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Effects of Community-Based Care for People Living with HIV/AIDS on Their Well-Being in Benue State, Nigeria

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Abstract: The study examined the effects of care and support provided by community and family members of People Living with HIV/AIDS (PLWHA) on the well being of the PLWHA in Benue state, Nigeria. Data were collected from a purposively selected sample of 312 respondents (96 family members of PLWHA, 96 PLWHA and 120 community members) through interview guide and focus group discussions. The data collected were subjected to descriptive and inferential (t-test, Pearson Product Moment Correlation (PPMC) and regression analysis) statistics. Study revealed that the family (100.0%) and community (98.3%) were actively involved in care and support of PLWHA. The t-test analysis showed significant difference between the care offered by family and community members ($t = 20.53$, $p = 0.0000$). PPMC showed significant relationship between the total psychological care offered by family members and the total opinion of the PLWHA about psychological care received ($r = 0.208$, $p<0.05$) indicating the need for improvement in other forms of care. However, the ordinal regression showed that a unit increase in the community based care will lead to improvement in the well being of the PLWHA by 56.9% ($\beta = 0.569$, $R^2 = 0.026$, $p = 0.321$). This suggests the potency of community based intervention in care for PLWHA. The study recommends that intervention programme that is aimed at improving the knowledge of the family and community members about care and support for PLWHA should be designed. Relevant stakeholders should intensify their efforts towards care and support.

Key words: PLWHA, family members, community members, well being, satke holders, Nigeria

INTRODUCTION

Few crises have affected human health and threatened national, social and economic progress the way that HIV/AIDS has. The Society for Family Health (SFH, 2006) affirmed that HIV/AIDS is a major challenge to health and development in Nigeria. It was shown by Federal Ministry of Health (FMOH, 2006) that a number of efforts have been devoted to addressing the problem of HIV/AIDS, the current picture in the country shows that the situation is still far from the ideal and desired status. The spread of HIV/AIDS has increased significantly in Nigeria since, the official report of the first case in 1986. The adult HIV prevalence has increased from 1.8% in 1991 through 4.5% in 1996 to 5.8% in 2001 (National Policy on HIV/AIDS, 2003). Estimate using the 2001 HIV/syphilis prevalence sentinel survey among women attending antennal clinics indicates that >3.5 million Nigerians aged 15-49 years may be infected with the virus. Some parts of the country are more affected than others but no state is unaffected.

With the exception of few states in Nigeria, parts of most states are still predominantly rural. Akinrinola *et al.* (2003) observed that about three quarters of adolescent women live in rural areas. In general, underdevelopment in rural areas limits people's access to the health information and services that could help them avoid threats posed by HIV/AIDS. Secondary school and health services including reproductive health care are usually less common in rural areas than in urban areas and the availability of reproductive health information through newspaper and magazine, radio and television is lower in the rural areas than the urban areas. In parts of the country where most people lack adequate housing, food and clothing, the everyday struggle to survive absorbs most of their energy and resources. People in such areas may consider other needs more pressing than protecting their sexual and reproductive health (FMOH, 2003).

Stigma and discrimination are two major problems often faced by People Living With HIV/AIDS (PLWHAs) in many developing countries including Nigeria (FMOH, 2006). Stigma and discrimination shown to persons living with and affected by HIV/AIDS can worsen the spread and impact of the dreaded disease. Songwathana and Manderson (1998) stated that because there is no vaccine

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or effective treatment for HIV/AIDS, people respond to AIDS patients with considerable fear and anxiety. PLWHAs themselves perceived that once they are infected with HIV/AIDS, the destination is death alone. Death from HIV/AIDS is perceived to be different from death from other causes. Extensive health seeking may start after diagnosis and/or the emergence of physical symptoms. Hospital and clinics are ranked as the first priority for specific treatment such as receiving antiviral drugs. However, these were not the only places used or preferred by all AIDS patients, traditional healers and herbalists were also sought alternatively.

Food Agriculture Organization (FAO, 2002) stressed that meeting immediate physical, psychological and socio-economic needs is essential if HIV/AIDS-affected households are to live with dignity and security. Providing physical care and support for people living with HIV/AIDS is an important part of caring at all stages of the disease. The virus that causes AIDS attacks the immune system of the affected person. In the early stages of infection, a person shows no visible signs of illness but later many of the signs of AIDS will become apparent including weight loss, fever, diarrhoea and opportunistic infections (such as sore throat and tuberculosis).

During this period, the family will have the burden of caring for the sick person, paying for health care and absorbing the loss of earnings while the ill person is unable to work. In addition, good nutrition can help to extend the period when the person with HIV/AIDS is well and working. Therefore, proper care and support promote well-being, self-esteem and a positive attitude to life for people and their families living with HIV/AIDS (Ssengonzi and Moreland, 2001).

The number of people infected with HIV/AIDS, its mode of transmission and its impact on the whole society have led to the conception that AIDS is not just an infectious disease but also a social problem (Ankrah, 1991; Velimirovic, 1987). Despite the success of the HIV/AIDS campaign which has promoted 100% condom use and a slowing in the number of people infected with HIV/AIDS, sexual behaviour does not appear to have changed much and the number of people who are sick with HIV/AIDS and the prevalence of HIV/AIDS in groups such as among pregnant women is increasing (Songwathana and Manderson, 1998). Primary emphasis continues to be placed on knowledge and prevention however and less attention has been directed to care and support of people with HIV/AIDS in the community.

During the year 2000, an estimated 2.4 million people died of HIV/AIDS related illnesses in sub-Saharan African while a further 3.8 million became infected. Indeed about 80% of the global total of HIV/AIDS death during 2000 occurred in sub-Saharan Africa and almost 72% of the new infections. Although, adult prevalence in Nigeria is still below 5%, it was found that Nigeria has a large and growing number of HIV/AIDS infected individuals. From an estimated 2.2 million in 1997, the number of people currently living with HIV/AIDS in Nigeria has risen to about 4 million (Izugbara, 2002).

In the 1999, 2001 and 2005 national antenatal HIV sero-prevalence survey, Benue state recorded the highest infection rates of 16.8% in 1999, 13.5% in 2001 and 10% in 2005 (FMOH, 1999, 2001, 2005). Policy Project (2004) estimated that some 325, 000 inhabitants of Benue were HIV positive in 2003 out of a total population estimated at 3.78 million. Most of those infected will fall ill and die within the next 5-10 years. Another alarming implication of the HIVAIDS epidemic is the emergence of large numbers of orphans. It was estimated in 2000 that there were approximately 139,000 orphans in Benue state and by 2010 there will be over 683 thousand orphans (FMOH, 2006).

HIV/AIDS presents many challenges to health education, health services and policies, particularly for family and community members who are assumed to be responsible for the care of people living with HIV/AIDS. Attempts to promote behavioural changes and the provision of care in the household and at community levels are key objectives for many HIV/AIDS prevention and care programmes.

However, approaches should not only focus on a few aspects because HIV/AIDS is a complex issue and appropriate HIV/AIDS policies and programmes need to take account of the cultural and social context in which individuals experience illness and in which their illness is managed (SFH, 2006).

Without care and support for the PLWHAs, millions of adults in the prime of their lives will die of HIV/AIDS and take with them the skills and knowledge base that are necessary for human and economic development. Therefore, it becomes imperative to examine the effect of the care and support being offered by family and community members for PLWHAs on the well-being of the PLWHA.

The study will also explore the care and support for PLWHAs by their family and community members to provide baseline information for policies and actions with a view to reducing poverty, mortality and HIV/AIDS prevalence.

Against this background, the research provided answers to the following research questions:

- What form of care and support are being offered by families of PLWHAs?
- Is there any community based care and support programme for the PLWHAs?
- What are the perceived effects of the care and support offered by family and community members on the well being of the PLWHA?

Objectives of the study:

- Identify the type of care and support offered by families for PLWHAs
- Investigate the availability and relevance of community based care and support programme for the PLWHAs
- Identify the opinions of the PLWHAs on the care and support being provided by family and community members
- Assess the well being of the PLWHAs with the kinds of care and support they receive

Hypotheses of the study: The hypotheses for this study were as follow:

- There is no significant relationship between the levels of care and support given by family and community of the PLWHAs
- Care and support offered by family and community has no effect on the well being of the PLWHA

MATERIALS AND METHODS

The study was conducted in Benue state, Nigeria. Benue is a state in East-Central Nigeria with a population of about 4, 219, 244 National Population Commission (NPC, 2006) estimates. Benue state occupies 34, 059 km^2. The population of the study are the People Living With HIV/AIDS (PLWHA), their family and community members in Benue state, Nigeria. Multistage sampling procedure was used. At the first stage, all the twenty three Local Governments in Benue were stratified into three using the existing senatorial districts; Benue North East, Benue North West and Benue South senatorial districts. Benue South senatorial district is made up of Otukpo, Obi, Ohimini, Ado, Apa, Agatu, Ogbadibo, Oju and Okpokwu local government areas. Benue North West is made up of Makurdi, Konshisha, Gwer West, Gwer East, Gboko, Tarka and guma local government areas while Benue North East includes Buruku, Ushongo, Logo, Katsina-Ala, Ukum, Kwande and Vandeikya. Otukpo and Okpokwu local government areas were purposively selected from the Benue South senatorial district, Makurdi and Gwer East local government areas from the Benue North West senatorial district and Buruku and Vandeikya from Benue North East, due to their high number of PLWHAs (Alubo *et al*., 2002; Amolo, 2003; UN-Habitat, 2003; USAID, 2006; Ekwowusi, 2006). Two communities with high prevalence were purposively selected from each of the local governments, making a total of 12 communities. A support group was then selected randomly from each of the communities, using the updated list of the support groups in Benue state compiled by Network of People living With HIV/AIDS in Nigeria (NEPWAN). Eight respondents (PLWHAs) were randomly selected from each of the support groups, using the support group attendance register. Family members corresponded with the number of PLWHAs and 10 community members were purposively selected from each of the community thereby giving a total of 312 respondents. A well-structured interview guide and a Focus Group Discussion (FGD) were used to elicit information from the respondents.

RESULTS AND DISCUSSION

Family care and support: Bloom and Mahal (1996) opined that economic cost of HIV/AIDS will be felt not by nations but by households. Therefore, to respond with effective mitigation against HIV/AIDS, the way that the family care and support the PLWHAs should be examined. Psycho-social support for the PLWHAs can best be provided by the family of the PLWHAs to help them regain their morale, courage and desire to live. Such support cut across provision of basic needs of life such as food, housing and clothing (United Nations Development Programme (UNDP, 2003). Table 1 shows the responses of family members to the different levels of care and support by for PLWHAs.

As shown in Table 1, it could be discovered that the family members had a high level of caring and supporting the PLWHAs. Some kinds of care and support are seen to receive more attention than others. This types of care and support include maintaining proper hygiene around the PLWHA (76.0%), maintaining the dignity of the PLWHA (74.0%). Table 1 also shows the average score of the respondents per statement. It can be deduced from the scores that majority of the respondent provide the care and support for the PLWHAs always that is anytime the care and support are needed. This might have been influenced by their perception about HIV/AIDS or series of sensitization campaigns taking place in the

Table 1: Distribution of respondents on the type of care and support by families for PLWHAs (N = 96)

Care and support	Always (%)	Some times (%)	Never (%)	Average score
Carrying out laundry services for the PLWHA	58.3	36.5	5.2	2.5
Taking PLWHA out for light exercise	13.5	60.4	26.0	1.9
Running errands for PLWHA	44.8	51.0	4.2	2.4
Fetching water for PLWHA	56.3	41.7	2.1	2.5
Fetching firewood for the PLWHA	19.8	54.2	26.0	1.9
Cooking for the PLWHA	56.3	41.7	2.1	2.5
Taking meal to the hospital for the PLWHA	50.0	43.8	6.3	2.4
Maintaining proper hygiene around the PLWHA	76.0	22.9	1.0	2.8
Housing the PLWHA	53.1	36.5	10.4	2.4
Encouraging the PLWHA to always take proper rest	55.2	40.6	4.2	2.5
Accompanying the PLWHA to health facilities	45.8	45.8	8.3	2.4
Showing love and sense of belongings	68.8	29.2	2.1	2.7
Making the PLWHA acceptable in the family	61.5	36.5	2.1	2.6
Attending to the PLWHA on hospital bed	65.6	31.3	3.1	2.6
Understanding the feelings of PLWHA	63.5	32.3	4.2	2.6
Reassuring the PLWHA	64.6	31.3	4.2	2.6
Counselling the PLWHA	44.8	47.9	7.3	2.4
Maintaining the dignity of the PLWHA	74.0	20.8	5.2	2.7
Purchasing medicine for PLWHA	57.3	35.4	7.3	2.5
Providing nutritional supplement for the PLWHA	60.4	35.4	7.3	2.6
Treating PLWHA for opportunistic infection	38.5	41.7	19.8	2.2
Organizing complementary home-based care	46.9	43.8	9.4	2.4
Taking care of the children of PLWHA	47.9	36.5	15.6	2.3
Avoiding stigma and discrimination within the family	66.7	27.1	6.3	2.6
Financial support for dependents of PLWHA	44.8	33.3	21.9	2.2
Accompanying PLWHA to religious worship	45.8	39.6	14.6	2.3
Taking PLWHA out for spiritual counselling	38.5	42.7	18.8	2.2
Inviting religious leader to pray for PLWHA	30.2	42.7	27.1	2.0

Field survey, 2008

communities. The statements by some of the family members during the focus group discussion crisply explain this:

> .....the kind of care and support we provided for him and his wife ranged from cooking, washing and taking to hospital for treatment

> I have to make sure that her food is ready before going to work as a banker I have a very tight schedule so, my house help takes care of the lunch and dinner. But when I return later in the night I still have to go to her room and encourageher that she can still achieve her dreams. First 3 years were very difficult because the drugs were not readily available; they were sold at the rate of ₦15, 000 and ₦20, 000. But for me to get it easily and on time, I have to go through some people which invariably increased the cost to ₦25, 000 and ₦30, 000. But all the same I have to get the drugs and some other things for her because she is the only family I have left

Community care and support: Community involvement in care and support in Nigeria is very important for the PLWHAs; this is in view of the deprivation and violation

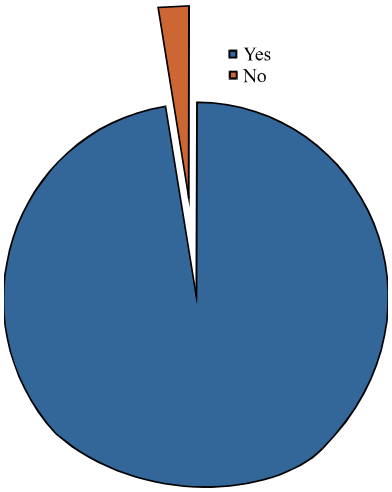

Fig. 1: Pie chart showing the distribution of community members on the availability of community care and support (N = 120)

that a PLWHA may face as a result of their HIV positive sero-status (UNDP, 2003). Through community care and support for the PLWHAs, provision of basic materials for the neediest PLWHA can be met. Similarly, economic support through skill acquisition, training and financing income generating activities can be provided by the community to assist the PLWHAS and their families. Pie chart in Fig. 1 shows the distribution of community members on the availability of community care and

Table 2: Distribution of community members on care and support (N = 120)

Care and support	Always (%)	Some times (%)	Never (%)	Average score
Establishment of free housing scheme	5.8	39.2	55.0	1.5
Provision of clothing and foodstuff	47.5	50.8	1.7	2.5
Showing love and sense of belongings	62.5	35.8	1.7	2.6
Maintaining positive attitude towards PLWHAs	57.5	39.2	3.3	2.5
Training PLWHAs as counsellors	57.5	37.5	5.0	2.5
Making PLWHAs acceptable in the society	48.3	47.5	4.2	2.4
Provision of first aid kit	30.8	60.8	8.3	2.2
Organizing counselling services	47.5	50.0	2.5	2.5
Response to HIV/AIDS epidemics	47.5	50.0	2.5	2.5
Making ART accessible	65.8	30.8	3.3	2.6
Effective basic health system	98.3	1.7	-	3.0
Financial empowerment	24.2	50.8	25.0	2.0
Partnership with specialized organizations to improve PLWHAs' livelihoods	47.5	45.0	7.5	2.4
Setting up of small scale business	18.3	62.5	19.2	2.0
Promoting skill acquisition programmes	23.3	59.2	17.5	2.1
Provision of enabling environment	54.2	39.2	6.7	2.5
Giving scholarship to children of PLWHAs	15.0	61.7	23.3	2.0
Taking care of PLWHAs' dependents	7.5	61.7	30.8	1.8
Creating job opportunities	29.2	63.3	7.5	2.2
Avoiding stigma and discrimination	52.5	45.8	1.7	2.5
Organizing retreats for PLWHAs	50.0	42.5	7.5	2.4
Organizing spiritual counselling for PLWHAs	41.7	51.7	7.6	2.4

support programmes. Majority (97.5%) of the respondents agreed on the availability of community level care and support while 2.5% disagreed. Table 2 shows the responses of the community members to the different care and support for the PLWHAs. The most notable agents of community care and support at the study location were the religious organizations, support groups and individuals. They are involved in providing counselling as well as material needs to the PLWHAs. Many of the religious organization even go to the extent of assisting the PLWHAs financially. Statements by the coordinator of one of the religious organizations support groups and a community member explain further:

> We give them loan of ₦10, 000 and the moment they pay back they will be entitle to another loan. There is scholarship for the PLWHAs' children. This has really help some of them to be productive even with their status. We give them foodstuff from time to time and the reverend fathers come to pray for them twice every week

> We always hear of donation of money to the PLWHAs by people in the community, government and .....they usually meet together monthly and I think they share foodstuffs, clothing and other assistance to themselves. In the last few years, some NGOs, support groups and even the government have been helping them with free drugs and some other things to assist

Opinions of PLWHAs about the care and support received: It was shown by FMOH (2006) that a number of efforts have been devoted to addressing the problem of HIV/AIDS but the current picture in the country shows that the situation is still far from the ideal and desired status. There have been situations where the family and community showed that they are providing series of care and support for the PLWHAs whereas, they are providing none. Therefore, in order to confirm the care and support by family and community members, the responses obtained from the family and community members were confirmed from the PLWHAs and the responses were shown in Table 3. The PLWHAs had high opinions about some care and support that others, some of those care and support that received high opinions are maintaining proper hygiene (76.0%), provision of clothing and foodstuff (79.2%), making ART accessible (75.0%), training PLWHAs as counsellors (74.0%), carrying out laundry services (71.9) and positive attitude towards the PLWHAs (71.9%). Majority (94.8%) of the respondents opined that they receive the care and support always that is anytime it is needed while 5.2% are of the opinion that they sometimes receive the care and support. The total opinion of the PLWHAs on the care and support received are shown in a bar chart in Fig. 2. This therefore, explained the observation of the researcher during the survey that some of the PLWHAs are looking very healthy and even actively in series of activities in their support groups. But they all have series of bitter experiences to share such as the experiences of a medical who was sacked by her boss and patients afraid to go to her for treatment and a coordinator of one of the support groups:

Table 3: Distribution showing the opinions of the PLWHAs about the care and support (N = 96)

Opinions of PLWHAs	Always (%)	Some times (%)	Never (%)	Average score
Carrying out laundry services for PLWHAs	71.9	18.8	9.4	2.6
Taking PLWHA out for exercise	41.7	27.1	31.3	2.1
Running errands for PLWHAs	76.0	18.8	5.2	2.7
Fetching water for PLWHAs	75.0	20.8	4.2	2.7
Fetching firewood for PLWHAs	46.9	24.0	29.2	2.2
Cooking for PLWHAs	69.8	16.7	13.5	2.6
Taking meal to the hospital for PLWHAs	63.5	25.0	11.5	2.5
Maintaining proper hygiene around the PLWHA	76.0	15.6	8.3	2.7
Housing the PLWHAs	71.9	19.8	8.3	2.6
Encouraging PLWHA to take proper rest	56.3	18.8	25.0	2.3
Free housing scheme for the PLWHAs	13.5	17.7	68.8	1.4
Provision of clothing and foodstuff for PLWHAs	79.2	20.8	-	2.8
Attending to PLWHAs on hospital bed	47.9	47.9	4.2	2.4
Accompanying PLWHA to health facilities	86.5	10.4	3.1	2.8
Showing love and sense of belonging to PLWHAs	66.7	24.0	9.4	2.6
Training PLWHA as counsellors	74.0	19.8	6.3	2.7
Maintaining positive attitude towards PLWHAs	71.9	22.9	5.2	2.7
Making PLWHAs acceptable	66.7	29.2	4.2	2.6
Understanding the feelings of PLWHAs	52.1	30.2	17.7	2.3
Reassuring the PLWHAs	51.0	46.9	2.1	2.5
Providing pre/post/follow up counselling for PLWHAs	1.0	16.7	82.3	1.2
Maintaining PLWHAs dignity	22.9	77.1	-	2.2
Purchasing medicine for PLWHAs	59.4	28.1	12.5	2.5
Provision of first aid kits for home-based care providers	40.6	46.9	12.5	2.3
Organizing institutionalized counselling for the PLWHAs	68.8	22.9	8.3	2.6
Response to HIV/AIDS epidemics at all levels	38.5	53.1	8.3	2.3
Establishing effective basic health system for the PLWHAs	60.4	33.3	6.3	2.5
Making ART accessible to PLWHAs	75.0	15.6	9.4	2.7
Providing nutritional supplement for the PLWHAs	32.3	51.0	16.7	2.2
Treating PLWHAs for opportunistic infections	58.3	40.6	1.0	2.6
Organizing basic complimentary home-based care	4.2	18.8	77.1	1.3
Empowering the PLWHAs financially	44.8	30.2	25.0	2.2
Setting up small scale business for the PLWHAs	31.3	21.9	46.9	1.8
Provision of skill acquisition programmes for the PLWHAs	26.0	45.8	28.1	2.0
Provision of enabling environment for PLWHAs	45.8	39.6	14.6	2.3
Provision of scholarship for the children of PLWHAs	30.2	26.0	43.8	1.9
Taking care of the children of PLWHAs	27.1	35.4	37.5	1.9
Taking care of the dependents of the PLWHAs	31.3	31.3	37.5	1.9
Partnership with specialized organizations to improve the livelihoods of PLWHAs	56.3	24.0	19.8	2.4
Creating job opportunities for PLWHAs	44.8	36.5	18.8	2.3
Avoiding stigma and discrimination of PLWHAs	53.1	46.9	-	2.5
Financial support for PLWHAs dependents	13.5	65.6	20.8	1.9
Organizing spiritual counselling for PLWHAs	46.9	37.5	15.6	2.3
Organizing retreats for PLWHAs	37.5	45.8	16.7	2.2
Accompanying PLWHAs to religious worship	41.7	46.9	11.5	2.3
Taking PLWHAs out for spiritual counselling	45.8	42.7	11.5	2.3
Inviting religious leaders to pray for PLWHAs	46.9	42.7	10.4	2.4

> We were all instructed to go for HIV/AIDS screening by our director, he just sentthe result and a sack letter to my table and that was how I lost my job, it was really tough because people were afraid to come to me for treatment until I was employed by this support group to be the medical adviser.....throughout this period my family members were very helpful

I was infected in 2003, my village was too remote so I came to Makurdi to search for Job and get well informed about HIV/AIDS.....I was not able to get anything so I returned home to continue farming.....that was what I doing till I became the coordinator of this support group with my diploma in Law and am about rounding up my degree..... One remarkable thing throughout those periods wasthat my family (mother, sisters and wife) stood by me. Meanwhile, some of them had remarkable experiences of care and support.

> There has been no help from the state all we hear are just promises but the support groups and Ochi-Idoma's wife have been really helping us

I was infected in 1994.....my family members and few of my friends have been supportive, one of them even got me enrolled for the government ART programme when ART was very hard to get the most notable agent of care and support here is the Redeemed Church in Makurdi, they train PLWHAs and give them some money to establish a small scale business.

Table 4: Distribution of PLWHAs according to their well-being (N = 96)

Distribution	Outstanding (%)	Good (%)	Satisfactory (%)	Fair (%)	Poor (%)	Average score
Physical well-being						
Diet	17.7	40.6	34.4	6.3	1.0	3.7
Accommodation	18.8	43.8	22.9	11.5	3.1	3.6
Sleep/Rest	22.9	22.9	30.2	20.8	3.1	3.4
Exercise	20.8	26.0	24.0	16.7	12.5	3.3
Personal hygiene	45.8	30.2	13.5	6.3	4.2	4.1
Psychological well-being						
Love and sense of belongings	58.3	24.0	15.6	2.1	-	4.4
Attitude of people	42.7	30.2	20.8	5.2	1.0	4.1
Encouragement from people	42.7	28.1	25.0	3.1	1.0	4.1
Acceptance in the society	51.0	19.8	21.9	5.2	2.1	4.1
Dignity	62.5	17.7	14.6	3.1	2.1	4.4
Medical well-being						
Functional status	53.1	24.0	12.5	4.2	6.3	4.1
Accessibility to ART	63.5	25.0	8.3	2.1	1.0	4.5
Institutionalized counseling service	61.5	25.0	9.4	2.1	2.1	4.4
Management of opportunistic infections	51.0	28.1	12.5	3.1	5.2	4.2
Appetite	42.7	33.3	18.8	3.1	2.1	4.1
Socio-economic well-being						
Financial empowerment	15.6	20.8	14.6	14.6	34.4	2.7
Opportunities for skill acquisition	10.4	35.4	12.5	21.9	19.8	2.9
Enabling environment	36.5	31.3	17.7	7.3	7.3	3.8
Networking and partnership for PLWHAs livelihood development	38.5	32.3	13.5	9.4	6.3	3.9
Income	38.5	27.1	15.6	9.4	9.4	3.8
Spiritual well-being						
Spiritual counseling	46.9	33.3	13.5	2.1	4.2	4.2
Group support and assistance	54.2	29.2	11.5	2.1	3.1	4.3
Clergy support	45.8	36.5	11.5	4.2	2.1	4.2
Spiritual commitment	51.0	29.2	11.5	6.3	2.1	4.2
Retreat	29.2	30.2	28.1	6.3	6.3	3.7

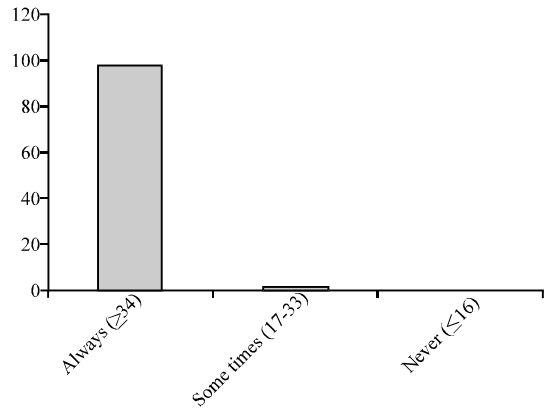

Fig. 2: Bar chart showing the distribution of PLWHAs according to their total opinion on care and support received

> My family have been very supportive since I was infected in 1996, they give me physical and psychological supports.....the support group is really helping too....they encourage and counsel us, they even give financial supports

Well being of the PLWHA: Crisp (2005) describes well-being as a level of happiness, confidence, physical condition and general outlook on life of an individual. It is about feeling good and taking care of one self; responsibilities that can often be neglected when juggling the rigorous demands of everyday living in the 21st century. Well-being and healthy living go hand in hand. Healthy living goes beyond eating a balanced diet, taking regular exercise and avoiding illness. It also reflects the mental, emotional and social aspects of an individual's life. World Health Organization (WHO, 2007) opined that health is a state of complete physical, mental and social well being and not merely the absence of disease or infirmity. Table 4 shows the responses of the PLWHAs about their well being.

From the Table 4, it can be deduced that the PLWHAs experienced some form of well-being than others. Psychological, medical and spiritual well-beings seem to receive more attention. The total well-being of the respondents is hereby shown in the bar chart in Fig. 3.

The mean of the total well-being is 4.43 and standard deviation is 0.71. Majority (54.2%) of the respondents were outstanding in their well-being, 35.4% are good, 9.4% are satisfactory and 1.0% have fair well-being. The confessions of the PLWHAs during the group discussion clearly explain further:

> I become infected in 2003, my family and this support group take good care of me, now I don dey work again.....I dey do okada work and I dey alright

Table 5: The t-test analysis of the difference in the levels of care and support given by family and community of the PLWHAs

	Care and support mean						
Care and support	Family	Community	Combined mean	SD	SEM	t-value	p-value
Total physical care and support	23.95	3.97	20.00	2.43	0.25	80.70	0.000
Total psychological care and support	20.52	10.12	10.50	2.68	0.27	38.50	0.000
Total medical care and support	9.62	12.73	- 3.21	2.16	0.22	- 14.50	0.000
Total socio-economic care and support	7.16	19.33	-12.40	2.84	0.29	-42.70	0.000
Total spiritual care and support	6.54	4.78	1.77	1.82	0.19	9.53	0.000
Total care and support	67.80	50.92	16.70	7.98	0.81	20.53	0.000

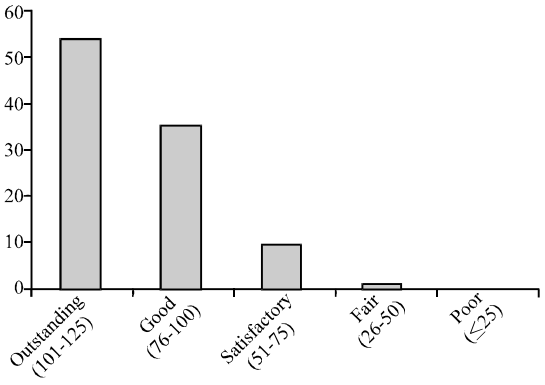

Fig. 3: Bar chart presentation of the PLWHAs according to their total well-being score, Field survey, 2008

HIV/AIDS was severe on the first set of people infected because there were no support groups……..immediately we discovered our status we identified with support group….they counseled and encourage us……and now we are living fine

When I was sacked in 2006, I was devastated but when I became the medical adviser of this support group and I see other PLWHAs and even doctors who are infected….I discovered I was not alone……I have being living well with no feelings of HIV/AIDS because I take my drugs regularly

I start to dey take treatment immediately dem test me……..I never fall sick since I do the test in 2005… I dey fine and na me dey even take care of other people when dem sick (I started treatment immediately after I was diagnosed……..I have not fallen sick since I was tested in 2005…….I am fine and I am the one who take care of others when they are sick).I am still living with the grace of God…..when I became infected in 1999, there was nobody to take of me……..I took care of myself……my husband is dead and his family just came and pack the children……but am better now and am working

Hypotheses testing

Differences between the levels of care and support by family and community: NEPWHAN (2007) opined that providing series of care, support and solidarity for the growing population of PLWHA by enabling them to protect themselves and others is the requirement of families, communities and the whole nation at large. A t-test analysis was conducted to therefore ascertain the difference in the care and support offered by family and community of PLWHA. The t-test analysis as shown in Table 5 that there is significant difference between the entire levels of care and support by family and community members. The families were observed to be the most available agent of care and support for the PLWHA. This mean care and support for the physical care (23.95) and psychological care (20.52) by family are far higher than the mean for physical care (3.97) and psychological care (10.12) by community. It was observed that the community which include the immediate environment, NGOs, government and individuals, deliver some care and support that are capital intensive. This includes medical and socio-economic care and support. The mean for medical and socio-economic care and support by community are 12.73 and 19.33 respectively while the mean for family medical and socio-economic are 9.62 and 7.16, respectively. Therefore, the mean total care and support by family (67.80) is higher than the mean total care and support by community (50.92) showing that the family is generally more involved in care for PLWHA than the communities. This implies that despite the interaction between the community and family, a high level of differences exist between all the cares and supports provided. This therefore, confirmed NEPWHAN (2007) that commitment to HIV response by government was slow but non-governmental organizations, faith based and community organizations and some family members responded, albeit under a political climate that was far from conducive.

Correlation of care and support by family and community with the Opinion of PLWHAs: Pearson Product Moment Correlation (PPMC) was used to examine the relationship between the care and support by family and community members and the opinions of the PLWHAs on the care and support received. The results are as shown in

Table 6: Correlation of the care and support by family with the opinion of the PLWHAs on care and support received

	Total opinion of PLWHAs about care and support					
Correlation of the care and support by family	Physical care and support	Psychological care and support	Medical care and support	Socio-economic care and support	Spiritual care and support	Total opinion of PLWHAs
Total physical care and support by family	0.010	-	-	-	-	-
Total psychological care and support by family	-	0.208*	-	-	-	-
Total medical care and support by family	-	-	-0.001	-	-	-
Total socio-economic care and support by family	-	-	-	-0.014	-	-
Total spiritual care and support by family	-	-	-	-	0.121	-
Total care and support by family	-	-	-	-	-	0.134

*Correlation is significant at the 0.05 level (2 tailed)

Table 7: Correlation of the care and support by community with the opinion of the PLWHAs on care and support received

	Total opinion of PLWHAs about care and support					
Correlation of the care and support by community	Physical care and support	Psychological care and support	Medical care and support	Socio-economic care and support	Spiritual care and support	Total opinion of PLWHAs
Total physical care and support by community	0.070	-	-	-	-	-
Total psychological care and support by community	-	-0.007	-	-	-	-
Total medical care and support by community	-	-	-0.028	-	-	-
Total socio-economic care and support by community	-	-	-	-0.154	-	-
Total spiritual care and support by community	-	-	-	-	-0.188	-
Total care and support by community	-	-	-	-	-	-0.115

*Correlation is significant at the 0.05 level (2 tailed)

Table 6 and 7. Table 6 shows that there was a significant relationship between the total psychological care and support by family and the total opinion of PLWHAs about psychological care and support. This might be in terms of encouragement given by family members, showing of sense of love and belonging, disallowing discrimination and stigmatization within the family and so on. Aggleton and Warwick (1999) and World Bank (1999) asserted that the family is the main source of care and support for PLHWA in most developing countries. Table 7 shows that there is no significant relationship between the care and support by community members and the opinion of the PLWHA about the care and support received. This might be that the care and support given are not up to the required level or the impact has not been felt by the PLWHA.

Perceived effect of care and support by family and community members on the well being of the PLWHAs: Using the complete model with the logit link to build the ordinal regression model, the never level of community care and support and sometimes level of family care and support exhibited negative regression coefficients as shown in Table 8.

The implication of this is that an improvement in the care and support by community from never to sometimes and that of family from sometimes to always will lead to decrease in the well being of the PLWHAs that is a unit increase in the care and support will lead to reduction in the well being of the PLWHAs by 97.0 and 25.5%, respectively. An increase in the family care and support from sometimes to always might affect some other form of care and support for the PLWHAs which might be detrimental to their well being. An example is a respondent who is a farmer and trader, she is able to take care of the PLWHA in the morning before going to work and her house maid does the rest. In an attempt for her to extend the time for the care and support, her occupation might be affected which can lead to her inability to carry out some of the necessary care and support such as medical and socio-economic care and supports. The sometimes level of the community care and support exhibited a positive regression coefficient indicating a 56.9% improvement in the well-being with a unit increase in the care and support by the community. This further emphasized the view of Matemilola (2004) that PLWHAs will be better of when equipped with information and strategies which they can use to preserve and improve their health for as long as possible. A person's well being is what is good for them. Health then might be said to be a constituent of well being but it is not plausibly taken to be all that matters for proper well being. The uncontrolled spread of HIV/AIDS in particular poses a major threat to any development efforts in an economy. It challenges the capacity of the communities and the government to care for the sick,

Table 8: Ordinal regression analysis of perceived effect of care and support by family and community members on the well being of the PLWHAs using logit link

Variables	Regression coefficient	p-value
Total community care and support (Never)	-0.970	0.514
Total community care and support (Sometimes)	0.569	0.321
Total family care and support (Sometimes)	-0.255	0.579

Goodness of fit: Pearson Chi-square = 27.074, p-value = 0.012; Pseudo R^2: Nagelkerke = 0.026

educate orphans and replace the labour force, for instance in agriculture. Women, children and the elderly pay a particularly heavy price. The quality of a life is determined by its activities. By adopting a healthy attitude to life, the government can aid in improving the quality of living of the PLWHA. Well being is not just about avoiding illness and staying fit. Determination of PLWHAs' well being depends largely on their functional status and consumption of nutritious foods (Akinsete, 2006).

The model fitting information, the Chi-square ($\chi^2 = 2.127$ with df of 3 and $p = 0.546$) for the logit link model and Chi square ($\chi^2 = 1.886$ with df of 2 and $p = 0.389$) for the complementary model indicated that there was no significant difference for the corresponding regression coefficient across the response categories.

CONCLUSION

From the findings of the study, it could be concluded that there was a positive perception in the study location about HIV/AIDS. This in turn was believed to have motivated the family and community members towards the effective delivery of care and support to the PLWHAs. The opinions of the PLWHAs according to the study also indicated that they received good care and support from the family and community. Evidences from the study showed that the PLWHAs had high well being. The t-test analysis revealed that there is significant differences between the entire levels of care and support by family and community members. Pearson Product Moment Correlation (PPMC) also revealed that there was a significant relationship between the total psychological care and support by family and the total opinion of PLWHAs about psychological care and support. The complete model with the logit link showed a significant association between the well being care and support provided.

An increase in the family care and support from sometimes to always might affect some other form of care and support for the PLWHAs which might be detrimental to their well being. The sometimes level of the community care and support exhibited a positive regression coefficient indicating an improvement in the well being with an increase in the care and support by the community.

RECOMMENDATIONS

Based on the findings of the study the following recommendations are made:

- Intervention programme that is aimed at improving the knowledge of the family and community members about care and support for PLWHAs should be designed and developed by the concerned bodies (Ministry of Health, Ministry of Agriculture and Rural Development and NGOs) through seminars and sensitization programmes
- The Non-Government Organizations (NGOs), government should intensify their efforts towards care and support by supporting the PLWHA socio-economically and medically
- The communities should provide enabling environment and support the formation of support groups for PLWHA
- Programmes to encourage infected persons to seek knowledge on how to overcome stigmatization and discrimination should be developed by the government, NGOs and other concerned agencies
- Individuals in the community should also contribute to the support of the PLWHA by supporting them emotionally, physically and spiritually

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