted by Abraham (2006) on perceptions of HIV and AIDS related stigma among Moslems in a Cape Town community, the majority of the participants perceived HIV and AIDS as a curse or punishment from God. This might have resulted from the understanding that Moslems were compelled by God to follow his rules and he

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punished them when they chose not to do so. Islam prohibits Moslems from having pre-marital and extra-marital sexual relations and based on that, any member who did so was regarded as having committed sin, and hence was punished by God through HIV and AIDS. They reported that a participant lamented as follows:

> "In all religions ……. HIV …….we talk about it as punishment from God. If you look at the prostitutes, right, she or he knows that HIV/AIDS is right outside. You can pick it up anytime now why you still go out and do your thing outside and at the end of the day you get the disease. So if you decide that I wanna go that direction of HIV /AIDS that is a punishment".

Thus, such persons were seen as guilty, bad and shameful based on the belief that they chose behaviours that put them at risk of HIV infection. The underlying belief was that if you have HIV and AIDS, then you are guilty of a transgression against God through illegitimate behaviours such as sexual promiscuity, homosexual relationships and drug/needle abuse; and therefore you chose to be bad and sinful and accordingly, you were deserving of punishment.

The teachings of religious leaders, which link HIV illness to immoral behaviour, according to Anane (1999) account for their reluctance to address the issue of HIV illness in Ghana. In support of this assertion, Judy (1999) also indicated the unwillingness of PLWHAs to disclose their status to church communities due to stigma. This was confirmed when a participant, who is a church secretary stated that churches in Ghana played a significant role in the propagation of AIDS stigma.

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In yet another study by Adoo-Adeku et al (2010) in Ghana, the relationship between immoral behaviour, or for that matter, sexual sins and HIV were given expressions as reflected by the respondents concerning their perceptions about PLWHAs. In this study, respondents considered people living with HIV and AIDS variously as: “Sinners who are being punished and therefore need no sympathy”, “Not God-fearing people”, “People with no values and worthless”, “Immoral people” and “They are people paying for their bad deeds”.

What is significant from these statements is that some people still do not know the causes of the illness due to lack of relevant information and knowledge. It may, therefore, be argued that in view of the insufficient or lack of relevant knowledge on the causes of HIV and AIDS, more intensive sensitization and education on the illness targeted at religious groups and their leaders is very paramount. This will promote a more compassionate and caring environment for PLWHAs.

Ever since the outbreak of HIV and AIDS disease around 1985, Islamic ethical literature has considered the illness as something that pertains to only Europeans and American homosexuals. With the recognition now being held that HIV and AIDS are spread mainly by multiple partners and heterosexual activity, Moslem leaders have done all they could to avoid having any discussion on the topic due to the strong religious taboos in relation to sex.

Rademakers, Mouthaan and de Neef (2005) stated that Islam stresses sexual abstinence before marriage for both males and females. Al-Islam (2001) held the opinion that in the Islamic view, HIV and AIDS are as a result of behaviour that displeases and disobeys God and therefore merits punishment. On the other hand, Francesca (2002) reiterated

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that some Moslem religious groups, however, stress the great tolerance of Islam, which should include people living with HIV and AIDS.

The issue of HIV and AIDS has therefore created a sense of dilemma for Moslem religious leaders. As highlighted by Amod (2004), Muslim religious leaders in South Africa, a country with one of the highest prevalence rates for HIV and AIDS, are torn between avoiding any discussion of HIV and AIDS and considering it as an admonition from God to avoid illicit conduct, denying the threat of the pandemic to their societies (Hassan, 2004; Kelley & Eberstadt, 2005), or promoting tolerance or favourable attitudes towards PLWHAs (Francesca, 2002). Thus, the dilemma of Moslems is how to reconcile compassion for PLWHAs with the issue of punishment as deserved divine retribution.

HIV2 infection, which is characterized by promiscuous behaviour, has divided Islamic religious opinion as to whether persons living with HIV and AIDS (PLWHA) should be punished or stigmatized for their sinful behaviour or embraced or accepted based on religious tolerance. Notwithstanding inconsistent and confusing messages from religious and political leaders, a study conducted in South Africa targeting Moslem students' attitudes to people living with HIV and AIDS, did not only show their high levels of religiosity but also displayed an unexpectedly tolerant attitude towards people living with HIV.

2.3.7 The Islamic Religion: Beliefs and Practices

The Islamic religion constitutes the second largest religious group worldwide and according to gordonconwell.edu, it has a population of 1.7 billion as at 2015. Moslems, according to Rassool (2000) are linked by their common Islamic faith, heritage and

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belief in: one God; angels; God's revealed books; prophets through whom God's revelations were brought to mankind; a day of judgement; individual accountability for actions; God's complete authority over human destiny; and life after death. The holy Qur'an is considered by Moslems as a record of the exact words, revealed by God through the Angel Gabriel, to the Prophet Mohammed and then to the people. The Qur'an thus, serves as the main basis of every Moslem's faith and life practices (A study in 2015/16).

The religion also encompasses ritual practices and guidelines for a complete way of life, and is shown in Moslem cultural beliefs and their practices. The five pillars of Islam, which constitute the foundation of the religion, are faith (Sahadad), prayer (Salat), concerns for the needy (zakat), self- purification (fasting) and pilgrimage by those who are able, to Mecca (Abdul-Wahid, 2016).

As far as the Moslems' world is concerned, Hasnain (2005) remarks that Islam defines culture, and culture gives meaning to every aspect of an individual's life including behaviours, perceptions, emotions, language, family structure, diet, dress, body image, concepts of space and time, and attitudes towards health and illness. According to Athar (2007), each aspect of a Moslem's life has implications for the delivery of health care. Moslems view health, illness, suffering and dying as part of life and as a test from Allah. Thus, they are encouraged to receive illness, suffering and death with patience, meditation and prayers. Also, Moslems believe they are to consider illness and suffering as atonements for sins, and death as a part of their journey to meet God. The idea of seeking appropriate treatment and care for a person is strongly encouraged in Islam. It is also stated that health, illness and caring are considered part of the human experience of performing worship activities while on earth (Athar 2007).

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Moslems' view about caring, according to Rassool (2000) is embedded in the theological framework of Islam. The concept of caring in the religion is founded in the belief that providing care to others is a service to God, which should be given freely and without ties to commercialism. Caring is viewed as a natural outcome of having love for Allah and the prophet Mohammed, and refers to having the will to be responsible, sensitive, concerned, motivated and committed to acting the right way in order to achieve perfection in life. It is also important to note that the religion advocates its adherents to follow the guidelines delineated in the Qur'an and the Sunnah (the prophetic traditions of Mohammed). Moslems believe that the prophet was sent to provide mankind examples of how to live, including matters of health and personal hygiene.

There exist several Islamic traditions that relate to health care practices which coincide with specific traditions that take place along the human life span. Homosexuality is condemned, and considered sinful and punishable by Allah. Moslem couples are encouraged to have children and sex outside marriage is discouraged while contraception and family planning are allowed (Akhtar 2002).Abortion is not permissible in Islam except if the pregnancy threatens the life of the mother, since children are seen as a gift from Allah. Boys born into the Moslem family are circumcised to enable them to maintain cleanliness through washing (wudlu) and to prevent urine from collecting in the foreskin.

Moslems prefer to be cared for by a member of the same gender. In addition, the Islamic faith emphasized cleanliness, which includes eating with the right hand, consuming only permissible (halal) food. The forbidden or non-permissible (haram) foods and items include pork, non-halal meat, alcoholic beverages, gelatin products and illegal drugs (Islamic Council of Queensland 1996).

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In Islam, human life is considered precious and the will of Allah should be allowed to prevail. In that regard, the taking of a life through suicide or euthanasia is considered a major sin. Moslems also believe in life after death and the Day of Judgment. The religion also enjoins its adherents to treat terminally ill patients with sympathy and compassion and also take care of their spiritual needs.

2.3.7 Islam and Economic Related Activities

The history of Islam in most West African countries, and for that matter Ghana cannot be written without mentioning the role of the trans-Sahara trade between Africa and the Mediterrean. The North African traders were the main players in bringing Islam into West Africa. This is because their main aim was to trade. They nevertheless transported their religion, Islam since some of them were scholars interested in propagating their religion by teaching the natives the Arabic language, which was more of a secular education than the formal type. This probably might be the reason why most of the Moslems had only secular education making it difficult for them to gain formal sector employment due to lack of formal education particularly in Ghana. It has also affected HIV and AIDS stigma and discrimination messages which are mostly in the English language.

Islam as a religion is not only about spirituality but deals with every aspect of human life. It gives directions in social life, political life, marital as well as economic or business transactions (Azmi 2015). According to Al-Ghazali and Mohammed (2001) striving for the sustenance is required. It is part of human nature to earn the livelihood for himself as well as for the dependants. As stated by Al-Maududi and AbulAala (2009), an individual can get nothing unless he puts his efforts.

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As a religion, Islam is very particular with encouraging economic activity and exhorting its followers to hard work, which is productive and profitable as opposed to unemployment, dependency and idleness. This is meant to fight poverty, a phenomenon considered social illness, which effects do not affect only the poor but the society as a whole (Azimi, 2015). The view of Islam is that society cannot be established on a firm solid foundation when a section of its population suffers from the effects of poverty. It is on these that economic activities or business transactions are considered very vital in Islamic communities.

According to Shafi (2002) business simply refers to trading, buying, selling and transactions which deal with things and services of physical and spiritual value. Business transactions in the Islamic religion must be based on the Quran, traditions and practices of the Prophet and his companions as specified in the books of Jurisprudence.

Economic related activities or business transactions are considered as the foundation of any society and growing business or economic related activities play a significant role in raising the social status of the individual and the community as it consequently contributes to the development of the economy. In this regard, the role of all those persons engaged in this enterprise cannot be over-emphasised once they all contribute to the development of the community. Thus, there should not be any reason why certain categories of persons due to their conditions, should be excluded from this enterprise or stigmatised against when it comes to business transactions .This is important when viewed from the position of Islam as a religion which does not discriminate based on one's tribe, colour, sex, social or health status as exemplified in its religious practices and rituals such as prayers and the Hajj performance.

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From the perspective of Islam, economic related activities and business transactions are conducted for the purpose of distribution of wealth and not for the control of resources. This is captured in the Quran, Surah Al Nisa (4), Ayat 29 and 30:

> 29. 'O ye who believe! Eat not your property among yourselves in vanities; but let there be among you traffic and trade by mutual good-will: nor kill (or destroy) yourselves: for verily God hath been to you.
>
> 30. 'if any do that in rancor and injustice, soon shall We cast them into Fire: and easy it is for God'.

As in other aspects of life, business transactions should also be governed by the main concept of Islam. According to At-Tirmidhi and Mohammed IbnIsa, 'how the man earns the wealth and where he spends it "will be questioned one day. One of the important verses in the Quran as regards business transactions is quoted below:

> "What Allah has bestowed on His Messenger (and taken away) from the people of the townships,-belongs to Allah,-to his Messenger and to kindred and orphans, the needy and the wayfarer; In order that it may not (merely) make a circuit between the wealthy among you. So take what the Messenger assigns to you, and deny yourselves that which He withholds from you. and fear Allah. for Allah is strict in punishment''.

The import of this verse is that in Islam wealth should not be confined in the hands of the rich alone. It must spread in the society for every individual whether rich, poor, sick, healthy, black or white to have equal benefits of it. It is important to state that the flow of wealth should not be from the poor to the rich to make the latter richer and the poor poorer. It should rather be from the rich to the poor and the needy in the society not only

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to empower them but also raise them to the level where they could be in the position to contribute their quota to the welfare of the larger community and strengthen the economy.

In the light of this, it is against the tenets of Islam for people not to engage in business transactions or patronize the goods and services provided by the sick especially PLWHA because of their situation, since they constitute the vulnerable, needy and disadvantaged in the society. They must survive and not be dependent on others.

Rather, zakat was made mandatory and voluntary charities were recommended and generosity appreciated. A great proportion of the revenue was fixed to cooperate the socially and occasionally deprived people and to assist them come out of their debt burdens if ant accrue as indicated by Abdullah and IbnAnas (2015).

It is also important to state that as far as businesses are concerned, there is no fixed list of permissible businesses in Islam. Originally, all kind of business transactions were allowed. However, business transactions should not involve forbidden things such as gambling, wine and pork. Also, Moslems are not allowed to engage in business transactions that cause harm or reciprocates harm. Any business transaction that has clear uncertainty or speculation is not permissible in Islam because it leads to problems or disputes between the parties involved.

It is important to emphasise that these principles governing business transactions in Islam have been put in place to ensure the sustainability of the economy and above all spread the profit to benefit majority of the people who are less privileged, vulnerable, needy and the sick in the society.

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2.3.8 Islam and HIV and AIDS related Stigma

As far as Islam is concerned, the issue of stigmatisation in general and HIV and AIDS related stigma is not encouraged at all. Reference is made to the time when the Holy Prophet came with the divine message and proclaimed that no Arab was superior over a non-Arab and no white was superior over black and that superiority was by righteousness and God-fearing alone as captured in Surat Al-Hujurat 49:13. Thus, the problem of racial or colour discrimination was eradicated and that one's superiority should not be based on birth or colour or blood but by God-fearing and righteousness, suggesting that discrimination of any type does not have a place in the religion.

It is also significant to mention the Prophet's address to the people during the last Hajj (pilgrimage), which is also known as the last sermon, saying:

> 'O People! Your God is one; your father is one; no preference of an Arab neither over non-Arab nor of a non- Arab over an Arab or red over black or black over red except for the most righteous .Verily the most honored of you is the most righteous" (Al-Bukhari, Hadith 1623, 1626, 6361).

Islam emphasizes the fact that all people are equal and belong to one race and therefore there is no need for segregation or discrimination based on one's situation which could be poverty, sickness or any unfortunate circumstances.

It is reported by Abu Hurayrah that the Messenger of Allah (Mohammed) said: 'Do not envy one another; do not outbid one another, do not hate one another, do not shun one another…It is a serious evil for a Moslem that he should look down upon his brother Moslem. All things of a Moslem are inviolable for his brother in faith; his blood, his wealth and his honour.'(Hadith 35)

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Another important illustration, according to Moustapha 2005; Yaqut; 2007 is the daily and Friday prayers in the mosque where equality is practically demonstrated with no signs of discrimination and differences. Whoever went to the mosque first took his place in front rows notwithstanding his financial or social status and whoever went late will find himself in the back or last rows. Thus, the rich and poor, the knowledgeable and non-knowledgeable, the short and tall, the black and white, the stout and lean all find themselves in the same row. This is even manifested clearly during the Hajj and Umrah pilgrimage where everyone is expected to wear simple white clothes, which equates the rich and poor, the ruler and ruled all walking around the Holy Kaaba asking one lord. All these are suggestive to the fact that as far as the religion is concerned, there is no discrimination and all Moslems are equal before the lord (Moustapha, 2005).

Reference is also made to the Holy Prophet who once refused to pray against the people of At-Ta'if for once stigmatising and injuring him, though Allah gave him the opportunity to take revenge for their injustices against him. The prophet declared 'No, I shall beseech Allah to make from among their progeny a generation of true believers!'(Hadith of Mercy, Sahih-al-Bukhari 3059 & Sahih Muslim 1759). The prophet went ahead to pray for them to be guided and their unjust acts forgiven.

Islam also enjoins all Moslems to always visit and show love to the sick and that explains why it is not Islamic to stigmatise PLWHA. Gloating over others' misfortune is the manner of the unbelievers and hypocrites. Allah Almighty says, "If a lucky chance befalls you, it is evil unto them, and if disaster strikes you they rejoice thereat. But if ye persevere and keep from evil their guile will never harm you. Lo! Allah is surrounding what they do" (Aal- 'Imran 3:120).

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It is important to remark that equally significant Islamic religious leaders' responses to HIV and AIDS, and for that matter, stigmatisation are worthy of consideration since they are supportive of positive attitudes towards PLWHAs: "...We also acknowledge that people living with HIV/AIDS need unconditional love and support and are not to stigmatise and discriminated' (International Pre-conference Muslim Workshop on HIV/AIDS, Bangkok, Thailand, 9 July 2004).

Islamic Relief (2008) wrote that 'there is no 'us' and 'them' and that all attempts to split society into 'us' and 'them' are counterproductive-whether manifested in a reluctance to use toilets and shake hands, in exclusion from the labour market or in condemnation and exclusion. In that context, infection patterns need to be identified to enhance the effectiveness of HIV and AIDS –related programming but, once a person is infected, the single priority is how the person and their community are affected'. Subsequently, research has revealed that:

> "Instead of gloating over the misfortune of those who are afflicted by AIDS, we should help them get proper care and treatment .Instead of stigmatising them for carrying or having a disease for which they may not be responsible, why don't we make du'aa for them? Why don't we earnestly ask Allah to shower them with His mercy? (Moustapha 2005)

Islam places a high premium on life and discourages one from having a sense of hopelessness or abuse regarding life. It is against this stance that when Moslems become HIV positive or develop AIDS, other Moslems are supposed to care for them since they are still part of the Moslem fraternity. It is important to state that Moslems are not supposed to avoid or neglect those living with HIV or AIDS due to the disease (www.positivemuslims.org.za/hivaidsis.htm; retrieved 20/10/18).

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Instead, Moslems believe that there is the need to give considerable attention; care, love and affection to PLWHA so as to enable them lead dignified lives (Moustapha, 2005). Moreover, it is their conviction that no Moslem has the right to judge or condemn PLWHA since the right to forgive or punish is in the bosom of Almighty Allah. Love and compassion are considered the qualities of a good Moslem and PLWHA cannot be denied this powerful emotion. The Holy Prophet recommended that Moslems should give much attention to visiting and caring for the sick and that since PLWHA need compassion, love, support and affection, Moslems should feel comfortable embracing them (Yaqut, 2007).

It is important to stress that the Islamic tradition and ethics stress empathy for the sick, no matter the type of illness. As reported by Abu Hurayra cited in Al-Nawawi (1997) the prophet of Islam stated that one of the five rights a Moslem has over another Moslem is to visit the sick. This is evidenced in the quotation:

> "The Messenger of Allah, may Allah bless him and grant him peace, said 'Allah, the Mighty and Exalted, will say on the Day of Rising, 'Son of Adam I was ill and you did not visit me". The man will say,"O Lord how could I visit You when You are the Lord of the worlds? He will say, 'Do you not know My slave was ill and you did not visit him? Do you know that if you had visited him, you would have found Me with him?

Based on the above statement, it is clear that it is not permissible in Islam to treat persons who are sick, especially PLWHA differently or show negative attitudes towards them just because they have AIDS. What is required of Moslems is kindness, care and love and above all assist such people to get medical treatment.

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It is however important to point out that notwithstanding these, which are pointers to the fact that Islam has positive attitudes towards PLWHAs, Lake and Wood (2005) stated that some Moslems are of the belief that HIV and AIDS is a punishment from God for bad behaviour and /or sins committed' and that the only way persons are infected is through illicit drug use, male-to-male intercourse and /or extra-marital sexual activity. It is therefore not coincidental that Hasnain (2005) remarked that such incorrect beliefs contribute to stigmatization and discrimination towards persons living with HIV and AIDS, which appears to be more widespread among Moslem communities than in other populations.

Studies conducted by Lohrmann et al (2000) and Williams et al (2006) indicate that among non-Moslem populations, people's knowledge and attitude towards persons living with HIV and AIDS are strong determinants in relation to one's willingness to care for PLWHA. On the contrary, however, in Moslem communities, whether one does or does not willingly care for PLWHA appears inconsistent and dependent upon the community. While negative attitudes towards PLWHA have been found to exist among Tunisians, it is rather the opposite as far as Turkey and Iran are concerned where the people exhibit positive attitudes towards PLWHA in view of their adequate knowledge about HIV and AIDS (Ayranci, 2005; Montazeri, 2005).

Though there is limited information as regards caring practices for PLWHA in Moslem communities, knowledge generated from earlier studies on the same issue among non-HIV and AIDS populations, studies within the context of the Islamic faith, can be used to better understand how Moslems care for those with chronic illness. Islamic religious practices and cultural norms are factors that have been shown to influence individuals providing care to family members with schizophrenia. The said family caregivers have

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been found to interpret caring as love and concern, obligation of family members, acceptance as prescribed by Allah and a test of patience set by Allah (Vanaleesin, 2007).

It is however regrettable to state that as Martin (2004) stated, in some areas of Asia, Moslem practices continue to be influenced by local cultural beliefs traceable to previous traditions. Issues in relation to spirituality respect for ancestors, beliefs in spirits and mystics, and gender relations are some of the beliefs that are derived from pre-Islamic beliefs. What is significant to note is that Asian cultures stress maintenance of social and religious harmony with the universe, which influences one's attitude toward health and disease (Martin, 2004).

In this regard, since HIV and AIDS has been viewed as an immoral disease, seeking health care for the illness or disclosing the presence of a sero-positive status can bring a lot of shame to one's family and the community. In order to avoid such an embarrassing situation, PLWHA often become isolated or are totally rejected by the Moslem community (Ibrahim and Songwathana 2010).

What is significant to note is that Islamic beliefs and traditions determine the culture and the Moslems way of life as well as directly influence their health care practices. It is, however, the misperceptions and lack of knowledge about HIV and AIDS that continue to exist among many Moslems thereby fueling stigmatisation, discrimination and neglect of PLWHA (Ibrahim and Songwathana 2010).

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2.3.9 Policy Interventions on HIV and AIDS related Stigma and Discrimination

The Cambridge English Dictionary (2019) defines a policy as a set of ideas or a plan of what to do in a particular situation that has been agreed to officially by a group of people, a business Organisation, a government or a political party. A policy is therefore a law, procedure, administrative action, incentive or voluntary practice of governments and other institutions. A policy is a deliberate system of principles, set of ideas or plans meant to serve as a basis for making organisational decisions, which may include the identification of diverse alternatives such as programme or spending priorities in order to achieve rational outcomes.

From these definitions, one may conclude that a policy is a legality, which implies that it is founded on law and anyone who flouts it is likely to face the necessary punishment as may be prescribed for offenders.

HIV and AIDS related stigma has been considered as one of the greatest obstacles in any effective fight against the epidemic. Apart from the fact that its devastating effects are felt at the individual, social and national levels, it has also been singled out as the main hindrance to accessing prevention, care and treatment services. That notwithstanding, the varied negative treatment meted out to PLWHA by individuals, society and its institutions, various efforts by the community, national and international actors have yielded minimal results in reducing the negative effects of HIV and AIDS stigma. It is in the same vein that the belief is commonly held that any interventions in the area of stigma will definitely lead to reduction in HIV and AIDS related stigma and not its total elimination.

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In a review of research studies and future directions for prevention strategies on HIV /AIDS –related stigma and discrimination in Nigeria, Monjok,Smesny and Essien (2009) suggested that the news media, home videos, radio jingles should be employed to produce de-stigmatisation programmes in schools, hospitals and religious centres. Apart from stressing that the introduction of AIDS education should be integrated into the curriculum of teaching in the country from the primary to university level, they also mentioned the empowerment of the stigmatized groups such as PLWHA, sex workers, drug users as well as their involvement in the design and implementation of prevention programmes in the country as ways of addressing stigma. Another important intervention has to do with focusing more prevention activities in the rural and remote areas than in urban centres since majority of the population in most developing countries reside in such areas where they lack access to modern day mass media.

In their study on Stigma in the HIV/AIDS epidemic: A review of the literature and recommendations for the way forward, Mahajan, Sayles, Patel, Remien, Ortiz, Szekeres and Coates (2008) noted some of the stigma reduction strategies as those designed to reduce stigma at the community level by increasing the tolerance of the general population towards PLWHA. The strategy employed was education through provision of factual information about HIV and AIDS.

Another strategy was the mass-media campaigns relating to HIV and AIDS knowledge, attitudes and behaviours. Such campaigns include broadcast such as the radio and television which target national audiences or small media in the form of posters, pamphlets and drama aimed at localities which disseminate messages about HIV and AIDS with the aim of potentially reducing HIV and AIDS related stigma.

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In the view of Mahajan et al, the above and several other existing stigma reduction strategies are focused on cognitive-behavioural and social-cognitive models engaging activities such as information dissemination, empathy induction, counseling, and cognitive behavioural therapy at the individual level. They rather propose a more comprehensive conceptualization of HIV and AIDS stigma and discrimination, development of stigma reduction programmes at the institutional and structural levels, whose designs must be influenced by the prevailing social and cultural forces that provide the dominant groups the power to create stigmatising and discriminatory conditions.

The need for community level mobilization with the sole aim of re-awakening the power of resistance of the PLWHA in collaboration with the support of important structural targets such as religious leaders, the judiciary and the legislative bodies can effectively respond to stigma. Also, the importance of appropriate reporting and enforcement mechanisms like legal aid services and hotlines to report discrimination cannot be over-emphasised when it comes to socially endorsed rights based approach (Parker and Aggelton 2005).

Derived from the principles of community organizing and community building requested the need for new models for advocacy and social change in response to HIV and AIDS related stigma. The principle of GIPA (Greater Involvement of People Living with HIV and AIDS) is vital for effective social programme response to HIV and AIDS stigma. According to UNAIDS Policy brief (2007), GIPA aims to realize the rights and responsibilities of PLWHA, including the right to self-determination and participation in decision making process that affect their lives. The Public participation of PLWHA at both community and social levels would not only promote individual level responses to

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internalized stigma on the part of PLWHA but could also prove a powerful deterrent to stigmatising impulses of the general population.

In his study on the role of religious leaders in curbing the spread of HIV /AIDS in Nigeria, Oluduru (2010) recommended constant and regular training of religious leaders on HIV and AIDS prevention, as well as counseling since equipping them with accurate information on the disease will enable them to disseminate such accurate information to their congregation thereby eliminating misconceptions which fertilizes stigma and discrimination.

Religious organisations role in assisting prevention and care through the dissemination of information in the local FM stations using the local languages are essential. Trained religious leaders can either through press statements or interviews in the media discuss the factors that fuel the epidemic and its impact on the individual, families and societies (UNICEF, 2003).

Another important intervention worthy of mention is the need for religious leaders to employ their spiritual or religious teachings to emphasise compassion and support for PLWHA. According to UNICEF(2003), they must also 'work with other religious leaders, faith-based coalitions and community leaders to find common beliefs, spiritual teachings and moral, legal and social standards that can help prevent HIV and alleviate the sufferings of those affected by AIDS.

One other equally important intervention is to channel valuable resources at the disposal of religious organisations such as schools, clinics, hospitals and orphanages for HIV work. These could be used for creating awareness about the disease and its related effects

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and providing the necessary care and support for PLWHA (Afrol News http://bit.ly/ha8D69; UNAIDS Partnership with Faith-based organisations).

According to Ulasi et al (2009), educational interventions should take into consideration the prevailing sociocultural, religious and economic environment, and address areas such as the harm of cultural and religious judgments of PLWHAs, benefits of testing and knowing one's HIV status, inability to contract the disease through mere social contact. To them, PLWHA and their families are to be provided with factual information about the disease including information on home management and psychological aspects of the disease. Also, PLWHAs need training to assist them improve their self-esteem and self - efficacy and positive coping skills. Such educational intervention should erase the minds of the community people that they can be physically, socially, and morally be tainted by interacting with PLWHAs (Ulasi et al, 2009).

2.3.10 HIV and AIDS Policy in Ghana

The current policy, known as the National HIV and AIDS, STI policy is a revision of the 2004 policy, anchored on the dictates of the 1992 Fourth Republican Constitution and other government's policies, international conventions and protocols, which include the Millennium Development Goals. The policy is meant to address the very serious health and developmental challenges occasioned by HIV and AIDS. The eleven strategic thrusts of the policy are : (1) human rights, legal and ethical issue,(2) prevention of HIV and STIs infections,(3)treatment, care and support,(4) mitigation of social and economic effects of HIV and AIDS,(5) health systems strengthening,(6) community systems strengthening, (7) public sector policy, roles and responsibilities, (8) private sector

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policies, roles and responsibility, (9) national HIV and AIDS, STIs workplace policy (10) research, monitoring and evaluation (11) funding mechanisms.

It must be stated that as far as HIV and AIDS related activities in Ghana are concerned, it is the Ghana AIDS Commission, (GAC), a multi sectoral institution, which co-ordinates them. The Commission provides support, guidance and leadership for the national response to HIV by formulating national policies, coordinating the national response to HIV, and managing and monitoring the utilization of resources (GBSN, 2006). It must however be pointed out that GAC is not directly involved in service provision for PLWHAs and key populations. Rather, it co-ordinates and develops policy.

Goals and Objectives:

The main goal of the objective is to create a favourable environment for every aspect of HIV and AIDS, STI prevention, care and support. Some of the main objectives, which are relevant to the study are:

- Identify components that ensure that the basic rights of each person in Ghana, especially persons infected and affected by HIV are respected, protected and upheld.
- Alleviate the social, cultural and economic effects of HIV and AIDS at individual, household and community levels by reducing HIV- related stigma by providing information, basic needs and legal and community safety nets for PLWHAs, orphans and vulnerable children (OVC) and key and vulnerable populations
- Ensure that access to social and economic opportunities remains open to PLWHAs and key and vulnerable populations.

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Under human rights, legal and ethical issues, the policy calls for an HIV and AIDS prevention law and information to the public about their health rights in the Patients charter of the Public Health Act 2012 (Act 851).

The policy establishes that discrimination against a person infected or affected by HIV or AIDS is prohibited. Thus, a person who dies of an AIDS –related condition, or is perceived to be HIV positive, is not to be denied burial services on grounds of HIV status. This also applies to the workplace. All workplaces, whether public or private are to have HIV and AIDS policies. Legal proceedings may be instituted for discrimination by CHRAJ, Legal Aid scheme and public interest groups.

The right to privacy and confidentiality is safeguarded in the policy, subject however to certain exceptions. The policy also advocates against any mandatory medical exams as part of the pre-employment or pre-enrolment to an educational institution. However, where a person is charged with a criminal offence mandatory testing is to be conducted. This also applies to procedures for the transfer of body parts or fluid.

Cultural practices that serve as obstacles to HIV prevention should be proscribed by law, supported with educational campaigns to encourage the people to stop the practice. The policy also states that the Criminal Offences Act 1960 (Act 29) should be used to prosecute the offenders of willful infection.

Guidance is also give as regards HIV prevention, treatment, care and support and STIs in the policy in view of the importance of prevention to the reversal of the devastating effects of epidemic.

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The policy also identifies areas, which deal with the mitigation of social and economic effects of HIV and AIDS, STIs and addresses issues of HIV and AIDS related stigma and discrimination, sexuality, gender, differences in cultural practices and the socio-economic status of the infected and affected. The main aim of mitigation is to reduce HIV and AIDS related stigma and discrimination towards persons infected and affected by HIV and AIDS and above all draw attention to the compelling public health rational to overcome stigma and discrimination at the individual, household and community levels.

The policy also identifies a role for government, non-governmental and private sectors and outlines specific responsibilities. The public sector has the responsibility to provide an enabling environment to achieve the nation's development goals and objectives. Key line ministries have been singled out as critical in successfully mainstreaming HIV and AIDS in the public sector and are required to incorporate issues of HIV and AIDS into the main core business. They include Ministries, Departments and Agencies (MDAs), coordinating bodies, GAC, National Development Planning Commission (NDPC) and National Population Council (NPC).

The private sector organisations and enterprises are required to develop and implement workplace policies and programmes for HIV and AIDS, STIs in consonance with the National Workplace HIV and AIDS policy. They include HIV and AIDS, STIs prevention, education for workers, condoms distribution and protection of PLWHAs.

Under the private sector policies, roles and responsibilities, provision is made for faith-based organisations. Among others, faith-based organisations are not required to demand HIV testing as a prerequisite for marriage, though couples could be encouraged to

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undertake confidential testing before marriage. The policy also advocates faith-based organisations not to perpetuate stigmatising messages against PLWHAs and vulnerable populations.

It is remarkable to state that research, monitoring and evaluation are key to effective planning and co-ordination of the national HIV and AIDS, STI policy.

In view of the importance of funding to the successful implementation of any policy or programme, the policy also contains funding mechanisms for internal and external funds. In this regard, it stresses the need for adequate and sustainable funding for HIV and AIDS programme as paramount to the national response. The policy advocates the establishment of an HIV and AIDS fund with legal support.

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CHAPTER THREE

RESEARCH METHODOLOGY

3.1 Introduction

This chapter presents information on the research design, the population and sampled population, the sampling techniques used and the sample size, the data collection instrument, pre-testing of the data collection instrument (pilot study), data collection and data analysis methods as well as ethical issues.

3.2 Profile of the study Area

a. Location and Position

The Upper West Region is located in the North-Western quadrant of Ghana. It is bordered on the north by Burkina Faso, the south by the Northern Region, the west by Cote d' Ivoire and on the east by the Upper East Region. The region covers a geographical area of 18,476 sq.km, which constitutes 12.7 percent of the total land area of Ghana. It is the seventh largest among the regions in terms of land size though, also the least populated region. The capital and largest town is Wa with other towns such as Lawra, Tumu, Jirapa and Nadowli.

b. Population Composition and Distribution

The total population of the region is 702,110 made up of 341,182 males (48.6%) and 360,928 females (51.4%), which represents 2.8% of the national population. The sex population favours females and it has a sex ratio of 94.5 males per 100 females (2010 Population and Housing Census).The age structure of the region indicates that the proportion of the population aged 0-14(under 15years) is 41.7%, and those aged 15-64 and 65+ are 52.3% and 6.0% respectively. The region experiences more outflows of people to other parts of the country than people migrating into the region. This therefore

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gave the region a negative net migration value of -209,144. The total fertility rate is 5.0 and contraceptive prevalence rate that is the use of modern contraceptives among currently married women was 24.8% in 2014.The HIV prevalence rate in the region was 0.8% which was lower than the national HIV prevalence of 1.3 % (National Population Council, Upper West Secretariat, 2015).

c. Ethnicity

The region is ethnically heterogeneous .The different ethnic groups that are found in the region form part of the over 100 groups in Ghana, which are distinguishable by language and cultural differences. The two major ethnic groupings in the region fall under the broad generic categories of the Mole-Dagbani and Grusi. The main ethnic groups are the Dagaaba, Sissala, Waala, Chakalei and Lobi, though there are other smaller groups such as the Hausa, Fulani and the Moshie, who are settlers from the neighbouring countries.

d. Religious Affiliation

The 2010 Population and Housing Census indicated that in terms of religious affiliation, there are three major religious groupings in the region namely Christianity (44.2%), Islam (38.1%) and Traditional (13.9%), those who do not practise any religion (3.5%) and others (0.3%), (2010 Population and Housing Census). There are very marked differences among the districts in relation to religious affiliation. Christians make up the largest religious group in Nadowli/Kaleo, Lawra, and Nandom and with strong presence in Jirapa and Wa municipality. A very large number of adherents of the traditional religion are also found in Jirapa, Karni-Lambussie with fairly good presence in Wa West and Daffiama/Bussie/Issa districts respectively. The Islamic religion has most of its

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adherents in Sissala East and Sissala West respectively, Wa Municipality, Wa East and Wa West respectively.

e. Local Economy

The major economic activity of the region is agriculture. This is supported by the fact that 72.2 per cent of the economically active group is engaged in agriculture or related activities. Food production is poor with resultant seasonal food insecurity. Crops grown include corn, guinea corn, millet, rice, yam, groundnuts and beans. The region is a leading producer of cotton and Shea nuts which are two main cash crops. Livestock rearing is buoyant with cattle, sheep, goats, pigs and poultry dominating. Due to the fact that the region's dry season is long, which extends roughly from October to May, many people leave the region to work in the southern part of Ghana from November to April of the year. Other economic activities include production and transport equipment, sales, service and professional, technical and related work respectively.

f. Socio-cultural Practices.

The notable festivals in the region include the Dumba, Kobine, Kakube, Zumbeti, Willa, Bagre, Paragbiele, Kala, Bongngo and Singma. The Zumbeti festival is celebrated in the Dagaare speaking traditional areas such as Nadowli/Kaleo and Chakalei speaking areas, Kobine and Kakube in the Lawra and Nandom traditional areas respectively. While the Zumbeti festival is celebrated to usher in the New Year, those of the Kobine and Kakube are meant to offer thanks to God through the ancestors for blessing them with bumper harvest. It is however, instructive to note that the Dumba festival, which means the birth and naming ceremony of the Holy Prophet, is celebrated by the chiefs and people of the Wala Paramountcy who are mostly Moslems. Apart from serving as an occasion to foster

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unity among the people of the area, it also commemorates the birthday of the Holy Prophet Mohammed and more significantly, renews the people commitment to Islam.

Another important institution in the region is that of chieftaincy. It is not only a respected but a major medium for community mobilization. Among the Waalas and Dagaaba, the title Naa is used such as Wa Naa or Nandom Naa. The Sissalas and Chakalei also use the title Kuoro. For example, Tumu Kuoro and Gwollu Kuoro. The Imams (Islamic religious leaders) and Tendaambas (landowners) also play important roles as far as the traditional administration of the region is concerned.

g. Education and Literacy

As regards education, the region can boast of educational institutions at all levels with tertiary institutions such as Colleges of Education, a polytechnic and university. Thus, there is at least a secondary school in every district capital. Wa Polytechnic and University for Development Studies campuses are hosted in the regional capital. According to the 2010 Population and Housing Census, the adult literacy rate in the region is 40.5 percent. The low literacy rate will definitely affect health and HIV and AIDS education since studies have shown a high positive correlation between literacy and HIV and AIDS awareness.

UNESCO (2007) asserted that non-literacy and low level of education often contribute to lack of awareness and low level of adoption of HIV and AIDS prevention and management measures. This implies that the level of literacy determines the level of HIV and AIDS awareness. According to Kickbuschi (2005), people's inability to read and write makes them vulnerable to getting the virus. Literacy education, as noted by Oyedeji

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(1985) is needed to empower the recipient and acquire indispensable knowledge and skills that will enable them perform more effectively in every societal activity like family planning and HIV and AIDS prevention and management. The level of literacy determines how well a person will be able to protect and manage themselves in the contact of HIV and AIDS. The more literate a person is, the more that person will be able to make meaningful decisions about them and the society. It is important to state that a literate person would more readily accept and practise HIV and AIDS preventive measures and would be more able to manage the disease.

h. Health Facilities

The region has a number of health facilities, which include a regional hospital located at Wa, eleven (11) district hospitals, four (4) polyclinics, fifteen (15)clinics, seventy(70) health centres, two hundred and forty four (244) Community-based Health Planning and Services (CHPS) compounds and five (5) maternity homes. Most of these facilities are government- owned with the few being Mission and privately owned facilities. More than half of the available manpower in the health sector is supporting staff while the auxiliary nurses make up about 38.8%. The situation with medical doctors has improved considerably with 46 of them being at post since at a point in time the whole region could only boast of fifteen (15) medical doctors (Upper West Regional Health Directorate).

3.3 Research Design

The research is largely quantitative and the design employed by this study was the cross sectional survey to collect data on Moslems for the study. The cross sectional survey research design was adopted for the study based on its inherent advantages and

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appropriateness. It enabled the researcher to replicate the data and generalise the findings to the whole Upper West region, though the study was undertaken in three districts in view of the fact that numerical data was less opened to ambiguities of interpretations. In addition to that, the said approach also afforded the researcher the opportunity to collect, analyse and interpret the data within a relatively short time. Thus, it ensured rapid analysis (Antonius, 2003). Significantly, the issue of addressing the core question of interest of the thesis, which is 'how and to what extent', was realized through this approach. Furthermore, against the backdrop of its objective nature, the said approach also ensured that the conventional standards of reliability and validity were achieved.

The survey research design was chosen because it enabled the researcher to gather data from a wide spectrum of Moslems of diverse backgrounds at a single point in time. In addition, it afforded the researcher the opportunity to sample the varied opinions, knowledge, expressions and views of Moslems about the extent to which religious beliefs and practices, how their socio–demographic or personal characteristics have influenced their religious, social, economic and political relations with PLWHAs. Furthermore, it was also considered because it allowed the researcher to sample the population, use descriptive statistics to present and analyse primary data collected from Moslems from three sampled districts of the study area about the population to make generalization (Fowler, 1998; Badu-Nyarko, 2012).

3.4 Population of the Study

The population of the study comprised all practising Moslems in the Upper West region aged 18 years and above who are deemed to be actively observing the tenets and beliefs of the religion, Islam.

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3.5 Sampled Population of the Study

The sampled population of the study was Moslems in three districts of the Upper West region-(Wa Municipality, the Sissala East, Wa West) selected randomly in the study area out of the eleven districts of the region.

3.6 Sampling Techniques

The sampling techniques used by the study included multi stage sampling technique, convenience and purposive sampling methods.

First, the multi- stage sampling technique was used to select three districts out of the eleven districts of the Upper West region. The multi stage technique was seen by the study as suitable and appropriate because it allowed the researcher to sample large and dispersed population such as the selection of districts in the region and villages in the districts.((Badu- Nyarko, 2012; Atindanbila, 2013). Also, in view of the absence of a sampling frame and for that matter a complete list of all practising Moslems in the region coupled with the high cost of data collection involved in travelling to a widely dispersed sample of villages to undertake the in-person interview survey, the choice of this technique was seen as very appropriate (Battaglia, 2011).

The three districts were selected by writing all the names of the eleven districts on pieces of paper, folded and placed in an empty packet. This was reshuffled several times to mix. Three districts namely (Wa Municipal, Wa West and Sissala East) were then selected randomly out of the eleven districts for the study.

Secondly, out of each of the three districts selected, five villages were selected making a total of fifteen villages selected using the simple random sampling method for the study. The total number of villages in the Wa Municipality was 19 but because Wa Township was large enough, it was subdivided into six communities and for the purpose of this

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study termed villages thus giving a total number of villages as 25. There were 19 villages in the Sissala East District and 20 villages in the Wa West District. The three (3) sampled districts and the five (5) selected villages in each of the sampled districts was occasioned by financial challenges and limited time at the disposal of the researcher to go round all the eleven (11) districts and sixty four (64) villages. Lastly, twenty respondents were selected from each of the fifteen villages using the convenience and purposive sampling methods.

The convenience sampling was employed to interview who ever were at the mosque and willing to be interviewed whilst the purposive was used or assisted to select 18 and above years Moslems at the mosque. The purposive allowed the researcher to select and interview the target population for rich information on the study topic. The convenience and purposive sampling techniques used afforded the researcher to interview 178 Moslem males and 122 Moslem females for the study using structured interview instruments.

In total, three hundred (300) respondents were selected from the 15 selected villages for the study. In each village, 20 respondents were selected using the convenient and purposive sampling methods at the central mosque of each village. Depending on the availability and willingness of respondents, in some villages more men than women were interviewed while in others it was the same numbers. This may be due to engagement of the women in the household chores, which therefore makes it difficult for them to pray at the mosque. However, what was significant was the required number of twenty respondents for each selected community.

The issue here was that it was difficult to get the exact population of Moslems, especially those who were 18 years and above in each village which makes up the district, thus giving each district an equal percentage of respondents. In this case, no

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required formula was applied. The other reason was that it was somewhat a homogeneous group (Moslems) and adults above 18 years and living in the selected village. Depending on the respondent, they were interviewed in any place they feel is convenient to them, which was either in or outside the mosque or any shady area with the premises of the mosque

The fact that the simple random technique is both efficient and easy to apply when it comes to issues of eliminating personal bias and subjectivity in the selection of subjects for a study, especially from a homogenous population such as Moslems, or for that matter districts of the Upper West region, accounted for its employment in the study. More importantly, it afforded all the individual districts the same chance of being selected from the population of the study to be in the sample (Badu- Nyarko, 2012; Atindanbila, 2013).

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3.7 Sample Size

The total respondents of the study were three hundred (300), made up of 178 males and 122 females. The breakdown is in table 3.1

Table 3.1: Sample Size of the Study

No	District	Village	No of Respondents	
			Women (f)	Men (f)
1	Wa Municipality (25 villages)	Bamahu	9	11
		Charia	6	14
		Dondoli	10	10
		Kabanye	10	10
		Tampaalipaani	8	12
2	Wa West (20 villages)	Dorimon	7	13
		Polee	7	13
		Ponyentanga	8	12
		Tanina	8	12
		Wechiau	8	12
3	Sissala East (19 villages)	Bugubelle	8	12
		Bichenbelle	6	14
		Kong	7	13
		Tumu Zongo	10	10
		Wellembelle	8	12
Total			122	178

Source: Field survey, 2018

3.8 Data Collection Instrument

The study employed semi-structured interview schedules to gather data from the wide spectrum of respondents. This instrument is suitable and appropriate for this study because the study anticipate that there will be literates and highly non- literates or semi-literates that could hardly read nor write to comprehend and respond to the research questions posed (Borg, Gall & Gall, 1992).

It also enabled the researcher to have a personal and direct contact with the participants and also eliminated non- response rate. Finally, it had an added advantage of the fact that the respondents were in a compact geographical area.

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The data collection instrument, semi-structured interview schedule, which covered sixty five (65) items, was organized into (five) sections. Section A sought information on the socio- demographic and personal characteristics of Moslem respondents such as age, sex, and educational background as a way to determine the profile of Moslem respondents using close-ended questions.

Section B, which employed the close-ended and open-ended questions sought to confirm from the Moslem respondents the basic Islamic beliefs and practices as they relate to their attitudes towards PLWHAs, their opinion on the reality of HIV and AIDS related stigma and discrimination as well as the identified areas of their engagement with PLWHAs such as religious, social, economic and political relations.

The section C also sought information on the Moslems assessment of their respective opinions on the extent to which their beliefs and practices as Moslems have influenced their attitudes towards PLWHAs in relation to religious, social, economic and political activities by using a five (5) point Likert scale measure such as (i) Very large extent, (ii) Large extent, (iii) Uncertain, (iv) Very small extent, (v) Small extent.

Section D of the data collection instrument sought responses on the opinions of Moslem respondents as regards whether it is Islamic to stigmatise and discriminate against PLWHAs with beliefs and teachings of Islam to support their stance. These were sought with both open-ended and close-ended questions. The section, also using a five (5) point Likert scale measure such as (i) Strongly Agree, (11) Agree, (iii) Neutral, (iv) Disagree, (v) Strongly Disagree as well as open-ended questions sought information on the Moslems assessment of their views on disclosure of HIV and AIDS status, the effects of stigma and discrimination on PLWHAs, their families and community as a whole.

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The final section, E sought from the Moslem respondents' strategies to reduce and possibly eliminate stigma and discrimination among PLWHAs in their communities by the use of open-ended questions.

3.9 Pre-Testing for validity and reliability of Data collection instrument

Reliability of the data collection instruments:

A pre-testing was done with a sample size of thirty Moslem respondents who were randomly selected in Nadowli-Kaleo District that was not part of the study. The purpose was to establish the consistency (reliability) of the instrument (interview schedules) and the extent to which the instrument measure what it supposed to measure and perform what it designed to perform as regard the set objectives of the study. The selection of Nadowli- Kaleo for the pilot study was because of the belief that it has similar and relevant characteristics like that of the Districts under study such as education, economic, political and geo-socio-cultural conditions. Also, the said district was very close to the regional capital. After the pre-test, some of the items on the instrument, which were ambiguous or not understood for consistency were modified to be in tune and consistent with the research questions and more importantly, the objectives of the study.

Validity of the data collection Instruments

As a way of ensuring the instrument (interview schedules) measure what it supposed to measure and perform what it designed to perform (validity), the said instruments were given out for experts (knowledge and professionalism) such as the supervisors and other senior faculty research fellows as well as by peers-other PH.D students both within and outside the University of Ghana for assessment and corrections.

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3.10 Data collection

The study employed both secondary and primary data. The secondary data were generated from journals, books, research and conference reports and papers as well as internet sources, which included UNICEF, UNAIDS, Ghana AIDS Commission, National HIV prevalence and AIDS Estimates as well as HIV Sentinel Survey reports. The primary data were gathered by the researcher and three research assistants using the semi-structured interview schedules. The personal interviews were conducted in the local languages spoken in the selected districts. The questions on the interview schedules were interpreted or read to the hearing of the respondents in the respective local language that they understood and the corresponding answers written appropriately to the questions. In order to ensure that whatever responses they gave were correctly captured, a tape recorder was used, however, with permission sought from the respondents. The said responses were then read back to the respondents in their local languages for them to confirm. That was done to ensure credibility and validity. These are Waali in the Wa municipality and Wa West district and Sissala in the Sissala East district. The researcher and research assistants were found to be conversant with the popular languages spoken in the study area –Waali, Dagaare and Sissali that were coincidentally relevant for the data collection task. Little training was needed since they were all graduates already in the business of data collection for quite a good number of years as field workers. They also had the advantage of being natives of the respective study districts.

Prior to the data collection especially in Wa Municipal and Wa West district, the researcher and his research assistants were able to contact the local Imam or other opinion leaders depending on who was available and explained to them and permission sought to conduct the said interviews. The time, which was after night prayers (Isha)

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every day and after Friday prayers (Jummat) was agreed to be convenient to the community members and the researcher. As regards the Sissala East, where one of the research assistants, who also happens to be the researcher's former student is a native and understands and speaks the language, the arrangements of meeting the relevant opinion leaders was handled by him due to the language barrier. At the said meetings however, the researcher was always present.

On the appointed dates whoever happened to be at the mosque and was 18 years and above and willing and ready was interviewed. The researcher was always on the field with the research assistants not only to assist with the data collection but to ensure the speedy and prompt resolution of any challenges that might crop up. Five (5) questionnaires were always completed if it was only one research assistant in the field but on a day if two persons went the number always doubled. The researcher actively participated in the Kabanye, Dondoli, Tampaalipaani, Charia, Tanina, Polee, Ponyentanga and Tumu Zongo communities in the administration of the questionnaire. Depending on which ever community the researcher found himself, there was always a daily briefing of activities to strategize for the next day data collection. It took approximately three months for the data collection to be completed (2nd October to 26th December, 2018).

The data collection process was however not without challenges. The researcher faced the challenge of perpetual postponement of interviews. At other times, the researcher or research assistant will get to the community and would not get anyone willing to be interviewed because they were tired after spending the whole day working on their farms and would not be in the right mind frame to provide the right answers. There was also the difficulty of funding research assistants to conduct the interviews and also meeting

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the financial demands of some of the respondents for refreshment/entertainment after the interviews.

The community, and in particular the participants, were very accommodating and co-operative especially because they believed that such a study would go a long way in assisting to get ways that would reduce the level of stigmatisation and discrimination, which they claimed was a source of worry to most known PLWHAs and their families.

3.11 Data Analysis Methods

The primary data were organized and presented with the assistance of computer package, SPSS (Statistical Package for Social Sciences) and Excel. The primary data gathered from the respondents were coded, imputed and then analyzed using descriptive and nonparametric statistics as well as using narratives to describe the open-ended questions. The closed-ended questions which yielded quantitative data were analysed using mean scores, standard deviations, and the chi square test statistic to explain the extent of independence of the variables. The open-ended questions were analysed quantitative and qualitatively. The research adopted the Cross-case approach where same or similar answers or responses from the various Moslem respondents to the same question asked were organised together under common themes for purposes of easy classification, presentation and analysis. The qualitative responses were narrated and supported by statements made directly by the respondents from the field (anecdotes).

3.12 Ethical Issues

The researcher, before engaging the respondents to collect the data sought and obtained informal permission from the Imams (religious leaders) and chiefs of the various mosques and villages respectively where the study was conducted. The researcher also

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allayed the fears of the respondents by disclosing the goal and purpose of the research, which is for purely academic reason, that is, thesis for the awards of PH.D degree at the University of Ghana. Also, they were assured of the confidentiality of the information they provide and their anonymity before commencing the interview that is references were not made to the respondents by way of their names but in terms of socio-demographic characteristics when appropriate.

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CHAPTER FOUR

PRESENTATION OF RESULTS

In this chapter, the analyses of the primary data gathered from the field based on the research questions of the study are presented. These were largely opinions of Moslems in the three districts of the Upper West Region. In this case, their beliefs and practices as well as how their socio-demographic and personal characteristics such as sex, age and educational background influence their religious, social, economic and political relationships with PLWHAs, i.e. discrimination and stigmatisation were analysed.

To achieve this, the chapter was therefore divided into four (4) sections. Section A presented data on the Moslems' perception on the existence of HIV and AIDS related stigma and discrimination and the extent to which their beliefs and practices have influenced their attitudes towards PLWHAs in their identified areas of engagements such as in religious, social, economic and political relations.

Section B dealt with the assessment of the extent to which the Moslem respondents' attitudes towards PLWHAs are associated with selected socio-demographic characteristics.

The third section covered data on the Moslems respondents' opinions on the beliefs and teachings of Islam that support and influence their attitudes based on religious, social, economic and political relations with PLWHAs. It also includes the Moslems views on disclosure of HIV and AIDS status, effects of disclosure on stigmatisation and discrimination on PLWHAs, their families and the community as a whole.

Finally, section D dealt with the Moslem respondents' suggestions with regards to the strategies in reducing HIV and AIDS stigma and discrimination.

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4.1 Section A: HIV and AIDS related Stigma and Discrimination

This section analyses data on responses of the Moslems and their perception of the existence of HIV and AIDS related stigma and discrimination, and the extent to which their beliefs and practices have influenced their attitudes towards PLWHAs in their identified areas of engagements such as in religious, social, economic and political relationships.

4.1.1 Moslems' Opinion on the Reality of HIV and AIDS related Stigma and Discrimination

Responses sought from the Moslem respondents on their opinions on whether HIV and AIDS related stigma and discrimination in reality existed. This revealed that almost all the respondents 297 or 99% confirmed that HIV and AIDS related stigma and discrimination is real among the Moslem respondents.

4.1.2 Moslems Beliefs and Practices:

4.1.2 a. Faith (Belief) in Almighty Allah (God)

In response to the question whether PLWHAs should continue to have faith in Almighty Allah or in spiritual powers, all the respondents, 300 or 100% stated that they should have faith in Almighty Allah.

4.1.2 b. Reasons for Answer

Their reasons are that Allah is the creator of everything in the universe including one's health and all sicknesses, and has the power to cure such sicknesses. Thus, if one puts your trust in Allah, he will be able to cure all sicknesses. They also mentioned that Allah is the master of all things and all powers in heaven and earth are under his control.

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Sickness, according to the respondents, is to test one's faith and therefore PLWHAs should continue to have faith in Allah. Some of the above responses are captured below:

> 'Whatever bestowed on you, the first thing is to have faith and trust in Almighty Allah ((Q: 2:155; 9:23); (Male Mallam, 56 above years, Wa Municipality).
>
> 'In order to get (Janna) from Almighty God, we have to go through a lot of challenges and test from Almighty Allah' (Q 29: 2); (Male Arabic teacher, 31-55 years, Sissala East).
>
> 'Almighty Allah can use such phenomenon to test a person's faith to see how the person will react to it but it shouldn't prevent the person from taking his /her faith from Allah to other spiritual powers (Female, 18-30 years, Wa West).

4.1.2 c. Belief in Destiny

As to the question whether in their opinion, a PLWHA should attribute his/her condition to destiny or supernatural forces, all the respondents (300) mentioned that they should attribute it to destiny.

4.1.2 d. Reasons for Answer

The reasons they advanced were that Allah has already destined what will happen to every person including sickness and therefore PLWHAs should consider their situation as part of their destiny. Thus, whatever happens to everyone on this earth, whether good or bad is the will of God, and there is nothing that one can do about it. According to them, God does everything for everybody and knows what is best for each and every one, and hence HIV and AIDS.

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This stance is expressed by the following statements:

> 'Allah created mankind and knows the future of everyone, where we were born, where we will die, how we will die and the day we will die. So destiny is part of every mankind life and we should accept it as such whether good or bad' (An Imam, 56above, Wa West).
>
> 'Nothing happens to believers except what God ordains for them, so whether you are sick or healthy, rich or poor, male or female, white or black, God has already destined that before you are born into this world and nothing can change it unless the will of God' (Female, 31-55 years, Sissala East)
>
> 'Only Allah has the power to decide for his slaves and everything happens to humans in Allah's permission. No spiritual force has any authority over Allah's slaves' (Male, 31-55 years, Wa Municipality).

4.1.2 e. Fasting

In response to the question, whether in their opinion, a PLWHA should fast during the month of Ramadan, 198 (66%) of the respondents opined that they should not fast during the month of Ramadan while 102 (34%) hold the contrary opinion.

4.1.2 f. Reasons for No Answer

One of the reasons they adduced was that fasting, as one of the rites prescribed by the religion in both the Quran and Hadith, is only for those who are fit and healthy and not the sick such as PLWHAs. They also mentioned that PLWHAs will not be able to follow their medication routine and that may seriously affect their health and possibly lead to their death. Finally, they mentioned that it is stated in the Quran that those who are

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unable to fast will fulfil that rite by giving zakat (charity) to the poor. Some of their responses include the following:

> ‘ The prophet said it in the Hadith that every Moslem should fast in the month of Ramadan except Muslims who are very sick to the extent that they cannot fast such as women who are menstruating and people suffering from severe sicknesses’ (Female, 31-55 years, Wa Municipality).
>
> ‘A PLWHA cannot fast during the month of Ramadan if the virus would harm him/her and cause additional health risk to him/her ‘(Male, 18- 30years, Wa West)
>
> ‘PLWHAs cannot abstain from food and drugs because of their health condition and because of that they should be excluded from fasting (Female, 18-30 years, Sissala East).

For those respondents who said they should fast, they mentioned that once it is not mentioned anywhere in the teachings of the religion that Moslems should not perform their religious rites, which include fasting because of sickness and in particular, HIV and AIDS, they should therefore fast. Furthermore, the respondents also stated that PLWHAs should fast in order to seek forgiveness from God and be healed. Their stance is supported with the following statement:

> ‘PLWHAs should fast because HIV does not prevent the person from doing any work imposed by his/her creator if he/she has the faith in the creator. In this way, once the creator has asked that all Moslems should fast, it is therefore necessary for PLWHAs to also fast’ (Female, 56 above years, Wa West)
>
> ‘It is Allah who gives all sicknesses including HIV and AIDS and he never said his followers should not worship him because of their sicknesses. In this regard,

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PLWHAs can worship him including fasting during the period '(Male, 31-55 years, Wa Municipality).

4.1.2 g. Relating with PLWHAs

As to how respondents will relate with PLWHAs who stay in the same house 287 (95.6 %) said they will relate well and warmly with them by respecting their feelings and emotions. They claimed that they will do things in common such as sharing same toilet, household facilities, cooking as well as eating with them. They will also attend other social events such as funerals, weddings, and outdoorings with them. Some of their responses are depicted below:

'I will relate very well with PLWHAs by giving them the encouragement to cope up with life, shake hands and eat together, assist them in their household activities without showing any discrimination' (Female, 31- 55 years, Wa Municipality)

'I will associate with them as fellow human beings because the disease is not contagious. Moreover, we should not leave them alone as they can harm themselves when they start to think about the illness or the diseases' (Male English Arabic teacher, 31-55 years, Sissala East).

'I will relate with such a person in a friendly and kindly manner to make him feel that he is still part of the society by playing, chatting and being close to him in order to prolong his lifespan' (Female 18-33 years, Wa West)

The minority, (4.3%) however said they distance themselves by being cautious not to eat or share other household items for fear of infection as revealed by the following statements:

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> 'I will make sure that I don't get very closer to them and will not share same toilets, dishes, cutlery sets, razor blades, needles and toothbrush with them since I can easily get the disease.' (Female, 56 above years, Wa Municipality)

4.1.2 h. Pilgrimage to Mecca

On their opinion about a PLWHA undertaking a pilgrimage to Mecca, 268 (89.3%) of the respondents are of the opinion that a PLWHA can undertake a pilgrimage to Mecca. The reasons they gave were that it is a religious duty upon every Moslem once he /she has the resources to undertake it. Secondly, the respondents stated that there was no verse in the Quran or Hadith which excludes PLWHAs from performing the pilgrimage once the disease was not contagious and moreover, such a pilgrimage will offer them the opportunity to seek forgiveness and mercy in the next life. The below statements support their position:

> 'PLWHAs should undertake the pilgrimage if they have the wealth to do so because HIV/AIDS is not a fluid contagious air borne disease where the virus can transfer easily from one person to another' (Female 18-30 years, Sissala East).
>
> 'The yearly pilgrimage to the holy place (Mecca) is a religious duty for every Moslem to be there once in his/her lifetime and there is no verse in the Quran or Hadith that I know of that prevent (PLWHA) from undertaking pilgrimage to Mecca (Hajj), hence they shouldn't be hindered to Mecca' (Male, 41 years, Wa West).
>
> 'It is the privilege of the person to undertake the pilgrimage to Mecca in order to seek forgiveness from his creator so that she/he may have his mercy on the next life (Male, 31-55years, Wa Municipality)

'

Those minority Moslems who are of the view that PLWHAs should not undertake the Hajj mentioned the issue of their health status, considering the energy sapping activities they will go through as part of the performance of the pilgrimage, which will have dire

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consequences for them as one main reason. Thus, some of their statements are captured below:

> 'PLWHAs may encounter challenges regarding their anti-retroviral therapy, the use of drugs, forgetfulness of drug intake during the pilgrimage (Female, 31-55years, Wa Municipality,)
>
> 'Some of the rituals will be very difficult for them because of the strength and energy that will be involved in undertaking them and since they are not very healthy, it may be difficult for them' (Male, 31-55years, Wa West)

4.2.1 Moslem Respondents and Related Religious Engagement with PLWHAs

The study sought to group the areas of engagement into religious, social, economic and political for easy analysis and interpretation. One of the greatest challenges in the fight against stigmatisation and discrimination towards PLWHAs, especially in Africa is the linkage of HIV and AIDS with certain religious beliefs and practices. Studies by Abraham (2006), Shisana & Simbayi (2002); Duffy (2005) among others, indicated that some Moslems believe PLWHAs are persons who committed sexual sins and are being punished by God, or the ancestors or they might have had the disease through witchcraft, supernatural forces, and a curse as in the case of some traditional African communities. In the light of these religious beliefs, most persons are therefore compelled not to associate with PLWHAs for fear of also being punished.

It is therefore against this background that the study elicited responses from the Moslem respondents to ascertain their religious engagement with PLWHAs to enable the researcher make informed analysis and conclusions. The responses gathered to that effect are presented in Table 4.1

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Table 4.1: Identified Religious related areas of Engagement with PLWHAs (Yes)

Religious related activities with PLWHAS	Yes (*f*)	Yes *(%)*
Perform Prayers	300	100
Give alms	300	100
Accept alms	45	15
Accept as an Imam	5	1.6

Source: Field Survey, 2018

The results in Table 4.1 suggests all the Moslem respondents confirmed performing together with them prayers and offer alms to PLWHAs whilst 15% and 1.6% respectively indicated either accepting alms from PLWHAs or accepting or recognizing them as their Imam or religious leader .

This implies that religiously some level of discrimination exist regarding PLWHAs in leadership and charity from such persons but rather offer them alms and perform prayers together.

4.2.2 Related Social Engagement with PLWHAs

One of the significant features of every social life is social interactions or social activities or the manner in which people act with other people. Against the backdrop of John Done's statement that 'No one is an Island' society can only grow and survive if there are interactions among the people. It is also important to state that social order, which is a necessity for any society can only be possible if there is effective social interactions or social related activities.

Social-related activities provide a platform for people to socialize and interact with one another. Such activities could be occasions of happiness or sorrow such as marriage,

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outdoorings, festivals, funerals and others that may involve some level of communality like eating, sleeping, shaking of hands or embracing. These activities constitute an important component of every society or community in view of the fact that they are the vehicle through which people learn and educate others about the society's norms, values, practices and beliefs. More importantly, they also provide an opportunity for people not only to share in the joy and sorrow but more fundamentally, to form attitudes, opinions and behaviours based on the interactions among the various people assembled.

Thus, the question on the related social relations the Moslem respondents had with PLWHAs was to gather information to establish their areas of their social engagement with PLWHAs. The information gathered is presented in Table 4.2.

Table 4 2: Identified Social related areas of Engagement with PLWHAs (Yes)

Social related Activities with PLWHAS	Yes *(f)*	Yes *(%)*
Attend social events (weddings, funerals etc.)	258	86.0
Marry	4	1.3
Embrace	260	86.7
Shake hands	261	87.0
Share same utensils	30	10
Sleep in same room	278	92.7
Children attend same school with theirs	291	97.0
Visit them when sick	295	98.3

Source: Field Survey, 2018

The results in Table 4.2 show that among the areas of social engagement, discrimination was identified in marriage and sharing items relating to food. However, they were willing to participate in social events, shake hands, embrace and allow their children to attend same school with such children and visit PLWHAs when they are sick.

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4.2.3. Related Economic Engagement with PLWHAs

It is important to mention that apart from farming which is the major pre-occupation, trading or engaging in buying and selling is another main activity found in most Moslem communities and especially the study area. The activity is engaged in by both males and females depending on the items involved as a way of economic venture to provide income for the individuals to satisfy their basic as well as other important financial obligation

Information on what economic areas the Moslem respondents were engaged in with PLWHAs was to determine the economic related areas they have generally found themselves engaged in to enable the study make informed analysis. Responses gathered are presented in Table 4.3.

Table 4.3: Identified Economic related areas of Engagement with PLWHAs (Yes)

Economic related activities with PLWHAS	Yes*(f)*	Yes (%)
Offer employment	275	90.7
Accept employment	294	97.0
Trade	283	93.3
Consumption of their products	15	3

Source: Field Survey, 2018

The data in Table 4.3 suggest that over 90% of the Moslem respondents agreed to engage in the economic related activities with PLWHAs except consuming their products (1.3%). This also implies that the Moslems may not drink or eat items prepared by PLWHAs for fear of being infected.

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4.2.4 Related Political Engagement with PLWHAs

Participation is an important component of every society whether small or big and hence political participation, which is a critical part of any democracy, is the process that affords the individual the opportunity to take part in the political process by making his or her opinion, beliefs and interest known. The most important ingredient in political participation is voting for someone or persons to represent your interests and equally making yourself available to be voted for into any political office. Participation ensures that the society or community benefits from the talents and skills of those who are voted to represent the larger society, no matter their disability or state of health. It is therefore important to state that those who fail to participate, due to neglect or exclusion are likely to be denied certain benefits which include their ability to influence policies which will inure to their benefits.

Information was sought on which of the political related activities or engagement were the Moslem respondents engaged in with PLWHAs to establish their attitudes politically towards PLWHAs. The responses are presented in Table 4.4.

Table 4.4: Identified Political related areas of engagement with PLWHAs by the Moslems (Yes)

Political related activities with PLWHAS	Yes*(f)*	Yes *(%)*
Elect as an Imam	11	3.7
Vote as an Assembly Member	120	40
Vote as Member of Parliament	97	32
Vote as a chairperson of an event	9	3

Source: Field Survey, 2018

The data in Table 4.4 suggest that less than 50% of the Moslem respondents actually favour any of the identified related political activities. Interestingly but not surprising, over 96% of the moslem respondents would not engage in or favour the election of PLWHAs as an Imam (3.7%) or as a chairperson for any event be it political or social

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(3%). This implies that the Moslems' attitude towards PLWHAs in political related issues is negative or low.

4.3 Assessment of Attitude towards PLWHAs and Moslems' Beliefs and Practices

Beliefs and practices of individuals or group of persons that form their value systems most often than not is a function of their lives and for that matter, define their attitudes and culture. In view of this, the study sought to assess the extent to which the Moslem respondents' beliefs and practices influence their attitudes towards PLWHAs in terms of their religious, social, economic and political relations or engagements using a five-point Likert scale measure.

A. Influence of Moslem Respondents beliefs and practices and their Attitudes towards PLWHAs - Religious relations

The opinions of the respondents were sought to assess the extent to which their beliefs and practices have influenced their attitudes towards PLWHAs in terms of their religious relationship or engagements so as to make an informed assessment as it were.

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The respective weighted mean scores of the responses and the associated standard deviations are shown in Table 4.5

Table 4.5: Assessment of Moslem Respondents Attitudes and their Religious relations with PLWHAs

Attitude towards Religious Relations with PLWHAs	Very large extent (5)	Large extent (4)	Uncertain (3)	Very Small extent(2)	Small extent (1)	$\bar{x}$	Sd
	%	%	%	%	%		
Perform Prayers	48.6	30.8	5.8	2.2	6.5	4.20	1.00
Give alms	34.1	34.4	12.3	6.9	6.9	3.86	1.19
Accept alms	19.2	39.9	14.1	2.2	20.3	3.37	1.10
Accept as an Imam	38.0	19.9	14.5	8.3	8.3	3.79	1.33
General Opinion (A)						3.80	1.15

Source: Field Survey, 2018

The results in Table 4.5 reveal that Moslems' attitude towards PLWHAs in terms of religious relations as revealed by the weighted mean scores and standard deviation was to a large extent ($\bar{x}$=3.80) influenced by their beliefs and practices. This means that Moslems have a positive attitude towards PLWHAs in religious related activities.

B. Influence of Moslem Respondents beliefs and practices and their Attitudes towards PLWHAs - Social relations

The data on the opinions of the Moslem respondents on the extent to which their beliefs and practices have influenced their attitudes towards PLWHAs that were sought on their social relations or engagements so as to make an informed analysis are presented in Table 4.6

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Table 4.6: Assessment of Moslem Respondents Attitudes and their Social relations with PLWHAs

Attitude towards Social Relations with PLWHAs	Very large extent (5)	Large extent (4)	Uncertain (3)	Very Small extent(2)	Small extent (1)	$\bar{x}$	Sd
	%	%	%	%	%		
Attend Social events (i.e,weddings, funerals etc)	42.0	29.0	8.7	8.3	8.3	3.77	1.28
Marry	15.2	28.6	13.8	12.7	14.5	2.71	1.33
Embrace	26.8	43.5	12.0	4.3	4.7	3.57	0.53
Shake hands	42.8	29.0	18.8	2.2	7.2	3.98	1.05
Share same utensils	16.7	23.2	16.7	13.8	21.4	2.80	1.34
Sleep in same room	25.0	27.2	22.8	8.3	8.0	3.34	1.23
Children attend same school with theirs	62.0	18.4	15.6	4.0		4.38	1.18
Visit them when sick	57.6	22.4	12	8.0		4.29	1.14
General Opinion (B)						3.60	1.13

Source: Field Survey, 2018

Data in Table 4.6 show that to a large extent, Moslems' attitude towards PLWHAs in terms of social relations or engagements was influenced by their beliefs and practices. Though the data also show Moslems will discriminate in marrying and sharing the same cooking utensils with PLWHAs, the weighted mean scores and standard deviation ($\bar{x}$=3.60, sd= 1.1) however revealed a positive and unanimous attitude towards PLWHAs in social interactions. They will willingly allow their wards to attend same school with children of PLWHAs ($\bar{x}$=4.38) or visit them while sick ($\bar{x}$=4.29) respectively.

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C. Influence of Moslem Respondents beliefs and practices and their Attitudes towards PLWHAs – Economic relations

The opinions of the respondents were sought to assess the extent to which their beliefs and practices have influenced their attitudes towards PLWHAs in terms of their economic relationship or engagements so as to make an informed assessment are shown in Table 4.7

Table 4.7: Assessment of Moslem Respondents Attitudes and their Economic relations with PLWHAs

Attitude towards Economic Relations with PLWHAs	Very large extent (5)	Large extent (4)	Uncertain (3)	Very Small extent(2)	Small extent (1)	$\bar{x}$	Sd
	%	%	%	%	%		
Offer employment	57.6	18.6	19.6	4.0		4.29	1.14
Accept employment	45.6	11.2	11.6	31.6		3.94	0.94
Trade	73.2	14.8	8.0	4.0		4.57	1.27
Consumption of the their Products	12.0	11.2	15.6	46.4	14.8	2.59	0.87
General Opinion (C)						3.84	1.01.

Source: Field Survey, 2018

The data in Table 4.7 show that Moslems attitude towards PLWHAs in terms of economic interactions or engagement was positive or non-discriminatory ($\bar{x}$ =3.84; sd= 1.01) .However in terms of consumption of products, they showed discriminatory tendencies ($\bar{x}$ =2.59; sd= 0.87).The data also show that even though in terms of individual economic activities such as consumption of products of PLWHAs, Moslems will discriminate, the weighted mean scores and standard deviations reveal that their relationship with PLWHAs in economic engagement on the whole were largely positive and may be influenced by the Moslems' beliefs and practices ($\bar{x}$=3.84)

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D. Influence of Moslem Respondents beliefs and practices and their Attitudes towards PLWHAs - Political relations

The opinions of the respondents were elicited on the extent to which their beliefs and practices have influenced their attitudes towards PLWHAs in terms of their political relations or engagements as a means of their civic responsibilities and rights of PLWHAs.

The data gathered and the related computed weighted mean scores and standard deviations using the five point Likert scale measure are shown in Table 4.8

Table 4.8: Assessment of Moslem Respondents Attitudes and their Political relations with PLWHAs

Attitudes towards Political relations with PLWHAs	Very large extent (5)	Large extent (4)	Uncertain (3)	Very Small extent(2)	Small extent (1)	$\bar{x}$	Sd
	%	%	%	%	%		
Elect as am Imam	25.0	27.2	22.8	8.3	8.0	3.26	1.23
Vote as an Assembly Member	26.8	43.5	12.0	4.3	4.7	3.57	0.53
Vote as a Member of Parliament	42.8	29.0	18.8	2.2	7.2	3.98	1.05
Vote as a Chairperson of an event	42.0	29.0	8.7	8.3	8.3	3.77	1.28
General Opinion (D)						3.64	1.02

Source: Field Survey, 2018

Data in Table 4.8 shows that Moslems' attitude towards PLWHAs in terms of political relations was to a large extent influenced by their beliefs and practices as shown by the weighted mean scores and standard deviation ($\bar{x}$ = 3.64; sd= 1.02) Their relations is therefore positive. In fact they will highly elect PLWHA as an MP and chairperson of an event than as an Imam.

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Putting all these attitudes .religious, social, economic and political together, it produced the data in Table 4.9

Table 4.9: Overall Attitudes towards PLWHAs based on Religious Beliefs and Practices

Area of Attitude	$\bar{x}$	Sd
Religious Related Activities	3.80	1.15
Social Related Activities	3.60	1.13
Economic Related Activities	3.84	1.01
Political Related Activities	3.64	1.02
General Opinion	3.72	1.07

Source: Field Survey, 2018

The common or general opinion on the Moslems' attitude towards PLWHA in terms of religious, social, economic and political relations based on their beliefs and practices was high showing positive relations. Yet, social relations recorded the lowest level of attitude among the four variables studied.

4.4. Assessment of Attitudes towards PLWHAs and Moslems Socio-Demographic and Personal Characteristics

Studies by Rosabelle (2011); Dahlui, Azahar, Bulgiba, Zaki, Oche , Adekunji & Chinna (2015); Ulasi, Preko, Baidoo, Bayard, Ehiri, M.Jolly E.Jolly (2009) and Kwashie (2010) have shown that there is a relationship between socio-demographic characteristics such as age, sex, education, socio-economic status, place of residence and among others of respondents and their attitudes towards PLWHAs. These have been found to inform people's attitudes towards PLWHAs just as in other influence (Kwashie, 2014). It is in view of this, the study sought data on the Moslem respondents' demographic characteristics (age, sex and educational level) and their attitudes towards PLWHAs in

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related religious, social, economic and political engagement to establish whether there is a significant relationship between the two variables.

4.4. a. Sex and Religious Relations with PLWHAs

The relationship between the sex of Moslem respondents and their attitudes towards PLWHAs in religious related engagements were sought to establish whether there exists any relationship between them and to determine the extent of influence sex had on their attitudes towards their respective religious relations PLWHAs. Data gathered to that effect is presented in Table 4.15.

Table 4.10: Sex of Moslem respondents and related religious relations with PLWHAs (Yes)

Sex of Respondent	Religious relation									
	Perform Prayers		Give alms		Accept alms		Accept as an Imam		Total Responses	
	f	%	*f*	%	*f*	%	*f*	%	*f*	%
Male	178	46.9	178	46.9	21	5.5	2	0.5	379	100
Female	122	45	122	45	24	8.8	3	1.1	271	100
Totals	300	46.1	300	46.1	45	6.9	5	0.7	650	100

Source: Field Survey, 2018 *Multiple responses

Responses in Table 4.10 show that Moslems of both sexes are willing to perform prayers and offer charity to PLWHAs as part of their religious duties. On the contrary, they may not, either male or female try to accept alms from PLWHAs (6.9%) and accept them as their Imam or religious leader (0.7%) respectively.

This implies that there is limited differential level of engagement with PLWHAs by the two categories of sex of the Moslem respondents. In order to confirm the above statistics, a correlation analysis was performed as in Table 4.11

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4.4.a. Correlation on Sex of Moslem Respondents and their Attitudes towards PLWHAs in Religious related Engagement

The computed correlation coefficients in Table 4.11 on Moslems responses on the influence of sex on their attitude towards PLWHAs in religious relations or engagement was to determine the extent of influence sex had on their attitude towards PLWHAs in religious related activities by establishing the respective significance of their relationships, degree or strength of relationship and their co-efficient of determination.

Table 4.11: Sex of Moslems respondents and related religious relations with PLWHAS

Attitude towards PLWHAs	N	R	r^2	r^2%	Sig. @ 0.05
Perform Prayers	300	1	1	100	1
Give alms	300	1	1	100	1
Accept alms	300	0.081	0.162	16.2	0.161
Accept as an Imam	300	0.234	0.468	46.8	0.000

Source: Field survey, 2018.

The results in Table 4.11 reveal that at 0.05 level of significance there is a positive relationship or correlation between sex of the respondents and their attitude towards PLWHAs in all the four related religious activities. The relationship between the influence of sex of the Moslems and their attitude in terms of accepting a PLWHA as an Imam was positive and significant but weak (r=0.234; 0.000) while that of their attitude towards the issue of prayers (r=1; 1), and alms giving (r= 1; 1) was highly positive. The issue of accepting alms (r=0.081; 0.161) was nil and insignificant. This shows that they will not in any way differentiate when accepting alms from PLWHAs. As regards the relative degree or strength of the relationships, the issue of performing prayers and giving of alms (r=1) were very strong (r >0.7) while that of accepting alms and accepting PLWHA as an Imam were weak (r< 0.3).

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With regards to the extent to which the sex of the Moslems' respondents has influenced or is associated with the Moslems attitudes towards PLWHAs, the computed co-efficient of determination showed that less than 48% of their attitude of accepting PLWHAs by religious engagements was by sex. This implies that other factors are associated with their attitudes other than sex.

4.4.b: Age of Respondents and Religious Relations with PLWHAs

Responses on the Moslem respondents' age and their attitude towards PLWHAS in their respective religious engagements or relations were sought to determine the relationship and the extent to which the Moslem respondents' age is associated with their respective related religious engagement with PLWHAS. The result is presented in Table 4.12

Table 4.12: Age of Moslem Respondents and their Religious relations with PLWHAs (Yes)

Age range of respondents	Religious relation									
	Perform Prayers		Give alms		Accept alms		Accept as an Imam		Total responses	
	f	*%*	*f*	*%*	*f*	*%*	*f*	*%*	*F*	*%*
18-30	111	48	111	48	8	3.4	1	0.4	231	100
31-55	180	46.2	180	46.2	28	7.1	1	0.2	389	100
56 above	9	30	9	30	9	30	3	10	30	100
Totals	300	46.1	300	46.1	45	6.9	5	0.7	650	100

Source: Field Survey, 2018 *Multiple responses

Data in Table 4.12 showed that Moslems, no matter their age, will engage in prayers and give alms to PLWHAs. The young and middle (matured) adults however will discriminate more against PLWHAs by rejecting their charity and acceptance as well as recognizing them as Imams than those who are older.

This implies that at least there is some differential level of engagement with PLWHAs by all the age categories of the Moslem respondents. As a way of confirming the above statistics, a correlation analysis was performed as shown in Table 4.13.

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4.4. b: Correlation on Age of Moslem Respondents and their Attitude towards PLWHAs in Religious related Activities

Correlation results at 0.05 significance levels in Table 4.13 on the age of the Moslem respondents and their religious relations or engagement with PLWHAs also produced the respective significance, degree or relative strengths as well as the coefficients of determination to measure the strengths of relationships and the extent to which the respondents' age ranges are associated with their attitude towards PLWHAs in religious related relations.

Table 4.13: Age of Moslem Respondents and their attitude towards Religious relations with PLWHAs (Yes)

Attitude towards PLWHAs	N	R	r^2	r^2%	Sig. @ 0.05
Perform Prayers	300	1	1	100	1
Give alms	300	1	1	100	1
Accept alms	300	0.050	0.1	10	0.390
Accept as an Imam	300	0.213	0.426	42.6	0.000

Source: Field survey, 2018.

The correlation results in Table 4.13 show that there is a very strong positive relationship between the ages of the Moslem respondents and their attitudes towards PLWHAs in religious related activity of accepting them as Imam which was positive and significant. However, their attitude towards other religious activities such as prayers, alms giving and accepting alms were positive but not significant. This shows that both the aged and young will discriminate religiously. Significantly the old would not likely accept PLWHA as their Imam. On the relative degree or strength of the relationship, the Moslems' attitude towards PLWHAs in the areas of prayers and alms giving were very strong while those of accepting alms and accepting them as Imam were weak. As captured in the Table 4.13, the computed co-efficient of determination also showed that

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less than 45% of their attitude towards PLWHAs was associated with other factors than age.

4.4. c: Educational level and Religious Relations with PLWHAs

A cross tabulation of responses on the educational level of Moslem respondents and their attitudes towards PLWHAs in religious- related engagement were sought to establish whether there exists any significant relationship between the two variables. Data gathered is presented in Table 4.14

Table 4.14: Educational Level of Respondents and their Religious relations with PLWHAs (Yes)

Educational level of Moslems Respondents	Religious Relations									
	Perform Prayers		Give alms		Accept alms		Accept as an Imam		Total Responses	
	f	*%*	*f*	*%*	*f*	*%*	*f*	*%*	*f*	*%*
No Formal Education	65	48.1	65	48.1	5	3.7	-	-	135	100
Basic Education (Primary-JHS)	45	48.9	45	48.9	2	2.1	-	-	92	100
Secondary Education	40	25	40	25	-	-	-	-	160	100
Post-Secondary (Nursing, Agric.ext, Teacher etc.)	39	49.3	39	49.3	3	3.7	-	-	79	100
Tertiary Education (Polytechnic, University)	111	42.2	111	42.2	35	13.3	5	1.9	262	100
Total	300	41.2	300	41.2	45	6.1	5	0.6	728	100

Source: Field Survey, 2018 *Multiple responses

Responses in Table 4.14 showed that none of the Moslems with limited education is ready or likely to accept PLWHAs as an Imam and only 5.8% of them are ready to accept alms from PLWHAs in the identified related religious relations. The Moslems, notwithstanding their level of education will however not discriminate on the basis of performing prayers with PLWHAs and offering charity to them. This shows that irrespective of the level of education, Moslems share similar sentiments religiously on the basis of charity and common group prayers (congregational).

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This further suggests that when it comes to perhaps certain critical related religious areas the Moslem respondents seem to have different attitudes towards PLWHAs, hence the need to determine the extent of influence of their education levels on their attitude towards PLWHAs in terms of related religious relations. A correlation analysis was performed in order to confirm the above statistics as depicted in Table 4.15

4.4. c: Correlation on Education level of Respondents and their Attitudes towards PLWHAs in Religious Related Relations

The correlation results at 0.05 significance levels in Table 4.15 on the educational level of the Moslem respondents and their religious relations or engagement with PLWHAs also produced the respective significance, degree or relative strengths as well as the coefficients of determination to measure the strengths of relationships and the extent to which the respondents' educational levels are associated with their attitude towards PLWHAs in religious related matters.

Table 4.15: Educational level of Moslem Respondents and their Religious relations with PLWHAs (Yes)

Attitude towards PLWHAs	N	R	r^2	r^2%	Sig@ 0.05
Perform Prayers	300	1	1	100	1
Give alms	300	1	1	100	1
Accept alms	300	0.341	0.682	68.2	0.000
Accept as an Imam	300	0.101	0.202	20.2	0.081

Source: Field survey, 2018.

The results in Table 4.15 showed that there is a highly positive but insignificant relationship between the Moslem respondents' level of education and performing congregational prayers with the PLWHAs (r=1; *p*=1.00) and giving alms to PLWHAs (r=1; *p*=1.00) as well as accepting PLWHAS as their Imams (r=0.101; *p*=0.081) while that of accepting alms from them (r=0.341; *p*=0.000) was lowly positive but significant.

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The respective computed coefficients of determination in Table 4.15 showed that over 68% of their attitudes in terms of giving alms (100%), doing prayers (100%) and accepting alms from PLWHAs (68.2%) were associated with their level of education. However, their attitude towards PLWHAs in terms of accepting them as Imam was minimally associated (r^2% =20.2) with their level of education.

This implies that, generally, there is a strong relationship or influence of their level of education on their attitude towards their religious engagements with PLWHAs. It can therefore be inferred that, the higher the formal educational attainment of adult Moslems of a community, the more likely their attitude will be positive towards their religious engagement with PLWHAs.

Social Relations and Personal Characteristics of Practising Moslems

Social relations refers to a dynamic changing sequence of social activities between individuals or group who modify their actions and reactions as a result of the actions or behaviour of those they relate with .It is thus a relationship between two, three or more individuals. Social relations or engagement is very important and necessary for social order and its growth .It also provides a platform on communal occasions such as marriages, outdoorings, festivals funerals for people not only to socialize and interact with one another but to learn and educate others about the society's norms, values ,beliefs and practices. It is therefore important that all members of the society are part of these social relations.

4.4.d: Sex and Social Relations with PLWHAs

A cross tabulation of responses on the sex of Moslem respondents and their attitudes towards PLWHAs in socially related engagements were sought to establish whether

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there exists any significant relationship between the two variables. Data gathered is presented in Table 4.16

Table 4.16: Sex of Moslem respondents and their social relations with PLWHAs (Yes)

Respondents Social Relations with PLWHAs	SEX OF RESPONDENTS				TOTAL	
	Male		Female			
	F	*%*	*f*	*%*	*f*	*%*
Attend social events	152	58.9	106	41.0	258	100
Marry	1	25	3	75	4	100
Embrace	153	58.8.	107	41.1	260	100
Shake Hands	161	61.6	100	38..3	261	100
Share same Utensils	5	16.6	25	83.3	30	100
Sleep in same room	156	56.1	122	43.8	278	100
Visit them when sick	173	58.6	122	41.3	295	100
Children attend same school with theirs	70	36.6	121	63.3	191	100
TOTAL RESPONSES	871	55.2	706	44.7	1577	100

Source: Field Survey, 2018 *Multiple responses

Data in Table 4.16 showed that in terms of sex, Moslems will discriminate against PLWHAs depending on the particular social activity they relate with them. Moslem men will have positive social engagement or relations with PLWHAs except in the area of marriage (25%) and in the sharing of utensils (16.6%). The women will also discriminate in a similar way.

4.4. d: Correlation on Sex of Moslem Respondents and their Attitudes towards PLWHAs in Social related Engagement

Correlation results at 0.05 level of significance on the sex of the respondents and their attitude towards PLWHAs in social related activities in Table 4.17 shows the respective relationships and the extent to which sex of the respondents has influenced or associated with their respective attitudes towards PLWHAs in social related activities.

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Table 4.17: Correlation between Sex of Moslem Respondents and their attitude towards Social relations with PLWHAs (Yes)

Attitude towards PLWHAs	N	R	r^2	r^2%	Sig. @ 0.05
Attend social events	266	0.143	0.286	28.6	0.019
Marry	295	0.112	0.224	22.4	0.055
Embrace	295	0.083	0.166	16.6	0.154
Shake hands	295	0.076	0.152	15.2	0.191
Share same utensils	290	0.106	0.212	21.2	0.072
Sleep in same room	300	0.103	0.206	20.6	0.076
Children attend same school with theirs	300	0.146	0.292	29.2	0.012
Visit them when sick	300	0.157	0.314	31.4	0.006

Source: Field survey, 2018.

The correlation results in Table 4.17 showed a weak positive relationship between the sex of the Moslems' respondents and their social relations with PLWHAs (r<or equal to 3). While Moslems were willing to attend social events, marry, allow their children to attend same school with PLWHAs and visit them when they are sick were all positive and significant, the rest were not significant. The co –efficient of determination was less than 32% which implies that over 70% of their attitude in social relations was associated with other factors other than sex. Thus, sex has less influence on social relations or interactions with PLWHAs.

4.4.e Age range of Respondents and Social Relations with PLWHAs

A cross tabulation of responses on the age of moslem respondents and their attitudes towards PLWHAs in social related engagements were sought to establish whether there exists any significant relationship between the two variables. Data gathered is presented in Table 4.18

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Table 4.18: Age of Moslems Respondents and their Social relations with PLWHAs (Yes)

Age of Moslem Respondents	Related Social Relations														Total responses	
	Attend Social events		Marry		Embrace		Shake hands		Share same utensils		Sleep in same room		Visit them when sick			
	F	*%*	*f*	*%*	*f*	*%*	*f*	*%*	*f*	*%*	*f*	*%*	*f*	*%*	*f*	*%*
18-30	100	20.1			93	18.7	101	20.3			95	19.1	108	21.7	497	100
31-55	151	18.1	1	0.1	158	18.9	151	18.1	21	2.5	174	20.8	178	21.3	834	100
56 above	7	12.7	3	5.4	9	16.3	9	16.3	9	16.3	9	16.3	9	16.3	55	100
Total	258	18.6	4	0.2	260	18.7	261	18.8	30	1.6	278	20	295	21.2	1386	100

Source: Field Survey, 2018 *Multiple responses

Responses in Table 4.18 depict that all Moslem respondents of all the age categories had some level of social engagement with PLWHAs. The young and middle-aged Moslem adults however, are not ready or likely to marry or share same utensils with PLWHAs. Elderly adult Moslems will distance themselves from PLWHAs in social events such as family or community gatherings and will also not visit a sick PLWHA.

It is significant to note that none of the young Moslems, 18-30 years was ready to marry or share same utensils with PLWHA. This implies that there is differential attitude towards PLWHAs by the Moslem respondents at the individual and general levels of social engagement with PLWHAs. As a way of confirming the above statistics, a correlation analysis was performed as captured in Table 4.18

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4.4. e: Correlation on Age of Moslem Respondents and their Attitude towards PLWHAs in Social related Engagements

Correlation results at 0.05 significance levels in Table 4.19 on the age of the Moslem respondents and their social related engagements with PLWHAs also produced the strengths of relationships and the extent to which the respondents' educational levels are associated with their attitude towards PLWHAs in religious related relations.

Table 4.19: Age of Moslem Respondents and their attitude towards Social relations with PLWHAs (Yes)

Attitude towards PLWHAs	N	R	r^2	r^2%	Sig.@ 0.05
Attend social events	266	0.116	0.232	23.2	0.058
Marry	295	0.001	0.002	0.2	0.985
Embrace	295	0.115	0.23	23	0.048
Shake hands	295	0.035	0.072	7.2	0.552
Share same utensils	290	0.048	0.096	9.6	0.419
Sleep in same room	300	0.059	0.118	11.8	0.305
Children attend same school with theirs	300	0.112	0.224	22.4	0.052
Visit them when sick	300	0.083	0.166	16.6	0.152

Source: Field Survey, 2018.

The correlation analysis results in Table 4.19 showed that there exists a positive relation or correlation between the age of the respondents and their social relations with PLWHAs. The relationship between age and their willingness to attend social events (r=0.116; p=0.058), embrace PLWHAs (r=0.115; p=0.048) and let children and relations to attend the same school with PLWHAs children (r=0.112; p=0.052) were positive and significant whilst that the rest were also positive but not significant.

As regards the relative degree or strength of the relationships, all the respective relationships were weak($r<0.3$). In the same vein, the computed respective coefficients of determination (r^2%) in Table 4.19 also revealed that less than 25% of the Moslem

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respondents' attitude towards PLWHAs in social related engagements could be explained or associated with the influence of their age. This implies that over 75% of the respondents' attitude towards PLWHAs could be attributed to or explained by extraneous or other factors other than that of their age.

4.4.f: Education level and Social Relations with PLWHAs

The relationship between the educational level of Moslem respondents and their attitudes towards PLWHAs in social engagements were sought to establish whether there exists any relationship between them and to determine the extent of influence education had on their attitudes towards their respective related social activities. Data gathered to this effect is presented in Table 4.20

Table 4.20: Education and their Social relation with PLWHAs (Yes)

Educational Level of Respondents	Related Social Relations														Total responses	
	Attend social events		Marry		Embrace		Shake hands		Share same utensils		Sleep in same room		Visit them when sick			
	f	%	*f*	%	*f*	%	*f*	%	*f*	%	*f*	%	*f*	%	*f*	%
No formal education	58	21			52	18.9	53	19.2			51	18.5	61	22.1	275	100
Basic Education (primary-JHS)	37	17.4			45	21.2	45	21.2			41	19.3	44	20.7	212	100
Secondary Education	31	17			35	19.2	35	19.2	4	2.1	37	20.3	40	21.9	182	100
Post-Secondary (Nursing, Agric.ext, Teacher etc.)	39	19.3	1	0.4	39	19.3	39	19.3	6	2.9	39	19.3	39	19.3	202	100
Tertiary Education (Polytechnic, university)	93	18	3	0.5	89	17.2	89	17.2	20	3.8	110	21.3	111	21.3	515	100
Total Responses	258	18.6	4	0.2	260	18.7	261	18.8	30	2.1	278	20	295	21.2	1386	100

Source: Field Survey, 2018 *Multiple responses

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The results in Table 4.20 showed that the Moslem respondents of all the educational level categories have had some level of engagement with PLWHAs in the related social activities. Though all Moslems of all the educational level will not relate well with PLWHAs in the areas of marriage and sharing cooking facilities, however, those with limited or no formal education will discriminated strongly in those areas. The data also indicate that more than half of Moslems with higher level of education will relate well with PLWHAs in social related events particularly sleeping in the same room and visiting them when sick.

4.4.f: Correlation on Educational level of Moslem Respondents and Attitudes towards Social related relations with PLWHAs

Correlation results on the educational level of the respondents and their attitude towards PLWHAs in social related activities in Table 4.21 shows the respective relationships and the extent to which education of the respondents has influenced or associated with their respective attitudes towards PLWHAs in social related activities.

Table 4.21: Educational level of Moslems' Respondents and their social relations with PLWHAs (Yes)

Attitude towards PLWHAs	N	R	r^2	r^2%	Sig. @ 0.05
Attend social events	300	0.137	0.274	27.4	0.025
Marry	300	0.189	0.378	37.8	0.001
Embrace	300	0.110	0.22	22	0.059
Shake hands	300	0.127	0.254	25.4	0.029
Share same utensils	300	0.094	0.188	18.8	0.111
Sleep in same room	300	0.158	0.316	31.6	0.006
Children attend same school with theirs	300	0.032	0.064	6.40	0.586
Visiting them when sick	300	0.187	0.374	37.4	0.001

Source: Field Survey, 2018.

Data in Table 4.21 on the correlation study of educational level and the respective social relations of the Moslems respondents reveals a low or weak ($r<0.3$) positive relationship.

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With regards to the significance of the relationship it was clear that sharing the same utensils with PLWHAS and allowing children to attend the same school with them have no significant relationship. With regards to the extent to which their level of education was associated with positive engagements of the Moslems with PLWHAs in the respective social engagements or relations, the computed co-efficient of determination revealed that less than 40% (r^2%<40%). thus suggesting that over 60% of their attitude towards PLWHAS in social engagements or events was associated with other factors or extraneous variables. Hence, it can be concluded that even though there exist a positive relationship between the level of education of the Moslems and their social engagement or relations with PLWHAs it was weak (r<0.3).

Economic Relations and Personal Characteristics

Economic or business transactions is one of the important aspects of life that Islam stresses on because striving for sustenance is required of all Moslems in view of the fact that it is characteristic of human nature to earn a livelihood for himself and that of his dependents. This therefore explains why Islam encourages economic activity and hard work as a way of not only discouraging dependency and idleness but also fighting poverty. Islam's view is that there cannot be a well sound and just society when a section of its population suffers from the consequences of poverty. It is on the basis of these that everybody in the society should be offered the opportunity to engage in such an important enterprise.

4.4.g: Sex and Economic relations with PLWHAs

The study sought responses on the sex of Moslem respondents and their respective attitudes towards PLWHAS in commerce or economic related engagements and to

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determine the relationships and the extent to which their sex have influenced their respective attitudes towards PLWHAs in economic engagements. The result is presented in Table 4.22.

Table 4.22: Sex of Moslem Respondents and their Economic relations with PLWHAs (Yes)

Sex of respondent	Economic Relations									
	Offer employment		Accept employment		Trade		Consumption of their products		Total Reponses	
	f	*%*	*f*	*%*	*f*	*%*	*f*	*%*	*f*	*%*
Male	165	31.6	172	32.9	178	34	7	1.3	522	100
Female	110	31.8	122	35.3	105	30.4	8	2.3	345	100
Total	275	31.7	294	33.9	283	32.6	15	1.7	867	100

Source: Field Survey, 2018 *Multiple responses

Responses in Table 4.22 showed that all the Moslem respondents in both sex categories will engage in one form or the other in the identified related economic relations with PLWHAs. However, both sexes were ready to employ or work with them, engage them in trading activities. . Both male and female Moslems will, however not tolerate the patronage of PLWHAs' products. In order to confirm the above statistics, a correlation analysis was conducted as Table 4.23 shows.

4.4.g: Correlation on Sex of Moslem Respondents and their Attitudes towards PLWHAs in Economic related relations

Correlation results at 0.05 significance levels in Table 4.23 on the sex of the Moslem respondents and their economic relations or engagement with PLWHAs also produced measurements of the strengths of relationships and the extent to which the respondents' sex are associated with their attitude towards PLWHAs in economic related relations.

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Table 4.23: Sex of Moslem Respondents and their attitude towards Economic relations with PLWHAs (Yes)

Attitude towards PLWHAs	N	R	r2	r2%	Sig. @ 0.05
Offer employment	296	0.089	0.178	17.8	0.125
Accept employment	300	0.118	0.236	23.6	0.041
Trade	300	0.296	0.592	59.2	0.000
Consumption of their products	294	0.150	0.3	30	0.010

Source: Field survey, 2018.

The results in Table 4.23 on the correlation study of the relationship between the sex of the Moslem respondents and their economic relations with PLWHAs revealed a weak (r<3) but positive correlations between the variables. However, with the exception of offering employment to PLWHA (r=0.089; p=0.125) which was not significant, the rest of the economic related activities were significant.

The co-efficient of determination was less than 65%.This explains only 35% of their attitude towards PLWHAs in economic engagement was associated with other factors than sex suggesting that sex may likely influence moderately their attitude in economic relations or engagement with PLWHAs. Hence, sex has less influence on economic relations or engagement with PLWHAs.

4.4.h Age of Respondents and Economic relations with PLWHAs

The relationship between the age of Moslem respondents and their attitudes towards PLWHAs in economic related engagements were sought to establish whether there exists any relationship between them and to determine the extent of influence age had on their attitudes towards their respective economic relations PLWHAs. Data gathered to that effect is presented in Table 4.24.

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Table 4.24: Age of Moslems' Respondents and their Economic relations with PLWHAs (Yes)

Age of Moslem Respondents	Economic relation									
	Offer employment		Accept employment		Trade		Consumption of their products		Total Responses	
	f	%	*f*	%	*f*	%	*f*	%	*f*	%
18-30	106	32.8	111	34.3	106	32.8			323	100
31-55	160	31.3	174	34.1	168	32.9	8	1.5	510	100
56 above	9	26.4	9	26.4	9	26.4	7	20.5	34	100
	275	31.7	294	33.9	283	32.6	15	1.7	867	100

Source: Field Survey, 2018 *Multiple responses

Responses in Table 4.24 showed that though the Moslem respondents of all the age categories were in one way or the engaged in economic related activities with PLWHAs, those within the younger and middle adulthood were very discriminatory in areas of consumption of PLWHAs products although the majority will offer and accept them in employable situations. The elderly Moslems unlike the younger and middle aged counterparts will associate well with PLWHAs in the areas of offering employment, engaging in trading and accepting employment from PLWHAs respectively. This implies that there is some differential level of engagement with PLWHAs by the various age categories of the Moslem respondents.

4.4.h: Correlation on Age Moslem Respondents and their Attitudes towards PLWHAs in Economic related Engagements

The computed correlation coefficient in Table 4.25 on the Moslems' responses on the influence of age on their attitudes towards PLWHAs in economic related engagement was to establish the extent of influence of the respondents' age on their attitude towards PLWHAs in economic engagements by determining the respective significance of their relationship, degree or strength of relationship and their coefficients of determination.

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Table 4.25: Age of Moslems Respondents and attitude towards Economic relations with PLWHAs (Yes)

Attitude towards PLWHAs	N	R	r^2	r^2%	Sig. @ 0.05
Offer employment	296	0.055	0.11	11	0.346
Accept employment	300	0.091	0.182	18.2	0.115
Trade	300	0.021	0.042	4.2	0.716
Consumption of their products	294	0.024	0.048	4.8	0.686

Source: Field survey, 2018.

The analysis in Table 4.25 reveals that at 0.05 level of significance, there is a positive correlation or relationship between the age of the respondents and their respective economic engagements or relations with PLWHAs. However, the relationship between the influence of age and their attitude towards the respective economic related engagements such as offering employment to PLWHAs (r=0.055; p=0.346), accepting employment from PLWHAs (r=0.091; p=0.115), trading with PLWHAs (r=0.021; p=0.716) and consumption of PLWHAs products (r=0.024; p= 0.686) were positive but not significant and strong. In relation to the relative degree or strength of the relations, all the respective relationships were very weak (r<0.3). It is significant to note that all were less than 0.1 establishing no relationship. This means age has nothing at all when it comes to economic activities.

Also, the computed respective coefficients of determination ((r^2%) also revealed that less than 20% of the respondents attitude towards PLWHAs in offering employment to PLWHAs (r^2%=18.2%) could not be explained or associated with the influence of their age. Only less than 5% of their attitude in trading with PLWHAs (r^2%=4.2%) and consumption of their products (r^2%=4.8%) were associated with the influence of age. Thus, less than 20% of the Moslem respondents' attitude towards PLWHAs in economic related engagement could be explained or associated with their age. The implication is that over 75% of the Moslems' attitude towards PLWHAs in economic related relations

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could be explained or attributed to extraneous or other factors other than that of age. That is any age-group is willing to engage in economic activities with PLWHAs without discrimination.

4.4.i: Education and Economic Related Relations with PLWHAs

The study sought responses on educational levels of Moslem respondents and their respective attitudes towards PLWHAS in economic related engagements or relations to determine the relationships and the extent to which their level of education have influenced their respective attitudes or economic engagements and relations with PLWHAs. Data gathered to that effect from the field is presented in Table 4.26.

Table 4.26: Educational level of Respondents and their Economic relations with PLWHAs (Yes)

Educational level of Moslems Respondents	Economic relations									
	Offer employment		Accept employment		Trade		Consumption of their products		Total Responses	
	f	%	*f*	%	*f*	%	*f*	%	*F*	%
No Formal Education	55	31.7	65	37.5	53	30.6			173	100
Basic education (Primary-JHS)	45	33.3	45	33.3	45	33.3			135	100
Secondary Education	36	30.5	40	33.8	40	33.8	2	1.6	118	100
Post-Secondary (Nursing, Agric.ext, Teacher etc.)	39	32.5	39	32.5	39	32.5	3	2.5	120	13.8
Tertiary Education (Polytechnic, University)	100	31.1	105	32.7	106	33	10	3.1	321	100
Totals	275	31.7	294	33.9	283	32.6	15	1.7	867	100

Source: Field Survey, 2018 *Multiple responses

Data in Table 4.26 showed that the Moslem respondents of all the categories of the educational levels will not engage equally regarding economic activities with PLWHAs.

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For example, those with basic education and no formal education (lowly educated) will not consume products prepared by PLWHAs. A correlation analysis performed in Table 4.27 was used to confirm the above statistics.

4.4. i: Correlation on Moslem Respondents' Educational level and their Attitudes towards Economic related activities with PLWHAs

The correlation results in Table 4.27 shows the respective significance of relationships, degree of strengths and the coefficients of determinations between the Moslem respondents' education and their attitudes towards PLWHAs in economic related activities to help establish the extent of correlations and influence of education on the Moslems' attitudes towards PLWHAs.

Table 4.27: Educational level of Moslems Respondents and their Economic relations with PLWHAs (Yes)

Attitude towards PLWHAs	N	R	r^2	r^2%	Sig. @ 0.05
Offer employment	300	0.034	0.068	6.8	0.565
Accept employment	300	0.153	0.306	30.6	0.008
Trade	300	0.171	0.342	34.2	0.003
Consumption of their products	300	0.161	0.322	32.2	0.006

Source: Field survey, 2018.

The correlation analysis results in Table 4.27 showed that there is a low positive and significant relationship or correlation between the level of education of the Moslems respondents and their attitude towards the rest of the economic related relations. However, the data also revealed that even though these relationships are positive and significant, their relative degree or strengths were weak ($r<0.3$).The area in which they will unanimously relate well economically with PLWHAs was offering employment to them irrespective of their level of education.

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The computed coefficients of determinations of the respective economic related engagements showed that the extent to which their attitudes are associated with their education varied from one economic engagement to another. For instance, 6.8% of the attitude towards offering employment, 30.6%of accepting employment, 34.2%oftrading or doing business and 32.2% of consumption of PLWHAs products were associated with or attributed to the influence of the Moslem respondents' level of education. This suggests that over 60% of their attitude towards PLWHAs in economic related activities was associated with other factors or extraneous variables and not education.

This implies that there is a positive and significant correlation but weak and minimal association or influence of education of the Moslem respondents on their attitudes towards economic related engagements with PLWHAs. Moslems will moderately discriminate economically based on their educational level.

Political relations and Personal Characteristics

Political participation or engagement offers the individual the opportunity to take part in the political process by making his or her opinion, beliefs and interests known. It ensures that the community or society benefits from the skills, knowledge and talents of those who are voted to represent the interest of the larger society. In this regard those who fail to participate or are denied the opportunity to participate as a result of their health conditions will be denied the opportunity of enjoying certain benefits or influencing policies that will be in their favour.

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4.4. j: Sex of Respondents and Political Relations with PLWHAs

The relationship between the sex of Moslem respondents and their and their attitudes towards PLWHAs in political related engagements were sought to establish whether there exists any relationship between them and to determine the extent of influence sex had on their attitudes towards their respective political relations with PLWHAs. Data on this is presented in Table 4.28

Table 4.28: Sex of Moslem Respondents and their Political relations with PLWHAs (Yes)

Sex of respondent	Political relation									
	Elect as an Imam		Vote as Assembly Member		Vote as Member of parliament		Vote as a chairperson		Total Responses	
	f	*%*	*f*	*%*	*f*	*%*	*f*	*%*	*F*	*%*
Male	5	4.5	54	49	47	42.7	4	3.6	110	100
Female	6	4.6	68	52.7	50	38.7	5	3.8	129	100
Totals	11	4.6	120	50.2	97	40.5	9	3.7	239	100

Source: Field Survey, 2018 *Multiple responses

The data in Table 4.28 depict that Moslem respondents of both sexes had some level of political engagement with PLWHAs. Moslem females are ready and willing to elect a PLWHA as an assembly person compared to their male counterparts who will not discriminate in voting a PLWHA as a Member of Parliament. However, they will share the same opinion when it comes to electing PLWHA as an Imam or Chairperson of an event.

This implies that at least there is limited differential level of engagement with PLWHAs by both sexes of the Moslem respondents when it comes to political related engagement. This implies that they will discriminate in religious leadership as compared to political leadership. The reason might be that they want to maintain the sanctity of the religious

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office of Imamship since persons of low moral standards are not expected to occupy that position.

4.4.j: Correlation on Sex of Moslem Respondents and their Attitudes towards PLWHAs in Political related Engagements

The correlation results in Table 4.29 shows the respective significance of relationships between the Moslem respondents' sex and their attitudes towards PLWHAs in politically related activities to help establish the extent of influence of sex on the Moslems' attitudes towards PLWHAs.

Table 4.29: Sex of Moslem Respondents and their attitude towards Political relations with PLWHAs (Yes)

Attitude towards PLWHAs	N	R	r^2	r^2%	Sig. @ 0.05
Elect as an Imam	300	0.097	0.194	19.4	0.094
Vote as an Assembly member	300	0.005	0.01	1.0	0.935
Vote as a Member of Parliament	300	0.025	0.05	5.0	0.670
Vote as a Chair person of an event	300	0.056	0.112	11.2	0.333

Source: Field survey, 2018.

Correlation results in Table 4.29 on the relationship between sex of Moslem respondents and their political activism or engagement shows a weak (r<3) but positive and insignificant relationship.

The computed co-efficient of determination revealed that less than 20% of all the political engagements were associated with other factors than sex. This therefore implies that over 80% of Moslems respondents' attitude towards PLWHAs in terms of political relations or engagement was due to other factors and not sex.

4.4. k: Age range of Respondents and Political Relations with PLWHAs (Yes)

The study sought responses on the age of Moslem respondents and their respective attitudes towards PLWHAS in politically related engagements to determine the

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relationships and the extent to which their age have influenced their respective attitudes or political engagements with PLWHAs as in Table 4.30.

Table 4.30: Age of Moslems' Respondents and their Political relations with PLWHAs (Yes)

Age of Moslems' Respondents	Political relation									
	Elect as an Imam		Vote as Assembly member		Vote as a Member of Parliament		Vote as a Chair person		Total Responses	
	f	%	*f*	%	*f*	%	*f*	%	*f*	%
18-30			105	88.9	13	11			118	100
31-55	5	2	157	64	77	31.4	6	2.4	45	100
56 above	6	24	9	36	7	28	3	12	25	100
Totals	11	2.8	2.8	30.9	97	25	9	2.3	388	100

Source: Field Survey, 2018 *Multiple responses

Results in Table 4.30 showed that all the Moslem respondents of all the age categories had some level of engagement with PLWHAs in the identified related political activities. It is evident that young adult Moslems are not willing or ready to elect a PLWHA as an Imam or as a chairperson but will highly vote him or her as assembly person. For although these middle aged and elderly somewhat will elect PLWHA as an Imam or chairperson, they will mostly vote them as assembly person or Member of Parliament.

This suggests that there are varied attitudes of the Moslem respondents towards the respective political related relations with PLWHAs as far as age is concerned. As a way to confirm the above statistics, a correlation analysis was conducted as shown in Table 4.31

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4.4.k: Correlation on Moslem Respondents Age and their Attitudes towards Political Related activities with PLWHAs.

The correlation results in Table 4.31 shows the respective significance of relationships, degree of strengths and the coefficients of determinations between the Moslem respondents' age and their attitudes towards PLWHAs in political related activities to help establish the extent of correlations and influence of age on the Moslems' attitudes towards PLWHAs.

Table 4.31: Age of Moslem Respondents and attitude towards Political relations with PLWHAs (Yes)

Attitude towards PLWHAs	N	R	r^2	r^2%	Sig. @ 0.05
Elect as an Imam	300	0.171	0.342	34.2	0.003
Vote as an Assembly member	300	0.082	0.164	16.4	0.158
Vote as a Member of Parliament	300	0.075	0.15	15	0.194
Vote as a Chair person	300	0.050	0.1	10	0.390

Source: Field survey, 2018.

The correlation analysis results in Table 4.31 show that at 0.05 level of significance there was a positive correlation between the Moslems' age and their respective political relations with PLWHAs. However, even though the relationships between age and their willingness to vote a PLWHAS as an assembly person (r=0.082; p=0.158), Member of Parliament(r=0.075; p=0.194) as well as a chairperson of an event (r=0.050; p=0.390) were positive they were not significant. The issue of electing a PLWHAs as an Imam was both positive and significant (r=0.171; p=0.003).With reference to the relative degree or strength of the relationships, all the respective relationships of their political engagements and their age were very weak(r<0.3).

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This explains that the Moslems respondents' willingness to engage in political related engagements with PLWHAs is related to their age. The younger the person, the more discriminatory he becomes in relation to religious and community leadership than national affairs. The computed coefficient of determination showed that age explains about 35% (r^2%=34.2%) of their attitude towards PLWHAs in political related issues. This implies that age has some influence though minimal on the attitude of the Moslems towards PLWHAs in political related issues.

4.4.l:. Education and Attitude towards Political Relations with PLWHAs

Responses on the Moslem respondents' level of education and their attitude towards PLWHAS in their respective political engagements or relations were sought so as to determine the relationship and the extent to which the Moslem respondents' education is associated with their respective political engagement with PLWHAS. Data gathered are shown in Table 4.32

Table 4.32: Educational level of Moslem Respondents and their Political relations with PLWHAs (Yes)

Educational level of Moslems' Respondents	Political relations									
	Elect as an Imam		Vote as an Assembly member		Vote as a Member of Parliament		Vote as a Chair person		Total Responses	
	f	*%*	*f*	*%*	*f*	*%*	*f*	*%*	*f*	*%*
Secondary Education	2	22.2	5	55.5	2	22.2			9	100
Post-Secondary (Nursing, Agric.ext, Teacher etc.)	2	4	25	50	20	40	3	6	50	100
Tertiary Education(Polytechnic, University)	7	3.9	90	50.5	75	42.1	6	3.3	178	100
Totals	11	4.6	120	50.6	97	40.9	9	3.7	237	100

Source: Field Survey, 2018 *Multiple responses

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The data in Table 4.32 depicts that persons with limited or low literacy levels will not engage in any political interactions with PLWHAs. On the contrary, among the educated although they may associate politically, it was very moderate as over 50% of them will vote a PLWHA as an Assembly member or Member of Parliament (40%) In order to confirm the above statistics, a correlation analysis was performed as in Table 4.33

Table 4.33: Educational level of Moslems Respondents and their Political relations with PLWHAs (Yes)

Attitude towards PLWHAs	N	R	r^2	r^2%	Sig. @ 0.05
Elect as an Imam	300	0.084	0.168	16.8	0.148
Vote as an Assembly Member	300	0.031	0.062	6.2	0.599
Vote as a Member of Parliament	300	0.135	0.27	27	0.019
Vote as a Chairperson	300	0.099	0.198	19.8	0.086

Source: Field survey, 2018.

The correlation study analysis in Table 4.33 shows a weak positive relationship($r<0.3$) between the educational levels of the Moslems respondents and their respective political engagements or activities with PLWHAs. However, the relationship or correlation between the level of education of the Moslem respondents and their political engagements with PLWHAs such as willingness to elect as an Imam ($r=0.084$; $p=0.148$), vote as an assembly member($r=0.031$; $p=0.599$), vote as a Member of Parliament ($r=0.135$; $p=0.019$), or as a chairperson of an event (0.099; $p=0.086$) was not significant. The coefficients of determination were less than 28%.This implies that over 80% of their attitude towards PLWHAs in political engagement was associated with other factors other than education. Educational level has less influence on political relations or interactions with PLWHAs as Moslems will discriminate politically irrespective of their educational level especially electing someone as Imam or Chairperson.

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4.5 Moslem Respondents' Attitudes towards PLWHAs based on Teachings and Beliefs of Islam.

This section of the chapter presents and analyses data on the Moslems' opinions on the beliefs and teachings of Islam that influence their attitudes towards PLWHAs in religious, social, economic and political relations.

On the opinions of the Moslem respondents as regards whether it is Islamic to stigmatise or discriminate against PLWHAs showed marked and varied views as data gathered to that effect are presented in Table 4.34

Table 4.34: Islam and Stigmatisation and Discrimination against PLWHAs

Islamic to Stigmatise and Discriminate against PLWHAs	*F*	*%*
Yes	9	3
No	289	96.3
Uncertain	2	0.6
Total	300	100

Source: Field Survey, 2018

The results in Table 4.34 showed that a predominant majority (96.3%) of the Moslem respondents indicated that it was not Islamic for a Moslem to discriminate against PLWHAs. Only 3% of the respondents claimed it was Islamic to discriminate particularly against PLWHAs. This implies that the Moslem respondents, to some extent are positively unanimous on the position of Islam viz a viz the discrimination against PLWHAs.

Buttressing their position that it is not Islamic to discriminate particularly against PLWHAs, the Moslem respondents proffer many and varied teachings as follows;

- *As a practicing Moslem, you have to show love and kindness towards the sick people. The prophet Mohammed (S.A.W) entreated all Moslems to visit the homes of the sick.*

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- *All Moslems should lead exemplary life when it comes to the sick because the Prophet in his visits did not discriminate against ailing people. He even visited sick –non Muslims as reported in one of the Hadiths*

It is also reported in one of the Hadith that the prophet in addressing those with illnesses and disabilities told them that no Moslem who is pricked with a thorn or anything larger than that will expect anything except that a hasanah will be recorded for him and a sin will be erased as a reward for that.

Islam encourages Moslems to have sympathy on sick people and even emphasised we seek prayers for them

Islam encourages Moslems to be kind towards each other whether sick or not

Islam rather encourage Moslems to be compassionate towards the sick and weak people

Islam teaches us to take care of the sick and provide support for them

Islam teaches us to love and appreciate the sick

Moslems believe that sickness is a test from Allah therefore PLWHAs should not be stigmatised for going through Allah test

The respondents also cited references such as the first verse of the Holy Quran 'Iqra' which encourages reading:

> 'Proclaim or read in the name of the Lord and Cherisher, who created. Created man, out of a leech like clot. Proclaim and your Lord is most Bountiful, He who taught the use of the pen. Taught man that which he knew not.' (HQ 96:1-5).). (An Imam, Wa Municipality).

Adhering to the Islamic teachings and practices and following Allah's guidance may not show any discriminatory tendencies towards the sick and especially PLWHAs.

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It is reported by Abu Hurayrah that the Messenger of Allah (Mohammed) said: Do not envy one another; do not outbid one another, do not hate one another, do not shun one another…….It is a serious evil for a Moslem that he should look down upon his brother Moslem. All things of a Moslem are inviolable for his brother in faith; his blood, his wealth and his honour (An English /Arabic teacher, Wa West District).

This is an indication that Moslems should consider themselves as the same people who should treat one another fairly and there should not be hatred or discrimination based on one's situation or condition such as his faith, socio-economic, tribe and health status.

They also made references to worship during the daily and Friday prayers in the mosque where equality is practically demonstrated with no signs of discrimination and differences. Any adherent who first enters the mosque take his place in the front rows notwithstanding his financial or social status and whoever went late will find himself in the back or last rows.

The respondents also made reference to the prophet who once refused to pray against the people of At-Ta'if for once stigmatising and injuring him, though Allah gave him the opportunity to take revenge for their injustices against him.

From the responses, it can therefore be inferred that the Moslems believed that discrimination contravenes the teachings of Islam and for that matter; Islam frowns on such an attitude – stigmatising and discriminating against PLWHAs. Notwithstanding this, there was a very insignificant minority who held the opinion that Islam favours stigmatisation and discrimination against PLWHAs. Some of their responses include:

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- *The sick especially PLWHAs are people who disobeyed their creator, Allah and are therefore being infected with the disease*
- *Islam believes that sick people and for that matter PLWHAs are cursed from Allah due to disobedience and negligence of their duties as Moslems*
- *Islam frowns on fornication and adultery and those who are sick, PLWHAs are being punished for going against the teachings of Islam*

4.5.1 Moslems views on Disclosure of HIV and AIDs Status

One of the causes of stigmatisation and discrimination has been identified as the element of disclosure. Many Moslem respondents and their relatives are reluctant to disclose their HIV and AIDS status. This study therefore sought to find out Moslem respondents views on a five point Likert scale of 5 =Strongly Agree; 4 = Agree; 3 = Neutral; 2 = Disagree and 1 = strongly disagree. This is represented in Table 4.35

Table 4.35: Disclosure and Non-disclosure and Stigmatisation and Disclosure

Statements on Disclosure	SA (%)	A (%)	N (%)	D (%)	SD (%)	Mean	SD
I will disclose my identity if I am HIV/AIDS positive to an Imam	11.1	25	16.7	5.6	41.7	2.58	1.52
I will disclose my identity if I am HIV/AIDS positive to a relative	25	25	27.8	2.8	19.4	3.33	1.41
I will disclose the identity of a relative who is HIV positive	11.1	16.7	19.4	22.2	30.6	2.26	1.38
I will disclose the identity of a community member who is HIV positive	5.6	16.7	16.7	22.2	38.9	2.28	1.3
I will seek help for a relative who is HIV positive in a hospital	72.2	22.2	2.8		2.8	4.61	0.8
Health professionals should disclose the status of HIV patients to their colleague health professionals	13.9	13.9	5.6	16.7	50	2.25	1.53
Health professional should disclose the status of HIV/AIDS patients to their relatives	8.8	19.4	13.9	22.2	36.1	2.24	1.38
GENERAL VIEW						**2. 79**	**1.33**

Source: Field Survey, 2018

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From Table 4.35, it became evident that Moslems in the study will not disclose their status either to an Imam ($\bar{x}$ =2.58; sd= 1.52) or a relative ($\bar{x}$ =3.33; sd= 1.41). They will as well not disclose the identity of a relative or community member who is HIV positive ($\bar{x}$=2.26; sd=1.38) and ($\bar{x}$=2.28; sd=1.3) respectively. As to whether they will like health professionals to disclose the identity of an HIV and AIDS person to their colleague health professional or their relatives, they disagreed as the means scores ($\bar{x}$ = 2.25; sd=1.53 and $\bar{x}$ = 2.24; sd= 1.38) showed. On the whole, it could be deduced that the Moslem respondents will relatively show a high level of discrimination to PLWHAs. It is also remarkable to note that 94.4 percent of the respondents will seek medical assistance for relatives who are living with HIV and AIDS. This is confirmed by the mean score of ($\bar{x}$ = 4.61) and standard deviation of (sd = 0.8.). On the whole, this statement showed the greatest concentration and unanimous decision on the part of the respondents. In order to ascertain whether there is an association between the disclosure and personal characteristics, a chi square test was conducted as in Tables 4.36 4.37 and 4.38

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Table 4.36: Sex by Disclosure of HIV status variables

HIV Status Variables	Chi-square value	Df	Sign @ 0.05
Self-Disclosure as HIV positive to Imam	3.63	4	0.458
Self-Disclosure as HIV positive to a Relative	3.89	4	0.547
Disclosure of HIV positive	2.97	4	0.563
Disclosure of Community member who is HIV positive	4.4,4	4	0.352
Seek help for an HIV positive relative in hospital	15.48	3	0.14
Health Professionals to disclose status of HIV positive to Colleague Health Professionals	18.035	4	0.029
Health Professionals to disclose status of HIV/AIDS patients to Relatives	10.83	4	0.05

Source: Field Survey, 2018

The chi-square test did not establish significant differences in terms of sex and disclosure of HIV status among the Moslems except disclosure of HIV patients status to other health professionals from their colleagues (=18.035; df =4; p=0.029) and relatives (=10.83; df =4; p=.0.05). This indicates that males would likely favour health professional disclosing the status of HIV positive persons to fellow health professionals and relatives than females.

In furtherance to this, the study sought to find out if similar results would be found out regarding age of the respondents. This is provided in Table 4.37.

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Table 4.37: Age by Disclosure of HIV status variables

HIV Status Variables	Chi-square value	Df	Sign @ 0.05
Self-Disclosure as HIV positive to Imam	7.18	8	0.517
Self-Disclosure as HIV positive to a Relative	9.23	8	0.324
Disclosure of HIV positive	6.84	8	0.554
Disclosure of Community member who is HIV positive	7.44	8	0.49
Seek help for an HIV positive relative in hospital	4.00	8	0.67
Health Professionals to disclose status of HIV positive to Colleague Health Professionals	7.36	8	4.98
Health Professionals to disclose status of HIV/AIDS patients to Relatives	11.32	8	0.18

Source: Field Survey, 2018

The result in Table 4.37 indicates that there is no significant association between the age of Moslem respondents and their interest to disclose their status or any other person to anybody or seek medical support for an HIV positive. This means based on the circumstances they find themselves, they will disclose or not for fear of stigma and discrimination.

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Table 4.38: Educational level by Disclosure of HIV status variables

HIV Status Variables	Chi-square value	Df	Sign @ 0.05
Self-Disclosure as HIV positive to Imam	7.19	8	0.516
Self-Disclosure as HIV positive to a Relative Self	7.974	4	0.436
Disclosure of HIV positive	8.79	8	0.36
Disclosure of community member who is HIV positive Seek help for an HIV positive relative in hospital	7.55	8	0.48
Seek help for an HIV positive relative in hospital	1.68	6	0.946
Health professionals to disclose status of HIV positive to colleague health professionals	7.69	8	0.46
Health professions to disclose status of HIV/AIDS patients to relatives	5.64	8	0.68

Source: Field Survey, 2018

Table 4.38 indicates that there was no significant association between education and disclosure or otherwise of HIV status as shown by the probability levels. Thus, depending on the situation, Moslems will find themselves, they will or will not reveal their HIV status due to fear of stigma and discrimination.

4.5.2: Effects of Disclosure on Stigmatization and Discrimination

Studies have shown that the effects of disclosure by individuals often lead to ridicule, frustration in life and often for the fear of people pointing accusing fingers. For this reason, the study sought to find out the Moslems views on what will happen to individual if he or she discloses his or her HIV status. This may have implication for stigma and discrimination. The results are captured in Table 4.39

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Table 4.39: Effects of Disclosure on stigma and discrimination on a PLWHA

Responses	Frequency	Percentage
Suicide	95	20.8
Early death	59	12.9
Depression	89	19.5
Low self –esteem	36	7.9
Isolation	123	26.9
Lose hope and emotional trauma	54	11.8
Total	456*	100

Source: Field survey, 2018. ***multiple responses**

Table 4.39 shows that the greatest effect that disclosure will bring to the individual is isolation from public view that may lead to loneliness as expressed by 26.9%. Another area mentioned was the tendency of such persons to commit suicide when exposed. The study also cited depression as an outcome of disclosure of one's status, which can have serious psychological problems for the individual. There were other effects such as early death, loss of hope and emotional trauma and low self- esteem. It is for these reasons that Moslems will not like to disclose their status. Some of the responses are stated below:

> 'If the individual discloses his/her HIV status, it might lead to people not associating with him thereby making him lonely and rejected. Such a situation will make him depressed' (Male, 31-55, Wa Municipality).
>
> ' Most people fear disclosing their HIV status because if it is known by the general public, all your close friends and relatives will desert your company leaving you as an individual and a lone person to man your own business. Thus, you will be left to your own fate as a lonely person, which may even lead to thoughts of suicide' (Female, 56 above years, Sissala East).
>
> 'A person who reveals his / her HIV status to others will definitely be bringing more trouble to him or herself since it will lead to psychological problems such

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as mental illness due to the loneliness he will face due to society avoiding his company' (Male 31-55 years, Wa West).

4.5.3 Effects of Disclosure on Relatives and Community

The effects of disclosure are not only felt by the individual PLWHA but also his/her relatives as well as the community. It is on the basis of this the study sought to find out the opinions of Moslems on the consequences of disclosure on the persons relatives and the community as a whole as captured in Table 4.40

Table 4.40: Effects of stigma and discrimination on relatives of a PLWHA

Responses	Frequency (f)	Percentage (%)
Shame	59	13.7
Embarrassment	69	15.9
Insecure	11	2.5
Economic effect	39	9
Withdrawal from care and support	34	7.8
Affects employment	23	5.3
Last of respect	30	6.9
Feeling of guilt	31	7.1
Psychological problems	28	6.4
Isolation	108	25
Total*	432	100

Source: Field survey, 2018.*Multiple responses**

Result depicted in Table 4.40 establishes that one of the significant effects of disclosure of HIV status on the relatives is isolation as mentioned by 25%. The issue of embarrassment, which relatives experience as a consequence of disclosure, was also cited by the Moslems. The study also stated shame as an outcome of disclosure of one's HIV status. Other similar consequences of disclosure include economic effects, withdrawal of care and support, feeling of guilt, loss of respect and related psychological problems. Some of the expressions made include the following:

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'It is risky to disclose your HIV status to anybody because when that is done, it will embarrass your relatives who are taking care of you and in order not to be disgraced, they may refuse to support you in any way' (Female, 18-30 years, Sissala East).

'If the individual decides to reveal his HIV status to any person, it can lead to the relatives being denied the opportunity to interact with the rest of that community members due to the shame they are associated with.' (Male, 31-55 years, Wa Municipality).

Any person who willingly reveals his/her HIV status to a third party should also know that not only is he bringing shame and embarrassment to them but will also lead to the society isolating them from other social activities because of the fear that they will feel insecure by associating with such a family (Male,31-55 years, Wa Municipality).

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4.6: Moslem Respondents' Suggestion on Strategies for Reducing HIV and AIDS Related Stigma and Discrimination

This section elicited the Moslems' responses as regards the suggestions on strategies that could be implemented to reduce and possibly eliminated stigma and discrimination against PLWHAs

Table 4.41: Respondents Strategies for Reducing HIV and AIDS related Stigma and Discrimination

Strategy	*f*	*%*
Call on religious leaders to intensify and refocus their teachings based on the treatment of the sick as espoused in the Quran and Hadith	138	46.0
Train Islamic religious leaders as Resource persons to sensitise and conscientise the Moslem community on HIV and AIDS stigma and Discrimination	98	32.7
Legislation of a public policy to incorporate HIV and AIDS stigma and Discrimination in the curriculum of all Arabic schools at all levels	33	11.0
Call on all Moslems to treat PLWHAs with compassion, love and care.	31	10.3
Total	300	100

Against the backdrop of the negative and dire effects of stigmatisation not only on the PLWHA but also the family, community and the society as whole in respect of health, education, economic, social and religion ,the need for coming out with strategies to mitigate and prevent these effects was appropriate. The outcome of the study therefore produced strategies regarding the respondents' views of addressing or reducing HIV and AIDS related stigma and discrimination. More than 45% of the respondents suggested the need for Imams, sheiks and mallams to intensify and refocus their teachings on what the Quran or Hadith espouse on what a true Moslem ought to observe in terms of the treatment, discrimination or stigmatisation of the sick. Some of the responses are captured below

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> "We need our religious leaders to intensify their education on HIV and AIDS stigma and education by referring to what the Quran teaches on the way Moslems should treat those who are sick in the society'(Female, 18-30 years, Wa Municipal).

> "The level of stigma and discrimination in our communities can be minimised if our Imams are able to relate to our fellow Moslems the way our Holy prophet related with those who were sick or distressed during his era'(Male, 56above years, Wa municipality).

> 'As Moslems our lives should be influenced by the teachings of the Holy Quran and Hadith and one way through which we can as Moslem reduce stigma and discrimination is for our religious leaders such as our Imams, sheikhs and other scholars of the religion to use the Quran and Hadith as the reference material to educate the community members on how to relate with the AIDS persons' (Male, 31-55 years, Sissala East).

About 33% of the respondents also suggested the need for religious leaders to be trained as resource persons and educators by the relevant government and NGOs to assist in sensitizing and conscientising the Moslem community on stigma and discrimination as well as focusing their sermons on Fridays (Jummat) and other special prayers like the Eid ul-Fitr and Eid ul-Adha on importance of showing love and compassion to the sick, especially PLWHAs. Thus, responses such as:

> 'Imams and opinion leaders should emphasise during their sermons and preaching on daily and Friday prayers, and on other special prayers like the Id

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ul-Fitr and Id ul-Adha that we are all at risk and that we should not discriminate against PLWHA' (Female, 18-30 years, Sissala East)

'Our religious leaders should be trained as resource persons by the relevant HIV and AIDS bodies to enable them also undertake sensitization programmes in our Moslem communities on how the Quran and Hadith said we should treat AIDS patients in our communities' (Male, 18-30 years, Wa west).

Another important strategy suggested by 11% of the respondents were for a public policy to be legislated to ensure that HIV and AIDS related stigma and Discrimination be incorporated in the curriculum and made examinable in all Arabic schools (Makaranta) at all levels. These were some of the responses:

' In view of the negative effects of HIV and AIDS stigma an discrimination on the individual and the larger society as a whole ,it will be necessary for the relevant bodies to consider adding it as a subject in all Islamic educational institutions' (Female,31-55years, Wa Municipality)

'The government and other relevant bodies should consider coming out with a policy which will ensure that all students in all levels of the Islamic educational institutions are not only taught a compulsory course on HIV and AIDS stigma but also examined on it.(Female, 18- 30years, Sissala East).

In addition, 31 (10.3%) of the respondents suggested that one other strategy that could reduce stigma and discrimination is for Moslems to socialize with, show love and care to PLWHAs to facilitate acceptance, and for that matter reduce HIV and AIDS related stigma and discrimination. Some of their responses are stated below:

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> ‘One way we can fight stigma and discrimination in our communities is for us as Moslems to start involving these our unfortunate brothers and sisters in our social activities and showing concern and compassion to them’ (Female, 31-55, Wa West)

> ‘As Moslems we should not shun the company or maltreat PLWHAs in any way since that may lead to very serious problems for them and their families. The best we can do as Moslems is to treat them in a humane way and as our own relatives (Male, 31-55 years, Wa Municipality).

Interestingly but not surprisingly, all the suggested strategies are largely but plans to reduce HIV and AIDS related stigma and discrimination through education or adult education. This lends support to the role of adult education in empowering individuals and groups to realize their own selves (Coombs, 1985).

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CHAPTER FIVE

DISCUSSION OF RESEARCH FINDINGS

5.0 Introduction

This chapter discusses the results on the beliefs and practices of Moslems and how their socio-demographic characteristics have influenced their attitudes towards PLWHAs in religious, social, economic and political relationships or engagement. It also covered the discussion on the respondents' opinions on the beliefs and teachings of Islam that support and influence their attitudes towards PLWHAs.

Moslems' Opinion on the Reality of HIV and AIDS related Stigma and Discrimination

The outcome of the study revealed that almost all the respondents 297 or 99% confirmed that HIV and AIDS related stigma and discrimination was real. This indicated that the Moslems had the required exposure, knowledge and information about the ailment and how to engage with PLWHAs based on their religious beliefs and practices.

5.1 Moslems Beliefs and Practices on their Attitudes towards PLWHAs

Religious beliefs and practices influence the daily behaviours and attitudes of PLWHAs just as they also influence other people's attitudes towards PLWHAs. They play a significant role in influencing people's attitude towards HIV and PLWHAs. People who hold the belief that HIV is a punishment from God or that PLWHAs did not follow the word of God were significantly more likely than those who do not hold such views to express negative attitudes towards PLWHAs leading to stigma and discrimination. In

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addition, shame-related HIV stigma was significantly prevalent among people who attach religiously- based shame to PLWHAs as noted by Zou, Yamanaka, John, Watt, Ostermann & Thielman (2009).

The objective of every religion is to assist people excel in their personal conduct and dealings and to help them build a society characterised by justice, human equality, peace, sharing and pursuit of excellence. Thus, the religious beliefs and practices or pillars provide the foundation for building such a society or community. It is in this regard that this study sought to confirm from the Moslems the basic Islamic beliefs and practices as they relate to their attitudes towards PLWHAs. Among some of the beliefs and practices are faith in one God, destiny, the prophets, prayers, charity, fasting and pilgrimage. These are explained in the following paragraphs

Faith (Belief) in Almighty Allah (God) and Destiny

On Islamic beliefs and practices, all the Moslems (300) respondents asserted that PLWHAs should not only have faith in God but that their health condition is part of their destiny. This is in view of the fact that just as God is the source of every creation on this earth, he also planned even before the creation whatever will befall each and every creature and therefore, PLWHAs who are part of this creation, should consider their situation as their destiny and not attributable to any other super natural force. The illness is therefore used to test the faith or commitment of PLWHAs, which may reduce stigma and discrimination. This falls in tune with Athar (2007) who asserted that Moslems view health, illness, suffering and dying as part of life and a test from Allah.

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Fasting

The study also established that more than half of the Moslems, 66 percent believed that though PLWHAs are Moslems and by implication required to perform the religious obligation of fasting, they should not perform that rite because of their health condition. Their stance is in fulfillment of both the Quran and Hadith teachings which preclude the sick from fasting though required to compensate for it by giving charity to the poor in the society during the fasting period. This shows the compassionate nature of the religion, which does not impose hardships on its followers. The health of its followers takes precedence over religious obligations, which may serve as a threat to their overall well-being. The minority who stated that PLWHAs should fast may reason on the belief that such a practice will lead to their recovery though there is no evidence to support such a stance.

Pilgrimage to Mecca

The data revealed that almost 90 percent (89.3%) of Moslems opined that PLWHAs can perform the religious rite to Mecca. Their opinion is founded not only on the religious duty upon every Moslem to perform the pilgrimage once they have the resources but also because the illness is not contagious. This falls in line with Islam as a religion of social inclusion, which considers every believer, notwithstanding the race, sex, socio-economic or health status on equal social pedestal. It also illustrates the awareness and knowledge level of the Moslems about the causes or modes of transmission of the illness, AIDS. This definitely has implications for HIV and AIDS related stigma and discrimination. The concern of the minority who oppose PLWHAs undertaking the pilgrimage is on the basis of the latter ability to go through the strenuous religious rites but not due to stigma

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and discrimination. This is in line with Fatoki (2016) who stated that causes of restriction in participation involving activities of life reduce the management of HIV and AIDS.

Relationships of Moslems with PLWHAs

Relationships are very important for PLWHAs, who stay in the same house. Over 95 percent (95.6%) will interact positively with PLWHAs who stay with them as tenants in the same house by sharing common household facilities and attending social events together. This attitude may stem from Islam as a religion, which encourages its followers to interact, socialise and visit each other no matter the circumstances, whether in times of sadness or joy. This therefore falls in tune with the generally held belief that a better understanding and practice of religious beliefs and practices will result in positive social inclusion and less social exclusion.

Areas of Engagement with PLWHAs

Four areas were identified by the practising Moslems. These are religious, social, economic and political.

Related Religious Engagement with PLWHAs

Moslem respondents' engagement with PLWHAs revealed that there is a high level of discrimination regarding religious leadership and receiving alms from them (Table 4.1). In fact, only 15% were willing to accept alms from PLWHAs while 1.6% showed their readiness to accept PLWHAs as their religious leaders.

The reason for this discrimination might probably be that religious leaders or for that matter Imams, are considered as respected persons who are expected to be very responsible, disciplined and an embodiment of high moral values and standards. They

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are therefore seen as role models in their communities. In the light of this, anyone living with the disease will be considered as someone who has failed the test of morality since it is the belief of some people that HIV is mainly contracted through immoral practices such as prostitution, adultery or pre-marital sex (Abraham, 2006). It is also commonly held among some religious adherents that HIV and AIDS is the result of divine punishment for disobeying the laws of Almighty Allah and this might also be the reason why the Moslem respondents will not accept a PLWHA as an Imam.

The refusal to accept alms from PLWHAs could also be linked to this false belief that PLWHAs are sinners and therefore anything associated with them are sinful, and hence unwillingness on the part of these Moslems to relate with them. This is in support of Kafuko's (2009) finding which revealed that there was no significant difference between the degree of stigma of Christians and non-Christians', though both are more likely to have stigma toward PLWHAs in view of the assumption that PLWHAs have many sexual partners. Also, the notion that the virus is transmitted sexually and God forbids fornication as stated in Quran 17: 32, Surah Al Isra, 32 and Surah An Nur, 3 as well as in the Bible, Mathew 15:19 which all condemn the act of fornication and other sexual immoralities, which might lead to stigma and discrimination based on their beliefs and doctrines as punishment by God.

The implication is that information and education on the disease has not gone down well with the people to know that it is not only through sex that one can be infected but there are other external and uncontrollable ways that could lead to the disease. Apart from that the mere contact with PLWHAs does not lead to infection once there is no transfusion of any contaminated fluid such as blood from such a person. The teachings of the religion,

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which are captured in the Quran and the Hadith on the concept of compassion, care and love to the sick are clear manifestation as to how Moslems should relate to their fellow Moslems, especially the less fortunate and afflicted members

Related Social Engagement with PLWHAs

An outcome of the study (Table 4.2) on the identified social related activities moslem respondents engage in with PLWHAs showed that Moslem respondents were not willing to marry PLWHAs and share items relating to food but were ready to participate in the other social related events. The results are consistent with the findings of Adoo-Adeku et al (2010) in Ghana, which revealed that the majority of people are not in favour of PLWHAs marrying their relatives or children. Also, Rosabelle's (2011) study on socio-economic status and discrimination against PLWHAs in Lagos State revealed a similar trend in which more than half of the respondents would not share cutlery with PLWHAs.

Based on the teachings of the Holy Quran and Hadith, which stress the need for Moslems to maintain friendly relationship among themselves, it may therefore be concluded that Moslems social engagement with PLWHAs was influenced by their religious beliefs and practices. This is predicated on the fact that both the Hadith and the Imams have emphasized the significance of visiting one another, establishing and maintaining cordial relationship among themselves, making believers happier, visiting the sick as well as participating in their funerals, marriages and outdoorings. As Imam as-Sadiq stated 'Anyone who visits his brother (in faith) for the sake of Allah, Almighty Allah will say, 'You have visited Me, therefore your reward is upon Me, and I will not be satisfied with a reward for you less than Paradise'. As Africans and for that matter Ghanaians, social interactions and community living is highly cherished. The community, thus, identifies the individual not as an isolated ego but as an entity whose being and survival is

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consequent upon his relationship or association with other members in the community. The individual is therefore known and identified in by and through his community. The individual lives, more from and revolves around the community (Ogbujah, 2006, p34). Members of the society are regarded as brothers and sisters and so one's calamities are considered collectively.

The fact that Moslems in the Upper West Region are ready to interact with PLWHAs stresses the significance of the communal way of life, where the individual is regarded as part and parcel of the family and the wider society where the problem of an individual is seen as that of the whole family and community. By accepting and engaging PLWHAs in these social activities is an indication of enhancing their social inclusion, which is the process of improving the basics on which individuals and groups, especially the disadvantaged and excluded based on their disability, gender, race, religion or health status enable them fully participate in the community's or society's political, economic and social life.

As regards Moslems' social distancing with PLWHAs in areas of marital relations and sharing of items relating to food, one may state that it is due to fear of infection that they are uncomfortable to engage with PLWHAs in those activities. Such fears probably might be due to the misconceptions about the disease and ignorance as regard its modes of transmission (Nkansa- Kyerematen & Attua, 2013). It is however, important to state that the unwillingness of Moslems to marry PLWHAs is denying them their sexual and reproductive rights. This is in view of the importance of marriage in African and in particular Ghanaian society, where it is considered not only as mark of respect but as mechanism to procreate and keep alive the lineage or clan. This therefore connotes that culturally acceptable educational programmes are required to help sensitize the

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population on the disease and also protect the rights of PLWHAs. On the other hand, since the disease is spread through sexual intercourse, people are cautious to engage in marital relationship except when they do not want biological children.

Related Economic Engagement with PLWHAs

On economic related activities Moslems may engage with PLWHAs, the results in Table 4.3 indicate that over 90% of the Moslem respondents agreed to engage in economic related activities with PLWHAs except consuming their products (1.3%). This implies that the Moslems may not drink or eat items prepared by PLWHAs for fear of being infected. The study's results validate that of Dahlui et al (2015) in Nigeria on HIV and AIDS related stigma and discrimination, which revealed that only half of the population indicated their willingness to purchase vegetables from a PLWHA. The findings of Adoo- Adeku et al (2010) on stigma and discrimination in Ghana also revealed that respondents were divided on whether or not to purchase cooked food from PLWHAs.

The behaviour of people refusing to patronize products of PLWHAs may affect their source of income and possibly aggravate their situation as far as their attempt to live meaningful and productive life is concerned. More importantly, their stance also undermines Islam's fear that society cannot be established on a fair and strong foundation when part of its population suffers from the effects of poverty. The findings of the study therefore merit the need to promote positive and acceptable attitudes among the Moslem population or community. This calls for pragmatic programmes to increase the awareness on HIV and AIDS, promote compassion and love towards PLWHAs, which are very important aspects of Islamic religion and above all, focusing on respect for the rights of PLWHAs leading to a reduction or elimination of stigma and discrimination.

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Related Political Engagement with PLWHAs

The results (Table 4.4) reveal that less than 50% of the Moslems actually favour the identified related political activities. Interestingly but not surprising, over 96% of the Moslem respondents would not engage in or favour the election of PLWHAs as an Imam or as a chairperson for any event be it political or social. This implies that the Moslems discriminatory attitude towards PLWHAs in political related issues is positive and high. The result corroborates with Adoo-Adeku et al (2010) who found that majority of the respondents in the study were not ready to elect PLWHAs into political offices such as committees, District Assemblies or Parliament. Rosabelle's (2011) study also showed that more than 35% of the respondents will not vote for a PLWHA contesting for any political position.

As has been indicated, it is the view of the respondents that electing PLWHAs as an Imam is indirectly supporting people not in upright positions. But the issue is that political office is more of intellectual abilities and capabilities of performance, advocacy and lobbying than sickness. In voting for such persons, they can champion the cause of HIV and AIDS patients through legislation.

It is evident that discrimination could also affect PLWHAs citizenship rights since most PLWHAs who may have the desired competencies and qualification to perform satisfactorily in the chosen political field would be denied due to these wrongly held views. The mere interaction with PLWHAs is not an avenue for infection and more importantly, being a PLWHA does not erode the person's capability, performance or competence.

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Attitudes towards PLWHAs

The outcome of the study on the influence of Moslems' beliefs and practices on their attitudes towards PLWHAs show many but varied degree of influence in terms of religious, social, economic and political relations as shown in Tables 4.5; 4.6; 4.7; 4.8 and 4.9

5.1.1 Attitudes towards PLWHAs in Religious relations

Islam like any other religion is hinged on certain fundamental beliefs and practices, which serve as the guiding or binding principles for its adherents. Some of these are the confession of faith or the acceptance or acknowledgement of Almighty Allah as the only God worthy of worship and that the Holy Prophet, Mohammed is his Messenger, prayers or Salat, fasting, the giving of alms or Zakat (charity) and the performance of the pilgrimage to Mecca or Hajj. For the purpose of this study only the prayers, giving and accepting alms were employed.

Attitude, especially religious- oriented most often than not is a function of many and varied factors, which include one's knowledge or belief about the object. It can also result from the individual's personal experience or observation of the object and the social roles or norms of the community or society of the individual. It is also important to state that learning could also influence the individual's attitude towards a particular object.

The study revealed in Table 4.5 that in general, and to a large extent the attitude towards PLWHAs in terms of religious relations was influenced by their respective beliefs and practices($\bar{x}$=3.80). The respondents' willingness and readiness to perform prayers give and accept alms as well as accept PLWHAs as Imams was positive. This is in

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consonance with the teachings and beliefs of Islam particularly in terms of the five pillars of Islam, among which are prayers and offering of alms or zakat, which constitute the foundation of the Islamic religion and are to be observed and followed by all Moslems with utmost devotion, love and obedience. This probably suggests that the religious does nothing to conflict with the given tenets of their beliefs and teachings as Moslems. It can therefore be concluded that to a large extent, the attitudes of Moslems towards the sick or PLWHAs is a function of their adherence to their beliefs and practices as dictated by the teachings of their religion (Islam). The more a Moslem is religiously curious to the tenets and teachings of the Quran or Islam, the more likely they would apply the beliefs and practices in their behaviour or attitude.

The fact that society's civil responsibility is reflected in the Quran, which stresses that Moslems are not only responsible for taking care of the sick but also improving their conditions also necessitates the need for such a positive attitude towards PLWHAs. This is evidenced by the below verses:

> "We sent our Messengers with clear signs and sent down with them the Book of the Measure in order to establish justice among the people ……." (Qur'an 57:25)

> "O people: Behold, your Lord is one. There is no superiority for an Arab over a non-Arab or for a non-Arab over an Arab. Indeed the best among you are those who are more pious and righteous ……." (Baihaqi, Roohul Ma'ani 13:163 -164).

Surat Al – Hujarat 49:13, condemns discrimination of any type and emphasises that one's superiority over the other should not be based on birth, colour, and blood but on one's righteousness in the eyes of Allah.

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5.1.2 Attitudes towards PLWHAs in Social relations

People living with HIV and AIDS do not only suffer health and demographic consequences but also experience social exclusion or discrimination. They are shunned by family, peers, and the wider community, which leads to stress, low self-esteem, suicide, job losses and loss of confidence (Yarney, 2016). It is to address this issue of social exclusion of PLWHAs from social interactions that emphasis was focused on the need for the general Moslem population to positively integrate them into the socio-cultural, economic and productive life of the family and community. This will greatly lead to a reduction or elimination of HIV and AIDS related stigma and discrimination as advocated by Adoo- Adeku et al (2010).

Data in Table 4.6 show that to a large extent, Moslems' attitude towards PLWHAs in terms of social relations or engagements was largely influenced by their beliefs and practices. Notwithstanding that, the data also revealed Moslems will discriminate in marrying and sharing cooking utensils with PLWHAs. They will, however willingly allow their wards to attend same school with PLWHAs children ($\bar{x}$ =4.38) or visit them while sick ($\bar{x}$ =4.29). In general, the weighted mean scores and standard deviations ($\bar{x}$ =3.60, sd=1.13) however showed a positive and unanimous attitude towards PLWHAs in social relations. This in consonance with the teachings and beliefs of Islam not to despise fellow men that are in distress or afflicted in any way. This is supported by the following Hadith:

> "The Muslim is the brother of his fellow Muslim; he does not wrong him or let him down… Whoever relieves a Muslim of distress, Allah will relieve him of distress on the Day of Resurrection." (Al-Bukhaari (2442) and Muslim (2580).).

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> " The one who stays with the one who is sick, and takes care of him and looks after him has done good by serving him and caring for him, and Allah, may He be glorified and exalted, "and do good. Truly, Allah loves Al-Muhsinoon (the good-doers)" (Al-Baqarah 2:195).
>
> "Helping the one who is sick and serving him is an act of charity. The Prophet (blessings and peace of Allah be upon him) said: "Helping a man onto his mount or lifting up his luggage onto it is a charity."(Muslim (1009).

The Moslem respondents' attitude towards PLWHAs might have been influenced by the teachings and practices of the religion, Islam, which simply means peace and submission to Allah and focuses on compassion, love and kindness to one another no matter the race, sex, colour, socio-economic or health status. Also, the religion encourages its adherents to interact, socialize, and visit each other no matter the circumstances of the person, in times of sorrow such as sickness or death and in times of happiness like marriage, outdooring and others. It is only through such interactions that the virtues of care, compassion and love will be exhibited. In this light the respondents, no matter the circumstances, were ready to fulfil their religious obligations by showing positive attitude towards PLWHAs in social engagements. This therefore falls in tune with the generally held view that a deep and better knowledge of religious beliefs and practices can lead to positive and less discrimination toward PLWHAs.

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5.1 Attitudes towards PLWHAs in Economic relations

The data in Table 4.7 show that Moslems' attitude towards PLWHAs in terms of economic engagement was positive or non-discriminatory ($\bar{x}$ =3.84; sd= 1.01). They however, showed discriminatory tendencies in terms of consumption of PLWHAs products ($\bar{x}$ =2.59; sd=0.87), which perhaps might be due to fear of infection once it deals with eating, which will ultimately go into the body. The result reveals that on the whole, Moslems economic engagement with PLWHAs was largely influenced by their beliefs and practices. It is also probable that other extraneous factors particularly business interest-profit considerations, investments as well as the popular notion that in business, people consider emotion and not morals could also have occasioned their positive attitude. Thus, when it comes to issues of economic survival, discrimination is relegated to the background.

One may also suggest that the respondents' attitude in economic related activities with PLWHAs is also premised on their adequate level of knowledge about the disease. This is because studies have shown that a person's knowledge and beliefs about HIV and AIDS are likely to affect the treatment of PLWHAs since adequate and correct beliefs will translate into positive attitudes towards PLWHAs and vice versa (Bandyopadhyay, Das & Mondal, 2017; Phiri, 2012). In this regard, the respondents' attitude may have stemmed from the fact that they know merely interacting with PLWHAs through trading will not in any way lead to their infection. This will improve the adjustment process of the PLWHAs and eliminate stigma and discrimination.

It is also pertinent to state that Islam, as a religion is very particular about encouraging economic activity and exhorting its followers to hard work, which is productive and profitable as opposed to unemployment, dependency and idleness. This is meant to fight

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poverty, a phenomenon considered social illness, which effects are not felt by only the poor but the society as a whole. The view of Islam is that society cannot be established on a firm solid foundation when a section of its population suffers from the effects of poverty. It is thus against this backdrop that economic activities or business transactions are considered very vital in Islamic communities.

5.1.4 Attitudes towards PLWHAs in Political relations

Political participation or engagement is a process which provides individuals the opportunity to influence political decisions and become an integral part of the democratic decision making process. The most important form of political participation or engagement is that of voting, which does not only ensure that the people elected are those that the citizens want but also affords them the opportunity to determine who governs them since that can affect many areas of the people's life including health, education, agriculture and economic related areas like employment.

Thus, when there is lack of political engagement or participation or when only a few people are engaging in political activities, voices will be unheard, needs unmet and there will not be full information on what is really happening. On the basis of this, the denial of PLWHAs the opportunity to engage in political activities such as to elect or to be elected into religious leadership or political positions will not only deny them their political rights but their concerns as a vulnerable group to be addressed, which ultimately will affect their wellbeing leading to their emotional and psychological imbalance, and hence death.

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It was based on these that their level of tolerance or attitudes was measured on how far they will engage with PLWHAs politically. The assessment in Table 4.8 suggests that to a large extent the Moslems' attitude towards PLWHAs in terms of political participation was influenced by their beliefs and practices. ($\bar{x}$ =3.64; sd=1.02). In fact, they will highly elect PLWHA as a Member of Parliament and Chairperson of an event than as an Imam. This is understandable for politics and their activities including acceptability of people, individuals or group of people into collective decision making. As it were, if the society's (Moslems) perception of the individual's image or characteristics is negative to the society's value systems, norms or beliefs and practices, they will reject and if acceptable they will welcome such a person. It can, therefore, be inferred that the situation of PLWHAs is religiously acceptable to their beliefs and practices and hence their position of political engagement with PLWHAs becoming their religious leader.

Thus, the unwillingness to elect PLWHAs into leadership positions such as an Imam and chairperson bring to the fore issues of denying them the opportunity to participate in political related-engagement, which is against their fundamental human and political rights. It also has an implication as far as social inclusion is concerned. It may be argued that PLWHAs are socially excluded in the political sphere due to their health status.

The overall attitudes of Moslems towards PLWHAs in religious, social, economic and political relations as in Table 4.9 showed high positive relations ($\bar{x}$= 3.72; sd= 1.07). However, social relations recorded the lowest level of attitude among the four variables studied. This has serious implications because such an attitude can force PLWHAs to leave their homes and change their daily activities, which will result in loss of social position or belongingness. Aside these, the social distancing experienced by them will

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catapult them into isolation leading to low self-esteem, depression and thoughts of acts of suicide (Fatoki, 2016).

It is important to state though religious beliefs and practices play a significant role in influencing positive attitudes towards PLWHAs, one area that needs to be considered critically in the fight against stigma and discrimination in Moslem communities in the Upper West region is the enforcement of the laws on discrimination. In view of the fact that there are laws in the country, which frown on discrimination based on one's tribe, race, sex, religion, socio-economic or health status and for that matter stigma and discrimination against PLWHAs, there is therefore the urgent need for Moslem leadership such as Imams, mallams, sheiks and the various Moslem communities in the Upper West region to act as vanguards by ensuring that people who go against these laws by showing stigmatization and discrimination against PLWHAs are not only reported but also prosecuted by the relevant government institutions and agencies . This will certainly serve as a deterrent to others and consequently lead to reduction and possibly elimination of stigma and discrimination.

5.2. Socio Demographic Characteristics and Attitudes towards PLWHAs

5.2.2. Sex of the Moslem Respondents and Attitude towards PLWHAs

Sex is one of the socio-demographic characteristics that play a role in determining a person's attitude towards PLWHAs. Women by their nature are generally considered to be sympathetic, caring and tolerant than their male counterparts. This might be due to the fact that women are the main caregivers in the household especially in developing countries (Letamo, 2003) as revealed in a study undertaken where women were more tolerant to PLWHAs compared to men.

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i. Sex and Religious Relations

The results in Table 4.11 on the correlation between sex of the respondents and their attitude towards the issue of prayers and 'zakat' established a very strong positive but insignificant relationship (r=0.081; 0.161) except that of accepting PLWHAs as Imam which was significant (r=0.234; 0.000). Similarly, both males and females will not accept alms from PLWHAs. In terms of prayers and charity, male PLWHAs were more willing to perform them with PLWHAs than the females. This might be because women are generally committed to their religious faith and beliefs and will therefore not entertain or engage in any act, which goes contrary to her faith.

The computed co-efficiency of determination outcome as captured in Table 4.11 showed that less than 48% of their attitude of accepting PLWHAs by religious engagements was by sex. This implies that sex of Moslems has a moderate influence in their religious engagement with PLWHAs.

The implication is that when it comes to issues in relation to religious related issues, the predominant factor will certainly be adherence to the teachings of the religion as it pertains to that particular issue. In this regard the respondents' attitude will be influenced by what the Quran and Hadith say concerning their relationship with the sick and for that matter, PLWHAs, the underlying factor.

Probably the Moslem respondents' attitude towards PLWHAs in religious engagement could also be influenced by the cause of the infection attributable to uncontrollable and external factors, which were beyond the control of the PLWHAs, and hence merit the pity and sympathy of the respondents and for that matter more tolerant to them. This falls in tune with the Attribution-Affect –Action theory, which propounds that if the cause of

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the need is viewed as controllable or attributable to the person's own responsibility, it is expected that more anger and less sympathy will be exhibited and by extension less support to the affected person.

i. Age and Religious Relations

The results (Table 4.13) from the study on the correlation analysis of the relationship between the ages of the Moslems' respondents and their attitudes towards religious rites of prayers and charity revealed a very strong and positive relationship. Though there was positive correlation in relation to accepting alms from PLWHAs and accepting them as Imams, only the latter was significant. This means that Moslems discriminate very strongly when it comes to the religious rite of accepting a PLWHA as their religious leader based on age.

The computed co-efficient of determination results (Table 4.13) showed that Moslems attitude in terms of performing prayers with PLWHAs and giving them alms were explained largely by their age. This implies that generally there is a strong influence of their age on their attitude towards religious interactions with PLWHAs. The result showed that the matured adults (59.8%) are likely to be more tolerant towards PLWHAs in religious engagements than the other age categories namely the young (35.5%) and old (4.6%) respectively.

This finding gives credence to the results of a study carried out in Botswana by Maswabi and Ngome which found out that people in the older groups (late adulthood) were most likely to have stigma towards PLWHAs as compared to the other age groups. Also, other similar findings include that of EKOS Research Associates (2006) study which indicated that senior citizens were less likely to support the rights of PLWHAs while that of Maldi

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et al (2004), indicated that persons less than 30 years were more likely to be less tolerant to PLWHAs as compared to those above 30 years.

The reason why older people are likely to discriminate against PLWHAs in this study religiously might be due to the fact that they do not compromise with their religion and faith and have very strong belief in the doctrines of a religion, which most often than not are based on spiritual conviction rather than on proof; and also associating the disease with immorality, which has religious connotations. The fact that these people have passed the age of producing children makes them irrelevant when it comes to discussing issues in relation to reproductive health and for that matter, HIV and AIDS.

The young adults are yet to experience married life and therefore do not have any knowledge and experience in marital and sexual life, where issues of sex and its related matters are discussed. Whatever knowledge they may have acquired would have been from their peers or hearsay, which more often than not are rumors or based on misconceptions. In this regard their attitudes towards PLWHAS, which is fear becomes real. They want to live long, enjoy sex and avoid promiscuity. For the matured adults, they may have probably been educated formally and had more information regarding the disease and understand issues relating to religious representations.

5.2.1 Education level of Moslem Respondents and Attitude towards PLWHAs in Religious

Education plays a major role with respect to HIV and AIDS related stigma against PLWHAs. This is because studies Adoo-Adeku et al (2010), Rosabelle (2011) and Kwashie (2014) have indicated that most people exhibit stigmatising attitudes towards

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PLWHA due to misconceptions and lack of or insufficient knowledge on the disease and more specifically its modes of transmission. It may therefore be stated that people with formal education are likely to show favourable attitudes to PLWHAs in view of their exposure to wide range of valuable material through reading and other modes of learning. This increases their awareness and knowledge on the various aspects of the disease, and more especially on the modes of transmission.

Conversely, people without formal or who are less educated may have very little or no knowledge about HIV and AIDS and its mode of transmission. As a result, they may show stigma towards PLWHAs due to fear of the virus (Maswabi and Ngome, 2015).

It may, however, be indicated that some studies on the contrary, establish that people with higher levels of education have more discriminatory attitudes when compared with those with no formal or lower education (Masoudnia, 2016). Generally, it is argued that there is a relationship between the level of education and HIV and AIDS knowledge vis a vis the level of attitude towards PLWHAs (Genberg 2009, Sudha et al 2005).

i. Educational level and Religious Relations

In terms of the relationship between the educational level of the Moslem respondents and their religious relations or engagement with PLWHA, the correlation results in Table 4.15 show that there is a highly positive but not significant relationship between the Moslem respondents' level of education and doing prayers with the PLWHAs (r=1; *p*=1.00), giving alms to PLWHAs (r=1; *p*=1.00) and accepting PLWHAs as their Imams (r=0.101; *p*=0.081). However, on the other hand, that of accepting alms from them was low (weak) but positive and significant (r=0.341; *p*=0.000), thus suggesting that

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education of the Moslem has a significant role to play in their religious relations with PLWHAs albeit low or weak.

The results (Table 4.15) also shows that over 68% of their attitudes in terms of giving alms, doing prayers and accepting alms from PLWHAs were associated with their level of education. However, their attitude towards PLWHAs in terms of accepting them as Imam was minimally associated with their level of education.

It can therefore be inferred that, the higher the educational attainment of adult Moslems of a community, the more likely their attitude will be positive towards their religious engagement with PLWHAs. The finding is in congruence not only with the results of a study by Sudha et al (2005) and that of Ayaranci (2005) which revealed that literates or well educated individuals were more likely to show more positive attitudes towards PLWHAs than non-literates. However, that of Maswabi and Ngome (2015) study in Botswana showed that the level of HIV and AIDS knowledge was the most important factor associated with stigmatisation towards PLWHAs, which invariably means that people with high level of education were more likely to be tolerant towards PLWHAs than those with less education.

As noted by Oyedeji (1985) literacy education is needed to empower the recipient to acquire indispensable knowledge and skills that will enable them perform more effectively in every societal activity like family planning and HIV and AIDS prevention and management. He also asserted that the more literate a person is, the more they will be able to make meaningful decisions about themselves in the society. In the same light, non-literate or people with low literacy are likely to express negative attitudes towards

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PLWHAs in view of their inability to read and learn more about the disease and erase any myth and misconceptions about its transmissions.

The implication is that literacy, and for that matter formal educational programmes addresses or erases people's perceptions and attitudes as they readily have access to relevant information and knowledge on the modes of transmission of the disease. This does not only erase people's fear of the disease but also reduce or eliminate the stigma towards PLWHAs

ii. Sex and Social Relations

The correlation results from the study in Table 4.17 showed a weak positive relationship between the sex of the Moslems' respondents and their social relations with PLWHAs (r, ≤or 3). It also indicated that both male and female Moslems were willing to attend social events, marry, allow their children to attend same school with PLWHAs' and visit them when they are sick which were positive and significant. The co-efficient of determination was less than 32% which implies that over 70% of their attitude in social relations was associated with other factors other than sex. Thus, sex has less influence on social relations or interactions with PLWHAs. Only 20% of the Moslems will stigmatise or discriminate socially based on their sex. This has implications for education and advocacy .They will irrespective of their sex socialise or interact with PLWHAs.

The above findings are not in tune with Al- Owaish et al (1999) results, which reported that the association between the sex of respondents and their attitude towards PLWHA was significant.

One of the reasons that may probably have accounted for the attitude of Moslem respondents towards PLWHAs in social engagement is their faith and beliefs in Allah.

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This stemmed from the fact that Moslems general attitude towards the sick, which include the disabled and PLWHAs for that matter, is influenced by their faith and their religious beliefs and practices. Some of the basic principles which influence their attitude are the belief in fate or destiny ('qadar') and concept of 'reward and punishment.' As stated by Hasnain et al (2008), the belief in fate or destiny supports the idea that 'what is meant to be, will be, and what is not meant to happen will never occur' (Quran 9:51). Following from this, sickness in whatever form, could be seen as Almighty Allah's act and an aspect of the individual's 'qadar' or destiny. Thus, believing in destiny is by extension believing in Allah and His divine wisdom and plan.

ii. Age and Social Relations

A weak but positive relationship was found of the age of Moslem respondents and their willingness to attend social events with PLWHAs, embrace them and allow children attend the same school with theirs as significant, while the rest were insignificant as in Table 4.19. This implies that that though there is a positive influence or relationship between the age of the Moslems and their attitude towards PLWHAs in socialization the relationship is not strong, and it also brings out the fact that age has a differential influence on their attitude towards PLWHAs in the varied social engagements such as marriage, sharing of household utensils and visiting PLWHAs when ill.

The basis for such a cordial and warm reception of PLWHAs in the area of the related social activities might be attributed to the fact that mere bodily interaction with PLWHAs is not a source of HIV and AIDS infection. This therefore means that attendance to school with children of PLWHAs does not constitute a threat once it is the

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parents and not their children who are infected. Such a move will in no small measure make the child happy and enhance their dignity.

This will definitely impact on the emotional and psychological well-being of PLWHAs since their rejection has the tendency to lead to negative outcomes for emotional and behavioral health, which include depression. Furthermore, they will exhibit withdrawal syndrome such as shyness, passiveness and maladaptive behaviours especially in the eye of Moslem females.

The results of the computed co-efficient of determination was less than 24% implying that age has limited influence in relation to attitudes towards social being that over 75% of their attitude towards PLWHAs in social engagement was due to other factors and not age.

The age of the Moslem respondents and their social engagements with PLWHAs are not significantly related as each group may socialize based on specific issues that relate to their personal lives although younger and very old people may religiously exhibit discriminatory attitudes towards PLWHAs.

The middle adulthood stage is a very active one where members are engaged in productive family raising as well as in active work. In view of their working life such people are bound to come into contact with all categories of people where they will learn a lot and gain experience in matters related to social engagements and interactions, which include PLWHAs. As a result of their knowledge, they will not hesitate to interact with them so as to give them confidence, which will also lead to empathy and comfort thereby leading to a meaningful and productive life for them.

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In this light, age is not the main factor that influences the respondents' attitude towards social related activities but probably their attitude as Moslems might have been influenced by some of the core values of the society, which include kindness, fellow–feelings, empathy, togetherness, their personal experiences or observations with PLWHAs, the benefits they stand to gain as espoused by the religious beliefs and practice, which constitute their faith (Islam) when one treats the sick with kind-heartedness as Moslem community members.

ii. Educational level and Social Relations

The correlation study results in Table 4.21 on the relationship between the educational level of the Moslem respondents and their respective social relations with PLWHAs reveals a low or weak but positive relationship. The results (Table 4.21) also show that there is no significant relationship between the educational level of the respondents and sharing the same facilities with PLWHAS (r=0.094; *p*=0.111) and allowing their children to attend the same school with their wards (r=0.032; *p*=0.586).

The extent to which their level of education was associated with positive engagements with PLWHAs in the respective social engagements or relations showed that over 60% of their attitude towards PLWHAS in social engagements or events was associated with other factors or extraneous variables probably their religious beliefs and practices, their social roles or societal norms, their personal experiences with PLWHAs, attribution of responsibility, and level of knowledge of the disease. The results however is at variance with the findings of Kwashie (2014) and Genberg et al (2009), which reveal that education, among other demographic factors, has an influence in determining people's attitude towards PLWHA.

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Another important factor that could have framed their positive attitudes towards PLWHAs is their perception as regards the cause of infection. The general view could be that the PLWHAs source of infection was not attributable to their own responsibility but as a result of external causes they did not have any control over. For that matter, we could not assign blame to them but rather show sympathy by interacting with them in political related activities. This is in line with the attribution theory which states that persons tend to have more sympathy towards an affected person when the causes of an event are traceable to external uncontrollable factors and beyond the individual own responsibility, whilst there is anger or little pity or sympathy if the causes are due to controllable internal factors.

iii. Sex and Economic Relations

An outcome of the results in Table 4.23 on the correlation study of the relationship between the sex of the Moslem respondents and their economic relations with PLWHAs revealed a weak ($r<3$) but positive correlations between the variables. However, with the exception of offering employment to PLWHA ($r=0.089$; $p=0.125$)) which was not significant, the rest of the economic related activities were significant. Both sexes were ready to employ or work with PLWHAs and engage them in trading activities. They will, however discriminate when it comes to patronizing their product. This may be because of the fear that once it is connected with food products, it might be contaminated with the virus, which could infect them with the disease.

The co-efficient of determination was less than 65%.This explains only 35% of their attitude towards PLWHAs in economic engagement was associated with other factors than sex suggesting that sex may likely influence moderately their attitude in economic

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relations or engagement with PLWHAs. Hence, sex has some influence on economic relations or engagement with PLWHAs.

The fact that Moslem respondents were ready to engage in economic related activities with PLWHAs supports the results of Rosabelle's study which established that more than sixty percent (61%) of the respondents would not mind purchasing from PLWHAs. More than 64 percent were willing to transact business with PLWHAs.

This might be explained by the fact that in issues relating to one's economic survival or sustenance, which is trading, Moslems, whether males or females will not show unfair or bad feelings towards PLWHAs. They will definitely want to ensure that their livelihoods are sustained, which is for their self- interest. According to Al-Ghazali and Mohammed (2001) striving for the sustenance is required. It is part of human nature to earn a livelihood for him or herself as well as for the dependant.

iii Age and Economic Relations

As regards the relationship between the age of the respondents and their attitude towards the respective economic engagements with PLWHAS such as readiness to offer employment and accept employment from PLWHAs, trade with them and consumption of their products, the results (Table 4.25) revealed a positive but weak and insignificant relationship.

The extent of influence of their attitude towards PLWHAs in the respective economic related engagement by age in Table 4.25 was less than 20%. In other words, only 20% of the Moslems' attitude towards PLWHAs in economic relations was associated with their age. These findings suggest strongly that when it comes to economic issues other

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considerations could be more influential than that of age. This finding is inconsistent with those of Lau's study in Hong Kong and Letamo's in Botswana which revealed a significant relationship between the age of respondents and attitudes towards PLWHA.

Age is not significantly related to economic engagement with PLWHAs in view of the fact that respondents were ready to engage in trading no matter their age. This finding therefore suggest strongly that the age of the Moslem does not matter when it comes to economic issues but other considerations such as profits and investment he/she intends to accrue from the PLWHAs .

iii. Educational level and Economic Engagement

An outcome of the correlation analysis of the relationship between the level of education of the Moslems respondents and their attitude towards on economic-related relations issues in Table 4.27 revealed a weak but positive and significant relationship. The computed coefficients of determinations of the respective economic-related engagements results (Table 4.27) show that over 60% of their attitude towards PLWHAs in economic related activities was associated with other factors or extraneous variables and practices such as the their personal experiences or observations of the lifestyles of PLWHAs, the social norms of the Moslem community, their learning experiences and knowledge of the disease as well as religious beliefs and practice and not education.

Thus, this implies that there is a positive and significant correlation but weak and minimal association or influence of education of the Moslem respondents on their attitudes towards economic related engagements with PLWHAs. Moslems will moderately discriminate economically based on their educational level.

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Another reason that could be responsible for their attitude is the nature of occupation of the respondents. Apart from agriculture, trading or buying and selling are other occupations undertaken in most Moslem communities including that of the study area. The said trading is undertaken by all categories of educational levels, ages and sexes. In view of the fact that it serves as their main source of income, respondents will do whatever they could to transact or engage in business with anybody no matter the status of the person involved, including PLWHAs In this case, the level of education of the Moslem has no relation or discrimination when it comes to business or commerce.

iv. Sex and Political Relations

On the relationship between sex of Moslem respondents and their political activism or engagement with PLWHA, the study (Table 4.29) found a weak but positive and insignificant relationship. This implies that though there was a positive influence of sex on the attitudes of Moslems towards PLWHAs in political relationship it was not strong($r<3$).

The computed co-efficient of determination results (Table 4.29) also indicated that less than 20% of all the political engagements were associated with sex. This therefore implies that over 80% of Moslems respondents' attitude towards PLWHAs in terms of political relations or engagement was due to other factors and not sex.

Moslem females are ready and willing to elect a PLWHA as an assembly person compared to their male counterparts who will not discriminate in voting a PLWHA as a Member of Parliament. However, they will share the same opinion when it comes to electing PLWHA as an Imam or Chairperson of an event.

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This implies that at least there is limited differential level of engagement with PLWHAs by both sexes of the Moslem respondents when it comes to political related engagement.

iv. Age and Political Relations

An outcome (Table 4.31) of the correlation analysis between the age of Moslem respondents and their respective political engagements with PLWHAs revealed a very weak and insignificant relationship with respect to their political engagement such as readiness to elect PLWHAs as an assembly member (r = 0,082; p= 0.158), Member of Parliament (r=0.075; p=0.194) as well as a chairperson for an event (r=0.050; p=0.390). The implication is that there is a relationship between the age of the Moslem and their attitude towards PLWHAs in political participation. The extent of influence of their attitude towards the respective political engagements with PLWHAs by age in Table 4.31 showed that it was less than 35%. This implies only 30% of the attitude of the Moslems towards PLWHAs in political related issues can be attributed to or explained by other factors other than age. The other factors could be linked to the cultural and traditional values in relation to honesty, loyalty, empathy, the Moslems' personal experiences and their expectations from such an action or person as well the beliefs and practices of the religion.

This has a serious implication for participation of PLWHAs in the political arena since it is an important component of every society, which provides the opportunity for individuals to make known their opinions and beliefs known. The most important ingredient in political participation is electing or voting for someone or putting yourself up to be elected or voted for a political position. It is important to state that that those

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who fail to participate due to neglect or exclusion are likely to be denied certain benefits, which include the ability to influence policies that will inure to their benefit.

iv. Education level and Political Relations

The correlation distribution of level of Moslems education and attitude towards PLWHAs political engagements or activities with PLWHAs, as presented in Table 4.33 showed a weak but positive and insignificant relationship. The results (Table 4.33) of the coefficients of determination were less than 28%. This implies that only 20% of their attitude towards PLWHAs in political engagement was associated with education. Educational level has less influence on political relations or interactions with PLWHAs as Moslems will discriminate politically. Moslems will discriminate politically irrespective of their educational level.

All in all, it could be concluded that there was a significant influence of Moslems socio-demographic characteristics on their attitude towards PLWHAs, and for that matter, stigma and discrimination in terms of religious, social, economic and political engagement. There was however, insignificant relationship between the sex of Moslems and their attitude towards PLWHAs in political relationship as well as the age of Moslems and their attitude towards PLWHAs in economic engagement.

5.3. Identified teachings of Islam that support Moslems Non-Stigma and or Positive Attitudes towards PLWHAs

The study findings in Table 4.34 showed that a dominant majority (over 96%) of the respondents found it non-Islamic to discriminate against PLWHAs by advancing many varied teachings and tenets of Islam. Thus, showing of compassion, love and care to the

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sick, visiting of the sick as well as praying for the sick were the teachings upheld by the dominant majority of the Moslem respondents that influenced their attitudes towards PLWHAs.

The respondents said that the religion enjoins all Moslems to always visit and show love to the sick and that explains why it is not Islamic to stigmatise PLWHA as these statements and quotations from the Quran and Hadith illustrate:

'As a practicing Moslem, you have to show love and kindness towards the sick people. The prophet Mohammed (S.A.W) entreated all Moslems to visit the homes of the sick' ('Male, 31-55, Sissala East)

'It is also reported in one of the Hadith that the prophet in addressing those with illnesses and disabilities told them that no Moslem who is pricked with a thorn or anything larger than that will expect anything except that a hasanah will be recorded for him and a sin will be erased as a reward for that'. (Mallam, 56 above, Wa Municipality)

> "There are five duties that the Moslem owes to his brother", one of which is visiting the sick". Another version states that "The rights of one Moslem over another are visiting the sick'' and "Feed the hungry, visit the sick and free the captives". (As narrated by Abu Hurayra in Saheeh Bukhari as what the Prophet (PBUH) said)

The Moslem respondents mentioned the significance and reward of visiting the sick and afflicted:

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> "On the day of Resurrection, God the Almighty and Majestic will say: "O child of Adam! I became sick and you did not visit me!' The person will say, 'O Lord, how can I visit you and you are the Lord of all that Exists! ''…Did you not know that if you visited him, you would have found me with him?'' (Saheeh Muslim).

> "... And do not let the hatred of a people prevent you from being just. Be just; that is nearer to righteousness…' (Holy Quran Chapter 5:8)

> "God does not forbid you to be kind and equitable to those who have never fought against your faith nor driven you out of your homes. In fact God loves the equitable "(Quran 60.8)

The respondents apart from the above also made other references which include the first verse of the Holy Quran 'Iqra' which encourages reading:

> 'Proclaim or read in the name of the Lord and Cherisher, who created. Created man, out of a leech like clot. Proclaim and your Lord is most Bountiful, He who taught the use of the pen. Taught man that which he knew not.'(HQ 96:1-5).). (An Imam, Wa Municipality).

Adhering to the Islamic teachings and practices and following Allah's guidance may not show any discriminatory tendencies towards the sick and especially PLWHAs. It is reported by Abu Hurayrah that the Messenger of Allah (Mohammed) said: Do not envy one another; do not outbid one another, do not hate one another, do not shun one another……..It is a serious evil for a Moslem that he should look down upon his

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brother Moslem. All things of a Moslem are inviolable for his brother in faith; his blood, his wealth and his honour' (An English /Arabic teacher, Wa West District).

This is an indication that Moslems should consider themselves as the same people who should treat one another fairly and there should not be hatred or discrimination based on one's situation or condition such as his faith, socio-economic, tribe and health status. From the view point of Islam, all people are equal and it is against the tenets of the religion to discriminate or treat someone with disrespect. In this light the sick are to be treated with respect and not shunned because of their peculiar health condition.

They also made references to worship during the daily and Friday prayers in the mosque where equality is practically demonstrated with no signs of discrimination and differences. Any adherent who first enters the mosque take his place in the front rows notwithstanding his financial or social status and whoever went late will find himself in the back or last rows. Thus, the rich and poor, the knowledgeable and non-knowledgeable, the short and tall, the black and white, the stout and lean all find themselves in the same row. This is even manifested clearly during the Hajj and Umrah pilgrimage where everyone is expected to wear simple white clothes, which equates the rich and poor, the ruler and ruled all walking around the Holy Kaaba seeking favour from one Lord. All these are suggestive to the fact that as far as the religion is concerned, there is no discrimination and all Moslems are equal before the Lord.

The respondents also made reference to the prophet who once refused to pray against the people of At-Ta'if for once stigmatising and injuring him, though Allah gave him the opportunity to take revenge for their injustices against him. This calls for religious tolerance and forgiveness.

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From these responses, it can be inferred that the Moslems believed that discrimination contravenes the teachings of Islam and for that matter; Islam frowns on such an attitude – stigmatising and discriminating against PLWHAs. Notwithstanding this, there was a very insignificant minority who held the opinion that Islam favours stigmatisation and discrimination against PLWHAs. Some of their responses include:

'The sick especially PLWHAs are people who disobeyed their creator, Allah and are therefore being infected with the disease' (Female, 31-55years, Sissala West)

'Islam believes that sick people and for that matter PLWHAs are cursed from Allah due to disobedience and negligence of their duties as Moslems' (A male Arabic teacher 31-55years Wa West)

'Islam frowns on fornication and adultery and those who are sick, PLWHAs are being punished for going against the teachings of Islam' (Female,18-30years,Wa Municipality).

This stance and generalization is problematic in view of the fact that it is not all PLWHAs who might have been infected through bad ,immoral and unacceptable life styles .For instance others might have acquired the disease through no fault of theirs such as through birth, blood transfusion, breastfeeding and other means beyond their control.

Moslem Respondents' views on Disclosure of HIV and AIDS Status

Disclosure of one's HIV status is one important factor in mediating stigma and discrimination towards PLWHAs and is influenced by both individual and societal attitudes and beliefs and perceptions surrounding HIV and AIDS. Disclosure has positive and negative consequences. While it can lead to less social isolation and increased social support, it can also result in rejection, blame, abandonment, isolation, verbal and

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physical abuse and withdrawal of financial support (Kalichman et al; 2007; Sowell et al 2003).

The majority of Moslems will not disclose their status or that of community member to an Imam (64%), relative (72.2%) or any other community member (78%) as in Table 4.35. This is surprising as Imams are regarded to be trustworthy, able to keep secrets and not expose people's bad behaviour to others either through sermons or preaching. They will neither disclose the identity of an HIV positive relative or community member. The study also established that Moslems disagree with health professionals disclosing the identity of an HIV and AIDS person to their colleague health professionals or their relatives. It is however remarkable that Moslems will seek medical care for PLWHAs.

The decision of non-disclosure of their status or those of other community members may probably be due to fear of stigma and discrimination that will result with its accompanying effects of identity crisis, rejection, blame, abandonment of the person and ridicule, marginalization, disgrace, sense of discomfort and social disgrace of the concerned family. This corroborates Kalichman et al (2007); Sowell et al (2003) and Fatoki (2016) studies which assert non-disclosure to be associated with fear of negative consequences such as rejection, blame, abandonment, isolation and withdrawal of financial support. This as Fatoki, (2016) indicated "a spoiled identity that often cuts the stigmatized person off from the society and from himself so that he stands as a discredited person against an unaccepting world' p638. The effects of disclosure are so terrible for HIV persons which makes it a difficult thing to do as exemplified by this statement of a pregnant woman : "Telling my husband I have HIV is too heavy to come out of my mouth" in a qualitative study by Rujumba, Neema, Byamugisha, Tylleskar,

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Tumwine and Heggenhougen (2012). It is however important to state that some disclosure can lead to less social isolation and enhanced social support.

Sex by Disclosure of HIV status

An outcome of the study (4.36) on the relationship between disclosure of HIV status and sex of Moslems revealed significant differences in terms of sex and disclosure of HIV status among the Moslems except disclosure of HIV people's status to other health professionals from their colleagues (males $\bar{x}$ =2.61; females $\bar{x}$ =1.8) and relatives (males $\bar{x}$ =2.8; females =1.9). This suggests that males would likely favour health professionals revealing the status of HIV positive to fellow health professionals and relatives than females. The reason could be that males by their nature are 'care free', not very emotional but honest and will always want to face the reality than their female counterparts, who are very emotional, strong-will, easily discouraged and do not trust people. Moreover; they feel that revealing the status to other health professionals will assist in providing the necessary health care support since other categories of health professionals and relatives also have a role to play in the management of the disease. Based on the important role of relatives in the care and management of HIV illness and the patients, it is appropriate to inform the relatives so that they can take the necessary care of the person. This is similar to Fatoki (2016).

Age by Disclosure of HIV status

The age of the Moslems and interest to disclose his/her status or any other person or seek medical support for an HIV positive person showed that there was no significant relationship. The implication is that Moslems will disclose or not disclose their status based on the circumstances due to fear of stigma and discrimination. This places

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emphasis on the true teachings of the religion, which focuses on treatment of the sick and how Moslems should relate with each other either in times of sorrow or happiness is very critical in encouraging disclosure. This fits into the model where the personality of the individual counts in the formation of attitudes towards a person positively or negatively.

Educational level by Disclosure of HIV status

The study indicates that in terms of educational level and disclosure of HIV status there was no significant association between education and disclosure or otherwise of HIV status as shown by the probability levels (Table 4.38). Thus, depending on the situation, Moslems at any educational level will or will not reveal their HIV status. This will probably heighten the level of isolation.

The fact that people will not disclose has serious implications for the spread of the disease. Moslems could be encouraged to disclose their status if the community is very accommodating and very inclusive of all persons without rejecting persons who are HIV positive. An accommodating community can be realized if they have adequate knowledge about HIV transmission because persons or communities that lack knowledge about HIV transmission are positively associated with negative perceptions of HIV and AIDS. It was encouraging that Moslems of all educational levels would support or help their close relations affected by HIV and AIDS to seek medical attention.

Effects of Disclosure of HIV status on the Individual

Disclosure of HIV status, which affects the individual, the relatives and community as a whole plays a double-edge role as far as stigma and discrimination is concerned. It can lead to positive consequences as well as negative effects for both the individual and

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associates. The results of the study (Table 4.39) showed that disclosure results in isolation of the individual HIV positive person as stated by almost 30 percent of the Moslems, suicidal tendencies (20.8%) and depression (19.5%). Apart from these, the study also cited early death, loss of hope with its attendant emotional trauma and low self -esteem.

The relatives and community are not spared the effects of disclosure as revealed in Table 4.40. The dominant effects as mentioned by the Moslems are isolation, embarrassment and shame. The relatives will also face economic and employment challenges, withdrawal of care and support, a feeling of guilt and loss of respect and above all psychological problems. The findings are in congruence with Fatoki's (2016) study which indicated among others mental disorders like depression, low self-esteem, isolation and feeling of hopelessness due to disclosure and its associated stigma and discrimination.

The implication is that it will affect the management of the disease since persons of HIV positive will delay in the diagnosis and entry into the treatment regime, which will ultimately affect the adoption of a healthy life style.

5.4. Identified Strategies for Reducing HIV and AIDS Stigma and Discrimination

Against the backdrop of the negative and dire effects of stigmatisation not only on the PLWHA but also the family, community and the society as whole in respect of health, education, economic, social and religion, the need for coming out with strategies to mitigate and prevent these effects was appropriate. The outcome of the study therefore produced strategies regarding the respondents' views of addressing or reducing HIV and

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AIDS related stigma and discrimination, which include among others the call for Imams, Sheiks and Mallams to intensify and refocus their teachings on what the Quran or Hadith espouse on what a true Moslem ought to observe in terms of the treatment, discrimination or stigmatisation of the sick.

Mallams, Sheiks and Imams are the teachers of the faith and their words of encouragement and sympathy or empathy could reduce stigma and discrimination positively. Their co-option and training as resource persons and educators by government and NGOs into reducing HIV and AIDS related stigma and discrimination may assist in sensitizing and conscientising the Moslem community on stigma and discrimination as well as encouraging moslem clerics to always focus their sermons during Fridays (Jummat) and other special prayers like the Eid ul Fitr and Eid ul Adha on the importance of showing love and compassion to the sick, especially PLWHAs.

Other strategies suggested were for a public policy to be legislated to ensure that HIV and AIDS related stigma and discrimination be incorporated in the curriculum and made examinable in all Arabic schools (Makaranta)at all levels. This will ensure that children are provided with the right information on HIV and AIDS related stigma and discrimination and how to relate positively with PLWHAs.

In addition, the Moslems are to socialise with, show love and care to PLWHAs to facilitate acceptance, and for that matter reduce HIV and AIDS related stigma and discrimination. Interestingly, but not surprisingly, all the suggested strategies are largely but plans to reduce HIV and AIDS related stigma and discrimination through attitudinal change by persuasion, critical self-examination, motivation, self-regulation and knowledge dissemination to overcome myths and misconceptions. This lends support to

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the role of adult education in empowering individuals and groups to realize their own selves (Coombs, 1985).

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CHAPTER SIX

SUMMARY, CONCLUSION AND RECOMMENDATIONS

6.1 Introduction

This chapter is a summary of the study on attitudes of Moslems in the Upper West Region towards persons living with HIV and AIDS (PLWHAs) and how these attitudes have been influenced by their beliefs and practices and their demographic characteristics. It draws conclusion and presents recommendations based on the findings of the thesis. It also covers the contribution to knowledge and an agenda for change as well as implications of the study for adult education.

6.2 Summary of the Study

Several studies in Ghana on stigma and discrimination have contended that it has been the bane of fighting the reduction and elimination of HIV and AIDS; Mills (2003); Mwinituo and Mills (2006), Adoo-Adeku, Badu-Nyarko, Kwashie & Benneh (2010), Ayiworoh (2016).

However, little or no study or data exists on the influence of beliefs and practices of Moslems on their attitudes towards People living with HIV and AIDS (PLWHAs), particularly in the Upper West Region. In view of this, the study sought to find out the extent to which the beliefs and practices and socio-demographic characteristics in terms of sex, age and educational level of Moslems in the Upper West Region have influenced their attitudes towards people living with HIV and AIDS regarding their religious, social, economic and political engagement.

To achieve the study objective, it employed Thomas Weiner's Attribution theory as its theoretical foundation and the cross sectional survey research design. With the aid of

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structured interview schedules as well as the multi stage, incidental and purposive sampling techniques, the primary data was gathered from 300 (178 males and 122 females) Moslem respondents from three sampled districts namely Wa Municipality, Wa West and Sissala East. Pearson correlation co efficient and the chi square test statistics as well as descriptive statistics (mean scores, standard deviation, frequency counts, percentages and cross tables) were also employed to analyse significance, the extent of relationship and or influence.

To help minimise the negative impact of HIV and AIDS related stigma and discrimination, the study recommended that:

- Moslem leaders teachings should be centered on what Islam espouses on attitudes towards the sick and vulnerable, especially PLWHAs.
- Adult education institutions (National Commission on Civic Education, Institute of Local Government Studies, Department of Adult Education, University of Ghana and the District Assemblies) should organise training programmes to educate and sensitise religious leaders, tutors and students of Islamic educational institutions to enable them accept the sick, especially PLWHAs.
- Moslem leaders, National Commission on Civic Education and District assemblies should organise education and training programmes for Moslem communities to help reduce HIV and AIDS related stigma and discrimination.

The study also expanded the attribution theory of Bernard Weiner (1974) to include religious beliefs and practices as its contribution to knowledge.

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6.3 Summary of the Study's Findings

6.3.1 Extent of Beliefs and Practices of Moslems attitudes towards PLWHA in Religious, Social, Economic and Political Relations

In relation to the study's findings, the results established that Moslems attitude towards PLWHAs was positive and to a large extent, influenced by their beliefs and practices.

6.3.2 Extent of Influence of Moslems' Socio-Demographic Characteristics on their Attitude towards PLWHAs

There was also a significant relationship between the socio-demographic or personal characteristics (sex, age and educational background) of the Moslems and their attitudes towards PLWHAs in relation to religious, social, economic and political engagement.

6.3.3 Teaching of Islam that influence Moslems attitude towards PLWHAS

Showing of compassion, love and care to the sick, visiting of the sick as well as praying for the sick were the teachings upheld by the dominant majority of the Moslem respondents that influenced their attitudes towards PLWHAs

6.3.4 Disclosure and its Effects on the individual, Family and Community

Most Moslem respondents will not disclose their status or that of community member to an Imam or any other community member due to fear of stigma and discrimination, which carries in its trail a sense of isolation with its attendant depression, embarrassment, low self-esteem and suicidal tendencies .

It is important to state that against the backdrop of the significant role of civil society organisations and independent media not only in the dissemination of information on developmental issues but also bringing to the fore ills of the society as well as

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championing the rights of the vulnerable and marginalized such as PLWHAs in the society, calls for the urgent need of collaboration among the Moslem leaders, civil society organisations and the independent media in terms of sensitisation, education and advocating the rights of PLWHAs as a way of eliminating stigma and discrimination against PLWHAs. This will certainly go a long way to encourage Moslems to disclose their status.

6.3.5 Strategies for reducing HIV and AIDS related Stigma and Discrimination

Education was seen as the strategic tool in reducing HIV and AIDS related stigma and discrimination among Moslems. Education and Training programmes or/and workshops should focus on the teachings of positive attitudes based on the teachings on the treatment of the sick as espoused in the Quran and Hadith.

6.4 Conclusion

Based on the findings of the study, it can therefore be concluded that to a large extent, religious beliefs and practices of Moslems have been found to significantly influence their attitudes towards PLWHAs, and for that matter stigma and discrimination. This assertion of the study is in congruence with the teachings or pillars of Islam and Quranic verses that encourage Moslems to be compassionate, caring, show respect and equity, loving and sociable with persons who believed in the faith: Islam. This is also evident and particularly observed by all practising Moslems during the daily and Friday (Jummat) prayers.

Apart from the beliefs and practices of the Moslems, their socio-demographic and personal characteristics have been found to have had a significant influence on their attitude towards PLWHAs and for that matter, stigma and discrimination. There was

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however, insignificant relationship between the sex of Moslems and their attitude towards PLWHAs in political relationship as well as the age of Moslems and their attitude towards PLWHAs in economic engagement. The differentials in attitudes of Moslems towards PLWHAs observed by the study may be due to varied capacity building or education or sensitization.

The Islamic teachings in the Quran and Hadith that were focused on compassion, love and care to the sick, visiting of the sick as well as praying for the sick were key in influencing the Moslems' attitudes towards PLWHA. Thus therefore re-echoed the need for all Moslems to be educated and sensitised on the tenets of Islam.

6.5 Contribution to knowledge

Based on the findings of the study, the attribution theory of Bernard Weiner (1974) was found to be necessary but not sufficient in explaining the attitudes of the Moslems towards PLWHAs. The study has contributed to the expansion of the theory by adding the influence of religious and practices.

The attribution theory posits that controllable and internal factors and uncontrollable and external factors influence peoples' attitude towards an event, action or person. Thus, if the cause of an event, action or situation (e.g. HIV and AIDS) is traceable to controllable and internal factors, society will have less pity, sympathy and unwilling to offer any support and hence express negative attitudes to the person,

On the contrary, if the action, event or situation occurs as a result of uncontrollable and external factors, society will show more pity and sympathy and therefore willing to support and show positive attitude.

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The study has expanded the attribution theory to include the influence of religious beliefs and practices as a variable. Thus, people particularly Moslems attitude towards an event, action or situations such as chronic health conditions, particularly HIV and AIDS will be greatly influenced by their religious beliefs and practices. :

$$\mathbf{AT} = f(Ci+Ue)$$

$$\mathbf{EAT} = f(Ci+Ue+RB\&P)$$

AT-Attribution Theory; **EAT**-New Attribution Theory; **Ci-** Controllable internal factors **Ue-** Uncontrollable external factors; **RB&P**- Religious Beliefs and Practices

6.6 Recommendations

Against the backdrop of the study's findings, these recommendations are made for adult education and related institutions for knowledge, theory and practice as well as for future research.

6.6.1 For Institutions

To help minimise the negative impact of HIV and AIDS related stigma and discrimination, the study recommended that Moslem leaders' teachings should be centered on conscientising their congregants on what Islam espouses on attitudes towards the sick and vulnerable, especially PLWHAs.

To enable those Moslems who stigmatise and discriminate against PLWHA overcome their negative attitudes, it is recommended that adult education institutions (National Commission on Civic Education, Institute of Local Government Studies, Department of

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Adult Education, University of Ghana and the District Assemblies) plan and organise regular training and education programmes in collaboration with the Moslem leaders for the Moslems in the communities on the teachings and tenants of Islam that espouse or advance compassion, care and love of the sick .

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6.6.2 Development of knowledge

Given the limitation of Weiner's theoretical framework in explaining the Moslems' attitudes towards stigmatising PLWHAs, it is recommended that the beliefs and practices as well as their socio-demographic characteristics be considered alongside the attribution theory variables (internal controllable and external uncontrollable factors) to understand fully attitudes towards PLWHAs.

6.6.3 For Further Research

The study further recommends three areas for further Research:

It is recommended that a study be conducted using same research objective and questions on a wider scale to include all regions on the extent of Moslems beliefs and practices have influenced their attitudes towards PLWHAS.

I. Social demographic characteristic of practicing Christians and their attitude towards PLWHAS in Upper West Region.
II. A comparative study on Moslem and Christian Religious leaders' attitude towards PLWHAS in Upper West Region.
III. An assessment of the impact of Religion on stigma and Discrimination against PLWHAS.

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APPENDICES

Appendix A: Questionnaire

UNIVERSITY OF GHANA

SCHOOL OF CONTINUING AND DISTANCE EDUCATION

TOPIC: ATTITUDES OF MOSLEMS ON HIV AND AIDS RELATED STIGMA AND DISCRIMINATION IN UPPER WEST REGION, GHANA

STRUCTURED INTERVIEW SCHEDULE FOR MOSLEMS IN THE UPPER WEST REGION

Introduction: The survey is meant to collect data on the opinions of practicing adult Moslems on the extent to which their beliefs and practices as well as their socio-demographic characteristics have influenced their relations with Persons living with HIV and AIDS (PLWHAs) in the religious, social, economic and political aspects. The study is solely for academic purposes, a Ph.D. thesis, and participants are assured of confidentiality of any information provided and can withdraw as and when desired.

Name of District /Municipal

…….

Section A: Socio-Demographic Characteristics

1. Age Range: (years)
   18 – 30 years (1)
   31 – 55 years (2)
   56 above (3)

2. Sex:
   Male (1)
   Female (2)

3. Educational Background:
   No formal Education (1)
   Basic Education (Primary -JHS) (2)
   Secondary Education (3)
   Post-Secondary (Nurse, Agric. Ext, Teacher etc.) (4)
   Tertiary Education (Polytechnic, University (5)

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Section B: Beliefs and Practices of Moslems and Attitudes towards PLWHAs

4.Will a person living with HIV and AIDS still continue to have faith in Allah (God) or spiritual forces ? Yes (1) No (2)

5. Give reasons for your answer

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6. Should a PLWHA attribute his /her condition destiny or supernatural forces? Yes (1) No (2)

7. Give reasons for your answer

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8. What is your opinion about a PLWHA fasting during the month of Ramadan?

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9. How will you relate with a PLWHA who stay in the same house with you?

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10. What are your views about a PLWHA undertaking the pilgrimage to Mecca?

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11. In your opinion do you think HIV and AIDS related stigma and discrimination towards PLWHAs is real? Yes (1) No (2)

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I Religious Related Activities with Persons Living with HIV and AIDS:

As a practising Moslem, please indicate in Table 1.1 the religious related activity (ies) that you do with PLWHAs?

Table 1.1: Religious Related Activities

No	Religious related Activities with PLWHAs	Yes(1)	No (2)
12	Perform Prayers		
13	Give alms		
14	Accept alms		
15	Accept as an Imam		

ii. Social Related Activities with Persons Living with HIV and AIDS:

As a practising Moslem, please indicate in Table 1.2 the social related activity (ies) that you do with PLWHAs?

Table 1.2: Social related Activities

No	Social related Activities with PLWHAs	Yes(1)	No (2)
17	Attend social events i.e. (weddings, funerals etc.)		
18	Marry		
19	Embrace		
20	Shake hands		
21	Share same utensils		
22	Sleep in same room		
23	Children attend same school with theirs		
24	Visit them when sick		

iii. Economic Related Activities with Persons Living with HIV and AIDS:

As a practising Moslem, please indicate in Table 1.3 the economic related activity (ies) that you do with PLWHAs?

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Table 1.3: Economic related Activities

No	Economic related Activities with PLWHAs	Yes(1)	No (2)
25	Offer employment		
26	Accept employment		
27	Trade		
28	Consumption of their products/produce		

iv. Political Related Activities with Persons Living with HIV and AIDS:

As a practising Moslem, please indicate in Table 1.4 the political related activity (ies) that you do with PLWHAs?

Table1.4: Political related Activities

No	Political related Activities with PLWHAs	Yes(1)	No (2)
29	Elect as an Imam		
30	Vote as an Assembly Member		
31	Vote as a Member of Parliament (MP)		
32	Vote as a Chair person of an event		

Section C: Assessment of Moslems Respondents' Beliefs and Practices on their Attitudes towards PLWHAs

i. Very large extent (5), ii. Large extent (4), iii. Uncertain (3), iv. Very Small extent (2), v. Small extent (1).

Please, indicate in the Table below the extent to which your beliefs and practices as a Moslem have influenced your attitude towards PLWHAs in the respective related activities.

Question No.	Areas the Moslems relate with PLWHAs	Very large extent (5)	Large extent (4)	Uncertain (3)	Very Small extent(2)	Small extent (1)
	A: RELIGIOUS RELATIONS					
33	Perform Prayers					
34	Give alms					
35	Accept alms					
36	Accept as an Imam					
	B: SOCIAL RELATIONS					
37	Attend social events					
38	Marry					
39	Embrace					

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40	Shake hands					
41	Use same utensils					
42	Sleep in the same room					
43	Children attend same school with theirs					
44	Visit them when sick					
	C: ECONOMIC RELATIONS					
45	Offer employment					
46	Accept employment					
47	Trade					
48	Consumption of their products					
	D: POLITICAL RELATIONS					
49	Elect as Imam					
50	Vote as an Assembly member					
51	Vote as a Member of parliament					
52	Vote as a Chairperson of an event					

Section D: Islam and Attitudes towards PLWHAs

53. As a practising Moslem, do you think it is Islamic to stigmatise or discriminate against the sick especially PLWHAS? Yes (1) No (2)

54 If Yes to question 45, please give or state the teachings of the Quran/Islam that support your answer

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55. If No to question 45, please give or state the teachings of the Quran/Islam that support your answer.

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. Please, in the Table below answer the questions using **5= Strongly agree; 4 = Agree; 3 =Neutral 2 =Disagree; 1 = Strongly disagree**

NO	STATEMENT	5	4	3	2	1
56	I will disclose my identity if I am HIV positive to an Imam					
57	I will disclose my identity if I am HIV positive to a relative					
58	I will disclose the identity of a relative who is HIV positive					
59	I will disclose the identity of a community member who is HIV positive					
60	I will seek help for a relative who is HIV positive in a hospital					
61	Health professionals should disclose the status of HIV patients to their colleague health professionals					
62	Health professionals should disclose the status of HIV patients to their relatives					

Please answer the following questions as vividly as you can

63. What will be the effect of stigmatization and discrimination on a person living with HIV and AIDS?

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64. What do you think will be the effect of stigmatization and discrimination on the relatives of a person living with HIV and AIDS?

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SECTION E: Suggestions /Strategies for Reducing Stigma and Discrimination against PLWHAs

65 In your opinion, what do you think should be done to reduce or eliminate stigma and discrimination against PLWHAs in your community?

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Thank you

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UNIVERSITY OF GHANA

SCHOOL OF CONTINUING AND DISTANCE EDUCATION

TOPIC: ATTITUDES OF MOSLEMS ON HIV AND AIDS RELATED STIGMA AND DISCRIMINATION IN UPPER WEST REGION, GHANA

STRUCTURED INTERVIEW SCHEDULE FOR MOSLEMS IN THE UPPER WEST REGION

Introduction: The survey is meant to collect data on the opinions of practicing adult Moslems on the extent to which their beliefs and practices as well as their socio demographic characteristics have influenced their relations with Persons living with HIV and AIDS (PLWHAs) in the religious, social, economic and political aspects. The study is solely for academic purposes, a Ph.D.thesis, and participants are assured of confidentiality of any information provided and can withdraw as and when desired.

Name of District /Municipal

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Section A: Socio-Demographic Characteristics

1. Age Range: (years)
   18 – 30 years (1)
   31 – 55 years (2)
   56 above (3)

2. Sex:
   Male (1)
   Female (2)

3. Educational Background:
   No formal Education (1)
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   Post-Secondary (Nurse, Agric. Ext, Teacher etc.) (4)
   Tertiary Education (Polytechnic, University (5)

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Section B: Beliefs and Practices of Moslems and Attitudes towards PLWHAs

4. Will a person living with HIV and AIDS still continue to have faith in Allah (God) or spiritual forces /? Yes (1) No (2)

5. Give reasons for your answer

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6 Should a PLWHA attribute his /her condition destiny or supernatural forces? Yes (1) No (2)

7 Give reasons for your answer

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8. What is your opinion about a PLWHA fasting during the month of Ramadan?

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9. How will you relate with a PLWHA who stay in the same house with you?

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10. What are your views about a PLWHA undertaking the pilgrimage to Mecca?

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11. In your opinion do you think HIV and AIDS related stigma and discrimination towards PLWHAs is real? Yes (1) No (2)

I Religious Related Activities with Persons Living with HIV and AIDS:

As a practising Moslem, please indicate in Table 1.1 the religious related activity (ies) that you do with PLWHAs?

Table 1.1: Religious Related Activities

No	Religious related Activities with PLWHAs	Yes(1)	No (2)
12	Perform Prayers		
13	Give alms		
14	Accept alms		
15	Accept as an Imam		

ii. Social Related Activities with Persons Living with HIV and AIDS:

As a practising Moslem, please indicate in Table 1.2 the social related activity (ies) that you do with PLWHAs?

Table 1.2: Social related Activities

No	Social related Activities with PLWHAs	Yes(1)	No (2)
17	Attend social events i.e. (weddings, funerals etc.)		
18	Marry		
19	Embrace		
20	Shake hands		
21	Share same utensils		
22	Sleep in same room		
23	Children attend same school with theirs		
24	Visit them when sick		

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iii. Economic Related Activities with Persons Living with HIV and AIDS:

As a practising Moslem, please indicate in Table 1.3 the economic related activity (ies) that you do with PLWHAs?

Table 1.3: Economic related Activities

No	Economic related Activities with PLWHAs	Yes(1)	No (2)
25	Offer employment		
26	Accept employment		
27	Trade		
28	Consumption of their products/produce		

iv. Political Related Activities with Persons Living with HIV and AIDS:

As a practising Moslem, please indicate in Table 1.4 the political related activity (ies) that you do with PLWHAs?

Table1.4: Political related Activities

No	Political related Activities with PLWHAs	Yes(1)	No (2)
29	Elect as an Imam		
30	Vote as an Assembly person		
31	Vote as a Member of Parliament (MP)		
32	Vote as a Chair person of an event		

Section C: Assessment of Moslems Respondents' Beliefs and Practices on their Attitudes towards PLWHAs

i. Very large extent (5), ii. Large extent (4), iii. Uncertain (3), iv.Very Small extent (2),
v. Small extent (1).

Please, indicate in the Table below the extent to which your beliefs and practices as a Moslem have influenced your attitude towards PLWHAs in the respective related activities.

Question No.	Areas the Moslems relate with PLWHAs	Very large extent (5)	Large extent (4)	Uncertain (3)	Very Small extent(2)	Small extent (1)
	A: RELIGIOUS RELATIONS					
33	Perform Prayers					
34	Give alms					
35	Accept alms					

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36	Accept as an Imam					
	B: SOCIAL RELATIONS					
37	Attend social events					
38	Marry					
39	Embrace					
40	Shake hands					
41	Use same utensils					
42	Sleep in the same room					
43	Children attend same school with theirs					
44	Visit them when sick					
	C: ECONOMIC RELATIONS					
45	Offer employment					
46	Accept employment					
47	Trade					
48	Consumption of their products					
	D: POLITICAL RELATIONS					
49	Elect as Imam					
50	Vote as an Assembly member					
51	Vote as a Member of parliament					
52	Vote as a Chairperson of an event					

Section D: Islam and Attitudes towards PLWHAs

53. As a practising Moslem, do you think it is Islamic to stigmatise or discriminate against the sick especially PLWHAS? Yes (1) No (2)

54 If Yes to question 45, please give or state the teachings of the Quran/Islam that support your answer

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55. If No to question 45, please give or state the teachings of the Quran/Islam that support your answer.

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. Please, in the Table below answer the questions using **5= strongly Agree; 4 = Agree; 3 =Neutral 2 =Disagree; 1 = strongly disagree**

NO	STATEMENT	5	4	3	2	1
56	I will disclose my identity if I am HIV positive to an Imam					
57	I will disclose my identity if I am HIV positive to a relative					
58	I will disclose the identity of a relative who is HIV positive					
59	I will disclose the identity of a community member who is HIV positive					
60	I will seek help for a relative who is HIV positive in a hospital					
61	Health professionals should disclose the status of HIV patients to their colleague health professionals					
62	Health professionals should disclose the status of HIV patients to their relatives					

Please answer the following questions as vividly as you can

63. What will be the effect of stigmatization and discrimination on a person living with HIV and AIDS?

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64. What do you think will be the effect of stigmatization and discrimination on the relatives of a person living with HIV and AIDS?

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SECTION E: Suggestions /Strategies for Reducing Stigma and Discrimination against PLWHAs

65 In your opinion, what do you think should be done to reduce or eliminate stigma and discrimination against PLWHAs in your community?

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Thank you.

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