INFLUENCE OF SOCIAL SUPPORT ON GENERAL WELLBEING AMONG WOMEN WITH HIV/AIDS CORMOBID WITH PSYCHIATRIC DISORDERS IN MAKURDI METROPOLIS

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ABSTRACT
This study assessed the influence of social support on the general wellbeing of women with HIV/AIDS co morbid with psychiatric disorders at the Federal Medical Center, Makurdi, Nigeria. The study employed the Cross sectional design. One hundred (100) women whose age ranged from 15to 79witha mean age of 47years took part in the study. The participants had been diagnosed by medical doctors and psychiatrics with HIV/AIDS co morbid with various psychiatric disorders. Data was collected using a questionnaire comprising scales for multidimensional scale for perceived social support (MSPSS), and general wellbeing scale (GWBS).Four hypotheses were stated and tested. Results showed that Social Support, from significant others significantly influence the general wellbeing of women with HIV/AIDS co morbid with psychiatric disorders β=.536, t= 4.03, P<0.05. Social Support from family did not significantly influence general wellbeing of women with HIV/AIDS co morbid with Psychiatric disorders β=.113, t= 0.99, P= .321. Social support from friends did not influence general wellbeing of women with HIV/AIDS co morbid with psychiatric disorders β=-.114, t=-1.07, P= .288. There was no statistical significant difference in economic statuses ($F_{(2,95)}$=2.67, P=.075). In the light of the findings, it was concluded that social support from significant others significantly influence general wellbeing of women with HIV/AID comorbid with psychiatric disorders. Recommendation is, the findings contribute to the evidence for promotion of knowledge about social supports from significant others for people living with HIV/AIDS and psychiatric disorders for improved quality of life of the patients.

INTRODUCTION

Sub-Saharan Africa accounts for about 70% of the global HIV burden with 4.4% prevalence as of 2015 (Global Health Observatory, GHO) data - HIV/AIDS [http: //www.who.int/gho/hiv/en/]. Nigeria is the most populous nation in Africa with an estimated population of over 170 million people (Nigeria: WHO statistical profile (http://www.who.int/gho/countries/nga.pdf?ua=1). HIV prevalence in Nigeria as of 2015 was 3.2% (amounting to about 3.5 million people living with HIV in the country), (HIV and AIDS in Nigeria: http://www.avert.org/professionals/hiv-aroundworld/sub-saharan-africa/nigeria.) . The emergence of the HIV/AIDS pandemic brought with it many burdens on the society, health system, families, and the people who are infected with HIV (Whiteside, 2008).At the onset of the pandemic, initial interventions focused mainly on how to reduce infection rates and the death rates of those already infected with the virus (Whiteside, 2008). Globally, attention is now being increasingly drawn towards improving the quality of life of people living with HIV/AIDS (Oguntibeju, 2012). This trend is important especially with the positive strides already gained in the fight against AIDS over the years regarding improved anti-retroviral drugs (ARVs), leading to increased life expectancy of people infected with the virus, as well as, reduced rates of new infection (Oguntibeju, 2012).

The reason for the shift in the focus of the care for People Living with HIV/AIDS is due to the co-morbidity of HIV infection with many other diseases (apart from the established opportunistic infections) which tend to reduce the quality of life of People Living with HIV/AIDS. For example, it has been found in various studies within and outside Nigeria that many People Living with HIV/AIDS also suffer from depression and other mental disorders (Adewuya, Afolabi, Ola, Ogundele, Ajibare, &Oladipo 2008).

Common mental disorders are also more common among People Living with HIV than in the general population (Chibanda, Cowan, Gibson, Weiss, & Lund, 2016), (Brandt, 2009). Common Mental Disorders have been known to increase disease progression among People Living with HIV and are the leading cause of disability among People Living with HIV (Chibanda, Cowan, Gibson, Weiss& Lund 2016). Some of the reasons proffered for the higher prevalence of Common Mental Disorders among People Living with HIV include decreased adherence to antiretroviral therapy (Primeau, Avellaneda, Musselman, St Jean, &Illa, 2013),emotional stress associated with the knowledge of one's HIV-positive status (Kidia, Machando, Bere, Macpherson, Nyamayaro, & Potter, 2015),externalized and internalized AIDS-related stigma (Yi, Chhoun, Suong, Thin, Brody, &Tuot, 2015) and a compromised immune system (Yi, Chhoun, Suong, Thin, Brody, &Tuot, 2015).

In Benue State, Nigeria Federal Medical Center Makurdi alone has recorded about 0.5% of HIV/AIDS disease comorbid with psychiatric disorders from 2011 till date,(data from case records, Federal Medical centreMakurdi) but recently the number has reduced from 0.5% to 0.1%. No research or survey has been done as to why but it could probably be due to a lot of reasons which may be social and economical.

The syndemic between HIV/AIDS and several psychiatric illnesses remains an important concern worldwide. The problem is complex since each illness is affecting the other negatively: First, there is an association between serious psychiatric illness and the risk of acquiring HIV (Prince, Walkup, Akincigil, Amin, & Crystal.2012).Psychiatric illness may further affect HIV-infected individuals in all stages of disease, including disclosure of HIV diagnosis through the whole process related to ART; readiness to start treatment as well as the need for life-long adherence to medication. (Badiee, Riggs, Rooney, Vaida, Grant, &Atkinson, 2012),(Battegay, Haerry, Fehr, Staehelin, Wandeler, &Elzi, 2014).

On the other hand there also exists an increased risk of acquiring mental problems due to the HIV-diagnosis with worries for complications and the stigma that still exists towards HIV infected individuals. Despite virological and immunological stability thanks to effective ART, a substantial proportion of people living with HIV have significantly lower health-related quality of life than the general population, which has been attributed to co-morbid psychiatric problems(Adams, Zacharia, Masters, Coffey,& Catalan 1990-2014 & 2016), (Mirani, Williams, Chernoff, Abzug,Levin, &Seage ,2015).

According to severalstudies, HIV-infected individuals with co-existing psychiatric illness again had elevated rates of non-adherence to bothART and psychiatric medications. (Moore, Posada, Parikh, Arce, Vaida, &Riggs , 2012), (Rossier, Cox, Niesor,& Bentzen.1989).

The prevalence rates of psychiatric disorders in people living with HIV has been reported to be up to 50% when symptomatic rating scales have been used. (Bing, Burnam, Longshore, Fleishman, Sherbourne,& London 2001), (.Lyketsos, Hanson, Fishman, McHugh, &Treisman 1994). Co-occurrence of psychiatric illnesses such as bipolar and sub-stance abuse was associated with impulsivity, impaired judgment, and risk-taking. (deSousa, da Silva, Barreto, Negreiros, do Menino,& de Ma-tos, 2013), (Meade, Graff, Griffin, & Weiss, 2008).

HIV infections continue to increase rapidly among women, who made up 22 percent of cases in the U.S. in 1997 and now make up 42% percent of cases worldwide. (www.HIV+standard of women 2005).Since the start of the global HIV epidemic, women have been disproportionately affected by HIV in many regions. Today, women constitute more than half of all people living with HIV (The Foundation for AIDS Research (amfAR) 2015). AIDS-related illnesses remain the leading cause of death for women of

reproductive age UNAID (2015).Young women (10-24 years), and adolescent girls (10-19 years) in particular, account for a disproportionate number of new HIV infections. In fact, young women are twice as likely to acquire HIV as their male counterparts. UN Women (2016). In 2015, 20% of new HIV infections among adults were among women aged 15-24 despite this group only accounting for 11% of the global adult population. UNAIDS (2016). This equates to some 7,500 young women across the world acquiring HIV every week. UNAIDS (2017)

In East and Southern Africa young women will acquire HIV five to seven years earlier than their male peers. Dellar (2015). In 2015, there were on average 4,500 new HIV infections among young women every week, double the number in young men. UNAIDS (2016). In west and central Africa, 64% of new HIV infections among young people in 2015 occurred among young women. UNAIDS (2016) The difference is particularly striking in Cameroon, Côte d'Ivoire and Guinea where adolescent girls aged 15–19 are five times more likely to be infected with HIV than boys of the same age. UNAIDS (2015), even in regions such as Eastern Europe and Central Asia, where the population most affected by HIV is injecting drugs users, the majority of whom are men, women make up a rising proportion of people living with HIV. In Russia, for example, the number of young women living with HIV aged 15-24 doubles that among men of the same age. UNAIDS (2012).

Women are experiencing problems in almost all aspects of their lives also as a result of the low status that culture has placed on them. Unfortunately, as in all aspects of life, the men who are decision makers have refused to make any change that will ultimately change the position that culture has accorded women. Women living with HIV/AIDS in rural Nigeria might even find it more difficult to sustain themselves especially in a situation where they were not infected by their husbands or whereby their husbands have other wives. Some of the major challenges faced by HIV/AIDS infected women include fear, rejection, and loneliness, only to mention a few. Most women living with the disease in Nigeria are said to be infected because they were subjected to forced sex and rape, migration, women/girl trafficking and sexual exploitation (Ezedum, 1999).

The influence of social support on the general wellbeing of women with HIV/AIDS may differ by gender and culture. In the United States, researchers have documented differences between men and women when receiving support. According to Taylor (2007), it was observed that social support may be experienced differently across cultures and is an area in need of further study

In this study, social support suggests that spouses of infected women, their children and relatives (family), friends and significant others will influence general wellbeing, that is if these women are treated with love, respect and outmost care, they will live better lives (Kemp, 1995), unlike what some infected women have come up to state in the news media and at the clinics that they were rejected and sent packing from their homes because of their HIV status.

According to Kemp, experiences from the print media also indicate that most health workers treat them with disdain, which is one of the reasons why they hardly visit the hospitals. Unfortunately, infected women risk the co morbidity of psychiatric disorders and dying early as a result of ignorance and are not likely to observe that the disease is progressing. The situation is even worse when such women become psychotic. Therefore, social support for the infected women involves evaluating certain indices for maintaining good health (general wellbeing) and coping with the disease. These include support from significant others, family and friends which can provide information that can lead to health promotion/prevention of illness (nutritional care,

hygiene and sanitation, prevention of opportunistic infections) and early diagnosis/treatment.

Social Support from family for instance includes provision of daily needs of the patients. According to Kemp (1995), support from family should be encouraged to create support network of similar care givers such as religious groups, women's groups, NGOs and community health workers who should help families to identify local resources. Health promotion/illness prevention connotes provision of good healthy food capable of nourishing the infected women, which also helps to prevent illness to enable them live with dignity and security, World Health Organization/Food and Agricultural Organization of the United Nations (WHO/FAO, 2002) and enhance general wellbeing. In view of the foregoing, this study investigated the influence of social support on the general wellbeing of women with HIV/AIDS comorbid with psychiatric disorders at federal medical centre in Makurdi, Benue State.

METHOD

Design

The study utilized the cross sectional design, where a questionnaire was administered to the participants. The study used this design because data was collected at one specific point in time over a short period of time and it involved the analysis of data collected from a population or a representative subset. Also to see if there is a difference or a relationship between the independent variables and dependent variable, if one influences the other (find the causal effects of one or more IV upon the DV of interest at a given point in time) and its individuals with a specific characteristics, with a sample from a tiny minority, of the rest of the population.

Setting of the study

The setting for the study was the Psychiatric unit and the US President Emergency Plan for AIDS Relief (PEPFAR) unit of Federal Medical Centre Makurdi in Benue State. The psychiatric unit of Federal Medical Centre is located adjacent to Aper Aku Stadium; it comprised 36 beds (18 for male and 18 for female). The unit has a capacity to admit 36 patients at a time, and there is an outpatient department. Clinic days for Out Patient Department (OPD) are Mondays and Fridays. PEPFAR unit is situated at the main centre (mission ward) at Wadata area of Makurdi. Clinic days are Monday to Friday approximately fifty (50) patients are seen on a daily basis.

Benue state is in North Central Nigeria, it is in the mid-east region of Nigeria with a population of about 4,253,641 in 2006 census. Idoma and Tiv are spoken predominantly. There are other ethnic groups, including Igede, Etulo and Abakwa, Jukun, Hausa, Akweye and Nyifon. With its capital at Makurdi, Benue State is named after the River and was formed from the former Benue-Plateu State in 1976.Benue state lies within the lower River Benue trough in the middle belt region of Nigeria. Its geographical coordinates are longitude 7. 47' and 10.0' east.Latitude 6.25' and 8. 8' North; and shares boundaries with five other states namely: Nasarawa State to North, Taraba State to the east, Cross River state to the south , Enugu state to the south –west and Kogi state to the west. The State also shares a common boundary with the republic of Cameroon on the south-east. Benue occupies a landmass of 34,059 square kilometers. This is the only tertiary health institution in Benue State that has a psychiatric department where most

people with psychiatric problems access their treatment. It has both a psychiatric unit and medical wards. Patients were sourced from the psychiatric unit and PEPFAR unit.

Participants

One hundred (100) women participated in the study. It was only HIV/AIDS patient's cormobid with psychiatric disorders, attending the clinic at Federal Medical Centre Makurdi that responded to the questionnaire. Their ages range from 15 to 79 years, mean age (M = 34.96 and SD = 9.823). The rationale behind restricting the participants of the study to women was based on the premise that they report more HIV/AIDS disease co morbid with psychiatric disorders than men (From Observation), and are the most vulnerable group and more likely to be badly treated than children and men UNAIDS (2014).

Instruments/Measure

Demographic: variables such as age, sex, marital status, religion, educational background, occupation, and economic status were measured.

Multidimensional Scale of Perceived Social Support (MSPSS)

Multidimensional Scale of Perceived Social Support(MSPSS)was developed by Zimet, Dahlem, Zimet and Farley(1988). It was developed as a brief self report measure of subjective assessed social support in which 12-item ratings were made on a 7-point likert-type scale ranging from very strongly disagree(1) to very strongly agree 7, (Zimet, et al., 1988). The 12-item MSPSS was designed to measure the perceived adequacy of support from the following three sources: family (items 3,4,8 and 11), friends(items 6,7,9 and 2) and significant others(items 3,4,8 and 11). The coefficient alpha for the subscales and whole scale ranged from .85 to .91. Similarly, test-retest values ranged from .72 to .85. In this present study the reliability scale of social support is the Cronbach's alpha of .918.

The General Well-Being Scale (GWBS)

This was developed by National Center for Health Statistics in 1970 by Dr Harold Dupuy. It is an 18 item questionnaire. The scores are added together. The coefficient alpha for the scale is 0.90. In this present study the Cronbach's alpha for the scale is .920

Procedure

The researcher with assistance personally administered the multidimensional scale for perceive social support and general wellbeing scale questionnaire to the participants, and collected them back. They were instructed on what to do and those that were willing but could not answer due to inability to read or write were assisted .One hundred (100) women with HIV/AIDS co morbid with psychiatric disorders participated in the research, age ranging from 15 to 79, mean age (x = 34.96 yrs SD = 9.823).

Participants were identified at the female psychiatric ward and PEPFAR clinic. Those who met the criteria for the study were selected at convenience and their consent obtained. The inclusion criteria are as follows:

- Those that have been clinically diagnosed with HIV/AIDS induced psychosis.
- Patients ages ranges from 15 to 79.
- The questionnaire was administered to both in and out patients. Those on admission were identified during ward rounds, out patients were identified during clinic days, until the required number of patients was obtained.

- The respondents were women.

The participants that were identified during ward rounds or clinic days were taken to a separate room and their consent to participate in the study was obtained. Those who consented were explained the objectives of the study and questionnaires were administered to those who are literate and can read, understand and provide responses by themselves. Those who are illiterate were assisted by the researcher or assistants by reading out the statements and them providing the answers. The researcher sought and obtained the permission of the hospital management before administering the questionnaire to the participants. Consent of the participants was also obtained from them.

Data Analysis

Analysis of data was performed using statistical programme for social sciences (SPSS) version 20.0. Descriptive statistics such as means, standard deviations and percentages were used to describe the demographic characteristics of participants. Correlation and regression statistics were used to test the statistical relationship of the study variables and reveal how well independent variables predict dependent variables. One way ANOVA was also used to test the difference of economic status on general wellbeing.

RESULTS

Table 1Demographic characteristics of the participants

Variable	Frequency (N)	Percent(%)
Marital status		
Single	25	26.0
Married/cohabitant	44	45.8
Divorced/Separated	15	15.6
Widowed	12	12.5
With whom do you live		
Alone	15	15.0
My husband/wife/partner/cohabitant		
My daughter	42	42.0
My son	10	10.o
My brother	4	4.0
My sister	4	4.0
My grand children	1	1.0

Paid personnel	9	9.0
Other person	1	1.0
	14	14.0
What is your Education		
Cannot read nor write	25	26.3
Less than primary school	1	1.1
Primary school/similar	3	3.2
Secondary education	41	43.2
University/similar	25	26.3
What is your main profession		
No education	18	18.0
Student	8	8.0
Artisan	6	6.0
Civil servant	23	23.0
Business	28	28.0
Farming	15	15.0
House wife	1	1.0
Cleaner	1	1.0
Economic status		
Low economic status	26	26.0
Average economic status	23	23.0
High economic status	51	51.0
Do you still work		
Yes	27	55.1
No	22	44.9
Have you been sick leave the past year		
Yes	13	39.4
No	20	60.6

Have you been unemployed the past year		
Yes	6	19.4
No	25	80.6
If retired, since how long		
1	1	50.0
2	1	50.0
How long have you been unemployed totally in your life		
Never	19	52.8
12 months or less	5	13.9
More than 12 months	12	33.3
How many hours do you do unpaid work		
1	9	12.5
2	13	18.1
3	13	18.1
4	11	15.3
5	8	11.1
6	6	8.3
8	1	1.4
9	3	4.2
10	1	1.4
11	2	2.8
24	4	5.6
30	1	1.4
Main source of financial support		
Business	29	36.7
None	7	8.9

Labour	1	1.3
Salary	20	25.3
Patients	6	7.6
Farming	11	13.9
Husband	4	5.1
Children	1	1.3
How often do you worry about the daily expenses		
Never	10	11.4
Quite often	27	30.7
Often	29	33.0
Always	22	25.0
Where do you live		
Own house	53	54.6
House renting	39	40.2
Apartment renting	1	1.0
sheltered housing	3	3.1
others	1	1.0

Table 2.Inter correlation matrix of the study variables

S/N	Variables	M	SD	1	2	3	4	5	6	7	8	9	10	11	12
1	Age	34.7	9.83	-											
2	Marital Status	2.15	.951	.603**	-										
3	Number of persons living in household	7.94	6.37	-.073	-.077	-									
4	Education	4.16	1.97	-.312**	-.520**	-.154	-								
5	Profession	3.21	1.57	.391**	.428**	.144	-.381**	-							
6	Sick leave	1.61	.496	.153	-.172	.420*	-.110	.073	-						
7	Unemployment status	1.81	.402	.398*	-.090	-.026	.165	.040	-.183	-					
8	Source of financial support	3.27	2.12	.190	-.098	-.045	.001	-.005	.090	.624**	-				
9	Significant Others	169.3	7.06	.107	.248*	-.003	-.229*	.073	.185	.105	-.221	-			
10	Family Support	17.19	6.74	.166	.119	.006	-.114	-.007	-.068	.048	.025	.625**	-		

11	Friend Support	13.53	6.73	-.115	.117	.126	-.055	-.040	.302	-.068	-.299**	.564**	.234*	-	.
12	General well being	53.00	22.99	.232*	.279**	.061	-.117	.281**	.386*	-.305	-.260*	.542**	.421**	.215*	-

**=P<0.01, *=P<0.05

Table 2 shows the inter correlation of study variables, if there is a positive significant relationship between the Independent Variables(social support from friends, family and significant others), Social Demographic Variables(age, marital status, number of persons in household, education, profession, sick leave, unemployment, source of financial support,) on the dependent variable (General Wellbeing). The result showed that there is a positive significant relationship between the independent variables (social support from significant others r= .542, P<0.01, social support from family r=.421, P<0.01, and social support from friends r= .215, P<0.05) on the dependent variable (General wellbeing). The result is also shows there is a positive significant relationship between the social demographic variables (age r= .232, P<0.05, marital status r= .279, P<0.01, profession r= .281, P<0.01, and sick leave r= .386, P<0.05,) on the dependent variable (General Wellbeing).

Hypothesis one: States that Social support from family will significantly influence general wellbeing of women with HIV/AIDS comorbid with psychiatric disorders.

Table 3: Multiple Regression analysis showing the influence of Social Support on General Wellbeing

Variables	R	r^2	F	df	B	T	p-value
Constant	.56	.314	13.88	3,91			0.000
Significant others					.536	4.03	0.000
Family support					.113	0.99	0.321
Friend support					-.114	-1.07	0.288

Note: Betas (β) reported are variables entered into equation.

The result of multiple regression presented in table 3 shows that there is a statistical significant relationship between the predicting variables (Significant others, Family support and friends support) on general wellbeing of women with HIV/AIDS comorbid with psychiatric disorders. ($F_{(3,91)}$= 13.88, P<0.05). The variance accounted for (R^2) with the three predicting variables mentioned above was 31.4%.

In the regression analysis, family support, friends support and significant others support was entered into the equation;

Result from table 3 shows that family support accounted for 11.3% of the variation in general well-being, which was not statistically significant (β=.113, t= 0.99, P> .321). The implication is that, family support has no significant influence on general wellbeing among women with HIV/AIDS comorbid with psychiatric disorders. Therefore, the hypothesis, which states that "social support from family will significantly influence general wellbeing of women with HIV/AIDS comorbid with psychiatric disorders", is hereby rejected.

Hypothesis Two: States that social support from friends will significantly influence general wellbeing of women with HIV/AIDS comorbid with psychiatric disorders.

Result from table 3 further showed that support from friends accounted for 11.4% of the variation in general well-being, which was not statistically significant (β=-.114, t=-1.07,

P>.288). This implies that friends support has no significant influence on general wellbeing of women with HIV/AIDS comorbid with psychiatric disorders. Thus, the hypothesis, which states that "social support from friends will significantly influence general wellbeing of women with HIV/AIDS comorbid with psychiatric disorders", is hereby rejected.

Hypothesis three: states that social support from significant others will significantly influence general wellbeing of women with HIV/AIDS comorbid with psychiatric disorders.

Result from table 3 indicated that significant others accounted for 53.6% of the variation in general well-being, which was statistically significant (β=.536, t= 4.03, P<0.05). This implied that significant others have significant influence on the general well-being of women with HIV/AIDS comorbid with psychiatric disorders. Thus, the hypothesis, which states that "support from significant others will significantly influence general wellbeing of women with HIV/AIDS comorbid with psychiatric disorders" is hereby accepted.

Hypotheses four: states that women with HIV/AIDS comorbid with psychiatric disorders with low socio economic status will significantly differ on general wellbeing from those with average and high economic status.

Table 4: One way analysis of variance showing the difference between low and high socioeconomic status of HIV/AIDS patients comorbid psychiatric disorders

Variables	Sum of Squares	df	Mean Square	F	Sig.
Between Groups	2726.571	2	1363.286	2.669	**.075**
Within Groups	48527.429	95	510.815		
Total	51254.000	97			

Variables	N	M	SD	df	F	P	Remark
Low economic status	25	44.88	23.09				Not significant
Average economic status	23	51.87	23.59	2,95	2.67	0.075	
High economic status	50	57.58	21.90				

Lastly ANOVA was used to determine the difference between economic status (Low, Average and high) on general wellbeing among women with HIV/AIDS co morbid with psychiatric disorders. There was no statistical significant difference on economic status. ($F_{(2,95)}$=2.67, P=.075). Therefore, the hypothesis which states that women with HIV/AIDS comorbid with psychiatric disorders with low socioeconomic status will significantly differ on general wellbeing from those with average and high economic status is hereby rejected.

DISCUSSIONS

The study examined the influence of social support on the general wellbeing of women with HIV/AIDS comorbid with psychiatric disorders. The findings in part indicate that there was no statistical significant relationship between social support from family and friends on the general wellbeing of women with HIV/AIDS comorbid with psychiatric disorders in this study, this result is in contrast to the works of Ahmadi (2015), Oluwale (2011), and Njodiet. al.(2005). Ahmadi (2015) reported a significant relationship between social relations and wellbeing. Their findings in that context, social relations have been found to affect different aspects of people's life. This research is a systematic review of attempts to consider social support as a major determinant of health during life span. The study confirms the importance of social relationship to health and longevity and its different implications in women's health. In Conclusion, to be healthier and more usefully active in the society, women need to have different kinds of support from social relationships. Women are required to be better informed about the significance of enjoying positive social relationships which provide potential health benefits, by social support, from both relatives and other people.

Oluwole, Hammed & Awaebe (2011) state that social support is physical and emotional comfort given to people by family, friends, co-workers and others, it is believed that such support patterns have a positive impact on women. Thus, feeling loved and supported by family members and friends is more beneficial to women but not men; and that it is a deep human need to be loved and cared for.

Njodi, Bwala &Olaitan (2005) also observed that women's health is one of the most fundamental issues in national development even as the quality of their lives depends on the resources available, access to health facilities as well as the social support they receive from by their families, friends and significant others. They also noted that the quality of the existence of the infected would imply slowing down the progression of the disease, minimizing pain and maximizing general wellbeing.

Part of the findings showed a significant relationship between social support from significant others and general wellbeing of women with HIV/AIDS comorbid with psychiatric disorders in this study. This concurs with prior research by Ahmadi (2015) and Oluwale et al. (2011) who also reported a significant relationship between social support and general wellbeing.

Furthermore another part of the study reveals that there was no statistical significant difference on the economic status of women with HIV/AIDS comorbid with psychiatric disorders. This is contrary to the works of (Xiaoyuan , Yuan ,& Jing, 2015) based on the theoretical analysis, with first-hand data collection and using multiple regression models, this study explored the relationship between social support, socioeconomic status and well-being. We draw on the following conclusions: (1) Family support and general support of others have positive influences on general well-being. And these influences largely remain constant for the sampled subjects regardless of their socioeconomic status.(2) One dimension of socioeconomic status(family annual income) has a positive influence on general well-being.

Decreased access to health insurance and preventive services is a major contributor to health disparities between high- and low-Social Economic Status individuals. Low-income individuals are not likely to have health coverage or receive

optimal treatment and care for HIV/AIDS, such as Highly Active Antiretroviral Therapy (HAART) (Wood et al., 2002).

It is also important to note from a measurement perspective that the researcher is not satisfied. Data was collected based on self-report which gave room for participant bias response to the questions, which may have tendencies of depicting social desirability and in return affect the outcome of result. Therefore these findings are not conclusive.

Conclusion

This research examined the impact of social support on general wellbeing among women with HIV/AIDS co morbid with psychiatric disorders in Makurdi metropolis, It sought to find out if support from family, friends and significant others will influence the wellbeing of these group of people. However all the hypothesis in the study was rejected except one. Finally this present study has come out with the conclusion that social support from significant others influences general wellbeing among women with HIV/AIDS comorbid with psychiatric disorders.

Recommendations/Suggestions

Further research to be done in this area because data was collected based on self report which gave room for participant bias response to the questions which may have tendencies of depicting social desirability which may have affected the outcome of the result. The researcher suggests that more systematic and authentic means of gathering data which may include other techniques as observation of participants in different environmental situations may be used.

1. The finding in this study should get the clinical psychologists to draw the attention of every significant person in a woman with HIV/AIDS life, let them be informed that they can be a protective factor in helping this group of people experience better health outcomes by getting them informed on the need to seek early treatment, comply with medications and provide them with the resources necessary to access treatment, in other to avoid development of co morbidities
2. The government, hospitals and the communities should develop programmes for this group of people, (help groups,) was they come and share experiences, information and experiences healing properties (group cohesiveness, universality, catharsis etc.).
3. Clinical psychologist handling these particular cases should get the significant others involved, letting them know of the impotence of their support to the patient.
4. Health Professionals (Clinical psychologists) be sponsored on local and international workshops, conferences and seminars to train them in the area of psycho-social issues affecting women with HIV/AIDS that may trigger the development/comorbidity of psychiatric disorders and update the knowledge already acquired in the area, to make them more efficient and effective in their provision of Psychological Services to these patients.
5. Clinical Psychologist should develop programmes that will create awareness to these groups of people, programmes that educate and enlightened them about the need to comply with medication need for support and about the danger of the

comobidity of mental illness since this field (clinical psychology and their services) is new in Nigeria.

6. Clinical psychologist handling these cases should see the need to always psycho-educate the care givers, on the importance of social support.

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