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Social Support Systems of HIV/AIDS Rural Women

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Abstract

This study investigated social support systems of HIV/AIDS rural women in Rivers State of Nigeria. The descriptive survey was employed and a sample of 81 HIV/AIDS infected women were selected from five Local Government Areas in the state using the purposive sampling technique. The purpose of the study was to examine the types of care giver roles which the respondents perceived to have impacted positively on their lives and the most important/needed social support systems required by them. A researcher-designed instrument titled 'Rural Women HIV/AIDS Social Support Questionnaire (RWHASSQ) was used to elicit information from the respondents. The responses were analyzed using frequency counts and percentages. Results revealed that the highest care giver roles as indicated by respondents in ranking order included those of relatives (88.9%), children (75.3%), the church (64.2%), and NGOs (59.3%).The care giver roles which had less impact were those of their spouses (48.1%), health care workers (34.6%), friends (18.5%) and neighbours (6.2%). It further showed that the most important social support needs required by the respondents were healthcare/promotion (90.1%), emotional support (83.9%), nutritional support (76.5%), financial support (54.3%), physical support (29.6%) and others (25.9%). Based on these findings, recommendations were made.

Key words: care giver roles, support systems, HIV/AIDS, rural women, Nigeria

1. Introduction

One of the most serious health conditions that threaten the existence of the family in recent times is the HIV/AIDS scourge. HIV/AIDS is capable of affecting any member of a society, and its prevalence among the rural poor women in a developing country like Nigeria spells doom. Although HIV/AIDS cases are prevalent in all parts of the world, 95% of such reside in the low and middle income countries, of which Nigeria is one (UNAIDS, 2006). Literature also shows that about 3.8 million people are living with HIV/AIDS in Nigeria. This implies that 1 in 7 of Africans living with the disease is a Nigerian (Adetunji, 2000). It also shows that HIV/AIDS epidemic has reached every community and locality in Nigeria. To this end, it was reported in the 1999 survey that there was a higher rate of prevalence in the rural areas in three zones namely South-South, North-East and North-West (Ekoja, 2006).

Unfortunately, when women who are considered as care givers in the family are affected by this disease, it puts an additional strain on them physically, mentally and emotionally (Iwere, 2000). Women and young girls are said to be mostly affected due to social and cultural inequality, economic marginality, restricted access to power, among others. For example, HIV/AIDS was found to be more prevalent among females and single individuals of less than 40 years of age in Rivers State of Nigeria (Isife, Nnodim & Opusunju, 2010). Thus, women who are considered as the poorest of the poor are the worst hit, especially in the face of unavailable financial assistance which they require to feed well and take care of their health condition. Furthermore, childbearing in spite of their being infected is not negotiable because culture rarely gives women opportunity to dictate how and when to stop childbearing. In support of this idea, Kiragu (2000) noted that women in Africa are deprived of the control of their own bodies which extends to their inability to refuse or negotiate safe sex with their husbands who in some cases engage in several heterosexual relationships which is supported by culture.

Women are experiencing problems in almost all aspects of their lives as a result of the low status that culture has placed them. Unfortunately, as in all aspects of life, the men who are decision makers have refused to make any change that will ultimately change the position that culture has accorded women. Women living with HIV/AIDS in rural Nigeria might even find it more difficult to sustain themselves especially in a situation where they were not infected by their husbands or whereby their husbands have other wives. Some of the major challenges faced by HIV/AIDS infected women include fear, rejection, loneliness, only to mention a few. Most women living with the disease in Nigeria are said to be infected because they were subjected to forced sex and rape, migration, women/girl trafficking and sexual exploitation (Ezedum, 1999).

Social support system in this study suggests that spouses of infected women, their children and relatives only to mention a few treat them with love, respect and utmost care, unlike what some infected women have come up to state in the news media that they were rejected and sent packing from their homes because of their HIV status. Experience from the print media also indicate that most health workers treat them with disdain, which is one of the reasons why they hardly visit the hospitals. Unfortunately, infected women risk dying early as a result of ignorance and are not likely to observe that the disease is progressing. The situation is even worse when such women become pregnant. Therefore, social support system for the infected women involves evaluating certain indices for maintaining good health and coping with the disease. These include care giver support, health promotion/prevention of illness (nutritional care, hygiene and sanitation, prevention of opportunistic infections) and early diagnosis/treatment.

Care giver support for instance includes provision of daily needs of the victims. According to Kemp (1995), care giver support should be encouraged to create support network of similar

care givers such as religious groups, women's groups, NGOs and community health workers who should help families to identify local resources. Health promotion/illness prevention connotes provision of good health food capable of nourishing the infected women, which also helps to prevent illness to enable them live with dignity and security (WHO/FAO, 2002). In view of the foregoing, this study investigated social support systems of rural women living with HIV/AIDS in Rivers State, Nigeria.

2. Literature Review

Women's health is one of the most fundamental issues in national development even as the quality of their lives depend on the resources available, access to health facilities as well as the social support they receive from by their families, friends and others. This idea is corroborated by Njodi, Bwala and Olaitan (2005) who noted that the quality of the existence of the infected would imply slowing down the progression of the disease, minimizing pain and stigmatization. Thus, social support system for women living with HIV/AIDS become imperative due to the cultural upbringing of the Africans where each person in the family is his brother's keeper. For instance, supporting women who are living with the disease helps to prolong their lives, especially emotional support, which will go a long way in cushioning the effect of the disease.
Social support system is a term used to mean physical and emotional comfort given to people by family, friends, co-workers and others (Oluwole, Hammed & Awaebe, 2011). It is believed that such support patterns have a positive impact on women. Thus, feeling loved and supported by family members and friends is more beneficial to women but not men; and that it is a deep human need to be loved and cared for (New York Reuters Health, 2005; Kendler, 2005). It was revealed that HIV thrives mostly among the poor, illiterate, unemployed and the socially disadvantaged in terms of access to healthcare (Ezedum, 1999; Adetunji, 2000). A disproportionate number of those infected with HIV were noted to be found among members of some families, cultures, social groups, age and resources (Adetunji, 2000).

Purpose of the study

The purpose of this study was to examine the social support systems of rural women living with HIV/AIDS in Rivers State of Nigeria. Specifically, the study examined the extent of care giver support which respondents received from significant support givers on one hand and the most important support system indices required by the respondents on the other.

3. Research Questions

The study sought answers to the following questions:

1. What is the extent of care giver support provided for HIV/AIDS rural women by their family members and significant others?
2. What are the main support system indices required by HIV/AIDS rural women?

4.0 Research Method

4.1 Research Design

The study adopted descriptive survey design to gather information concerning the subject matter. The population of the study comprised all rural women infected with HIV/AIDS in five

rural centres in Rivers State of Nigeria. Rivers State of Nigeria has a total of 23 Local Government Areas. Five Local Government Areas were randomly selected from this number for the study.

4.2 Sample and Sampling Techniques

As a result of the sensitive nature of the study and unavailable records of all infected women in the rural areas, the researcher relied on accidental sampling and only those who attended clinic as at the time of this study and voluntarily agreed to participate were purposively selected. The sample consisted of 81 rural women. This consist of 37 women, aged between 20-35, considered as young and 41 women, aged 36-49 who ere regarded as old. Also, the sample had 39 unmarried and 42 married women. 47 women were from monogamous families and 34 from polygamous families. Finally, the infected women from monogamous families were 67 and 14 from polygamous families.

4.3 Instrumentation

The instrument used was a researcher-designed questionnaire. The questionnaire items were derived from review of literature on care giving and social support systems of the sick. The questionnaire has three sections. Section A was for the respondents' personal data, Section B consists of Three areas measuring the extent of various care giver support roles which had positive impact on the respondents such as (spouse's role, childrens' neighbours', friends' etc). Section C required respondents to indicate their most urgent support indices/needs such as Provision of Finance (money to cater for their personal needs/start a trade), health care/prevention of opportunistic infections (provision of drugs and advice/encouragement by health workers), Emotional support (love and encouragement from spouse to cushion effect of illness), nutritional care/hygiene (provision of good/balanced meal, clean environment), physical needs (clothing, housing) and others. The pattern of response was 'Yes' in case they received assistance and 'No' where they did not. The respondents were told to rate by ticking if they received any of the support stated in the questionnaire. In all, there were 24 items in the questionnaire titled 'Rural Women's HIV/AIDS Social Support Questionnaire' (RWHASSQ).

4.4 Validation of Instrument

The instrument was assessed by a panel of three HIV/AIDS specialists in hospitals, who adjudged the instrument to possess face validity. Reliability of the instrument was ascertained using 20 HIV/AIDS infected women who did not participate in the final study. The instrument yielded a cronbach alpha of 0.72. The responses were analyzed using frequency counts and percentages. A respondent scoring 50 and above signifies agreement with the item and scores below 50 indicates that the respondent is not in agreement or is negative in terms of those items.

4.5 Procedure for Administration and Data Collection

A total of 81 copies of the questionnaire forms were administered to the respondents with the help of two nursing staff in each of the five Local Government Areas of Rivers State of Nigeria. The items were interpreted to the respondents, especially those who were not literate in English Language, with the assistance of health workers who gave the necessary guidance. All the questionnaire forms were retrieved.

5.0 Results

The analysis of results are presented in Table 1-2.

Table 1: Ranking of extent of care giver support indicated by HIV/AIDS rural women

S/No.	Care Giver	Response Categories (N=81)				
		Yes		No		Ranking
.		Frequency	%	Frequency	%	
1.	Relatives	72	88.9	09	11.1	1st
2.	Children	61	75.3	20	24.7	2nd
3.	The Church	52	64.2	29	35.8	3rd
4.	NGOs	48	59.3	33	40.7	4th
5.	Spouse	39	48.1*	42	51.9	5th
6.	Health care workers	28	34.6*	53	65.4	6th
7.	Friends	15	18.5*	66	81.5	7th
8.	Neighbours	05	6.2*	76	93.8	8th

Note: Figures marked with * in the 'Yes' column have below 50% response rate which shows that the care givers offered the least assistance as indicated by the respondents.

Table 1 shows that care givers' extent of assistance as indicated by the respondents from the highest to the least, includes relatives of respondents (88.9%) and ranked as first, followed by respondents' children (75.3%), the church (64.2), NGOs (59.3%), spouse (48.1%), Health care workers (34.6%), friends (18.5%) and lastly neighbours (6.2%).

Table 2: Ranking of Respondents' required Social Support System Needs

		Response Categories N= (81)				
		Yes		No		
S/No.	Social Support System Needs	Frequency	%	Frequency	%	Ranking
1.	Health care/Promotion	73	90.1	08	9.9	1st
2.	Emotional Support	68	83.9	13	16.1	2nd
3.	Nutritional Support	62	76.5	19	23.5	3rd
4.	Financial Support	44	54.3	37	45.7	4th
5.	Physical Support	24	29.6*	57	70.4	5th
6.	Others	21	25.9*	60	74.1	6th

Note: Figures marked with * in the 'Yes' column have below 50% response rate which shows that the support systems were the least required as indicated by the respondents.

Table 2 shows that respondents' required support systems in order of importance and ranking includes Health care/Promotion (90.1%), Emotional support (83.9%), Nutritional support (76.5%), Financial support (54.3%), Physical support (29.6%) and others (25.9%).

6.0 Discussion

The study has shown that in terms of care giver support received by the respondents as seen in their responses to the first research question, four of them were significant (Table 1 refers). This means that respondents received positive care giver support from their relatives (88.9%), children (75.3%), the church (64.2%) and NGOs (59.3%). However, they indicated having the least assistance from their spouses (48.1%), health care workers (34.6%), friends (18.5%) and lastly neighbours (6.2%). The result of this study is surprising in the sense that the most important persons in the lives of the respondents who should offer the greatest care-giver support in terms of love and encouragement such as their spouses and health care workers were

perceived to be less caring. This could be attributed to the non-challant attitude as reported earlier by some HIV/AIDS infected persons in the news and print media that society discriminates against them. The attitude portrayed by society is probably the reason why most infected victims fail to declare their status or seek medical attention. For instance, the attitude of some people concerning care of the victims who are sometimes treated like outcasts contribute to the deterioration of their condition. As observed by Nwachukwu (2007), one of the effects of HIV/AIDS on the patients amongst others is 'loss of respect, dignity, boycott from peers, friends and society in general'. Similarly, Olawale (2001) in corroborating this point of view asserted that perception, attitude and belief about an issue can have an impact on observable behaviour. Thus, it could be said that the attitude of spouses and health care workers could be partly blamed on the way they perceive the ailment and invariably their negative attitude towards those infected with HIV/AIDS.

The second research question which examined the most important social support system needs of the respondents showed that Health Care/Promotion (90.1%), Emotional Support (83.9%), Nutritional Support(76.5%) and Financial Support (54.3%) were the most important as indicated by the respondents (See Table 2). On the other hand, Physical Support(29.6%) and others (25.9%) were perceived to be less important to them.

Obviously, respondents require a lot of health care which is said to delay the disease and prolong the lives of victims. Furthermore, they indicated emotional support due to the fact that many of them might have experienced emotional and psychological trauma which if not carefully addressed have the tendency of making the victims suffer depression. Financial support is also needed as shown by this study probably because most rural women are poor and indulge in petty trade and businesses which could help them to feed better and cater for other needs. Unfortunately, some of the drugs required for them to stay healthy might be expensive or not available in the health centres. Also, some of the respondents might not find it easy demanding money from their spouses, who are perceived to be less caring. Some other factors noted to influence their demands for financial assistance, especially in Africa and Asia were reported to be poverty, female powerlessness, unemployment, illiteracy, only to mention a few (Nwachukwu, 2007).

7.0 Conclusion and Recommendations

This study has noted the various care giver roles which respondents indicated impacted well and not so well in their situation. Some of the recognized care giver roles with high scores included the roles of victims' relatives, children, the church and NGOs. The others which made little or no impact on the respondents were the roles of their spouses, health care workers, friends and neighbours. Furthermore, the social support systems required mostly were found to include health care, emotional, nutritional and financial support. On the basis of these findings, the recommendations made include the following:

1. There is need for more efforts on the part of Health workers to improve on their care-giving roles, encourage infected victims to come along with their spouses; teaching husbands how to take care of their wives by showing love, emotional support and other forms of assistance required.
2. Health workers, especially nurses should be re-trained on how to assist HIV/AIDS victims better to make them feel liked, instead of discriminating against them. Thus, seminars, symposia and conferences should be organized for them periodically by the Federal and State Ministry of Health.

3. Trained counsellors should set up more counselling centres in every community in the Local Government Areas studied to enable infected victims communicate their concerns. Counsellors should adopt the cognitive restructuring approach to help the individuals correct their irrational thinking. More so, irrational fears and beliefs observed in the literature as responsible for such behaviours should be dispelled. They should also organize seminars for infected rural women, while calling on NGOs fighting the cause of women to help them to build up their hope as well as helping them financially to set up small scale businesses in their communities.
4. The Government should do more by ensuring that campaigns are taken to the grass roots in creating awareness on the way individuals suffering from HIV/AIDS can obtain assistance and ensure that the health centres are well equipped with necessary drugs and health personnel to offer the needed help to infected victims. In view of the respondents need for financial assistance, the government should empower the affected rural women economically in order to alleviate poverty, which is one factor that makes them vulnerable to HIV/AIDS.
5. Religious leaders should organize programmes for members, especially in churches and mosques, teaching couples on mode of transmission of HIV/AIDS, prevention and how each person can be of help to the other by ensuring that love and care is maintained at home.

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