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PSYCHOLOGIA

THE SOCIAL-PSYCHOLOGICAL CONSEQUENCES OF HIV/AIDS STIGMATIZATION ON SOCIAL RELATIONS IN NIGERIA

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Abstract

As HIV/AIDS continues to ravage sub-Sahara Africa, questions about the Social-Psychological effects of the pandemic affecting social relationship and networks have become pronounced. People's behavioural response to the disease and relationship with victims is often shaped by their beliefs, values and social expectations about appropriate behavioural dispositions. Despite the increasing knowledge and awareness that people have concerning HIV/AIDS and its mode of transmission, discrepancies still exist regarding the attitudinal and behavioural responses of members of the society to HIV/AIDS victims. This paper seek to examine the socio-cultural and psychological dynamics underlying this attitudinal disposition and the consequences it has on the quality of life of victims and their responses to the infection. The paper concludes that the increased stigmatization and discrimination surrounding HIV/AIDS infection is exacerbated by its being the object of intense moral scrutiny which must be redressed by pragmatic legislations.

The problem with the truth is that it is mainly uncomfortable and often dull.
-H. L. Mencken

Introduction

Since the first HIV/AIDS case was diagnosed in 1981 in the United States, the world has struggled to come to grips with its extra-ordinary dimensions particularly as it affect social relationships between persons infected with HIV and the non-infected members of the society (both in the formal/informal

sectors). So malevolent is the threat that the economic prospects and social stability of entire regions are at risk, which is seriously affecting the quality of life of victims and in many other cases seriously damaging the fabric of societies. HIV/AIDS represents both a medical and social problem of monumental proportion.

While various efforts are on-going in most quarters-including national governments, international organizations and private sector groups like WHO, UNAIDS, UNFPA,UNICEF, NGOs etc on ways to fight the epidemic through the provision of treatment, prevention and care; however, one issue that has remain a major challenge in the fight against the spread of HIV/AIDS relates to the question of behavioural disposition, reaction and responses of members of society in relating to and with HIV/AIDS victim in all walks of life (family, schools, hospitals, workplace, church etc).This situation have led to various incidences of stigmatization and discrimination against infected persons which is a serious violation of their fundamental rights that have had serious implications for controlling the scourge of the infection around the world, particularly in Africa.

This paper therefore seek to examine the social psychological dynamics of HIV/AIDS stigmatization and discrimination against infected persons and the social consequences it has on their quality of life, social relationship with members of society and the management of the infection itself. To achieve this purpose the paper will be divided into the following sections. The first part will look at the history of HIV/AIDS pandemic in Nigeria. Part two would address the culture of sexuality in the Nigerian society. The third section discusses the theoretical underpinnings that underlie the problematic of stigmatization and discrimination associated with social relations, particularly as it relate to HIV/AIDS stigmatization and discrimination. Part four deals with the social- psychological consequences of HIV/AIDS stigmatization on victims. The final section provides the conclusion and make recommendations on ways of redressing the trend as it relate to the exhibition of appropriate behavioural and attitudinal dispositions toward HIV/AIDS victim.

History of HIV/AIDS in Nigeria

With the incidence of HIV/AIDS remaining a serious public health threat affecting all segment of the world's population, the continent of Africa had not faired better, with nearly 30 million people having the virus—including 3million children under the age of 15(USAID, 2005).With the first case of HIV/AIDS in Africa reported in Kenya in 1984, the epidemic has assumed a worrisome

dimension that it does not only affect the health and living conditions of the people, their social relations with one another, but also the overall manpower development of the continent with 20 to 40% of people aged 15-49 living with the HIV, of which a third are youths, while about 5.8% is living with the HIV/AIDS in Nigeria(UNAIDS 2002; Stover and Bollinger 2002:23-27). The first case of HIV/AIDS in Nigeria was reported in Lagos and Enugu, in 1986, among prostitutes, including a 13 year old girl, through vaginal sexual intercourse (Halimah, 2003:99).

Although the numbers and trajectory of Nigeria's epidemic are difficult to predict due to underreporting as a result of lack of diagnostic facilities and people's unwillingness to give in for voluntary test, few experts would dispute that, given the current trend of spread and Nigeria's massive population, in the next ten to fifteen years Nigeria will have the largest number of people living with HIV/AIDS of any country in Africa (Panchaud.C.V.W., S. Singh, J.E. Darroch and A. Bankole 2002:11-29). The lack of good data is indeed very worrisome and this perhaps contributes both to official and popular neglect of the potential magnitude of the public health, social, economic and political implications of the epidemic. The major route of HIV/AIDS transmission is through heterosexual intercourse, accounting for 85% of infected persons. Other high prevalence routes occur among commercial sex workers, patients transfused with unscreened blood, patients with STD, tuberculosis, mother to child in pregnancy, childbirth or breast-feeding, psychiatric disorders, and long distance truck drivers and prisoners etc. The peak age of infection is 15-25 years, with female preponderance in both rural and urban areas, thus reflecting promiscuity and careless unsafe sexual disposition.

Given the spread of the HIV/AIDS epidemic in Nigeria, the impact is bound to have socio-economic consequences on the society as it affect the sexually active, highly educated and economically productive members of communities, resulting in the loss of able manpower and productivity. Today, the National Action Committee on AIDS (NACA) in collaboration with the Federal ministry of health and other international agencies like WHO, UNICEF, USAID etc coordinates activities in combating the HIV/AIDS scourge in Nigeria.

The Culture of Sexuality in Nigeria

As the old sayings goes, birds do it and so do bees. Nature tends to offer us many striking insight about mating in the animal and human world. However, regarding sexuality, human beings

remains the only creatures who attach meanings to all behaviour, what they 'do' when it comes to sex varies quite a bit from culture to culture, as does over time. Sexuality as a theme is found throughout society and in all walks of life. It is an important part of how we think about ourselves as well as how we evaluate others. Sex has a biological foundation, but like all dimensions of human behaviour, it is very much a cultural issue. Sexual attraction and expression are complex experiences, shaped by culture, learned through socialization and sanctioned within social networks (Simon and Gagnon, 1986).

Around the world, some societies tend to restrict sexuality, while others are more permissive. In time past, our cultural norms tend to regulate sexuality so that a few people have sexual intercourse before they marry. Besides, in most Nigerian culture, sex conduct was viewed as an important indicator of personal morality. Sex has been a cultural taboo which people don't talk about. For example, Girls in particular are often reluctant or unable to enquire about sex for fear of being considered morally 'loose'. But today, sex is exploited and glorified everywhere in most culture-intercourse before marriage has become the norm, and people may choose to have sex even when there is no strong commitment between them.

The incidence of HIV/AIDS pandemic in Nigeria can best be understood in terms of the people's behavioural responses to the disease as shaped by their beliefs, values, and social expectations about appropriate fertility behaviour. The threads that tie attitudes and beliefs about sexual behaviour related to HIV/AIDS are multiple and intertwining and sometimes run in contradictory directions. The desire for reproduction is an obvious barrier to condom use and to HIV prevention within marriage. On the one hand, parents, family and religious messages assert that sex before marriage is immoral; on the other hand, pre-marital sexuality is associated with modern, educated urban life styles.

Furthermore, in Nigeria, as in many other societies, poverty, unequal gender dynamics creates additional pressures for people, especially young women who have to rely on sexual relationships for access to resources (Smith 2002:4-23; Parikh. 2004). Clearly, some people who may wish to abstain from sex or who might want to protect themselves with condoms during sex are unable to do so because of economic circumstances and gender inequality (Schoef 1996; 1997; Farmer 1999). When people are poor and unemployed, they feel hopeless, and the drive to engage in risky sexual behaviour is high.

Theories of Social Relations and Stigmatization

Social Science scholars have argued that a person's behaviour is mostly a reflection of the situation he happens to be in. Inherent in the situation are the social forces that shape and determine his behaviour at any given moment, although it is recognized that his previous experience with such situations has predisposed him to act in certain ways in the particular circumstances. Understanding issues that underlie stigmatization and discrimination against HIV/AIDS victim can be situated within the context of Social relations theory which the Symbolic Interactionist perspective provides us the broad understanding by focusing on social interaction in specific situations. The paradigm asserts that through social interaction we create the reality in which we live, in terms of how people act and react in relation to others. According to "Thomas theorem" of W.I. Thomas (1966:301; orig.1931): Situations that are defined as real are real in their consequences. It is this social structure of society that guides our social interaction and relationships.

The conceptual framework for understanding HIV/AIDS Stigmatization and Discrimination (S&D) is to see it as a product of social processes which can only be challenged and addressed by social action. The dominant definition that describes stigma as a "discrediting attribute" and stigmatized individuals are those who possess an "undesirable difference" and ignores aspects that describe stigma as something that is socially constructed (Goffman, 1963: Marshall, 1998). This paper do therefore emphasize the need for us to go beyond limiting our analysis of the underlying causes and possible responses to HIV/AIDS S&D as an individual processes or as what some individuals do to other individuals. As social processes, S&D are used to create and maintain social control and to produce and reproduce social inequality. So all cultural meanings and practices embody interests and are used to enhance social distinctions between individuals, groups, and institutions. Stigmatization and discrimination do not only help to create differences, but also plays a key role in transforming differences based on class, gender, ethnicity or sexuality into social inequality.

Accordingly, Goffman (1967) in his dramaturgical analysis saw social relations and interaction in terms of theatrical performance. He describes each individual's performance in social life as the presentation of self, which involves an individual's effort to create specific impression in the minds of others- a process he called impression management. which has several distinctive elements. For

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as we present ourselves in everyday situations, we convey information- consciously and unconsciously to others. It is the definition of the situations that control our behaviour. Furthermore Goffman (1963) in analyzing stigmatization was interested in looking at the gap between "what a person ought to be and what a person actually is." It is when there is a gap between these two identities that a person is stigmatized. Stigmatization, therefore, is a powerful negative label that greatly changes a person's self-concept and social identity. The issue with stigmatization results from the problem of managing the tension produced by the fact that people know of the problem being stigmatized such as HIV/AIDS.

Stigmatization in the case of HIV/AIDS infection by victim carries a moral blemish that attaches a deviant characteristic, which becomes a "master status" trait through which all other perceptions are filtered. This stigma overpowers other aspect of social identity so that a person is discredited in the minds of others, becoming socially isolated, which eventually leads to discrimination. Thus HIV/AIDS victims in the community most often stand to be labelled in a negative rather than in a positive way. Once people stigmatize an individual, they may engage in retrospective labeling, interpreting someone's past in the light of the present happenings (Scheff, 1984). Once applied, stigma can have a powerful effect on the individual, as is often seen in the case of people living with HIV/AIDS (PLWHA), who are unable to overcome negative attitudes of other people despite efforts to cope with the infection (Link, B.G., J. Mirotznik and F.T. Cullen 1991).

AS for Garfinkel (1967) the process of stigmatization emanate in terms of how we build reality from our surrounding culture. He argues that the only way we can make sense of events is to purposely break the rules. By deliberately ignoring conventional rules and observing how people respond, we "tease out" how people build a reality. Mead (1962, orig.1934) in his conceptual analysis of the "Self" argues that an individual's personality is composed of self-awareness and self image. The self is a product of social experience which develops only as the individual interact with others. Social interaction and relationships involves seeing ourselves as others see us- a process Mead termed taking the role of the other. Understanding intentions requires imagining the situation from the other's point of view.

HIV/AIDS stigmatization and Discrimination (S&D) represents a "mirror" through which HIV/AIDS victim see themselves in terms of what people think of them. HIV/AIDS S&D is

therefore a means by which people living with the virus becomes self-aware of their immediate social environment and relationships with others. Social life demands that we see ourselves in terms of cultural norms as anyone else might. Mead used the term "generalized other" to refer to widespread cultural norms and values we use as reference on evaluating ourselves. Local cultural beliefs and explanations about disease and the causes of disease may contribute to HIV/AIDS related stigmatization and discrimination. Thus HIV/ AIDS epidemic is replete with evidence of the stigmatization associated with the disease. For example, where illness is believed to be the result of "immoral" or improper behaviour, HIV/AIDS S&D may reinforce existing stigma of those whose behaviour is considered to be "deviant"(Warwick , I. and Aggleton, P. 1998).

Analyzing the Social Psychological Consequences of HIV/AIDS Stigmatization and Discrimination

Understanding the political, economic, socio-cultural and psychological mechanisms underlying the discrepancy between knowledge and behavioural change with regard to HIV/AIDS stigmatization and discrimination, and designing effective interventions to address this discrepancy are among the most important challenge for scholars and public health practitioners interested in preventing the spread of HIV/AIDS (Caldwell, J.C., I.O. Orobuloye, and P. Cadwell; 1999; Caldwell 1999).

HIV/AIDS stigmatization and discrimination analysis are basically linked to the actions and attitudes of families, communities, and the societies (UNAIDS, 2000).Therefore an examination of the processes of HIV/AIDS stigmatization and discrimination (S&D) must take account of the social, cultural, political, and economic determinants prevalent in the society. HIV/AIDS Stigmatization and discrimination in the Nigerian context are linked to the actions and attitudes of families, communities and societies, whose impact do take different forms and are manifested at different levels- individual, communities, societal and in different contexts (Ibid). The key factors contributing to the incidence and perpetuation of stigmatization and discrimination include ignorance and fear, moral attitudes, cultural values, religious teachings, the absence of legal sanctions, lack of rights awareness, the design of government, and NGOs programmes, and inaccurate and/or irresponsible media coverage. Furthermore, HIV stigma and discrimination are often entangled with the discrimination attached

to being a woman, being poor, having a different and irresponsible sexual orientation, engaging in sex work or drug use, and being in prison.

Most HIV/AIDS stigmatization and discrimination are related to sexual stigma. This is because HIV is mainly sexually transmitted and the epidemic is prevalent among populations whose sexual practices are different from the norm. HIV/AIDS S&D has therefore appropriated and reinforced pre-existing sexual stigma associated with sexually transmitted diseases, promiscuity, prostitution and sexual deviance (Gagnon and Simon, 1973; Plummer, 1975; Weeks, 1981). Most people see the issue of HIV/AIDS as a death sentence rather than a chronic disease syndrome. In social settings like Nigeria where heterosexual transmission is significant, HIV/AIDS stigmatization is linked to gender- related stigma.

The spread of HIV infection has mostly been associated with female sexual behaviour that is not consistent with gender norms. For example, prostitution is widely perceived as a non-normative female behaviour, and female sex workers are often identified as "vectors" of infection that put at risk their clients and their clients' sexual partners. This impact of HIV/AIDS stigmatization on women reinforces pre-existing economic, educational, cultural, and social disadvantages and unequal access to information and services (Aggleton and Warwick, 1999). Equally, in many other settings, men are also blamed for heterosexual transmission of HIV/AIDS given men's behaviour regarding their preference for multiple sex partners.

While it is crucial to state here that the incidence of HIV/AIDS epidemic occurred during a period of rapid globalization and growing polaralization between the rich and poor. New forms of social exclusions associated with these global changes have reinforced pre-existing social inequalities and stigmatization of the poor, homeless and jobless. As a result, poverty which is prevalent in Africa continent has been seen as a major factor that increases vulnerability to HIV/AIDS and HIV/AIDS exacerbates poverty (Parker, R.G., D. Easton, and C. Klein, 2000). HIV /AIDS stigmatization and discrimination is therefore the result of interaction between diverse pre-existing sources of stigmatization and discrimination and fear of contagion and disease. This interaction has contributed to the deep- rooted nature of HIV/AIDS S&D, which exacerbates the stigmatization of individuals and groups who are already oppressed and marginalized, thus increasing their vulnerability to HIV, and which in turn causes them to be further stigmatized and marginalized.

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At the context of the individual, the way HIV/AIDS S&D are manifested depends on family and social support and the degree to which people are open about issues as their sexuality as well as their serostatus. Because HIV/ AIDS is highly stigmatized, fear of its stigma may and do cause individuals to isolate themselves to the extent that they no longer feel part of civil society and are unable to gain access to the support, care and services they need. In extreme cases inability to bear the trauma of S&D often result in people committing suicide. In family settings, negative family responses to HIV/AIDS victim which ordinarily should provide care and support for people living with HIV, has made many people choose not to know or reveal their serostatus. Infected individuals often experience S&D in the home, and women are likely often to be badly treated than men or children. Negative family responses to victim include blame, rejection, and loss of children and home especially for women. Besides, families may reject people living with HIV not only on the ground of their HIV status, but also because HIV is associated with promiscuity, homosexuality and drug abuse.

Similarly, HIV/AIDS related stigmatization and discrimination has been reinforced by religious leaders and organizations, which have used their power to maintain the status-quo rather than challenge negative attitudes toward marginalized groups and PLWHA. It is noted that religious doctrines, moral and ethical positions regarding sexual behaviour, sexism and denial of the realities of HIV/AIDS have helped create the perception that those infected have sinned and deserve their "punishment," thus increasing the stigma associated with HIV/AIDS (Singh 2001).

Furthermore the type of cultural system that exist in a society and where it fits within the continuum of individualism and collectivism influences the ways in which communities respond to HIV/AIDS and the way stigmatization is manifested. In some cultural system that emphasizes individualism, HIV is perceived as a result of irresponsibility. In contrast, in societies where cultural systems place greater emphasis on collectivism, HIV/AIDS is perceive as bringing shame on the family and community (PANOS 1990).

Also at the level of governmental institutions, the failure of the state to protect the rights, confidentiality of PLWHA through legislation or to enforce existing legislations has been described as a form of discrimination and neglect. This has resulted in the lackluster attitude toward the provision of effective prevention, treatment and care to persons most vulnerable to HIV/AIDS

especially children and for PLWHA. In the same vein, stigmatization and discriminatory practices have been reported in developed and developing countries, where persons have lost their job or being denied employment for testing positive for HIV. Reports of S&D from health settings of HIV/AIDS testing without consent from patients, breaches of confidentiality, and denial of treatment and care to PLWHA permeates our society. These incidences do greatly undermine prevention, care and treatment efforts and increase the impact of the epidemic on individuals, families, communities and nations.

In all the social psychological consequences of HIV/AIDS stigmatization and discrimination is powerful and pervasive because the disease is usually closely associated with such fundamental issues as life and death, sex and sexuality, and morality. To begin with, HIV/AIDS Stigmatization and discrimination affect every one especially from children to women with HIV/AIDS who are particularly vulnerable to violations of their social, property and inheritance rights. Besides social exclusion from social relations and interaction, the basic rights of PLWHA to health, housing, education and employment benefits are greatly abused. Families and communities can fall apart as a result of HIV stigmatization, the infection do also lead to increases in infant mortality and orphaned children. At the economic level, increases in adult infection and fatality can reduce national growth and income.

Furthermore HIV/AIDS stigmatization and discrimination impact is particularly damaging on the poorest and most vulnerable individuals and groups in society, many of whom are already disadvantaged and discriminated against- i.e. prostitute, orphans, injecting drug users etc. Stigmatization at the societal level can lead to silence and denial- refusal to acknowledge and deal with HIV/AIDS. This reinforces ignorance, and fear, allowing for prejudice to thrive, risky behaviour to go unchallenged and uncaring behaviour to go unchanged. It also ensures that some of the key stakeholders in the response to HIV/AIDS, people living with HIV/AIDS (PLWHA) and their families, to remain silence and sidelined.

These experiences contribute to a climate of apprehension where people are afraid to discover, let alone disclose their HIV/AIDS status, which prove a major barrier to effective prevention, care, and support. It is the combination of these issues together with the intensity that makes it difficult for those affected with HIV to

overcome the impact of HIV/AIDS related stigmatization and discrimination in managing their emotional and physical health.

Conclusion

It is evident from the foregoing discourse that stigmatization, silence, denial, discrimination as well as lack of confidentiality are fundamental issues that greatly undermine prevention, care, and treatment efforts, which increases the impact of the HIV/AIDS epidemic on individuals, families, communities and nations. The challenge now is that we must all work together to reduce the stigma of HIV/AIDS and deal with the many severe problems that it causes at the community, national and international levels.

Reducing the stigma against PLWHA through education is the key to developing effective prevention and care responses to the spread of HIV/AIDS. This must begin through the use of social action taken by people living with HIV/AIDS towards resisting the forces that discriminate against them. This can be done through rigorous mobilization and networking of social movements, at the community, national and international levels aimed at achieving social change rather than just individual behavioural change. Priority should be given to approaches and interventions that aim to strengthen capacity for resistance among stigmatized and marginalized groups.

Greater efforts should be made by governments at all levels, civil society organizations and NGOs in their campaigns and enlightenment to empower and integrate fully the positive perceptions of people living with HIV/AIDS, and support the demand and recognition of their existence, needs and rights through enforceable legislations. This is fundamentally crucial in that People living with HIV understand each other's situation better than anyone and are often best placed to counsel and advise one another and to represent their needs in decision- and policy-making forums. Such activities designed to empower marginalized groups should complement on-going efforts to change individual and community attitudes toward PLWHA and those affected by the epidemic through media campaigns that helps to promote tolerance and compassion.

Most fundamentally, the problem of economic underdevelopment that breed poverty which exacerbate susceptibility to various infections including HIV/AIDS and gender inequalities should be tackled by the various governments in Africa through the adequate provision of social and health services at all levels. Integrating voluntary and counseling test into sexual and

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reproductive health services and incorporating compulsory HIV/AIDS education programmes into school curriculum both at the secondary and tertiary levels can help reduce the stigma associated with HIV/AIDS, strengthen healthy sexual behaviour and increase access to and use of health services.

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Acronyms

AIDS	Acquired Immune Deficiency syndrome
HIV	Human Immunodeficiency Virus
NACA	National Action Committee on AIDS
NGO	Non Governmental Organization
PLWHA	People Living with HIV/AIDS
S & D	Stigmatization and Discrimination
UNAIDS	United Nations Joint Programme on HIV/AIDS
UNESCO	United Nations Economic, Social and Cultural Organization
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
USAID	United State Agency for International Development
WHO	World Health Organization