SOCIAL AND EMOTIONAL CONSEQUENCES OF LIVING WITH HIV/AIDS ON WOMEN IN KADUNA METROPOLIS.

An Educational Intervention

BY

BELLO MOHAMMED HADIZA
MED/EDU/40966/2004 – 2005

A THESIS SUBMITTED TO THE POSTGRADUATE SCHOOL, AHMADU BELLO UNIVERSITY, ZARIA IN PARTIAL FULFILLMENT OF THE REQUIREMENT FOR THE AWARD OF MASTER DEGREE IN EDUCATIONAL PSYCHOLOGY.

NOVEMBER, 2008.

DECLARATION

I declare that this thesis entitled Social and Emotional Consequences of Living with HIV/AIDS on Women in Kaduna Metropolis has been written by me in the department of Educational Psychology under the supervision of Dr. Aisha Mohammed and Dr. (Mrs.) E. F. Adeniyi. The information derived from the literature has been dully acknowledged in the text and a list of references provided. No part of this thesis was previously presented for another degree or diploma in any university.

BELLO, MOHAMMED HADIZA **DATE**

CERTIFICATION

This thesis titled Social and Emotional Consequences of Living with HIV/AIDS on Women in Kaduna Metropolis by Bello, Mohammed Hadiza, meets the regulation governing the award of master degree of Ahmadu Bello University, and is approved for its contribution to knowledge and awareness to the general public towards stigmatization, discrimination and rejection of women living with HIV/AIDS.

_____	_____
Dr. Aisha Mohammed Chairman Supervisory Committee	**Date**
_____	_____
Dr. E.F. Adeniyi Member Supervisory Committee	**Date**
_____	_____
Dr Sadiq Mohammed Head of Department	**Date**
_____	_____
Prof. S.A. Nkom Dean Post graduate School	**Date**

DEDICATION

This research work is dedicated to my dearest Husband Dr. Muhammad Bello, my late father Mallam Mustapha Kabbam, my mother and my four children Hasiya, Abdulmajid, Nana Yusra and Ahmed.

ACKNOWLEDGEMENT

I wish to express my profound gratitude to the Almighty Allah for giving me life, good health and the opportunity to complete this research work. I am particularly indebted to my major supervisor, Dr. Aisha Mohammed and my second supervisor Dr. (Mrs.) E.F. Adeniyi who despite their tight schedules found time to read through, guided and make useful corrections in the process of writing this thesis.

My special thanks go to Dr. Musa Balarabe, Dr. Khadijah Mahmud Hamman, Dr. Umma Abdulwaheed, Dr. Lawal Mohammed. All staff of faculty of Education, Ahmadu Bello University, Zaria for their advice and assistance towards the success of the work. I would also like to acknowledge my husband for his love, support and assistance. My classmate Joe Ogbu, Mr. John Obemeata, the statistician and my computer typist Hajiya Fatima T. Abdullahi for their wonderful contributions. My principal Mrs. Laraba Jim, and Murna Sawok and Kaduna State Ministry of Education will not be left out. All mentioned and not mentioned who contributed to the success of this work, may the Almighty Allah reward you abundantly and thank you very much.

ABSTRACT

The study investigated the social and emotional consequences experienced by women living with HIV/AIDS in Kaduna metropolis. The ex-post factor survey method with stratified random sampling technique was used in the collection of the data. Three hundred and fifty one women living with the disease within Kaduna metropolis were sampled for the study. Among the variables investigated are: social stigma, social discrimination, social rejection and emotional consequences of living with the disease by the women. t-test, Analysis of variance (ANOVA) were used to identify significant differences between groups. The result of the data analysis revealed among others that marital status, age, educational level and occupation of women are significant factor in the social and emotional consequences they experience as a result of living with HIV/AIDS in the metropolis. The women who were not married tended to suffer from social rejection because of the way the society regards victim of the disease. Women who were above forty years suffered more than those below 40yrs from the social and emotional consequences. Of the social consequences, social Stigma was ranked the highest by the victims. Based on these findings, it was recommended among others that there should be increased enlightenment campaign by both NGOs and concerned Government agencies and infected individuals should cooperate and form associations in their different locations towards encouraging and supporting one another.

TABLE OF CONTENTS

Title Page		
Declaration		i
Certification		ii
Dedication		iii
Acknowledgement		iv
Abstract		v
Operational Definition of Terms		vi
Table of Contents		vii
List of Tables		viii
CHAPTER ONE: INTRODUCTION		
1.1	Background to the Study	1
1.2	Statement of the Problem	4
1.3	Objectives of the Study	6
1.4	Research Questions	7
1.5	Research Hypotheses	8
1.6	Basic Assumption	9
1.7	Significance of the Study	10
1.8	Scope/Delimitation of the Study	10
CHAPTER TWO: REVIEW OF RELATED LITERATURE		
2.1	Introduction	12
2.2	Concept of HIV/AIDS	12
2.3	Causes of HIV/AIDS	15
2.4	HIV/AIDS and Gender	17
2.5	Stigma as a Concept	23
2.6	Social Discrimination	30
2.7	Social Rejection	35
2.8	HIV/AIDS and Emotional Adjustment	37
2.9	Review of Related Studied	41
2.10	Summary	50

CHAPTER THREE: RESEARCH METHODOLOGY

3.1	Introduction	52
3.2	Research Design	52
3.3	Population of the Study	53
3.4	Sample Size and sampling Technique	54
3.5	Instrumentation	55
3.6	Validity and Reliability	56
3.6.1	Validity	56
3.6.2	Reliability	57
3.7	Procedures for the Administration of the instrument	58
3.8	Procedures for Statistical Analysis	59

CHAPTER FOUR: DATA ANALYSIS AND DISCUSSION

4.0	Introduction	61
4.1	The demographic characteristics of women living with HIV/AIDS	62
4.2	Presentation of Responses on the Social and Emotional Consequences of Living with HIV/AIDS	65
4.3	Test of Hypotheses	77
4.3	Summary of Findings	91
4.4	Discussion	92

CHAPTER FIVE: SUMMARY, CONCLUSION AND RECOMMENDATIONS

5.1	Introduction	99
5.2	Summary	99
5.3	Educational Implications	103
5.4	Recommendations	107
5.5	General Recommendations	109

REFERENCES 111
APPENDIX 118

LIST OF TABLES

4.1 Classification of the respondents by their age ranges

4.2 Classification of the respondents by their marital status

4.3 Classification of the respondents by their respective occupations

4.4 Classification of the respondents by their educational status

4.5 Perception of Respondents on Social Discrimination as a Result of Living with HIV/AIDS

4.6 Opinion of the Res Table 4.6: Opinion of the Respondents on the Social Stigma Suffered by Women Living with HIV/AIDS

4.7 Perception of Respondents on Social Rejection as a Consequence of Living with HIV/AIDS

4.8 Perception of Respondents on the Emotional Consequences Suffered by Women as a Result of Living with HIV/AIDS

4.9 Emotional Consequences of Living with HIV/AIDS by Married and Unmarried Women.

4.10 Two sample test on social stigma, discrimination and social rejection by marital status of the respondents.

4.11 Chi-square distribution of the respondent rating of the most devastating of social consequences of women living with HIV/AIDS

4.12 One way analysis of variance on social and emotional consequences of women living with HIV/AIDS in Kaduna metropolis by ages of respondents.

4.13 Means scores of respondents on social and emotional consequences by age

4.14 Result of the Scheffe procedure on the mean scores by the age groups

4.15 Two sample test on the overall consequences of women living with HIV/AIDS by marital status of the respondents.

4.16 One-way Analysis of Variance on social and emotional consequences of women living with HIV/AIDS in Kaduna metropolis by their occupation.

4.17 Mean scores of respondents on social and emotional consequences by occupation

4.18 Result of the Scheffe procedure on the mean scores by the occupation.

4.19 Two sample test on the social and emotional consequences of women living with HIV/AIDS educational status of the respondents.

4.20 One way analysis of variance on impact of the social consequences of women living with HIV/AIDS

4.21 Mean scores for the social consequences of women living with HIV/AIDS

4.22 Result of the Scheffe procedure on the mean scores.

CHAPTER ONE

INTRODUCTION

1.1 Background to the Study

Today, more than 20 years into the epidemic of HIV/AIDS, women account for nearly half the 40 million people living with HIV worldwide. In sub-Saharan Africa, 57% of adult with HIV are women. Young women aged between 15 and 24years are more than three times likely to be infected than young men within the same age bracket (UNAIDS/UNFPA/UNIFEM; UNIFEM, 2004). It was further reported that, despite this alarming trend, women know less than men about how HIV/AIDS is transmitted and how to prevent infection. The little they know is often rendered useless by the discrimination and violence they face.

According to UNAIDS Nigeria (2006), it is about two decades ago, since the first case of HIV/AIDS was diagnosed in Nigeria and this was precisely in 1986. After this period, many individuals, families, communities, businesses and Nigerians at large have felt the impact of the epidemic. Cornu, & Grinstead; (2003) explained that, stigma, discrimination and social rejection contributed to people's vulnerability not only to HIV infection but also to other threats to health and well-being. The consequences deprived people of their rights, dignity, isolate and oppress them in all ramifications. It has been further

ascertained that the social stigma makes life worse for many people living with HIV/AIDS.

People living with HIV/AIDS face stigma, legal and social discrimination in all countries of Africa like Ghana, South Africa, Uganda and Nigeria. Nigeria is one of the countries that have launched various programmed to combat this major obstacle to the reduction in the spread of the epidemic. The Bahamas is one of a number of countries that have out law discrimination against HIV – infected people in the work place (international conference on population and development; 2004). United Nations population (2004), reported that despite the campaign by non-governmental organization (NGO's) and government agencies like the National Action Committee on AIDS (NACA), a major global concerns as the war against the virus rages, is the discrimination problem faced by people living with HIV which manifest in many forms. Such forms include segregation in schools, hospitals and other public places, refusal of employment opportunities, denial of marriages and denial of the right to return to their countries upon confirmation of being HIV positive. Some of the victims have committed suicide due to fear of stigmatization (AIDS Alliance in Nigeria 2003).

Salihu (2003) observes that HIV/AIDS is the epidemic of stigmatization, discrimination, rejection, blame and collective denial. These make it so difficult to effectively tackle the disease in Nigeria. The society perpetuates this

discrimination against victims and treats those infected as inferior member of the community. Garko (2004) observes that there is a gloomy picture of the HIV/AIDS situation in Kaduna metropolis. Available statistics shows that between January and July, 2003, 1000 new HIV/AIDS cases were recorded on monthly basis and in Kaduna state at large over 500 new HIV/AIDS cases were also recorded on a monthly basis. There is no community or segment of the state that is not affected. Despite the support groups formed by people living with HIV/AIDS in Kaduna metropolis in 2003 to reduce the isolation of HIV positive women and young girls, evidence shows that, social rejection and discrimination are still prevalent among infected women. This means that women living with HIV/AIDS in Kaduna metropolis still encounter hostile attitudes, discrimination and social condemnation from the public in countless ways (Garko; 2004). In the same vein, the society still experiences a situation where a husband abandons his wife because she is HIV positive. A family shies away from caring for a member with HIV. A landlord who would not accept a tenant with HIV, an employer who would fire an infected woman, a community that would not touch the body of a person who died of causes related to HIV. A society, which through every pillar that upholds it religion, culture, law and media, condemns people living with HIV/AIDS is a society at risk (AIDS Alliance in Kaduna; 2004). It is in the light of this ugly trend that this study was prompted to investigate social and emotional consequences of women living with HIV/AIDS.

1.2 Statement of the Problem

At no time in history has there been such a wide spread and fundamental threat to social relationship as that brought about by HIV/AIDS related diseases to people of Kaduna State in General and Kaduna Metropolis in particular. In Kaduna State, the epidemic has spread through sere-prevalence sentinel survey of 0.9% in 1991 to 3.8% in 1993 and 6.0% in 2003 with over 160,000 people infected with the virus. There is no community or segment of the state that has not been affected. (Garko, 2004: AIDS Alliance in Nigeria, 2003). The HIV prevalence rate in Kaduna north rose from 4% in 2001 and to 6% in 2003 (Ministry of Health, 2004).

There is a high rate of different ethnic groups, an industrial, junction town composed of civil servants and other different categories of people in the metropolis. This amounted to different socio-cultural practices within the metropolis. There is also the high number of military men especially those who have served in the various Peace Keeping Missions outside the country. These groups of people are considered to be at high risk.

Even though the HIV/AIDS epidemic is a disease that has claimed millions of lives, it ought to be seen like any other deadly disease where the sufferers should not allow themselves to be thrown emotionally off balance or be made to suffer any social consequences. Moreover, today, people living with HIV/AIDS have the prospect of living normal lives if their condition is

discovered earlier. Unfortunately, it appears as if people living with HIV/AIDS, particularly women suffer untold emotional and social consequences which become much more hazardous to their health [life span] than the HIV/AIDS scourge itself. It is apparent that women victims have been retrenched from their jobs, abandoned by their husbands and relatives, lost their relationship with friends etc. Besides, such women seem to be so disillusioned, dejected, and emotionally drained that their death becomes too soon.

Salihu [2001] notes for instants that many deaths of people living with HIV/AIDS is not directly from the effect of the disease itself, but rather from their depressed state of mind as a result of loss of hope and ill-treatment from people around them. Similarly, AIDS Alliance in Nigeria, [2004] 0bserves that HIV/AIDS victims seems to die earlier because of the social and emotional trauma they are subjected to at the knowledge of their status as victims. It is based on this that this study prompted to gather empirical data on the social and emotional consequences of living with HIV/AIDS on women in Kaduna Metropolis since this has not been determined. Besides, the study intends to investigate how social and emotional consequences of living with HIV/AIDS on women affect their emotional stability, age, occupation, educational status etc.

1.3 Objectives of the Study

The objectives of this study are to:-

1. Determine the consequences of HIV/AIDS on infected women in respect to:
   a Social Consequences (social stigma , Social discrimination ,social rejection).
   b. Emotional Consequences (Depression, Frustration, Aggression , Fear, Shame, Anxiety, irritation, Annoyance denial Low Self Esteem, Low Self Confidence and Suicidal Idealation)
2. To determine which social consequences of living with HIV/AIDS is most devastating among infected women.
3. To ascertain any association between the ages of infected women and the social and emotional consequences of living with HIV/AIDS
4. To determine how emotional consequences of HIV/AIDS impact on the emotional stability of infected women.
5. To ascertain effect of living with HIV/AIDS on the occupation of infected women.
6. To find out the effect of educational status on the consequences of women living with HIV/AIDS.
7. To find out the impact of social stigma, social discrimination, social rejection on women living with HIV/AIDS

1.4 Research Questions

1. What are the consequences of HIV/AIDS on social relationship in respect to:
   a. Social Consequences: (Social stigma, Discrimination, Social rejection)
   b. Emotional Consequences **(**Depression, Frustration, Aggression , Fear, Shame, Anxiety, irritation, Annoyance denial Low Self Esteem, Low Self Confidence and Suicidal Idealation)
2 Which social consequences of HIV/AIDS is most devastating to women living with HIV/AIDS?
3 Does the age of infected women have any significant impact on the consequences of living with the disease in Kaduna Metropolis?
4 How does the emotional consequence of HIV/AIDS impact on the emotional stability of infected women?
5. How does occupation of infected women impact on their experiences of living with HIV/AIDS?
6 What is the effect of educational status of infected women on the social and emotional consequences they experience as a result of living with HIV/AIDS?
7. What is the impact of: (a) Social Stigma, (b) Social discrimination and (c) Social Rejection on women living with HIV/AIDS?

1.5 Research Hypotheses

1. There is no significant difference between married and single women in the consequences of HIV/AIDS with respect to:
   a. Social consequences: (Social stigma, Discrimination, Social rejection).
   b. Emotional consequences **(**Depression, Frustration, Aggression, Fear, Shame, Anxiety, irritation, Annoyance denial Low Self Esteem, Low Self Confidence and Suicidal Ideals).
2. Married and single women infected with HIV/AIDS will not differ significantly in their rating of the most devastating social consequences of HIV/AIDS.
3. There is no significant difference between infected women of different ages and the social and emotional consequences they experience as a result of living with HIV/AIDS in Kaduna Metropolis
4. Married and single women will not differ significantly in their experiences of the social and emotional consequences.
5. There is no significant difference between the occupations of infected women in their experiences of the social and emotional consequences of living with HIV/AIDS.
6. There is no significant differences between the educated and non-educated women living with HIV/AIDS in the social and emotional consequences they experience

7 There is no significant difference among the impact of social stigma, social discrimination and social rejection experienced by women living with HIV/AIDS.

Basic Assumptions

Some of the assumptions of the study are that women living with HIV/AIDS in contemporary Nigerian society have the tendency to face:-

1. Stigma, discrimination and social rejection in the area in which they live.
2. Some social consequence of HIV/AIDS will be more devastating on infected women than others.
3. The nature and extend of social and emotional consequences of HIV/AIDS on infected women vary according to the ages of women.
4. The nature and extent of social and emotional consequences of women infected with HIV/AIDS will depend on the experiences they encounter.
5. The social and emotional consequences of HIV/AIDS on infected woman will depend on the type of jobs the women do.
6. The extent of social and emotional consequences of HIV/AIDS infected woman will depend on the educational status of the infected woman.
7. The extent of social stigma, social discrimination and social rejection will depend on the impact it has on women living with HIV/AIDS.

1.7 Significance of the Study

This study examines the social and emotional consequences of living with HIV/AIDS. To this effect, the significance of the study can be seen in the following perspectives:-

1. It will help to disabuse the minds of the public towards people living with HIV/AIDS and influence a change of attitude towards caring and giving them social support rather than stigmatizing, discriminating and rejecting them.
2. The findings of the study will help to change the assumption of people toward people living with HIV/AIDS and create a society where individuals, families and communities understand, accept and address HIV infected persons with due respect and cordiality. This will create a change of attitude toward people living with the virus.
3. This study will help in presenting the issue of HIV/AIDS as a subject which could be taught to pupils and student in schools at various levels since the issue of HIV/AIDS concerns every individual.

1.8 Scope /Delimitation of the Study

This study covered Kaduna metropolis in Kaduna state. The respondents were women living with HIV/AIDS and they were selected from:-

- 44 military reference hospital at Tudun Wada-Kaduna
- Old A.B.U Teaching hospital independence way
- Saint Gerald's' Hospital at Kakuri – Kaduna.
- Nursing Home Hospital
- Family Resources Centre.
- Cosgik Communal Support group, living with hope support group at family support multi-purpose center – Kaduna.
- Al-Umma Support group at U/Rimi

These areas are chosen due to proximity and willingness to cooperate by the women infected with HIV/AIDS with the help of their support group, coordinators and their doctors. The findings would therefore be limited to the affected areas but could have general implication for the larger society.

CHAPTER TWO

REVIEW OF RELATED LITERATURE

2.1 Introduction

This chapter focuses attention on what past researchers, articles, publication, conferences, seminars and experts have written concerning and in relation to this present study. The review of the related literatures is segmented into the concept of HIV/AIDS, HIV/AIDS and Gender, HIV/AIDS and Social Adjustment, HIV/AIDS and Emotional Adjustment.

2.2 Concept of HIV/AIDS

HIV is found in the blood and in the body fluids (semen in men, virginal secretion in women) of infected persons. This means that HIV is spread in three major ways:-

i. Through sexual intercourse with infected partner.

ii. Through transfusion of infected blood to uninfected persons, through a needle or blade that has been used on a person with HIV and not sterilized afterwards.

iii Through pregnant mother to the unborn child. In this process women with HIV can pass it to their babies. The baby becomes infected while in

the mother's womb or as it is being born. There is also some risk of transmission through breast milk.

AIDS on the other hand is the group of sickness that comes after HIV has made the body weak. According to Nwokedi (2003), people with AIDS get sickness like cough, fever, rashes and diarrhea. They also lose weight. At the moment, there is no known cure for AIDS. But people with AIDS and HIV should be comforted by the fact that there are drugs that can help people with AIDS to feel much better and to live longer.

According to Cipla (2001), HIV infection refers to the illness, which occurs when HIV first infects an individual. This stage is characterized by non-specific flu-like symptoms such as fever, sore throat, malaria, rashes, and headaches. These symptoms usually occur within 2 to 6 weeks after acquiring the virus. Most symptoms usually resolve within 2 – 3 weeks. He further asserted that within 2 weeks after the initial infection high levels of virus are present in the blood. The Immune System now begins to recognize the virus and produce antibodies, HIV antibodies can be detected in the blood usually within 1-3 weeks after symptoms appear. He further explained that, AIDS on the other hand is when the CD4 cells decreased to 200 cells or the patient starts suffering from a characteristics range of severe opportunistic infections (AIDS defining illnesses), then the person is said to be suffering from AIDS. It may take 8 – 10

years to reach this stage, although this may vary between patients. Thus, AIDS represents an advanced stage of HIV infection, when the patient suffers from a characteristic range of opportunistic infections.

For Alexander (2003), HIV is a virus that attacks the body's Immune system and leaves the body unprotected from other infections. We all have a defensive mechanism in our body, which fights off infections and diseases. It is called the Immune System. The virus HIV, slowly damages this vitals defensive mechanism against diseases and eventually destroy it. By killing or damaging cells of the body's Immune System HIV progressively destroys the body's ability to fights infections and certain cancers. HIV acts by gradually destroying the Immune System of the infected person. It may take several years for HIV to damage the immune system so much so that a person becomes ill. After about 5 to 10 years (although much earlier in a minority of cases) the immune system becomes so weak or deficient – that it cannot fight off infections as it used to. During these years a person with HIV may look and feel well, and may not even know that they are infected with the virus.

Alexander (2003), further explained that, AIDS applies to the most advanced stages of HIV infection. It is a collection of the most common illnesses which characteristically affect people with HIV: most of these conditions are opportunistic infections, which rarely cause harm in healthy people. In people with AIDS, these infections are often severe and sometimes

fatal because the immune system is so ravaged by HIV that the body cannot fight off certain bacteria and viruses. He further outlined the opportunistic infections common in people with AIDS as:-

- Coughing and shortness of breath
- Seizures and lack of coordination
- Difficult or painful swallowing
- Mental symptoms such as confusion and forgetfulness
- Severe and persistent diarrhoea.
- Fever
- Vision loss
- Nausea, abdominal cramps and vomiting
- Weight loss and extreme fatigue
- Severe headaches
- Coma

The overwhelming majority of people infected with HIV do eventually develop AIDS. The length of time this takes varies from person to person.

2.3 Causes of HIV/AIDS.

The spread of HIV/AIDS in Nigeria has been attributed to a number of social economic and cultural factors, often acting together in a mutually reinforcing manner across many communities. The main factors include the

social-cultural norms and values around sex, sexuality and gender relations, poverty and economic need. Inadequate knowledge and awareness about the infection in early years and a focus on individual risk rather than response have all contributed to continuing spread of the epidemic (Action AIDS Nigeria; 2005)

For Andrew (2005), poverty is one of the driving factors of controlling HIV/AIDS. The extreme high level of poverty in Nigeria coupled with the lack of education and skills for livelihood have forced many girls and women to use sex as coping strategy. This he said, was worsened by the socialization and gender dimension that reduce the self worth of a lot of these women involved. Poverty on the other hand also forces families to give their underage daughters in marriage for the same reasons. Many women and girls in Nigeria are forced into transactional sexual relations in exchange for money and other favors, such as employment, job retention, promotion at work, social and academic support at school, etc. This puts the poor at risk in as much as it exposes those with access to disposable income or favors' to offer.

Peter & Neolean (2004) reported, the causes of HIV/AIIDS as a crises of gender inequality, with women less able than men to exercise control over their bodies and lives. Nearly universal, cultural expectations have encouraged men to have multiple partners, while women are expected to abstain or be faithful to one partner. There is also a culture of silence around sexual and reproductive

health. Simply by fulfilling their expected gender roles, men and women are likely to increase their risk of HIV infection. They further explained that, violence and the threat of it also limit women's ability to protect themselves from HIV/AIDS. Women risk violence if they insist on protection. It was opined that women may give in to male demands for unprotected sexual relations, even when they know the danger. That in addition, poverty pushes some women into risky behaviors or dangerous situations, with no other options in sight that women may resort to sex work to feed their families.

2.4 HIV/AIDS and Gender

A large body of literature exists on the negative impact of societies stringent Ascription of gender roles on vulnerability to HIV infection and one, once infected, to receiving appropriate or quality care and treatment. Gender based expectations as well as increased rates of poverty and persistent forms of discrimination against vulnerable groups [including discrimination based on gender] are well known economic, social and cultural sources providing fuel for the HIV epidemic.

Salihu [2001] mentioned that gender based violence is understood as any type of violence directed at groups or individuals on the basis of their gender, It encompasses, but its not limited to, violence against women [vaw]. This is an

important distinction as Gender based violence and violence against women are often erroneously used synonymously.

Mohammed [2004] agrees that unequal gender relation are a key factor underpinning women's inability to protect themselves from sexuality transmitted infections including HIV/AIDS, as well as influencing how HIV infection and AIDS impacts on women's lives. They are also a root cause of violence against women. More specifically, physically violence, threat of physical violence, and sexual violence and coercion are all likely to be important factors associated with HIV transmitted for women of all ages and in a range of settings.

According to women aids (2005).Africa is the only continent where HIV prevalence is higher for women than men. For every 15-19 year old boy that is affected there are five to six girls infected in the same age group. Of Africans 28.1million people living with HIV/AIDS 15.5 million (or 55%)are women, constituting 88% of the world's women with HIV/AIDS. It was further reported that three critical factors place gender issues at the center of the HIV/AIDS epidemic in Africa.

1. Risk and vulnerability to HIV/AIDS
2. The economic vulnerability of women makes it more likely that they will exchange sex for money or favors', less likely that they will succeed in negotiating protection and less likely that they will leave a relationship that they perceive to be risky.

3. That the impact of HIV/AIDS differs markedly along gender lines reflecting men's and women's different roles and responsibilities in household and market activities this has implications for care, support and treatment programs including addressing the needs of the rapidly growing number of AIDS orphans and the pattern of women's and men's roles and relationship in Africa puts women at greater risk tackling the AIDS epidemic is fundamentally about behavior change aimed at effecting a transformation of gender relations and roles in Africa.

UNAIDS (2004) reported on gender analysis on the social, cultural, economic and resulting behavioral underpinnings of the spread of HIV/AIDS. That men are usually infected at later age of 30 years, while women usually infected at 5-10 years earlier than men, especially aged 11-29, while men take multiple sex partners as norm, women take high risk behavior of regular sexual partner, men have lower physiological risk vulnerability and physiology, women four times are more likely to contract HIV and other STDs than men and transmission to unborn child is (20oC-40Oc risk)

It was further classified socio-cultural factors prevailing norms and expectations on both men and women as:- Sexual domination on the part of men and emphasis on virginity and value of marriage and motherhood for women. That there is culture of silence on sexual matters (in appropriate to be aware of

sexuality or to suggest condom use) on women, on men presumption of knowledge (prevents seeking information contraception treatment), violence associated with drugs alcohol, frequency of drug abuse, including injection, link between socializing and alcohol use imbalance of sexual power including violence and lack of responsibility for own sexuality, while women face cultural practices, like female genital cutting ritual cleansing, widow inheritance, link between substance abuse and exchange of sex for drugs or money, vulnerable to coerced sex, including rape and other sexual abuse practice of dry sex.

Fleishman, (2003) asserts that the HIV/AIDS crisis makes lethal the subordinate status of women and girls. In some of the worst affected countries in Southern Africa, HIV prevalence among girls aged 15 to 19 is four to seven times higher than among boys their age, a disparity linked to widespread sexual abuse, coercion, discrimination and impoverishment. That in sub-Saharan Africa, the epicenter of the epidemic, women and girls account for more than half-58 percent of those living with HIV/AIDS and infection rates is rising rapidly among young women in many parts of the world.

According to (UNAIDS; 2004) women are not expected to discuss or make decision about sexuality “Good” women are expected to be virgins before their marriage, to be “ignorant” or uniformed of any matters relating to sex, including their own sexuality. If women refuse sex or request condom use, they risk abuse. Violence against women (especially domestic violence) includes

forced sex. Marital rape is not recognized as a crime in many countries. Marriage condones non-consensual sex between a man and his wife at any time. It was further reported that, for men, multiple partners and sex outside marriage are widely accepted. Women are expected to have relations with or marry older men who are more sexually experienced and more likely to be infected. Arranged marriages, particularly, among relatives without the partners knowing each other is a common occurrence.

UNAIDS/UNFPA/UNIFEM (2002), asserts that the rates of HIV infection among women and girls are a cause for deep concern, but when combined with the work load that women take on as well in caring for AIDS patient, AIDS orphans and their own families the situation becomes untenable. It is a crisis of gender inequality, with women less able than men to exercise control over their bodies and lives. It added that nearly universal, cultural expectations have encouraged men to have multiple partners while women are expected to abstain or be faithful. Simply by fulfilling their expected gender roles, men and women are likely to increase their risk of HIV infection.

UNAIDS (2004) reported that, women in many region do not own properly or have access to financial resources and are dependent on men: husband, fathers, brothers and sons – for support. Without resources, women are susceptible to abuse of power. That, violence and the threat of it also limit women's ability to protect themselves from HIV/AIDS. They risk violence if

they insist on protection. They may stay in violent relationship because they have nowhere else to go. They may give in to male demands for unprotected sexual relations, even when they know the danger. Whether in conflict areas or in the home, rape and sexual abuse make a mockery of the notion of safer sexual relations. In the report, poverty is said to push some women into risky behaviors or dangerous situations. With no other options in sight, they may resort to sex work to feed their families. Women and girls are susceptible to the growing trade of human trafficking. Shainsa (2005) explained that, in Nigeria and Kaduna in particular many older men seek out young women and adolescent girls for sexual favors while providing them with school fees, food and highly sought after consumer goods.

Olaoshebikan (2005) commented on the gender issue and HIV/AIDS. He opined that Nigeria is a male dominated society and that women are seen as inferior to men. The women's traditional role is to have children and to be responsible for the home. Their low status and lack of access to education increases their vulnerability to HIV infection. Certain social and also cultural practices also make women vulnerable to HIV. Harmful marriage practices violate women's human rights and contribute to increasing HIV rates in women and girls. He further asserted that in Nigeria there is no legal minimum age for marriage and early marriage is still the norm in some areas. He opined that parent sees early marriage as a way of protecting young girls from the outside

world and maintaining their chastity. He further explained that, many girls get married between the age of 12 and 13 and that there is usually a large age gap between husband and wife. He opined that young married girls are at risk of contracting HIV from their husbands since it is acceptable for men to have sexual partners outside marriage. Some men have more than one wife (polygamy) and because of their age, lack of education and low status, young married girls are not able to negotiate condom use to protect themselves against HIV/AIDS. He asserted that, although prostitution is illegal in Nigeria, there are more than 1 million female sex workers and that HIV infection rates among sex workers have been estimated to as high as 30% in some areas. He opined that there is a low level of condom use among sex workers because of lack of knowledge about HIV transmission and poor acceptance by male clients.

HIV/AIDS and Social Adjustment

2.5 Stigma as a Concept

Social stigma occurs when an individuals is labeled with negative attributes so that he finds it difficult to have normal inter-personal relationship with other people in the way non-stigmatized person do. Goffman (1963:56), summoned this up succinctly when he wrote.

> "*An individual who might have been easily received into ordinary social intercourse posses a trait that can obtrude itself upon attention and turn*

those of us whom he meets away from him, breaking the claims that his other attitudes have on us. He possesses a stigma, an undesirable difference from what we had anticipated; we believe that the person with stigma is not quite human- we tend to impute a wide range of imperfections on the basis of the original one. Further we may perceive his defensive response as a direct expression of his defect".

Goffman also explained that, the basic social problem encountered by a stigmatized person is therefore that of social rejection. He becomes some kind of misfit in the society.

Muhammad (2003), opined that today's reality is that people living with HIV/AIDS (PLWHAS) are stigmatized and discriminated against in society. He asserted that the repercussions are numerous ranging from fear of being rejected by loved ones, spreading the infection, the denial of any treatment to the difficulty of finding employment or housing.

Brandts (1986), opined that the way a society responds to the problems of disease reveals its deepest social and moral values. He further explained that, as a result of this, AIDS-related stigma earlier victims did not receive much sympathy and support but were rather discriminated against. Despite the progress that has been made of the micro-biological level giving us a better understanding of the virus, the stigma associated with it is far from being

removed. He also revealed that individuals infected with HIV have reported intensive negative reactions and experiences from the general public.

Boco (2005), reported that, ever since scientist identified HIV/AIDS, fear denial, stigma, discrimination and rejection have accompanied the epidemic. In Nigeria in particular, since the first case of AIDS was identified in 1986 raising prevalence rate from 1.8% in 1988 to 5.8% in 2001, stigma and discrimination against affected groups has continued to rise. The most recent survey conducted by the Federal Ministry of Health estimated that 3,300,000 adults were living with HIV/AIDS, 1,900,000 (57%) of those were women. He further explained, that stigma and discrimination against people living with HIV/AIDS is common place in Nigeria. Both Christians and Muslims see immoral behavior as being the cause of HIV/AIDS epidemic. This notion affects attitudes towards people living with HIV/AIDS. They often lose job or are denied health care services because of the ignorance and fear about HIV/AIDS. There is so much ignorance about HIV/AIDS that 60% of health care workers think HIV positive patient should be isolated from other patients.

Kelly (2001) opined that the impact of HIV/AIDS on women is particularly acute. Nigeria is a male dominated society and women are seen as inferior to men. Women's traditional role is to have children and to be responsible for the home. Their low status and lack of access to education increases their vulnerability to HIV and provide a basis for the further stigma of

women within the content of HIV/AIDS. He went on to explain that, HIV positive women are treated differently from men who are likely to be 'executed' for their behaviors that resulted in their being infected. But women members of the family can find themselves stigmatized and discriminated against within the home. That there is also mounting evidence that women are more likely to be badly treated than children and men. He opined that many reports revealed the extent to which people are stigmatized and discriminated against especially women by health care systems. Many studies revealed the reality of withheld treatment, non-attendance of hospital personnel and denied medications. HIV related stigma and discrimination remains an enormous barrier to effective fighting of HIV/AIDS epidemics.

The website of international HIV/AIDS Alliance, opined that traditional people infected with HIV/AIDS, have always had to contend with stigma, rejection and discrimination. People living with HIV/AIDS are so stigmatized that they start doubting their self worth. It also revealed that women living with HIV/AIDS are refused even exchange of greetings with people not infected lest it to be transmitted through the air. The instant the word go round, such infected persons see themselves being stared at wherever they go with some pitying, yet self-righteous looks. At this point, an undeclared social ostracism has started, and it does not abate, no matter the level of awareness in the particular environment.

Ododigbo (2005) explained stigmatization and discrimination on the economic front, that employers, ventures capitalist and even risk insurers approach HIV/AIDS victims facing the opposite direction because they are bad business any way. That even hospitals, in order not to endanger their other patients send them away.

An article written by Parker and Peter Aggleton (2002) as part of the Nigeria governments response to HIV/AIDS opined that due to the fact that the first HIV/AIDS infected groups were already socially marginalized, the stigma attached to HIV/AIDS is often layered upon pre-existing stigma of the sexual, illegal or socially frowned upon activities associated with these groups. They further explained that communities often believe that HIV/AIDS infected people deserve what has happened because their activities lie outside the moral boundaries of society. To a large extent, this leads many people to stigmatise and discriminate against anyone infected by the HIV. It also drives the persistent denial of the scourge by those infected and the society at large.

Shainsa (2005) asserts that, stigma and discrimination cause persons with HIV/AIDS to face socio-isolation, increase emotional distress and a loss of socio-economic support. They also may influence non-HIV positive individuals to avoid being tested for their HIV status, thus, impeding preventing and surveillance efforts. He further explained that stigma related to HIV/AIDS appear to be more severe than that associated with other life threatening

conditions. It extends beyond the infected person to significant others and loved ones, close associates, social groups, professionals, providers and even volunteers involved with the HIV related work. The undesirable differences and spoiled identities that HIV/AIDS stigma causes, do not exist naturally. They are created by individuals and communities and are reinforced by social in equalities.

Cornu et al (2002) assert that, stigma and discrimination may be enshrined into two categories of people living with HIV/AIDS. These are those who have disclosed their Sero-Positive and those who have not. He further explained that, non disclosure of status is due to stigma and discrimination accompanying the disease.

In the view of grinstead (2001), disclosure of HIV status is also related to negative consequences such as increased violence, particularly among women. And that the major barrier to disclosure is stigma and discrimination, which erodes fundamental human rights and takes away human dignity. He further explained that, support groups usually do not include professionals and other highly educated people, because they are less willing to disclose their status. Care and support work are also being relegated to people living with HIV/AIDS as others willing to provide this support.

Mamman,(2002), Grinstead (2001), Lie and Bismalo (1996) classified stigma and discrimination into programmed and service delivery levels. They

explained that, programmed level refers to various programmers and their related stigma and discrimination. Home based care, prevention of mother to child transmission, access to Anti retroviral drugs, attitude of health care professionals, access to financial resources and support groups. They further explained that, in the provision of home based care, stigma and discrimination is mainly targeted at the caregivers, who are perceived to be HIV positive or to be receiving some huge amount of money. This may also refer to the quality of care being given which may be seen as discriminatory. This they explained may be pictured in poorly stocked care kits and lack of facilities or transportation when there is an emergency. They opined that people with HIV/AIDS also faced stigma and discrimination in instance where the home based care providers portray people living with HIV/AIDS as those being punished by God for evil doing deserving of the punishment. They further assert issues of accessing such services and even reproductive health services especially younger women living with HIV/AIDS thereby stigmatizing them. They explained that, there are issues of stigmatization from health care providers to both younger and older women. That the providers give poor quality heath care and case management and in some cases outright rejection, loss of confidentiality and use of derogatory language are some of the forms of stigma and discrimination seen among health care providers. And that there have been, reports of sexual harassment and demand for favors and certain extraneous fees to provide such care.

Herek's (1999), opined that, AIDS related stigma refers to prejudice, discounting and discrimination directed at people perceived to have AIDS or HIV and the individual, groups and communities with which they are associated. That AIDS stigma inflicts suffering on people and interferes with attempts to fight the AIDS pandemic. Stigma is a powerful tool of social control. It can be used to marginalize, exclude and exercise power over individuals who show certain characteristic. It was further asserted that the stigma attached to HIV/AIDS can extend into the next generation, placing an emotional burden on those left behind.

2.6. Social Discrimination

Social discrimination occurs when a person or group of person's is or are treated unfairly or unjustly on the basis of their belonging or being perceived to belong to a particular group. One of such stigma's manifestations is through discrimination (Nigerian AIDS bulletin, 2003). Discrimination has spread rapidly fuelling anxiety and prejudice against the groups infected as well as those living with HIV/AIDS (American journal of public health, 2002). HIV related discrimination remains an enormous barrier to people seeking treatment for AIDS or from admitting their HIV status publicly. People with or suspected of having HIV may be turned away from health care services, employment, refused entry to foreign countries e t c. in some cases, they may be evicted from

home by their families and rejected by their friends and colleagues. (UNAIDS, 2001).

Brandts (1986) assert that, AIDS related discrimination against earlier victims was despite compassion and sympathy towards people living with HIV/AIDS, that the discrimination associated with the disease is far from being removed. Ship (1986), points out that, individual infected with HIV has reported intense negative reactions and experiences from the general public. In certain instances, the discrimination meted out to them has forced individual to leave their jobs, withdraw from school or be evicted from their houses by landlords.

Zugar (1987) explains that, unfortunately the discrimination experienced by HIV infected individuals sometimes extends to the health care setting. That with the relatively few cases of transmissions to health care workers, they have stood up to assert the right to refuse care for infected persons. This is violating the fundamental principles of medical ethics which requires that all care be rendered without discrimination and unconditionally. Salihu (2001), agrees with the work of Brandts (1986) on social discrimination in the work place. He explains that, AIDS victims are discriminated against and rejected at work place. Employers believe HIV positive person may not be able to work full-time.

Boco (2005) reported that, discrimination has spread widely and rapidly causing prejudice against the groups most affected as well as those living with

HIV/AIDS. He further reported that, across the world the global epidemic of HIV/AIDS has shown itself capable of triggering responses of compassion and support, bringing out the best in people, their families and communities. But the disease is also associated with stigma, repression and discrimination. And that individuals infected with HIV have been rejected by their families, their loved ones and their communities. This rejection occurs in both rich and poor countries.

Adinna (2004), opined that, Nigeria in particular, since the first case of AIDS was identifies in 1986 raising prevalence rate from 1:8 percent in 1988 to 5:8 percent in 2001, discriminated against infected groups has continued to rise. The most recent survey conducted by the Federal Ministry of Health estimated that 3,3000,000 adults were living with HIV/AIDS, 1,9000,000 (57%), of these groups were women. In Kaduna 151,000 adults were living with HIV/AIDS by 1988. In 1999 the figure rose to 300,000 and by 2005 it was estimated that about 70% of the infected persons were women. There had been an alarming increase in the number of HIV positive children in recent years, 90% of whom contracted the virus from their mothers. He further explained that, denial goes hand in hand with discrimination and that many people continue to deny that HIV exist in their communities. Today, HIV/AIDS threatens the welfare and well being of people throughout the world. At the end of the year 2004 39.4million people were living with HIV/AIDS and during the year, 3.1 million people died of

AIDS related illness. Combating the stigma and discrimination against people who are infected by HIV/AIDS is as important as developing the medical cures in the process of preventing and controlling the global epidemic.

Annune (2004), observed that, a large proportion of the Nigerian society in general and Kaduna state in particular, infected by HIV are already dead persons. They were discriminated against, even as all forms of stigmatization are meted out to them. For the persons living with HIV, especially women, there is no job security, they are fired from job on the flimsiest of excuses. He noted that, in most cases that the employer is courageous enough to tell the worker point blank that she is being fired for being HIV positive. For the person living with HIV, there is no place for the child in the school. Many children have been dismissed from their schools because of the HIV status of their parents. He further reported that, not a few in the country still believe that somebody living with HIV is not responsible for her health status. For them, HIV/AIDS is only for the promiscuous persons. Stigmatization and discrimination have been accepted to be one of the leading causes of spread of HIV/AIDS. When this should not be the case, people out of fear of what would become their lot should they test positive therefore refuse to go for screening.

Shainsa (2005) assert that, there is a very high discrimination against low-income women in most communities. Also that HIV/AIDS have driven them to extreme poverty with only family members providing the desired care and

support, but would often keep it secret from the community. He further pointed out that, where both partners are infected with HIV/AIDS the women are often more discriminated against than men.

Ekpen (2003) reported that, the impact of HIV/AIDS on low income women often result in a lot of undesirable effects such as orphaned children, stigmatization by the society, marital conflicts which often leads to separation and divorce as well as economic hardship. He further reported that, in most work places, there is the problem of denial as most respondents claimed they are not aware of any people living with HIV/AIDS in their work places. Sometimes denials are fuelled in work places due to the fear of dismissal from work. Work place policies for people living with HIV/AIDS will not allow people to come out of this stage.

A new development in some organization now is that new employees are being subjected to Voluntary Counseling and Testing (VCT) before formal employment. Gender imbalance within the society has put more women at greater risk of HIV/AIDS infection. Rights of women are not being fully appreciated within the society. Inability to negotiate safer sex as well as knowledge about sexual and reproductive health issues all contribute into making women more vulnerable to HIV/AIDS. He further reported that, from the analysis about stigma and discrimination, existing HIV/AIDS activities are being undermining in Kaduna State and Kaduna metropolis respectively.

Isolating families and communities affected by the epidemic HIV/AIDS related stigma is inhibiting HIV test, care seeking behavior for people who test positive. The quality of care and support provided to HIV positive clients and acceptance of people living with AIDS and their families in communities is being affected.

2.7 **Social Rejection**

Herek, (1999), opined that individuals infected or believed to be infected by HIV have been rejected by their families, loved ones and their communities. These rejection phenomena are true in the rich as well in poorer countries of the south. According to a report from UNAIDS (2004)'s head of welfare centre for Girls orphanage (Mrs. Achara Yodphet), the first time they tried to send HIV infected girls to school, they were faced with rejection from both the students and teachers. Their rejection underscores the level of acceptance and understanding of people with HIV/AIDS. Even in a country known to be tolerant and has an aggressive programmed against the pandemic, parent ordered their children not to attend any classes if HIV positive children were present. They believed that the virus could be spread by the young children through physical contact and through mosquito bites.

United Nations AIDS (2005) reported that, women were avoided by doctors when they were moved to rooms at the conference hall of the Health Ministry of Tanzania. They explained that, they were assigned a separate

bathroom, plates, forks, knives and spoons and were told to wash them themselves. One of the victims disclosed that every day, the porter made sure that none of them had touched the main door handle. That it was some small wonder when even doctors working at the ministry avoid and rejected them.

In another report by (UNAIDS; 2004), Nowak opened a centre for women living with HIV/AIDS in Plastow. She explained that, she has had to fend off abuse from resident and their protest group and the remonstrative committee. That after threats and unsuccessful attacks, the centre is under constant police protection and Piastow's only patrol car stands watch at the gate of the centre" We don't want AIDS here; said one of the protest committees leaders. "There could be empty soviet barracks in secluded area where these people could be lodged. Why expose our children?" they complained (UNAIDS; 2004).

UNAIDS/UNIFPA/UNIFEM (2003) reported that, although women experience support from family, friends and community after disclosing their status, that many women with HIV experiences violence and rejection and are thrown out by their families when it is discovered that they are HIV positive. They are often-incorrectly blamed for bringing the virus into the family. Since they are often the first to be tested, for instance at antenatal clinics, rejection and violence are often fuelled by fear and lack of knowledge. Women often tell their families and friends last for fear of rejection from those whose support they need

most. But the best protection against rejection is knowledge (UNAIDS/UNFFEM 2003).

2.8 HIV/AIDS and Emotional Adjustment

HIV/AIDS related stigma influences individual's responses to testing positive. It aggregates the emotional burden of receiving a positive HIV test (Chesney and Smith, 1999). Earlier in the history of the epidemic, there were reports of severe emotional responses to notification, including denial, anxiety, lower self esteem, depression and suicidal idea (Coates el al 1987; Ostrow et-al; 1989). Over time, studies have shown a decrease in severe reaction to being notified of positive test result. However, research continued to show that notification is associated with high distress. Distress is greatest immediately after notification and typically declines with 2 to 10 week Ironson (1990), perry (1990).

Jean-Emile Ngue (2003), reported in a conference held in Abuja (Nigeria) on the emotional effects of HIV/AIDS on patients and their families. He explained that, in the context of the HIV/AIDS epidemic, sibling within a family may therefore develop emotional and mental disorders. He further listed 5 emotional disorders which are:-

1. The syndrome of negation which is a reaction of denial from the family members who are skeptical about the positive result of an HIV test. And

that they find it difficult to accept such a situation where the person is HIV positive and yet does not appear to be ill. Rev. Ngue views this period as short lived and suggested that it is better to avoid confrontation with the patient's family at this stage.

2. Effect or condition of HIV/AIDS patients and their families as the syndrome of anger. He indicated anger as a normal emotional state in the process of learning that one is condemned to death.
3. The syndrome of shame. Rev. Ngue clearly highlighted the difference in meaning between shame and guilt. He asserted that, shame affects a person's identity because it is aimed at oneself and questions one's own being and one's place in the community. He also asserted that, the African society is shame oriented and therefore advised that all deeds in the response to HIV/AIDS should be designed to change such belief. He therefore opined that involving family members in the treatment of HIV/AIDS is essential to overcoming the feeling of shame and making them feel respectable again.

The fourth emotional consequences of HIV/AIDS patients and their family is feeling of doom.

Isah (2005) compared being HIV positive to being on the death row. Drawing on an example of young woman who felt doomed as soon as she was

told she was HIV positive. He defined such feeling as “a thick wall that fences out every hope of survival a wall of isolation, a wall that imprisons our thought as we analyze the nations imposed on us by society”. He asserted that, the psychological effects of HIV/AIDS patient and their family is crises of confidence in people living with HIV/AIDS. That the crisis of confidence has two sources. People living with HIV/AIDS can experience betrayal of the body which he pointed out that people with HIV undergo a crisis of confidence due to the psychological change of their bodies which they feel are betraying them and starts losing confidence in themselves particularly women. He further highlighted that the patient’s awareness of the social prejudices linked to HIV/AIDS made him question her own social relations and even society in general.

According to Isah (2005), social crisis of confidence is another source which draws on a personal experience in hospital. He underlined the ever-present existence of discriminatory attitudes from the medical staff, families and society towards people living with HIV/AIDS especially women. He asserted that, this crises makes life apathetic especially in the African context where by an individual exists only because we belong to a family, an ethnic or social group. Feeling or ostracized from that family, group or community is synonymous with being dead or killed. It was re-instated that man by nature is a social being and longs for acceptance from other people and that this need for

acceptance has however been stifled for some enterprising women because of their HIV positive status. Indeed, they have gone into deep melancholy often times thinking of suicide. It was further reported by UNAIDS that, at the collapse of the immune system, precipitating opportunistic infections, the victim has climaxed from conflict to crises stage which is associated with assorted behavioral disorders such as affective street disorders, self-persecution disorder, suicide, stresses disorders etc.

Aggleton (2004) asserted that, stigmatization has resulted in resentment and frustration, anger, blame and fear among several people living with HIV/AIDS and some unscrupulous medical personnel have began to exploit the situation that a team of a centre of right to health officers who carried out instigations on the phenomenon of stigmatization was told that the situation was so bad that some people living with HIV/AIDS in their bid to avoid being stigmatized now financially induce certain unscrupulous medical personnel to change the laboratory result of their HIV screening to indicate that they are negative. As disturbing as this revelation is, it simply shows how far people can go as a result of the emotional state and fear of living with HIV in the face of growing stigmatization, rejection and discrimination. Shainsa (2005), highlighted some emotions of the patients with HIV/AIDS as anticipatory grief from both patient and family. Feelings include fear, anxiety and sadness,

depression and discouragement express in the following ways as short temper and loss of interest in everything.

2.9 Review of Related Studies

Many studies have been done on stigmatization, discrimination and rejection of people living with HIV/AIDS around the world. From available data, a high proportion of people living with HIV/AIDS especially women suffers discrimination, rejection and stigmatized. Herek (1990), from a study reported that people with AIDS are evaluated more negatively especially women than people diagnosed with other incurable diseases, even by healthcare workers. He also cited studies where it was observed to be common among caregivers, to avoid people with AIDS and to over estimate the risks of casual contact with people infected with HIV/AIDS

Herek and Capitonto (1993) in their study found that HIV/AIDS related stigma and discrimination exists in a significant minority of the United State's population. They used a 1991 random digit telephone survey to examine stigmatization and discriminative attitudes about HIV/AIDS especially on women. Of the 1,145 households surveyed, 538 were defined "black". The result of the survey showed 27.1% of all participants gave a "stigmatizing response". When asked if they felt angry towards people with AIDS and if people with AIDS should be separated from the general population, 35.7% of the

participants gave a stigmatizing response. When participants in the 1991 telephone survey were asked if people with AIDS have "gotten what they deserved" 20% of white respondents and 16.5% of black respondents said yes. Thirty three percent (33.0%) of the white respondent agreed that people with AIDS should be legally separated or quarantined, compared with 40% of black respondents who shared a similar view. And 19.2% of white respondents said they would avoid a co-worker with AIDS, compared with 21.1% of black respondents who shared the same opinion. White women were the least likely of any group surveyed to over estimate the risks of casual contact or to anticipate that they would avoid people with AIDS. The study on stigma discrimination and emotional consequences of people living with HIV/AIDS was carried out in the United State of America. The study failed to look at the fact that, stigmatization, rejection and discrimination against people living with HIV/AIDS can have serious effects of emotional consequences. This study was carried out in Kaduna metropolis of Kaduna state in Nigeria.

In another study by Herek (1999), found that younger and more highly educated people typically manifest lower levels of HIV – related stigma than do older people and those who are less educated. Herek did not particularly look at women, but generally at older people. This study will focus on women irrespective of their level of education.

Huebner (2004) in a study of harassment, discrimination and physical violence among young and older women living with HIV/AIDS examined the 6 month cumulative incidence of harassment, discrimination and violence among young and older women with HIV/AIDS, both young and older women from 3 cities in the South Western Unite States were issued self-administered questionnaires. The result showed that 37% of women reported experiencing harassment in the previous 6 months; 11.3% reported discrimination and 4.8% reported physical violence. Younger women reported more to those experiences because they were more open in disclosing their HIV- status to others. Reports of mistreatment were associated with lower self- esteem and increased suicidal ideation. In their discussions, recent experiences of HIV positive women verbal harassment, discrimination and physical violence were reported by a substantial minority of women in their sample, younger women aged 18-12 years who are more open in disclosing their HIV-status to others most often reported such events. These types of mistreatment were associated with lower self-esteem and a 2 fold increase in the odds of reporting suicidal ideation.

Huebner (2004) focused on women living with HIV/AIDS in terms of harassment, discrimination and physical violence they face from the public. The study is similar to the present study in the examination of the social and emotional consequences in terms of discrimination; stigmatization and rejection .They used women from 3 cities in United States and administered

questionnaires. The present study will use population in kaduna metropolis of Kaduna state and will also administer questionnaires.

In a comparative study on stigmatizing and discriminating attitudes attached to HIV/AIDS among women adult and female youths in Benin city by F.B. Charles. The methods used in their survey were cross-sectional by design. It utilized both quantitative (using structured interview) and qualitative techniques (key informant interview and focus group discussion) to collect information on HIV/AIDS in the study area. In their result, among adult women in general HIV related stigma is quite high in the study, population with 85.7% of the respondents held at least one discriminatory attitude towards people living with HIV/AIDS (PLWHAS). Also the most prevalent discriminatory attitude reported was the discrimination of respondents to buy food from a shopkeeper known to have HIV (62.2%). This was followed by unwillingness to sit at the some table with an infected person (65%.3) and to care for a family member who has the virus (54.3%). The observed high level of HIV-related stigma and discrimination in this population is portly explained by the prevailing high level of misconception on the possible routes of HIV transmission.

They further reported that, the fact that a substantial proportion of the population did not want to care for an AIDS patient, may partly indicate the limited economic ability of the community to provide care and support for such patient. Some respondent may indeed fear the possibility of getting the virus via

contamination, while caring for an AIDS patient. Youth respondents on the other hand, held a stigmatized attitude towards people living with HIV/AIDS. About 78% of them held at least one discriminatory attitude towards people living with HIV/AIDS. Such attitude, they reported, was significantly higher among females. The most prevalent discriminatory attitude reported among the youths was refusing to associate with people in particular women living with HIV/AIDS. This study is a bit different from the present study in terms of respondents. The study should have included those infected by the virus to ascertain the reliability and validity of the study. This study will use respondents infected with the virus to know and ascertain the extent of stigmatization, rejection, discrimination and the emotional consequences they have on the infected women.

In a survey of HIV/AIDS related stigma and discrimination in health care settings, Gebre (2005), reported that, medical and nursing care for people living with HIV/AIDS constitutes one aspect of a comprehensive care and support intervention. He asserted that the provision of this service largely depends on the existence of a well functioning health care system. The quality of care of the service is what translates into individual clients' satisfaction. That an important issues related to the later is making the service accessible to all those who need them without any form of discrimination. Because of stigma, rejection and discrimination, patient may be given substandard care, treated with disdain, face

limited access to service, or avoid service altogether, thus preventing them from receiving life saving health care. The survey was conducted in 12 purposefully selected health facilities in Kaduna state. Four referral hospitals and eight health centers were included in their survey. Over 300 technical and supportive health care workers were interviewed, and 50 units/sections were observed.

From the result, it was identified that there was significant stigmatization and discrimination going on in the health facilities. The result revealed that there was a huge breach of confidentially which is an ample ground to stigmatize and discriminate against clients. Different modalities of labeling clients with HIV or AIDS were observed. More than 75.0% of the staff reported that they were always alert about any staff working in the department with regards to the status of a client who is HIV positive or presumed to be HIV infected. Almost 66.6% of the respondents reported that, any client clinically suspected of HIV infection or AIDS will be tested without counseling or seeking his consent. This is particularly true for “high risk” clients. Ninety percent of health workers asserted that client suspected of HIV infection would be tested before any surgery and 83% believe that they have the right to know clients HIV status. Some 13% believe that HIV infection clients and AIDS patients should be segregated and kept away from other clients. Clothes used by HIV infected clients should be disposed off according to 17% of respondent. The study looked at stigma and discrimination against HIV/AIDS patient in Health care settings

only. It did not cover other settings in which HIV/AIDS patients or persons are stigmatized and discriminated against.

In another study conducted in a community survey in Zaria: one pathway for change on the relationship between in-depth knowledge of HIV/AIDS and stigmatizing attitudes Mohammed (2004); reported that, success of interventions on the prevention of HIV and mitigate the AIDS epidemic impact depends partly on a supportive environment or behavior change and service utilization. However, stigma and discrimination towards people living with HIV/AIDS impedes behavior change and use of services. Result from the stigma and discrimination baseline survey identified characteristics of those with stigmatizing attitudes and information needed to target programmed for reducing stigma and ensuring service use.

The method used was a population based survey conducted in 2004 in Kaduna state. He used a two–stage sampling to select households and interviewed eligible members. The questionnaire identifies HIV/AIDS knowledge attitude and exposure to people living with HIV/AIDS. Data analysis examined factors associated with negative attitudes towards people living with HIV/AIDS. The result showed that most of the 973 respondents had attended school and had some HIV/AIDS awareness. Thirty nine percent of the people living with HIV/AIDS were treated differently in the community. Thirty three

percent had witnessed at least one form of discrimination with people living with HIV/AIDS in previous years.

Over one third thought people living with HIV/AIDS should be ashamed of themselves and that HIV/AIDS is a punishment for bad behavior from God.

Respondents with less education, less in- depth knowledge about HIV/AIDS and less contact with people living with HIV/AIDS were more likely to agree with those negative attitudes. The responses for how community members would respond to identical statement were consistently higher than personal responses. The individual perception of the prevalence of stigma in communities was observed to be much higher than actual prevalence rate or the existence of social desirability bias. In their conclusion, education and HIV/AIDS in-depth knowledge significantly affected individuals stigmatizing attitudes towards people living with HIV/AIDS. Therefore, equipping individuals with in-depth knowledge about HIV/AIDS is one way of reducing the stigmatization and increasing use of HIV/AIDS services.

Mohammed (2004), observation agree with the fact that in-depth knowledge about HIV/AIDS is one way of change stigmatizing attitudes towards people living with HIV/AIDS. The study should have used the people infected too to get their views about these stigmatizing and discriminating attitudes bestowed on them. It should have also looked at the emotional consequences, the stigmatizing attitudes has impacted on them. This would have

enabled the study to understand how people living with the virus actually feel about these negative attitudes.

Richard; William and Andrew in their study combating the cross sectional emotional consequences of HIV/AIDS – related stigma and discrimination (2003) reported that stigma is an undesirable attitude. That it result in the reduction of a person/group's status in the eyes of society. That discrimination result in being treated unfairly on the basis of belonging or being perceived to belong to a particular group is serious problems associated with HIV/AIDS. HIV/AIDS – related stigma and discrimination and rejection manifest at the societal and community levels. In the health care system, within schools and at the family and individual level these manifestations are felt by victims of the disease. They explained that, the issues arising from the devastation caused were not only affecting the socio-cultural fabric of the communities but also the preventive treatment and care efforts.

In the report, they observed that, the tendency to place blame on victims of HIV/AIDS creates an attitude that seeks to punish and repudiate responsibility. HIV – positive individuals also have to suffer the shame and guilt that comes to their families because of their sere-positive status. They explained that, negative responses to sere-positive status affect women disproportionately while lack of open communication can lead to internalized shame or isolation. The result they opined are that the individual feels that they are not a valuable

part of the community and are therefore unable to seek appropriate help and resources.

In conclusion, many studies have been conducted on the prevention, treatment, stigmatizing and discriminating attitudes by the public to people living with HIV/AIDS in Kaduna metropolis of Kaduna State. But none of the studies have directed their attention to the people infected with the virus in general and women in particular as regards stigmatization, discrimination and rejection bestowed on them and the emotional consequences it has on them. It is in the light of these problems of social stigma by husbands, relatives, children, friends, institutions, community and how they relate to women living with HIV/AIDS that this study critically examined the social and emotional consequences of women living with HIV/AIDS with special reference to the social stigma, discrimination and social rejection.

2.10 Summary

The results of available empirical research have indicated that people living with HIV/AIDS are socially discriminated, stigmatized and rejected by their loved ones and the communities. This has effect on the emotional stability of people living with HIV/AIDS. However, all the available literature as well as empirical studies have not been particular about how these could have effected women living with HIV/AIDS in Kaduna metropolis. More so, previous studies

have not determined how social consequences of living with HIV/AIDS affect interpersonal relationship and most devastating in women with such disease.

Ability to ascertain all these will no doubt help disabuse the minds of the public towards people living with HIV/AIDS. It will also influence a change of attitude towards caring and giving them support rather than stigmatizing, discriminating and rejecting them. This will help in having a society where individuals, families and communities understand and address HIV infected persons with care and sympathy instead of constantly discriminating, stigmatizing and rejecting them in Kaduna metropolis.

CHAPTER THREE

RESEARCH METHODOLOGY

3.1 Introduction

This study examines the social and emotional consequences of women living with HIV/AIDS in Kaduna metropolis. To this end this chapter describes and discusses the design and procedure for the study. The chapter describes the research methodology, the population and sample used. A description is also made of the instrumentation for data collection as well as discussion of the validity and reliability of the instrument. Also discussed in this chapter are the procedures for the administration of the instrument and statistical analysis.

3.2 Research Design

The research method used for this study is basically the survey design. This method involves gathering data about the target population from a sample and generalizing the finding that was obtained from the analysis of the sample to the entire population. This design is thus adopted because the study seeks to find out the opinion of women on social and emotional consequences they experience as a result of living with HIV/AIDS.

3.3. Population of the Study

The population for this study consisted of women living with HIV/AIDS in Kaduna metropolis of Kaduna State. From available records, the total is estimated to be 3,468. These figures were obtained from the various Health care centre and hospitals within the metropolis. The rationale behind restricting the population of the study to women based on the premise that they are the most vulnerable group and more likely to be badly treated than children and men. Moreover, they are directly involved and able to give or present adequate information on the social and emotional consequences of living with the virus. The estimated population from the different health care units and centers are presented in Table 3.1. The table shows the number of infected women in the each of the units and their age brackets.

Table 3.3.1: Population of the Study

Names of Hospitals and Support Groups	Ownership	Statistics of women population living with HIV/AIDS	Age bracket
Nursing home hospital	Govt.	548	15 – 65 years
44 army reference hospital	Govt.	620	18 – 60 years
St. Gerald's Hospital	Govt.	560	12 – 65 years
Family resources centre (old ABUTH)	Govt.	400	13-65 years
Aids Alliance Kaduna	Private	560	12- 60
Living with hope foundation	Support group	560	12 – 60
Al-ummah support group	Support group	150	20 – 65
Rakiya memorial hospital	Private	20	22 – 45
All people foundation diagnostic centre	Private	50	20 – 50 years.
Total		**3,468**	

3.4 Sample Size and Sampling Techniques

Consequently, out of a total population of 3,468, the researcher used 351 women for the study. The selection of the 351 women who constituted the main respondents for the study was selected through stratified random sampling. This was to achieve a proportional representation of women living with HIV/AIDS from each centre of the metropolis.

To systematically select the sample needed to be included in the study, the researcher used the simple random sampling technique. To do this, the hat drawn method was used to select the respondent in order to give every member of the population an equal chance of being selected piece of paper was numbered and dropped in a bowl. Those who picked odd numbers were selected till the required sample size was obtained. Table 3.2 presents the selected units, the population size and the number of women selected for the study.

Table 3.3: Population of Women and the Number Selected from each of the Units

S/no	Hospital Selected	Population	Stratified Sample Size
1	Nursing home hospital	548	55
2	44 army reference hospital	620	61
3	St.gerald's hospital	560	55
4	Family resources centre	400	41
5	Aids alliance Kaduna	560	53

6	Living with hope foundation	560	53
7	Al-Ummah support group	150	17
8	Rakiya memorial hospital 20	20	7
9	All people foundation diagnostic centre	50	9
	Total	**3,468**	**351**

3.5 Instrumentation

The instrument used for data collection in this study was the questionnaire developed by the researcher. The questionnaire is tagged Social and Emotional Consequences of living with HIV/AIDS questionnaire {SECLHQ}. The questionnaire was divided into sections. The format of the questionnaire was based on 5 point Likert scale of strongly Agreed (5), agreed (4), Undecided (3), Disagreed (2), strongly disagreed (1).

The design of the questionnaire is clustered around three (3) section viz:-

a. Personal data such as marital status, age, occupation, educational status of respondents.

b. Social consequences comprising (i) social stigma, (ii) Discrimination and (iii) Social rejection.

c. Emotional Consequences.

Section A: This was made up of close ended questions and two open ended question. These required the respondents to tick their marital status, educational status, while they also gave their actual ages and occupation.

Section B: This section was made up of items on the social consequences of living with HIV/AIDS. They included items on social relationship, social stigma, discrimination and rejection of women living with HIV/AIDS

Section C: Deals with the emotional consequences that women living with HIV/AIDS experience in the metropolis.

3.6 Validity and Reliability

3.6.1 Validity

Establishment of validity is necessary to ensure that an instrument measures accurately what it sets out to measure. Content validity is one of the several types of validity which deals with content measurement (Kerlinger, 1973).

The questionnaire was validated by five experts in Educational Psychology. These experts were to judge the appropriateness of the items in the questionnaire in view of the subject matter of investigation as well as the research questions that guided the study. Five copies of the questionnaire were

given to the five experts and all were returned. Their modification. and correction resulting from their observations was adopted in the final draft of the instrument. Experts in this case are persons who posses thorough knowledge and high degree of competence in the area of Educational psychology.

3.6.2 Reliability

A pilot study was carried out with 40 respondents in two selected hospitals. Governor Awwan Memorial Hospital at Kakuri and Yusuf Dantsoho Memorial Hospital at Tudun-Wada. To pre-test and see how easily understood the questionnaire was. It was also to determine whether it measure what exactly the researcher intended to measure with consistency. The 40 respondent did not form part of the main investigation. The respondents were requested to indicate their response to each statement by ticking one of the alternative responses built in the Likert type 5 point scale. This was to ensure that individual opinion about the social and emotional consequences are adequately expressed.

The respondent were given five days to fill out the questionnaire and the researcher was in touch with the heads of the support groups to check if they have any problems with the questions. The responses of the test were scored and the split – half reliability procedure was used to determine the result of the pilot study. The split-half co-efficient obtained using the SPSS (13^{th} Edition) was 0.876 and the internal consistency co-efficient was 0.887. This means that the

instrument was reliable. Tuckman (1975), observed that the nearer to 1 the reliability co-efficient of an instrument and consistency co-efficient, the more reliable, the instrument. Therefore this instrument could be considered reliable for this study and studies of this nature.

3.7 Procedures for the Administration of the Instruments

The respondents were identified through their support group meetings held ones every month and in hospitals where they visit for follow up and collection of drugs. The researcher used research assistance to help administer the questionnaire to the infected women for smooth and proper administration. The respondents responded freely to the questionnaire, because their responses on the questionnaire were highly confidential. Two letters were prepared to accompany the instrument. One of the letters was addressed to the heads of the hospitals and support groups seeking their permission to allow the researcher to carry out the study in the designated hospitals and centers. Besides the letters were intended to earn the cooperation of the heads of the centers and impress the respondents to fill the questionnaire. The second letter prepared was attached to the instrument and addressed to the respondents. This was meant to introduce the researcher to the respondents and to state the purpose and significance of the study to the respondents. The researcher got the permission of the various heads

of the units (centers & hospitals) to explain what the letter contains to those that are uneducated.

In the administration of the instrument, the researcher first met with the head of the groups with the letters of permission addressed to them. After obtaining the permission, the respondents were then contacted at the hospitals and centers where the task at hand was explained. The simple random sampling technique, in form of the Hat Drawn method was used to select the required number of respondents was adopted. In each hospitals and support group center, women who picked the odd number up to the required number were selected as tests and of course for the fact that the population is made of two groups. The married and unmarried that are compared respondents for the study. The respondents were given five days to fill and return the questionnaire. The heads of the support groups and research assistance were used to help administer and collect the filled out questionnaire. It was assumed that the five days will enable the respondent to reflect on the instrument and fill them properly.

3.8 Procedures for Statistical Analysis

The study made use of a number of statistical techniques to help in the organization, analysis and interpretation of data. The statistical techniques are summarized as follows:

i. Frequency counts and percentages were used to determine responses on the personal data asked. Tables were used to summarize the frequencies.

ii. The mean, standard deviation and frequencies, were used to analyze the data based on the research questions

iii. Two tailed T-test was used to test for significance on the hypotheses 1,4 and 6 with the aid of a computer using the statistical package for social sciences(S.P.S.S) two tailed T-test was appropriate because the hypotheses are parametric

iv. Chi – square (x^2) was used to test hypothesis two to determine the differences in the rating of the most devastating social and emotional consequences of HIV/AIDS

v. Anova was used to test hypotheses 3, 5, and 7 with the aid of a computer using the statistical package for social sciences (S.P.S.S.)

All the hypotheses were tested at 0.05 level of confidence. Best (2002a) suggested that in educational circles, the 5 percent (0.05) level of significance is often used as a standard for rejection or acceptance.

CHAPTER FOUR

DATA ANALYSIS AND DISCUSSION

4.0 Introduction

This chapter presented the statistical analysis of the data collected in relation to the social and emotional consequences of women living with HIV/AIDS. The structure of the chapter consisted of the demographic characteristics of the respondents presented in tables of frequencies and percentages. In the second section, a general presentation, of the responses on the social and emotional consequences of living with HIV/AIDS on the victims were presented in relation to the general objectives of the study. The other sections consisted of the test of hypotheses for the study and were followed by a discussion of the findings and solutions to the research questions raised in the study. In computation of the main variables investigated, the item scores for each respective variable were summed up and divided by the total number. The mean scores obtained are all within the scale used in the measurement of the respondents' opinion. This will enable decisions that would give a conclusive solution on whether the respondents were in favour (Agree) of the issue raised in the item / variable or not (Disagree).

4.1 The demographic characteristics of women living with HIV/AIDS.

Three hundred and fifty one (351) women living with HIV/AIDS within Kaduna Metropolis were involved in this study. Among their demographic variables selected for the study were age, marital status occupation and the educational satus. Each of the variables are tabulated in frequencies and percentages below.

Table 4.1: Classification of the Respondents by their Age Range.

Age range	**Frequency**	**Percentage**
20years and below	24	6.8
21-30years	130	37.0
31-40years	138	39.3
41-50yrs	51	14.5
Above 50years	8	2.3
Total	351	100.0

The distribution in the table revealed that 39.3% of the respondents were within the 31 and 40years age range. This group were more than any other range in the table. Those who were 20years and below were only 6.8% of the total respondents while those within 21 and 30years were 37.0%. Respondents who were between 41 and 50 years were 14.5% while those above 50years were 2.3% of the entire respondents involved in the study. By this distribution, the respondents could be said to understand the subject matter of the study and

could therefore be expected to provide valid response to the questions raised in the questionnaire.

The marital statuses of the respondents were classified into two categories as indicated in Table 4.2.

Table 4.2: Classification of the Respondents by their Marital Status.

Marital status	**Frequency**	**Percentage**
No response	7	2.0
Married	230	65.6
Single	114	32.4
Total	351	100.0

Table revealed that 65.6% of the total respondents were married. Only 32.4% of the respondents said they were single and 2.0% of the total respondents did not indicate their marital statuses. The importance of this variable is that it clearly reveals that all the different groups among women within the metropolis were well represented in the study.

The occupations of the respondents were classified into four group for purpose of identification as indicated in Table 4.3.

Table 4.3: Classification of the Respondents by their Respective Occupations.

Occupation	Frequency	Percentage
No response	54	15.5
Civil servant	58	16.5
Business/trader	20	14.2
Artisan	10	2.8
House wife/Others	179	51.0
Total	351	100.0

The classification in the table indicated that house wives and other unspecified occupation accounted for 51.0% of the total respondents. Those who said they were civil servants among the respondents were 16.5% while 14.2% of the total respondents claimed to be either business women or traders. Those belong to one form of trade (Artisans) or another were 2.8% of the total respondents. But 15.5% of the total respondents did not indicate their occupations. By this distribution it implies that the various occupations within the metropolis were represented in the study.

The educational status of the respondents was basically classified into two categories. These were whether the respondent was educated or not educated as indicated in Table 4.4.

Table 4.4: Classification of the Respondents by their Educational Status.

Educational status	Frequency	Percentage
No response	9	2.5
Educated	235	57.0
Not educated	107	30.5
Total	351	100.0

The table revealed that 57.0% of the respondents were educated. Those who were not educated were 30.5% of the total respondents and 2.5% of the respondents did not answer the question. By this classification all groups of women within the Kaduna metropolis could be said to be adequately represented in the study.

4.2: Presentation of Responses on the Social and Emotional Consequences of Living with HIV/AIDS

Among the objectives of this research was the determination of the social and emotional consequences suffered by women living with HIV/AIDS in the study area. These two variables were further structured into different components and presented in different tables towards addressing the main objectives of the study. The social consequences included Social discrimination, social stigma and social rejection. Emotional consequences included depression, frustration, aggression, fear, shame, anxiety, irritation, annoyance, low self

esteem, suicidal thoughts and isolation. The assessment of these variables was conducted in a rated interval scale for the respective items used in evaluating the perceived social and emotional consequences experienced by the respondents as a result of living with HIV/AIDS. These two variables were further compartmentalized into social discrimination, social stigma and social rejection. In Table 4.5, the opinions of the respondents on the social discrimination suffered by the victims of HIV/AIDS in the study area are presented in frequencies and percentages.

Table 4.5: Perception of Respondents on Social Discrimination as a Result of Living with HIV/AIDS

Social discrimination as a result of living with HIV/AIDS	**SA**	**A**	**U**	**D**	**SD**
1. Unfaithfulness in marriages increase HIV rates in women	235 (67.0)	102 (29.1)	9 (2.6)	5 (1.4)	-
2. Women are not able to negotiate condom use to protect themselves against HIV/AIDS	142 (40.5)	97 (27.6)	50. (14.2)	52 (14.8)	10 (2.8)
3. Violence in marriage limits women's ability to protect themselves from HIV/AIDS	124 (35.3)	136 (38.7)	56 (16.0)	26 (7.4)	9 (2.6)
4. Poverty causes the spread of HIV/AIDS among women and girls	169 (48.1)	103 929.3)	4 (1.1)	36 (10.3)	39 (11.1)
5. Beliefs that HIV/AIDS is a curse not a disease leads to the use of traditional healer as the solution	134 (38.2)	110 (31.3)	48 (13.7)	41 (11.7)	18 (5.1)

6. Immoral behavior exposes one to the danger of HIV/AIDS	213 (60.7)	115 (32.8)	14 (4.0)	6 (1.7)	3 (0.9)
7. Illiterate women contracts HIV/AIDS easily than educated women	139 (39.6)	107 (30.5)	13 (3.7)	78 (22.2)	14 (4.0)
8. The kind of jobs women engage in exposes them to contracting HIV/AIDS	46 (13.1)	126 (35.9)	98 (27.9)	64 (18.2)	17 (4.8)
8. Fear of discrimination makes HIV/AIDS infected women to avoid relationship with other	94 (26.8)	227 (64.7)	13 (3.7)	15 (4.3)	2 (0.6)
9. Fear of discrimination prevent women from admitting their HIV status publicly	209 (59.5)	133 (37.9)	7 (2.0)	1 (0.3)	1 (0.3)
10. Women with or suspected of having HIV are turned away from health care services	17 (4.8)	102 (29.1)	42 (12.0)	106 (30.2)	84 (23.9)
11. Women with HIV/AIDS are refused employment due to discrimination	79 (22.5)	191 (54.4)	36 (10.3)	37 (10.5)	8 (2.3)
12. Women with HIV/AIDS are refused entry to foreign countries due to discrimination	73 (20.8)	115 (32.8)	92 (26.2)	56 (16.0)	15 (4.3)
13. Women with HIV/AIDS do not receive much sympathy and support, but were rather discourage against	74 (21.1)	192 (54.7)	37 (10.5)	38 (10.8)	10 (2.8)
14. Women with HIV/AIDS face negative reaction and experiences from the general public	193 (55.0)	119 (33.9)	18 (5.1)	17 (4.8)	4 (1.1)
15. The discrimination displayed by the public force infected women to leave their jobs	27 (7.7)	176 (50.1)	37 (10.5)	69 (19.7)	42 (12.0)
16. The discrimination displayed by the	17	151	47	111	25

public force infected women to withdraw from school	(4.8)	(43.0)	(13.4)	(31.6)	(7.1)
17. Women living with HIV/AIDS are being fired from their jobs	110 (31.3)	159 (45.3)	30 (8.5)	39 (11.1)	13 (3.7)
18. There is a very high discrimination against low income women living with HIV/AIDS in most communities	85 (24.2)	179 (51.0)	34 (9.7)	38 (10.8)	15 (4.3)
19. Where both men and women are infected with HIV/AIDS, women are often more discriminated against than men.	111 (31.6)	125 (35.6)	46 (13.1)	50 (14.2)	19 (5.4)

In the table, the respondents agreed with the expressed opinion that the women victims of HIV suffers from social discriminations which included all the items listed. The only item that the respondents did not agree that is adversely affecting the women living with HIV/AIDS in the table is item 10, where the respondents disagreed that women with HIV or suspected of having HIV are turned away from health care services. The second variable of the social consequences of living with HIV/AIDS is social stigma. In Table 4.6, the respondents' opinion on the effect of living with the virus with respect to social stigma is presented in frequencies and percentages.

Table 4.6: Opinion of the Respondents on the Social Stigma Suffered by Women Living with HIV/AIDS

Social stigma as a consequence of living with HIV/AIDS	SA	A	U	D	SD
1. Women living with HIV/AIDS are stigmatized that they find it difficult to have normal interpersonal relationship with other people	149 (42.5)	179 (51.0)	12 (3.4)	9 (2.6)	2 (0.6)
2. Women with HIV/AIDS are so stigmatized that they becomes a misfit in the society	66 (18.8)	227 (64.7)	34 (9.7)	20 (5.7)	4 (1.1)
3. Women living with HIV/AIDS are stigma results into fear of being rejected by loved ones	159 (45.3)	168 (47.9)	9 (2.6)	11 (3.1)	4 (1.1)
4. Due to stigmatization women living with HIV/AIDS are denied any form of treatment	24 (6.8)	69 (19.7)	62 (17.7)	102 (29.1)	94 (26.8)
5. Stigmatization result in difficulty of finding employment by women living with HIV/AIDS	58 (16.5)	212 (60.4)	35 (10.0)	39 (11.1)	7 (2.0)
6. Stigmatization by the public has resulted in difficulty of finding housing by women with HIV/AIDS	47 (13.4)	145 (41.3)	65 (18.5)	86 (24.5)	8 (2.3)
7. Women living with HIV/AIDS are isolated from other patients in health care centers due to stigma	185 (52.7)	116 (33.0)	19 (5.4)	22 (6.3)	9 (2.6)
8. Low status of women increases the basis for stigma of women in terms of HIV/AIDS	84 (23.9)	155 (44.2)	48 (13.7)	52 (14.8)	12 (3.4)

9. Women' lack of access to education increases the chance of being positive	174 (49.6)	111 (31.6)	25 (7.1)	29 (8.3)	12 (3.4)
10. The problems of HIV/AIDS stigma ere created by individual and communities	76 (21.7)	178 (50.7)	21 (6.0)	45 (12.8)	31 (8.8)
11. Stigma makes women with HIV/AIDS to face social isolation	192 (54.7)	126 (35.9)	22 (6.3)	9 (2.6)	2 (0.6)
Stigmatization of women living with HIV/AIDS is the creation of the society	55 (15.7)	169 (48.1)	37 (10.5)	33 (9.4)	57 (16.2)
12. People see women with HIV/AIDS as being punished by God for evils	67 (19.1)	167 (47.6)	74 (21.1)	33 (9.4)	10 (2.8)
13. AIDS stigma inflict suffering on women and interferes with attempts to fight the HIV/AIDS pandemic	131 (37.3)	143 (40.7)	57 (16.2)	16 (4.6)	4 (1.1)
14. Lack of educative programmes to reduce the stigma makes infected women not to declare their status	115 (32.8)	212 (60.4)	12 (3.4)	12 (3.4)	

From the expressed opinion of the respondents in Table 4.6, women living with HIV/AIDS actually suffer from stigmatization. This is seen from the frequencies scores and the correspondent percentages for the items in the table. The respondents did not agree that this stigmatization extended to the extent where women living with HIV/AIDS are denied any form of treatment in the health care centres in the study area. Social stigmatization is therefore one of the major social consequences suffered by women living with HIV/AIDS.

The Third aspect of the social consequences is social rejection suffered by victims of the disease. The opinion of the respondents on the level of experience of this variable by the women is presented in Table 4.7.

Table 4.7: Perception of Respondents on Social Rejection as a Consequence of Living with HIV/AIDS

Social Rejection as a Consequences of Living with HIV/AIDS	**SA**	**A**	**U**	**D**	**SD**
1. Women infected by HIV/AIDS are rejected by their families and love ones	80 (22.8)	168 (47.9)	15 (4.3)	36 (10.3)	52 (14.8)
2. Women infected by HIV/AIDS are rejected by their communities	107 (30.5)	152 (43.3)	15 (4.3)	72 (20.5)	5 (1.4)
3 Women with HIV/AIDS refused to disclosed their HIV status for fear of being rejected from those whose support they need most	214 (61.0)	114 (32.5)	16 (4.6)	6 (1.7)	1 (0.3)
4 Inadequate knowledge about how HIV/AIDS can be contracted make people to reject infected women			33 (9.4)	149 (42.5)	169 (48.1)
5 HIV/AIDS infected women are treated as outcast by their environment	57 (16.2)	173 (49.3)	37 (10.5)	77 (21.9)	7 (2.0)
6 Public health workers have negative attitude towards HIV/AIDS infected women when rendering their services	65 (18.5)	177 (50.4)	46 (13.1)	48 (13.7)	15 (4.3)
7 Women who died of HIV/AIDS are not given befitting burial	55 (15.7)	115 (32.8)	66 (18.8)	63 (17.9)	52 (14.8)

As much as the respondents agreed that women living with HIV/AIDS suffer from social rejection in the table, they did not agree that this social rejection is a direct consequence of ignorant of the disease within the study area. This is seen in item 4 where the respondents disagreed that inadequate knowledge about how HIV/AIDS can be contracted made people to reject infected women. This means that victim of the disease suffer from social rejection purely because of the held notions of the virus in the society.

Another objective of the research was the determination of the emotional consequences (depression, frustration, aggression, fear, shame, anxiety, irritation, annoyance, low self esteem, suicidal thoughts and isolation) suffered by women living with HIV/AIDS in the study area. In Table 4.8 the opinion of the respondents on each of these items is expressed in frequencies and percentages.

Table 4.8: Perception of Respondents on the Emotional Consequences Suffered by Women as a Result of Living with HIV/AIDS

Emotional consequences as a result of living with HIV/AIDS	**SA**	**A**	**U**	**D**	**SD**
1. Women living with HIV/AIDS feel worthless	116 (33.0)	200 (57.0)	16 (4.6)	19 (5.4)	
2 Women living with HIV/AIDS lose self confidence	118 (33.6)	214 (61.0)	9 (2.6)	8 (2.3)	2 (0.6)
3 Women living HIV/AIDS feel ashamed	217 (61.8)	120 (34.2)	11 (3.1)	1 (0.3)	2 (0.6)

4 Women living with HIV/AIDS feel worried	201 (57.3)	127 (36.2)	19 (5.4)	3 (0.9)	1 (0.3)
5 Some women living with HIV/AIDS commit suicide	76 (21.7)	121 (34.5)	75 (21.4)	50 (14.2)	29 (8.3)
6 Women with HIV/AIDS feel inferior	62 (17.7)	243 (69.2)	29 (8.3)	7 (2.0)	10 (2.8)
7 Women living with HIV/AIDS feel frustrated	205 (58.4)	134 (38.2)	9 (2.6)	3 (0.9)	
8 Women living with HIV/AIDS don't have hope in life	63 (17.9)	113 (32.2)	75 (21.4)	48 (13.7)	52 (14.8)
9. HIV/AIDS infected women are easily annoyed	96 (27.4)	198 (56.4)	27 (7.7)	19 (5.4)	11 (3.1)
10. HIV/AIDS positive women ask Doctors to change their result due to fear of rejection	27 (7.7)	171 (48.7)	113 (32.2)	27 (7.7)	13 (3.7)
11. HIV/AIDS positive women are not interested in any life activity	104 (29.6)	157 (44.7)	50 (14.2)	34 (9.7)	6 (1.7)
12. Women with HIV/AIDS feel tired of the world	109 (31.1)	137 (39.0)	75 (21.4)	18 (5.1)	12 (3.4)
13. Women with HIV/AIDS often feel irritated	117 (33.3)	173 (49.3)	45 (12.8)	12 (3.4)	4 (1.1)
14. Women with HIV/AIDS often feel depressed	148 (42.2)	172 (49.0)	26 (7.4)	5 (1.4)	
15. HIV/AIDS infected women some times becomes aggressive	118 (33.6)	143 (40.7)	48 (13.7)	28 (8.0)	14 (4.0)
16. Women living with HIV/AIDS have the feeling of anxiety	138 (39.3)	162 (46.2)	33 (9.4)	18 (5.1)	
17. Women living with HIV/AIDS have the feeling of denial	140 (39.9)	176 (50.1)	31 (8.8)	3 (0.9)	1 (0.3)

The Table revealed that the respondents were unanimous about the emotional consequences that women living with HIV/AIDS go through in the study area. As indicated in the table, these include depression, frustration, aggression, fear, shame, anxiety, irritation, annoyance, low self esteem, suicidal thoughts and isolation enforced by the feeling of worthlessness, lose self confidence, shame and others indicated in the table. Of all these items, depression, frustration, and anxiety were the most devastating emotional consequences experienced by the victims. These are indicated in Items 1, 2, 3, 7 and 14 respectively.

Another major objective of this study was the establishment of the most devastating emotional consequences among the listed factors in terms of the marital status of the women. In this regard, the respondents were classified into two groups of married and unmarried (single). The opinion of the respondents on the emotional consequences on the two groups is presented in Table 4.9. The distribution of the consequences between the two groups was tested with the chi-square and the observed probability level of significance for the test is presented along the scores for the respective items.

Table 4.9: Emotional Consequences of Living with HIV/AIDS by Married and Unmarried Women.

Emotional Consequences	Married			Single			X^2	P
	D	UD	A	D	UD	A		
1. Women living with HIV/AIDS feel worthless	17	144	76	2	72	40	4.460	.108
2 Women living with HIV/AIDS lose self confidence	10	155	72	0	68	46	7.487	.024
3 Women living HIV/AIDS feel ashamed	2	79	156	1	52	61	4.999	.082
4 Women living with HIV/AIDS feel worried	2	92	143	2	54	58	3.116	.211
5 Some women living with HIV/AIDS commit suicide	59	125	53	20	71	23	3.272	.195
6 Women with HIV/AIDS feel inferior	14	187	36	3	85	26	4.421	.110
7 Women living with HIV/AIDS feel frustrated	3	87	147	0	56	58	5.993	.050
8 Women living with HIV/AIDS don't have hope in life	62	124	51	38	64	12	6.782	.034
9. HIV/AIDS infected women are easily annoyed	23	165	49	7	60	47	16.498	.000
10. HIV/AIDS positive women ask Doctors to change their result due to fear of rejection	21	199	17	19	85	10	5.213	.074
11. HIV/AIDS positive women are not interested in any life activity	25	130	82	15	77	22	8.644	.013

12. Women with HIV/AIDS feel tired of the world	20	132	85	10	80	24	8.120	.017
13. Women with HIV/AIDS often feel irritated	11	158	68	5	60	49	7.168	.028
14. Women with HIV/AIDS often feel depressed	1	140	96	4	58	52	6.541	.038
15. HIV/AIDS infected women some times becomes aggressive	33	133	71	9	58	47	5.635	.060
16. Women living with HIV/AIDS have the feeling of anxiety	15	136	86	3	59	52	4.194	.123
17. Women living with HIV/AIDS have the feeling of denial	4	136	97	0	71	43	2.236	.296

The table revealed that the two groups equally suffered from most of the emotional consequences expressed. However, the groups differed in lose of self confidence, level of frustration, level of hope and annoyance These are indicated in items 2, 7, 8, 9, 10, 11, 12 and 13 with $P < 0.05$. The two groups also differed in the level of depression they experience as a result of living with the disease. This is indicated in item 14 with $P < 0.05$.

4.3 Test of Hypotheses

A number of hypotheses were raised in this study to validate the identified social and emotional consequences of living with HIV/AIDS in the metropolis. The scores of each of the variables used in these hypotheses were computed by the summation of the total number of items and diving the scores with the items within each of the specified variable. This would enable the verification of a conclusive result of the score. The hypotheses are as follows:

Hypothesis I: There is no significant difference between married and single women in the consequences of HIV/AIDS with respect to:

a. Social consequences**:** (Social stigma, Discrimination, Social rejection)
b. Emotional consequences **(**Depression, Frustration, Aggression, Fear, Shame, Anxiety, irritation, Annoyance denial Low Self Esteem, Low Self Confidence and Suicidal Idealation)

This hypothesis was tested with the two sample t-test because of the two independent variables (Married and Single) involved in the test. The total items for each of the variables were summed up and divided by the number to arrive at the mean used in the test. Each of the variables (Social stigma, Discrimination and Social rejection) were tested separately as indicated in Table 4.5.

Table 4.5: Two Sample Test on Social Stigma, Discrimination and Social Rejection by Marital Status of the Respondents

Marital status	N	Mean	SD	SE	t-value	DF	P	Remarks
Social stigma								
Married	230	57.52	7.329	0.483	1.15	342	0.252	Not Sig.
Single	114	58.43	5.979	0.560				
Social discrimination								
Married	230	76.56	9.359	0.617	0.38	342	0.705	Not Sig.
Single	114	76.14	10.329	0.942				
Social rejection								
Married	230	23.48	4.373	0.288	2.39	342	0.017	Is Sig.
Single	114	24.63	3.829	0.359				

Note: SD= Standard Deviation, SE = Standard Error, t=observed t-value, DF= Degree of Freedom, P = Observed level of significance Critical value of t = 1.96 at P = 0.05)

The result in the table did not reveal a significant difference between the married and the unmarried respondents in their opinion on the social stigma and social discrimination experienced by women living with HIV/AIDS within the Kaduna metropolis. The observed t-values for the two variables were 1.15 and 0.38 respectively while the critical value of t is 1.96 at 342 degree of freedom. The observed t-value is lower than the critical value (P > 0.05). The hypothesis could not be rejected on this basis. There was however a difference of opinion between the two groups on the social rejection experienced by people living

with the disease in the metropolis. The observed t-value is 2.39 and it is higher than 1.96 which stands for the critical value. The hypothesis could be rejected on this basis.

Hypothesis II: Married and single women infected with HIV/AIDS will not differ significantly in their rating of the most devastating social consequences of HIV/AIDS.

This hypothesis was tested with the rating of the respondents with regards to their marital status on the social consequences of experienced by women living with HIV/AIDS in the metropolis. The Chi-square (X^2) was used to determine the differences in the distribution of their rating as indicated in Table 4.6.

Table 4.6: Chi-square Distribution of the Respondents' Rating of the most Devastating of Social Consequences of Women Living with HIV/AIDS

Marital status	Social Stigma	Social Discrimination	Social Rejection	Total
Married	120(35.0)	89(25.9)	21(6.1)	230(67.1)
Single	46(13.4)	56(16.3)	11(3.2)	113(32.9)
Total	166(48.4)	145(42.3)	32(9.3)	343(100.0)

$X^2 = 4.203$ DF = 2 P = 0.122 (P > 0.05) (Not significant)

In Table 4.6, the percentage ratings of the social consequences experienced by the respondents are enclosed in brackets along the frequency counts. The rating of the social consequences of the respondents in the table did

not indicate that one particular social consequence was rated significantly higher by the married or single respondents in the table. The observed chi-square value for the test is 4.203 and it is lower than 5.9 which stand for the critical value of chi-square at 2 degree of freedom and at 0.05 level of significance. This means the hypothesis that married and single women infected with HIV/AIDS will not differ significantly in their rating of the most devastating social consequences of HIV/AIDS can not be rejected (P > 0.05).

Hypothesis III: There is no significant difference between infected women of different ages and the social and emotional consequences they experience as a result of living with HIV/AIDS in Kaduna Metropolis.

The ages of the respondents were categorized into four groups of ten years interval for the purpose of this analysis. The aggregate mean scores for the social and emotional consequences were used for this hypothesis. The respondents who did not indicate their ages were not included in this test. The one way analysis of variance was used for the test as indicated in the analysis of variance model in Table 4.7

Table 4.7: One Way Analysis of Variance on Social and Emotional Consequences of Living with HIV/AIDS by Age of Respondents

Source of variation	Sum of Squares	DF	Mean Square	F	Sig.
Between Groups	16532.457	3	5510.819	10.715	.000
Within Groups	178467.719	347	514.316		
Total	195000.177	350			

The result in the table indicated that ages of infected women is a significant factor in the type of social and emotional consequences they experience in the metropolis as a result of living with HIV/AIDS. The observed significant level for the test is 0.000 ($P < 0.05$). This means that the hypothesis that there is no significant difference between infected women of different ages and the social and emotional consequences they experience as a result of living with HIV/AIDS in Kaduna Metropolis could be rejected.

The mean scores, standard and standard error by the different age groups of the women living with HIV/AIDS in relation to the social and emotional consequences they suffer as a result of living with HIV/AIDS in the metropolis is tabulated in Table 4.8.

Table 4.8: Mean Scores of the Different Age Groups on the Social and Emotional Consequences of Living with HIV/AIDS in Kaduna Metropolis.

Age group	N	Mean	Std. Deviation	Std. Error
16-25YRS	60	222.12	21.824	2.818
26-35YRS	173	224.10	21.777	1.656
36-45YRS	95	229.40	25.880	2.655
ABOVE 45YRS	23	250.87	16.294	3.397
Total	351	226.95	23.604	1.260

The mean scores revealed that experience of the social and emotional consequences of living with HIV/AIDS progress with the age of the

respondents. The means ere subjected to a post hoc test in order to determine the groups that were significantly different from the other in their experience of the social and emotional consequences of living with HIV/AIDS in the metropolis. The Scheffe procedure as used for the post hoc test as indicated in Table 4.9.

Table 4.9: Result of the Scheffe test on the mean scores by the groups

(i) Age group	(j) Age group	Mean Difference (I-J)	Std. Error	Sig.
16-25yrs	26-35yrs	-1.987	3.398	.952
	36-45yrs	-7.283	3.740	.286
	Above 45yrs	-28.753(*)	5.562	.000
26-35yrs	16-25yrs	1.987	3.398	.952
	36-45yrs	-5.296	2.896	.343
	Above 45yrs	-26.766(*)	5.033	.000
36-45yrs	16-25yrs	7.283	3.740	.286
	26-35yrs	5.296	2.896	.343
	Above 45yrs	-21.470(*)	5.270	.001
Above 45yrs	16-25yrs	28.753(*)	5.562	.000
	26-35yrs	26.766(*)	5.033	.000
	36-45yrs	21.470(*)	5.270	.001

Note: The mean difference is significant at the .05 level.

The respondents who were above 45years of age tended to suffer more from the social and emotional consequences of living with HIV/AIDS than all other respondents as indicated in Table 4.9. There was a significant difference between the respondents who were above 45years and all others respondents in

the social and emotional consequences they experienced as a result of the disease. Between the other age groups indicated in the table, no significant difference was observed in their experiences of the social and emotional consequences.

Hypothesis IV: Married and single women will not differ significantly in their experiences of the social and emotional consequences.

The expressed opinion of the respondents on the overall consequences of living with HIV/AIDS in section C of the instrument was used as the dependent variable for this test. The marital status of the respondents was used as the independent variable. The two sample t-test was used for the hypothesis because of the two groups (married and single) involved in the test. The scores and the result of the test of differences between the two groups are presented in Table 4.10.

Table 4.10: Two Sample Test on the Overall Consequences of Living with HIV/AIDS by Marital Status of the Respondents

M. status	N	Mean	SD	SE	t-value	DF	P	Remarks
Married	230	226.13	24.471	1.614	0.74	342	0.457	Not Sig.
Single	114	228.44	22.151	2.075				

Note: SD= Standard Deviation, SE = Standard Error, t=observed t-value, DF= Degree of Freedom**,** P = Observed level of significance Critical value of t = 1.96 at P = 0.05)

Table presents the result of the t-test procedure on the over all consequences of women living with HIV/AIDS by the marital status of the respondents involved in the study. The test revealed no significant difference between the two groups on the emotional consequences experienced by women living with HIV/AIDS in the metropolis. The observed t-value is 1.96 at 342 degree of freedom and 0.05 level of significance ($P > 0.05$). This means that the hypothesis that married and single women infected with HIV/AIDS will not differ significantly in their experiences of the social and emotional consequences of HIV/AIDS is retained.

Hypothesis V: There is no significant difference between the occupations of infected women in their experiences of the social and emotional consequences of living with HIV/AIDS.

The occupations of the respondents were classified into five groups as indicated in Table 4.3 where the analyses of the demographic variables of the respondents were presented. This variable (occupation) was the independent variable used in the test of this hypothesis while the scores on the social and emotional consequences of the women living with HIV/AIDS were used as the dependent variable. The one way analysis of variance was used in the test because of the multiple levels of the independent variable (occupation).

Table 4.11: One Way Analysis of Variance on Social and Emotional Consequences of Women Living with HIV/AIDS in Kaduna Metropolis by their Occupations.

Source of variation	Sum of Squares	DF	Mean Square	F	Sig.
Between Groups	6848.284	3	2282.761	4.135	.007
Within Groups	161752.551	293	552.056		
Total	168600.835	296			

The result in the table revealed that the respondents were significantly different in their opinion on the social and emotion consequences of women living with HIV/AIDS, with regards to their different occupations. The observed level of significance for the test is 0.012 ($P < 0.05$). This means that the hypothesis that there is no significant difference between the occupation of infected women in their experiences of the social and emotional consequences of living with HIV/AIDS in the metropolis could be rejected. The mean score of the respondents with regards to the different occupational classification are presented in Table 4.12.

Table 4.12. Mean Scores of Respondents on Social and Emotional Consequences by Occupation

Occupation	N	Mean	Std. Deviation	Std. Error
Civil servant	58	220.81	31.516	4.138
Business	50	229.54	19.347	2.736
Artisan	10	214.70	14.080	4.452
Others	179	231.36	21.854	1.633
Total	297	228.43	23.866	1.385

The scores in the table were subjected to a mean separation test using the Scheffe procedure to establish the occupation that was significantly different from the other(s) in their experiences of the social and emotional consequences of living with HIV/AIDS by women in the metropolis. The result of the Scheffe procedure is presented in Table 4.13.

Table 4.13: **Result of the Scheffe Procedure on the Mean Scores by the Occupation**

(i) Occupation	(j) Occupation	Mean Difference (I-J)	Std. Error	Sig.
Civil servant	Business	-8.730	4.534	.297
	Artisan	6.110	8.045	.902
	Others	-10.547(*)	3.550	.033
Business	Civil servant	8.730	4.534	.297
	Artisan	14.840	8.139	.346
	Others	-1.818	3.758	.972
Artisan	Civil servant	-6.110	8.045	.902

	Business	-14.840	8.139	.346
	Others	-16.658	7.635	.193
Others	Civil servant	10.547(*)	3.550	.033
	Business	1.818	3.758	.972
	Artisan	16.658	7.635	.193

Note * The mean difference is significant at the .05 level.

The table revealed that artisan were least affected by the social and emotional consequences of living with HIV/AIDS in the metropolis. Between the other occupations no significant difference was observed in their experiences of the social and emotional consequences of living with HIV/AIDS in the metropolis.

Hypothesis VI: There is no significant differences between the educated and non-educated women living with HIV/AIDS in the social and emotional consequences they experience.

The educational status of the respondents was classified into two groups as indicated in Table 4.4. In the test of this hypothesis, the variable (educated) was used as the independent variable and the scores of the respondents on the social and emotional scores were used as the dependent variable. The two sample t-test was used in the test of the hypothesis because of the two groups (educated and non-educated) involved in the independent variable. The result is presented in Table 4.14.

Table 4.14: Two Sample Test on the Social and Emotional Consequences of Living with HIV/AIDS Educational Status of the Respondents

Educational Status	N	Mean	S. D	S. E	t	DF	P	t-critical
Educated	235	223.63	24..426	1.593	3.675	340	.000	1.96
Non-educated	107	233.66	20.958	2.026				

Note: SD= Standard Deviation, SE = Standard Error, t=observed t-value, DF= Degree of Freedom, P = Observed level of significance Critical value of t = 1.96 at P = 0.05)

The observed t-value (3.675) in the table is higher than the critical value of t (1.96) indicated in the table. The observed significant level is 0.000 ($P < 0.05$). These means that two groups are significantly different from the experiences of the social and emotional consequences they experience as a result of living with HIV/AIDS in the metropolis. Therefore the hypothesis that there is no significant differences between the educational status of the infected women living with HIV/AIDS in the social and emotional consequences they experience as a result of living with HIV/AIDS in Kaduna Metropolis is rejected.

Hypothesis VII: There is no significant difference among the impact of social stigma, social discrimination and social rejection experienced by women living with HIV/AIDS.

To test this hypothesis, it was necessary to reduce all the mean scores to equal level by taking the aggregate mean. In this procedure the mean score for each of the three variables were divided by the total number of items in each of the respective variable. This was necessary because of the unequal number of items in variables. The hypothesis was tested by staking the mean scores of the respondents on social discrimination, social stigma and social rejection and comparing using the one way analysis of variance. The analysis of variance model is presented in table 4:15.

Table 4.15: One Way Analysis of Variance on Impact of the Social Consequences of Living with HIV/AIDS

Source of variance	**Sum of squares**	**DF**	**Mean square**	**F**	**Sig**
Between Groups	43.788	2	21.894	82.049	.000
Within Groups	280.181	1050	.267		
Total	323.968	1052			

The result revealed significant differences between the social consequences experienced by the women living with HIV/AIDS. The observed f-value is 82.049 while the critical value is 3.00 and $P<0.05$. The hypothesis that there is no significant difference between the impact of social stigma, social discrimination and social rejection experienced by women living with

HIV/AIDS is therefore rejected. The mean score for the different social consequences by the respondent are listed in table 4:16.

Table 4.16: Mean Scores for the Social Consequences of Women Living with HIV/AIDS

Consequences living with HIV/ADS	N	Mean	Std. deviation	Std. Error
Social discrimination	351	3.8214	.47667	.02544
Social stigma	351	3.8567	.45743	.02442
Social rejection	351	3.4075	.60337	.03221
Total	1053	3.6952	.55494	.01710

The mean scores in the table were subjected to a post hoc test using the Scheffe procedure as indicated in table 4.17

Table 4.17: Result of the Scheffe procedure on the mean scores.

(i) Type	(j) Type	Means Difference (I –J)	Std. error	Sig.
Social discrimination	Social stigma	-.03536	.03899	.663
	Social rejection	.41382(*)	.03899	.000
Social stigma	Social discrimination	.03536	.03899	.663
	Social rejection	.44917(*)	.03899	.000
Social rejection	Social discrimination	-.41382(*)	.03899	.000
	Social stigma	-.44917(*)	0.3899	.000

* The mean difference is significant at the .05 level.

The result revealed that social stigma was rated the highest and was followed by social discrimination. Social rejection was least scored by the respondents. Between social discrimination and social stigma, no significant difference was observed in the experiences of the women living with HIV/AIDS. But there was significant difference between social rejection and social discrimination on one hand and social rejection and social stigma on the other. This is indicated in the post hoc test in Table 4.17.

4.3 Summary of Findings

The findings from the analyzed data are summarized below:

1 Social stigma ranked the first of the social consequences experienced by the women living with HIV/AIDS and was followed by social discrimination, while social rejection was the least of the experiences suffered by the women.

2 That the women living with HIV/AIDS suffer from social stigma, social discrimination and rejection within the metropolis.

3 That there was no significant difference in the experience of stigma, and social discrimination suffered by the women.

4 That their experiences of Social rejection differ significantly according to their marital status. The unmarried women among them tended to suffer more from social rejection than the married ones

5 That the ages of the women living with HIV/AIDS is significantly related to the emotional and social consequences they suffer as a result of living with the disease.

6 The occupation of the women is a significant factor in the type of social and emotional discrimination they experience as a consequence of living with the disease.

7 That women who are artisans were less exposed to the social and emotional consequences experienced by women living with HIV/AIDS.

8 That educational status of women could play a significant role in the type of social and emotional consequences they experience as a result of living with the disease.

4.4 Discussions

Among the objective of this study was the examination of the social and emotional consequences of women living with HIV/AIDS in Kaduna metropolis. For this purpose, the social consequences were structured into the social discrimination, social stigma and the social of rejection of such women within the metropolis. Apart from these effects, the women were observed to also experience some emotional consequences which were all investigated in this study. From the observation in Table 4.5, all the respondents were of the view that women living with HIV/AIDS suffers from social discrimination, and

social stigma combined with emotional consequences which they also experiences as a direct consequence of living with the disease in the metropolis. These finding are consistent with Goffma (1963), where it was opined that an individual who might have been easily received into an ordinary social intercourse possess a trait that can obtrude itself and upon attention and turn those of us who he meet away from him or her. This is also consistent with Brandts (1986) who opined that a society's response to the problems of a disease reveals it deepest social and moral values attached to such disease. HIV/AIDS are seen in the Nigerian society as products of immoral behaviour thus victims of HIV/AIDS are viewed as suffering from the consequences of decadent acts. Mohammed (2003) Also toll this line where it was reported that people living with HIV/AIDS are stigmatized and discriminated against in the society. The finding also correspond to the report of Boco (2005) where it was reported that ever since scientist identified HIV/AIDS, fear, denial, stigma, discrimination and rejection have accompanied the epidemic.

But there was no consensus among the respondents on the aspect of social rejection of women living with HIV/AIDS from data collected for this study. The overall mean score by the respondents for social rejection was 3.41 compared to 3.82 and 3.86 for social discrimination and 4.05 for the emotional consequences they experienced as a result of living with HIV/AIDS in the

metropolis. This could be attributed to some form of awareness about the disease within the metropolis.

This leads on to the first research question of the study which sought to identify the social and emotional consequences of the women living with HIV/AIDS within the metropolis. The question is "what are the social and emotional consequences of HIV/AIDS on the social relationship of the victims with respect to, a) Social stigma, b) Discrimination and C) rejection". The social and emotional consequences of women living with HIV/AIDS are revealed here to be of significant consideration. In particular are the stigmatization and discrimination experienced by the women living with HIV/AIDS. In the test of first hypothesis in Table 4.5, all the respondents agreed that they suffer social stigmatization and discriminations because of the HIV/AIDS. But there was no concession on the experience of social rejection by the victims. Only the unmarried women were of the opinion that they were socially rejected. This observation is in line with Udodigbo (2005) who reported that stigmatization and discrimination are regarded as bad for business in Nigeria even among insurances.

The second research question was aimed at identifying the most devastating social consequences among the stigmatization, discrimination and rejection suffered by the respondents. In the test of the second hypothesis, the differences in the ratings of the respondents of the different social consequences

of living with HIV/AIDS were not significant. The victims suffer these social (stigmatization, discrimination and some times rejection in their relationship with others within the metropolis. In some cases, some of the respondents were of the opinion that the society sees their predicament as a product of unfaithfulness to their spouses. This view by the society, combined with the impression that the disease is a curse, go a long way to perpetuate the discrimination and stigmatization of the victims who are seen products of decadents behaviours. This finding is line with Kelly (2001) where it was reported that the impact of HIV/AIDS on women is particularly acute. The finding here is consistent with Shainsa (2005) where it was asserted that stigma and discrimination causes persons with HIV/AIDS to face social isolation, increase emotional distress and a loss of socio-economic support.

The third research question was related the effect of age of infected women on their social and emotional consequences of living with HIV/AIDS. In the test of hypothesis III, it was observed that age significantly affect the experience of the social and emotional consequences experienced by the women living with HIV/AIDS. Women who were between 41 and 50 years and those who were above 50years were observed to be more affected by the accompanying social and emotional consequences of living with HIV/AIDS in the metropolis. Between the younger women no significant relationship was observed. This means that age could be a factor in the level of social and

emotional consequences experience by women living with HIV/AIDS in Kaduna metropolis.

The fourth research question was the determination of the effect of marital status on the social and emotional consequences experienced by women living with HIV/AIDS in the metropolis. In the test of Hypothesis IV, no significant difference was observed between the two groups in their experiences of social and emotional consequences they experience as a result of living with HIV/AIDS. The mean responses were 4.03 and 4.07 respectively for the married and the single women. This means that they experience both social and emotional consequences as result of living with HIV/AIDS. This finding is related to Herek(1999) where it was reported that AIDS related stigma refers to prejudice, discounting, discrediting and discrimination directed at people perceived to have AIDS or HIV and the individuals, groups and communities with which they are associated.

The fifth research question was aimed at examining the effect of the social and emotional consequences on occupation of the women living with HIV/AIDS. In the test of hypothesis five, significant difference was observed between the different occupations in their experiences of the social and emotional consequences of living with HIV/AIDS. All other occupations were observed to have differs from the experiences of the artisan group. This difference could be attributed to the fact that the artisan does not really go out to

solicit for client in most cases. They therefore did not beg for acceptance or mind very much the opinion of people about their status. This fact could account for the less stigma and social discrimination they experience. This finding is in accordance with report by Shipp(1986) where it was pointed out that individual infected with HIV have reported intense negative reactions and discrimination meted out to them and thereby forcing them to leave their jobs, withdraw from school or be evicted by their landlords. The finding also agree with Zugar (1987) where it reported that discrimination against HIV/AIDS infected persons even extend to health care centers. The finding also correspond with Salihu (2001) who reported that HIV/AIDS infected persons are discriminated against in their work places and that employers believe that HIV positive persons may not be able to work their full time. This finding echoes the result of similar study by Huebner (2004) in three cities of the United stated of America. In the study, it was reported that among adult working women, HIV related stigma was high

The sixth research question of the study was aimed at identifying the effect of educational status on the social and emotional consequences experienced by women living with HIV/AIDS within the Kaduna metropolis. The result of hypothesis VI revealed that the educated victims of the disease were more able to cope with the social and emotional consequences than the non-educated group. However, this observed difference was more on the level of

agreement of the two groups on consequences of living with the disease. This is because both groups were of the opinion that the consequences were severe and their respective mean scores were 3.74 for the educated group and 3.86 for the non-educated group. This finding is consistent with Boco(2005) where it was reported that discrimination has spread widely and rapidly causing prejudice against the group infected and living with HIV/AIDS. The finding is also consistent with Adinna (2004) where it was reported that discrimination against infected groups has continued to rise. Annune (2004) also reported similar findings where it was opined that a large proportion of the Nigerian society in general and Kaduna state in particular discriminated against HIV infected persons and that all forms of stigmatization are meted out to them. In relation to this observation, Aggleton (2004) also reported that stigmatization has resulted in resentment and frustration, anger blame and fear among several people living with HIV/AIDS and that some unscrupulous medical personnel have began to exploit the situation.

CHAPTER FIVE

SUMMARY, CONCLUSION AND RECOMMENDATION

5.1 Introduction

The summary of the study along with the findings and conclusion of this investigation of the social and emotional consequences of women living with HIV/AIDS within the Kaduna metropolis are presented in this chapter. The chapter contains the recommendations on how the issue of discrimination and social stigmatization of women with HIV could be reduced as well as need for further research on the issues of awareness on the part of the populace within the society.

5.2 Summary

This study investigated the social and emotional consequences of women living with HIV/AIDS within the Kaduna Metropolis. A total of 351 respondents made of married and single women were involved in the study. Among the variables investigated in relation to the social consequences were stigmatization, discrimination and social rejection of women living with the disease. In all, discrimination and stigmatization were observed to be significantly high among the social consequences along the emotional consequences experienced by the victims.

The issue of social rejection was more common among the unmarried women involved in the study. The unmarried (single) women were of the opinion that they were socially rejected by the society but this was not the case of the married women involved in the study. It was observed that the women living with HIV/AIDS were of the opinion that they suffer social stigmatization, discrimination and rejection in some cases and emotional consequences. Non- of these consequences was underplayed by the respondents. Age, educational status and occupation were observed to have effect on the level of experience of the social and emotional consequences experienced by the women living with HIV/AIDS in the metropolis.

The study was structured into five chapters in order to effectively carry out the research. Chapter one of the study, gives an insight to the background and purpose of the study. The statement of the problem and the research questions and the study's hypotheses are all within the chapter. Other aspects of the chapter were the basic assumptions, significance of the study, scope and delimitation of the study. In chapter two the related literatures to the study were reviewed. These included the concept of HIV/AIDS, causes of HIV/AIDS and the social consequences of living with HIV/AIDS. The chapter also reviewed the concept of stigma in relation to HIV/AIDS infected persons, the social discrimination Social rejection and emotional consequences of living with

HIV/AIDS. There were followed with the review of related studies and a summary of the related literatures.

The research methodology was given in chapter three. This was made up of the research design, the population of the study and the sample size. The sampling technique used in selecting the population size was given within the chapter along with the instrument for the data collection. The chapter gave the validity and reliability of the instrument, the procedure for the administration of the instrument and the method for the statistical analysis of the data collected for the study.

The statistical analysis and interpretation of the findings from the analyzed data were presented in chapter four. The chapter is made up of the description of the demographic variables of the respondents as well as the test of the study's hypotheses. Seven null hypotheses were tested in the chapter. The hypotheses were tested as follows:

Hypothesis I, tested for significant difference between marital status of the respondents with respect to Social stigma, discrimination and social rejection. The two sample t-test procedure was used in this test. The result revealed that the two groups (married and single) of women did not differ significantly on social stigma and discrimination experiences they suffer as a result of living with HIV/AIDS within the metropolis. The hypothesis is retained on this basis. But significant difference was observed between the two groups on

the area of social rejections. The single women were of the opinion that they were socially rejected by the society. The hypothesis was rejected on this basis.

The second hypothesis tested for significant differences in the rating of the respondents on the most devastating social consequences of women living with HIV and AIDS. The hypothesis was tested with chi-square procedure. The result did not revealed significant differences in the rating of the social stigmas by the respondents. This hypothesis was therefore retained.

Hypothesis III tested the effect of age on the experienced social and emotional consequences of the women living with HIV/AIDS. The result revealed, that older women aged 45years and above were more affected by the social and emotional consequences experienced as a result of living with HIV/AIDS in the metropolis. This hypothesis was therefore rejected.

The effect of marital status in relation to the social and emotional consequences of living with HIV/AIDS was tested in hypothesis IV. The two sample t-test procedure was used in the test of this hypothesis. The result did not reveal significant difference between the two groups. The hypothesis was therefore retained.

Hypothesis V tested the effect of occupation on the social and emotional experiences of the women living with HIV/AIDS within the metropolis. The one way analysis of variance was used for the hypothesis. The result revealed that only women who were artisans did not really suffer those experiences like the

other different occupational groups. The women in the artisan group were significantly different from others in the different occupational groupings. This hypothesis was rejected.

The sixth hypothesis tested the effect of the educational status on the social and emotional consequences experienced by the women living with HIV/AIDS within the metropolis. The two sample t-test was used for this test. The result revealed that women who were educated suffer less severe social and emotional consequences experienced by those living with the disease. This hypothesis was therefore rejected.

The seventh hypothesis tested for the most severe among the social consequences experienced by women living with HIV/AIDS. Of all the social consequences, social discrimination ranked the highest. There was no significant difference between social discrimination and social stigma experienced by the women living with the disease. Social discrimination was significantly different from social rejection experienced by the women. The hypothesis was therefore rejected.

5.3 Educational Implications

Education for HIV prevention should begin at an early age, before children and young people are expose to risks, and should be sustained over time. Education Is one of the core challenges facing humanity; wining the fight

against AIDS. Education is life sustaining, it furnishes the tools with which children and young people carve out their lives and is a life source of comfort, renewal and strength (UNAIDS 2006) without education, Aids will continue its rampant spread, with AIDS out of control, education will be out of reach, it then implies that HIV/AIDS and education is for policy makers in both education and AIDS, but its massage speaks to everyone touched by the epidemic, teachers, education administrators, school children, young people out of school , adult learners and community leaders living in the world With AIDS has a role to play to combat the scourge

1. The fact that allover the world HIV/AIDS is causing devastation destroying communities and families and taking away hope for the future, particularly severe is the epidemic impact on schools and education, it implies that the educational administrators should ensure that teachers are well prepared and supported in their teaching on HIV/AIDS through pre-service and in service educational training.
2. The evidence that HIV/AIDS reduces the supply of education by reducing the number of teachers who are able to carry out their work, and the resources available for education, as children are withdrawn from school and college in respond to raising house hold expenditure , and provide care for family members. The epidemic affects the quality o f education because of the stains on the materials and human recourses of the system

of education and on health and presence of learners. It implies that policy makers and educational administrators should ensure proper preparation and distribution of scientifically, accurate, good quality teaching and learning materials on HIV/AIDS communication and life skills.

3. The evidence that in worst affected countries the epidemic is decimating the educational work force and causing untold suffering to children, young people and their families. In a report on world education forum in Dakar (2000), that HIV/AIDS also poses major threads to the broader goals for sustaining development and eliminating poverty set during the millennium summit including those related to universal access to primary education. It implies that a diversity responses is required including work to raise awareness and to stimulate action among education decision makers as well as directly targeting young people whether in or out of school.

4. The fact that social and emotional consequences of leaving with HIV/AIDS on women no doubt have educational implications and women who are socially and emotionally depressed because of their HIV/AIDS statues lack the motivation to achieve in education. They tend to see educational attempts as wasteful ventures since to them, they may not live to reap from such investment.

Shainsa (2005) makes it Clear that such individual will naturally judge their engagement in educational programs in terms of how far they are going to benefit from it or how it will get out of their sate as HIV/AIDS victims. Their motivation to learn is destroyed by their feelings of despondency and worthlessness. Further more, for the fact women leaving with HIV/AIDS tend to suffer social stigma such as rejection, abandonment, socio-metric relationship, they will find it different to cope with schooling since effective schooling requires free social relationships with teachers and school mates.

Garko (2005) equally mention that women living with HIV/AIDS feel so bad and dejected that they do not see any need to engage in educational activity. Their academic motivation and optimism for future success in school work is undermined. This confirms the fact that motivation is a psychological construct that has relevance to education and once it is lacking in people living with HIV/AIDS, the tendency is withdrawal. Such HIV/AIDS sufferers (women) will find it difficult to develop the zeal and anxiety to engage in any meaningful academic activity.

It is a known fact that leaning and memory are very much connected with motivation because one leans better and faster the experiences (stimuli) that interest one.

Among the common motivational factors of learners are the desires for feelings of importance, social approval, social approval, self-esteem, enjoyment

of all things which are tension-reducing, a desire for friendly social atmosphere but since the social and emotional consequences of living with HIV/AIDS on women denies them of such desires in life, by implication, it will be difficult for them to develop appropriate enthusiasm to engage in educational activity.

Adeyanju (1996) note that for effective leaning to take place, a social environment should be conducive. this implies that, elimination of stigma and discrimination with a view to respecting human rights and encouraging greater openness concerning the epidemic should be ensured by policy makers and educational administrators and all those involved in teaching and leaning process should be engage in a web of understanding ,love friendship, warmth, give and take and cordial relationship. This will facilitate effective learning. If women leaving HIV/AIDS suffer uncontrollable social consequences so much so that they are denied such a conducive social environment their learning will seriously be affected.

5.5 Recommendations

Based on the findings from this study, the researcher would want to recommend as follows:

1 That awareness of HIV/AIDS by State Action for AIDS [SACA] should also include the acceptance of those living with the disease since by

available knowledge; the disease is not contracted by casual interaction and non-involvement of body fluids.

2 Effort should be made by both Non-governmental Organizations and other Government agencies towards enlightening families, employers, and the community that the disease is not only contracted through immoral acts. As such women living with HIV/AIDS should not be discriminated, stigmatised and rejected, this is necessary to accommodate both married and single women living with the disease in the community.

3 Government should as much as possible encourage health centres not to discriminate against victims of the disease. This can be accomplished with necessary sanctions and enabling policy.

4 Drugs provided (Anti-retroviral drugs) to agency should be directed to actual victims of the diseases. This could be achieved by due process and transparency in the process of administration.

5 A comprehensive national counselling and testing scale-up plane at all specific levels with active involvement of civil society groups, faith-based organisation, people living with HIV/AIDS, support groups, public and private sectors should be develop and implemented by National Action Commission for AIDS (NACA) to reduce and stop the discrimination, stigmatization of people living with HIV/AIDS.

General Recommendations

1. Infected individual should not hide their HIV status for fear of stigmatization and discrimination and should endeavour to register in health care centres. This will enhance their access to anti-retroviral drugs
2. Infected individual should cooperate and form associations or support groups in their locations towards encouraging and supporting one another. These can be achieving by their contact in a registration centre.
3. Infected individual should seek for education and in depth knowledge of HIV/AIDS this would help manage and also help them build their self confidence and to cope with the social and emotional trauma accompanied with the disease. This can be achieved through attending sensitization programs workshops and seminars.
4. Infected individual should engage themselves in trade with high patronage to be able to cope with the stigmatization. This can be achieved through registration with cottage industries as artisans do not really go out to solicit for client in most cases as such they do not mind very much the opinion of people about their status.
5. Infected individual should engage in activities to keep them busy to take their mind off the predicaments. This can be done through their involvement into all preventive care and treatment programs including

implementing and evaluating response to mitigate HIV/AIDS especially the older women infected.

6. The unmarried individual should endeavour to have inter personal relationships with the opposite sex infected to enable them get married like the uninfected people. This can be achieved through their monthly meetings in their various support groups.

7. Individual infected and those not infected should access voluntary counselling and testing (VCT) which is an entering point into HIV/AIDS prevention and care programs.

5.6 Recommendations for Further Study.

It was observed in this study that social discrimination, stigmatization and rejection were prominent experiences of the women living with HIV/AIDS in this study. These factors are avoidable if necessary action are undertaken. The researcher would therefore wish to recommend investigation into the "effect of pastoral counseling on stigmatization of people living with HIV/AIDS" This could be done in places of worships like the Mosque, the church and other religious organizations. The aim here would be to reduce social discrimination, stigmatization and rejection. It could also go a long way in reducing the emotional effect of people living with HIV/AIDS.

REFRENCES

Adeyanju,G.A.[1996]. *Creativity: Learning and learning style.* Zaria, Nigeria: Dept of education, ABU Zaria.

Afolabi, M. (1993). Introduction to research for writing proposals. Projects and thesis: Zaria, *Alpha Publisher*

Aggleton, H. (2004). " The fight against AIDS" *Newsletter for Nigeria Population Community*, No.2 March.

AIDS Alliance in Nigeria,(2003). Breaking the silence in Nigeria and understanding HIV/AIDS. *Real magazine.*

AIDS Alliance In Nigeria, (2004). Support from AIDS prevention initiative Nig. (A. P. I. N.) Harvard School of public Health and funding from the bill and meunda Gates foundation

Akanidomo, .J.L. & Zamani, .A. (2003). AIDS pandemic: challenges for Nigeria psychologist. *Jornal of research in department of psychology*, university of Jos, Jos Plateau State Nigeria.

Andrew, .S.(2005). Care and support for people living with HIV/AIDS. *HIV/AIDS project Kaduna*, 30/08/2005.

Anthony .N.(2003). AIDS prevention and control. *Published by Nigeria AIDS counseling organization.*

Archi L. (2000-2010). making a major difference to the health of vulnerable people in Africa. *International Federation of Red Cross and Red crescent societies.*

Auwal, C. E. (2002). Reducing stigma and discrimination related to HIV/AIDS. Engender health, Trainer Manual.

Alexander, D. K. (2003). Prevention of HIV?AIDS infection: Looking back, looking ahead. JAMA 273: 1143-8

Baum, .A. & Nesselhop, S.E.A.(1988). Psychology research and the prevention etiology and treatment of AIDS. *American psychologist 43(11)900-906.*

Bayer,.R. (1988). AIDS and the ethnics of public health challenges posed by a maturing epidemic. *AIDS (supplement D.217-221)*

Best .K. (2002a). HIV/AIDS does not spare older people, *Network.Vol.22, No.1 Pg. 26 -28.*

Benjamin, .U. (2005). HIV/AIDS and the problem of stigmatization. *New Nigeria Weekly 19 March, 2005)*

Boco, .E. (2005). HIV/AIDS: The monster called stigma. *New Nigeria, Wednesday, July27, 2005.*

Brandt, A.M.(1989). AIDS. From social history to social policy law, medicine and health care 14.231-242.

Burris, .S. (2000). surveillance, social risk and symbolism: framing the analysis for research and policy. *Jornal of acquired immune deficiency syndrome*, 25(supplement 2j,S1, 207.

Capitanio, J.P. and Herek, G. (1999). AIDS related stigma and attitudes towards injecting drugs users. *American behavioural scientist*, 42, 1148-1161.

Chesney, M.A. and Smithy, A.W.(1999). Critical delays in HIV testing and care. The potential role of stigma. *American behavioural scientist* 42, 1162-1174.

Cipla, (2001). HIV/AIDS. A clinical Guide: Cipla Ltd., MuMBAi,, Central MuMBAi, 400 008.

Cornu, G.M. & Grinstead, W.T. (2003). "Introduction" A Presentationat the Expert group meeting on the HIV/AIDS Pandemic and its gender implication, Windhock, Namibia.

Commander, .N.E.(2003). HIV positive Nigerians speak out. Harvard school of public health and funding from the bill and Mehinda gates foundation. *Coping with ease.*

Douglas, K. M,. & John, T. C. (2005): supportive affective group experience for persons with life threatening illness, reducing psychological and death related distress in dying patient. *Journal of palliative medicine volume 8* number 2, 2005.

Jean, E. N, (2003). Pastoral close support for people living with HIV/AIDS. Proceeding of the international congress of dialogue on civilizations, religious and cultures in west Africa held at Abuja Nigeria

Ekpen, E. (2003). Public Health Service Guide Lines for Counseling and anti-body testing to prevent HIV/AIDS infection and Aids. MMWR-36: 509-15.

Eugene, W. F, & Hamid M. (2003). Meaning of illness and psychological adjustment to HIV/AIDS. *Journal from the department of psychiatry and behavioural sciences*. Emory university school of medicine, Atlanta

Fagan, .N. and weisal, D. (1987). Aids and employment laws 137, 752-753.

Gilmore N. and juigens (1992): strategies for action. AIDS action.17,2-4

Fleishman,J. [2003] *Fatal vulnerability Reducing the acute Risk of HIV/AIDS among women and girls*. Washington: CSIS.

Gabre , J. A. (2005). HIV/AIDS related stigma and discrimination in health care settings. Aids: Aids-1371-89.

Garko, S. (2005). Reporting HIV/AIDS *New Nigeria, Monday march* 14th 2005

Goffman, E. (1963). Stigma: *Notes on the management of spilled identity. Prectic – Hall Inc. Englewood cliffs*.

Gregory, M. H , & John, P. C. (2004). stigma social risk and health Policy public attitudes towards HIV surveillance policies and the social construction of illness. *Department of psychology, university of California* at Davis.

Herek, G.M. (1990). illness, stigma and AIDS *American behavioural scientist* 41, 1120 – 11130. s

Herek, G.M. & Capitanio, J.P. (1999). AIDS stigma and sexual prejudice. *American behavioural scientist* 42, 1130 0 1147.

Herek, G.M. & Glunt, E.K. (1999). An epidemic of stigma, public reaction to AIDS. *American psychologist* 43, 886-8911.

Hope, C. 1120 Chukwu, (2001). Awareness and facts about STDs and HIV/AIDS. Hopkins investment service LTD. kaduna, Nigeria

Huebner, D.M. (2004). Experiences of harassment , discrimination, and physical violence among young gay, Bisexual men and HIV/AIDS. *American Journal of Public Health, 00900036, Vol. 94, issue 7.*

Ibanga, I. (1996). HIV antibody testing public attitudes and reactions. *Nigeria Journal of basic and applied psychology* 4 (1 & 2 pg. 39-49)

Inp. T.C.& G.R. vandenbos, G.R. (Eds) (2003). Psychological aspects of serious illness chronic conditions, fatal diseases and clinical care (Pp107-150)

Isah, D. A. (2005). Common questions and answers on HIV/AIDS, *inter gender monograph series*, No.1Pg. 21- 26.

John, G. L. (2003). The demographic and socio- economic effects of HIV/AIDS in Kaduna state: *thesis submitted to the Post Graduate School, Ahmadu Bello University, Zaria*. Department of Geography, Faculty of Science, Ahmadu Bello University, Zaria.

Jonathan, .M. (2003). Coping with Ease, people living with HIV/AIDS. Harvard school of public Health and Funding from the Bill and Melinda Gates foundation.

Joseph, R. Z. & Christiana, M. M.,(2003). altered mental status. *Health care provider, Horizons program,* Tulane university September

Kaine, N. (2003). Building an interfaith coalition against HIV/AIDS. *A Nigerian experience.*

Kelly, M.J. (2001). "Challenging the challenger, understanding and expanding the responses of Universities in Africa to HIV/AIDS *"A synthesis report for the working group on higher education (WGHE) Association for the development of education in Africa (ADFA).*

Kerlinger, F.N (1970). Foundation of behavioural research. London, holt Rinehart and wiston.

Kerlinger, F.N (1979). Behaviourral research sample" educational and psychological measurement Pp 609-610.

Mamman, .M. (2002). "Combating sexually transmitted diseases and Human Immune Deficiency Virus through community –based health education, Kamuni –Ikulu district Kaduna State." A research proposal submitted to the J.D. and C.T. Mac Author Foundation.

Marry, D. K. & Williams, L.M. (2005). "Combating the cross sectional effects of HIV/AIDS related stigma and discrimination" Abuja Nigeria.

Nwokedi, A. (2003). Aids prevention and control. Nigerian Aids Counseling organization (NACO) 59, Deunis Osadebay Way, Asaba, Delta State.

Kelly M.J (2001): challenging the challenger understanding and expanding the response of university in Africa to HIV/AIDS.

Mayer, M, (2005). Addressing HIV/AIDS related stigma and discrimination. *A case study of the project hope programme in Cameroon.* 14th Icasa international conference held at Abuja, Nigeria.

Mohammed, A. (2004), "AIDS: a global problem control strategies" *AIDS ACTION,* issue 1 November pg. 4-5.

Okey N, (2004). Stigma as a hurdle in the fight against HIV/AIDS *vanguard, Tuesday October 26th 2004.*

Okonofua, F, (1992). Women Health research foundation, Benin city, Nigeria. Pg. 40 – 45.

Oppenheim, .D.(1996). "AIDS Threatens the grassroots *Tell Magazine*, No.3 Jawary, Pg. 14 – 17.

Ostrow, O.G , (1988). Models of understanding psychiatric consequences of aids. Int. peter bride et al's (ed) psychological Nemo psychiatric and substances Abuse aspects of AIDS *New York: Raven Press*.

Real, (2003). Reassuring and Rekindling Hopes: understanding HIV/AIDS, *conference held in Lagos by AIDS Alliance in Nigeria.*

Real, (2004). Reassuring and kindling Hope: Treatment information on HIV/AIDS. produced by AIDS Alliance in Nigeria with support from AIDS Prevention initiative Nigeria. *Harvard school of public health and funding* from the bill and Melinda gates foundation.

Rose, T.S. (2005). Stigmatisation of people living with HIV/AIDS. Windows. People's parliament, *New Nigeria Weekly,13 August*, 2005.

Salihu, .M. (2001). "HIV and the invincibility of women, is there a need to redefine
AIDS "*Feminist Review*.no.4 Pg.65

Seale, J.R. & Kum, I. (1987). AIDS and aberrant social bahaviour. *Journal of research in social medicines* 80 – 200 -2001.

Ship, K. L. (1986). Prevalence Aids related risk factors and condom use in the United States Science 258: 1101-6.

Strategy – 2010 to improve the lives of humanity – 1999 international federation of Red Cross and Red Crescent Societies

Strengthening Nigeria's response to HIVAIDS (SNR) programme in Nigeria. (2005). A five years programmed (2004 – 2009) implemented on reducing HIV/AIDS related stigma and discrimination.

Tross .S. & Hirsch, D. A. (1988). Psychological distress and neuro- Psychology complications on HIV infection and AIDS *American psychologist*
43.

Tuckman, B.W. (1975). Measuring educational outcomes. Fundamental of testing.

Uche A, (2004). Test for HIV status and fear of discrimination. *New Nigeria Monday October* 25th 20005.

Uche, .A.(2004). Stigmatization is worse than HIV/AIDS. *Vanguard 3/1/2004 Pp. 39.*

UNAIDS/UNFPA/UNIFEM, (2004). Women and HIV/AIDS:. *Confronting the crisis. A joint report by UNAIDS/UNFPA/UNFEM* ISBN:0-89714-708-1.

UNAIDS, (2006). Social Economic Impact of AIDS in Africa. *Annual report ISBN:* 0-89612-604-1

UNESCO,(2003). Proceedings of the International congress of dialogue and civilizations, religious and cultures in West Africa held at Abuja, (Nigeria).

United Nations Population Fund, (UNFPA), (1998): Violence against Girls and Women. *A public Health Property.*

United Nations Population Fund, (UNFPA),(2004):*Annual Report 2003 on combating HIV/AIDS in Africa*. New York, NY 10017, U.S.A.

Website, (2005). Fight AIDS-not people with AIDS! From *website www. Aidsstigma.net*

Website,,(2005). Stigma, discrimination and attitudes to HIV/AIDS. As contained in website: http*//www/avert.org/aidsstigma.htm*

Website, (2005). Women and Girls: HIV/AIDS related research at NIH.http:/*www.nih.gov/od/oar/about/research/women.htm 8/31/2005.*

Women AIDS, (2005). International Women Health Problems. Briefing paper BPH/20 from website http:/ *www. womenaids. org/press /info /health/ bph20/ html.*

Zuger, A. Miles, A.H. (1987). AIDS and occupational risk: historic traditions and ethnical obligations**,** *Journal of American Medical Association,* **258.1924-1928.**

APPENDIX I

Dear Respondents,

CONSEQUENCES OF LIVING WITH HIV/AIDS ON WOMEN IN KADUNA METROPOLIS

I am a Post Graduate Student of Ahmadu Bello University Zaria, Department of education (Psychology). I am conducting a study on the topic above in partial fulfillment for the award of Master of education Degree.

I am requesting you to kindly fill the attached questionnaire meant for the above purpose. I assure you that the information provided will be treated confidentially.

Yours faithfully,

BELLO, M. HADIZA

QUESTIONNAIRE

SECTION A: Respondents' Bio-Data

1. Respondents Age Range

20years and below ☐

21-30years ☐

31-40years ☐

41-50yrs ☐

Above 50years ☐

2. **Respondents Marital Status**

Married ☐

Single ☐

3. **Respondents Occupations**

Civil servant ☐

Business/trader ☐

Artisan ☐

House wife/Others ☐

4. **Respondents Educational Status**

Educated ☐

Not educated ☐

Key: SA= strongly agree, A= agree, U= undecided, D= disagree, SD= strongly disagree

SECTION B

SOCIAL DISCRIMINATION AS A RESULT OF LIVING WITH HIV/AIDS

Social discrimination as a result of living with HIV/AIDS	**SA**	**A**	**U**	**D**	**SD**
1. Unfaithfulness in marriages increase HIV rates in women					
2. Women are not able to negotiate condom use to protect themselves against HIV/AIDS					
3. Violence in marriage limits women's ability to protect themselves from HIV/AIDS					
4. Poverty causes the spread of HIV/AIDS among women and girls					
5. Beliefs that HIV/AIDS is a curse not a disease leads to the use of traditional healer as the solution					
6. Immoral behavior exposes one to the danger of HIV/AIDS					
7. Illiterate women contracts HIV/AIDS easily than educated women					
8. The kind of jobs women engage in exposes them to contracting HIV/AIDS					
8. Fear of discrimination makes HIV/AIDS infected women to avoid relationship with other					
9. Fear of discrimination prevent women from admitting their HIV status publicly					
10. Women with or suspected of having HIV are turned away from health care services					
11. Women with HIV/AIDS are refused employment due to discrimination					
12. Women with HIV/AIDS are refused entry to foreign countries due to discrimination					
13. Women with HIV/AIDS do not receive much sympathy and support, but were rather discourage against					
14. Women with HIV/AIDS face negative reaction and experiences from the general public					
15. The discrimination displayed by the					

public force infected women to leave their jobs					
16. The discrimination displayed by the public force infected women to withdraw from school					
17. Women living with HIV/AIDS are being fired from their jobs					
18. There is a very high discrimination against low income women living with HIV/AIDS in most communities					
19. Where both men and women are infected with HIV/AIDS, women are often more discriminated against than men.					

SECTION C
SOCIAL STIGMA SUFFERED BY WOMEN LIVING WITH HIV/AIDS

Social stigma as a consequence of living with HIV/AIDS	**SA**	**A**	**U**	**D**	**SD**
1. Women living with HIV/AIDS are stigmatized that they find it difficult to have normal interpersonal relationship with other people					
2. Women with HIV/AIDS are so stigmatized that they becomes a misfit in the society					
3. Women living with HIV/AIDS are stigma results into fear of being rejected by loved ones					
4. Due to stigmatization women living with HIV/AIDS are denied any form of treatment					
5. Stigmatization result in difficulty of finding employment by women living with HIV/AIDS					
6. Stigmatization by the public has resulted in difficulty of finding housing by women with HIV/AIDS					
7. Women living with HIV/AIDS are isolated from other patients in health care centers due to stigma					
8. Low status of women increases the basis for stigma of women in terms of					

HIV/AIDS					
8. Women' lack of access to education increases the chance of being positive					
10. The problems of HIV/AIDS stigma ere created by individual and communities					
11. Stigma makes women with HIV/AIDS to face social isolation					
12 Stigmatization of women living with HIV/AIDS is the creation of the society					
13. People see women with HIV/AIDS as being punished by God for evils					
14. AIDS stigma inflict suffering on women and interferes with attempts to fight the HIV/AIDS pandemic					
15. Lack of educative programmes to reduce the stigma makes infected women not to declare their status					

SECTION D
SOCIAL REJECTION AS A CONSEQUENCE OF LIVING WITH HIV/AIDS

Social Rejection as a Consequences of Living with HIV/AIDS	**SA**	**A**	**U**	**D**	**SD**
1. Women infected by HIV/AIDS are rejected by their families and love ones					
2. Women infected by HIV/AIDS are rejected by their communities					
3 Women with HIV/AIDS refused to disclosed their HIV status for fear of being rejected from those whose support they need most					
4.Inadequate knowledge about how HIV/AIDS can be contracted make people to reject infected women					
5. HIV/AIDS infected women are treated as outcast by their environment					
6. Public health workers have negative attitude towards HIV/AIDS infected women when rendering their services					
7. Women who died of HIV/AIDS are not given befitting burial					

SECTION E

EMOTIONAL CONSEQUENCES SUFFERED BY WOMEN AS A RESULT OF LIVING WITH HIV/AIDS

Emotional consequences as a result of living with HIV/AIDS	**SA**	**A**	**U**	**D**	**SD**
1. Women living with HIV/AIDS feel worthless					
2 Women living with HIV/AIDS lose self confidence					
3 Women living HIV/AIDS feel ashamed					
4 Women living with HIV/AIDS feel worried					
5 Some women living with HIV/AIDS commit suicide					
6 Women with HIV/AIDS feel inferior					
7 Women living with HIV/AIDS feel frustrated					
8 Women living with HIV/AIDS don't have hope in life					
9. HIV/AIDS infected women are easily annoyed					
10. HIV/AIDS positive women ask Doctors to change their result due to fear of rejection					
11. HIV/AIDS positive women are not interested in any life activity					
12. Women with HIV/AIDS feel tired of the world					
13. Women with HIV/AIDS often feel irritated					
14. Women with HIV/AIDS often feel depressed					
15. HIV/AIDS infected women some times becomes aggressive					
16. Women living with HIV/AIDS have the feeling of anxiety					
17. Women living with HIV/AIDS have the feeling of denial					

SECTION F

EMOTIONAL CONSEQUENCES OF LIVING WITH HIV/AIDS BY MARRIED AND UNMARRIED WOMEN

Emotional Consequences	Married			Single			X^2	P
	D	UD	A	D	UD	A		
1. Women living with HIV/AIDS feel worthless								
2 Women living with HIV/AIDS lose self confidence								
3 Women living HIV/AIDS feel ashamed								
4 Women living with HIV/AIDS feel worried								
5. Some women living with HIV/AIDS commit suicide								
6 Women with HIV/AIDS feel inferior								
7 Women living with HIV/AIDS feel frustrated								
8 Women living with HIV/AIDS don't have hope in life								
9. HIV/AIDS infected women are easily annoyed								
10. HIV/AIDS positive women ask Doctors to change their result due to fear of rejection								
11. HIV/AIDS positive women are not interested in any life activity								
12. Women with HIV/AIDS feel tired of the world								
13. Women with HIV/AIDS often feel irritated								
14. Women with HIV/AIDS often feel depressed								
15. HIV/AIDS infected women some times becomes aggressive								
16. Women living with HIV/AIDS have the feeling of anxiety								
17. Women living with								

HIV/AIDS have the feeling of denial								