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HIV and AIDs Stigma and its Influence on Coping Mechanisms: A Case of People Living with HIV and AIDS within a Rural Set up in Maragua District, Kenya

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Abstract

This paper explores how HIV and AIDs stigma is experienced in rural communities and the mechanisms exercised to cope with it. The research explores the experiences of HIV positive persons within the communities they live in, focusing on the influence of socio economic factors on HIV stigma, ways of coping with the stigma and influence of stigma on coping mechanisms embraced by HIV positive persons. The research interviewed 60 persons living with HIV and AIDS enrolled in support groups in Maragua district in Central Kenya. Ten key informants including nurses, clinicians, professional social workers, and counselors were purposively selected from within the health care facilities HIV and AIDS in the area. Raw data was collected through face to face interviews with the 60 respondents using questionnaires that contained open and close ended questions while an interview guide was used on the key informants. The data was analyzed by the use of statistical package for social scientists (SPSS). The study found that HIV and Aids stigma impact negatively on the health seeking behavior among the HIV positive, and also on their social, political and economic advancement. The study also found that in spite of stigma being complex it is also dynamic in the sense that as people learn more about HIV and AIDS their attitudes change. The paper recommends concerted efforts from key players including people living with HIV and AIDS, the government, local leaders, community and health care providers to ensure raising HIV and AIDS awareness levels and prevention care.

Keywords: HIV and AIDS Stigma, Coping Mechanisms, HIV and AIDS Management, Rural Areas, Murang'a -Kenya

1. Introduction

Since the first case of HIV was diagnosed in Kenya in 1984, there has been a marked improvement in the country to understand the epidemic in terms of its causes, how to prevent its spread and how to treat and manage both HIV and AIDS. The epidemic has fueled demand for preventive and promotion services including condom distribution, prevention from mother to child transmission (PMTCT), blood safety, post exposure prophylaxis (PEP) and voluntary counseling and testing (VCT). Massive awareness and education campaigns have been conducted on modes of HIV transmission, prevention methods and management strategies including use of antiretroviral drugs (ARVS). In spite of these efforts HIV and AIDS stigma remains the most serious problem contributing to continued spread of the pandemic. Generally, stigmatization of a health condition, disease or behavior involves the labeling of the concerned individual as deviating from societal expectations; hence, making him/her feel tainted or inferior (Goffman, 1963) and discriminated against (Gilmore and Somerville, 1994). Unfortunately nearly all Kenyan ethnic traditional cultures rely heavily on belief systems, power relations and psychological pre-dispositions which are very conducive to the practice of stigma. Thus despite there being other modes of transmission such as blood transfusion, exposure to contaminated body fluids among others, HIV infection has been associated with sexual promiscuity. HIV and AIDS stigma could be patterned by social factors that may include gender, rural-urban dichotomy, age, marital status, education level, and socioeconomic status (Yebei et al., 2008; Kenya Demographic Health Survey, 2003). These factors may play a significant role in the manner in which HIV and AIDS stigma is felt by infected persons and how HIV negative persons relate with HIV positive persons. A study comparing stigma among HIV infected persons in rural and urban areas in Kenya found that the major factors influencing HIV stigma were residing in rural areas and being male(Yebei et al. 2008). The study observed that HIV positive persons living in rural areas expressed more felt stigma because of the close knit relationships typical of rural communities as opposed to the diverse relationships generally found in urban areas.

The Kenya Demographic and Health Survey (KDHS 2003) has examined other HIV and AIDS stigma social modifiers such as marital status, gender, age, education level, and socioeconomic status in a study where enacted stigma was measured on four items as follows: willingness to care for a relative who is HIV positive at home; would buy fresh vegetables from a vender with AIDS; believe an HIV positive female teacher should be allowed to teach; and would not want a family member positive HIV status to remain a secret. The study found that discriminatory attitudes towards the HIV infected were higher among women, younger people, less educated, rural dwellers and less wealthy among others.

Persons living with HIV and AIDS may continue to encounter challenges of gaining acceptance by their families and communities once it is realised that HIV is the cause of their illness (Nyblade and Nguer, 2001). HIV positive persons may therefore go on infecting others due to reluctance to know their status while those who know their status may fail to seek treatment and risk infecting others and/or deteriorating their health condition. This may impact negatively on prevention and management strategies in place like voluntary testing, care-seeking behavior upon diagnosis, quality of care given to HIV-positive patients, and disclosure of infection (Herek and Glunt, 1988; Muyinda et al., 1997; Yebei et al., 2008).

Since coping with stigma is the greatest challenge in the management of HIV and AIDS, some mechanisms like counseling, joining a support group, disclosing one's HIV status, embracing positive lifestyles and seeking alternative explanations to being HIV positive have been investigated. These studies have been classified as reactive and proactive, based on how they are exercised and as emotional and problem focused, depending on the specific purpose they serve.

Siegel, Lune and Meyer (1998) argue that HIV positive persons who adopt reactive coping mechanisms may opt to conceal their HIV status within their close networks. Those who are proactive on the other hand may construct and promote alternative views of HIV so as to address societal values, beliefs, practices, and power imbalances behind stigma rather than situations in which stigma might be experienced.

Makoae et al. (2008) define emotional coping strategies as those employed by individuals who seek alternative explanation to HIV infection in order to relieve their negative feelings towards their status. The problem focused mechanisms, on the other hand, are those that could address the problem more directly by engaging with others. This study investigates various mechanisms inclined to any of the perspectives without doing any classifications.

Studies have explained that some coping mechanisms, though deemed appropriate, may not be applicable in certain situations. For instance, disclosure as a coping strategy, can on the other hand lead to HIV and AIDS stigmatization and, thus non disclosure, denial and hiding could also be a way of coping with HIV and AIDS stigma (Brown et al. 2001). However these studies have not exhausted what coping mechanisms are appropriate for every prevailing social circumstance.

1.1 The Impact of Stigma on HIV and AIDS Management

Kenya's HIV prevalence rate remains high (7.1%) with approximately 1.4 million persons living with HIV and AIDS. The greatest burden of disease is in rural areas, where three-quarters of the population live (KAIS 2007; Voeten 2006). The country has however taken a major step forward in the control and management of HIV and AIDS including subsidizing the cost of most HIV related services and offering them at no cost. All government health facilities are now providing HIV and AIDS management to all Kenyans irrespective of their geographic location.

But despite concerted efforts by the government of Kenya to promote accessibility and affordability of HIV services among all persons, there is still a gap in the utilization of these services. According to KAIS (2007) only 39% of the infected persons know their status and are on ARVS, 4% know their status but are not on ARVS, and 57% are do not know their status and are not on ARVS. Such discrepancies could be a result of

limited knowledge on available HIV services, accessibility of certain services in selected hospitals, fear of being seen seeking HIV services, among other reasons.

The fear of stigmatization and discrimination when someone tests HIV positive or seen seeking HIV and AIDS treatment could be a major hindrance to seeking HIV services. Many people have been seen traveling long distances including crossing geographical boundaries far from their community to seek HIV testing, acquire ARVS, and treat opportunistic infections. And HIV counseling and testing services have been offered at night or on a mobile service in homesteads, among other methods, in order to conceal the identities of those seeking the services.

Although much progress has been made to raise knowledge levels about HIV and AIDS and improve related services like testing and treatment, stigma remains a major drawback to these efforts. The multifaceted nature of stigma which is largely attributed to how HIV and AIDS is understood, and the short history of the disease has complicated its control. This is not withstanding how several social factors including demographic and social economic factors influencing HIV and AIDS stigma coping mechanisms; the level of HIV and AIDS transmission knowledge possessed by communities; prevention and management strategies by social support organizations and health care service providers, come into play.

The social factors such as urban - rural dichotomy, age, gender, social economic class, education levels, among others have a great role in influencing HIV and AIDS stigmatization. However, data from available literature shows there are research gaps on what infected persons feel about stigma and on interventions against stigma. This study sought to find out how HIV and AIDS stigma is manifested in rural communities; establish the demographic and socio-economic factors that influence HIV and AIDS stigma; examine the HIV and AIDS stigma coping mechanisms in rural communities; and investigate how stigma influence coping with HIV and AIDS in the rural communities.

1.2 Scope and Limitations of the Study

The study examined how HIV infected persons' internalize felt stigma and enacted stigma. The coping strategies employed to overcome the same were also examined. It also examined stigma from the HIV infected persons perspective as experienced in their life situations and also the mechanisms they exercise to cope with the same. The study concentrated on positive and negative stigma coping mechanisms. The study did not explore other social factors like ethnicity, social class, and interventions addressing stigma that influence stigma and coping mechanisms because they are not highly pronounced in rural areas. The study was limited to the rural environment and the data generated reflect the characteristics that are typical of rural set up and the findings may not apply to populations within the urban environment.

2.0 Methodology

This research used purposive sampling technique to select 60 persons living with HIV and AIDS in Maragua district, Kenya, and 10 key informants including nurses, social workers, and community peer counselors from two local hospitals. The key informants provided in depth information about the subject which was useful in triangulation of views and perceptions generated from persons living with HIV and AIDS. According to Maragua District Strategic Plan (2005 – 2010), HIV and AIDs prevalence rate is estimated at 14% with AIDS related diseases occupying about 40% of all 33 public and mission hospital beds in the district.

Information on how HIV infected persons felt about their status and how other community members perceived them; the coping strategies they embraced to deal with internalized feelings and actions directed to them by those who are not infected; and how stigma challenged their coping mechanisms, was recorded.

Closed and open ended questions were administered to the 60 respondents in face to face interviews within the locations where they held their support group meetings. Key informants were also interviewed at their own convenience. All non verbal clues including inhibited feelings of shame, guilt, bitterness, regrets and

cheating while responding to questions, were recorded in order to reinforce the data generated from the respondent's interviews.

3. Results and Discussions

The focus of the study was to find out the determinants of HIV and AIDS stigma, the social demographic and social economic factors influencing HIV and AIDS stigma, the HIV and AIDS stigma coping mechanisms in rural communities and how stigma influence coping with HIV and AIDS in the rural communities.

3.1 Socio-Demographic Characteristics

Four explanatory variables including sex, age, marital status and religion are discussed in view of the role they play in modifying HIV and AIDS stigmatization. This study population comprised 41 females and 19 males. More than three quarters respondents were aged 30-49 years and only 5% were 18-29 years. The youth were reluctant to join support groups for fear of being exposed to have engaged in premarital sex since HIV contraction is highly associated with sexual promiscuity. Some 61.7% respondents were married, 13.3% were single, 13.3% separated, 10% widowed, and 1.7% living together. Majority of the respondents were Christian (98.3%) distributed across three major denominations of Protestant (38.3%), Pentecostal (30%) and Catholic 30%).

Table 1 Socio demographic characteristics of HIV positive persons

Category	**Frequency**	**Percentage (%)**
Sex		
Female	41	68.3
Male	19	31.7
Totals	**60**	**100**
Age (yrs)		
0-19	1	1.7
20-29	2	3.3
30-39	22	36.6
40-49	25	41.7
50-59	9	15
60-69	1	1.7
Totals	**60**	**100**

Source: Researcher (2010)

3.2 Socio Economic Characteristics

Education is an important socio-demographic/economic factor that largely influences the level of one's income as well as knowledge about HIV and AIDs and how to cope with disease stigma which was the subject of this study. Majority respondents had primary education (63.3%), secondary education (33.3%), and only 1.7% had university education.

Poor people are likely to develop low self esteem because their dependency on others makes them vulnerable to internalization of HIV stigma. More than 63% respondents engaged in farming, 23.3% in small businesses, 6.7% in salaried employment, and 5% in casual labour. More than three quarters of the

respondents earned less than Kshs. 5,000 while only 8.4% earned above Kshs. 10,000 (table 2).

Table 2 Socio economic characteristics of HIV positive persons (1US$=Kshs. 86)

Category	Frequency	Percentage (%)
Education levels		
Primary school certificate	38	63. 6
Secondary school certificate	20	33
University degree	1	1.7
None	1	1.7
Total	**60**	**100**
Occupation		
Farming	38	63.3
Business	14	23.3
Salaried employment	4	6.7
Casual labour	3	5
Total	**59**	**98.3**
Income level per month		
Less than Kshs 1,000	15	25
1000-5000	31	51.6
5,001-10,000	9	15
10,001-15,000	3	5
15,001-20,000	1	1.7
20,001-31,000	1	1.7
Total	**60**	**100**

Source: Researcher (2010)

3.3 Manifestations and Internalization of HIV and AIDS Stigma

In order to gauge manifestation of HIV and AIDS stigma the research assessed how respondents internalized felt stigma at individual level, the experiences they underwent as a group, and the actual discrimination and treatment they faced from the community. More than 88% respondents related closely with others with same HIV status, but 60% respondents reported that their counterparts indicated that they faced treatment that amounted to stigmatization by those not living with the virus.

The respondents were also asked whether - they thought it was their fault to be HIV positive; had irresponsible behavior that lend to contraction of HIV; felt ashamed for being HIV positive; or had poor morals that lend to contraction of HIV. Fifteen percent agreed that it was their fault to contract the virus, 18.3% agreed that they had irresponsible behavior that lend to contraction of HIV, and 18.4% agreed that they had poor morals that lend to contraction of the virus. The respondents were expected to internalize lower levels of stigma because they had lived with the virus for over 2 years and were members of support groups for a similar period. Support groups are avenues where members vent out ill feelings, overcome fears, and get encouragement from fellow persons living with HIV and AIDS. The recorded percentages

reflect a significant level of internalized stigma among the HIV positive persons.

All respondents expressed feelings of loss of hope and despondency due to having acquired unknown disease with uncertain prognosis. They exhibited several broad forms of internal stigma including internalised shame, guilt, and blame for being HIV-positive and feelings of inferiority. The association of HIV with promiscuity made the infected feel they were responsible for acquiring the virus. Self blame lead to self condemnation and made it more difficult for respondents to integrate with other members of the community. This supports the views of Yebei el. al who argued that many persons living with HIV and AIDS still experience felt stigma by considering themselves inferior. Self blame did not only impact on their relationships with others but also on their health. It was also established that they were not fond of openly seeking health services within their location for fear of meeting familiar faces. Key informants revealed that some respondents mingled with other people seeking generalized health services whenever they visited the hospital to avoid being seen visiting the HIV and AIDS specialised units. Others would feign sickness and spend time at the general outpatient areas and pick HIV and AIDS drugs when familiar people leave hospital premises.

3.3.1 Treatment of HIV positive persons by significant others

In response to the question whether HIV positive persons were treated with respect by significant others, 41.7% of the respondents said that their friends were hostile, 38.3% said family members treated them poorly while 25% said their neighbours disregarded them. These percentages are significant because these groups of people were expected to protect the HIV positive persons but were found to subject them to ill treatment. Family members and friends of the respondents were also found to exhibit secondary stigma. For instance all respondents complained that family members preferred to avoid the infected persons, hide them or even force them to leave home. This is consistent with Nyblade and Nguer (2001) who observed that HIV infected persons are denied care and support by families and community members upon realization that HIV is the cause of their illness.

3.3.2 The community's perception about persons living with HIV and AIDS

The respondents were further asked to give their views on what they thought was the community's perception about their status. More than 80% confirmed that persons living with HIV and AIDS were treated differently. All respondents reported that they were excluded from such duties like handling food and washing dishes during social functions, were never lent finances at times of need, and community members gossiped about the respondents whenever they appeared in their midst. Two third respondents believed that community members perceive HIV positive persons to be of poor morals, maintain that infected persons engage in irresponsible sex behaviour that lend to contraction of HIV(58.3%), and think that it is the fault infected persons for being HIV positive (51.7%). These findings show that internalization of HIV stigma is not only about how persons living with HIV and AIDS feel about themselves but also their perceptions about how the community views them for being HIV positive.

3.4 Internalization of HIV and AIDS stigma by Gender

More than 89% males compared to 78% females agreed that HIV positive persons were treated differently. Also 35.3% males compared to 7.3% females felt it was their fault that they contracted HIV; 41.2% of males compared to 10% females agreed they had irresponsible sex behavior that led to contraction of HIV; 20% of males compared to 12 % of females felt ashamed for contracting HIV; and 41.2% of males compared to 9.8% females agreed they had poor morals (tables 3, 4).

Table 3 Internalization of HIV and AIDs stigma by Males

Indicator	Strongly agree	Agree	Neutral	Disagree	Strongly disagree	Totals
It is my fault for being HIV positive	35.3	0	17.6	29.4	17.7	**100**
I had irresponsible sex behavior led to contraction of HIV	29.4	11.8	11.8	23.5	23.5	**100**
I feel ashamed for being HIV positive	13.3	6.7	6.7	20	53.3	**100**
My poor morals led to contraction of HIV	35.3	5.9	11.8	17.6	29.4	**100**

Source: Researcher (2010)

Yebei et al. (2008) argued that being male or female is a major factor that influences HIV stigmatization. Their research found that women disagreed with all stigma items and did not internalize stigma because they did not feel responsible of acquiring HIV virus. Similarly more males agreed to stigma measuring items compared to females in this study.

Table 4 Internalization of HIV and AIDs stigma by Females

Indicator	Strongly agree	Agree	Neutral	Disagree	Strongly disagree	Totals
It is my fault for being HIV positive	7.3	0	4.9	29.3	58.5	**100**
I had irresponsible sex behavior led to contraction of HIV	10	0	2.5	27.5	60	**100**
I feel ashamed for being HIV positive	7.5	5	12.5	20	55	**100**
My poor morals led to contraction of HIV	9.8	0	0	14.6	75.6	**100**

Source: Researcher (2010)

The fact that more men internalize stigma compared to women is evident in this study in which women constitute 68.3% of the respondents in the support groups of persons living with HIV and AIDS. Men were not comfortable to attend support group meetings held at central community grounds for fear of exposing their HIV status. Normally men inhibit more feelings of guilt for being blamed by their families, friends and community at large of being HIV positive. The key informants supported this argument by reporting that male clients were reluctant to seek health services even after recommendation from their HIV positive partners. Most male clients visited the HIV and AIDS care centers after their health broke down and long struggles with their wives. Men would live in denial for long even when tests indicate they had the virus.

3.4.1Internalization of HIV and AIDs stigma by Age of respondents

The age of HIV positive persons played a vital role in patterning stigma (tables 5, 6). The data shows that persons above 50 years internalized more HIV stigma compared to those between 30 and 39 years. A third of respondents aged 50-59 agreed compared to 14.3% of those aged 30-39 years said they had irresponsible behavior that led to contraction of HIV. Similarly 44.4% of those aged 50-59 agreed that they had poor morals that led to contraction of HIV compared to 13.6% aged 30-39. Finally 28.6% respondents aged 50-59 felt ashamed for being HIV positive compared to 9.1% aged 30-39.

Table 5: Internalization of stigma by HIV positive persons aged 30-39

Indicator	Strongly agree	Agree	Neutral	Disagree	Strongly disagree	Totals
It is my fault for being HIV positive	18.2	0	4.5	27.3	50	**100**
I had irresponsible sex behavior led to contraction of HIV	14.3	0	0	33.3	52.4	**100**
I feel ashamed for being HIV positive	9.1	0	9.1	18.2	63.6	**100**
I had poor morals led to contraction of HIV	13.6	0	0	13.7	72.7	**100**

Source: Researcher (2010)

Internalization of HIV stigma by age categories largely rests on social construction of roles according to status occupied by people by virtue of their age, gender, marital status among other social attributes. In every society, each individual member is expected to channel their behaviours according to socially acceptable rules that are specific to the social status they occupy in the society. This explains the difference in internalization of HIV stigma by those above 50 years compared to those below 40 years.

Since HIV infection has long been associated with sexual promiscuity, the elderly who are expected to have decreased sexual activities and the young who are expected to abstain from sex face greater challenge in coping with HIV and AIDS than the sexually active groups. There is a false notion that women in the rural areas are not expected to engage in sex until they get married and this possibly explains the low percentage (5%) of young people enrolled in the support group of persons living with HIV and AIDS. The KDHS (2003) study also found out that age is a factor that influenced stigmatization by those who were not living with the virus since discriminatory attitudes were higher among younger persons aged between 14 and 19 years.

Table 6: Internalization of stigma by HIV positive aged 50-59

Indicator	Strongly agree	Agree	Neutral	Disagree	Strongly disagree	Totals
It is my fault for being HIV positive	33.3	-	11.1	33.4	22.2	**100**
I had irresponsible sex behavior led to contraction of HIV	33.3	0	22.3	0	44.4	**100**
I feel ashamed for being HIV positive	28.6	0	0	14.3	57.1	**100**
I had poor morals led to contraction of HIV	33.4	11.1	11.1	11.1	33.3	**100**

Source: Researcher (2010)

3.4.2 Internalization of HIV and AIDs Stigma by Marital Status

Marriage is a highly respected institution in all Kenyan societies due to the role it plays in reproduction and regulation of sex activities among adults. Although the institution is increasingly getting challenged paving way to single parenthood, the esteem attached to marriage has not completely diminished. The study found that HIV stigma was higher among the married compared to the divorced/separated (tables 7, 8).

Results from this study found that 22.8% of the married persons compared to 12.5% of the divorced/widowed agreed that they had irresponsible behavior that led to contraction of HIV. Some 18.7% married respondents felt ashamed for being HIV positive but none of the widowed/separated persons felt so. And 22.9% married respondents compared to 12.5% of the divorced/separated agreed that they had poor morals that led to contraction of HIV. Again the married internalized more stigma than the separated because society expects the married to be faithful and not to contract HIV.

Table 7: Internalization of stigma by married HIV positive persons

Indicator	Strongly agree	Agree	Neutral	Disagree	Strongly disagree	Totals
It is my fault for being HIV positive	17.2	0	11.4	25.7	45.7	**100**
I had irresponsible sex behavior that led to contraction of HIV	17.1	5.7	5.7	31.4	40.1	**100**
I feel ashamed for being HIV positive	12.5	6.2	9	29.3	43	**100**
I had poor morals led to contraction of HIV	20	2.9	2.9	20	54.2	**100**

Source: Researcher (2010)

Table 8: Internalization of stigma by HIV positive persons who are divorced/separated

Indicator	Strongly agree	Agree	Neutral	Disagree	Strongly disagree	Totals
It is my fault for being HIV positive	12.5	-	0	25	50	**87.5**
I had irresponsible sex behavior that led to contraction of HIV	12.5	0	12.5	12.5	62.5	**100**
I feel ashamed for being HIV positive	0	0	12.5	12.5	75	**100**
I had poor morals led to contraction of HIV	12.5	0	12.5	0	75	**100**

Source: Researcher (2010)

The research was informed that females walked out of marriage upon realizing that they had been infected with HIV by their spouse. They in most cases grew angry with their partners for alleging that they were responsible for infecting them with HIV virus. Since the partner who walked out of marriage did not carry any blame, the divorced/separated did not internalize much stigma.

3.4.3 Education Level and Internalization of HIV and AIDs stigma

There is no doubt that the level of education of an individual influences his/her level of income, comprehension of various social issues including HIV and AIDs, and coping with disease stigma. Twenty five percent respondents with secondary school education believed they had poor morals compared to 16.6% with primary school education. About 20% respondents with primary school education compared to 10% with secondary education believed it was their fault for being HIV positive. People with higher levels of education have higher levels of exposure, better life opportunities and strong coping abilities when faced by hard circumstance. Majority respondents experienced more challenges coping with stigma because they were people of low education levels.

Table 9: Internalization of stigma by HIV positive persons who had attained the primary level of education

Indicator	Strongly agree	Agree	Neutral	Disagree	Strongly disagree	Totals
It is my fault for being HIV positive	19.4	-	5.6	22.2	52.8	**100**
I had irresponsible sex behavior led to contraction of HIV	16.6	2.8	5.6	22.2	52.8	**100**
I feel ashamed for being HIV positive	11.4	2.9	8.6	14.2	62.9	**100**
I had poor morals led to contraction of HIV	16.6	0	5.6	11.1	66.7	**100**

Source: Researcher (2010)

Table 10: Internalization of stigma by HIV positive persons who had attained secondary school level of education

Indicator	Strongly agree	Agree	Neutral	Disagree	Strongly disagree	Totals
It is my fault for being HIV positive	10	0	10	40	40	**100**
I had irresponsible sex behavior led to contraction of HIV	15	5	5	30	45	**100**
I feel ashamed for being HIV positive	5.5	11.1	16.7	27.8	38.9	**100**
I had poor morals led to contraction of HIV	20	5	0	25	50	**100**

Source: Researcher (2010)

3.4.4 Income levels and internalization of HIV and AIDs stigma

Low income renders the HIV infected vulnerable to internalized stigma and potential for discrimination by those who are not infected because they depend on the latter when they fall ill. Poor HIV infected persons fall sick more often due to low immunity and non affordability of healthy foods. This makes them feel more unaccepted and inferior to an extent of developing low self esteem. This research found that individuals who earned higher incomes internalized less stigma compared to those who earned less. More than 35% respondents earning less than Kshs. 1,000 compared to 10% who earned higher agreed that they had poor morals and irresponsible sex behavior that led to contraction of HIV. Lower incomes subject people living with HIV and AIDS to poor living conditions and high dependency. One respondent reported that, *'The reason persons living with HIV and AIDS are discriminated against is the thought that they are 'sick' and 'unproductive' and need to be supported materially.'*

4. Coping with HIV and AIDS Stigma

This study found that respondents comforted themselves by seeking counseling services, positive thinking, frequent prayers and joining support groups. They only exercised disclosure to close family members. More females than males disclosed their status and 20% of all respondents said that their relationship with significant others was affected negatively after disclosure. Siyam'kel (2003) has recognised the role of counseling in helping the HIV infected persons to cope with their status. This research found that 53.3% respondents disclosed their status to a professional counselor. The respondents also employed positive

thinking as a coping mechanism since it helped them find alternative views about their status thus relieving negative feelings about it. In extreme cases some individuals relocated from their homes to rented premises after failing to withstand stigma emanating from significant others. More than 93% respondents acknowledged that joining a support group enabled them effectively cope with their status since they encouraged one another to remain positive. This is consistent with Banteyerga et. al (2003) study which reported a young man saying "*I tell my HIV positive friends; they advise me not to be disappointed about anything, rather that I should ignore it"*. Individuals in the support groups shared fear about their health status, disclosed status to significant others, and discussed about side effects of antiretroviral drugs. The key informants reported that the respondents improved health wise, socially and psychologically once they joined support groups.

4.1 Stigma influence on coping mechanisms and acquisition of support services

The negative influence of stigma on how individuals cope with HIV and AIDS closely relate to Mechanic (1995) argument that the way in which individuals discover and disclose their HIV status and cope with HIV status is influenced by cultural and community beliefs and values regarding causes of illness, learned patterns of response to illness, social and economic contexts, and social norms. Most HIV infected persons develop real or imagined fear of societal attitudes and potential for discrimination because of their status. HIV and AIDS stigma impacts negatively on HIV and AIDS services like: voluntary testing, care-seeking behavior upon diagnosis, quality of care for HIV-positive patients, and disclosure of infection. Whereas 90% respondents had known their status two years in advance, research showed that 55% of them sought health services from institutions far away from their vicinity in order to conceal their status. Key informants in this study reported that because of the same reason some of their clients were reluctant to be transferred to facilities within their locality as per the requirement of the ministry of health.

5. Conclusions

The overall objective of the study was to investigate on how HIV and AIDs stigma is experienced in the rural communities and how the infected exercise coping mechanisms. The study found that, in the rural areas, HIV and AIDS stigma is not only a health problem, but also a social, economic, political and cultural problem. While the persons living with HIV and AIDS suffer from internal stigma their relatives and friends suffer from secondary stigma. All these lead to depressive life and avoidance and exclusion of people living with HIV and AIDS. The study also shows that stigma is not only a barrier to individual's quality of life but also a challenge to the existing social norms, values and beliefs.

The study found out that gender, marital status, age, education level, and economic status influence internalization of HIV stigma among infected persons. The HIV positive persons cope with stigmatizing and discriminatory experiences by adopting positive and negative strategies. Although most respondents support disclosure and use of VCT services, many of them are reluctant to seek the services openly. Other coping strategies like disclosure though essential were not adequately embraced. The HIV positive persons and the key informants indicated that in order to control stigma, concerted effort from key stakeholders who include local leaders, health care providers, HIV positive persons and general community members is necessary.

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