

Socioeconomic Needs of Adults Living With HIV/AIDS in Jos, North Central Nigeria

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ABSTRACT

Introduction: Nigeria has the highest number of people living with HIV/AIDS (PLWHA) in the world except for India and South Africa. PLWHA and their families have a wide variety of problems PLWHA and their families have a wide variety of problems which manifest in various degrees in the community, workplace, and health setting. This has given rise to a broad range of needs which require comprehensive care and support services. The needs include medical, psychosocial, socioeconomic and human rights/legal needs and involvement of PLWHA in the planning and delivery of care and support services.

Methods: A descriptive cross-sectional study was carried out to identify the socioeconomic needs, determine the effect of HIV/AIDS on income and measure the socioeconomic needs of adults living with HIV/AIDS attending two hospitals in Jos, Nigeria.

Results: The mean age of all 390 respondents interviewed was 33.4±7.7 years. In all, 245 (62.8%) respondents were females and 145 (37.2%) were males. Food clothing and shelter was reported as the most important socioeconomic needs for 63.6% of the respondents followed by money (54.5%). Over 47% reported a decrease in their income due to their HIV status (higher proportion of males (51.7%) compared with females (45.3%) ($X^2 = 1.669$, $p = 0.43$) and higher professionals (60.0%) compared with other level of skills ($X^2 = 11.78$, $P = 0.161$). About 12% reported change of jobs. Most (80%) reported that their total income is not enough to meet their basic needs and a quarter reportedly cannot feed themselves and their family for the next 3-5 years.

Conclusion: In conclusion, although food, clothes, shelter and money were considered as the most important socioeconomic needs among

adult PLWHA in Jos, majority reported they cannot meet these needs for the next 3-5 years more so that their HIV positive status has led to a decrease in the income of some and even sack for a few. This calls for steps to strengthen socioeconomic support for PLWHA in order to meet these needs thus improving their quality of life.

Key words: socioeconomic needs, adult, HIV/AIDS, PLWHA.

INTRODUCTION

Since the first case of HIV/AIDS in Nigeria was reported in 1986, the adult prevalence of HIV/AIDS had gradually increased from 1.8% in 1991 to 5.8% in 2001. It dropped to 5.0% in 2003 ⁽¹⁾ and further dropped to 4.4% at the end of 2005. ⁽²⁾

There were about 3.6million PLWHA in Nigeria at the end of the 2003. ⁽³⁾ With an estimated population of 126.2million, Nigeria is the most populous nation in Africa and the 10th largest in the world thus the spread of the disease has grave consequences for the country, continent & the world. Already, Nigeria has the highest number of people living with HIV/AIDS (PLWHA) in the world except for India and South Africa. The Nigerian epidemic has different phases with different geopolitical zones in the country recording different prevalence rates. Some are above the national average while others are below it but the worst hit geopolitical zone is the North central zone with a prevalence of 7.0% where Jos is located. Prevalence of HIV/AIDS in Jos is 7.7% (2003). ⁽⁴⁾ Although there are no available estimates of

the number of PLWHA in Jos, a study carried out by the Plateau State AIDS Control Agency (PLACA) showed that 26,374 people tested positive for HIV infection out of 122,253 that were screened in health facilities in the state from 1999 to 2004. ⁽⁵⁾

PLWHA and their families have a wide variety of problems which manifest in various degrees in the community, workplace, and health setting. This has given rise to a broad range of needs which require comprehensive care and support services. The needs include medical, psychosocial, socioeconomic and human rights/legal needs and involvement of PLWHA in the planning and delivery of care and support services. This study provides a “snapshot” of these needs and the adequacy and efficiency of services offered in two different settings; a government hospital (Plateau State Specialist Hospital, PSSH) and a non-governmental hospital (Faith Alive Hospital, FAH).

Care and support services should consist of different elements which adequately address the various needs of PLWHA. Medical/nursing services should include voluntary counseling and testing (VCT), prevention of mother to child transmission (PMTCT), preventive therapy for opportunistic infections (OIs) and tuberculosis (TB), management of sexually transmitted infections (STIs), OIs and TB; nutritional support, palliative care and antiretroviral treatment (ART). Van Praag in 1995 reported that in countries with high prevalence, 50-70% of hospital beds for adults are occupied by PLWHA. ⁽⁶⁾ The study also showed that lifetime medical/nursing costs of PLWHA in Europe and North America is about 100,000 US dollars (USD).

Socio-economic consequences of sickness and death due to HIV/AIDS are enormous. Material support, economic security and food security are crucial needs, which require appropriate services.

Social impact of HIV/AIDS on Households (HH): The Household (HH) is the first unit of socialization. The HIV/AIDS pandemic also holds grave social implications for HH in sub Saharan Africa. The epidemic may lead to a change in HH generation and children being cared for by grandparents and other relatives. In some cases the older children may act as surrogate parents for their younger siblings, thus leading to an increase in one generation HH headed by older children.

An adult death may lead to the dislocation or dissolution of the HH and children may be sent to live with relative. Some of the children may withdraw from school if the family can no longer afford to pay fees or buy supplies. Children may also drop out of school if they are needed at home, on the farm or in the market. However, the death of a male breadwinner will increase the number of impoverished female headed households. When the AIDS victim is a female, the impact can be very severe especially for the welfare of children.

Community attitudes towards helping needy HH will contribute either positively or negatively to the impact of the disease. Therefore, in communities where financial and social support is available, HIV/AIDS affected HH may be able to cope more effectively with the epidemic than those in communities where a stigma is attached to those infected with the virus.

Most studies have found that the epidemic tends to increase the number of female headed households and the number of HH in which grandparents are caring for children. A study in Uganda found that HIV/AIDS contributes to the rise of female headed HH. Compared to women whose husbands died of other causes, AIDS widows tend to be younger and have dependent children who need to be looked after, which restricts their contribution to farm work and off-farm income-generating activities. ⁽⁷⁾ A cohort study conducted in Uganda covering 10,000 individuals in 15 villages found that the proportion of HH

headed by grandparents increased between the first and sixth round. ⁽⁸⁾

Economic impact of HIV/AIDS on Households: The impact of HIV/AIDS on households (HH) begins when a member of the HH starts suffering from HIV related diseases. In addition to social and psychological consequences, three kinds of economic impacts can be distinguished. The first is the loss of income of the family member in particular if he or she is the breadwinner. The second is increase in the in the HH expenditures to cover the medical costs. The third is the indirect cost resulting from the absenteeism of members of the family from work or school to care for the AIDS patient. The illness of the family breadwinner may result in his or her absence from work. This may result in loss of income when the person dies hence the loss becomes a permanent one. The medical costs to care for AIDS related illness may increase. The HH may exhaust its savings or sell its assets to cover the medical costs resulting in a low level of production and consumption. This could lead to reduction in the nutritional intake of children leading to malnutrition. This affects poorer HH more than better off HH. AIDS can push HH into poverty or further impoverish already poor ones.

The most direct cost of HIV/AIDS are those that are usually measured in cost of illness studies are the cost of treatment and the cost of lost work time, although there are also substantial secondary costs such as funeral expenses. AIDS affected HH often makes a rapid transition from relative wealth to relative poverty. Haworth and others (1991) survey of AIDS affected families in which the deceased father was both the breadwinner and tenant of a house provided through his job. Many such families were forced to move after the death of the father, with a majority of those families reporting economic difficulties.

In another longitudinal study, conducted in Rakai, Uganda between 1989 and 1992, the proportion of households owning a car, lorry, radio on bicycles

decreased HH that experienced an adult AIDS death, while HH in which there were no adult deaths saw an increase in the ownership of durable goods. The authors concluded that HIV-related adult illness and burial costs composed great financial burdens on households, leading to a depletion of economic resources (Menon & others 1998). More recently, found similar results in South Africa. ⁽⁹⁾ HH that had experienced illness or death in the recent past were more than twice as likely to be poor than non-affected HH, and they were more likely to experience long term poverty.

Two studies, one in Thailand and another in Sri Lanka, assessed the direct and indirect costs of an adult HIV/AIDS related death on rural HH. In the Thailand study, 116 HH with an AIDS related death were compared to 100 HH with a non-AIDS related death and to 108 HH with no death. ⁽¹⁰⁾ The study found that the economic impact of an AIDS related death was substantial and generally greater than that for a non AIDS related death. The largest part of the economic cost was the loss of earnings of the deceased, but loss of HH income from other sources was also important, as were decreases in HH consumption. In order to cope with the loss of income resulting from the illness and death of a member of a HH, HH resorted to spending their savings, borrowing and selling possession including land, vehicles and livestock.

The Sri Lanka study found that the direct cost per HIV/AIDS related cases were between 250 and 985 USD depending on the treatment region where as indirect costs ranged from 5,240 to 17,695 USD. ⁽¹¹⁾ The bulk of the direct cost in the case of Sri Lanka is borne by the public sector, whereas indirect costs were more likely to be borne by persons living with HIV/AIDS and their families and caretakers.

In another study in Eastern Zimbabwe, nearly 80% of those who died were the primary income earners for their HH (Mushati and others 2003) and 60% lost their jobs during the illness. One in 7

caregivers gave up a job to care for the sick person. Most healthcare costs were paid by the sick person and his or her spouse (42%) and by other HH members (41%).

The needs of PLWHA are enormous while resources available for care and support services in Nigeria are grossly inadequate. Allocation of available resources must therefore be based on proper-planning and resource utilization for optimal results. This requires knowledge of the peculiar needs of PLWHA and regular assessment of care and support services received by PLWHA.

There are a number of governmental and non-governmental healthcare institutions offering care and support to PLWHA in Jos North L.G.A. This study therefore hopes to contribute in generating evidence for sound planning and optimal allocation of available resources in the fight against HIV/AIDS in Jos and other similar settings in Nigeria.

Aim: Assess the socioeconomic needs of adults living with HIV/AIDS attending health care institutions in Jos North central Nigeria.

Objectives

Identify the various socioeconomic needs of adults living with HIV/AIDS attending healthcare institutions in Jos.

Determine the effect of HIV/AIDS on income of respondents.

Measure socioeconomic needs of adults living with HIV/AIDS attending healthcare institutions in Jos.

METHODOLOGY

STUDY AREA

Jos North Local Government Area was carved out of old Jos Local Government Area in 1991 with Jos town as the council headquarters. It is made up of one district – Gwong with population 450,000 (1991 NPC Census).

This study was carried out in the Faith Alive Hospital (owned by a non-governmental organization – Faith alive

Foundation) and Plateau State Specialist Hospital (owned by the Plateau State Government). The estimated patient load is over 4,000 with over 2,000 on ART and care and support services cover Adults, pregnant women and children.

The PSSH is a well-staffed training center for general medical practice in Plateau State. It has over 120 bed capacity and also serves as referral centre for most general and cottage hospitals in the state. By February 2006, the PSSH became a PEPFAR Centre. As at the period of this study, July, October 2006, over 1,720 adult patients were registered with over 750 adults on ART.

Study Populations: This consists of adult men and women between the ages of 15-49 years, who have been confirmed positive for HIV/AIDS and receiving care and support from FAH and PSSH.

Study Design: This is a Hospital based descriptive cross sectional study.

Sampling Technique: Systematic random sampling technique was used for selecting subjects. This involved selection of every 4th patient visiting the HIV clinic who gives consent for the interview. When a patient declines consent, the next patient who consents to be interviewed is then selected until the sample size is attained.

Sample Size determination

Total sample size = 388.

Data Collection: The purpose, content and implications of the study were explained to attendees individually or in a group at the hospital. Informed consent was obtained either verbally or in writing. Afterwards, self-administered questionnaires were distributed to the patients for responses if the patient was literate enough. Where the patient needed any assistance or is illiterate the researcher, assisted by trained assistants, was on hand to administer the questionnaires.

Data Collection Instruments: A semi-structured questionnaire with closed and few open-ended questions were self-administered (if the client was literate enough) or interviewer administered if not literate. Information was collected on socio-demographic characteristics, socioeconomic. The instrument was pre tested by the researcher at ECWA Evangel Hospital HIV Clinic.

Data Analysis: Data clearing and editing was done manually and using computer. Identified errors and omissions were checked and corrected. Data analysis was done using SPSS 11.0 edition. Frequencies were generated and test statistic was Chi Square for proportions with level of significance set at $P < 0.05$ and 95% confidence limit

Validity: To ensure validity and reliability, the instrument (questionnaire) was pre-tested at the HIV clinic of the ECWA Evangel Hospital, at Jos North LGA. This ensured that questions were easily understood and measured what they were intended to measure. Difficult or ambiguous questions were either restructured or removed. To further reduce interviewer bias and errors, research assistants were selected from the hospital of study and trained adequately.

Ethical Considerations

1. Permission and Approval was sought and obtained from the Ethical Review Committee of PSSH and the Research and Grants Department of FAH.
2. Informed consent was sought and obtained from all patients either in writing or verbally.
3. Confidentiality was ensured as names were not required from Respondents.

RESULTS

The mean age of all 390 respondents interviewed was 33.4 ± 7.7 years with minimum age of 16 years and maximum of 49 years. Age group 30-39 has the highest proportion (42.3%) followed by 20-29

(33.1%) – together they make 75.4% of the respondents.

Table 1: SOCIODEMOGRAPHIC CHARACTERISTICS OF RESPONDENTS

Variables	N	n%
Age category		
<19 years	4	1%
20-29 years	129	33.10%
30-39 years	165	42.30%
>40 years	92	23.60%
Marital status		
Never married	114	29.20%
Married	162	46.70%
Separated	12	3.10%
Divorced	18	4.60%
Widowed	64	16.40%
Education		
None	13	3.320%
Quranic	3	0.80%
Primary	67	17.20%
Secondary	147	37.70%
Tertiary	160	41.10%
Occupation		
Higher professional	5	1.30%
Lesser professional	180	46.20%
Skilled manual	69	17.70%
Partly skilled occupation	55	14.10%
Unskilled	81	20.80%
Religion		
Christianity	365	93.60%
Islam	23	5.90%
Others	2	0.50%
Sex		
Male	145	37.20%
Female	245	62.80%
Duration of illness		
<12 months	194	49.7%
12 months and above	196	50.3%
Facility		
FAH	199	51%
PSSH	191	49%
Total	390	100%

In all, 199 (51%) respondents attend FAH while 191 (49%) attend PSSH. The highest proportion of respondents were lesser professionals (46.2%) like Civil Servants, teachers, clerks while the least proportion (1.3%) were higher professional like Lecturers, doctors, bankers or engineers.

Majority of the respondents (46.7%) were married. This is followed by those who have never married (29.2%) then widowed (16.4%), divorced (4.6%) with separated as the least 3.1%.

Highest of the respondents 160 (41.0%) have tertiary education followed by those with secondary education. Hence 78.8% have at least Secondary School education. Of the 390 respondents

interviewed, 245 (62.8%) were females and 145 (37.2%) were males.

Distribution by religion shows that 93.6% of the respondents were Christians while 5.9% were Muslims. Only 2 people (0.5%) were neither Christian nor Muslims. Concerning duration of illness, 49.7% were diagnosed less than 12 months prior to the study while 50.3% of the respondents were diagnosed at least 1 year before the study. Table 1

Table 2: Most important socioeconomic needs

Food, Clothes & Shelter	
Yes	147 (63.6%)
No	84 (36.4%)
	231 (100%)
Money	
Yes	126 (54.5%)
No	105 (45.5%)
	231 (100%)

Food clothing and shelter is the most important basic needs for 63.6% of the respondents. Money is reported as the most important needs for 54.5% of the respondents. Table 2

Table 3: Effect of HIV status on income/change of occupation

Effect on income	N (%)
Increase	31 (7.9%)
Decrease	186 (47.7%)
Changed occupation	
Yes	50 (12.8%)
No	340 (87.2%)
Total	390 (100%)

Table 4: Effect of HIV status on income

Gender	Increase	Decrease	X ²	P-value
Male	12 (8.3%)	75 (57.7%)	1.669	0.43
Female	20 (8.2%)	111 (45.3%)		
Marital status				
Never married	12 (10.5%)	47 (41.2%)	5.40	0.714
Married	14 (7.7%)	90 (49.5%)		
Separated	2 (16.7%)	6 (50.0%)		
Widowed	3 (4.7%)	34 (55.1%)		
Divorced	1 (.6%)	9 (50.0%)		
Occupation				
Higher Professional	-	3 (60.0%)	11.78	0.161
Lesser professional	22 (12.2%)	86 (47.8%)		
Skilled manual	4 (5.8%)	37 (53.6%)		
Partly skilled occup.	1 (1.8%)	27 (49.1%)		
Unskilled	5 (6.2%)	33 (40.7%)		
Total	32 (8.2%)	185 (47.7%)		

Only 7.9% reported increase in income in spite of their HIV status. Over 47% reported

decrease while 44.4% said their income had not been affected by their HIV status. Over 12% reported change of jobs because of their HIV status. Table 3

A higher proportion of males (51.7%) reported decrease income due to HIV status when compared with females (45.3%). (X² = 1.669, p = 0.43)

Regarding the effect of HIV status on income by marital status, the proportion of people reporting decrease in income is highest (53.1%) amongst the widowed followed by these separated and divorced (50%) each. (X² = 5.40, p = 0.714)

On the effect of HIV on income by occupation, the highest proportion that reported decrease in income is among the higher professionals (60.0%) while the least is among unskilled workers. (X² = 11.78, P = 0.161) Table 4

Table 5: Total income adequate to meet needs

Income adequate	N (%)
Yes	78 (20.0%)
No	312 (80.0%)
Total	390 (100%)
Able to feed for 3-5 years	
Yes	137 (35.1%)
No	100 (25.6%)
Don't know	153 (39.2%)
Total	390 (100%)

Most of the Respondents (80%) reported that their total income is not enough to meet their basic needs while a quarter reported that they cannot feed themselves and their families for the next 3-5 years. Table 5

Table 6: Income adequate to meet needs

Marital status	Yes	No
Never married	22 (19.3%)	92 (80.7%)
Married	42 (23.1%)	140 (76.9%)
Separated	1 (8.3%)	11 (91.7%)
Widowed	11 (17.2%)	53 (82.8%)
Divorced	2 (11.1%)	16 (88.9%)
Duration of illness		
<12 months	37 (19.1%)	157 (80.9%)
1yr & above	41 (20.9%)	155 (79.1%)
Total	78 (20.0%)	312 (80.0%)

Married respondents reported the highest proportion (23.1%) of those able to meet their needs, while the least 8.3%) is reported among separated respondents. Most respondents (80.9%) diagnosed less than 12months ago cannot meet their basic needs. Same for 79.1% of those diagnosed

at least 1yrs ago. ($X^2 = 0.208$, $P = 0.371$).
Table 6

DISCUSSION

In all, respondents were almost equally divided between FAH and PSSH. Mean age of the respondents was 33.4 ± 7.7 years with the youngest patient being 16 years old and the oldest being 49 years old. Majority (75.4%) of the respondents are between 20-39 years of age. This is slightly lower than that during the 2003 National HIV sero-prevalence survey in which those between age 20-39 years make up 87.8% of the total number of respondents. ⁽¹²⁾ The single largest group in this study is age group 30-39 (42.3%) as against 27.9% obtained for the same age group in the National survey. The group 20-29 years is second largest (33.1%) but in the National survey this group makes up 59.9% (the largest) of the respondents. In both cases the most affected age groups also make up the most productive age groups. With time this will impact negatively on the home, the community and the nation with severe social and economic consequences. It will certainly slow down and eventually reverse the development gains achieved in recent years if not properly checked. Attaining the Millennium Development Goals (MDGs) may therefore turn out to be impossible except the necessary steps are taken to stop the trend.

Overall, 145 (37.2%) of the respondents were males while 245 (62.8%) were females. In both facilities proportion of female patients is higher than males. This is also the case nationally and globally. The estimated number of women living with HIV in Nigeria is 1,900,000, which is 57.6% of the total number of adults (3,300,000) living with HIV. ⁽¹²⁾ Women also comprise about half of all people living with HIV worldwide. In Sub-Saharan Africa where the epidemic is worst, they make up 57% of people living with HIV and the three quarters of young people infected on the continent are young women aged 15-24 years. ⁽¹³⁾

Inevitably this brings to the fore, gender issues which must be taken into consideration in the design of HIV prevention and care programs. In unprotected heterosexual intercourse, a female is about twice as likely as a male to contract HIV from an infected partner. In addition to this biological vulnerability is the prevalent condition of gender inequality. Economic and social dependence on men often limit women's power to refuse sex or negotiate the use of condoms. Inadequate access to education and employment opportunities encourages many women to sell or barter sex to survive. In essence sexual inequality endangers women's lives.

Most of the respondents were lesser professionals, a group that includes civil servants, teachers, and clerks while the least occupational group is higher professionals including doctors, lecturers, accountants, bankers and engineers among others. Higher professionals are probably better able to take care of themselves in terms of awareness, prevention and care of HIV while among lesser professionals there is a reasonable level of awareness but the financial requirement for taking care of themselves outside these settings may be the reason why most patients opt for these centers where care is free. This is however not very clear.

With regards to duration of illness, about half the total numbers of respondents were diagnosed less than a year ago. More of these were in PSSH as it is relatively a newer facility compared to FAH.

Most of the respondents were married. This is followed by those who have never married, then widowed, then divorced and finally the least is separated. Curiously it would be worth finding out how married people contracted the virus as this is even lower than that obtained during the 2003 National HIV sero prevalence sentinel survey in which 96.6% were married. ⁽¹⁴⁾ Understandably, the National Survey respondents were pregnant women attending Ante Natal clinics in various sites in the nation hence these are more likely to be

married in a socio-cultural setting like Nigeria.

About 78% of the respondents had at least secondary school education. This is much higher than the 57.1% reported for the North Central zone in the 1999 National Demographic Health Survey (NDHS 2000) in Nigeria. ⁽¹⁵⁾ It is also higher than 51.8% obtained during the 2003. National HIV sero prevalence sentinel survey. ⁽¹⁶⁾ It is however lower than that (90%) observed in another study in South Western Nigeria in 1995. ⁽¹⁷⁾ This is not surprising since Jos North LG is a metropolitan area with a concentration of the enlightened/educated people from various parts of the state and beyond.

This study revealed that almost all the respondents were Christians (93.9%). Could this be reflective of the true distribution of the disease by religion? Is it possible that this reflects the level of awareness amongst adherents of the various religions? It is indeed important to find out what impact the various faith based organizations are having on the populace. Though FAH is a Christian NGO, a distribution of religion by facility shows that there is a higher proportion of Muslims attending the facility than those attending PSSH a government and secular hospital. This finding is rather alarming and should be taken into consideration in the planning of HIV/AIDS interventions. Religious leaders and community leaders certainly have a role to play in the prevention and care of PLWHA.

Most respondents were diagnosed in a government facility. The reasons for testing were 1st voluntary, then prolonged illness, spouse's undisclosed illness, spouse's HIV +ve status, premarital test and doctors request in descending order of importance. Even though most gave their consent for the test to be carried out, not all who gave consent gave informed consent as a number of them were not told the meaning of the test and results before the test. However, this could be because of their critical state of health when they were

brought for medical attention. A higher proportion of respondents were counseled after the test.

Most of the respondents had commenced ART and all reported receiving their drugs at their respective health facility free of charge. This is because both facilities enjoy sponsorship from PEPFAR and other donor organizations. Half of the respondents reported availability of nutritional support of some kind in their facilities, although much less reported receiving either food/food supplements or nutritional advice from their facilities. The respondents attending FAH are significantly more likely to receive nutritional support than those attending PSSH. Malnutrition with resulting weight loss is present in the majority of patients with HIV infection and may lead to impaired organ function, inability to perform daily tasks and decreased facility of life. An evaluation of nutritional support in HIV patients showed that in 71% of cases given nutritional support, either further weight loss was prevented or weight gain was achieved. ⁽¹⁸⁾ Nutritional support is thus an important component of a comprehensive care and support program for PLWHA.

About a third of the respondents reported having medical problems at the time of the study. Most had fever followed by diarrhea, cough and weight loss. Most went to their respective facilities for medical attention even though a few attended private hospitals, chemists or herbalists. For most that go elsewhere for medical help, their main challenge is finance for transport to the facility they are receiving ART from.

This study revealed that respondents attending FAH are significantly more likely to be referred elsewhere for services such as confirmatory tests, radiology, further medical/surgical treatment and CD₄ counts. It is however not clear whether this is a reflection of better referral services at FAH or availability of more of these services at PSSH. In any case, functional referral system is a pre requisite for effective care and support programs for PLWHA. This will enable PLWHA access services not

offered at the facility where they are receiving care.

Every 4 out of five respondents reported that their total income was not enough to meet their basic needs which included food, clothing shelter and money. This was more likely with those diagnosed less than a year ago in spite of the fact that most of their drugs were given freely. This is in contrast with another study in India which concluded that financial burden of care and support services increases with stage of disease. ⁽¹⁹⁾ However, it is possible that those diagnosed less than a year ago are just beginning to come to terms with the realities of their status and hence their judgment may be more subjective or even exaggerated. Another study showed that economic support is an urgent need for 70.8% of respondents in Puerto Rico, ahead of psychological services (35.8%), medications (34%) and transportation (31.1%). ⁽²⁰⁾

It was also found that married respondents had the highest proportion of those whose income was able to meet their needs. It is however not clear what the reasons were although it is possible that the couple combine resources to cater for themselves and dependants. A quarter of the respondents say they cannot feed self and dependants in the next 3-5 years. This category of people urgently needs economic support to help improve their quality of life. Almost half the respondents further reported a decrease in income as a result of the disease – associated more with the male respondents, and higher professionals. In terms of marital status, widowed respondents' income was worst hit. This is not totally unexpected as the loss of a loved one who was probably the breadwinner of the family would further impoverish such households. If the deceased died of a chronic illness such as HIV, the burden of care would have probably drained the family of much needed resources.

Most of the respondents are not aware of any income earning opportunity in their health facility; of those who are aware,

those attending FAH were significantly more likely to receive socioeconomic services than those attending PSSH. Given that PSSH PEPFAR program is a much recent one compared to FAH, it would probably evolve with time.

Strictly speaking, provision of socioeconomic support is not the primary responsibility of the health facilities but that of other public and private organizations. It is the direct and indirect responsibility of the government to improve the socioeconomic wellbeing of the general populace and by extension that of PLWHA. Government can create jobs directly and can provide an enabling environment for private or non-government organizations to create jobs, hence creating jobs indirectly. With a good referral system in place, PLWHA may then be linked up with the appropriate agency either for skill acquisition, employment or loans for businesses of their choice.

CONCLUSION

Food, clothes, shelter and money were considered as important socioeconomic needs among adult PLWHA in Jos. Some feel their HIV positive status has led to a decrease in their income and even sack for a few. Majority of the respondents, however, could not meet their basic needs including food, shelter, clothing and money. Some reported that they cannot feed their families for the next 3-5 years. This calls for steps to strengthen socioeconomic support for PLWHA in order to meet these needs thus improving their quality of life.

Recommendations

1. There is need to raise awareness on the socioeconomic needs of PLWHA.
2. Socioeconomic services should be made an integral component in all care and support programs for PLWHA.
3. Since transportation is a major challenge for a significant proportion of the patient, there is a need to initiate and support community driven program that

provide comprehensive services to PLWHA and their families. This should be made a vital part of the Primary Health Care services, thus bringing these services closer to where people live and work and reducing costs to patient.

4. PLWHA should play a key role in planning and delivery of socioeconomic care and support services for PLWHA. This will contribute to the relevance of the programs and their sustainability.
5. There is need to strengthen capacity of existing HIV/AIDS care providers to enable them provide more comprehensive care and support services and to integrate successfully with community level services providers.
6. Research is needed to better understand the various socioeconomic needs of PLWHA and how best to mitigate these needs.

ACKNOWLEDGEMENT

1. The management and staff of Faith Alive Hospital, Jos, Plateau State.
2. The management and staff of Plateau State Specialist Hospital, Jos.
3. The management and staff of ECWA Evangel Hospital, Jos, Plateau State.

Conflict of interest

The authors wish to declare that there is no conflict of interest.

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How to cite this article: Adamba GE, Nwankwo BB. Socioeconomic needs of adults living with HIV/AIDS in Jos, North Central Nigeria. Galore International Journal of Health Sciences & Research. 2019; 4(3): 20-30.
