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Psychosocial Implications of Visual Loss among Destitutes in Onitsha, Nigeria

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ABSTRACT

Background: Visual loss and psychosocial problems of destitute have not been well studied in our environment. Many scholars have identified various attribute of poverty including poor health as important factors that drive people into destitution. **Objectives:** To assess the relationship between psychologic disorders and visual loss among destitute in order to provide useful data for planning social, mental and eye health services for the destitute. **Materials And Methods:** This study was approved by the Ethics Committee of NAUTH Nnewi. It was a cross-sectional study conducted among destitute in Onitsha between July and August 2011. Destitute clusters were identified, enumerated and 10 clusters selected by a simple random sampling. All participants in the selected clusters were interviewed and examined using a structured interviewer-administered questionnaire. A Focus Group Discussion (FGD) was also conducted to obtain more information. SPSS version 16 and chi-square tests were used for data analysis. **Results:** One hundred and sixty-eight participants were studied, consisting of 93 males (55.4%) and 75 females (44.6%) and the age range was 11-78 years; mean 38.2± 21 years. Majority did not have formal education; none was employed; one hundred and fifty-eight (94.0%) earned less than one United States dollar per day. All were street beggars. Stigmatization 146(86.9%), depression 142(84.5%) and verbal abuse 120(71.4%) were the commonest psychosocial problems. **Conclusion:** Although All The Subjects With Severe Visual Loss Had Psychosocial Disorders, This Was Not Statistically Significant. Stigmatization, Depression And Verbal Abuse Were The Commonest Psychosocial Problems.

Keywords: Psychosocial, Visual loss, Destitute, Nigeria.

INTRODUCTION

Visual loss and psychosocial problems of destitute are important public health issues in our environment. However some scholars have examined the various factors that put people at risk of destitution.[1-4]Poverty remains an important factor that drives people to destitution. Mosley and Verchio identified attributes of poverty such as poor health, lack

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of education, lack of skill, lack of self-confidence or support mechanism, lack of physical asset or borrowing power, and malnutrition.[5] As a result, the poor are trapped in the situation with little chance of escape such that a vicious cycle process of poverty is maintained among the poor across the generations.[6] Extreme poverty could be a cause and as well a consequence of physical disabilities such as visual loss. This situation could tip an individual into a vicious cycle of severe depression, lack of will or zeal to cope with daily socioeconomic challenges of life, loss of job and unemployment. Eventually destitution is perpetuated as illustrated in Figure 1.

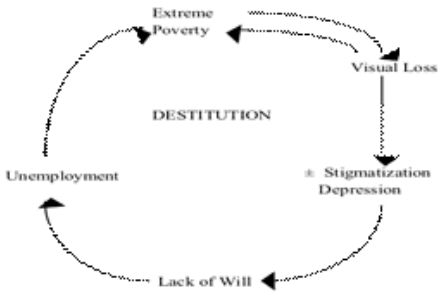

Figure 1: Destitution and influencing factors

Destitution describes a lack of the means to meet the basic needs of shelter, warmth, food, water and health.[7] It is commonly used to refer to the poverty experience of individuals without social, emotional and economic support and as such unable to cope with the basic challenges of daily life.[7]
Destitution is of global concern. The United Nations International Children Emergency Fund (UNICEF) representative in Nigeria observed in 1996 that poverty in Nigeria has been a long-standing issue and that 70% of households representing about 34 million Nigerians were officially recognized as poor.[8]

Among the American working families, 10 million are estimated to be poor or nearly poor.[2]About 15% of all American families and 32% of single parents lived below the Federal Poverty line in 2006.[9] Many families did not earn adequate wages and one fifth of all jobs in United States of America did not keep a family of four out of poverty.[10]

In most societies, destitution is high among the disadvantaged groups. Those mostly affected are women and children in both rural areas and urban slums. The destitute children are more than any group vulnerable to environmental and social influences like crime and violence.[11] Thapa *et al* studied health problems among street children of Dharran Municipality, Nepal and that 68.8% of the children between 11-15 years of age had one or more health problems. Up to 25% of these street children in Dharran had eye problems. In United States, the National Centre on Family Homelessness noted that children in destitution were sick four times more than other children; four times more likely to show delayed development and often ended with physical disabilities.[12]

Physical disability including visual loss is a major risk factor for destitution.[3] In a survey of 85,112 beggars in Kano, northern Nigeria, Sabo observed that 11.7% of the destitutes (beggars) had impaired vision.[3] In another study, Daniel classified 183 destitutes in Gbagada Lagos, Nigeria by their physical disabilities and up to 45.4% of the physical handicaps were represented by visual loss.[13]

The Nigerian National Blindness and Visual Impairment Survey conducted in 2009 estimated that 4.25 million adults aged 40 years and above in Nigeria had visual loss.[14] The World Health Organisation in 2017 estimated that 36 million people were blind while 217 million were visually impaired.[15] About 85% of all visual impairment was avoidable (preventable or curable) and 90% of blind people live in low-income countries where increasing poverty perpetuates destitution.[15] However psychosocial effects of visual loss among the destitute population have not been well studied.

The present study assessed the psychosocial consequences of visual loss among the destitute in Onitsha. The objectives included: To determine the

distribution of physical deformities among destitute in Onitsha, To determine the levels of visual loss among destitute in Onitsha, To determine the distribution of psychologic disorders among destitute in Onitsha, to assess the inter-relationship between mental and eye health of the destitute in our environment and to recommend relevant measures to minimise the ocular related psychologic disorders among these less privileged Nigerians.

MATERIALS AND METHODS

This study was approved by the Ethics Committee of Nnamdi Azikiwe University Teaching Hospital Nnewi. It was a cross-sectional study conducted among destitute in Onitsha, Anambra State, Nigeria between July and August 2011. Destitute clusters were identified and selected by a simple random sampling. A written informed consent was obtained from the participants and the same document transcribed to Igbo language and pidgin English was explained to the less educated ones before they thumb-printed. All subjects in the selected clusters were interviewed and examined using a pretested structured interviewer-administered questionnaire. Information was obtained on age, sex, marital status, educational attainment, length of destitution and distribution of psychological disturbances. Economic status was assessed through information on previous employment status, sources of social and financial support, possession of personal assets (like houses, land, cars, shares and business) and estimates of average monthly income in relation to needs. The estimated monthly income was then divided by 30 (30 days in 1 month) to obtain the estimated daily income of the subjects. Poverty was defined as a living below 1 USD per day. The August 2011 exchange rate of 1 USD = N153 (one hundred and fifty three naira) was used in the estimation.

A secondary data was obtained through a Focus Group Discussion (FGD), to get more information on the perception of the subjects. Ten participants, one from each cluster were randomly selected for the FGD. Information from the FGD was the data recorded on audiotape to capture all issues and transcribed into record sheets. Statistical Package for Social Sciences (SPSS) version 16 was used for data analysis. The statistical tests employed were Chi-Square and 95% Confidence Interval (95% CI) with significance level at 0.05.

RESULTS

There were ten clusters selected by a simple random sampling. One hundred and sixty-eight destitutes were studied, consisting of 93 males (55.4%) and 75 females (44.6%). The age range was 11-78 years; median- 45 years; interquartile range= 31-62 years. Nighty- eight (58.3%) participants were 40 years or older while 10 (6%) were < 16 years old. Ninety-five (56.5%) were single, 50 (29.8%) married, 13 (7.7%) widowed, 9 (5.4%) separated, and 1 (0.6%) divorced. One hundred and twenty-nine (76.8%) did not have formal education; 36 (26.4%) had primary education. None had tertiary education. One hundred and fifty-eight (94.0%) participants earned less than 1 United States dollar per day. None of the subjects received support from extended family, the government or non-governmental organisations; none was employed or had any personal asset. All the participants were street beggars. Ninety-eight (58.3%) participants have been in destitution for > 5 years, 50 (29.8%) for 2-5 years and 20 (11.9%) for < 2 years.

Table 1: Distribution of Physical deformities among destitute

S/ N	Physical Deformity	No	%
1	Ocular	56	33.3%
2	Cripple	37	22.0%
3	Leg Ulcer	4	2.4%
4	Hernias	3	1.8%
	Total	**100**	**100.0**

Table 1 shows the distribution of physical deformities among the participants. One hundred out of 168 destitute (59.5%) had physical deformity with 56 (33.3%) having ocular problems.

The presenting visual acuity in the better eyes of

twenty-one participants was < 3/60 giving a prevalence of 12.5% for blindness while seventeen participants had VA in the better eye < 6/18, with a prevalence of 10.2% for visual impairment. Cataract caused 9 (52.9%) of the visual impairment.

Table 2: Distribution of self-reported psychosocial disturbances

S/N	Phychosocial Disorder	NO	%*
1	Stigmatization	146	86.9
2	Depression	142	84.5
3	Verbal Abuse	120	71.4
4	Feels useless	76	45.2
5	Physical Abuse	60	35.7
6	Fear	54	32.1
7	Sleep-Wake Disorder	44	26.2
8	Indignation	24	14.3

** Percentage based on 168 participants, since some participants reported more than one psychosocial disorder.*

Table 2 shows the distribution of psychosocial disorders. Twenty-two (13.1%) participants did not report any psychosocial problems. Stigmatization 146 (86.9%), depression 142 (84.5%) and verbal abuse 120 (71.4%) were the commonest psychosocial problems.

Table 3: Visual impairment among the study participants

Visual status	No	%
Mild or no visual impairment (≥6/18)	130	77.3
Moderate visual impairment (<6/18 -6/60)	14	8.4
Severe visual impairment (<6/60 – 3/60)	3	1.8
Blindness (<3/60)	21	12.5
Total	168	100.0

Table 4: Self-reported psychological disorder versus visual impairment

	Psychological disorder No {%}**							
Visual status	Stigma (%)	Depression (%)	Verbal abuse (%)	Feels useless (%)	Physical abuse (%)	Fear (%)	Sleep disorder (%)	Indignation (%)
Mild or no VI* (≥6/18)	113(67.3)	106(63.1)	102(60.7)	43(25.6)	48(28.6)	33(19.6)	29(17.3)	13(7.7)
Moderate VI* (<6/18 - 6/60)	10(6.0)	12(7.1)	7(4.2)	10(6.0)	5(3.0)	12(7.1)	7(4.2)	4(2.4)
Severe VI* (<6/60 – 3/60)	2(1.2)	3(1.8)	1(0.6)	18(10.7)	2(1.2)	3(1.8)	1(0.6)	1(0.6)
Blindness (<3/60)	21 (12.5)	21(12.5)	10(6.0)	5(3.0)	5(3.0)	6(3.6)	9(5.4)	6(3.6)
Total	146(86.9)	142(84.5)	120(71.4)	76(45.2)	60(35.7)	54(32.1)	44(26.2)	24(14.3)

*VI = Visual impairment, * Some participants gave multiple responses ** Percentage based on 168 participants*

Although all the subjects with severe visual impairment and blindness had psychological disorders, this was not statistically significant (P> 0.05). A good proportion of the participants with mild or no visual impairment also had psychosocial disorders

The Focus Group Discussion (FGD) showed that all the destitutes beg for alms. Up to 100 (59.5%) of them believed eye problems are caused by evil spirit, enemy's poison, punishment from the gods, witchcraft, swearing of false oath. All participants used self- medication and 109 (64.9%) had not visited any eye care facility. Majority, 157 (93.5%), had used traditional eye medication; 137 (81.5%) of them had negative attitude towards eye surgeries and other orthodox treatment modalities based on cultural, social, economic, religious and psychologic experiences. Duration of destitution is independent of level of visual loss. More than two-third 146 (86.9%) had experienced one or the other form of psychosocial disorder.

DISCUSSION

In the present study, psychologic disorders experienced by the destitute as direct consequences of complex factors including visual loss were discernable. These psychologic experiences also influence their approach to treatment options for the identified causes of visual loss. The major causes of visual loss, cataract and glaucoma among the destitutes are in keeping with the findings in the general population.[14] Surgery is the definitive treatment option for these blinding conditions. However as found in FGD, majority of the destitutes in the present study harbour negative attitudes to eye surgeries and other orthodox treatment modalities. Nwosu studied the beliefs and attitude to eye diseases and blindness in Anambra State, and noted the low rating the people had for eye surgery as reflected in his findings that 40.3% would not submit to eye surgery and 18.4% and 8.6% viewed eye surgery as frightening and useless respectively.[16] Another study at Ibadan showed that only 18% of glaucoma patients would accept surgery as a treatment option.[17] Efforts should be made towards improving acceptability of eye surgery by awareness creation and promotion of relevant health education required to improve positive perception of eye surgeries which is the mainstay of the treatment of the major causes of visual loss found in the studied destitute. This will restore the sight of destitutes and provide a better opportunity for basic skill acquisition useful for everyday life, and make escape from poverty a lot easier for the destitute.

Visual loss causes considerable economic loss, social burden, loss of functional ability and self-worth. The physical impairment leads to exclusion from opportunities and services through discrimination. This follows the understanding brought by the social model of disability which reveals the loss of opportunities encountered by people with disabilities as a consequence of the physical and social barriers in the society rather than a functional disability. The discrimination leading to exclusion of the disabled people takes many forms and can be classified as institutional, environmental and attitudinal.[18] Institutional discrimination is a systematic marginalization by established laws, customs and practices which can occur regardless of the intent of the individual carrying out the institutional activities. For example, in some countries, disabled children are not required by law to go to school. Environmental discrimination involves factors in the physical environment that creates exclusion such as the scarcity of information available in Braille or audiotape. The third aspect of discrimination is the prevailing attitude such as beliefs that associate disability with evil and low expectations of disabled people that lead to overprotection or exclusion.[18]
In the present study, negative attitudes especially to treatment modalities and views on eye diseases aetiology such as witchcraft, enemy poison, swearing of false oath and punishment from the gods are important factors why destitutes do not access health facilities (FGD). For any deformity perceived to be a punishment from the gods, treatment in some cultures may include performing the necessary rites to appease the gods.[16] Even the immediate relatives and kinsmen who would have ordinarily contributed to treat a fellow kinsman would avoid doing so in deference to the gods.[16] This is because some of these deformities have come to be associated with sin, defilement and punishment and people tend to dissociate themselves at all cost from the victim. It is not surprising that a blind subject from the northern part of Igbo land described his community as wicked because he felt he was regarded as dead and worthless.

The findings therefore revealed much more complex pictures of causes, symptoms and perpetuating factors influencing mental health of the destitute. The major determinants of health are based on Engel's Biopsychosocial (BPS) Model of Health and Illness (Engel 1980).[19] This model considers factors outside biological process of illness when trying to understand health and disease. In this approach, an individual social context and psychological wellbeing are key factors in the

illness and recovery along with their thoughts, beliefs and emotions.

In the present study, stigmatization, depression, loss of self-worth, fear, sleep-wake disorder, shame and indignation are usually related psychosocial behaviours in the evolution of the patient's reaction to visual loss. Thus most blind destitute would wish their sights were restored. In contemporary Nigerian Igbo literature, blindness is a much stigmatized illness.[20] In the patient, these features may lead to total resignation and indifference in the pursuit of treatment options and destitution becomes a good alternative. The present study observes that the psychosocial status of destitute manifest as behavioural disturbances. For instance, subconscious feeling of guilt may drive the patient towards accepting his illness as divine punishment, the mechanism of negation may produce an unwilling patient, while over compensation may produce an aggressive difficult patient. While these factors might be responsible for reduced access to health facilities by the destitute, it should be emphasized that unfriendly reception and frustration with usually long queues when consulting with the ophthalmologist in public hospitals could not be ignored. Most of the subjects also cited lack of eye health facilities in their respective communities as reasons for the use of unorthodox eye medication. Thus the use of traditional eye medications was rife for all manner of ocular ailments and consequently, treatment of ocular diseases remained more grievous than the endurance of the same among the destitute.

It is therefore necessary to integrate both eye care and mental health services in the existing primary health centers for improved access. It was also noted that despite the presence of visual loss, the need for treatment was still not felt by some of the destitute. This could be attributed to poor knowledge of causes of ocular problems, depression and strong affiliation to superstition. All these are not unrelated to social and material poverty.

The role of poverty as a causative factor and a consequence of destitution can be inferred from indicators like high level of unemployment, lack of education and poor daily income among destitute in the present study. The immediate social and economic environment interact with the individual's psychological and coping skills to determine the health and illness status.

It is therefore very urgent for the mobilization of these disadvantaged individuals (destitute) and their enrolment into an effective community-based socioeconomic support-scheme and comprehensive eye health services. This will surely restore their psychosocial rights and move them out of the streets.

Finally, the findings in the present study will be useful in planning and implementing eye health and social services for the destitute.

CONCLUSION

Although all the participants with severe visual loss had psychosocial disorders, this was not statistically significant. Stigmatization, depression and verbal abuse were the commonest psychosocial problems.

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Author Contributions

All authors were involved in conceptualizing, writing and revision of the manuscript

Data Availalbility

The data used to support the findings of this study are available from the corresponding author upon reasonable request.

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Conflict of Interest

The authors declare no conflict of interest.

Ethical Approval

This study was approved by the Ethics Committee of Nnamdi Azikiwe University Teaching Hospital, Nnewi.

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