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RESEARCH ARTICLE

SOCIAL ADAPTATION LOGICS OF PEOPLE LIVING WITH HIV/AIDS IN ABIDJAN, COTE D'IVOIRE

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ABSTRACT

People living with Human immunodeficiency virus (PLWHA) are ostracized, judged morally and mostly rejected by their communities. This study aims to highlight and analyze the processes of stigmatisation of PLWHA as well as the rationale for their adaptability. The theories of causal attribution and stigmatization have been used to account for this phenomenon of rejection as well as the adaptation logics developed by victims. Methodologically, the research was conducted in Abidjan, Côte d'Ivoire, and 56 people, including 30 people living with HIV/AIDS, participated in the survey. Semi-structured interviews were conducted with these individuals. The method of analysis is qualitative and phenomenological in nature and aims to show that PLWHA have difficulties in social adaptation. The results show that despite adversity, the best adapted PLHIV use a coping waybased on a triptych: acceptance of HIV status, concealment of status (moving, diversification of consulted health centres, etc.) and maintenance of professional status.

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INTRODUCTION

The Acquired Immunodeficiency Syndrome (AIDS) or the Human Immunodeficiency Virus or HIV[1], is for many, a pathology that is considered to be due, to a significant extent, to the risk behaviours of populations. Despite the commitments made[2] and strategies adopted by states to combat this pandemic, HIV continues to represent a major public health problem worldwide. This is particularly true in Africa where, as in Côte d'Ivoire, the situation is alarming[3]. This transmissible infection, combined with high mortality, has permanently altered the social and family ties specific to African culture, where for a long time mechanical solidarity seemed to prevail. The perception of people affected by this pandemic would be problematic. Does it not touch the taboo of sexuality? Such a perception, says Traoré (2003), has updated fears already known since the Middle Age. And its worrying, even distressing nature has never ceased to permeate the collective imagination to such an extent that only fear, hatred and rejection have resulted. Such a "disease", in addition to the constraints inherent in its medication, actualizes in the African field the issue of bond, fraternity and solidarity. And raises, says Dannecker (2002), a central problem: the marginalization of certain stigmatized populations in our contemporary societies, as well as their adaptation. The status of people living with HIV (PLWHA) as patients has ushered in a new dialectic in the way victims relate to their social biotope. The attributive process that appeared with the disease was not built in neutrality: it referred, at least implicitly, to representations involving forms of deviance. The "biological disorder" was perceived as a consequence of a "social disorder", according to Augé and Herzlich (1986). Stigma would reflect a likely "moral inferiority" as well as a structural disability in the observance of "healthy behaviours" (Peretti-Watel and Moatti, 2009). As a result, there is a gap in relations between individuals (N'dri, 2013), a weakening of social integration and life, and therefore a threat to the established order. Eager to protect itself, the doxa will put the burden of a daily life

[1]AIDS becomes Aids in English, for Acquired Immuno-Deficiency Syndrome. We will find Aids or HIV instead of HIV in some French scientific expressions.

[2] Indeed, States have reaffirmed their determination to build a State governed by the rule of law in which human rights, civil liberties, human dignity, justice and good governance are promoted, protected and guaranteed. This is reflected in the international legal instruments to which Côte d'Ivoire is a party, in particular the United Nations Charter of 1945, the Universal Declaration of Human Rights of 1948, the African Charter on Human and Peoples' Rights of 1981 and its additional protocols, the Constitutive Act of the African Union of 2001. In Côte d'Ivoire, ActNo. 2014-430 of 14 July 2014 on the prevention, protection and repression of HIV/AIDS, in articles 18, 19, 26 and 30, recognizes the fundamental rights of PLWHA and vulnerable populations, such as the right to health, the right of access to employment on equal and equitable terms and the right to education and information. Through Article 28 of the Constitution, the State also undertakes to guarantee the specific needs of vulnerable persons, to guarantee access to health services, education and employment.

[3] HIV prevalence is 3.7% (EDSIII-MICS, 2012). And according to *spectrum* estimates, by 2015, Côte d'Ivoire is expected to register 460,000 people living with HIV, including 250,000 women aged 15 and over and 29,000 children aged 0-14.

marked by moralizing judgments on PLWHA. The question of the social adaptation of PLWHA is therefore an acute one. As well as the mirror image of the victimization process of stigmatization. According to Mr. Cusson (1998, 2005), "Stigmatization means attaching to an individual the label of deviant, which leads to exclusion, the internalization of negative identity and the amplification of deviance". Alonzo and Reynolds (1995) propose four stages, serialized according to the infectious phases: identification of the individual with a risk group, highlighting his responsibility, stigmatization for fear of contagion and rejection. Stigma evolves, as victims in turn try to minimize its effects. For Desclaux (2003), the constraints associated with HIV infection would come from the social environment. Parker and Aggleton (2003), accurately identify the economic and social origin of victims and establish a causal link between stigmatization processes and inequalities related to gender, class and social origin. Should it be deduced - in view of the erosion of traditional solidarity in Côte d'Ivoire - that any process of stigmatization would be linked to the previous social profile? And that only "negotiated" solidarity in the agglomeration would prevail?

Social adaptation takes into account the subject's own willingness to integrate. While it is true that a situation of stigmatization would induce a feeling of isolation that could lead to despair, it also depends on the degree of acceptance of the disease and the willingness to take charge of oneself (Lacroix and Assal, 1998). The person isolating himself and denying the disease will limit his access to health services. And may run the risk of not being recognized by the social care referents. It will itself, says Thoits (2011), contribute to reinforcing its marginalization. Heurtier (2010), lists strategies for positive individualized dynamics: acceptance and recognition of the disease, moderation of negative emotional impact, planning of solutions, distance from discriminating groups, positive reassessment of one's situation and involvement in the conduct of care. Resilience depends, Lavallée (2003) adds, on the prior adaptive capacities of the individuals concerned. And we will want to see the individual strategies deployed in Côte d'Ivoire. Two theories of social psychology can be convened: that of causal attribution and that of stigmatization, the victimological side of which indicates the role of the active subject in dealing with stigma. Causal attribution is defined as a process of "corresponding inferences" (Jones and Davis, 1965); observing behaviours, individuals seek to infer internal and stable dispositions in individuals. Initially, Heider's theory of equilibrium (1946 and 1958) shows that the similarity between two events implies that the first is taken as the cause of the second. And that the probability of attribution will be more in favour of the person than in favour of the environment or the situation. PLWHA would appear to be "responsible" for their infection because of alleged deviant practices. But what factors, internal or external, would cause people to react in this way?

Constantly revised, the theory now proposes this thesis: overestimating internal causes (responsibility) would be part of a socially determined and reinforced norm of "internality", valued and useful for intergroup categorization and social functioning (Dubois, 1991). It leads to stigmatic analysis. Lemert (1951) understood this labelling as a socially and retrospectively organized response to "sociopathic individuation" that promotes identification with the norm. Link (1987), in his modified labelling theory, was able to describe the foreseeable consequences of stigma: difficulties in accessing housing, employment, care, and maintaining family ties... and victimization through self-tagging. Stigmatization would constitute a social reaction of stereotyping PLWHAs separating assets from others (PLWHAs), inflicting a loss of status and discrimination on them in their various living environments, in conjunction with social inequalities and self-blame that promote the maintenance of stigma. What will the subject threatened with "social disintegration" do in return? How will it act to de-stigmatize him? PLWHA is an "all-encompassing" lexeme, studded with prejudice, a pretext for condemning other implicit actors to alleged unlawful behaviour. It is therefore necessary to distinguish the objective criterion from the deviation of perception or social reaction as here. Lemert (1967), recalls Cusson (op. cit.), describes the person who bears the stigma as a "secondary deviant". After him, authors such as Dericquebourg (1989), announce two possible attitudes of the person: observing others with more prominent stigmas, he will cut himself off from them, strengthen his self-esteem and share the point of view of compliance on the stigma. On the contrary, by coming together with others, she will reduce her sense of uniqueness, strengthen her social ties and share information. This will sometimes lead to the emergence of a subculture working to change the majority's attitude towards stigma. In the face of prejudice, the victim will develop coping strategies, without a clear preference for a tendency to regroup or avoid. What about PLWHA in in Abidjan?

What would be their ability to "bounce back" from stigma? Would they be subject to the burdens associated with the taboo on sexuality and the erosion of mechanical solidarity? How can we adapt to such an environment? What strategies should be deployed? Do they really feel victimized?

The research question will be to understand the problems faced by PLWHA in Côte d'Ivoire to adapt to their environment. This study would pursue the general objective of highlighting and analysing the processes of stigmatisation of PLWHA as well as those that promote their adaptability. To achieve this objective, two hypotheses have been proposed: the first is that PLWHA in Côte d'Ivoire feel victimized by HIV. And the second is that PLWHA are able to adapt to their environment by concealing their status.

MATERIALS AND MEHTODS

This study examined the psychosocial and cultural determinants that make it difficult for PLWHAs to adapt in Côte d'Ivoire. It was conducted in Abidjan from February to June 2018. It took place in three entities in Abidjan: 1. The public services specialized in the care of people living with HIV in the University Hospital Centres (CHU) of Cocody, Treichville and Yopougon; 2. The community health centres (CSC) of Angré 8ème Tranche, Yopougon Wassakara, Niangon and Aboboté and 3. The offices of the NGOs Aconda-vs in Angré, Red Ribbon of Yopougon Kénéya, Raoul Follereau in Gonzagville and the NGO Lumière Action in Abobo. The research was qualitative in nature. It could not be supported by a quantitative approach, as the analysis units discussed mobilize the subjective sphere of the actors. In order to cover a broad spectrum of points of view, no volume of people to be investigated has been set. During the survey period (1 February to 30 June 2018), any subject visiting the survey sites and wishing to do so, whether a professional

worker, HIV carrier, parent or accompanying person of a PLWHA, could be investigated. Each actor may only be questioned once in order to guarantee the sincerity of the comments. In the absence of a sampling frame, the sample was constructed gradually. A nonprobability sample was chosen by "snowball". It was based on fifty-one (51) people distributed as follows: thirty (30) people living with HIV/AIDS, ten (10) parents or carers of PLWHA and eleven (11) actors in the care of PLWHA; six (6) who work at university hospitals and community health centres, and five (5) within the above-mentioned NGOs. The table below gives an overview.

Table 1. Sample distribution

Type of population	Size
TYPE 1	
PLWHA	30
Parent/Guardian PLWHA	10
Speaker/CHU/CSC	6
NGO speaker	5
Total	51

Source: Survey data

A daily investigator was present in each of the structures. With the agreement of their managers, he was presented to the respondents as an "intern", conducting an "official" investigation. All investigators wore a badge bearing the inscription "trainee". The pre-survey consisted of interviewing twenty (20) subjects, representing 30% of the total number of employees surveyed. These topics were distributed as follows: 6 (six) local institutional actors, responsible for services dealing with the issue of AIDS within university hospitals and community health centres surveyed; two (2) persons occupying positions of responsibility within Côte d'Ivoire's partner organizations in the fight against HIV, namely the Joint United Nations Programme on HIV/AIDS (UNAIDS) and the American Emergency Plan for the Fight Against HIV/AIDS (PEPFAR); five (5) community leaders and seven (7) PLWHAs, people met in university hospitals and community health centres (CHCs), who will no longer be interviewed afterwards. These investigations allowed us to familiarize ourselves with the subject of the investigation. And to acquire, from the structures investigated, the authorizations necessary for the investigation.

The research method was phenomenological in that it involved transcribing people's subjective experiences. It is through these that an interpretation has been attempted of how the socio-cultural environment and the individual construct or deconstruct the processes of stigmatization or de-stigmatization of PLWHA. For the collection of information, the technique used was a semi-structured one-on-one interview. With the informed consent of the interviewers, the interviewer followed his interview grid and took notes in a closed office, protected from any intrusion during the interview. The investigator did not set any time limit in order to gather as much information as possible. The themes of the interview grid were as follows: 1. stigmatization. 2. Social adaptation strategies. Each theme was then subdivided into specific analysis units based on the data from the pre-survey. Thus, theme number one (1) "Stigma" included three analytical units: 1.1. Stigmatization. 1.2. Discrimination. 1.3. Rejection. As for theme number two (2), "The logic of social adaptation", three analytical units also completed it: 2.1. Management of serological status. 2.2. The protection of secrecy and 2.3. Adaptation reactions. A total of six (06) analysis units were identified for the two (2) themes investigated, which led to the construction of the interview guide. The transcribed texts were then analyzed after the oral interviews from each analytical unit to identify general trends in our sample. Since the units were predefined, there was a risk that the author's thinking would impact the results. This bias was taken into account in the analysis of the results. For each of the two (2) themes, this thematic analysis made it possible to understand the experiences of PLWHAs and their care givers, as well as the point of view of institutional and community structures on the following central issues: the logic of social adaptation and stigmatization.

RESULTS

The presentation of the results is based on the verification of our assumptions.

3-1- Hypothesis 1: PLWHA in Abidjan, would feel victimized because of HIV and cultural taboos.

A – Stigmatization: It appears from the interviews that this transmissible infection is associated with the lexeme of "shameful disease", implying the victim's own responsibility in the contamination process. M.K, a homosexual, testifies: "According to my neighbours, it is because I am homosexual and have transgressed the norms governing sexual practices that I have AIDS. People here have existing negative beliefs and attitudes about sexuality, same-sex sexual relations, sex work and drug use. Since they learned that I am sick, everyone here considers me to be a marginal person with poor morals. In addition to this pejorative perception stemming from the socio-cultural context and reinforced by the lack of treatment to "cure", there is the idea of imminent death and the fear of contamination. For some protagonists, members of PLWHA families or simple relationships, HIV would be contracted simply by touching the "sick" person, or following a hug. According to O. C., an accompanying person of an infected parent, the point of view of many would be that "We do not yet master all the contours of this disease, it is better to stay away from someone who has AIDS so as not to get the disease". It is therefore the knowledge of the person's HIV status and the fear of death that is the problem**.**

B – Discrimination: ActNo. 2014-430 of July14, 2014 on AIDS prevention, protection and repression prohibits all forms of discrimination against PLWHA. This discrimination also seems to be due to the fear of contamination. Most of the respondents with the infection, 24/30, testify that they were forced into isolation as soon as their HIV status was disclosed or when it seemed that they developed visible signs (spots, weight loss, diarrhea, fatigue...). They felt like they were being watched. Others were rejected and discriminated against in the community or in employment. I.K. recounts: "My boss and colleagues always complained about my repeated absences due to illness. My boss didn't offer me another job to ease my work pace and under pressure, I had to resign and today I have nothing left. Similarly, D. D. - a nanny[4] by profession - claims to have been fired because she"... seemed too thin and had "suspicious spots" on her back", without knowing his HIV status. According to G.R.: "I was a domestic worker, a boy-cook to be exact. When I started having spots on my skin, my

[4] Nanny: servant attached in a house to the care and supervision of young children.

boss started asking me a lot of questions and I was fired. I didn't think it was necessary to tell him I was HIV-positive. I have not had a job for six (6) months. In hospitals or CHCs, sometimes overly sanctimonious or benevolent comments have appeared intrusive to PLWHA. Some care providers have proposed alternative care in traditional therapy; traditional conceptions of the disease are still prevalent, despite Western ("bleached") knowledge about the disease.

C - Rejection and social exclusion: There is a loosening of social ties. Let's listen to S.T.: "My cousin, with whom I used to come from time to time, denied me access to her kitchen and all contact with her children". We "forget" to invite the PLWHA to family reunions, weddings, etc., as J.C.**,** another accompanying person of a parent, testifies. Visits are becoming scarce, as is the expected financial support. In a context where employment is the basis of identity, 25/30 of PLWHA report that they receive no support from extended family members in the event of professional difficulties. However, they consider that the State's handling of the situation is partial. Some patients die in indifference, sometimes on their own. Dr. Y., a doctor, testifies: "N.O. did not wish to inform her family of her HIV status during her lifetime and excluded herself from any relationship with her for fear of being discovered in advance. The patient, he said, was suffering from shame, fear, anxiety and anger as well as depression. Others have behavioural problems. Dr. H. explains: "Prejudice can induce negative emotional states in some patients characterized by depression and a sense of isolation. Denial, avoidance, social and family withdrawal can then lead to various reactions: impulsiveness, irritability, desire for revenge, search for a "scapegoat" and lack of empathy towards other victims. There is also sometimes, he adds, a need for escape resulting in overuse of drugs, alcohol or medication. This is a desperate search for a return to a lost normativity, as C indicates. A.:"I developed an addiction to drugs and alcohol. This is my way of staying zen and accepting this situation where I have to live with HIV.".

D - Other adaptation difficulties: According to Dr. Y, for many PLWHA, "The challenges are fourfold: informative, psychological, therapeutic and socio-economic. Most respondents with HIV do not work, have lost their jobs, or are no longer able to do so. In precarious situations, their main concern is care. Access to medicines - supposedly free - can be problematic. "Drugs are often unavailable in dedicated facilities, and they are always more expensive in pharmacies, "says I.K. According to G.R.:" Certainly NGOs and PLWHA care facilities give us free drugs, but that's not enough, we have lost our jobs, we don't have any money". People with sufficient resources or better adapted care (four people) would fare better. With funding, K.D. and his wife were able to carry out a pig breeding project. Once widowed, Mrs. K.D., assisted by the Ministry in charge of Women, was able to continue her activity, and take care of her children, despite her HIV status. "I feel autonomous and well in my head," she says. While the stigmatization of PLWHA, in relation to prejudice, is real, it is also accompanied by discrimination, exclusion and rejection. However, it was noted that its negative psychological impacts on PLWHA, including depression, seemed to be counterbalanced when legal protection existed, a certain standard of living that would allow for satisfactory social, health, professional and family adaptation.

3-2- Hypothesis 2: PLWHAs are able to adapt to their environment by concealing their status.

A - Concealment of serological status: Medical confidentiality, confidentiality and the right to protection of the patient's private life are at the heart of article L. 1110-4 of the Public Health Code (CSP), which is[5] incorporated into Ivorian law. However, the law provides that they may exceptionally be broken, the information being communicated to "whoever is entitled", in order to prevent the risk of contamination in certain cases of illness, particularly in the workplace. The example of a private executive R.A. illustrates this necessary confidentiality: ″Only the company doctor and the boss are informed. No colleague is aware of my HIV status, and that's good. A misinterpretation of these provisions leads to abuses. O. K. testifies: "Our neighbour, a nurse's assistant at the CHC, disclosed information about my wife's HIV status as a doughnut seller to the whole neighbourhood. A. D. explains: "Next to me is a merchant who moved away; his status was known and customers were visiting his stall anymore. In turn, when I learned of my HIV status, I kept it a secret and continued to work normally.

B - Other adaptation strategies implemented

*1)**Acceptance of serological status:*** The acceptance of his status also seems to be decisive. According to Ms. S. T.: "I had a chronic cough. During a consultation at the hospital, the doctor told me to go for the AIDS test. When I got the results of my HIV status, I immediately tested my two children who are also HIV positive. My spouse immediately abandoned us. The world was crumbling around me. I had no money and no work. I started a business that works quite well. An NGO supported me with its advice. I accepted the disease. I have regained my self-confidence. This has been the key to my success. The previous actor, A.R., confirmed this relationship: "After accusing the blow, once my HIV status was known, my concern was sharing information with my wife. I immediately began my care and have been living with HIV for more than ten (10) years. My children are healthy, so is my wife. It's funny, but actually... everything's fine."

2)***The change of residence:*** Extending the need for confidentiality, nomadism is an adaptive tool as well as an attempt to reconquer the link. We will distinguish two types of them here. First of all, the "residential" type, that of V.T.: "I am the president of the local youth association, and the HIV care centre is not far from my home. When I found out I was HIV-positive, I preferred to leave the neighbourhood to live elsewhere, where no one knows me. I had to lie to my son and my friend when I told them that the apartment was uncomfortable and especially too far from my workplace. And secondly, N'doye (2013), which targets the treatment site(s). S. T., although living in the same dwelling, frequented various care facilities, opening a path incompatible with quality follow-up and reliable collection of statistics, but allowing this young woman to maintain confidentiality about her infection in her ordinary place of life.

3)***The development of sources of community resilience:*** Participation in the community, whether through developed or strengthened links with a church or mosque, or in a secular associative setting, is a source of resilience for many PLWHA, who would benefit from secondary benefits: improved physical

These are the French5 Public Health Code (CSP) in its article L.1110-4, the law of 4 March 2002 on the rights of patients and the quality of the health system, in force in France and whose provisions are taken over by Ivorian law.

and moral health, self-confidence, better therapeutic follow-up, distance from drugs or alcohol, participation in sport and absence of depression. It can be an operating aid, as in the case of S.T.: "I am a Muslim, but if I had not taken refuge in a church, I would not have left this difficult period; when I was really very sick, they kept me alive and took care of my children". But also the definition of new goals. E. K. confides to us**:** "Since this experience of listening within the host structure, I have more and more confidence in myself. I realize that I have a lot to give; and I now work as a volunteer to receive new infected patients. However, most of our respondents, even those involved in community activity (only 3 out of 30 are), continue to be afraid of accusatory judgments if their status were disclosed to the extended family. In order to avoid stigmatization, rejection and discrimination, due to negative value judgments against them, judgments related to cultural ethos and lack of knowledge about how HIV infection is transmitted and managed, PLWHA most often hide their HIV status from their family, professional and community circle. The attitude confirms our hypothesis. However, subsequent social adaptation does not only depend on a good strategy of concealment. But also the acceptance of its own status. Since they result from them: the decision to follow care and the development of sources of additional resilience that allow self-confidence, the development of life projects and personal growth.

DISCUSSION AND CONCLUSION

The objective of this study is to highlight and analyse the processes of stigmatisation of PLWHA as well as the logic behind their adaptability. The results show that despite adversity, the most appropriate PLWHA use a tryptic-based mode of functioning: acceptance of HIV status, concealment of status (moving, diversification of health centres consulted, etc.) and maintenance of professional status. In addition, this study made it possible to denounce the victimization of PLWHAs since this transmissible infection is always associated with the lexeme of "shameful disease", implying the victim's own responsibility in the contamination process. The theory of causal attribution and that of stigmatization, whose victimological side indicates the role of the active subject in dealing with stigma, were used in the conduct of the study. This contribution also made it possible to understand the difficulties of adaptation of PLWHA and to analyse the strategies developed by these people to promote their adaptability. The objective pursued in this study has been achieved. The results of the study confirm Traoré's (2003) thesis that HIV, which affects the taboo of sexuality and its disturbing, even distressing, nature, has constantly permeated the collective imagination to such an extent that only fear, hatred and rejection have resulted. Such a perception has updated fears already known since the Middle Ages. Dannecker's (2002) thesis that the central problem here is the marginalization and adaptation of certain stigmatized populations in our contemporary societies is also confirmed. In the same vein, Augé and Herzlich (1986) note that the status of people living with HIV (PLWHA) as patients has ushered in a new dialectic in victims' relationships with their social biotope. According to them, the attribute process that appeared with the disease was not built in neutrality: it referred, at least implicitly, to representations involving forms of deviance. Thus, the "biological disorder" was perceived as a consequence of a "social disorder". Stigma would reflect a likely "moral inferiority" as well as a structural disability in the observance of "healthy behaviours" (Peretti-Watel and Moatti, 2009). Link (1987), in his theory of modified labelling, describes the foreseeable consequences of stigma: difficulties in accessing housing, employment, care, and maintaining family ties... and victimization through self-tagging. For the author, stigmatization would constitute a social reaction of stereotyping PLWHAs, separating them from others, inflicting a loss of status and discrimination on them in their living environment, while at the same time contributing to social inequalities and self-blame, thus maintaining stigma. The four stages, indicated by Alonzo and Reynolds (1995), are serialized according to the infectious phases: identification of the individual with a risk group, highlighting his or her responsibility, stigmatization for fear of contagion and rejection, are also observed among PLWHA in Abidjan.

The results of the study show that PLWHA in Abidjan are marginalized and suffer from stigma and discrimination. Sometimes even in hospitals or CHCs, moralizing or overly benevolent comments have appeared intrusive to PLWHA. This pejorative perception from the socio-cultural context is reinforced by the lack of care and treatment to cure HIV. As N'dri (2013) pointed out, this results in a gap in relationships between individuals, a weakening of social integration and life, and a relaxation of social ties. Our results corroborate the conclusions of Lacroix and Assal (1998) and Thoits (2011), who argue that social adaptation takes into account the subject's own willingness to integrate. While it is true that a situation of stigmatization induces a feeling of isolation that can lead to despair, it also depends on the degree of acceptance of the disease and the willingness to take charge of oneself. Indeed, the person isolating himself and denying the disease will limit his access to health services. As a result, it may run the risk of not being recognized by social care referents and contribute itself to reinforcing its marginalization. Indeed, the risk of self-image self-depreciation and depression among victims would seem to be lower when professional integration and financial autonomy are maintained. These two factors, which are decisive for the preservation of satisfactory family ties, indicate more broadly the transition from organic solidarity to so-called negotiated solidarity in the modern city.
This preservation of family, social and professional ties in a cultural environment where sexuality remains a taboo subject also implies that subjects must accept their HIV status and develop strategies to conceal their HIV status. However, our results did not confirm Parker and Aggleton's (2003) thesis that identify the economic and social origin of victims and establish a causal link between stigmatization processes and inequalities related to gender, class and social origin. Our objective is to highlight and then analyse the processes of stigmatisation of PLWHA as well as the logic behind their adaptability. The theories presented do not shed light on the primary process and acceptance. And perhaps in this case, the concept of psychological flexibility highlighted by the contextual therapy of acceptance and commitment (ACT) should be convened in order to redefine the therapeutic and integration strategies of PLWHA in Abidjan, Côte d'Ivoire.

REFERENCES

ALONZO Angelo and REYNOLDS Nancy, 1995, Stigma, HIV and AIDS: Exploring and developing a stigma trajectory, Social Science and Medicine, 41(3), 303-315. Online: https://doi.org/ 10.1016/0277-9536(94)00384-6; https://jhu.pure.elsevier.com/en/

publications/stigma-hiv-and-aids-an-exploration-and-elaboration-of-a-stigma-tr. (Accessed 2018).

AUGE Marc and HERZLICH Claudine, 1986, Le sens du mal. Anthropology, history, sociology of the disease. Paris: Editions des Archives contemporaines. Coll. Social Orders. Online: http://documentation.unicaen.fr/Default/doc/FLORA/21655/le-sens-du-mal-anthropologie-histoire-sociologie-de-la-maladie-sous-la-direction-de-marc-auge-et-cla?_lg=en-EN. (consulted in April 2018).

CUSSON Maurice, 1998, La Criminologie. 5th edition, Paris, Hachette. Online: https://sites.google.com/site/karsinglefbirth/la-criminologie-66431912. (consulted in April 2017).

DANNECKER M, 2002, HIV Prevention and Sexuality. Online: = (accessed April 14, 2003).

DESCLAUX A, 2003, Stigmatization, discrimination: what can we expect from a cultural approach? In HIV/AIDS, stigmatization and discrimination: an anthropological approach. Studies and reports, Special Series No. 20, Division. Online: https: //halshs.archives-ouvertes.fr/halshs-00079800/document (accessed 2017).

DERICQUEBOURG R, 1989, Stigma, prejudice, discrimination from a psychosocial perspective. Inter-ethnic studies, University of Lille 3. Online: https://halshs.archives-ouvertes.fr/halshs-00067978. (consulted in 2018).

DUBOIS N, 1991, Perception of social value and norm of internality in children. French Psychology.

HEIDER F, 1946, Attitudes and Cognitive Organization. Journal of Psychology 21: 107-112.Online:http://snap.stanford.edu/ class/ cs224w-readings/heider49balance.pdf (consulté en 2018).

HEURTIER D, 2010, Stress coping strategies. Online: www.fr.viadeo.com (Accessed March 2018).

JONES E and DAVIS K E, 1965, From acts to decisions. The process of attribution in the perception of the person. Advances in experimental social psychology. Online: https://journals. openedition.org/linx/509#bibliography.

LACROIX A and ASSAL, J.-P, 1998, L'éducation thérapeutique des patients: nouvelles approches de la maladie chronique. Paris: Vigot. Online https://livre.fnac.com/a279652/Anne-Lacroix-L-education-therapeutique-du-patient

LAVALLEE F, 2003, A mode of intervention based on resilience. Ph. D. Psychologist, UQTR.

LEMERT E. M, 1951, The theory of social reaction. Online: https://www.academia.edu/28596105/Edwin_M._LEMERT_1912 - 1996_La_th%C3%A9orie_de_la_r%C3%A9action_sociale.

LINK B G, 1987, Understanding the Effects of Labelling in the Field of Mental Disorders: Assessing the Effects of Rejection Expectations. American Sociological Review, 52, 96-112. Online: http: (consulted in 2017). LAWNo. 2014-430 of July 14,2014. Official Journal.

NDOYE T, (2012). From the experience of PLWHA to careers as chronic patients. ird-00711191.

N'DRI S E, 2013, Risk factors for patients on ARV treatment who have been lost to follow-up in the service of PPH: pneu-phtisiology from the University of Abidjan-Cocody.

PARKER R. and AGGLETON P, 2003, Stigma and discrimination related to HIV and AIDS: conceptual framework and implications for action. Online: https://www.ncbi.nlm.nih.gov/pubmed.

PERETTI-WATEL P and MOATTI J-P, 2009, The principle of prevention. The cult of health and its excesses. Collection La République des idées, Seuil, Paris. Online: https://www.cairn. info/revue-sante-publique-2010-2-page-265.htm (Accessed April 2018). http://bibliotheque.bordeaux.fr/in/details.xhtml?id=mgroup%3A9782021009958&&jscheck=1

THOITS PA,2011, Mechanisms Linking Social Ties and Support to Physical and Mental Health. in Journal of Health and Social Behavior, 52(2).Online :https://journals.sagepub.com/doi/abs/ 10.1177/0022146510395592?journalCode=hsbb

TRAORE Massandjé, 2003, La lutte contre le SIDA dans les pays en développement: Réflexion sur la situation en Côte d'Ivoire. Thesis for the Doctorate in Public Law, Faculty of Law and Political Science, University of Rennes 1.

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