Original Article

Perceived Social Support and Socio - Demographic Variables as Correlates of Quality of Life among Patients with Human Immunodeficiency Syndrome

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Abstract

Background: Human Immunodeficiency Virus (HIV) is an incurable disease that makes the casualty susceptible to other diseases. This menace remains a vital public health issue in Africa countries. The Quality of Life among this patient is crucial because of their need for adaptation to changes in their lives which include financial and societal changes.

Objectives: To evaluate the perceived social support and socio-demographic variables as correlates of quality of life among patients with human immunodeficiency syndrome**.**

Methods: A descriptive correlational survey design was used to elicit information from a sample of 160 People living with HIV/AIDS. World Health Organization Quality of Life Brief Instrument and Multidimensional scale for perceived social support were used for data collection.

Results: The findings from the analysis showed that participant disagree to the kind of social support given (mean=3.65, SD=2.11). Quality of life was moderate and participant averagely dissatisfied with them (mean=3.48, SD=1.21). Spirituality domain has the highest mean score and environment has the lowest mean score. The findings also showed that gender, occupation, educational level and HIV Seros-status does not influence the Quality of Life of People living with HIV/AIDS. Moreover, it also shows that there is a statistical significant negative relationship between social support and Quality of life (p<0.05), educational level and social support (P=0.027), socio-demographic variable and social support.

Conclusion: An improvement in the kind of social support will result in a better Quality of life.

Therefore, it is recommended that appropriate intervention programs on social support should be encouraged.

Keywords: demography, quality of life, humanism, humans, humanities, immunologic deficiency syndromes, patients, perception, social support

Introduction

Human Immunodeficiency Virus and Acquired Immune Deficiency Syndrome (HIV/AIDS) is a pandemic disease in which the body's defense mechanism is weak and this makes the body unable to get rid of infection (NACA, 2001).

HIV/AIDS is an incurable diseases that makes the casualty susceptible (Rajeev, 2012), and is associated with significant morbidity and mortality despite the availability of treatment and care. (Smeltzer, Bare, Hinkle & Cheever, 2010). As at the end of 2015 – 36.7 million people probably

were living with the virus, 2.1 million people were nearly infected; 1.1 million people died from the disease; and 18.2 million people were accessing ART as June 2016. Since the beginning of the epidemic, over 78 million people have become infected; and 3.5 million have died from AIDS related diseases thus challenging improvements to world health today (UNAIDS, 2016). In sub Saharan Africa about 21 million people are living with HIV/AIDS and 32% of this population are presently on ART as at 2012 (UNAIDS, 2013). Also, in Nigeria, estimated 3.1 % adults within the ages of 15 – 49 are living with HIV/AIDS which is equal to about 3.5 million people from about 141 million of the total population (UNAIDS, 2016).

Nigeria is Africa most populous country with 140,4311,790 population figure as at the last census, and is also rated as tenth largest country in the world with the approximate estimation of 55% literate and 70% poor in the population (UNAIDS, WHO & Nigerian Population Commission 2009). Also, in Nigeria, estimated 3.1 % adults within the ages of 15 – 49 are living with HIV/AIDS which is equal to about 2.6 million people from about 141 million of the total population (UNAIDS, 2008). Another report from NACA (2009) statistics shows average 4.6% prevalence HIV rate among Nigerians (NACA, 2009). HIV/AIDS in Nigeria remains a vital public/ community health issue since Nigeria is a base or environment with many people living with HIV with South Africa prevalence 19.2% as at the end of 2015 (UNAIDS, 2016). The widespread of this disease has negative effect on the psychosocial, cultural, and developmental aspects of life, which makes the diseases a critical public health issue (UNAIDS, 2008). Social support is associated to better quality of Life among PLWHA in different studies (Khumaseen, Aoup-por & Thammachak, 2012). Social support is defined as "the view or experience that one is loved and cared for by others, esteemed and valued, and part of a social network of mutual assistance and obligations" (Taylor, 2007, p. 145). Social support assistance, user fees friendly, good patient – health workers relationship can help to curb non-adherence. An in-depth knowledge of the multifaceted interrelationship of the biological sociological factors is required to understand non-adherence, and Quality of life thus creating avenue for more effective non-adherence intervention programs

(Olowookere, *et al,* 2012). Also, Adedimeji & Odutolu (2007) in a quantitative research to determine the extent to which certain factors contribute to improvement in Quality of life of PLWHA reported that availability of care and social support from spouse friends and family members yielded good Quality of life with 93%. Social support services is limited and lacking in this country and this makes evaluation of the wellbeing and longevity of PLWHA important as to how individual perceive their own health using different instrument such as World Health Organization Quality of Life BREF version instrument. (Folasire, Irabor & Folasire 2013).

The incurable and pandemic nature of HIV/AIDS calls for mobilization of resources such as human, money & material resources to improve quality of life among PLWHA. HIVAIDS is a serious humanitarian problem that could affect the physical, psychological, social status of PLWHA. The Quality of Life (QOL) of HIV/AIDS patient is crucial as well as the disease progression because of their need for adaption to changes in their lives which include financial & societal changes. Therefore, consideration for improving their quality of life is paramount (Fan, Kuo, Kao, Morisky & Chen 2011). According to World Health Organization (2005) quality of life is described as individual's perceptions of their position in the life in the context of culture and value systems in which they live and in relation to their goals, standards, expectations, and concerns. The indicator of physical, mental, social, and spiritual, wellbeing is Health Related Quality of life and this could serve as means of measuring the total wellbeing of PLWHA which include their functions and perceptions based on life experiences (Malucclo, Palemo, Kadliyala, & Rawat, 2015). According to United States Department of Health and Human Services (HHS) (2011).The two overarching goals of Healthy people 2020 include (1.) Improving the overall quality of life (2.) Improving the health of all groups. The QoL of PLWHA can be traced to the increase in life span of infected individuals due to availability and access to ART. Socio economic conditions of individuals with HI/AIDS can alter QoL thereby affecting health-seeking behaviours (Mawar, Katendra, Bagul,.Bembalker, Vedamurthachar, Tripathy, et *al.,* 2015).

Demographic factors had been proven to improve quality of life and are seen as determinant of quality of life. Socio demographic charasteristics like income level, Marital status, educational level, occupation when investigated among PLWHA in China was found to influence quality of life which means people with higher income and are married tend to show positive quality of life.(Rajeev etal.., 2012). The explanation for this could be as a result of the knowledge gained from the exposure in the workplace which could impact quality of life. Also employment among other demographic factors like gender, higher income, and gender are associated

with improved quality of life as seen among PLWHA in India (Basavaraj etal.., 2010). The reason for the employment may be a source of income, care and social support to the individual that are affected which means having a good job may directly or indirectly improve QoL. Kehinde, Fatiregun, & Osagbemi (2013) reported that certain sociodemographic/ economic factors like occupation, income, educational level have been proven to impact QoL where low income and low educational level brings about poor QoL among the HIV/AIDS patient in Kogi state of Nigeria (Kehinde, Fatiregun & Osagbemi, 2013). Also, gender difference has been documented to influence QoL being a major predictor of QoL where statistical result revealed lower score of QoL among men (Sanyang, 2011).

In Nigeria, Joint United Program on HIV/AIDS (2014) reported estimated National HIV prevalence of 4.6% and Nigeria is said to be the 2nd in Africa in terms of People Living with HIV/AIDS (PLWHA) Africa with over 3.2 million (UNAIDS, 2014). Compounding the lack of cure for HIV/AIDS is the fact that PLWHA are still faced with social support issues even being a predictor of Quality of life PLWHA are also faced with Poor Quality of Life which has been attributed to certain socio demographic variables like lack of social support system or dissatisfaction with the perceived social support given. People still struggle with coping with AIDS and related diseases in the recent times and this called for evaluating Quality of life among PLWHA (Oliveira, Moura, Araujo, & Andrade, 2015). Moreover, limited information about Quality of life is a major problem in African setting even with ART in place for PLWHA. Little or no information

on QoL has been documented in Ogun state despite the high prevalence of 6.1 % which is believed to be one of the highest in the south west Geopolitical zone in Nigeria (NACA, 2014). It is in the light of these that the researcher carried out this study to explore perceived social support, and socio demographic variables as correlates of Quality of life among Human Immunodeficiency Syndrome patients in a teaching hospital, Ogun State.

Methods

A descriptive, correlational design was used to show relationships among social support certain socio-demographic variables and Quality of life

Study Settings: The setting for this research was Virology Clinic, Olabisi Onabanjo University Teaching Hospital, Sagamu Ogun State. It is a tertiary health institution and a specialized care centre for HIV/AIDS patient in the state with the support from Institute of Human Virology. It is owned and managed by the State government. OOUTH is located between Lagos- Benin express roads, hospital road in Sagamu local government of the state. It is a referral centre and because of its location it serves neighboring states like Lagos, Oyo, Ondo and Edo

Study Population, sampling and Sample Size Determination: The Population for this study was HIV/AIDS Patients attending virology clinic and the target population will be Adult Men and Women over 18years living with HIV/AIDS which is 700 participant. Sample frame was gotten from the database of virology clinic. From the record, the average monthly attendance is about 700 which represent the target population. The sample was taken from the inclusion criteria: male and female above the ages of 18, and inpatient and outpatient that attend virology clinic. Exclusion criteria: Children were excluded.
Sample Size Determination

$$\frac{N \times P \times (1 - P)}{(N - 1) \times D + P \times (1 - P)}$$ (Scheaffer, 1993)

Where N= Population (700), P= the proportion having the attribute = 0.5 =155.69
Sample size n = 155. ≈160 was used because of precision error. Simple random sampling was used to select the participant for this study.

Instrumentation: The questionnaires were distributed by the researcher with other trained research assistants to participants during the course of their visit for four weeks.

The instrument for data collection in this study was in three major sections and two major tools were used in addition to socio demographic variables.

Tool A. administered questionnaire that assess Socio demographic Variables,

Tool B. Multidimensional Scale of Perceived Social Support by Zimet, Dahlem, Zimet & Farley, 1988 to measure satisfaction with support from family members, significant others.

Tool C. WHO Quality of life for HIV brief version instrument (WHOQOL-HIV BREF),   25 items was selected from all the 6 domains each item are rated on five point likert scale. The Domains include: Physical, Psychological, Level of Dependence, Social Relationship, Environment, and Spiritual. These questions respond to the definition of Quality of Life as 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, expectations, standards and concerns. WHOQOL- HIV user manual was used as a guide. The reliability and validity of WHOQOL HIV BREF is between 0.7-0.9 and internal consistency range from 0.7 – 0.83 as seen in other studies. Reliability and internal consistency of multi-dimensional scale of perceived social support were evaluated by Cronbach alpha. Comments, suggestions and modifications on the instrument will studied carefully and used in improving the quality of the instrument. Multidimensional scale for perceived social support has internal consistency reliability with Cronbach alpha for 0.85 & subscales 0.85 and adequate construct validity. It has been translated and psychometrically tested in different studies worldwide among people with different illnesses (Nakigudde et al 2009; Ramaswamy et al 2009; Wonypekaran et al 2011). 20 HIV patients from another teaching hospital in Ogun State were used to pretest the instrument. Face and content validity of the instruments was assured by presenting them to the project supervisor and experts in community/public health for correction and which was affected before administration.

Ethical Consideration: Ethical approval for the study was obtained from Babcock university health Research Ethics Committee on November 30th

2016 with ref. number: BUHREC600/16, and Olabisi Onabayo university teaching hospital on 8th may 2017 with REF Number: 00UTH/HREC/109/2017.

Results

Respondents' Demographic Characteristics

This depicted that females (77.9%) were more represented in this study than the males (19.5%). Furthermore, respondents between ages 38-47 were more represented (41.6%) in this study, followed by those between ages 38-37 (31.5%) however, aged 57and above were least represented in this study. Also, of the sample studied, the married People Living with HIV and AIDS had a percentage of 65.1 (n=97), widowed were 12.8 percent (n=19), singles were 9.4 percent (n=14). In addition, respondents separated from their spouses had a percentage of 4.0 (n=6). This shows that the selection of respondents captured all categories of people living with HIV/AIDS. On the study participants' occupation, 60.4 percent (n=90) were self-employed while 12.8 percent were unemployed. This shows that the employed were more represented than the unemployed. Furthermore, 76.5 percent of the study participants were Christians while 21.5 percent were Muslims. This depicts that Christians were more represented than the Muslims. On respondents' ethnicity, 78.5 percent (n=117) were Yoruba, 10.7 percent were Igbo however, 1.3 percent were Hausa. This suggests that the Yoruba ethnic group were more represented in this study. For the study participants' educational background, 40.9 percent had a maximum of secondary school education, 31.5 percent had Primary school education, 22.1 had University education however, and 4.0 percent had no formal education. 32.2 percent of the study participants had been aware of their HIV status for more than 5 years while 21.5 became aware of their status less than a year ago. Of all the respondents, 64.4 percent were asymptomatic, 28.9 percent were symptomatic however, 13 percent had developed to Full Blown AIDS.

Table 3: indicates that the quality of life of people living with HIV/AIDS generally on the average as depicted was moderate, Table 3.1.3 also shows that they had moderate quality of life and were averagely dissatisfied with their quality of life (Total Average Weighed Mean=3.48, SD=1.21).

The spirituality domain of Quality of life of PLWHA was very moderate (Average Mean=3.70, SD=1.33), physical domain of the quality of life of people living with HIV/AIDS was very moderate (Average Mean=3.64, SD=1.24). This implies that people living with HIV/AIDS had a high quality of life in respect of spiritual and physical aspects of rating of quality of life. Level of dependence domain was on the moderate level with (Average mean=3.48, SD=1.19).

Psychological domain was moderate (average mean= 3.43, SD=1.17). It should be noted that they were averagely satisfied with their ability to perform activities of daily living like bathing, feeding, washing (Mean=3.94, SD=1.06) and their capacity for work (Mean=3.83, SD=1.16). However, their quality of life dropped from the perspective of level of dependence when they indicated that they on the average moderately needed medical treatment to function in your daily life (Mean= 2.68, SD=1.34).

The environment domain of quality of life was also moderate but with the least mean score (Mean = 3.34, SD=1.13). This may suggest or implies that money financial status of an individual might influence the physical environment or living condition and in turn affect opportunity for leisure.

Table 4. depicts that HIV Serostatus does not significantly influence quality of life of people living with HIV/AIDS (p=0.132). This may mean that their status which may be Asymptomatic, symptomatic and full blown AIDS does not significantly affect their quality of life. Therefore, Serostatus does not significantly explain the variation in quality of life of people living with HIV/AIDS.

Test of Hypotheses

Decision Rule

The pre-set level of significance for this study is 0.05. The hypotheses assume a relationship between the variables being considered. The p-value indicates the significance or the probability value, if it exceeds the pre-set level of significance (P>0.05), the hypothesis stated will be rejected, however, if the p-value is less than or equal to 0.05 (≤0.05), the hypothesis will be accepted.

Hypothesis One: There is a significant relationship between social support and Quality of life of people living with HIV/AIDS

Table 4.8 shows that social support has a low negative significant relationship with quality of life of people living with HIV/AIDS (β= -0.270, p=0.003). This implies that social support is negatively associated with quality of life of people living with HIV/AIDS, hence there exists an inverse relationship which may imply that an increase in social support will lead to a proportional decrease in the quality of life of people living with HIV/AIDS and a reduction in social support will lead to a proportional increase in the quality of life of people living with HIV/AIDS. This points out that the way and manner in which social support is structured around people living with HIV/AIDS may be faulty to the extent that instead of increasing the quality of life of people living with HIV/AIDS, it rather has the propensity to reduce the quality of life of people living with HIV/AIDS. Therefore, the hypothesis is accepted.

Hypothesis Two: There is a significant relationship between socio demographic variables and Quality of life

Table 6: indicate that quality of life has no significant relationship with gender (β= -0.124, p=0.168), educational level (β= -0.140, p=0.115), occupation (β= 0.118, p=0.190) and marital status (β= -0.007, p=0.942) of people living with HIV/AIDS. This suggests that quality of life of people living with HIV/AIDS has no individual significant relationship and is not associated with gender, educational level, occupation and marital status of people living with HIV/AIDS. Consequently, the hypothesis is rejected.

Hypothesis Three: There is a significant relationship between socio demographic variables and social support.

From Table 7: social support has a low negative significant relationship with educational level of people living with HIV/AIDS (β= -0.188, p=0.115). However, social support has no significant relationship with gender, marital status and occupation of people living with HIV/AIDS (p>0.05).

This suggests that social support is not significantly associated with gender, marital status and occupation of people living with HIV/AIDS. The hypothesis that there is a significant relationship between educational level and social support is accepted while, the hypothesis that there is a significant relationship between gender, marital status, and occupation of people living with HIV/AIDS is rejected.

Table 1: The level of social support as perceived by the People living with HIV/AIDS

Items	N 1	VSD 2	SDS 3	D 4	MA 5	A 6	SA 7	Mean	SD
There is a special person who is around when I am in need	4 2.7	17 11.4	7 4.7	6 4.0	6 4.0	68 45.6	40 26.8	5.41	1.76
I can talk about my problems with my friends	11 (7.4)	24 (16.1)	17 (11.4)	13 (8.7)	29 (19.5)	12 (8.1)	43 (28.9)	4.56	2.06
My friends really tries to help me	26 (17.4)	11 (7.4)	24 (16.1)	7 (4.7)	20 (13.4)	12 (8.1)	49 (32.0)	4.45	2.30
I can count on my friends when things go wrong	30 (20.1)	16 (10.7)	18 (12.1)	8 (5.4)	22 (14.8)	10 (6.7)	45 (30.2)	4.25	2.34
I have friends with whom I can share my joys and sorrows	33 (22.1)	15 (10.1)	27 (18.1)	4 (2.7)	15 (10.1)	10 (6.7)	42 (28.2)	4.03	2.37
I can talk about my problems with my family	31 (20.8)	24 (16.1)	32 (21.5)	5 (3.4)	14 (9.4)	11 (7.4)	28 (18.8)	3.63	2.20
My family is willing to help me make decisions	38 (25.5)	28 (18.8)	30 (20.1)	4 (2.7)	14 (9.4)	12 (8.1)	23 (15.4)	3.38	2.17
I have a special person who is real source of comfort to me.	59 (39.6)	11 (7.4)	42 (28.2)	1 (0.7)	9 (6.0)	10 (6.7)	17 (11.4)	2.92	2.09
There is a special person in my life who cares about my feelings	49 (32.9)	29 (19.5)	36 (24.2)	2 (1.3)	7 (4.7)	9 (6.0)	17 (11.4)	2.89	2.02
I get the emotional help and support I need from my family	63 (42.3)	11 (7.4)	36 (24.2)	6 (4.0)	9 (6.0)	9 (6.0)	15 (10.1)	2.83	2.05
My family really tries to help me	65 (42.3)	5 (3.4)	40 (26.8)	5 (3.4)	9 (6.0)	9 (6.0)	13 (8.7)	2.77	2.01
There is a special person with whom I can share my joys and sorrows	62 (41.6)	3 (2.0)	53 (35.6)	5 (3.4)	4 (2.7)	10 (6.7)	11 (7.4)	2.73	1.89
Average Mean								3.65	2.11

KEY: SA= Strongly Agree, A= Agree, MA= Mildly Agree, D= Disagree, SDS= Strongly Disagree, VSD= Very Strongly Disagree,, N= Neutral
Decision Rule if mean is ≤ 1.49 = Neutral, 1.5 to 2.49 = Very Strongly Disagree, 2.5 to 3.49 = Strongly Disagree, 3.5 to 4.49 = Disagree, 4.5 to 5.49 = Mildly Agree, 5.5 to 6.49 = Agree, 6.5 to 7 = Strongly Agree.

Table 3: Quality of Life of People Living with HIV/AIDS

Items	NA 1	L 2	M 3	VM 4	E 5	Mean	SD	Average Mean
Spirituality								
To what extent are you bordered by people blaming you for your HIV status?	66 (44.3)	36 (24.2)	16 (10.7)	25 (16.8)	5 (3.4)	3.90	1.24	
How much do you worry about death?	66 (44.3)	22 (14.8)	13 (8.7)	25 (16.8)	9 (6.0)	3.82	1.38	**3.70 (SD=1.33)**
How much do you fear the future?	65 (43.6)	23 (15.4)	11 (7.4)	3 (24.2)	10 (6.7)	3.67	1.43	
To what extent do you feel your life to be meaningful?	21 (14.1)	12 (8.1)	27 (18.1)	61 (409)	25 (16.8)	3.39	1.27	
Physical								
*To what extent do you feel that physical pain prevents you from doing what you need to do	70 (47.0)	38 (25.5)	12 (8.1)	24 (16.1)	5 (3.4)	3.97	1.23	
*How much are you bordered by any physical problems related to HIV infection?	59 39.6	38 (25.5)	10 (6.7)	33 (22.)	9 (6.0)	3.70	1.35	**3.64 (SD=1.24)**
How satisfied are you with your sleep?	11 (7.4)	20 (13.4)	15 (10.1)	79 (53.0)	24 (16.1)	3.57	1.13	
Do you have enough energy for everyday activities?	19 (12.8)	22 (14.8)	21 (14.1)	67 (45.0)	20 (13.4)	3.32	1.25	
Level of Dependence	NSND 1	VD 2	D 3	S 4	VS 5			
How satisfied are you with your ability to perform activities of daily living like bathing, feeding, washing etc.?	10 (6.7)	6 (4.0)	10 (6.7)	80 (53.)	43 (28.9)	3.94	1.06	
How satisfied are you with your capacity for work?	14 (9.4)	9 (6.0)	3 (2.0)	85 (57.0)	38 (25.5)	3.83	1.16	**3.48 (SD=1.19)**
	NA 1	L 2	M 3	VM 4	E 5			
*How much do you need any medical treatment to function in your daily life?	25 (16.8)	16 (10.7)	19 (12.8)	64 (43)	25 (16.8)	2.68	1.34	
Psychological	NA 1	L 2	M 3	VM 4	E 5			
How well are you able to concentrate?	7 (4.7)	16 (10.7)	43 (28.9)	66 (44.)	17 (11.4)	3.47	0.99	
Are you able to accept your body appearance?	17 (11.4)	14 (9.4)	35 (23.5)	63 (42.)	20 (13.4)	3.37	1.18	**3.43 (SD=1.17)**
	N	S	QO	VO	A			
*How often do you have negative feelings like anxiety depression?	46 (30.9)	31 (20.8)	33 (22.1)	24 (16.)	15 (10.1)	3.46	1.34	
Social Relationship	NSND 1	VD 2	D 3	S 4	VS 5			**3.40 (SD=1.23)**
How satisfied are you with your personal relationship?	12 (8.1)	14 (9.4)	11 (7.4)	78 (52.3)	34 (22.8)	3.72	1.16	
How satisfied are you with the support you get from your friend?	24 (16.1)	24 (16.1)	20 (13.4)	57 (38.)	24 (16.1)	3.22	1.34	
How satisfied are you with your sex life?	30 (20.1)	17 (11.4)	19 (12.8)	57 (38.)	26 (17.4)	3.21	1.40	
	NA	L	M	VM	E			

	1	2	3	4	5		
To what extent do you feel accepted by the people you know?	9 (6.0)	14 (9.4)	49 (32.9)	57 (38.)	19 (12.8)	3.43	1.03

Environment	NA 1	L 2	M 3	VM 4	E 5		
How healthy is your physical environment?	6 (4.0)	17 (11.4)	23 (15.4)	84 (56.)	18 (12.1)	3.61	0.98
Do you feel satisfied with where you live?	12 (8.1)	16 (10.7)	35 (23.5)	69 (46.)	17 (11.4)	3.42	1.09
How available to you is the information that you need in your day-to-day life?	8 (5.4)	33 (22.1)	62 (41.6)	31 (20.)	14 (9.4)	3.07	1.01
To what extent do you have the opportunity for leisure activities such as picnic, games?	23 (15.4)	30 (20.1)	40 (26.8)	43 (28.)	12 (8.1)	2.94	1.20
Do you have enough money to meet your daily need?	15 (10.1)	43 (28.9)	53 (35.6)	26 (17.)	12 (8.1)	2.85	1.08
	NSND 1	VD 2	D 3	S 4	VS 5		
How satisfied are you with your access to health care?	16 (10.7)	6 (4.0)	4 (2.7)	88 (59.1)	35 (23.5)	3.81	1.17
How satisfied are you with the conditions of your living place?	27 (18.1)	6 (4.0)	6 (4.0)	80 (53)	30 (20.1)	3.54	1.35

The Environment section has an overall mean of **3.32 (SD=1.13)**.

Total Average Weighted Mean	**3.48 (SD=1.21)**

KEY: (a) E=Extreme, VM=Very Much, M=Moderately L=Little, NA=Not at all   (b) VS=Very Satisfied, S=Satisfied, D=Dissatisfied, VD=Very Dissatisfied, NSND=Neither Satisfied nor Dissatisfied (c) A=Always, VO=Very Often, QO=Quite Often, S=Seldom, N=Never   *** Decision Rule if mean is ≤ 1.49 = (NA, NSND, N); 1.5 to 2.49 = (L, VD, S); 2.5 to 3.49 = (M, D, QO); 3.5 to 4.49 = (VM, S, VO); 4.5 to 5= (E, VS, A)

*=items were reverse scored

Table 4: Simple Linear Regression Showing the Influence of HIV Sero-status on Quality of Life of People Living with HIV/AIDS

Model		Unstandardized Coefficients		Standardized Coefficients	T	Sig.
		B	Std. Error	Beta		
1	(Constant)	87.527	3.201		27.340	0.000
	HIV Serostatus	-3.411	2.250	-0.137	-1.516	0.132

a. Dependent Variable: Quality of Life

Table 5: Pearson Product Moment Correlation Showing the Relationship between Social Support and Quality of Life of People Living with HIV/AIDS

Variable		Quality of Life
	Pearson Correlation	**-0.270**[**]
Social Support	Sig. (2-tailed)	**0.003**
	N	123

**. Correlation is significant at the 0.01 level (2-tailed).

Table 6: Pearson Product Moment Correlation Showing the Relationship between Quality of Life of People Living with HIV/AIDS and Socio Demographic Variables

Variable		Gender	Educational Level	Occupation	Marital Status
	Pearson Correlation	-0.124	0.140	0.118	-0.007
Quality of Life	Sig. (2-tailed)	**0.168**	**0.115**	**0.190**	**0.942**
	N	126	128	125	127

Table 7: Pearson Product Moment Correlation Showing the Relationship between Social Support and Socio Demographic Variables

Variable		Gender	Marital Status	Occupation	Educational Level
	Pearson Correlation	-0.039	-0.156	-0.032	-0.188[*]
Social Support	Sig. (2-tailed)	0.651	0.069	0.715	**0.027**
	N	135	136	134	137

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

Discussion

According to this study, females were more represented than males. social support was on the average or moderate level as perceived by the participant and the results show that patient disagree to the level of social supported given using the decision rule above (average mean = 3.65). This might be because of social issues like stigma, discrimination and isolation associated with HIVAIDS and it may differs according to the culture around the world. This is similar to Lifson, Workneh, Ita, Emichael, Demissie (2015) who found moderate and varying stages of professed social support among Ehopians. This study contradicts the findings of Okonkwo, Larkan, Galcign 2016 which finds low level of social support among older adult living with HIV in Dublin

Findings from Table 4.3 reveal that quality of life of people living with HIV/AIDS in the spiritual domain was higher (mean =3.70) and environment domain was found to have lower mean score. The reason for the highest mean score in the Spirituality domain could be attributed to the settings, culture or the environment that the individual find themselves, especially in this

African setting people tends to believe and hope in God through their prayers despite the unpleasing circumstances that might surrounds them. In the same vain, the lowest mean score was found in the Environment domain which may be due to the fact that people are faced with financial challenges and they tried to move on around it. Thus, allowing them to have more problems with housing. Financial status of an individual can readily influence the physical environment especially the living condition and in turn affect opportunity for leisure. This study is similar to Odili et al., (2011) who reported highest and lowest QoL mean score in the spirituality and environmental domains respectively. Akinboro et al, (2014) opined strongest and highest mean score in the spirituality and weakest/lowest with environmental and social relationship domain. The result from this study contradict a study conducted among HIV positive Patient in UCH Ibadan Nigeria by Folasire Irabor and Folasire (2012) whose result revealed increased mean score in the psychological domain & decreased mean score in social relationship. Yadav (2010) reported highest and lowest mean score in psychological domain which is different from this study. Moreover, Mawar et al., (2013), in an intervention study concluded that there was improvement in the QoL scores of three major domains (Physical, physchological and level of dependence).

In addition, the result showed no influence exist between participant HIV serostatus and Quality of life (p=0.132) which means HIV serostatus asymptomatic, symptomatic or full blown AIDS cannot determine whether PLWHA have a good or bad QoL. This could be as a result of their exposure to frequent counselling/education during their visit. It might be a major reason why symptoms or no symptoms does not readily account for variation in the Quality of Life of PLWHA. Folasire et al., 2013 found out statistical relationship between HIV serostatus and QoL in that there was higher positive relationship between patient without symptoms and QoL. Odili et al., 2014 revealed statistical higher QoL among patient without symptoms. Akinboro et al., 2014) reported that relationship exists between HIV serostatus and QoL in that patient with full blown AIDS had poor Quality of life in all domains.

The hypothesis shows that there is a statistical significant negative relationship between social support and Quality of life but this relationship is a low negative one. This could be as a result of the way and manner which the social support is been given to the participant and how it is meeting individual needs at the time, it might not be delivered through the proper channel. This may be due to environmental and cultural influence. This is similar to Ichakwa and Napktan (2006) where the researchers discovered that there is a substantial link between social support and Quality of life with supportive environment from family and friends. Yadav (2010) in an empirical study among HIV positive patient in Nepal revealed significant positive association between social support and QoL. Folasire et al., (2013) are of the opinion that perceived social support is associated with QoL among PLWHA. Bekele et al., (2013) opined that high social supporher social support leads to better Quality of life when there is health behavioural promotion, pdychological and physical function improvement. This differs from this study in that lower social support will bring about higher QoL.   Similarly, Abrefeo-Gyan et al., (2015) indicated a positive relationship between social support and QoL among HIV infected patient and this differs from this study in that lower social support brings about higher QoL.

From this study, hypothesis indicates that certain socio demographic variables like occupation, gender and Marital status were not significantly related or associated with social support. There was a statistical significant negative relationship between educational level and social support. The reason might be because the high class people tend to be secluded and does things on their own especially within their vicinity or domain. This might further cause segregation among other people, seeking for VIP treatment so thereby not allowing them to receive higher social support. Lifson et al., 2015 reported in their findings lower educational level is significantly associated with lower social support. Misganaw, Mariam and Araya 2013 revealed that participant with lesser social support are those with lower educational background. This is similar to the result from this finding. The result from this research has validated the role of social support and Quality of life in life

of PLWHA. There was a statistical significant negative relationship between social support and quality of life of people living with HIV/AIDS, no statistical significant relationship exists among socio-demographic variables and QoL. However, Quality of life was moderate. Therefore specific needs in relation to their area of support should be adequately catered for so that it will improve QoL of PLWHA. QoL can be improved by addressing the issues regarding the domains that are lacking. The QoL can get better by involving PLWHA in decision making regarding their health. The researcher concluded that more attention should be given to the type and structure of social support given to People living with HIV and also to QoL assessment occasionally because it revealed that environmental domain has the lowest score.

Conclusion and Recommendation

The results from this research have validated the role of social support and Quality of life among PLWHA. However, Quality of life was moderate. Therefore specific needs in relation to their area of support should be adequately addressed so that it will improve QoL of PLWHA. QoL can be improved by addressing the issues regarding the domains that are lacking. The QoL can get better by involving PLWHA in decision making regarding their health. More attention should be given to the type and structure of social support given to People living with HIV and also to QoL assessment occasionally because it revealed that environmental domain has the lowest score Strategies to encourage voluntary participation through community service to keep People living with HIV/AIDS fit in all domains of Quality of life. Government should collaborate with non-Governmental agencies to improve the QoL of PLWHA. Continuous effort should be made to deal with the constraint of social support by addressing issues related to stigmatization and discrimination by family and friends.

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