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Perceived Psychosocial Impacts of Stigmatization and Coping Styles amongst People Living with HIV/AIDS (PLWHA) in Selected Hospitals, Abeokuta, Ogun State, Nigeria

Ajibade, B.L (RN, Ph.D, FWACN)
Ladoke Akintola University of Technology, Ogbomoso, Department of Nursing, FCS, College of health sciences, Osogbo

Oseni, R.E (R.N, RPHN, BNSc)
General Hospital, Abeokuta, Ogun State, Nigeria

Akinpelu, A.O (RN, MSc (N))
Achievers University, Owo, Department of Nursing Science

Abstract
Objective:- HIV/ AIDS stigma and discrimination exist worldwide, therefore this research was to determine perceived psychosocial impacts of stigmatization and coping strategies among PLWHA.**Methodology:-** This is a cross-sectional descriptive study. 240 respondents were selected in two hospitals with multistage sampling technique. Data were collected using COPE and Nottingham health profile apart from demographic characteristics of respondents.**Results:** Respondents' age showed that 30-39 (38.8%) constituted the highest percentage. In terms of gender, females constituted 86.3% while 77.5% were married, traders constituted 66.3%, 72.6% were educated up to tertiary level stigma was considered to be separating oneself from other (30.0%) being avoided/isolated by family, friends, community and health care workers (28.8%), rejection by spouse, family and friends (21.3%. HIV is solely sexually transmitted (13.6%) stigmatization of PLWHA is significantly of PLWHA is significantly related to perceived psychosocial impacts experienced as x^2 > critical valued (p = 0.05). 36.2% agreed that their present health status affect their sex life, home life (22.5%), and work (18.7%) among others. Majority of the respondents agreed to have accepted their status (Mean Score 190.5) were using active and positive coping (mean cores 166.5) and 175.5 respectively such as utilizing religions coping styles (mean score 212.25) among others.**Conclusion:-** It was concluded that government should ensure statutory protection of PLWHA.
Keywords: Stigma, psychosocial, impacts, coping strategies, PLWHA.

Significance : The relevance of coping strategies have a positive role in the management of stigmatization associated with HIV / AIDS. Religion institution should be involved by health care workers as prayers and disclosure were found to be efficacious. Problem discussed is problem solved. Health information and education with HIV / AIDS patients should reinforce prayers and disclosure to significant others.

Dozier, while quoting several authors in her may 28, 2010 blog stated that from time immoral stigma has been a characteristics of numerous diseases parlcualaryl those that are transmitted sexually or terminal diseases stigma has been used in the explanation of an array of varying problems, particularly it has been identified as a major reason behind the reluctance by many individuals to disclose their conditions, go for voluntary counseling and testing and health care. Stigma has also been recognized as a major cause of non-adherence to treatment. It has also been employed in explaining discrimination and negative attitude against people living with HIV/AIDS (PLWHA) (Dozier, 2010). HIV related stigma is a social phenomenon whereby a person is considered to possess a dispelling attribute and thus deem tainted and or flawed by others HIV – related stigma can hinder HIV prevention efforts and inhibit treatment adherence. Recent research had shown that experiences of stigmatization have as advice impact on the psychological wellbeing of people living with HIV/AIDS (PLWHA), manifestations of HIV related stigma vary according to setting certain manifestations in specific social settings impact the psychological well-being of PLWHA more than other (Aggleton, 2002). HIV related stigmatization remains a potent stressor for HIV positive people stigma was associated with depressive symptoms receiving recent psychiatric care, and greater HIV related symptoms stigma was also associated with poorer adherence and more sore status disclosure to people other than sexual partners, but showed no association to sexual risk beheviour it is confirmed that stigma is associated with psychological adjustment and adherence difficulties and is experienced more commonly among people who disclose HIV status to a broad range of social contacts. Although over of HIV related stigma have declined in the past decade nearly me in four Americans reported that they would activity avoid intenerating with a person they knew to be HIV positive (Holzemer & Uys 2004). Hofzemer and Uys (2004); Alonzo, (1995), opined that social discomfort, prejudice, and discrimination and experienced social discomfort, prejudice, and discrimination are experienced in response

to a variety of medical and psychiatric challenges. Barteryergah (2003), went further to say that stigmatizing altitudes and behaviors directed towards HIV positive persons can be especially severe, HIV to them is highly stigmatized because of its historic association with sub-groups of men and women who already experience marginalization within society, including gay men and infection users. Young and Bendavid (2011) stated that among the more than I million PLWHA in the USA, an estimated 25% are unaware that they are infected. They identified potential stigmatization as one of the most notable causes preventing individuals from testing and seeking care, and are of the opinion that people may be reluctant to test because the discovery of a positive HIV test may lead to loss of friendship, family ties, employment and housing, dismissal from school, and denial of health life insurance and health care. An HIV diagnosis can cause family members, neighbours, and even medical providers to shun the HIV infected person (us health resources and services Administration 2003). It wants further to say that the devaluation of identity and discrimination association with HIV related stigma does not occur naturally rather, they are created of individuals, their loved ones, and even the care givers are often subjected to rejection by their social circles and communities when they needed support the most.

They may be forced out of their homes, lose jobs, or be subjected to violence assaults. According to Insideout Report (2003) and Messer et al (2010), drivers of stigma include far, availability and relevance of AIDs related information, lack of social spaces to engage in dialogue about HIV/AIDS, perceived links between HIV/AIDS, sexual moralities and the control of woman and young people, inadequate HIV/ADIS management services, and the ways in which poetry shapes peoples reaction to HIV/AIDS. According to U.S Health resources and services Administration (2003), consequences of stigma include deterioration of interpersonal relations, Negative emotions, rejection of the HIV anybody test, stress related to the hiding of the condition, Anxiety, Depression guilt, loss of support, isolation, difficulties with family dynamics, emotional or physical violence and deterioration of relations with health care providers.

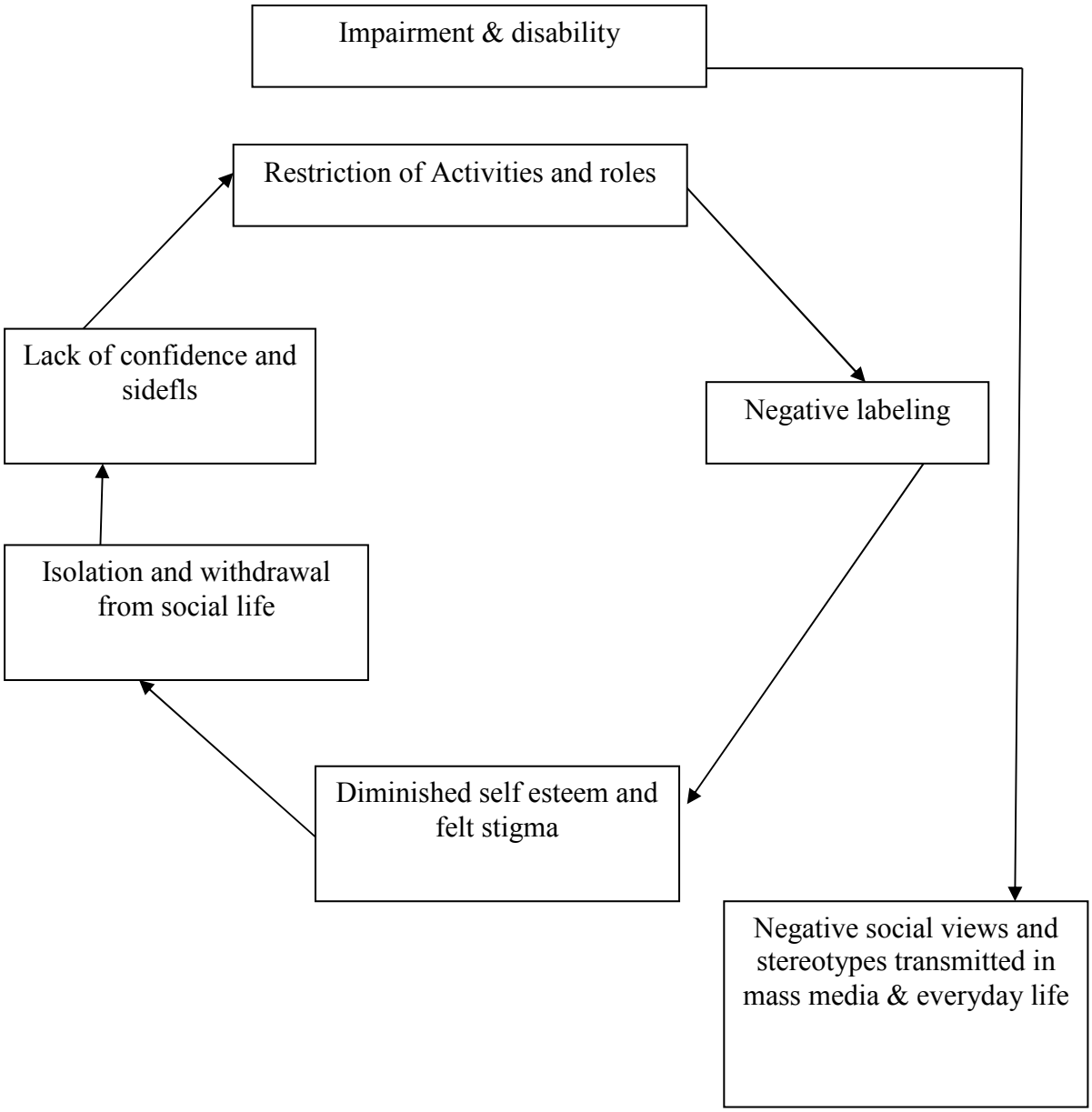
Expenses stigma and discrimination can be very painful. Try not to bottle up your feelings about their experiences, first of all, don't blame yourself remind yourself that stigma and decimation are wrong. If you can talk to somebody close to you that you trust, or make contact with an HIV support organization so that you safety talk through your experiences and feelings (Dealing with stigma and discriminations, www.aidsmap.com/stigmal/deading 16/03/2016. According to Manjunafar (2008), seventeen different self-care strategies were identified in coping with stigma associated with HIV/ADIS restricting, seeing oneself as ok, lifting go, turning to God, hoping, changing behaviour keeping oneself active using humor, joining a support or social group, disclosing one's HIV status, speaking to others to cope with unless, educating others, learning from others acquiring knowledge and understanding about the disease, and getting help from others. He concluded that coping appears to be self taught and only modestly helpful in managing perceived stigma Coetzee and Spangerbeg (2003), documented that problem focused active coping styles were superior to emotion focused, passive coping styles such as avoidance, in reducing psychological distress.

Disclosure was used carefully as a coping strategy, depending on whether it was judge to make things better or worse. Disclosure as a coping strategy was used mostly in situations when the PLWIT thought disclosure might lead to support from spouses and family members (Nyblade et al 2003, inside out report (2003), found that disclosure was the most challenging action to take as many feared being judged, being rejected by a spouse and family monsters and being rejected by the community. However, not all respondents in their study faced negative consequences when they disclosed their HIV status. The participants reported that they felt relieved after disclosing, especially to a spouse or family member, as if something had been lifted from their shoulders. Brown et al (2009) reported that non disclosure, denial, and hiding could also be a way of coping, especially if it protected one from stigma. Majundar (2004) reported that participating in social networks reduced physical and social isolation due to HIV status she reported an example of some women in India who were forced to reside on the custards of their voltages because of their HIV station. However, their social network provided a platforms where all can tell their stories share their pies, chat, an develop friendship several studies (incident report, 2003; Majundar,, 2004; Nyblade et al, 2003) reported. That becoming more religious and getting (import through immersing one's or self in religion was common as a coping strategy. Religion plays a vital role in the care of HIV – infected persons and their families. Religions participation provides spiritual and emotional support, offering religious leaders an opportunity to incorporate ways to reduce stigma in community services. Spirituality emerged as coping strategy in the study and was manifested through prayer, medication and hope in god. Religion as a self-care strategy for HIV has been reported as a strategy for HIV has been reported as a strategy to relieve HIV related symptoms (Chou, Holzemer, Portillo & Slaughter 2004). Collymore (2002) and Horizos Program (2002), reported that HIV infected persons who get counseling, acquired more knowledge, antlered from others, did better than those who adopted passive strategies. The inside out research report (2003), stated that HIV infected participants who experienced supportive environments, such as support of families, religious faith groups, non – governmental organizations such as an AIDs support groups. AIDs training and counseling centers, had success in overcoming internal stigma. The majority emphasized the importance and the value of consents information, and support group in the journey to overcoming the emotional upheavals o

discovering their HIV status counseling and health information have been reported to empower HIV infected person to change risk behavour and to adopt heathery life steeples. Nurse, like other health workers, have been recipients of stigma because they are for PLWHS, and they may also be the sources of stigma (Holzermer & Uys, 2003).

Theoretical framework: The theory that serves as bless of the study is labeling theory by Becker (1963). The theory explains the social basis of deviance by saying that social group create deviance. Appling these rule of dehiscence to individuals or groups means labeling Ram as outsiders or outcast. He goes on to argue that deviance is not a quality that lies in the behavior itself but in the interaction between the person who commits an act and those who respond to it. The drain is therefore the one to who the label has successfully been applied in the case PLWHA

Fig 1: *diagram of impact of labeling and its consequences*



Source: (Taylor & field, 1993). Negative field back between stigmatization self-esteem and participation in social activities

Statement of Problem: HIV/AIDS stigma and discrimination exist worldwide, although they manifest themselves differently across countries, communities, religious groups and individuals. Stigma makes it difficult for people to come to terms with HIV and manage their illness on a personal level but it also interferes with attempts to fight the HIV/ADIS epidemic as a shield AIDS related stigma and discrimination refers to prejudice,

negative attitudes, abuse and maltreatment directed at PLWA. The consequences are wide ranging, being should by family, pears and the wide community, poor treatment in health care and education setting an erosion of rights psychological damage, and a negative effect on the success of HIV testing and treatment (WHO, 2003). Having witnessed what may be teamed stigmatizing behaviors from healthcare workers such as double gloving, only when caring for HIV/AIDS patients' neglecting to care for and outright isolation of PLWHA, this research is set to identify the psychosocial impacts of stigmatization and coping strategies adopted during stigmatization.

Objective of the study: The objectives are to

- Assess the demographic characteristics of respondents
- Determine the knowledge and stigmatizing experience
- Evaluate the perceived impact of stigmatization
- Determine the coping straggles
- Assess relationships between stigmatization and psychosocial impacts

Research Questions: Four research question were answered by the research: They were

- What are the demographic characteristics of respondents?
- What are the knowledge and stigmatizing experiences of requirement?
- What are the perceived impacts of stigmatization?
- What are the coping stipples admitted by respondents?

Hypothesis: only one hypothesis was set in the null form and the same was tested using chi-square (x^2). It states that there is no significant relationship between stigmatization and perceived psychological impacts among PLWHA

Research design

The design adopted for this study was cross sectional descriptive design. This design was adopted for the fact that the researcher only described the variables as occurred in the study and no variable was manipulated.

Research Setting

The settings were Sacred Heart Hospital, Abeokuta a Cooperate Catholic Hospital in Lantoro Area of the Metropolis and Ogun State Hospital, Ijaye, Abeokuta a government owned hospital. The Sacred Heart Hospital was one of the oldest medical hospital in Nigeria. The hospital is a 300 beds capacity Ogun State Hospital, Abeokuta was formerly owned the state government and was handed over to the Federal government of Nigeria on the 21st April, 1983 to serve as tertiary health institution. The two hospitals have facilities for the treatment of PLWHA

Study Population (Participants)

The study population consisted of selected PWLA between the period of November 2015 and March 2016. It consisted of those currently receiving treatment in the out-patients department of the HIV/AIDS clinic of the two selected hospitals. They were selected irrespective of their age, gender, socio-economic status, religious affiliation, ethnic differences and level of education.

Instrumentation

Two standardized instruments were used to collect data from the respondents

Nottingham health profile: This instrument is to provide a brief indication of patients perceived emotional social and physical health problem

The Breakdown of questionnaire :-

Part 1: Consisted of 38 questions in 6 sub areas, with each question assigned weighted value; the sum of all weighted values in a given sub areas – energy level of pain, emotional reaction, sleep, social dissolution and physical abilities

Part 2: 7 life areas affected each questions fixed with 'Yes' or 'No' response. If the patient is not sure whether to say 'Yes' or 'No' to a problem he/she is instructed to answer the one more true at that time.

The second instrument was cope inventory by carver, C.S (2013). The questionnaire asks you to indicate what you generally do and feel when you experiences stressful events. The instrument consisted of 60 items of which the respondents are scored as 1 – 1 usually don't, 2 – 1 usually do this a little bit, 3 – 1 usually do this a medium amount and 4 – 1 usually do this a lot.

The two instruments were administered one after the other to the respondents at each of the clinics with the help of researcher's assistants (3). They have been given that question earlier on for their perusal in order to ensure that they understand the items on the instrument.

The section A of the instrument was on the demographic characteristics of respondents Eight (8) main areas which include the age to the place where the respondents are receiving treatment

Validity and Reliability of Instruments:

The instruments are standardized instrument the content validity of the two main instruments was carried out by a Professor of hematology while the reliability of Nottingham Health profile. Showed coefficient alpha of 0.66 and COPE showed 70% in test retest reliability

Sample Size Determination and Sampling Techniques

The sample size was determined by Tar Taman (1972) sample size determination

$$nt \ \frac{N}{1+N\ (c)^2}$$

Nf = Deserted sample size
N = The universe (Accessible population
I = Constant
C = Level of precision (0.05)

The total population of the patient in the last 6 months in the two hospitals was one thousand and fifteen (1015) with general hospital was 605 while the sacred heart hospital amounted to 410.

$$\text{nf} = \frac{1015}{1+1015\ (0.05)^2} = \frac{1015}{1+2.5375} = \frac{1015}{3.5375}$$

nf = 286.9 = 287

Proportionate sample size was used as follow

- for the general hospital = $\frac{605}{1015}\ x\ \frac{287}{1} = 171$
- for sacred heart hospital = $\frac{410}{1015}\ x\ \frac{287}{1} = 116$

= 171 + 116 = 287.

Therefore 171 respondents were selected from general hospital and 116 respondents were selected at Sacred Heart Hospital

Sampling Techniques: Multistage sampling technique was adopted for the study. All the hospitals in Abeokuta were first cluster by listing them and two of the hospitals that carried out the services for PLWHA were randomly selected through balloting. After which the clinics were visited Wednesdays and Thursdays and respondents were selected through simple randomization using their sitting arrangements.

Two hundred and eighty seven (287) questionnaires were distributed and only two hundred and seventy (270) were returned out of which 30 were not properly filled, hence the sample size remained two hundred and forty (240) respondents

Results

Table 1: Socio Demographic Characteristics of Respondents

From the table 1 above, majority of the respondents are female (86.3%) and the remaining 13.8% were male. 38.8% were between age range of 30-39years, 40-49years (27.5%), 50years and above (20.0%), while 20-29 years (13.8%). 51.3% were Christians and the remaining 48.8% were Muslims, of which 77.5% were married, 11.3% were widow, 7.5% where single, and the remaining 3.8% were divorced. Majority of the respondents had less than tertiary education (with primary and secondary education having 36.3% respectively, HND (13.8%), BSc (75%), MSc (1.3%)and others (illiterate) accounts for the remaining 5.0%. Majority of the respondents had less than tertiary education (7.5%), and the remaining 2.5% were students. Majority of the respondents were diagnosed within the last 5years, 20% 16years and above, 12.5% were diagnosed 6-10years ago, 2.5% were diagnosed between 11-15years ago. 61.3% of the respondents were receiving treatment at state hospital, Ijaye, 2.5% of those attending state hospital are yet to commence medications, while 36.3% receives treatment at sacred heart Hospital, Lantoro.

Table 2: Knowledge and experience of stigmatization

From table 2 above

Stigma was considered to be: being avoided / isolated by family members, friends and neighbors (28%.8%), rejection by family members and friends (21.3%), laid off work (7.5%), separation from spouse (30.0%), receiving unnecessary attention (10.0%), and healthcare worker refusing to render care (8.8%) 76.3% of the respondents said they had not been stigmatized before while the remaining 23.8% said they had been stigmatized out of which 3.8% were stigmatized every time, quite often 5.0% less often and least often 7.5% respectively. They were stigmatized by family members (10%), friends (3.8%), 2.5% by coworker and neighbors respectively, and 5.0% by healthcare workers. Reasons for stigmatization were given as: PLWHA are blamed for predicament (12.5%), HIV/AIDS is considered to be solely sexually transmitted (13.6%), fear of contacting the disease (53.8%), family and friends of PPLWHA are also isolated (3.8%), healthcare workers caring for PLWHA are also considered to be HIC positive (1.3%), non-availability of cure and preventive vaccine (18.8%).

Table 3: **Perceived impact of stigmatization part 1(a)**

From table 3 above, 27.5% of respondents indicated that it took them a long time to get to sleep 31.2% said worry keeps them awake at night 20.0% feels they were a burden to people, 23,7% felt life is not worth living. 17.5% said they find it hard to get along with people. While 31.2% said they do wake up felling depressed.

Table 4: Impacts of stigmatization on state of health (Part 1b)

From table 3 above, 18.7% agreed that their present state of health affects their work, 13.7% were of the option

that it affects looking after the home, affects social life and interest; and hobbies (18.7% respectively), home life (22.5%), sex life (36.2%), and vacations (17.5%).

Table 5: Coping Strategies

From table 5 above; majority of the respondents agreed to have accepted their status with mean score of 190.5; and utilize positive coping (175.5), with religious coping style (mean score 212.25) being the most used, rather thn use alcohol and drug (43.75) to cope with their status.

Table 6: Relationship between stigmatization and perceived psychological impacts

Hypothesis; State thus:- There is no significant relationship between stigmatization and perceived psychosocial impacts on PLWHA

Note:

Level of significance $\alpha = 0.05$

Degree of freedom df = 2

Calculated x^2 value (X^2_c) = 21.26

Table (critical) value $x^2_t = 5.991$

x^2_c > critical value, therefore null hypothesis is accepted

Inference: there is significant relationship between stigmatization and perceived psychosocial impacts on PLWHA.

Discussion: Respondents of ages 30-39 years constituted the highest percentage (38.8%). Most of the respondents are fameless (86.3%). Majority (77.5%) were married. 51.3% of the respondents are Christian, trader constitute 66.3%, in all 72.6% are not educated up to tertiary level. Majority of respondents (65.0%) were diagnosed within 1-5 years ago, 61.3% received treatment at the state hospital while 2.5% are yet to commence medication. Only 21.3% had been stigmatized. Stigma was considered to be – separating oneself from other (30.0%), being avoided/isolated bys family, friends community and health coworkers (28.8%), rejection by spouse family and friends (21.3%), Receiving unnecessary attention (10.0%) refusing to render services by health workers (8.8%), followed by being laid off work (07.5%). Majority (53.8%) were of the opinion that fear of contracting HIV is the reason for stigmatization, followed by non-availability of care and prevention vaccine (18.8%), HIV is solely sexually transmitted (13.6%). This finding were congruent with the findings of USA health resources and services Administration (2003). Stigmatization of PLWAHA is significantly related to preview psychosocial impacts as x2> critical value (P= 0.05) 36.2%, agreed that their present health status affect their sex olive home life (22.5%), and work (18.7%) among others. This finding was in support of Ingrid and Naemah (2013) when they said that HIV/AIDS impasses significant psychological and social burden on men and women. The finding was similar to that of Lucaia et al (2008), claymore (2002) and Faber et al (2003). HIV related stigma affects people ability to earn a living making it even more difficult for them to lift themselves out of poverty majority of the respondents agreed to have accepted their status (mean score 190.5), were suing active and positive coping (men scores 166.5 and 175.5 respectively) such as utilizing reclaims coping style (mean score 212.25), instrumental social support and emotional support (mean scores 137.25) respectively). The above finding were similar to Faber et al (2003), Lucia (2008), brown et al (2001), Collymore (2002), Coetzec and Spangerberg (2003) and Chou et al (2004)

Conclusion: PLWHA who accepts their status are more likely to utilize and positive coping styles, making plans to attain a healthy living though instrumental social and emotional support especially when positive religious coping is used they are better able to cope with their status treatment regimen and complication of both the disease and associated stigma, without resulting to the use of alcohol and drugs to deal within and this will present mental and emotional disengagement

Implication for Mental Health /Psychiatric Nursing Practice

The result of this study stuffiest that PLWHA have at one time or the other experienced stigmatizing attitudes from people (coworkers, friend, family members and other), and health professionals with consequences impacting on their social and psychological interaction such as withdrawal and from social roles, depressions and suicidal thoughts. Nurse such should therefore keep up with the information on the mode of transmission of HIV, co pathetic, eschew stigmatizing and discrimination attitudes toward PLWHA. Ensure PLWHA are giving necessary information on coping techniques in order to prevent frustration.

Recommendation

Consequent upon the results of this research, the PLWHA should be encouraged to disclose their status to their family and enlist the support of the family members. Nurses should be compassionate and understand while carrying for PLWHA and avoid discriminatory altitude toward them. Government should make an enactment / policy informal of statutory protection for PLWHA, compulsory HIV screening by employers for the purpose of screening out the HIV positive employees should be discouraged, religious institutions. Should be involved in the campaign against stigmatization and discrimination toward PLWHA, and social support system should be established and made accessible for PLWHA.

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Table 1: Socio Demographic Characteristics of Respondents

s/no	Items	Frequency	Percentage	Valid percent	Cumulative percentage
1.	AGE				
	20-29	33	13.8	13.8	13.8
	30-39	93	38.8	38.8	52.5
	40-49	66	27.5	27.5	80.0
	50 AND ABOVE	48	20.0	20.0	100.0
	TOTAL	240	100.0	100.0	
2	SEX	**Frequency**	**Percentage**	**Valid percent**	**Cumulative percentage**
	MALE	33	13.8	13.8	13.8
	FEMALE	207	86.3	86.3	100.0
	TOTAL	240	100.0	100.0	
3	RELIGION				
	CHRISTIANITY	123	51.3	51.3	51.3
	ISLAM	117	48.8	48.8	100.0
	TOTAL	240	100.0	100.0	
4	MARITAL STATUS				
	SINGLE	18	7.5	7.5	7.5
	MARRIED	186	77.5	77.5	85.0
	DIVORCED	9	3.8	3.8	88.8
	WIDOW	27	11.3	11.3	100.0
	TOTAL	240	100.0	100.0	
5	LEVEL OF EDUCATION				
	PRIMARY	87	36.3	36.3	36.3
	SECONDARY	87	36.3	36.3	72.5
	HND	33	13.8	13.8	93.8
	BSC	18	7.5	7.5	95.0
	MSC	3	1.3	1.3	100.0
	OTHERS	12	5.0	5.0	
	TOTAL	240	100.0	100.0	
	OCCUPATION	**Frequency**	**Percentage**	**Valid percent**	**Cumulative percentage**
	STUDENT	6	2.5	2.5	2.5
	UNEMPLOYED	18	7.5	7.5	10.0
	TRADING	159	66.3	66.3	76.3
	CIVIL SERVANT	21	8.8	8.8	85.0
	OTHERS	36	15.0	15.0	100.0
	TOTAL	240	100.0	100.0	
	TEAM DIAGNOSED	156			
	1-5YEARS	30	65.0	65.0	65.0
	6-10	6	12.5	12.5	77.5
	16 AND ABOVE	48	20.0	20.0	100.0
	TOTAL	240	100.0	100.0	
	TREATMENT RECEIVES AT				
	SACRED HEART HOSPITAL	87	37.2	37.2	37.2
	STATE HOSPITAL IJAYE	147	61.3	62.8	100.0
	YET TO COMMENCE DRUGS	4			
	TOTAL	240	100	100	

Table 2: Knowledge and experience of stigmatization

	What is stigma	**Frequency**	**Percentage**	**Valid percent**	**Cumulative percentage**
	a.	69	28		
	b.	51	21.3		
	c.	18	7.5		
	d.	72	30.0		
	e.	24	10.0		
	f.	21	8.8		
	Have you ever been stigmatized				
	No	183	76.3	76.3	76.3
	Yes	57	23.8	23.8	100.0
	Total	240	100.0	100.0	
	If yes, how often	**Frequency**	**Percentage**	**Valid percent**	**Cumulative percentage**
	Least often	18	7.5	8.1	8.1
	Less of ten	18	7.5	8.1	16.2
	Quite often	12	5.0	5.3	21.5
	Every time	9	3.8	4.0	25.5
	None	183	76.3	74.5	100.0
	Total	240	100.0	100.0	
	From whom				
	Family member	24	10.0	10.7	10.7
	Friends	9	3.8	4.0	14.7
	Co-worker	6	2.5	2.7	17.3
	Healthcare workers	12	5.0	5.3	22.7
	Neighbors	6	2.5	2.7	25.3
	None	183	76.3	74.6	100.0
	Total	240	100.0	100.0	
	Reasons for Stigmatization				
	a	30	12.5		
	b	33	13.8		
	c	129	53.8		
	d	9	3.8		
	e	3	1.3		
	f	45	18.8		

Table 3: **Perceived impact of stigmatization part 1(a)**

Items	Frequency		Percent	Valid percent	Cumulative percentage
a. Long time to sleep	No	174	72.5	72.5	72.5
	Yes	66	27.5	27.5	100.0
b. Burden to people	No	192	80.0	80.0	80.0
	Yes	48	20.0	20.0	100.0
c. Worries keep then awake	No	165	68.8	68.8	68.8
	Yes	75	31.2	31.2	100.0
d. Felt life not worth living	No	183	76.3	76.3	76.3
	Yes	57	23.7	23.7	100.0
e. Getting along with people	No	198	82.5	82.5	82.5
	Yes	42	17.5	17.5	100.0
f. Wake up feeling depressed	No	165	68.8	68.8	68.8
	Yes	75	31.2	31.2	100.0

Table 4: Impacts of stigmatization on state of health (Part 1b)

Items	Frequency		Percent	Valid percent	Cumulative percentage
a. Work	No	195	81.3	81.3	81.3
	Yes	45	18.7	18.7	100.0
b. Looking after the home	No	207	86.3	86.3	86.3
	Yes	33	13.7	13.7	100.0
c. Affect social life	No	195	81.3	81.3	81.3
	Yes	45	18.7	18.7	100.0
d. Home life	No	186	77.5	77.5	77.5
	Yes	54	22.5	22.5	100.0
e. Sex life	No	153	63.8	63.8	63.8
	Yes	87	36.2	36.2	100.0
f. Hobbies	No	195	81.3	81.3	81.3
	Yes	45	18.7	18.7	100.0
g. Variations	No	198	82.5	82.5	82.5
	Yes	42	17.5	17.5	100.0

Table 5: Coping Strategies

Scale name and items	Scale name and items
Active coping (mean – 166.5) I take addition action to t4ry to get rid of the problem 117 I concentrate my efforts on doing something about it 168 I take direct action to get around the problem 180 I do what has to be done, one step at a time 201	POSTIVE COPING (MEAN 175.5) I look for something good in what is happening 138 I try to see it in a different light, to make it seem more positive 168 I learn something from the experience 207 I try to grow as a person 189
PLANNING (MEAN – 159.75) I try to come up with a strategy about what to do 144 I make a plan of action 174 I think hard about what steps to take 153 I think about how I might best handle the problem 168	ACCEPTANCE (MEAN – 190.5) I learn to live with it 204 I accept that this has happened and that it can't be changed 180 I get used to the idea that it happened 183 I accept the reality of the fact that it happened 195
SUPPRESSION OF COMPETING ACTIVITIES (MEAN-155.75): I put aside other activities in order to concentrate on this 123 I focus on dealing with this problem, and if necessary let other things slide a little 168 I keep myself from getting distracted by other thoughts or activities 158 I try hard to prevent other things from interfering either my efforts at dealing with this 174	RELIGIONUS COPING (MEAN 21.25) I seek God's help 216 I put my trust in God 216 I try to find comfort in my religion 201 I pray more than usual 216
RESTRAINT COPING (MEAN 143.25) I force myself to wait for the right time to do something 153 I hold off doing anything about it until the situat8ion permits 141 I make sure not to make matters worse by acting too soon 150 I restrain myself from doing anything too quickly 129	FOCUSING AND VENTING (MEAN 115.25): I get upset and let my emotion out 122 I let my feelings out 99 I feel a lot of emotional distress and I find myself expressing those feelings a lot 111 I get upset, and am really aware of it 129
USE OF INSTRUMETAL SOCIAL SUPPORT (MEAN-137.25) I ask people who have had similar experiences what they did 126 I try to get advice from someone about what to do 165 I talk to someone to find out more about the situation 129 I talk to someone who could do something concrete about the problem 129	DENIAL (MEAN 153) I refuse to believe that it has happened 105 I pretend that it hasn't really happened 162 I act as though it hasn't ev4n happened 183 I say to myself 'this isn't real' 162
USE OF EMOTIONAL SUPPORT (MEAN 137.25) I talk to someone about how I feel 147 I try to get emotional support from friends or relatives 144 I discuss my feelings with someone 126 I get sympathy and understanding from someone 132	BEHAVIORAL DISENGAGEMENT (MEAN 126) I give up the attempt to get what I want 114 I just give up trying to reach my goal 129 I admit to myself that I can't deal with it, and quit trying 111 I reduce the amount of effort I'm putting into solving the problem 150
USE OF HUMOR (MEAN 107.25) I laugh about the situation 162 I make fun of the situation 90 I make jokes about it 111 I kid around about it 66	MENTAL DISENGAGEMENT (MEAN 160) I turn to work or other substitute 177 I go to movies or watch TV, to think about it less 183 I daydream about things other than this 114 I sleep more than usual 166
ALCOHOL AND SUBSTANCE USE (MEAN 43.25): I drink alcohol or take drugs, in order to think about it less 45 I use alcohol or drugs to make myself feel better 36 I use alcohol or drugs to help me get through it 53 I try to lose myself for a while by drinking alcohol or taking drugs 39	

Table 6: Relationship between stigmatization and perceived psychological impacts
Hypothesis; State thus:- There is no significant relationship between stigmatization and perceived psychosocial impacts on PLWHA

Is your present state of health causing problems with:	Yes	No	Row total	X^2c	df	X^2_t
Social life? (going out, seeing friends, going to movies etc)	45(62)	195(178)	240	21.26	2	5.991
Home life? (relationship with other people in your home)	54(62)	186(178)	240			
Sex life?	87(62)	153(178)	240			
COLUMN TOTAL	**186**	**534**	**720**			

Note:
Level of significance $\propto = 0.05$
Degree of freedom df = 2
Calculated x^2 value (X^2_c) = 21.26
Table (critical) value $x^2_t = 5.991$
x^2_c > critical value, therefore null hypothesis is accepted