

**STRATEGIES FOR ENHANCING FAMILY SUPPORT FOR PEOPLE LIVING
WITH HIV AND AIDS IN DELTA STATE NIGERIA**

BY

ANENE-OKEAKWA JOSEPHINE EMEBIZIOGO

REG. NO. PG/PhD/11/58676

**DEPARTMENT OF HOME ECONOMICS AND HOSPITALITY
MANAGEMENT EDUCATION
FACULTY OF VOCATIONAL AND TECHNICAL EDUCATION
UNIVERSITY OF NIGERIA, NSUKKA.**

OCTOBER, 2016

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**THESIS PRESENTED TO THE DEPARTMENT OF
HOME ECONOMICS AND HOSPITALITY MANAGEMENT EDUCATION,
FACULTY OF VOCATIONAL AND TECHNICAL EDUCATION,
UNIVERSITY OF NIGERIA, NSUKKA IN FULFILMENT OF THE
REQUIREMENT FOR THE DEGREE OF DOCTOR OF PHILOSOPHY (Ph.D)
IN HOME ECONOMICS AND HOSPITALITY MANAGEMENT EDUCATION**

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APPROVAL PAGE

This thesis has been approved for the Department of Home Economics and Hospitality Management Education, University of Nigeria, Nsukka.

By

Prof. E. U. Anyakoha
Supervisor

Internal Examiner

External Examiner

Prof. E. U. Anyakoha
Head of Department

Prof. E. E. Agomuo
Dean, Faculty of Vocational and Technical Education

CERTIFICATION

Anene-Okeakwa Josephine Emebiziogo., a postgraduate student in the Department of Home Economics and Hospitality Management Education, Faculty of Vocational and Technical Education, University of Nigeria, Nsukka and with registration number PG/PhD/11/58676, has successfully completed all the requirements for research work for the degree of Doctor of Philosophy (Ph.D) in Home Economics and Hospitality Management Education. The work embodied in this thesis is original and has not been submitted in part or full for any other diploma, degree or professional qualification in this or any other institution.

Anene-Okeakwa Josephine Emebiziogo
(Student)

Prof. E. U. Anyakoha
(Thesis Supervisor)

DEDICATION

This work is dedicated to Almighty God, who is my great provider. This work is also dedicated to my children ó Chukwuemeka, Uchechukwu, Ndubisi, Ekenedilichukwu, Onyekachukwu, and Kaosisochukwu.

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Anene-Okeakwa Josephine E.
PG/PhD/11/58676

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ABSTRACT

The study was carried out to determine strategies for enhancing family support for people living with HIV and AIDS in Delta State Nigeria. In carrying out the research, seven research questions and seven null hypotheses were formulated for the study. The study adopted descriptive survey research design. The population for the study was 27,216 PLWHIV/AIDS and comprising also of family members of PLWHIV and AIDS, all NGO's such as civil societies, donor agencies and prevention programme experts; public and private healthcare workers, government agencies in the urban and rural communities of Delta State who were directly involved in the provision of support to family members living with or affected by HIV and AIDS.. This consists of PLWHIV and AIDS, members of families of PLWHIV and AIDS, persons from NGO's, persons from public and private healthcare workers, as well as persons from government agencies. The sample for this study was 669 persons selected from the different groups of the population using simple random sampling technique. This consisted of 63 persons for focused group discussion and 606 persons for the questionnaire. The sample was selected using simple random sampling technique. For the focus group discussion, the sample consists of 33 persons living with HIV and AIDS as well as 30 persons who are family members of people living with HIV and AIDS. For the questionnaire, the sample consists of 205 PLWHIV and AIDS, 205 members of families of PLWHIV and AIDS, 10 persons from NGO's, 126 persons from public and private healthcare workers, as well as 60 persons from government agencies. Questionnaire was the instrument used for data collection. Focus group discussion using structured questions as contained in copies of the questionnaire was also used to collect information for the study. The instrument was validated by five experts. The reliability of the instrument was established by administering twelve copies of the questionnaire to people living with HIV and AIDS, people from nuclear and extended families, as well as some members of the Family of People Living With HIV and AIDS. An overall reliability coefficient of 0.61 was obtained. Data collected for the study was analyzed using mean. t-test for independent samples was used to test the hypotheses at 0.05 level of significant. The findings revealed that PLWHIV&AIDS require 14 nutritional strategies from their families, 16 medical support strategies from their families, nine emotional support strategies, 15 socio-economic support strategies. It was also found that families of PLWHIV and AIDS face 45 challenges in rendering support to PLWHIV and AIDS, while PLWHIV and AIDS face 15 challenges in receiving support from their family members. Also, it was found that there are 28 families strengthening strategies in supporting PLWHIV&AIDS. The findings of the study revealed that there was a significant difference in the responses of families of PLWHIV&AIDS and families of PLWHIV&AIDS on the nutritional support strategies PLWHIV&AIDS require from their families. From the findings, it was revealed that there was a significant difference in the responses of families of PLWHIV&AIDS and PLWHIV&AIDS on the emotional support strategies PLWHIV&AIDS require from their families. The study revealed that there is a significant difference in the responses of PLWHIV&AIDS and families of PLWHIV&AIDS on the challenges families face in rendering support to PLWHIV and AIDS. Based on the findings of this work, seven recommendations were made which include: PLWHIV and AIDS should not complain so much about the ways their family members are rendering support to them, they should also appreciate the effort being made by their family members to help them, among others. This will motivate their family members in being more patient with them; families of PLWHIV and AIDS should be patient and adopt the necessary strategies in rendering nutritional, medical, emotional, economic, and social support to PLWHIV and AIDS, among other recommendations. Suggestions for further study were also made.

CHAPTER ONE

INTRODUCTION

Background of the Study

Sick people generally require some levels of care and family support to enable them cope with challenges of the ailments they are affected with. Family support in the context of Human Immuno-deficiency Virus (HIV) Acquired Immuno-deficiency Syndrome (AIDS) connotes catering to needs such as medical treatment, assisting in overcoming challenges of people living with HIV and AIDS (PLWHIV/AIDS) or simply showing empathy and consideration to persons in need and providing appropriate support for persons affected by it (National Guidelines on HIV and AIDS Care and Support, 2014).

According to Blessing (2014), family is a fundamental social group in society typically consisting of one or two parents and their children. In the opinion of Hammond, Cheney and Pearsey (2015), family is a complex, dynamic, and changing collection of parts, subsystems and family members and could be described as either consisting of a mother and a father and their children or consisting of step-parents or step-siblings or both as a result of remarriage, or of relatives such as cousins, aunts and uncles, grandparents and great grandparents. According to Anyakoha (2015) family is a group of persons united by ties of marriage, blood or adoption and often characterized by common residence and economic co-operation. Anyakoha (2015) further asserts that family members depend upon each other for many things such as intensive and extensive relationships which involve intimacies that other relationships do not have. This is because, family living includes the sharing of work, play, food, rest, joy, crises, and so on.

Families are frequently the main source of support in times of illness. For every family, they have something that they believe in, which binds them together. Based on this belief, family members tend to strengthen their support for one another. Therefore,

family support can be viewed as a set of beliefs and an approach to strengthening and empowering families and communities so that they can foster the optimal development of children, youth, and adult family members. In relation to PLWHIV and AIDS, Family support for PLWHIV and AIDS is one where every person living with HIV and AIDS has access to quality care and is treated with respect to help them lead a life of dignity without stigma and discrimination. It is an integrated network of community-based resources and services that strengthens family practices and the healthy development of the PLWHIV and AIDS. It is one provided in the natural environment of the family, to address the needs of the PLWHIV and AIDS as related to their emotional well-being, health, material well-being, parenting, stigma and discrimination-related considerations, and family interactions, in a manner that builds on a family's strengths, is culturally responsive to the PLWHIV and AIDS receiving the support, assists the family to maximize the self-determination of the member living with HIV and AIDS, is controlled, determined, and directed by the family itself, in partnership with those who provide the services, using best practices. It is practical support in performing various tasks that support the PLWHIV and AIDS such as support for treatment adherence and compliance, social and socio-economic support, psychological support, support for children and families, self-support, support for socio-professional integration, legal support and the fight against discrimination, spiritual support, nutritional advice and family mediation and or social and therapeutic.

Family support initiatives for individuals living with or affected by HIV and AIDS often range from providing social and psychological support, with some nutritional support and basic nursing care to dispensing anti-retroviral (ARV), helping to treat opportunistic infections, counseling, providing income generating opportunities for widows as well as assisting with payment of school fees for orphans (Amiya, Poudel, Poudel-Tandukar, Pandey, Jimba, 2014; WHO, 2000 & WHO, 1999).

In a study on understanding family support for people living with HIV and AIDS in Yunnan, China, Lee, Wu, Rotheram-Borus, Detels, Guan, & Li (2005) observed that

people living with HIV and AIDS (PLWHIV and AIDS) have been severely discriminated not only by the general public; but also by their family members (Root, 2010) and by health care workers (Anderson, Zheng, Wu, Li, & Liu, 2003). Family members with individuals living with or affected by HIV and AIDS are often afraid of losing face and bringing shame to the family because one member of the family is HIV-positive and because to most people in Africa, HIV and AIDS is associated with promiscuous sex and drug abuse, both of which are considered to represent low moral status. Consequently, family relations change causing family members living with HIV and AIDS to feel isolated and/or restricted when they interact. This change in family behaviour comes in the form of not communicating or relating with the individuals living with or affected by HIV and AIDS because of fear and anxiety of being infected from such relationships (Iiebani & Eniola, 2011). Moreover, family members do not share or discuss with members living with HIV and AIDS, their emotions as a way of helping them, or have an open attitude towards them (Gao, 2002).

Human Immuno-deficiency Virus (HIV) is the virus that causes Acquired Immuno-deficiency Syndrome, while AIDS is a viral disease that destroys human immunity by depleting the lymphocytes (the t-cell), which is the most critical to the immune response (Sizer & Whitney, 2000) and exposes the body to all kinds of opportunistic infections. The pathology of HIV infection involves three stages namely, primary HIV infection, the asymptomatic phase, and AIDS.

According to UNAIDS (2002), primary HIV infection is the first stage where transmitted HIV replicates rapidly causing acute flu-like symptoms in some persons, which usually persist for one to two weeks, as well as enlarged lymph nodes, sore throat, muscle and joint pain, rash, and malaise. Standard HIV tests measuring antibodies to the virus are initially negative. The level of HIV in the blood decreases as the immune response to the virus ensues. The second phase lasts an average of 10 years during which the virus continues to replicate concurrent to a gradual decrease in the number of helper T cells. With the fall of helper T cells count to about 200 cells per micro-litre of blood (in

an uninfected adult it is typically about 1,000 cells per micro-litre), patients begin to experience opportunistic infections. This is Acquired Immunodeficiency Syndrome (AIDS) (UNAIDS, 2002). AIDS is caused by infection with HIV, a virus that is transmitted primarily by sexual contacts, contacts with infected blood and needles shared among drug users or fluids transferred from an infected mother to her fetus or infant (Sizer & Whitney, 2000). It is the final stage of HIV infection (UNAIDS, 2002a).

Nigeria's response to HIV and AIDS has moved progressively from initial denial by government that HIV and AIDS was a major threat between 1986 and 1990; publication of the first National Policy on HIV and AIDS and sexually transmitted infections (STI) in 1997; establishment of National Action Committee on HIV and AIDS (NACA) in 2000; launching of HIV and AIDS Emergency Action Plan (HEAP) in 2001; publication of Revised National Policy on HIV and AIDS in 2005, and publication of the HIV and AIDS National Strategic Framework for Action also in 2005 (Adogu, Ilika & Asuzu, 2007).

By the year 1999, the nation launched serious effort towards HIV prevention, treatment, care, and support activities. For example, in 2001 the Federal Government of Nigeria hosted the Organization of African Unity's first African Summit on HIV and AIDS and other related infectious diseases. In the same year, a broader AIDS control program, which included the Presidential Committee on AIDS and the multi-sectoral National Action Committee on AIDS (NACA) was initiated and further extended to all states through the state action committees on AIDS (SACAs) and to the district level through the local action committees on AIDS (LACAs). NACA was charged with the responsibility of developing policies for the prevention and control of HIV AND AIDS through effective multi-sectoral response strategies nationwide (Federal Ministry of Health, 2001). Through the efforts of NACA the first multi-sectoral medium-term plan of action known as the HIV and AIDS Emergency Action Plan (HEAP) was developed. The action plan had two main components: to break down barriers to HIV prevention at the

community level and support community-based responses, and to provide prevention, care, and support interventions directly.

In 2004, the National HIV and AIDS Strategic Framework (2005-2009) was developed to succeed HEAP (Federal Ministry of Health, 2001; National Action Committee on AIDS, 2005). Although, the HIV prevalence is much lower in Nigeria than other African countries, Nigeria has the second highest number of HIV-positive adults in sub-Saharan Africa and third in the world in terms of the total number of people infected, behind India and South Africa (UNAIDS, 2004c, UNAIDS, 2004d). This infection rate should however be considered in the context of the size of Nigeria's population of about 140 million people of which an estimated 2.6 million people are infected with HIV (UNAIDS, 2008a).

The HIV and AIDS prevalence rate in Delta State stood at 3.4 per cent in 2008 and dropped to 2.5 per cent in 2010, rose in 2011 to 2.6 per cent and skyrocketed to 2.9 per cent in 2012 (Adebawal, 2013). United Nations Organization (2014) recent survey and analysis of HIV and AIDS by states, ranked Delta State 9th (4.1 per cent), with prevalence rate higher in the urban areas than in the rural areas perhaps due to her urbanized and oil producing status with an admixture of immigrants and in-migrants of different ethnic groups and social lifestyles.

On the family front, implications of having AIDS in the family have been documented in many parts of the world. They range from increased medical costs and expenditures on funerals to withdrawal of family members from work or school to look after those who are ill (UNAIDS 2006). In order to fulfill the demand for care and treatment, families, friends, and the community can be major sources of support (Yadav, 2010).

Delta State is one of the oil producing states and a leading producer of crude oil and gas. It lies roughly between longitude 5°00 and 6°45'E and latitude 5°00 and 6°30'N. The state was carved out of the former Bendel State in 1991 and once integrated in the

mid-western state from 1963 to 1976. The name Bendel (Ben-Del) meant Benin-Delta to reflect the integration of Benin and Delta provinces. The capital city is Asaba located at the northern end of the state with an estimated land area of 762Km² (Delta State Government (DTSG), 2010).

In Delta State, families still account for a large proportion of the support sick people rely on. Unfortunately, the supports received sometimes are not regular and adequate. Coupled with this is the challenge of physical separation of parents, children and relatives due to increase in urbanization and rural to urban migration. This has far reaching effects for the care of the people living with HIV and AIDS. More worrisome is the fact that the effects of AIDS on families and society is still not fully understood, particularly when the long term effects are considered (UNAIDS, 2006). AIDS shines a spotlight on human rights and societal issues (Mann, 1994) and exacerbates other major challenges to development. Without care and support for the individuals living with or affected by HIV and AIDS, millions of adults in the prime of their lives will die of HIV and AIDS and take with them the skills and knowledge base that are necessary for human and economic development (Ilebani &Eniola, 2011).

The understanding and awareness of the need for enhancing family support for these individuals living with or affected by HIV and AIDS therefore becomes very germane. Although government, international donor agencies and non-governmental organizations (NGOs) at different levels have endeavoured to work out modalities on how to enhance family support for people living with HIV and AIDS in the society and eliminate other forms of discrimination and stigmatization on them, these supportive programmes cannot substitute for unsupportive family relationships hence, several public approaches to this effect have been employed. Limited studies have been conducted in the state on how individuals living with or affected by HIV and AIDS perceive their lives in relation to the type of care they are getting. Even when political, legal and social environments are conducive, the participation of people living with or affected by HIV and AIDS is seldom reflected in the formulation of state policies and programmes. There

is an absence of appropriate mechanisms to ensure that the experiences, perceptions and capacities of those living with or affected by HIV and AIDS are expressed, valued, understood, and taken into consideration in the development of policies and programmes affecting them. Even when an appropriate forum is provided, individuals living with HIV and AIDS often lack the skills required to engage state institutions and governments in policy designs. Many of the individuals do not have gainful employment and therefore are too weak to engage in any serious discussions. Even when they are employed, the kind of institutions they work for are unlikely to generate and institute policy changes. As a result of the stigmatization experienced by HIV and AIDS, especially from among their family members who are supposed to care for them. This situation necessitates this study, which aims at finding out what the PLWHIV and AIDS require and what they are getting in Delta State. This is with a view to establishing the gap and developing the needed strategies, which will help improve the situation.

Statement of the Problem

The effects of HIV and AIDS on families in Delta State are devastating with the majority of the PLWHIV/AIDS being young productive adults. The arrival of Antiretroviral Therapy in the state was received with great excitement and the immediate priority of government was to make this effective treatment widely available to all eligible persons. Consequent upon this, no plans were made for the provision of non-medical care and support for the PLHIV and AIDS. Thus, the consequences of the epidemic for most family members and the PLWHIV and AIDS have been comparatively overlooked, leaving behind a generation of family members and PLWHIV and AIDS with great financial, emotional and developmental challenges. Many of the PLWHIV and AIDS do not only have children but also parents and older persons who are likewise affected by their illness because of their inability to earn income. They therefore become dependent on other family members, whose income may be too meager, to support them and their offsprings.

Although the Delta State government has been giving greater attention to the prevention of HIV and AIDS as well as educating society against the stigma of HIV and AIDS and on caring for PLWHIV and AIDS, many family members still feel withdrawn from fellow family members with the disease, making the situation far from the ideal and desired status. There is little or no emphasis on family members' interrelationship with AIDS sick family members as they dread the sharing of foods, toilets, bathrooms, cloths, handshakes and sitting close with infected family members. They are often downcast because of fear of contamination. This tends to increase the psychological and emotional rejections of the PLWHIV and AIDS within the family cycle. In addition to this challenge, less or nothing is often available to caregivers who are often burdened with financial demands relating to the healthcare costs and the provision of material support to PLWHIV and AIDS within their family cycle. This affects the care available to the sufferer and their families making it difficult for many to access drugs, income and support. Little wonder situations exist where family and community members showed that they were providing series of care and support for individuals living with or affected by HIV and AIDS whereas they were providing none and thus creating grievous gaps in the support that individuals living with or affected by HIV and AIDS ought to get from their family members.

Limited studies have been conducted in the State on how individuals living with or affected by HIV and AIDS perceive their lives in relation to the type of care they require and the type of care they are getting. Even when political, legal and social environments are conducive, the participation of people living with or affected by HIV and AIDS is seldom reflected in the formulation of state policies and programmes. There is an absence of appropriate mechanisms to ensure that the experiences, perceptions and capacities of those living with or affected by HIV and AIDS are expressed, valued, understood, and taken into consideration in the development of policies and programmes affecting them. Even when an appropriate forum is provided, individuals living with or affected by HIV and AIDS often lack the skills required to engage state institutions and governments in

policy designs. Many of the individuals do not have gainful employment and therefore are too weak to engage in any serious discussions. Even when they are employed, the kind of institutions they work for are unlikely to generate and institute policy changes. As a result of the stigmatization experienced by individuals living with or affected by HIV and AIDS, especially from among their family members who are supposed to care for them. This situation necessitates this study, which aims at finding out what the PLWHIV and AIDS require and what they are getting in Delta State. This is with a view to establishing the gap and developing the needed strategies, which will help improve the situation.

Purpose of the Study

The major purpose of this study was to evolve strategies for enhancing family support for people living with HIV and AIDS in Delta State. Specifically, the study determined the:

1. nutritional support strategies required by PLWHIV and AIDS from their families
2. medical support strategies required by PLWHIV and AIDS from their families
3. emotional support strategies required by PLWHIV and AIDS from their families
4. socio-economic support strategies required by PLWHIV and AIDS from their families
5. challenges families of PLWHIV and AIDS face in providing support to PLWHIV and AIDS.
6. challenges PLWHIV and AIDS face in receiving support from their family members.
7. strategies for strengthening families to support PLWHIV and AIDS.

Significance of the Study

The findings from this study shall be of immense benefit to families, the PLWHIV and AIDS, communities, the government, non-governmental organizations (NGOs) and

HIV programme managers working on family support for the PLWHIV and AIDS within the context of existing realities on ground. The findings will be published with a view to reaching and impacting on the people it is meant for. To the PLWHIV and AIDS, the findings will help reveal the gap between the type of family support they need and those they are presently getting with a view to strengthening families towards the provision of the needed supports.

To the communities, the findings will help raise awareness on ways they can help strengthen families in supporting the PLWHIV and AIDS by highlighting the challenges families face in giving support to the PLWHIV and AIDS for their possible interventions. This will help improve upon the level of satisfaction derived from family support by the PLWHIV and AIDS through conferences, seminars and workshops.

To the government, the findings of the study will help provide a framework for better understanding of the challenges faced by family members in giving supports to the PLWHIV and AIDS, the challenges faced by the PLWHIV and AIDS in receiving such supports, and the gap that exists between the types of family support needed by the PLWHIV and AIDS and those presently received by them. This will help strengthen government roles towards evolving ways of enhancing family support for the PLWHIV and AIDS in the state.

To non-governmental organizations (NGOøS), the findings of the study will help them develop an integrated support approach that recognizes the growing importance of the involvement of families, the PLWHIV and AIDS, communities, the government, non-governmental organizations (NGOøS) and HIV programme managers. This will enable them reposition their activities geared towards ameliorating the challenges facing families and the PLWHIV and AIDS in providing and receiving needed supports respectively.

To HIV programme managers, given the various programmes in place on HIV and AIDS, the findings of this study will serve as a useful guide to them in understanding the gaps that exists between what PLWHIV and AIDS require and what they are getting. By

so doing, the gaps can be closed and the PLWHIV and AIDS can come to terms with their state of health and still live a normal life.

Research Questions

The following research questions were answered by the study:

1. What nutritional support strategies do PLWHIVAIDS require from their families?
2. What medical support strategies do PLWHIV and AIDS require from their families?
3. What emotional support strategies do PLWHIV and AIDS require from their families?
4. What socio-economic support strategies do PLWHIV and AIDS require from their families?
5. What are the challenges families of PLWHIV and AIDS face in rendering support to PLWHIV and AIDS?
6. What are the challenges PLWHIV and AIDS face in receiving support from their families?
7. What are strategies for strengthening families to support PLWHIV and AIDS?

Hypotheses

The following hypotheses were tested by the study at 0.05 level of significant:

H₀₁: There is no significant difference in the mean responses of families of PLWHIV&AIDS and PLWHIV&AIDS on the nutritional support strategies PLWHIV&AIDS require from their families.

H₀₂: There is no significant difference in the mean responses of families of PLWHIV&AIDS and PLWHIV&AIDS on the medical support strategies PLWHIV&AIDS require from their families.

Ho3: There is no significant difference in the mean responses of families of PLWHIV&AIDS and PLWHIV&AIDS on the emotional support strategies PLWHIV&AIDS require from their families.

Ho4: There is no significant difference in the mean responses of people from nuclear and extended families on the socio-economic support strategies PLWHIV&AIDS require from their families.

Ho5: There is no significant difference in the mean responses of families of PLWHIV&AIDS and PLWHIV&AIDS on the challenges families face in rendering support to PLWHIV&AIDS.

Ho6: There is no significant difference in the mean responses of families of PLWHIV&AIDS and PLWHIV&AIDS on the challenges PLWHIV&AIDS face in receiving support from their families.

Ho7: There is no significant difference between the mean responses of people from nuclear and extended families on families strengthening strategies in supporting PLWHIV&AIDS.

Scope of the Study

The study was delimited to types of support strategies-nutritional, medical, emotional as well as socio-economic, respectively, as provided for and received by the PLWHIV and AIDS. It was also focused on the challenges associated with providing support to PLWHIV and AIDS by their families and families strengthening strategies in supporting PLWHIV and AIDS.

The study was delimited to the three geo-political zones of the state namely, Delta North, Delta Central and Delta South, which is made up of twenty-five (25) local government areas.

The population comprised PLWHIV and AIDS, family members of PLWHIV and AIDS, all NGOs such as civil societies, donor agencies and prevention programme

experts; public and private healthcare workers, government agencies in the urban and rural communities of the state. These constituted the respondents for the study.

CHAPTER TWO

REVIEW OF RELATED LITERATURE

This topic will be discussed under the following sub-headings:

- **Conceptual framework**
 - a. Human Imuno Virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS)
 - b. Families of People Living With Human Imuno Virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS)
 - c. People Living With Human Imuno Virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS)
 - d. Family support for the PLWHIV and AIDS
 - e. Challenges relating to family support for PLWHIV and AIDS
 - f. Ways of strengthening families to support the PLWHIV and AIDS
- **Theoretical framework**
 - a. Theory of spoilt identity
 - b. Theory of culture
 - c. Integrated Continuum of Care Partnership Model
- **Review of related empirical literature**
- **Summary of Review of Related Literature**

Conceptual framework

A. HIV & AIDS

HIV connotes human immunodeficiency virus. It is the virus that causes Acquired Immune Deficiency Syndrome (AIDS). To be transmitted to another person, one of the

persons must be infected with HIV; the virus must be very concentrated as it is in blood; a small amount of the blood is enough to infect someone but much larger amounts of other body fluids would be required and the virus must get into the bloodstream through an open cut or sore or through contact with the mucous membranes in the anus and rectum, the genitals, the mouth, or the eyes. The virus destroys the body's immune system leaving the body open to infections that it cannot fight in the normal way and when this happens, a person has AIDS (Rosserr, 2006).

HIV targets and kills the T4 helper cells, which are a population of lymphocytes that are essential to the body's defense against diseases (Bakare, 1996). Olaleye (2000) observed that the two major types of HIV-HIV-1 and HIV-2-could be distinguished genetically and anti-genically. Olaleye further stressed that by the last count, at least 12 HIV-1 subtypes and 5 HIV-2 subtypes had been registered with the Gene-Bank. The viruses are highly heterogeneous in a variety of biologic, serologic and molecular features. These variables features coupled with the other properties of the virus make it difficult to produce effective vaccine or therapy against the virus (Olaleye, 2000).

On the other hand, Acquired Immune Deficiency Syndrome (AIDS) is a clinical condition that results from infection with the Human Immunodeficiency Virus (HIV), which progressively damages the body's ability to protect itself from disease organisms (Office of Educational Research and Improvement, 1990). "Acquired" means that the infected person got the infection from another person. "Syndrome" means a collection of health problems or diseases, which may include a variety of opportunistic infections, neurological disorders and malignancies (Prath, 2005).

AIDS, according to the World Health Organization (WHO) (1994) is the end stage of infections with HIV virus characterized by a cluster of illnesses. Such cluster of illnesses often referred to as opportunistic infection arise as a result of the victim's suppressed immune system due to the HIV infection. Churchill (2004) stressed that AIDS is a syndrome because of its aggregate of signs, symptoms or other manifestations considered to constitute the characteristics of a morbid entity used especially when the cause of condition is unknown. AIDS is a sexually transmitted disease; it can be passed

from woman to man, from man to woman, and from man to man (Royce, Sena, Cates & Cohen, 2005).

AIDS is a deadly disease and the majority of people who become infected with HIV will develop AIDS or dementia or associated neurological diseases within 10 years (Katona, 2003). Haseltine (1993) described AIDS as a progressive degenerative disease of major organs and systems including the immune system and the central nervous system. It is also generally considered a fatal and incurable disease and in such a context, the medical management of an HIV infected person is considered a negative investment (Semguruka, 2004).

The signs and symptoms of AIDS mainly depend upon the types of infections or diseases that a person has acquired as a result of HIV infection. However, there are some common signs and symptoms of HIV and AIDS, such as the following: Weight loss, persistent fever, headaches, prolonged diarrhea, night sweats, excessive tiredness and swollen lymph nodes in the neck, armpits or groin. Others include dry cough, shortness of breath, skin rashes, memory loss, confusion, difficult in concentration, sadness or depression, persistent herpes zoster and persistently painful legs (Koffi, 1995). Semguruka (2004), further stated that when a person is infected with HIV, the virus may remain in the body without causing any harm for a long time. The exact period when a person starts to develop signs and symptoms is not known. If the person remains healthy, well nourished, and free of other diseases then the period they remain free of symptoms may be longer. However, because the person carries the virus they can still pass on the infection to another person even if they show no symptoms.

Individuals living with or affected by HIV and AIDS are activists, informed patients, care givers, educators, researchers, policy makers, and healthcare providers. They ask questions, and do not rest before they have an answer or a solution to their challenges. They are leaders in stopping HIV and show visionary leadership in implementing and supporting prevention, treatment and care. They are persons living with HIV and AIDS and who have been tested positive with HIV virus while a person affected by AIDS is one who has a relation living with the virus (Baro, 2014).

B. Family and family support for the PLWHIV/AIDS

Family can be further defined as "Two or more people who share goals and values, have long-term commitments to one another and reside usually in the same dwelling (Blessing, 2014). This definition encompasses the vast majority of modern family units. The traditional family consists of a father, mother and children. However, the 21st century showcases a variety of family units. Today, children are also often raised in single parent homes, by grandparents or by homosexual parents. Some families opt to have no children, or cannot have children due to some medical or emotional barriers. The idea that parents and children make a family is a basic definition; however, in order to accurately acknowledge other family structures, a broader definition is necessary. In addition to a more universal family definition, there are also plenty of people who consider a group of friends to be family, and adults who consider pets as defining members of the family unit (Blessing, 2014).

The functions of the family are fundamental to human lives; they could be domestic, sexual, economic and reproductive/educational (Milkah, 2001). They achieve these functions by living together, which is a form of social interaction whereby members of the family depend on each other for a lot of things. They share values, life styles, love, joy, disappointments, sorrows and communications. They depend on each other, support each other, work together and share intimacies. In some cases, in order to keep the secret within the family, the family members usually make collective effort to face outside pressure or family members who know about the situation also keep it a secret from other family members.

Support is help or assistance given *e.g.* practical support in performing domestic task, which people are unable to undertake (Semguruka, 2004). It is to hold up and add strength to (Korubo, 2006). It relates to provision of holistic care and support to various groups of infected people as well as the affected, including children orphaned by AIDS and other vulnerable children. It also involves empowering communities to provide support structures for individuals living with or affected by HIV and AIDS (National

Agency for the Control of AIDS, 2009). Therefore, support means amongst other things, to sustain a person in mind, spirit and body.

Up to 80per cent of AIDS-related deaths occur in the home (Uys, 2003). Thus, effective family support becomes the panacea for improving the quality of life for people living with HIV and AIDS. According to Semguruka (2004), Uys (2003) and Ogden (2006),research evidence clearly demonstrates that between 70 to 90 percent of care for people living with HIV and AIDS takes place within the home and it is the best way for most people to be cared for and to die (WHO, 1999). With proper care and support provided by family members, people living with HIV and AIDS are believed to live healthy longer lives because being around family members, they feel happy and productive and with better food and medical treatments from family members coupled with rest and exercise, their immune system can be strengthened.

Past researches have often demonstrated that HIV and AIDS is a family disease and that throughout the world, most caregivers are family members, usually women and young girls, and these caregivers are valued as the main source of care for ill people (Semguruka, 2004). Furthermore, the burden of care is often inevitably borne by poor family members. Worst still, when one member of a family has HIV and AIDS, the impact radiates through the entire family (Boe, Miller & Goldman, 1993; Pequegnat, Bauman, Bray, DiClemente, Di-Iorio & Hoppe, 2001; Rotheran-Borus & Lightfoot, 2000). Vulnerability to this HIV and AIDS scourge among family members increases when women's time from caring for the sick is taken away for other productive tasks within the household (WHO, 2002; 2000).

With adequate support, individuals living with or affected by HIV and AIDS are more likely to be able to respond adequately to the stress of being infected and are less likely to develop serious mental health problems (WHO, 2014). Thus, providing support for people with HIV and AIDS in the home has many potential benefits for both HIV infected and affected people. During these difficult times, it becomes particularly important for families to stay close and to help and support each other, yet there are many failings in the support given to carers (Avert, 2014). In the later stages of HIV and AIDS,

family caregivers face a long list of tasks, including helping feed, toilet, and wash the patient; cleaning and dressing sores and ulcers; administering medications; and providing comfort and company (UNAIDS, 2000) as well as washing, walking and going to the toilet Bowie (2006). Thus, when facing hardships related to HIV and AIDS, a strong and supportive family is one of the first lines of defense (Li, Wu, Cui & Jia, 2009).

Family support is generally one of the most important factors affecting how patients adapt to illnesses (Amiya, Poudel, Poudel-Tandukar, Pandey & Jimba, 2014). It is associated with better adjustments and coping treatments adherences during home based care of individuals living with or affected by HIV and AIDS and who represent one of greatest burdens of the families, given that the impact of HIV and AIDS is more severe among rural households and communities (UNAIDS, 2008b). Akintola (2005a) noted that the presence of persons living with HIV and AIDS in a family necessitates the performance of a range of caring of responsibilities over and above normal domestic and care work.

Care complements and enhances antiretroviral treatment (ART), going beyond medical disease management to address symptoms and minimize suffering. It begins with the HIV-positive diagnosis and extends though the end of life, using a family-centered approach (US President's Emergency plan for AIDS relief, 2008). Caring for a loved one with AIDS is no easy task. Not only does it require physically caring for someone you love at home, but it also means facing your own concerns about the diagnosis and eventual outcome of the disease. Thus, family members' assistance to person(s) living with HIV and AIDS depends on their stages of illness. Such assistances include instrumental activities of daily living, household chores such as cooking, securing documentations necessary to access state grants (Akintola, 2005a; Uwimana & Struthers, 2007). Support for individuals living with or affected by HIV AND AIDS can be related to families and friends as well as community-based, government agencies, and the healthcare industries (Yadav, 2010).

Support from families and others has been reported to have either positive or negative effects after disclosure. Against the heavy burden of psychiatric co-morbidities

associated with a chronic illness such as HIV and AIDS, social and family support may have a moderating effect and present a promising mechanism through which the health needs of individuals living with HIV and AIDS might fruitfully be addressed such as overcoming depression, reducing high-risk behaviors, seeking medical treatment, and going on with life normally (Amiya, Poudel, Poudel-Tandukar, Pandey & Jimba, 2014; Folasire, Akinyemi & Owoaje, 2014). This finding was also reported to encourage safer sex practice and is best positive predictor of medication adherence in individuals living with HIV and AIDS (Salter, Go, Minh, Gregowski, Ha & Rudolph, 2010; Vyavaharkar, Moneyham, Tavakoli, Phillips, Murdaugh & Jackson, 2007).

Wiley (2010) reported that intensive home-based nursing in HIV and AIDS patients significantly improved self-reported knowledge of HIV, awareness of medications and self-reported adherence to medication programmes as well as significantly impacted on HIV stigma, worry, and physical functioning. It did not, however, help improve depressive symptoms, mood, general health and overall functioning (Wiley, 2010). On the contrary, Hong, Li, Fang, Zhao, Lin, Zhang, 2010.; Zhao, Li, Fang, Zhao, Hong, (2011) reported that high level of perceived social support is associated with better psychological health. Expenditure on transport and hospital costs is also reduced (Ogden, 2006). Pindani, Maluwa, Nkondo, Nyasulu and Chilemba (2013) in their study observed that *the majority of the participants explained that home based care was more beneficial to them than hospital based care. They explained that during the home based care, the individuals living with HIV and AIDS were in the company of family members who cared for and gave them support. They further noted that home based care also provided an opportunity for the caregivers to undertake other household chores. In addition, participants explained that home based care prevented them from getting infected with other diseases from fellow patients due to congestion in hospital wards, as narrated by a 35 year old female participant that in her house she was happy and free to do anything that she wanted such as to go outside if she want to bask in the sun but this was not the same when she was at the hospital. At the hospital, only her daughter was with her and she wished to see her other children but they could not come*

because they had no money for transport. At home she has most of her relatives with her and she felt better to be nursed at home than at the hospital. She observed that when she was at home the environment was different, with no fear of anything but when at the hospital one was afraid of nurses who shout at patients because they feel the patients are difficult and troublesome. Besides, at the hospital there is a high chance of getting infected from fellow patients because the wards are always congested.

According to Shor, Roelfs and Yogev (2013), among the different types of social support, family support is generally one of the most important factors affecting how patients adapt to illness. The perception of a supportive family environment may protect individuals from the potential psychopathological effects stemming from the physical impact of their disease. Moreover, family is frequently the main source of support in times of illness, whether through tangible instrumental support, such as preparing meals and administering medication, or through emotional support (Amiya, Poudel, Poudel-Tandukar, Pandey & Jimba, 2014).

C. Components of family support for PLWHIV/AIDS

Given the often debilitating effects of AIDS, the PLWHIV/AIDS may need assistance performing basic household tasks. These can include washing, cooking, feeding, cleaning, purchasing household essentials, going to the toilet and other needs not necessarily specific to HIV and AIDS. More HIV related tasks may include purchasing, administering and supporting adherence to ARV drugs and medication. Monitoring and recording progress, making notes of events such as toilet visits, fluid intake and symptom occurrence, are other tasks that can be undertaken by family members. These very practical measures are in addition to seeing to the person's social, psychological and emotional needs – often termed 'psychosocial' needs – which everyone has but which are often broader and more severe if living with HIV.

I. Types of support the PLWHIV and AIDS require from their families

According to Li, Wu, Cui and Jia, family support starts with the disclosure process and may include financial assistance, help with daily activities, medical assistance,

maintaining proper hygiene around the individuals living with or affected by HIV and AIDS and maintaining the dignity of the individuals living with or affected by HIV and AIDS. Ngwenya and Kgathi (2006) emphasized the use of water as an element in the care of HIV and AIDS patients. They noted that water was not readily accessible to many rural communities in Africa including Nigeria and Delta State, which meant that people may have to fetch water from rivers, streams, wells, boreholes and public standpipes, which may be long distance away from their homes. So, family members have to assist them to fetch water as their condition/state might not allow them to do so.

In the views of Amiya, Poudel, Poudel-Tandukar, Pandey, Jimba (2014), families are frequently the main source of support in times of illness, whether through tangible instrumental support such as preparing meals and administering medication or through emotional support. According to WHO (2009), family support initiatives for individuals living with or affected by HIV and AIDS have evolved, and they vary in the types of care and support they provide. Some home-based care services focus on providing social and psychological support, with some nutritional support and basic nursing care. Others also dispense ARVs and treat opportunistic infections. It has shifted from an exclusive focus on medical and nursing care to include counseling, food assistance, and welfare support, school fees for orphan and income generation for widows (WHO, 2000 & WHO, 1999). These services, whether provided through NGOs, government health clinics, or community groups, are essential in supporting people living with HIV and AIDS, as well as people who provide care and support within families.

According to Etu (2013), many countries in Africa and South America have developed community-based programs to deliver better care and support for people with HIV and AIDS with a number of key things to be done such as organizing counseling and emotional support for people with HIV and AIDS and their families, setting up organizations that bring together people living with HIV and AIDS to fight for change, setting up wellness programmes and medical treatment to help people keep their immune systems strong and fight opportunistic infections, organizing grants, food parcels and poverty alleviation projects to help families survive and providing home-based care and

medical treatment for people who are ill. It includes routine screening for conditions of heart disease, diabetes, or cancer (Infectious Diseases Society of America, 2009).

In the view of Wiley (2010), it includes counseling, medical management, exercise, and spiritual support to try to improve patients' quality of life in familiar surroundings, while reducing costs and pressure on hospital bed. Community involvement in care and support in Nigeria is very important for the individuals living with or affected by HIV and AIDSs; this is in view of the deprivation and violation that individuals living with or affected by HIV and AIDS may face as a result of their HIV positive zero-status (UNDP, 2003 in Ilebani &Eniola, 2011). Through community care and support for the individuals living with or affected by HIV and AIDSs, provision of basic materials for the neediest individuals living with or affected by HIV and AIDS can be met. Similarly, economic support through skill acquisition, training and financing, income generating activities can be provided by the community to assist the individuals living with or affected by HIV and AIDS and their families (Ilebani &Eniola, 2011).

These various forms of support can be further explained thus as:

- 1. Financial support:** Beside the need to pay for medical expenses, there is a need for financial support for families caring for individuals living with or affected by HIV and AIDS as many individuals living with or affected by HIV and AIDS are unable to work. More so, most of these individuals living with or affected by HIV and AIDS maybe widowed with no steady source of income from gainful employment or business due to the chronic nature of the disease. With the epidemic showing little or no signs of abating, individuals and families including communities are finding it increasingly impossible to sustain support. In a study by Uwimana and Struthers (2007), it was observed that majority (77 per cent) of individuals living with or affected by HIV and AIDS identified the need for financial assistance as they were unable to pay for their medical care or that of their family members.

2. Psychological support: Psychological support includes physical, emotional and moral supports. It provides mental health counseling, family care and support groups, memory books, cultural and age-specific approaches for psychological care, identification and treatment of HIV-related psychiatric illnesses, and bereavement preparedness (US President's Emergency plan for AIDS relief, 2008). Individual counseling, meeting with other people infected with HIV in support groups and support from community and family members can help people accept their situation, talk about their diagnosis, and cope with anxiety and depression (Perriens, 2000 & UNAIDS, 2000).

Despite declining financial and material supports, Akintla (2008c) observed that families and communities still provide physical, emotional and moral supports. Li, Wu, Cui and Jia (2009) further observed that family members helped individuals living with or affected by HIV and AIDS make important decisions such as taking an HIV test and enrolling in HIV-training programs.

3. Nutritional support: Often clinical management of HIV and AIDS has focused on medical interventions to the detriment of nutritional interventions (Ministry of Health, 2002). The need for food was reported as the third greatest need of individuals living with or affected by HIV and AIDS (Uwimana & Struthers, 2007) since HIV lowers food intake, due to the depression of appetite and/or difficulty in swallowing food, mal-absorption and diarrhea resulting in malnutrition, which in turn leads to further suppression (Ministry of Health, 2002).

A close relationship exists between nutritional factors and physical weakness, malnutrition, anemia, muscle wasting and other micronutrient deficiencies. The need for nutrition is related to their use of medication and their health status. Nutrition helps the immune system of individuals living with or affected by HIV and AIDS fight diseases and infections. According to Etu (2013), nutritional support includes educating people with HIV and AIDS and their families about healthy eating, starting vegetable garden projects to help provide the right food types to people who cannot afford them, and starting food projects

that collect food from supermarkets and farmers and distribute it to people who need it. However, indirect costs such as expenses of medicine for treatment of opportunistic infections, leaves little money for food.

- 4. Medical support:** The need for medical care is usually expressed through the need for pain relief, ARVs or prophylactic medication. Additionally, individuals living with or affected by HIV and AIDS indicated that they needed physiotherapy for the management of neuropathic pain (Uwimana & Struthers, 2007).
- 5. Psychosocial support:** Psychosocial support for the individuals living with or affected by HIV and AIDS can best be provided by the family of the individuals living with or affected by HIV and AIDS to help them regain their morale, courage and desire to live. Such support cut across provisions of basic needs of life such as food, housing and clothing [United Nations Development Programme (UNDP), 2003]. It addresses the ongoing psychological and social problems of HIV infected individuals, their partners, families and caregivers (WHO, 2014).

According to WHO (2014) psychosocial support is important because HIV infection affects all dimensions of a person's life: physical, psychological, social and spiritual. It can result in stigma and fear for those living with the infection, as well as for those caring for them, and may affect the entire family. Infection often results in loss of socio-economic status, employment, income, housing, health care and mobility. For both individuals and their partners and families, psychosocial support can assist people in making informed decisions, coping better with illness and dealing more effectively with discrimination. It improves the quality of their lives, and prevents further transmission of HIV infection.

Counseling and social support can help people and their caregivers cope more effectively with each stage of the infection and enhance their quality of life (WHO, 2014). Assessment and interventions may be aimed at the acutely stressful phase following notification of HIV infection, the ensuing adjustment period, and

the process of dealing with chronic symptomatic HIV infection and disease progression through to death (WHO, 2014).

6. **Physical support:** Individuals living with may be so sick that they are unable to stand up or sit down. They should be lovingly helped to stand up or sit down and on no account must they be reminded of what brought him to this present condition. The provider should keep encouraging and reassuring them (Korubo, 2006). According to FAO (2002), providing physical care and support for people living with HIV AND AIDS are an important part of caring at all stages of the disease.
7. **Material support:** individuals living with or affected by HIV and AIDS will not be able to do farm work or go fishing for their upkeep. They should be given food stuffs, clothing and money. Friends and members of the family should thus all provide victuals (food or clothing) for individuals living with or affected by HIV and AIDS (Korubo, 2006).
8. **Emotional support:** The stigma surrounding AIDS makes it a more difficult disease to live with for people with HIV and AIDS and for their families Etu (2013). Individuals living with or affected by HIV and AIDS are usually depressed, anxious and fearful. They wallow in regrets and self-pity. Some even contemplate suicide. It is important therefore when dealing with medical aspects of sexual health and the presence of HIV infection that practitioners be sensitive to the emotive nature of all aspects of care. Newly diagnosed patients are likely to need much emotional support. Some may have been unaware of their risk until diagnosed *e.g.* during antenatal screening (Knott, 2012).

The care providers must keep encouraging and reassuring them. Their mind should be taken off their condition. Indoor games like ludo, cards, scramble, snake and ladder, *e.t.c.* should be introduced. The care providers should keep the individuals living with or affected by HIV and AIDS company, crack jokes with them and try to keep them happy (Korubo, 2006). People should organize

themselves into activist groups or support groups where they can share their experiences and feelings with other people in similar situations and where possible, support groups should be set up for children who are coping with death and dying (Etu, 2013).

9. **Social support:** This supports community mobilization, leadership development for people living with HIV and AIDS, legal services, linkages to food support and income-generating programs, and other activities to strengthen the health and well-being of affected households and communities (US President's Emergency plan for AIDS relief, 2008). The providers should keep individuals living with or affected by HIV and AIDS informed about happenings around them in the political, religious and secular circles. The providers can organize small simple party for the individuals living with all to keep him abreast of the time and thereby heal him/her of depression (Korubo, 2006).
10. **Counseling support:** It is a face to face communication in which a client is helped to identify, clarify and be able to make an informed decision to test for HIV or resolve his/her own problem in relation to HIV. This process, either pre or post counseling helps individuals to express and to find realistic solutions and alternatives to problems (Lie & Biswalo, 1994; Krabbendam, Kuijper, Wolffer & Drew, 1998). Its basic goal is to help people deal with the results of the HIV test. Individuals living with HIV and AIDS need and deserve a listening ear. They need to be encouraged to open up and listen attentively and helped to make informed decisions about their life and solve their problems (Korubo, 2006). Counseling should be conducted in an atmosphere of cultural appropriateness, confidentiality, trust, respect and warmth (Lie & Biswalo, 1994).
11. **Spiritual support:** This includes assessment, counseling, facilitating forgiveness, and life completion tasks (US President's Emergency plan for AIDS relief, 2008). Dimkpa (2011) in examining the most important social support system needs of respondents showed that health care/promotion (90.1 per cent), emotional support

(83.9 per cent), nutritional support(76.5 per cent) and financial support (54.3 per cent) were the most important as indicated by the respondents. On the other hand, physical support (29.6 per cent) and others (25.9 per cent) were perceived to be less important to them. Commenting further, he noted that health care was needed by the respondents to delay the disease and prolong the lives of victims; emotional support was important due to the fact that many of the victims might have experienced emotional and psychological trauma, which if not carefully addressed have the tendency of making the victims suffer depression; financial support was needed probably because most of the respondents were poor and indulged in petty trade and businesses, which could help them to feed better and cater for other needs.

II. Types of support, which PLWHIV/AIDS are presently getting from their Families

The type of care and support services the PLWHIV and AIDS receive depends on the clinical, emotional, social and economic impact of the disease on the individual (National Guidelines on HIV and AIDS Care and Support, 2014).According to Ilebani and Eniola (2011), the PLWHIV and AIDS experienced some form of wellbeing from family members such as psychological, medical and spiritual wellbeing. These they observed seemed to receive more attention. They further observed that there was a significant relationship between the total psychological care and support given by family members and the total opinion of individuals living with HIV and AIDS about these types of support. This they guessed 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.

In Ilebani and Eniola (2011) study of the effects of community-based care for people living with HIV and AIDS on their wellbeing in Benue State, Nigeria, one of the patients observed that he was infected in 2003,his village was too remote so he came to Makurdi to search for Job and get well informed about HIV and AIDS. He was not able

to get anything so he returned home to continue farming and that was what he was doing till he became the coordinator of this support group with his diploma in Law and was about rounding up his degree. One remarkable thing throughout those periods was that his family (mother, sisters and wife) stood by him. Another patient observed that he was infected in 1994. His family members and few of his friends had been supportive. One of them even got him enrolled for the government ART programme when ART was very hard to get. According to him, the most notable agent of care and support here was the Redeemed Church in Makurdi, so they train him and give gave him some money to establish a small scale business.

III. Gaps between what the PLWHIV and AIDS require and what they are getting

The needs of the PLHIV and AIDS are myriad and they cut across different disciplines making it difficult for any single service provider to address all of them. Infected individuals suffer a number of concerns and fears related to future economic security, sexuality, disease transmission, infections, eventual ill health and death (Okeke, 2014). According to (Usman, 2014), studies have pointed out that psychiatric distress/disorders may be reported in a high percentage of PLHIV and AIDS and that several variables facilitate the onset of emotional disturbances secondary to HIV infection. Moreover, supportive programmes may not be considered useful unless the individual perceives it as supportive and failure to secure social support would further elevate the level of stress among the PLWHIV/AIDS (Au, Chan, Li, Chung, Po, & Yu, 2004).

Gaps are measures of the differences in what the PLWHIV and AIDS require and what they are getting. It can also be seen as the difference between utilization versus availability of family support. It can also be expressed in terms of difference in the type of support received versus evaluation of satisfaction with support. It also bothers on what form the support takes and what social structure provides the support: family, friends, and significant others (Dahlem, Zimet & Walker, 1991; Adedimeji & Odutolu, n.d). Researchers agree that the person as well as the situation affects perceived social support,

and that the concept deals with the interaction between individual and social variables (Sarason & Sarason, 1986).

According to Kidd, Clay and Chiiya (2007), families under serious economic pressure can become discouraged by the demands of PLHIV. PLHIV may ask for things that the family cannot afford. Some caregivers get fed up with these demands and want to run away ó to go somewhere else where they don't need to face this pressure. Others feel angry and frustrated and sometimes take this out on the PLHIV. They depicted the gap between what the PLWHIV and AIDS need and what they are getting from their family members in a role play argument as follows:

PLWHIV and AIDS: You're not giving me enough attention.

Family caregiver: You are short-tempered.

PLWHIV and AIDS: You don't understand my needs.

Family caregiver: I can never satisfy you. You are so demanding.

PLWHIV and AIDS: You never listen to me. You are always rushing away to do something.

Family caregiver: I don't have time to talk to you. I only have time to cook and clean for you.

PLWHIV and AIDS: You treat me as if I am invisible.

Family caregiver: You keep demanding food and other things we can't afford.

PLWHIV and AIDS: You don't spend enough time with me. You are always shouting at me.

Family caregiver: I have to go to the market to sell things for our survival.

PLWHIV and AIDS: You do things for me rather than with me. You always assume things that I want rather than asking me what I need. You are neglecting me.

Family caregiver: I don't have time to look after you.

Evaluation of satisfaction with support by the PLWHIV and AIDS is the beliefs or evaluations that the PLWHIV and AIDS have about the relationships in their life (Galvan, Davis, Banks & Bings, 2008). It is said to be the feeling of being cared for,

loved, valued and esteemed or being able to count on other people if need arises (Ahmed & Lemkau, 2007). It also refers to the perceived comfort, care, esteem, or help a person receives from other people or groups (Ahmed & Lemkau, 2007). It is the feeling of wellbeing or improved quality of life as provided by family members. Crisp (2005) as cited in Ilebani and Eniola (2011), describes wellbeing 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 oneself; responsibilities that can often be neglected when juggling the rigorous demands of everyday living in the 21st century.

Quality of life (QOL) is individuals' perceptions of their position in life in the context of the culture and value systems in which they live and in relation to their goals, standards, expectations and concerns. It emphasizes the importance of an overall subjective feeling of wellbeing pertaining to aspects of morale, happiness and satisfaction. QOL, therefore, relates to both an adequacy of material circumstances as to how satisfied an individual is with these circumstances of life. It usually refers to the degree to which a person's life is desirable or undesirable. QOL comprises a collection of interacting objective and subjective dimensions, which may change over time in response to life, health events and experiences. The concept of QOL captures exactly the notion that the ultimate goal of medical intervention is to improve the well-being of the patient. Quality of life and healthy living go hand in hand. Healthy living goes beyond eating a balanced diet, taking regular exercises and avoiding illnesses. It also reflects the mental, emotional and social aspects of an individual's life. Quality of life can be explained by asking questions about one's income (this suggests objective aspect of QOL) and how satisfied one is with his/her income (this suggests subjective aspect of QOL).

Through reflection on the sense of wellbeing and satisfaction experienced by the PLWHIV and AIDS under their current life circumstances, the assessment of the level of satisfaction by the PLWHIV and AIDS aims at providing a comprehensive evaluation of the individuals' wellbeing, which includes an assessment of their role functioning, community integration and personal adjustment. The level of satisfaction of the PLWHIV and AIDS is determined by their activities. By adopting a healthy attitude to life, the

government can aid in improving the quality of living of the individuals living with or affected by HIV AND AIDS. Wellbeing is not just about avoiding illness and staying fit. Determination of wellbeing depends largely on their functional status and consumption of nutritious foods (Akinsete, 2006 as cited in Ilebani &Eniola, 2011).

It was reported that anxiety and depression can be present as an enduring clinical syndrome that affects clients' health status and compliance to treatment protocol and can also significantly alter clients' quality of life. Thus, the need to evaluate what the PLWHIV and AIDS are getting from family members represents a field of specific interest in HIV and AIDS literature.

Literature reviews report mixed results about the buffering effects of social support on health-related issues the PLWHIV and AIDS. In the opinions of Xiaoyou, Lau, Mak, Chen, Choi, Song, Zhang, Zhao, Feng, Chen, Liu, Liu, Liu and Cheng (2013), if buffering effects actually exist, interventions fostering better social support for the PLWHIV and AIDS would potentially reduce the stress caused by perceived discrimination. Ilebani & Eniola (2011) showed that there was no significant relationship between the care and support by community members and the opinion of the individuals living with or affected by HIV and AIDS about the care and support received. This they guessed might be as a result that the care and support given are not up to the required level or the impact has not been felt by the individuals living with or affected by HIV and AIDS. According to Dimkpa (2011), the least assistance for the PLWHIV and AIDS came from their spouses (48.1 per cent), health care workers (34.6 per cent) and friends (18.5 per cent) and lastly neighbours (6.2 per cent). In Tibebu, Mariam and Belachew (2007) study of home based care, neighbors and friends were two times more likely to have favorable attitude towards home based care as compared to family members. According to Dimkpa, the result of the study was surprising in the sense that the most important persons in the lives of the respondents who should offer the greatest caregiver support in terms of love and encouragement such as their spouses and health care workers were perceived to be less caring. This, the researcher observed could be attributed to the non-challant attitude of society as they discriminated against them. According to the

National Guidelines on HIV and AIDS Care and Support (2014), significant gaps in care and support for the PLWHIV and AIDS still exist. Delays exist with early enrollment of PLHIV and AIDS (immediately after diagnosis) into Care and Support programs. In addition, referral, linkage and network systems that will ensure a robust continuum of care are ineffective.

D. Challenges relating to family support for PLWHIV and AIDS

I. Challenges families face in giving the support needed by the PLWHIV and AIDS

The uncontrolled spread of HIV and AIDS poses a major threat to any development efforts in an economy. It challenges the capacity of family members to care for the sick, educate orphans and replace the labour force, for instance in agriculture. Women, children and the elderly pay a particularly heavy price. While family members may be willing to care for the sick, this changes in a situation where the relative suffers from AIDS. This is despite the fact that most of the people with AIDS immediately turn to their families especially their öblood relativesö who form the vast majority of the caregivers for people with HIV and AIDS (Caldwell, 1993). This problem linked up with caring for a family member with HIV and AIDS can disrupt a family (Osei óHwedie, 1994).

African societies have been portrayed as community-based and providing support for their members as indicated by Goody as cited in Kofi (1995) that öFamily responsibility (in Africa) has not diminished to the point that national welfare agencies have constantly to step inö. According to Kofi, one of the areas known to have strong familial support is health. However, the available evidence suggests that this 'idealized past' is under strain, either independent of or as a result of HIV and AIDS infection. That sick family members are ostracized is contrary to expectations, creating conditions of despair and hopelessness. Also, very little if any public assistance is available to persons with AIDS, but even less or nothing is available to caregivers (Ferreira, 2004).

Thus, support for people living with HIV and AIDS is still low in Nigeria especially in the rural communities where there are high rates of illiteracy, poor

healthcare facilitates insufficient healthcare administrators and limited means of communication such as radio, television and telephones, *e.t.c.* to educate rural people on health issues (Ilebani & Eniola, 2011). At the moment, families and sometimes just individuals cope with HIV and AIDS without much community support. In most cases, very few people know that someone is HIV positive and when they become ill, their families and children bear the burden alone (Etu, 2013). Children and partners also have to deal with the grief of watching a loved one suffer and die. Illness and death of a breadwinner usually increases poverty. Poor people do not have the resources to provide proper care for someone with HIV and AIDS (Etu, 2013). Like all other Sub-Saharan African countries, family support for individuals living with or affected by HIV and AIDS has enormous challenges, which need to be resolved to help improve the quality of care to individuals living with or affected by HIV and AIDS. These challenges include:

- 1. Support not adequately accessible:** Support to the people living with HIV and AIDS in terms of provision of medications, legal, physical and financial supports are sometimes not adequately accessible to many individuals who suffer from the disease or their families, due to the implementation design and problems like logistics and insufficient registration of patients by health centers (Ssengonzi & Morelnd, 2001).
- 2. Burden of caring for sick family members:** Physical and emotional care can be time-consuming and exhausting. Many caregivers of people with AIDS have concerns about their loved one's illness and future health prospects. Practical concerns, such as worries about financial issues and time management, are also common. Many families carry the burden of caring for sick family members, paying for health care and absorbing the loss of earnings while the ill persons are unable to work (Ssengonzi & Morelnd, 2001). On the other hand, in the case of infected women, they receive less support than their men counterpart (Serovich, Kimberly, Mosack & Lewis, 2001). They are frequently thought of as the source of infection and are likely to be chased away from home, abandoned, isolated by the community, economically deprived, exposed to violence or even murdered, if

their status is discovered. According to Serovich, Kimberly, Mosack and Lewis (2001), the husbands and families do not help sick wives in case of HIV infection and might even chase them away.

3. **Inadequate support structures for caregivers:** According to Campbell (2004), there exists the challenge of inadequate support structures for caregivers. In support of this, Chikalipo (2007) reported that most home based care support givers are located in the urban and peri-urban centres because of the proximity to the NGOs and faith based institutions to which they are affiliated. In addition, independent support groups are also located within the proximity of persons that facilitate the formation of the groups rather than where the individuals living with or affected by HIV and AIDS are found (Mahommad & Gikonyo, 2005). In view of this, the home based care programmes are located in places that are not most convenient to the individuals living with or affected by HIV and AIDS making it difficult for individuals living with or affected by HIV and AIDS to access the services.
4. **Current shift of health service:** Home-based care as noted by Akintola (2006b) reduces contact between the ill and public health institutions. This causes a major shift in the primary place of care for people living with HIV and AIDS from public institutions to the very poor families who make use of public health facilities and from health workers to the very poor women who previously carried a disproportionate share of the burden for caring for the ill.

The current shift of health service emphasis from hospital based care to home based care affect family members' responsibility for providing direct care at home to their relatives (Youseef & Wong, 2002). The wives often have to forgo some of their daily chores to care for their beloved chronically ill HIV and AIDS patients. Due to increased demand for patient care, many female caregivers have less time to earn an income, produce food and look after the rest of the members of the household. Young girls at times miss school lessons because they have to take care of their sick ones during hospitalization. Consequently a vicious cycle of

poverty and poor health is created, which increases further the risk of HIV infection (Chikalipo, 2007).

- 5. Lack of training for the care providers:** Caregivers are not well informed and are ill prepared about what to do. Research from around the world indicates gaps in knowledge about HIV transmission and treatment availability (Ahmed, Hassali & Aziz, 2009). Research has also established that a vast majority of women and girls, who shoulder the HIV and AIDS care burden, do so, with very little material or moral support (WHO, 1999). They receive no training, no materials such as gloves, medication, food and no means to pay for children's school fees. Akintola (2008b) noted that families often do not have the necessary skills for providing adequate care and support for the ill.

Caregivers, usually females, may not know how to care for sick family members, or understand how treatment works, or know how to support adherence. Moreover, they may not know when follow-up care should be sought from health facilities, or where to seek such care (WHO, 2000 & 2001). Also, caregivers may not have been trained in universal precautions or may not observe them when providing care as some women have expressed concern that using gloves and other protective clothing would show a lack of love for their family members (WHO, 2000). According to Pindani, Maluwa, Nkondo, Nyasulu and Chilemba (2013), close family members as caregivers *that were actually caring for the individuals living with or affected by HIV and AIDS did not receive any training as narrated by a 48 year old woman that none of her relatives had received any education concerning her care at home. This according to her was very unfortunate because she had heard them sometimes discussing among themselves regarding what to do especially when she was very sick.*

Limited knowledge on home based management of individuals living with or affected by HIV and AIDS creates fear among the home based caregivers (Nkhandwe, 2001). This affects the quality of care for participants and this often times compromise the quality of care given (Li, Wu, Cui & Jia, 2009). The

insufficiency of quality home based care has often been attributed to fear and misconceptions about the disease (Berhane & Zakus, 1995). Consequently, the individuals living with or affected by HIV AND AIDS are shunned by friends and other community members. According to Ndaba-Mbata and Seloilwe (2000), families that received detailed information about the condition of patients manifested more vigilant coping skills compared with families that had little information.

6. **Inadequate access to quality health information:** Access to quality health information by individuals living with or affected by HIV and AIDS is a sine qua non. In spite of research and intervention efforts for prevention and treatment, access to appropriate health information by individuals living with or affected by HIV and AIDS in Nigeria constitutes a great barrier (NACA, 2005). In a survey carried out by Erica (2008) on barriers to equitable access to health information, major barriers among others were identified as lack of information infrastructure and high cost of accessing up to date, timely, and relevant information. Information is an indispensable tool for care providers. Losce (1990) in Edewor (2010) describes information as the knowledge communicated or received concerning particular circumstances. In the opinion of Okwilagwe (2000) information is an input, which reduces the level of uncertainty in any decision process. It is a crucial factor for a healthy life. Access to quality health information is critical to many facets of health care design and delivery (Edewor, 2010). Information is vital to relieve pain and discomfort, both physical and mental. As posited by Peterson and Obileye (2002), information helps extend and improve the quality of life by reducing viral load. The absence of information can lead to interrupted treatment and self-medication (Colebunder, 1997).
7. **Secrecy of family members:** Usually close family members bear the burden of home caring for their patients because they live in secrecy, tend to hide their patients and do not share their family members' diagnosis with the extended family relations (Mwinituo & Mill, 2006). As a result there are speculations,

mistrust and gossip among the community members and thus, the negative attitude of the community members may have been created due to hoarding of information by the close family members (Ndaba-Mbata & Seloilwe, 2000).

Disclosure may be necessary to get social support and to take steps in promoting good health. However, research has shown a linkage of violence with disclosure, as majority of individuals living with or affected by HIV AND AIDS is often stigmatized, discriminated and isolated with fear of being rejected and with negative financial consequences (Mbwambo, 2001 & Krabbendam, Kuijper, Wolffer, Drew, 1998). In this context infected persons will find it difficult revealing their status to close friends and relatives.

- 8. Limited capacity of the human resource:** In several cases AIDS has disrupted the capacity of the nuclear and extended families to respond to the needs of people infected by HIV and AIDS (Ankrah, 1993). There is not enough staff to meet the palliative care needs of all individuals living with or affected by HIV and AIDS (Uwimana & Struthers, 2007).
- 9. Stigma and discrimination:** Stigma and discrimination are a major problem with home based care (Pindani, Maluwa, Nkondo, Nyasulu & Chilemba, 2013) and rank among the biggest and most pervasive barriers to effective response to the AIDS epidemic (Semguruka, 2004). Affected households may face stigmatization (McGrath, 1993; Gilmore & Somerville, 1994), which can in turn affect their responses to AIDS (Powell & Brown, 1994).

Stigma is a social process that marginalizes and labels those who are different and discrimination is the negative practice that stems from stigma or enacted stigma (UNAIDS, 2002b). Stigma and discrimination form a vicious circle, generating, reinforcing and perpetuating each other and the outcome, in the World of AIDS is life-threatening (Semguruka, 2004). Stigma increases people's vulnerability by isolating and depriving them of treatment, care and support and worsens the impact of infection (Krabbendam, Kuijper, Wolffer & Drew, 1998; Meursing & Sibindi 1992). It is associated with a high rate of depressive symptoms particularly among women

In Nigeria, when one member of a family becomes HIV positive, the whole family is called an *AIDS family* by other villagers (Alubo, Zwandor, Jolayemi & Omudu, 2002). According to Pindani, Maluwa, Nkondo, Nyasulu and Chilemba, this was shared by a 32 year old female participant who observed that stigma and discrimination were the biggest problem that they faced in the villages. When people discovered that they had HIV positive, they lose friends, even some of the best friends shun you. Sometimes even when they call for a close friend, they reply saying that they were not around.... they had gone away...when in actual fact, they were available but they just did not want to be associated with them anymore. Gossip was also another challenge. Relatives, friends and even fellow church members gossip a lot. The biggest source of stigma and discrimination was unfortunately their own distant relatives and they were the same people that were expected to provide care to them. As a result, the home based care burdens only the close family members such as spouses and children.

There is the stigma related to the fact that AIDS is generally transmitted sexually or through drug use. Many people feel judged because their loved one has AIDS. Then there is the stigma attached to having a potentially life-threatening disease. This makes people uncomfortable, and some friends and family can become distant. At a time when one needs it most, one may find it hard to get support (US President's Emergency plan for AIDS relief, 2008). The stigma and discrimination against individuals living with or affected by HIV and AIDS may be due to myths in the communities such as the belief that HIV can be transmitted through sharing of dishes or cups with the patient, which is an indication of lack of knowledge (Berhane & Zakus, 1995).

According to Alubo, Zwandor, Jolayemi and Omudu, (2002), families of individuals living with HIV and AIDS often experience HIV-related stigma and discrimination because of their association with an infected family member. The stigma results not only from being HIV positive, but from risk behaviours that bring the disease such as drug use and commercial sex (Nkya, Lyamuya, Outwater, 1993), a concept often referred to as *double stigma* in the literature. However, this pattern is less likely to hold for other non-infectious illnesses.

In a study by Cloete, Strebel, Simbayi, Wyk, Henda, and Nqeketo (2010) on challenges faced by people living with HIV and AIDS in Cape Town, South Africa: Issues for group risk reduction interventions, Cloete, Strebel, Simbayi, Wyk, Henda, and Nqeketo observed that a dominant challenge was the extent to which stigma and discrimination remained a central concern for individuals living with or affected by HIV and AIDS as narrated by one of the respondents who observed that stigma still existed a lot and would never perish, because maybe if one got sick and lose weight, people would point fingers at them even when one is not HIV-positive, and they would say that one had AIDS. According to another, the problem that they were facing as a person living with this virus, was stigma and discrimination. According to him, people, were going to chase them away if they say they were HIV positive.

Stigma and discrimination directed at individuals living with or affected by HIV and AIDS has a lot of implications on the fight against HIV and AIDS. The stigma associated with HIV and AIDS makes many people reluctant to admit they are infected or seek care and can make health workers reluctant to provide care (WHO, 2000). This stigma creates barriers to curbing the further spread of the disease amongst people who are aware of their HIV-positive status (Peltzer, Nzewi & Mohan, 2004). It does not only make it difficult for people to come to terms and manage their illness on a personal level, but it also interferes with attempts to fight the AIDS epidemic as a whole because it makes it difficult for the diagnosis of the disease (Berhane & Zakus, 1995; US President's Emergency plan for AIDS relief, 2008) and thus, posing the greatest barrier hindering effective delivery of HIV prevention and care services (UNAIDS, 2001). In addition, social stigma isolates the people affected by HIV and AIDS and limits community support, while the scale of the epidemic intensifies emotional stress, financial stress and mental health disorders on families who may lose multiple members to the disease (Kols, 2001; Freeman, Nkomo, Kafaar, & Kelly, 2007; Green, 1995; Sowell & Misener, 1997). The stigma attached to AIDS is not restricted to the sick person, but can affect people in the direct environment. Relatives are therefore, also deprived of support, often when they need it the most (Semguruka (2004). The physical, emotional, economic and social

burden is then totally carried by the family, particularly by caregivers, mostly women (Trou, 2000).

According to Cloete, Strebel, Simbayi, Wyk, Henda, and Nqeketo (2010), related to stigma is the extent of ordering of the disease, with notions of the virus spread by being promiscuous (especially for women), gay or black as observed by the narration of respondent that her mother had AIDS and they said that she was sleeping around and she was drinking a lot. Furthermore, Cloete, Strebel, Simbayi, Wyk, Henda, and Nqeketo (2010) noted that in addition, people tended to distance themselves from HIV, giving it other names. They also did not talk openly about HIV in the community and this fostered stigma

10. Gender: Gender plays a strong role in experiences of stigma. In the views of Rohleder and Gibson (2005) and Derlega, Winstead, Greene, Servoich and Elwood (2002), AIDS-related stigma for women is intensified because of their subordinate role in society. According to Cloete, Strebel, Simbayi, Wyk, Henda, and Nqeketo (2010), AIDS-related stigma is a barrier for women accessing free voluntary counseling and testing (VCT) and prevention of mother-to-child transmission (PMTCT) services. For example, mothers who are HIV-positive find it difficult to comply with medical advice to formula feed, because of the fear of having their HIV status exposed. On the other hand, due to the male *ōmachoö* culture of needing to be seen to be strong, while HIV was still seen as largely a *ōfemale* thing, men avoided seeking help, treatment or support once diagnosed of been HIV-positive, for fear of stigma. This often resulted in women mainly attending the support groups. Continuing, Cloete, Strebel, Simbayi, Wyk, Henda, and Nqeketo (2010) observed that stigma attached to being HIV-positive may be due to sexual orientation

11. Fear: Most people fear an AIDS diagnosis in spite of the fact that the disease can generally be treated. Also, people living with HIV and AIDS fear a loss of social status and prestige occasioned by discrimination, rejection and isolation (Serovich, Kimberly, Mosack & Lewis, 2001). Caregivers of AIDS patients are often their

partners. Hearing that one's partner has AIDS may make one fear for one's own health (US President's Emergency plan for AIDS relief, 2008).

10. **Lack of food:** Lack of food and other resources such as transport were identified by Pindani, Maluwa, Nkondo, Nyasulu and Chilemba (2013) as one other reason that made some individuals living with or affected by HIV and AIDS prefer health facility care to home based care as explained by a 38 year old male participant that when there was no food at home they slept on empty stomach. At the hospital there was always food available. When they were not feeling well and were at home, it was not easy to access the hospital immediately due to lack of transport or money to hire a vehicle to go to the hospital on time. They reached the hospital after a long time had elapsed from the time that the need for hospital care arose.
11. **Inadequate counseling:** Although counseling is available in government hospitals for patients, there is not enough and some patients do not attend these sessions for a number of reasons including the inability of some of them to afford the cost, that they do not want people to know they are suffering from AIDS for fear of stigmatization, or they are too weak to move on their own. At some of these fixed locations the staff are few, over-stretched and without adequate logistic support (Kofi, 1995). Helping families affected by AIDS meet basic needs for food, water and shelter can be as important as offering nursing care and counseling. When the adults in a family become too sick to work, old people and children struggle to make up the difference.
12. **Transmission to stigmatized groups:** AIDS also raises sensitive sexual issues that can be politically difficult to address, and transmission often is attributed to stigmatized groups such as sex workers, drug users, and homosexual men (Ainsworth & Teokul, 2000).
13. **High costs of anti-retro viral drugs:** Globally, an estimated six million people living with HIV and AIDS are currently in urgent need of antiretroviral therapy but however, fewer patients have access to the treatment (WHO, 2003a& WHO, 2004). This development is attributed to the high costs of the drugs and monitoring of the patients using the drugs.

14. The provision of nursing care usually includes bathing patients and cleaning their private parts. Men and women living with HIV may not want such care to be provided by someone of the opposite sex. Moreover, lifting and carrying sick relatives can be difficult for females, especially girls (WHO, 2009).
15. Certain symptoms related to AIDS may affect women and men living with HIV differently. For example, women may experience specific pain and symptoms associated with their reproductive systems, including conditions such as pelvic inflammatory disease, genital warts and ulcers, and cancer of the cervix (National Institute of Allergy and Infectious Disease, 2007).
16. There may be differences between women and men in how they cope with pain. Research has indicated that while men may have a better tolerance for pain, partly determined by cultural expectations of them to be strong, women usually have a better ability to cope with, seek help for, and manage pain (Miller & Newton, 2006; National Institutes of Health, 2007).

Furthermore, there is still the challenge of poorly-defined national standard package for care and support services and training curriculum for HIV and AIDS care and support. The implementation plans and tools for quality assessment are also not standardized (National Guidelines on HIV and AIDS Care and Support, 2014).

II. Challenges the PLWHIV and AIDS face in receiving the support needed from family members

According to Ilebani and Eniola, (2011), in as much as some of the individuals living with HIV and AIDS may look very healthy and active in series of activities in their support groups, they all have series of bitter experiences to share. Amiya, Poudel, Poudel-Tandukar, Pandey, Jimba observed that while the beneficial impacts of support from social and family networks are widely recognized, the same intimate relationships can also be a source of tension and discord. Such *negative* social interactions constitute a distinct dimension of social support, with separate and potentially deleterious impacts on mental health (Okun & Keith, 1998; Ingram, Jones, Fass, Neidig & Song, 1999).

Most importantly, sustained interpersonal strains tend to be more characteristic of relationships with family than with non-related peers, as friendships high in unsupportive elements are generally less likely to be maintained relative to the more obligatory bonds of family (Reinhardt, 2001). Similarly, Olawale (2001) in Dimkpa (2011) in corroborating this point of view asserted that perception, attitude and belief about an issue could have an impact on observable behaviour.

In Pindani, Maluwa, Nkondo, Nyasulu and Chilemba (2013) study of the perception of people living with HIV and AIDS regarding home based care, *the narrations of participants suggested that caregivers who were close family members did not show any negative attitudes towards them. However, as the illness progressed, the members and distant relations developed negative attitudes towards them. Thus, the nature and type of the relationship determined the resilience of the caregivers towards the participant as explained by a 46 year old woman that she had problems with the attitude of her relatives, which kept on deteriorating everyday. She knew they changed their attitude everyday because they were getting tired of her and her sickness. But so far she hadn't noticed any change in the attitude of her husband, and her children who were her main care providers. The problem with distant relations and community members in caring for the individuals living with HIV and AIDS was also shared by a 28 year old woman who noted that when she was admitted at the hospital nobody stayed at the hospital except her daughter and her volunteer who came often to see her in the hospital. Her relatives didn't even visit her until she came back home. She knew they had negative attitude towards her because of her HIV positive status. Regarding her caregivers who happened to be members of her family she had no problems with their attitude because they were caring for her very well. But few friends she thought discriminated against her.*

From the above narratives, some of the major challenges faced by the PLWHIV and AIDS are centered on their perceptions, attitude and belief system about the PLWHIV and AIDS.

E. Ways of strengthening families to support the PLWHIV and AIDS

Care and support for PLHIV and AIDS is the responsibility of every individual who should treat them with empathy and dignity. According to the National Guidelines on HIV and AIDS Care and Support (2014), families of persons living with HIV and AIDS are also eligible for care and support services, to cope with the stress that results from close association with persons living with HIV and AIDS. These stresses include stigma and discrimination, loss of income, impoverishment and the emotional burden of caring for the PLHIV and AIDS. They are equally eligible for care and support services to deal with doubts, safety concerns, fears, myths and misconceptions that fuel stigma and discrimination and burnout associated with HIV and AIDS infection. By supporting livelihoods of PLHIV and AIDS and their families, families can be helped to reduce their vulnerability and increase their resilience in dealing with the socio-economic impacts of AIDS (International Federation of Red Cross Society (IFRCS, 2014). According to the IFRCS, families can be strengthened in helping the PLWHIV and AIDS by:

1. ensuring that the PLHIV and AIDS and their family members have access to nutritious food and ART, given that $\text{sharing} \emptyset$ (often inevitable) will reduce food intake of the HIV infected person
2. providing nutritional education to the PLHIV and their families to slow the progression of HIV into AIDS
3. providing support for saving water and fuel so that families can economize on both money and time ó enabling them to look after the sick and to meet medical costs
4. providing support for backyard gardens so that sufficient and good quality foods can be produced for and by families. In addition, surpluses can provide small revenues and through gardening adolescents in the family can increase their farming skills

According to Kidd, Clay and Chiiya (2007), communities can help strengthen families in caring for the PLWHIV and AIDS by:

1. organizing community meetings to discuss what to do about HIV in the community
2. forming associations of families, neighbours and church groups to deal with HIV
3. finding out about ARVs and sharing the information
4. talking about adherence strategies and how to support each other to stick to adherence
5. identifying the most vulnerable households (e.g. child or orphan-headed households, grandparent-headed households) and providing support
6. providing exemptions for HIV-affected families from water fees, school fees, etc
7. providing neutral people to help mediate disclosure or conflicts in families
8. facilitating the sharing of HIV survival knowledge among community members
9. organising a regular system of visits to HIV-affected households
10. donating food, clothing and agricultural inputs to destitute households
11. carrying out repairs to houses or help cultivate the fields of vulnerable households
12. organising income-generating activities to support vulnerable households
13. providing communal fields for vegetable gardening
14. forming burial associations and rotating credit and loan clubs

According to the National Guidelines on HIV and AIDS Care and Support (2014), government through her agencies such as the Small and Medium Enterprises Development Agency of Nigeria (SMEDAN), Industrial Training Fund (ITF) and others similar to the defunct National Directorate of Employment (NDE), Federal and State Ministries of Health, National Agency for the Control of HIV and AIDS (NACA), relevant line ministries such as the Ministries Labour, Education, Women Affairs and Social Development, Agriculture, Justice, can strengthen families in helping the PLWHIV and AIDS by providing:

1. an enabling environment for provision of meaningful Care and Support services to PLHIV
2. nutritional interventions with food-based supplements

3. prevention of opportunistic infections through provision of safe water
4. distribution of long lasting insecticide treated nets (LLITN) for prevention of diarrheal diseases and malaria respectively
5. supportive supervision of providers of HIV and AIDS services in health facilities and collecting, collating, analysing and reporting on data from the health facilities
6. sustained activities on awareness creation in form of workshops, seminars, airing jingles on radio and television
7. Anti-Retroviral Centres and regularly providing them with drugs and materials to take care of people living with HIV and AIDS
8. HIV Counseling and Testing (H.C.T.) Centres in the States in almost all the Government Hospitals in the State with facilities for HIV screening.
9. technical support for the activities of State Action Committees on Aids (SACA) in the State

In the views of UNAIDS (2002b), non-governmental organizations (NGOs) can remove the barriers of stigma and discrimination with a view to enhancing family support for members living with HIV and AIDS by:

1. encouraging leaders at all levels, and in all walks of life to visibly challenge HIV and AIDS-related discrimination, spearhead public action against the many other forms of discrimination that are faced in relation to HIV and AIDS
2. involving people living with HIV and AIDS in the response to the epidemic
3. creating positive legal environment for fighting discrimination
4. enabling the challenge against discrimination and receive redress through national institutions and
5. ensuring that prevention, treatment, care and support services are accessible to the ill

In the views of Ilebani and Eniola, (2011), the following measures can be used in improving family support for members living with HIV and AIDS. They include:

1. The design and development by concerned bodies such as Ministries of Health, Ministries of Agriculture and Rural Development and NGOs, through seminars and sensitization programmes, intervention programmes that are aimed at improving the knowledge of the family and community members about care and support for individuals living with or affected by HIV and AIDS.
2. The Non-Governmental Organizations (NGOs) and the government should intensify their efforts towards care and support by supporting the individuals living with or affected by HIV and AIDS socio-economically and medically.
3. Communities should provide enabling environment and support the formation of support groups for individuals living with or affected by HIV and AIDS.
4. 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.
5. Individuals in the community should also contribute to the support of the individuals living with or affected by HIV and AIDS by supporting them emotionally, physically and spiritually.

Other measures according to the National Guidelines on HIV and AIDS Care and Support (2014) include:

1. Strengthening capacity for policy formulation, resource allocation and advocacy to empower young people, women and communities
2. Strengthening the implementation of various HIV prevention activities within mandate areas and in accordance with national priorities
3. Increasing uptake of preventive services among young women as part of antenatal services and in the communities
4. Increasing knowledge skills and use of services by HIV-positive women to prevent unintended pregnancies
5. Making available and using policies, guidelines and plans to support integrated HIV and AIDS services
6. Increase access to HIV and AIDS preventive services

UNICEF (2006) noted that regarding the situation of Orphans and vulnerable children, a national plan of action has been finalized under the coordination of the Federal Ministry of Women Affairs, with UNICEF support. This it observed would need to be implemented urgently as responses to the situation of vulnerable children are mostly confined to families and communities and considering the burden of poverty, these support mechanisms provided by families and communities are under considerable strain.

Burlew, Puckett, Bailey, Caffrey and Brantley (2014) observed that the United States Government (USG) had dedicated significant resources in Nigeria to combating the HIV and AIDS epidemic through the President's Emergency Plan for AIDS Relief (PEPFAR) and has invested more than US\$2.5 billion to reduce the HIV and AIDS burden in Nigeria (United States Diplomatic Mission to Nigeria, n.d). PEPFAR is managed at the country level in Nigeria through the United States Agency for International Development (USAID), the Centers for Disease Control and Prevention, the Department of Defense, and the US Embassy (Burlew, Puckett, Bailey, Caffrey & Brantley, 2014). The majority of PEPFAR activities are conducted through national-level implementing partners that include international non-governmental organizations and local government agencies (USAID, 2010; Sessions, n.d)

Ilebani and Eniola (2011) observed that providing series of care, support and solidarity for the growing population of individuals living with or affected by HIV and AIDS enabled them to protect themselves and others and it is the requirement of families, communities and the whole nation at large. From a t-test analysis of their result to ascertain the difference in the care and support offered by family and community of individuals living with or affected by HIV and AIDS, result of the analysis showed that there was 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 individuals living with or affected by HIV and AIDS. The mean care and support for the physical care and psychological care by family were found to be far higher than the mean for physical care and psychological care by community. The mean total care and support by family was found to be higher than the mean total care

and support by community showing that the family was generally more involved in care for individuals living with or affected by HIV and AIDS than the communities. By this finding, the researchers implied that despite the interaction between the community and family, a high level of differences existed between all the cares and supports provided therefore, confirming 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.

Ilebani and Eniola (2011) observed that the community, which included the immediate environment, NGOs, government and individuals, delivered some care and support that were capital intensive. This included medical and socio-economic care and support. Using the complete model with the logit link to building the ordinal regression model, Ileban and Eniola (2011) observed that the never level of community care and support and sometimes level of family care and support exhibited negative regression coefficients. By this finding, Ileban and Eniola (2011) implied that an improvement in the care and support by community from never to sometimes and that of family from sometimes to always would lead to decrease in the wellbeing of the individuals living with or affected by HIV and AIDS. That is to say, a unit increase in the care and support by community and family members would lead to reduction in the wellbeing of the individuals living with or affected by HIV and AIDS by and observing that an increase in the family care and support from sometimes to always might affect some other form of care and support for the individuals living with or affected by HIV and AIDS which might be detrimental to their well-being.

Continuing, they observed that the sometimes level of the community care and support exhibited a positive regression coefficient indicating an improvement in the wellbeing with a unit increase in the care and support by the community. Citing an example of a respondent who was a farmer and trader, they observed that while the respondent was able to take care of the individuals living with or affected by HIV and AIDS in the morning before going to work, her housemaid did the rest. In an attempt for her to extend the time for the care and support, her occupation might be affected, which

could lead to her inability to carry out some of the necessary care and support such as medical and socio-economic care and supports.

Kiragu (2001) further observed that knowledge about HIV and AIDS was among the most important tool for fighting the epidemic especially among young people. Education according to (Kiragu, 2001) uses several strategies for its mission achievement of raising awareness about HIV and AIDS. These include workshops, seminars, meetings, campaigns, field days, home visits etc. In collaboration with other stakeholders, it uses the radio to disseminate information. Recipes and leaflets can be distributed to the general public to motivate people through a variety of extension methods that emphasize the value of **“sustainable livelihoods.”**

According to Coombe and Kelly (2001), education changes the socio-cultural climate within which people live and behave and even in the absence of any concerted effort to bring about change, education modifies certain aspects of the family and community environment for strengthening families to support the PLWHIV and AIDS. It also plays significant role in communicating regular and sensible eating among people already infected with HIV (Johnson, 2010).According to Coombe and Kelly (2001), addressing the HIV and AIDS crisis creatively and flexibly means allowing schools, colleges and communities to regulate scheduling in ways that respond to locally experienced needs.

In addressing the challenges of psychosocial support for individuals living with or affected by HIV and AIDS, World Health Organization (2011) advocates the following measures in improving family support for members living with HIV and AIDS. They include:

1. Specifically including psychosocial support in national guidelines for the management of HIV and AIDS.
2. Incorporating into the curriculum for all healthcare providers, the training on the provision of psychosocial support.

3. Development of guidelines for home care services and the inclusion of the provision of basic psychosocial care by community volunteers and family caregivers.
4. Organizing training courses for community volunteers by health care workers.
5. Making available at the national and international levels, trainings in professional disciplines (counselling, psychology, psychiatry).
6. Developing strategies for providing psychosocial support for specific groups (e.g. women, youth, men who have sex with men, injecting drug users, health care workers, etc.).
7. Assessing what HIV and AIDS and supportive services are available at both the governmental and non-governmental levels that could be strengthened or replicated. Assess what additional services are needed.
8. At the community level, groups can be started to provide for the needs of individual patients and affected family members. Psychosocial support services that address the specific needs of vulnerable groups can be especially important (e.g. women, children, etc.).
9. A comprehensive support system linking and coordinating existing psychosocial services with each other and to health services needs to be established.
10. Peer groups (whether of health workers working under stressful conditions, people living with HIV and AIDS, or family members of people with HIV and AIDS) can be a very effective way of providing psychosocial support.
11. A comprehensive support system linking and coordinating existing psychosocial services with each other and to health services thus maximizing all resources needs to be set up.
12. Building community capacities to provide counseling and support will ensure sustainability, continuity of interventions and community development.
13. Identification of needs and the training of adequate personnel (e.g. social workers, counselors, psychologists, psychiatrists) will be an important step taken at the

national level to ensure that psychosocial support becomes a viable part of the care of individuals living with or affected by HIV and AIDS, their families and their caregivers.

14. A review of the national essential drug list will be important to ensure that pharmacological supplies are available when needed. Information detailing potential interactions between medicines used for psychological care and antiretroviral therapy should be available.
15. Community groups can be trained in the provision of psychosocial care. This will entail training costs but should not be expensive to maintain.

From the angle of nutrition, the Food and Agricultural Organization (2002) recommendations for caregivers of those living with HIV and AIDS include:

1. Spending time with the person(s) living with HIV and AIDS, discussing the foods they need to maintain and gain weight and manage their illness and get to know what kind of foods they like and do not like as well as involving them in planning their meals.
2. Keeping an eye on their weight. If possible, weigh them regularly and keep a record and look out for any unexpected weight loss and take action.
3. Checking the medicines they are taking by reading the instructions to find out when they need to be taken, what foods to be avoided and any side-effects.
4. Be encouraging and loving by trying to get for them, food of their choice at any time of the day and understanding that they may suddenly stop liking a food, refuse what has been prepared and want something different, not because they are trying to be difficult but because of their illness.
5. Being firm about the importance of eating and encouraging them to eat frequently, but not force them to eat as giving them too much food at one time may cause them to refuse.
6. Making sure that they have something to drink and a snack nearby if they are too sick to leave their beds.

7. Keeping a watchful eye on them by looking around to see if the house is clean and that there are no hygiene problems and there is enough food.
8. Inviting them to join the family for a meal and encourage others in the community to visit them and invite them out, if the sick person lives alone.

According to Etu (2013), government support and grants can be given to people with HIV and AIDS and their families in a number of ways such as:

1. Disability grants for people who are unable to work because of illness and have very little income
2. Foster care grant for people who are the official foster parent of a child. This can be used to provide for the child adequate food, medical care, clothing, schooling and shelter.
3. Care dependency grant for parents or foster parents or anyone who is responsible for looking after children who are ill or disabled and need special care from AIDS.
4. Child support grant for anyone who is poor and looks after a child under 7 years old
5. Social relief for social workers to give temporary relief for people who are in urgent need of support.

Dimkpa (2011) observed the following measures aimed at improving family support for members living with HIV and AIDS to include:

1. The teaching of spouses by health workers, on how to take care of their spouse by showing love, emotional support and other forms of assistance required.
2. Campaigns at the grass roots level by the government, in creating awareness on the way individuals suffering from HIV and AIDS can obtain assistance and ensuring that health centres are well equipped with necessary drugs and health personnel to offer the needed help to infected victims.
3. Financial empowerment by the government to affected victims in order to help them alleviate poverty, which is one factor that makes them vulnerable to HIV and AIDS.

4. Health workers, especially nurses should be re-trained on how to assist HIV and 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.
5. Religious leaders should organize programmes for members, especially in churches and mosques, on how each person can be of help to the other by ensuring that love and care is maintained at home.

According to Kols (2001), improving family support for members living with HIV and AIDS will include:

1. Community education to counteract the stigma associated with HIV and AIDS
2. Using community-based care programs to give family members the training and psychological support they need to do these jobs well, including a thorough grounding in infection prevention
3. Community volunteers helping with domestic tasks.
4. Overcoming negative community attitudes, which will enable people living with HIV and AIDS to find needed support among their families, friends, and neighbours
5. Involving people living with HIV and AIDS in policy making and program design and implementation to ensure that services meet their needs

HIV and AIDS alters family structures: when their adult children die older persons once again become the head of the household, providing care for orphaned children. More so, the number of grandparents caring for AIDS orphans in developing countries has doubled over the last ten years and up to half of the world's 15 million AIDS orphans are being cared by a grandparent who face serious financial, physical and emotional stress due to their belated care giving responsibilities (WHO, 2014). WHO recommendations for mitigating the impact of HIV and AIDS on older people therefore include:

1. providing concrete support to older people (for example social pensions);
2. training HIV and AIDS service and health providers on gerontological issues;

3. providing psychological and medical support for older people living with ill family members;
4. including older people in HIV and AIDS education/training programmes

Local NGOs are also trying to reinforce the social safety net for affected families and households, but their action remains limited. Strengthening the capacity of families to protect and care for children by providing economic, psychosocial and other support should therefore be a Government priority. Ensuring access for orphans and vulnerable children to essential services, including quality education, health care and birth registration is equally important (UNICEF, 2006). Other studies have identified specific counselling and psychological support needs in HIV affected households (Lippmann *et al.*, 1993) and have drawn attention to the need to strengthen the family's capacity to offer support.

In the view of UNDP (2006), since HIV&AIDS is much more than a health issue, dealing with it in Delta State requires an integrated approach involving federal, state and local governments, the NDDC and other government agencies, the private sector, civil society groups and international organizations. It observed that strong leadership is needed at all levels to push for meaningful results. Policies need to focus not only on the control of the HIV virus, but also on coping mechanisms for the large number of infected people in the region. Food Agriculture Organization (FAO, 2002) stressed that meeting immediate physical, psychological and socio-economic needs is essential if HIV AND AIDS-affected households are to live with dignity and security.

Theoretical framework

The study is based on the theory of spoiled identity and the cultural theory.

A. Theory of Spoilt Identity

The theory of spoiled identity as propounded by Erving Goffman, an inter-actionist and a social anthropologist observes that anyone who exhibits a gap between what he/she ought to be *i.e.* virtual social identity and what he/she actually is, *i.e.* actual social

identity, has spoiled his/her identity Goffman (1963). This socially constructed identification lays the foundation for discrimination against individuals living with or affected by HIV and AIDS and is so perceived by the society as having spoiled their identities. This theory is linked with the present study because it lends itself to the interpretations legitimizing rejection.

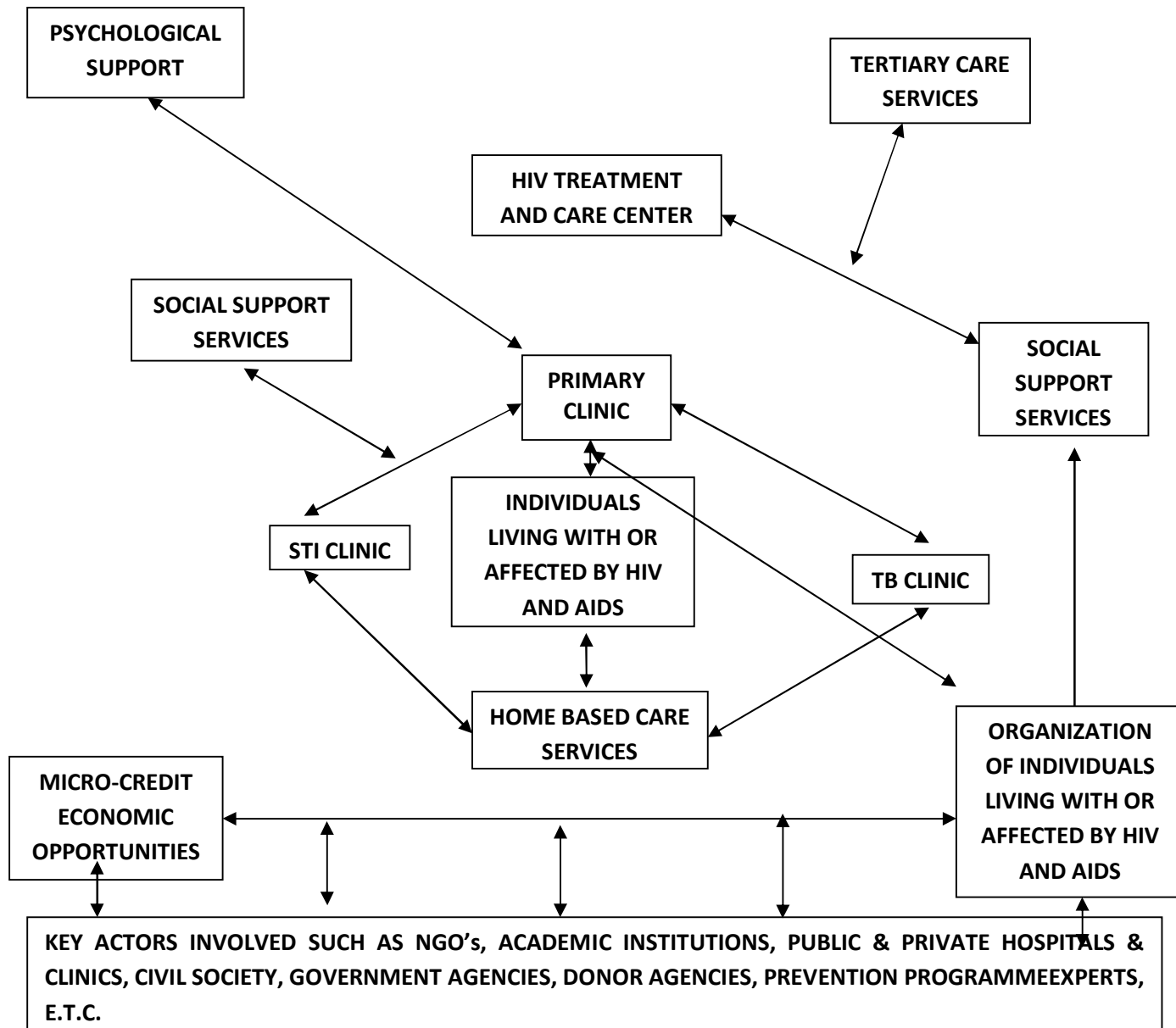
B. The Cultural Theory

The cultural theory propounded by Desclaux postulates that the root of forms of exclusion that the perpetrators often defend as a means of protecting their own social group is often based on myths and misconceptions of HIV and AIDS has been of foreign origin compounded by the near-universal representation of others as dangerous and as punishment Desclaux (2002). This theory is linked with the present study because it lends itself to the interpretations legitimizing stigmatization.

C. Integrated Continuum of Care Partnership Model

The integrated continuum of care model is as proposed by Ministry of Health Government of Pakistan (2007). The model is based on an integrated support approach for HIV and AIDS treatment, care and support, in line with national priorities. The model involves diverse stakeholders involved in HIV and AIDS treatment, care and support, together with the individuals living with or affected by HIV and AIDS, in the development process. It highlights the importance of sustainability issues and strengthening of institutional mechanisms for programme managers and policymakers, aimed at improving the standards of HIV and AIDS treatment, care and support for individuals living with or affected by HIV and AIDS.

Fig. 1 Integrated Continuum of Care Partnership Model



Source: Ministry of Health, Government of Pakistan (2007)

The integrated continuum of care partnership model is distilled into four overlapping and interrelated areas namely, medical care and treatment, psychological support, socioeconomic independence and legal support. The medical care and treatment component involves the use of conventional medicine where prevention and curative medical services are provided to individuals living with or affected by HIV and AIDS. The psychological support component addresses stressors factors affecting individuals

living with or affected by HIV and AIDS and proactively assisting them in finding appropriate coping mechanisms. The socioeconomic independence means finding sustainable mechanisms for individuals living with or affected by HIV and AIDS in achieving socioeconomic independence for themselves and their families including rehabilitation back into mainstream of society. The legal services component addresses social milieu and helps create an enabling environment for safer behaviours, providing legal protection and recourse and ensuring basic human rights in line with national HIV policy and legal framework, to ensure a unified national approach in containing the epidemic. It is related to this study by highlighting the various aspects of support, which individuals living with or affected by HIV and AIDS can receive and be offered, respectively.

Review of Related Empirical Studies

In a study on the duration of stay for people living with HIV and AIDS in community care centres and its correlates, Chiranjivi and Arjun (2014) examined the factors correlated and associated with duration of stay in community care centres. Using secondary data of 62 PLHIV registered during Aug 8, 2012 to Jan 13, 2013, the study found out that most married people lived in community care centres for more than two weeks compared with single or unmarried persons. This study is related with this work because it portrays the fact that the PLWHIV and AIDS are discriminated against at family and community levels and so and so would need some form of family support.

On care and support for the PLWHIV and AIDS, Muoghalu and Jegede (2011) studied the attitudes towards people living with HIV and AIDS in Idemmili North and Oyi local government areas of Anambra State, Nigeria. The study aimed at exploring those practices or behaviours that affected the PLWHIV and AIDS. Using a survey research design method, quantitative methodology was used to elicit information from respondents who were adult males and females of 18 years and above, using copies of questionnaire administered on 1000 respondents. The results of the study showed that the people generally had very positive attitudes to the PLWHIV and AIDS. This study is useful in

understanding how the people's positive attitude can be used in providing concrete family support to PLWHIV and AIDS as against a mere show of positive attitude to those practices or behaviours that affected the PLWHIV and AIDS. However, the study is limited in its use of only copies of questionnaire.

On care and social support, Adedimeji, Alawode and Odutolu (2010) examined the impact of social, economic, psychological and environmental factors on health and wellbeing among the PLWHIV and AIDS in southwest Nigeria. The objectives of the study explored how care and social support affected the wellbeing the PLWHIV and AIDS in view of constraints to accessing antiretroviral drugs. Using qualitative participatory methodology, 50 HIV positive people, 8 health personnel and 32 care providers were interviewed. The findings of the study highlighted several factors, apart from antiretroviral drugs, that impacted on the wellbeing of the PLWHIV and AIDS to include concerns about deteriorating physical health, family and children's welfare, pervasive stigma, financial pressures and systemic failures relating to care among others. The study further described how psychosocial and social support structures could considerably contribute to improving health outcomes among the PLWHIV and AIDS because of how they affected the functioning of immune system, self-care activities and other illness behaviours. This study is related to this present study in the sense that it highlights some of the challenges the PLWHIV and AIDS and their caregivers face. The present study intends to highlight practicable solutions to these challenges beyond raising mere concerns by critically proffering concrete solutions to the psychosocial, socio-economic and other systemic issues that negatively influence the wellbeing of PHWHIV and AIDS. The study is limited by its focus on the wellbeing of the PLWHIV and AIDS with little or no emphasis on the persons that assist with the wellbeing.

On stigmatization as one of the problems associated with HIV and AIDS epidemic in the society, Agweda and Dibua (2010) studied the impact of stigmatization on the acceptance and care for people living with HIV and AIDS (PLWHIV and AIDS) among civil servants in Auchi in Edo State, Nigeria. The objectives of the study included examining the difference in knowledge about HIV and AIDS between the male and

female gender, their perception of the causes of HIV and AIDS, the effect of their attitude towards PLWHIV and AIDS in the society as a result of stigmatization and the effect of advocacy and enlightenment programmes on change of people's attitude towards PLWHIV and AIDS. Three hundred and twenty-four (324) participants took part in the study and questionnaire and focus group discussion were used to obtain information from the participants in the study. Some of the findings of the study were that people had high knowledge of HIV and AIDS, stigmatization could affect the acceptance and care for people living with HIV and AIDS in the society and that enlightenment programmes could change people's attitude towards people living with HIV and AIDS in the society. This study is related to this present study in the sense that it highlights one of the major challenges the PLWHIV and AIDS face in receiving support from their family members with a pointer on how this challenge can be overcome. It is however silent on the type of care for people living with HIV and AIDS.

In Underwood, Hendrickson, Van Lith, Lengwe Kunda and Mallalieu (2014) study of the role of community-level factors across the treatment cascade: A critical review, using qualitative data method, community-level factors (CLFS) in relation to the HIV and AIDS treatment cascade were assessed. Social support and social networks, cultural norms, gender norms, and stigma were found to be the key CLFs associated with treatment and care. Interventions designed to affect CLFs were based on communication interventions designed to create a more positive environment for HIV testing and access to treatment and care. This study is relevant to the present study because it points to some potential extra-individual effects of communication interventions, which can help clarify the pathways to enhanced outcomes across the family support cascade and thereby help families to properly support the PLWHIV and AIDS in their families. The study however majorly focused on the social and medical wellbeing of individuals, to the exclusion of wellbeing of family members.

Abasiubong, Bassey, Ogunsemi and Udobang (2011) carried out a study on assessing the psychological well-being of caregivers of people living with HIV and AIDS in Niger Delta region, Nigeria, the levels of stress among caregivers of people

living with HIV and AIDS in Niger Delta region of Nigeria, in order to determine their coping strategies. Using Zung's Self-Rating Depression Scale (SDS) and Self-Report Questionnaire (SRQ-20), 322 caregivers of people living with HIV and AIDS attending HIV clinic of the University of Uyo Teaching Hospital were randomly assessed for stress (anxiety and depression). The result of the study showed that there was increasing level of stress among caregivers. This study is important in portraying the needs for adequate attention to be given to the psychological well-being of caregivers, which will enable them contribute positively, to the care of people living with HIV and AIDS. Again, focus of study appears to be only caregivers without a balanced view from care-receivers.

In Klerk (2012) study of 'Being tough, being healthy: Local forms of counselling in response to adult death in northwest Tanzania', using a local concept known as oyegumisilize - meaning 'to move on and push grief and worries aside', the way older Tanzanians framed feelings of loss caused by the untimely death of young adults and how they advised other bereaved about how to manage loss was examined. The findings of the study showed that older people tried hard to manage memories of loss whilst simultaneously struggling to fulfill the social obligations around mourning that contributed to their ongoing bereavement. This study is important because it draws our attention to the need for local counselling practices, which are forms of therapeutic speech that can help the PLWHIV/AIDS and their families to move on with life and feel normal. It is also important because it shows the need of not placing emphasis on 'talking through' emotions, but on speech that is aimed at 'toughening up' the PLWHIV and AIDS. The study however fails to realize that the burden of death, and therefore the need for exercising the traditional counseling concept, actually begins while the PLWHIV are still alive.

In exploring the challenges in meeting the psychosocial needs of HIV-positive children, McCleary-Sills, Anjala, Brakarsh, Vujovic, Dlamini Med, Namisango, Nasaba, Fritz, Wong, Kgethi, and Bowsky (2013) studied the 'Foundation for the Future: Meeting the Psychosocial Needs of Children Living With HIV in South Africa and Uganda'. The findings of the study identified strategies and good practices in providing immediate post-

diagnosis support, stigma reduction, capacity building, addressing grief, and promoting peer support. This study is important because it highlights some ways of strengthening families in supporting the PLWHIV and AIDS. The study is limited in its focus on identifying strategies and good practices in providing care but not extended to the receiving of the care.

On mitigating the economic impacts of HIV on affected households and communities, Holmesa, Winskella, Henninka and Chidiac (2010) studied "Microfinance and HIV mitigation among people living with HIV in the era of anti-retroviral therapy: Emerging lessons from Cote d'Ivoire". The qualitative study examined the socio-economic impacts of economic strengthening activities on people living with HIV (PLHIV) in the era of increased access to anti-retroviral therapy to determine if savings-led, community-managed microfinance was a justified activity for HIV programmes. Findings of the study revealed that when appropriate medical treatment was available, the PLHIV and AIDS were capable of participating in and benefiting from microfinance activities, which increased HIV-positive clients' access to money and economic self-sufficiency. This study is important to this present study because it emphasizes the need for savings and loan groups, which can act as self-support groups providing psychosocial support while reducing stigmatisation and increasing members' sense of dignity and self-worth.

On social support, Folasire, Akinyemi, and Owoaje (2014) studied the perceived social support among HIV Positive and HIV negative people in Ibadan, Nigeria. Using a cross sectional comparative study method, the study compared the satisfaction with perceived social support of people living with HIV and AIDS with HIV negative patients. The findings of the study showed that all respondents had the poorest perception of support from family and that for the HIV negative group, not being married and living outside family setting were the strongest factors for poor social support. The study is important because it depicts some of the factors responsible for poor social support for the PLWHIV and AIDS. However, the study was based on cohort of PLWHA already involved in one form of support intervention. This present study will however go beyond

the study of only one form of support intervention for the PLWHIV and AIDS. The study however failed to balance its findings by eliciting family members' position on the issue.

On the challenges faced by people who are living with HIV and AIDS and by their caregivers in resource-poor areas, Basanti and Nomathemba (2010) studied the experiences of people living with HIV and AIDS and of their direct informal caregivers in a resource-poor setting in Eastern Cape Province of South Africa. Using in-depth interviews method, nine persons living with HIV and AIDS and their nine direct informal caregivers were interviewed. The interviews explored the themes of physical, emotional and social wellbeing. Two focus groups, one involving community leaders and one with local healthcare providers were conducted to build on themes emerging from the in-depth interviews and a thematic analysis of the transcripts performed. The study revealed the needs of persons living with HIV and AIDS and the needs of their direct informal caregivers to include physical or medical, social, material, financial, physiological or emotional, gender issues, and instrumental. The study is important because it is vital in considering the perceived needs of persons living with HIV and AIDS and their direct informal caregivers and serves as a basis for the development of a home-based care programmes.

Summary of Review of Related Literature

The study examined the concepts of HIV & AIDS, family and family support for the PLWHIV and AIDS, components of family support for PLWHIV and AIDS, challenges relating to family support for PLWHIV and AIDS and ways of strengthening families in supporting PLWHIV and AIDS. The theoretical framework of the study was based on the theory of spoiled identity, theory of culture and the integrated Continuum of Care Partnership Model.

Based on the stated objectives, the review of related literature showed that family support for individuals living with or affected by HIV and AIDS vary in the types of care and support they provide. While some support focus on providing social, psychological, nutritional, basic nursing support, others dispense ARVs and treat opportunistic

infections as well as provide counseling, welfare, school fees for orphan and income generation supports for widows. Among problems ranging from social, economic and psychological, stigma and discrimination was found to be a major problem with family support and ranked among the biggest and most pervasive barriers to effective response to family support for the PLWHIV and AIDS. Buffering effects of social support are barely enough to reduce the stress caused by perceived discrimination. Caregivers who were close family members do not show any negative attitudes towards individuals living with or affected by HIV and AIDS. However as the illness progressed, the community members and distant relations developed negative attitudes towards the individuals living with or affected by HIV and AIDS. Hence, the study was based on the theory of spoilt identity and cultural theory.

The review of related literature revealed multiple gaps in family support for the PLWHIV and AIDS. A clear need emerged for a stronger categorization of family-level supports for the PLWHIV and AIDS to ensure enhanced support. While the literature described various aspects related to family support for PLWHIV and AIDS, no strong categorization of family support was identified for the PLWHIV and AIDS. Other gaps identified included few robust evaluations of balanced inclusion of both sides of the divide (i.e. people living with HIV and AIDS and their family members), and equitable interventions for the PLWHIV and AIDS by their families, communities, NGOs and the government or adequately captured complexity of family members' equity as it influences provision of family support for the PLWHIV and AIDS. No family support pathways model currently exist that captures the most salient family level factors or describes their influence on care and support for the PLWHIV and AIDS. There is minimal evidence on interventions positively associated with decreasing stigma and improving family support outcomes. Towards this end, this study focused on strategies for enhancing family support for People Living With HIV and AIDS in Delta State Nigeria.

CHAPTER THREE

METHODOLOGY

This chapter describes the design of the study, area of the study, population of the study, sample and sampling technique, instrument for data collection, validation of the instrument, reliability of the instrument, method of data collection and analysis.

Design of the Study

The study adopted a descriptive survey design. Descriptive survey research according to Ezeji (2004), is concerned with specifying the properties of educational and other phenomena. It is aimed at collecting data and describing the characteristics, features of facts about a given population using questionnaire, interviews and observation as instrument for data collection. Descriptive survey design is considered suitable for this study since it identified strategies for enhancing family support for people living with HIV and AIDS in Delta State.

Area of the Study

The area of the study was Delta State. Delta State is one of the oil producing states and a leading producer of crude oil and gas. It lies roughly between longitude 5⁰00 and 6⁰45E and latitude 5⁰00 and 6⁰30N. The state was carved out of the former Bendel State in 1991 and once integrated in the Mid-Western state from 1963-1976. The name òBendelö (Ben-Del) meant Benin-Delta to reflect the integration of Benin and Delta provinces (Delta State Government (DTSG), 2010).

The capital city is Asaba located at the northern end of the state with an estimated land area of 762km². The state has a total land area of 16842km² and border Edo State to the north, Ondo State to the north-west, Anambra State to the east, Bayelsa and Rivers States to the south-east. In the south-west and south, it has approximately 122 kilometers of coastline bordered by the Blight of Benin on the Atlantic Ocean (DTSG, 2010). Its population stands at 4,098,391 (National Population Commission, 2006).

The state comprises mainly Ibo (Anioma people), Urhobo, Isoko, Ijaw and Itsekiri. These groups are administratively grouped into three senatorial districts or agricultural zones, namely Delta North (9 LGAs), Delta South (7 LGAs) and Delta Central (9 LGAs) for ease of administrative purpose. Delta North consists of Oshimili South and North, Aniocha North and South, Ika South and North-East, Ukwuani and Ndokwa East and West. Delta South consists of Ughelli North and South, Isoko North and South, Patani, Bomadi and Burutu. Warri North, South West and South; Sapele, Ethiope West and East, Okpe, Uvwie and Udu, together make up Delta Central.

The health programme of the state conforms to the National Health Policy and has a vast number of health facilities to support its health programme particularly as regards caring for people living with HIV and AIDS. There are a total of 62 hospitals in the state. These hospitals are grouped into eleven (11) Medical Zones for administrative convenience. Each of the eleven (11) zones comprises at least four (4) hospitals with six (6) Central Hospitals namely: Warri, Agbor, Sapele, Ughelli, Oleh and Kwale, twenty-five (25) General Hospitals, Primary Health Care Centres, Maternal and Child Care Hospitals at Warri and Ekpan; and Delta State University Teaching Hospital, Oghara (DTSG), 2010). The people of the state are of mixed occupational backgrounds with cases of HIV and AIDS. The choice of the area is based on the State's ranking by the United Nations Organization (2014) as the 9th (4.1 per cent), with prevalence rate higher in the urban areas than in the rural areas and also because of her urbanized status with an admixture of immigrants and in-migrants of different ethnic groups and social lifestyles.

Population for the Study

The target population for the study was 27,216 PLWHIV/AIDS (Delta State Government (DTSG), 2014) and comprising also of family members of PLWHIV and AIDS, all NGOs such as civil societies, donor agencies and prevention programme experts; public and private healthcare workers, government agencies in the urban and rural communities of Delta State who were directly involved in the provision of support to family members living with or affected by HIV and AIDS.

The PLWHIV and AIDS are people diagnosed of having the virus that causes HIV and AIDS and who are regular attendees to aids prevention initiative programmes, antiretroviral clinics of private and public hospitals in Delta State, Nigeria and those living in the house and who are not regular attendees to the clinics of private and public hospitals in the state. They form part of the population because they are the final consumers or end receivers of family support.

The families of PLWHIV and AIDS are two or more persons who are related by blood, marriage, adoption, step or fostering, and who are usually resident in the same household with the family member having HIV and AIDS or living in another household.

The NGOØS are civil societies and international organizations involved with treatment, care and support of the PLWHIV and AIDS. They are the Civil Society Consultative Group on HIV and AIDS in Nigeria (CISCGHAN), Society of Women against AIDS in Africa-Nigeria (SWAN), Society for Family Health (SFH) and international agencies such as USAID & UNICEF. Their inclusion is based on the fact that they are involved in providing coping mechanisms, information around treatment, care, support and healing to the PLWHIV and AIDS and their family members and they bring with them their experience of community level work in enhancing peopleØ participation in support for the PLWHIV and AIDS.

The public & private healthcare workers are doctors, pharmacists, lab technicians, nurses or social workers who have set timetables on when they will see clients, a folder with clientsØ history, a set programme and specific purpose. They are included in the population because of their specialized training in the counseling, treatment, care and medical support for the PLWHIV and AIDS.

Government agencies are the different government ministries and units such as the Small and Medium Enterprises Development Agency of Nigeria (SMEDAN), Industrial Training Fund (ITF) and others similar to the defunct National Directorate of Employment (NDE), Federal and State Ministries of Health, State Agency for the Control of HIV and AIDS (SACA), relevant line ministries such as the Ministries of Labour,

Education, Women Affairs and Social Development, Agriculture, Justice. They form part of the population because they are responsible for the implementation of the state government support programmes for the PLWHIV and AIDS.

Sample and Sampling Technique

The sample for this study was 669. This consisted of 63 persons for focused group discussion and 606 persons for the questionnaire. The sample was selected using simple random sampling technique. For the focus group discussion, the sample consists of 33 persons living with HIV and AIDS as well as 30 persons who are family members of people living with HIV and AIDS. For the questionnaire, the sample consists of 205 PLWHIV and AIDS, 205 members of families of PLWHIV and AIDS, 10 persons from NGOs, 126 persons from public and private healthcare workers, as well as 60 persons from government agencies.

The 205 PLWHIV and AIDS were drawn from the daily clinic attendance list, at a regular time each clinic day and from households with the PLWHIV and AIDS, from across the three (3) senatorial districts of the State namely Delta North, Delta South and Delta Central. A corresponding number of 205 members of families of PLWHIV and AIDS were selected, one family member from each household of PLWHIV and AIDS.

Two respondents selected from the five NGOs, giving a sample number of 10 respondents. This sample sized was based on the work schedules of the NGOs where one or two staff may be placed in charge of duties and responsibilities of dispensing support towards the PLWHIV and AIDS.

Seven public and seven private healthcare workers each were randomly selected from nine public and private hospitals; three hospitals from each senatorial district in the state, out of the 60 hospitals in the state, giving a total sample population of 126 public and private healthcare workers.

Six respondents each were selected from government agencies comprising Small and Medium Enterprises Development Agency of Nigeria (SMEDAN), Federal and State

Ministries of Health, State Agency for the Control of HIV and AIDS (SACA), Ministries of Labour, Education, Women Affairs and Social Development, Agriculture, Justice, giving a sample population of 60 respondents.

Instrument for Data Collection

The instruments used for data collection were questionnaire and Focused Group Discussion (FGD). Questionnaire was used to elicit information from the respondents. The structured questionnaire, which was drawn from the purpose of study, contains two sections. Section 1 contains questions on socio-economic characteristics of respondents such as place of residence, age, highest level of education, nature or type of family, type of health facility available, employment status, type of occupation, marital status, number of children, income level, HIV and AIDS awareness and family support. Section 2 contains one hundred and twenty-four (124) multi-dimensional scale items on nutritional support strategies, medical support strategies, emotional strategies, and socio-economic support strategies, respectively, which PLWHIV and AIDS require from their families. It also included the challenges associated with providing support to PLWHIV and AIDS by their families and families strengthening strategies in supporting PLWHIV and AIDS? Questions in section A of the questionnaire are based on a simple tick of the right response to various options provided. In section B, questions 1, 2, 3, 4, 5 & 6 was based on a 4-point scale type rating of Very Important (VI) =4, Important (I)=3, Not Very Important (NVI)=2 and Not Important (NI)=1.

The focus group comprised of nine (9) groups. The focus group discussion was conducted to elicit information from the PLWHIV and AIDS and their family members. The focus group discussion schedule was based on the purpose of study. The focus group discussion was used to further establish the nutritional, emotional, medical, social, and economic support the PLWHIV and AIDS are presently getting from their families; gaps between what the PLWHIV/AIDS require and what they are getting, challenges families face in giving the support needed by the PLWHIV and AIDS, challenges the PLWHIV and AIDS face in receiving the support needed from family members and ways of

strengthening families to support the PLWHIV and AIDS. The subject matter was clearly defined for the respondents. The size of the focus group ranged from 18 ó 23 persons from each senatorial district.

Validation of the Instrument

The questionnaire was validated by five experts who are familiar with PLWHIV&AIDS. They include: two experts from the Departments of Home Economics and Hospitality Management Education, University of Nigeria, Nsukka; one expert in the Department of Education, University of Benin, Asaba Campus, Asaba; a medical doctor and a social welfare officer in federal medical centre Asaba for face validation. The comments made by these experts were considered in the preparation of the final copy of the questionnaire.

Reliability of the Instrument

The reliability of the instrument was established by administering 12 copies of the instrument to 12 persons which included people living with HIV and AIDS, people from nuclear and extended families, as well as some members of the Family of People Living With HIV and AIDS, in Edo State of Nigeria, which is not part of the population.

After collection of the 12 copies of the questionnaire, the responses of the respondents were subjected to reliability analysis using Cronbach Alpha to determine the internal consistency of the instrument. The choice of Cronbach Alpha is because the instrument is not dichotomously scored but homogenously scored. This means that each response given by a respondent attracts a score. An overall index of (0.61) was obtained, (0.81) for research question one, (0.63) for research question two, (0.57) for research question three, (0.78) for research question four (0.94) for research question 5, (0.94) for research question six, and (0.96) for research question seven, showing that the instrument is reliable. Detailed analysis using Statistical Package for Social Sciences (SPSS) version 21 is shown in Appendix 21.

Method of Data Collection

Data were collected using copies of validated questionnaire personally administered and with the aid of five (5) guided research assistants who were given 4 days briefing on the purpose of study, design and tools. The copies of the questionnaire were collected on the spot by the researcher and her research assistants. The questionnaire was pilot-tested at the nearest HIV and AIDS center. Experiences from the pilot study was discussed at an extra session together with the research assistants and necessary changes made to the questionnaire where necessary while the research assistants receive additional guidance.

Prior to the collection of the data, all participants were briefed on the study procedures with the aid of a prepared information sheet, after which each was asked to provide written informed consent prior to being interviewed. Numerical codes were used in place of names in all records to ensure confidentiality.

Method of Data Analysis

The data collected for this study was analyzed using mean for research question one to seven. t-test for independent samples was used to test the seven null hypotheses at 0.05 level of significant. The Statistical Package for Social Sciences (SPSS) was employed for data analysis. The response to the items was interpreted using table of real limit of numbers as follows:

Very Important (VI)	3.50 to 4.00
Important (I)	2.50 to 3.49
Not Very Important (NVI)	1.50 to 2.49
Not Important (NI)	1.00 to 1.49

Based on the above limits, any item in sections A, B, C, D, E, F, and G that has a mean score of 3.50 ó 4.00 was regarded as Very Important, 2.50 ó 3.49 was regarded as Important, 1.50 ó 2.49 was regarded as Not Very Important, 1.00 ó 1.49 was regarded as Not Important. Data collected from Focused Group Discussion were analyzed qualitatively by summarizing the responses of the respondents.

CHAPTER FOUR

PRESENTATION AND ANALYSIS OF DATA

This chapter deals with the analysis of the data. The presentation and analysis are organized based on the research questions and hypotheses of the study.

Research Question 1

What nutritional support strategies do PLWHIV&AIDS require from their families?

Table 1: Mean and standard deviation of Responses on the Nutritional Support Strategies PLWHIV&AIDS Require from their Families.

N = 606				
s/n	Nutritional Support Strategies	\bar{x}	S.D	Remarks
1	Understand the nutritional needs.	3.55	0.73	Very Important
2	Plan adequate meals based on the nutritional needs.	3.39	0.78	Important
3	Prepare appropriate meals using the best digestible methods such as steaming and boiling.	3.42	0.87	Important
4	Adopt attractive method of serving the meals.	3.48	0.76	Important
5	Render appropriate encouragement at meal times.	3.41	0.81	Important
6	Adopt meal time table that suits them.	3.34	0.80	Important
7	Serve quality of foods that is suitable.	3.08	0.93	Important
8	Choose suitable place of service.	3.21	0.88	Important
9	Serve meals on demand even when an initial meal has been served.	3.18	0.84	Important
10	Serve meals with the right temperature.	3.20	0.85	Important
11	Clear dishes immediately after meals.	3.19	0.88	Important
12	Serve suitable snacks.	3.09	0.90	Important
13	Encourage fluid intake to avoid dehydration.	3.12	0.90	Important
14	Encourage owning vegetable garden to help provide right type of food	3.10	0.92	Important
	Cluster Summary	3.25	0.58	Important

Table 1 presents the mean ratings of items 1 to 14 on the nutritional support strategies PLWHIV&AIDS require from their families. The table revealed that item 1 had mean values of 3.55 which fall within the response option of very important. This implies

that the respondents agreed that understanding the nutritional needs are very important nutritional support strategy PLWHIV&AIDS require from their families. Also, the result revealed that item 2 to 14 had mean values that ranged from 3.08 to 3.48 which fall within the response option of important. This implies that the respondents agree that the items are important nutritional support strategy PLWHIV&AIDS require from their families. They include: plan adequate meals based on the nutritional needs; prepare appropriate meals using the best digestible methods such as steaming and boiling; adopt attractive method of serving the meals; render appropriate encouragement at meal times; adopt meal time table that suits them; serve quality of foods that is suitable; choose suitable place of service; serve meals on demand even when an initial meal has been served; serve meals with the right temperature; clear dishes immediately after meals; serve suitable snacks; encourage fluid intake to avoid dehydration; and encourage owning vegetable garden to help provide right type of food. The result also revealed that the 14 items had a cluster mean of 3.25, which fall within the response option of important. The standard deviation for all the items ranged from 0.73 to 0.92. This indicated that the respondents were not far from the mean and from one another in their responses.

Focus group discussion results.

Focus group discussion results on research question one which is on nutritional support strategies PLWHIV&AIDS require from their families revealed the following:

- a. Understand the nutritional needs.
- b. Plan adequate meals based on the nutritional needs.
- c. Prepare appropriate meals using the best digestible methods such as steaming and boiling.
- d. Adopt attractive method of serving the meals.
- e. Render appropriate encouragement at meal times.

- f. Adopt meal time table that suits them.
- g. Serve quality of foods that is suitable.
- h. Choose suitable place of service.
- i. Serve meals on demand even when an initial meal has been served.
- j. Serve meals with the right temperature.
- k. Clear dishes immediately after meals.
- l. Serve suitable snacks.
- m. Encourage fluid intake to avoid dehydration.
- n. Encourage owning vegetable garden to help provide right type of food

Hypothesis 1: There is no significant difference in the mean responses of families of PLWHIV&AIDS and PLWHIV&AIDS on the nutritional support strategies PLWHIV&AIDS require from their families.

Table 2: t-test analyses of responses of families of PLWHIV&AIDS and families of PLWHIV&AIDS on the nutritional support strategies PLWHIV&AIDS require from their families.

s/n	Nutritional Support Strategies	PLWHIV&AIDS (n ₁ = 205)				Families of PLWHIV&AIDS (n ₂ = 205)				df	t-value	Sig.	Decision
		PLWHIV&AIDS (n ₁ = 205)		Families of PLWHIV&AIDS (n ₂ = 205)									
		\bar{x}_1	SD ₁	\bar{x}_2	SD ₂								
1	Understand the nutritional needs.	3.26	0.89	3.61	0.66	394	-4.387	0.00	S				
2	Plan adequate meals based on the nutritional needs.	3.25	0.91	3.47	0.74	404	-2.675	0.01	S				
3	Prepare appropriate meals using the best digestible methods such as steaming and boiling.	2.98	1.10	3.60	0.65	395	-6.832	0.00	S				
4	Adopt attractive method of serving the meals.	3.21	0.95	3.61	0.61	404	-5.010	0.00	S				
5	Render appropriate encouragement at meal times.	3.06	0.98	3.54	0.69	402	-5.678	0.00	S				
6	Adopt meal time table that suits them.	3.10	0.97	3.50	0.70	402	-4.715	0.00	S				
7	Serve quality of foods that is suitable.	2.84	1.07	3.12	0.86	403	-2.857	0.01	S				
8	Choose suitable place of service.	3.05	1.00	3.30	0.88	403	-2.661	0.01	S				
9	Serve meals on demand even when an initial meal has been served.	2.94	1.00	3.23	0.76	393	-3.224	0.00	S				
10	Serve meals with the right temperature.	2.93	0.99	3.28	0.78	399	-4.012	0.00	S				
11	Clear dishes immediately after meals.	2.79	1.06	3.41	0.68	397	-6.936	0.00	S				
12	Serve suitable snacks.	2.88	1.01	3.10	0.86	399	-2.347	0.12	NS				
13	Encourage fluid intake to avoid dehydration.	2.76	1.01	3.26	0.78	401	-5.517	0.00	S				
14	Encourage owning vegetable garden to help provide right type of food	2.78	1.05	3.12	0.89	399	-3.454	0.00	S				
	Cluster Summary	2.97	0.65	3.33	0.55	408	-6.062	0.00	S				

Key: NS = Not Significant, S = Significant, df = Degree of freedom, t-value = Calculated value of t-test using SPSS, SD₁ = Standard Deviation of PLWHIV&AIDS, SD₂ = Standard Deviation of Families of PLWHIV&AIDS, \bar{x}_1 = Mean for PLWHIV&AIDS, \bar{x}_2 = Mean for Families of PLWHIV&AIDS, n₁ = number of PLWHIV&AIDS, n₂ = number of Families of PLWHIV&AIDS, Level of Significance = 0.05.

The result in table 2 shows that there is a significant difference in the mean responses of PLWHIV&AIDS and families of PLWHIV&AIDS on items 1 to 11, as well

as items 13 and 14. Since their probability values ranges from 0.00 to 0.01, which are less than 0.05 level of significant. Therefore, the null hypothesis of no significant difference at 0.05 level of significant was rejected for the items.

The result also revealed that there was no significant difference in the mean responses of PLWHIV&AIDS and families of PLWHIV&AIDS on item 12. Since their probability value is 0.12 which is more than 0.05 level of significant. Therefore the null hypothesis of no significant difference was retained at 0.05 level of significant for the item.

The implication of this is that PLWHIV&AIDS and families of PLWHIV&AIDS did not significantly differ in their responses on one item on the nutritional support strategies PLWHIV&AIDS require from their families but, significantly differed on 13 items.

The result of the cluster revealed that there was a significant difference in the mean responses of PLWHIV&AIDS and families of PLWHIV&AIDS on the items. Since their probability value is 0.00 which is less than 0.05 level of significant. Therefore the null hypothesis of no significant difference was rejected at 0.05 level of significant for the cluster.

Research Question 2

What medical support strategies do PLWHIV&AIDS require from their families?

Table 3: Mean and standard deviation of Responses on the medical support strategies PLWHIV&AIDS require from their families.

N = 606				
s/n	Medical Support Strategies	\bar{x}	S.D	Remarks
1	Make sure they are scheduled for their visits to clinics.	3.52	0.81	Very Important
2	Encourage them to check their viral loads.	3.43	0.79	Important
3	Encourage them to help their helper T-cell counts.	3.46	0.82	Important
4	Advise them to always check blood level.	3.30	0.91	Important
5	Encourage them to obey their clinic dates.	3.11	0.90	Important
6	Encourage them to take their anti retroviral drugs.	3.28	0.86	Important
7	Advise not to have sexual intercourse.	2.95	0.97	Important
8	Help them treat associated infections.	2.77	1.06	Important
9	Organise counselling sessions for them.	2.89	0.97	Important
10	Encourage them to take their anchillary (helper) drugs.	2.74	1.07	Important
11	Encourage them to carry campaign and awareness programme.	2.85	0.98	Important
12	Escort them to clinics as at when necessary.	3.02	0.95	Important
13	Encourage them to take their bath regularly.	2.88	0.99	Important
14	Encourage them to do some exercises.	2.82	1.03	Important
15	Advise them to observe proper hygiene.	2.95	0.98	Important
16	Help in cleaning and dressing of sores and ulcers.	3.12	0.95	Important
Cluster Summary		2.87	0.71	Important

Table 3 presents the mean ratings of items 1 to 16 on the medical support strategies PLWHIV&AIDS required from their families. The table revealed that item 1 had mean value of 3.52 which fall within the response option of very important. This implies that the respondents agreed that making sure they are scheduled for their visits to clinics is a very important medical support strategy PLWHIV&AIDS require from their families. Also, the result revealed that item 2 to 16 had mean values that ranged from 2.88 to 3.46 which fall within the response option of important. This implies that the respondents agree that the items are important medical and physiological support strategies PLWHIV&AIDS require from their families. They include: encourage them to

check their viral loads; encourage them to help their helper T-cell counts; advise them to always check blood level; encourage them to obey their clinic dates; encourage them to take their anti retroviral drugs; advise not to have sexual intercourse; help them treat associated infections; organise counselling sessions for them; encourage them to take their anchillary (helper) drugs; encourage them to carry campaign and awareness programme; escort them to clinics as at when necessary; encourage them to take their bath regularly; encourage them to do some exercises; advise them to observe proper hygiene; as well as help in cleaning and dressing of sores and ulcers.

The result also revealed that the 16 items had a cluster mean of 2.87, which fall within the response option of important. The standard deviation for all the items ranged from 0.79 to 1.07. This indicated that the respondents were not far from the mean and from one another in their responses.

Focus group discussion results.

Focus group discussion results on research question two which is on medical support strategies PLWHIV&AIDS require from their families revealed the following:

- a. Make sure they are scheduled for their visits to clinics.
- b. Encourage them to check their viral loads.
- c. Encourage them to help their helper T-cell counts.
- d. Advise them to always check blood level.
- e. Encourage them to obey their clinic dates.
- f. Encourage them to take their anti retroviral drugs.
- g. Advise not to have sexual intercourse.
- h. Help them treat associated infections.

- i. Organise counselling sessions for them.
- j. Encourage them to take their anchillary (helper) drugs.
- k. Encourage them to carry campaign and awareness programme.
- l. Escort them to clinics as at when necessary.
- m. Encourage them to take their bath regularly.
- n. Encourage them to do some exercises.
- o. Advise them to observe proper hygiene.
- p. Help in cleaning and dressing of sores and ulcers.

Hypothesis 2: There is no significant difference in the mean responses of families of PLWHIV&AIDS and PLWHIV&AIDS on the medical and psychological support strategies PLWHIV&AIDS require from their families.

Table 4: t-test analyses of responses of families of PLWHIV&AIDS and PLWHIV&AIDS on the medical and psychological support strategies PLWHIV&AIDS require from their families.

s/n	Medical Support Strategies.	PLWHIV& AIDS ($n_1 = 205$)		Families of PLWHIV&AI DS ($n_2 = 205$)		df	t-value	Sig.	Decision
		\bar{x}_1	SD ₁	\bar{x}_2	SD ₂				
1	Make sure they are scheduled for their visits to clinics.	3.23	1.02	3.57	0.73	373	-3.741	0.00	S
2	Encourage them to check their viral loads.	3.11	0.94	3.56	0.71	397	-5.425	0.00	S
3	Encourage them to help their helper T-cell counts.	3.06	0.97	3.57	0.75	401	-5.886	0.00	S
4	Advise them to always check blood level.	2.82	1.07	3.45	0.81	402	-6.697	0.00	S
5	Encourage them to obey their clinic dates.	2.78	1.05	3.13	0.83	396	-3.642	0.00	S
6	Encourage them to take their anti-retroviral drugs.	2.92	1.02	3.36	0.79	393	-4.818	0.00	S
7	Advise not to have sexual intercourse.	2.86	1.06	2.78	1.00	391	0.841	0.40	NS
8	Help them treat associated infections.	2.76	1.11	2.55	1.10	397	0.711	0.05	NS
9	Organise counselling sessions for them.	2.77	1.08	2.78	0.96	396	-0.098	0.92	NS
10	Encourage them to take their anchillary (helper) drugs.	2.71	1.03	2.46	1.14	396	2.244	0.03	S
11	Encourage them to carry campaign and awareness progamme.	2.72	1.03	2.63	0.98	393	0.869	0.39	NS
12	Escort them to clinics as at when necessary.	2.73	1.02	3.00	0.95	399	-2.661	0.01	S
13	Encourage them to take their bath regularly.	2.86	1.02	2.63	1.02	399	2.285	0.02	S
14	Encourage them to do some exercises.	2.70	1.04	2.57	1.07	398	1.193	0.23	NS
15	Advise them to observe proper hygiene.	2.58	1.07	2.99	0.90	399	-4.157	0.00	S
16	Help in cleaning and dressing of sores and ulcers.	2.56	1.10	3.33	0.76	401	-8.110	0.00	S
Cluster Summary		2.70	0.64	2.73	0.74	408	-0.424	0.67	NS

Key: NS = Not Significant, S = Significant, df = Degree of freedom, t-value = Calculated value of t-test using SPSS, SD₁ = Standard Deviation of PLWHIV&AIDS, SD₂ = Standard Deviation of Families of PLWHIV&AIDS, \bar{x}_1 = Mean for PLWHIV&AIDS, \bar{x}_2 = Mean for Families of PLWHIV&AIDS, n_1 = number of PLWHIV&AIDS, n_2 = number of Families of PLWHIV&AIDS, Level of Significance = 0.05.

The result in table 4 shows that there is a significant difference in the mean responses of PLWHIV&AIDS and families of PLWHIV&AIDS on items 1 to 6, 10, 12, 13, 15 and 16. Since their probability values ranges from 0.00 to 0.01, which are less than 0.05 level of significant. Therefore, the null hypothesis of no significant difference at 0.05 level of significant was rejected for the items.

The result also revealed that there was no significant difference in the mean responses of PLWHIV&AIDS and families of PLWHIV&AIDS on items 7, 8, 9, 11, and

14. Since their probability values ranges from 0.05 to 0.92 which is more than 0.05 level of significant. Therefore the null hypothesis of no significant difference was retained at 0.05 level of significant for the items.

The implication of this is that PLWHIV&AIDS and families of PLWHIV&AIDS did not significantly differ in their responses on 5 items on the medical and psychological support strategies PLWHIV&AIDS require from their families but, significantly differed on 11 items.

The result of the cluster revealed that there was no significant difference in the mean responses of PLWHIV&AIDS and families of PLWHIV&AIDS on the items. Since their probability value is 0.67 which is more than 0.05 level of significant. Therefore the null hypothesis of no significant difference was retained at 0.05 level of significant for the cluster.

Research Question 3

What emotional support strategies do PLWHIV&AIDS require from their families?

Table 5: Mean and standard deviation of Responses on the emotional support strategies PLWHIV&AIDS require from their families.

N = 606

s/n	Emotional Support Strategies	\bar{X}	S.D	Remarks
1	Show them love and affection.	3.40	0.83	Important
2	Give them attention at all times.	3.25	0.82	Important
3	Establish proper communication channels.	3.26	0.82	Important
4	Work with them and not work for them.	3.18	0.90	Important
5	Avoid discouragement.	3.15	0.87	Important
6	Respect their dignity.	3.21	0.87	Important
7	Spend time with them.	3.34	0.85	Important
8	Tolerate them.	3.20	0.93	Important
9	Encouraging and reassuring them	3.02	0.93	Important
	Cluster Summary	3.20	0.62	Important

Table 5 presents the mean ratings of items 1 to 9 on the emotional support strategies PLWHIV&AIDS required from their families. The result revealed that item 1 to 9 had mean values that ranged from 3.02 to 3.40 which fall within the response option of important. This implies that the respondents agree that the items are important emotional and spiritual support strategies PLWHIV&AIDS required from their families. They include: show them love and affection; give them attention at all times; establish proper communication channels; work with them and not work for them; avoid discouragement; respect their dignity; spend time with them; tolerate them; and encouraging and reassuring them.

The result also revealed that the 9 items had a cluster mean of 3.20, which fall within the response option of important. The standard deviation for all the items ranged from 0.82 to 0.93. This indicated that the respondents were not far from the mean and from one another in their responses.

Focus group discussion results.

Focus group discussion results on research question three which is on emotional support strategies PLWHIV&AIDS required from their families revealed the following:

- a. Show them love and affection.
- b. Give them attention at all times.
- c. Establish proper communication channels.
- d. Work with them and not work for them.
- e. Avoid discouragement.
- f. Respect their dignity.
- g. Spend time with them.
- h. Tolerate them.
- i. Encouraging and reassuring them

Hypothesis 3: There is no significant difference in the mean responses of families of PLWHIV&AIDS and PLWHIV&AIDS on the emotional and spiritual support strategies PLWHIV&AIDS required from their families.

Table 6: t-test analyses of responses of families of PLWHIV&AIDS and PLWHIV&AIDS on the emotional and spiritual support strategies PLWHIV&AIDS required from their families.

s/n	Emotional Support Strategies Show them love and affection.	PLWHIV&AI Families of PLWHIV&AI				df	t-value	Sig.	Deci sion
		DS ($n = 205$)							
		\bar{x}_1	SD ₁	\bar{x}_2	SD ₂				
1	Give them attention at all times.	3.27	0.96	3.37	0.82	401	-1.116	0.27	NS
2	Establish proper communication channels.	2.80	0.92	3.40	0.72	401	-7.398	0.00	S
3	Work with them and not work for them.	2.90	0.97	3.36	0.71	401	-5.501	0.00	S
4	Avoid discouragement.	2.81	1.09	3.26	0.79	400	-4.714	0.00	S
5	Respect their dignity.	2.84	1.01	3.25	0.82	400	-4.496	0.00	S
6	Spend time with them.	2.78	1.00	3.39	0.75	396	-6.921	0.00	S
7	Tolerate them.	2.98	1.01	3.51	0.75	401	-5.915	0.00	S
8	Encouraging and reassuring them	2.81	1.09	3.29	0.82	402	-5.066	0.00	S
9	Emotional Support Strategies	2.74	1.05	3.07	0.90	399	-3.413	0.00	S
	Cluster Summary	2.85	0.67	3.29	0.60	408	-6.941	0.00	S

Key: NS = Not Significant, S = Significant, df = Degree of freedom, t-value = Calculated value of t-test using SPSS, SD₁ = Standard Deviation of PLWHIV&AIDS, SD₂ = Standard Deviation of Families of PLWHIV&AIDS, \bar{x}_1 = Mean for PLWHIV&AIDS, \bar{x}_2 = Mean for Families of PLWHIV&AIDS, n₁ = number of PLWHIV&AIDS, n₂ = number of Families of PLWHIV&AIDS, Level of Significance = 0.05.

The result in table 6 shows that there is a significant difference in the mean responses of PLWHIV&AIDS and families of PLWHIV&AIDS on items 2 to 9. Since each of the items has a probability value 0.00, which is less than 0.05 level of significant. Therefore, the null hypothesis of no significant difference at 0.05 level of significant was rejected for the items.

The result also revealed that there was no significant difference in the mean responses of PLWHIV&AIDS and families of PLWHIV&AIDS on item one. Since their probability value is 0.27 which is more than 0.05 level of significant. Therefore the null

hypothesis of no significant difference was retained at 0.05 level of significant for the item.

The implication of this is that PLWHIV&AIDS and families of PLWHIV&AIDS did not significantly differ in their responses on one item on the emotional and spiritual support strategies PLWHIV&AIDS required from their families but, significantly differed on 8 items.

The result of the cluster revealed that there was a significant difference in the mean responses of PLWHIV&AIDS and families of PLWHIV&AIDS on the items. Since their probability value is 0.00 which is less than 0.05 level of significant. Therefore the null hypothesis of no significant difference was rejected at 0.05 level of significant for the cluster.

Research Question 4

What socio-economic support strategies do PLWHIV&AIDS require from their families?

Table 7: Mean and standard deviation of the responses of the respondents on the socio-economic support strategies PLWHIV&AIDS require from their families.

N = 606

s/n	Socio-economic Support Strategies	\bar{x}	S.D	Remarks
SocialSupport Strategies				
1	Creating awareness about healthy living.	3.59	0.66	Very Important
2	Encourage self disclosure.	3.23	0.90	Important
3	Involve them in family relationships.	3.03	0.89	Important
4	Create appropriate communication channels.	3.01	0.95	Important
5	Sharing information on political happenings	2.95	0.96	Important
6	Sharing information on religious happenings.	3.03	0.97	Important
7	Sharing information on secular happenings.	3.02	0.93	Important
8	Organising social gatherings e.g. birthday parties for PLWHIV and Aids as a form of recreation.	2.93	0.93	Important
9	Helping with legal services in work and living places.	2.83	1.01	Important
EconomicSupport Strategies				
10	Mobilizing financial empowerment community support.	3.13	0.92	Important
11	Securing financial documentations necessary to secure grants for studies or establishing income generation venture.	3.09	0.94	Important
12	Paying for medications for PLWHIV and Aids because of their limited financial resources.	3.13	0.94	Important
13	Providing needed clothing materials for PLWHIV and Aids.	2.99	0.90	Important
14	Providing housing accommodations for PLWHIV and Aids whose house owner have rejected because of their having HIV and Aids or have limited financial resources to pay their rents.	3.03	0.95	Important
15	Providing take off grants for PLWHIV and Aids after training.	2.88	0.99	Important
Cluster Summary		2.97	0.73	Important

Table 7 presents the mean ratings of items 1 to 15 on the socio-economic support strategies that PLWHIV&AIDS require from their families. The table revealed that item one had a mean value of 3.59 which falls within the response option of very important. This implies that the respondents agreed that creating awareness about healthy living is a social support strategy that PLWHIV&AIDS require from their families. Also, the table revealed that items 2 to 15 had mean values that ranged from 2.83 to 3.23 which fall within the response option of important. This implies that the respondents agreed that the important social support strategies PLWHIV&AIDS require from their families include: creating awareness about healthy living; encourage self disclosure; involve them in family relationships; create appropriate communication channels; sharing information on political happenings; sharing information on religious happenings; sharing information on secular happenings; organising social gatherings e.g. birthday parties for PLWHIV and Aids as a form of recreation; as well as helping with legal services in work and living places.

Also, economic support strategies which PLWHIV&AIDS require from their families include: mobilizing financial empowerment community support; securing financial documentations necessary to secure grants for studies or establishing income generation venture; paying for medications for PLWHIV and Aids because of their limited financial resources; providing needed clothing materials for PLWHIV and Aids; providing housing accommodations for PLWHIV and Aids whose house owner have rejected because of their having HIV and Aids or have limited financial resources to pay their rents; as well as providing take off grants for PLWHIV and Aids after training.

The result also revealed that the 15 items had a cluster mean of 2.97, which fall within the response option of important. The standard deviation for all the items ranged from 0.66 to 1.01. This indicated that the respondents were not far from the mean and from one another in their responses.

Focus group discussion results.

Focus group discussion results on research question four which is on socio-economic support strategies PLWHIV&AIDS require from their families revealed that the social support strategies PLWHIV&AIDS require from their families include:

- a. Creating awareness about healthy living.
- b. Encourage self disclosure.
- c. Involve them in family relationships.
- d. Create appropriate communication channels.
- e. Sharing information on political happenings.
- f. Sharing information on religious happenings.
- g. Sharing information on secular happenings.
- h. Organising social gatherings e.g. birthday parties for PLWHIV and Aids as a form of recreation.
- i. Helping with legal services in work and living places.

The focus group discussion also revealed that the economic support strategies PLWHIV&AIDS require from their families include:

- a. Mobilizing financial empowerment community support.
- b. Securing financial documentations necessary to secure grants for studies or establishing income generation venture.
- c. Paying for medications for PLWHIV and Aids because of their limited financial resources.
- d. Providing needed clothing materials for PLWHIV and Aids.
- e. Providing housing accommodations for PLWHIV and Aids whose house owner have rejected because of their having HIV and Aids or have limited financial resources to pay their rents.
- f. Providing take off grants for PLWHIV and Aids after training.

Hypothesis 4: There is no significant difference in the mean responses of people from nuclear and extended families on the socio-economic support strategies PLWHIV&AIDS require from their families.

Table 8: t-test analyses of responses of people from nuclear and extended families on the socio-economic support strategies PLWHIV&AIDS require from their families.

s/ n	Types of Support Strategies	People from Nuclear Family ($n_1 = 311$)		People from Extended Family ($n_2 = 229$)		df	t-value	Sig.	Decision
		\bar{x}_1	SD ₁	\bar{x}_2	SD ₂				
Social Support Strategies									
1	Creating awareness about healthy living.	3.64	0.59	3.52	0.74	356	1.720	0.09	NS
2	Encourage self-disclosure.	3.23	0.90	3.27	0.87	512	-0.592	0.55	NS
3	Involve them in family relationships.	3.04	0.92	3.04	0.85	528	0.034	0.97	NS
4	Create appropriate communication channels.	3.05	0.94	2.96	0.95	525	0.986	0.33	NS
5	Sharing information on political happenings	3.01	0.94	2.88	0.99	522	1.512	0.13	NS
6	Sharing information on religious happenings.	3.07	0.96	3.00	0.98	526	0.857	0.39	NS
7	Sharing information on secular happenings.	3.07	0.97	2.91	0.92	526	1.941	0.05	NS
8	Organising social gatherings e.g. birthday parties for PLWHIV and Aids as a form of recreation.	2.93	0.97	2.92	0.89	529	0.099	0.92	NS
9	Helping with legal services in work and living places.	2.96	0.98	2.65	1.00	525	3.506	0.00	S
Economic Support Strategies									
10	Mobilizing financial empowerment community support.	3.19	0.90	3.04	0.93	529	1.871	0.06	NS
11	Securing financial documentations necessary to secure grants for studies or establishing income generation venture.	3.17	0.94	2.99	0.93	529	2.276	0.02	S
12	Paying for medications for PLWHIV and Aids because of their limited financial resources.	3.20	0.94	3.07	0.92	527	1.617	0.11	NS
13	Providing needed clothing materials for PLWHIV and Aids.	3.06	0.91	2.88	0.87	527	2.333	0.02	S
14	Providing housing accommodations for PLWHIV and Aids whose house owner have rejected because of their having HIV and Aids or have limited financial resources to pay their rents.	3.06	0.93	2.99	0.98	525	0.850	0.40	NS
15	Providing take off grants for PLWHIV and Aids after training.	2.88	1.00	2.83	0.99	522	0.612	0.54	NS
Cluster Summary		3.02	0.73	2.91	0.73	538	1.704	0.09	NS

Key: NS = Not Significant, S = Significant, df = Degree of freedom, t-value = Calculated value of t-test using SPSS, SD₁ = Standard Deviation of people from Nuclear Family, SD₂ = Standard Deviation of people from Extended Family, \bar{x}_1 = Mean for people from Nuclear Family, \bar{x}_2 = Mean for People from Nuclear Family, n_1 = number of people from Nuclear Family, n_2 = number of People from Extended Family, Level of Significance = 0.05.

The result in table 8 shows that there is a significant difference in the mean responses of people from nuclear and extended families on items 9, 11, and 13. Since

their probability values are 0.00, 0.02, and 0.02 respectively, which are less than 0.05 level of significant. Therefore, the null hypothesis of no significant difference at 0.05 level of significant was rejected for the items.

The result also revealed that there was no significant difference in the mean responses of people from nuclear and extended families on items 1 to 8, 10, 12, 14, and 15. Since their probability values ranges from 0.05 to 0.97 which is more than 0.05 level of significant. Therefore the null hypothesis of no significant difference was retained at 0.05 level of significant for the items.

The implication of this is that people from nuclear and extended families did not significantly differ in their responses on 12 items on the on the socio-economic support strategies PLWHIV&AIDS require from their families but, significantly differed on 3 items.

The result of the cluster revealed that there was no significant difference in the mean responses of people from nuclear and extended families on the items. Since their probability value is 0.09 which is more than 0.05 level of significant. Therefore the null hypothesis of no significant difference was retained at 0.05 level of significant for the cluster.

Research Question 5

What are the challenges faced by families in providing support to PLWHIV & AIDS?

Table 9: Mean and standard deviation of Responses on the challenges families face in rendering support to PLWHIV and AIDS.

				N = 606
s/n	Challenges families face in rendering support to PLWHIV and AIDS	\bar{x}	S.D	Remarks
Nutritional Challenges				
1	Insufficient or lack of food for PLWHIV and Aids and their family members.	3.15	0.91	Important
2	Lack of knowledge of proper method of preparing and serving meals.	2.85	0.89	Important
3	Selective in the choice of food by PLWHIV and AIDS	2.98	0.91	Important
Medical Challenges				
4	Medications are not adequately accessible.	2.83	0.93	Important
5	Poor health care facilities.	2.79	0.96	Important
6	Insufficient health care administrators to attend to the health needs of PLWHIV and Aids and those of their families.	2.86	0.95	Important
7	Insufficient registration of patients by health centres.	2.91	0.93	Important
8	Insufficiency of health personnel to support family care givers.	2.96	0.93	Important
9	Little available material support such as gloves, medications, foods.	2.88	0.93	Important
10	Insufficiency of understanding of how treatment works.	2.84	0.97	Important
11	Insufficiency of knowledge on when to seek for follow-up services from health personnel.	2.84	0.93	Important
Emotional Challenges				
12	Limited means of communication between care providers PLWHIV and Aids and their family members.	2.75	0.94	Important
13	Little available moral support for PLWHIV and Aids and their family members by the society.	2.80	0.93	Important
14	Fear of being infected by PLWHIV and Aids.	2.74	0.94	Important
15	Fear of being over-burdened by PLWHIV and Aids.	2.92	0.98	Important
16	Fear of discriminations and stigmatization by society for PLWHIV and Aids and their family members.	2.86	0.92	Important
17	Care giver fatigue and burn out.	2.88	0.93	Important
18	Non observance of universal precautions when caring for sick family members.	2.88	0.91	Important
Social Challenges				
19	Legal services not adequately accessible.	2.86	0.92	Important
20	Very little of public assistance is available.	2.79	0.93	Important
21	No public assistance is available.	3.19	0.81	Important
22	High level of illiteracy.	2.98	0.84	Important
23	Insufficiency of community support for PLWHIV and Aids and their family members.	2.96	0.86	Important
24	Support groups are not conveniently located.	2.94	1.00	Important
25	Insufficiency of trainings on universal precautions to be taken when caring for sick family members.	2.93	0.96	Important
26	Secrecy of family members about the true health status of sick members.	2.86	0.91	Important
27	Speculations, mistrust and gossip among community members.	2.94	0.90	Important
28	Myths in the communities about HIV and AIDS in relation to PLWHIV and Aids and their family members.	2.86	0.95	Important
29	Inadequate counselling for PLWHIV and Aids and their family members.	2.83	0.97	Important
30	Non-attendance by patients to counselling services	2.88	0.92	Important
31	Inadequacy of counselling personnel.	2.95	0.96	Important
32	Gender differences in caring for sick relatives.	2.88	0.98	Important
33	Poor sexual relationship among discordant couples.	2.89	0.96	Important
34	Problems associated with non-disclosure.	2.89	0.95	Important
35	Non attendance by family care givers to counselling services.	2.91	0.91	Important
36	Non availability of home base care for PLWHIV and Aids to complement that of family care givers.	2.84	0.91	Important
37	Misconceptions by family members about HIN and AIDS transmission and treatment available.	2.80	0.97	Important
38	Little available moral support for PLWHIV and AIDS and their family members by the society.	2.79	0.97	Important
39	Fear of stigmatization by society for PLWHIV and AIDS and their family members.	2.77	0.98	Important
Economic Challenges				
40	Financial supports are not adequately accessible.	2.70	0.98	Important
41	High cost of accessing up-to-date, timely and relevant quality health information.	2.80	0.93	Important
42	High cost counselling services.	2.84	0.92	Important
43	High cost of medications.	2.80	0.88	Important
44	Insufficiency of resources to provide proper support.	2.78	0.89	Important
45	Practical concern about loss of earnings from business engagements.	2.88	0.95	Important
Cluster Summary		2.84	0.59	Important

The result from table 9 revealed that items 1 to 45 had mean values that ranged from 2.70 to 3.19 which fall within the response option of important. This implies that the respondents agree that the items are important challenges families face in rendering support to PLWHIV and AIDS. They are: nutritional challenges which include: insufficient or lack of food for PLWHIV and Aids and their family members; lack of knowledge of proper method of preparing and serving meals; selective in the choice of food by PLWHIV and AIDS; medical challenges which include: medications are not adequately accessible; poor health care facilities; insufficient health care administrators to attend to the health needs of PLWHIV and Aids and those of their families; insufficient registration of patients by health centres; insufficiency of health personnel to support family care givers; little available material support such as gloves, medications, foods; insufficiency of understanding of how treatment works; insufficiency of knowledge on when to seek for follow-up services from health personnel; emotional challenges which include: limited means of communication between care providers PLWHIV and Aids and their family members; little available moral support for PLWHIV and Aids and their family members by the society; fear of being infected by PLWHIV and Aids; fear of being over-burdened by PLWHIV and Aids; fear of discriminations and stigmatization by society for PLWHIV and Aids and their family members; care giver fatigue and burn out; non observance of universal precautions when caring for sick family members; social challenges which include: legal services not adequately accessible; very little of public assistance is available; no public assistance is available; high level of illiteracy; insufficiency of community support for PLWHIV and Aids and their family members; support groups are not conveniently located; insufficiency of trainings on universal precautions to be taken when caring for sick family members; secrecy of family members about the true health status of sick members; speculations, mistrust and gossip among community members; myths in the communities about HIV and AIDs in relation to PLWHIV and Aids and their family members; inadequate counselling for PLWHIV and Aids and their family members; non-attendance by patients to counselling services; inadequacy of counselling personnel; gender differences in caring for sick relatives; poor

sexual relationship among discordant couples; problems associated with non-disclosure; non-attendance by family care givers to counselling services; non availability of home base care for PLWHIV and Aids to complement that of family care givers; misconceptions by family members about HIN and AIDs transmission and treatment available; little available moral support for PLWHIV and AIDS and their family members by the society; fear of stigmatization by society for PLWHIV and AIDS and their family members; economic challenges which include: financial supports are not adequately accessible; high cost of accessing up-to-date, timely and relevant quality health information; high cost counselling services; high cost of medications; insufficiency of resources to provide proper support; practical concern about loss of earnings from business engagements.

The result also revealed that the 45 items had a cluster mean of 2.84, which fall within the response option of important. The standard deviation for all the items ranged from 0.81 to 1.00. This indicated that the respondents were not far from the mean and from one another in their responses.

Focus group discussion results.

Focus group discussion results on research question five which is on the challenges associated with providing support to PLWHIV&AIDS by their families revealed that nutritional challenges families face in rendering support to PLWHIV and AIDS include:

- a. Insufficient or lack of food for PLWHIV and Aids and their family members.
- b. Lack of knowledge of proper method of preparing and serving meals.
- c. Selective in the choice of food by PLWHIV and AIDS.
- d. Medical Challenges.
- e. Medications are not adequately accessible.
- f. Poor health care facilities.

- g. Insufficient health care administrators to attend to the health needs of PLWHIV and Aids and those of their families.
- h. Insufficient registration of patients by health centres.
- i. Insufficiency of health personnel to support family care givers.
- j. Little available material support such as gloves, medications, foods.
- k. Insufficiency of understanding of how treatment works.
- l. Insufficiency of knowledge on when to seek for follow-up services from health personnel.

Also, the focus group discussion revealed that emotional challenges families face in rendering support to PLWHIV and AIDS include:

- a. Limited means of communication between care providers PLWHIV and Aids and their family members.
- b. Little available moral support for PLWHIV and Aids and their family members by the society.
- c. Fear of being infected by PLWHIV and Aids.
- d. Fear of being over-burdened by PLWHIV and Aids.
- e. Fear of discriminations and stigmatization by society for PLWHIV and Aids and their family members.
- f. Care giver fatigue and burn out.
- g. Non observance of universal precautions when caring for sick family members.

The focus group discussion also revealed that social challenges families face in rendering support to PLWHIV and AIDS include:

- a. Legal services not adequately accessible.
- b. Very little of public assistance is available.
- c. No public assistance is available.
- d. High level of illiteracy.
- e. Insufficiency of community support for PLWHIV and Aids and their family members.
- f. Support groups are not conveniently located.
- g. Insufficiency of trainings on universal precautions to be taken when caring for sick family members.
- h. Secrecy of family members about the true health status of sick members.
- i. Speculations, mistrust and gossip among community members.
- j. Myths in the communities about HIV and AIDs in relation to PLWHIV and Aids and their family members.
- k. Inadequate counselling for PLWHIV and Aids and their family members.
- l. Non-attendance by patients to counselling services.
- m. Inadequacy of counselling personnel.
- n. Gender differences in caring for sick relatives.
- o. Poor sexual relationship among discordant couples.
- p. Problems associated with non-disclosure.

- q. Non attendance by family care givers to counselling services.
- r. Non availability of home base care for PLWHIV and Aids to complement that of family care givers.
- s. Misconceptions by family members about HIN and AIDs transmission and treatment available.
- t. Little available moral support for PLWHIV and AIDS and their family members by the society.
- u. Fear of stigmatization by society for PLWHIV and AIDS and their family members.

From the focus group discussion, it was revealed that economic challenges families face in rendering support to PLWHIV and AIDS include:

- a. Financial supports are not adequately accessible.
- b. High cost of accessing up-to-date, timely and relevant quality health information.
- c. High cost counselling services.
- d. High cost of medications.
- e. Insufficiency of resources to provide proper support.
- f. Practical concern about loss of earnings from business engagements.

Hypothesis 5: There is no significant difference in the mean response of families of PLWHIV&AIDS and PLWHIV&AIDS on the challenges families face in rendering support to PLWHIV&AIDS.

Table 10: t-test analyses of responses of PLWHIV&AIDS and families of PLWHIV&AIDS on the challenges families face in rendering support to PLWHIV and AIDS.

s/n	Challenges families face in rendering support to PLWHIV and AIDS	PLWHIV& AIDS ($n_1 = 205$)		Families of PLWHIV& AIDS ($n_2 = 205$)		Df	t-value	Sig.	Decision	
		\bar{M}_1	SD ₁	\bar{M}_2	SD ₂					
Nutritional Challenges										
1	Insufficient or lack of food for PLWHIV and Aids and their family members.	3.07	1.02	3.40	0.88	400	-3.453	0.00	S	
2	Lack of knowledge of proper method of preparing and serving meals.	2.77	0.99	3.02	0.94	394	-2.535	0.01	S	
3	Selective in the choice of food by PLWHIV and AIDS	2.78	0.99	3.29	0.86	396	-5.448	0.00	S	
Medical Challenges										
4	Medications are not adequately accessible.	2.70	1.10	3.04	0.88	397	-3.411	0.00	S	
5	Poor health care facilities.	2.79	1.04	2.91	1.02	396	-1.110	0.27	NS	
6	Insufficient health care administrators to attend to the health needs of PLWHIV and Aids and those of their families.	2.82	1.03	2.96	0.98	400	-1.465	0.14	NS	
7	Insufficient registration of patients by health centres.	2.80	1.05	3.15	0.86	396	-3.634	0.00	S	
8	Insufficiency of health personnel to support family care givers.	2.78	1.09	3.23	0.90	397	-4.503	0.00	S	
9	Little available material support such as gloves, medications, foods.	2.88	1.05	3.09	0.92	397	-2.123	0.03	S	
10	Insufficiency of understanding of how treatment works.	2.85	1.10	2.99	0.99	395	-1.368	0.17	NS	
11	Insufficiency of knowledge on when to seek for follow-up services from health personnel.	2.70	1.06	3.11	0.92	390	-4.070	0.00	S	
Emotional Challenges										
12	Limited means of communication between care providers PLWHIV and Aids and their family members.	2.64	1.07	2.98	0.92	393	-3.473	0.00	S	
13	Little available moral support for PLWHIV and Aids and their family members by the society.	2.73	1.04	2.94	0.98	393	-2.130	0.03	S	
14	Fear of being infected by PLWHIV and Aids.	2.61	1.08	2.85	0.95	392	-2.387	0.02	S	
15	Fear of being over-burdened by PLWHIV and Aids.	2.73	1.13	3.16	0.97	397	-4.079	0.00	S	
16	Fear of discriminations and stigmatization by society for PLWHIV and Aids and their family members.	2.67	1.07	3.07	0.89	392	-4.050	0.00	S	
17	Care giver fatigue and burn out.	2.70	1.13	3.15	0.85	396	-4.472	0.00	S	
18	Non observance of universal precautions when caring for sick family members.	2.76	1.07	3.09	0.89	397	-3.368	0.00	S	
Social Challenges										
19	Legal services not adequately accessible.	2.72	1.02	3.08	0.86	398	-3.769	0.00	S	
20	Very little of public assistance is available.	2.48	1.08	3.17	0.87	396	-7.054	0.00	S	
21	No public assistance is available.	3.16	0.94	3.32	0.82	389	-1.811	0.07	NS	
22	High level of illiteracy.	2.90	0.94	3.20	0.84	389	-3.255	0.00	S	
23	Insufficiency of community support for PLWHIV and Aids and their family members.	2.79	0.97	3.17	0.87	386	-4.060	0.00	S	
24	Support groups are not conveniently located.	2.80	1.15	3.11	0.99	389	-2.852	0.01	S	
25	Insufficiency of trainings on universal precautions to be taken when caring for sick family members.	2.84	1.12	3.02	0.96	391	-1.721	0.09	NS	
26	Secrecy of family members about the true health status of sick members.	2.75	1.03	3.08	0.91	391	-3.360	0.00	S	
27	Speculations, mistrust and gossip among community members.	2.81	0.99	3.16	0.92	389	-3.549	0.00	S	
28	Myths in the communities about HIV and AIDs in relation to PLWHIV and Aids and their family members.	2.71	1.08	3.16	0.89	387	-4.488	0.00	S	
29	Inadequate counselling for PLWHIV and Aids and their family members.	2.83	1.04	2.85	1.08	386	-0.179	0.86	NS	
30	Non-attendance by patients to counselling services	2.69	1.04	3.15	0.92	388	-4.564	0.00	S	
31	Inadequacy of counselling personnel.	2.82	1.10	3.06	1.00	387	-2.292	0.02	S	
32	Gender differences in caring for sick relatives.	2.71	1.13	3.06	0.96	388	-3.241	0.00	S	
33	Poor sexual relationship among discordant couples.	2.81	1.11	3.03	0.95	388	-2.132	0.03	S	
34	Problems associated with non-disclosure.	2.77	1.11	3.04	0.93	387	-2.599	0.01	S	
35	Non attendance by family care givers to counselling services.	2.78	1.08	3.05	0.93	390	-2.643	0.01	S	
36	Non availability of home base care for PLWHIV and Aids to complement that of family care givers.	3.65	1.03	3.04	0.88	390	-4.056	0.00	S	
37	Misconceptions by family members about HIN and AIDs transmission and treatment available.	2.76	1.04	2.87	1.05	385	-1.024	0.31	NS	
38	Little available moral support for PLWHIV and AIDS and their family members by the society.	2.67	1.07	2.99	0.96	387	-3.139	0.00	S	
39	Fear of stigmatization by society for PLWHIV and AIDS and their family members.	2.70	1.05	2.89	1.09	389	-1.705	0.09	NS	
Economic Challenges										
40	Financial supports are not adequately accessible.	2.63	1.07	2.76	1.03	387	-1.210	0.23	NS	
41	High cost of accessing up-to-date, timely and relevant quality health information.	2.77	1.00	2.86	1.01	387	-0.894	0.37	NS	
42	High cost counselling services.	2.62	1.02	3.12	0.88	388	-5.162	0.00	S	
43	High cost of medications.	2.69	0.98	2.94	0.91	384	-2.666	0.01	S	
44	Insufficiency of resources to provide proper support.	2.55	0.99	3.03	0.89	390	-4.957	0.00	S	
45	Practical concern about loss of earnings from business engagements.	2.65	1.10	3.20	0.89	387	-5.363	0.00	S	
Cluster Summary		2.72	0.58	2.99	0.68	408	-4.361	0.00	S	

Key: NS = Not Significant, S = Significant, df = Degree of freedom, t-value = Calculated value of t-test using SPSS, SD₁ = Standard Deviation of PLWHIV&AIDS, SD₂ = Standard Deviation of Families of PLWHIV&AIDS, \bar{M}_1 = Mean for PLWHIV&AIDS, \bar{M}_2 = Mean for Families of PLWHIV&AIDS, n_1 = number of PLWHIV&AIDS, n_2 = number of Families of PLWHIV&AIDS, Level of Significance = 0.05.

The result in table 10 shows that there is a significant difference in the mean responses of PLWHIV&AIDS and families of PLWHIV&AIDS on items 1 to 4, 7, 8, 9, 11 to 20, 22, 23, 24, 26, 27, 28, 30 to 36, 38, 42, 43, 44, and 45. Since their probability values ranges from 0.00 to 0.03, which are less than 0.05 level of significant. Therefore, the null hypothesis of no significant difference at 0.05 level of significant was rejected for the items.

The result also revealed that there was no significant difference in the mean responses of PLWHIV&AIDS and families of PLWHIV&AIDS on items 5, 6, 10, 21, 25, 29, 37, 39, 40, and 41. Since their probability values ranges from 0.07 to 0.86 which is more than 0.05 level of significant. Therefore the null hypothesis of no significant difference was retained at 0.05 level of significant for the items.

The implication of this is that PLWHIV&AIDS and families of PLWHIV&AIDS did not significantly differ in their responses on 10 items on the challenges families face in rendering support to PLWHIV and AID but, significantly differed on 35 items.

The result of the cluster revealed that there was a significant difference in the mean responses of PLWHIV&AIDS and families of PLWHIV&AIDS on the items. Since their probability value is 0.00 which is less than 0.05 level of significant. Therefore the null hypothesis of no significant difference was rejected at 0.05 level of significant for the cluster.

Research Question 6

What are the challenges faced by PLWHIV & AIDS in receiving support from their families?

Table 11: Mean and standard deviation of Responses on the challenges PLWHIV/AIDS face in receiving support from family members.

N = 606

s/n	Challenges PLWHIV/AIDS face in receiving support from family members	\bar{x}	S.D	Remarks
Emotional Challenges				
46	PLWHIV and Aids require attention but family care givers are too short tempered.	3.12	0.90	Important
47	PLWHIV and Aids require understanding of their needs but family care givers can never satisfy them because they feel PLWHIV and Aids are too demanding.	2.99	0.87	Important
48	PLWHIV and Aids require time with family members but they are always shouting at them giving excuses of rushing to the market to sell things or to go and look for resources for their survival.	2.97	0.89	Important
49	PLWHIV and Aids need family members to do things with them but they are rather doing for them.	2.89	0.94	Important
50	Family members assume things for PLWHIV and Aids rather than asking them what they need.	2.96	0.89	Important
51	Interpersonal strains with family members.	2.89	0.91	Important
Social Challenges				
52	Poor perception of the nature of the state of health of PLWHIV and Aids.	2.82	0.92	Important
53	Poor attitude towards attending to their needs.	2.73	0.94	Important
54	Poor understanding of the needs of PLWHIV and Aids by family members.	2.96	0.89	Important
55	Discrimination and stigmatisation from family members.	2.85	0.91	Important
56	Lack of proper communication between PLWHIV and Aids and family members.	2.83	0.92	Important
Economic Challenges				
57	Stinginess of rich family members towards assisting with care for PLWHIV and Aids.	2.88	0.95	Important
58	PLWHIV and Aids require adequate resources for their upkeep but family care givers cannot adequately satisfy them due to their poverty level.	2.81	0.94	Important
Nutritional Challenges				
59	Meals are not properly planned and prepared.	2.87	0.96	Important
60	Meals not properly and adequately served.	2.85	0.92	Important
Cluster Summary		2.83	0.75	Important

The result from table 11 revealed that items 46 to 60 had mean values that ranged from 2.73 to 3.12 which fall within the response option of important. This implies that the

respondents agree that the items are important challenges PLWHIV/AIDS face in receiving support from family members. They are: emotional challenges which include: PLWHIV and Aids require attention but family care givers are too short tempered; PLWHIV and Aids require understanding of their needs but family care givers can never satisfy them because they feel PLWHIV and Aids are too demanding; PLWHIV and Aids require time with family members but they are always shouting at them giving excuses of rushing to the market to sell things or to go and look for resources for their survival; PLWHIV and Aids need family members to do things with them but they are rather doing for them; family members assume things for PLWHIV and Aids rather than asking them what they need; interpersonal strains with family members; social challenges which include: poor perception of the nature of the state of health of PLWHIV and Aids; poor attitude towards attending to their needs; poor understanding of the needs of PLWHIV and Aids by family members; discrimination and stigmatisation from family members; lack of proper communication between PLWHIV and Aids and family members; economic challenges which include: stinginess of rich family members towards assisting with care for PLWHIV and Aids; PLWHIV and Aids require adequate resources for their upkeep but family care givers cannot adequately satisfy them due to their poverty level; nutritional challenges which include: meals are not properly planned and prepared; meals not properly and adequately served.

The result also revealed that the 15 items had a cluster mean of 2.83, which fall within the response option of important. The standard deviation for all the items ranged from 0.86 to 0.96. This indicated that the respondents were not far from the mean and from one another in their responses.

Focus group discussion results.

Focus group discussion results on research question five which is on the challenges PLWHIV/AIDS face in receiving support from family members revealed that emotional challenges families face in receiving support to PLWHIV and AIDS include:

- a. PLWHIV and Aids require attention but family care givers are too short tempered.
- b. PLWHIV and Aids require understanding of their needs but family care givers can never satisfy them because they feel PLWHIV and Aids are too demanding.
- c. PLWHIV and Aids require time with family members but they are always shouting at them giving excuses of rushing to the market to sell things or to go and look for resources for their survival.
- d. PLWHIV and Aids need family members to do things with them but they are rather doing for them.
- e. Family members assume things for PLWHIV and Aids rather than asking them what they need.
- f. Interpersonal strains with family members.

The focus group discussion also revealed that the social challenges families face in receiving support to PLWHIV and AIDS include:

- a. Poor perception of the nature of the state of health of PLWHIV and Aids.
- b. Poor attitude towards attending to their needs.
- c. Poor understanding of the needs of PLWHIV and Aids by family members.
- d. Discrimination and stigmatisation from family members.
- e. Lack of proper communication between PLWHIV and Aids and family members.

Also, the focus group discussion also revealed that the emotional challenges families face in receiving support to PLWHIV and AIDS include:

- a. Stinginess of rich family members towards assisting with care for PLWHIV and Aids.
- b. PLWHIV and Aids require adequate resources for their upkeep but family care givers cannot adequately satisfy them due to their poverty level.

The focus group discussion also revealed that the nutritional challenges families face in receiving support to PLWHIV and AIDS include:

- a. Meals are not properly planned and prepared.
- b. Meals not properly and adequately served.

Hypothesis 6: There is no significant difference in the mean response of families of PLWHIV&AIDS and PLWHIV&AIDS on the challenges families face in rendering support to PLWHIV&AIDS and those faced by PLWHIV&AIDS in availing themselves of such support.

Table 12: t-test analyses of responses of families of PLWHIV&AIDS and PLWHIV&AIDS on the challenges PLWHIV/AIDS face in receiving support from family members.

s/n	Challenges PLWHIV/AIDS face in receiving support from family members	PLWHIV&AI DS ($n_1 = 205$)		Families of PLWHIV&AI DS ($n_2 = 205$)		Df	t-value	Sig.	Decision
		\bar{x}_1	SD ₁	\bar{x}_2	SD ₂				
Emotional Challenges									
46	PLWHIV and Aids require attention but family care givers are too short tempered.	3.26	0.95	3.16	1.01	391	1.060	0.29	NS
47	PLWHIV and Aids require understanding of their needs but family care givers can never satisfy them because they feel PLWHIV and Aids are too demanding.	3.09	0.90	3.16	0.91	391	0.518	0.43	NS
48	PLWHIV and Aids require time with family members but they are always shouting at them giving excuses of rushing to the market to sell things or to go and look for resources for their survival.	2.98	0.98	3.16	0.95	391	-1.860	0.06	NS
49	PLWHIV and Aids need family members to do things with them but they are rather doing for them.	2.89	1.09	3.07	0.96	390	-1.815	0.07	NS
50	Family members assume things for PLWHIV and Aids rather than asking them what they need.	3.02	0.99	3.09	0.94	390	-0.805	0.42	NS
51	Interpersonal strains with family members.	2.94	0.99	3.02	0.99	386	-0.858	0.39	NS
Social Challenges									
52	Poor perception of the nature of the state of health of PLWHIV and Aids.	2.88	1.00	2.94	1.00	386	-0.514	0.61	NS
53	Poor attitude towards attending to their needs.	2.66	1.03	2.86	1.03	378	-1.875	0.06	NS
54	Poor understanding of the needs of PLWHIV and Aids by family members.	3.06	1.00	3.10	0.90	385	-0.418	0.68	NS
55	Discrimination and stigmatisation from family members.	2.78	0.97	3.12	0.92	383	-3.602	0.00	S
56	Lack of proper communication between PLWHIV and Aids and family members.	2.76	1.03	3.07	0.94	385	-3.132	0.00	S
Economic Challenges									
57	Stinginess of rich family members towards assisting with care for PLWHIV and Aids.	2.81	1.04	3.17	0.94	388	-3.608	0.00	S
58	PLWHIV and Aids require adequate resources for their upkeep but family care givers cannot adequately satisfy them due to their poverty level.	2.71	0.98	3.12	0.99	386	-4.134	0.00	S
Nutritional Challenges									
59	Meals are not properly planned and prepared.	2.80	1.05	3.15	1.03	392	-3.283	0.00	S
60	Meals not properly and adequately served.	2.69	1.04	3.18	0.85	392	-5.040	0.00	S
Cluster Summary		2.83	0.72	2.94	0.92	408	-1.365	0.17	NS

Key: NS = Not Significant, S = Significant, df = Degree of freedom, t-value = Calculated value of t-test using SPSS, SD₁ = Standard Deviation of PLWHIV&AIDS, SD₂ = Standard Deviation of Families of PLWHIV&AIDS, \bar{x}_1 = Mean for PLWHIV&AIDS, \bar{x}_2 = Mean for Families of PLWHIV&AIDS, n_1 = number of PLWHIV&AIDS, n_2 = number of Families of PLWHIV&AIDS, Level of Significance = 0.05.

The result in table 12 shows that there is a significant difference in the mean responses of PLWHIV&AIDS and families of PLWHIV&AIDS on items 55 to 60. Since each of the item has a probability value 0.00, which is less than 0.05 level of significant. Therefore, the null hypothesis of no significant difference at 0.05 level of significant was rejected for the items.

The result also revealed that there was no significant difference in the mean responses of PLWHIV&AIDS and families of PLWHIV&AIDS on items 46 to 54. Since their probability values ranges from 0.06 to 0.68 which is more than 0.05 level of significant. Therefore the null hypothesis of no significant difference was retained at 0.05 level of significant for the items.

The implication of this is that PLWHIV&AIDS and families of PLWHIV&AIDS did not significantly differ in their responses on 9 items on the challenges PLWHIV/AIDS face in receiving support from family members but, significantly differed on 6 items.

The result of the cluster revealed that there was no significant difference in the mean responses of PLWHIV&AIDS and families of PLWHIV&AIDS on the items. Since their probability value is 0.17 which is less than 0.05 level of significant. Therefore the null hypothesis of no significant difference was retained at 0.05 level of significant for the cluster.

Research Question 7

What are the strategies for strengthening families to support PLWHIV&AIDS?

Table 13: Mean and standard deviation of Responses on the strategies for strengthening families to support PLWHIV&AIDS.

				N = 606
s/n	Ways families can be strengthened to support PLWHIV and AIDS	\bar{x}	S.D	Remarks
Nutritional Strategies				
1	Spending time with PLWHIV and Aids and discussing the foods they need to maintain and gain weight and manage their illness.	3.45	0.79	Important
Medical Strategies				
2	Establishing comprehensive support system linking and coordinating existing psychosocial services with each other and health services.	3.24	0.84	Important
3	A review of the national essential drug list to ensure that pharmacological supplies are available when needed.	3.22	0.92	Important
4	Making available information detailing potential interactions between medicines used for psychological care and antiretroviral therapy.	3.09	0.95	Important
Social Strategies				
5	Encouraging leaders at all levels and in all works of life to visibly challenge HIV and AIDs ó related discrimination.	3.32	0.85	Important
6	Spearheading public actions against the many other forms of discrimination faced in relation to HIV and AIDs.	3.25	0.83	Important
7	Creating positive legal environment for fighting discrimination.	3.24	0.84	Important
8	Increasing knowledge about the transmission and treatment of HIV and AIDs among the populace through seminars, sensitisation and intervention programmes.	3.17	0.85	Important
9	Communities should provide enabling environment and support the formation of support groups for individual living with or affected by HIV and AIDs.	3.29	0.84	Important
10	Educating the sick and family members on how to overcome stigmatisation and discrimination.	3.01	0.88	Important
11	Individual living within the communities should contribute to the support of the individual living with or affected by HIV and AIDs by supporting them emotionally, physically and spiritually.	3.10	0.93	Important
12	Assessing available HIV and AIDs supportive services at both the governmental and non-governmental level. That could be strengthened or replicated.	3.07	0.89	Important
13	Building community capacities to provide counselling and support services.	3.08	0.91	Important
14	Provision of needs Assessment of people living with HIV and AIDs.	3.34	0.90	Important
15	Training of adequate personnel to cater for these needs.	3.21	0.88	Important
16	Spouses should be taught by health on how to take care of their sick spouses.	3.21	0.88	Important
17	Having strong leadership at the Federal, State and Local Government levels, to push for meaningful results.	3.13	0.92	Important
18	Assessing additional needs.	3.30	0.85	Important
Emotional Strategies				
19	Involving people living with HIV and AIDs in response to the epidemic.	3.12	0.89	Important
20	Starting up groups comprising health workers, people living with HIV and AIDs and their family members at the community level, to provide for the needs of individual patients and affected family members.	3.23	0.87	Important
21	Organisation of programmes for members on how each person can be of help to the other in ensuring that love and care is maintained at home for people living with HIV and AIDs.	3.13	0.93	Important
22	Using community-based care programmes to give family members the training and psychological support they need to do their job well.	3.16	0.91	Important
23	Involving PLWHIV and Aids in policy making and programme design and implementation, to ensure that services meet their needs.	3.05	0.90	Important
24	Including older people in HIV and AIDs education/training programme.	3.07	0.94	Important
25	Reassuring both the PLWHIV and Aids and their family care givers that HIV and AIDs are never death sentences.	3.17	0.92	Important
26	Having community volunteers help families with people living with HIV and AIDs, with domestic task.	3.15	0.93	Important
Economic Strategies				
27	Providing disability grants for people who are unable to work because of illness and have very little income.	3.13	0.93	Important
28	Financial empowerment by government to affect victims in order to help them alleviate poverty.	3.21	0.96	Important
Cluster Summary		3.10	0.77	Important

The result from table 13 revealed that items 1 to 28 had mean values that ranged from 3.01 to 3.45 which fall within the response option of important. This implies that the

respondents agreed that the items are important strategies for strengthening families to support PLWHIV&AIDS. They are: nutritional strategies which include: spending time with PLWHIV and Aids and discussing the foods they need to maintain and gain weight and manage their illness; medical strategies which include: establishing comprehensive support system linking and coordinating existing psychosocial services with each other and health services; a review of the national essential drug list to ensure that pharmacological supplies are available when needed; making available information detailing potential interactions between medicines used for psychological care and antiretroviral therapy; social strategies which include: encouraging leaders at all levels and in all works of life to visibly challenge HIV and AIDs ó related discrimination; spearheading public actions against the many other forms of discrimination faced in relation to HIV and AIDs; creating positive legal environment for fighting discrimination; increasing knowledge about the transmission and treatment of HIV and AIDs among the populace through seminars, sensitisation and intervention programmes; communities should provide enabling environment and support the formation of support groups for individual living with or affected by HIV and AIDs; educating the sick and family members on how to overcome stigmatisation and discrimination; individual living within the communities should contribute to the support of the individual living with or affected by HIV and AIDs by supporting them emotionally, physically and spiritually; assessing available HIV and AIDs supportive services at both the governmental and non-governmental level. That could be strengthened or replicated; building community capacities to provide counselling and support services; provision of needs Assessment of people living with HIV and AIDs; training of adequate personnel to cater for these needs; spouses should be taught by health on how to take care of their sick spouses; having strong leadership at the Federal, State and Local Government levels, to push for meaningful results; assessing additional needs; emotional strategies which include: involving people living with HIV and AIDs in response to the epidemic; starting up groups comprising health workers, people living with HIV and AIDs and their family members at the community level, to provide for the needs of individual patients and

affected family members; organisation of programmes for members on how each person can be of help to the other in ensuring that love and care is maintained at home for people living with HIV and AIDs; using community-based care programmes to give family members the training and psychological support they need to do their job well; involving PLWHIV and Aids in policy making and programme design and implementation, to ensure that services meet their needs; including older people in HIV and AIDs education/training programme; reassuring both the PLWHIV and Aids and their family care givers that HIV and AIDs are never death sentences; having community volunteers help families with people living with HIV and AIDs, with domestic task; economic strategies which include: providing disability grants for people who are unable to work because of illness and have very little income; financial empowerment by government to affect victims in order to help them alleviate poverty.

The result also revealed that the 28 items had a cluster mean of 3.10, which fall within the response option of important. The standard deviation for all the items ranged from 0.79 to 0.96. This indicated that the respondents were not far from the mean and from one another in their responses.

Focus group discussion results.

Focus group discussion results on research question six which is on the strategies for strengthening families to support PLWHIV&AIDS revealed that nutritional strategies strengthening families to support PLWHIV&AIDS include:

- a. Spending time with PLWHIV and Aids and discussing the foods they need to maintain and gain weight and manage their illness.

Also, the medical strategies strengthening families to support PLWHIV&AIDS include:

- a. Establishing comprehensive support system linking and coordinating existing psychosocial services with each other and health services.

- b. A review of the national essential drug list to ensure that pharmacological supplies are available when needed.
- c. Making available information detailing potential interactions between medicines used for psychological care and antiretroviral therapy.

The focus group discussion also revealed that the social strategies strengthening families to support PLWHIV & AIDS include:

- a. Encouraging leaders at all levels and in all works of life to visibly challenge HIV and AIDS ó related discrimination.
- b. Spearheading public actions against the many other forms of discrimination faced in relation to HIV and AIDS.
- c. Creating positive legal environment for fighting discrimination.
- d. Increasing knowledge about the transmission and treatment of HIV and AIDS among the populace through seminars, sensitisation and intervention programmes.
- e. Communities should provide enabling environment and support the formation of support groups for individual living with or affected by HIV and AIDS.
- f. Educating the sick and family members on how to overcome stigmatisation and discrimination.
- g. Individual living within the communities should contribute to the support of the individual living with or affected by HIV and AIDS by supporting them emotionally, physically and spiritually.
- h. Assessing available HIV and AIDS supportive services at both the governmental and non-governmental level. That could be strengthened or replicated.
- i. Building community capacities to provide counselling and support services.
- j. Provision of needs Assessment of people living with HIV and AIDS.
- k. Training of adequate personnel to cater for these needs.

- l. Spouses should be taught by health on how to take care of their sick spouses.
- m. Having strong leadership at the Federal, State and Local Government levels, to push for meaningful results.
- n. Assessing additional needs.

From the result of the focus group discussion, it was revealed that the emotional strategies strengthening families to support PLWHIV&AIDS include:

- a. Involving people living with HIV and AIDs in response to the epidemic.
- b. Starting up groups comprising health workers, people living with HIV and AIDs and their family members at the community level, to provide for the needs of individual patients and affected family members.
- c. Organisation of programmes for members on how each person can be of help to the other in ensuring that love and care is maintained at home for people living with HIV and AIDs.
- d. Using community-based care programmes to give family members the training and psychological support they need to do their job well.
- e. Involving PLWHIV and Aids in policy making and programme design and implementation, to ensure that services meet their needs.
- f. Including older people in HIV and AIDs education/training programme.
- g. Reassuring both the PLWHIV and Aids and their family care givers that HIV and AIDs are never death sentences.
- h. Having community volunteers help families with people living with HIV and AIDs, with domestic task.

The focus group discussion also revealed that the economic strategies strengthening families to support PLWHIV&AIDS include:

- a. Providing disability grants for people who are unable to work because of illness and have very little income.
- b. Financial empowerment by government to affect victims in order to help them alleviate poverty.

Hypothesis 7: There is no significant difference between the mean responses of people from nuclear and extended families on families strengthening strategies in supporting PLWHIV&AIDS.

Table 14: t-test analyses of responses of people from nuclear and extended families on strategies for strengthening families to support PLWHIV&AIDS.

s/n	Strategies for strengthening families to support PLWHIV&AIDS	People from Nuclear Family ($n_1 = 311$)		People from Extended Family ($n_2 = 229$)		Df	t-value	Sig.	Decision
		\bar{x}_1	SD ₁	\bar{x}_2	SD ₂				
Nutritional Strategies									
1	Spending time with PLWHIV and Aids and discussing the foods they need to maintain and gain weight and manage their illness.	3.47	0.77	3.45	0.80	522	0.399	0.69	NS
Medical Strategies									
2	Establishing comprehensive support system linking and coordinating existing psychosocial services with each other and health services.	3.23	0.86	3.25	0.81	520	-0.264	0.79	NS
3	A review of the national essential drug list to ensure that pharmacological supplies are available when needed.	3.26	0.93	3.14	0.90	523	1.452	0.15	NS
4	Making available information detailing potential interactions between medicines used for psychological care and antiretroviral therapy.	3.09	0.96	3.12	0.93	524	-0.368	0.71	NS
Social strategies									
5	Encouraging leaders at all levels and in all works of life to visibly challenge HIV and AIDs ó related discrimination.	3.33	0.84	3.45	0.86	524	-0.264	0.79	NS
6	Spearheading public actions against the many other forms of discrimination faced in relation to HIV and AIDs.	3.28	0.82	3.22	0.84	521	0.869	0.39	NS
7	Creating positive legal environment for fighting discrimination.	3.24	0.87	3.23	0.81	520	0.242	0.81	NS
8	Increasing knowledge about the transmission and treatment of HIV and AIDs among the populace through seminars, sensitisation and intervention programmes.	3.23	0.86	3.07	0.84	523	2.134	0.03	S
9	Communities should provide enabling environment and support the formation of support groups for individual living with or affected by HIV and AIDs.	3.23	0.87	3.12	0.81	521	1.448	0.15	NS
10	Educating the sick and family members on how to overcome stigmatisation and discrimination.	3.05	0.86	2.95	0.89	521	1.386	0.17	NS
11	Individual living within the communities should contribute to the support of the individual living with or affected by HIV and AIDs by supporting them emotionally, physically and spiritually.	3.11	0.93	3.04	0.95	523	0.922	0.36	NS
12	Assessing available HIV and AIDs supportive services at both the governmental and non-governmental level. That could be strengthened or replicated.	3.09	0.87	3.05	0.93	521	0.603	0.55	NS
13	Building community capacities to provide counselling and support services.	3.11	0.89	3.06	0.94	522	0.594	0.55	NS
14	Provision of needs Assessment of people living with HIV and AIDs.	3.37	0.88	3.30	0.91	511	0.795	0.43	NS
15	Training of adequate personnel to cater for these needs.	3.16	0.90	3.29	0.85	517	-1.651	0.10	NS
16	Spouses should be taught by health on how to take care of their sick spouses.	3.15	0.90	3.30	0.85	518	-1.927	0.06	NS
17	Having strong leadership at the Federal, State and Local Government levels, to push for meaningful results.	3.13	0.93	3.15	0.92	522	-0.348	0.73	NS
18	Assessing additional needs.	3.30	0.83	3.32	0.86	522	-0.221	0.83	NS
Emotional strategies									
19	Involving people living with HIV and AIDs in response to the epidemic.	3.05	0.88	3.20	0.91	522	-1.852	0.07	NS
20	Starting up groups comprising health workers, people living with HIV and AIDs and their family members at the community level, to provide for the needs of individual patients and affected family members.	3.19	0.92	3.27	0.82	516	-1.852	0.07	NS
21	Organisation of programmes for members on how each person can be of help to the other in ensuring that love and care is maintained at home for people living with HIV and AIDs.	3.04	0.96	3.21	0.90	521	-2.049	0.04	S
22	Using community-based care programmes to give family members the training and psychological support they need to do their job well.	3.10	0.93	3.22	0.90	521	-1.471	0.14	NS
23	Involving PLWHIV and Aids in policy making and programme design and implementation, to ensure that services meet their needs.	3.04	0.93	3.05	0.88	521	-0.222	0.82	NS
24	Including older people in HIV and AIDs education/training programme.	3.04	0.94	3.09	0.91	518	-0.533	0.60	NS
25	Reassuring both the PLWHIV and Aids and their family care givers that HIV and AIDs are never death sentences.	3.13	0.93	3.24	0.87	521	-1.363	0.17	NS
26	Having community volunteers help families with people living with HIV and AIDs, with domestic task.	3.15	0.95	3.14	0.89	519	0.146	0.88	NS
Economic strategies									
27	Providing disability grants for people who are unable to work because of illness and have very little income.	3.16	0.91	3.10	0.95	521	0.625	0.53	NS
28	Financial empowerment by government to affect victims in order to help them alleviate poverty.	3.18	0.98	3.25	0.91	518	-0.860	0.39	NS
Cluster Summary		3.12	0.72	3.10	0.78	538	0.290	0.77	NS

Key: NS = Not Significant, S = Significant, df = Degree of freedom, t-value = Calculated value of t-test using SPSS, SD₁ = Standard Deviation of people from Nuclear Family, SD₂ = Standard Deviation of people from Extended Family, \bar{x}_1 = Mean for people from Nuclear Family, \bar{x}_2 = Mean for People from Nuclear Family, n_1 = number of people from Nuclear Family, n_2 = number of People from Extended Family, Level of Significance = 0.05.

The result in table 14 shows that there is a significant difference in the mean responses of PLWHIV&AIDS and families of PLWHIV&AIDS on items 8 and 21. Since the probability value of the items are 0.03 and 0.04 respectively, which are less than 0.05 level of significant. Therefore, the null hypothesis of no significant difference at 0.05 level of significant was rejected for the items.

The result also revealed that there was no significant difference in the mean responses of PLWHIV&AIDS and families of PLWHIV&AIDS on items 1 to 7, 9 to 20, as well as items 22 to 28. Since their probability values ranges from 0.06 to 0.88 which are more than 0.05 level of significant. Therefore the null hypothesis of no significant difference was retained at 0.05 level of significant for the items.

The implication of this is that PLWHIV&AIDS and families of PLWHIV&AIDS did not significantly differ in their responses on 2 items on the families strengthening strategies in supporting PLWHIV&AIDS but, significantly differed on 26 items.

The result of the cluster revealed that there was no significant difference in the mean responses of PLWHIV&AIDS and families of PLWHIV&AIDS on the items. Since their probability value is 0.77 which is more than 0.05 level of significant. Therefore the null hypothesis of no significant difference was retained at 0.05 level of significant for the cluster.

Findings of the study

The following findings emerged from the study with respect to the research questions and hypotheses tested.

1. Nutritional support strategies PLWHIV&AIDS required from their families include: understand the nutritional needs; plan adequate meals based on the nutritional needs; prepare appropriate meals using the best digestible methods such as steaming and boiling; adopt attractive method of serving the meals; render appropriate encouragement at meal times; adopt meal time table that suits them;

serve quality of foods that is suitable; choose suitable place of service; serve meals on demand even when an initial meal has been served; serve meals with the right temperature; clear dishes immediately after meals; serve suitable snacks; encourage fluid intake to avoid dehydration; and encourage owning vegetable garden to help provide right type of food.

Focus group discussion on nutritional support strategies PLWHIV&AIDS require from their families reveal the following: that the members of their families understand their nutritional needs; plan adequate meals based on their nutritional needs; prepare appropriate meals using the best digestible methods such as steaming and boiling; adopt attractive method of serving the meals; render appropriate encouragement at meal times; adopt meal time table that suits them; serve quality of foods that is suitable; choose suitable place of service; serve meals on demand even when an initial meal has been served; serve meals with the right temperature; clear dishes immediately after meals; serve suitable snacks; encourage fluid intake to avoid dehydration and encourage owning vegetable garden to help provide right type of food.

2. Medical support strategies PLWHIV&AIDS require from their families include: make sure they are scheduled for their visits to clinics; encourage them to check their viral loads; encourage them to help their helper T-cell counts; advise them to always check blood level; encourage them to obey their clinic dates; encourage them to take their anti retroviral drugs; advise not to have sexual intercourse; help them treat associated infections; organise counselling sessions for them; encourage them to take their anchillary (helper) drugs; encourage them to carry campaign and awareness programme; escort them to clinics as at when necessary; encourage them to take their bath regularly; encourage them to do some exercises; advise them to observe proper hygiene; as well as help in cleaning and dressing of sores and ulcers.

Focus group discussion on medical support strategies PLWHIV&AIDS require from their families reveal that the members of their families should: make sure

they are scheduled for their visits to clinics; encourage them to check their viral loads; encourage them to help their helper T-cell counts; advise them to always check blood level; encourage them to obey their clinic dates; encourage them to take their anti retroviral drugs; advise not to have sexual intercourse; help them treat associated infections; organise counselling sessions for them; encourage them to take their anchillary (helper) drugs; encourage them to carry campaign and awareness programme; escort them to clinics as at when necessary; encourage them to take their bath regularly; encourage them to do some exercises; advise them to observe proper hygiene; as well as help in cleaning and dressing of sores and ulcers.

3. Emotional support strategies PLWHIV&AIDS require from their families include: show them love and affection; give them attention at all times; establish proper communication channels; work with them and not work for them; avoid discouragement; respect their dignity; spend time with them; tolerate them; as well as encouraging and reassuring them.

Focus group discussion on emotional support strategies PLWHIV&AIDS require from their families reveal that the members of their families should:show PLWHIV&AIDS love and affection; give them attention at all times; establish proper communication channels; work with them and not work for them; avoid discouragement; respect their dignity; spend time with them; tolerate them; as well as encouraging and reassuring them.

4. Socio-economic support strategies PLWHIV&AIDS require from their families include:
 - b. Social support include: creating awareness about healthy living; encourage self disclosure; involve them in family relationships; create appropriate communication channels; sharing information on political happenings; sharing information on religious happenings; sharing information on secular happenings; organising social gatherings e.g. birthday parties for

PLWHIV and Aids as a form of recreation; and helping with legal services in work and living places.

- c. Economic support include: mobilizing financial empowerment community support; securing financial documentations necessary to secure grants for studies or establishing income generation venture; paying for medications for PLWHIV and Aids because of their limited financial resources; providing needed clothing materials for PLWHIV and Aids; providing housing accommodations for PLWHIV and Aids whose house owner have rejected because of their having HIV and Aids or have limited financial resources to pay their rents; as well as providing take off grants for PLWHIV and Aids after training.

Focus group discussion on social support strategies PLWHIV&AIDS require from their families reveal that the members of their families should: create awareness about healthy living; encourage self-disclosure; involve PLWHIV and Aids in family relationships; create appropriate communication channels; sharing information on political happenings; sharing information on religious happenings; sharing information on secular happenings; organising social gatherings e.g. birthday parties for PLWHIV and Aids as a form of recreation; and helping with legal services in work and living places.

Also, the focus group discussion revealed that economic support strategies PLWHIV&AIDS require from their families include: mobilizing financial empowerment community support; securing financial documentations necessary to secure grants for studies or establishing income generation venture; paying for medications for PLWHIV and Aids because of their limited financial resources; providing needed clothing materials for PLWHIV and Aids; providing housing accommodations for PLWHIV and Aids whose house owner have rejected because of their having HIV and

Aids or have limited financial resources to pay their rents; as well as providing take off grants for PLWHIV and Aids after training.

5. Challenges families face in rendering support to PLWHIV and AIDS include:
 - a. Nutrition challenges include: insufficient or lack of food for PLWHIV and Aids and their family members; lack of knowledge of proper method of preparing and serving meals; as well as selective in the choice of food by PLWHIV and AIDS.
 - b. Medicals challenges include: medications are not adequately accessible; poor health care facilities; insufficient health care administrators to attend to the health needs of PLWHIV and Aids and those of their families; insufficient registration of patients by health centres; insufficiency of health personnel to support family care givers; little available material support such as gloves, medications, foods; insufficiency of understanding of how treatment works; as well as insufficiency of knowledge on when to seek for follow-up services from health personnel.
 - c. Emotional challenges include: limited means of communication between care providers PLWHIV and Aids and their family members; little available moral support for PLWHIV and Aids and their family members by the society; fear of being infected by PLWHIV and Aids; fear of being over-burdened by PLWHIV and Aids; fear of discriminations and stigmatization by society for PLWHIV and Aids and their family members; care giver fatigue and burn out; as well as non-observance of universal precautions when caring for sick family members.
 - d. Social challenges include: legal services not adequately accessible; very little of public assistance is available; no public assistance is available; high level of illiteracy; insufficiency of community support for PLWHIV and Aids and their family members; support groups are not conveniently located; insufficiency of trainings on universal precautions to be taken when caring for sick family members; secrecy of family members about the true health status of sick

- members; speculations, mistrust and gossip among community members; myths in the communities about HIV and AIDs in relation to PLWHIV and Aids and their family members; inadequate counselling for PLWHIV and Aids and their family members; non-attendance by patients to counselling services; inadequacy of counselling personnel; gender differences in caring for sick relatives; poor sexual relationship among discordant couples; problems associated with non-disclosure; non-attendance by family care givers to counselling services; non availability of home base care for PLWHIV and Aids to complement that of family care givers; misconceptions by family members about HIN and AIDs transmission and treatment available; little available moral support for PLWHIV and AIDS and their family members by the society; as well as fear of stigmatization by society for PLWHIV and AIDS and their family members.
- e. Economic challenges include: financial supports are not adequately accessible; high cost of accessing up-to-date, timely and relevant quality health information; high cost counselling services; high cost of medications; insufficiency of resources to provide proper support; as well as practical concern about loss of earnings from business engagements.

Focus group discussion revealed that the nutritional challenges families face in rendering support to PLWHIV and AIDS include:insufficient or lack of food for PLWHIV and Aids and their family members; lack of knowledge of proper method of preparing and serving meals; as well as selective in the choice of food by PLWHIV and AIDS. Also, the focus group discussion revealed that the medical challenges families face in rendering support to PLWHIV and AIDS include: medications are not adequately accessible; poor health care facilities; insufficient health care administrators to attend to the health needs of PLWHIV and Aids and those of their families; insufficient registration of patients by health centres; insufficiency of health personnel to support family care givers; little available material support such as gloves, medications, foods; insufficiency of

understanding of how treatment works; as well as insufficiency of knowledge on when to seek for follow-up services from health personnel. From the focus group discussion, it was revealed that emotional challenges families face in rendering support to PLWHIV and AIDS include: limited means of communication between care providers PLWHIV and Aids and their family members; little available moral support for PLWHIV and Aids and their family members by the society; fear of being infected by PLWHIV and Aids; fear of being over-burdened by PLWHIV and Aids; fear of discriminations and stigmatization by society for PLWHIV and Aids and their family members; care giver fatigue and burn out; as well as non-observance of universal precautions when caring for sick family members. Again, the focus group discussion revealed that social challenges families face in rendering support to PLWHIV and AIDS include: legal services not adequately accessible; very little of public assistance is available; no public assistance is available; high level of illiteracy; insufficiency of community support for PLWHIV and Aids and their family members; support groups are not conveniently located; insufficiency of trainings on universal precautions to be taken when caring for sick family members; secrecy of family members about the true health status of sick members; speculations, mistrust and gossip among community members; myths in the communities about HIV and AIDs in relation to PLWHIV and Aids and their family members; inadequate counselling for PLWHIV and Aids and their family members; non-attendance by patients to counselling services; inadequacy of counselling personnel; gender differences in caring for sick relatives; poor sexual relationship among discordant couples; problems associated with non-disclosure; non-attendance by family care givers to counselling services; non availability of home base care for PLWHIV and Aids to complement that of family care givers; misconceptions by family members about HIN and AIDs transmission and treatment available; little available moral support for PLWHIV and AIDS and their family members by the society; as well as fear of stigmatization by society for PLWHIV and AIDS and their family

members. The result from focus group discussion also revealed that economic challenges families face in rendering support to PLWHIV and AIDS include: financial supports are not adequately accessible; high cost of accessing up-to-date, timely and relevant quality health information; high cost counselling services; high cost of medications; insufficiency of resources to provide proper support; as well as practical concern about loss of earnings from business engagements.

6. Challenges PLWHIV/AIDS face in receiving support from family members include:

- a. Emotional challenges include: PLWHIV and Aids require attention but family care givers are too short tempered; PLWHIV and Aids require understanding of their needs but family care givers can never satisfy them because they feel PLWHIV and Aids are too demanding; PLWHIV and Aids require time with family members but they are always shouting at them giving excuses of rushing to the market to sell things or to go and look for resources for their survival; PLWHIV and Aids need family members to do things with them but they are rather doing for them; family members assume things for PLWHIV and Aids rather than asking them what they need; as well as interpersonal strains with family members.
- b. Social challenges include: poor perception of the nature of the state of health of PLWHIV and Aids; poor attitude towards attending to their needs; poor understanding of the needs of PLWHIV and Aids by family members; discrimination and stigmatisation from family members; as well as lack of proper communication between PLWHIV and Aids and family members.
- c. Economic challenges include: stinginess of rich family members towards assisting with care for PLWHIV and Aids; also PLWHIV and Aids require adequate resources for their upkeep but family care givers cannot adequately satisfy them due to their poverty level.
- d. Nutritional challenges include: meals are not properly planned and prepared; also meals not properly and adequately served.

The result of the focus group discussion revealed that the emotional challenges PLWHIV/AIDS face in receiving support from family members include: PLWHIV and Aids require attention but family care givers are too short tempered; PLWHIV and Aids require understanding of their needs but family care givers can never satisfy them because they feel PLWHIV and Aids are too demanding; PLWHIV and Aids require time with family members but they are always shouting at them giving excuses of rushing to the market to sell things or to go and look for resources for their survival; PLWHIV and Aids need family members to do things with them but they are rather doing for them; family members assume things for PLWHIV and Aids rather than asking them what they need; as well as interpersonal strains with family members. From the focus group discussion, it was revealed that social challenges PLWHIV/AIDS face in receiving support from family members include: poor perception of the nature of the state of health of PLWHIV and Aids; poor attitude towards attending to their needs; poor understanding of the needs of PLWHIV and Aids by family members; discrimination and stigmatisation from family members; as well as lack of proper communication between PLWHIV and Aids and family members. The focus group discussion also revealed that economic challenges PLWHIV/AIDS face in receiving support from family members include: stinginess of rich family members towards assisting with care for PLWHIV and Aids; also PLWHIV and Aids require adequate resources for their upkeep but family care givers cannot adequately satisfy them due to their poverty level. Also, the focus group discussion revealed that nutritional challenges PLWHIV/AIDS face in receiving support from family members include: meals are not properly planned and prepared; also meals not properly and adequately served.

7. Ways families can be strengthened to support PLWHIV and Aids include:
- a. Nutritional strategies include: spending time with PLWHIV and Aids and discussing the foods they need to maintain and gain weight and manage their illness.
 - b. Medical strategies include: establishing comprehensive support system linking and coordinating existing psychosocial services with each other and health services; a review of the national essential drug list to ensure that pharmacological supplies are available when needed; making available information detailing potential interactions between medicines used for psychological care and antiretroviral therapy.
 - c. Social strategies include: encouraging leaders at all levels and in all works of life to visibly challenge HIV and AIDs-related discrimination; spearheading public actions against the many other forms of discrimination faced in relation to HIV and AIDs; creating positive legal environment for fighting discrimination; increasing knowledge about the transmission and treatment of HIV and AIDs among the populace through seminars, sensitisation and intervention programmes; communities should provide enabling environment and support the formation of support groups for individual living with or affected by HIV and AIDs; educating the sick and family members on how to overcome stigmatisation and discrimination; individual living within the communities should contribute to the support of the individual living with or affected by HIV and AIDs by supporting them emotionally, physically and spiritually; assessing available HIV and AIDs supportive services at both the governmental and non-governmental level. That could be strengthened or replicated; building community capacities to provide counselling and support services; provision of needs Assessment of people living with HIV and AIDs; training of adequate personnel to cater for these needs; spouses should be taught by health workers on how to take care of their sick spouses; having strong leadership at the Federal, State and

Local Government levels, to push for meaningful results; as well as assessing additional needs.

- d. Emotional strategies include: involving people living with HIV and AIDs in response to the epidemic; starting up groups comprising health workers, people living with HIV and AIDs and their family members at the community level, to provide for the needs of individual patients and affected family members; organisation of programmes for members on how each person can be of help to the other in ensuring that love and care is maintained at home for people living with HIV and AIDs; using community-based care programmes to give family members the training and psychological support they need to do their job well; involving PLWHIV and Aids in policy making and programme design and implementation, to ensure that services meet their needs; including older people in HIV and AIDs education/training programme; reassuring both the PLWHIV and Aids and their family care givers that HIV and AIDs are never death sentences; as well as having community volunteers to help families with people living with HIV and AIDs, with domestic task.
- e. Economic strategies include: providing disability grants for people who are unable to work because of illness and have very little income; as well as financial empowerment by government to affected victims in order to help them alleviate poverty.

The result of the focus group discussion revealed that the ways families can be strengthened to support nutrition of PLWHIV and Aids include: spending time with PLWHIV and Aids and discussing the foods they need to maintain and gain weight and manage their illness. Also, the result of the focus group discussion revealed that the medical strategies families can be strengthened to support PLWHIV and Aids include: establishing comprehensive support system linking and coordinating existing psychosocial services with each other and health services; a review of the national

essential drug list to ensure that pharmacological supplies are available when needed; making available information detailing potential interactions between medicines used for psychological care and antiretroviral therapy. The focus group discussion revealed that the social strategies families can be strengthened to support PLWHIV and Aids include: encouraging leaders at all levels and in all works of life to visibly challenge HIV and AIDs ó related discrimination; spearheading public actions against the many other forms of discrimination faced in relation to HIV and AIDs; creating positive legal environment for fighting discrimination; increasing knowledge about the transmission and treatment of HIV and AIDs among the populace through seminars, sensitisation and intervention programmes; communities should provide enabling environment and support the formation of support groups for individual living with or affected by HIV and AIDs; educating the sick and family members on how to overcome stigmatisation and discrimination; individual living within the communities should contribute to the support of the individual living with or affected by HIV and AIDs by supporting them emotionally, physically and spiritually; assessing available HIV and AIDs supportive services at both the governmental and non-governmental level. That could be strengthened or replicated; building community capacities to provide counselling and support services; provision of needs Assessment of people living with HIV and AIDs; training of adequate personnel to cater for these needs; spouses should be taught by health on how to take care of their sick spouses; having strong leadership at the Federal, State and Local Government levels, to push for meaningful results; as well as assessing additional needs. From the focus group discussion it was revealed that the emotional strategies families can be strengthened to support PLWHIV and Aids include: involving people living with HIV and AIDs in response to the epidemic; starting up groups comprising health workers, people living with HIV and AIDs and their family members at the community level, to provide for the needs of individual patients and affected family members; organisation of programmes for members on how each person can be of help to the other in ensuring that love and care is maintained at home for people living with HIV and AIDs; using community-based care programmes to give family members the training

and psychological support they need to do their job well; involving PLWHIV and Aids in policy making and programme design and implementation, to ensure that services meet their needs; including older people in HIV and AIDs education/training programme; reassuring both the PLWHIV and Aids and their family care givers that HIV and AIDs are never death sentences; as well as having community volunteers help families with people living with HIV and AIDs, with domestic task. From the focus group discussion it was also revealed that the economic strategies families can be strengthened to support PLWHIV and Aids include:providing disability grants for people who are unable to work because of illness and have very little income; as well as financial empowerment by government to affect victims in order to help them alleviate poverty.

8. It was found out from hypothesis one that there was no significant difference in the mean responses of PLWHIV&AIDS and families of PLWHIV&AIDS on item 12. However, significant difference existed in the mean responses of PLWHIV&AIDS and families of PLWHIV&AIDS on items 1 to 11, as well as items 13 and 14. Therefore, the hypothesis of no significance difference was upheld for item 12 because its probability value (0.12) is more than the stated 0.05 level of significant, but was rejected for items 1 to 11, as well as items 13 and 14, because their probability values are less than the stated 0.05 level of significant.
9. The result from hypothesis two shows that there is a significant difference in the mean responses of PLWHIV&AIDS and families of PLWHIV&AIDS on items 1 to 6, 10, 12, 13, 15 and 16. However, there was no significant difference in the mean responses of PLWHIV&AIDS and families of PLWHIV&AIDS on items 7, 8, 9, 11, and 14. Therefore, the hypothesis of no significance difference was upheld for items 7, 8, 9, 11, and 14, because their probability values are more than the stated 0.05 level of significant, but was rejected for items 1 to 6, 10, 12, 13, 15 and 16, because their probability values (0.00, 0.00, 0.00, 0.00, 0.00, 0.00, 0.03, 0.01,0.02, 0.00, and 0.00 respectively) are less than the stated 0.05 level of significant.

10. The result from hypothesis three shows that there is a significant difference in the mean responses of PLWHIV&AIDS and families of PLWHIV&AIDS on items 2 to 9. However, there was no significant difference in the mean responses of PLWHIV&AIDS and families of PLWHIV&AIDS on item 1. Therefore, the hypothesis of no significance difference was upheld for item 1, because its probability value (0.27) is more than the stated 0.05 level of significant, but was rejected for items 2 to 9, because their probability values (0.00 each) are less than the stated 0.05 level of significant.
11. The result from hypothesis four shows that there is a significant difference in the mean responses of PLWHIV&AIDS and families of PLWHIV&AIDS on items 9, 11, and 12. However, there was no significant difference in the mean responses of PLWHIV&AIDS and families of PLWHIV&AIDS on items 1 to 8, 10, 13, 15, and 16. Therefore, the hypothesis of no significance difference was upheld for items 1 to 8, 10, 13, 15, and 16, because their probability values are more than the stated 0.05 level of significant, but was rejected for items items 9, 11, and 12, because their probability values (0.00, 0.02, and 0.02) are less than the stated 0.05 level of significant.
12. The result from hypothesis five shows that there is a significant difference in the mean responses of people from nuclear family and people from extended family on items 1 to 4, 7, 8, 9, 11 to 20, 22, 23, 24, 26, 27, 28, 30 to 36, 38, 42, 43, 44, 45, as well as 55 to 60. However, there was no significant difference in the mean responses of PLWHIV&AIDS and families of PLWHIV&AIDS on items 5, 6, 10, 21, 25, 29, 37, 39, 40, 41, , as well as 46 to 54. Therefore, the hypothesis of no significance difference was upheld for items 5, 6, 10, 21, 25, 29, 37, 39, 40, 41, as well as 46 to 54, because their probability values are more than the stated 0.05 level of significant, but was rejected for items 1 to 4, 7, 8, 9, 11 to 20, 22, 23, 24, 26, 27, 28, 30 to 36, 38, 42, 43, 44, 45,as well as 55 to 60 because their probability values (from 0.00 to 0.03) are less than the stated 0.05 level of significant.

13. The result from hypothesis six shows that there is a significant difference in the mean responses of people from nuclear family and people from extended family on items 55 to 60. However, there was no significant difference in the mean responses of PLWHIV&AIDS and families of PLWHIV&AIDS on items 46 to 54. Therefore, the hypothesis of no significance difference was upheld for items 46 to 54, because their probability values are more than the stated 0.05 level of significant, but was rejected for items 55 to 60, because their probability values(0.00 each) are less than the stated 0.05 level of significant.
14. The result from hypothesis seven shows that there is a significant difference in the mean responses of people from nuclear family and people from extended family on items 8 and 21. However, there was no significant difference in the mean responses of PLWHIV&AIDS and families of PLWHIV&AIDS on items 1 to 7, 9 to 20, and 22 to 28. Therefore, the hypothesis of no significance difference was upheld for items 1 to 7, 9 to 20, and 22 to 28, because their probability values are more than the stated 0.05 level of significant, but was rejected for items 8 and 21, because their probability values(0.03 and 0.04) are less than the stated 0.05 level of significant.

Discussion

Nutrition and HIV/AIDS has commonality. Nutritional imbalance and exposure to HIV can increase the risk of AIDS later in life (Ministry of Health, 2002). Concerning nutritional support strategies from family members, almost all groups of participants put emphasis on the following items: understand the nutritional needs; plan adequate meals based on the nutritional needs; prepare appropriate meals using the best digestible methods such as steaming and boiling; adopt attractive method of serving the meals; render appropriate encouragement at meal times; adopt meal time table that suits them; serve quality of foods that is suitable; choose suitable place of service; serve meals on demand even when an initial meal has been served; serve meals with the right temperature; clear dishes immediately after meals; serve suitable snacks; encourage fluid

intake to avoid dehydration; and encourage owning vegetable garden to help provide right type of food. This finding is in line with the results of other studies (Uwimana & Struthers, 2007; Etu, 2013 and UNDP, 2003). For instance, the need for food for PLWHIV/AIDS was stressed by Uwimana and Struthers (2007) when they reported that food was the third greatest need of individuals living with or affected by HIV and AIDS. Etu (2013) reported nutritional support for PLWHIV/AIDS as starting vegetable garden projects to help provide the right food types to people who cannot afford them. This finding may be connected with the close relationship existing between nutritional factors and physical weakness, malnutrition, anemia, muscle wasting and other micronutrient deficiencies in PLWHIV and AIDS. Nutrition is important to the PLWHIV/AIDS and the use of medication and development of better health status. Nutrition helps to boost their immune system for fight against opportunistic diseases and infections. The implication of this is that an improvement in the nutrition strategies by families from *important* to *very important* will lead to increase in the wellbeing of the PLWHIV/AIDS and also of their family members.

This study also showed that medical support strategies PLWHIV&AIDS required from their families include: make sure they are scheduled for their visits to clinics; encourage them to check their viral loads; encourage them to help their helper T-cell counts; advise them to always check blood level; encourage them to obey their clinic dates; encourage them to take their anti retroviral drugs; advise not to have sexual intercourse; help them treat associated infections; organise counselling sessions for them; encourage them to take their anchillary (helper) drugs; encourage them to carry campaign and awareness programme; escort them to clinics as at when necessary; encourage them to take their bath regularly; encourage them to do some exercises; advise them to observe proper hygiene; as well as help in cleaning and dressing of sores and ulcers.. This finding agrees with the findings of Ngwenya and Kgathi (2006), Uwimana and Struthers (2007), Wiley (2010), Etu (2013), US President's Emergency plan for AIDS relief (2008) and Korubo (2006). Ngwenya and Kgathi (2006) emphasized the use of water as an element in the care of HIV and AIDS patients and the need for family members to assist with the

fetching of water from rivers, streams, wells, boreholes and public standpipes, which may be long distance away from their homes. Uwimana and Struthers (2007) and Wiley (2010) reported physiotherapy support as an important form of exercise needed by PLWHIV and AIDS. Etu (2013) reported setting up of organizations that would bring together people living with HIV and AIDS, to help fight for change. US President's Emergency plan for AIDS relief (2008) opined for writing of memory books and bereavement preparedness as part of physiological support strategies PLWHIV&AIDS required from their families. Keeping company individuals living with or affected by HIV and AIDS, cracking jokes with them and trying to keep them happy was emphasized by Korubo (2006). Therefore, raising the mark from 'important' to 'very important' can make considerable difference to the long-term health and well-being of PLWHIV and AIDS, including how well they manage their condition and adhere to treatments.

Based on the results of this study, emotional support strategies PLWHIV&AIDS require from their families include: show them love and affection; give them attention at all times; establish proper communication channels; work with them and not work for the; avoid discouragement; respect their dignity; spend time with them; tolerate them; as well as encouraging and reassuring them.. This finding is in line with the results of some other studies. For instance, Etu (2013) advocated that people should organize themselves into activist groups or support groups for sharing of their experiences and feelings with other people in similar situations and for coping with death and dying, particularly for children. US President's Emergency plan for AIDS relief (2008) advocated counseling, facilitating forgiveness, and life completion tasks. This finding may be due to the importance of psychosocial (emotional and spiritual) support in reducing stigma and fear among those caring for PLWHIV and AIDS, those living with the infection, and as well as their entire family. This can help reduce loss of their socio-economic, employment, income, housing, health care and mobility statuses. It aids individuals and their partners and families in making informed decisions and coping better with the illness. Therefore, based on the finding of this study and in line with the studies mentioned above, providing emotional and spiritual supports for PLHIV can go a long way in minimizing the impact

of stigmatization by society and subsequently reduce the transmission of HIV/AIDS among the state population.

With respect to socio-economic support strategies PLWHIV&AIDS require from their families, this study identified these social strategies to include: creating awareness about healthy living; encourage self disclosure; involve them in family relationships; create appropriate communication channels; sharing information on political happenings; sharing information on religious happenings; sharing information on secular happenings; organising social gatherings e.g. birthday parties for PLWHIV and Aids as a form of recreation; as well as helping with legal services in work and living places. Economic strategies include: mobilizing financial empowerment community support; securing financial documentations necessary to secure grants for studies or establishing income generation venture; paying for medications for PLWHIV and Aids because of their limited financial resources; providing needed clothing materials for PLWHIV and Aids; providing housing accommodations for PLWHIV and Aids whose house owner have rejected because of their having HIV and Aids or have limited financial resources to pay their rents; as well as providing take off grants for PLWHIV and Aids after training. Other studies have also confirmed these findings. For example, the US President's Emergency plan for AIDS relief (2008) reported supports for community mobilization, leadership development for people living with HIV and AIDS, legal services. Korubo (2006) advised on caregivers organizing small simple parties for individuals living with HIV and AIDS, keeping them abreast of the time and so, help heal the PLWHIV and AIDS of depression. Accessing and benefiting from socio-economic support is one of the important factors in paying for medical care for PLWHIV and AIDS or that of their family members (Uwimana and Struthers 2007). Paying more attention therefore to the development and provision of socio-economic support for PLWHIV and AIDS can go a long way in alleviating the sufferings of the people.

Based on the findings of this study, the challenges faced by families in rendering support to PLWHIV and AIDS, nutritional challenges faced by families in rendering support to PLWHIV and AIDS include: insufficient or lack of food for PLWHIV and

Aids and their family members; lack of knowledge of proper method of preparing and serving meals; selective in the choice of food by PLWHIV and AIDS. Medical challenges faced by families in rendering support to PLWHIV and AIDS include: medications are not adequately accessible; poor health care facilities; insufficient health care administrators to attend to the health needs of PLWHIV and Aids and those of their families; insufficient registration of patients by health centres; insufficiency of health personnel to support family care givers; little available material support such as gloves, medications, foods; insufficiency of understanding of how treatment works; as well as insufficiency of knowledge on when to seek for follow-up services from health personnel. Emotional challenges faced by families in rendering support to PLWHIV and AIDS include: limited means of communication between care providers PLWHIV and Aids and their family members; little available moral support for PLWHIV and Aids and their family members by the society; fear of being infected by PLWHIV and Aids; fear of being over-burdened by PLWHIV and Aids; fear of discriminations and stigmatization by society for PLWHIV and Aids and their family members; care giver fatigue and burn out; as well as non observance of universal precautions when caring for sick family members. Social challenges faced by families in rendering support to PLWHIV and AIDS include: legal services not adequately accessible; very little of public assistance is available; no public assistance is available; high level of illiteracy; insufficiency of community support for PLWHIV and Aids and their family members; support groups are not conveniently located; insufficiency of trainings on universal precautions to be taken when caring for sick family members; secrecy of family members about the true health status of sick members; speculations, mistrust and gossip among community members; myths in the communities about HIV and AIDs in relation to PLWHIV and Aids and their family members; inadequate counselling for PLWHIV and Aids and their family members; non-attendance by patients to counselling services; inadequacy of counselling personnel; gender differences in caring for sick relatives; poor sexual relationship among discordant couples; problems associated with non-disclosure; non attendance by family care givers to counselling services; non availability of home base care for PLWHIV and

Aids to complement that of family care givers; misconceptions by family members about HIN and AIDs transmission and treatment available; little available moral support for PLWHIV and AIDS and their family members by the society; as well as fear of stigmatization by society for PLWHIV and AIDS and their family members. Economic challenges faced by families in rendering support to PLWHIV and AIDS include: financial supports are not adequately accessible; high cost of accessing up-to-date, timely and relevant quality health information; high cost counselling services; high cost of medications; insufficiency of resources to provide proper support; as well as practical concern about loss of earnings from business engagements. Other studies have also confirmed these findings. For example, the results of a study on HIV and AIDS and family well-being in southern Africa showed very little if any, of public assistance to persons with AIDS, and even less or nothing for caregivers (Ferreira, 2004). Although its specific case study is southern Africa, the situation is not far from different in the Nigeria context. This is seen in Ilebani and Eniola (2011) study of the effects of community-based care for people living with HIV and AIDS on their well-being in Benue State. They reported low support for people living with HIV and AIDS in Nigeria especially in the rural communities where there are high rates of illiteracy, poor healthcare facilitates in radio, television and telephones to educate rural people on health issues. Ssengonzi and Morelnd (2001), Uwimana and Struthers (2007) and Etu (2013) reported non-availability or insufficiency of resources (for example, human, physical and financial resources) to provide proper care for PLWHIV and AIDS. Serovich, Kimberly, Mosack and Lewis (2001) reported gender differences in caring for sick relatives particularly in the case of infected women where they receive less support than their men counterpart. Mahommad and Gikonyo (2005) informed that support groups were not located within the proximity of individuals living with or affected by HIV and AIDS. This provides room for non-availability of home base care for PLWHIV and AIDS to complement that of family caregivers. Ahmed, Hassali and Aziz (2009) reported gaps in knowledge about HIV transmission and treatment availability. WHO (2000 and 2001) found caregivers inability to know when follow-up care should be sought from health facilities, or where to seek

such care. Nkhandwe (2001) reported limited knowledge on home based management of individuals living with or affected by HIV and AIDS. This creates fears among home based caregivers (Nkhandwe, 2001; Berhane & Zakus, 1995). Mwinituo and Mill (2006) noted that close family members lived in secrecy, tended to hide their patients and did not share their family members' diagnoses with extended family relations. This finding underscores the importance of the social context in explaining the challenges families face with regard to rendering support to PLWHIV and AIDS. It also explains the need for research that incorporates social units in which community-based adherence workers support families.

The findings on various challenges PLWHIV/AIDS faced in receiving support from family members highlight various issues such as: Challenges faces by PLWHIV and Aids in receiving support.

Based on the findings of this study on the challenges faced by PLWHIV/AIDS in receiving support from family members, emotional challenges faced by PLWHIV/AIDS in receiving support from family members include: PLWHIV and Aids require attention but family care givers are too short tempered; PLWHIV and Aids require understanding of their needs but family care givers can never satisfy them because they feel PLWHIV and Aids are too demanding; PLWHIV and Aids require time with family members but they are always shouting at them giving excuses of rushing to the market to sell things or to go and look for resources for their survival; PLWHIV and Aids need family members to do things with them but they are rather doing for them; family members assume things for PLWHIV and Aids rather than asking them what they need; as well as interpersonal strains with family members. Social challenges faced by PLWHIV/AIDS in receiving support from family members include: poor perception of the nature of the state of health of PLWHIV and Aids; poor attitude towards attending to their needs; poor understanding of the needs of PLWHIV and Aids by family members; discrimination and stigmatisation from family members; as well as lack of proper communication between PLWHIV and Aids and family members. Economic challenges faced by PLWHIV/AIDS in receiving support from family members include: stinginess of rich family members

towards assisting with care for PLWHIV and Aids; as well as PLWHIV and Aids require adequate resources for their upkeep but family care givers cannot adequately satisfy them due to their poverty level. Nutrition challenges faced by PLWHIV/AIDS in receiving support from family members include: meals are not properly planned and prepared; and meals not properly and adequately served. These findings are in line with considerable amounts of previous research findings (Reinhardt, 2001; Pindani, Maluwa, Nkondo, Nyasulu and Chilemba, 2013) that examined challenges PLWHIV and AIDS faced in receiving support from family members. Reinhardt (2001) for example, reported sustained interpersonal strains as tending to be more characteristic of relationships with families than with non-related peers. Pindani, Maluwa, Nkondo, Nyasulu and Chilemba (2013) reported that *close family members and distant relations who did not show any negative attitudes towards PLWHIV and AIDS however, developed negative attitudes towards them as the illness progressed*. By paying closer attention to the history of past relationships between the PLWHIV and AIDS and their family members, family members' responses to support for the PLWHIV and AIDS could be better understood. A previous history of disturbed relationships (such as physical violence, emotional and economic neglect, mistrust and suspicion between partners) can influence attitudes and feelings with which the PLWHIV/AIDS receive support from family members. Therefore, building on the socio-relationship perspective, the interrelatedness and interdependency between individuals and their broader social contexts, can help improve strategies for enhancing family support for people living with HIV and AIDS.

With reference to appropriate strategies through which families can be strengthened to support PLWHIV and Aids, the study discovered that nutritional support strategies through which families can be strengthened to support PLWHIV & AIDS include: spending time with PLWHIV and Aids and discussing the foods they need to maintain and gain weight and manage their illness. Medical support strategies through which families can be strengthened to support PLWHIV & AIDS include: establishing comprehensive support system linking and coordinating existing psychosocial services with each other and health services; a review of the national essential drug list to ensure

that pharmacological supplies are available when needed; as well as making available information detailing potential interactions between medicines used for psychological care and antiretroviral therapy. Social support strategies through which families can be strengthened to support PLWHIV&AIDS include: encouraging leaders at all levels and in all works of life to visibly challenge HIV and AIDs ó related discrimination; spearheading public actions against the many other forms of discrimination faced in relation to HIV and AIDs; creating positive legal environment for fighting discrimination; increasing knowledge about the transmission and treatment of HIV and AIDs among the populace through seminars, sensitisation and intervention programmes; communities should provide enabling environment and support the formation of support groups for individual living with or affected by HIV and AIDs; educating the sick and family members on how to overcome stigmatisation and discrimination; individual living within the communities should contribute to the support of the individual living with or affected by HIV and AIDs by supporting them emotionally, physically and spiritually; assessing available HIV and AIDs supportive services at both the governmental and non-governmental level. That could be strengthened or replicated; building community capacities to provide counselling and support services; provision of needs Assessment of people living with HIV and AIDs; training of adequate personnel to cater for these needs; spouses should be taught by health on how to take care of their sick spouses; having strong leadership at the Federal, State and Local Government levels, to push for meaningful results; as well as assessing additional needs. Emotional support strategies through which families can be strengthened to support PLWHIV&AIDS include: involving people living with HIV and AIDs in response to the epidemic; starting up groups comprising health workers, people living with HIV and AIDs and their family members at the community level, to provide for the needs of individual patients and affected family members; organisation of programmes for members on how each person can be of help to the other in ensuring that love and care is maintained at home for people living with HIV and AIDs; using community-based care programmes to give family members the training and psychological support they need to do their job well;

involving PLWHIV and Aids in policy making and programme design and implementation, to ensure that services meet their needs; including older people in HIV and AIDs education/training programme; reassuring both the PLWHIV and Aids and their family care givers that HIV and AIDs are never death sentences; having community volunteers help families with people living with HIV and AIDs, with domestic task. Economics support strategies through which families can be strengthened to support PLWHIV&AIDS include: providing disability grants for people who are unable to work because of illness and have very little income; financial empowerment by government to affect victims in order to help them alleviate poverty. This finding is in agreement with those of National Guidelines on HIV and AIDS Care and Support (2014), IFRCs (2014), Kidd, Clay and Chiiya (2007), UNAIDS (2002b), National Guidelines on HIV and AIDS Care and Support (2014) and Kiragu (2001). Families of persons living with HIV and AIDS are eligible for care and support services, to cope with the stress (for example, stigma and discrimination, loss of income, impoverishment, emotional burden of caring for the PLHIV and AIDS, doubts, safety concerns, fears, myths and misconceptions that fuel stigma and discrimination and burnout associated with HIV and AIDS infection) that results from close association with persons living with HIV and AIDS (National Guidelines on HIV and AIDS Care and Support, 2014). IFRCs (2014) reported the need to support the livelihoods (for example, nutritious food, ART, education, water and fuel) of PLHIV and AIDS and their families in other to reduce their vulnerability and increase their resilience in dealing with the socio-economic impacts of AIDS. Clay and Chiiya (2007) emphasized social support strategies (for example, community meetings, associations of families, neighbours and church groups, regular system of visits, fees exemptions for HIV-affected families, food, clothing and agricultural inputs donations, providing income-generating activities and communal fields, rotating credit as well as formations of loan clubs and burial associations) as measures in strengthening families in supporting PLWHIV and AIDS. UNAIDS (2002b) advised on creating positive legal environment for fighting discrimination, seeking redress through national institutions and public advocacy involving PLWHIV and AIDS against HIV and AIDS-related

discriminations. National Guidelines on HIV and AIDS Care and Support (2014) reported strengthening of policies, guidelines and plans for HIV and AIDS services. Kiragu (2001) reported increasing knowledge about the transmission and treatment of HIV and AIDS among the populace through seminars, sensitization and intervention programmes.

These findings may be as a result of the fact that strengthening families in supporting PLWHIV and AIDS could better translate the lives of PLWHIV and AIDS into higher levels of hope. It may be that they act as catalysts to families in adapting to new circumstances in their environments and acting as cooperative entities. The interplay between an enabling environment and well-functioning families results in higher levels of hope for PLWHIV and AIDS. Hope is an essential dimension of successful coping in the context of HIV/AIDS and can substantially impact on present behaviour. With higher levels of hope, PLWHIV and AIDS are better positioned to seek alternative pathways in attaining life goals prior to their positive diagnosis and also, in setting new goals appropriate to their changed health statuses. Thus, strengthening families and hoping are inextricably linked.

The observed significant difference in the mean responses of PLWHIV&AIDS and families of PLWHIV&AIDS on the nutritional support strategies PLWHIV&AIDS require from their families corroborates the report of the National Guidelines on HIV and AIDS Care and Support (2014). National Guidelines on HIV and AIDS Care and Support (2014) reported that significant gaps in care and support for the PLWHIV and AIDS still existed. This may be due to Africans' cultural views about PLWHIV&AIDS. For example, in the case of infected women, they receive less support than their men counterpart (Serovich, Kimberly, Mosack & Lewis, 2001) because they are frequently thought of as the source of infection and are likely to be chased away from their homes, abandoned, isolated by the community, economically deprived, exposed to violence or even murdered if their status is discovered. Also, some cultures are of the belief that individual families are under obligations to provide support for their family members, and so, nothing special if they are unable to do so. This is unlike the case in other

societies where the government may be providing most of the social support in which case, it is viewed as special.

Etu (2013) opined that the stigma surrounding AIDS makes it a more difficult disease to live with for people with HIV and AIDS and for their families. A t-test analysis was conducted to therefore ascertain the difference in the mean responses of PLWHIV&AIDS and families of PLWHIV&AIDS, on emotional and spiritual support strategies PLWHIV&AIDS require from their families. The families were observed to be the most responsive on the emotional and spiritual supports PLWHIV&AIDS require from their families. This means that the mean (3.29) response by families is far higher than the mean response by PLWHIV&AIDS (2.85). This shows that the family has better understanding of the needs of PLWHIV&AIDS. The significant difference in the mean responses of PLWHIV&AIDS and families of PLWHIV&AIDS implies that there is existing gap between what the PLWHIV&AIDS and their families feel about emotional and spiritual support strategies actually required. This therefore, confirms National Guidelines on HIV and AIDS Care and Support (2014) report that significant gaps in care and support for the PLWHIV and AIDS still existed. The gap may be as a result of the fact that caring for PLWHIV and AIDS could be time consuming and very stressful, coupled with the economic and financial burdens that HIV/AIDS brings. These may make PLWHIV and AIDS have a poor perception of the emotional and spiritual support strategies they should be getting from their family members.

Goody as cited in Kofi (1995) opined that African societies was idealized as community-based and providing support for their members, but that this 'idealized past' was under strain, either independent of or as a result of HIV and AIDS infection. The result from hypothesis five shows that there was a significant difference in the mean responses of families of PLWHIV&AIDS and the PLWHIV&AIDS on the challenges families face in rendering support to PLWHIV&AIDS and those faced by PLWHIV&AIDS in availing themselves of such support. The mean (2.99) response score of the families, which is higher than the mean (2.72) response score of the PLWHIV&AIDS is indicative that the challenges might be more on the families trying to

provide for the PLWHIV&AIDS than on the PLWHIV&AIDS receiving the supports as been provided by the families. This might be in terms of insufficient healthcare administrators, poor community support, lack or insufficiency of resources to provide proper care, poor education and so on. For example, Ilebani and Eniola (2011) reported challenges of insufficient healthcare administrators and limited means of communication such as radio, television and telephones, *e.t.c.* to educate rural people on health issues. Etu (2013) reported poor community support in most cases, which often resulted in very few people knowing that someone is HIV positive. This leaves their families and children with much burden to bear alone (Etu, 2013). Most of these families being poor do not have the resources to provide proper care for family members living with HIV and AIDS (Etu, 2013). Ferreira (2004) reported also that very little if any public assistance was available to persons with AIDS, but even less or nothing is available to caregivers.

CHAPTER FIVE

SUMMARY, CONCLUSIONS AND RECOMMENDATIONS

This chapter presents the re-statement of the problem, purpose of the study, procedure used in the study, findings of the study, conclusion, educational implication, recommendations and suggestions for further study.

Restatement of the Problem

The effects of HIV and AIDS on families in Delta State are devastating with the majority of the PLWHIV/AIDS being young productive adults. With the arrival of Antiretroviral Therapy in the state, no plans were made for the provision of non-medical care and support for the PLHIV and AIDS. This has left behind a generation of family members and PLWHIV and AIDS with great financial, emotional and developmental challenges.

Although the Delta State government has been giving greater attention to the prevention of HIV and AIDS as well as educating society against the stigma of HIV and AIDS and on caring for PLWHIV and AIDS, many family members still feel withdrawn from fellow family members with the disease, making the situation far from the ideal and desired status. Limited studies have been conducted in the State on how individuals living with or affected by HIV and AIDS perceive their life in relation to the type of care they require and the type of care they are getting

Purpose of the study

The major purpose of this study was to evolve strategies for enhancing family support for people living with HIV and AIDS in Delta State. Specifically, the study determined (i) nutritional support strategies required by PLWHIV and AIDS from their families (ii) medical support strategies required by PLWHIV and AIDS from their families (iii) emotional and spiritual support strategies required by PLWHIV and AIDS from their families (iv) socio-economic support strategies required by

PLWHIV and AIDS from their families (v) challenges associated with providing support to PLWHIV and AIDS by their families (vi) families strengthening strategies in supporting PLWHIV and AIDS.

Description of the Procedures Used

The study adopted a descriptive survey design in identifying strategies for enhancing family support for people living with HIV and AIDS in Delta State. The study population comprised twenty-seven thousand, two hundred and sixteen PLWHIV and AIDS, family members of PLWHIV and AIDS, NGOø, public & private healthcare workers, and government agencies in the urban and rural communities.

Simple random sampling techniques were employed in selecting respondents used for the study. The sample comprised six hundred and six respondents made up of two hundred and five PLWHIV and AIDS, two hundred and five family members of PLWHIV and AIDS, ten NGOø respondents, one hundred and twenty-six public and private healthcare workers and sixty respondents from government agencies. As well as 63 persons for focused group discussion.

Interview method using validated structured questions was used in eliciting information for the study. The data collected was analyzed using mean and t-test for independent samples, at 0.05 level of significant with the aid of Statistical Package for Social Sciences (SPSS).

Major Findings of the Study

A summary of the major findings of the study is as follows:

- a. PLWHIV&AIDS require nutritional support from their families. The nutritional support PLWHIV&AIDS required from their families include: understanding their nutritional needs, plan adequate meals based on the nutritional needs, prepare

appropriate meals using the best digestible methods such as steaming and boiling, among others.

- b. PLWHIV&AIDS required medical support from their families. The medical support PLWHIV&AIDS required from their families include: making sure they are scheduled for their visits to clinics, encouraging them to check their viral loads, encouraging them to help their helper T-cell counts, among others.
- c. PLWHIV&AIDS require emotional support from their families. The emotional support PLWHIV&AIDS require from their families include: showing them love and affection, giving them attention at all times, establish proper communication channels, among others.
- d. PLWHIV&AIDS require social support from their families. The social support PLWHIV&AIDS require from their families include: creating awareness about healthy living, encouraging self-disclosure, involving them in family relationships, among others.
- e. PLWHIV&AIDS require economic support from their families. The economic support PLWHIV&AIDS require from their families include: mobilizing financial empowerment community support, securing financial documentations necessary to secure grants for studies or establishing income generation venture, paying for medications for PLWHIV and Aids because of their limited financial resources, among others.
- f. Families face challenges in rendering support to PLWHIV&AIDS. Such challenges which families face in rendering support to PLWHIV&AIDS include: nutritional challenge, which include insufficient or lack of food for PLWHIV and Aids and their family members; medical challenges which include medications are not adequately accessible; emotional challenges which include limited means of communication between care providers PLWHIV and Aids and their family members; social challenges which include legal services not adequately

accessible; as well as economic challenges which include financial supports are not adequately accessible.

- g. PLWHIV&AIDS face challenges in receiving support from their families. Such challenges which PLWHIV&AIDS face in receiving support from their family members include: emotional challenges which include PLWHIV and Aids require attention but family care givers are too short tempered; social challenges which include poor perception of the nature of the state of health of PLWHIV and Aids; economic challenges which include stinginess of rich family members towards assisting with care for PLWHIV and Aids; as well as nutritional challenges which include meals are not properly planned and prepared, and meals not properly and adequately served.
- h. Families can be strengthened to support PLWHIV and Aids through: nutritional strategies which include spending time with PLWHIV and Aids and discussing the foods they need to maintain and gain weight and manage their illness; medical strategies which include establishing comprehensive support system linking and coordinating existing psychosocial services with each other and health services; social strategies which include encouraging leaders at all levels and in all works of life to visibly challenge HIV and AIDs ó related discrimination; emotional strategies which include involving people living with HIV and AIDs in response to the epidemic; as well as economic strategies which include providing disability grants for people who are unable to work because of illness and have very little income and financial empowerment by government to affect victims in order to help them alleviate poverty.
- i. There was a significant difference in the mean responses of PLWHIV&AIDS and families of PLWHIV&AIDS on the nutritional support strategies PLWHIV&AIDS require from their families.

- j. There was no significant difference in the mean responses of PLWHIV&AIDS and families of PLWHIV&AIDS on the medical support strategies PLWHIV&AIDS require from their families.
- k. There was a significant difference in the mean responses of PLWHIV&AIDS and families of PLWHIV&AIDS on the emotional support strategies PLWHIV&AIDS require from their families.
- l. There was no significant difference in the mean responses of people from nuclear and extended families on the socio-economic support strategies PLWHIV&AIDS require from their families.
- m. There was a significant difference in the mean responses of PLWHIV&AIDS and families of PLWHIV&AIDS on the challenges families face in rendering support to PLWHIV&AIDS.
- n. There was a significant difference in the mean responses of PLWHIV&AIDS and families of PLWHIV&AIDS on the challenges faced by PLWHIV&AIDS in receiving support from members of their families.
- o. There was no significant difference in the mean responses of people from nuclear and extended families on families strengthening strategies in supporting PLWHIV&AIDS.

Conclusion

From the findings of the study, it can be concluded that the strategies for enhancing family support for people living with HIV and AIDS in the study location included nutritional, medical, emotional, as well as socio-economic support strategies. The opinions of the PLWHIV and AIDS and family members according to the study also indicated that gaps exist in the provisions and receipts of these support strategies. Evidences from the study showed that the family members of the PLWHIV and AIDS had better understanding of the needs of the PLWHIV&AIDS.

Implications of the Study

The study has implications for PLWHIV&AIDS, family members of PLWHIV&AIDS, Non-Governmental Organizations, and HIV programme managers working on family support for PLWHIV&AIDS. Through the study, it is implied that:

- (1) PLWHIV&AIDS require nutritional support from their families implies that family members of PLWHIV&AIDS should provide adequate nutritional support to PLWHIV&AIDS.
- (2) PLWHIV&AIDS require medical support from their families implies that family members of PLWHIV&AIDS should provide adequate medical support to PLWHIV&AIDS.
- (3) PLWHIV&AIDS require social support from their families implies that family members of PLWHIV&AIDS should provide adequate social support to PLWHIV&AIDS.
- (4) PLWHIV&AIDS require economic support from their families implies that family members of PLWHIV&AIDS should provide adequate economic support to PLWHIV&AIDS.
- (5) Families face challenges in rendering nutritional, medical, social, emotional, as well as economic support to PLWHIV&AIDS implies that family members of PLWHIV&AIDS should be aware of such challenges and try to overcome them in rendering support to PLWHIV&AIDS.
- (6) PLWHIV&AIDS face challenges in receiving nutritional, medical, social, emotional, as well as economic support from family members implies that PLWHIV&AIDS should be aware of such challenges and try to avoid letting behaviours arising from such challenges from weighing them down.

- (7) Family members of PLWHIV&AIDS should adopt such strategies to enable them render the desired support to PLWHIV&AIDS.
- (8) Also, challenging stigma, discrimination and denial in the context of HIV/AIDS requires support at all levels including families, governments, civil societies, communities and individuals. HIV/AIDS is much more than a health problem; it touches human conditions, security, rights as well as social and economic development of society. The implications therefore of this study is strengthening national, state and local policies in finding common grounds by all stakeholders for evolving strategies for enhancing family support for people living with HIV and AIDS.

Recommendations

Based on the findings and the conclusion drawn, the following recommendations were made:

1. PLWHIV and AIDS should not complain so much about the ways their family members are rendering support to them, they should also appreciate the effort being made by their family members to help to them. This will motivate their family members in being more patient with them.
2. Families of PLWHIV and AIDS should be patient and adopt the necessary strategies in rendering nutritional, medical, emotional, economic, and social support to PLWHIV and AIDS. Being friendly and patient with PLWHIV and AIDS will enable PLWHIV and AIDS to receive those supports with happiness.
3. Creation of enabling environment for families to function well in providing higher levels of hope for PLWHIV and AIDS. This can be done by government and non-government economic empowerment of the families for sustainable livelihoods.
4. There is need for family members of People Living With HIV and AIDS to pay serious attention to the various supports required of them from PLWHIV&AIDS.

Adequate attention given to PLWHIV&AIDS by the members of their families will enable them to feel they are loved hence the hope for a living.

Suggestions for Further Research

The following related areas have been suggested for further research:

1. Impact of gender on women's experiences with family support strategies for PLWHIV and AIDS.
2. Effects of HIV/AIDS on family relationships in planning for future needs for members living with HIV and AIDS.

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APPENDIX 1

Department of Vocational Teacher Education,
University of Nigeria, Nsukka.

January 1, 2016

Dear Sir;

Request for Validation of Research Instrument

I am a Ph.D. student of the Department of Home Economics and Hospitality, University of Nigeria, Nsukka, carrying out a research work titled “**STRATEGIES FOR ENHANCING FAMILY SUPPORT FOR PEOPLE LIVING WITH HIV AND AIDS IN DELTA STATE**”. A draft copy of the instrument is attached to this letter. You are please requested to read through the items and vet for clarity, relevance and total coverage of the study.

Thank you for your anticipated cooperation.

Yours faithfully,

ANENE-OKEAKWA JOSEPHINE E.

APPENDIX 2
LETTER OF INTRODUCTION

Department of Vocational Teacher Education,
University of Nigeria, Nsukka.

January 1, 2016

Dear Respondents;

Request for Completion of Research Instrument

I am a Ph.D. student of the Department of Home Economics and Hospitality, University of Nigeria, Nsukka, carrying out a research work titled “**STRATEGIES FOR ENHANCING FAMILY SUPPORT FOR PEOPLE LIVING WITH HIV AND AIDS IN DELTA STATE**”. Please kindly and candidly respond to the questions below. All responses shall be kept confidential and strictly used for academic research purposes only.

Thanks for your anticipated cooperation.

Yours faithfully,

ANENE-OKEAKWA JOSEPHINE E.

APPENDIX 3

Part 1

QUESTIONNAIRE

Socioeconomic Characteristics of respondents

Place of residence	Urban { }, Rural { }, Marginal Urban { }
How old are you?	18-24 { }, 25-30 { }, Above 30 { }.
What is your highest level of education?	1. Primary education { } 2. Secondary education { } 3. Higher education { } 4. Adult education { }
What is the nature of your family?	Nuclear { }, Extended { }
Which health facilities are close to where you live?	1. Health center { } 2. Hospital { } 3. Private hospital { } 4. None { }
Are you employed?	1. Yes { } 2. No { }
What income generating activities are you engaged in?	1. Small business (sales, services) { } 2. Agriculture (small garden) { } 3. No any activities{ }
Marital status	1. Single{ } 2. Married{ } 3. Widowed{ } 4. Cohabiting{ } 5. Divorced{ }
Do you have children?	1. Yes{ } 2. No{ }
If yes how many?	1-3 { }, 4-6 { }, Above 6 { }
What is your level of income per month	Below N10,000{ }, Between N10, 000-N50,000 { }, Above N50, 000
Are you aware of HIV and AIDS& family support?	1. Yes{ } 2. No{ }

Part II: Main body of the Questionnaire in Sections A–F

Instruction: For each of the items rate your response, using the following scaling statements code as a guide

KEY

4=Very Important

3=Important

2=Not Very Important

1=Not Important

Section A: Nutritional Support Strategies.

Please indicate the extent of the importance or not importance of the following items as nutritional support to PLWHIV and AIDs

S/N	Types of Support Strategies	Rating			
		4 VI	3 I	2 NVI	1 NI
1.	Understand the nutritional needs.				
2.	Plan adequate meals based on the nutritional needs.				
3.	Prepare appropriate meals using the best digestible methods such				
4.	Adopt attractive method of serving the meals.				
5.	Render appropriate encouragement at meal times.				
6.	Adopt meal time table that suits them.				
7.	Serve quality of foods that is suitable.				
8.	Choose suitable place of service.				
9.	Serve meals on demand even when an initial meal has been				
10.	Serve meals with the right temperature.				

11.	Clear dishes immediately after meals.				
12.	Serve suitable snacks.				
13.	Encourage fluid intake to avoid dehydration.				
14.	Encourage owning vegetable garden to help provide right type of food				

Any other support, please indicate:

(i).....

(ii).....

(iii).....

Section B: Medical Support

Please indicate the extent of the importance and not importance of the following items as medical and physiological support to PLWHIV and AIDs.

S/N	Types of Support Strategies	Rating			
		4 VI	3 I	2 NVI	1 NI
15.	Make sure they are scheduled for their visits to clinics.				
16.	Encourage them to check their viral loads.				
17.	Encourage them to help their helper T-cell counts.				
18.	Advise them to always check blood level.				
19.	Encourage them to obey their clinic dates.				
20.	Encourage them to take their anti retroviral drugs.				
21.	Advise not to have sexual intercourse.				
22.	Help them treat associated infections.				
23.	Organise counselling sessions for them.				
24.	Encourage them to take their anchillary (helper) drugs.				
25.	Encourage them to carry campaign and awareness progamme.				
26.	Escort them to clinics as at when necessary.				
27.	Encourage them to take their bath regularly.				

28.	Encourage them to do some exercises.				
29.	Advise them to observe proper hygiene.				
30.	Help in cleaning and dressing of sores and ulcers.				

Any other support, please indicate:

(i).....

(ii).....

(iii).....

Section C: Emotional & Spiritual support

Please indicate the extent of the importance or not importance of the following items as Emotional and Spiritual Support to PLWHIV and AIDs

S/N	Types of Support Strategies	Rating			
		4 VI	3 I	2 NVI	1 NI
31.	Show them love and affection.				
32.	Give them attention at all times.				
33.	Establish proper communication channels.				
34.	Work with them and not work for them.				
35.	Avoid discouragement.				
36.	Respect their dignity.				
37.	Spend time with them.				
38.	Tolerate them.				
39.	Encouraging and reassuring them				

Any other support, please indicate:

(i).....

(ii).....

(iii).....

Section D: Socio-economic support

Please indicate the extent of the importance or none importance of the following items as Socio-Economic Support to PLWHIV and AIDs.

S/N	Types of Support Strategies	Rating			
		4 VI	3 I	2 NVI	1 NI
	Social Support Strategies				
40.	Creating awareness about healthy living.				
41.	Encourage self disclosure.				
42.	Involve them in family relationships.				
43.	Create appropriate communication channels.				
44.	Sharing information on political happenings				
45.	Sharing information on religious happenings.				
46.	Sharing information on secular happenings.				
47.	Organising social gatherings e.g. birthday parties for PLWHIV and Aids as a form of recreation.				
48.	Helping with legal services in work and living places.				
	Economic Support Strategies				
49.	Mobilizing financial empowerment community support.				
50.	Securing financial documentations necessary to secure grants for studies or establishing income generation venture.				
51.	Paying for medications for PLWHIV and Aids because of their limited financial resources.				
52.	Providing needed clothing materials for PLWHIV and Aids.				
53.	Providing housing accommodations for PLWHIV and Aids whose house owner have rejected because of their having HIV and Aids or have limited financial resources to pay their rents.				
54.	Providing take off grants for PLWHIV and Aids after training.				

Any other support, please indicate:

(i).....

(ii).....

(iii).....

Section E: Challenges faced by families in rendering support to PLWHIV and AIDs

Please indicate the extent of the importance or non importance with the following items as challenges faced by families

S/N	Challenges families face in rendering support to PLWHIV and AIDs	Rating			
		4 VI	3 I	2 NVI	1 NI
	Nutritional Challenges				
55.	Insufficient or lack of food for PLWHIV and Aids and their family members.				
56.	Lack of knowledge of proper method of preparing and serving meals.				
57.	Selective in the choice of food by PLWHIV and AIDs				
	Medical Challenges				
58.	Medications are not adequately accessible.				
59.	Poor health care facilities.				
60.	Insufficient health care administrators to attend to the health needs of PLWHIV and Aids and those of their families.				
61.	Insufficient registration of patients by health centres.				
62.	Insufficiency of health personnel to support family care givers.				
63.	Little available material support such as gloves, medications, foods.				

64.	Insufficiency of understanding of how treatment works.				
65.	Insufficiency of knowledge on when to seek for follow-up services from health personnel.				
	Emotional Challenges				
66.	Limited means of communication between care providers PLWHIV and Aids and their family members.				
67.	Little available moral support for PLWHIV and Aids and their family members by the society.				
68.	Fear of being infected by PLWHIV and Aids.				
69.	Fear of being over-burdened by PLWHIV and Aids.				
70.	Fear of discriminations and stigmatization by society for PLWHIV and Aids and their family members.				
71.	Care giver fatigue and burn out.				
72.	Non observance of universal precautions when caring for sick family members.				
	Social Challenges				
73.	Legal services not adequately accessible.				
74.	Very little of public assistance is available.				
75.	No public assistance is available.				
76.	High level of illiteracy.				
77.	Insufficiency of community support for PLWHIV and Aids and their family members.				
78.	Support groups are not conveniently located.				
79.	Insufficiency of trainings on universal precautions to be taken when caring for sick family members.				

80.	Secrecy of family members about the true health status of sick members.				
81.	Speculations, mistrust and gossip among community members.				
82.	Myths in the communities about HIV and AIDs in relation to PLWHIV and Aids and their family members.				
83.	Inadequate counselling for PLWHIV and Aids and their family members.				
84.	Non-attendance by patients to counselling services				
85.	Inadequacy of counselling personnel.				
86.	Gender differences in caring for sick relatives.				
87.	Poor sexual relationship among discordant couples.				
88.	Problems associated with non-disclosure.				
89.	Non attendance by family care givers to counselling services.				
90.	Non availability of home base care for PLWHIV and Aids to complement that of family care givers.				
91.	Misconceptions by family members about HIN and AIDs transmission and treatment available.				
92.	Little available moral support for PLWHIV and AIDS and their family members by the society.				
93.	Fear of stigmatization by society for PLWHIV and AIDS and their family members.				
	Economic Challenges				
94.	Financial supports are not adequately accessible.				
95.	High cost of accessing up-to-date, timely and relevant				

	quality health information.				
96.	High cost counselling services.				
97.	High cost of medications.				
98.	Insufficiency of resources to provide proper support.				
99.	Practical concern about loss of earnings from business engagements.				

Any other support, please indicate:

(i).....

(ii).....

(iii).....

Section F: Challenges faced by PLWHIV and AIDs in receiving support.

Please indicate the extent of importance or non importance of the following items as challenges you face in receiving support.

S/N	Challenges PLWHIV/AIDS face in receiving support from family members	Rating			
		4 VI	3 I	2 NVI	1 NI
	Emotional Challenges				
100.	PLWHIV and Aids require attention but family care givers are too short tempered.				
101.	PLWHIV and Aids require understanding of their needs but family care givers can never satisfy them because they feel PLWHIV and Aids are too demanding.				
102.	PLWHIV and Aids require time with family members but they are always shouting at them giving excuses of rushing to the market to sell things or to go and look for resources for their survival.				
103.	PLWHIV and Aids need family members to do things with them but they are rather doing for them.				
104.	Family members assume things for PLWHIV and Aids rather				

	than asking them what they need.				
105.	Interpersonal strains with family members.				
	Social Challenges				
106.	Poor perception of the nature of the state of health of PLWHIV and Aids.				
107.	Poor attitude towards attending to their needs.				
108.	Poor understanding of the needs of PLWHIV and Aids by family members.				
109.	Discrimination and stigmatisation from family members.				
110.	Lack of proper communication between PLWHIV and Aids and family members.				
	Economic Challenges				
111.	Stinginess of rich family members towards assisting with care for PLWHIV and Aids.				
112.	PLWHIV and Aids require adequate resources for their upkeep but family care givers cannot adequately satisfy them due to their poverty level.				
	Nutritional Challenges				
113.	Meals are not properly planned and prepared.				
114.	Meals not properly and adequately served.				

Any other support, please indicate:

(i).....

(ii).....

(iii).....

Section G: Family strengthening Strategies

Please indicate the extent of importance or non importance of the following items as ways families can be strengthened to support PLWHIV and AIDs.

S/N	Ways families can be strengthened to support PLWHIV and AIDs	Rating			
		4 VI	3 I	2 NVI	1 NI
	Nutritional Strategies				
115.	Spending time with PLWHIV and Aids and discussing the foods they need to maintain and gain weight and manage their illness.				
	Medical Strategies				
116.	Establishing comprehensive support system linking and coordinating existing psychosocial services with each other and health services.				
117.	A review of the national essential drug list to ensure that pharmacological supplies are available when needed.				
118.	Making available information detailing potential interactions between medicines used for psychological care and				
	Social Strategies				
119.	Encouraging leaders at all levels and in all works of life to visibly challenge HIV and AIDs ó related discrimination.				
120.	Spearheading public actions against the many other forms of discrimination faced in relation to HIV and AIDs.				
121.	Creating positive legal environment for fighting discrimination.				
122.	Increasing knowledge about the transmission and treatment of HIV and AIDs among the populace through seminars, sensitisation and intervention programmes.				

123.	Communities should provide enabling environment and support the formation of support groups for individual living with or affected by HIV and AIDs.				
124.	Educating the sick and family members on how to overcome stigmatisation and discrimination.				
125.	Individual living within the communities should contribute to the support of the individual living with or affected by HIV and AIDs by supporting them emotionally, physically and spiritually.				
126.	Assessing available HIV and AIDs supportive services at both the governmental and non-governmental level. That could be strengthened or replicated.				
127.	Building community capacities to provide counselling and support services.				
128.	Provision of needs Assessment of people living with HIV and AIDs.				
129.	Training of adequate personnel to cater for these needs.				
130.	Spouses should be taught by health on how to take care of their sick spouses.				
131.	Having strong leadership at the Federal, State and Local Government levels, to push for meaningful results.				
132.	Assessing additional needs.				
	Emotional Strategies				
133.	Involving people living with HIV and AIDs in response to the epidemic.				
134.	Starting up groups comprising health workers, people living with HIV and AIDs and their family members at the community level, to provide for the needs of individual patients and affected family members.				
135.	Organisation of programmes for members on how each person				

	can be of help to the other in ensuring that love and care is maintained at home for people living with HIV and AIDs.				
136.	Using community-based care programmes to give family members the training and psychological support they need to do their job well.				
137.	Involving PLWHIV and Aids in policy making and programme design and implementation, to ensure that services meet their needs.				
138.	Including older people in HIV and AIDs education/training programme.				
139.	Reassuring both the PLWHIV and Aids and their family care givers that HIV and AIDs are never death sentences.				
140.	Having community volunteers help families with people living with HIV and AIDs. with domestic task.				
	Economic Strategies				
141.	Providing disability grants for people who are unable to work because of illness and have very little income.				
142.	Financial empowerment by government to affect victims in order to help them alleviate poverty.				

Any other support, please indicate:

(i).....

(ii).....

(iii).....

Appendix 4

Population

Group	Population Size
PLWHIV and AIDS	13,650
Families of PLWHIV and AIDS	12,720
Consultative groups on HIV and Aids	12
SWAN	14
SFH	13
USAID	17
UNICEF	14
Public health workers	721
Private health workers	873
SMEDAN	67
State Ministries of Health	77
Federal Ministries of Health	38
SACA	86
Ministry of Labour	62
Ministry of Women Affairs	74
Ministry of Education	75
Ministry of Social Development	66
Ministry of Agriculture	69
Ministry of Justices	68
Total	27216

Appendix 5

Sample	Sample Size
PLWHIV and AIDS	33
Families of PLWHIV and AIDS	30
PLWHIV and AIDS	205
Families of PLWHIV and AIDS	205
Consultative groups on HIV and Aids	2
SWAN	2
SFH	2
USAID	2
UNICEF	2
Public health workers	63
Private health workers	63
SMEDAN	6
State Ministries of Health	6
Federal Ministries of Health	6
SACA	6
Ministry of Labour	6
Ministry of Women Affairs	6
Ministry of Education	6
Ministry of Social Development	6
Ministry of Agriculture	6
Ministry of Justices	6
Total	669

APPENDIX 6

Names of Medical Centres, Teaching Hospitals, General Hospitals, Primary Health Care Centres and NGO's in the study area

Federal Medical Centre, Asaba
 Delta State University Teaching Hospital, Oghara
 General Hospital, Asaba
 General Hospital, Akwukwu-Igbo
 General Hospital, Issele-Uku
 General Hospital, Ogwashi-Uku
 General Hospital, Agbor
 General Hospital, Owa-Oyibo
 General Hospital, Obiaruku
 General Hospital, Aboh
 General Hospital, Kwale
 General Hospital, Ugheli
 General Hospital, Out-jeremi
 General Hospital, Ozoro
 General Hospital, Oleh
 General Hospital, Patani
 General Hospital, Bomadi
 General Hospital, Burutu
 General Hospital, Koko
 General Hospital, Ogbe-Ijoh
 General Hospital, Warri
 General Hospital, Sapele
 General Hospital, Oghara
 General Hospital, Isiokolo
 General Hospital, Orereokpe
 General Hospital, Effurun
 General Hospital, Utor-Udu
 Central Hospital, Warri
 Central Hospital, Agbor
 Central Hospital, Sapele
 Central Hospital, Ugheli
 Central Hospital, Oleh
 Central Hospital, Kwale
 Maternal and Child Care Hospital, Warri
 Maternal and Child Care Hospital, Warri and Ekpan

Maternal and Child Care Hospital, Ekpan

Primary Health Care Centres in all twenty-five (25) L.G.As

Civil Society Consultative Group on HIV and Aids in Nigeria (CISCGHAN) Society of

Women against AIDS in Africa-Nigeria (SWAN)

Society for Family Health (SFH)

USAID

UNICEF

APPENDIX 7

Research Question 1

Descriptives

Descriptive Statistics

	N	Minimum	Maximum	Mean	Std. Deviation
Item1	590	1.00	4.00	3.5508	.73475
Item2	598	1.00	4.00	3.3946	.77962
Item3	589	1.00	4.00	3.4211	.86659
Item4	602	1.00	4.00	3.4767	.76113
Item5	599	1.00	4.00	3.4107	.80858
Item6	599	1.00	4.00	3.3372	.80330
Item7	600	1.00	4.00	3.0750	.93139
Item8	601	1.00	4.00	3.2097	.87520
Item9	588	1.00	4.00	3.1803	.84274
Item10	593	1.00	4.00	3.2040	.85455
Item11	594	1.00	4.00	3.1919	.87703
Item12	595	1.00	4.00	3.0908	.90370
Item13	599	1.00	4.00	3.1235	.89672
Item14	596	1.00	4.00	3.1023	.92287
ClusterMean	606	.00	4.00	3.2525	.58002
Valid N (listwise)	540				

APPENDIX 8

Hypothesis 1

T-Test

Group Statistics					
	Respondents	N	Mean	Std. Deviation	Std. Error Mean
Item1	PLWHIV&AIDS	201	3.2587	.89036	.06280
	Families of PLWHIV&AIDS	195	3.6051	.66035	.04729
Item2	PLWHIV&AIDS	204	3.2451	.90903	.06364
	Families of PLWHIV&AIDS	202	3.4653	.74064	.05211
Item3	PLWHIV&AIDS	201	2.9801	1.09982	.07758
	Families of PLWHIV&AIDS	196	3.6020	.65225	.04659
Item4	PLWHIV&AIDS	203	3.2118	.95413	.06697
	Families of PLWHIV&AIDS	203	3.6108	.61441	.04312
Item5	PLWHIV&AIDS	203	3.0640	.98042	.06881
	Families of PLWHIV&AIDS	201	3.5423	.68517	.04833
Item6	PLWHIV&AIDS	202	3.0990	.96717	.06805
	Families of PLWHIV&AIDS	202	3.4950	.70002	.04925
Item7	PLWHIV&AIDS	203	2.8473	1.07230	.07526
	Families of PLWHIV&AIDS	202	3.1238	.86360	.06076
Item8	PLWHIV&AIDS	204	3.0539	1.00346	.07026
	Families of PLWHIV&AIDS	201	3.3035	.87888	.06199
Item9	PLWHIV&AIDS	197	2.9391	.99813	.07111
	Families of PLWHIV&AIDS	198	3.2273	.76328	.05424
Item10	PLWHIV&AIDS	204	2.9265	.98735	.06913
	Families of PLWHIV&AIDS	197	3.2843	.78273	.05577
Item11	PLWHIV&AIDS	202	2.7871	1.06001	.07458
	Families of PLWHIV&AIDS	197	3.4061	.67579	.04815
Item12	PLWHIV&AIDS	202	2.8812	1.00533	.07073
	Families of PLWHIV&AIDS	199	3.1005	.85868	.06087
Item13	PLWHIV&AIDS	204	2.7598	1.01037	.07074
	Families of PLWHIV&AIDS	199	3.2563	.77827	.05517
Item14	PLWHIV&AIDS	204	2.7794	1.05297	.07372
	Families of PLWHIV&AIDS	197	3.1168	.89304	.06363
ClusterSummary	PLWHIV&AIDS	205	2.9728	.65020	.04541
	Families of PLWHIV&AIDS	205	3.3341	.55258	.03859

Independent Samples Test

		Levene's Test for Equality of Variances		t-test for Equality of Means						
		F	Sig.	t	Df	Sig. (2-tailed)	Mean Difference	Std. Error Difference	95% Confidence Interval of the Difference	
									Lower	Upper
Item1	Equal variances assumed	20.303	.000	-4.387	394	.000	-.34642	.07896	-.50166	-.19118
	Equal variances not assumed			-4.407	368.848	.000	-.34642	.07861	-.50101	-.19183
Item2	Equal variances assumed	16.686	.000	-2.675	404	.008	-.22025	.08234	-.38212	-.05838
	Equal variances not assumed			-2.678	389.583	.008	-.22025	.08226	-.38197	-.05853
Item3	Equal variances assumed	57.825	.000	-6.832	395	.000	-.62194	.09104	-.80092	-.44296
	Equal variances not assumed			-6.873	326.701	.000	-.62194	.09049	-.79996	-.44392
Item4	Equal variances assumed	38.011	.000	-5.010	404	.000	-.39901	.07965	-.55560	-.24243
	Equal variances not assumed			-5.010	344.949	.000	-.39901	.07965	-.55568	-.24235
Item5	Equal variances assumed	19.458	.000	-5.678	402	.000	-.47825	.08423	-.64384	-.31266
	Equal variances not assumed			-5.688	361.570	.000	-.47825	.08409	-.64361	-.31289
Item6	Equal variances assumed	15.570	.000	-4.715	402	.000	-.39604	.08400	-.56118	-.23090
	Equal variances not assumed			-4.715	366.243	.000	-.39604	.08400	-.56123	-.23085
Item7	Equal variances assumed	16.170	.000	-2.857	403	.005	-.27647	.09678	-.46673	-.08622
	Equal variances not assumed			-2.858	386.242	.004	-.27647	.09673	-.46665	-.08629
Item8	Equal variances assumed	1.815	.179	-2.661	403	.008	-.24956	.09379	-.43393	-.06519
	Equal variances not assumed			-2.664	397.553	.008	-.24956	.09370	-.43376	-.06536
Item9	Equal variances assumed	11.106	.001	-3.224	393	.001	-.28819	.08938	-.46391	-.11246
	Equal variances not assumed			-3.222	366.865	.001	-.28819	.08944	-.46407	-.11231
Item10	Equal variances assumed	7.115	.008	-4.012	399	.000	-.35779	.08917	-.53310	-.18248
	Equal variances not assumed			-4.028	384.524	.000	-.35779	.08882	-.53242	-.18316
Item11	Equal variances assumed	47.201	.000	-6.936	397	.000	-.61896	.08925	-.79442	-.44351
	Equal variances not assumed			-6.972	342.454	.000	-.61896	.08877	-.79357	-.44435
Item12	Equal variances assumed	6.039	.014	-2.347	399	.019	-.21931	.09343	-.40299	-.03564
	Equal variances not assumed			-2.350	391.161	.019	-.21931	.09332	-.40279	-.03584
Item13	Equal variances assumed	15.808	.000	-5.517	401	.000	-.49648	.09000	-.67340	-.31956
	Equal variances not assumed			-5.534	380.663	.000	-.49648	.08971	-.67287	-.32009
Item14	Equal variances assumed	14.478	.000	-3.454	399	.001	-.33734	.09766	-.52933	-.14535
	Equal variances not assumed			-3.464	392.499	.001	-.33734	.09738	-.52880	-.14588
ClusterS ummary	Equal variances assumed	14.606	.000	-6.062	408	.000	-.36129	.05960	-.47844	-.24414
	Equal variances not assumed			-6.062	397.658	.000	-.36129	.05960	-.47845	-.24413

Appendix 9

Research Question 2

Descriptives

Descriptive Statistics					
	N	Minimum	Maximum	Mean	Std. Deviation
Item15	567	1.00	4.00	3.5150	.81029
Item16	594	1.00	4.00	3.4293	.78512
Item17	597	1.00	4.00	3.4556	.82135
Item18	599	1.00	4.00	3.2988	.91028
Item19	591	1.00	4.00	3.1134	.90142
Item20	590	1.00	4.00	3.2831	.85813
Item21	588	1.00	4.00	2.9524	.97207
Item22	593	1.00	4.00	2.7723	1.05608
Item23	592	1.00	4.00	2.8919	.96739
Item24	591	1.00	4.00	2.7496	1.06798
Item25	588	1.00	4.00	2.8503	.98440
Item26	595	1.00	4.00	3.0218	.95056
Item27	596	1.00	4.00	2.8758	.98630
Item28	593	1.00	4.00	2.8212	1.02918
Item29	596	1.00	4.00	2.9530	.97592
Item30	598	1.00	4.00	3.1171	.95089
ClusterMean	606	.00	4.00	2.8677	.70981
Valid N (listwise)	505				

APPENDIX 10

Hypothesis 2

T-Test

Group Statistics					
	Respondents	N	Mean	Std. Deviation	Std. Error Mean
Item15	PLWHIV&AIDS	181	3.2265	1.01574	.07550
	Families of PLWHIV&AIDS	194	3.5670	.73276	.05261
Item16	PLWHIV&AIDS	200	3.1050	.94256	.06665
	Families of PLWHIV&AIDS	199	3.5578	.70741	.05015
Item17	PLWHIV&AIDS	202	3.0594	.97043	.06828
	Families of PLWHIV&AIDS	201	3.5672	.74613	.05263
Item18	PLWHIV&AIDS	203	2.8227	1.06617	.07483
	Families of PLWHIV&AIDS	201	3.4527	.80561	.05682
Item19	PLWHIV&AIDS	200	2.7800	1.05221	.07440
	Families of PLWHIV&AIDS	198	3.1263	.83040	.05901
Item20	PLWHIV&AIDS	202	2.9158	1.01621	.07150
	Families of PLWHIV&AIDS	193	3.3575	.78505	.05651
Item21	PLWHIV&AIDS	197	2.8629	1.05777	.07536
	Families of PLWHIV&AIDS	196	2.7755	1.00287	.07163
Item22	PLWHIV&AIDS	202	2.7624	1.11211	.07825
	Families of PLWHIV&AIDS	197	2.5482	1.09915	.07831
Item23	PLWHIV&AIDS	199	2.7739	1.07502	.07621
	Families of PLWHIV&AIDS	199	2.7839	.95798	.06791
Item24	PLWHIV&AIDS	202	2.7079	1.02643	.07222
	Families of PLWHIV&AIDS	196	2.4643	1.13849	.08132
Item25	PLWHIV&AIDS	198	2.7222	1.02685	.07298
	Families of PLWHIV&AIDS	197	2.6345	.97856	.06972
Item26	PLWHIV&AIDS	202	2.7327	1.02108	.07184
	Families of PLWHIV&AIDS	199	2.9950	.95080	.06740
Item27	PLWHIV&AIDS	202	2.8614	1.02243	.07194
	Families of PLWHIV&AIDS	199	2.6281	1.02120	.07239
Item28	PLWHIV&AIDS	203	2.6995	1.03568	.07269
	Families of PLWHIV&AIDS	197	2.5736	1.07424	.07654
Item29	PLWHIV&AIDS	204	2.5784	1.07306	.07513

Item30	Families of PLWHIV&AIDS	197	2.9898	.89779	.06396
	PLWHIV&AIDS	204	2.5588	1.10149	.07712
ClusterSummary	Families of PLWHIV&AIDS	199	3.3266	.76465	.05420
	PLWHIV&AIDS	205	2.6970	.63848	.04459
	Families of PLWHIV&AIDS	205	2.7260	.74447	.05200

Independent Samples Test

	Levene's Test for Equality of Variances		t-test for Equality of Means						
	F	Sig.	t	df	Sig. (2-tailed)	Mean Difference	Std. Error Difference	95% Confidence Interval of the Difference	
								Lower	Upper
Item15 Equal variances assumed	21.541	.000	-3.741	373	.000	-.34049	.09102	-.51946	-.16152
Item15 Equal variances not assumed			-3.700	325.634	.000	-.34049	.09202	-.52152	-.15946
Item16 Equal variances assumed	10.480	.001	-5.425	397	.000	-.45279	.08347	-.61688	-.28870
Item16 Equal variances not assumed			-5.429	369.177	.000	-.45279	.08341	-.61680	-.28878
Item17 Equal variances assumed	16.156	.000	-5.886	401	.000	-.50776	.08626	-.67734	-.33817
Item17 Equal variances not assumed			-5.890	377.033	.000	-.50776	.08621	-.67727	-.33825
Item18 Equal variances assumed	19.562	.000	-6.697	402	.000	-.63008	.09409	-.81504	-.44511
Item18 Equal variances not assumed			-6.706	375.890	.000	-.63008	.09396	-.81483	-.44532
Item19 Equal variances assumed	17.137	.000	-3.642	396	.000	-.34626	.09508	-.53318	-.15935
Item19 Equal variances not assumed			-3.646	377.303	.000	-.34626	.09496	-.53299	-.15954
Item20 Equal variances assumed	9.225	.003	-4.818	393	.000	-.44167	.09166	-.62188	-.26146
Item20 Equal variances not assumed			-4.846	376.672	.000	-.44167	.09114	-.62087	-.26247
Item21 Equal variances assumed	.279	.597	.841	391	.401	.08743	.10399	-.11702	.29188
Item21 Equal variances not assumed			.841	390.096	.401	.08743	.10398	-.11699	.29186
Item22 Equal variances assumed	.137	.711	1.934	397	.054	.21415	.11072	-.00352	.43182
Item22 Equal variances not assumed			1.934	396.929	.054	.21415	.11070	-.00349	.43179
Item23 Equal variances assumed	4.550	.034	-.098	396	.922	-.01005	.10207	-.21072	.19062

	Equal variances not assumed			- .098	390.852	.922	-.01005	.10207	-.21073	.19063
	Equal variances assumed	7.322	.007	2.244	396	.025	.24364	.10859	.03015	.45712
Item24	Equal variances not assumed			2.240	389.087	.026	.24364	.10876	.02980	.45747
	Equal variances assumed	.154	.695	.869	393	.385	.08770	.10094	-.11074	.28615
Item25	Equal variances not assumed			.869	392.272	.385	.08770	.10093	-.11072	.28613
	Equal variances assumed	7.504	.006	-2.661	399	.008	-.26230	.09856	-.45607	-.06853
Item26	Equal variances not assumed			-2.663	397.742	.008	-.26230	.09851	-.45597	-.06864
	Equal variances assumed	.241	.624	2.285	399	.023	.23325	.10206	.03261	.43388
Item27	Equal variances not assumed			2.285	398.924	.023	.23325	.10206	.03261	.43388
	Equal variances assumed	1.099	.295	1.193	398	.233	.12590	.10550	-.08150	.33330
Item28	Equal variances not assumed			1.193	396.242	.234	.12590	.10555	-.08161	.33342
	Equal variances assumed	26.009	.000	-4.157	399	.000	-.41142	.09898	-.60600	-.21684
Item29	Equal variances not assumed			-4.170	391.115	.000	-.41142	.09867	-.60541	-.21743
	Equal variances assumed	51.122	.000	-8.110	401	.000	-.76781	.09467	-.95393	-.58169
Item30	Equal variances not assumed			-8.145	362.429	.000	-.76781	.09426	-.95318	-.58244
Cluster	Equal variances assumed	3.390	.066	-.424	408	.671	-.02907	.06850	-.16373	.10558
Summ ary	Equal variances not assumed			-.424	398.739	.671	-.02907	.06850	-.16374	.10559

Appendix 11

Research Question 3

Descriptives

Descriptive Statistics					
	N	Minimum	Maximum	Mean	Std. Deviation
Item31	599	1.00	4.00	3.4007	.83189
Item32	599	1.00	4.00	3.2454	.81881
Item33	599	1.00	4.00	3.2571	.82032
Item34	596	1.00	4.00	3.1779	.89925
Item35	598	1.00	4.00	3.1538	.87382
Item36	592	1.00	4.00	3.2111	.86540
Item37	599	1.00	4.00	3.3356	.84556
Item38	600	1.00	4.00	3.2000	.92814
Item39	596	1.00	4.00	3.0151	.93022
ClusterSummary	606	.00	4.00	3.1991	.61959
Valid N (listwise)	576				

									Lower	Upper
Item31	Equal variances assumed	7.216	.008	-1.116	401	.265	-.09946	.08910	-.27462	.07570
	Equal variances not assumed			-1.115	390.2 58	.266	-.09946	.08920	-.27483	.07591
Item32	Equal variances assumed	7.282	.007	-7.398	401	.000	-.60596	.08191	-.76698	-.44493
	Equal variances not assumed			-7.403	379.5 86	.000	-.60596	.08186	-.76691	-.44500
Item33	Equal variances assumed	21.663	.000	-5.501	401	.000	-.46714	.08491	-.63408	-.30021
	Equal variances not assumed			-5.506	367.2 62	.000	-.46714	.08485	-.63400	-.30029
Item34	Equal variances assumed	34.921	.000	-4.714	400	.000	-.44812	.09507	-.63502	-.26122
	Equal variances not assumed			-4.721	366.8 16	.000	-.44812	.09492	-.63478	-.26146
Item35	Equal variances assumed	12.682	.000	-4.496	400	.000	-.41294	.09185	-.59350	-.23237
	Equal variances not assumed			-4.496	382.7 40	.000	-.41294	.09185	-.59353	-.23234
Item36	Equal variances assumed	18.332	.000	-6.921	396	.000	-.61563	.08896	-.79051	-.44074
	Equal variances not assumed			-6.949	373.3 37	.000	-.61563	.08859	-.78982	-.44144
Item37	Equal variances assumed	15.428	.000	-5.915	401	.000	-.52470	.08871	-.69910	-.35031
	Equal variances not assumed			-5.928	372.9 42	.000	-.52470	.08852	-.69876	-.35064
Item38	Equal variances assumed	27.378	.000	-5.066	402	.000	-.48565	.09587	-.67413	-.29718
	Equal variances not assumed			-5.073	374.7 90	.000	-.48565	.09574	-.67391	-.29740
Item39	Equal variances assumed	16.127	.000	-3.413	399	.001	-.33273	.09748	-.52438	-.14108
	Equal variances not assumed			-3.417	391.2 04	.001	-.33273	.09737	-.52416	-.14129
ClusterS ummary	Equal variances assumed	2.480	.116	-6.941	408	.000	-.43555	.06275	-.55890	-.31220

Equal variances not assumed			-6.941	402.127	.000	-.43555	.06275	-.55890	-.31220
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Appendix 13

Research Question 4

Descriptives

Descriptive Statistics					
	N	Minimum	Maximum	Mean	Std. Deviation
Item40	396	1.00	4.00	3.5934	.65900
Item41	575	1.00	4.00	3.2348	.89842
Item42	594	1.00	4.00	3.0253	.89464
Item43	591	1.00	4.00	3.0068	.94598
Item44	589	1.00	4.00	2.9491	.96227
Item45	592	1.00	4.00	3.0287	.97386
Item46	589	1.00	4.00	3.0204	.92743
Item47	594	1.00	4.00	2.9293	.93375
Item48	587	1.00	4.00	2.8262	1.00873
Item49	590	1.00	4.00	3.1288	.92155
Item50	594	1.00	4.00	3.0875	.93773
Item51	591	1.00	4.00	3.1337	.94101
Item52	589	1.00	4.00	2.9864	.90341
Item53	589	1.00	4.00	3.0340	.95237
Item54	586	1.00	4.00	2.8771	.99155
ClusterSummary	606	.00	4.00	2.9694	.72801
Valid N (listwise)	362				

APPENDIX 14

Hypothesis 4

T-Test

Group Statistics

	Family	N	Mean	Std. Deviation	Std. Error Mean
Item40	Nuclear Family	226	3.6372	.58972	.03923
	Extended Family	132	3.5152	.73604	.06406
Item41	Nuclear Family	299	3.2274	.90215	.05217
	Extended Family	215	3.2744	.86686	.05912
Item42	Nuclear Family	305	3.0426	.91846	.05259
	Extended Family	225	3.0400	.85210	.05681
Item43	Nuclear Family	303	3.0462	.94089	.05405
	Extended Family	224	2.9643	.94635	.06323
Item44	Nuclear Family	303	3.0066	.94201	.05412
	Extended Family	221	2.8778	.99018	.06661
Item45	Nuclear Family	306	3.0686	.96080	.05493
	Extended Family	222	2.9955	.97710	.06558
Item46	Nuclear Family	304	3.0724	.96542	.05537
	Extended Family	224	2.9107	.91870	.06138
Item47	Nuclear Family	306	2.9281	.96567	.05520
	Extended Family	225	2.9200	.88781	.05919
Item48	Nuclear Family	304	2.9605	.98088	.05626
	Extended Family	223	2.6547	1.00093	.06703
Item49	Nuclear Family	304	3.1908	.89909	.05157
	Extended Family	224	3.0402	.93425	.06242
Item50	Nuclear Family	306	3.1732	.93707	.05357
	Extended Family	225	2.9867	.92813	.06188
Item51	Nuclear Family	305	3.2000	.94382	.05404
	Extended Family	224	3.0670	.92304	.06167
Item52	Nuclear Family	305	3.0590	.91216	.05223
	Extended Family	224	2.8750	.87440	.05842
Item53	Nuclear Family	304	3.0625	.93310	.05352
	Extended Family	223	2.9910	.98178	.06574
Item54	Nuclear Family	301	2.8837	1.00487	.05792
	Extended Family	223	2.8296	.99441	.06659

ClusterSummary	Nuclear Family	311	3.0165	.73160	.04149
	Extended Family	229	2.9080	.73066	.04828

Independent Samples Test

		Levene's Test for Equality of Variances		t-test for Equality of Means						
		F	Sig.	T	df	Sig. (2-tailed)	Mean Difference	Std. Error Difference	95% Confidence Interval of the Difference	
									Lower	Upper
Item40	Equal variances assumed	6.848	.009	1.720	356	.086	.12202	.07092	-.01746	.26150
	Equal variances not assumed			1.624	228.912	.106	.12202	.07512	-.02600	.27003
Item41	Equal variances assumed	.382	.537	-.592	512	.554	-.04699	.07937	-.20292	.10893
	Equal variances not assumed			-.596	471.679	.551	-.04699	.07885	-.20193	.10794
Item42	Equal variances assumed	3.144	.077	.034	528	.973	.00262	.07829	-.15118	.15643
	Equal variances not assumed			.034	501.222	.973	.00262	.07741	-.14947	.15472
Item43	Equal variances assumed	.050	.823	.986	525	.325	.08192	.08311	-.08136	.24519
	Equal variances not assumed			.985	479.091	.325	.08192	.08319	-.08153	.24537
Item44	Equal variances assumed	3.820	.051	1.512	522	.131	.12877	.08515	-.03851	.29606
	Equal variances not assumed			1.500	460.227	.134	.12877	.08582	-.03988	.29742
Item45	Equal variances assumed	.002	.966	.857	526	.392	.07313	.08531	-.09446	.24073
	Equal variances not assumed			.855	471.640	.393	.07313	.08554	-.09496	.24122
Item46	Equal variances assumed	.906	.342	1.941	526	.053	.16165	.08329	-.00197	.32528
	Equal variances not assumed			1.955	493.217	.051	.16165	.08267	-.00077	.32408
Item47	Equal variances assumed	2.854	.092	.099	529	.921	.00810	.08198	-.15294	.16915
	Equal variances not assumed			.100	503.435	.920	.00810	.08094	-.15091	.16712
Item48	Equal variances assumed	3.019	.083	3.506	525	.000	.30582	.08724	.13444	.47719
	Equal variances not assumed			3.495	472.978	.001	.30582	.08751	.13387	.47777
Item49	Equal variances assumed	.093	.760	1.871	526	.062	.15061	.08050	-.00752	.30875

	Equal variances not assumed			1.860	470.092	.063	.15061	.08097	-.00849	.30971
	Equal variances assumed	.512	.475	2.276	529	.023	.18654	.08196	.02552	.34755
Item50	Equal variances not assumed			2.279	485.368	.023	.18654	.08184	.02573	.34735
	Equal variances assumed	.815	.367	1.617	527	.107	.13304	.08228	-.02860	.29468
Item51	Equal variances not assumed			1.622	486.524	.105	.13304	.08200	-.02808	.29416
	Equal variances assumed	.328	.567	2.333	527	.020	.18402	.07888	.02907	.33897
Item52	Equal variances not assumed			2.348	491.567	.019	.18402	.07837	.03004	.33799
	Equal variances assumed	.076	.783	.850	525	.396	.07147	.08411	-.09377	.23671
Item53	Equal variances not assumed			.843	464.309	.400	.07147	.08477	-.09512	.23805
	Equal variances assumed	.187	.666	.612	522	.541	.05412	.08839	-.11953	.22777
Item54	Equal variances not assumed			.613	481.170	.540	.05412	.08826	-.11929	.22754
	Equal variances assumed	.102	.750	1.704	538	.089	.10850	.06367	-.01657	.23357
ClusterS ummary	Equal variances not assumed			1.704	491.774	.089	.10850	.06366	-.01657	.23357

Appendix 15

Research Question 5

Descriptives

Descriptive Statistics					
	N	Minimum	Maximum	Mean	Std. Deviation
Item55	597	1.00	4.00	3.1457	.90702
Item56	591	1.00	4.00	2.8494	.89405
Item57	592	1.00	4.00	2.9764	.91024
Item58	595	1.00	4.00	2.8269	.93489
Item59	593	1.00	4.00	2.7943	.95587
Item60	597	1.00	4.00	2.8576	.95441
Item61	591	1.00	4.00	2.9086	.92706
Item62	594	1.00	4.00	2.9646	.93486
Item63	594	1.00	4.00	2.8838	.92646
Item64	593	1.00	4.00	2.8432	.96774
Item65	585	1.00	4.00	2.8393	.93165
Item66	588	1.00	4.00	2.7534	.93870
Item67	590	1.00	4.00	2.8034	.93343
Item68	589	1.00	4.00	2.7368	.93878
Item69	592	1.00	4.00	2.9155	.98016
Item70	589	1.00	4.00	2.8608	.91527
Item71	594	1.00	4.00	2.8771	.93285
Item72	595	1.00	4.00	2.8840	.91471
Item73	595	1.00	4.00	2.8605	.88897
Item74	592	1.00	4.00	2.7922	.93208
Item75	586	1.00	4.00	3.1860	.80885
Item76	585	1.00	4.00	2.9846	.83877
Item77	582	1.00	4.00	2.9639	.85653
Item78	587	1.00	4.00	2.9404	.99736
Item79	588	1.00	4.00	2.9269	.95722
Item80	588	1.00	4.00	2.8571	.91365
Item81	586	1.00	4.00	2.9352	.89589
Item82	584	1.00	4.00	2.8613	.94603
Item83	581	1.00	4.00	2.8348	.97214

Item84	586	1.00	4.00	2.8754	.92441
Item85	584	1.00	4.00	2.9469	.95827
Item86	583	1.00	4.00	2.8816	.97638
Item87	585	1.00	4.00	2.8923	.95643
Item88	583	1.00	4.00	2.8937	.94833
Item89	587	1.00	4.00	2.9063	.90867
Item90	588	1.00	4.00	2.8435	.90954
Item91	582	1.00	4.00	2.7973	.97302
Item92	583	1.00	4.00	2.7907	.96544
Item93	587	1.00	4.00	2.7700	.98448
Item94	584	1.00	4.00	2.6986	.97916
Item95	582	1.00	4.00	2.8041	.93292
Item96	583	1.00	4.00	2.8405	.91772
Item97	581	1.00	4.00	2.8038	.88438
Item98	588	1.00	4.00	2.7755	.89325
Item99	579	1.00	4.00	2.8808	.95285
ClusterSummary	606	.00	4.00	2.8409	.59127
Valid N (listwise)	461				

APPENDIX 16

Hypothesis 5

T-Test

Group Statistics					
	Respondents	N	Mean	Std. Deviation	Std. Error Mean
Item55	PLWHIV&AIDS	203	3.0690	1.02212	.07174
	Families of PLWHIV&AIDS	199	3.3970	.87513	.06204
Item56	PLWHIV&AIDS	199	2.7688	.99333	.07042
	Families of PLWHIV&AIDS	197	3.0152	.93937	.06693
Item57	PLWHIV&AIDS	201	2.7811	.99088	.06989
	Families of PLWHIV&AIDS	197	3.2893	.86457	.06160
Item58	PLWHIV&AIDS	203	2.6995	1.10056	.07724
	Families of PLWHIV&AIDS	196	3.0408	.88194	.06300
Item59	PLWHIV&AIDS	203	2.7931	1.04197	.07313
	Families of PLWHIV&AIDS	195	2.9077	1.01620	.07277
Item60	PLWHIV&AIDS	203	2.8177	1.02989	.07228
	Families of PLWHIV&AIDS	199	2.9648	.98153	.06958
Item61	PLWHIV&AIDS	202	2.7970	1.05255	.07406
	Families of PLWHIV&AIDS	196	3.1480	.86145	.06153
Item62	PLWHIV&AIDS	202	2.7822	1.09366	.07695
	Families of PLWHIV&AIDS	197	3.2335	.89574	.06382
Item63	PLWHIV&AIDS	203	2.8818	1.04636	.07344
	Families of PLWHIV&AIDS	196	3.0918	.92361	.06597
Item64	PLWHIV&AIDS	202	2.8515	1.09623	.07713
	Families of PLWHIV&AIDS	195	2.9949	.98702	.07068
Item65	PLWHIV&AIDS	201	2.7015	1.05851	.07466
	Families of PLWHIV&AIDS	191	3.1099	.91964	.06654
Item66	PLWHIV&AIDS	200	2.6350	1.07122	.07575
	Families of PLWHIV&AIDS	195	2.9846	.92210	.06603
Item67	PLWHIV&AIDS	201	2.7264	1.04391	.07363
	Families of PLWHIV&AIDS	194	2.9433	.97740	.07017
Item68	PLWHIV&AIDS	200	2.6050	1.08390	.07664
	Families of PLWHIV&AIDS	194	2.8505	.95131	.06830
Item69	PLWHIV&AIDS	203	2.7291	1.12597	.07903

	Families of PLWHIV&AIDS	196	3.1582	.96635	.06902
Item70	PLWHIV&AIDS	197	2.6701	1.06798	.07609
	Families of PLWHIV&AIDS	197	3.0711	.88929	.06336
Item71	PLWHIV&AIDS	203	2.6995	1.13161	.07942
	Families of PLWHIV&AIDS	195	3.1487	.84551	.06055
Item72	PLWHIV&AIDS	203	2.7586	1.07439	.07541
	Families of PLWHIV&AIDS	196	3.0918	.88968	.06355
Item73	PLWHIV&AIDS	203	2.7192	1.02202	.07173
	Families of PLWHIV&AIDS	197	3.0761	.86265	.06146
Item74	PLWHIV&AIDS	202	2.4802	1.07532	.07566
	Families of PLWHIV&AIDS	196	3.1735	.87149	.06225
Item75	PLWHIV&AIDS	197	3.1624	.94438	.06728
	Families of PLWHIV&AIDS	194	3.3247	.82242	.05905
Item76	PLWHIV&AIDS	198	2.9040	.93759	.06663
	Families of PLWHIV&AIDS	193	3.1969	.83703	.06025
Item77	PLWHIV&AIDS	196	2.7908	.97250	.06946
	Families of PLWHIV&AIDS	192	3.1719	.87228	.06295
Item78	PLWHIV&AIDS	199	2.8040	1.15329	.08175
	Families of PLWHIV&AIDS	192	3.1146	.99074	.07150
Item79	PLWHIV&AIDS	199	2.8392	1.12109	.07947
	Families of PLWHIV&AIDS	194	3.0206	.96013	.06893
Item80	PLWHIV&AIDS	199	2.7538	1.02724	.07282
	Families of PLWHIV&AIDS	194	3.0825	.90674	.06510
Item81	PLWHIV&AIDS	199	2.8141	.98504	.06983
	Families of PLWHIV&AIDS	192	3.1563	.91900	.06632
Item82	PLWHIV&AIDS	198	2.7071	1.07819	.07662
	Families of PLWHIV&AIDS	191	3.1571	.88641	.06414
Item83	PLWHIV&AIDS	198	2.8333	1.04104	.07398
	Families of PLWHIV&AIDS	190	2.8526	1.08348	.07860
Item84	PLWHIV&AIDS	198	2.6919	1.04276	.07411
	Families of PLWHIV&AIDS	192	3.1458	.91502	.06604
Item85	PLWHIV&AIDS	198	2.8182	1.10250	.07835
	Families of PLWHIV&AIDS	191	3.0628	.99801	.07221
Item86	PLWHIV&AIDS	198	2.7121	1.13234	.08047
	Families of PLWHIV&AIDS	192	3.0573	.96094	.06935
Item87	PLWHIV&AIDS	198	2.8081	1.10996	.07888
	Families of PLWHIV&AIDS	192	3.0313	.94844	.06845
Item88	PLWHIV&AIDS	197	2.7716	1.10823	.07896
	Families of PLWHIV&AIDS	192	3.0417	.93132	.06721
Item89	PLWHIV&AIDS	198	2.7828	1.07501	.07640

	Families of PLWHIV&AIDS	194	3.0515	.93156	.06688
Item90	PLWHIV&AIDS	199	2.6482	1.03323	.07324
	Families of PLWHIV&AIDS	193	3.0415	.87699	.06313
Item91	PLWHIV&AIDS	196	2.7602	1.04201	.07443
	Families of PLWHIV&AIDS	191	2.8691	1.05063	.07602
Item92	PLWHIV&AIDS	198	2.6667	1.06633	.07578
	Families of PLWHIV&AIDS	191	2.9895	.95691	.06924
Item93	PLWHIV&AIDS	198	2.7020	1.04570	.07432
	Families of PLWHIV&AIDS	193	2.8860	1.08851	.07835
Item94	PLWHIV&AIDS	196	2.6276	1.07133	.07652
	Families of PLWHIV&AIDS	193	2.7565	1.02965	.07412
Item95	PLWHIV&AIDS	198	2.7727	1.00449	.07139
	Families of PLWHIV&AIDS	191	2.8639	1.00645	.07282
Item96	PLWHIV&AIDS	197	2.6193	1.02132	.07277
	Families of PLWHIV&AIDS	193	3.1192	.88465	.06368
Item97	PLWHIV&AIDS	197	2.6853	.98065	.06987
	Families of PLWHIV&AIDS	189	2.9418	.90613	.06591
Item98	PLWHIV&AIDS	199	2.5528	.99289	.07038
	Families of PLWHIV&AIDS	193	3.0259	.89230	.06423
Item99	PLWHIV&AIDS	196	2.6531	1.10107	.07865
	Families of PLWHIV&AIDS	193	3.1969	.88541	.06373
ClusterSummary	PLWHIV&AIDS	205	2.7216	.57889	.04043
	Families of PLWHIV&AIDS	205	2.9945	.68360	.04774

Independent Samples Test

		Levene's Test for Equality of Variances		t-test for Equality of Means						
		F	Sig.	t	df	Sig. (2-tailed)	Mean Difference	Std. Error Difference	95% Confidence Interval of the Difference	
									Lower	Upper
		Item55	Equal variances assumed	3.304	.070	-3.453	400	.001	-.32802	.09499
Equal variances not assumed				-3.459	392.913	.001	-.32802	.09484	-.51448	-.14156
Item56	Equal variances assumed	6.424	.012	-2.535	394	.012	-.24638	.09717	-.43743	-.05534
	Equal variances not assumed			-2.536	393.180	.012	-.24638	.09715	-.43738	-.05539

	Equal variances assumed	7.053	.008	-5.448	396	.000	-.50825	.09329	-.69165	-.32484
Item57	Equal variances not assumed			-5.456	390.783	.000	-.50825	.09316	-.69141	-.32508
	Equal variances assumed	30.801	.000	-3.411	397	.001	-.34131	.10006	-.53802	-.14460
Item58	Equal variances not assumed			-3.424	384.064	.001	-.34131	.09968	-.53729	-.14533
	Equal variances assumed	1.139	.287	-1.110	396	.268	-.11459	.10322	-.31752	.08834
Item59	Equal variances not assumed			-1.111	395.908	.267	-.11459	.10317	-.31742	.08824
	Equal variances assumed	2.006	.157	-1.465	400	.144	-.14709	.10038	-.34443	.05025
Item60	Equal variances not assumed			-1.466	399.684	.143	-.14709	.10033	-.34433	.05015
	Equal variances assumed	17.172	.000	-3.634	396	.000	-.35093	.09657	-.54079	-.16107
Item61	Equal variances not assumed			-3.645	385.124	.000	-.35093	.09628	-.54024	-.16162
	Equal variances assumed	16.546	.000	-4.503	397	.000	-.45132	.10022	-.64835	-.25430
Item62	Equal variances not assumed			-4.515	385.544	.000	-.45132	.09997	-.64788	-.25477
	Equal variances assumed	6.170	.013	-2.123	397	.034	-.21006	.09894	-.40457	-.01556
Item63	Equal variances not assumed			-2.128	393.866	.034	-.21006	.09872	-.40415	-.01598
	Equal variances assumed	10.263	.001	-1.368	395	.172	-.14339	.10481	-.34945	.06267
Item64	Equal variances not assumed			-1.371	393.108	.171	-.14339	.10462	-.34907	.06229
	Equal variances assumed	10.845	.001	-4.070	390	.000	-.40846	.10037	-.60579	-.21112
Item65	Equal variances not assumed			-4.084	386.935	.000	-.40846	.10001	-.60509	-.21182
	Equal variances assumed	18.298	.000	-3.473	393	.001	-.34962	.10068	-.54755	-.15168
Item66	Equal variances not assumed			-3.479	387.080	.001	-.34962	.10049	-.54719	-.15204
	Equal variances assumed	5.745	.017	-2.130	393	.034	-.21693	.10183	-.41714	-.01672
Item67	Equal variances not assumed			-2.133	392.640	.034	-.21693	.10172	-.41691	-.01696
	Equal variances assumed	14.221	.000	-2.387	392	.017	-.24552	.10286	-.44775	-.04328
Item68	Equal variances not assumed			-2.392	388.161	.017	-.24552	.10266	-.44736	-.04368
	Equal variances assumed	15.294	.000	-4.079	397	.000	-.42910	.10521	-.63593	-.22226
Item69	Equal variances not assumed			-4.089	391.648	.000	-.42910	.10493	-.63539	-.22281
Item70	Equal variances assumed	25.018	.000	-4.050	392	.000	-.40102	.09902	-.59568	-.20635

	Equal variances not assumed			-4.050	379.555	.000	-.40102	.09902	-.59570	-.20633
	Equal variances assumed	38.139	.000	-4.472	396	.000	-.44921	.10044	-.64668	-.25174
Item71	Equal variances not assumed			-4.498	373.622	.000	-.44921	.09987	-.64559	-.25283
	Equal variances assumed	18.700	.000	-3.368	397	.001	-.33322	.09894	-.52772	-.13871
Item72	Equal variances not assumed			-3.379	388.052	.001	-.33322	.09861	-.52710	-.13933
	Equal variances assumed	14.730	.000	-3.769	398	.000	-.35693	.09470	-.54311	-.17075
Item73	Equal variances not assumed			-3.779	390.536	.000	-.35693	.09446	-.54265	-.17121
	Equal variances assumed	24.514	.000	-7.054	396	.000	-.69327	.09828	-.88649	-.50005
Item74	Equal variances not assumed			-7.076	383.901	.000	-.69327	.09798	-.88591	-.50063
	Equal variances assumed	3.036	.082	-1.811	389	.071	-.16231	.08961	-.33849	.01388
Item75	Equal variances not assumed			-1.813	383.281	.071	-.16231	.08952	-.33832	.01370
	Equal variances assumed	.503	.479	-3.255	389	.001	-.29285	.08996	-.46972	-.11598
Item76	Equal variances not assumed			-3.260	386.046	.001	-.29285	.08983	-.46947	-.11623
	Equal variances assumed	5.319	.022	-4.060	386	.000	-.38106	.09385	-.56558	-.19654
Item77	Equal variances not assumed			-4.065	383.049	.000	-.38106	.09375	-.56538	-.19674
	Equal variances assumed	7.930	.005	-2.852	389	.005	-.31056	.10890	-.52468	-.09645
Item78	Equal variances not assumed			-2.859	383.901	.004	-.31056	.10861	-.52411	-.09702
	Equal variances assumed	15.521	.000	-1.721	391	.086	-.18142	.10541	-.38866	.02582
Item79	Equal variances not assumed			-1.725	384.645	.085	-.18142	.10520	-.38827	.02542
	Equal variances assumed	8.559	.004	-3.360	391	.001	-.32871	.09783	-.52105	-.13636
Item80	Equal variances not assumed			-3.365	387.220	.001	-.32871	.09768	-.52075	-.13666
	Equal variances assumed	2.710	.101	-3.549	389	.000	-.34218	.09643	-.53176	-.15260
Item81	Equal variances not assumed			-3.553	388.565	.000	-.34218	.09631	-.53152	-.15284
	Equal variances assumed	16.938	.000	-4.488	387	.000	-.45000	.10027	-.64715	-.25285
Item82	Equal variances not assumed			-4.503	377.581	.000	-.45000	.09992	-.64648	-.25352
Item83	Equal variances assumed	.842	.359	-.179	386	.858	-.01930	.10786	-.23136	.19276

	Equal variances not assumed			-5.170	382.280	.000	-.49988	.09669	-.69000	-.30976
	Equal variances assumed	9.017	.003	-2.666	384	.008	-.25652	.09621	-.44568	-.06736
Item97	Equal variances not assumed			-2.671	383.463	.008	-.25652	.09605	-.44537	-.06767
	Equal variances assumed	11.912	.001	-4.957	390	.000	-.47314	.09544	-.66079	-.28550
Item98	Equal variances not assumed			-4.966	387.767	.000	-.47314	.09529	-.66048	-.28580
	Equal variances assumed	22.750	.000	-5.363	387	.000	-.54383	.10140	-.74319	-.34447
Item99	Equal variances not assumed			-5.372	372.189	.000	-.54383	.10123	-.74288	-.34478
	Equal variances assumed	1.787	.182	-4.361	408	.000	-.27285	.06256	-.39584	-.14986
ClusterS ummary	Equal variances not assumed			-4.361	397.219	.000	-.27285	.06256	-.39585	-.14985

Appendix 17

Research Question 6

Descriptives

Descriptive Statistics					
	N	Minimum	Maximum	Mean	Std. Deviation
Item100	587	1.00	4.00	3.1175	.89642
Item101	586	1.00	4.00	2.9915	.87213
Item102	586	1.00	4.00	2.9659	.88994
Item103	583	1.00	4.00	2.8868	.94208
Item104	586	1.00	4.00	2.9590	.89157
item105	582	1.00	4.00	2.8883	.91247
Item106	581	1.00	4.00	2.8210	.91857
Item107	574	1.00	4.00	2.7282	.93563
Item108	580	1.00	4.00	2.9621	.89246
Item109	578	1.00	4.00	2.8529	.90875
Item110	581	1.00	4.00	2.8330	.91802
Item111	583	1.00	4.00	2.8782	.94918
Item112	582	1.00	4.00	2.8144	.94237
Item113	588	1.00	4.00	2.8656	.97532
Item114	589	1.00	4.00	2.8523	.92043
ClusterSummary	606	.00	4.00	2.8252	.74535
Valid N (listwise)	533				

APPENDIX 18

Hypothesis 6

T-Test

Group Statistics					
	Respondents	N	Mean	Std. Deviation	Std. Error Mean
Item100	PLWHIV&AIDS	200	3.2600	.94704	.06697
	Families of PLWHIV&AIDS	193	3.1554	1.00865	.07260
Item101	PLWHIV&AIDS	201	3.0896	.89551	.06316
	Families of PLWHIV&AIDS	192	3.1615	.90950	.06564
Item102	PLWHIV&AIDS	201	2.9751	.98203	.06927
	Families of PLWHIV&AIDS	192	3.1563	.94706	.06835
Item103	PLWHIV&AIDS	200	2.8850	1.08520	.07674
	Families of PLWHIV&AIDS	192	3.0729	.95714	.06908
Item104	PLWHIV&AIDS	200	3.0150	.98978	.06999
	Families of PLWHIV&AIDS	192	3.0938	.94429	.06815
item105	PLWHIV&AIDS	200	2.9350	.98775	.06984
	Families of PLWHIV&AIDS	188	3.0213	.99172	.07233
Item106	PLWHIV&AIDS	199	2.8844	.99580	.07059
	Families of PLWHIV&AIDS	189	2.9365	.99797	.07259
Item107	PLWHIV&AIDS	193	2.6632	1.02852	.07403
	Families of PLWHIV&AIDS	187	2.8610	1.02754	.07514
Item108	PLWHIV&AIDS	199	3.0553	.99593	.07060
	Families of PLWHIV&AIDS	188	3.0957	.90239	.06581
Item109	PLWHIV&AIDS	196	2.7755	.96642	.06903
	Families of PLWHIV&AIDS	189	3.1217	.91733	.06673
Item110	PLWHIV&AIDS	200	2.7550	1.02970	.07281
	Families of PLWHIV&AIDS	187	3.0695	.93928	.06869
Item111	PLWHIV&AIDS	201	2.8109	1.04119	.07344
	Families of PLWHIV&AIDS	189	3.1746	.94317	.06861
Item112	PLWHIV&AIDS	198	2.7071	.97951	.06961
	Families of PLWHIV&AIDS	190	3.1211	.99261	.07201
Item113	PLWHIV&AIDS	201	2.8010	1.05366	.07432
	Families of PLWHIV&AIDS	193	3.1451	1.02555	.07382
Item114	PLWHIV&AIDS	201	2.6915	1.04133	.07345

ClusterSummary	Families of PLWHIV&AIDS	193	3.1762	.85394	.06147
	PLWHIV&AIDS	205	2.8332	.72096	.05035
	Families of PLWHIV&AIDS	205	2.9445	.91826	.06413

Independent Samples Test

		Levene's Test for Equality of Variances		t-test for Equality of Means						
		F	Sig.	t	df	Sig. (2-tailed)	Mean Difference	Std. Error Difference	95% Confidence Interval of the Difference	
									Lower	Upper
Item100	Equal variances assumed	.311	.577	1.060	391	.290	.10456	.09866	-.08941	.29853
	Equal variances not assumed			1.059	387.236	.290	.10456	.09877	-.08964	.29876
Item101	Equal variances assumed	.418	.518	-.790	391	.430	-.07191	.09106	-.25094	.10713
	Equal variances not assumed			-.789	389.530	.430	-.07191	.09109	-.25100	.10719
Item102	Equal variances assumed	.419	.518	-1.860	391	.064	-.18113	.09739	-.37260	.01035
	Equal variances not assumed			-1.861	390.963	.063	-.18113	.09731	-.37244	.01019
Item103	Equal variances assumed	5.679	.018	-1.815	390	.070	-.18792	.10351	-.39142	.01559
	Equal variances not assumed			-1.820	387.249	.070	-.18792	.10325	-.39091	.01508
Item104	Equal variances assumed	.335	.563	-.805	390	.421	-.07875	.09778	-.27099	.11349
	Equal variances not assumed			-.806	389.985	.421	-.07875	.09769	-.27081	.11331
item105	Equal variances assumed	.096	.757	-.858	386	.391	-.08628	.10053	-.28394	.11139
	Equal variances not assumed			-.858	384.323	.391	-.08628	.10055	-.28397	.11141
Item106	Equal variances assumed	.032	.859	-.514	386	.607	-.05209	.10125	-.25116	.14698
	Equal variances not assumed			-.514	384.883	.607	-.05209	.10126	-.25117	.14700
Item107	Equal variances assumed	.441	.507	-1.875	378	.062	-.19775	.10549	-.40517	.00967
	Equal variances not assumed			-1.875	377.644	.062	-.19775	.10549	-.40516	.00966
Item108	Equal variances assumed	4.544	.034	-.418	385	.676	-.04047	.09679	-.23077	.14983

	Equal variances not assumed			-419	384.337	.675	-.04047	.09652	-.23024	.14930
	Equal variances assumed	3.146	.077	-3.602	383	.000	-.34618	.09610	-.53513	-.15724
Item109	Equal variances not assumed			-3.606	382.906	.000	-.34618	.09601	-.53495	-.15741
	Equal variances assumed	6.903	.009	-3.132	385	.002	-.31452	.10041	-.51193	-.11711
Item110	Equal variances not assumed			-3.142	384.769	.002	-.31452	.10010	-.51132	-.11771
	Equal variances assumed	4.920	.027	-3.608	388	.000	-.36366	.10081	-.56185	-.16546
Item111	Equal variances not assumed			-3.619	387.467	.000	-.36366	.10050	-.56125	-.16607
	Equal variances assumed	.076	.783	-4.134	386	.000	-.41398	.10013	-.61085	-.21712
Item112	Equal variances not assumed			-4.133	384.852	.000	-.41398	.10016	-.61090	-.21706
	Equal variances assumed	.856	.355	-3.283	392	.001	-.34408	.10481	-.55014	-.13802
Item113	Equal variances not assumed			-3.285	391.927	.001	-.34408	.10475	-.55003	-.13814
	Equal variances assumed	14.447	.000	-5.040	392	.000	-.48462	.09616	-.67368	-.29557
Item114	Equal variances not assumed			-5.060	382.704	.000	-.48462	.09578	-.67294	-.29631
	Equal variances assumed	7.969	.005	-1.365	408	.173	-.11129	.08154	-.27158	.04900
ClusterSummary	Equal variances not assumed			-1.365	386.252	.173	-.11129	.08154	-.27160	.04903

APPENDIX 19

Research Question 7

Descriptives

Descriptive Statistics					
	N	Minimum	Maximum	Mean	Std. Deviation
Item115	584	1.00	4.00	3.4538	.79098
Item116	582	1.00	4.00	3.2371	.84136
Item117	584	1.00	4.00	3.2158	.91754
Item118	584	1.00	4.00	3.0942	.94970
Item119	586	1.00	4.00	3.3191	.85267
Item120	583	1.00	4.00	3.2453	.82895
Item121	582	1.00	4.00	3.2354	.84286
Item122	584	1.00	4.00	3.1678	.85437
Item123	582	1.00	4.00	3.1873	.84473
Item124	582	1.00	4.00	3.0120	.87509
Item125	585	1.00	4.00	3.1009	.92995
Item126	583	1.00	4.00	3.0703	.89492
Item127	584	1.00	4.00	3.0788	.90962
Item128	572	1.00	4.00	3.3409	.89611
Item129	578	1.00	4.00	3.2093	.88475
Item130	579	1.00	4.00	3.2090	.88011
Item131	584	1.00	4.00	3.1318	.92316
Item132	584	1.00	4.00	3.3014	.84569
Item133	583	1.00	4.00	3.1235	.89010
Item134	577	1.00	4.00	3.2253	.87471
Item135	583	1.00	4.00	3.1304	.92511
Item136	583	1.00	4.00	3.1561	.90701
Item137	583	1.00	4.00	3.0463	.90412
Item138	580	1.00	4.00	3.0672	.93519
Item139	582	1.00	4.00	3.1684	.91601
Item140	581	1.00	4.00	3.1463	.92714
Item141	583	1.00	4.00	3.1252	.93045
Item142	579	1.00	4.00	3.2073	.95860
ClusterSummary	606	.00	4.00	3.0990	.77254

Valid N (listwise)

519

APPENDIX 20**Hypothesis 7****T-Test****Group Statistics**

	Family	N	Mean	Std. Deviation	Std. Error Mean
Item115	Nuclear Family	302	3.4735	.76746	.04416
	Extended Family	222	3.4459	.79833	.05358
Item116	Nuclear Family	301	3.2292	.86252	.04971
	Extended Family	221	3.2489	.80711	.05429
Item117	Nuclear Family	302	3.2616	.93356	.05372
	Extended Family	223	3.1435	.90397	.06053
Item118	Nuclear Family	303	3.0858	.95904	.05510
	Extended Family	223	3.1166	.93232	.06243
Item119	Nuclear Family	303	3.3300	.83586	.04802
	Extended Family	223	3.3498	.86138	.05768
Item120	Nuclear Family	300	3.2833	.81973	.04733
	Extended Family	223	3.2197	.83890	.05618
Item121	Nuclear Family	300	3.2433	.87177	.05033
	Extended Family	222	3.2252	.80928	.05431
Item122	Nuclear Family	303	3.2277	.85600	.04918
	Extended Family	222	3.0676	.84013	.05639
Item123	Nuclear Family	303	3.2310	.86856	.04990
	Extended Family	220	3.1227	.81000	.05461
Item124	Nuclear Family	300	3.0533	.86001	.04965
	Extended Family	223	2.9462	.89381	.05985
Item125	Nuclear Family	303	3.1122	.92819	.05332
	Extended Family	222	3.0360	.94585	.06348
Item126	Nuclear Family	301	3.0930	.87444	.05040
	Extended Family	222	3.0450	.93099	.06248
Item127	Nuclear Family	301	3.1063	.89181	.05140
	Extended Family	223	3.0583	.94498	.06328
Item128	Nuclear Family	295	3.3661	.88152	.05132
	Extended Family	218	3.3028	.90574	.06134

								Lower	Upper	
	Equal variances assumed	.661	.417	.399	522	.690	.02756	.06902	-.10802	.16315
Item115	Equal variances not assumed			.397	465.522	.692	.02756	.06943	-.10888	.16401
	Equal variances assumed	1.150	.284	-.264	520	.792	-.01963	.07437	-.16573	.12647
Item116	Equal variances not assumed			-.267	490.645	.790	-.01963	.07361	-.16427	.12501
	Equal variances assumed	.074	.786	1.452	523	.147	.11809	.08133	-.04168	.27786
Item117	Equal variances not assumed			1.459	486.718	.145	.11809	.08093	-.04093	.27711
	Equal variances assumed	.342	.559	-.368	524	.713	-.03078	.08363	-.19507	.13350
Item118	Equal variances not assumed			-.370	485.820	.712	-.03078	.08327	-.19439	.13282
	Equal variances assumed	.482	.488	-.264	524	.792	-.01974	.07471	-.16651	.12703
Item119	Equal variances not assumed			-.263	470.286	.793	-.01974	.07505	-.16722	.12774
	Equal variances assumed	.003	.957	.869	521	.385	.06360	.07321	-.08021	.20742
Item120	Equal variances not assumed			.866	472.309	.387	.06360	.07346	-.08074	.20794
	Equal variances assumed	2.722	.100	.242	520	.809	.01811	.07488	-.12899	.16521
Item121	Equal variances not assumed			.245	494.175	.807	.01811	.07405	-.12738	.16360
	Equal variances assumed	2.596	.108	2.134	523	.033	.16016	.07503	.01275	.30756
Item122	Equal variances not assumed			2.141	481.288	.033	.16016	.07482	.01315	.30716
	Equal variances assumed	5.641	.018	1.448	521	.148	.10830	.07480	-.03865	.25524
Item123	Equal variances not assumed			1.464	489.764	.144	.10830	.07397	-.03705	.25364
	Equal variances assumed	.788	.375	1.386	521	.166	.10714	.07733	-.04477	.25906
Item124	Equal variances not assumed			1.378	468.094	.169	.10714	.07777	-.04567	.25996
	Equal variances assumed	.210	.647	.922	523	.357	.07618	.08266	-.08622	.23857
Item125	Equal variances not assumed			.919	471.217	.359	.07618	.08290	-.08673	.23908
	Equal variances assumed	.006	.940	.603	521	.547	.04798	.07952	-.10824	.20420
Item126	Equal variances not assumed			.598	459.005	.550	.04798	.08028	-.10978	.20574
	Equal variances assumed	.202	.654	.594	522	.553	.04802	.08083	-.11077	.20680
Item127	Equal variances not assumed			.589	462.587	.556	.04802	.08153	-.11219	.20823

	Equal variances assumed	.042	.838	.795	511	.427	.06335	.07966	-.09315	.21985
Item128	Equal variances not assumed			.792	460.559	.429	.06335	.07998	-.09383	.22053
	Equal variances assumed	.706	.401	-1.651	517	.099	-.12852	.07786	-.28149	.02445
Item129	Equal variances not assumed			-1.666	488.926	.096	-.12852	.07716	-.28012	.02308
	Equal variances assumed	.502	.479	-1.927	518	.055	-.15062	.07817	-.30420	.00295
Item130	Equal variances not assumed			-1.944	484.583	.052	-.15062	.07746	-.30283	.00158
	Equal variances assumed	.123	.726	-.348	522	.728	-.02843	.08177	-.18907	.13220
Item131	Equal variances not assumed			-.348	475.680	.728	-.02843	.08170	-.18897	.13210
	Equal variances assumed	.073	.788	-.221	522	.826	-.01641	.07443	-.16262	.12980
Item132	Equal variances not assumed			-.219	464.856	.826	-.01641	.07482	-.16344	.13061
	Equal variances assumed	1.262	.262	-1.852	522	.065	-.14629	.07901	-.30150	.00892
Item133	Equal variances not assumed			-1.843	466.411	.066	-.14629	.07936	-.30223	.00965
	Equal variances assumed	2.855	.092	-1.048	516	.295	-.08178	.07803	-.23507	.07151
Item134	Equal variances not assumed			-1.066	499.965	.287	-.08178	.07669	-.23246	.06889
	Equal variances assumed	.019	.892	-2.049	521	.041	-.16962	.08277	-.33222	-.00703
Item135	Equal variances not assumed			-2.072	491.591	.039	-.16962	.08188	-.33049	-.00875
	Equal variances assumed	.119	.730	-1.471	521	.142	-.11786	.08010	-.27522	.03950
Item136	Equal variances not assumed			-1.485	489.564	.138	-.11786	.07935	-.27376	.03805
	Equal variances assumed	.662	.416	-.222	521	.824	-.01787	.08042	-.17585	.14010
Item137	Equal variances not assumed			-.224	489.042	.823	-.01787	.07969	-.17444	.13870
	Equal variances assumed	.027	.869	-.533	518	.595	-.04411	.08281	-.20680	.11858
Item138	Equal variances not assumed			-.535	476.323	.593	-.04411	.08238	-.20598	.11776
	Equal variances assumed	.317	.574	-1.363	521	.174	-.10947	.08033	-.26727	.04834
Item139	Equal variances not assumed			-1.377	490.416	.169	-.10947	.07952	-.26572	.04678
	Equal variances assumed	1.310	.253	.146	519	.884	.01202	.08211	-.14929	.17333
Item140	Equal variances not assumed			.148	487.332	.882	.01202	.08122	-.14755	.17160
Item141	Equal variances assumed	.527	.468	.625	521	.532	.05156	.08248	-.11047	.21359

	Equal variances not assumed			.621	462.205	.535	.05156	.08303	-.11162	.21473
	Equal variances assumed	1.963	.162	-.860	518	.390	-.07279	.08468	-.23916	.09358
Item142	Equal variances not assumed			-.869	491.766	.385	-.07279	.08376	-.23736	.09178
	Equal variances assumed	.000	.999	.290	538	.772	.01884	.06488	-.10861	.14630
ClusterSu mmary	Equal variances not assumed			.287	469.974	.774	.01884	.06562	-.11010	.14779

APPENDIX 21

Reliability of the Instrument

Overall Reliability

Scale: ALL VARIABLES

Case Processing Summary

		N	%
Cases	Valid	5	41.7
	Excluded ^a	7	58.3
	Total	12	100.0

a. Listwise deletion based on all variables in the procedure.

Reliability Statistics

Cronbach's Alpha	N of Items
.611	142

Research Question 1 Reliability

Scale: ALL VARIABLES

Case Processing Summary

		N	%
Cases	Valid	9	75.0
	Excluded ^a	3	25.0
	Total	12	100.0

a. Listwise deletion based on all variables in the procedure.

Reliability Statistics

Cronbach's Alpha	N of Items
.805	14

Research Question 2 Reliability

Scale: ALL VARIABLES

Case Processing Summary

		N	%
Cases	Valid	10	83.3
	Excluded ^a	2	16.7
	Total	12	100.0

a. Listwise deletion based on all variables in the procedure.

Reliability Statistics

Cronbach's Alpha	N of Items
.630	16

Research Question 3 Reliability

Scale: ALL VARIABLES

Case Processing Summary

		N	%
Cases	Valid	12	100.0
	Excluded ^a	0	.0
	Total	12	100.0

a. Listwise deletion based on all variables in the procedure.

Reliability Statistics

Cronbach's Alpha	N of Items
.571	9

Research Question 4 Reliability

Scale: ALL VARIABLES

Case Processing Summary

		N	%
Cases	Valid	12	100.0
	Excluded ^a	0	.0
	Total	12	100.0

a. Listwise deletion based on all variables in the procedure.

Reliability Statistics

Cronbach's Alpha	N of Items
.780	15

Research Question 5 Reliability**Scale: ALL VARIABLES****Case Processing Summary**

		N	%
Cases	Valid	8	66.7
	Excluded ^a	4	33.3
	Total	12	100.0

a. Listwise deletion based on all variables in the procedure.

Reliability Statistics

Cronbach's Alpha	N of Items
.944	60

Research Question 6 Reliability**Scale: ALL VARIABLES****Case Processing Summary**

		N	%
Cases	Valid	8	66.7
	Excluded ^a	4	33.3
	Total	12	100.0

a. Listwise deletion based on all variables in the procedure.

Reliability Statistics

Cronbach's Alpha	N of Items
.944	60

Research Question 7 Reliability**Scale: ALL VARIABLES****Case Processing Summary**

		N	%
Cases	Valid	10	83.3
	Excluded ^a	2	16.7
	Total	12	100.0

a. Listwise deletion based on all variables in the procedure.

Reliability Statistics

Cronbach's Alpha	N of Items
.956	28