INFLUENCE OF EMOTIONAL LABOUR AND JOB STRESS ON ATTITUDES TOWARDS PEOPLE LIVING WITH HIV/AIDS AMONG YOUTH HEALTH CARE PROFESSIONALS IN NIGERIA

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ABSTRACT

Human Immunodeficiency Virus Acquired Immune Deficiency Syndrome (HIV/AIDS) is a significant global epidemic, vast in Africa and Nigeria that should be eradicated by 2030. Discrimination has negative impact on the global attempt to control HIV/AIDS, aggravates global HIV epidemic because despite UNAIDS intervention through nations' health sectors, People Living with HIV/AIDS (PLWHA) still shun free treatment. The health sector is saddled with the responsibilities of treatment of PLWHA through the healthcare professionals. This study examined the emotional labour and job stress of currently serving health care professionals in the National Youth Service Corps (NYSC) Nigeria on their attitudes towards PLWHA. NYSC members comprise of fresh Nigerian graduates of tertiary institutions who are 30years and below on mandatory service to the nation. Participants were chosen through purposive sampling method. A total of 325 participants responded to quantitative study with data collection through structured psychological scales. Appropriate statistical analyses were made utilizing regression method. Both emotional labour and job stress accounted for 24.1% of the total variation in attitude towards PLWHA. The implication of the findings is discussed in line with the eradication of HIV/AIDS and realisation of the agenda of Sustainable Development Goals.

Keywords: *Attitudes toward people living with HIV/AIDS, Discrimination, Emotional labour, Job stress, Youth health care professionals*

INTRODUCTION

Human Immunodeficiency Virus Acquired Immune Deficiency Syndrome (HIV/AIDS) is a significant global epidemic; hence there could exist attitudes toward People Living with HIV/AIDS (PLWHA) among non-affected others. Attitude towards PLWHA is HIV-related stigma from non-affected others towards PLWHA which may lead to discrimination of PLWHA. Discrimination is the behavioral response (Link & Phelan 2001) to stereotype and prejudice. Stereotype is a cognitive-belief while prejudice is a negative emotional-attitude and abusive reactions towards PLWHA. There is a global-aid of free intervention for HIV/AIDS which is offered to PLWHA. In the course of receiving intervention from the health sector, when PLWHA perceive discrimination, they likely experience devaluation of status and keep social distance (Wagner, Hart, McShane, Margolese & Girard, 2014) in essence PLWHA shun free treatment.

Globally, some 35% of countries and over 50% people reported discriminatory attitudes towards PLWHA (UNAIDS, 2015). Dahlui, Azahar, Bulgiba, Zaki, Oche, & Adekunjo (2015) indicated discrimination against PLWHA in Nigerian Population. Out of 1.9 million Nigerians living with HIV, only about one million persons are on treatment (NAISS, 2019). The key affected population does not assess treatment, even though it is free. PLWHA avoid treatment from the health care professionals (Kinsler, Wong, Sayles, Davis & Cunningham, 2007). . Health care professionals are trained health care providers like nurses, doctors, physiotherapies, social workers and psychologists. Health care professionals expedite patients' health with quality care. Health care professionals are first line care providers to PLWHA, and may enact HIV-related stigma which are perceived by PLWHA (Link & Phelan, 2001). As health care work is carried out among many professions in the health care sector so does health care work is carried out by both youth and adults.

HIV-related stigma exhibited among health care professionals is widespread and is built on a global belief that PLWHA are at fault for contraction of the illness (Wagner, Hart, McShane, Margolese & Girard, 2014) from their immoral acts. Furthermore, the enduring lifelong care for HIV/AIDS given to PLWHA, the contagious nature of HIV/AIDS especially from body fluid and clinical specimen may put the health care professionals at risk of being infected (Bemelmans, Akker, Pasulani, Tayub, Hermann & Mwagomba, 2011). Those stereotypic belief and prejudicial emotional attitudes of health care professionals may lead

to discrimination which makes the PLWHA ignore treatment. The health care professionals experience emotion towards the PLWHA because PLWHA suffer feelings of frustration, helplessness especially disability and eventual death of AIDS patients **(***Marzán-Rodríguez & Varas-Díaz, 2006).* Health care professionals are expected to be able to manage their emotions and emotional labour. Emotional labour is the display of organisationally desired emotions (Hochschild, 1983). As employee performs work, the employee could make use of outward countenance such as facial gestures, voice tone and display emotions which influence other people's emotions and behavior. However, employee's internal emotion may be different from organisationally desired emotions for performance. Researchers (Ashforth & Humphrey, 1993; Diefendorff, Croyle & Gosserand, 2003) highlighted three strategies of emotional labour which are surface acting, deep acting and natural emotions. Surface acting is when the employee does not control the inner emotional state but change the outward countenance to display desired emotions. Deep acting is the employee conscious strategy to adjust one's internal emotions to conform to organizational desired emotions. While, natural emotions is employee's expression of genuine emotions as one feels because the employee's inner emotional state is consistent with organisation's desired emotion for performance.

Futhermore, emotional labour is the effort, planning and control needed by employees such as health care professionals to display organisationally desired emotions (Morris, & Feldman, 1996) that produces the proper state of mind in PLWHA when being cared for (Hochschild, 1983). Emotional labour exhibited in health care profession is particularly needed because it is distressing to work and treat patients with HIV and AIDS (Vilelas & Diogo, 2014; Hunter & Smith, 2007; Smith 2012).Especially, as health workers including health care professionals are prone to HIV infection which is a major cause of health worker mortality in Africa (JLI, 2006) and in Nigeria.

Generally, stress is an unwanted reaction to severe pressures or demands placed upon one; stress is feelings about the uncontrollability and unpredictability of ones' life. Specifically, job stress is one's perception about the degree of a given situation in daily life that is considered stressful (Cohen, Kamarack & Mermelstein, 1983). Health care professionals respond to job stress related to AIDS in the course of treatment when they are presented with unexpected responsibilities, work demands and pressures that are not aligned to their knowledge, skills, abilities and expectations which challenge their ability to cope.

Adapted from theory on intersectionality (Goffman, 1963), Link and Phelan (2001) conceptualizes stigma from four acts namely labeling, stereotyping, outgrouping and discrimination. The four acts occur in a social context to create stigma. Labeling distinguishes people and labels them according to human differences or traits. Stereotyping refers to the dominant cultural beliefs that link labeled persons to undesirable characteristics e.g. to negative stereotypes. Notably stereotyping is a product of power differentials and perceived differences. Outgrouping consist of separation of the stigmatised group as ''others'' with status loss when compared to non-others. Remarkably, labeled persons are placed in distinct categories so as to accomplish some degree of separation of "us" from "them." Labeled persons experience status loss and discrimination that lead to unequal outcomes. Subsequently, discrimination is negative consequence of stigma; that are meant to disadvantage people. The health care professionals are sometimes less committed to treat PLWHA (Hoffart, Ibrahim, Lam, Minty, Theam & Schaefer, 2012). PLWHA perceive HIV-stigma as exhibited by health care professionals. Thus, According to Link & Phelan (2001), the term stigma is applied when elements of labeling, stereotyping, separation, status loss, and discrimination co-occur in a power situation that allows the components of stigma to unfold.

Researchers (Earnshaw,Jin, Wikersham, Kamarulzaman, John, & Altice, 2014) find that health care professionals have attitude towards PLWHA.. Emotionally laborious work has effect on the individual (Rafaeli, Anat, Sutton & Robert,1987; Shoptaw, Steven & Stein, 2000 and among HIV health care testers (Caldwell, 2016). *Marzán-Rodríguez and Varas-Díaz (2006)* found that emotion plays role in the process of stigmatization of PLWHA by health professionals. Furthermore, Vileas & Diogo (2014) specified that emotional labour has negative and positive impact on health professionals. Atukunda, Memiah and Shumba1 (2013) showed that stress has effect on health workers, specifically Marine, Ruotsalainen, Serra &Verbeek (2006) indicated that job stress has impact on healthcare workers. According to Pleck,

O'Donnell, O'Donnell and Snarey (1988) job stress rooted in concerns of contracting HIV/AIDS is common and leads to negative attitude towards PLWHA.

Despite global aid provision of free treatment to eradicate the Human Immunodeficiency Virus Acquired Immune Deficiency Syndrome (HIV/AIDS); almost 47.3% Nigerians living with HIV are currently not on treatment. The health sector is saddled with the responsibilities of treatment of PLWHA through the health care professionals. There has been report that People living with HIV feel stigmatized by health care providers Nyblade, Stangl, Weiss & Ashburn (2009). Discrimination from health professionals decreases the likelihood that people living with HIV will access treatment (UNAIDS, 2017). Consequent on the Nigeria HIV/AIDS Indicator and Impact Survey (NAIIS) in conjunction with international agencies and global donors, HIV/AIDS epidemic in Nigeria is appropriated to factors such as stigma, discrimination and lack of health personnel. It is the health care professionals in the course of duty that form the point of contact with the PLWHA to deliver global efforts and intervention.

Moreover, almost a million Nigerians living with HIV are currently not on treatment (NAIIS, 2019). This number may escalate unless there is an attitudinal change to abuse reactions towards PLWHA in the course of administering intervention. There is a need to eradicate HIV-stigma among health care professionals. There is a need to ascertain if health care professionals are ready to perform to the best of their knowledge and abilities in representing the global interest to the PLWHA. That is health care professionals' behavioural response in the issue of discrimination against PLWHA. Of particular interest are the youth health care professionals in National Youth Service Corps programme. National Youth Service Corps (NYSC, 2013) is a mandatory service to Nigeria by fresh graduates of tertiary institutions of age 30years and below for a period of one year outside their state of origin. So, they are youth professional in the service of the nation who give health care to patients in any part of the nation. Are emotional labour in health care profession and job stress such as in treating patients with HIV and AIDS inevitable and expedient? There is a dearth of study on influence of emotional labour and job stress on attitude towards PLWHA by healthcare professionals.

From the ongoing, the objective of this study is to examine the influence of emotional labour and job stress among youth health care professionals on their attitudes towards PLWHA in Nigeria.

Hypothesis

Emotional labour and job stress will significantly jointly and independently influence attitude towards People Living with HIV/AIDS (PLWHA).

METHOD

This study employed a survey research design, because it is dealing with a large group of people (Otokiti, 2010). The study took place in 5 geopolitical zones of Nigeria and Federal Capital Territory (FCT). In South West are Ipaja in Lagos State, Ado-Ekiti in Ekiti State. In South East is Owerri in Imo State. In South-South is Port-Harcourt in Rivers State. In North West is Sokoto in Sokoto State. In North Central is Ilorin in Kwara State. In FCT is Abuja.

Participants

National Youth Service Corps (NYSC) membership has representation of most ethnic groups of Nigeria. The total number of youth corps members in Nigeria in 2018 was 318,474 (NYSC, 2018). The target population for this study is only the health care professionals among the youth corps members. Since the population is greater than 10,000, the sample size was determined using the formula provided by Araoye (2004). Participants are NYSC health care professionals comprising of laboratory scientists, nurses, doctors, physiotherapies, social workers and psychologists. The choice of NYSC health care professionals as participants is because they are new entrants into the health profession, and also represent a group that could be targeted for early stigma reduction interventions. 325 participants were chosen through purposive sampling procedure from both the northern and southern parts of Nigeria.

Inclusion-Exclusion Criteria

Graduate health care professionals aged 30 and below, who are NYSC members were included in this study. The participants include health care professionals (laboratory scientists, nurses, doctors, physiotherapists, social workers and psychologists) who are in good physical condition (self-reported) who are willing to spend about 15 minutes on the study and provide a written informed consent. Those not meeting these criteria were excluded. The inclusion-exclusion criteria of this study facilitate easier and more effective data collection and help to ensure that all participants were adequately informed of the purpose of the study, thereby fostering motivation and true response. Based on the criteria that must be fulfilled to be considered to participate in this study, purposive sampling method was adopted for the selection of participants for this study.

Instrument

Attitude towards People Living with HIV/AIDS (PLWHA) was measured by Health Care Provider HIV/AIDS Stigma Scale (HPASS) developed by Wagner, Hart, McShane, Margolese and Girard (2014). The HPASS comprises of has 30-items made up of three subscales which are prejudice, stereotypes, and discrimination. HPASS employed a 5-point Likert scale with the following anchors: 1 = extremely uncharacteristic; 2 = somewhat uncharacteristic, 3 = uncertain, 4 = somewhat characteristics, 5 = extremely characteristic. Some of the items are "I worry about contracting HIV from HIV patients" and "I would rather not come into physical contact with HIV patients". Higher score indicates high attitude of prejudice, stereotype and discrimination towards PLWHA, lower score indicates low Attitude of prejudice, stereotype and discrimination towards PLWHA. (HPASS measures stigma which reflects negative attitude). The authors revealed each subscale have internal consistency (Cronbach's alphas of 0.91, 0.82, and 0.92 for prejudice, stereotypes, and discrimination, respectively) and the total scale has (Cronbach's alpha of .94). The scale demonstrated good test-retest reliability ($r = 0.93$, $p < .001$). The present study showed reliability estimates (Cronbach's alphas of the three sub-scales ranges from 0.700 – 0.859, and the overall scale has (Cronbach's alpha of 0.882).

Emotional labour was measured by Emotional Labour Scale (ELS) by Brotheridge and Lee (2003). The ELS comprises is a 15-item scale that measures six domains of emotional display in the workplace, including the frequency, intensity and variety of emotional display, the duration of interaction, and surface and deep acting. In the ELS, items are rated on a 5-point Likert scale of 1 to 5, where 1 = Never, 2 = Rarely, 3 = Sometimes, 4 = often, 5 = Always. ELS uses a response stem: 'On an average day at work, how frequently do you . . .' with items such as "Resist expressing my true feelings" and item "Express particular emotions needed for your job" Negative worded items were reversed, higher score indicates high emotional labour, lower score indicates low emotional labour. The authors reported internal consistency for the subscales ranged from 0.74 to 0.91. The present study reported internal consistency (Cronbach's alphas) of the subscales ranges from 0.817 – 0.943 while the overall scale has a good measure of internal consistency (Cronbach's alpha) of 0.957.

Job stress was measured by Perceived Stress Scale (PSS) developed by Cohen, Kamarack & Mermelstein, (1983). PSS is a 14-item scale with two-factor scale. The first factor consists of items which reflect general stress while the second factor consists of items which reflect the perceived ability to cope with stressors. PSS-14 is made up of seven positively worded 'stress' items such as "How often have you felt upset because of something that happened unexpectedly?" and seven negatively worded 'counter-stress' items such as "How often have you felt confident about your ability to handle personal problems?". The PSS-14 items employed a 5-point Likert scale of occurrence of these statements over the past 4 weeks with the following anchors: (0 = never, 1 = almost never, 2 = sometimes, 3 = fairly often, 4 = very often). "In the last month, how often have you found that you could not cope with all the things that you had to do?" and "In the last month, how often have you felt difficulties were piling up so high that you could not overcome them?" For scoring, negatively worded items were reversed. Higher score indicates high job stress, lower score indicates low job stress. According to the authors the two factors of the PSS showed good reliability ranging from Cronbach's alpha of 0.73 to 0.82. The present study showed the overall scale has a good measure of internal consistency (Cronbach's alpha) of 0.940.

Procedure

A total of 325 NYSC health professionals responded to structured psychological scales. The participants were assured of their confidentiality and participation was voluntarily. The questionnaires were given to the participants by the research assistants, filled and were collected back during the Youth corps members' weekly Community Development Service meeting at each Local Government. Participants were handed a consent form where they were required to give their consent by filling the consent sheet. Participants were requested to fill copies of the questionnaire booklet. The filled copies of the questionnaire were collected back and participants were thanked for their participation as well as their time. Participants were genuinely assured of their confidentiality. Out of 500 copies of questionnaires distributed, 325 (65%) were properly filled and returned. Prior to data collection, the researcher got ethical approval from Redeemer's University Ethics Committee (RUN-IREC). The research assistants received letter of introduction from Department of Behavioural Studies.

RESULTS

Table 1: Respondents Socio-demographic Characteristics

Variables	Frequency (%)	Mean±SD
Age		25.68±2.23
<25 years	99 (30.5)	
25 – 30 years	205 (63.1)	
Not Reported	21 (6.5)	
Gender		
Female	180 (55.4)	
Male	145 (44.6)	
Religion		
Christianity	289 (88.9)	
Islam	33 (10.2)	
Traditional	3 (0.9)	
Level of Religiosity		
1 – 3	23 (7.1)	
4 – 5	144 (44.3)	
6 –7	135 (41.5)	
Not Reported	23 (7.1)	
Region of Origin		
North Central	88 (27.1)	
North West	11 (3.4)	
North East	3 (0.9)	
South West	131 (40.3)	
South East	68 (20.9)	
South South	17 (5.2)	
Not Reported	7 (2.2)	
Region of Service		
North Central	165 (50.8)	
North West	21 (6.5)	
South West	85 (26.2)	
South East	33 (10.2)	
South South	21 (6.5)	

Participants Socio-demographic Characteristics

A total of 325 youth health professionals participated in this survey. Emotional labour, AIDS-related job stress and PLWHA among youth health care professionals were included in the analyses. The participants' socio-demographic characteristics are presented in Table 1. Majority (63.1%) are at least 25years of age (Mean = 25.68 years, SD = 2.23) and more than half (55.4%) of them were females. Also, most (88.9%) of the young health care professionals profess to be Christian and 44.3% of them has their

level of religiosity to be between 4 – 5 rating. Furthermore, more than half (66.5%) of the participants region of origin were from the South and more than half (57.2%) of their region of service were in the North (Table 1).

Table 2: Pearson Moment Correlation Coefficients

	M	SD	1	2	3	4	5	6
1. Attitude towards PLWHA	105.72	14.61	1.000					
2. Job Stress	35.29	9.57	0.312*	1.000				
3. Emotional Labour	53.40	10.93	0.454*	0.291*	1.000			
4. Surface Acting	10.26	2.55	0.427*	0.137*	0.942*	1.000		
5. Deep Action	10.80	2.35	0.477*	0.345*	0.940*	0.878*	1.000	
6. Natural Emotions	32.34	5.03	0.430*	0.314*	0.987*	0.890*	0.890*	1.000

*Significant at 5% level of significance

Inter-correlation Analysis

The inter-relationship among variables which are attitude towards PLWHA, emotional labour and job stress were examined using Pearson's Correlation Analysis as presented in Table 2. This was performed to see how each variable correlated with one another. Both emotional labour {r(324) = 0.454} and perceived stress {r(324) = 0.312}were positively and significantly correlated with attitude towards PLWHA (Table 2) Each of the three dimensions of emotional labour which are surface acting {r (324) =0.427} deep acting {r (324) = 0.477} and natural emotions {r (324) = 0.430} were positively and significantly associated with attitude towards PLWHA. As the participants exhibited increased emotional labour and experienced job stress; their attitude of towards PLWHA increased. The PLWHA therefore experienced increased stigma

Test of Hypothesis

Emotional labour and job stress will significantly jointly and independently influence attitude towards People Living with HIV/AIDS (PLWHA).

Table 3: Multiple Linear Regression Analysis Predicting Attitude towards PLWHA

Model	Sum of Squares	Degree of Freedom	Mean Square	F	R Square	P-value
Regression	17322.028	2	8661.014	51.18	0.241	<0.001
Residual	54487.529	322	169.216			
Total	71809.557	324				

	Variables	Coefficients	Std. Error	Beta	T-test	P-value
Model	**Constant**	66.327	3.990		16.624	<0.001
	Emotional Labour	0.540	0.069	0.396	7.806	<0.001
	Perceived Stress	0.306	0.079	0.197	3.882	<0.001

Multiple Linear Regression Analysis Predicting Attitude towards PLWHA

The predictors of the scores of participants on attitude towards PLWHA are presented in Table 3. Multiple linear regression analysis was used to fit the model and significant predictors were evaluated at 5% level of significance. The predictors of the scores of participants on Attitude towards PLWHA scale were emotional labour and job stress.

The result in Table 3 shows the R Square of 0.241, which indicates that emotional labour and job stress jointly accounted for 24.1% of the total variation in attitude towards PLWHA. Also, Table 3 reveals that the analysis of multiple regression data produced a statistically significant F-ratio value ($F(2, 322) = 51.18$, $P<0.001$). Table 3 shows the independent contribution of emotional labour and job stress. When observed individually, both independent predictors emotional labour ($\beta = .397$, $t = 7.806$, $p<0.001$) and job stress ($\beta = 0.197$, $t = 3.882$, $p=0.037$) shows statistically significant prediction of attitude towards PLWHA. Both emotional labour displayed and job stress experienced by participants influenced their attitude towards PLWHA.

DISCUSSION

The findings of the hypothesis which stated that emotional labour and job stress will significantly jointly and independently influence attitude towards People Living with HIV/AIDS by youth health care professionals collaborates studies of (Vilelas & Diogo, 2014; Hunter & Smith, 2007; Smith 2012) that emotional labour when working in distressing situations affects health care professional in treating PLWHA. *The significant independent contribution of emotional labour on* attitude towards PLWHA substantiates the study of (*Marzán-Rodríguez & Varas-Díaz, 2006)* that attitude towards PLWHA is influenced by emotions *and the study of* Vileas and Diogo (2014) that emotional labour has positive and negative impact on health professionals. Also, the findings of inter-correlation analysis further showed that the three dimensions of emotional labour which are surface acting, deep acting and natural emotions have significant positive relationship with attitude towards PLWHA. Surface acting is a false emotional state and an artificial behavior of outward countenance of organizational desired emotions displayed by participants. Surface acting does not control the inner emotional state of the participants therefore as surface acting increases attitude towards PLWHA increases. Attitude of youth health care professionals towards PLWHA measures stigma of prejudice, stereotype and discrimination towards PLWHA.

PLWHA are a labeled group due to those perceived difference which are based on negative stereotype. Health care professionals have to regulate their emotions in line with organisation's preferred emotions when caring for PLWHA. Health care professionals' emotional labour is necessary to sustain their outward countenance which in turn produces the appropriate state of mind in PLWHA. The state of mind in PLWHA is a retort to health care professionals' outward countenance (e.g. surface acting) , in particular their behavioural response termed discrimination. When PLWHA perceive discrimination, they experience devaluation of status. In essence emotional labour of the health care professionals influences their attitude towards PLWHA.

The significant independent contribution of job stress on attitude towards PLWHA authenticates the study of Pleck, O'Donnell, O'Donnell & Snarey (1988) that *job AIDS stress leads to negative* attitude towards PLWHA. Job stress related to AIDS may include PLWHA capability of infecting others, health care professionals' perceived risk and fear of contracting AIDS as HIV is a major cause of health workers' mortality. Hence, there is abuse reactions towards PLWHA based on prejudice. Prejudice is followed by discrimination. Health care professionals observe the PLWHA as a labeled group, placed in distinct categories so as to accomplish some degree of separation of non-affected group from affected group. The PLWHA are the affected group. When PLWHA perceive discrimination they experience status loss, leading to unequal consequences of keeping social distance as well as avoiding treatment even when treatment is free. In essence job stress related to AIDS of the health care professionals influences their attitude towards PLWHA.

Implication and Recommendation

Health care professionals' behavioural response is the issue of discrimination towards PLWHA based on stereotypic beliefs and prejudice against PLWHA. Emotional labour and job stress related to AIDS of health care professionals has implication for their attitude towards PLWHA. Specifically, surface acting a dimension of emotional labour is associated with attitude towards PLWHA. It is however recommended that the health sector and organisations should ensure training on emotional management for health care professionals and also stress management especially for handling job related for Health care professionals. The health care professionals require attitudinal change in inhibiting abuse reactions towards PLWHA in the course of administering intervention. PLWHA should present self for treatment so

as to get cured and to support global move for eradication of HIV/AIDS. There should be zero tolerance for discrimination of PLWHA in order to attain realisation of the agenda of Sustainable Development Goal (SDG) 5 and to drive sustainable all-inclusive health provision for all SDG 3.

Limitation of study

Future studies should not only make use of only health care professionals but should embrace all health care workers who give support to health care professionals. Moreover, participants should include not only the youth but all age groups. Additionally, there should be studies on attitude towards other epidemics in the nation.

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