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RESEARCH ARTICLE

SUBJECTIVE WELLBEING AND FELT STIGMA WHEN LIVING WITH HIV IN MAIDUGURI METROPOLIS

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ABSTRACT

HIV as an illness affects the person first and foremost at the biological level in the form of an aggressive virus that compromises immunity. Every illness experience represents a unique and dramatic negative experience for the patient; it is associated with a profound and authentic psychological engagement of patients themselves and the significant people in their lives.

Objective: The study assessed the impact of "felt" stigma on Subjective Well-Being when living with HIV among people living with HIV in Maiduguri Metropolis.

Methodology: A cross-sectional descriptive survey design was adopted for the study, 100 clients were selected using systematic random sampling and data was collected through questionnaire. Analysis was done using frequency count, percentages and inferential statistics of chi-square was used to test the hypothesis at 5% level of significance.

Result: findings of this study revealed that majority of respondents were within 26-45years of age. The respondents had good abstract feeling of satisfaction with their live as a whole, standard of living, health, achievement in life, personal relationship, safety, feeling of being part of the community and future security. However, there was a low cognitive judgment of satisfaction with life among the respondents. The study also revealed that gender (sex) has no influence on the subjective wellbeing of the respondents.

Conclusion: The study suggests that Professionals in clinical psychology should be invited from time to time to the clinics for counseling of saddened and hopeless clients.

INTRODUCTION

In the early 1980's, the emergence of Human Immune Deficiency Virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS) in developing nations created an epidemic of stigma unprecedented in modern day of medicine (Herek Glunt, 1988). In 2012, there was an average of 35.3 million people living with HIV resulting to 1.6 million deaths (UNAIDS, 2013). Fear of contagion coupled with negative, value based assumptions about people who are infected leads to high levels of stigma surrounding HIV and AIDS (UNAIDS 2008).HIV-related stigma is usually regarded as operating in two major ways, as either "felt" or "enacted". Generally, enacted stigma is defined by acts of discrimination, abuse or ostracism whereas felt stigma is defined as feeling stigmatized or experiencing the fear of being stigmatized (Block, 2009). Stigma in people living with HIV affects the quality of life of individuals and subjective wellbeing as well as effectiveness of many public health programs. Subjective wellbeing (SWB) casually affects both health and longevity. SWB refers to people's evaluations of their lives, which can be judgments such as life satisfaction, evaluations based on feelings, including moods and emotions. When people feel sad mood or a joyful mood or emotion, it is because they feel their lives are going badly or well. Thus, SWB is a heterogonous category that includes diverse phenomenon ranging from optimism to, low anger to work satisfaction (Dierner and Chan, 2011). Individuals suffer from felt stigma when they internalize negative perceptions regarding themselves. People living with HIV employ diverse coping mechanisms when their self-worth and networks are disrupted by stigma (Yebei, Fortenberry and David, 2008). Stigma not only makes it more difficult for people trying to come to terms with HIV and manage their illness on a personal level, but it also interferes with attempts to fight HIV and AIDS epidemic as a whole (Herek,2007). Stigma is a common human reaction to a disease (Brown, Trijillo and Macintyre, 2003). It can be conceptualized in different ways. Individuals suffer from self-stigma when they internalize negative perception regarding themselves, as

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against perceived or felt attitudes they suffer from other people's prejudicial attitudes and discriminatory behaviors (Yebei, Fortenberry and David, 2008; Busko, 2009, Odegunwa, Akinwotu, Adeoye,2014). This is due to the fact that fear of judgment or discrimination from others can profoundly influence the way people living with chronic diseases view themselves and cope with their disease stage. Whichever kind of stigma it is, can lead to impoverishment, social marginalization and low quality of life (Busko, 2009, Odegunwa, Akinwotu, Adeoye, 2014).

HIV as an illness affects the person first and foremost at the biological level in the form of an aggressive virus that compromises immunity. Every illness experience represents a unique and dramatic negative experience for the patient; it is associated with a profound and authentic psychological engagement of patients themselves and the significant people in their lives (Schwetzer, Mizwa and Michael, 2013). Probably, the single most important factor in producing and extending the negative psychosocial effect of HIV and AIDS is stigma. Consequently, actions to reduce or protect against stigma may be the most significant step that can be taken to improve the psychosocial wellbeing of people with HIV and AIDS (Schwetzer, Mizwa and Michael, 2013).

Stigma prevents people from talking about and acknowledging HIV as a major cause of illness and death. Stigma prevents HIV infected people from seeking counseling, obtaining medical and psychological care, and taking preventive measures to avoid affecting others (Schwetzer, Mizwa and Michael, 2013). Despite antidiscrimination legislation, felt stigma in the form of unsupportive social interactions continues to exert a negative impact on SWB. Reduced SWB may increase the risk of adverse health behaviors, such as medication non-adherence, substance abuse, risky sexual behaviors and non-disclosure of HIV serostatus (Hutton, Misajon and Collins 2013). This study was therefore designed to assess the level of satisfaction with life when living with HIV, examine the personal well-being of individuals living with HIV and identify the impact of HIV on satisfaction with personal relationships among people living with the virus in Maiduguri Metropolis.

Research Hypothesis

The researchers tested the following hypothesis: There is no significant relationship between gender and subjective wellbeing when living with HIV.

METHODS AND MATERIALS

Research Design

The design used was a non-experimental descriptive survey design to enable the researcher to describe the impact 'felt' stigma has on subjective well-being when living with HIV.

Study Setting

The study was conducted in two HIV clinics in Maiduguri Metropolis. Maiduguri is located in North-eastern Nigeria, the ancestral home of the Kanuri's and ancient capital city of the defunct Kanem-Borno Empire. Maiduguri is a city and administrative center for Borno. It is located on latitude/longitude of: $N11^{0}50^{1}42.00^{11,}$ $E13^{0}9^{1}36.00^{11}$ (11.84500, 13.16000) and has a population of 1,112,449 according to National Bureau of Statistics, 2006. Maiduguri has the following amenities: International Airport, Central and Commercial Banks, Bureau de Change, Custom office, Markets, Fuel depot, Supermarkets, Taxi service, Telephone GSM services, Veterinary hospital and a Federal University just to mention but a few. The areas of interest in this setting are two HIV clinics within Maiduguri Metropolis. They include: Umaru Shehu Ultramodern Hospital (USUH) and General Mohammed Shuwa Memorial Hospital (formally called Nursing Home).

Sample and Sampling Technique

The target population in this study was people living with HIV who attend HIV clinics in Umaru Shehu Ultramodern Hospital and General Mohammed Shuwa Memorial Hospital. The total number registered and on drugs were 547 in Umaru Shehu Ultramodern Hospital and 425 at General Mohammad Shuwa Memorial Hospital making a total of 972 patients. 100 respondents were selected using systematic random sampling which is 10% of the total population (n = 100). The researcher chose this percentage as adopted by Christy and John (2009) who stated that when a population runs in hundreds, 10-30% should be used.

Instrument for Data Collection

Two standard instruments were used in this study for data collection: Personal Wellbeing Index Adult (PWI-A) and Satisfaction with Life Scale (SWLS). The PWI-A questionnaire was adopted from the International Wellbeing Group (2006) manual while the SWLS was adopted from Diener, Robert, Emmons, Randy, Larsen and Sharon (1985) as noted in the Journal of Personality Assessment. Both instruments were merged for the purpose of this study. The merged questionnaire was grouped into three sections: Section A: a structured demographic data, Section B: PWI-A which was a 9-item section designed to measure the respondents' abstract feeling of satisfaction as a whole and eight broad life domains: standard of living; personal health; achieving in life; personal relationships; feeling safe; community-connectedness; future security and spirituality or religion. Section C: SWLS was a short 5-item section designed to measure global cognitive judgments of satisfaction with life. The reliability of the instrument was pre-tested in HIV clinic at Federal Medical Center Keffi, Nasarawa State using a test re-test method. A Crombach alpha of 0.72 was determined which made the instrument fit for use in the study area.

Method of Data Collection

The researchers obtained approval from the research and ethical committee of both Umaru Shehu Ultramodern Hospital and General Mohammed Shuwa Memorial Hospital. 100 respondents were selected over a period of two week using systematic random sampling. Consent was obtained from the respondents after explanation of the purpose and objective of the research. The researchers then administered copies of the questionnaire directly to the literate clients, while those that were uneducated, the questions were interpreted for them to choose the right options. Out of the 120 copies of the

questionnaire served, only 100 were retrieved. The identities of the respondents remained anonymous throughout the study period. The retrieved copies of the questionnaire and responses were treated with confidentiality after retrieval.

Data Analysis

Data collected was analyzed with SPSS version 20. Descriptive statistics of frequency counts and percentages was used to answer research questions, while inferential statistics of chi- square was used to test the relationship between independent and dependent variables at 5% level of significance.

RESULTS

From Table 1 it is seen that 37% were between 18 and 25 years of age, 48% between the ages of 26 and 45 years, 11% of the respondents were between 46-55 years while 4% were between 56 and 60 years of age, there was no respondent above 61years. 31% were males while 69% were females with 38% practicing Christianity, 60% practicing Islam's (Muslims) and 2% were neither Christian nor Muslim. However, 62% of the respondents were married, 26% single, 8% divorced while 4% were separated. The table shows 29% of the respondents as self-employed, 12% as civil servants, another 12% as students and 47% as others of which majority identified themselves as housewives. 28% of the respondents had no child, 13% had 1 child, 23% with 2 children, 17% with 3 children and 19% of the respondents with 4 children and above respectively.

Table 1. Demographic distribution of the respondents

S/No	Variables	Frequency	Percentage (%)
1.	Age		
	18-25	37	37.0
	26-45	48	48.0
	46-55	11	11.0
	56-60	4	4.0
	61 and above	0	0
	Total	100	100.0
2.	Sex		
	Male	31	31.0
	Female	69	69.0
	Total	100	100.0
3.	Religion		
	Christian	38	38.0
	Islam	60	60.0
	Others	2	2.0
	Total	100	100.0
4.	Marital status		
	Married	62	62.0
	Single	26	26.0
	Divorced	8	8.0
	Separated	4	4.0
	Total	100	100.0
5.	Occupation		
	Self employed	29	29.0
	Civil servant	12	12.0
	Student	12	12.0
	Others	47	47.0
	Total	100	100.0
6.	No of children		
	None	28	28.0
	1	13	13.0
	2	23	23.0
	3	17	17.0
	4 and above	19	19.0
	Total	100	100.0

Table 2. Response of respondents to Personal Well-being Index-Adult (PWI-A)

S/No	Variables	Frequency	Percentage (%)
1.	"Thinking about your life and personal circumstances, how satisfied are you with your life as a whole?"	0	0.0
	Completely dissatisfied	12	12.0
	Dissatisfied	22	22.0
	Neutral	50	50.0
	Satisfied	16	16.0
	Completely satisfied	100	100.0
	Total		
2.	"How satisfied are you with your standard of living?"	0	0.0
	Completely dissatisfied	9	9.0
	Dissatisfied	10	10.0
	Neutral	62	62.0
	Satisfied	19	19.0
	Completely satisfied	100	100.0
	Total		
3.	"How satisfied are you with your health?"	2	2.0
	Completely dissatisfied	9	9.0
	Dissatisfied	12	12.0
	Neutral	67	67.0
	Satisfied	10	10.0
	Completely satisfied	100	100.0
	Total		
4.	"How satisfied are you with what you are achieving in life?"	1	1.0
	Completely dissatisfied	12	12.0
	Dissatisfied	12	12.0
	Neutral	63	63.0
	Satisfied	12	12.0
	Completely satisfied	100	100.0
	Total		
5.	"How satisfied are you with your personal relationships?"	0	0.0
	Completely dissatisfied	5	5.0
	Dissatisfied	9	9.0
	Neutral	64	64.0
	Satisfied	22	22.0
	Completely satisfied	100	100.0
	Total		
6.	"How satisfied are you with how safe you feel?"	2	2.0
	Completely dissatisfied	18	18.0
	Dissatisfied	11	11.0
	Neutral	69	69.0
	Satisfied	0	0.0
	Completely satisfied	100	100.0
	Total		
7.	"How satisfied are you with feeling part of your community?"	0	0.0
	Completely dissatisfied	12	12.0
	Dissatisfied	11	11.0
	Neutral	69	69.0
	Satisfied	8	8.0
	Completely satisfied	100	100.0
	Total		
8.	"How satisfied are you with your future security?"	1	1.0
	Completely dissatisfied	11	11.0
	Dissatisfied	13	13.0
	Neutral	62	62.0
	Satisfied	13	13.0
	Completely satisfied	100	100.0
	Total		
9.	"How satisfied are you with your spirituality or religion?"	1	1.0
	Completely dissatisfied	3	3.0
	Dissatisfied	4	4.0
	Neutral	42	42.0
	Satisfied	50	50.0
	Completely satisfied	100	100.0
	Total		

From the Table 2, none of the respondents were completely dissatisfied with their lives as a whole, 12% were dissatisfied,

22% were neither satisfied nor dissatisfied, 50% were satisfied and 16% completely satisfied. Looking at satisfaction with their standard of living, none was completely dissatisfied with his/her standard of living, 9% dissatisfied, 10% neither satisfied nor dissatisfied, 62% of the respondents were satisfied with their standard of living and 19% completely satisfied respectively.

In their personal relationships, no one was completely dissatisfied (0%), 5% were dissatisfied, 9% neutral, 64% satisfied and 22% being completely satisfied. However, 2% were completely dissatisfied with their safety, 18% dissatisfied with how safe they feel, 11% neither feels safe nor unsafe, 65% feels satisfied with their safety and no respondent feels completely satisfied.

Table 3: Response of respondents to Satisfaction with Life Scale

S/N	Variables	Frequency	Percentage (%)
1.	In most ways, my life is close to my ideal		
	Strongly agree	2	2.0
	Agree	11	11.0
	Slightly agree	4	4.0
	Neither agree nor disagree	17	17.0
	Slightly disagree	24	24.0
	Disagree	26	26.0
	Strongly disagree	16	16.0
	Total	100	100.0
2.	The conditions of my life are excellent		
	Strongly agree	5	5.0
	Agree	13	13.0
	Slightly agree	19	19.0
	Neither agree nor disagree	16	16.0
	Slightly disagree	15	15.0
	Disagree	24	24.0
	Strongly disagree	8	8.0
	Total	100	100.0
3.	I am satisfied with my life		
	Strongly agree	3	3.0
	Agree	11	11.0
	Slightly agree	12	12.0
	Neither agree nor disagree	17	17.0
	Slightly disagree	17	17.0
	Disagree	23	23.0
	Strongly disagree	17	17.0
	Total	100	100.0
4.	So far I have gotten the most important things I want		
	Strongly agree	7	7.0
	Agree	21	21.0
	Slightly agree	16	16.0
	Neither agree nor disagree	16	16.0
	Slightly disagree	17	17.0
	Disagree	16	16.0
	Strongly disagree	7	7.0
	Total	100	100.0
5.	If I could live my life over, I would change almost nothing		
	Strongly agree	59	59.0
	Agree	12	12.0
	Slightly agree	8	8.0
	Neither agree nor disagree	5	5.0
	Slightly disagree	2	2.0
	Disagree	9	9.0
	Strongly disagree	5	5.0
	Total	100	100.0

Table 4: Cross tabulation of gender and SWB

Gender (sex)	Subjective wellbeing					Total	Statistics	Remark
	Completely dissatisfied	Dissatisfied	Neutral	Satisfied	Completely satisfied			
Male	0	12	19	0	0	31	FET=	Not significant
Female	0	0	3	50	16	69	95.692	
Total	0	12	22	50	16	100	DF=4 P=0.000	

According to their response on satisfaction with health, 2% responded with complete dissatisfaction, 9% dissatisfied, 12% neutral, 67% responded as satisfied and 10% were completely satisfied. 1% of the respondents were completely dissatisfied with their achievements in life, 12% were dissatisfied, neutral and completely satisfied each and 63% were satisfied with their achievements in life.

No respondent was completely dissatisfied with feeling of being part of the community, 12% feels dissatisfied, 11% were neutral, 69% are satisfied and 8% were completely satisfied. Out of a 100%, 1% was completely dissatisfied with his/her future security, 11% dissatisfied, 13% neutral, 62% satisfied and 13% felt completely satisfied with their future security. Finally, based on satisfaction with spirituality or religion, 1%

felt completely dissatisfied, 3% dissatisfied, 4% were neutral towards their spirituality, 42% of the respondents were satisfied and 50% felt completely satisfied. Table 3 posed a statement: "in most ways, my life is close to my ideal", of which 2% of the respondents strongly agreed with the statement, 11% agreed, 4% slightly agreed, 17% neither agreed nor disagreed, 24% slightly disagreed, 26% disagreed while 16% of the respondents strongly disagreed with the statement.

The response of the respondents to this statement: "the conditions of my life are excellent" reveals that 5% strongly agreed with the statement, 13% agreed, 19% slightly agreed, 16% neither agreed nor disagreed, 15% slightly disagreed, 24% disagreed and 8% strongly disagreed respectively. 3% of the respondents strongly agreed to this statement "I am satisfied with my life", 11% agreed, 12% slightly agreed, 17% neither agreed nor disagreed,17% slightly disagreed and strongly disagreed each while 23% disagreed with the statement. "So far I have gotten the important things I want" was a statement strongly agreed by 7% of the respondents, 21% agreed, 16% slightly agreed, neither agreed nor disagreed and disagreed each with the statement. 17% slightly disagreed and 7% strongly disagreed. Finally, respondents responded to this statement; "if I could live my live over, I would change almost nothing" with 59% strongly agreeing to the statement, 12% agreed to the statement, 8% slightly agreed, 5% neither agreed nor disagreed, 2% slightly disagreed, 9% disagreed and 5% strongly disagreed respectively.

Testing of Hypothesis

There is no significant association between gender and subjective well-being when living with HIV in Maiduguri Metropolis.

From table 4, the calculated p value of 0.00 is less than 0.05 at 4 degree of freedom; hence the null hypothesis is accepted, meaning that there is no significant relationship between gender (sex) and subjective wellbeing.

Discussion of Findings

From this study it was revealed that majority of the people living with HIV who attend HIV clinics were between the ages of 26-45years. This may be because this age range is a sexually active period where both male and female will like to settle down in marriage or those that are not married would like to satisfy their sexual urge and as such are predisposed to indiscriminate and unsafe sex which is one of the routes of transmission of HIV. It was also observed in this study that majority of the respondents were females resulting to 69% of the total respondent, the researchers deduced that this may possibly be due to the fact that: men are known to shy away from attending the clinic in the study area visa vie their refusal to partake in the study.

It may also be because of the acceptance of men to marry more than a wife in this environment which increases the risk of infection and conversely increase in the number of women attending the clinics. Finally it may also not be unconnected to the careful attitude of women in general which stimulates them to seek medical help when confronted with health challenges.

Assessing the level of satisfaction with life among people living with HIV in Maiduguri Metropolis, a large percentage disagreed with being satisfied with their lives, this is in consonant with the findings of Stanley, Sethuramalingam and Sathia (2013), who conducted a study on life satisfaction and pessimism in HIV positive people, the life satisfaction scale showed highly significant negative correlations with the overall hopelessness score and its sub-dimension. With this, it can be deduced that there is a level of dissatisfaction with life when living with HIV. Test of hypothesis also showed no statistical significance between gender and subjective wellbeing of people living with HIV in the study population. This implies that gender has no influence on the subjective wellbeing of people living with HIV. This high level of dissatisfaction with life could be as a result of strict adherence to daily HAART (Highly Active Anti-Retroviral Therapy), low immunity, perceived stigma and feelings of disappointment.

Furthermore, the study revealed that for each item in the abstract feeling of satisfaction, respondents were satisfied with, life as a whole, standard of living, health, achievement in life, personal relationships, personal safety, community connectedness and future security with an increase in satisfaction with spirituality or religion of which majority expressed as complete satisfaction. These findings were completely at variance with Hutton, et al, (2013), who reported mean PWI-A total scores of 54.7, considerably below the normative range of 70–80 for Western populations. A probable reason for the increase in the abstract feeling of satisfaction in this study area may be because of the religious perception of the people in this location, expressing a form of contentment with whatever they face in life either good or bad irrespective of the discomfort it may have on their lives.

The impact of HIV on personal relationships when living with HIV in Maiduguri Metropolis revealed a large percentage (64%) as being satisfied with their personal relationships, this finding is at variance with, Herrmann, McKinnon, Hyland, Lalanne, Mallal, Nolan, Chassany and Duracinsky (2013). Who conducted a study using interview method. Herrmann et al reported the long standing difficulties of living with HIV, particularly in the domains of intimate relationships, perceived stigma and chronic ill health. The analysis showed that psychological distress was a major influence on Health Related Quality of Life (HRQL) in their cohort. On the contrary, majority of the respondents in this study proves to have satisfaction with their personal relationships despite living with HIV, it was deduced that a possible reason for their satisfaction may be as a result of keeping their condition secret with no one getting to know except their spouse and health workers.

Conclusion

The PWI-A instrument shows a significant positive response to personal wellbeing which means that the respondents has good abstract feeling of satisfaction with their lives and as such could cope with the disease. However, the respondents cognitive judgment of satisfaction with life reveals disagreement with having a close to ideal life, conditions of their lives being excellent and satisfaction with life, an agreement with getting the most important things they want and a strong agreement with changing almost nothing, if live is

lived over again when living with HIV. With the abstract feeling of satisfaction, felt stigma had a no negative impact on subjective wellbeing (SWB), while with the cognitive judgment of satisfaction with life, felt stigma had a negative impact on SWB of people living with the disease.

Recommendations

To bring about a smile on the face of a person with HIV (SWB), stigmatization has to stop. When there is no longer stigmatization, then there will be no room or feeling stigmatized (felt stigma). The following are recommended to achieve the above:

- The public should be encouraged on early screening and genetic counseling before marriage.
- The entertainment industries (advertisement and home videos) should depict people living with HIV as those who can live normal lives not always sickly or unhealthy.
- Free drugs should be readily available in the clinics either by government or non-governmental authorities.
- Professionals in psychology should be invited from time to time to the clinic for counseling of saddened and hopeless clients.

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