

Assessment of Stigmatization and Coping Strategies of People Living with HIV/AIDS in Taraba State, Nigeria

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Abstract. The study assessed Stigmatization and coping Strategies of People Living with HIV/AIDS in Taraba State, Nigeria. Two objectives, two research questions and one hypothesis guided the study. Descriptive cross-sectional survey design was used for the study. The population for the study comprised all people living with HIV/AIDS in Taraba State. A sample of 749 people living with HIV/AIDS was selected using proportionate sampling technique. The instrument used for data collection was a 30 item self-developed questionnaire. Analysis of data was done using frequency count, percentages, and inferential statistics of chi-square was used to test hypothesis. Results showed that People Living with HIV/AIDS experienced different levels of Perceived 42 (5.6%) internalized 452 (60.3%) and enacted stigma 255 (34.0%). Majority of PLWHA were Coping well 426(56.9%), 317(42.3%) were coping very well and lastly 6(0.8%) are coping with difficulty. Significant relationship exists between stigmatization and coping with HIV/AIDS χ^2 (111.079) df (4) $p < 0.05$. The study recommended that PLWHA and their relations require education on the consequences of stigmatization and means of coping with the disease. There is need for provision of HIV/AIDS counseling and testing with other HIV/AIDS services in all health facilities in Taraba State.

Key words: Assessment, Stigmatization, People living With HIV/AIDS and coping strategies

1. Introduction

Stigmatization in the concept of this study is a mark of shame, disgrace or disapproval that results in an individual being shunned or rejected by others. Stigmatization is a hidden burden because PLWHA who experienced stigma are often rejected by friends, relatives, neighbors and employers leading to aggravated feelings or rejection, loneliness and depression. PLWHA experienced denial of equal participation in family life, normal social networks and productive employment. Stigma has a detrimental effect on PLWHA as regards to disclosure of diagnosis, finding access to care and acceptance in the society (Boyd, 2008). Boyd (2008) further reported and ascribed the cause of stigmatization experienced by PLWHA to include myths, misconceptions and negative stereotypes about HIV/AIDS held by many people in the communities. Stigma are in three levels, they are (1) felt or perceived stigma (2) Internalized and (3) enacted stigma. Felt or perceived stigmatization is the mental process of becoming aware or recognizing an object or idea, is a primary cognitive rather than affective. Internalized is an aspect of being cautious by an individual with the ailment, while enacted stigma is the aspect of people in the community knowing the problem and thus employing all

sorts of stigmatization. These levels make PLWHA become secrecy, develop depression and thus withdraw from social activities. Stigmatization is a significantly discrediting attribute possessed by a person with an “undesired difference (Goffman, 1963) in the concept of this study is a powerful means of social control applied by marginalizing, excluding and exercising power over PLWHA who display certain traits as seen by the stigmatizers. Jacoby (1994) reported that enacted stigma is an actual experience of stigmatization, that Felt stigma often precedes enacted stigma and may limit the extent to which the later is experienced; for example PLWHA are aware that PLWHA have been treated badly by others and so will conceal their serostatus this will free them from been stigmatized and discriminated in certain events and issues; at least for certain period. The impact of psychosocial challenge in form of stigma experienced by women in many developing countries is particularly acute. Women are often economically, culturally and socially disadvantaged and lack equal access to treatment, financial support and education. In a number of societies in the study area, most times women are mistakenly perceived as the main transmitters of sexually transmitted diseases (STDs) together with traditional beliefs about sex, and transmission of other diseases. These beliefs provided basis for further stigmatization and discrimination of women (Jacoby,1994) Network of People Living with HIV/AIDS in Nigeria, (NEPWHAN) (2011) reported that psychosocial challenge in form of HIV- related stigma is a barrier to accessing HIV prevention, treatment and care services. The study reported that stigma is prominent and persistent part of life in people living with HIV/AIDS. The survey involved 706 PLWHA in rural areas and villages (60%, n = 424) and urban area (40%, n = 282) across 12 states of Nigeria. One in three respondents had been excluded from social, religious or family meeting in the past year. Half of the population felt that stigma and discrimination faced by PLWHA is due to fear of infection through casual contact. In a study conducted by NEPWHAN (2011) reported that some forms of psychosocial challenges experienced by PLWHA originated from

stigmatization; that 28% (n= 202) of respondents have been refused accommodation, while 29%, (n = 185) have lost job or source of income. Most of these people attributed this to their HIV status. Fear of being the subject of gossip was mentioned by 54% (n = 381) of respondents, with 35%, (n = 244) fearing harassment and 28% (n =196) fearing physical assault. Feeling ashamed 53% (n = 376) feelings of low self-esteem because of HIV status and guilt about being HIV positive affected 44% (n= 311) with 39% (n = 244) avoiding clinic while 12% (n = 84) avoiding hospitals. Additionally 29% (n= 204) decided not to have children. Adeyi, Kanki and Odutolu, (2006) stigmatization is the sign or mark placed on a person or group that sets them apart as different from the rest of the society. The stigma attached to individuals can be extended to those who associate with them. The stigma that a person with HIV carries becomes a liability only when the society declares it so. Brown (1999) explained the reasons for stigma in AIDS: that AIDS was considered invariably fatal, the predominant impression was that HIV infection was as a result of deviant and stigmatized behaviors such as homosexual practice, sex work, drug use as well as sex outside marriage and promiscuity. The identification of already stigmatized group as „high risk“ increased their vulnerability to stigmatization. Green, (2003) stated that stigmatization associated with HIV/AIDS prevents PLWHA from seeking evaluation and treatment, disclosing the diagnosis to the people most likely to provide support and in following treatment guidelines. While there are many illnesses such as leprosy that have been severely stigmatized in the past, it is generally agreed that HIV/AIDS is the most stigmatized psychosomatic medical condition in the history of mankind. Oruonye, (2011) reported that while some societies elevate the status of those receiving treatment for some conditions such as cancer or serious injuries as heroes, those infected with HIV are subjected to layers upon layers of stigma with assumptions that PLWHA deserve punishment for their “assumed behaviors that led them to get HIV” and they are often shunned in Taraba State. Bakari, (2014) reported that stigmatization prevents women living with HIV/AIDS in Nigeria and

particularly in Taraba State, (the study area) from disclosing their HIV status, seeking medical care and other HIV/AIDS preventive services, it also prevents adhering to treatment follow up. Fear of divorce, social abandonment and losing intimate partners prevent many PLWHA from sharing the diagnosis with their loved ones and sexual partners. Stigma has become a major reason why HIV epidemic continues and many more people are getting infected, some are dying with HIV every year not because of the disease but because of stigmatization (John, 2014). Brown, (1999) reported the reasons for stigma in HIV/ AIDS as in their research finding: that it was considered invariably fatal, the predominant impression was that HIV/AIDS infection was as a result of deviant and stigmatized behaviors such as homosexual practice, sex work, drug use as well as sex outside marriage and promiscuity. Human Immunodeficiency Virus and Acquired Immune-Deficiency Syndrome (HIV/AIDS) is one of the most challenging public health issues facing the world today because of its morbidity and mortality fears created in the minds of People Living With HIV/AIDS and their relations such as anxiety, feelings of insecurity, and guilt lead to experiencing psychosocial challenge such as stigma (Iliyasu, Abubakar, Kabir and Aliyu, 2007) Infection by HIV leads to Acquired immune Deficiency Syndrome (AIDS) which is the clinical name of the disease resulting from the infection of HIV, with symptoms that are non- specific and can include constant fatigue, night sweats, weight loss, constant diarrhea and colouring of the hair. This stage of the ailment (AIDS) is the most difficult stage when People Living With HIV/AIDS (PLWHA) think deeply as whether they will survive, will they be accepted by family members, friends or colloquies in work place this often results to self-stigma and stigmatization from the society (TASACA,2013). Stigma is a psychosocial challenge that refers to unfavorable attitude, beliefs and policies directed towards people living with HIV/AIDS as well as their loved ones, associates, social groups and their communities. People living with HIV/AIDS in Taraba State experience sadness, because they face stigmatization from their families, other

people around and also at health facilities by health workers (Okembo & Odimegwu, 2004)

Folkman and Lazarus (1984) Coping refers to cognitive and behavioral efforts to master reduce or tolerate the internal or external demands that are created by stressful situations. In this study, forms of coping strategies like emotion focused and problem focused coping strategies help to reduce or tolerate psychosocial challenges like stigmatization, rejection and shame that people living with HIV/AIDS encounter. The two types of coping strategies serve two major functions in people living with HIV/AIDS they perform regulatory and management functions. Patterson, Semple ,Temoshok, Atkinson, McCutchan, Straits-Troster, Chadle, and Grant (1993)defined coping as conscious rational ways of dealing with the anxieties of life, in their finding they identified two major ways of coping which include: (i) Problem- Focused-Coping: which are efforts to do something active so as to alleviate stressful circumstances. (ii) Emotion-Focused Coping involves efforts to regulate the emotional consequences of stressful or potentially stressful events. Researches indicated that people use both types of coping to combat most stressful events (Folkman and Lazarus 1980, 1988; Carver, Scheier and Weintraub, 1989). The predominance of one type of coping over another is determined, in part by personal style (for example some people cope more actively than others) and also by the type of the stressful event; for example, people typically employ problem-focused coping to deal with potential family – related problems (discrimination and stigmatization of PLWHA in a family). Whereas stressors perceived as less controllable such as certain kinds of physical health problems (withdrawal) prompt more emotion-focused coping. Reeves, (2001) reported that self-help group is both problem-focused and emotion focused coping as the principles and functions of both strategies are applicable. PLWHA who joined self-help support benefits from it as it provides edification of the public and less and less depression will be recorded. Most research on coping with chronic stress tends to focus inquiry on strategies that help the person manage stressor-related demands. In the case of coping with a

debilitating illness like HIV/AIDS, the search often focuses on strategies that are related to managing the primary consequences of the illness, including disease-related limited mobility, pain, or dysphonia, and the secondary consequences of the illness, including disrupted family relationships or changes in role functioning. NEPHWAN (2011) reported that the lives of people with a debilitating illness consist of more than just their illness. They may have warm family relationships, friends with whom they talk, or work or other activities that interest them. These other aspects of people's lives may play an important role in sustaining their well-being while they are coping with their illness. NEPHWAN (2011) further added that a full understanding of the coping process in the context of this study may need to take into account aspects of people's lives that impose new habits such as: frequent visits to doctors, undergoing long treatment, medication intake, undergoing several examinations, difficulty in dealing with the disease, as well as changes in family life. What is required by PLWHA in order to cope with the situation includes: creating conducive atmosphere and good inter personal relationship, encourage PLWHA to join associations, involve them in communal activities, encourage them to participate in recreational activities, browsing, reading newspapers, watching television, are therapies that have immediate coping effect (Brown, 1999).

2. Objectives

The objectives of this Study were to determine:

- (i) Levels of stigmatization of people living with HIV/AIDS in Taraba State, Nigeria?
- (ii) Coping strategies of people living with HIV/AIDS in Taraba State, Nigeria?

3. Research Questions

The following research questions were answered:

- (i) What are the levels of stigmatization of people living with HIV/AIDS in Taraba State Nigeria?
- (ii) What are the coping strategies of people living with HIV/AIDS in Taraba State, Nigeria?

4. Hypothesis

There is no significant difference between stigmatization and coping of people living with HIV/AIDS in Taraba State, Nigeria.

5. Materials and Method

The research design for this study was descriptive cross-sectional survey that involved administration of questionnaire designed by the researchers. Njodi and Bwala (2010) explained that descriptive cross-sectional survey is used to gather data at a particular point in time with the intention of describing the existing conditions or identifying standards against which existing conditions can be compared. Burns and Grove (2001) explained that descriptive cross-sectional survey provides accuracy in that it describes what exists and the frequency with which it occurs, assigns new meaning to phenomenon, and add information into categories. The researchers adopted descriptive cross-sectional survey because of its appropriateness to the topic as it revealed current challenges and issues related to HIV/AIDS such as; stigmatization and means of coping with HIV/AIDS used by people living with HIV/AIDS in Taraba State, Nigeria.

6. Population and Sample

The population for this study was made up of all people living with HIV/AIDS in the sixteen (16) Local Government Areas of Taraba State, Nigeria. It is assumed that this set of people living with HIV/AIDS who have reached the AIDS stage and have experienced stigmatization in the family, community, health facility, and in places of work. Respondents for the study who formed the sample are registered members of people living with HIV/AIDS, selected from eight (8) Local Government Areas (LGAs) out of sixteen LGAs in the state attending fourteen health facilities. . The sample for the study was 750 which are 15% of the 4996 of PLWHA in the eight sampled LGAs. The sample was drawn through the use of probability proportion to size sampling technique (the probability proportion to size depends on the population of people living with HIV/AIDS). The selection of the sample was based on Ogbazi and Okpala's, (1994) assertion that 15% of a population was to be selected if it is up to 1,000 and will serve as representative sample in a study. The

instruments (questionnaire) were administered and retrieved on that day by the researcher and research assistants who were focal persons at each health facility. Before the administration of the questionnaire at each health facility, respondents were informed of the purpose of the research and the ethical issues to maintain.

7. Results

Table 1: Levels of stigmatization of PLWHA in Taraba State (n = 749)

VARIABLE	TOTAL
Levels of stigmatization	Perceived Internalized Enacted
	42(5.6%) 452(60.3%) 255(34.0%) 749(100.0%)

Table 1 is a summary of frequency and percentage distribution on stigmatization of people living with HIV/AIDS in Taraba State, Nigeria. The result showed that 452 (60.3%) majority of PLWHA had internalized stigmatization, 255(34.0%) suffered from enacted stigmatization while 42(5.6%) experienced perceived stigmatization. The implication of the result is that PLWHA in the study area require more education, integrated care and strategies to prevent further spread of HIV among the populace.

Table 2: Stigmatization and coping with HIV/AIDS by PLWHA in Taraba State (n=749)

Levels of coping	Levels of stigmatization			df	χ ² value	p-value
	Perceived	Internalized	Enacted			
Coping with difficulty	2(33.3%) 12(2.8%)	3(50.0%) 324(76.1%)	1(16.7%) 90(21.1%)	4	111.079	0.000
Coping well	28(8.8%)	125(39.4%)	164(51.7%)			
Coping very well						

Table 2 above is a chi-square analysis on the association between stigmatization and coping with HIV/AIDS among PLWHA in Taraba State. Based on the result of the analysis the null Hypothesis which states that there is no significant difference between stigmatization and Coping with HIV/AIDS by PLWHA in Taraba State was rejected (p<0.05).

8. Discussion

The finding of this study on stigmatization is in agreement with Adeyi, Kanki and Odutolu (2006) who reported that PLWHA experienced stigmatization. The finding also conformed to

the work of Green (2003) who reported that PLWHA face stigmatization and that it prevents them from seeking evaluation and treatment, and disclosing their diagnosis to husbands for fear of divorce. The result of this finding on stigmatization is in line with Jacoby (1994) who reported that women are denied access to care and other HIV/AIDS preventive services for fear of been stigmatized. This finding also agreed with that of Bakari (2014) who reported that stigmatization prevents women in Nigeria and the study area from seeking medical care as they are accused and perceived as transmitters of AIDS. Regarding stigmatization of PLWHA, the study found that perceived, internalized and

enacted stigma was faced by PLWHA in Taraba State, Nigeria. This finding agreed with the study conducted by Boyd (2008) who reported on three levels of stigma. The result of this finding concurred also with Taraba State Agency for the control of AIDS (2013) who reported that stigma act as a barrier to HIV/AIDS prevention. The result of this finding on coping used by PLWHA, found that Emotion focused and problem focused coping were the two types used, some PLWHA used the two types together. This study is an agreement with Folkman and Lazarus (1984) who reported the use of the two types of coping. The finding of this study on coping is in line with that of Reeves (2001) who reported Joining self-help support group, browsing, watching television, Reading newspapers, joining association of PLWHA, and recreational activities are useful coping strategies for PLWHA, th report continued that they are combination of emotion focused and problem focused coping strategies. Likewise Jacoby (1994) who reported that denial, concealing HIV/AIDS status, participation in recreational activities are coping used by PLWHA.

9. Conclusion and Recommendations

This study concludes that stigmatization is a psychosocial challenge faced by PLWHA and has consistent and clinical influence on HIV/AIDS progression. The effects of stigma on both PLWHA, their relations and associates requires mediation through education and positive behaviors change to enable PLWHA cope with the situations they find themselves.

It is recommended that: 1. PLWHA, their relations and associates require to be educated on stigmatization and its affects 2. Provision of more HIV/AIDS services in all health facilities in Taraba State.

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