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CARE AND SUPPORT FOR PEOPLE LIVING WITH HIV/AIDS AMONG THE YORUBA OF SOUTHWESTERN NIGERIA

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BY

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ABSTRACT

Despite preventive measure at the local, national and international level, there is no commensurate attention in the area of care and support for people living with HIV/AIDS (PLWHA). Efforts yielded so far are based on biomedical perspective of prevention and cure. Little or no attention has been paid to the psychosocial needs of PLWHA, no adequate knowledge on the pattern and use of existing care and support services as well as hindrances to accessibility. Little information exists about alternative therapy and the network system in choice of therapy. This study therefore investigates care and support for PLWHA in Oyo and Osan states of Nigeria in order to determine availability, accessibility and impact on psychosocial needs of PLWHA. The study also investigates the hindrances to accessibility of services within sociocultural context of care and support in the study areas

The methods of data collection are: participants observation, key informant interview, in-depth interview, focus group discussion (FGD) and case studies. In all, seventeen (Focus Group Discussion) FGDs, twelve key informants, forty in-depth interviews and seven case studies were carried out. Fieldwork was conducted between October 2002. Two hundred and forty participants representing one hundred and eighty-four People living with HIV/AIDS) PABA participated in the study. Content analysis of data was carried out.

Three patterns of care and support services were available to PLWHA in the study areas. These were: hospital, non-government organization (NGO) and family support. Data revealed that NGO is the most accessible and the most utilized while family support is the least available and the least utilized. Love and acceptance are most important needs of the PLWHA above other needs such as drugs, testing and food. Limitations of PLWHA in accessing care and support include: poverty, stigmatization, rejection, cost of ARV (antiretroviral) drugs, exorbitant testing fees and inadequate number of NGOs working on HIV/AIDS care and support. Data revealed that non-disclosure of HIV seropositive status; relocation and religious affilation were main coping strategies for the PLWHA. Also, Christian faith healers are mostly patronized. Similarly, the use of traditional preparations such as Orin ata (special chewing stick), mixture of aloe vera and honey, ose dudu (black soap), agba (herbal preparations) and agunmu (dry misture) in treating opportunity infections was reported by majority of respondents.

Lack of family care affects response to treatment and predisposes PLWHA to self-pity and psychological imbalance. It is therefore suggested that majority of the PLWHA will live positively if accepted the way they are. This is need for intensive enlightenment programme on the role of the family in care and support for the PLWHA. Finally, it is concluded that majority of the clients will do well if given smiles and are accepted the way they are. One of the lessons of this study is that many PLWHA may not die from AIDS but from other man made preventable circumstances such as depression, loss of will to live, suicidal attempt etc. There is therefore the need to reverse earlier HIV/AIDS education campaign, which depicts AIDS as death personified and more involvement of PLWHA in AIDS education programmes should be encouraged. Also, the family should be relocated to perform it basic and traditional role of earing.

Key words: HIV/AIDS, care and support, PLWHA, PABA and Nigeria

DEDICATION

My late parents, Prince Waleola Abraham ADELEKE who died during my undergraduate study and to my mother, Victoria Abike Makanjuola who died also during the course of this postgraduate work. You both laboured so hard but never lived to reap the fruits of your labour. May your gentle souls rest in perfect peace

And

People Living With HIV/AIDS (PLWHA)

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To the innumerable others whose names are not mentioned, the lord knows you and you will not miss your reward in Jesus name.

CERTIFICATION

I certify that this work was carried out under my supervision by Mrs prisca Olabisi ADEJUMO in the Department of Sociology, Faculty of the Social Sciences, University of Ibadan, Ibadan.

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ACRONYMS AND ABBREVIATIONS

AIDS:	ACQUIRED IMMUNE DEFICIENCY SYNDROME
ARV:	ANTI-RETROVIRAL
CBO:	COMMUNITY BASED ORGANIZATION
CHBC:	COMMUNITY HOME BASED CARE
CHESTRAD:	CENTRE FOR HEALTH SCIENCES TRAINING AND DEVELOPMENT

CISCGHAN:	CIVIL SOCIETY CONSULTATIVE GROUP ON HIV/AIDS IN NIGERIA
CSWS:	COMMERCIAL SEX WORKERS
CWIQ:	CORE WELFARE INDICATOR QUESTIONNAIRE
DFID:	DEPARTMENT OF INTERNATIONAL DEVELOPMENT
ELISA:	ENZYME LINKED IMMUNO-SORBENT ASSAY
EPI:	EXPANDED PROGRAMME ON IMMUNIZATION
FGM:	FEMALE GENITAL MUTILATION
FGM:	FEMALE GENITAL MUTILATION
FGN:	FEDERAL GOVERNMENT OF NIGERIA
FME:	FEDERAL MINISTRY OF EDUCATION
FMOH:	FEDERAL MINISTRY OF HEALTH
FMWAYD:	FEDERAL MINISTRY OF WOMEN AFFAIRS AND YOUTH DEVELOPMENT
FMWR:	FEDERAL MINISTRY OF WATER RESOURCES
FOS:	FEDERAL OFFICE OF STATISTICS
HBM:	HEALTH BELIEF MODEL
HEAP:	HIV/AIDS EMERGENCY ACTION PLAN
HIV:	HUMAN IMMUNE DEFICIENCY VIRUS
IDUS:	INJECTION DRUG USERS
IECT:	INFORMATION EDUCATION AND COMMUNICATION TECHNOLOGY
ILO:	INTERNATIONAL LABOUR ORGANIZATION

LGAS:	LOCAL GOVERNMENT AREAS
MTCT:	MOTHER TO CHILD TRANSMISSION
NACA:	NATIONAL ACTION COMMITTEE ON AIDS
NACP:	NATIONAL AIDS CONTROL PROGAMME
NASCP:	NATIONAL AIDS/SIDS CONTROL PROGAMME
NDHS:	NIGERIA DEMOGRAPHIC AND HEALTH SURVEY
NHMS:	NATIONAL HEALTH MANAGEMENT INFORMATION SYSTEM
NHP:	NATIONAL HEALTH POLICY
NIPRD:	NATIONAL INSTITUTE OF PHARMACEUTICAL RESEARCH AND DEVELOPMENT
NPC:	NATIONAL POPULATION COMMISSION
NGOS:	NON-GOVERNMENTAL ORGANIZATION
PABA:	PEOPLE AFFECTED BY AIDS
PHC:	PRIMARY HEALTH CARE
PLWHA:	PEOPLE LIVING WITH HIV/AIDS
SIDA:	STATE INTERNATIONAL DEVELOPMENT AGENCY
SMOH:	STATE MINISTRY OF HEALTH
STLS:	SEXUALLY TRANSMITTED INFECTIONS
U5MR:	UNDER FIVE MORTALITY RATE
UNAIDS:	UNITED NATIONS PROGRAMME ON HIV/AIDS
UNICEF:	UNITED NATIONAL CHILDREN FUND
USAID:	UNITED STATE AGENCY FOR INTERNATIONAL DEVELOPMENT

CHAPTER ONE

1.0 INTRODUCTION

1.1 Background Information

The world was unprepared for the currently most challenging health problem called Acquired Immune Defficiency Syndrome (AIDS). Previously unknown, the human immunodeficiency virus (HIV), is a lethal pathogen that has now infected millions of persons throughout the world. Every sub-population group in a country is affected by the problems caused by HIV and AIDS in medical, ethical, legal, political, financial or social dimensions. AIDS has responded poorly to conventional bio-medical and public health solutions, in part because of the complexity and unique feature of the virus. About three decades after the diagnosis of HIV, there is no vaccine, and the benefit of medical therapies, although helpful in controlling complications are transient. The medical, scientific and behavioural community has accumulated enormous amount of knowledge concerning the HIV epidemic rapidly. Public health measures such as effective and comprehensive testing has reduced the spread of HIV by blood and blood products, and the ongoing education effort directed towards individuals and communities have provided information and skills to alleviate fears and to reduce HIV transmission.

However, little attention has so far been given to the problems of People Living with HIV/AIDS (PLWHA). This trend is likely to increase in the nearest future if adequate care and support is not given to the people living with HIV/AIDS. Since inception of HIV in the 1980s, it gradually progressed from an endemic to a pandemic status. This is because certain aspects of human efforts that could have been harnessed for fruitful results in the area of care and support have been neglected. Though the world is witnessing the third decade of the AIDS epidemic, Nigeria is only in the first decade of a serious prevention effort.

The global epidemic of HIV infection and subsequent AIDS has been very devastating. By the year 2000, the cumulative HIV/AIDS associated with mortality worldwide was 21.8 million; 3.2 million of which were children. Most of these deaths were in sub-Sahara African countries including Nigeria (UNAIDS, 2000). Nigeria is the most populous country in Africa with an estimated population of approximately 136 million (World Population Data, 2003) and contributing about 8 percent of the global burden of HIV/AIDS (UNAIDS, 2000). The prevalence of HIV/AIDS has brought to bare the need for alternative course of action of care and support. From the first officially diagnosed case of HIV in Nigeria in 1986 and with a steady rise in the HIV prevalence from less than one percent in 1990 to 1.2 percent in 1991 and the progressive increase of 3.8 percent in 1993, 4.5 percent in 1995, 5.4 percent in 1999, and 5.8 percent in 2001, it is not surprising that more than 3.5 million Nigerians are living with HIV (FMOH, 2001).

In response to the epidemic therefore, various measures have been taken at the local, state, national and international levels to prevent the transmission. Despite these prevention programmes, efforts made so far are yet to sufficiently address the care and support needs of PLWHA. This is because these efforts are based on biomedical perspective of prevention and cure. Various drugs have been invented, new ones are being discovered and administered; yet, people are still being infected and are still being subjected to various excruciating experiences.

HIV/AIDS has become a major public health problem in Nigeria and few human tragedies in recent history have focused the world's attention as this. AIDS certainly affects people from diverse backgrounds and there are no signs yet anywhere that the HIV virus "exhausts" itself so that the epidemic could fade out. On the contrary, the virus is taking new forms and continues to spread across human societies. At this level, care and support of those infected become essential. People infected with HIV need health care and medical treatments to deal with infection and diseases. They need social and psychological support to face this lethal disease.

At the same time, many people who are affected by the epidemic such as spouses, children and family members need emotional, economic and legal support to cope with the HIV/AIDS consequences. There is therefore the need for a shift towards social and cultural perspectives of the care and support for PLWHA. Much has been done on prevention through behavioural risk reduction but less has been done on those already infected? HIV/AIDS studies show that an HIV infected person is capable of living positively. This makes care and support for PLWHA to pose a great challenge.

From the aforementioned, it is therefore pertinent to address the following questions: Do we allow the PLWHA to continue in their excruciating experiences? What are the impacts of kin group and other social network on PLWHA? Are these impacts relative or universal in all human societies? Can these be integrated into care and support for PLWHA? These curiosities provoked this particular research.

1.2 Statement of Problem

HIV/AIDS has become widespread in Nigeria (Adewole, 2001; Ajuwon, 2001; Soyinka, 2002; Olaleye, 2003). In fact, Nigeria has become one of the few countries to cross the 5 percent threshold. This implies that Nigeria is now in the explosive phase of the epidemic with potentially grave consequences and implications for care and support (FMOH, 2001). This is because, as the AIDS epidemic worsens in Nigeria, the need for care and support becomes increasingly evident. Before the HIV/AIDS epidemic, many countries notably in sub-Sahara Africa had very weak health care system with lack of equipment for diagnosis, treatment and erratic drug supplies. HIV/AIDS competes for scarce resources with malaria, tuberculosis and other communicable diseases. A 1995 sentinel surveillance report reveals that 71.9 percent of HIV infection was found among adults below age 40, which is the age range of economic productivity. The effect of this is felt by both the private and public sectors through loss of employees to sickness, absenteeism, and death.

In the worst affected countries, HIV/AIDS has contributed to a doubling of mortality among adults in productive ages. (UNAIDS, 1997). Rising mortality level is the same as falling life expectancies such that in many sub-Saharan African countries, life expectancy is back to levels similar to what these countries had 30 – 40 years ago (UNAIDS 1997a). Nigeria's rapid population growth and uneven economic development have resulted in an increasing poverty rate, outpacing the Government of Nigeria's ability to provide adequate health and social services. With this, HIV/AIDS is among the top 10 challenges facing development in Nigeria (UNAIDS, 2000).

Similarly, the human death toll from AIDS has become a tragic reality being experienced by families and communities at large. HIV/AIDS leads to a loss of household income due to the illness and death of household members as well as the time spent on caring for them. Also, expenditures increase as a result of medical, funeral and mourning expenses. Many affected households live on small incomes, the resultant effect of which is increasing poverty and deteriorating food security. Children, especially girls, have to leave school because there is no money for school fees or because their labour is needed at home for income-generating activities (UNICEF, 2000).

The epidemic adds to an already considerable impact of other conventional health hazards. Also, it makes the household increasingly vulnerable to further changes of household composition (by illness, death, migration etc.). AIDS leaves women with an increased workload. They have to spend time caring for the sick household members and take on tasks usually done by those who are ill apart from trying to keep up with their normal and other domestic responsibilities. The effects of these adaptations are exhaustion, less attention to children and deteriorating health and diet. According to Olaleye (2003), "HIV is no respecter of gender, age or status, it devours male and female, young and old, rich and poor, literates and illiterates, strong and weak, high and low, priests and alfas, herbalists and babalawos, doctors, nurses and patients, teachers and students, bankers and depositors, buyers and sellers, urban and rural, without any respect of power or position."

Consequently, the premature deaths from AIDS of large number of professionals, skilled workers and other trained and experienced manpower at all levels have a growing impact on the quality of the workforce. These devastating effects of the epidemic on human capital and productive forces in all sectors of society weaken its capacity to successfully reduce the further spread of HIV, and to handle the growing needs for care and support. Also, before the advent of AIDS, most of the affected countries were already struggling with a wide range of serious social and economic development problems. Besides, the AIDS epidemic is a long wave phenomenon, which may probably last several decades. Currently, of all HIV infected in a country, only one tenth or less is openly sick with AIDS, nine-tenths may manifest within one decade, and in their footsteps come new waves of infected group so that those who are not dead are plagued with opportunistic infections. Successful prevention will gradually reduce the size of this group but cannot prevent adult deaths from AIDS from being with the society for a long time ahead.

Furthermore, prevalence continues to rise and the cost of medical care is soaring in the face of non-accessibility and non-affordability of the cost of procurement of anti retroviral drugs. A progression very rapidly and deeply into the epidemics has been reached such that the nation cannot afford to continue to repeat the same processes that have failed to help. The permanent cure is not found yet and no one knows how long it would take for an appropriate vaccine to be developed. Similarly, no one knows how many more Nigerians would have become infected or are expected to die through the infection. The fact is that many more people will still get infected despite various measures that have been put in place to prevent its spread. The dawning task therefore is to embark on aggressive care and support programmes.

However, in the Traditional African Society, the role of kin group in illness and disease cannot be over emphasized. Care and support in illness and disease involve all members of the family. Attention in a family shifts to the sick and other members of the family would cease to be centres of attraction. This is attributed to the supportive elements and caring role of the kin group. They constitute a great determinant of motivation for sick members of the family to be willing to seek medical help on the assurance that other members of the household would not suffer due to his or her absence. At this crucial period, extended family members are willing to render necessary support even if it means selling their valuables.

A pertinent question is whether these still exist in contemporary Yoruba communities and whether they translate to care and support for PLWHA. Therefore, this study attempts to bridge this gap. Hence, the following research questions become necessary:

1.3 Research Questions

The study attempts to answer the following questions:

(i) What are the existing patterns of care for the sick?

(ii) What are the available support systems for the sick?

(iii) Are these patterns the same for a person infected with HIV?

(iv) What are the support systems available for PLWHA?

(v) How do PLWHA cope with the infection and disease?

(vi) Does disclosure influence pattern of care and support?

(vii) What are the problems encountered by PLWHA in seeking care and support?

(viii) What are the effects of socio-cultural factors on care and support for PLWHA?

1.4 Aim and Objectives

Aim: The study explored care and support systems for PLWHA in Ibadan and Ilesa. In order to achieve this aim, the following **specific objectives** were addressed. These could be identified as follows:

(i) Identify the pattern of care and support systems available in the study areas;

(ii) Assess the impact of the available support systems on care of PLWHA;

(iii) Investigate the limitations of PLWHA in seeking care;

(iv) Determine the coping strategies of PLWHA; and

(v) Examine the effect of socio-cultural factors on care and support for PLWHA;

1.5 Significance of the Study

The rapid spread of HIV/AIDS in Nigeria calls for a definitive response from the society. The study therefore becomes important as it is hoped that its findings will contribute to this quest. Although HIV is probably the most investigated infectious agent in history, there is still much to be known about the virus (Levy, 1992). Hence, this study is timely because it contributes to the dearth of literature on care and support for PLWHA. This is particularly significant because the findings apart from its practical utility contributes immensely to knowledge in filling the gap between traditional and modern perspectives of care and support for the sick especially in matters relating to stigmatisation of diseases like AIDS.

It reveals the direction of kin group perception of HIV/AIDS. The study also situates HIV/AIDS within the context of social institutions. It mediates between social and biomedical science toward therapeutic programming for the dreadful disease. It is more significant in the case of HIV/AIDS considering that AIDS has no cure, yet it can be managed not only through biomedical means but greatly by social and cultural support and integration of the PLWHA in the society.

More specifically, in Oyo State from where Ibadan was selected for the study, the first case of AIDS in the state was diagnosed in 1987. By 1994, a prevalence survey was carried out and from the findings; two percent of the population were HIV positive. Another survey two years later (1996) puts it at two percent again. However from 1999 and 2001 surveys, the prevalence increased to 3.5 percent and 4.2 percent respectively while in Ilesa, the second study site was designated 'hot spot' in 1999 with the highest HIV/AIDS prevalence of 4.7 percent in Osun state (FMOH, 1999). At this rate, perhaps there is no better time to conduct this type of study bearing in mind the transitional stage of the Nigerian society.

Also, AIDS is more than a medical challenge. Hence, real and sustainable solutions are only possible when those already infected are given adequate care and support and when they are helped to develop positive attitudes. It is assumed that the result of this study when transformed into policy would improve care for PLWHA and reduces the burden of care on formal institutions. Also, the findings of this study will be useful to a variety of professionals such as sociologists and epidemiological experts, who for example can interpret its findings as a useful tool for predicting the spread of the virus especially in Nigeria. Clinical care specialists especially nurses can through the findings identify new strategies for PLWHA to cope with their Social service professionals can also deduce clues from the findings to enhance their counselling techniques. Similarly, political scientists and economists can provide the framework and the tools with which government can realise changes for care programmes through the findings of this study while international health experts can use the findings to provide adequate guidance for programmes to comply with international best practices.

CHAPTER TWO

2.0LITERATURE REVIEW AND THEORETICAL FRAMEWORK

2.1 Preamble

HIV/AIDS had, and continues to have substantial and sometimes dramatic impact on mortality levels in countries most seriously affected by it. In fact, communities with the highest infection rates are often the most impoverished. This section therefore reviews relevant literature in the following areas; International epidemiology of HIV/AIDS, HIV/AIDS in the developing world, Contextual analysis of HIV transmission in Nigeria, Africa and in the world. Others, such as, impacts of HIV/AIDS, Health care delivery system in Nigeria, Existing health facilities and Knowledge and attitude to HIV/AIDS were also reviewed. Theoretical considerations for this study as well as the study assumptions were described.

2.2. International Epidemiology of HIV/AIDS

2.2.1 Worldwide Spread of HIV

In the first decade of the AIDS pandemic, cases were reported largely from North America, Africa, Europe, Australia, and parts of Latin America. As we enter the third decade, serologic studies show rapid increase of HIV infection in America, Asia, and the spread of HIV from urban to rural Africa, as well as large numbers of infected persons in Latin America. These data reflect a significant expansion of the epidemic to the most populous regions of the world, with the prospect of much larger numbers of AIDS cases in the future.

Success in reducing HIV transmission in some communities in the developed world is being overwhelmed by failure to prevent millions of new infections in Africa, Asia, and elsewhere. In India, for example, one hundred AIDS cases have been reported, but one million persons are estimated to be infected. At least thirty percent of commercial sex workers in Bombay are estimated to be HIV-positive, and the city represents one of the fastest growing centres of the epidemic in the world. China has reported only 11 AIDS cases, but the number of known HIV infections, which greatly underestimates the true number, is nearly 100 times the number of AIDS cases. In Thailand, the epidemic rapidly spread among injection drug users (IDUs) and Commercial Sex Workers (CSWs) between 1988 and 1990. In 1989 and 1990 in that country's Chang Mai Province, three to ten percent of a sample of CSWs seroconverted each month. Two percent of recent Thai army recruits, age twenty to twenty-two, tested HIV- positive. (Mann, et al. 1992). This alarming expansion of the epidemic gives great urgency to intensifying prevention efforts and to developing an effective care and support programme all over the world.

2.2.2 Patterns of HIV Transmission

HIV affects different populations in different parts of the world, reflecting social and economic differences that determine the predominance of routes of transmission in a region. In North America, Europe, and Australia, AIDS has been predominantly a disease of homosexual men, followed by IDUs and their sexual partners, and haemophiliacs and transfusion recipients. In Africa, most HIV infection is attributed to heterosexual transmission, and seroprevalence is especially high among CSWs.

Three paterns of HIV transmission in the world have been distinguished: type I, the pattern described above for North America; type II, the African pattern of heterosexual transmission; and type III, a pattern of few cases mostly attributed to imported contaminated blood products or sexual contact with an infected person outside the country, (Mann, et al., 1992). This third pattern is an early stage of HIV spread that once applied to most of Asia but is becoming less characteristic of many regions as the epidemic expands within countries through injection of drug and heterosexual transmission. Earlier AIDS cases in Asia that were not transfusion recipients were homosexual males, and the reported cases still reflect this distribution of high risk factors, but seroprevalence studies imply heterosexual transmission.

WHO estimates the male-to- female ratio of HIV infection in Asia as 1.4 to 1.0 - similar to the estimate for Africa? Thus, the African pattern appears now to be becoming the pattern in Southeast Asia, with drug use in the "golden triangle" region of Thailand, Burma and Cambodia and in major cities like Bangkok and Bombay being an important contributing factor. Countries in the western hemisphere, such as Haiti, which early in the epidemic had a pattern of AIDS cases intermediate between the predominantly homosexual epidemic of Africa, have seen a relatively greater increase in heterosexual cases.

2.2.3 HIV-1 Versus HIV-2

Most reported cases of AIDS around the world have been attributed to HIV-1. A few cases of AIDS in North America, Europe and Asia have been associated with HIV-2, but Africa remains the primary site of HIV-2 infections. HIV-2 is found predominantly in western Africa, while HIV-1 is the predominant virus in eastern, central and southern Africa. However, in a study of PLWHA from the two largest hospitals in Abidjan, Ivory Coast (West Africa), HIV-1 was the dominant cause of AIDS. Approximately half of the PLWHA were infected with both viruses, but only four percent were infected with HIV-2 alone. The greater proportion of HIV-1 of PLWHA in Ivory Coast compared with the proportion of seropositives in western Africa may indicate that HIV-1 is more pathogenic than HIV-2. It has been suggested that HIV-2 viremia is typically at a lower level than HIV-1 and this difference accounts both for the diminished virulence of HIV-2 and a lower probability of transmission.

Both HIV-1 and HIV-2 are common in Nigeria. These have been reported in virtually all parts of the country but particularly, in the urban areas. Nigeria has now reached the explosive stage of the HIV epidemic with all the risks of the infection. This is a challenge for all Nigerians to be actively involved in the battle against AIDS.

Infection with any of the two viral subtypes (HIV 1 and HIV2) does not differ significantly in terms of pathogenicity and ultimate outcome of the infection. Two comprehensive studies to isolate the various viral strains in Nigeria were conducted in 1999, one by NASCP in the Federal Ministry of Health and the other by the National Institute of Pharmaceutical Research Development (NIPRD) in conjunction with the Institute of Human Virology (IHV), Baltimore. The NASCP survey revealed that eighty-seven percent of HIV infection in Nigeria is due to HIV- I, seven percent due to HIV- 2 and six percent due to double infection with both HIV I and 2. The NIPRD/ HIV collaborative survey, which concentrated on isolating the various HIV- 1 strains, indicated that Nigeria has a clear dominance and widespread distribution of sub-type A (forty three percent) and G (fifty-seven percent).

Sero prevalence of 5.8 percent in the general population means that five out of every one hundred Nigerian are living with the virus. This interprets to the fact that soon, figures will metamorphous into faces. Meanwhile, are we going to fold our arms and allow this silent weapon of AIDS, which is killing us to continue? There is need for adequate care linked with good counselling and the development of patient support units, community and home based care especially when one takes a closer look at table 2 below and compare the differences within a space of one year.

2.3 HIV/AIDS in the Developing World.

Ninety five percent of the vast majority of those affected by the scorge of HIV/AIDS live in the developing world. Africa alone accounts for two third of current HIV/AIDS cases. In seven African countries, HIV prevalence in Adults is twenty percent or higher and in nine additional countries, it exceeds ten percent as shown in figure 2.1.

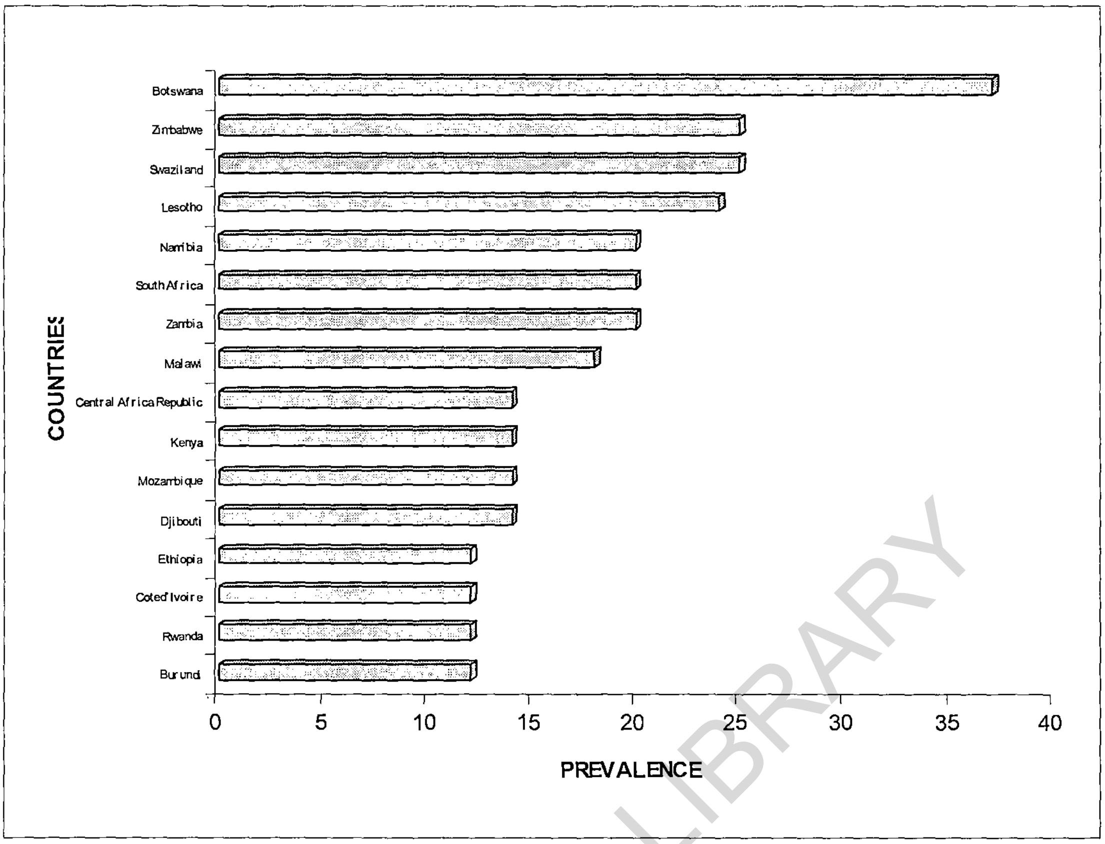


Figure 2.1 African countries with greater than 10 percent prevalence

Source: UNAIDS / U.S. Bureau of the Census.

2.3.1 HIV /AIDS in Africa.

Over the last decade, HIV-1 has spread throughout the world, producing a global epidemic of HIV disease. By June 1993, 718,894 cumulative AIDS cases had been reported to the World Health Organisation (WHO). Thirty-four percent (247,577) of the cases were reported from 54 countries in Africa as seen in Table 2.1 below.

Table 2. 1. Acquired Immunodeficiency Syndrome (AIDS)

COUNTRIES	CASES
Algeria	138
Angola	608
Benin	465
Botswana	439
Burkina Faso	1307
Burundi	7,131
Cameroon	2,174
Cape Verde	65
Central African Republic	3730
Chad	899
Comoros	3
Congo	5267
Cote d'Ivoire	14,655
Djibouti	355
Egypt	64
Equatorial Guinea	31
Eritrea	372
Ethiopia	4861
Gabon	392
Gambia	240
Ghana	10,285
Guinea	397
Guinea-Bissau	288

Kenya	31,185
Lesotho	219
Liberia	28
Libyan Arab Jamahiriya	10
Madagascar	4
Malawi	26,955
Mali	1,479
Mauritania	40
Mauritius	16
Morocco	145
Mozambique	737
Namibia	311
Niger	795
Nigeria	552
Reunion	65
Rwanda	9,486
Sao Tome and Principe	12
Senegal	911
Seychelles	1
Sierra Leone	95
Somalia	13
South Africa	1,803
Sudan	727
Swaziland	248
Togo	1,953
Tunisia	136
Uganda	34,611
United Republic of Tanzania	38,719
Zaire	21,008
Zambia	7,124
Zimbabwe	14,023

Source: Adapted from WHO quarterly AIDS statistics. Weekly Epidemiological Records 2003

Striking, as these figures seem, because of under-reporting and under-diagnosis in many countries, the figure are underestimates. Approximately, seventy percent of all AIDS cases are thought to occur in Africa. Further more, the WHO estimates that, of the thirteen million HIV infected persons worldwide, eight million persons, or almost two thirds, are in sub-Saharan Africa.Thus, one out of forty adults in sub Saharan Africa may be infected with HIV.

Although, the underlying defect in cellular immunity is the same as in Western countries, the epidemiology and clinical presentation of HIV disease in Africa are strikingly different. Unlike in North America and Europe, heterosexual transmission is the predominant mode of HIV-1 in Africa. Infection through blood transfusion and perinatal transmission from mother to child has also contributed to the spread of HIV-1 across the continent. There are numerous cultural, socio-economic and technological differences, not only between African and western countries, but also within Africa itself. Among countries in Africa, there are differences in the rate of spread of HIV, the male to female patient ratio, prevalence of HIV infection and extent of involvement in rural areas and different socio economic groups. Yet, these figures are far from the figures recorded in 2003.

(a) **Historical Perspective of HIV/AIDS in Africa.**

There are few studies on the natural history of HIV infection in Africa. In general, progression to symptomatic disease of AIDS seems more rapid in Africa than in the United States or Europe. In Kinshasa, Zaire, among one hundred and one asymptomatic HIV infected persons, after two years sixteen percent of them had developed symptomatic HIV disease, while three percent had advanced HIV disease qualifying as AIDS, and twelve percent had died (Nachmias, 1986). Unfortunately, the time of sero conversion was not known. In a cohort study of CSWs in Nairobi, where the time of sero conversion was known, the median times from sero conversion to the occurrence of symptomatic or advanced HIV disease was 34.2 and 44.6 months, respectively. In contrast, only three percent of homosexual men in western countries developed CDC- defined AIDS within two years of seroconversion. The rate of progression to CDC-defined AIDS among recipients of blood transfusions in Kinshasa was six percent after twelve months of follow-up, a rate much higher than the 0.5 percent rate seen in transfusion recipients in the United States. It is not yet known why there seems to be a more rapid progression of HIV and AIDS in Africa.

After the development of symptomatic or advanced HIV, survival time is shorter in Africa than Western countries. In the United States, the median of survival from CDC- defined AIDS to death was 18.4 months for those whose conditions were diagnosed between 1987 and 1989. A retrospective study from Muhimbili Medical Center in Dar es Salaam, Tanzania, reported that only 7.5 percent of hospitalised patients with advanced AIDS were alive 3 months later. Prospective studies of outpatients in Africa have documented more favourable mortality rates. The mortality was 7 percent after 2 years of follow-up in a prospective study of HIV infected women of childbearing age in Rwanda. However, the mortality was 21 percent for those meeting the WHO clinical AIDS definition. In comparison, the mortality was only 0.3 percent in seronegative women. The short survival time reported in retrospective studies is probably because of delays in seeking care and the lack of diagnostic and treatment facilities compared with industrialised countries. A more accurate survival time lies somewhere between those reported in the retrospective and prospective studies.

By 1988, HIV infection was the leading cause of death in Abidjan, Cote d'Ivoire, among adult men and the second leading cause of death among adult women. Ninety percent of all deaths in urban Rwanda women of child- bearing age are due to HIV infection (Van de perre et al.1984) Considering the number of Africans infected with HIV, disease will likely become the leading cause of death in many more sub- Sahara African cities. The findings of the Centre for Disease Control and Prevention (CDC) was quite revealing as Table 2.1 shows.

(b) Contextual Analysis of HIV Transmission in Africa.

In the struggle to prevent further spread of HIV and AIDS, everyone-government, authorities, business and industry, religious and secular organisations have important roles to play. An equally important task is to identify, analyse and respond to key contextual factors behind the spread of HIV. Labour migration is one of the most obvious contextual factors in the transmission of HIV. Classical example is short-term labour concentrations for infrastructure constructions such as a road, a dam or a power station. International Labour Oganisation (ILO, 2000) has identified these areas as priority areas for action, and Swedish experiences from Tanzania are available to guide action (Moen & Egero 1998).

Government policy on deployment of staff to different parts of the country creates another category of mobile labour. Civil servants are regularly posted to regional or district offices. Teachers are stationed where schools exist but lack teachers. Staff in agriculture extension is required to work in areas away from home. This type of labour migration is rarely addressed in terms of its relation to HIV/AIDS. The danger of infection comes from separating people from their families over extended periods of time. Much of the HIV threat against educated categories of people can be linked to their separation from family and home, Egero, Hammarskjold & Munek (2000). In another dimension, one factor at work with HIV/AIDS, as with any serious threat to people is denial. Governments have tried to reduce the HIV/AIDS problems by saying that AIDS in their country is different from the AIDS of USA and Europe (Egero 2000). Even people affected may react by denial. This is linked to the close relation between sex and death around AIDS. Apart from these, other contextual factors include skin cutting, which is common in many societies, at times rooted in culture and traditions. Male circumcision and female genital mutilation are examples. Tattooing and piercing are very common in Sub-Saharan Africa, and increasingly in the West.

In Sub-Saharan Africa and many of the affected countries, transmission through sexual relations between men and women is by far the most common way of the spread of HIV. This can be traced to the contextual factor of female virginity as an ideal before marriage in many societies. However, studies show that both men and women in their teens and early 20s are sexually active although not yet married. In many countries in sub-Saharan Africa, casual sexual encounters between older men (sugar daddies) and younger girls are common; the men search for uninfected partners and the girls may be lured into a relationship or drawing material benefits from it. Community-based studies inform that in practically all countries in Africa, at least three times as many girls as boys are infected (UNAIDS, 1997). As a result, girls may infect their boyfriends, and young men may risk marrying an HIV-positive woman.

In the same vein, mutual monogamy is a social ideal in most societies, and sexual fidelity to one loyal partner is an effective protection against HIV. However, social practices vary, some of them sanctioned by society. Men in particular, are likely to both report and indeed to have more extramarital sexual partners than women. Among the factors that contribute to this difference is the migrant worker system UNAIDS (2000).

(i) Wife inheritance

Widowhood is a practice common in most traditional African societies. It is an attempt to ensure continuity in family relationship due to disruption caused by death. It is a practice in which a female who lost her husband is married to her husband's next of kin. The danger in this is that nobody cares to take into consideration why the deceased husband died, which may be to AIDS. Cases of remarrying women whose husbands died of AIDS may be accompalished but not yet reported in literature. In fact, this constitutes one of the means of transmissions of HIV/AIDS in Uganda in the late 1990s. This aspect even though is currently neglected, needs critical anthropological investigation as widowhood practice is reinforced by property inheritance saying eni to leru lo leru (meaning who owns the property owns the slave).

Another closely related contextual factor is where so-called wife inheritance by close male relative is practised. This may give AIDS-widows better conditions to feed their children and protect their property. On the other hand, this traditional coping mechanism entails sexual intercourse, which contributes to the spread of HIV. Efforts to replace sex with symbolic 'inheritance' rites have been successful, for instance in Zambia (Egero 2000). In Yoruba land, the moment a man dies, “the immediate younger brother is encouraged to inherit the widow, though it is not compulsory” said an Ekiti widow inheritor in a study of widowhood rites and wife inheritance in Ondo and Ekiti States of Nigeria by Aderinto (2000). The result of this is a further HIV/AIDS spread.

(ii) Male Preference and value for children

In traditional African societies, people place high value on children. It is a curse for someone to remain barren throughout his or her lifetime. Hence, every one wants to have a child of his or her own. Another fact is that most African societies place high value on sons or at least a son. This is especially so in patriarchal societies like Nigeria. These practices expose men and women to the danger of contracting STDs especially when desperately looking for a child or a male child. As a result, many men marry as many wives as possible while women may try as many husbands as possible until they can get a child or a male child.

(iii) Patriarchy

Many of these factors are rooted in patriarchy. Increasingly, women have been keenly studied, most especially, in relation to men concerning a number of issues in many societies. The general consensus is that "men's role has been valued a lot in every place and time, and women's role has been valued less" (Gray, 1982). It is widely believed that women are disadvantaged in most things, if not all. According to Joss (1990), the disadvantaged nature of women's life starts at birth when everyone (men and women alike) feel disappointed at the newborn baby who is not a boy. Boys are valued more than girls in most societies (Isiugo-Abanihe 1994, Jegede 1999). The girl-child is often not educated as the boy and in her adulthood, she moves from dependence on her father to dependence on her husband and how to submit to "family expectations" and as an old woman when she must have passed menopause, she is more likely to depend on her sons and brothers. "To that extent, women may have been trapped in a world of men, a world dominated and controlled by men through cultures and structures created by men". And what more, when the toll of care and support for PLWHA is added? The common label for such a world in the literature is patriarchy.

(iv) Form of marriage

In Nigeria, heterosexual relationship is more common among people in polygamous union. As a cultural practice, people do not consider having sex with more than one person dangerous. Studies have shown high prevalence of polygyny in Nigeria especially in Muslim-dominated societies (Babalola, 2001). Although Christianity is against polygyny, many still marry more than one wife. The danger is that it becomes easier to transmit STDs among sexual mates. Clinical evidence from STD clinics has shown positive cases among polygamous families. (Babalola,2001). This suggests a possible source of high rate of transmission in Nigeria.

2.3.2 Nigeria Situation in the Global HIV Epidemic

By December 2002, over forty- two million across the world were living with HIV/AIDS, out of which 5.3 percent were people newly infected in 2002 alone (AIDS Epidemic Update, 2002). Already, over 3.1 million people have lost their lives to the epidemic. The situation in sub-Saharan Africa is disproportionately serious as this accounts for over seventy percent of those infected with HIV. About sixteen Sub-Saharan African countries have already crossed the ten percent seroprevalence threshold, amongst the general adult population. Botswana, which has a relatively small population, has the world's highest prevalence, with 35.8 percent. South Africa, with an adult prevalence of 19.9 percent and a much larger total population (about 40 million), has the world's largest pool of PLWHA (4.2 million). Although the situation in West Africa is at present less dramatic in terms of scale and velocity of the epidemic, Cote d'Ivoire is already among the fifteen worst affected countries in terms of HIV prevalence.

With a population of one hundred and thirty six million, Nigeria is one of the first few "large populations" in the world to cross the five percent threshold. Beyond five percent prevalence, it is known that the HIV epidemic enters an explosive phase and becomes a generalised problem of the entire population, irrespective of risk group classification. Once the epidemic is generalised, the risk of sexual transmission increases manifold, simply because the chances of encountering an infected partner in a sexual relationship are much higher. In addition, whereas the HIV prevalence in Nigeria as a whole was 5.4 percent in 1999, there are localities within the country with a prevalence that is very much higher than this national average.

Nigeria, because it has the largest population in Africa, also has a very high number of PLWHA. By 1999, with over 2.6 million Nigerians between the ages of 15-49 infected, the country had the fourth largest number of people infected with HIV, after South Africa (4.2 million), India (3.7million) and Ethiopia (3.0 million). Nigeria contributes to about eight percent of the global HIV/AIDS burden and over ten percent of the African burden.

The epidemic is still on an upward trend of one infection per minute although, the rate of growth is slower than in many other African countries, especially, in Eastern and Southern Africa. This slower rate of growth suggests that, if Nigeria had overcome its phase of denial much earlier, it would have been possible to alter, more easily, the course of the epidemic.

Table 2. 2: Global Summary of the HIV/AIDS Epidemic (December 2002)

	NUMBER OF PLWHA	NEWLY INFECTED	AIDS DEATHS IN 2002
Total	42m	5m	3.1m
Adults	38.6m	4.2m	2.5m
Women	19.2m	2m	1.2m
Children under 15 years	3.2m	800,000	610,000

Source: AIDS epidemic update: December 2002.

Table 2.3: Global Summary For Adults And Children Living With HIV And AIDS, Newly Infected And AIDS Death In 2002.

	NO. OF PLWHA	NEWLY INFECTED	AIDS DEATHS (2002)
Sub-Saharan Africa	29,400,000	3,500,000	2,400,000
South & South Asia	6,000,000	700,000	440,000
Latin America	1,500,000	150,000	60,000
Eastern Europe & Central Asia	1,200,000	250000	25000
East Asia & Pacific	1,200,000	270,000	45,000
North America	980,000	45,000	15,000
Western Europe	570,000	30,000	8,000
North Africa &Middle East	550,000	83,000	37,000
Caribbean	440,000	60,000	42,000
Australia & New Zealand	15,000	500	< 100
TOTAL	42 million	5 million	3.1 million

Source: AIDS epidemic update: December 2002

(a) Trends of HIV/AIDS in Nigeria

AIDS cases have been reported in all the states of the federation "and millions of those who are expected to die from the scourge are mostly those in the prime of their lives, who are supposed to be future leaders" (Barley, 1992). Over four million Nigerians were estimated to have contracted the virus by the end of 1998. This makes Nigeria the second country in Africa with the heaviest burden of the disease in terms of absolute number of those afflicted, second only to South Africa.

The disease has now permeated the entire Nigerian social fabric, affecting men and women in urban and rural areas, as well as adolescents, commercial sex workers, traders, high profile politicians and socialites, service men and women, truck drivers, students and so on. It is as such rampaging the most productive age groups in the Nigerian population. Several thousands died from the disease, and this has brought untold hardship and disorganisation to many Nigerian families. (Planned News, 1998).

The first case of AIDS in Nigeria involving a 13-year-old girl was officially reported in 1986 (FMOH, 1992). Since then the number of people infected with HIV has been increasing rapidly. (FMOH, 1994). HIV has been reported among a broad spectrum of the Nigerian population. These are apparently healthy persons (Mohammed et al. 1988); clients of sexually transmitted disease clinics, tuberculosis patients and distance truck drivers (FMOH, 1994), and pregnant women attending antenatal clinics (FMOH, 2001).

The Federal Ministry of Health established in 1991 HIV Sentinel Surveillance Survey as a means of monitoring the HIV and AIDS epidemic in the country. The result of these surveys confirms the trend of a fast growing epidemic in Nigeria except the 2003 data in which there was a reduction from 5.8 percent in 2001 to 5.0 percent in 2003. There is a need for consecutive reduction in the prevalence rate in the nearest future for this to be justified. Based on the 2001 seroprevalence for the entire country, HIV prevalence in pregnant women ranged from 0.5 percent to 21.0 percent with a median prevalence of 5.8 percent. This is bound to have major socio-economic impacts on the Nigeria society; including reduced life expectancy, increased burden of medical care, increase in the number of orphans, and declines in economic growth.

In order to look more closely at HIV prevalence trends, between 1993 and 1999, a total of eighteen sites where surveys were conducted in 1993, 1995 and 1999 were reviewed. The result revealed that HIV prevalence increased in almost all the sites. The estimate of HIV infections, based on the last sentinel survey result, was 2.6million and it was estimated that at the end of the year 2003, there would be about 4.9million adult Nigerians infected with HIV (FMOH, 1999).

(b) Mode of Transmission and Risk Factors

The mode of transmission of HIV in Nigeria can be classified into three principal categories: the sexual route, mother to child transmission (MTCT) and parenteral transmission, which can in turn be subdivided into transmission through contaminated blood and through the use of contaminated instruments. The personal behaviour or practices of an individual may expose him or her to additional risks of infection through one of these routes as shown in Table 2.2. However, there are also known underlying factors, which may be beyond the control of individuals and which directly or indirectly expose them to additional risks. These dynamic factors that influence risk and vulnerability are referred to as the driving forces of the epidemic.

On global basis, ninety percent of new infections result from either sexual transmission (eighty percent) or mother-to-child transmission (ten percent). HIV infection also results from blood transfusion and use of contaminated needles by injection drug users as shown in Table 2.4 below.

Table 2.4: Local Factors that Enhance the Risk of HIV Transmission in Nigeria

Routes of Transmission	Local practices/ behaviour or conditions	Epidemiological implications
Sexual Route	High mobility of CSWs	Enhances geographical Spread
	Polygyny and multiple sexual practices. High risk practices of itinerant workers like long- distance truck drivers, armed forces personnel, migrant labourers and itinerant civil sevants	Increases number at risk within the relationship. Enhances geographical spread.
	High prevalence of STIs	Enhances risk of HIV transmission.
	High risk clandestine homosexual practices	Increases risk to group, contacts and families.
	International trafficking of girls and young women	Increases local and international risks
Blood transfusion	Irregular screening of blood for transfusion	Iatrogenic infection and risk to families and contacts
	Unverified HIV vaccine claims that involve the transfusion or innoculation of human blood for supposed curative or preventive purposes.	Increases risk to recipients, families and contacts. Increases risk of new strains.
Vertical Transmission	High prevalence of HIV among antenatal clients (5.4% in 1999). Rising rate of breastfeeding. Poor access to reproductive health care.	Increases risk of mother to child transmission (MTCT)
Inoculation through skin piercing/blood letting procedures	Unsterile instrumentation in sub-standard clinical settings, e.g. unsafe abortion, un sterile traditional instrumentation e.g. in Female Genital Mutilation. Unsterile traditional shaving and pedicure. Traditional markings and tattooing.	Increases risk of HIV transmission

Source: Modified from Sani-Gwarzo, (19 96)

The 1999 sentinel survey, which was conducted in 73 urban centres and rural communities, indicated that the epidemic has permeated every community and locality in Nigeria with varying degrees of severity. The distribution of the epidemic by geo- political zones in 1999 is illustratedby the figure below.

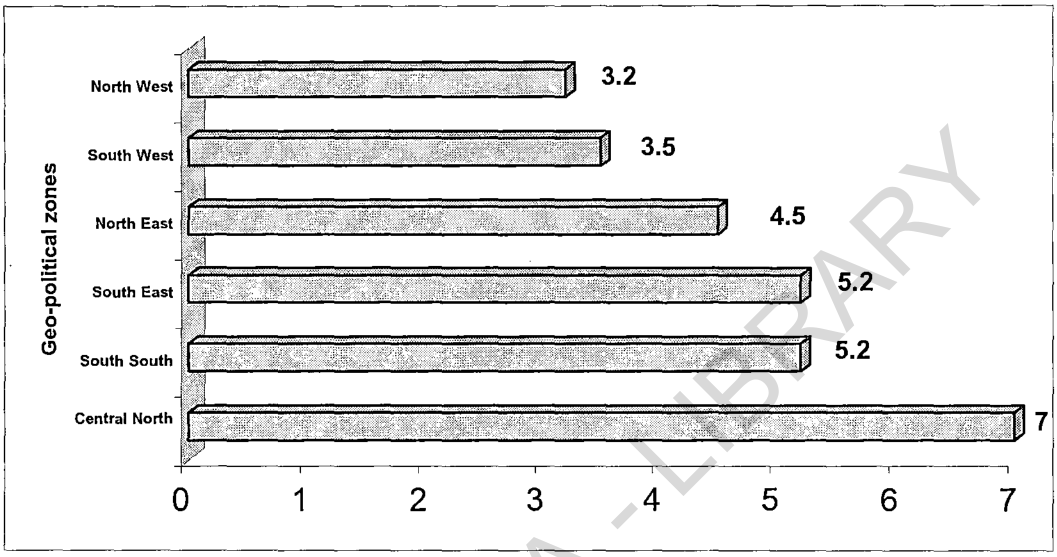


Figure 2.2:HIV Prevalence By Geo-political Zones, 1999 (Percentage of population aged 15-49)
Source: FMOH, 1999a

2.3.3 Impacts of HIV/AIDS on the Household in Nigeria.

All members of the household share the problems caused by HIV/AIDS. It places new demands on family resources and reduces the time adults can spend on income generating activities or subsistence agriculture. Medicine, treatments and other forms of care often consume a significant share of the family income. When HIV infection results in illness, adult family members are less able to care for children and the elderly.

HIV/AIDS causes dissolution of households. Perhaps because of our natural sympathies for the suffering children, increased numbers of orphaned children certainly will be the most visible demographic shift caused by the pandemic. Children may be fostered or adopted prior to the death of a parent. Grandparents, uncles, aunts or siblings care for orphans. Orphans are more likely to be removed from school because of the loss of household income and labour. They experience higher morbidity and mortality and decreased nutrition. The changes experienced by children, families and communities vary around the world. The question is whether our natural sympathy for children in Africa translates to high level of care and support for children living with HIV/AIDS or children orphaned by AIDS.

(a) Impact of HIV/AIDS on Children

Rapidly increasing numbers of children lose one or both of their parents. Before AIDS, orphans in developing countries used to make about two percent of all children below fifteen years. By 2000, the figure had jumped to between seven and twelve percent in many African countries (Hunter and Williamson 2000). Revised estimates from thirty-four countries show that seven million children below fifteen years had lost their mother or their both parents by the end of 2000. This is almost twice as many as in 1990. With 34.3million HIV infected adults globally and 23.4million in sub-Saharan Africa only, the numbers will increase for decades ahead. Estimates show that there will be at least fourteen million maternal and double orphans by 2010. The impact of the HIV and AIDS epidemic in Nigeria will be especially pronounced in the paediatric age group, as time goes on, threatening to reverse the modest gains made in reducing infant and under five mortality through immunisation and other child survival strategies. Due to mother-to child-transmission (MTCT), an estimated 200,000 children under the age of five had died by the end of 2000 as a result of HIV and AIDS and, unless action is stepped up, this cumulative figure is projected to increase to over 700,000 by 2010.

The impact of HIV on children extends far beyond illness and death. Children will suffer greatly as AIDS deaths among economically active adults plunge them into poverty, or push them deeper into poverty than they already are. This process of pauperisation will adversely affect children's nutrition and health, and diminish their access to education. More children are likely to become victims of homelessness, child trafficking, harmful forms of child labour and sexual exploitation in these dire conditions. In turn, higher levels of child prostitution would lead to greater risk of HIV infection.

Among the most seriously affected children will be those who lose one or more of their parents to the epidemic. By 1999, Nigeria already had a cumulative total of over 1.4 million AIDS orphans (children loosing either or both parents). Of these, about 700,000 children below the age of ten years are currently alive. According to projections derived from the AIDS Impact Model, the cumulative total of AIDS orphans (on the same definition) will have climbed to almost 2.5 million by 2010. Besides, emotional suffering or psychological distress from the loss of mothers and fathers, children who have lost both their parents are the most likely to face a situation of absolute destitution, in the absence of effective measures of support and care.

Table 2.5: AIDS –orphans*/2000 and 2010 in selected Sub-Saharan African countries

Countries	2000	2010
Ethiopia	1040 00	2 540 000
Kenya	380 000	600 000
Mozambique	290 000	880 000
Tanzania	480 000	920 000
Uganda	590 000	680 000
South Africa	360 000	1 820 000
Zambia	430 000	530 000
Zimbabwe	420 000	660 000

**/ AIDS-orphans are children who have lost their mother or both parents to AIDS. Source: Hunter & Williamson (2000).*

Nine out of every ten AIDS-orphan live in Sub-Saharan Africa. The above table shows that the number of AIDS-orphans in many countries can be counted in hundreds of thousands, and that they will increase dramatically during the next ten years.

(b) Impact of HIV/AIDS on Education

In many countries, high prevalence is undermining education, as the disease takes a toll among teachers, and the number of students in school declines. The death of HIV-infected women in their childbearing years leads to fewer births and thus fewer children. And even healthy children may leave school temporarily or permanently to care for sick family members, work in the field, seek income-earning employment, or simply because their families can no longer afford the school fees. In KwaZuluNatal, South Africa, first grade enrollment declined by 12 percent between 1998 and 1999, largely due to the impact of HIV/AIDS. A 2000 study reported that in Malawi, teacher absenteesm was estimated at 20 percent due to HIV/AIDS. The same study found absenteesm among pupils who care for sick relatives to be 30 percent.

An article in the New York Times (Onishi 2000) gives a snapshot of the threat posed by AIDS to the already troubled education systems in Sub-Saharan Africa. The journalist visits a school in a Cote d'Ivoire village, which has been closed since 1997, when the last teacher died of AIDS. According to a 1998 government study, six teachers a week were dying of AIDS and 70percent of all teachers' deaths were AIDS-related. The children of Cote d'Ivoire are far from being the only ones to find their schools closed by AIDS. During 1999, an estimated 860 000 children in sub-Saharan Africa lost their teachers as a result of deaths due to AIDS (UNICEF 2000). The worst affected countries were South Africa, Kenya and Zimbabwe, where in each country more than 85,000 children lost their teachers. Additionally, in Zambia during the first 10months of 1998 (UNAIDS 2000a) 1,300 teachers died of AIDS.

Like any other sector, the educational sector has to carry all the costs of sickness benefits for teachers getting ill and subsequent deaths benefits for their families. The costs to train additional teachers to replace those who have died as a result of AIDS add to the problems, which have already over-streched education budgets in many African countries. In poor countries, the education sector was under-financed already before AIDS began to make an impact. With AIDS, public spending is shifted away from education to cope with other aspects of the AIDS crisis (UNICEF, 2000). Classrooms become increasingly overcrowded as teachers take on pupils who have lost their teachers as a result of AIDS. In many schools, the children are forced to attend in shifts, and other schools are simply closed, due to lack of replacements for dead teachers. Also, children drop out of school when their families can no longer afford the costs (UNICEF 2000).

(c) Financial and Other Losses for Family and Communities

The illness, progressive disability, and death of one or more family members from HIV and AIDS affect not just the individual but also the entire household in multiple ways. The most immediate impact is financial- loss of income and increased medical expenditures, particularly when the ill family member is the breadwinner. If other family members, usually daughters and wives, have to leave school or work to take care of the family member who is sick, household income and long- term prospects decline even more. Children, some very young, are forced to care for their parents, and in many cases, to act as head of households. Family savings are needed to cover medical and funeral expenses. There is little money for food or shelter and none for school fees and uniforms. Grain stocks are used up and livestock sold to cover expenses. This loss of income, savings and productive assets jeopardises the family's survival. The average cost of treatment, funeral and mourning expenses outweigh the average household income.

But the effect on the household is not just economic. When adults in the family die, the very structure of the household changes. Grandparents, uncles, aunts and even children take on new responsibilities. With fewer household resources and less available time, children receive less attention and less health care and become more vulnerable to malnutrition. When large numbers of families, experience such losses, the communities in which they live are affected as well. They may have large numbers of orphans significantly fewer productive adults.

(d) Macro-Economic Effect

HIV/AIDS puts considerable strains on the macro-economic performance of already troubled economies. The difficulties to mobilise the necessary resources to control the epidemic and mitigate its effects might lead the economy into a downward spiral of stagnation and crisis (Lawanson & Kerkhoven 1995; Brown 1996). In the hardest hit –areas, AIDS- related illness and death have had a significant effect on the business sector both by increasing expenditures and decreasing revenues. Firms experience increased expenditures for a number of reasons including higher health care costs, cost associated with recruiting and training replacement workers, and payment of burial fees for employees or the family members. Revenues are affected by time employees spent away from work either sick or attending funerals, time spent on training, the inexperience of replacement staff, time spent on training new staff and reduced productivity of staff who may be ill but are still trying to work. Some companies have estimated that AIDS-related costs could reduce productivity by 5 percent annually, and profit by 6 to 8 percent.

Countries with adult prevalence rates of less than five percent will experience only a modest impact on the GDP growth rate. However, as prevalence rises, UNAIDS estimates that a prevalence rate of twenty percent or more leads to a decline in the GDP growth rate with two percent a year, and in per capita income with one percent (UNAIDS 2000c). Compared to historical poor economic performance in sub-Saharan Africa, such losses are very economically significant.

(e) Increased Political Instability and Violence.

In many of the countries hardest hit by HIV/AIDS, worsening economic, social, and political trends contribute to instability across all sectors and increase the potential for violent conflict, ethnic unrest, and migration. Where the AIDS crisis is most severe, governing institutions and civil society are weakened, and key personnel such as civil service technicians, teachers, health workers, and military professionals are dying. The armed forces of some African countries have significant higher infection rates than general populations of same. This has clear national security and peacekeeping consequences.

A particular dangerous consequence of AIDS pandemic is the large cohort of youths left to struggle to survival without family support, education or employment opportunity. They often live on the streets join gangs, use drugs, or are forced to steal to eat and can become victims of sexual predators. Poor, uneducated, and with little hope for the future, these young people are vulnerable to recruitment by corrupt individuals, or criminal organisations and thus pose a threat to both domestic and international security.

(f) Impact of HIV/AIDS on Agriculture

In a continent where eighty percent of the population depends on small- scale, subsistence agriculture for their livelihood and food, the Food and Agriculture Organisation of the United Nations (FAO) estimates that some seven million African agricultural workers died from AIDS in the twenty five most affected countries between 1985 and 2000. Another sixteen million may die in the next 20 years unless an effective response is implemented. This loss of so many people is arresting and reversing development efforts in Africa.

In most African countries, agriculture is the largest sector, contributing to both food security and income. The loss of even a few workers can make a significant difference in the size of the harvest. In families that are dependent on subsistence level farming, surviving children and family members sometimes go hungry when the farm worker in the family dies. As the number of people available to plant and harvest food declines, the production of both food crops and cash crops declines as well. There are places in Malawi, Uganda, Zambia, and Zimbabwe where HIV/AIDS has taken such a toll of farmers and farm workers that we now see alarming rates of malnutrition, even near famine-like conditions where food supply should be abundant and the people healthy.

(g) **Impact of HIV/AIDS on the Health Sector**

A serious source of strain is the loss of trained health staff. Little attention has so far been given to this problem, which is likely to become increasingly serious in the nearest future. A study performed at a Zambian hospital showed that deaths among health workers had increased 13-folds from 1980 to 1990, mainly because of AIDS (UNAIDS 2000c). South African newspapers reported in September 2000 that one-fifth of all registered nurses in the country were HIV positive. At one nursing school, half of the first year students were infected (UPI 2000). Another newspaper report described the staffing situation in a ward for AIDS-sick women at a Malawi hospital (O'Kane 2000). During the past year the ward had lost two nurses, one laboratory technician, one electrician and two hospital attendants to AIDS. One of the nurse srespondents also told the reporter that of her graduate class of 20, three were dead and two ill with AIDS. When technical or experienced staff is lost to AIDS, the effective functioning of a ward, clinic or a department is negatively affected.

Yet in countries hardest hit by HIV/AIDS and AIDS related diseases such as tuberculosis, demand for service is overwhelming in health care systems. As a result few patients receive even the most rudimentary palliative care and most suffer and die in pain. In many hospitals, AIDS patients occupy more than half of the hospital beds. In some countries, AIDS is projected to take up more than half the health ministry's budget within the next couple of years. Because resources are limited, the hardest- hit

– and poorest countries are facing terrible trade offs between treating AIDS and preventing HIV transmission, between treating AIDS and other diseases, and between spending for health and for spending for other objectives.

Hospital bed occupancy by PLWHA is increasing and in some hospitals, they are the majority of admitted patients. In fact in several countries as much as 50 – 80 percent of hospital HIV-infected patients occupy beds in urban areas. As an effect other patients are crowded out. (UNAIDS 2000a). Kenya for example has seen increased mortality among HIV negative patients, due to admission at later stages of illness (UNAIDS 2000a).

In the most affected countries, it is virtually impossible to get a correct HIV diagnosis at district and primary health care centres. The large hospitals also have serious problems as evidenced in a UNAIDS (1997) Survey of 22 University Hospitals in 19 African and 2 Asian cities. The hospitals involved could correctly diagnose and treat only three conditions: pneumonia, pulmonary tuberculosis and oral thrush, which are the only three HIV-related conditions easy to diagnose and inexpensive to treat. For other HIV related illnesses, X-rays, laboratories and drug supplies were so inadequate, that a patient had less than 50percent chance of being correctly diagnosed and treated. Relief for difficulty in breathing was unavailable in half of the hospitals. Strong painkillers were only available for 40percent of the patients (UNAIDS 2000a).

2.4 Existing Health Services

2.4.1 Availability of and Access to Health Facilities.

The National Health Policy (NHP) of 1998 set the goal of achieving " a level of health that will enable all Nigerians to achieve socially and economically productive lives" and stated that " the National Health System shall be based on primary health care" (FMOH, 1998). To this end, it made provision for a health system with three tiers: primary, secondary and tertiary. At the base, the primary tier, consisting of health centres and clinics, as well as outreach services, focused on health promotion, preventive health services and basic curative services. The secondary level, which is mainly composed of general hospitals, provides curative services, while the tertiary tier provides more specialised curative, rehabilitative and reconstructive services. The National Health Policy envisaged that each state would have one tertiary facility, namely a specialist hospital. These institutions would serve the secondary tier, which in turn would provide referral and other back-up services for the primary level facilities closest to the grass roots. This would ensure that each state had a fully articulated health system, with the three tiers of services functionally interdependent.

Under the constitution, health is on the concurrent list of Federal, State and LGA responsibilities, and so all three tiers of government are involved in health service delivery. The tertiary facilities are mainly at federal and state levels, the secondary facilities at state level and primary facilities at LGA and community levels.

In addition to facilities owned and operated by the federal, state and local tiers of government, there are numerous private sector institutions, mission hospitals and facilities run by community-based organisations and other NGO's.

Overall, data from the National Health Management Information System (NHIS) indicate that in 1999, there were 18,258 registered PHC facilities across the country, 3,275 secondary facilities and 29 tertiary facilities. The public sector accounted for 67 percent of PHC facilities, 25 percent of secondary facilities and all but one of the tertiary facilities. Generally, in terms of health infrastructure, the country is reasonably covered. However, the fact that health facilities physically exist does not necessarily mean that they functionally exist. Many are poorly equipped, lacking essential supplies and qualified staff. In addition, distortions in the geographical distribution of health infrastructure still leave certain communities with difficult physical access to health facilities.

The 1999 NDHS reported that fifty three percent of the population lives in 1 Km of a health centre, clinic or hospital, and 73 percent within 5 Km. The fact that 47 percent of the population lives within 15Km of a town facilitates physical access. However, one third of rural communities are accessible by seasonal roads only (N Pop., 2000). In addition, logistical problems and the weaknesses of referral systems mean that timely access to secondary and tertiary health facilities is much more problematic, especially in the rural areas, than these figures would suggest. It is also important to note that 9 percent of households surveyed in the NDHS did not have access to any health facility (health centre, clinic or hospital); 34 percent had no access to a private doctor, and 24 percent had no access to a pharmacy. There were wide zonal variations, with the north and centre of the country worse served than the south as the figure below shows.

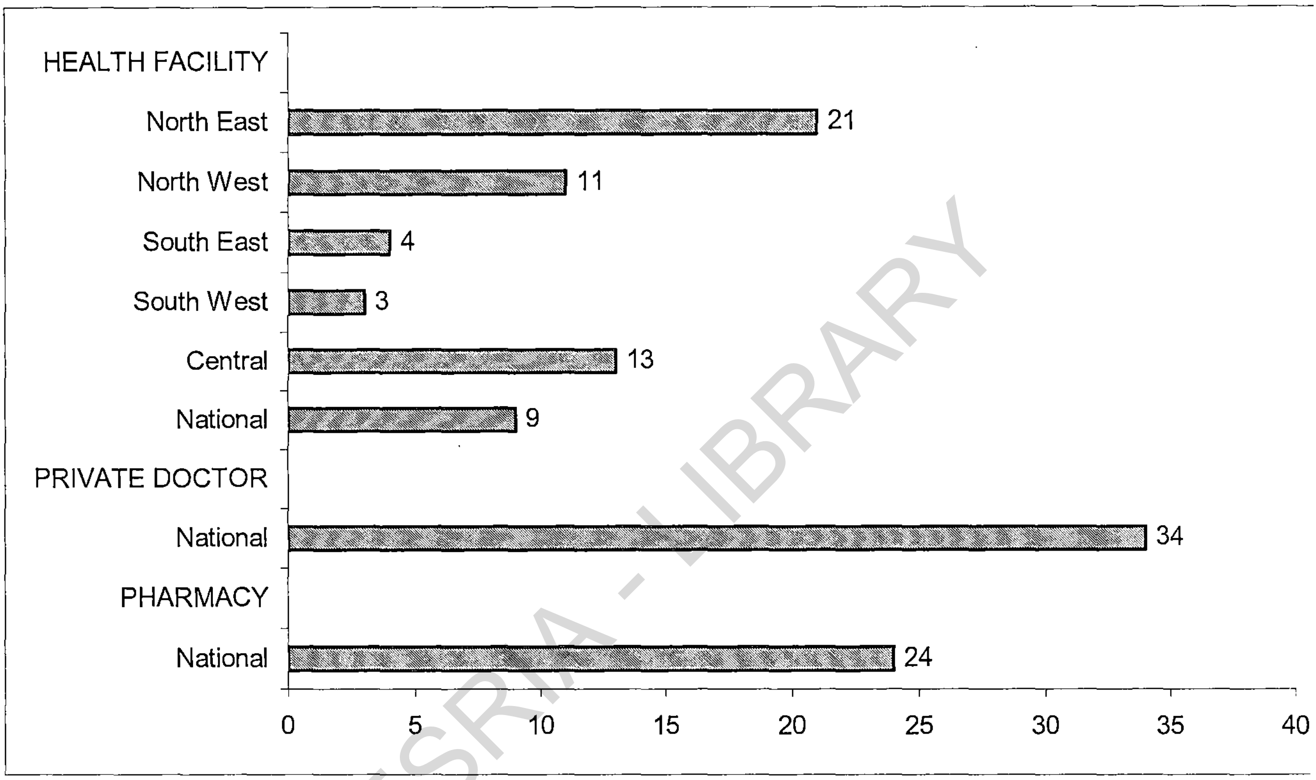


Figure 2.3 Percentage of population with no access to Health services, 1999.
Source: NDHS 1999 (N Pop. 2000).

Investments in health infrastructure have been distorted by too great an emphasis on tertiary facilities, where the federal and state governments have been duplicating each other. For example, six state governments have their own teaching hospitals, in addition to the 13 owned by the Federal Government, as well as the general hospitals maintained by the state governments. While this has resulted in the expansion of tertiary- level health infrastructure, it has adversely affected the quality of services, by spreading the limited resources including qualified personnel too thinly and straining health budgets, to the detriment of other tiers of the system. Paradoxically, while new hospitals have been built, the overall contraction in health expenditure and inadequate maintenance have resulted in the decay of the older health facilities.

2.4.2 Availability and Quality of Health

The existence of health care facilities does not automatically mean that they provide all or most of the health care services that they are supposed to provide, or operate at the desired level of quality.

Standards in health facilities vary significantly with higher standards of equipment, personnel and infrastructure in federal level hospitals and the private sector. However, the system as a whole has been plagued by problems of service quality, including unfriendly attitudes to clients, inadequate skills, decaying infrastructure and chronic shortages of essential drugs, the well-known out-of-stock syndrome". These problems have been documented in various studies. Thus, an evaluation report on the PHC systems/ Bamako Initiative Project in ten local government areas in Katsina, Kebbi and Oyo states, commissioned by the UK Department for International Development (DfID), reported that many PHC facilities were dilapidated, with little or no evidence of preventive maintenance or repair, and no provision for consultations in privacy. Most of the facilities visited by the evaluation team were not using prescribed diagnostic tools, sterilising their instruments or maintaining good standards of hygiene and cleanliness, and often they lacked sources of clean water (IDS. 1998).

Another study, in the Southwest found that many primary health care facilities are not providing the range of basic services expected of them. The figure below provides data from this study, which inquired about the services available in public sector health facilities at the local government in Ekiti, Ogun. Osun, and Oyo states. It is worthy of note that no service was reported to be available in more than fifty percent of the facilities surveyed.

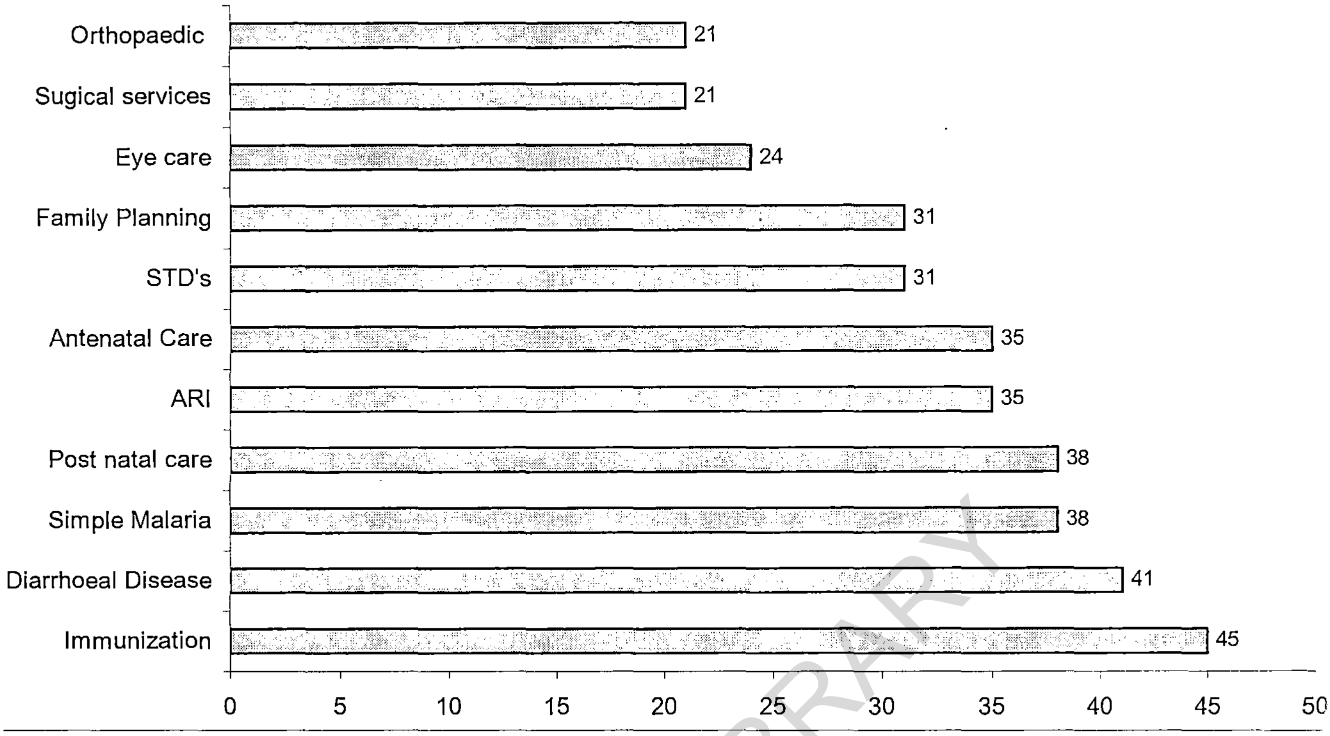


Figure 2. 4: Availability of services at PHC facilities in Southwest Nigeria, 1997/1998.
Source: CHESTRAD, G-1999

2.4.3 Anti-retroviral Therapy

About 1995, anti-retroviral drugs became available. They have made an enormous change for many people with HIV, notably in the richer countries. These drugs do not cure HIV/AIDS, but they attack the virus itself, thus hindering the breakdown of the immune system and delaying the onset of AIDS. Life is extended, but death still occurs prematurely thereby justifying the need for adequate social support. Besides, studies show that many persons with AIDS where anti-retroviral therapy is available do not get the treatment. For example, 60 percent of injecting drug users in Canada were not on treatment, a year after they had been diagnosed (USAIDS 2000a). In Sub-Saharan Africa, only a few people in a handful of countries have access to anti-retroviral. The costs are too high. It has been estimated that to provide the drugs to 25percent of people with HIV in Kenya would consume forty three percent of Kenya's GNP (USAID 2000)

Nigeria is Africa's most populous nation with 3.5 million people infected with HIV. In April 2001, Nigerian President Olusegun Obasanjo ordered the commencement of free antiretroviral administration as part of a comprehensive care programme for the public sector. Nigeria utilises both brand name and generic medicines for antiretroviral treatments. A tiny fraction of the millions of Africans in need of antiretroviral treatment are receiving it. Many millions are not receiving medicines to treat opportunistic infections, either. (UNAIDS, 2003).

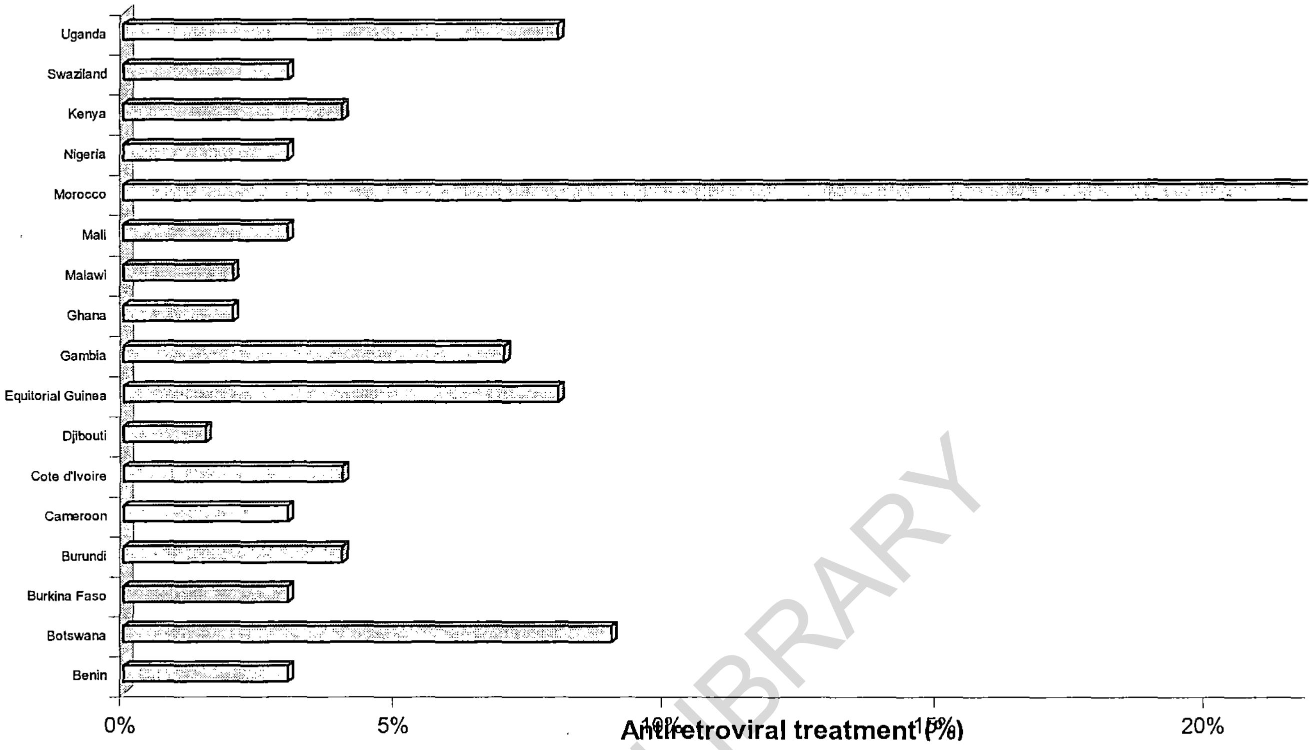


Figure 2.5: Antiretroviral treatment coverage in selected African countries.
Source: UNAIDS/UNGASS Surveys 2003.

Mauritius reported hundred percent coverage in 2003. The Seychelles reported 68.2% coverage in 2003. Angola, the Central African Republic, the Democratic Republic of Congo, Eritrea, Ethiopia, Lesotho, Mozambique, Namibia, Rwanda, Senegal, Sierra- Leone, South Africa, the United Republic of Tanzania, Zambia and Zimbabwe rate between zero percent and one percent coverage.

2.4.4 Home and Community-based Care

Although it is an individual who becomes ill there also exist the kin-group members who at times accompany such an individual to the health facility and are interested in the diagnosis and treatment plan. Patients rely much on the support of the kin-group members in interpreting their ill-health conditions. As a result, they may consult relations in the village, and in the wider group of kin and who live in the neighbouring settlements who play significant role relative to the sick person.

According to Mead (1966), what the kinsfolk do is to take notice of illness, take care of and comfort the sick person, and make him feel that he has their support in his predicament. While other members of the kin group may be called in to observe the symptoms and if these do not respond to home remedies that are advised, they decide to go to the hospital. The study among the Navaho Indians shows that there is close identification of kin group with the sick person from the onset of illness since the kin group takes decision about treatment and participate in it. Studies have shown that patients rely and depend on the group for support and help and at the same time the kin group share the feeling of the illness as a crisis for all of them. Hence, the members' obligation and preparedness to assist are the measures of their perception of danger to the whole group. The greater the degree of danger perceived the more they are ready to assist.

In the severely affected countries in sub-Saharan Africa, such as Nigeria, the public health sector has neither the coverage nor the capacity to provide even a minimum of care for those living with HIV and AIDS, who need it. Health services, NGOs and mission hospitals have therefore developed programmes to enable people with chronic illnesses to be cared for at home. Although these programmes can reduce costs and demand on in-patient facilities, saving money is not their main aim. Long-term hospital care is rarely needed for people with HIV, although it may be necessary for some special investigations and treatment or intensive nursing care.

Many people prefer to be cared for at home with adequate resources and support. Most HIV- related infections such as diarrhoea, coughs and fever could be treated at home with support aand advice from visiting health workers. People with incurable illnesses often choose to die at home where they can be with their family and spiritual or religious adviser. For many people, staying at home is the only option. Hospital care is not always available or accessible- families cannot afford transport or medical costs, or to stay with the sick person while they receive treatment.

Volunteers play a major role in reducing pressure on families in many home-care programmes. Increasingly, programmes are encouraging men to volunteer as well as women. In Uganda, for example, both men and women in existing community groups are providing practical support such as bringing food, doing laundry, or cultivating land. The involvement of local people can also stimulate the community to support families affected by HIV/AIDS, reduce stigma and promote changes in traditions and practices that increase risk. All too often volunteers from church or community groups are involved simply as an inexpensive way to increase service capacity. But they are essential partners in comprehensive care service and maintaining their active involvement and motivation is important.

Home-based care services in five districts in Malawi were evaluated in 2000. The report points at many of the weaknesses in home-based care. Women are much more likely to utilise home-based care services than men, who are more likely to be cared for by their wives. Overall the current system for providing care and support to persons living with AIDS is inadequate.

2.5 The Concept of Social Support

Support has received considerable attention in the social and behavioural sciences. A central emerging theme is that an individual's "human climate" plays a significant role in the maintenance of health and in responses to life stressor. A vital aspect of the human experience, one that is particularly important for achieving and sustaining a high level of functioning and life satisfaction is a person's connection with or link to others.

Since the early work by Bott (1955, 1956 and 1957) social networks as a mediating factor in human behaviour have been studied with respect to political elections, urban organisation, personal crises, help-seeking behaviour, hospital admissions, and avowed happiness. From these studies the belief that social support is a critical function of the social network has emerged. Kahn and Antonucci (1980) define social support as interpersonal transactions that include one or more of the following: affect, affirmation and aid. Affect is seen as expressions of liking, admiration, respect or love. Affirmation means expression of agreement or acknowledgment of the appropriateness or rightness of some act or statement of another person. Aid includes direct aid or assistance such as money, information, time and entitlements.

Social support is viewed in terms of existence or quality of social relationships in general, in terms of the structure of a person's social relationships and in terms of the functional content of relationships (House and Kahn 1985). The structure and functional characteristics of a social network influence the potential availability of support (Stylianos and Vachom, 1993). The individuals or groups that may provide social support range from informal sources, that is family and friends and persons connected with major life roles such as work, to professional and semi professional persons and groups who provide specific services including forms of support (Kahn 1979, Kahn and Antonucci 1980 and House 1981). Social support can be divided into perceived support and actual support (Levy and Derby 1992; Kannacki et al 1996). Perceived helpful social support was found to have a positive relationship with the grieving person's health (Gass, 1987; Stroebe, & Stroebe, 1993) and coping after the death (Hogan and Desantis, 1994; Robinson 1995 and Thuen 1995). It has been suggested that an impoverished social network is linked with the mortality of elderly bereaved males (Gallangher-Thompson Futterman, Faberow and Petterson, 1993) or with depression (Kanacki, 1996). It has also been suggested that social support perceived to be unhelpful hinders coping (Hogan and Desantis, 1994) and places widows at risk for mortality (Gass, 1987). There has been much research carried out into the relationship between social support and health, with the general agreement that individuals having high levels of social support are more likely to have better mental and physical adjustment (House, 1985).

Cohen and McKay (1984) concentrate on tangible or material support, appraisal support, self esteem support and belonging support and it is only those interpersonal relationships that provide the appropriate forms of support that will operate as effective buffers. Tangible support refers to the provision of material resources or instrumental help. Social support during the appraisal process is the exchange of information which either alters one's assessment of the symptoms or the ability to cope with the symptoms. The framework therefore requires a multi-dimensional measure of functional support. Functional measures assess whether one's interpersonal relationship serves particular functions? e.g. provide one with affection, feelings of belonging, or the opportunity for self-appraisal. As recent findings have suggested that perceived support rather than actual support received is a better predictor of adaptation to illness (Kessler and McLeod, 1985; Wethington & Kessler, 1986), a measure of perceived availability of functional resources would be most useful. Since the coping requirements of symptoms may vary over time, the optimal methodological strategy is to track both coping requirements and social support resource over the course of the illness.

Social support begins in utero; it is fostered through maternal and paternal attachment behaviour and develops through family, peer and community relationships as the person grows. A number of sociologic and family theories attest to increased stress and illness when the family structure is disrupted. Social support facilitates the coping behaviours of a person; however, this is dependent on the nature of the social support. People can have extensive relationships and interact frequently but the necessary support comes only when there is a deep level of involvement and concern, not when people merely touch the surface of each other's lives. The critical qualities within the network are the exchange of intimate communications and the presence of solidarity and trust.

2.6 Knowledge of and Attitude to HIV/AIDS

Inadequate knowledge and attitude has been considered as one of the serious problems confronting health workers worldwide on the management of HIV/AIDS clients. Inadequate training on the field of research on HIV/AIDS has been identified as the key limitating factor by various researchers. For instance, Haughey, Schever and Wu (1989), identified knowledge deficit in relation to treatment and care of PLWHA. Again, Melby (1995) also identified that inadequate knowledge contributed to negative attitudes of health workers to HIV/AIDS care. And, according to Elliot (1987), caring for a patient with AIDS or HIV related illness is not different from nursing any other ill patient; it is the need of individual patients that varies.

Swanson et al. (1990) carried out a study on knowledge, attitude and practices related to HIV infection and care of people with AIDS. The researcher found out that knowledge about AIDS was not always translated into HIV/AIDS prevention, because negative attitudes towards HIV transmission and people with AIDS still persist. From these studies, it would appear that while health workers are likely to have more knowledge about AIDS than the person on the street, they still require regular training on the field.

In the study on nurses, knowledge about AIDS by Haughey, Schever and Wu (1989), five hundred and eighty one nurses were studied and they discovered that the greatest knowledge deficit observed was in relation to treatment and care of PLWHA. Hence, increasing nurses' knowledge base is a vital step in maximising quality nursing care for patient with AIDS. In line with this suggestion on increasing nurses knowledge base, Bard and Beadslee (1990) carried out a study on developing an in-service programme on AIDS. The study showed that the more knowledgeable registered nurses were, the more positive were their beliefs about caring for people with AIDS. However, Paris (1992) reported that after the first AIDS patients were diagnosed in 1983 in Trinidad and Tobago, every health worker attended a large group lecture on HIV/AIDS which lasted for one or two days. Even though the information acquired helped them greatly in infection control, the lectures did not prepare them adequately for caring for PLWHA. They did not want to treat them and would not make home visits.

According to Borman, Brent and Mood (1995), “No matter what the illness, there is only one way to learn and that is by doing” For them, nursing students felt more comfortable talking about death with PLWHA than touching them to provide physical care. Also practising nurses reportedly have avoided and neglected patients because of fear of contagion. They concluded by saying that if such avoidance were viewed in line with the increasing number of PLWHA a major health care crisis would result.

In a similar study, Eakes and Lewis (1991) reported of ambivalent responses to providing care by student nurses studied. While these students saw it a legal duty to care for PLWHA, they also opined that nurses should have a choice either to nurse or not to nurse them. In another study, Steele and Melby (1995) compared knowledge and beliefs about AIDS among health workers in hospital, community and hospital settings. According to their findings, health workers in hospital settings appear more knowledgeable and exhibit a more positive approach to PLWHA and appear less fearful than those in the other settings. Those who work in the hospital and community settings, hold negative and biased beliefs and have inadequate knowledge and misguided perceptions regarding their risk of contracting HIV through implementation of routine care. On the whole, knowledge was positively correlated to approach to AIDS clients.

Hewitt (1993) had said several years after AIDS diagnosis that health care workers still remain fearful of contracting AIDS from clients. Time and experience has done little to change their attitude. These reactions, according to him, ranged from refusal to go into an AIDS patient's room, to naïve fearfulness of the disease. This generates anxiety so intense that the emergence of compassion and empathy is prevented.

2.7 Summary of Literature Review

Current literature on the state of affairs on HIV/AIDS were reviewed generally and care and support specifically. In all, HIV/AIDS is a major public health problem in the world. There is a gap in knowledge concerning part played by the family institution as well as factors responsible for this gap. Hence, the study is poised to fill this gap. Much was not documented on care and support for PLWHA in literature, since this has not been given adequate attention. The concept of care and support as well as sociocultural factors relating to the problem of the study was critically examined.

Existing literature revealed that causes and prevalence of HIV/AIDS have been brought to public awareness. However, despite this information, one begins to wonder why PLWHA are still suffering in their excruciating experiences? Upon all arrays of literature available, yet the problem of attitude, behaviour and health is yet to be ascertained (Olaleye, 2003). This study, therefore, establishes the relevance of traditional social institution such as the family in care and support for PLWHA. This is with the purpose of placing the role of the family in the proper perspective of care and support for PLWHA.

2.8 Theoretical Framework

Weberian Action theory and Health Belief model provide theoretical basis for this study. Weberian action theory tries to analyse the action of individuals in typical situations. Weber believed that the analysis of the society by sociologists should not be abstractive but should reflect the action of social individuals. Action is seen as a unit act and for an action to take place there must be an actor (Parson, 1974).

Action theory defines action as social when it involves more than one individual and that action has subjective meaning to the actor. Weber argued that all human actions are directed by meanings. Hence, to understand human action, the meaning and motive behind such action must be understood and appreciated. Weber further classified action based on the meaning behind them as rational and non-rational action. Rational action involves clear awareness of goals, systematic assessment of the various means of attaining the goals and the selection of the most appropriate means of attaining it. Non-rational action refers to affective and traditional action. Affection is based on the actor's emotion at a particular time while traditional action is based on custom.

The main actors are PLWHA. Sexual behaviour can be in form of a rational or non-rational action. Heterogeneous sexual relation, which is the major mode of transmission of HIV/AIDS in Nigeria, can be a non-rational action prior to being infected. However, in many cases after exposure, sexual practices are in form of rational action whereby an individual evaluates the information available to him or her. The social actor takes a subjective meaning of the situation around him or her, evaluates it and acts upon it. His or her evaluation will depend on various factors like the knowledge of the situation, the actor's situation, affective disposition, norms and values. For example, perception of own risks status, risk status of partner, knowledge about HIV/AIDS and socio-demographic variables such as level of education and economic status could serve as a determinant of action.

The type of information received by a PLWHA, for example, about transmission of HIV/AIDS will influence his or her attitude and practices. For PLWHA, information about HIV/AIDS can come from parents, peers or mates, religious leaders, media, health workers, etc. These factors will influence the PLWHA's cognition, for example, the link between sex and HIV/AIDS. Relationship between these various factors can be explained using health belief model.

2.8.1 Health Belief Model (HBM)

Rosenstock (1974) and Becker and Maiman (1975), Health Belief Model (HBM), address the relationship between a person's belief and health behaviours. It assumes that belief and attitudes of people are important determinants of their health related actions. It provides a way of understanding and predicting how clients will behave in relation to their health and how they will comply with health care therapies. The HBM has various types but the more popular version used by various scholars is that of Kasl and Cobb (1976) which identified two major variables which influence behaviour in health.

(1) Perceived amount of threat. This has three sub-variables:

(a) importance of health matters to the individual
(b) the perceived susceptibility to the disease
(c) the perceived seriousness of the consequences of the disease

(2) The attractiveness or value of the behaviour, which depends on the following:

(a) the perceived probability that the action will lead to the desired preventive result. For example, screening for HIV infection. Does it prevent the disease? Or what next after the screening?

(b) the unpleasantness or cost of taking the action compared with taking no action and suffering the consequence.

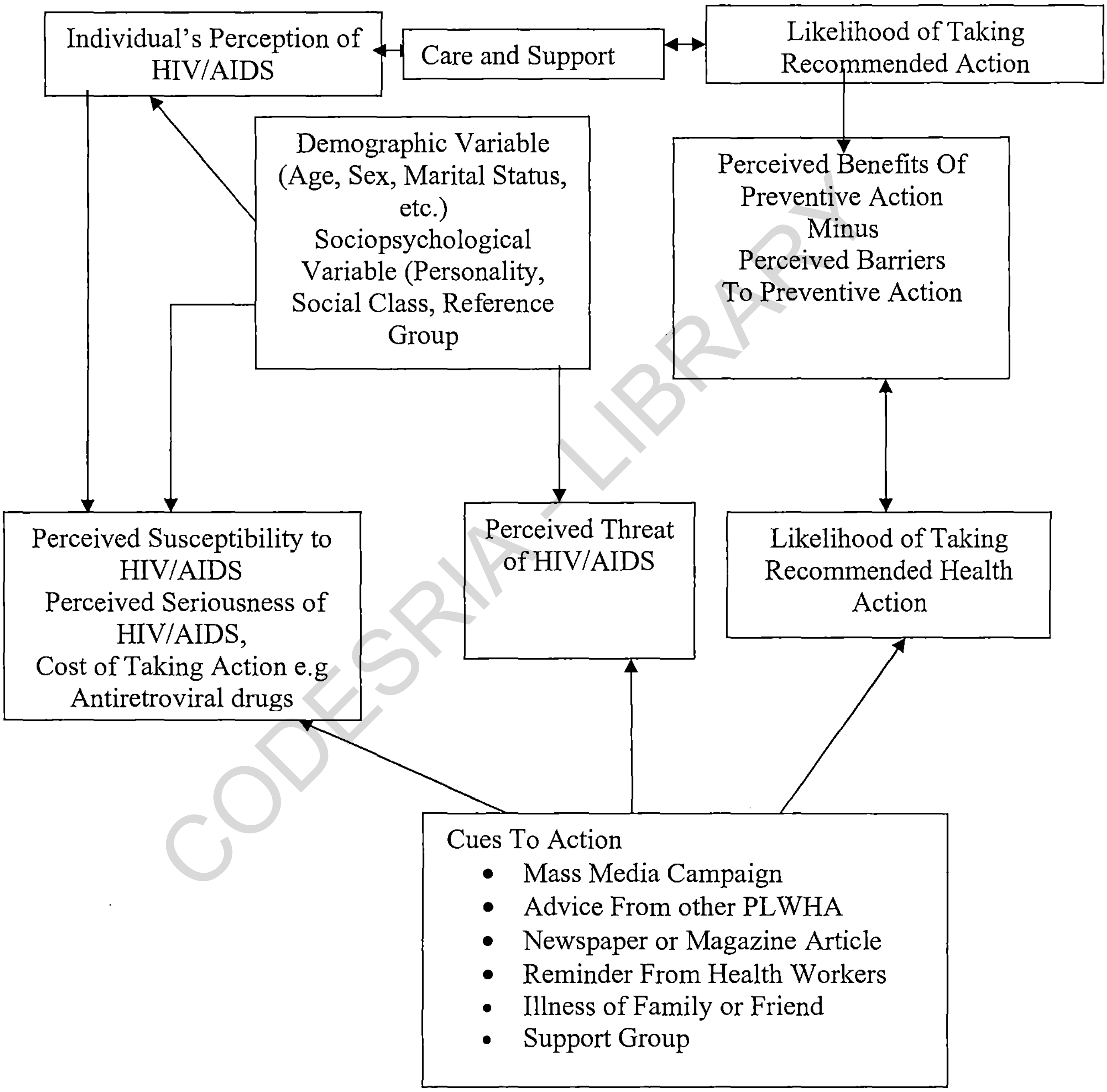
The first component in this model involves individual's perception of his or her HIV status. For example, PLWHA need to recognize the familiar link between blood contact and HIV/AIDS. After this link is recognized, further risk may then be perceived of self or of others. The second component is the individual's perception of the seriousness of HIV/AIDS. Do PLWHA perceive it as ''one of those things, since a person will die of something anyway." This perception is influenced and modified by demographic and socio-psychological variables, perceived threats of the illness, and cues to action (for example, mass media campaigns, action from family, friends, other PLWHA, health care providers, etc.).

The third component, the likelihood that a person will take preventive action is the person's perception of the benefits of taking action. Preventive action may include increased adherence to medical therapies or a search for medical advice or treatment.

In case of HIV/AIDS, a person who is counselled to go for HIV screening may be interested in finding out what next after the screening. Is there a cure? If not, of what benefit then is the screening?

In other words, it is the above factors that propel an individual to act in a given way towards a health problem. In this study, HIV/AIDS care and support that is generally conceived, as cultural health behaviour is valued based on the belief pattern of the individual. Demographic and socio-economic characteristics of PLWHA are found to be important in understanding their utilization of care and support systems. This is because these factors condition the individual's power of 'belief', the vulnerability of self and the significant others to the risk or reward of non-compliance or compliance to a given health prescription.

In conclusion, in a nation like Nigeria with pluralistic health care delivery systems, the PLWHA have several options or pathways to utilisation of available care and support. This could be at home, hospital, traditional or faith healing centres and so on. However, utilisation of care and support services in HIV/AIDS has much to do with the conceptualisation of the disease – AIDS. The concept of the disease is determined by culture and incorporates belief systems, which in turn underlie the perception and interpretation of AIDS disease. Bearing this in mind, the behaviour patterns of PLWHA are then best illustrated by the prevalent concept of the disease in the study areas and the pathways they are likely to employ. Socio-cultural factors in the selected communities for example, determine the way in which HIV and AIDS are perceived and acted upon.



Source: Variable For Health Seeking Behavour Adapted From Becker & maiman (1975)

2.1.0 Conceptual Framework (Fig.2.6)

Using this framework, therefore, is based on the individual perception of HIV/AIDS either as being susceptible, or in terms of the seriousness of the disease and the cost (social, psychological, and economical) of taking the preventive action if not infected and therapeutic regimen e.g. antiretroviral drugs if diagnosis is confirmed. This is modified by intervening variables such as whether the person is a child or an adult, a male or a female, single or married, the personality of the infected person, whether introvert who will shrink into his own world and the new world of HIV/AIDS or an extrovert who will share the burden with others. Another intervening variable is socio-economic class; is he aware and knowledgeable about HIV/AIDS, his level of education, income and so on will determine his access to useful information about the disease, available support systems and facilities for care as well as referral services. This will go a long way to mediate on the perceived threat of the disease and will also determine his cue to action. The likelihood of taking recommended preventive health action, either not to be infected or minimise impact and further spread. Seeking or not seeking care and support facilities (which is the likelihood of outcome) is a social action from social individuals which, according to Weber, has subjective meaning to the actor, depending on the intervening variables directing or influencing the meaning. According to him, the meaning and motive behind such action on the part of both PLWHA and their care providers must be understood and appreciated.

Also, the function of the "belief" of the social actor is explained in the HBM.There is a number of factors influencing this function in the context of care and support of PLWHA. For example, among the Yoruba, magico-religious explanation of diseases still holds. And to this extent, diseases including HIV/AIDS are believed to be caused by evil spirits or as a result of supernatural causes, or a punishment from gods. Hence, claim is still held to supernatural healing. This has great implication for care and support of PLWHA.

2.9 Assumptions

1. PLWHA with low level of education are not likely to use modern health care services
2. Female PLWHA are likely to seek care more than men
3. Educational background is a determinant of utilisation of patterns of care and support services.
4. People who disclose their HIV status are likely to receive adequate care and support than those who do not.
5. Belief system influences care and support.

2:10 Operational Definition of Terms

People Living With HIV/AIDS (PLWHA): A group of people or someone who has been infected with the Human Immune Deficiency Virus, or which, has now progressed to the full-blown disease state of AIDS.

People Affected By AIDS (PABA): Family members, friends and those who have any significant relationship with PLWHA.

Care: This means actions and activities directed towards assisting, supporting, or enabling PLWHA to cope with the disease.

Support: This denotes the availability and usefulness of significant others (close ties, friends, spouses or confidants, nearness of relatives or health care providers). It includes: social, spiritual, emotional, economic, psychological or material support).

Care and Support: Is the meeting of the overall needs of PLWHA, which include: health needs, emotional and spiritual needs, nutritional needs, social needs, financial and other day-to-day needs.

Educational background: refers to the description of the nature of the level of academic attainment of PLWHA. It is considerd high if secondary school education and post secondary school is embarked upon, whereas it is low if there is no formal education or if only primary school is attended.

Care Provider: A person who is involved with care and support of PLWHA either at home, hospital, or a non-governmental organisation Southwest Nigeria: This refers to the homeland of the Yoruba speaking people of Ibadan and Ilesain this study.

Social Institution: This refers to any given and important organisation that has a particular purpose such as the family in this study.

CHAPTER THREE

3.0 RESEARCH METHODOLOGY

3.1 Introduction

A scientific methodology is a system of explicit rules and procedures upon which research is based and against which claims for knowledge are evaluated (Frankfort-Nachmias and Nachmias, 1996:13). This chapter, therefore, provides an explanation of the underlying principles and rules such as the study area and population, sample size and sampling technique, instruments, methods of data collection and analytical procedure.

Research design

This is an explorative research design in which triangulation approach would be adopted for the collection of data.

3.3 Study Area

The study site is situated in the tropical region of the South-western Nigeria, which is part of Yoruba population estimated to be forty six million (NPC, 2001). The Yoruba culture is one of the cultures, which emphasize social affinity among its members. The social affinity is expressed through family and kinship, lineage and clan and at various associational levels. This social affinity is extended beyond economy and politics most especially on the biologically distressed members. Special attention is provided from the network of family, kinship and other associations (Fadipe, 1970).

The Yoruba people inhabit Oyo, Osun, Ondo, Ogun, Lagos and parts of Kwara, Kogi and Edo state of Nigeria. They are also found in some parts of the Republic of Benin and Togo. They organised themselves into many kingdoms in the past, the most prominent among which were Oyo (which grew into an empire comprising a number of Yoruba speaking and non- Yoruba speaking tributaries) The Yoruba are generally united in their tradition of common origin and in their culture.

3.3.1 Political organisation

The political organisation of the Yoruba is town-based with the leader of the founding lineage usually assuming the political and the spiritual headship of the settlement. And at the head of each of almost all of Yoruba towns was an Oba (King), a crowned ruler or baale, an uncrowned ruler. Each town was divided into (wards) adugbo and each ward was further subdivided into Agbo Ile (compound), each under the headship of its most elderly man.

The Yoruba were an intensely religious people. Religion featured in almost all the spheres of their activities. They consulted Ifa oracle and propitiated appropriate gods or goddesses. Like other people in Africa and elsewhere, they believed that the gods and goddesses, and even, the departed ancestors were capable of warding off natural disasters, repelling the forces of evil and ensuring the general well-being of the society. It is equally believed that their neglect and even failure to propitiate them adequately might incur their wrath and their world bring disasters like epidemicson the people.

Southwest Nigeria is the homeland of the Yoruba speaking people of Nigeria, and they are by far the most urbanised group of indigenous people in Africa South of the Sahara. Accordingly, the largest concentration of urban centres in Africa is in Yoruba land where not fewer than seventy-seven towns had a population of not less than 200,000 during the 1963 census. In addition, most of the largest urban centres in Nigeria are concentrated in the Yoruba urban zone.

The typical Yoruba traditional attire of flowing garment, *agbada* with an underwear, *dansiki* or *buba* worn over a pair of trousers, *sokoto* with cap *fila* to match represents their traditional wear. Common among the elders is the use of a walking stick called *opa*. The chiefs wear necklaces made of beads *akun* regalia of office. Women, on the other hand dress in wrapper called *iro* with headgear *gele* to match with a broad cloth usually placed around the shoulder or tied around the waist. This is referred to as iborun. Although many young people tend to wear different types of dresses, traditional dresses still remain the most valuable in the society especially for important occasions such as wedding, funeral, naming, birthday and house warming ceremonies.

3.3.2 Geographical position

Yoruba land lies between the parallels 5.86^0 and 9.22^0 north and between 2.65^0 and 5.72^0 east. Its southern boundary is the Bight of Benin, and extends from the eastern limit of (former) French Dahomey on the west to the western border of the kingdom of Benin on the east. To the east, it is bounded by the territory of the same kingdom, and by the Niger up to Etobe, at about 7.3^oN. From this point, the boundary is in a northwest direction, along a straight line drawn rather arbitrarily to meet the $9^0$of latitude until it merges with the political boundary between the northern province and the southern province of Nigeria, which ends at the river Okpara on the French frontier.

3.3.3 Physical features.

The extreme south of Yoruba land is a network of island divided from the mainland by a system of creeks and lagoons; and this whole complex of islands, sandbanks, creeks and lagoons is a part of a wider system which stretches from Keta on the eastern border of Gold Coast Colony (New Ghana) across the seaboards Togoland, Dahomey and Yoruba land until south of Benin city. It merges with the Niger Delta. This great stretch of water, which is the distinguishing feature of the whole system is over the greater part of its extent extraordnarily shallow. Like those of Ghana, most of the rivers of Yoruba land almost dry up during the dry season and, consequently, have little or no chance of carrying their load beyond seashore during that period.

3.3.4 Climatic Features

As Yoruba land is situated between 6^0 and 10^0 north of the equator, one of its geographical features is the almost equal division of the day into periods of sunlight and darkness, and the consequent almost abrupt nature of the transitional change. At five o'clock, the first faint streaks of dawn are only just appearing, but by 6.30am, it is fully light, and the glowing orbit of the sun is visible on the horizon. Between this hour and 10.30 am, anybody who wishes to avoid the inconvenience of the tropical sunshine must transact any business that takes him into the open air for an appreciable length of time. Between 10.30 a.m and 3.30 p.m, people who can afford to do so keep in the shade, if possible. Between 3.30p.m and 6.30 p.m, twilight is rapidly succeeded by darkness. The greatest heat of the day is concentrated between 10.30 a.m and 3.30 p.m. Thereafter, it gradually begins to cool down until during the night and the early hours of the morning and the temperature then drops to its lowest point .The mean annual range of temperature is lowest at the coast.

With regard to rainfall, Yoruba land except immediately near the coast may be said to have barely enough rainfall. While often the coastal area has more rain than it needs, it is not always so in the hinterland. The pattern of rainfall is therefore such that there is a gradual drop as one goes from the south to the north. Thundering storms and tornadoes, those preceding the rainy season being often extremely violent, usher both the dry and the rainy seasons in. Huge trees are uprooted and it is not unusual occurrence for entire corrugated iron roofs of houses, covering an area of over two-hundred square yards, to be lifted bodily, complete with joints and roof struts, and deposited at great distances away. The rainy season itself can be sub-divided into 'heavy and light' rains, the heavy rains occurring during the months of April, May, June and July, and the light rains during August, September, and October.

3.3.5 Lineage and Other Socio-economic Ties

A Yoruba town was an aggregate of lineage, some of which must have accompanied the founder while others would have settled after the town had been founded. Each lineage constituted a social unit and its members claimed descent from a single ancestor.

They lived in a compound built in a rectangular form with an open enclosure in the middle. The head of the compound, that is the *baale*, was usually the eldest man.

Apart from settling disputes, the other duties of a *baale* were to propitiate the departed ancestors as well as ensure the general well-being of the members of his lineage. When a compound became overpopulated either as a result of births or additions of people from other communities, a new compound might be built to accommodate the excess population. Consequently, a large lineage might live in more than one compound.

It was within the compounds that individuals developed their personalities and received their early childhood education. It was there they learnt to respect elders and behave with decorum in the society, for the Yoruba highly valued deference to age and respect for authority. The children respected and obeyed their parents and all the elderly men and women in the compound who, in turn, paid similar deference to their immediate seniors. The compound or the lineage head was the most respected.

Whether the members of a lineage lived in a compound or many compounds, they still maintained close ties and assisted one another whenever the need arose. They came together on important festive occasions, such as the annual propitiation of their departed ancestors. They supported one another materially and psychologically during marriage, chieftaincy, birth and even funeral ceremonies. The lineage was the core of the extended family system in Yoruba land. Though its members might come from different parents, they did not forget that they were chips of the same block. This ancestral link constituted them into one *ebi* (family) (Lloyd, 1955).

Apart from the lineage, the Yoruba maintained strong ties with their age grade associations. (Fadipe, 1970). Age- grade associations can be explained as associations of people of relatively the same age. Members of these associations provide assistance for one another in various spheres of human endeavours such as marriage, religious festivals, and burial ceremony. In some parts of Yoruba land, such as Ekiti, Ondo, Ijesa, and Ijebu, age- grade associations were so elaborately developed that they performed both social and political functions in the society.

Beside the age-grade, there were certain socio-economic associations or societies whose members maintained close ties and rendered useful services to one another. Prominent among these were the *Aaro* and *Esusu* mutual help societies. Others were the professional guilds. The Aaro and Esusu probably originated from the desire by the Yoruba to derive succour from outside one's lineage or to supplement and augment the assistance provided by one's extended family and age-grade. The members of the *Aaro* provided labour for themselves in a rotational form. While the *Aaro* was organized for providing free rotational labour service among its members, the esusu was an association organized for the economic benefits of its members. Esusu members contributed certain fixed sums of money to their president periodically. The total contribution collected each period was given to a member. This was done in rotation till all the members of the association had their turns in the collection. In another form, members might contribute various sums of money, each according to his or her means, to their president for a given period, usually a year. At the end of the year, each member collected the total of his or her contribution. This is one of the means by which the Yoruba saved money for diverse purposes, such as building, marriage, burial ceremonies and settling debts.

3.3.6 Art, Culture and Religion

Archaeological findings have corroborated oral evidence that Ile- Ife was the fountain- head of Yoruba culture and religion (Wilet, 1967). Like other peoples in Africa and elsewhere, they believed that the gods and goddesses and even, departed ancestors were capable of warding off natural disasters, repelling the forces of evil, providing children and ensuring the general well-being of the society. It is equally believed that their neglect and even failure to propitiate them adequately might incur their wrath and they would bring disasters. Thus, such disasters and untoward occurrences, like epidemics such as HIV/AIDS, childlessness, sudden death, draught, earthquakes, etc. were often ascribed to the wrath of the gods. Consequently, the fear of death, diseases, natural disasters and the need to ensure the general welfare of the members of their communities make religious observances compelling to the Yoruba. Each of the gods and goddesses they worship had its priests and devotees.

3.3.7 Social Psychology of the Yoruba

The Yoruba are gregarious and sociable. Life under the conditions which exist in compounds would have been intolerable if ways and means had not been devised for living together in harmony in such comparatively confined places where large numers of men and women are normally together. There is an elaborate code of manners and etiquette, the observance of which serves to reduce the strain and frustrations of interpersonal relationships. For example, a Yoruba has a salutation for every conceivable occasion and situation in which he may find a fellowman any time of the day while sitting or standing, when overtaking another person on the road and when at work or at play, when carrying a load, in cold or warm weather and so on. He extends these modes of salutation to friends, acquaintances and strangers. Part of the code of courtesy is of course, the duty to be deferential to seniors. The male must prostrate before his senior while the female must kneel down, and sometimes, touch the ground with her elbow as well. The process of salutation is a long one on the first meeting day in the course of a day for two people who do not belong to the same compound since general and specific enquiries must be made about the well-being of close relatives.

An extension of the greeting code is the obligation to offer condolences to anyone who is bereaved, ill, injured and so on. Failure to offer such greetings usually gives rise to bad feelings especially among close friends and relatives. In some cases it may lead to suspicion of sorcery or witchcraft, the idea being that only the latter could be so hard-hearted and unfeeling as not to offer appropriate greetings. Habitual offenders are particularly vulnerable to this kind of suspicion. It may readily be imagined that this code is apt to prove burdensome in some respects to the generation who have imbibed western education. Indeed, educated Christians and, in many cases Muslims, have produced modifications according to their conception of modern requirements in big towns. Thus, prostration is dispensed with in favour of doffing the hat, and there is less time wasted on salutation as a whole. Politeness demands that the second person plural of personal pronoun to be used in addressing elderly people and people in authority. It is also in a bad taste to offer something to another person with the left hand.

Hospitality is part of the code of good behaviour. The fear of the evil one has nothing to do with it. It is the rule for a person who is having his meal to invite any person who comes in without notice to the table, even when it is not convenient to prepare additional food. Unless the visitor has just finished eating, he will accept that invitation after being offered two, three or more times. A guest from afar, however unexpected on arrival, receives hospitality from the host for as long as he cares to stay. His own sense of propriety alone will warn him against unnecessarily prolonging his stay. It is extremely bad to give the impression that one's hospitality is extended to him at some inconveniences. On the other hand, the guest goes on expressing his concern and gratitude for the expense his host has been incurring on his behalf. Yoruba hospitality is far more spontaneous than what the white man is ready to offer to his quest.

It is usual to give presents to the relatives of a dead person as a contribution towards the performance of funeral rites. A man might be called upon to give such presents on three or four occasions in the course of a year. It might be argued that this is a form of self-insurance and that over a period of time, a man will gain back what he has given away. This may be true on an actual calculation. But the actual view of the custom does not fit into the pattern of traditional obligation. A man also gives presents to a young woman and her parents when he feels it is his duty to bring back on his return from a trip good for relative and friends. Similarly, when a person is setting out on a journey, he will be given presents from all sides for his distribution to those he is visiting.

3.3.8 Change and Adaptation

Over the years, the Yoruba socio-political system, as well as other aspects of their culture, has been subjected to a continuous process of change and adjustment in response to internal and external stimuli. This process has been facilitated by the ability of the Yoruba to adapt to changing conditions. For instance, when government could no longer be confined to towns alone as a result of internal factors, such as the growth of satellite to villages from the metropolitan town or the subordination of many towns and villages to the authority of a powerful ruler, the Yoruba were able to evolve various forms of administrative system to cope with the complex changing situation.

Furthermore, Yoruba towns became more cosmopolitan in their ethnic composition. The consequence of this ethnic composition was that the Yoruba became more culturally diffused than hitherto and emphasis on lineage ties began to wane gradually. A number of external factors also contributed to social changes in Yoruba land. The first was the introduction of foreign religions: Islam and Christianity. These two religions introduced new faith entirely different from those of the African traditional religions. Muslims and Christians became distinct classes of people distinguishable from the traditional Yoruba, not only in their faith, but also in their style of dressing and their ways of life. The resultant cultural change is manifested in other spheres of Yoruba life. One of these was marriage. As Islam and Christianity began to have grips on people in many Yoruba towns, new social ties began to emerge.

Ibadan is located near the forest grassland boundary of South Western Nigeria. Indeed, according to oral tradition, the word, 'Ibadan' is derived from Eba Odan, which literally means 'near the grassland, this means that the city is located in a forest country but close to a grassland environment (Mabogunje, 1968). Ibadan is located approximately on longitude $3^{o}\ 5^{1}$ East of the Greenwich Meridian and latitude $7^{o}\ 23^{1}$ North of the equator at a distance some one hundred and forty five to one hundred and fifty kilometres North east of Lagos State. It is structurally described as the area extending for about fifty-five kilometres from Asejire in the East to Agemo in the West and for about seventy kilometers from Iroko in the North to Mamu in the South, which now extends to Omotunde.

The study was also conducted in Ijesa land of Osun state, southwestern Nigeria. Osun state was excised from the old Oyo state in 1991, which was also the break-up of the old western region .The western region, before the break-up was composed of Oyo, Egba, Ijebu, Ondo, Ilaje, Ikale, Ekiti, Igbomina and Ife – Ijesa people. There is little or no cultural variation among these people. One noticeable variation is their dialect, which features different notations, but similar meanings. Osun state occupies the western region of Nigeria. That provides opportunity for the growth of arable crops and cash crop. They convert arable crops such as yam, maize, cassava, plantain, cocoyam, beans, etc. to various staple foods such as pounded yam iyan (pap) eko, (yam) or (cassava flour) elubo for amala and beans for moin moin or (bean- cake) akara. The environment provides opportunity for the growth of vegetables such as *okro*, *ila* pepper, tomatoes, *ewedu* and many species of leafy vegetables. Out of all these staple foods, *iyan, eba, amala, fufu, eko,* (both in solid and liquid forms) are the common foods especially in the traditional family setting. These common foods are taken with desired soup. Sometimes, among the farmers, their protein is derived from the "bush meat" or wild animals, which are occasionally trapped or hunted for. To meet the regular supply of bush meat, the Yoruba usually engage in group hunting.

Their ways of life in terms of what they use and their behaviours have significant influence on their health. For example, accessibility to food in terms of requirements for labour in the farm influences family sizes and encourages polygyny. Their mode of dressing protected them against excessive cold environment while the abundant fauna and flora in their location provides sufficient herbs for therapy, which was also exploited in HIV/AIDS care and treatment of opportunistic infections. Also, the farmers exchange their game for their needs in what is similar to trade by barter.

The structural arrangement of society could inform the kind of policy and society arrangement in terms of who should have or should not have access to care. Also, it determines what care means to different classes of people and to what extent is the care available. It is also related to level of relationship, is it by blood or by marriage? For example, if one is related by blood he could receive better care than somebody who is not related by blood.

Following the creation of Osun state in 1991, the state is composed of four main Yoruba dialectical groups. They are the Igbominas who spread across the northern part of the state, while the Ifes and Ijesas occupy the southeastern portion of the state. The fourth group is the Oyo-Yoruba found within the central and western part of the state. Osun state is bounded in the North by Kwara state, while the western border is occupied by Oyo state. In the southern border, there is Ogun state with Ondo and Ekiti state inhabiting the Eastern border of the state.

The 1991 census figure put the population of the state at 2,158,143. The state has thirty local government areas out of which the Ijesas are found in eight of them. Out of these eight LGAs, two were purposively selected for the study. This is due to the fact that they are contiguous and they harbour the *hot spot* according to FMOH (1999). The two Local Government Areas are: Ilesa-East and Ilesa-West.

A selection of these two Yoruba communities, namely Ibadan and Ilesa was purposive because the study identified some organisations where PLWHA are being cared for. In Ilesa, the study took place at State Hospital and Living Hope Care (A

Non Governmental Organization-NGO). In Ibadan, the following NGOs were also selected: NELA (Network on Ethics, Human Rights, Law and HIV/AIDS - Prevention, Care and Support), PLAN (Positive Living Association of Nigeria) and FAHPAC (Family and Health Population Action Committee).

In Ibadan, the setting was not well defined as clients came from different local government areas such as Ibadan north, Egbeda, and Lagelu. However, in Ilesa the table below provides the list of areas covered.

List of areas covered in Ilesa

Table 3.1 Ilesa East Local Government Area

WARD	AREAS COVERED
1	Okesa and Obokun Avenue
2	Imo, Omi Asoro, Fadahunsi Avenue and Kajola
3	Igbaye, Okesa and Ifosan
4	Ilemo, Lemodu, Itisin and Ogudu
5	Ijamo
6	Ijoka, Lejoka, Abiola, Ireti-ayo
7	Iloro, Idio and Iroye
8	Isare, Orogba and Arogbo
9	Irojo, Sabo and Ilerin
10	Bolorunduro, Ijofi, Isona, Oke-iro and Ita-Balogun.

Table 3.2 Ilesa West Local Government Areas

WARD	AREAS COVERED
1.	Egbeidi and Itakogun
2.	Cappa and Omi-eran
3.	Upper and lower Igbogi
4.	Omofe and Idasa
5.	Isokun
6.	Ikoti, Ikoyi and Araromi
7.	Ilaje,
8.	Isida and Adeti
9.	Ereja
10.	Ayeso

3.4 Study Population

A population is the entire aggregation of cases that meet a designated set of criteria. The nature of this study warrants making a distinction between study population and accessible population. According to Polit and Hungler (1999:278) "The accessible population is the aggregate of cases that conform to the designated criteria and that are accessible to the researcher as a pool of subjects for a study". Therefore, the study population will consist of people living with HIV/AIDS. This is the actual population, which the study will focus on. However, others such as family members and care providers will also be included. The fundamental reason for their inclusion is the significant role they play in HIV/AIDS care, this will also facilitate generation of balanced data.

3.5 Inclusion Criteria

To be eligible for the study, the PLWHA must have tested positive to HIV and be confirmed, be in clinically stable condition and demonstrate willingness to participate in the study through a consent form.

All available and willing People Living With HIV/AIDS (PLWHA) and People Affected By AIDS (PABA), at the desinated organisations in selected states were recruited to participate in the study.

3.6 Sample size.

The study involved two hundred and forty-four participants out of whom thirty were People Affected By AIDS (PABA), another thirty (30) were people service care providers and the remaining one hundred and eighty four (184) were PLWHA. This was the total number of people who were available during data collection and were willing to participate in the study.

3.7 Sampling Technique

Based on information from initial enquiries about HIV/AIDS care and support activities in the selected states, the study will utilise a purposive sampling technique. This is aimed at selecting all PLWHA who are willing to participate in the study.

3.8 Research Instruments.

- Semi-structured interview
- Key Informant interview (K.I.I);
- Focus Group Discussion (FGD); and
- Case studies.

3.8.1 Key Informant Interview

The study started with the identification of some resource persons in the field of HIV and AIDS research. Various consultations and initial visitations were made. The result of this is the identification of key informants from whom specific information concerning location of PLWHA, the prevalence of HIV and AIDS in the study area and location of organizations involved in caring for PLWHA in Osun and Oyo States was obtained. In all, 12 key informanr interviews were conducted and the key informants are listed out in Table . below.

Table 3.3: Showing Key informants in the study area

Ibadan	**Ilesa**
The President of PLWHA in Oyo State	The President of PLWHA in Osun State
Director of HIV/AIDS, Oyo State	A representative of Osun State director of HIV/AIDS
Project Director, FAHPAC	Project Director, Living Hope Care
Project Director, NELA	Project Manager and Head of Care and Support, Living Hope Care,
Executive Secretary, PLAN	A Ugandan volunteer worker with Life Vanguard, Osogbo
Head, Care and Support unit, NELA	A nurse at the State Hospital.

3.8.2 In-depth interview

The in-depth interview provided the study with in-depth data on cultural perception of care and support, attitude towards HIV/AIDS and responsibility of the PABA and AIDS service workere towards the PLWHA. Problems and challenges of seeking care and support as well as needs of PLWHA in terms of care and support were also elicited. In all, forty in-depth interviews were conducted: thirty four (34) between the PLWHA and six (6) among the PABA who were identified and reached through the PLWHA.

3.8.3 Focus Group Discussion (FGDs).

In all, 17 FGDs were conducted within a period of 10 months. Each of the sessions lasted between forty five minutes and one hour with a moderator, a time keeper and a field note-taker. Each group comprisedof between six and ten participants. This is made up of 100 PLWHA in Ilesa, 84 in Ibadan, 30 PABA and 30 care providers were also purposively selected from both states for FGDs.

To ensure that no idea raised in the discussion was lost, the proceedings of the sessions were recorded. Each organization provided a convenient venue with adequate ventilation, and the sitting arrangement adapted to suite face-to-face communication. Good entry point and ice-breaking activities preeded each discussion to enhance free interaction. Also, before the take-off of the field work, a training set was organized the research assistants on the successful way of eliciting responses.

In Ilesa, nine FGDs were carried out on age and sex-specific basis as follows: three sessions were conducted among women and two sessions among men who are PLWHA at the State Hospital, Ilesa. At the living Hope care, Ilesa, a group of PLWHA who were on ARV (Antiretroviral drugs) had a session. Similarly, a group of PABA and two other groups of care providers comprising a group of health care workers and another group of voluntary outreach workers. Eight sessions were also carried out in Ibadan involving a group of men and another group of women who are LWHA at FAHPAC. Also at FAHPAC, another session was conducted with the PABA. At NELA, a group of PLWHA who were on ARV had a session while three sessions: (two among women and one among men who are PLWHA were conducted also at NELA.)

3.8.4 Case Studies.

Seven cleints were recruited for case studies. The rational for selection was based on specific characteristics such as sex, age, occupation,educational background and willingness to give detailed information about their individual life as HIV positive person as well as changes in theirlifestyles as a result of HIV infection. Techniques used included observation and interview. After a brief follow up, two of the participants indicated their willingness to withdraw from the study, one in Ilesa due to relocation to Porthacourt from where she was brought home to her parents for proper care when she became sick, and the other in Ibadan who declined on the premises of tight schedule at work; being a Bank executive. Two other participants were lost to death; one in Ilesa who died as result of rigors of Youth service and the other at Ibadan whose death could not be ascertained.

3.9 Methods of Data collection

Having identified the study population, the researcher and the research assistants visited the Chief Executive Officers of the NGOs in both states. Also, various support group meetings and meetings of the voluntary outreach workers at both settings were visited. With this familiarization exercise, the researcher and assistants began to attend their meetings on the clinic days to build rapport in order to promote trust and facilitate acceptance. The aforementioned facilitated the data collection exercise.

Due to the sensitive nature of this study, all PLWHA may not be willing to come out. Hence, all available PLWHA who consented to interview participated in the study after appropriate explanation and signing of the consent forms was completed. Others who were not willing to participate were allowed to do so. Those who were willing were visited at home and some of them brought their family members as PABA to be interviewed or for participation in focus group discussions.

3. 10 Data Management

Data collected were stored in recorded tapes, which were reviewed, edited and transcribed on daily basis. The research assistants selected were individuals with a wealth of experience in HIV and AIDS research and they have been involved in similar studies in the past. They were also be asked to sign an agreement form to maintain strict confidentiality. Data were protected and no information from the study was contaminated, communicated or discussed with any spouse, partner or any other person without participant's permission

3. 11 Data Analysis

Basically, a content analysis approach was adopted. Analysis commenced with transcription of the recorded tapes and translation from Yoruba to English Language. The product was compared with the note taken during discussions and a final comprehensive list of ideas raised by various participants in response to the topic guide prepared. The next stage involves preparation of another list in line with each objective of study and based on these lists, the patterns of views on each objective and striking expressions were noted accordingly. The variables were then entered into matrices, and sorted out based on similarities and dissimilarities of ideas and opinions from respondents. Verbatim quotations of relevant statements were made.

Frequency distributions were drawn from the quatitative data and these were corroborated by findings from qualitative data. Findings from both complement each other and they produce a single report.

3.12 Ethical Considerations

Since all participants were expected to provide free and informed consent to partake in this study, an informed consent form was designed to obtain information from them. Risks and benefits as well as voluntary participation in the study were explained to them. They were told that they could withdraw from the study at any stage. They were also re-assured that such withdrawal or non-participation would not affect them in terms of benefiting from the study or in any other way.

CHAPTER FOUR 4.0 RESULTS

4.1 Introduction

This section presents the findings of the study, with an integration of qualitative data to complement quantitative data and produce a single report.

4.2 Socio-demographic Characteristics of the Participants

This section is based on the discussion of the socio-demographic background of the study population. Data showed that 65 percent of the respondents were females while 35 percent of them were males. The age distribution indicates highest infection rate among the age group 30-39 (36.4 percent). Those between ages 20 and 29 closely follow this with 30.4 percent. The next highest group is among those between 40 and 49 years old, which account for 20.1 percent. A significant finding which data revealed concerns those who were 60 years old and above and they comprise 2.7 percent of the respondents.

Occupational distribution of the sample population revealed that majority were self-employed. They constitute 50 percent as petty traders; thirty percent were unemployed and were dependent on relatives and friends for survival. Farmers constituted 3.3 percent of the respondents; seven percent were artisans while 10 percent were civil servants. Distribution, according to educational status, showed that 18.5 percent had no formal education, the highest percentage of 37.5 percent had primary school education, and 28.2 percent of them had secondary school education while only 15.8 percent had post secondary school education.

The religious affiliation of the participants revealed that seventy percent of the PLWHA were Christians while 18 percent were Muslims. 9 percent of them claimed they belong to African traditional religion while one percent claimed they did not have any religious affiliation. The characteristic nature of their marital status showed that majority of the respondents i.e. 75, constituting 40.8 percent and 41, (22.3 %), as well as 4, (2.1 %) were in different forms of marriage as shown in Table 4.1. Similarly, 15.8 percent were single, 13.6 percent were separated and 5.4 percent were widowed.

The income level of the participants was generally low with the majority earning less than ten thousand naira. This was made up of 152 respondents (82.6 percent). 24 respondents who constitute 13 percent of the respondents earn the next highest income of between ten thousand naira (N10, 000) and twenty four thousand naira (N24, 000). Only four respondents constituting 2.2 percent each earn income between thirty thousand (N30, 000) and fifty thousand naira (N50, 000) monthly. All the bits of information given above are presented in Table 4.1 below:

Table 4.1: Percentage distribution of PLWHA by Socio-demographic Characteristics.

N=184

Characteristics	Frequency	Percentage	Cumulative Percentage
Sex:			
Male	64	34.8	34.8
Female	120	65.2	100
Age:			
20-29	56	30.4	30.4
30-39	67	36.4	66. 8
40-49	37	20.1	86. 9
50-59	19	10.3	97.2
60 >	5	2.7	99.9
Occupation:			
Unemployed	55.	29.9	29.9
Farming	6	3.3	33.2
Artisan	13	7.1	40.3
Civil Service	19	10.3	50.6
Petty Trading	91	49.4	100

Education:			
No formal education	34	18.5	18.5
Primary School	69	37.5	56
Completed Sec.Sch	52	28.2	84.2
Post Secondary	29	15.8	100
Religion:			
Christianity	132	71.7	71.7
Islam	33	18	89.7
Traditional	17	9.2	98.9
Others	2	1.1	100
Marital Status:			
(Married) Monogamy	75	40.8	40.8
(Married) Polygyny	41	22.3	63.1
Cohabiting	4	2.1	65.2
(Unmarried) Single	29	15.8	81
Separated	25	13.6	94.6
Widow (er)	10	5.4	100

Income per month (N)			
Less than 10,000	152	82.6	82.6
10000-29,999	24	13	95.6
30,000-49,999	4	2.2	97.8
50,000 and above	4	2.2	100

Table 4.2: Frequency Distribution of Respondents According to Patterns of Care Received

Patterns of care	Frequency	Percentage
NGO's	84	45.7
Hospital	69	37.5
Spiritual	17	9.2
Home	14	7.6
Total	**184**	**100**

4.3 Available Support Systems for PLWHA

As shown in Table 4.2 above, three patterns of Care and Support systems were identified in the study area. A suitable pattern of religious institution was also identified through the NGOs. This is further illustrated in Figure 4.1 below.

Figure 4.1: Level of support system available in the study area

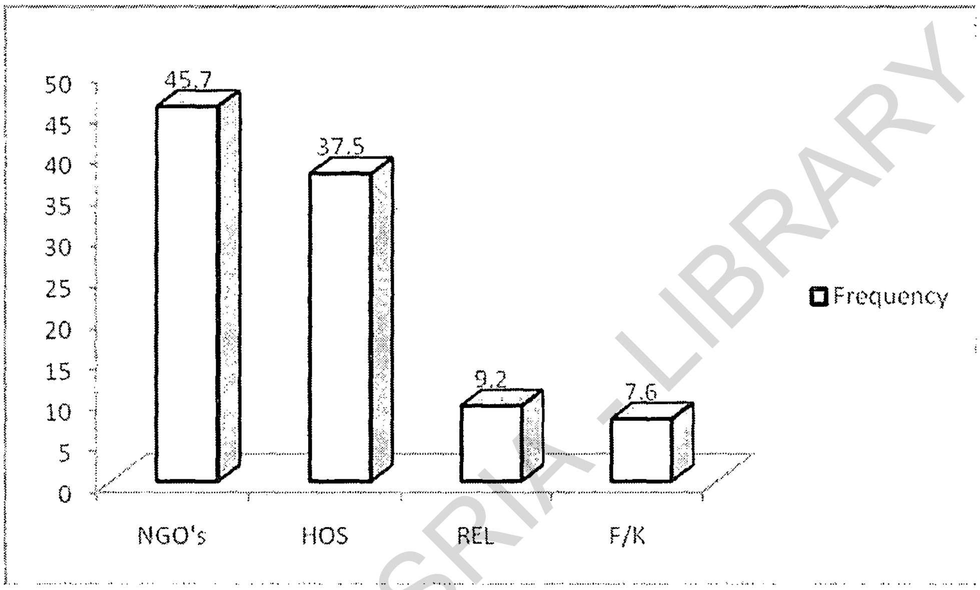


Figure 4.1: Patterns of Care and Support

KEY:

NGO's: Non-Governmental Organization.

HOS: Hospital

REL: Religious institution

F/K: Family & Kinship

Figure 4.1 reveals that 45.7 percent of the participants derived their care and support from NGOs; 37.5 percent felt that their care and support was derived from orthodox hospitals; 9.2 percent were of the opinion that religious organisations provided their care and support; and 7.6 percent reported that their family members and their kinsmen provided them with care and support.

Indepth interview as well as FGD participants expressed similar opinion. For example, a key informant (nurse) remarked:

Patterns of care for PLWHA in this community include health care workers in hospitals, various support groups in the community such as religious groups as well as very little family involvement in form of home-based care.

Furthermore, a PLWHA (FGD participant) said:

When one becomes sick, initially every member of the family becomes involved, not knowing the nature of the illness and usually end up in the hospital from where diagnosis is made. And then, the problem begins because as soon as this is done and result is positive for HIV, the patient is immediately referred to a non-governmental organisation for care and support.

The Table below reveals that hundred PLWHA (54.3 %) were from Living Hope Care, Ilesa while the remaining eighty-four were from Ibadan as shown in Table 4.3. In Ibadan, 62 (33.7 %) of them were from Network on Ethics, Human Right, Law and HIV/AIDS - Care and Prevention. (NELA). Family and Health Population Action Committee (FAHPAC) provided the link with 12 (6.5%) of the PLWHA while the remaining 10 (5.4 %) came from Positive Living Association of Nigeria (PLAN).

Table 4.3: Distribution According to Utilisation of NGO Facilities.

NGOs	Location	No. Of PLWHA	%
Living Hope Care	Isokun, Ilesa	100	54.3
NELA	Old Ife Road, Ibadan.	62	33.7
FAHPAC	Orita-Aperin, Ibadan	12	6.5
PLAN	Sango, Ibadan	10	5.4
Total		**184**	**100**

Table 4.4 below shows that all the major hospitals in the two study locations, including the Teaching Hospitals refer PLWHAs to non-governmental organisations for care and support. This was shown by the findings from qualitative data among PLWHA. For example, *a PLWHA in Ilesa explained:*

Nigba ti won yemi wo tan, won bere si toju mi ni Ile iwosan nla to wa ni Ile-Ife (OAUTHC) leyin naa won ni ki n ma a wa si odo mama (Living Hope Care coordinator).

(Which means)

Following the diagnosis at State Hospital, Ilesa, I was counselled, given some drugs and was then referred to Living Hope Care.

Also in Ibadan, explanation from a PLWHA went thus:

Ni osipita (hospital), won ma n won wa, won a tun se ifunpa fun wa. Won a si tun ye wa wo, ki won to fun wa ni oogun arun yi (antiretroviral drugs), ni eekan losu.

(Meaning)
In the hospital, they usally weigh us, do our blood pressure, they do some other tests as well and then they give us our antiretroviral drugs once in a month.

In summary, hospitals in the study area provided mainly medical and therapeutic support. In Ilesa, General Hospital, and Wesley Guild Hospital, Ilesa under Obafemi Awolowo University Teaching Hospital Complex (OAUTHC), Ile-Ife, were utilized while the PLWHA were referred from various hospitals, including University College Hospital, Oluyoro Catholic Hospital and other Mission and Private Hospitals in the city as shown in Table 4.4.

Table 4.4: Distribution According to Hospitals from where PLWHA were referred to the NGOs

Study Location:	**Referral Hospitals**
Ibadan	University College Hospital (UCH), Oluyoro Catholic Hospital, Oke- Ofa, State Hospital, Ring Road, Adeoyo Maternity Hospital,Yemetu and Privately owned hospitals in Ibadan.
Ilesa	State Hospital, Ilesha, Obafemi Awolowo University Teaching Hopital, Ile- Ife and Privately owned hospitals in Ilesa.

From Table 4.5, it could be seen that financial difficulty accounted for the highest limitation in seeking care and support by 55.4 percent of the PLWHA, while 27.2 percent of the respondents were discouraged by the attitudes of health workers to the care and support of PLWHA. Similarly, 15.2 percent were of the opinion that there was nobody to accompany them to such facilities to seek care and support. Also, 1.1 percent of the participants were of the opinion that transportation difficulty was the main challenge they encountered in seeking care and support. Same percentage of the PLWHA felt that the long-waiting period in hospitals was enough discouragement for their seeking of care and support. Qualitative data also supported these. A participant, during an in depth interview in Ilesa stated thus:

Without money, the most effective drug cannot work especially when there is no money for good food. And you know with HIV, according to what we were told, as a PLWHA you eat for two: one for the virus and one for yourself but what can one do when you can not even afford a three square meal?

According to another PLWHA in Ibadan:

The greatest problem we are facing is financial constraint and once this is gotten rid of, the remaining is settled. Explaining further, she said: As for me, I am not afraid of HIV, infact I am more afraid of the resultant incapacitation, which predisposes me to poverty.

The following is also a translated account of some of the PLWHA during Indepth interview and focus group discussions and this also buttress the findings from quantitative data on attitude of health workers:

The attitudes of doctors and nurses to those of us living with this disease have been very bad until perhaps very recently. It used to be so bad and discouraging that they don' even want to see us at all. I had actually considered drinking poison and committing suicide in the past because of the attitude of a doctor. I also knew of a person who personally came to my house that she saw AIDS patient and that the person who told her is her sister-in-law who is a nurse in this hospital. It is not for them to broadcast. In fact, before, they don't even want to let your dress not to talk of your body touch their own but now, they are gradually changing. For example, I have seen a nurse who came to check me at home that we even had a discussion and I was very happy. Thank God, we are beginning to see changes.

Another PLWHA said:

As for me, I don't share that opinion. Their attitude to us is still that of reluctance. Even in this hospital now, when we are going home they will keep looking at us. Many of us don't even like taking that side of the road. They complain and grumble over every little thing they have to do for you. In fact, their attitude bothers me more than the disease.

Below is another account of a participant during focus group discussion among care providers at Ilesa to buttress the aforementioned:

Whenever anybody comes out of this office whether or not the person is HIV positive, people around including my fellow nurses consider him so, and the PLWHA usually tell me that people are looking at them. They will be calling themselves and saying ''haven't you seen somebody living with HIV/AIDS? Come and see" I will then go with them from my office to make sure that they are comfortable.

Table 4.5: Limitations of Seeking Care and Support as Experienced by PLWHA N=184

Limitations	**Frequency**	**Percentage**
Don't have money	102	55.4
Attitudes of health workers	50	27.2
Don't have someone to accompany me	28	15.2
Waiting period too long in the hospital	2	1.1
Transportation	2	1.1

The figure below reveals that on reporting ill, the usual first point of seeking medical care and support is the hospital, where they are investigated and referred to NGOs. NGOs form the rallying point in the adoption, symptomatic management, rehabilitation and follow-up of PLWHA from where they are re- integrated back into their family and community or referred back to the hospital if need be.

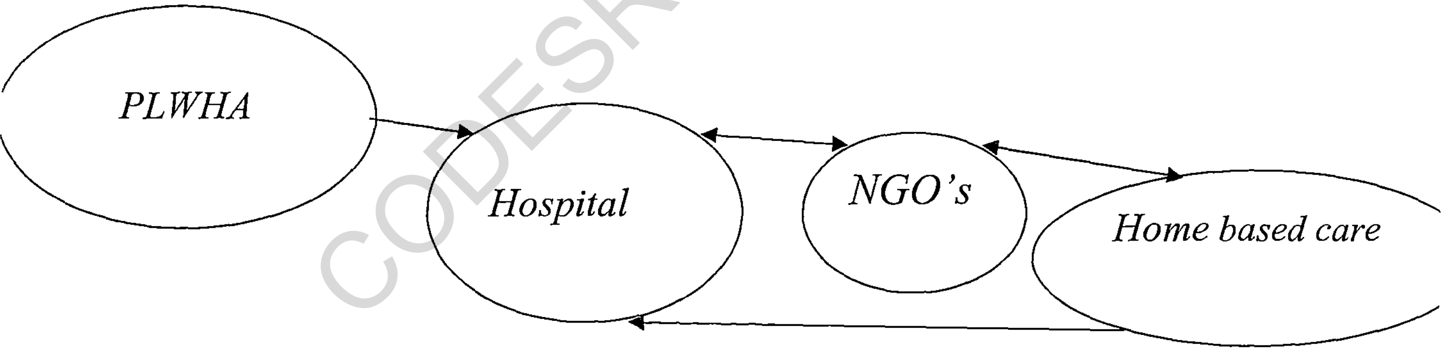


Figure 4.2: Showing the Pathway to Consultation and Support Services for PLWHA

The figure below represents patterns of interaction among various support systems available in selected communities. The pattern reflects collaboration of all the support systems in care and support of PLWHA. There is collaboration and networking among the support systems. It could be seen from Figure 4.3 that the interaction scheme revolves around non-governmental organisations. The hospital system provides the entry point into and from NGOs. PLWHA enter into NGO network through a two-way, multi- dimensional interaction to and from NGOs. NGO is conspicuously positioned and provides the link to voluntary agencies, associations of PLWHA, as well as family and kinship, which include PABA, religious institutions and so on.

A channel of interaction could be developed based on the findings of this research depicting a framework of interaction between the various care patterns and available support systems in the study area as shown in Figure 4.3. The Figure represents patterns of interaction among the various available care and support systems in the study areas. This pattern of interaction reflects collaboration and networking among the support systems. However, the NGOs occupy a strategic position and the hospital is also prominent whereas the family is hidden figuratively. This figurative hidden position of the family is translated to reality and confirmed by the findings of this study as illustrated in figure 4.3 below.

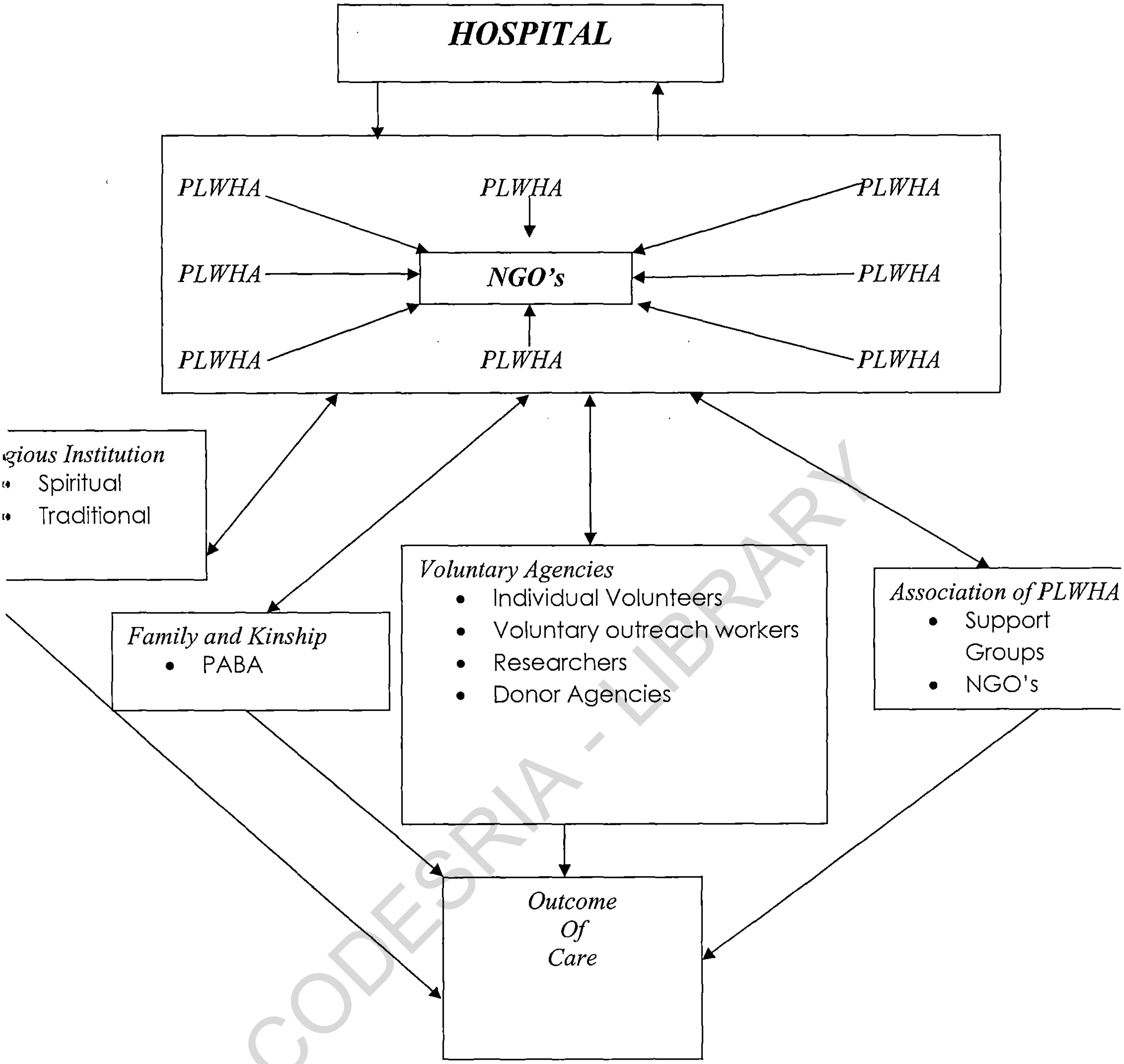


Figure 4.3: ***Pattern of Interaction in HIV/AIDS Care and Support***

Adejumo (2004)

From Table 4.6 it could be seen that 103 participants (56 %) of the respondents had low level of education, while 81 (44%), had high level of education. Of the respondents with low level of education, majority, 76.7 percent utilized the facilities of non-governmental organisations for care and support, while the remainng 24, (23.3 %) utilized the facilities available in the government hospitals for care and support while none of them was cared for nor supported by their family members. On the other hand, among the respondents with high level of education, 44 (54.3 %) utilized the facilities available in government hospitals for care and support, 33 (40.7%) utilized non-governmental organisations for care and support, while the remaining 4 (5%), with high educational background received some form of care and support from their families.

Table 4.6: Distribution According to Relationship between Level of Education and Utilisation of Care and Support

Level of education	Level of Care and support		
	NGO	Hospital	Family
High 81 (44)	33(40.7%)	44 (54.3 %)	4 (5%)
Low 103 (56)	79 (76.7%)	24 (23.3%)	---------

Table 4.7 below shows that 120 females, which formed 65.2 percent of the participants in this study all sought care and support for their HIV status. Males, on the other hand, were 64 in number, which constituted 34.8 percent of the respondents, 40 (62.5%) did not seek treatment, care or support, while the remaining 24(37.5%) sought treatment, care and support.

A project coordinator in one of the key informant interviews pointed out that:

> *When we diagnose men, they die early, I don't know the reason, when you attend our support group meetings at times you would see 30 to 40 females, by then you will see about five to six males. But they (males) usually die on time and I don't know why. May be it is stigma that disturb them or their ego. We have a few of these men coming to share their life experiences and how they contacted the virus. But you see the ladies, we have many of them that come out to share their experiences on how they contacted the virus and you see the ladies, they are doing fine. Another point is that men usually come when they are seriously ill.*

Table 4.7: Distribution According to relationship between Gender and Care and Support

Gender		Sought care	Care not sought
Males	64 (34.8)	24 (37.5)	40 (62.5)
Females	120 (65.2)	120 (100)	-------

Table 4.8 reveals that 100, (54.3 %) of the respondents perceived disclosure as a difficult thing to do. 45 (24.5 %) felt that disclosure of their HIV status was an impossible task, while 28, (15.2 %) had no response to the issue, and the remaining eleven (6 %) felt that it was easy for them to disclose their HIV status.

Commenting on this during an indepth interview, a key informant said:

If people are openly positve, that is if they are open about their status, they would be at less risk of infecting others or being reinfected with new strains of the virus. Also it facilitates care becauce it is when somebody knows that something is wrong with you that the person has the opportunity of thinking whether he wants to render any assistance in form of care and support or not. Hence the issue of disclosure is deeply rooted in several socio- cultural factors.

A PLWHA, FGD participant in Ilesa explained:

Gegebi aisan ti a nso oro re yi, pupo, ninu wa to wa ni ijoko yi ni awon ebi wa ko mo pe a ni iru arun yi, paa pa julo emi yi. Ko si enikeni ninu ebi mi to mo wipe mo ni kokoro yi ninu eje mi. Ohun kan soso ti won mo ni wipe mo ti ni arun ato suga nigba kan ri. Nkan soso ti won mo niyen

(Meaning)

On this disease we are talking about, many of us sitting here, our families are not aware that we are living with the disease, particularly myself. None of my family members knows that I am HIV positive. The only thing they knew was that I once had diabetes. That was the only thing they knew.

Another FGD participant buttressed this as follows:

Bakanna lemi, enikeni ninu ebi mi ko mo wipe mo ni iru arun yi titi di oni. Koda, bi won ba ti nsoro nipa arun yi ni emi na a ti da si wipe ko si ohun to nje be, koda iro nla gba a ni

(Meaning):

Likewise myself, none of my family members knows that I have this type of disease. In fact, once they start a discussion about it, I usually contribute that there is nothing like that and that in fact it is a lie.

Table 4.8: Distribution According to Perception of PLWHA about Disclosure of their HIV status

N= 184

Disclosure	Frequency	Percentage
Easy	11	6
Difficult	100	54.3
Impossible	45	24.5
No Response	28	15 .2

The Table below shows that 98, (53%) of the participants responded in the negative concerning notifying their partners of their HIV status, 68, (37%) of the respondents were in support of notifying their partners about their HIV status, while 18, (10%) of the respondents did not respond to this. Qualitative data also supported this as a PLWHA in Ibadan (male) revealed:

> *My wife ran away when I was told in her presence that I am HIV positive, and up till this moment she has not shown up. Even my biological father disowned me immediately I disclosed my status.*

Another one, a female, also indicated:

My husband left the house for my 4 children and I. He packed out to meet his second wife the very night he knew about my HIV status.

Table 4.9: Distribution According to Partner's notification of HIV/AIDS Status

Notification	Frequency	Percentage
Yes	68	37
No	98	53
No Response	18	10
Total	**184**	**100**

Data revealed a prevalence of less than one percent in 1995/96, 3.8 percent in 1997/98 and from there, a sharp increase in 1999/2000 to 20.7 percent as shown in Table 4.10 below. This could be attributed to the sequence of economic depression and military mis-governance of the nation. From there, a sharper increase of 53.3 percent in 2001/2002 still explaining the state of the nation as well as lack of comprehensive care and support. In 2003, the 21.7 percent was not conclusive because that was the end of data collection exercise. This is a manifestation of the fact that since the first AIDS case was officially reported in 1986, the number of cases has grown exponentially and is still growing. This finding depicts a progressive increase in prevalence of HIV/AIDS in the study area. This is a perfect representation of the national HIV/AIDS prevalence, which rose from 0.8 percent in 1990 to 1.2 percent in

1992/93, 3.2 percent in 1994, 4.5 percent in 1995, 5.4 percent in 1999, 5.8 percent in 2001 and 5.0 in 2003.

Table 4.10 Incidence of HIV/AIDS in the Study AreasYear

Year	Value	Percentage
1995-1996	1	0.5
1997-1998	7	3.8
1999-2000	38	20.7
2001-2002	98	53.3
2003	40	21.7
Total	**184**	**100**

According to Table 4.11 below, fifty of PLWHA (27.2%) were on ARVs, 32, (17.4%) started but could not sustain it and they stopped. Majority, 102 (55.4 percent) were not on ARV and have never had it. Qualitative data revealed reasons for inconsistence in drug administration. A PLWHA, FGD participant indicated that:

Mo ma n gba ogun aarun yi (antiretroviral drugs) lati Ile iwosan nla Oritamefa ni Ibadan (UCH), sugbon nigba ti won dase sile, mi o le gbaa oogun naa mo.

(Meaning)

I normally collected my antiretroviral drugs from UCH but since the beginning of the strike there, I have not been opportuned to get it.

Another PLWHA explained:

Antiretroviral drugs cost N1000 every month. For us at Ilesa here, we usually travel to Lagos every month to collect it. It is cash and carry. Also, there are certain tests to be done which cost another N6, 500. Where do you expect me to get money on regular basis for this?I cannot therefore help defaulting.

Table 4.11: Distribution According to PLWHA on ARV
N=184

ARV	**Frequency**	**Percentage**
Yes	50	27.2
Started but stopped	32	17.4
No	102	55.4

As shown below, non-disclosure (40.8%) accounts for the highest coping strategy among the PLWHA who participated in the study while vocational training (9.8%) is the least utilised. To 22.8% of the respondents, spiritual affiliation was their coping mechanism while 14.7% utilised relocation and 11.9% shared the testimony of their experience as PLWHA with others as a means of coping with challenges of living with HIV.

Table 4.12: Disribution According to coping strategies utilised by PLWHA N=184

Strategies	Frequency	Percentage
Non-disclosur	75	40.8
Spiritual affiliation	42	22.8
Relocation	27	14.7
Testimony Sharing	22	11.9
Vocational training	18	9.8

4.4 Awareness and Knowledge about HIV/AIDS

Unmarried PLWHA (20-29 Years)

Level of awareness of HIV/AIDS was very high among the singles who are living with HIV/AIDS across the states. Majority of them were able to explain the difference between HIV and AIDS. However, limited knowledge about it exists in the area of mode of transmission. This is probably due to sociocultural reasons.

For example, in Ilesa, a single PLWHA indicated:

HIV can be contracted from the toilet seat and I think that is how I contracted mine.

Some participants described mosquitoe bite as a means of transmitting HIV.

According to a participant:

I travelled to my village where I was bitten mercilessly by giant mosquitoes prior to my being diagnosed HIV positive...

Other participants referred to it as being transmitted through other means. A participant revealed that:

HIV is commonly spread through casual contact such as handshake and this is very common these days and that is why I have stopped shaking people I love so that they will not also contract it.

Married PLWHA (30-49 Years)

Awareness and Knowledge of HIV/AIDS was very high compared with the unmarried PLWHA. Participants were able to identify correct routes of transmission. This is probably due to their close association with the NGOs. For instance, a participant in Ilesa was able to link it to sexual route. According to her:

In my own opinion, unprotected sexual intercourse is the commonest route of HIV transmission. From my personal experience, I have never heard about HIV until early last year when my husband died of AIDS and I was asked to go for the test and it was positive.

Another participant said:

Contaminated needles and syringes can also serve as a means of transmission. For example in my case, I was sick and treated with daily injection for three months in a private hospital at Ibadan. Who knows wether the needles were contaminated? Anyway, as soon as I was told about my status I immediately recognised the source.

4.5 Stigmatisation, Rejection and Discrimination

Regarding general opinion about stigmatisation of PLWHA, for example, data showed that majority of the PLWHA who participated in this study indicated that they were stigmatised. They also gave account of rejection and how they were discriminated against. Care providers as well as PABA who participated in this study also supported this notion.

Another PLWHA, (a male) stated:

Like this hospital that we are in now, State Hospital, Ilesa as I told you earlier that in 1990 when I was first diagnosed, I did not see my result and they did not want to tell me. It was not until 1997 that I was fully aware of my diagnosis of HIV/AIDS. The nurses and doctors told my mother to drop me in the bush because I am HIV positive which she did. Someone else later picked me up in the bush and thank God I am alive today.

Also another participant, a PABA revealed:

My landlord gave me a quit notice when my daughter became infected with HIV and he heard about it, could you then imagine the reactions of other tenants? It is better imagined. Of course I had to look for another house immediately to conceal the shame.

To buttress this, a care provider shared her experience during FGD as follows:

In this community, the only problem we have is that of stigma. People don't want to associate with PLWHA and their family members are not excluded. Even those of us who are caring for them have been stigmatised. For example, when my colleagues see them with me, they will be asking "Se awon ara ile e niyen" meaning are those your people?

Data further revealed stigmatisation and discrimination as the following cases illustrated:

CASE 1: MISS A (Fictitious Name), an undergraduate student of one of the tertiary institutions in Nigeria is a 24-year-old lady who fell from a bike and was rushed to a private hospital where she was treated and was sent home. She became sick thereafter and was treated at a private hospital and had her dressing done. She was discharged home and became sick again and was rushed home from school from where she was taken to one of the teaching hospitals. At the hospital, she became the favourite of nurses and doctors, being a beautiful and young lady; she had her dressing done regularly and enjoyed maximum level of care from both her family members and the hospital staff. Suddenly, according to her:

Hell broke loose one afternoon when I observed that my dressing was left undone and people were passing with their faces turned to the other direction, all the smiles had disappeared and every face suddenly became gloomy and 'tight'. Sincerely, my sister I could not explain it. I needed an explanation that nobody was ready to give. It was simply hell on earth. Then my parents were sent for and we had to leave for home without yet any explanation. For those three days my dressing was left unattended to and had actually started to smell. I was miserable and was neither interested in going back to school nor going to another hospital. However, with the persuation of my parents, I agreed to go to another hospital where we were asked to do a test and was eventually told what the problem was.

CASE 2: For Mr. O. (Fictitious name), born in the year 1965, into a Christian family. He attended four primary schools, two secondary schools, one College of Education and a foremost University in Nigeria. He is a trained Teacher but later joined a construction industry as a site administrative officer for many years. He then went into private business for a few years before joining a consultancy outfit as a computer programmer and an instructor before the issue of HIV/AIDS came into his life. According to him: I heard of my health status in a rather indirect way. It was my late wife that was ill. She had the usual symptoms of AIDS. I never knew anything about HIV/AIDS before. In fact, I never knew the opportunistic infections associated with HIV/AIDS. Because she had a prolonged fever, diarrohoea and all the usual opportunistic infections, we took her to a hospital and when she got to the hospital, the doctor just gave us a form to take to the laboratory. He didn't tell us the kind of test we were taking in the first instance but I saw retroviral screening, which means *that she was going for HIV test. What came into my mind was what would my wife be doing with HIV testing? I did not pick her up from a brothel, and I knew the kind of background she came from and I knew the person I married. I never suspected that she was going to test HIV positive. We took the form to the laboratory and they took her blood samples, she had no idea what kind of test she was taking. When the results were being released to other people, and it came to my wife's turn, they just announced her name and they refused to give her the test result. That was what gave the suspicion that something was wrong and interestingly, the nurses were congratulating those they were giving their results. The laboratory attendant now said that he was not going to give the result to her and that it had to be given to the doctor. He then tiptoed to the doctor's room and said "Aha, docto r, a ma se nkan o"(meaning that something amiss has happened) while we sat in the waiting area. When he left, I went to the doctor to find out what happened and I told him that even if the result was positive we had a right to know. The doctor then said "Well, I can not say your result is positive or negative now because you still have to take another test." He then gave us another form to take to UCH for confirmation test for my wife and me. He did not tell us what was there anyway; he stapled the forms and said we should take it down. I started sweating even in air-conditioner and I quickly left for the bathroom instead of UCH to open the form to find out what was really inside it. To my greatest surprise, it was just their request for the test. When I got to UCH we took our test and when it was now time for us to recieve the result, the doctor there refused to give us the result. He said we just have to see somebody. When the nurse that went to collet the result from the laboratory was taking the result in, she now gave the result to the doctor inside the consulting room and just about two minutes later two nurses peeped into the door more or less to look at HIV positive people. So to get the result of our test, he said, we needed some counselling. At that time I told him " I think it is better you counsel these your nurses" He then apologised and asked me to come back for the result. I never went back for the result but then I knew that definitely by their reaction that the result of both my wife and I were positive. Because we had no opportunity of pre-test or post-test counselling, we really had a lot of problems that were attached to the situation.*

During a focus group discussion, participants were asked to discuss why these Yoruba Communities with emphasis on helping their fellow kinsmen in distress could not translate such caring attribute to care for PLWHA.

A respondent explained:

Se e ri, gbogbo aarun to ba ti jo mo iwa idojutini ni awon eniyan ma n ṣa a fun. Awon molebi ma n fe e sa fun alarun be e. Koda, won ki ba se omo won. Ti e ba wa wo bi aarun yi (HIV/AIDS) tun se je, ti won ti e tun ni ko gboogun. Awon eniyan ma n saa fun won gan an ni.

(Meaning)

You see, any illness that is linked with immorality is usually frowned at in our communities. In fact, family members are advised to run away from such people irrespective of the relationship, even if their children are involved. With the additional characteristic nature of HIV/AIDS of not been curable, they have no option than to run away from such a disease.

Another respondent explained:

We all agreed that Yoruba people are caring, okay, but who wants to die?

Another respondent however had a contrary opinion and her explanation was that:

They will abandon the person initially, but through sensitisation people are now changing their attitudes.

Another respondent shared this opinion but from different perspective. She said:

From my own experience, when the patient comes to the hospital initially, his family members will run around and even stay with him throughout the period of hospitalisation but as soon as they know that the patient is HIV positive, they will disappear.

On further exploration to know why this is so, the following respondents in their explanation said:

Ni temi o, oun ti mo ro ni wipe opolopo eniyan, paapaa awon molebi ma n sa a fun wa gan ni. Won ki ti e fe se bi enipe won mo wa ri. Won kii toju wa. Bi a ti se ma n ri ma n ba a won leru. Oju wa a ri kuru kuru, ara wa a ri palapala, a ma a wuko a si tun ma a yagbe nigba gbogbo. Eleyi je itiju fun awon molebi wa. Papa julo a ma ngbe bi igi idana.

(Meaning)

As for me, what I think make people, especially our family members, run away from us and not showing any willingness to care for us is the way we look. Our frail appearance with rashes and cough and persistent diarrhoea can be embarrassing to them,and most especially the accompanying weight loss that makes us appear as dried firewood sticks.

4.6 Care and Support

As noted by a key informant in Ilesa, the location of a prison and leper's home in Ilesa shows that the Ijesas care for their people. According to him:

For over twenty years of the existence of these two institutions in Ilesa, they have been enjoying the community support. Members of the community usually visit inmates and give them money, clothes, foods etc, members of various religious groups in the community also go there to pray and share with them spiritually.

The establishment of non-governmental organizations (NG0s) for taking care of the PLWHA in Ilesa was motivated by the caring attitude of the Ijesa people. These features are also evident in Ibadan where three functional NGOs involved in care and support of PLWHA were located. Through the NGOs, the PLWHA were linked to various support groups where spiritual, social, emotional and psychological as well as financial supports were given.

One of the respondents, (a community health officer) explained:

About the care, we are doing the little we can with the help of God. When they (PLWHA) come, we listen to their complaints, reassure and counsel them, treat their common complaints of oral thrush with a local remedy prepared from the bark of cashew tree, free of charge. We also use "aloe vera" for their skin rashes which is very effective. We also embark on voluntary counselling and testing. We explore their risky behaviours and educate them appropriately. We also educate them on personal and environmental hygiene.

During an in-depth interview, a project coordinator of one of the NGOs also said:

On the issue of support, this is in terms of meeting their needs through financial support (through various donor agencies) nutritional support and other forms of care generally. We usually support them based on their needs and address whatever problem arises especially as a result of the HIV infection or AIDS disease. Based on my interactions with over five hundred PLWHA here and a lot of others from outside, I think what we in the care and support NGOs do is simply to show them love. People think it needs big money. It is rather the love, like when you came in, see them, they were jumping on you, do you give them anything?

One of the voluntary outreach workers (VOW), commenting during a focus group discussion, said:

When you see me playing with a PLWHA you may not believe that she is HIV positive. This is because we are so free with each other. She comes to my house and I go to her house. I have taken her just like my daughter. In fact, we eat together in the same plate; sit on the same bed and gist together. What else? I tell you what these people need is just love.

A PLWHA (President of PLWHA) during an in-depth interview said:

HIV/AIDS care and support is not about dos or don'ts, it's about showing love. In a culture where you touch people, do you make that PLWHA feel welcomed? Does your facial expression encourage the PLWHA to open up and talk with you? I have some members of my group that will tell me the most intimate thing because of the level of trust that we have built over time. So like I said, what you need to arm yourself in order to fight HIV by way of care and support is that four-letter world called LOVE.

A project coordinator of one of the selected NGOs during in-depth interview said:

In 1998, I noticed that the death rate of PLWHA dropped. This is because we show them love and care. We accept them and make them feel the sense of belonging. After all, we don't need any equipment to show love neither does smile require any instrument apart from our face, lips and facial muscles which our creator has freely given us. We make them realize they are not alone in this situation, we also arrange for them to meet with other PLWHA through counselling. We observe that the death rate has dropped from one hundred percent (100%) to six percent (6%) now. For example, throughout last month (September, 2002) there was no record of any death though we had one this month. The death rate has dropped drastically and this makes us to have fewer orphans now unlike in 1994 through 1997, when we had so many orphans because by then our PLWHA usually die with mortality rate of 100 percent. By 1998, we intensified our effort and those PLWHA started sharing their experiences. We began to get invitation from community-based organisations like Churches, Mosques, Red Cross, Schools and so on. Then, suddenly, their outlook began to change. They continue to share their experiences and counsel others and that makes the death rate to drop.

Another case study also buttressed this as shown below:

Case 3: Miss T.I is a 27-year-old young lady who lived in Lagos prior to her illness before she was brought home for proper management of her illness by a good samaritan. She was a petty trader. According to her: ...I was sick at Lagos and became so lean that people stopped buying things from me. I was eventually tested and told I was HIV positive. One sister brought me to Living Hope Care and when I saw mummy (the project coordinator), she was just smiling over the matter. I became very angry that could it be that this woman is not aware of what I am passing *through? I have passed stool for good six months. I was advised to take "garri" but it didn't stop. Before I walked a distance you would have seen faeces all over my body. It came to a point that I started using nappies so that I wouldn't defaecate in public places. Whenever mummy came she would just be smiling and I used to wonder the kind of woman she was? Because I am dying like this and she is just smiling. Anyway, I took solace in the fact that I preferred to die here than to die in Lagos. After three days, I began to see clearly, one man came to see me and introduced himself as a PLWHA, which I didn't believe because his face was fine. Later, another PLWHA came to see me and I couldn't believe him also. I had this thought that they were deceiving me then. Every morning, mummy would come to sweep stool and vomit. She would clean the place up and I used to wonder if I would get well. Later, I started seeing others. And now over three years have passed, I now remember those smiles that mummy used to give me then as smiles of hope. It is clear that if we are given adequate care, there is hope for us.*

4.7 Patterns of Care Available In The Study Area

Basically, three patterns of care and support were identified in the study areas. They are as follows:

i. Institutional-based care

ii. Community-based care and

iii. Home-based care.

The institutional-based care features formal institutions interested in taking care of the sick generally; people with other ailments or diseases such as malaria and PLWHA alike. Notably, the institutions were the hospitals.

In Ilesa, refering to Table 4.4, the hospitals involved were: Wesley Guild Hospital, Ilesa (which is under the management of Obafemi Awolowo University Teaching Hospital Complex) as well as General Hospital Muroko in Ilesha. Ibadan, being a larger city, all hospitals ranging from private, and mission, Primary Health

Care, State and Teaching Hospitals were involved. This is of course a reflection of the pivotal role that each of these hospitals has been playing in the maintenance of the health of the members of these communities not only with the evolution of the HIV/AIDS pandemic. In other words, it has become a norm in these societies that for every critical physically attributed sickness, the hospitals identified in these study were usually the place to go when the interventions aimed at restoring health fail.

However, these hospital services are not freely and equitably available to every type of medical diagnosis. This implies that certain disease conditions such as HIV/AIDS are stigmatised and therefore not usually offered as much as the highest level of care provided for other non-stigmatising illnesses such as malaria. In practical reality, these hospitals undertook the admission, diagnosis and treatment of the diseases. In the case of seropositivity, the patients were then referred to non-governmental organizations involved in caring for PLWHA. In Ilesa, only one functional non-governmental organization (Living Hope Care), as mentioned in the methodology, met the criteria for this study. However in Ibadan, three of such organizations were identified.

Apart from these, Community Based Organizations (CBOs) were also observed to be involved in the care and support of PLWHA. Most of the CBOs found in this study are under the umbrella of the NGOs. These NGOs direct their attention to PLWHA. They provide psychological care in terms of counselling before the HIV test and after the test might have been done. They also provide nutritional support by making food supplements available for PLWHA. They also provide medication support through the provision of routine drugs such as haematinics (blood enriching drugs), antiretroviral drugs and other drugs for preventing opportunistic infections. Another care given by the NGO is social support; they work towards re-integrating the PLWHA back into the society. They also provide spiritual support through collaboration with religious organizations in the community to reaffirm the faith of the PLWHA in God.

Worthy of note in this study is the location of an integral part of the NGO in Ilesa within the premises of the State Hospital, Ilesa. This is contrary to the situation in Ibadan where the NGOs were located independently far from the various hospitals. Even within many of the hospital layouts, the clinics offering care services to PLWHA were isolated from the mainstream of the hospital layouts. Specifically in General Hospital, Ilesa the HIV/AIDS clinic is proximal to the hospital mortuary tucked away from easy accessibility. Of course, the reason that was given for this was that of the need to avoid possible on lookers. This could also be seen as a subtle manifestation of stigmatisation associated with HIV and AIDS. However, it served as a strong strategy for breaking the news of seropositivity to a newly infected person. The fact that most of the health workers involved in the care and support of PLWHA could be observed to be associated with NGOs raised the question of whether without any association to NGOs, workers in hospital services would also stigmatise, isolate, and discriminate against PLWHA?

The third pattern of care and support found in the study is the home-based care involving family and kinship group. Findings of this study are however contrary to the general belief of the caring attitude of the Yorubas. Explaining this issue,

4.8 Available Support System

As has been shown, three patterns of care and support existed for PLWHA in the study setting. These include:

- diagnostic support
- treatment of opportunistic infections and
- Medication support associated with antiretroviral drugs.

These were derived mainly from the hospitals.

4.9 Support from the Non-Governmental Organisations.

Another support system available in the study area is through the NGOs. Their services include linking the PLWHA with access to drugs from the hospitals. As at the time of data collection, the PLWHA in Ilesa were still travelling every month to Lagos for antiretroviral drugs, though, according to one of the key informants, efforts were in top gear to bring antiretroviral (ARV) drugs to Ife (OAUTHC). The NGOs through donor agencies were bearing the greater part of the financial burden, transportation, pocket money, etc.

4.10 Limitations of PLWHA in Seeking Care and Support

The study revealed certain factors militating against PLWHA in seeking care and support in selected Yoruba communities. The most prominent limitation is poverty which fifty-five percent of the PLWHA in the study admitted. Besides, of the seventy-three percent who were not on ARV (Table 4.11), fifty five percent of them gave non-affordability as the reason. Economic status of PLWHA as shown in table 1 is also a reflection of this.

Another limitation concerns misconception about HIV/AIDS. The people believe that the disease is associated with immoral behaviours, and that once the infection occurs, the patient will definitely die. The belief is that caring for PLWHA is a waste of time, money and other resources. These perceptions give rise to discrimination, stigmatisation and rejection of PLWHA. A key informant's statement below further supports the above point:

> *With this type of treatment from the community, alienation from the family and treatment with contempt of PLWHA by health workers, care and support become elusive.*

Access to ARV is another identified limitation. For example, as at the time of this data collection, PLWHA at Ilesa were travelling to Lagos every month with its attending risks. Another limitation to care which the study reveals is the problem of disclosure. Among the PLWHA who participated in this study, twenty-five percent found it impossible to disclose their status to any body as shown in Table 4.8. This definitely has implication for care and support.

Similarly, attitude of health care workers, though changing as this study suggests, has a negative impact on care and support. Poverty was the basic reason while treatment such as ARV drugs were either not sought or started and not sustained (Table 4.11), Similarly, 72.8 percent of the PLWHA could not access ARV therapy. This was simply because they could not afford the cost.

Another limitation was inadequate hospital facilities for care and support for PLWHA. At the time of data collection, only University College Hospital (UCH), Ibadan may be considered adequate for providing care and support for PLWHA. Yet, there were other patients to cater for.

Another limitation to care which the study reveals is the problem of disclosure. Among the PLWHA who participated in this study twenty-five percent found it difficult to disclose their status to anybody.

On why the caring attitude of the Yoruba has not been translated into care and support for PLWHA, respondents gave the following reasons:

Fear of death One hundred and seventy two of the two hundred and forty, i.e. 71.7% of the respondents felt that it is not that people who have failed to care for others are not caring; rather, it is the fear inherent in them. A further illustration of this included such comments by a PABA as Oh orun lala, Aa iku ni o meaning, oh, it sends straight to heaven, surely it leads to death".

Ignorance: One hundred and thirty four of two hundred and forty, (i.e.55.8% of the respondents) agreed that ignorance is a fundamental problem fuelling the inhibition of extending this attitude. For example, another PLWHA said "…as Yorubas, we appreciate people and it is natural to us but I tell you one thing, that ignorance breeds fear and fear breeds intolerance and the chain continues.' Also an AIDS service care provider asserted " if a mother knows that a child who is infected today can still be strong and be productive and even go ahead to benefit the mother in future, the mother will be motivated to care.

Fear of rejection by others: Thirty i.e 12.5 % out of two hundred and forty participants were of the opinion that Yorubas could not transfer their caring attitude as seen in other aspects of social relationships to PLWHA care and support because of the fear of also being rejected by others, and expressed reaction of others which is negative and discouraging. For example, One also remarked that she also regretted accepting to care for her (i.e a PLWHA) at home" Another respondent explained thus: "Because our family members like my own parents think HIV is contracted through immorality alone, I mean by indiscriminate sexual practices, they believe PLWHA are flirts and, as such, it is usual to believe that they are only paying for their sins," She added in Yoruba language that "O jere ise owo e ni" meaning he has reaped the fruit of his labour. For this reason, people are not usually interested, and as such are not willing to show care and support.

That ***AIDS has no cure*** is the expression of majority of the respondents. Ninety seven percent of the participants were of this opinion. An additional support to this finding could be observed in the comment of a voluntary outreach worker who said, “You will see, once the cure is found everybody including their family members will change their attitude”.

Another strong reason for the relatively poor attitude to care and support for PLWHA, as found in this study, is **discrimination and rejection**. Eighty three percent of two hundred and forty four respondents were of this opinion. Added to this a PLWHA said, “I think what is responsible for not being able to transfer the general attitude of caring of our people to those of us (i.e PLWHA) is that we are basically rejected by the society.”

From the aforementioned, the findings of this research show a wide gap in the care and support of PLWHA from the point of view of the role of the family, which is nonetheless being filled by the NGOs. As mentioned earlier, religious institutions also feature prominently as available support system for PLWHA as shown by the findings of this study. The NGOs are involved in support group activities where they meet the spiritual needs of the PLWHA. Through them, the spiritual significance of the PLWHA is enhanced.

4.11 Coping strategies

This section establishes how PLWHA cope with the problems associated with care and support. This was examined in relation to the attitudes, knowledge and practices associated with HIV/AIDS. Sick role of PLWHA was examined and their coping strategies were also revealed.

The first coping strategy revealed in the study was non- disclosure. Due to shame and ridicule, which HIV/AIDS attract, PLWHA do not disclose the incidence of their illness to their family members. They kept it secret and continued to suffer in silence. This situation delayed their visit to facilities close to their residence for care, because they do not want people who knew them to see them.

Another coping strategy was the use of traditional herbs in form of the local preparation made from the cashew tree for treatment of oral thrush, Agunmu (dry mixture), Agbo (herbal preparation) orin ata (special peppery chewing stick), mixture of Aloe Vera and honey, ose dudu (black soap) and so on were also found in the study to be useful to PLWHA in treating opportunistic infections. They usually take routine haematinics to enrich their blood and minimize their frail appearance.

Another coping strategy was the attendance of various support group meetings. Some among themselves, others between them i.e the PLWHA and voluntary outreach workers. The use of spiritual / faith healing was also found to be a coping strategy. Both Islamic and Christian faith healers were utilized, though the Christian faith healers were the mostly utilized as non-Christians also resorted to them for spiritual healing.Seventy five percent (75 %) of the respondents gave this account.

Part of the coping strategies was included in the activities of the NGOs. For example, various vocational trainings in form of basket making, crotchet weaving, nylon cutting, sponge and broom making as well as hairdressing, tailoring and so on were given to occupy the PLWHA and give them their means of livehood without undue stress. Small loan scheme to the tune of N5, 000 (five thousand naira) was also in place in some of the NGOS for PLWHA for petty trading such as pure water sales in Ibadan.

Also some of the PLWHA have learnt to adapt to their status through testimony-sharing. A PLWHA once said:

I am happy telling others about my status. I have no fear and I am not ashamed because I got it through my late husband. More so, as I share my experience especially to young ones in secondary schools, I see a determination in them to avoid this deadly virus. And I am happy, in fact I get better with each sharing experience.

CHAPTER FIVE

5.0 DISCUSSION OF FINDINGS

Data showed that 65 percent of the respondents were females and 35 percent of them were males. As in most developing countries, available data on HIV indicate a proportional distribution of HIV amongst males and females in Nigeria. However, long- term projections from the AIDS Impact Model point to a tilt towards female preponderance. This finding is corroborated by recent findings that the infection rate of HIV/AIDS is higher among women than men (UNAIDS, 2002; UNICEF, 2001). The biological fact that HIV more easily infects women than men is amplified here (Egero and Hammarskjold, 2000). Globally, however, more men are infected and dying than women (UNAIDS, 1999). Also men may not turn up due to culture of male superiority in Nigeria, which is evident in the study setting. HIV/AIDS started as gay disease among men. Women have, however taken over as revealed in this study. This has portrayed the vulnerability of women to HIV/AIDS more than men. This could be attributed to a lot of factors, one of which is sexual exploitation. Sexual exploitation of girls and women is not limited to prostitution, as many women and girls experience other forms of sexual abuse (Dare, Bachman, and Hill, 2000). Scarcity of jobs, the economic pressure of dependent children and inadequate financial support from husbands make some women vuluerable to sexual pressures at work. (Karanja Diejomoh, 1980 and Opong, 1995).

More specifically, the inequality between women and men may lead to sexual contacts being intertwined with male manipulation of economic advantage. As has been noted above, women and adolescent girls become involved in sexual affairs to obtain all kinds of favour. Students in tertiary education are also subjected to sexual pressure, as this study suggested. Findings of several studies indicated this (Ofoha, 1991; Rodipe 1992; Oloko and Omoboye 1993,).

In terms of vulnerability, HIV is most widespread among adults aged 20-24, with a nationwide prevalence rate of 8.1 percent in 1999. UNICEF (2001). From this study, highest infection rate was found among respondents of ages 20-39 years. All these PLWHA are in their reproductive years, which is a reflection of literature findings, that half of all HIV infections have occurred among sexually active individuals. (Isiugo-Abanihe, 1993; UNAIDS, 2000; Okesola, 2001; Jegede and Ajuwon, 2001).

The study also revealed that 2.7 percent of the PLWHA fall between ages sixty years and above. This becomes more important as two out of the five who fall into this category are sixty-six years while the remaining three are above seventy years.

Further probing revealed an exchange of farm products such as yam, palm oil, and bush meat for sex between farmers and the higher institutions girls in one of the settings. It has been estimated by AIDS Impact Model (AIM) that the number of infected persons in age fifteen to forty nine years group will soar to over five million by 2009, in the absence of major changes in sexual behaviour and other control measures. This is most likely where such farmers no longer engage in active farming and marry younger girls to take care of them and as such infect them. Such higher institution girls graduate from school and seek employment in other states and cities, and the spread of the intection continues.

This is a reflection of the proportional relationship between poverty and HIV/AIDS, which is supported by the findings of various studies. In fact Owumi and Ezeogu (2001), AIDSNET (2002) and UNAIDS (1999) corroborated the finding of this study in terms of age correlates with the national prevalence rate by age groups.

Occupational distribution of respondents, which showed the highest percentage of forty nine percent to be petty traders, is a further justification of the poverty among PLWHA. Also, the income level of less than ten thousand naira per month for over eighty percent of the PLWHA is a reflection of the proportional relationship between poverty and HIV/AIDS, which is supported by the findings of various studies. (FOS, 1999, Gwatkin et al. 2000, Dare, Bachman and Hill 2000,)

Generally the level of education of participants is low. This is a reflection of the low level of literacy in the nation as a whole (FOS/UNICEF, 2000). The implication of HIVand AIDS on the educational system as revealed in literature is further confirmed by this finding.

Generally in Yoruba culture, socio-biological problems are viewed from community perspective. An individual who falls sick is a concern of all the social systems to which he belongs. All the social systems work to ensure that the sick person regains his or her health. The social systems usually involved are the family and kinship, traditional and religious institutions, associational groups etc. In such a situation, all the groups work together in the perception of the disease, identifying the symptoms, providing home remedies and the logistics required to heal the sick person. When things seem not to be working out as desired, they then take the individual to the hospital.

Ilesa and Ibadan are fast growing cities and they have two-thirds of their population being Yorubas. Thus, the Yoruba culture of care for the sick manifest in these two communities.

These modern health care delivery system as well as others in most parts of the country are not able to cope with the health situation in Nigeria. For example, it is estimated that modern medical services cover about forty percent while the rest get catered for by medical auxiliaries and even quacks. In fact, as of now there are not yet adequate laboratory facilities for accurate diagnosis and confirmation of HIV positivity in the country. On some occasions, the needed reagents are not even available in the designated screening centres. Thus, the issue of absolute reliance on the hospitals for care and support of PLWHA may not yield desired results.

Nursing a PLWHA at home reduces the community's cost of reaching a PLWHA and encourages community's participation in the care of PLWHA (UNAIDS, I999). The essence of Home-Based Care (HBC) is that it does not require the creation of extra care where none exists. Sometimes hospital care is simply not possible. Home-based care also helps to ease the demand on the health system. According to UNAIDS, 1999, home care can mean that hospitals will be less crowded, so that doctors, nurses and other hospital staff can give better care to those who really need to be in hospital.

Nurses are the primary health care providers for patients with AIDS (Scherer, 1992); hence, literature abounds on nurses' attitudes towards, PLWHA. However, one area that has not received attention is whether or not there has been any significant changes in nurses' attitudes toward sPLWHA over time. The findings from this study revealed that majority of the PLWHA have encountered nurses in their care-seeking endeavours than any other health care worker and ninety-seven percent (97%) agreed to this. Although limitation exists, findings from this research provide information on changes in attitudes of healthcare providers especially nurses.

A very strong source of support is the family being the first point of contact. However, in this study few PLWHA enjoyed this as shown in table 4.3. Yet, this is an important aspect of care and support for PLWHA and it is the same in which its social support component is minimal as found in this study.

Already most African countries are employing HIV prevention interventions such as behaviour change and condom promotion, but these as interesting as they, are according to Makgoba (2002), have not been sufficient to reduce the incidence of HIV infections in all populations in Africa. A wide range of treatments for PLWHA is now available as presented in the findings of this study and as evidenced by literature review (Soyinka, 2002, Olaleye, 2003; Osotimehin, 2003). Antiretroviral drugs have been shown to be highly effective in controlling the progress of HIV disease in literature, but their high cost means they are not readily available to most patients in developing countries.

Patients may experience many treatable opportunistic infections and other symptoms, which put stress on health delivery systems as well as creating compliance problems when the treatments produce unpleasant side effects. And as PLWHA are living longer, they may become dependent on health care workers, and this can create psychological problems for both patients and care providers. Care givers working with PLWHA, especially those in the late stage of the disease, face the death of all their patients. Eventually, workers may become withdrawn and fatigued by multiple losses and the complex care needs of patients. In developing countries like Nigeria, these stresses are exacerbated by the lack of resources, in turn creating feelings of hopelessness because workers feel they have so little to offer patients in terms of treatment.

Many health care professionals find themselves unable to cope with the demands of the pandemic and begin to suffer from burnout because they can no longer actualise the healing and alleviation of suffering to which they are professionally committed. Hospitals are in undated and over flowing with very sick and dying AIDS patients while people with curable diseases and conditions are being turned away. HIV and AIDS make tremendous new demands on health services that cannot be met by hospitals alone. More so, because HIV infection (and all its accompanying complications) can last for months or years, a person with HIV infection or AIDS may move from the home to the hospital and back again several times. Because hospital care is very expensive, families can often not afford multiple admissions to hospitals. Hospitals themselves do not even have the personnel and resources to cope with the huges demands that AIDS makes on them.

Yet the loss of productivity and economic growth translates into less tax revenue for government-funded services, undermining a nation's ability to respond to AIDS. The already fragile health systems are also being robbed of skilled staff just at the time they are most needed. Skilled doctors and nurses are dying. UNAIDS calculates that, in some countries, illness and death rates among health workers have increased five or six folds as a result of AIDS (UNAIDS 2002). A sure hope therefore for coping effectively with HIV/AIDS is to look beyond the crisis and utilise the strength that has always resided in the family and community life.

In the study area mentioned, the central support system coordinating care and support for PLWHA is the non-governmental organisation as reflected in figure 4.3. The NGOs working with PLWHA link them with other available support systems. Hence, the impact of these available support systems was derived from the activities of the NGOs and the testimony of the PLWHA.

Record and statistics from the NGOs revealed a reduction in mortality rate of PLWHA from 50-80 percent in 1997 / 1998 to 5 - 8 percent in 2003. This is linked with care and support and demonstrated commitment to PLWHA.

The PLWHA linked with NGOs were observed to be less disturbed with opportunistic infections. Opportunities infections such as oral thrush and other minor signs and symptoms such as diarrhoea and skin rashes were well taken care of. As mentioned earlier, care rendered in Ilesa involves the use of local preparations for oral thrush, which clear it effectively. With this, mouth hygiene improved, appetite resumed and the PLWHA appeared better. In Ibadan, a corollary of this was "Orin-ata", a special chewing stick that also clears oral thrush and exercises the gum. According to some of the PLWHA in Ibadan, a mixture of aloe vera grinded into honey and rubbed on skin clears off skin rashes. All these were shared during support group meetings. They also provide routine haematinics (blood enriching drugs) at every clinic day both in Ibadan and Ilesa, which holds every 15 days.

Certain socio - cultural variables have implication on care and support for PLWHA in the selected communities. These variables include age, education, gender, economic status and belief system. The study revealed that majority of the PLWHA fall below 40 years of age. The "sexually active" nature of this age group makes them more vulnerable to HIV/AIDS. Also, exposure to infection in early 30s and late twenties may have expression in this age group. This implies that more PLWHA were in their productive years, and this productivity is supposed to be useful in development of their societies but rather was used in searching for care and support.

Another factor having implication for care and support for PLWHA is education. Eighty three percent of the identified PLWHA were either illiterate or do not attain more than low level of education. Only 15.8 percent of the PLWHA have higher educational standard. Implication of this is that there was low reporting of infection of HIV/AIDS among those having higher educational level. Another implication is that this group of PLWHA might have resulted into self-care as a result of shame and ridicule which has more impact on them due to their status. And it could also buttress the fact that HIV and AIDS affect the 'poor' more.

Another implication is that fifty four percent of those with high education receive care from hospital, while those with low level of education (76.7%) receive care from the NGOs. also PLWHA with low education have general appearance of self-pity, which is attributed to stigmatisation and rejection. Only five percent of those with high education received support from their immediate family and none among those with low level of education. This may be attributed to non-disclosure.

Gender also has implication for care and support because women faced more rejection, women very rarely own land, despite their heavy involvement in agriculture. Without collateral, it is difficult for them to obtain credit. To a considerable extent, these problems affect all the poor but women are doubly disadvantaged, and the PLWHA are not immune to it but rather are further susceptible. However, as it was found in this study, more women participated in support group activities and appeared to be coping better. There is a need to continue also to examine the role of gender in social aspects of HIV/AIDS. Women and men are clearly affected by HIV/AIDS differently, from coping strategies to media images. Belief system is another socio-cultural factor, which featured prominently in the study as having impact on care and support for PLWHA.

Similarly, attitude of health care workers though changing as this study revealed, is having a negative impact on care and support. Poverty was the basic reason treatments such as ARV drugs were either not sought, or sought and started but not sustained, Furthermore, attitudes of others including family members and health workers alike account for unwillingness of twenty percent of the two hundred and forty respondents to disclose their status and to seek care and support.

The social consequences of the HIV and AIDS epidemics have gone un-recognized for too long. Researchers of HIV/AIDS have for years examined drug unions, treatments and transmission of HIV, but far less work has examined the relationships of people with HIV and AIDS and how people with HIV and AIDS live with the disease.

With new treatments, PLWHA are living longer, even further reinforcing the need to study social aspect of HIV and AIDS. It may be that with increased awareness, more people are also aware of diagnosis earlier in the course of the disease and are receiving health care earlier. Very little research is presently available that explores the relationships of People with HIV. Much investigation of health problems has not been conducted given to increase the psychological, emotional, and relational quality of the lives of PLWHA.

Yet, there can only be little doubt that PLWHA are in need of a tremendous amount of social support. As Adelman and Frey (1997) explained:

> *Considering the physical devastation, uncertain symptomatology and omnipresent sense of impending death associated with this disease, the loss of significant others to AIDS and the fragile social network left behind for those still living with it and the society stigma associated with AIDS that often results in the loss of social support: no other group of people may have need for communication than those affected by AIDS.*

PLWHA need social support to restore self-esteem, to create meaning during the crisis and to gain control over their lives. Given the importance of social support for PLWHA, perhaps what is most insidious about this disease is the collapse of traditional institutions and system that are supposed to provide such support. Institutions such as health care, churches, mosques and schools have generally failed to adequately address the unique need of PLWHA.

The failure of these social institutions is, in part, a result of the stigma attached to AIDS as found in this study. Stigma and discrimination are the major obstracles to effective HIV/AIDS prevention and care. Fear of discrimination may prevent people from seeking treatment for AIDS or from acknowledging their HIV status. People with, or suspected of having, HIV may be turned away from health care services, denied housing and employment, shunned by their friends and colleagues, turned down for insurance coverage or refuse entry into foreign countries. In some cases, they may be evicted from home by their families, divorced by their spouses, and suffer physical violence or even murder. The stigma attached to HIV/AIDS may extend into the next generation, placing an emotional burden on children who may have lost their parents to AIDS. With its focus on stigma and discrimination, the campaign will encourage people to break the silence and the barriers to effective H IV/AIDS prevention and care. Only by confronting stigma and discrimination will the fight against HIV/AIDS be won.

Given the failure of various macrostructures to meet the need of PLWHA, we must then rely often on "healing web" of the constellation of informal care givers- community members, kins and lovers or friends who provide social support (Addman, 1989). Unfortunately, loss of support from caregivers is all too common. In the case of family system, for example, although AIDS is sometimes a catalyst for pulling a family together (Kaisch and Antonculver, 1989), loss of social support from family members is far more common (Melts, Manns, and Kruzic, 1996). The majority of PLWHA felt that family was not very close or warm, had minimal or no contact with their family and had been rejected by, at least, one family member (Weitz, 1990). Even in families with strong bonds, sons and daughters with AIDS are often abandoned.

Particularly, this shift is motivated for the reason of absence of cure for HIV and AIDS at present, and since nobody knows when cure would be discovered, the best option is to take good care of those infected. This will enable them to still contribute to society development. Despite this recognition, due to certain relative cultural and social factors, the fulfilment of this target is constrained in many societies; typical of this society is the Yoruba people of southwestern Nigeria. In the study area, conception of HIV/AIDS, and perception of PLWHA as shown in the findings, is governed by cultural misperception. These have created stigmatisation and rejection of PLWHA. Yet, the culture claims to have social institutions such as family, kinship and associational groups, both religious and non-religious.

As a result of this misconception of HIV/AIDS, and misperception of PLWHA, the Yoruba people fail to extend social affinity to PLWHA. Rather, PLWHA are treated as undisciplined, morally unfit sinners who should be left to die of their sins. It could be better if this conception is strictly upheld to prevent the infection, but since HIV/AIDS is not absolutely linked with immoral sexual practice only, it becomes impracticable to employ this perception and attitude to prevent the infection. Thus the alienation resulting from rejection and stigmatisation faced by PLWHA, as a result of cultural prejudice and misperception against their sick, does not work in favour of the society, but against development. As noted in the study, the misconceptions create barriers against care and support. Hence, the increase in morbidity and mortality associated with HIV and AIDS. The implication of this is progressive decline in human productivity and waste of enormous resources, which would have been invested on PLWHA before they were infected with the disease.

Similarly, poverty, low level of education and inadequate hospital facilities were other factors affecting better care and support for PLWHA in Yoruba communities. As the whole world is eagerly expecting permanent cure for HIV/AIDS, the only way to reduce its negative implication is to encourage everybody to be involved in care and support for PLWHA. To do this there is need to re establish the family institution, which is the corporate existence of members, break the backbone of stigmatisation in HIV/AIDS through appropriate health education.

From the aforementioned, it is evident that single organisation cannot solve the problem of HIV/AIDS. As many as such organizations may be, however, they need to rest on the community organizations such as the family, and not NGO and hospital as found in this study. This will reduce burdens on the already over - stretched health care delivery system. In the same way, it is the PLWHA themselves who can break stigmatisation and should be motivated and empowered to do so. Also, there is need for strong health education to reposition the role of family in illness and disease situation.

CHAPTER SIX

6.0 SUMMARY, CONCLUSION AND RECOMMENDATIONS

6.1 Summary

From the findings of this study, a number of inferences could be drawn which relate to the main objectives of the study, research questions and the theoretical background.

The respondents who participated in this study differed in terms of their socio-demographic characteristics as shown in Table 1. For example, they vary in terms of form of marriage, which include polygynous practices, spousal cohabitation and separation experiences. Out of the thirty percent respondents who were unemployed as shown in table 1, twenty percent were women, which is a reflection of the economic dominance of the male gender. The economic implication of HIV/AIDS care and support is as such felt more by women.

Also, more of the PLWHA who participated in the study were Christians. This may be due to the fact that there are more christians in the selected areas. Beside, it may also show that christians are open to care seeking behaviour. It could also mean that more chritians are living with HIV/AIDS. This reveals the impact of belief system on care and support.

Three patterns of care and support systems were identified. These were Family support, Hospital Support and support from the NGO's with the last been the most utilized and the first, the least utilized. This calls for more involvement of the family members in HIV/AIDS care and support.

Coping mechanisms of PLWHA in the study include non-disclosure of their status, religious affiliation and relocation. These are not healthy mechanisms, which show a further need for more involvement of the family in the care and support for PLWHA. Love and acceptance was found as the highest need of PLWHA, above the need for drugs, testing, job, food, money and others.

The findings of this study did not support the underlying assumption of Yoruba kinship role in HIV/AIDS care and support. This was attributed to fear, ignorance. Some of the limitations identified include: poverty, non-disclosure of HIV/AIDS status to partners and family members, difficulty in accessing ARV, exorbitant testing fee, negative attitudes of care providers and family members were other limitations of PLWHA in seeking care and support. The highest sources of limitation were discrimination, stigmatisation and poverty as revealed in the study.

In the same vein, it was found in the study, as shown in Table 1 that as high as sixty - five percent of the PLWHA were in one form of marriage or the other with 2.2 percent notification and self disclosure and these have implications also for care and support. Besides, 5.4 percent of them have lost their partners to AIDS. This is in agreement with SIDA report (2000) and UNAIDS (2002) that HIV/AIDS has contributed to the doubling of mortality among adults in reproductive ages.

6.2 Conclusion

It is necessary to note that AIDS is yet to have cure. What can be done therefore in order to stem the tide of the AIDS pandemic in our continent is to ensure that the family, as a basic unit of the society act in its rightful position as a reinforcing factor. The only practical and humane solutions deducible from this study could be summed up as follows:

i. That patients be cared for in their own homes and communities, for as long as possible, instead of what the practice is now where the family members are not actively involved in care and support of PLWHA. This will go a long way to facilitate disclosure and in the long-run minimize stigmatisation and discrimination.

ii. That clinics and other health care support, systems in the community be utilised for advice and support, and

iii. That hospitals be used as a last resort when a patient's condition has deteriorated and when professional help is needed.

6.3 Recommendations

Firstly, economically disadvantaged individuals are more prone to engage in high - risk behaviour, such as commercial sex work as seen in this study which was manifested in form of exchange of sex among young female students of higher institutions for farm produce. Majority of the PLWHA as shown in this study were also not well-educated and therefore were less likely to receive information or once infected or otherwise affected, to obtain access to services.

Furthermore, by its very nature, AIDS further impoverishes the affected individuals, families and communities due to its protracted nature, its high management cost and the fact that it particularly affects the economically active groups in society. This problem creates a vicious cycle, leading to an almost permanent trap in the absence of effective strategic interventions. Large number of deaths in the productive population age groups can ultimately lead to large - scale economic and developmental losses in affected communities and entire nations.

Beyond the individual level, national concerns about the cost of responding to HIV/AIDS is another major issue. Despite the threat that the epidemic poses to millions of Nigerians, the cost factor has discouraged actions to implement some measures which are known to be highly effective in combating and managing the disease. Top on the list of such is a comprehensive essential care and support package, and the provision of free anti-retroviral drugs to PLWHA, especially, to expectant mothers, a method of reducing the risk of mother- to - child transmission in Nigeria.

Others include voluntary counselling and HIV testing as well as the implementation of a system to ensure the safety of blood provided through the national blood transfusion service.

Some of the suggested recommendations to every stakeholder in the issue of HIV/AIDS issue at individual, community, government and non-governmental levels, therefore, include: reversing earlier education campaigns on HIV/AIDS which depict AIDS as death personified, more education and involvement of family members and health workers on care and support of PLWHA, establishment of more NGOs in HIV/AIDS care and support as well as effective utilization of IEC materials on care and support. There is, therefore, the need for more involvement of PLWHA in HIV/AIDS campaigns as well as assertiveness training for coping and disclosure of HIV/AIDS status there is also the need for more enlightenment programmes to re-orientate family members about HIV/AIDS and also reposition the family as far as proper aweaness of the scourge is concerned in its rightful position. Existing NGOs need to be strengthened and an enabling environment created for establishing new ones. Furthermore, there is an urgent need for integrative approach in care and support of PLWHA.

Specifically, Yorubas should be re-orientated on the importance and relevance of the rich value of kinship, mutual love, sharing and caring for one another. This goes a long way in reducing the stigmatisation, discrimination, and isolation of PLWHA, which have been found in this study to be the bedrock of the problems related to the care and support of PLWHA. As we eagerly expect the permanent cure, support for PLWHA is affordable by all.

6.4 Study Limitations

One of the major limiting factors in this study was the problem encountered in getting respoundents for the study. The researcher set out from the onset of the proposal with the beginning sample size of two hundred PLWHA, which could not be achieved. Therefore, only one hundred and eighty four PLWHA participated in the study.

Another major limitation was the serious hike in fuel prices and its attendant crises such as incessant strike actions, which nearly halted the process of data collection for the study. Similarly, the researcher was seriously finacialy constrained in the course of the study. The researcher attempted to take care of this by giving daily honorarium during data collection. The subsidy given in this direction was however limited compared to the total challenge of feeding and transportation.

High mortality rate among PLWHA was also contributory in limiting this study as all the seven PLWHA selected for case studies died as at the time of compiling this report thus hindering any possible follow up study.

6.5 Suggestions For Further Studies

The findings in this study must be considered as a preliminary to further studies and clearly require replication. Several limitations to the generalizability of the present findings need to be addressed. For example, the sample of PLWHA was not entirely representative; a larger sample is therefore desirable. Following from this research, it is suggested that future researchers covering a wider scope such as the entire country should replicate the study. And the finding that reveals a high preverence of HIV/AIDS among Christians sould also be further investigated.

It is also suggested that more studies on care and support should be embarked upon. In the same vein, there is need for studies to assess the impact of various HIV/AIDS education campaigns.

Similarly, the present study concentrated on adults and yet the PLWHA have children. A future study on the quality of care and support for children who are infected or affected by HIV/AIDS is recommended.

APPENDIX I: Interview Guide for PLWHA

Identification number:………………

Introduction:

Consent

1. General discussion about sport/trade/occupation or profession/politics/economy and so on.

- What do you do for a living?

- What is the duration of your training or education?

- What level of education can one attain to be able to function in this capacity?

2. Marriage and Family?

- Are you married? If yes, when? And if no at what age will you like to get married?

- How soon do you observe that members of this community usually get married and why?

- How do people spend their premarital lives and why?

- If you are to have only one child and you are given the option which one will you choose - a boy or a girl and why?

3. STDs/AIDS

- Have you ever heard of diseases that can be transmitted through sexual intercourse? If yes mention them.

- Have you ever heard of HIV or the germ that causes AIDS? If yes, when and where?

- What do you understand by HIV/AIDS? Describe the 3 common routes of transmission

- What are the signs and symptoms

- Since you heard of HIV/AIDS what changes have taken place in your behaviour to avoid been infected.

4. HIV Test

- Have you heard of HIV test before?

- Have you been tested? If yes when and where? If no, why?

- Do you think everyone should be tested? If yes, why? And if no, why?

- Do you think people will voluntarily go for test if it is freely available? If yes, why? And if no, why?

5. Stigma and Discrimination

- Would you be willing to relate in any way to a person you knew had HIV/AIDS? If yes, why? And if no, why?

- If the person is a member of your family will you still not relate with him? If yes why? and if no, why?

6. Care and Support

- What is the pattern of care in this community toward an ill person

- When the illness or disease is AIDS related does this pattern of care and support still holds?

- Irrespective of HIV/AIDS do children have a good chance of being supported and cared for?

- If yes to the above question explain and if no give reasons.

7. Attitude to Care and Support

- Would you be willing to care for a member of your family who is living with HIV/AIDS? If yes, why? And if no, why?

- In your own opinion should healthcare providers be allowed to refuse to care for a person who is HIV positive? Give explanation to your answer.

8. (A) Context of HIV/AIDS CARE AND SUPPORT

- What factors are militating against adequate care and support of PLWHA in your community?

- How can these factors be tackled?

- Whose responsibility it is to care for PLWHA

- Whom should HIV positive people disclose their HIV status

- Is there any relationship between means of becoming infected and quality of care received?

- Do socio-cultural factors such as belief system have impact on care given and care received? Explore reasons.

APPENDIX II: Interview Guide for Care Providers

Identification number:………………

Introduction:

Consent

1. General discussion about sports/trade/occupation or profession/politics/economy and so on.

- What do you do for a living?
- What is the duration of your training or education?
- What level of education can one attain to be able to function in this capacity?

2. Marriage and Family?

- Are you married? If yes, when? and if no at what age will you like to get married?
- How soon do you observe that members of this community usually get married and why?
- How do people spend their premarital lives and why?
- Have you ever heard of HIV or the germ that causes AIDS? If yes, when and where?
- What do you understand by HIV/AIDS? Describe 3 common routes of transmission
- What are the signs and symptoms of HIV/AIDS that you know
- Since you heard of HIV/AIDS what changes have taken place in your behaviour to avoid been infected both as an individual and as a care provider.

3. HIV Test

- Have you heard of HIV test before?

- Have you been tested? If yes when and where? If no, why? Does this have anything to do with your responsibility as a care provider?

- Do you think everyone should be tested? If yes, why? And if no, why?

- Do you think people will voluntarily go for test if it is freely available? If yes, why? And if no, why?

4. Attitude to care and support

- If you are given two choices: (1) Working in an outfit full of HIV-infected patients or (2) working with no HIV-infected patients, which one are you going to choose and why? Explore responses.

- What do you have to say about reactions of care providers to PLWHA in the past and now. Are there changes? If there are, what in your own understanding are responsible for these changes?

5. Context of HIV/AIDS CARE AND SUPPORT

- What is the single most important change you would suggest to improve services for HIV-infected individuals or families?

- List 3 barriers that your organisation has faced or is presently facing when providing care to people living with HIV/AIDS.

- To what extent will the following help you to better service clients/people living with HIV?

- Opportunities for networking among providers to share information and HIV care and available resources.

- Training to gain additional experience/knowledge about providing HIV care, such as ARV, dealing with opportunistic infections, and monitoring and explaining patient's health status.

- Providing services in a more convenient manner (such as better office hours, quicker appointments, less waiting)

- Training on how to better advocate for clients
- More funding
- Others (Specify) ---

6. What are your future plans in terms of HIV/AIDS care and support?

7. In the last one year, please estimate the total number of HIV/AIDS patients you have served.

8. Do you Cefer your Clients to any of the Following?

a. Medical Services

b. Social Services

c. Other Counselling services

d. NGOs

e. Family Planning and MCH Services

f. TB/Chest clinic

g. Spiritual groups

h. Traditional healers

i. Others (Specify): ---

When you refer clients, does your institution/facility have a way of tracking referrals? If yes, how? And if no, why?

9. In your Facility what Forms of care and Support do you render to PLWHA?

....
....
....
....

APPENDIX III : ITONISONA FUN IFORO-WA-NI-L'ENUWO

Nomba Idanimo

Oro Akoso

Gbigba ase fun ise iwadi

1. Ijiroro lori ere idaraya, oro aje, oko owo / ise oojo, oselu ati bebe lo

- Iru ise wo ni o n se gege bi ise onje oojo
- Kini akojopo iye odun ti o fi lo si ile iwe tabi iye eko ti o ni.
- Iru iye eko wo ni eniyan ni lati lee se iru ise e re.

2. Ipo tabi iru igbeyawo ati molebi

- Nje o ti ni l'oko /iyawo ? Beeni tabi Beeko? Bio ba je beeni , nigbawo ni? Bioba si je beeko, igba wo ni o fe ge'yawo tabi l/oko ?

3. Lati igba ti o ti gbo nipa kokoro arun tabi aisan eedi, kini awon iyato ti o ti de ba ihuwasi re lati sora lati ma l'ugbadi aisan naa?

4 Ayewo kokoro arun eedi

- Nje o ti gbo nipa iyewo kokoro arun eedi ri?
- Nje o ti se ayewo ri? Bi o ba je bee ni igbawo ati ni ibo ni? Bi o ba si je beeko, kini o faa?
- Nje o lero pe gbogbo eniyan ni o ye ki a ma se ayewo fun? Bi o ba je beeni, kini o se so bee? Bi ko ba je bee, kini o faa?
- Nje o lero pe awon lee ma a finufido lo maa se ayewo ara won bi iru anfaani ayewo ofe ba wa? Bi o ba je beeni, Kini ose so bee? Bi o ba je beeko, kini o se so pe beeko?

5 Fifi ami buburu si eni lara ati ideyesi

- Nje o lee finufido ba eni ti o mo pe o ni kokoro arun tabi aisan eedi da ounkoun po? Bi o ba je beeni, kini o fi so bee? Bi o ba si je beeko, kini o de ti o fi so bee?

- Bi iru eni bee ba je molebi re, se o o tun ko sibe lati ma ba iru eni bee da ounkoun po? Bi o ba je bee, kini omu o so bee? Bi o ba je beeko, kini o je ki o so bee?

6 Itoju ati atilehin

- Kini ona ti awon ara agbegbe yi ma n'gba toju awon alaisan laarin won?

- Bi iru aisan yi ba wa a niise pelu aisan eedi, nje iyato ma n ba iru itoju ati atilehin yi?

- Pelu eedi tabi aisi arun eedi nje awon omode maa n ni anfaani lati ni itoju ati atilehin ti o to?

- Bi idahun re loke yi ba je beeni, se alaye siwaju si, Bi o ba si je beeko se alaye siwaju si.

7 Ero okan ati ihuwasi nipa itoju ati atilehin

- Nje o lee se itoju molebi re ti o ni kokjoro arun tabi aisan eedi? Bi o ba je beeni, kini idi re? Bi o ba je beeko, kini idi re?

- Ni ero tire nje o ye ki a gba awon osise ilera laaye lati ko lati se itoju eni timo ba ni kokoro arun eedi? Se alaaye lori idi ti o fi dahun bayi?
8 Koko oro lori itoju fun kokoro tabi aisan eedi?
Kini awon idiwo fun itoju ati atilehin ti o pe'ye fun awon ti o ni aisan eedi ni agbegbe re?

Ona wo ni a lee gba lati mu isoro wonyi kuro?

Ojuse tani lati pese itoju fun eni ti o ngbe pelu kokoro tabi aisan eedi?

Tani o ye ki awon ti o ba ni kokoro tabi aisan eedi koko jewo fun pe won ni kokoro arun yi lara?

Nje ibasepo kankan wa laarin ona ti eniyan gba ko kokoro arun eedi ati iru itoju ti eniyan le ri gba ?

Nje awon oro asa ati awujo gegebi oun ti eniyan gbagbo ni ipa kankan lori iru itoju ti alaisan lee ri gba?

Bi a ba fun o ni anfaani lati yan eyi ti o fe laarin pe ki o maa sise laarin ibi ti awon alaisan ti o ni kokoro arun eedi po si ati ibi ti o je pe ko si alaisan ti o ni kokoro aisan eedi wa, ewo ni o o mu ninu mejeeji? Kini o faa ti o fi dahun bayi?

Kinin ohun iyato ti o se pataki julo ti iwo yio mu lati je ki aye derun fun eni ti oni arun eedi ati ebi won.

- So ohun idiwo meta ti Ile-ise yin ba pade nipa titoju awon ti oni kokoro arun eedi

- Bi bawo ni awon ohun ti a so nipa re le gba ran yin lowo lati ko ipa ti o posi ninu itoju awon ti o ni kokoro arun eedi

-Nje ajosepo ti o gun rege laarin awon ti o n pese itoju fun awon ti oni kokoro arun eedi ati bi won se

n'jijo lo awon ohun elo ti o wa ni ayika won.

-sise ilani loye lori itoju kokoro arun eedi, ogun fun kokoro arun eedi, didoju ko awon aisan ti on,suyo lati ara kokoro arun naa, itopinpin ati sise alaye lori ipo ilera ti alaisan wa.

-ati ma pese itoju ni ona ti o tun rorun si ju ti tele gege bi asiko ise ti o rorun, dida won lohun ni kiakia

- Idani leko lori bi a ti n se igbejoro fun eni ti oni kokoro arun eedi

- Ipese opolopo owo fun itoju awon eniyan toni kokoro arun eedi

- Awon miran (Se alaye)………………………….

9. Kini afojusun re nipa itoju ati atilehin fun awon eniyan ti o ni kokoro arun eedi?

10. Larin odun kan sehin so ni soki iye awon eniyan ti o ni kokoro arun eedi ti eti pese itoju fun.

11. Nje e man dari awon olugbatoju yin si eyikeyi ninu awon wonyi:

a. Onise eto ilera

b. Onise iranwo aarin awujo

c. Awon olugbani ni imoran

d. Olupese itoju ti o je ti aladani

e. Awon onise f'eto si omo bibi ati ilera iya

f. Ile ayewo arun iko fehe

g. Awujo awon onise ti elemi

h. Onisegun Ibile

i. Awon miran (Se alaye)…………………………

Ni igba ti e ba dari awon alaisan lo si ibi miran, nje e ni ona ti e ngba lati t'opinpin won lo si ibe? Bi o ba je beeni, bawo ni e se n see/ bi o je beeko, kini o faa?

12 Iru itoju ati atilehin wo ni e n fun awon ti won ni kokoro arun tabi aisan eedi?……………………………………………

FOCUS GROUP DISCUSSION TOPIC GUIDE FOR PLWHA

Introduction

- Introduction of research facilitators.
- Purpose of gathering
- Breaking the Ice
- Introduction of Participants.

Existing Patterns of Care for the Sick

1. Where do people go for health care when they are sick in this community?

2. Who own such facilities and who are the care providers?

3. What kind of relationship exists between type of facility and nature of illness?

4. Tell me about adequacy of these facilities to meet the health needs of the people in this community.

5. Are these patterns available on equal basis for all diseases? If yes, explain and if no, tell me about the factors responsible for this inequality.

6. Tell me about what providers should do to serve you better.

Availability of support systems

7. What are the available support systems for the sick in this community?

8. Where could you go today to get support if you or someone close to you is sick?

9. If the illness is as a result of HIV, will such support systems still be available?

10. Can you imagine any circumstances under which you were denied access to such support? (Probe for further eplanation)

11. Which of these support services do you find easily accessible and comfortable with? (Request for examples of vivid illustration to drive point home).

Challenges/ Problems/ Limitations of Seeking Care and Support by PLWHA

12. What problems or difficulties do you encounter in seeking care and support

13. Do you think these problems are peculiar to PLWHA alone? Why did you say so?

14. Rate these difficulties according to their magnitude

14.How would you describe your experience in receiving care and support services at the hospitals.(Explore explanation for reasons behind descption).

Coping with HIV/AIDS.

15. What coping mechanisms do you utilize in facing the enumerated challenges?

16. What are the changes that have taken place in your lifestyle as a result of HIV/AIDS?

17. How do you find this adjustment?

18. Would you feel insulted if unable to meet up with these challenges?

19. How have you been coping with societal reactions to your illness

Disclosure

20. Have you ever disclosed your status to anyone? (Probe to know when and why)

21. How did you find disclosure?

22. Do you think this has any influence on your care and support? Explain.

23. Did you inform your sexual partners about your HIV/AIDS status? (Probe for partners' reaction.)

24. Why do you think he or she responded that way?

Stigmatization and Discrimination.

25. Have you ever been rejected, stigmatized or discriminated against as a result of your HIV status?

26. Could you explain why you answer this way?

27. Have you noticed any differences in the way people treat you or other PLWHA in the recent times? Please share this experience with me.

Antiretroviral Therapy.

28. When were you diagnosed to be HIV positive?

29. Have you sought any treatment, which type and where?

How long after being diagnosed did you commence treatment? (Explore reasons for delay if any and what was done during that period.)

30. Are you on antiretroviral drugs? When did you commence treatment and how regular have you been on it. (Probe for cost and reasons for irregularity if any.)

31. Tell me your candid opinion about ARV drugs in terms of efficacy, side effects, cost, availability, and so on.

General Comments

In your own opinion what should care and support of PLWHA entail?

Rank in order of priority what can be done for you in terms of care and support to make you happy or that you will cherish.

Is there anything I ought to have talked about which I have not and you will like us to discuss?

Kindly mention whatever is bothering your mind that you will like to share with this gathering.

FOCUS GROUP DISCUSSION TOPIC GUIDE FOR CARE PROVIDERS

Introduction

- Introduction of research facilitators.
- Purpose of gathering
- Breaking the ice
- Introduction of participants.

Existing Patterns of Care for the Sick

1. Where do people go for health care when they are sick in this community?
2. Who own such facilities and who are the care providers?
3. What kind of relationship exists between type of facility and nature of illness?
4. Tell me about adequacy of these facilities to meet the health needs of the people in this community.
5. Are these patterns available on equal basis for all diseases? If yes, explain and if no, tell me about the factors responsible for this inequality.
6. Tell me about what you as care providers can do to serve PLWHA better.

Availability of support systems

7. What are the available support systems for the sick in this community?
8. Where could you get support if you need to help someone who is sick?
9. If the illness is as a result of HIV, will such support systems still be available?

10. Can you remember any circumstances under which you were denied access to such support because the person is living with HIV/AIDS (Probe for further eplanation)

11. Which of the support services do you think the PLWHA find easily accessible and are comfortable with? (Request for examples of vivid illustration to drive point home).

Challenges/ Problems/ Limitations of Seeking Care and Support by PLWHA

12. What problems or difficulties do PLWHA encounter in seeking care and support in your organization?

13. From your experience in relating with the PLWHA what can you say is or are responsible for these problems?

14. Do you think these problems are peculiar to PLWHA alone? Why did you say so?

15. Rate these difficulties in your opinion according to their magnitude.

16. List the three most difficult barriers you are currently facing in an attempt to provide care and support for PLWHA.

Attitudes Towards PLWHA

17. How would you describe your experience in terms of relating with the PLWHA in the past, now and probably in the nearest future? (Probe responses to elicit information about discrimination)

18. Share with me your limitations in providing care and support for PLWHA

19. What are your areas of need in terms of promoting your care and support services

20. What do you have to say about the relationship between care and support of PLWHA and their gender?

APPENDIX IV

FACULTY OF SOCIAL SCIENCES

DEPARTMENT OF SOCIOLOGY

UNIVERSITY OF IBADAN
IBADAN
Semi structured Questionnaire

Dear Respondent,

I am a postgraduate student of the above-named department currently undertaking a study titled "Care and Support of People Living with HIV/AIDS among the Yoruba of South Western Nigeria". The study is important in contributing to improving the quality of life of people living with HIVAIDS. Your honest response will be appreciated and your confidentiality is guaranteed.

CONSENT FORM

I am a postgraduate student of the Department of Sociology, Faculty of the Social Sciences, University of Ibadan, working on care and support for people living with HIV/AIDS (PLWHA) for my Ph.D thesis. The objective of this study is to explore care and support systems available for PLWHA among the Yoruba people of Ibadan and Ilesha, southwestern Nigeria. I hereby seek your consent to participate in this study and your participation is voluntary.

In the process, you will be asked some personal questions about your experiences regarding HIV/AIDS care and support. The interview will take about thirty to forty - five minutes to complete. No injury except for your time. Participation is entirely voluntary and even after the beginning of the study you can decide to terminate your participation at any point. Also, your confidentiality is guaranteed. This discussion will also be recorded for no other reason than academic purposes. Your participation or non - participation will have no effect on services that you may receive from health or social service providers or even the benefit of the study outcome.

This study will help develop a better understanding of the care and support of PLWHA. As a participant in the study you will receive reimbursements of your transport fare. If you decide to participate, you are hereby asked to sign or thumbprint below.

Mrs Prisca Olabisi ADEJUMO or head of sociology, U.I. is the person to contact if you have any question about the study or about your rights as a study participant. Mrs Adejumo can be reached through a call at 0803 392 3260 or bisiandbayo@yahoo.com

Date:--------------------- Respondent's signature ------------------------------------

Interviewer's signature ---

SECTION A: BIODATA

1. In what month and year were you born?

2. Day----- Month---- Year----.

Sex

1. Male [ ]

2. Female [ ]

3.Religion

1. Christianity [ ]

If Christian, denomination ------------

2. Islam [ ]

3. Traditional [ ]

4.Others (Specify---

4. Marital Status

1. Married [ ]

2. Single (never married) [ ]

3. Living together (cohabiting) [ ]

4. Engaged/about to be married [ ]

5. Separated [ ]

6. Widowed [ ]

5.

Educational Background (highest educational level)

1. No formal education [ ]

2,Primary School uncompleted [ ]

3. Pry completed [ ]

4. Secondary uncompleted [ ]

5. Secondary completed [ ]

6. Post Secondary [ ]

7. Others (Specify) ------------------

6. What is your Ethnic group?

1. Yoruba [ ]

2. Igbo [ ]

3. Hausa [ ]

7.What is your main occupation/profession?

1. Unemployed [ ]

2. Farming [ ]

3. Artisan/craft product [ ]

4. Wages/salaried work [ ]

5. Business [ ] Type__________

6. Unpaid family worker [ ]

7. Trading [ ]

8.Which local government area are you from?

……………………………………

9. How much is your actual or estimated income per month?

……………………………………

Section B: Knowledge of HIV/AIDS

10. What is the difference between HIV and AIDS?

----

11. Is everyone at risk of contracting the infection? Yes [ ] No [ ]

12. If yes, how?: --

If no, why? --

13. List 3 common ways of transmission of HIV

i.---

ii.---

iii.---

14. Is AIDS curable? Yes [ ] No [ ]

15. AIDS is actually a manifestation of the wrath of gods (1)Yes [ ] No [ ]

16. An individual infected with HIV is capable of infecting others despite the absence of symptoms (1) Yes [ ] (2) No [ ]

17.Should everyone be tested for the AIDS virus? (1) Yes [ ](2) No [ ]

18. If yes, why? --- and if no, give your reasons---

Kindly signify your knowledge by shading (1) for yes, (2) for No and (3) for not sure. One response should be given to a question.

Yes (1)

No (2)

Not sure (3)

19.

20.

. HIV is caused by a Bacterium

. HIV is caused by a Virus

. HIV is commonly spread through

- Sexual behaviour
- Food
- Perinatal transmission
- Airborne transmission
- Water
- Intravenous transmission
- Casual contact
- Unprotected vaginal intercourse
- Unprotected anal intercourse
- Sub-lingual route

- Toilet seats
- Tears
- Saliva
- Sharing needles and syringes
- Breast milk
- Mosquitoes
- Sharing tooth brushes
- Sharing razer blades
- Mouth-to-mouth resuscitation

SECTION C: CLIENT'S NEEDS AND SATISFACTION

21. How long ago did you learn you were HIV positive?

i.Lest than 12 months

ii.1-4 years [ ]

iii.5-9 years [ ]

iv.10 years or more [ ]

v.Don't remember [ ]

22. How did you come to know about it

1. While ill in the hospita [ ]
2. Voluntary testing [ ]
3. Routine check up [ ]

23. Where was the testing done?

1. NGO outfit [ ]
2. AIDS service organization [ ]
3. Hospital setting [ ]
4. Home/community [ ]

24. How soon after being diagnosed did you receive HIV-related medical care?

Hospital1. No medical care [ ]
2. Immediately after being diagnosed [ ]
3. Within 6 months of being diagnosed [ ]
4. When I became sick [ ]
5. I am on traditional medicine [ ]
vi.Others (Specify)------------------------

25. Do you have a regular place you go for HIV health care?

1. Yes [ ]
2. No [ ]

26. If yes, where ---

2. Non-Governmental Organisation
3. AIDS Service Organisation
4. Others (Specify)------------------------

27. Do you have a regular health care giver who takes care of your HIV health care needs?

1. Yes [ ]
2. No [ ]

28. If yes, identify

1. Nurse [ ]
2. Doctor [ ]
3. Social Worker [ ]
4. Counsellor [ ]
5. Psychologist [ ]
6. Others (Specify)------------------------

29. How did you find disclosure of your HIV status?

1. Easy [ ]
2. Difficult [ ]
3. Impossible [ ]
4. Others (Specify)-----------------------

30. To whom have you ever disclosed your HIV status?

1. Health care giver [ ]
2. Family member [ ]
3. Nobody [ ]

5. Others (Specify) ---------------------

31. Is there anyone else in your household (family members, partners/spouses, close friends or associate etc) who is also HIV positive?

1. Yes [ ]
2. No [ ]
3. Don't know [ ]

4. Others (Specify) ---------------------

32. If yes? How many? ---------------------------------

33. Do you think the quality of services you received is affected by (circle all that apply) to you?

1. Income [ ]
2. HIV status [ ]
3. Gender [ ]
4. Occupation [ ]
5. Mode of transmission of the virus [ ]
6. Age [ ]
7. Religion [ ]
8. Others (Specify)

....

....

34. How would you describe your experience in receiving care and support service at health institutions you have visited in terms of providers being able to meet your needs?

1. Very good [ ] 2. Very bad [ ] 3. Acceptable [ ]

4. A beggar has no choice [ ] 5. Others (Specify) -------------

35. Could you explain why you answer this way?

Give at least one example: --

----

36. How would you describe your experience in receiving care and support service at non-health facilities in terms of providers being able to meet your needs?

1. Very good [ ] 2. Very bad [ ] 3. Acceptable [ ]

4. A beggar has no choice [ ] 5. Others (Specify) ------------

37. Could you explain why you answer this way?

Give at least one example: --

----

38. Have you noticed any difference in the way people treat you or other HIV-infected people?

1. Yes [ ] 2. No [ ]

39. If yes, in what ways?

----

40. List the three most difficult barriers you have faced in an attempt to seek care and support.

----

41. How have you been coping with societal reactions to your illness?

----

42. Which of the following should providers do to serve you better (Circle all that apply)

1. Have access to ARVs (Anti retroviral therapy) [ ]

2. Be experienced/knowledgeable about providing HIV care
[ ]

3. Treatments dealing with opportunistic infections, monitoring and explaining my health status [ ]

4. Know what other HIV-related services are available in the area and provide referrals to them [ ]

5. Location that is easier to get to [ ]

6. Advocate for my needs within the service system [ ]

6. Others (Specify) --

43. From your experience, which of the following category of care workers are less fearful about HIV/AIDS

1. Hospital setting care workers [ ]
2. Home/community setting care givers [ ]

44. What factors do you think are responsible for this difference?

----

45. Which of the following signs and symptoms have you ever experienced?

1. Malaise/weakness/fatigue

Muscle ache	( )
Weakness	( )
Painful joints	( )
Fatigue	( )
Dry mouth	( )
Thirst	( )

2. Confusion/Distress

Difficulty concentrating	( )
Depression	( )
Memory loss	( )
Fear	( )
Anxiety	( )
Disorientation	( )

3. Fever/Chills

Fever	( )
Chills	( )
Day sweats	( )
Night sweats	( )

4. Gastro intestinal discomfort

Loose stools ( )

Diarrhoea ( )

Gas/Bloating ( )

Abdominal pain ( )

Oral thrush ( )

5. Shortness of breath

Shortness of breath at rest ( )

Wheezing ( )

Shortness of breath with activities ( )

6. Nausea/Vomiting

Nausea ( )

Vomiting ( )

Lack of appetite ( )

SECTION D

Client's Need of Satisfaction

This next section of questions deals with services you may have needed or wanted these past years. Please tell me which of these services you needed, whether you tried to obtain them, and whether you had any problems getting the services. If you did obtain the service, I will ask you to give it a rating on a scale from 1-4: If you did not obtain the service please indicate what prevented you from getting it. 1- very dissatisfied, 2- somewhat dissatisfied, 3 - somewhat satisfied, 4 - very satisfied.

Please Turn Over

APPENDIX V

EKA ETO EKO NIPA SAYENSI AWUJO

EKA EKO NIPA IMO AWUJO

YUNIFASITI IBADAN

Nomba iwe ibere.....................

IWE IBEREIWE LATI GBA ASE IWADI
Oludahun mi owon,

Eyi ni lati pe o lati k'opa ninu ise-iwadi lori itoju ati atilehin fun awon ti o ni kokoro arun eedi tabi aisan eedi larin awon yoruba ni guusu iwo-oorun Naijiria. Iwadi yi yio w'aye ni Ibadan ati ni Ilesa, mo si l'ero pe nipa abajade iwadi yi, itoju ati atilehin ti yio wa fun awon ti o ni kokoro tabi aisan eedi yio dara ju ti tele lo ni orile ede Najiria. Eko iwadi yi wa fun ikeko-gboye ijinle, ise iwadi yi nikan ni a o si lo gbọgbo orọ ti e ba sọ fun.

Bi o ba wu yin lati k'opa, emi , Iya Afin, Prisca Olabisi Adejumo n'ro yin lati lati dahun awon ibere wonyi ni tooto nipa oro ti o jo mo itoju ati atilehin fun itoju eni tio ni kokoro arun eedi. Gbogbo oun ti e ba so ni yio wa fun ise iwadi yi nikan, ipamo tio daju yio si tun wa fun oruko yin ati eyin gan an.

Eyi j'asi pe iwe yi wa fun un yin lati se ipinnu lati k'opa ninu iwadi yi tabi lati pinnu lati ma k'opa.

E seun fun ireti ifowosowopo yin.

E seun

Arabinrin Olabisi Adejumo

Ami ifowobowe..........

Ojo...............

EKA EKINI : ORO NIPA OLUKOPA

1. Ojo Ori

Ojo Osu Odun

2. Eya

Okunrin Obinrin

3. Esin

1. Igbagbo Kristieni

Bi o ba je kristieni iru eka wo ni

a. Ijo abalaye (ii) Ijo elemi

b. Katoliki

2. Esin Musulumi

3. Esin Ibile

4. Iru Esin Miran (Se alaye) ....

4. Ipo Igbeyawo

1. Moti loko tabi gbeyawo (i) Alarede

(ii) Alajopin

2. Danfo (nko gbeyawo tabi l'oko ri)

3. Ibagbepo pelu alajosepo

4. Ni afesona

5. Opo

5. Ipilese eto eko

1. Nko lo si Ile iwe ri

2. Ile-eko alakobere tabi girama ti n ko pari

3. Ile-eko ti girama to yanju

4. Ile eko-giga lehin girama

5. Awon miran (Salaye)...............

6. Eya Ilu

(Se alaye)............................

7. Ise A'se jeun

1. Kosi Ise kankan lowo mi

2. Ise Agbe

3. Onise Owo

4. Onise Okoowo

5. Ise molebi ti ko la owo lo

6. Awon miran (salaye)...............

8. Ijoba Ibile

Se alaye..........................

9. Eto ilegbe

(i) Idagbe (ii) Gbigbe pelu ebi

10. Eelo ni iye owo ti o n'wole fun o l'osoosu

....

EKA KEJI

11. Igba wo ni won rii pe o ni kokoro arun eedi

12. Jowo se apejuwe imo re nipa fifagi si idi (1)fun beeni (2) fun beeko ati (3) fun ko da mi loju. Idahun kansoso ni ki o fun ibeere kan.

Beeni (1)

Beeko (2)

Kodamiloju (3)

1.

Kokoro arun bakiteria ni o n fa arun eedi

Kokoro arun fairos ni o n fa arun eedi

ii.

Ona ti kokoro arun eedi n gba tan kale ni nipa

- Iba'lopo
- Ounje
- Irobi tabi ibimo
- Ninu ategun
- Ninu omi
- Ninu isan ti eje ngbe san kaakiri ara
- fifi ara kan enikeji (iboni - l'owo)
- ibalopo ti ko ni idaabobo

Ibalopo lati oju ile igbe laisi idabobo kankan

Fifi enu k'onu pelu ito enu

Ni ile igbonse

Nipa omije oju

Nipa jijeun papo

Nipa fifun omo l'oyan

Nipa kokoro yanmu-yanmu

Nipa yiya burosi ifonu lo

Nipa yiya abe tabi biledi lo

13. Nje o ti beere fun itoju fun ilera re

14. Bi ko ba ri bee, ki l'ode ti o ko fi gba itoju (i) ko nilo……. (ii) ko si owo ………..(ii) ihuwasi awon osise ilera……. (iv) awon idi miran (se alaye)…………………………..

15. Bi o ba je beeni, nibo ni ………………………………….

Bi itoju re ko baje mo ti oogun lilo lo si ibi ibere 22

16. Jowo se alaye awon ilana itoju re?………………………

17. Lati igba wo ni e I n,gba iru itoju yi?…………………

18. Igba wo ni e ma nlo fun itoju yi (i) Nigbakugba (ii) osoose (iii) Ose mejimeji (iii) Osoosu (v) Osu Mejimeji (vi) Oye igba miran (Se alaye) ……………………………

19. Kini o ri si iru itoju ti o maa n'gba ………………………

20. Lehin ti o ba gba itoju naa tan, bawo ni ilera re se ma a n'ri? (i) Maa ndara si gidigidi (ii) Ma a n yato die (iii) Kii yato rara (iv) Maa n'buru si …………………………

21. Nje o ma n ni iyonu lehin ti o ba lo awon oogun naa? (i) Beeni (ii) Beeko

22. Nje o maa n lo egboogi tabi eya itoju ibile miran? (i) Beeni (ii) Beeko Bi ko ba ri bee koja lo nomba 31 ni eka keta

23. Bi o ba ri bee, iru ewo ni e maa lo, fun itoju awon ami kokoro arun eedi

24. Bawo ni e se ma n lo awon egboogi (so nipa osuwon fun apeere, ife, sibi, ati alafo igba ti e n loo ni ojo kookan)………………..

25. Fun iru iyonu tabi ami kokoro arun eedi wo ni e nlo ogun naa fun? …………………………………………………

26. Fun gbedeke igba wo ni e maa n'lo (so oye ojo/ ose/ tabi ossosu………………………………………

27. Nje e ma n'ni iyonu lehin ti e ba lo egboogi (i) Beeni (ii) Beeko

28. Bi o ba je beeni, jowo se apejuwe iru iriri bee………………..

29. Lehin ti e ba lo egboogi, bawo ni ara yin se maa n'ri (i) maa adara si gidigidi ………(ii) Maa n'dara die sii………….. (iii) kii yipa…………(iv) maa nibu ru sii……………..

30. Eelo ni o ma a n'na fun itoju kookan (So oye owo naira naa pato)………………………………

EKA KETA

ITOJU ATI ATILEHIN

31. Igba wo s'ehin ni o o mo pe o ni kokoro arun eedi

1. ko tii pe osu mejila

2. Odun kan si odun merin

3. Odun marun si odun mesan

4. O ju odun mewa sehin lo

5. N' ko lee ranti

32. Bawo ni o se mo nipa re

1. Nigba ti mo d'ubule aisan ni ile iwosan
2. Ni asiko iyonda ara eni fun ayewo
3. Ni asiko ayewo ti won ma n'se fun gbogbo eniyan
4. Awon miran (Jowo se alaye)

33. Bi o ba je nipa ayewo, ni ibo ni won ti se ayewo naa?

1. Egbe ti kii se ti ijoba
2. Egbe ti n se itoju fun aisan eedi
3. Ni inu ile iwosan
4. Laari ile/ adugbo
5. Awon ona miran (Jowo se alaye)

34. Bawo ni ose pe to lehin ti o di mimo pe o ni kokoro arun eedi ki o to lee ri itoju gba?

1. N' ko ri rara
2. Ni kete lehin ti o f'oju han
3. Laari osu mefa ti aisan na a di mimo ni
4. Nigbati to mo saare
5. Mo n lo egboogi ibile
6. Awon miran (se alaye)

35. Nje o ni ibi ti o maa n'lo lati igba de igba lati gba itoju fun ilera nipa kokoro arun eedi

1. Beeni (2) Beeko

EKA KEJO

Ipele awon ibeere wonyi wa fun awon ise tabi itoju tie ti nilo lati igba die sehin.

Jowo so fun mi eyi ninu awon itoju wonyi ti e nilo; boya e gbiyanju lati ri won gba ati boya e ni isoro lati ri won gba. Bi e ko ba ri itoju naa gba., jowo se alaye oun ti o di o lowo lati rii gba. (1) Duro fun ko temi lorun rara (2) Duro fun ko te mi lorun, (3) Duro fun o te mi lorun die (4) Duro fun o te mi lorun gidigidi .

36 (a) Bi o ba ri bee, nibo ni ....

(b) Bi o ba je beeko kinni o faa?.............. (a) Egbe ti ki ise ti ijoba... (b)Egbe ti o wa fun itoju awon ti o ni kokoro arun eedi

(c) (d) ile iwosan

(d) (e) Awon miran (Se alaye).............

37. Nje o ni eni ti o se itoju re fun aisan eedi ni igba de igba (1) Beeni (2) Rara

38. (a) Bi o ba je beeni, se alaye ....

(1) Olutoju alaisan (Noosi)

(2) Dokita

(3) Onise Awujo

(4) Olugbani-ni-imoran

(5) Onimo nipa ihuwa-si eda

(6) Awon miran (se alaye)

(b) Bi ko ba je bee, kini o fa?.................................. …

39. Bawo ni o se ro o lorun si lati jewo pe o ni kokoro arun eedi

1. O rorun

2. O nira

3. Ko seese

4. Awon miran (Se alaye)

40. Tani o ti jewo pe o ni kokoro arun eedi fun

1. Onise iwosan

2. Molebi

3. Nko jewo fun enikeni

4. Awon Miran (se alaye)............................

41. Nje elomiran wa ninu agbo ile re (molebi eni ti e jo n se po, ore timo-timo tabi ojugba) ti oun naa ni kokoro arun eedi

1. Beeni

2. Beeko

3. N ko mo

4. Awon miran (Se alaye).........................

42. Bi o ba je bee ni, awon melo ni ....

....

EKA KERIN

IJEWO AISAN FUN OLUBASEPO

43. Bawo ni o se mo nipa pe o ni kokoro arun eedi

(i) Dokita so fun mi

(ii) Olugbaniniyanju lo sorfunmi

(iii) Noosi si funmi

(iv) Awomiran so fun mi (se alaye)

44. Nje o so fun olubasepo re nipa ipo ti ti o wa bayi

1. Beeni 2. Beekrom

45. Bi oba je beni, bawo ni o se se

46. bi ko ba je be, kinni o od to ko fi je be

47. Bi o ba je pe o so fun olubasepo re, ba wo ni ihuwasi re lein na ?
………………………………………………………

48. Kinni o ro pe o fa ti ofi wu iru iwa ti o salaye yi

49. Bi o ko ba ti see bee, nje yio wu o lati so fun olubasepo re 1. Beeni
2. Beeko

50. Bi o ba je bee, kinnni o se so be?……………………………

51. Bi ko ba se bee, kinni o se see?………………………..

52. Kinni o r"ope a la se lati mu awon ti o ni kokokro arun eedi lee so fun awon olubasepo ipo ti won wa?
EKA KARUN
AWON OUN AINI ATI ITELORUN TI O NILO JU

53. Nje o l'ero pe osunwon itoju ti o r"igba ni i se pelu awon oun wonyi (fi ami ofo yika eyi ti o ba kan o)?

1. Owo ti o ni lowo
2. Boya o ni kokoro arun eedi tabi o ko ni
3. Boya o je okunrin tabi obinrin
4. Ise Oojo
5. Ona ti o gba lati ni kokoro arun eedi
6. Ojo ori
7. Esin
8. Awon Miran (Se alaye)

54. Bawo ni o se le e se alaye iriri re nipa gbigba itoju ati atilehin ni awon ile itoju iwosan ti o ti de, bawo ni won se ba aini re pade to?

1. Koda, o koja a'fi enu so (Odara gan ni)
2. Ko dara rara
3. O se e t'ewogba
4. Ko si ohun ti mole se ju ki n'gba ohun ti mo ba pade lo
5. Awon Miran (Se apeere)

55. Nje o le so idi ti o fi dahun bayi?.................................... Fi apeere kan han

56. Kini o le so nipa iriri re nipa gbigba itoju ati iwosan ni awon ibi ti kii se Ile-iwosan, Bi awon egbe tabi apejopo ti o je ti aladani gege bi (NGOs) So nipa bi won se ba aini re pade.

1. O daraa gan ni

1 Ko dara rara

3. O see fi ara mo

1.4.1.1 Mo ni lati gba be ni tori ko si ohun ti mo le se

2 Nje ole so idi idahun re loke yi?.................................

....

3 Nje o se akiyesi iyato ninu ona ti awon enia ngba se itoju iwo tabi elomiran ti o ni kokoro arun eedi?

1. Beeni 2. Beko

4 Bi o ba je beni, ni ona wo ni ?............................

5 So nipa ona meta otooto ti o ti gba ni idiwo nipa gbigba itoju ati imoran ti o ti n ri gba lati igbayi wa?.................. .....
....

6 Bawo ni o ti se n' farada iha ti awon eniyan ni awujo ko si o ni tori kokoro aru eedi. ....
....

7 Ewo ninu awon oun ti a ko si isale yi ni a le se lati fun o ni itoju ti o dara ju ti tele lo ? (fa ila si idi gbogbo eyi ti o ba ba o mu)

7.4.1.1 Ni anfaani lati ri oogun kokoro arun eedi gba

7.4.1.2 Anfaani ati ni iriri tabi imo nipa si se itoju fun awon ti o ni kokoro tabi aisan eedi

7.4.1.3 Gbigba itoju nipa awon arun ti o maa n se eni ti o ni kokoro tabi aisan eedi nitori aini ajesara to,itoju a'tigba d'egba ati sise alaye lori ipo ilera mi fun mi.

7.4.1.4 Anfaani lati mo nipa awon itoju miran ti o wa nipa kokoro arun eedi ni agbegbe ati ona lati ri anfaani bee lo

7.4.1.5 Ibi itoju ti o sunmo tabi ti ororun lati de ni kia kia

7.4.1.6 Eni ti mo lee f' oju jo ni ile itoju

7.4.1.7 Awon ona miran (se alaaye)

8 Nipa iriri ati idojuko re, awon wo ninu awon wonyi ni o maa n'ni iberu ti o po ju fun kokoro tabi aisan eedi

8.4.1.1 Awon olusetoju ti o wa ni awon ile iwosan

8.4.1.2 Awon olutoju ti o wa ni aarin ile tabi adugbo

9 Kini awon oun ti o r'ope o se okunfa iyato yi.............................

10 Ni ero tire ona wo ni o ro pe o dara julo ti a le gba se itoju kokoro arun tabi aisan eedi ....

....

11 Idi wo ni o fi dahun bayi?..................................

12 Ni ero tire kini o ro pe itoju ati atilehin fun awon ti o ni kokoro arun tabi aisan eedi tunmo si? To won kale ni eseese bi won ba se se pataki si

12.4.1.1 ....

12.4.1.2 ....

12.4.1.3 ....

12.4.1.4 ....

EKA KEFAIMO ATI ERO NIPA OOGUN FUN ITOJU KOKORO ARUN EEDI

13 Nje o gbo nipa ero ijoba apapo lati je ki awon oogun ti won fi n'toju kokoro aisan eedi wa ni a'rowoto ni orile ede yi ?

13.4.1.1.1 Benni

13.4.1.1.2 Beko

14 Bi o ba je beeni, bawo ni o se gbo nipa re ?

14.4.1.1.1 Awon ebi ni o je ki n gbo nipa re

14.4.1.1.2 Lati odo ore ati aladugbo

14.4.1.1.3 Inu iwe iroyin ni mo ti kaa

14.4.1.1.4 Lati ori ero redio

14.4.1.1.5 Lati ori ero m'oun m'aworan ni mo ti gbo

14.4.1.1.6 Lati enu awon miran ti o ni kokoro arun tabi aisan eedi ni mo ti gbo

14.4.1.1.7 Awon ona miran (Jowo so nipa won)

15 Kini ero tire nipa erongba ijoba yii:

15.4.1.1.1 O dara o si seese

15.4.1.1.2 Ko si idaniloju nipa re

15.4.1.1.3 O dara sugbon ko tiito

15.4.1.1.4 Otito ni, sugbon owo re ga ju

16 Nje inu re yio dun lati maa bere fun oogun fun itoju kokoro arun eedi bi won ba n'fun ni l'ofe ?

72 Bi ko ba ri bee, kini o de ti o fi so bee? ....

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