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Self-Rejection and Self-Denial in HIV/AIDS

The Case of Ibibio PLWAs in South-South Nigeria

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Abstract. – Despite the progress in developing antiretroviral (ARV) drugs that prolong the life of many individuals with HIV infection, many people living with AIDS (PLWAs) are still unable to access intensive health care due to certain cultural forces. The fear of stigmatization, a social reaction to HIV/AIDS, leads Ibibio PLWAs to self-rejection and self-denial. This in turn leads to self-medication and secrecy of care in AIDS. PLWAs also lose both the support of the community and that of health care institutions. All these constitute the risks against PLWAs' health. Through an ethnographic study conducted in Uyo and Itu Local Government Areas (LGAS) of Akwa Ibom state in South-South Nigeria, coping mechanisms in response to HIV/AIDS were examined. The study also examines the people's actions towards certain HIV/AIDS-related behaviours. The study argues that anxiety and depression have combined effects in creating the stigma attached to PLWAs. This in turn leads to self-rejection and self-denial expressed in form of a health myth created around preternatural forces as agents of disease. This situation leads to higher rates of morbidity and mortality due to HIV/AIDS among the Ibibio. *[Nigeria, Ibibio, HIV/AIDS, self-denial, self-rejection, stigmatization]*

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Introduction

The impact of HIV and AIDS has affected many communities in Nigeria. Yet due to the lack of specific case studies on how people respond to the problem of HIV/AIDS in their particular cultural context, information on specific cultural actions related to HIV/AIDS is not commonly available to many local communities in Nigeria. Hence, HIV/AIDS continues to act as serious health problem in the country. However, had such cultural actions been clearly understood, it is likely that there could have been a more successful intervention, which could have dramatically scaled down the prevalence of HIV/AIDS in Nigeria. As noted by Read (1964), cultural actions and disease are inseparable, since health and disease are cultural patterns guided by actions and reactions. Thus, in many Nigerian local cultures, perceptions of disease and responses to such perceptions vary (Jegede 1998; Ajala 2007). These variations in turn influence how certain people react to their health problems. Some reactions constitute a health risk as shown in the case of HIV/AIDS in Ibibio society. As shown in this article, among the Ibibio, self-rejection and self-denial are responses to HIV/AIDS that prevent the people from taking positive action against the disease.

HIV infection is regarded sinful in many African societies, thus AIDS becomes a metaphor for moral and physical contamination. HIV infection creates a tarnished image and identity for the individual (Bharat 1995). This image and identity is projected unto life beyond physical death, reinforced, popularized, and legitimized by social and traditional religious values in such a way that HIV/AIDS is seen as a contamination of the individual and of the society's identity (Sontag 1989; Bradbury 1993). Unlike other incurable diseases, AIDS is an emotive, moralized, and socially stigmatized condition which

is transmitted through unprotected sexual contact (Bharat 1995; Songwathana and Manderson 2001). Among other means of HIV transmission, exposure to contaminated blood is also risky. But among many Africans, transmission through unregulated sexual contact, regarded as immoral, is still most popular. Hence, many African societies interpret the disease through moral lens. The moralization of HIV/AIDS in many of these societies influences health-seeking behaviour and the way in which PLWAs (People Living with AIDS) see themselves. It also affects how they relate to others and how they manage their sexual behaviour.

Among the Ibibio of South-South Nigeria, cultural responses to diseases are shaped by the cultural perception of the disease in question. People have ecological, preternatural, cultural, and biological explanations of disease (Ekong 2001). Such perceptions, depending on the particular disease, combined to produce varied actions, which have dialectical effects on disease and care. In this context, the Ibibio people associate HIV/AIDS with preternatural and cultural explanations. For many people, especially those who belong to the lower social strata of the society, the disease is in part due to the machination by gods, goddesses, or witches. More importantly and culturally, to the people HIV/AIDS is socially unacceptable and the PLWAs should not be exposed to the rest of the society. Since the disease is related to sexual immorality, people believe that such a disease should not be made public. The reaction is that of self-denial and self-rejection largely caused by fear, depression, and anxiety that accompany the disease. This in turn creates health risks for the society.

According to Herek (1988, 1990), Okafor (1994) and Soyinka (2001), anxiety, fear, and depression are universal problems that come with HIV diagnosis due to the fact that AIDS is a stigmatized disease. This suggests that stigma in AIDS implies prejudice and discrimination against and the discounting and discrediting of those perceived to have AIDS or its virus. It is a feeling that one is rejected and unwanted by others. In HIV/AIDS stigma means self-guilt and self-admission of HIV/AIDS as abnormal. It is also the anxiety by PLWAs that "others" (Non-PLWAs) have rejected them due to their infection of HIV. Herek (1988) observed that stigma can extend to individuals, groups, and communities associated with HIV/AIDS. It produces far-reaching effects on the spread, care, and entire management of the disease.

According to Goffman (1964) the concept of stigma refers to "an attribute that is deeply discrediting" (23). To Goffman, stigma is a complicated phenomenon that has three key dimensions. The first dimension is that the stigmatization and normal are not discrete categories but rather ends of a continuum. By implication, much of actual experience in stigmatization lies in the grey areas which are in-between (VanLandingham et al. 2005). According to VanLandingham et al. such a perspective belies the view of many who see some communities as harbouring stigma but others not, therefore suggesting that the reality of stigma may be more complicated. Secondly, stigma is concerned with discredited and discreditable identity and person. It suggests a distinction between actual experienced stigma (by a "discredited" person) and anticipated stigma (by a "discreditable" person). Lastly, stigma is a symbolic interaction which is evaluative (instrumental).

Following from the above dimensions of stigma, reaction to stigma according to Herek and Capitanio (1998) especially in relation to HIV/AIDS may be founded on prejudice. In many African societies such prejudice include social devaluation and the desecration of societal norms mostly through unacceptable sex as in the case of HIV/AIDS. It may also be based on instrumental criteria, such as fear of immoral death. Other scholars have examined how discredited or discreditable people feel, especially when experiencing disease roles and illness behaviours (Jacoby 1994; Malcolm et al. 1998). They have also explored how perceptions and experiences of stigma may vary over the course of the illness.[1] On both sides, according to Alonzo and Reynolds (1995) stigma have negative consequences. Those suffering from HIV may anticipate negative reactions from their communities and, therefore, have a more negative interpretation of community reaction towards them; at times possibly more negative than how the community actually perceives them. Mostly in societies where the perception of stigma is high, AIDS patients and the entire community are at risk. The effects of stigma are particularly felt in many Nigerian rural areas where it results in severe discrimination against people with HIV/AIDS (Ajala 2007). Stigma thus plays a major role in producing psychological stress such as depression or anxiety in PLWAs (Goldin 1994).

Despite the fact that among the Ibibio HIV/AIDS is considered a discriminatory disease that stigmatizes its victims and their relations, little attention has been paid to this in terms of how it constitutes a health risk. More importantly, it has not occurred to researchers to study the impact of coping mechanisms of the PLWAs in relation to the

1 Merson (1993); Alonzo and Reynolds (1995); Brashers et al. (1998).

culture of stigmatization in the society. As subsequently shown in this article, since the Ibibio culture of HIV/AIDS is enshrined within the template of stigma, it is important to know, how it constitutes a health risk to both the individual and the larger society of the Ibibio. Rather than dealing with stigma as a theoretical debate, this article examines how stigma creates self-rejection and self-denial in HIV/AIDS among the Ibibio. Hence, in what follows in the present discussion, an examination of community perception of stigma within the context of HIV/AIDS is done. Similarly, the Ibibio's local explanation of disease and health is provided with the intention of understanding how stigma is attached to certain categories of disease, without being extended to other diseases. Specifically attitudes and practices associated with HIV/AIDS, that are created from the community's local understanding of disease and health, also form a part of the ongoing discussions. Self-rejection and self-denial in HIV/AIDS constitute health risks, and thus, its impacts on increasing morbidity and mortality due to AIDS are analyzed.

The paper concludes that among the Ibibio, stigma is a label which distinguishes between those considered "normal" within the social order and those judged to be different or outside the social order. As it applies to the infection of HIV/AIDS, stigma exists as behavior, capable of generating other social/cultural actions associated with the disease. It generates cultural actions that socially isolate the carriers of the disease as culturally unacceptable and inferior. Stigma, therefore, results in PLWAs the feeling of social distress, which in turn provokes feelings of shame, guilt, and disgrace, as well as self-rejection and self denial that worsen the PLWAs health problem.

Methodology/Research Design

Study Methodology

This study evolved from ethnography conducted among the Ibibio of Itu and Uyo Local Government Areas of Akwa Ibom State in Nigeria. The study adopted multistage random sampling to select the study site, the research communities, the enumeration areas, and the respondents. As a qualitative ethnography, the focus was on both the individual and the community forming the unit of analysis. The individual unit of analysis is motivated by the need to examine individual perception of self during the infection of HIV/AIDS, which could either promote willingness to seek care or not. Whilst the community as a unit of analysis was adopted in order to measure collective perceptions and attitudes towards illness and health, with specific attention to HIV/AIDS.

Essentially, the qualitative methods employed in this particular study were concerned with the risky processes in AIDS management in Ibibio culture. Specifically, the methods of this study focused on the cultural implications of AIDS among the people involved in the study, so as to provide an understanding of why people with HIV/AIDS reject the health care system in Ibibio society. This attempt underscores the relativity of cultural concepts that qualitative research always attempts to achieve, as emphasized by Ajala (2002) and Nyamnjoh (2005). To this end, the study methodology is directed towards context-bound conclusions, which could potentially point the way to new policies and health decisions rather than scientific generalizations that may be of little use across all cultures. Through qualitative methods, such as in-depth interviews, key informant interviews, focus group discussions, and case study analyses which were employed in this study, the study is context-specific, collaborative/triangulative, and interventionist. As noted by Tashakkori and Teddlie (1998), in qualitative research it is important to avoid scientific generalization and focus the specific attitudes and behaviours influencing a particular case study in such a way that the study is specific to its particular context. However, to achieve this ethnographic feature it is also suggested, that collaborative methods of investigation otherwise known as triangulation should be used (Tashakkori and Teddlie 1998; Rubin and Rubin 1990). Thus, this ethnographic study could conveniently intervene in the society and culture being studied. The domain of intervention in this study is, however, not to alter the culture, but rather to understand it and possibly open the culture to planned change (Kerlinger 1986).

To ensure a balanced research perspective, both emic and etic views are carefully considered as the perspective focus for the study. In this case, the study seeks to avoid biases, which may arise from the exclusive use of either the emic or etic perspective (Tanner 2006). Thus, the emic perspective only considers the endogenous cultural attitudes, knowledge, and practices relating to HIV/AIDS, while the etic perspective explains how and why the exogenous factors interact with the Ibibio culture that sets stereotypes against care for HIV/AIDS. It also shows how such factors eventually cause health risks for the people carrying this disease. To a greater extent the study was driven by emic data, implying that the respondents' values guided our ob-

servations. This is simply because the study was concerned with how local culture translates to risky management of HIV/AIDS in the research community.

The ethnography employed in this study is reflexive. Reflexivity of the study was concerned with the need to deeply explore attitudes, beliefs, and practices which are mostly hidden, in order to explain self-rejection and self-denial in the Ibibio management of HIV/AIDS.

Sampling Technique

The larger concentration of Ibibio people live in the Uyo township and its metropolis, therefore two local government areas were purposively selected for the study. The use of purposive sampling was motivated by the need to select a rural and urban community where there are health care institutions. Itu and Uyo Local Government Areas (LGAs) were selected for the study, in which two communities were selected from each of the Local Government Areas. In each of the communities, thirty households were selected, making a total of 120 households selected through random sampling. From each of the households, a household head was selected for in-depth interview, resulting in 48 female household heads and 72 male household heads. Two heads of household were not available during the fieldwork, resulting in 118 household heads that were interviewed. This approach was favoured in the study to avoid unsystematic and obstructive selection of the study population (Agar 1980; de Yap 1951). For other methods of data collection, the study relied on purposive sampling as stated below.

Study Population

Only two out of 16 LGAs predominantly occupied by Ibibio people in the Akwa Ibom State were covered in the study. Akwa Ibom had 31 LGAs in July 2009. The LGAs were chosen purposively due to their proximity to each other and on the basis of rural and urban coverage. Hence Uyo and Itu LGAs were chosen as the study areas. While Uyo is urban, Itu is rural. Respondents were randomly chosen from Effiat Offort, Ukanna Offiot, and Fourtown of Uyo and Itam and Itu villages in the Itu LGA.

The study population comprised 118 household heads for in-depth interview. Furthermore, 144 key informants were purposively selected, which included 74 (29 from Itu and 45 from Uyo) people living with HIV/AIDS (PLWAs) selected from five nongovernmental organizations (NGO) who are caregivers for PLWAs in Uyo; 24 caregivers from the NGOs and hospitals; 23 PABAs; five officials associated with government agencies working on HIV/AIDS, and 18 community leaders. The study also conducted 12 sessions of Focus Group Discussions (FGD) of seven participants each, forming a total of 84 participants selected purposively among those who were identified as informative during the in-depth interview sessions.

In total, 346 respondents were interviewed for the study. Of all the respondents 163 were women, while 77 were men. The age distributions were as follows: 20 respondents were less than 20 years of age, with only 75 respondents falling between 21 and 30 years of age. Another 102 respondents were between 31 years and 40 years old. While 86 respondents were between 41 and 50 years old, the remaining 67 respondents were 60 years old above. The study engaged this large population due to the need to capture many individual perceptions of HIV/AIDS among the Ibibio. This helped the study to establish many varied and similar opinions that form the basis for comparison of responses as well as the objectivity of the inferences.

Data Collection Methods

Four methods of data collection were employed in this study: Focus Group Discussions (FGDs), in-depth/semi-structured interviews, Key Informant Interviews (KII), and case study analyses. The field investigation began with a pilot study to test the study instruments for feasibility. This was followed by KIIs from where patterns of household interviews were drawn. After the household interviews, the study engaged in FGDs and selected some PLWAs at the NGOs for case study analyses.

Actual fieldwork started with KIIs – having had a trial fieldwork earlier – it then became possible to enter the research site and identify resource persons who could be key informants for the study. Specifically, one-on-one intensive interviews were held with key informants.

Following KIIs, In-Depth Interviews (IDIs) were held. Certain opinions from KIIs that needed more specific corroboration formed the basis for IDIs. While KIIs focused on the individual, IDIs focused on the community as respondents, for IDIs were selected among the household heads. Both the KIIs and IDIs allowed the study to ascertain research subjects that have varied opinions about cultural construction of HIV/AIDS and health risks. Thus, to

align these varied opinions, FGDs were organized. 12 FGDs with 7 members each were held. The sociodemographic characteristics of the discussants are shown in Table 1 below.

Table 1: Sociodemographic Characteristics of the Discussants (84) at FGD Sessions (source: generated from ethnographic data collected in 2008 in Uyo and Itu).

Age	
Age Range	Frequencies
20–30 Years	9
31–40 Years	26
41–50 Years	27
50 Years above	22
Sex	
Male	28
Females	56
Education	
No School	12
Primary School	23
Secondary School	32
Post-secondary School	17
Locations	
Itu	48
Uyo	36
Religions	
Islam	3
Christianity	67
Others	14

The last stage of data collection was the use of case study analyses. During this session, individual perceptions of HIV/AIDS were further captured. The essence of case study analyses was to match the respondents' words with their actions. Thus, case study analyses provided that opportunity as the respondents were closely observed and interviewed informally. Eight respondents, mostly PLWAs, were engaged in the case study.

Data Analysis

The analysis of data was mostly descriptive, relying on content analysis of the generated data. The semi-structured data from the open-ended questionnaires were entered into code sheets after careful editing, before they were entered into the SPSS software which relied on computer commands as indicated in the Text Base Alpha package in SPSS software to configure the similar and different themes from the data, having earlier used the word processing software to categorize the research objectives into different themes. The results thereby provide an easy means of sorting and categorizing the configured data into different patterns based on the research objectives. This was done manually by the principal researcher as this stage of Qualitative Data Analysis (QDA) cannot be completed appropriately through the available software in QDA (Weitzman 2000). The process here involves writing each of the research objectives on a separate sheet or separate sheets of paper and appropriately merging the supportive and nonsupportive data under each of the listed objectives. From the information inferred by the analyzed data, the report was completed. The information reported is accompanied by verbatim quotes translated into English. They comprise the recorded responses of the research subjects extracted from the interviews.

The key informant data were transcribed and translated into English by hand before being typed and saved as Microsoft Word files. The research themes were also identified and sorted, using a manual approach, into likely and unlikely opinions based on the research objectives, and then assigned to appropriate research objectives as in the semistructured (in-depth) interviews. Some of these opinions were presented verbatim in the report.

The following case study analysis provided an opportunity for the description of individual views and perceptions which followed. The analysis involved the reading of the field notes where observations were recorded so as to extract attitudes and opinion that were related to the research objectives. As the case study only involved PLWAs, the study was able to obtain an inside view of the attitudes of PLWAs within the community. The descriptions of case study analyses were also supported by the respondents' opinions on the issues examined.

FGDs were recorded on tape recorders and the recordings were then transcribed. Most of the respondents communicated in English with a minimal number communicating in Ibibio language. However, very few responses in Ibibio were translated into English, and it was from the English responses that the opinions were grouped according to the research themes. This stage followed the sorting of the emerging themes, identifying the common patterns and the less common themes. The common patterns were then taken to be popular opinion and thus became the basis of our argument. Cumulatively, data

generated from the four data collection procedures were married together to form the research report. The reporting style follows a critical interrogation of the responses, in some cases presenting the translated voices of the respondents.

Ethical Consideration and Data Management

Due to the fact that the subject of this research deals with humans and sensitive behaviours in humans, the study first sought ethical approval from the Ethical Review Board of the University of Uyo on March 17th 2008. This was approved on April 22nd 2008. Following approval, the fieldwork commenced. Ethical issues, such as informed consent, confidentiality of information, and protection of the research subjects, were the main issues proved before the Ethical Review Board. Having convinced the board that the study would address all ethical issues in an appropriate manner, the board granted its approval. Throughout the fieldwork, all of the above-mentioned ethical issues were successfully applied.

Respondents' confidentiality was also maintained as no direct or imagined identities of the respondents were made public. Throughout the research respondents were protected against bodily harms as they were not interviewed when it was not convenient for them. Again they were interviewed where it was safe for them. They declared their consent formally before they were allowed to be involved in the research. The consents were expressed in writing.

Research Findings

The Ibibio Culture of Health and Disease

The Ibibio are people of Akwa-Ibom State in South-South Nigeria. Together with the Anang and Oron, whose cultures are very similar, the state comprises around 3.9 million people and forms one of the 36 federating units of the Federal Republic of Nigeria (Nigerian Population Commission 2006). The people are notoriously religious, with their traditional cultural setting reflecting a multiplicity of gods and goddesses. However, as a result of proximity to the eastern and southern Atlantic waterways in Nigeria, the people here had early contact with Christian missionaries who caused changes in the Ibibio belief system (NA Calabar 1948). In spite of this, the Ibibio's worldview is still largely shaped by the people's attachment to traditional beliefs.

Thus, in health and disease, the Ibibio hold firmly to the belief in preternatural causation of disease and illness. The people believe that the causes of many diseases can be traced to witchcraft or punishments from gods and goddesses (Ekong 2001). Hence, certain diseases are seen as atonement for the desecration of the society. The healing of those diseases first has to do with cleansing, involving the normalization of one's relationship with preternatural forces associated with the cause of such disease. Among the Ibibio, sacrifice and rituals are the first therapeutic options, as they are supposed to appease gods, goddesses, and witches. Such rituals should then result in the cleansing of the victim from the disease.[2] Informed by this belief, the people are attached to different forms of traditional medical practices, which include divination for diagnosis, healing prescriptions, the use of local herbs, and the traditional faith healing system. However, it would appear that such healing possibilities were never able to completely save people from sociobiological infirmities. Though the rates of morbidity and mortality were not accurately measured before the advent of modern medicine due to the lack of hospital records, yet it is safe to say that morbidity and mortality rates were high. As maintained by 82 out of 144 key informants in this study, cholera, malaria, small pox and measles were very common and often resulted to higher mortality especially among young children.

In 1912 and 1917, respectively, two acute outbreaks of measles and small pox were reported in Uyo, Ikot-Abasi, Ibespko, Itu, Itam, and Abak, which are the main Ibibio towns and villages (NA Calabar 1918). The people blamed these crises on witchcraft and the effects of the First World War (Schram 1973). Furthermore in 1964 and 1968, most of the communities in the Calabar and Ogoja provinces (which then belonged to the Ibibio region) experienced an outbreak of cholera which had a huge effect on the population in the area.[3] To combat all of these health issues, the Ibibio often resorted to traditional health care system, being the predominant health care facility in the society at that time. As observed in the fieldwork even now, poor financial status, low level of education, and lack of access to modern health care facilities are the most common reasons as to why the Ibibio continue to choose the traditional medical option. Although there are some ailments which people believe can-

2 Uduak, in a personal interview held in Uyo, in June 2008. She is a 36-year-old female PLWA and receiving care at an NGO in Uyo.

3 Udem, in a personal interview in Itu, in June 2008. He is a 76-year-old head of household.

not be successfully cured using modern medicine, the use of traditional medical care is fundamentally rooted in the users' low socioeconomic status. 97 out of 144 key informants who are mostly from rural areas affirmed their utilization of traditional medicine, while another 43, mostly from urban locations, similarly affirmed their utilization of modern health facilities in Ibibio society.

Despite the fact that Sexually Transmitted Diseases (STDs) were not unknown to the Ibibio, the advent of HIV/AIDS reshaped Ibibio beliefs, knowledge, attitudes, and practices related to STDs. In the recent, the practice of premarital sex, extramarital sex, and illicit adolescent sex, which defy cultural restrictions, is also common among the people. However, these practices were disregarded by a number of traditional codes in order to avoid sex crises and sexual ill-health. Attached with religious belief, the Ibibio like any other African local people regard such forms of sex as immoral. The ridicule and embarrassment caused by the infection of a STD is regarded as a punishment, as adultery is not part of the criminal law of the people.

As with other diseases, when STDs are noticed, individuals resort to traditional medical care where public exposure is less likely in order to forestall public ridicule and embarrassment. Thus, in the era of HIV/AIDS, similar cultural practices still prevail across Ibibio land. As noted by a respondent in the Itu Local Government Area, "who will go to hospital and tell doctor that he or she has HIV or AIDS? It is ridiculous; I do not believe that anybody can do that."[4] Underlying this opinion, another respondent in Ikot Effiot, Uyo, maintained that "most people detected having HIV/AIDS, were cited when they go to hospitals for pregnancy test and when they have coughs. If many of them knew before going to hospital that they had HIV/AIDS, they would not go to hospital for fear of ridicules and stigmatization."[5] The above cultural factors explain, why the level of HIV/AIDS in the Akwa Ibom State was as high as 8.2% in 2006, the state with the second highest rate of HIV/AIDS in Nigeria (*Sentinel Report* 2006).

HIV/AIDS Culture in Ibibio Society

Despite the fact that virulent STDs were common in Ibibio society prior to the 1980s, the type of STD referred to as HIV/AIDS was unknown to the Ibibio culture of disease until the early 1990s. Thus, as the people held the view that the disease was directly linked to homosexuality, which was very rarely practiced in traditional Ibibio society, the disease remained alien to the people.[6] In the 1990s, even when cultural contact became exponential in Ibibio land due to the booming crude oil economy that opened the society for higher degree of migration and urbanization, the Ibibio people first became aware of HIV/AIDS through the electronic media. This occasionally sensitized the people to the disease, however, many Ibibio still doubted the existence of HIV/AIDS. This can be compared to the Yoruba response to HIV/AIDS in western Nigeria where between 1980 and 1990 people denied the existence of the disease. As argued elsewhere, this epoch in HIV/AIDS is referred to as the age of ignorance (Ajala 2007: 235). Like many other societies in Africa that are exposed to the vagaries of globalization, the Ibibio, too, had started to experience global contact, which has accounted for unregulated sex especially among the adolescents, and the breakdown of traditional sexual norms before the emergence of HIV/AIDS.[7] Of course, sex culture in Ibibio society is a social action and a physiological need. Notwithstanding, its abuse is immoral, and sanctioned divinely by God. To Ibibio people, since HIV/AIDS was initially constructed through unregulated sexual activities, it was, therefore, an immoral disease and a punishment from God to those who engaged in such immoral sex (Ekott 2004). This perception, according to Willis (2002), is referred to as the God's wrath theory of causes of HIV/AIDS. The Ibibio thus hold the mysterious origin of the AIDS virus and have apparently hopeless expectations for its management. The people believe that AIDS is God's way of destroying sinners. The people similarly believe that AIDS is a means by which witches destroy their victims. A PLWA respondent in Fourtown explicitly stated: "I reject this in Jesus' name. I am not having AIDS. It is a disease inflicted on me by my enemies, the witches; because they saw me getting rich and they decided to bring me down. God will never make them to succeed on me."[8] While the above explains the rationale for the neglect of modern health care services in caring for HIV/AIDS, it equally provides an explanation why

4 Akpan, in a personal interview as a head of household. The 56-year-old man was interviewed in Uyo in June 2008.

5 Idongesit, in a personal interview. She is a 32-year-old caregiver at an NGO in Uyo and was interviewed in May 2008.

6 Edem, a 37-year-old medical doctor, interviewed in Uyo in June 2008.

7 Nkoyo, a 47-year-old woman, interviewed as a key informant in Itu in July 2008.

8 Anonymous female PLWA who was 27 years old and interviewed in an NGO in Uyo in June 2008. She said to have registered with the NGO two months before the interview.

the infected people deny the infection. The above perceptions explain the use of anti-witchcraft rituals and objects, as well as faith-based healings to deal with the infection.

The decreasing standard of living in Ibibio society, starting from the year 2000, increased the prevalence of HIV/AIDS in the society. Although at the time of this research a community-based prevalence rate of HIV/AIDS was not available for the Akwa Ibom State, the state had 8.2% prevalence rate as at 2005 (*Sentinel Report* 2006). Although it has scaled down to 6.3% as at 2008 (*Sentinel Report* 2009), yet the relationship between a poor socioeconomic standard of living and the prevalence of HIV/AIDS becomes clear in the context of the sexual explanation of HIV/AIDS in many African societies (Ajala 2007). The decline in the socioeconomic living standard of the Ibibio was reflected in the increased rate of unemployment, urban destitution, and many informal sectors holding little or no promise for sustaining a living. As a consequence, the level of sexual activity and orientation changed from passively regulated to actively unregulated.

As in many Nigerian societies, many women in Ibibio who were earlier forbidden through local custom from engaging in extramarital sex began to change their sexual behaviour in order to use sex as a way to gain financial means. Similarly, adolescent girls in households became free to access sex trade – a practice promoted by a changing economy (Ajala 2007). The cumulative effect is a higher degree of sexual permissiveness that reflected itself in premarital sex, having multiple sexual partners, commercial sex working, and extramarital relationships. Since the society regards sexual conduct as a social action, premarital sex and extramarital relationships in Ibibio culture, though considered immoral, were not publicly denounced. There was some degree of tacit acceptance and surreptitious approval as it acts as an alternative to poverty. While these new forms of sexual behaviour are regarded as a high point of sin, they are not publicly punished. Consequently, illicit sexuality grew at an alarming rate. This situation is not just restricted to the Ibibio of South-South Nigeria, but is equally prevalent in many societies in Nigeria. The implication is the exponential increase in HIV/AIDS among the people. As reflected by this study, although epidemiological study had not yet been conducted, nine out of the 60 households surveyed in Uyo city (urban) had HIV/AIDS-related patients, while five of the 60 households in Itu and Itam villages (rural) had HIV/AIDS-related patients. It becomes apparent, therefore, that HIV/AIDS seems to be a reality in Ibibio society. Thus as disease and health are cultural actions, the Ibibio response is self-denial and self-rejection in response to HIV/AIDS, driven by the cultural reactions of the society. Hence, HIV/AIDS is a social action. The dominant belief is that HIV/AIDS is due to unregulated sex, thus it is seen as a disease caused by immoral behaviour. Although the society does not openly condemn the unregulated sex, which is common due to the breakdown of traditional sexual norms and customs, at the same time no individual can publicly proclaim that they are engaging in such behaviour. Both adolescents and adults, who have multiple partners or engage in casual sex, do it in secret, yet casual observations of physiological appearances point to unregulated sex. As noted by one of the respondents, "No one will tell you that he or she is engaged in illicit sex, but once I see a lady who does it. I know they often have stress marks on their bodies and engage in flashy cosmetics among others."[9] This position is further stressed by a parent as follows: "I know that my daughter is into sex trade but if I say it to her[,] she denies. She does not work, but she uses costly materials, where does she get them? From men, of course. Me, I know that those men slept with her before given her money."[10].

Nonetheless sex behaviours could still attract stigma, when it attracts shame in form of unwanted pregnancy in the case of unmarried adolescent women or in the case of married women who had such pregnancy for another man other than their actual husbands. Similarly, if such sex conduct resorts to STD infection, in a worst case HIV/AIDS, the individuals involved are tagged as immoral and are often stigmatized. Also women who engage in commercial sex in Ibibio society do not often disclose to others that they are into commercial sex, for fear of shame and ridicules that could lead to stigma. A female, 27-year-old PLWA informant who was interviewed in Uyo in July 2008 noted: "Before I was infected, I was into commercial sex work. Then I hid my profession and I was practicing in a brothel in Lagos (about 650 Kilometers away from Uyo where many people could identify me). If people that know me are aware of my profession[,] they will call me bad names."

At the onset of HIV/AIDS infection the symptoms are rarely visible, but as the opportunistic infections set in, people around the infected persons at the workplaces, homes, and schools started to perceive that the victims are infected. While these per-

9 Emem, in a personal interview in Uyo, June 2008. She was a 28-year-old lady and a career in an NGO in Uyo and a member of a Pentecostal church in Uyo.

10 Akpan, June 2008 (see fn. 4).

ceptions lack clinical evidence, they hold a strong belief that symptoms expressed by the victims are that of AIDS. Hence, the neighbours and friends of the victims declare the victims as "others," while seeing themselves as "normal." This then marks the beginning of stigma fixation that continues to build up into alienation against the victims.

Another aspect of HIV/AIDS culture in Ibibio society is the culture of self- denial which complicates the infection. Self-denial is often due to perceived stigmatization by PLWAs. In this culture, PLWAs often deny the infection through the expression of certain excuses to rationalize their sick role behaviours. Amongst these, the worst aspect of self-denial regarding the actual infection of HIV/AIDS is the denial of HIV/AIDS symptoms. These symptoms are: general body ache, loss of appetite, oral thrush, vomiting, and regular episodes of malaria, among others. The victims often maintain that the symptoms are due to the stress of work, even when they are not engaged in any serious work. A PLWA respondent notes, "my mind told me that I had HIV/AIDS, immediately I started to experience opportunistic infections, but I denied it."[11] Another respondent shared a similar opinion which is supported by 27 out of 74 PLWA respondents. For two years she experienced HIV/AIDS symptoms she did not tell anybody and to herself she also denied it.[12]

Self-denial leads to self-rejection. Hence the AIDS victims in Ibibio withdraw from group actions. In what looks like Goffman's (1964) anticipated stigma, PLWAs in Ibibio suddenly withdraw from their peer groups, school friends, friends within the community, and even from distant members of their families. They also gradually dissociate from colleagues. This is because they believe that their friends are already aware of their AIDS status and that they will reject them. Due to this perception, many PLWAs refrain from attending public occasions where they could have benefited from community support systems and withdraw to hidden places where people cannot identify them. This usually provokes urban-rural migration of PLWAs in Ibibio society. Infection usually occurs in the cities and towns, as 63 out of 74 interviewed PLWAs were city residents at the point of infection. As soon as the disease began to manifest itself, the PLWAs withdrew from the cities to villages which are still ignorant of the sickness behaviour common to PLWAs. This is a similar coping pattern in relation to HIV/AIDS among the Yoruba PLWAs in western Nigeria (Ajala 2007).

The above situation provokes a culture of secrecy and self-medication common in HIV/AIDS care. With the advent of opportunistic infections associated with AIDS like fever, vomiting, body aching, cough, and loss of appetite among others, the perception of community rejection held by PLWAs, their anxiety and fear prevent proper public care and management of AIDS. Rather they exploit the situation of drug abuse within the society (the use of unprescribed medication and proliferation of chemist shops) in order to self-medicate in secret. They prescribe drugs for themselves and refuse to attend clinics and hospitals. This practice is more prevalent in Itu Local Government Area, where 21 out of 29 PLWA respondents confirmed that they had not attended any hospital. Although they claimed many reasons for doing so, the culture of rejection ranked highest (17 out of 29). Other reasons included the belief that traditional care of HIV/AIDS is better (18 out of 29). This pattern of care of HIV/AIDS is taken as a form of coping with rejection since care in traditional medicine is less publicly exposed. Similarly, some held the view that even in the hospitals there is always inadequate access to drugs (7 out of 29) and the remaining 3 out of 29 claimed that the location of the hospital was too far from their villages. On the other hand, in Uyo, only 32 out of 45 of the PLWA respondents defied the use of the public hospital due to self-rejection and fear of stigmatization. In all, it is clear that the majority of PLWAs have engaged in secret HIV/AIDS care and self-medication.

However, the culture of self-medication imposes danger to the health of PLWAs, as the use of drugs is not controlled. They tend to engage in drug use based on their personal knowledge of the severity of their ailment. Many of them used overdosed drugs and often use drugs without a medical examination which could have ascertained the effectiveness of such drugs before usage. Predominantly, the PLWAs used analgesics such as Ibuprofen, Paracetamol, Anagin, and Novalgin as the most common and cheapest analgesics in the Nigerian drug market. They also engaged in the use of Riboflavin, an affordable blood tonic and vitamin B-complex. The PLWAs are exposed to an unprescribed combination of these drugs, as they attempt to speed up their recovery.

Due to the fear of stigmatization, PLWAs mainly contact their carers at night. In fact, all the PLWAs

11 Ineo, in a personal interview held in Uyo, in June 2008. Ineo is a 38-year-old man and a PLWA enjoying support from NGO in Uyo.

12 Rosemary is a 41-year-old woman and an outpatient PLWA of a public hospital in Uyo. She was the only outpatient PLWA cited in Uyo during the research. She was interviewed in June 2008.

attending public health institutions go for medical care at night, when there won't be anybody or there are very few people who could identify them in the hospital. As stated by one of the anonymous PLWA key informants: "I cannot go to my doctor during the daytime, because I do not want to be identified with the disease. I do not even go out during the day."[13]

The above often resorted to delay in PLWAs' recovery. As the PLWAs continue to experience delay in recovery, they again resort to accusing preternatural forces such as witches for acting against their health. They then begin to engage in different forms of rituals and sacrifices to deal with such forces. By doing so, they are rejecting and denying the social actions that led them to the infection of HIV/AIDS. They create hatred against older women within their households and outrightly reject them. A case study of a PLWA in Fourtown, Uyo, explained how he had abandoned his mother in-law, whom he accused of being the force behind his health crisis. The respondent stated: "Even before I was told by my pastor, I know that the woman [his mother in law] is a witch. She caused this disease on me. She is still there and suckling the drugs I used from me. So the drugs refused to work. Sometimes she used her witchcraft to remove the potent in the drug that I want to use. She knows everything about me. My pastor has told me that he is going to deal with her through prayer."[14] The above text implies that PLWAs do not accept the infection of HIV/AIDS as the result of their own social actions. Rather they reject it and put the blame on others. This perception determines their health-seeking behaviour and imposes greater risks on health management in HIV/AIDS among the Ibibio.

While NGOs involved in care and support for PLWAs seem to break stigmatization, yet the risks of self-denial and self-rejection in HIV/AIDS and the complexities of stigma in HIV/AIDS as discussed above similarly reduced the NGOs' optimal success. Among the Ibibio, due to fixation of stigma, many PLWAs do not want to be identified with NGOs even when they know that they would receive better care and supports from the NGOs. Nonetheless, as many NGOs (three out five NGOs identified in Uyo) are directly attached to churches, they mostly recruit their clients from their individual churches. With the belief in faith healing of those churches, many of the few PLWAs receiving care from these NGOs were attracted to the NGOs. As many of these churches are Pentecostals with a strong belief in spiritual healings, they tend to appeal to the majority of PLWAs who believe in faith healing. Thus religion, in the case of Ibibio, where Christianity has grown deep, seems to be the pathway of accessing NGOs' care facilities.

The PLWAs receiving cares and supports of NGOs tend to have formed a social bond through which they used to break stigma among themselves, which included sharing their pre-HIV/AIDS' experiences and their current experiences as PLWAs. Having known that they manifest similar sick roles, they are free to interact and share whatever available among themselves. While these social bonds tend to reduce PLWAs in-group stigma, it does not work for stigma that are fixed on them by outside-groups. As they see themselves as "others" carrying the abnormal label, they often found it difficult to break the barrier of stigma generated from outside the PLWAs' group. This was noted by a PLWA in the NGO: "I do feel comfortable and free of embarrassment anytime I am at the NGO's office, but no sooner I go out than I do feel that I am different from all others I meet in the street. So, that makes me feel that my problem is already known to others and I see myself as abnormal."[15]

The foregoing suggests a link between Goffman's (1964) and Alonzo and Reynolds' (1995) theses on stigmatization within the context of the Ibibio culture of HIV/AIDS and its relationship with self-denial and self-rejection. Among the Ibibio, the stigma in HIV/AIDS is a complex and complicated phenomenon embodying a number of subjective feelings and perceptions that are expressed in several forms. Firstly, among the Ibibio, individuals seek to be normal, yet the fixation of normal and abnormal is subjected to personal moral valuation that surrounds individual conducts and behaviours. While those who are yet confirmed as having HIV/AIDS see themselves as normal, the PLWAs have a self-affliction of guilt, ridicules, and abnormal. The Ibibio PLWAs believe that their infections are due to their desecration of the societal norms through immoral sexual conducts. For this reason, many of them assume the sick role that conforms to the perception that their infections are already of public knowledge. Thus in Ibibio society, PLWAs are persons carrying both discredited and discreditable identity and person, hence they always assume a symbolic interaction within which they establish the culture of self-denial and self-rejection as the evaluative

13 Anonymous X, a male 38-year-old PLWA. He attends the public hospital in Uyo for treatment and was interviewed on many occasions at Uyo, in July 2008.

14 Anonymous X (see fn. 13).

15 Xavier, a 39-year-old male PLWA, receiving care from an NGO in Uyo. He was interviewed in June 2008.

means of coping with the stigma fixation. However, the situation is dangerous for the community, as it has a number of implications on both morbidity and mortality due to HIV/AIDS in the society.

Implications for Morbidity and Mortality

The incidence of self-rejection and self-denial of HIV/AIDS in Ibibio culture seems to create health risks with a greater impact on morbidity and mortality due to HIV/AIDS. This culture makes modern health care institutions inaccessible to PLWAs, despite the fact that in such institutions they could obtain information about their health status, undergo proper diagnosis and care, and access drugs to manage their health. Due to the culture of self-rejection and self-denial, 51 out of 74 interviewed PLWAs lack basic health information about HIV/AIDS. Many of the PLWAs believe that HIV/AIDS is a lethal disease which cannot be managed. They similarly lack knowledge about hygiene and the nutritional requirements of AIDS. Many PLWAs (63 out of 74) similarly do not believe in antiretroviral (ARV) drugs, while 58 out of 74 confirmed that they had never seen ARV drugs before, even talk less of using such drugs.

The belief that HIV/AIDS is due to witchcraft curses prevents PLWAs from proper diagnosis which could have established the accurate viral load in PLWAs at the window level and which could have caused viral reduction at the early treatment stage. It also prevents the opportunity of prescribing appropriate measures to manage the HIV/AIDS levels. Due to this belief, the PLWAs resort to divination which cannot reveal their specific HIV/AIDS status. Since many people, especially in rural communities, believe that witchcraft causes HIV/AIDS, voluntary testing is not encouraged. 113 out of 153 "Non-PLWA" respondents (through data from the IDI and KII) did not know their HIV status. This situation is dangerous, as it furthers the spread of HIV/AIDS, thus leading to an increase in HIV prevalence in the society.

PLWAs in Ibibio society also lose the support network which is vital to HIV/AIDS management (Ajala 2008). Rather, they live in secret and do not expose themselves to members of their kin. Unlike in the Yoruba society of western Nigeria, where nongovernmental or religious organizations and health care institutions provide emotional, social, financial, and medical support for many PLWAs (Ajala 2008), in Ibibio society, due to the people's perception of HIV/AIDS and the culture of secrecy, self-rejection, and self-denial, access to support systems through nongovernmental organizations is hindered. All these issues have resulted in an increasing morbidity and mortality rate due to HIV/AIDS.

Discussion and Conclusion

Worldwide, HIV/AIDS is associated with stigma and discrimination. This continues to have a wider influence and a serious impact on both the victims of the disease and the community at large. It also constitutes health risks. The effect of stigma on HIV/AIDS management is said to be more devastating than the virus itself (de Bruyn 1999).

Stigma as a social action in human behaviour is a feeling of inferiority or superiority which is expressed in many forms but always in a discrediting manner. According to Skindmore (1977) and Ritzer (1996), who are interactionists, behaviours in society are vast series of individual selves, fitting together their individual lines of actions. Of course, these actions occur recurrently and interconnectedly and thus form the core of social life. They are employed as responses to any problem which threatens human existence (Assavanonda 2001). Since HIV/AIDS is behavioural, its perception and management is subjected to interconnection existing between how the selves, that are direct victims, and others who observe selves relate to each other. It is, therefore, the generated behaviours, attitudes, and perception from these two synergies that create health-related behaviours in HIV/AIDS, just as in other stigmatized diseases.

However, the responses generated from the above may either bring positive or negative behaviours. In the case of HIV/AIDS and other diseases such as mental ill-health, especially in many traditional African societies like the Yoruba of western Nigeria (Jegede 1998) and the Igbo of eastern Nigeria (Okafor 2000), the perspective is negative and discriminatory towards the known victims of these diseases (Nyblade et al. 2003). The disease-carriers are assumed to carry the traits, attributes, and behaviours that isolate them, as they are defined and treated as "culturally unacceptable and inferior" (Brown et al. 2003: 51). The outcome of this is the imposition of feelings of shame, guilt, and disgrace on PLWAs. They distinguish themselves as abominations, blemished characters and despised social groups (Okafor and Holder 2005). The common reactions to these three distinguished conditions are self-rejection and self-denial, in which the disease-carriers place blame on specific individuals and groups that form powerful metaphors and imagery fixed against those with HIV/AIDS.

Among the Ibibio of South-South Nigeria, such powerful metaphors and imageries are reflected in the neglect and stigma surrounding PLWAs. Imageries of immorality and sin apportion guilt to PLWAs. In reaction, the PLWAs withdraw from public life and engage in self-rejection and self-denial. This, of course, is a condition which is inimical to the control of HIV and management of AIDS in the society. As shown in the data presented above, self-denial and self-rejection greatly undermine access to modern health care systems in AIDS and deny the PLWAs' support systems, which are imperative in HIV/AIDS management. Through self-rejection and self-denial Ibibio people are reluctant to be screened for HIV/AIDS, thus explaining the high prevalence of HIV/AIDS in the society.

Conclusively, there is a need for more ethnographic research on specific cultural attitudes and perceptions towards HIV/AIDS, not only to explain the prevalence level of the disease, but to allow for culture-specific modes of management of the disease. In the case of the Ibibio society, there is also an urgent need to engage in more elaborate ethnography, so as to create a pathway of breaking the cultural barriers militating against the care, support, and management of HIV/AIDS in the society.

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