

The Influence of Stigmatisation on Psychosocial Wellbeing of HIV/AIDS Clients Attending

Living Faith Support Group, Oyo Town, Nigeria

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Abstract

The study investigated influence of stigmatization on psychosocial wellbeing of HIV/AIDS clients attending Living Faith Support Group, Oyo town, Nigeria. The study examined whether stigmatization has influence on the psychological and sociological wellbeing of HIV/AIDS clients. It evaluated whether stigmatization has influence on the family relationship of HIV/AIDS clients in Oyo town. A descriptive research design of survey type was used. Population for the study consists of all registered HIV/AIDS patients attending state Hospital, Oyo town, Oyo State. Close-ended questionnaire was used for data collection. The instrument was validated by three Jurors in related fields. A reliability co-efficient of 0.73r was obtained through split-half method using Pearson Product Moment Correlation. The three null hypotheses were tested using the inferential statistics of Chi-square at 0.05 alpha level of significance. The findings of this study showed that HIV/AIDS clients suffered low morale, had the tendency to commit suicide, had disturbed mood disorders, experienced broken marital relationships, sexual denial, rejection, isolation and low self-esteem. The study concluded that stigmatization adversely affects psychological and sociological wellbeing and impairs family relationship of HIV/AIDS

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clients. The authors recommend the need for the integration of services of clinical psychologists into the antiretroviral clinic services in order to help improve the psychological state of HIV/AIDS clients. Also, family members should be educated on the importance of family therapy as a means of alleviating burdens of HIV/AIDS clients within the home.

Keywords: Stigmatization, Psychological Wellbeing, Sociological Wellbeing, Living Faith Support Group, Clinical Psychologists

Introduction

HIV/AIDS remains a public health threat without cure but, manageable with appropriate medical interventions. There are various challenges facing HIV/AIDS positive individuals in the society ranging from poor social and family interactions to economic and psychological issues. Psychosocial wellbeing of an individual cuts across psychological, sociological, family, educational and religious aspect of life. Wellbeing according to the researcher encompasses social, physical, psychological, economical and spiritual status of an individual. Campbell, Nair, Maimane and Nicholson (2007) define stigmatization as negative thoughts, feelings or actions towards HIV/AIDS positive people.

In Nigeria, as reported by Gaynes, Pence, Atashil, O'Donnell, Kats and Ndumbe (2012); Chikezie, Otakpor, Kuteyi and James (2013); depression was found to be five times more common among HIV positive patients. Among the HIV positive patients attending HIV clinic at the University of Benin Teaching Hospital, Nigeria, Chikezie et al. (2013) reported a prevalence rate of 29.3 percent depression among them. A study carried out in three hospitals in Enugu, Nigeria shows a prevalence rate of 33.3 percent of depressive disorders among HIV/AIDS patients receiving care (Iwudibia & Brown, 2014). Shittu, Issa, Olanrewaju, Mahmoud, Odeigah, Salami and Aderibigbe (2013) reported a prevalence rate of 56.7 percent depressed adults with HIV/AIDS attending HIV clinic in Kwara State specialist hospital, Sobi, Ilorin, Nigeria.

Personal interaction of the researchers with significant numbers of HIV/AIDS patients in Oyo town revealed that stigmatization in the form of negative reactions from society coupled with how HIV/AIDS clients view themselves heightened tension, worry and anxiety among them. In southern Nigeria, the results of the study of Ofovwé and Ofovwé (2013) revealed the following psychological symptoms among HIV/AIDS patients namely, paranoid ideation (34.5%), depression (27.4%), neuroticism (23.9%), interpersonal sensitivity (21.2%), anxiety (15.9%), psychoticism (13.3%), hostility (13.3%), phobic anxiety (11.5%), obsessive compulsive disorder (11.5%) and somatization (8.8%).

Most often, society stereotype's HIV positive individuals as intravenous drug users, homosexuals, promiscuous persons and sex workers (Thi, Brickley, Vinh, Colby, Sohn,

Trung, Giang & Mandel, 2008), and these prompt people to stigmatize HIV positive patients. The study of Bello and Bello (2013) in Sobi Specialist Hospital, Ilorin confirmed that social domain of HIV/AIDS patients in Nigeria was negatively affected by societal stigmatization. This report support the earlier findings of Fatiregun, Mofolorunsho and Osagbemi (2009) which was carried out in Kogi State, Nigeria and Folasire, Irabor and Folasire (2012) in University College Hospital, Ibadan, Nigeria. The two (2) reports observed a significant lower quality of life in the social relationship domain of HIV/AIDS patients.

Societal stigmatization is manifested as ostracism, rejection, verbal and physical abuse. Iwelunmor, Airhihenbuwa, Okoror, Brown and Belue (2006) asserted that some individuals refused to buy food from caterers who are known to be HIV/AIDS positive. Sengupta, Banks, Jonas, Miles and Smith (2011); Ankur, Yasoda and Anne (2013) highlighted avoidance of social gathering, broken relationships, reduction of preventive and care behaviour, increased inequalities, increased disability, concealment of the disease after diagnosis and participation restriction as direct influence of stigmatization against HIV positive people. According to Winskell, Hill and Obyerodhyambo (2011), the following attitudes in the community towards HIV/AIDS positive people were outlined: hostility which may lead to change of residence; refusal to marry daughter(s) of people who died of HIV/AIDS; rejection from neighbours; ridicule and torment against the spouse and the children of HIV positive person; and stoning to death.

In Yoruba culture, and virtually in all cultures, family members play significant roles in providing care and support for the sick. However, HIV positive members of the family can find themselves stigmatized within the home. Some family members provide unconditional psychological and material supports to HIV positive members; while some reject them (Liamputtong, 2013). As reported by Mandana, Sima, Eesa and Mino0 (2015), within the family, HIV/AIDS patients face isolation, separation, loneliness, hopelessness, rejection and often leave their homes.

In several parts of Nigeria, Alubo, Zwandor, Jolayemi and Omudu (2002) affirmed that when one member of a family becomes HIV positive, the whole family is nicknamed and likely to be called an AIDS family. The researchers observed that nearly all family members will avoid close interaction with a family member living with HIV/AIDS so as to protect their image in the society they found themselves. In an attempt to do that, the seropositive HIV member of the family will be isolated, neglected and probably denied of their family rights. Therefore, having one HIV positive member in the family is considered dreadful due to the risk of transmission of the virus and its associated effects (Li, Zunyou, Sheng, Manhong, Eli & Yao, 2008).

People in the society viewed HIV/AIDS as a disease that affected immoral people and therefore the victims must be punished (Muoghalu & Jegede, 2010). Hossain and Kippax (2011) reported that HIV positive people are often rejected by their partners, family members and relatives. For instance, some young women living with HIV/AIDS were prohibited by their mothers from cooking meals for the family members due to stigmatization (Okoror, Airhihenbuwa, Zungu, Makofani, Brown & Iwelunmor, 2007). Sometimes, family members may refuse food cooked by or dispose the utensils already used by HIV/AIDS patients. In fact, some were not allowed to interact with babies or children in the family (Bogart, Cowgill, Kennedy, Ryan, Murphy, Elijah, & Schuster, 2008; Liamputtong, 2013).

In India, AIDS patients were considered outcast from families and some were given places like separate huts to sleep in and were prevented from coming in contact with anyone (Hossain & Kippax, 2011). The study of Sangowawa and Owoaje (2012) conducted among youths living with HIV/AIDS in Ibadan, Nigeria shows that upon the disclosure of their HIV positive status, 25 percent were sent out of their matrimonial homes by their husbands, 25 percent were abandoned by their spouses and 12.5 percent had experienced broken relationships.

Despite the increased awareness about HIV/AIDS in the study area, and series of efforts put in place by the public health officials, social and medical workers including health educators to curtail HIV/AIDS stigmatization, the researchers observed that stigmatization against HIV/AIDS clients kept on increasing. It affects their positive self-concept, restricts their mobility, skyrocket depression, fuel loneliness and lowered their morale. Upon this premise, the researchers investigated influence of stigmatization on psychosocial wellbeing of HIV/AIDS clients attending Living Faith Support Group, Oyo town.

Research Hypotheses

The following null hypotheses were postulated and tested in this study:

1. Stigmatization will not have significant influence on the psychological wellbeing of HIV/AIDS clients attending Living Faith Support Group, Oyo town.
2. Stigmatization will not have significant influence on the sociological wellbeing of HIV/AIDS clients attending Living Faith Support Group, Oyo town.
3. Stigmatization will not have significant influence on the family relationship of HIV/AIDS clients attending Living Faith Support Group, Oyo town.

Methodology

A descriptive research design of survey type was employed for this study. The population of the study consists of all registered HIV/AIDS clients who were members of Living Faith Support Group in Atiba Local Government Area, Oyo town. Living Faith Support Group is an HIV/AIDS registered non-governmental organization under the government operating within Atiba Local Government Area of Oyo town, Oyo State, Nigeria. All their members were registered HIV/AIDS clients receiving care and treatment at the antiretroviral clinic, state hospital, Oyo town, Nigeria.

Living Faith Support Group is saddled with the responsibilities of caring, educating the masses on menace of HIV/AIDS, liaising with both the government and philanthropists in the society for the betterment of its members, tracking defaulted members on treatment and helping members to live positively among others. A total of eighty people living with HIV/AIDS were randomly selected. Stratified random sampling technique was used to put into strata the categories of clients in the support group, because children under 18 years, a total of ten and those who consented not to participate, a total of ten were excluded from the study. The excluded members amounted to twenty. Then, purposive sampling technique was used to select sixty consented male and female adults. Researchers' designed closed-ended questionnaire was the instrument used for data collection.

The permission to carry out the study was obtained from the executive members of the HIV/AIDS support group. Verbal consent of each respondent was sought, privacy provided, confidentiality assured and ethical approval was obtained from Ministry of Health, Oyo State Research Ethical Review Committee.

The reliability of the instrument was ascertained using split half method. Pearson Product Moment Correlation was used to estimate their degree of relationship. A reliability co-efficient of .73r was obtained. The copies of the questionnaire were administered to the respondents during their monthly meeting day with the aid of two trained research assistants. Data collected were sorted, collated and coded. Data analysis was done using Statistical Package for the Social Sciences software, version 21.0. The three postulated null hypotheses were tested using inferential statistics of Chi-square at 0.05 alpha level of significance.

Hypotheses Testing

Hypothesis 1: Stigmatization will not have significant influence on the psychological wellbeing of HIV/AIDS clients attending Living Faith Support Group, Oyo town.

Table1: Chi-square analysis showing influence of stigmatization on the psychological wellbeing of HIV/AIDS clients

S/N	ITEM	SA	A	D	SD	Row Total	Cal X ²	Df	Crit. Value	Rem.
1.	Most HIV/AIDS clients have lowered morale due to stigmatization.	36 (60.0%)	10 (16.7%)	12 (20.0%)	2 (3.3%)	60				
2.	HIV/AIDS clients are vulnerable to self-killing as a result of stigmatization.	20 (33.3%)	18 (30.0%)	12 (20.0%)	10 (16.7%)	60				
3.	Majority of HIV/AIDS clients often had disturbed mood as a result of stigmatization.	34 (56.7%)	18 (30.0%)	3 (5.0%)	5 (8.3%)	60	27.30	12	21.03	Ho
4.	Most HIV/AIDS clients are subjected to fear due to stigmatization.	24 (40.0%)	21 (35.0%)	6 (10.0%)	9 (15.0%)	60			Rejected	
5.	HIV/AIDS clients often experienced lowered self-esteem due to stigmatization.	26 (43.3%)	23 (38.4%)	6 (10.0%)	5 (8.3%)	60				
Column Total		140	90	39	31	300				

Significance level 0.05

Keys: Strongly Agreed(SA); Agreed(A); Disagreed(D); Strongly Disagreed(D); Calculated Chi-square(Cal X²); Degree of Freedom(Df); Critical Value(Crit.Value); Remark(Rem.); Hypothesis(HO).

A critical examination of table 1 shows that majority of the respondents agreed that stigmatization brings about low morale 46 (76.7%), vulnerable to suicide 38 (63.3%), had disturbed mood 52 (86.7%), subjected to fear 45 (75.0%) and often experienced lowered self-esteem 49 (87.7%) for people living with HIV/AIDS. The findings from the analysis in table 1 shows the calculated Chi-square (X²) value of 27.30 against the table value of 21.03 at 0.05 alpha level of significance with degree of freedom 12. Since the calculated X² value of 27.30 was greater than the table value of 21.03, thus, the null hypothesis was rejected, which means that, stigmatization adversely affects the psychological wellbeing of HIV/AIDS clients.

Hypothesis 2: Stigmatization will not have significant influence on the social wellbeing of HIV/AIDS clients attending Living Faith Support Group, Oyo town.

Table2: Chisquare analysis showing influence of stigmatization on the sociological wellbeing of HIV/AIDS clients

S/N	ITEM	SA	A	D	SD	Row Total	Cal X ²	Df	Crit. Value	Rem.
6.	Stigmatization makes HIV/AIDS clients to be nicknamed which affect their images in the society.	37 (61.7%)	21 (35.0%)	2 (3.3%)	0 (0%)	60				
7.	Stigmatization poorly affects social interaction of HIV/AIDS clients in the society.	18 (30.0%)	26 (43.3%)	6 (10%)	10 (16.7%)	60				
8.	HIV/AIDS clients do experience broken friendship due to stigmatization.	36 (60.0%)	20 (33.4%)	2 (3.3%)	2 (3.3%)	60				
9.	Due to stigmatization, HIV/AIDS clients often experienced rejection by colleagues.	29 (48.3%)	25 (41.7%)	3 (5.0%)	3 (5.0%)	60	30.38	12	21.03	Ho
10.	Stigmatization hinders active participation of HIV/AIDS clients in some social events in the society.	25 (41.7%)	20 (33.4%)	7 (11.6%)	8 (13.3%)	60			Rejected	
	Column Total	145	112	20	23	300				

Significance level 0.05

Keys: Strongly Agreed(SA); Agreed(A); Disagreed(D); Strongly Disagreed(D); Calculated Chi-square(Cal X²); Degree of Freedom(Df); Critical Value(Crit.Value); Remark(Rem.); Hypothesis(HO).

In table 2, 58 (96.7%), 44 (73.3%), 56 (93.4%), 54 (90.0%) and 45 (75.1%) of HIV/AIDS clients who formed the respondents agreed that due to stigmatization, they were being nicknamed, had poor social interaction, experienced broken friendship, rejected by colleagues and hindered from active participation in some social events in the society respectively. The findings from the analysis in table 2 shows the calculated Chi-square (X²) value of 30.38 against the table value of 21.03 at 0.05 alpha level of significance with degree of freedom 12. Since the calculated X² value of 30.38 was greater than the table value of 21.03, thus, the null hypothesis was rejected, which means that, stigmatization negatively affects the social wellbeing of HIV/AIDS clients.

Hypothesis 3: Stigmatization will not have significant influence on family relationship of HIV/AIDS clients attending Living Faith Support Group, Oyo town.

Table 3: Chi-square analysis showing influence of stigmatization on the family relationship of HIV/AIDS clients

S/N	ITEM	SA	A	D	SD	Row Total	Cal X ²	Df	Crit. Value	Rem.
11.	As a result of stigmatization, affected partner with HIV/AIDS do experience broken marital relationship.	36 (60%)	20 (33.3%)	3 (5.0%)	1 (1.7%)	60				
12.	Due to stigmatization, family members avoid sharing cooking/eating utensils with HIV/AIDS clients.	16 (26.7%)	28 (46.6%)	7 (11.7%)	9 (15.0%)	60				
13.	Sexual denial often occurs among couple having HIV/AIDS partner due to stigmatization.	34 (56.7%)	22 (36.7%)	2 (3.3%)	2 (3.3%)	60				
14.	Isolation within the family is frequently experienced by HIV/AIDS clients.	27 (45%)	27 (45%)	2 (3.3%)	4 (6.7%)	60	28.90	12	21.03 Rejected	Ho
15.	At times, because of stigmatization, family members refused foods cooked by HIV/AIDS clients.	24 (40%)	21 (35%)	8 (13.3%)	7 (11.7%)	60				
	Column Total	137	118	22	23	300				

Significance level 0.05

Keys: Strongly Agreed(SA); Agreed(A); Disagreed(D); Strongly Disagreed(D); Calculated Chi-square(Cal X²); Degree of Freedom(Df); Critical Value(Crit. Value); Remark(Rem.); Hypothesis(HO).

In table 3, 56 (93.3%), 44 (73.3%), 56 (93.4%), 54 (90.0%) and 45 (75.0%) of HIV/AIDS clients who formed the respondents agreed that due to stigmatization, they had experienced broken marital relationships, family members avoid sharing cooking/eating utensils with them, had experienced sexual denial from spouse, isolated within the family and family members refused foods cooked by them respectively. The findings from the analysis in table 3 shows the calculated Chi-square (X²) value of 28.90 against the table value of 21.03 at 0.05 alpha level of significance with degree of freedom 12. Since the calculated X² value of 28.90 was greater than the table value of 21.03, thus, the null hypothesis was rejected, which means that, stigmatization impairs family relationship of HIV/AIDS clients.

Discussion of Findings

Hypothesis one shows that stigmatization had significant influence on the psychological wellbeing of HIV/AIDS patients attending Living Faith Support Group, Oyo town. This finding corroborates Gaynes et al. (2012); Chikezie et al. (2013) that in Nigeria, depression was found to be five times more common among HIV positive patients. This is equally consistent with the previous findings of Shittu et al. (2013); Iwudibia and Brown (2014) in Ilorin and Enugu respectively who reported high prevalence rate of depressive disorders among HIV/AIDS patients. The finding of this study is buttressed among HIV/AIDS clients whereby they reported suicidal act, worry and palpitation due to societal stigmatization.

Hypothesis two revealed that stigmatization had significant influence on the social wellbeing of HIV/AIDS clients concurs with the previous findings of Fatiregun et al. (2009) in Kogi State, Folasire et. al. (2012) in University College Hospital, Ibadan; Bello and Bello (2013) in Sobi Specialist Hospital, Ilorin that social domain of HIV/AIDS patients in Nigeria was negatively affected by societal stigmatization. This is supported in which HIV/AIDS patients reported to have experienced broken courtship, denial by friends, excommunication, negative body reactions and denial of being invited to ceremonies like naming, marriage and funeral.

Hypothesis three shows that stigmatization had significant negative influence on the family relationship of HIV/AIDS clients. This finding was justified by the assertion of Mandana, Sima, Eesa and Mino (2015) that within the family, HIV/AIDS patients faced isolation, separation, loneliness, hopelessness, rejection and home-leave. Sangowawa and Owoaje (2012) reported that among youths living with HIV/AIDS in Ibadan who disclosed their status, significant numbers had experienced divorce, abandoned by spouses and had broken relationships. In line with the result of this finding, through the field experience of the researcher among HIV/AIDS clients, there were reported cases of broken homes, denial of conjugal rights and being locked up in a separate room to the point of death by the family members.

Conclusion and Recommendations

The study concluded that stigmatization adversely affects the psychological and social wellbeing of HIV/AIDS clients. It also concluded that stigmatization impairs the family relationship of HIV/AIDS clients in Oyo town, Oyo state, Nigeria. The researchers further concluded that stigmatization also impairs access to people living with HIV/AIDS in the study area.

There is need for the integration of services of clinical Psychologists into the antiretroviral clinic services in order to help improving the psychological state of HIV/

AIDS clients. It is important that for relatives, friends and community members at large to associate with HIV/AIDS clients so as to reduce the burden of societal stigmatization. Family members should be educated by stakeholders in the health sector on the importance of family therapy as a means of alleviating burdens of HIV/AIDS clients within the home.

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