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Review Article

Knowledge and Utilization of Social Support Groups among People Living with HIV Receiving Highly Active Antiretroviral Therapy in Health Institutions in Anambra State, Nigeria

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Abstract

The awareness and use of social support groups among HIV-positive individuals receiving HAART in particular healthcare facilities in Anambra State, Nigeria, were evaluated in this study. HIV-positive patients receiving care in particular medical facilities in Anambra State, Nigeria, participated in a facility-based mixed-method cross-sectional analytical study. 392 adult PLWHIV were chosen from 18 healthcare facilities offering HIV treatment, care, and support services using a multistage sample technique for the quantitative component. A semi-structured questionnaire that had been pre-tested and administered by an interviewer was utilised to gather data, and focus groups were utilised for the qualitative component. IBM Statistical Package for Social Sciences (SPSS) version 23 was used to analyse quantitative data, and the findings were displayed as percentages and frequencies. The Nnamdi Azikiwe University Teaching Hospital Ethics Committee granted ethical permission. Of the 392 respondents, 248 (63.3%) had heard of social support groups. Of the respondents, 218 (55.6%) were active members and 222 (56.6%) belonged to a social support group. About 58.4% of the respondents knew that social support groups were specifically established to support clients receiving HAART, while 59.9% were aware that such groups discussed HIV-related issues. The majority of respondents perceived social support groups as useful to people living with HIV (58.2%) and indicated that they would recommend membership of such groups to others (59.2%). Furthermore, 219 (55.9%) reported that they achieved the purpose for which they joined the support groups. Health workers were the commonest source of information about social support groups, accounting for 40.7% of respondents. The study demonstrated a relatively high level of awareness and moderate utilization of social support groups among people living with HIV receiving HAART in Anambra State. However, gaps in awareness and participation remain among a considerable proportion of clients. Strengthening health education, improving healthcare worker involvement, and promoting support group activities within HIV clinics may improve participation and optimize the psychosocial well-being of PLWHIV.

Keywords: *Social support, HIV, HAART, antiretroviral therapy, support groups, utilization, knowledge, Nigeria.*

Introduction

Despite tremendous advancements in prevention, diagnosis, and treatment, HIV infection remains a major worldwide health concern. People living with HIV (PLWHIV) now have a longer life expectancy thanks to the development of highly active antiretroviral therapy (HAART), which has dramatically decreased HIV-related morbidity and mortality. However, HIV is still a chronic illness that necessitates ongoing medical attention, rigorous treatment compliance, frequent clinical monitoring, and sufficient psychosocial support [1].

It is widely acknowledged that social support has a significant role in determining health and quality of life, particularly for those with chronic conditions. It describes the support—emotional, informational, practical, and appraisal—that one receives from peers, family, medical professionals, and social networks. Social support is essential for PLWHIV to lessen emotions of loneliness, fear, anxiety, and depression that may develop after diagnosis or throughout long-term treatment [2, 3].

Social support groups are structured platforms where individuals with similar health experiences come together to share knowledge, provide emotional encouragement, exchange coping strategies, and offer practical assistance. Among PLWHIV, these groups have been shown to improve acceptance of HIV status, encourage positive lifestyle modifications, enhance self-esteem, and reduce the impact of stigma and discrimination[4]. They also create opportunities for members to receive accurate information regarding HIV infection, antiretroviral therapy, treatment adherence, and available healthcare services[5].

Psychological challenges such as depression, anxiety, fear of disclosure, and social rejection remain common among people living with HIV. Treatment compliance, healthcare-seeking behaviour, and general quality of life may all be adversely affected by these psychological challenges. Adequate social support from peers, family members, and healthcare workers can promote resilience, improve mental health outcomes, and facilitate sustained engagement with HIV treatment and care services[6].

Many persons living with HIV in low- and middle-income countries continue to receive insufficient help despite the acknowledged value of social support due to stigma, discrimination, poverty, fear of disclosure, and a lack of knowledge about available support programs [7]. In Nigeria, where HIV remains a public health concern, understanding the level of knowledge and utilization of social support groups among clients receiving HAART is essential for designing interventions that improve patient-centred HIV care[8].

HIV treatment, care, and support services are offered by a vast network of governmental, commercial, and mission-based health facilities in Anambra State. On the other hand, little is known about the awareness, involvement, and perceived advantages of social support groups among HAART patients in these settings [9, 10]. Healthcare professionals, legislators, and HIV program managers will be able to increase psychological support techniques and raise the standard of HIV care by evaluating these aspects.

Thus, the purpose of this study was to evaluate the awareness and use of social support groups among HIV-positive individuals on highly active antiretroviral therapy in certain medical facilities in Anambra State, Nigeria.

Materials and Methods

Study Area

The study was conducted in Anambra State, South-East Nigeria. Anambra State was created on 27th August 1991 and has its capital in Awka. It occupies a land area of approximately 4,816.21 km² and is bounded by Delta State to the west, Imo and Rivers States to the south, Enugu State to the east, and Kogi State to the north. The State is divided into three senatorial districts (Anambra North, Anambra Central, and Anambra South), 21 Local Government Areas (LGAs), and numerous urban and rural communities.

The population of Anambra State is predominantly Igbo-speaking, with the major occupations being trading, farming, civil service, and artisan work. The state has an extensive healthcare network comprising tertiary, secondary, primary, mission, and private health institutions. HIV prevention, treatment, and support services are provided through public and private health facilities under the supervision of the Anambra State Ministry of Health, the State AIDS/STI Control Programme (SASCP), and the Anambra State Agency for the Control of AIDS (ANSACA).

This study was conducted in selected health institutions across six LGAs representing the three senatorial zones of the state. A total of 18 health facilities (comprising tertiary, secondary, and primary health institutions) that provide HIV treatment, care, and support services were selected for the study.

Study Design

A facility-based mixed-method cross-sectional analytical study design involving quantitative and qualitative components was employed. The quantitative component assessed the knowledge and utilization of social support groups among people living with HIV receiving highly active antiretroviral therapy (HAART), while the qualitative component explored participants' experiences, perceptions, and views regarding social support and HIV care through focus group discussions.

Study Population

The study population comprised adult HIV-positive clients receiving HAART at selected health institutions in Anambra State.

Inclusion Criteria

Participants included HIV-positive clients who:

- Were aged 18 years and above;
- Had confirmed HIV-positive status and were aware of their diagnosis;
- Had disclosed their HIV status to at least one person;

- Had been receiving HAART for at least six months before the study; and
- Attended routine follow-up clinics at the selected health facilities.

Exclusion Criteria

Clients who were critically ill or had medical conditions that could interfere with effective communication and reliable responses, including severe cognitive impairment or severe mental illness, were excluded from the study.

Sample Size Determination

The minimum sample size for the quantitative component was determined using the Cochran formula for cross-sectional studies:

$n = Z^2P(1 - P) / d^2$

Using a prevalence of 64.5% from a previous related study, a 95% confidence level ($Z = 1.96$), and a precision level of 5% ($d = 0.05$), the calculated minimum sample size was 352 participants. A 10% allowance for possible non-response was added, giving a final sample size of 392 respondents. The study achieved a 100% response rate.

Sampling Technique

A multistage sampling technique was employed for the selection of study participants.

Stage I: The three senatorial districts in Anambra State were included through complete enumeration.

Stage II: Two Local Government Areas were selected from each senatorial district using simple random sampling by balloting.

Stage III: The selected health facilities were stratified into tertiary, secondary, and primary healthcare facilities.

Stage IV: One health facility was selected from each stratum in each selected LGA using simple random sampling, resulting in a total of 18 health facilities.

Stage V: Eligible participants were selected from the HIV clinic registers of the selected facilities using systematic random sampling. The calculated sample size was proportionally allocated to each facility based on the average number of HIV-positive clients attending the facilities. The first participant was selected by simple random sampling, after which subsequent participants were selected at regular intervals determined by the sampling interval ($K = N/n$).

For the qualitative component, one focus group discussion (FGD) session was conducted in each selected health facility using convenience sampling. Each FGD consisted of approximately eight participants who were different from those involved in the quantitative survey.

Ethical Considerations

Ethical approval for the study was obtained from the Ethics Committee of the Nnamdi Azikiwe University Teaching Hospital, Nnewi, Nigeria. Written informed consent was obtained from all participants after explaining the objectives, procedures, benefits, and voluntary nature of the study. Participants were informed of their right to withdraw from the study at any stage without any consequences to their treatment or care. Confidentiality and anonymity were maintained throughout the study by ensuring that no personal identifiers were recorded on the study instruments.

Data Collection

Data collection was conducted using both quantitative and qualitative methods.

Quantitative Data Collection

Quantitative data were obtained using a pre-tested interviewer-administered semi-structured questionnaire adapted from relevant literature on social support among people living with HIV. The questionnaire comprised sections on socio-demographic characteristics, socioeconomic factors, knowledge of social support groups, level of social support, utilization of support groups, and factors influencing engagement with social support services.

Eight trained research assistants, who were HIV case managers, assisted with data collection after receiving training on the objectives of the study, ethical issues, and proper administration of the research instruments. A pilot study was conducted among 21 HIV-positive clients attending health facilities outside the study area. The reliability of the questionnaire was assessed using Cronbach's alpha, which yielded a coefficient of 0.80, indicating good internal consistency.

Qualitative Data Collection

The qualitative component involved focus group discussions using a structured FGD guide developed from previous literature. The discussions explored participants' understanding of social support, experiences with support groups, perceived benefits, and challenges affecting participation. Each session lasted approximately one hour and was audio-recorded with participants' consent. The recordings were transcribed and analysed using thematic content analysis.

Measurement of Variables

Knowledge of Social Support Groups

Knowledge of social support groups was assessed using a scoring system in which correct responses were assigned a score of one (1) and incorrect responses were assigned a score of zero (0). Participants with a total score of two or more were categorized as having good knowledge, while those with scores less than two were considered to have poor knowledge.

Utilization of Social Support Groups

Utilization was assessed based on respondents' membership in social support groups, level of active participation, intention to join support groups, perceived usefulness of the groups, and achievement of expected benefits from participation.

Statistical Analysis

Descriptive statistics were used to summarize variables and presented as frequencies and percentages. Findings on knowledge and utilization of social support groups were presented in tables and charts.

RESULTS

Table 1: Determination of Knowledge of Social Support

Variables	Frequency(n=392)	Percent(%)
Ever heard of social support group		
Yes	248	63.3
No	141	36.7
Belong to any social support group		
Yes	222	56.6
No	166	43.4
Active membership of the support group		
Yes	218	55.6
No	174	44.4
Intention of joining support group		
Yes	17	4.3
No	153	39.0
Social support group strictly for clients on HAART		
Yes	229	58.4
No	148	37.8
Do not know	15	3.8
Social support group talk about issue related to HIV		
Yes	235	59.9
No	141	36.0
Do not know	16	4.1
Encouragement derived from members on taking HAART.		
Yes	61	15.6
No	315	80.4
Do not know	16	4.0
Usefulness of membership to people living with HIV		
Yes	228	58.2
No	144	36.7
Do not know	20	5.1
Advice to people as regards membership position to this group		
Yes	232	59.2
No	142	36.2
Do not know	18	4.6
Achievement of purpose of belonging to the group		
Yes	219	55.9
No	144	36.7
Do not know	29	7.4

Majority 248(63.3%) of the respondents have heard of support groups before, 222(56.6%) belong to a social support group with 218(55.6%) being active members. Few 17(4.3%) of the respondents have plans to join social support group. Two hundred and nineteen 219(55.9%) were of the opinion that they achieved their aim of joining the group.

Figure 1: Source of information about social support

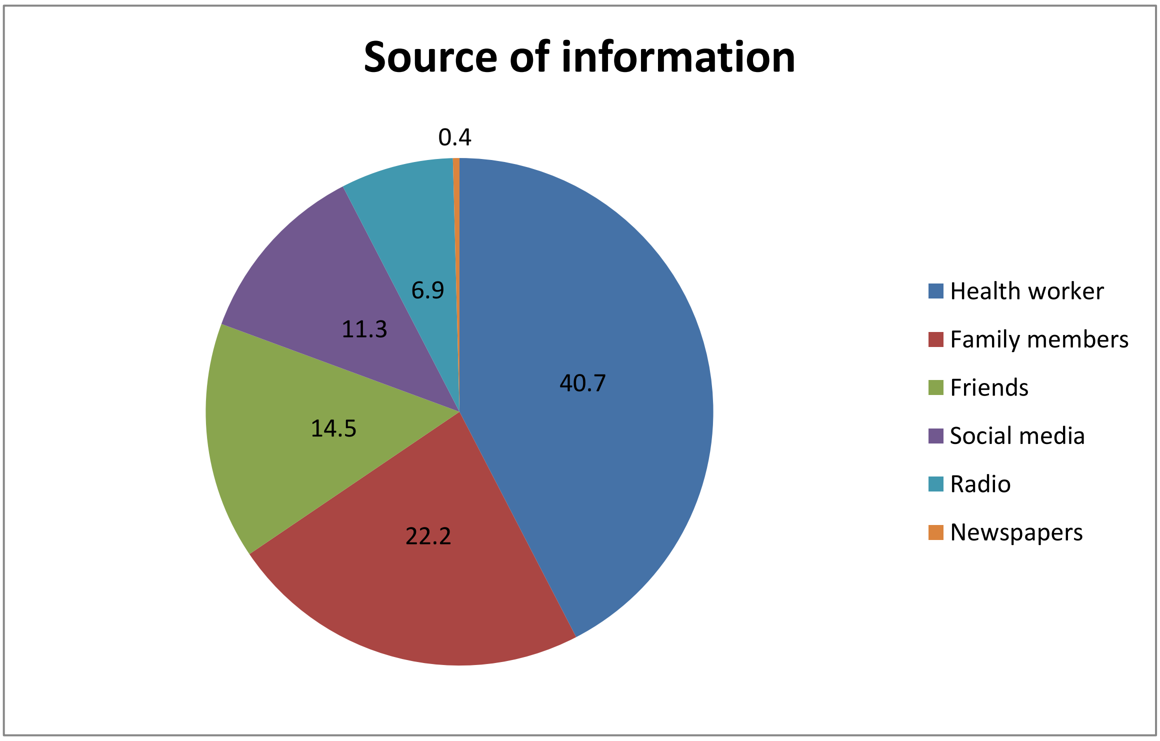

Table 1 shows the level of knowledge and utilization of social support groups among the 392 people living with HIV receiving HAART in selected health institutions in Anambra State, Nigeria.

The findings revealed that a majority of the respondents, 248 (63.3%), had previously heard about social support groups, indicating a relatively high level of awareness. More than half of the respondents, 222 (56.6%), reported belonging to a social support group, while 218 (55.6%) were active members, suggesting moderate utilization and engagement with available support structures.

Regarding knowledge of the purpose and activities of social support groups, 229 (58.4%) of the respondents correctly identified that the groups are specifically designed to provide support for clients receiving HAART, while 235 (59.9%) acknowledged that discussions within these groups are centred on HIV-related issues. Furthermore, 228 (58.2%) considered membership in social support groups beneficial to people living with HIV, and 232 (59.2%) indicated that they would recommend participation in such groups to other HIV-positive clients.

In terms of the perceived outcomes of participation, more than half of the respondents, 219 (55.9%), reported that they had achieved the objectives for which they joined the social support groups. However, only 61 (15.6%) stated that they received encouragement from other members regarding adherence to HAART, whereas the majority, 315 (80.4%), did not perceive such encouragement, indicating a potential gap in the supportive role of the groups in promoting treatment adherence.

Among respondents who were not members of social support groups, only 17 (4.3%) expressed an intention to join a support group, suggesting a low level of interest among non-members and highlighting possible barriers to enrolment and participation that may require further investigation.

Figure 1 showed that healthcare workers were the predominant source of information about social support groups, accounting for 40.7% of respondents. This underscores the important role of healthcare professionals in creating awareness, providing counselling, and encouraging participation in social support initiatives among people living with HIV.

Discussion

People living with HIV (PLWHIV) receiving highly active antiretroviral therapy (HAART) in specific healthcare facilities in Anambra State, Nigeria, were evaluated for their knowledge of and use of social support groups in this study. The results showed that respondents had a generally high level of knowledge and modest use of social support groups, underscoring the significance of social networks as elements of all-encompassing HIV care [11].

A comparatively high level of awareness among PLWHIV in the study area is demonstrated by the fact that around two-thirds of the respondents (63.3%) had heard of social support groups. The ongoing health education, counselling services, and information sharing offered by HIV clinics may be responsible for this degree of knowledge [12]. The result is in line with research done in other contexts that shown that HIV clients' awareness and knowledge of available psychosocial support services are improved by frequent engagement with healthcare professionals and peer educators [13]. However, the fact that over one-third of the respondents had never heard of social support groups points to a knowledge gap and implies that HIV treatment facilities should improve their awareness campaigns [14].

The study also showed that 55.6% of the respondents were active members of social support organisations, and over half of the respondents (56.6%) belonged to these groups. This indicates that PLWHIV in Anambra State use social support services at a modest rate. Participating in social support groups can give people who are dealing with similar health issues the chance to express their emotions, share their experiences, trade information, and encourage one another. This result is consistent with other research showing that social support groups enhance psychosocial adaptability, lessen stigma and feelings of loneliness, and encourage constructive coping strategies in PLWHIV [15]. However, the percentage of respondents who did not belong to any support group (43.4%) suggests that some clients may still be prevented from participating by obstacles such lack of interest, stigma, fear of disclosure, or concerns about confidentiality.

In terms of respondents' understanding of the roles and functions of social support groups, over half of the participants knew that these groups are intended to support clients on HAART (58.4%) and that HIV-related topics are discussed inside the groups (59.9%). This indicates that the research population has a reasonable comprehension of the goals of social support groups. In order to maximise the psychosocial and health benefits of group membership, PLWHIV must have a thorough grasp of the support mechanisms that are accessible to them [16].

Additionally, 58.2% of respondents said social support groups were helpful for those living with HIV, and 59.2% said they would recommend additional clients to join. Furthermore, 55.9% of participants said they were able to fulfil the reason they joined the support groups. These results imply that most members gain significant advantages from their involvement. Social support groups may help people feel better about themselves, feel less alone, have more confidence, accept their HIV status, and be better able to handle the social and emotional difficulties that come with living with the virus [17].

It's interesting to note that, despite the general favourable opinion of social support groups, only 15.6% of respondents said that group members encouraged them to adhere to HAART, while the majority (80.4%) said that they did not [18]. This result implies that while social support groups are acknowledged as helpful, their ability to encourage treatment compliance may not be properly utilised. It might also indicate a lack of peer-to-peer support explicitly focused on medication adherence or a lack of attention on adherence counselling during group meetings. Support groups may be more successful in promoting long-term HIV treatment outcomes if their structure and content are strengthened to incorporate frequent adherence instruction, peer mentorship, and motivating sessions [19].

Healthcare providers have a critical role in promoting social support services among PLWHIV, as evidenced by the result that they were the primary source of information regarding social support groups (40.7%). Healthcare professionals are ideally positioned to offer information, therapy, and recommendations to various support groups, and they frequently act as the initial point of contact for those who have just received a diagnosis. This emphasises the necessity of ongoing training for healthcare professionals to incorporate support-group enrolment and psychosocial assistance into standard HIV care [20].

The low percentage of respondents (4.3%) who said they intended to join social support groups among non-members is concerning and could indicate ongoing obstacles to involvement. These obstacles could include misconceptions about the advantages of social support groups, competing work or family obligations, fear of unintentionally disclosing one's HIV status, anticipated stigma, and a lack of confidence in secrecy [21]. Therefore, HIV program administrators and healthcare professionals should create focused interventions to remove these obstacles, raise knowledge, and improve client access to and interest in support groups.

Conclusion

The results of this study show that PLWHIV on HAART in Anambra State have a somewhat good understanding of and use of social support groups, although they are still not at their best. There are still large gaps in knowledge, membership, and the effectiveness of support groups in promoting HAART adherence, despite the fact that a sizable number of respondents acknowledged their value and actively participated in them. The contribution of social support groups to better psychosocial well-being and successful HIV treatment outcomes may be increased by bolstering patient education, enhancing the calibre and secrecy of support groups, and including organised adherence support into group activities.

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