

Pervasiveness of HIV-Related Stigmatization among PLWHA in South Eastern Nigeria

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Abstract: The aim of this study was to examine the pervasiveness of HIV/AIDS-related stigmatization among People Living with HIV/AIDS (PLWHA). The lived experience of stigmatization among people living with HIV/AIDS was examined. A total of 77 HIV seropositive patients and 77 of those that were not infected, all residing in 5 marginalized communities in South Eastern Nigeria participated in a study this tested eleven hypotheses. Using HIV/AIDS-related Stigmatization scale, results indicated a significant differences in overall stigmatization, psychosocial problem, behavioral problem, neglect, rejection, abuse, physical distance, denial of medical assistance but not significant on psychiatric disorder, self stigma and suicidal intrusive thought. Our results suggest that the devaluation in the well being of stigmatized PLWHA are significantly more manifest in their psychosocial and behavioral problems than in their psychiatric dimension. One implication of our findings is that reducing stigmatization is a core issue in the prevention and management of HIV/AIDS pandemic in resource poor countries.

Key words: HIV, stigmatization, pervasiveness, suicidal intrusive, PLWHA, Nigeria

INTRODUCTION

HIV/AIDS is currently the most devastating and contagious disease of the century. Empirical report indicate that HIV/AIDS has reached pandemic proportions in many states in South East Nigeria (Federal Ministry of Health Technical Report: HIV Sero-Prevalence Survey, 2003, 2006). Extensive research indicate that HIV/AIDS disease has reached endemic stage in some parts of Sub-Saharan Africa (Zainet, 1993; Linville and Fischhoff, 1993). In recent time, Empirical evidence Galtung (1969) indicate that stigmatization, discrimination, ostracism, alienation and indirect forms of oppression, or narcissisms of minor differences, or structural violence, are engaged by individuals, communities or social groups as forms of social control to implement their particular values, beliefs, norms, worldviews and their power within a society. In the literature, HIV-related stigmatization has been conceptualized as an attitude toward relatively marginalized groups that, in some communities, have been adversely affected by the HIV/AIDS epidemic (Herek *et al.*, 1998). Stigma has been defined as:

An attribute that is significantly discrediting (Goffman, 1963) and as an attribute used to set the affected person or groups apart from the normalized social order and this separation implies a devaluation (Gilmore and Somerville, 1994).

Stigmatization, therefore, describes the process of devaluation within a particular culture or setting, where certain attributes are defined as discreditable or unworthy. The stigmatized attribute is neither creditable or desirable as a thing in itself (Goffman, 1963); since the stigma is socially constructed and partially arises from cultural norms about what a person should be and what people who deviate from the norm are Bond *et al.* (2002).

In the case of people living with HIV/AIDS, there is an “extraordinary convergence” of many types, forms and dimensions of stigma, linked both to the actual HIV/AIDS infection itself on one hand and to high risk behaviors believed to lead to infection on the other hand (Bond *et al.*, 2002). The stigma attached to AIDS affliction is most often associated with pre-existing stigma of sexual anxiety (Herek and Glunt, 1988), substance abuse (Maluwa *et al.*, 2001) and moral decadence (Nnedum, 2006) and sexual anxieties (Smith, 2007). The most marginalized and excluded groups in societies, such as sex workers, poor people, orphans, widows, widower and single women in South Eastern Nigeria, frequently bear the brunt of stigmatization in relation to HIV/AIDS. In this study, HIV/AIDS-related stigma theoretically identified by Bharat *et al.* (2001) were recognized and explored. The first is the self stigma.

Self stigma is manifested in self blame and self deprecation. The second is perceived stigma. Perceived stigma is manifested in the fear that people are being

stigmatized if they are HIV positive and choose to disclose their HIV status to others. The third is enacted stigma. Enacted stigma is when people are actually discriminated against because they have, or are thought to have HIV/AIDS (Bharat *et al.*, 2001).

Therefore, HIV/AIDS-related stigma can result in discrimination, which can take many forms (Maluwa *et al.*, 2001) and which exists at many social levels (Bond *et al.*, 2002). Specifically, 10 key areas have been identified by UNAIDS as of particular relevance to what might be described as arbitrary discrimination (UNAIDS, 2000 a, b). Of particular interest to HIV/AIDS related stigmatization studies are institutional discrimination in health care, social welfare, employment and education settings and social discrimination, manifested at family, community and public level (UNAIDS, 2004a, b). In fact, Mann identified 3 phases of the HIV/AIDS epidemics as “the epidemic of AIDS and the epidemic of stigma, discrimination and the epidemic of denial”. Accordingly, it is believed that the 3rd phase is as central to the global AIDS challenge as the disease itself. Generally, HIV/AIDS-related stigma in sub-Saharan Africa is most closely related to sexual stigma. This is because HIV is mainly sexually transmitted and in most areas of the world, the epidemic initially affected populations whose sexual practices are different from the “norm” (Parker and Aggleton, 2002). However, HIV/AIDS-related stigmatization has therefore, rekindled anecdotal sexual stigma associated with sexually transmitted illnesses (STI), homosexuality, promiscuity, prostitutions and sexual anxieties (Weeks, 1981; Nnedum, 2006; Smith, 2007). One major consequence of this social stigma has been widespread discrimination, isolation and social exclusion of people with HIV/AIDS across communities, cultures, state, nations, continents and in virtually all spheres of life.

In the Western world, the belief that homosexuals are the only group at risk of HIV is still common (Parker and Aggleton, 2002). In Africa, promiscuous sexual behavior by women is also commonly believed to be responsible for the heterosexual epidemic, regardless of the reality of men’s sexual anxieties (Nyazema, 2005; Nnedum, 2006; Smith, 2007). In Hong Kong, HIV/AIDS is considered to be one of the most stigmatizing conditions among various infectious diseases (Mak *et al.*, 2007). In Nigeria, 5510 (58%) young people rejected routine HIV screening for fear of stigmatization (Omoigberale *et al.*, 2007). Similarly, Alubo *et al.* (2002) in a study on the stigmatization of people living with HIV/AIDS in South Benue State of Nigeria found that the level of stigmatization is high. In Jamaica, AIDS-related stigma is one of the biggest obstacles in the fight to prevent HIV/AIDS transmission (Mardi *et al.*, 2005). In Switzerland, Spring (2001)

conducted a qualitative study, based on critical hermeneutic, to assess insight about care giving experiences of HIV/AIDS affected families in the German speaking part in Switzerland and found that the result highlighted stigmatization in a context of silence. Accordingly, it implied, also, that HIV/AIDS families do not share their experiences in their closer and larger environment because of stigmatization among other factors. In America, Hodge (2001) stated that denial regarding how the disease is spread and stigmatization about the disease continue to be barriers to effective prevention campaign with African American communities in particular. In India, the silence and secrecy associated with institutional stigma and structural discrimination provided ideal conditions for escalation of the AIDS epidemic (Chakrapani *et al.*, 2007). In essence, at the community level, HIV/AIDS related stigmatization leads to inaccurate information about HIV/AIDS prevalence, making informed intervention and appropriated health care responses difficult (UNDP, 2003; Nnedum, 2006).

Theory and hypotheses: The socio-economic theory (Conyers *et al.*, 2005) explains the unique nature of stigmatization against people living with HIV/AIDS. It relates to the marginalized status of the vast majority of individuals affected by HIV/AIDS. Some stream of research (Conyers *et al.*, 2005; Leonard, 1985; Herek *et al.*, 2002) suggests that the nature of discrimination against individuals with HIV/AIDS may be grounded in deeper level of existing stigmatization than are held towards other disability groups. Increasingly, there is consensus that HIV/AIDS-related stigmatization is often related to pre-existing stigma which makes individuals with HIV/AIDS particularly vulnerable to cultural violence, subjugation, alienation, discrimination and stigmatization (Herek *et al.*, 2002; Studdert, 2002; Conyers *et al.*, 2005). On the other hand, the Benefit theory (Pranschke and Wright, 1995) highlights the unique nature of HIV/AIDS stigmatization and focuses particularly on the nature of the illness itself, with a primary attention on the fact that it is a potentially terminal, contagious, disease with no cure in sight. Consequently, misinformation about HIV/AIDS lead to the perception of it as a communicable disease resulting in social isolation, social exclusion, discrimination (Sontag, 1989) and social dislocation (Nnedum, 2006). In China, Li *et al.* (2007) in a study of stigmatization and shame using 478 medical care givers of PLWHA found that correlation analysis showed significant association between internalized shame reported by service provider and their perception of being stigmatized due to working with PLWHA. Increasingly, there have been empirical reports about HIV infected

persons being dismissed from work (Petrak Doyle *et al.*, 2001), socially dislocated because of their HIV status (Muula and Mfutso-Bengo, 2005). In Nigeria, a study on the PLWHA perception of stigmatization by others indicates that:

There were agreement among PLWHA about the general level of high rejection because of their HIV-positive status; the aids sufferer is a crucial transition from the realm of the living to that of the dead; the usual expectations and obligation toward the sick for sickness from other condition are withheld and gradually replaced by those towards the dead; the most obvious are separation and avoidance, isolation and rejection by the community, friends and family (Alubo *et al.*, 2002).

It is apparent that in the Nigerian village communities, once someone is infected with HIV/AIDS disease, people treat the individual as a dead person already (Alubo *et al.*, 2002). Consequently, a cursory look at stigma as one of the plausibly possible contributing psychological factors to the development and spread of HIV/AIDS pandemic in Eastern Nigeria will be heuristically relevant and important to our understanding of the psychology of HIV/AIDS epidemic in Nigeria. Thus, the following hypotheses were tested:

H1: The pervasiveness of lived experiences of stigmatization beliefs will be significantly higher among people living with HIV/AIDS than among non-infected people.

H2: The pervasiveness of lived experiences of psychosocial problem will be significantly higher among people living with HIV/AIDS than among non-infected people.

H3: The pervasiveness of lived experiences of behavioral problem will be significantly higher among people living with HIV/AIDS than among non-infected people.

H4: The pervasiveness of lived experiences of psychiatric disorder will be significantly higher among people living with HIV/AIDS than among non-infected people.

H5: The pervasiveness of lived experiences of neglect will be significantly higher among people living with HIV/AIDS than among non-infected people.

H6: The pervasiveness of lived experiences of rejection will be significantly higher among people living with HIV/AIDS than among non-infected people.

H7: The pervasiveness of lived experiences of abuse will be significantly higher among people living with HIV/AIDS than among non-infected people.

H8: The pervasiveness of lived experiences of physical distance will be significantly higher among people living with HIV/AIDS than among non-infected people.

H9: The pervasiveness of lived experiences of denial of medical assistance will be significantly higher among people living with HIV/AIDS than among non-infected people.

H10: The pervasiveness of lived experiences of self stigma will be significantly higher among people living with HIV/AIDS than among non-infected people.

H11: The pervasiveness of lived experiences of suicidal intrusive thought will be significantly higher among people living with HIV/AIDS than among non-infected people.

MATERIALS AND METHODS

Participants: The participants of this research were adults who resided in the South eastern Region of Nigeria. The questionnaires were distributed to two hundred adults, all the participants returned back the questionnaires and 154 were properly responded to. Of the one hundred and fifty four participants, 77 respondents endorsed HIV/AIDS status. Of those who did not endorse the HIV/AIDS status, through random sampling, seventy-seven questionnaires were useful. The purpose of the random sampling is to allow for more effective statistical analysis and comparisons following the research hypotheses. The mean age of the 154 participants was 31.23 years, with a standard deviation of 9.114 (Table 1). Regarding religious orientation, 149 (96.8%) identified themselves as Christians, 3 (1.9%) identified themselves as Muslims, 1 (0.6%) identified themselves as following the African traditional religion and 1 (0.6%) did not identify him/herself as having any religious belief (Table 2). Of these 77 adults who identified themselves as infected with the AIDS virus, 28 (36.4%) were males and 49 (63.6%) were females. These adults hailed from five states of the Southeastern Region of Nigeria (Table 3). Of those who did not endorse the AIDS virus, 56 (72.7%) were males and 21 (27.3%) were females. These adults also hailed from the different states of the Southeastern Region of Nigeria (Table 4). Furthermore, following the results, of the 77 participants who identified themselves as having the AIDS virus, 35 (45.5%) were married, 23 (29.8%) were

Table 1: Age of the 154 participants

Variable	X	SD
Age	31.23	9.114

Table 2: Gender and religious orientation of the 154 participants

Variable	N	(%)
Gender		
Male	84	54.5
Female	69	44.8
Religious orientation		
Christians	149	96.8
Muslims	3	1.9
Traditional	1	0.6
Other	1	0.6

Table 3: Gender and state of origin of participants living with the AIDS virus

Variable	N	(%)
Gender		
Male	28	36.4
Female	49	63.6
State of origin		
Anambra	15	19.5
Enugu	16	20.8
Imo	15	19.5
Abia	15	19.5
Ebonyi	16	20.8

single, 1 (1.3%) was divorced and 18 (23.4%) were widowed. Of the 77 who did not endorse the HIV status, 47 (61%) were single, 26 (33.8%) were married, 1 (1.3%) was divorced, 2 (2.6%) were separated and 1 (1.3%) was widowed (Table 5). The health status of the respondents was also evaluated. Of the 77 participants who endorsed the AIDS virus, 11 (14.3%) endorsed excellent health and 18 (23.3%) reported multiple hospitalizations within one year (Table 6). Of those 77 who did not endorse the AIDS virus, 35 (45.4%) endorsed excellent health and 4 (5.2%) reported multiple hospitalizations (Table 6). The demographic result did not indicate significant difference between males and females who reported excellent health and males and females who reported multiple hospitalizations (Table 7).

The level of education of the 154 participants was classified under the following: No education, primary/secondary education, College Degree and Graduate School. Of the 154 participants of these research, 6 (3.9%) identified themselves as having no educational background, 86 (55.9%) had primary or secondary or some vocational school, 48 (31.2%) identified themselves as having some college education including Bachelor's degree and 12 (7.8%) reported some graduate school education (Table 8). Additionally, to determine the number of participants employed, the level of employment was analyzed. Of the 154 participants, 55 (33.7%) claimed being employed and 96 (56.8%) reported no employment. Considering the different meanings associated with being employed and not employed in the Nigerian society,

Table 4: Gender and state of origin of participants not living with the AIDS virus

Variable	N	(%)
Gender		
Male	56	72.7
Female	21	27.3
State of origin		
Anambra	16	20.8
Enugu	15	19.5
Imo	17	22.1
Abia	15	19.5
Ebonyi	14	18.1

Table 5: Marital status of participants living and not living with the AIDS virus

Variable	N	(%)
Living with HIV		
Single	35	45.5
Married	23	29.8
Divorced	1	1.3
Separated	0	0.0
Widowed	18	23.4
Not living with HIV		
Single	47	61.0
Married	26	33.8
Divorced	1	1.3
Separated	2	2.6
Widowed	1	1.3

Table 6: General health status of participants living and not living with the AIDS virus

Variable	N	(%)
Living with HIV		
Excellent	11	14.3
1-2 Doctors' Visit/Year	34	44.2
Hospitalized Once or Twice	14	18.2
Multiple Hospitalizations	18	23.3
Not living with HIV		
Excellent	35	45.4
1-2 Doctors' Visit/Year	25	32.5
Hospitalized Once or Twice	13	16.9
Multiple Hospitalizations	4	5.2

Table 7: General health status and gender of the 154 participants

Variable	N	(%)
General health status-males		
Excellent	25	29.8
1-2 Doctor's Visit/Year	34	40.5
Hospitalized Once or Twice	14	16.7
Multiple Hospitalizations	11	13.0
General health status-female		
Excellent	21	30.0
1-2 Doctor's Visit/Year	25	35.7
Hospitalized Once or Twice	13	18.6
Multiple Hospitalizations	11	15.7

further analysis of employment status was completed. Individuals were asked if they were independently employed or not. Of these latter question, 99 (64.3%) reported that they worked for some other person or institution or government, 39 males (25.3%) reported that they had their own business, 13 women (8.4%) reported that they had their own business and 3 individuals (1.9%) reported no employment (Table 9).

Table 8: Level of the education of the 154 participants

Variable	N	(%)
No education	6	3.9
Primary-secondary	86	55.9
College education	48	31.2
Graduate education	12	7.8

Table 9: Employment status of the 154 participants

Variable	N	(%)
Employed		
Yes	55	35.7
No	96	56.8
Independently employed		
No-Has an employer	99	64.3
Own Business-Male	39	25.3
Own Business-Female	13	8.4
Unemployed	3	1.9

Instrument

The HIV/AIDS-Related stigmatization scale: Nnedum (2005) developed the HIV/AIDS Related stigmatization Scale (Nnedum, 2005) to assess the participants’ feelings of lived experiences of HIV/AIDS related problem of stigmatization. The 20 items stigmatization scale is a 5-point-response anchor questionnaire that provides a systematic assessment of the extent to which people living with HIV/AIDS endorses HIV/AIDS related problem of stigmatization or those dimensions of attitude, reactions and enacted responses that individuals living with HIV/AIDS displays to the self and feel that others display to them. It includes 7 subscales. These subscales are categorized into three underlying dimensions. The first is Psycho-social problem, measured by neglect, rejection and abuse. The second is behavioral problem, measured by physical distance and denying medical assistance. The third is Psychiatric disorders, measured by self stigma and suicidal intrusive thoughts. This questionnaire was administered individually after establishing adequate rapport with the participants. The Participants are encouraged to read and follow the instruction at the top of the test form. The Research assistants help the semi-literate participants to carry out the instruction. There is no time limit for completing HSS. The HSS items are scored on a 5 point response scheme:

- 1 = Never
- 2 = Seldom
- 3 = Sometimes
- 4 = Oftentimes
- 5 = Always

The items are scored directly by adding together the values of the numbers shaded. The original Psychometric properties for Nigerian Sample (Nnedum, 2005) provided the properties for the Igbo ethnic samples from South Eastern Nigeria. The norms reported by Nnedum (2005) are the mean scores obtained by adult living with

HIV/AIDS who regularly visit the HIV-Health City Centers in south eastern Nigeria. Nnedum (2005) reported a two weeks test-retest reliability co-efficient using data collected from south eastern Nigerian Sample. The 2005 subscale test-retest reliabilities include $r = 0.67$ for neglect, 0.85 for rejection, 0.91 for abuse, 0.98 for physical distance, 0.71 for medical assistance, 0.88 for self stigma, 0.78 for suicidal intrusive thoughts, 0.74 for psycho-social problem dimension, 0.81 for behavioral problem dimension and 0.92 for overall HSS scale. while another three weeks co-efficient reported by Nnedum (2006) using Igbo ethnic samples from South Eastern Nigeria ranged from $0.77-0.96$, respectively. Nnedum (2005) reported, using data from south eastern region reported that the alpha measure of internal consistency for the subscales were $\alpha 0.70$ for neglect, $\alpha 0.78$ for rejection, $\alpha 0.76$ for denying medical assistance, $\alpha 0.73$ for self stigma, $\alpha 0.72$ for suicidal intrusive thoughts, $\alpha 0.82$ for psycho-social problem dimension, $\alpha 0.91$ for behavioral problem dimension, $\alpha 0.88$ for psychiatric disorder dimension and $\alpha 0.89$ for the overall HSS Scale. In this study, using the same questionnaire the investigator assessed the reliability using SPSS. The result of the SPSS revealed a chronbach alpha of 0.80 for neglect subscale, 0.66 for rejection subscale, 0.89 for abuse subscale, 0.81 for physical distance subscale, 0.81 for suicidal subscale respectively. The 2005 survey norms or mean scores are the basis for interpreting the scores of participants. Scores higher than the norms indicate that the participants experiences high stigmatization while scores lower than the norm indicate low experience of stigmatization.

Procedure: The investigator introduced this research to three research assistants (2 males and a female), explaining the purpose of the research, the proposal and consent form. The research assistants were trained on the procedures for administering the research for one week at Nnamdi Azikiwe University. These trained research assistants are volunteers recruited from the local community based non-governmental organization (NGO) as well as academic institution in south eastern region to help in facilitating the data collection required for this study. These research assistants were provided with logistics, light refreshments and honorarium stipend on the days the questionnaires were administered. The investigator and the trained research assistants introduced the research and its purpose to the community development officer of the DFID unit at the British council’s office in Enugu. The British department for international development (DFID), British council-Enugu oversea the community projects targeted to alleviate the poverty status of people living with HIV/AIDS in the rural

communities of the entire South eastern region of Nigeria. The DFID community development officer then, introduced the investigator and the research assistants to the regional office of the executives of the coalition of HIV/AIDS organizations in their unit within the British councils' complex. The members of the coalition of HIV/AIDS organizations are people living with HIV/AIDS in each state in the entire south eastern region of Nigeria. The DFID staff, the investigator and the research assistants, discussed the research with the executives of the coalition of HIV/AIDS organizations and consent was obtained for the participation of their members in the research study. Access into the coalition organizations was secured through their coalition coordinators' office at the British councils' DFID office at Enugu; Enugu State; with the aid of the DFID community development staff who introduced the investigator to the executive members of the regional HIV/AIDS coalition. The coalition has a functional executive office at the DFID complex. The executive secretary of the Coalition who had a fruitful contact with the various state chairmen of their coalition, introduced the investigator to their various state chapters. The chairmen of each state coalition informed members that a researcher from an American university has come to visit them for research purpose and would like to have an interactive session with them as well. A date was scheduled to suite their major routine health care day in each state. The executive secretary accompanied the investigator to each state on the scheduled date with their coalition. In each state, the chairman of the coalition introduced the investigator to their members during the interactive session. The investigator introduced his research objectives to members. The participants had the opportunity of telling the investigator their problems. The investigator sought and obtained their informed personal consent to participate in the study. The HIV/AIDS positive participants used in the study was randomly drawn from the major coalition of HIV/AIDS related non-governmental organizations (NGOs), Community based organizations (CBOs) and Faith based organizations (FBOs)' voluntary counseling and testing (VCT) centers in each state, where people living with HIV/AIDS and those that are not, normally visit for routine Testing and health care services. The medically diagnosed HIV/AIDS positive participants and those that were not, were randomly selected on the scheduled days for routine testing and treatment in each of the 5 south eastern states VCT centers. The PLWHA participants belonged to various community based organizations (CBOs), faith based organizations (FBOs) and non-governmental organizations (NGOs) which differed from each other in terms of geographical locations, state of

origins of members, age of members, need focus of the organization and tenure of their existence within the state. These community based organizations (CBOs), Faith based organizations (FBOs) and Non-Governmental Organizations (NGOs) were all recognized by their various state governments and are partly sponsored by their state action committee on HIV/AIDS, DFID, UNIFEM, UNICEF and the federal ministry of Health through the federal action committee on AIDS. All the participants offer consent to participate in the study during the interaction sessions and responded to the consent form. The HIV/AIDS positive participants were given light refreshment and financial honorarium by the investigator at the end of the interactive session. A battery of questionnaire was administered to the randomly selected HIV-positive participants. The state chairmen of the coalition also introduced the investigator to the medical personnel in charge of VCT center in the state. The personnel in charge introduce the investigator to the chairman research ethics committee of the medical center for institutional approval for the use of tested non-HIV positive participants from their center for the study. After the institutional consent had been secured, the participants' informed consent was sought and secured voluntarily because the participants were allowed to respond to the battery of tests individually. The non-positive HIV/AIDS participants were given financial honorarium for their participation. The battery of test issued to the participants accessed and explored the level of poverty status of the individual. Certain critical demographic variables such as state of origin, place of residence, among others were collected from them.

RESULTS AND DISCUSSION

The primary purpose of this study was to examine the pervasiveness of stigmatization among people living with HIV/AIDS, in South Eastern region of Nigeria. The major variables measured in this study were stigmatization. Stigmatization measures explain the impact of psychosocial factors such as neglect, rejection, abuse and behavioral factors such as physical distance, denial of medical assistance and psychiatric disorders such as self stigma, suicidal intrusive thought, implications in the life of people living with HIV/AIDS. Consistent with the hypotheses that the people living with HIV/AIDS will experience greater levels of stigmatization, psychosocial problem, behavioral problem and psychiatric disorder than the non infected HIV-negative people, the findings from Table 10-12 indicated that there are significantly greater pervasiveness of stigmatization among the PLWHA than those that are not infected on psychosocial criteria and

Table 10: Summary of results of univariate test statistics for the dependent variables

Variable	F values	Mean square	Sig.
Overall stigmatization	12.41	3450.92	0.001
Psychosocial problem	25.14	1893.51	0.000
Behavioural problems	05.67	9 8.240	0.018
Psychiatric disorder	00.82	28.286	0.367
Neglect	19.49	80.006	0.000
Rejection	11.26	52.597	0.001
Abuse	20.50	746.24	0.000
Physical Distance	10.41	140.32	0.002
Denial of medical assistance	04.50	03.74	0.035
Self stigma	00.95	12.57	0.332
Suicidal intrusive thought	00.33	03.14	0.569

Note. p<0.0001

Table 11: Means and standard deviations for the dependent variables of people living with HIV/AIDS

Variables	M	SD	CI	N
Overall stigmatization	45.69	16.79	41.88-49.49	77
Psychosocial problem	24.34	09.02	22.29-26.38	77
Behavioural problems	08.82	04.33	07.84-09.80	77
Psychiatric disorder	12.53	05.80	11.22-13.85	77
Neglect	04.96	02.03	04.50-05.42	77
Rejection	04.40	02.46	03.84-04.96	77
Abuse	14.97	06.35	13.53-16.42	77
Physical Distance	07.53	03.99	06.63-08.44	77
Denial of medical assistance	01.29	00.78	01.11-01.46	77
Self stigma	06.91	03.64	06.08-07.73	77
Suicidal intrusive thought	05.62	03.02	04.94-06.31	77

Table 12: Means and standard deviations for the dependent variables of people not infected with AIDS/HIV

Variables	M	SD	CI	N
Overall stigmatization	36.22	16.56	32.46-39.97	77
Psychosocial problem	17.33	08.34	15.43-19.22	77
Behavioural problems	07.22	03.99	06.32-08.13	77
Psychiatric disorder	11.68	05.96	10.32-13.03	77
Neglect	03.52	02.02	03.06-03.98	77
Rejection	03.23	01.81	02.82-03.65	77
Abuse	10.57	05.70	09.28-11.86	77
Physical Distance	05.62	03.32	04.87-06.38	77
Denial of medical assistance	01.60	01.03	01.36-01.83	77
Self stigma	06.34	03.65	05.51-07.17	77
Suicidal intrusive thought	05.34	03.19	04.62-06.06	77

subscales, behavioral criteria and subscales but not on psychiatric criteria nor the subscales of self stigma and suicidal intrusive thought as predicted. The results of the present study supported hypotheses 1, 2, 3, 5, 6, 7, 8, 9, while hypotheses 4, 10, 11 were rejected. The findings of this study are in line with extensive reports (Bureau for Global Health, 2007; Federal Ministry of Health, 2003, 2006; Smith, 2007; UNAIDS, 2004) in Nigeria implicating stigma in the HIV/AIDS morbidity. Consistent with the findings that PLWHA are pervasively denied medical assistance, even when available, empirical evidence in Nigeria (UNAIDS, 2004) has shown that one in ten healthcare providers in Nigeria reported refusing to care for PLWHA and 65% of health care providers reported seeing other healthcare providers refusing treatment and care to PLWHA and 20% of healthcare providers believed that many people living with the AIDS virus deserve to be

infected because they contracted the virus through immoral sexual behaviors. In most collectivistic resource-poor societies, communities shun and gossip persons perceived to be living with HIV/AIDS. The result of such gossip are psychosocial problem such as non response to greetings, avoidance of holy embracing, rejection, denial of treatment, neglect and abuse. This devaluation is manifested in the behavior of PLWHA such as withdrawal from public functions, keeping safe distance from people and fear. The psychosocial and behavioural devaluations in the psychological well-being of HIV/AIDS patients are obviously manifest in the life of people living with HIV Aids and hence are significant in this study. On the contrary, the psychiatric well being of the PLWHA and those not infected are not significant in this study, even though there are differences observing the means. It is plausibly possible that the devaluation in the well being of PLWHA has not reached the clinical threshold to trigger off psychiatric disorder mainly because the nature of the participants used for this study are PLWHA residing in urban city center, well educated and have more access to information about HIV/AIDS management and care.

CONCLUSION

In conclusion, the present study provides valuable and important research information on the cultural and social experience of adults living with HIV/AIDS residing in selected states of the South Eastern Region of Nigeria.

RECOMMENDATIONS

This study recommends aggressive cultural specific educational campaign on HIV/AIDS using the native language as medium of communication. Similarly, Chen *et al.* (2007) found that full and accurate HIV knowledge the individual level is associated with decreased stigmatization of PLWHA. Accordingly, full and accurate knowledge of HIV transmission information at the individual level tends to reduce stigmatization of PLWHA, while individual-level inaccurate beliefs tends to increase stigmatization (Chen *et al.*, 2007). These findings indicate that increasing full and accurate knowledge and reducing inaccurate beliefs at individual level are both important for reducing negative attitudes toward PLWHA.

Public health and education programmes aimed at reducing stigmatization could be useful to enhance full and accurate knowledge of HIV/AIDS (Chen *et al.*, 2007). Thus, the findings of the present study suggest that effectively reducing negative attitudes toward PLWHA remains a challenge for public health intervention programmes in Nigeria.

LIMITATIONS

There were extensive limitations of the current study that should be considered. The use of people living with HIV/AIDS residing in selected states of the South Eastern Region of Nigeria was relevant to the design of the study, apparently the south eastern region of Nigeria is one of the 6 geo-political zones of Nigeria, but the findings of the study on PLWHA in this region do not represent that of PLWHA in the entire country because of the small sample size; this factor limits the generalizability of the results to the Nigerian population, taken as a whole. Nigeria is a multi-cultural, multi-linguistic, multi-ethnic country with diverse values, beliefs, religions, meaning attached to illness and disease, as well as legally asymmetrical laws and policies. The country's multi-cultural attitudes tend to limit, to a large extent, the generalizability of stigmatizing beliefs of PLWHA in the entire population. The result of this study focused on the stigmatizing beliefs of People living with HIV/AIDS in South eastern Nigeria. Due to the fact that all the adults participants living with HIV/AIDS attended at least primary school and lived in urban city center or frequently visit the urban city-where English is their general language of communication, one would expect that the adults would be able to understand social and cultural experience intelligently and rationally.

Additionally, more male adults than females participated in the study. Since, Gender inequality and religious culture impacts the social experience of PLWHA, the result of this study is limited in the sense that the experience of adults PLWHA females residing in selected states of the South Eastern Region of Nigeria is not fully explored.

SUGGESTIONS FOR FUTURE RESEARCH

Limitations of the current study raise several issues that could be explored in future research. It would be intellectually stimulating to explore the adult PLWHA'S level of stigmatizing beliefs in other parts of Nigeria and among Nigerian adult PLWHA from the rural area of South Eastern Region of Nigeria, but residing in the rural area. The result such studies could provide significant information on the level to which culture and environmental factors impact adult PLWHA's view of their lived stigmatization beliefs. The result of such studies would also provide insight on more practical methods of planning and implementing AIDS prevention and intervention programs for the adults living with HIV/AIDS in the South Eastern Region of Nigeria. The result of this study will be very significant in under-

standing the reasons for the spread of the AIDS virus, the cultural and social problems experienced by Persons Living with the HIV/ AIDS virus and cultural factors inherent in such experiences.

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