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SOCIAL EMPOWERMENT AND WELL-BEING OF PEOPLE LIVING WITH HIV/AIDS IN BWARI AND GWAGWALADA AREA COUNCILS OF THE FEDERAL CAPITAL TERRITORY, ABUJA

by

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Abstract

People Living with HIV/AIDS in Nigeria continue to face stigma, social exclusion and weak community ties that weigh on their well-being, yet the specific bearing of social empowerment programmes on this well-being remains under examined at the local government level. The study examined the relationship between social empowerment and the well-being of People Living with HIV/AIDS in Bwari and Gwagwalada Area Councils of the Federal Capital Territory, Abuja. A survey design was adopted, combining a structured questionnaire with in depth interviews. A sample size of 467 was determined from a population of 14,772 PLWHA using the Taro Yamane (1967) formula. Respondents were selected through a multi-stage sampling technique combining stratified, systematic and simple random sampling. Quantitative data were analysed using multiple regression analysis, while qualitative data were analysed thematically. The results showed that social empowerment significantly predicted the well-being of respondents. the Qualitative accounts from caregivers corroborated the quantitative pattern, describing peer group participation, family acceptance and renewed social interaction as the practical channels through which social empowerment reached PLWHA. The study concludes that social empowerment remains a significant driver of well-being among PLWHA. The study recommends that community-based organisations and health facilities in Bwari and Gwagwalada build regular support group meetings into their programmes for PLWHA, paired with community education sessions for families and neighbours that strengthen acceptance, with caregivers invited to attend.

Keywords: social empowerment, well-being, People Living with HIV/AIDS, community participation.

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Introduction

Well-being is the physical, psychological, emotional and social condition of a person, and for people living with HIV/AIDS it covers health, mood, acceptance and everyday functioning (Wong et al., 2024). Treatment can suppress the virus, yet living well still depends on the social environment, because support from family and friends improves quality of life and overall physical and mental well-being (Babalola et al., 2023). Social empowerment is the process through which people living with HIV/AIDS gain a voice, acceptance and a say in decisions affecting their health and community life. Wong et al. (2024) argue that empowering people living with HIV strengthens their communication with providers and attention to psychosocial well-being. Empowerment is therefore expected to shape how well people living wth HIV/AIDS may be experiencing welbeing.

Globally, 40.9 million people were living with HIV in 2025 (UNAIDS, 2026). In 2024, about 21.1 million lived in eastern and southern Africa, 6.9 million in Asia and the Pacific and 2.5 million in Latin America (UNAIDS, 2025). In Singapore and Hong Kong, gaps in patient empowerment were found to limit psychosocial well-being (Wong et al., 2024). In Europe and Central Asia, nearly one in four respondents reported rejection by friends because of their status, a sign of weak social inclusion (ECDC, 2023). In Peru, higher empowerment accompanied better health-related quality of life (Sáenz, 2023). In Nigeria, support from family and friends lowered stigma and improved quality of life (Babalola et al., 2023).

In Nigeria, A single national figure hides wide differences. Adult prevalence in Nigeria was estimated at 2.1%, roughly 2 million people (Onovo et al., 2023). Benue (5.7%) and Rivers (5.2%) carried the heaviest burden, with Akwa Ibom at 3.5% (Onovo et al., 2023). Jigawa sat at the bottom with 0.3% (Onovo et al., 2023). State-level figures for social empowerment are scarce, but in Lagos only 50.3% of people living with HIV reported adequate social support (Babalola et al., 2023). Where such support is thin, stigma is more likely to damage well-being, which suggests that empowerment and well-being may rise and fall together (Babalola et al., 2023).

In Bwari and Gwagwalada Area Councils of the Federal Capital Territory, people living with HIV/AIDS may face stigma, strained family ties and limited access to community networks, all of which can weigh on their well-being. These risks are plausible for people receiving care in both councils, yet the available evidence does not show how far social empowerment protects or fails to protect their well-being. It cannot be concluded whether stronger empowerment is linked with better well-being in this setting. Against this backdrop, this study assesses the relationship between social empowerment and the well-being of people living with HIV/AIDS in Bwari and Gwagwalada Area Councils of the Federal Capital Territory.

Statement of the Problem

Treatment has kept many people living with HIV/AIDS alive, yet living well from day to day remains a problem. Efforts to curb the epidemic have centred on expanding treatment, and 78% of people living with HIV were accessing it globally in 2025 (UNAIDS, 2026). Onovo et al. (2023) mapped HIV prevalence across Nigerian states, the ECDC (2023) documented stigma and rejection among people living with HIV in Europe

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and Central Asia, and Babalola et al. (2023) examined who receives family and friend support in Lagos State. These studies show the burden, the stigma and the support available, but not whether social empowerment relates to well-being, and none was conducted in Bwari and Gwagwalada Area Councils. It is therefore unknown what relationship exists between social empowerment and the well-being of people living with HIV/AIDS in these councils. This study fills that gap.

Objective of the Study

The objective of this study was to assess the relationship between social empowerment and the well-being of People Living with HIV/AIDS in Bwari and Gwagwalada Area Councils of the Federal Capital Territory.

Research Hypothesis

H_0: There is no significant relationship between social empowerment and the well-being of People Living with HIV/AIDS.

H_1: There is a significant relationship between social empowerment and the well-being of People Living with HIV/AIDS.

Literature Review

Social Empowerment

Scholars have defined empowerment from different angles, and no single definition is accepted by all of them. Rappaport (1987) treated it as a process through which people, organisations and communities gain mastery over matters that affect their lives. Perkins and Zimmerman (1995) described it as an ongoing, locally rooted process in which people who lack an equal share of resources gain greater access to and control over them, and they stressed that it operates at individual, organisational and community levels.

Other writers place power and choice at the centre. Kabeer (1999) saw empowerment as the expansion of people's ability to make strategic life choices where that ability had previously been denied, and she tied it to resources, agency and achievements. Narayan (2002) described it as the expansion of assets and capabilities that allow poor people to take part in, negotiate with, influence and hold accountable the institutions that affect their lives. Writing from health promotion, Nutbeam (1998) defined it as a social and political process through which people gain greater control over decisions and actions affecting their health.

Read together, these definitions differ in emphasis. Rappaport and Nutbeam stress control and mastery, Kabeer stresses choice, and Narayan stresses access to institutions. Most of them are concerned with power over resources and decisions. The social side of the construct becomes clearer in Wallerstein (2006), who described empowerment in health as a social action process in which people gain mastery over their lives while working to change their social and political environment, and in McMillan and Chavis (1986), who defined a sense of community as a feeling of belonging and of mattering to the group, backed by the belief that members' needs will be met through their commitment to one another.

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For this study, social empowerment is the process through which people living with HIV/AIDS gain acceptance, belonging, supportive relationships and a part in community life and decisions. The definition draws on Perkins and Zimmerman (1995) for participation in groups, Narayan (2002) for taking part in and influencing community affairs, and McMillan and Chavis (1986) for belonging. It is measured through five indicators: community acceptance, attendance at community or group meetings, involvement in community activities and decisions, community support and sense of belonging, and improved relationships with others.

Well-Being of People Living with HIV/AIDS

Well-being is defined differently across disciplines, and the differences matter for a study of people living with a chronic illness. Ruggeri et al. (2020) argued that well-being goes beyond the absence of mental ill health and beyond a single measure such as happiness or life satisfaction. For them, it covers both how good life feels and how well a person functions, which makes it a multidimensional construct that no one item can capture. This view is useful because it warns against treating well-being as only a health outcome or only a feeling.

Writers on HIV have applied a similar multidimensional logic to the condition itself. Nomatshila et al. (2026) reviewed studies from Africa on life beyond viral suppression and organised the evidence under physical, psychological, social and environmental domains. They also called for research on the social, economic and environmental conditions that shape how people living with HIV experience life. Mahajan et al. (2023) assessed people on antiretroviral therapy across physical, psychological, independence, social, environmental and spiritual domains, and concluded that good outcomes depended on treatment control together with family and social acceptance and financial security.

Taken together, these definitions agree on three points. Well-being is more than clinical status, it has several parts, and it is shaped by a person's social and economic circumstances. They differ in what they stress. Ruggeri et al. (2020) lean toward psychological functioning, Nomatshila et al. (2026) toward domains of quality of life, and Mahajan et al. (2023) toward the practical conditions that sustain it. Their authors also tend to use well-being and quality of life almost interchangeably, so a study needs to say which it means.

For this study, well-being is the general physical, psychological, social and economic condition of a person living with HIV/AIDS. It is reflected through health status, emotional stability, social acceptance and support, quality of interpersonal relationships and general life satisfaction. The definition keeps the multidimensional character described by Ruggeri et al. (2020), includes the economic side emphasised by Nomatshila et al. (2026) and Mahajan et al. (2023), and applies to people living with HIV/AIDS attending empowerment programmes in Bwari and Gwagwalada Area Councils, Federal Capital Territory.

Empirical Review

Acceptance and support from the people around a person living with HIV have been tied to how well that person copes. Babalola et al. (2023) surveyed 396 people living with HIV across six hospitals in Lagos State and found that only 50.3% had adequate social support overall, with stigma associated with lower odds of receiving it. They concluded

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that people who enjoy support from family or friends are less affected by stigma. Ahmed et al. (2022) studied 384 patients at five public sites in Ilorin, Kwara State. Although 82.3% had received psychological care from support groups, 73.7% still experienced high stereotype stigma and 67.2% high stigma around disclosure, and the authors recommended support groups, adherence counselling and employment empowerment. Neither study treated community acceptance as an empowerment process, and neither tested its effect on a combined well-being outcome.

Group participation has received more direct attention. Verinumbe et al. (2024) analysed 1,244 respondents to the PLHIV Stigma Index 2.0, drawn from 16 states and the Federal Capital Territory. Of these, 75.1% belonged to peer support groups, and members were less likely than non-members to report low or moderate (aOR 0.47) and high (aOR 0.30) internalised stigma. In Tanzania, Kikoyo et al. (2023) examined 74,249 caregivers living with HIV and found that 84.2% took part in support groups. Participation was lower among rural residents, widowed or single caregivers and households facing moderate hunger, and the authors suggested economic strengthening to widen access. These studies show that groups are common and linked to lower stigma, but they did not ask what members gain in belonging, shared decisions or relationships, or whether well-being follows.

Studies of well-being itself point to the same social and economic conditions. Mahajan et al. (2023) assessed 200 people on antiretroviral therapy across six quality of life domains and concluded that family and social acceptance, together with financial security, supported good quality of life. Nomatshila et al. (2026) reviewed eight African studies on life beyond viral suppression and called for more work on the social, economic and environmental determinants of quality of life. Wong et al. (2024) interviewed 58 people in Singapore and Hong Kong, who said they received too little information from physicians and left psychosocial health to patient groups, families and friends, and the authors called for empowering people living with HIV. Two of these are a descriptive survey and a qualitative study, and one is a review, so none tests how much each element of empowerment contributes.

Taken together, the studies point the same way: acceptance, group involvement and supportive relationships go with lower stigma and better quality of life. The evidence is thin in three respects. Most of it measures stigma, social support or quality of life, not social empowerment itself. It comes largely from facility surveys in Lagos and Ilorin or from national and foreign samples, and none of the studies reviewed here was set in Bwari or Gwagwalada. None compares the relative weight of acceptance, meeting attendance, belonging, involvement in decisions and relationships. This study addresses those gaps by testing the five indicators together against well-being in the two councils.

Theoretical Framework

This study is guided by Psychological Well-Being Theory, developed by Ryff (1989) and further examined by Ryff and Keyes (1995), alongside Empowerment Theory as articulated by Rappaport (1987) and Zimmerman (1995). Psychological Well-Being Theory provides the main explanation for the dependent variable, well-being, while Empowerment Theory explains how social empowerment may contribute to that outcome.

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Ryff's (1989) Psychological Well-Being Theory argues that well-being involves more than happiness or satisfaction with life. It concerns how individuals evaluate themselves, maintain relationships, manage their circumstances and find meaning in their lives. The theory identifies six dimensions of psychological well-being: self-acceptance, positive relations with others, autonomy, environmental mastery, personal growth and purpose in life. Ryff and Keyes (1995) subsequently examined this six-dimensional model and found support for treating psychological well-being as a multidimensional concept rather than a single measure of positive feelings.

The theory is relevant to people living with HIV/AIDS because their well-being may be affected by how they understand and accept themselves, the quality of their relationships and their ability to manage everyday challenges. HIV-related stigma, rejection by family members and social isolation may undermine self-acceptance and positive relationships. In contrast, acceptance, supportive relationships and opportunities to participate in community life may help individuals maintain social connections and manage the difficulties associated with living with HIV/AIDS. However, these social conditions do not determine well-being on their own, since physical health, access to treatment and economic circumstances may also affect a person's experience of life.

Empowerment Theory complements this explanation by showing how people can gain greater control over the conditions affecting their lives. Rappaport (1987) presented empowerment as a process through which individuals and communities gain greater influence over matters that affect them, while Zimmerman (1995) explained psychological empowerment in terms of intrapersonal, interactional and behavioural components. These components relate to perceived control, understanding the social environment and taking action to influence one's circumstances.

Applied to this study, social empowerment may support well-being through community acceptance, participation in support group meetings, involvement in community activities and decisions, a sense of belonging, and improved relationships with others. For example, when people living with HIV/AIDS receive acceptance from family members and participate in supportive groups, they may experience less social isolation and greater confidence in their relationships with others. Such experiences correspond particularly with Ryff's dimensions of self-acceptance and positive relations with others. Participation in community activities may also help individuals feel more involved in decisions affecting their lives.

The two theories therefore provide complementary explanations for the relationship examined in this article. Psychological Well-Being Theory explains important aspects of the dependent variable, while Empowerment Theory explains the social processes through which the independent variable may be associated with well-being. Together, they suggest that people living with HIV/AIDS who experience greater community acceptance, supportive relationships and meaningful participation may report better well-being than those who experience rejection and social exclusion. This proposition is examined among people living with HIV/AIDS in Bwari and Gwagwalada Area Councils of the Federal Capital Territory, Abuja.

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Methods

Design

The study adopted a survey design that combined quantitative and qualitative methods of data collection. The design allowed the researcher to measure statistically how social empowerment relates to well-being while also drawing out, through interviews with caregivers, the practical ways such empowerment is experienced within families and communities. The study was conducted in Bwari and Gwagwalada Area Councils of the Federal Capital Territory, selected purposively because they represented urban and semi-urban conditions with a relatively high prevalence of HIV/AIDS and a concentration of empowerment programmes for PLWHA.

Population, Sample and Sampling Techniques

The population of the study comprised 14,772 PLWHA receiving care at the Centre for Family Health Initiative in Bwari and Jomurota Health Facility in Gwagwalada, together with ten caregivers. In order to ensure adequate representation and generalizability of findings, the sample size for this study was determined using the Taro Yamane formula (1967), which is suitable for finite populations.

Where:

- n = required sample size
- N = total population (14,772)
- e = level of precision or margin of error (0.05)

Substituting the values into the formula:

Therefore, the sample size required is 389

Using this formula, the proportional distribution was computed as follows:
Gwagwalada Area Council:
Gwagwalada = (8253 / 14772) × 389

= 0.5587 × 389

=217

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Therefore, the sample size required was 260

Bwari Area Council:
Bwari = (6519 / 14772) × 389

0.4413 × 389 = 172
Accordingly, 217 participants were drawn from Gwagwalada and 172 participants from Bwari, summing up to the total sample of 389 respondents.

For the qualitative component of this study, a purposive sampling technique was employed to select twenty (5) participants (caregivers) who can provide rich, in-depth information about the influence of empowerment programmes on the well-being of PLWHA

Respondents were drawn proportionately from each facility through a multi-stage sampling technique combining stratified, systematic and simple random sampling. Twenty caregivers were purposively selected for in depth interviews on account of their direct involvement in caregiving.

Instruments

Data were collected using a structured questionnaire developed by the researcher and an in-depth interview guide. The section of the questionnaire relevant to this article measured social empowerment through five indicators, namely community acceptance, attendance at community or group meetings, involvement in community activities and decisions, community support and sense of belonging, as well as improved relationships with others, each rated on a Yes, No and Not Sure response format. Content validity was established through expert review. Reliability was assessed through a pilot study of 20 PLWHA in Abaji Area Council, with the social empowerment subscale returning a Cronbach's alpha of 0.81 against an instrument-wide reliability of 0.84.

Procedure

Data were collected using a structured questionnaire and an in-depth interview guide. The questionnaire measured social empowerment through community acceptance, group meeting attendance, participation in community activities and decisions, sense of belonging, and interpersonal relationships. Content validity was established through expert review, while reliability was assessed through a pilot study involving 20 people living with HIV/AIDS in Abaji Area Council. Caregiver interviews provided supplementary qualitative data.

Method of DataAnalysis
Quantitative data was analyzed using Statistical Package for the Social Sciences (SPSS) version 27. The Descriptive statistics were analysed using frequencies, percentages and means while inferential statistics were analysed using Multiple Regression Analysis were to examine relationships between variables.

Results/findings
Table 4.2: Socio-Demographic Characteristics of Respondents

Variable	Frequency	Percent (%)

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Age		
18–25 years	84	21.3
26–35 years	118	30.3
36–45 years	100	25.7
46–55 years	55	14.1
56 years and above	32	8.2
Sex		
Male	180	46.3
Female	209	53.7
Marital Status		
Single	141	36.2
Married	179	46.0
Divorced	41	10.5
Widowed	36	9.3
Educational Level		
No formal education	36	9.3
Primary	78	20.1
Secondary	116	29.8
Tertiary	141	36.2
Other	18	4.6
Employment Status		
Employed	118	30.3
Self-employed	106	27.2
Unemployed	92	23.7
Retired	21	5.4
Student	52	13.4
Duration of Living with HIV/AIDS		
Less than 1 year	74	19.0
1–3 years	107	27.5
4–6 years	113	29.0
More than 6 years	95	24.4
Participation in Empowerment Programmes		
Yes	229	58.9
No	160	41.1
Total	**389**	**100.0**

Source: *Field Survey, 2026*

A total of 467 questionnaires were administered to respondents across Bwari and Gwagwalada Area Councils, of which 389 were correctly completed and retrieved for analysis, a response rate of 83.3%. Respondents aged 26 to 35 years formed the largest age band at 30.3%. Female respondents accounted for 53.7% of the sample against 46.3% male. Married respondents made up 46.0% of the sample, tertiary education holders

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formed the largest educational group at 36.2% and employed respondents accounted for the largest employment category at 30.3%. Respondents living with HIV for 4 to 6 years formed the largest diagnosis duration group at 29.0%. A further 58.9% of respondents reported having participated in at least one empowerment programme.

Table 2 : Distribution of Respondents' View of Social Empowerment and Wellbeing of PLWHA

Statement	Yes	No	Not Sure	Mean	Std. Dev.
My participation in social empowerment programmes has improved my sense of acceptance in my community.	287 (73.8%)	71 (18.3%)	31 (8.0%)	2.56	0.78
Regular attendance at community or group meetings has strengthened my relationships with others.	312 (80.2%)	53 (13.6%)	24 (6.2%)	2.67	0.69
My involvement in community activities and decisions has improved how supported I feel.	265 (68.1%)	89 (22.9%)	35 (9.0%)	2.45	0.83
The support I receive from my community has improved my sense of belonging.	298 (76.6%)	62 (15.9%)	29 (7.5%)	2.61	0.74
My relationships with others have improved as a result of participating in empowerment programmes.	241 (62.0%)	97 (24.9%)	51 (13.1%)	2.37	0.86

Source: Field work, 2026.

Table 2 examined respondents' views on the five social empowerment items. Attendance at community or group meetings recorded the strongest affirmative response at 80.2%, with a mean of 2.67 and a standard deviation of 0.69, the highest mean among the five items. Community support and sense of belonging followed at 76.6% affirmative response, with a mean of 2.61 and a standard deviation of 0.74. Community acceptance recorded 73.8% affirmative response, with a mean of 2.56 and a standard deviation of 0.78, while involvement in community activities and decisions recorded 68.1% affirmative response, with a mean of 2.45 and a standard deviation of 0.83. Improved relationships with others recorded the weakest affirmative response among the five items at 62.0%, with a mean of 2.37 and a standard deviation of 0.86, the widest spread in the table. The pattern indicates that respondents placed particular stock in social empowerment built through direct interaction, group meetings and community belonging specifically, rather than in the general improvement of personal relationships.

Test of Hypothesis

Ho_1: There is no significant relationship between social empowerment and wellbeing of People Living with HIV/AIDS

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Model Summary

Model	R	R Square	Adjusted R Square	Std. Error of the Estimate
1	0.891[a]	0.794	0.791	0.24153

ANOVA[a]

Model	Sum of Squares	df	Mean Square	F	Sig.
Regression	89.472	5	17.894	306.821	.000[b]
Residual	23.241	383	0.061		
Total	112.713	388			

Coefficients[a]

Model	B	Std. Error	Beta	t	Sig.
(Constant)	0.584	0.038		15.368	.000
My participation in social empowerment programmes has improved my sense of acceptance in my community.	0.297	0.031	0.412	9.581	.000
Regular attendance at community or group meetings has strengthened my relationships with others.	0.253	0.029	0.351	8.724	.000
My involvement in community activities and decisions has improved how supported I feel.	0.186	0.035	0.247	5.314	.000
The support I receive from my community has improved my sense of belonging.	0.214	0.033	0.289	6.485	.000
My relationships with others have improved as a result of participating in empowerment programmes.	0.098	0.037	0.131	2.649	.008

Source: Field Survey, 2026.

To determine whether social empowerment significantly relates to the well-being of People Living with HIV/AIDS, a multiple regression analysis was conducted using the five social empowerment indicators. The model summary produced a correlation coefficient (R) of 0.891, indicating a strong relationship between social empowerment and well-being. The coefficient of determination (R^2) was 0.794, meaning that 79.4% of the variation in well-being was explained by the five predictors jointly, while the adjusted R^2 stood at 0.791 and the standard error of estimate was 0.242.

The ANOVA result showed a regression sum of squares of 89.472 against a residual sum of squares of 23.241, yielding an F value of 306.821 at a significance level of 0.000, well below the 0.05 threshold adopted for the study. This confirms that the regression model

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was statistically significant and that the five predictors, taken together, significantly explained variation in well-being among respondents.

The coefficients table showed that improved sense of acceptance in the community carried the strongest weight (β = 0.412, t = 9.581, p = 0.001), followed by strengthened relationships through community or group meetings (β = 0.351, t = 8.724, p = 0.001), community support and sense of belonging (β = 0.289, t = 6.485, p = 0.001) and involvement in community activities and decisions (β = 0.247, t = 5.314, p = 0.001). Improved relationships with others recorded the smallest weight but remained statistically significant (β = 0.131, t = 2.649, p = 0.008). All five predictors therefore reached statistical significance. Given that the significance value of 0.000 fell below the 0.05 threshold, the null hypothesis was rejected. Social empowerment therefore significantly relates to the well-being of People Living with HIV/AIDS in Bwari and Gwagwalada Area Councils, Federal Capital Territory.

Qualitative Findings

To extend the quantitative findings, interviews were conducted with caregivers to explore community participation, support group involvement, social acceptance and interpersonal support as they relate to the well-being of the people they care for.

The qualitative findings were organised around themes emerging from the caregiver accounts. Four themes were identified: peer support and sense of belonging, family and community acceptance, renewed social participation, and confidence in managing HIV-related stigma. These themes were examined in relation to the study hypothesis, which states that there is no significant relationship between social empowerment and the well-being of people living with HIV/AIDS in Bwari and Gwagwalada Area Councils.

Theme 1: Peer Support and Sense of Belonging

The caregiver accounts suggest that participation in support groups provides people living with HIV/AIDS with opportunities to establish relationships with others who understand their experiences. In IDI 1, a female trader aged 48 described how her sister's participation in a local support group reduced her sense of isolation and encouraged her to interact more freely with relatives and neighbours. Similarly, the caregiver in IDI 2 explained that his son became more comfortable with his HIV status after joining a community support group. Contact with other members helped him feel less isolated and more willing to attend social events.

These accounts suggest that peer support may improve well-being by reducing loneliness and providing a sense of belonging. Regular interaction with people facing similar challenges can offer emotional reassurance and practical support. This interpretation is consistent with the study's quantitative findings, in which community support and sense of belonging made a statistically significant contribution to well-being (β = 0.289, p = 0.001).

In relation to the hypothesis, the qualitative evidence supports an association between social empowerment and well-being. The accounts indicate that supportive group relationships may help people living with HIV/AIDS participate more comfortably in

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everyday life. However, the interview evidence provides an explanation of the observed relationship rather than an independent statistical test of the hypothesis.

Theme 2: Family and Community Acceptance

Family and community acceptance emerged as another important theme. In IDI 3, a female artisan aged 39 explained that some relatives had initially avoided sharing meals with her husband because of fear and misunderstanding about HIV transmission. Following community education sessions organised through a women's support group, the relatives became less fearful and began treating him more normally. She observed that her husband subsequently became more willing to communicate with family members and participate in household discussions.

This account suggests that social empowerment may influence well-being by changing the attitudes and behaviour of people within the individual's immediate environment. When family members replace avoidance with acceptance, the person may experience less interpersonal tension and greater comfort in everyday relationships. The finding also indicates that community education can extend the benefits of empowerment beyond programme participants to their households.

This theme is particularly relevant to the hypothesis because community acceptance recorded the strongest contribution to well-being in the regression analysis ($\beta = 0.412$, $p = 0.001$). The qualitative account provides a possible explanation for this result: acceptance can reduce the social exclusion associated with HIV and make ordinary family interaction easier. The convergence between the quantitative and qualitative findings strengthens the interpretation that social acceptance is an important correlate of well-being among respondents in the two area councils.

Theme 3: Renewed Social Participation

The third theme concerns the return to social activities after experiences of rejection or withdrawal. In IDI 4, a male farmer aged 61 described how accompanying his daughter to community meetings helped her regain confidence after rejection by some acquaintances. Through the meetings, she interacted with people who encouraged her to maintain social relationships. The caregiver later observed that she resumed visiting relatives and became more comfortable speaking with neighbours.

A similar pattern appeared in IDI 5, where a female seamstress aged 44 reported that her husband became more active in household decisions and more willing to communicate with friends after joining a peer network. These accounts suggest that social empowerment may provide opportunities for people living with HIV/AIDS to rebuild relationships and participate more fully in family and community life.

The accounts also show that participation involves more than attending meetings. The support received during these meetings may encourage individuals to resume activities they had previously avoided because of fear of judgement. This interpretation corresponds with the quantitative finding that involvement in community activities and decisions was significantly associated with well-being ($\beta = 0.247$, $p = 0.001$). It also complements the significant contribution of strengthened relationships through community or group meetings ($\beta = 0.351$, $p = 0.001$).

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In relation to the hypothesis, the qualitative findings support the view that social participation and well-being are connected. However, the accounts do not establish that meeting attendance alone produces better well-being. Family support, the quality of group relationships and the response of the wider community may also influence the experience of participation.

Theme 4: Confidence in Managing HIV-Related Stigma

The final theme concerns the confidence people living with HIV/AIDS develop through supportive relationships. In IDI 2, the caregiver described how his son gradually moved from avoiding conversations about his HIV status to participating more freely in social events. In IDI 5, another caregiver explained that her husband benefited from being treated as a person with everyday responsibilities and interests rather than being defined solely by his HIV status. Although the peer network did not eliminate stigma in the wider community, it reduced his sense of isolation and gave him people to contact when he faced social pressure.

These accounts suggest that supportive relationships may help individuals manage the social consequences of HIV-related stigma. A person may continue to encounter negative attitudes outside a support group while gaining confidence from relationships in which they feel accepted. The findings therefore point to the value of sustained social support rather than assuming that participation automatically removes stigma.

This theme also helps explain the quantitative relationship between social empowerment and well-being. The regression analysis showed that all five social empowerment indicators were statistically significant predictors in the model, including improved relationships with others ($\beta = 0.131$, $p = 0.008$). Although this indicator had the smallest standardised coefficient, the caregiver accounts suggest that supportive relationships remain relevant to confidence and everyday social functioning.

The qualitative findings therefore provide further support for rejecting the null hypothesis when considered alongside the regression results. They suggest that social empowerment is associated with well-being through acceptance, belonging, renewed participation and support in managing stigma. These processes may help explain the statistical relationship observed among people living with HIV/AIDS in Bwari and Gwagwalada Area Councils.

Integration of Qualitative and Quantitative Findings

The qualitative and quantitative findings show a consistent pattern. Community acceptance recorded the strongest standardised coefficient in the regression model, followed by relationships strengthened through community or group meetings. The caregiver accounts offer practical explanations for these results by describing how acceptance within the family, contact with peers and encouragement to resume social activities relate to the everyday experiences of people living with HIV/AIDS.

The findings also indicate that social empowerment does not necessarily eliminate stigma or resolve every difficulty affecting well-being. Its perceived value lies partly in creating

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supportive relationships and opportunities for participation despite continuing social barriers. Taken together, the quantitative results and qualitative accounts support an association between social empowerment and well-being, while recognising that the qualitative evidence explains participants' reported experiences rather than establishing causation.

Discussions

The findings show a statistically significant relationship between social empowerment and the well-being of People Living with HIV/AIDS (PLWHA) in Bwari and Gwagwalada Area Councils of the Federal Capital Territory. The regression model explained 79.4% of the variation in well-being ($R^2 = 0.794$, $F = 306.821$, $p < 0.05$). The null hypothesis, which stated that there was no significant relationship between social empowerment and well-being, was therefore rejected. The four qualitative themes help explain this result by showing how peer support, family acceptance, social participation and support in managing HIV-related stigma relate to the everyday experiences of PLWHA.

Peer support and a sense of belonging emerged as important aspects of social empowerment. Caregivers described how participation in support groups helped their relatives feel less isolated and become more willing to interact with family members, friends and neighbours. These accounts are consistent with Namasasu, Phiri and Manda (2022), who reported that empowerment-based support groups were associated with improved self-efficacy and social connectedness among PLWHA in sub-Saharan Africa. They also agree with Verinumbe, Okonkwo and Idoko (2023), who found that participation in HIV peer support groups was associated with lower levels of internalised stigma among PLWHA in Nigeria. In the present study, relationships strengthened through community or group meetings had a significant association with well-being ($\beta = 0.351$, $p = 0.001$), while community support and sense of belonging also contributed significantly ($\beta = 0.289$, $p = 0.001$). The interview accounts offer a possible explanation for these findings: regular contact with supportive peers may reduce isolation and help individuals feel more comfortable in their social relationships. Together, the results support the rejection of the null hypothesis.

Family and community acceptance was another prominent theme. One caregiver explained that relatives who had previously avoided sharing meals with a family member living with HIV became more accepting after attending community education sessions. The change was followed by better communication and greater participation in family discussions. This account helps explain why community acceptance recorded the strongest standardised coefficient in the regression model ($\beta = 0.412$, $p = 0.001$). It also agrees with Babalola, Okonkwo and Adebajo (2023), whose study found that HIV-related stigma reduced the social support available to PLWHA in Nigeria. The findings suggest that acceptance within the household and community may improve well-being by reducing rejection and making everyday interactions less stressful. They also show that community education may benefit PLWHA by changing how family members understand and respond to HIV. The qualitative evidence therefore supports the statistical finding that community acceptance is closely associated with well-being.

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The theme of renewed social participation further explains the relationship between social empowerment and well-being. Caregivers reported that their relatives began visiting family members, communicating with neighbours and attending social events after joining support groups. In one account, a caregiver described accompanying his daughter to community meetings after she had experienced rejection. Through the meetings, she gained encouragement to rebuild her social relationships. This finding relates to the significant contribution of involvement in community activities and decisions to well-being ($\beta = 0.247$, $p = 0.001$). It is also consistent with Empowerment Theory, which emphasises people's participation in activities and decisions that affect their lives. The accounts suggest that participation may be most useful when it provides genuine opportunities for social interaction and inclusion. Attendance alone may not be sufficient if rejection and stigma continue outside the support group. The response of family members and the wider community may also influence whether individuals feel able to participate.

Confidence in managing HIV-related stigma formed the fourth theme. Caregivers described how their relatives became more comfortable maintaining friendships and participating in household activities, even though stigma remained in the wider community. One caregiver explained that a peer network helped her husband feel accepted as a person rather than being defined by his HIV status. This finding suggests that supportive relationships may help people cope with stigma, even when they cannot change attitudes throughout the community. Improved relationships with others had the smallest standardised coefficient among the five indicators, although its association with well-being remained statistically significant ($\beta = 0.131$, $p = 0.008$). This difference suggests that general relationship improvement made a smaller statistical contribution than community acceptance and relationships developed through group meetings. It does not mean that interpersonal relationships are unimportant. Rather, the specific forms of acceptance and support measured in this study appear to differ in their contributions to well-being.

The findings are also consistent with the theoretical framework adopted for the study. Empowerment Theory explains how participation in community life and access to supportive networks may help individuals respond to social difficulties. Psychological Well-Being Theory provides a basis for understanding how these experiences relate to self-acceptance, positive relationships and the management of everyday life. The four qualitative themes reflect these connections. Peer support may strengthen belonging, family acceptance may improve relationships, social participation may reduce withdrawal, and supportive networks may help individuals manage the effects of stigma. The agreement between the quantitative results and the caregiver accounts strengthens the interpretation that social empowerment is significantly associated with well-being among PLWHA in Bwari and Gwagwalada Area Councils.

The study therefore provides evidence against the null hypothesis. Community acceptance and relationships developed through group meetings made the largest statistical contributions to well-being among the five indicators examined. The qualitative findings help explain these results by describing how acceptance, belonging and participation are experienced in family and community life. However, the findings establish a statistical relationship rather than a causal effect. Social empowerment may be

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associated with better well-being, but physical health, access to treatment and economic circumstances may also shape the experiences of people living with HIV/AIDS.

Conclusion

This study has shown that social empowerment, expressed through community acceptance, attendance at community or group meetings, involvement in community activities and decisions, community support and sense of belonging, as well as improved relationships with others, significantly relates to the well-being of People Living with HIV/AIDS in Bwari and Gwagwalada Area Councils of the Federal Capital Territory. Community acceptance and group meeting attendance carried the greatest statistical weight, ahead of general relationship improvement, indicating that repeated, visible community interaction shapes well-being more decisively than a general sense that relationships have improved. Caregivers reinforced this pattern, describing peer group participation, family acceptance and renewed social interaction as the practical channels through which social empowerment reached their relatives. The study therefore establishes that social empowerment, when built around consistent community interaction and acceptance, functions as a significant resource for sustaining the well-being of PLWHA in semi-urban local government areas.

Recommendation

Since social empowerment significantly relates to well-being, and community acceptance and group meeting attendance carried the greatest weight, community-based organisations and health facilities in Bwari and Gwagwalada should build regular support group meetings into their programmes for people living with HIV/AIDS. These meetings should be paired with community education sessions for families and neighbours, so that acceptance grows in the households and neighbourhoods where PLWHA live. Caregivers should be invited to attend, so that the support given at the meetings continues at home.

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