# Impact of psychosocial support on wellbeing of HIV infected older adults in Ibadan.

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## Abstract

**Older adults in sub-Sahara African societies are vulnerable group of people due to life experience of hardship, malnutrition, poverty and high susceptibility to chronic diseases like HIV epidemic. Hence, there are very few strategies that currently address the hidden psychosocial problem of HIV among the older adult's ages 50years and above. The study investigates the perceived impact of psychosocial supports on the general well-being of older adults in Ibadan.**

**The study was conducted among older adults attending the General Out-Patient clinic (GOP) and Geriatric Centre of University College Hospital, Ibadan. The study purposively selected 120 older adults ages 50years and above at the GOP clinic and Geriatric Centre. Ethical consent was received from UCH research ethical committee. The study used a self-constructed instrument tagged Psychosocial Support of HIV/AIDS Older Adults Questionnaire (PSHOAQ). The reliability of the instrument yielded r=0.84 Crobanch Alpha. Four (4) research hypotheses were tested with ANOVA.**

**The study established that there was a significant impact of counselling services on the general well-being of HIV Infected older adults in Ibadan (f-cal=128.058, P<0.05); there was a significant impact of financial support from the clinic on the general well-being of HIV Infected older adults in Ibadan(f-cal=64.821, P<0.05). Furthermore, the study established that, there was a significant impact of companionship from peers of the clinic on the general well-being of HIV Infected older adults in Ibadan (f-cal=32.506, P<0.05). Also, there was a significant impact of information access on the psychosocial well-being of the elderly (f-cal=120.655, P<0.05).**

**The study recommends that, HIV responses in African region needs to account for the older adults by reflecting on the risk, trends and providing comprehensive prevention, testing and treatment services. There is need for age-appropriate health services integrated with screening and treatment of non-communicable diseases among the older adults in Africa.**

**Keywords**: hypofunctional occlusion, occlusal recovery condition, root morphology, PDL space.

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## Background Information/Introduction

There a significant increase in the trend of global HIV epidemic among people aged 50 years and older. There are few HIV strategies in low and middle-income countries like Nigeria that address the previously hidden dimension of HIV epidemic, yet populations of 50 years and older hold important implications for HIV responses in the African region [1]. Worldwide, an estimated 3.6 (3.2–3.9) million people aged 50 years and older are living with HIV. For the first time since the emergence of the HIV epidemic, 10% of the adult population living with HIV in low- and middle-income countries is aged 50 or older (UNAID, 2013) [1]. In 2012 there was an estimated 2.9 (2.6–3.1) million people aged 50 years and above living with HIV in low- and middle-income countries like Nigeria. In high-income countries, approximately 30% of all adults living with HIV are aged 50 years and over. The proportion of adults living with HIV that is aged 50 years and older has increased in all regions, at varying rates, since 2007 (UNAIDS, 2013) [1]. However, the "aging" of the HIV epidemic is mainly due to three factors: the success of antiretroviral therapy in prolonging the lives of people living with HIV; decreasing HIV incidence among younger adults shifting the disease burden to older ages; and the often-unmeasured, and thus often overlooked, fact that people aged 50 years and older exhibit many of the risk behaviours also found among younger people [2].

An HIV/AIDS epidemic is striking at the heart of family and community support structures in Benue State. Evidence from past studies revealed that the aged and the young ones take up responsibilities of support and care of their needs [3,4]. This HIV/AIDS epidemic is changing family structures wiping out the middle generation of adults (both men and women) leaving behind the old and young to support each other (Help Age, 2013) [4]. The consequence is that families of older carers and orphans/vulnerable children are compelled to take on new roles of care and support. Recent studies Foster and Choice, found out that in South Africa and Uganda, 40% of patients attending the antiretroviral clinic are mostly older adults with poor social support systems [5]. These studies concluded that older carer people make up a significant proportion of the poorest in these areas as a result of HIV/AIDS epidemics [4].

Moreover, the poor financial support has reduced the wellbeing of older persons who are often forced to sell their assets or borrow money in order to cope with the burden of the illness [6]. There is scarcity of HIV/AIDS information on prevention, protection and how to access this information by older people limits their ability to protect themselves and their families. Past studies suggested that if older person are equally eligible to have access to this information on HIV/AIDS [7].

It is pertinent to note that, older people in most African societies are vulnerable group as due to lifetime hardship, malnutrition, poverty and other high susceptibility to age related chronic diseases. The AIDS pandemic is now posing an additional burden on the older population as they require psychosocial support and expected to be looked after. They have to take on the role of caring for others, without basic and necessary resources for survival. Thus, their health is the most precious asset not only to them, but also to their families and communities they connect with. Poor access to economic, social and psychological support, combined with poor access to health care services have constantly restrict their ability to provide the care expected of them [8]. Older people need to be counted, supported and educated in the fight against HIV/AIDS.

The different needs, roles and responsibilities of older men and women need to be acknowledged and included in programs and policies addressing this global epidemic [4]. There is relatively few HIV surveys have been conducted among individuals aged 50 years and older, but those available reveal high HIV prevalence [3]. In a 2012 national HIV survey in South Africa, for example, HIV prevalence was 13% among people aged 50–54 years and 12% among women and 6.9% among men aged 55–59 years (compared to 18% among men and women aged 15-49 years) [1]. A 2006–2007 national population-based survey in Swaziland, found 13% of men and 7% of women aged 60–64 years were living with HIV (compared to 27% among men and women aged 15-49 years) [1]. In Kenya, HIV prevalence was 5% among people aged 50-64 years (compared with 7.4% in people aged 15–49 years). An estimated 100 000 people in low- and middle-income countries aged 50 years or over acquire HIV every year. Of these, three quarters (74%) live in sub-Saharan Africa. It is possible that the rate of new HIV infections among people 50 years and older is higher than previously thought, but there is very little quantitative research into the sexual behaviours and HIV incidence among this age group in sub-Saharan African country.

More than any other disease, HIV/AIDS has proved its ability to disrupt the economic and social fabric of the community. This is because the disease is fatal, mainly affecting adults of working age who have young children and elderly parents to support. It is estimated that up to 25% of people between the ages of 15-49 are infected with the HIV virus. Often AIDS can also strike more than one member of a household or family. This does not mean that older people are not subject to the disease. Best found that, older people are not spared by HIV/AIDS despite the impression that AIDS is a younger person's disease. More people have died from HIV/AIDS over the last twenty years than from any other disease in human history. In the United States for instance, the devastation caused by the epidemic poses a clear and direct challenge to long-term U.S. economic and security interests [9].

Households consisting of older people and children are particularly at risk of poverty where other forms of social assistance are limited or non-existent, universal pensions can be a straightforward and cost-effective way to improve the health and income security of children and older people (especially older women) [10]. Pensions also increase older people's status, material security and access to health services, and make it easier for them to send children in their care to school.

In the few sub-Saharan African countries that do offer them (Nigeria, Botswana, South Africa and Lesotho), non-contributory pensions are acknowledged as a vital income support. They are used by older people and other household members for healthcare expenses, such as drugs or clinic fees, or related costs, such as transport and food – helping older people to maintain their health and livelihoods [11].

However, Oyinlola and Folaranmi observed that, Universal pensions alone are not sufficient, as eligibility depends on age [12]. For example, in Nigeria, where the minimum eligibility age is 60 or 65, pensions do not help grandparents in their forties, fifties or sixties. Universal pensions therefore need to be part of a wider package of social protection measures that includes free basic healthcare, free education, child and disability grants, community social-assistance funds and credit schemes. Older people – especially older women – often need support to claim social protection and other entitlements for themselves or those in their care. They may need legal advice, help with obtaining identity papers, financial support, or access to literacy programmes for older person

Older people are widely excluded from systems that track the HIV epidemic and the responses to it. In 2006 UNAIDS changed its global monitoring and reporting of HIV and AIDS, moving away from the conventionally used 15-49 year age group to focus on people aged 15 years and older, with no upper age limit. Today, its annual global epidemic updates and reports provide data on AIDS deaths, new infections and numbers of people living with HIV for all adults over the age of 15.

However, UNAIDS still collects HIV prevalence data (percentage of the population with HIV) for those aged 15-49 only. Similarly, core indicators used to track progress in the HIV response, including on access to voluntary counselling and testing, sexual behaviour and condom use, exclude those aged 50 and over. Focusing monitoring on such a narrow age range perpetuates the myth that older people are not sexually active, and suggests that increasing access to condoms and broader prevention efforts, including testing, is not a priority for people over the age of 49 [11]. There are indications that people 50 years and older may know less about HIV compared with younger people, as shown in surveys done in nine sites in West, East and Southern Africa; awareness was especially low among the women 50 years and older [1].

In Nigeria, the indicators of health and wellbeing, and measures of income and support, are vital to enable governments and NGOs to respond more effectively to the impact of HIV and AIDS. If we are to gain a comprehensive picture of the impact of the epidemic at the national and international level, data must be collected for all people and disaggregated by age, sex and socio-economic status – particularly in high-prevalence areas. Due to the fact that, the older people are so extensively excluded

from HIV monitoring and reporting, the following details are still largely unknown:

- Country-level HIV prevalence among those aged 50 and over
- Access to voluntary counselling and testing for those aged 50 and over
- Sexual behaviour and condom use among those aged 50 and over
- The number of 'skipped-generation' households, where older people and children live together
- Within skipped-generation households, the economic status, age and sex of the household head
- The number of households with only one or few adults caring for a large number of dependants
- The percentage of older-person-headed households, in which older people are caring for others living with HIV and AIDS and for orphans and vulnerable children.

From the foregoing, the study examines the perceived impact of psychosocial supports on the well-being of older adults in Ibadan

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## Research Objectives

1. To examine the impact of counselling services on the general well-being of HIV Infected older adults in Ibadan.
2. To investigate the impact of financial support from the centre on the general well-being of HIV Infected older adults in Ibadan.
3. To examine the impact of companionship from peers of the centre on the general well-being of HIV Infected older adults in Ibadan.
4. To examine the impact of information access from the centre on the psychosocial well-being of HIV Infected older adults in Ibadan;

## Emerging Roles of Geriatric Social Workers

As the society becomes more multicultural, social workers will increasingly need to serve diverse constituencies and achieve cultural competence [13]. Social workers should have a knowledge base of their clients' culture. This includes having an awareness of the value systems, including the experiences of a shared history, which may be unique to a particular generation. Social workers must be able to develop culturally appropriate interventions that speak to the needs and values of a population that is by definition unique in age, culture, and race/ethnicity (National Association of Social Workers [NASW] [13]. The National Association of Social Workers' policy statement on HIV/AIDS asserts that proactive efforts must continually be undertaken to educate the most vulnerable populations—those not reached by traditional prevention and educational programs [13].

The emerging roles of Geriatric Social Workers in providing psychosocial support services for Older Adults with HIV/AIDS was developed National Association of Social Workers and are as follows:

- Social workers are encouraged to facilitate open discussions with their older clients about their health history as well as their sexual and substance abuse histories.

- Social workers must be aware of their own comfort level in talking about sexuality, HIV/AIDS, aging and substance use.

- Social Worker must take comprehensive bio-psycho-social-spiritual assessment including questions about sexual practices; alcohol and drug use and creates an opportunity to talk with older clients about HIV transmission risk.

- Social Workers should share harm reduction practices and strategies that addresses drug and alcohol use and safer sex with older clients to promote HIV prevention.

- Social Workers should work toward dismantling barriers to resources and services for older adults with HIV/AIDS

- Social Workers should initiate dialogue with colleagues to identify and change institutional policies or practices that create barriers to providing comprehensive services to older adults, for example, build collaborations with AIDS service organizations and agencies that serve older adults.

- Social Workers must actively work to promote service messages that are welcoming to those communities within the older adult cohort who are at increased risk for HIV/AIDS, for example, people of colour, men who have sex with men (MSM) and persons who injection drugs.

- Work to support and advocate for public (federal, state, local) and private funding sources that support HIV/AIDS research, programs, training and education.

- Seek out education and other opportunities to better understand the nature of social diversity and oppression with respect to race, ethnicity, national origin, colour, sex, sexual orientation, age, marital status, political belief, religion and mental or physical disability [13].

## Methodology

### *Study site*

This study would be carried out at Ibadan, the capital city of Oyo state. Ibadan is located in the south-western area of Nigeria and has a population of 3.6million inhabitants. Ibadan is the largest city in Africa, south of the Sahara. The Yoruba tribe is the predominant ethnic group in Ibadan.

The University College Hospital (UCH) is a tertiary institution founded in 1957, and has 1000 beds. It has various specialty units and paramedical services with inpatient and outpatient services. UCH has patients referred from all parts of Nigeria and the West African sub-region.

### *Operations at the HIV/AIDS clinic*

The HIV/AIDS clinic is operated under the General Outpatients Department (G.O.P.D) which serves as the gateway to most of the patients coming to UCH, Ibadan. The clinic is run from 8 am to 4 pm every weekday, by consultant Family Physicians and postgraduate Resident Doctors in Family Medicine. All HIV/

AIDS patients presented at the clinic for the first time are seen by Consultants and Senior Resident Doctors and later referred to HIV/AIDS clinics of the General Outpatients Department. The patients with minor complaints are treated in the sorting hall, while those needing extensive examination and evaluation are registered to be seen in the consulting rooms of the G.O.P.D. For all adult patients, blood pressure and urinalysis are routinely done. The HIV/AIDS clinic also organizes HIV testing and counselling, as well as offer health education related to HIV/AIDS.

### *Study population*

Elderly patients aged 60 years and above presenting at the HIV/AIDS clinic of the General Outpatients Department and meeting the inclusion criteria would be recruited in the study.

### *Inclusion criteria*

All male and female patients aged 50 years and above who presented at the HIV/AIDS clinic during the study period. The age of the respondents would be determined by asking them, by the use of historical events, the age at marriage and the age of their first child.

### *Exclusion criteria*

All non-consenting adult patients would be excluded from this study.

### *The study design*

The elderly patients who met the inclusion criteria would be randomized and every third adult patient would be drawn into the study.

### *Sample size calculation*

Averagely, 1200 new elderly patients are seen monthly at General Outpatient Clinic. During the period of the study, elderly patients aged 50 years presenting at the HIV/AIDS clinic during the period of the study were purposively recruited.

### *Sample size determination*

The sample size will be determined using a recognized sample size determination formula.

$n=N/1+[n(e)^2]$

This formula is adopted by Yamane,

Where n=minimum sample size

N=total number of population

$e^2$=0.05, i.e., 0.05 which is constant

The study purposively sampled three hundred (120) consenting elderly patients utilizing HIV/AIDS clinic.

### *Participant*

Eligible respondents were registered patients of General Outpatient Department, UCH, and Ibadan. The researcher briefly interviewed potential respondents to determine their competency, the researcher judged their ability to understand the situation of transport service of the centre. Informed consent was obtained from the patient and ethical approval for the study and was granted by the Head of Department of General Outpatient Department of UCH, Ibadan.

### *Data collection*

The main instrument used for the research was the questionnaire tagged Psychosocial Support and Wellbeing of HIV/AIDS Older Adults Questionnaire (PSWHOAQ). The structured questionnaire was made-up of three (3) sections viz A-C.

**Section A: Measure of demographic characteristics:** This consisted of self-constructed item questions on social and demographic characteristics (age, gender, years of retirement, Stevenson's family model) of the elderly.

**Section B: Measure of psychosocial support:** This consisted of item questions developed by the researcher to measure the psychosocial variables of counselling services, financial support, companionship support and information access of the elderly. The questionnaire was modified and respondents were asked to respond to a two point scale Strongly Agree (SA) Agree (A) Strongly Disagree (SD) Disagree (D).

**Section C: Measure of general well-being:** This consisted of item questions developed by the researcher to measure the general wellbeing index of general health and social wellbeing. The questionnaire was modified and respondents were asked to respond to a two point scale Strongly Agree (SA) Agree (A) Strongly Disagree (SD) Disagree (D).

### *Data analysis*

Data analysis was done at the univariate, bivariate and the multivariate levels. The simple percentages and frequency count was used to analyse the demographic section while Pearson Analysis of Varian and Multiple Regression to test the magnitude of impact of the psychosocial properties on the wellbeing of the older adults. The result was analysed with Statistical Package of Social Sciences (SPSS version 20).

## Results

Based on the results presented above in Table 1 showed that,

***Table 1:*** *Distribution of respondents by demographic characteristics.*

| Demographic Characteristics | Frequency | Percentage % |
|---|---|---|
| **Age** | | |
| 50-55 years | 22 | 18.3 |
| 56-60 years | 50 | 41.7 |
| 61-65 years | 25 | 20.8 |
| 66 years and above | 23 | 19.2 |
| **Religion** | | |
| Christianity | 93 | 77.5 |
| Islamic | 14 | 11.7 |
| Others | 13 | 10.8 |
| Total | 120 | 100 |
| **Ethnicity** | | |
| Igbo | 22 | 18.2 |
| Hausa | 22 | 18.2 |
| Yoruba | 71 | 59.2 |
| Others | 5 | 4.2 |
| Total | 120 | 100 |
| **Level of Education** | | |
| Primary school certificate | 29 | 24.2 |
| Secondary school certificate | 32 | 26.7 |
| Tertiary institution certificate | 25 | 29.2 |
| No formal education | 24 | 20 |
| Total | 120 | 100 |

18.3% of the respondents are within the ages of 15-20 years, more than 41% of the respondents are within the ages of 21-25 years, 20.8% are within the ages of 26-30 years while over 19.2% of the respondents are aged 31 years and above. The implication the result revealed that, more than 41% of women who participated in the study are aged 21-25 years. In terms of religion of the respondents, Over 77% of the respondents are Christians, 11.7% of the women practice Islamic religion, while 10.8% of the women practice other religion. The indication of the result revealed that, more than half of the women infected with HIV/AIDS are Christians.

In the same vein, Less than 18% of women infected with HIV are Igbo and Hausa while 59.2% of women infected with HIV are Yoruba and 4.2% of the respondents represent other ethnic group. The indication of the result is that, over 59% of women infected with HIV/AIDS are Yorubas and they attend the HIV/AIDS clinic facilities in Ibadan. The study reported that, less than 24% of women had primary school certificate, 26.7% of women had secondary school certificate, 29.2% of women had tertiary institution certificate while 20% of the respondents had no formal education. The result indicated that, 29% of women infected with HIV/AIDS had tertiary institution certificate and more than half of the participants are educated.

Based on the results presented in Table 2, more than 35% of women got information about their health through health care worker, 29.2% of women got information about their health through mass media, 25.8% got information about their health through churches/mosques while 9.2% got information about their health through friends/family and neighbours. In the same vein, 33.3% of women were diagnosed of HIV infection about one week ago, 58.3% were diagnosed about one month ago while 8.3% were diagnosed about two months ago. 22.5 of women were infected through unsafe sexual behaviour, 26.7% were infected through IV drug use from the hospital, 15.8% were infected through contaminated blood transfusion, 25.8% were infected through hyperdemic needles while 9.2% of women were infected through other means. About 18.3% of women take their medication always, 40.8% had never taken their drugs, 36.7% sometimes takes their medication while 4.2% take their medication through other means. 45% of women adequately receive support from their siblings or close family relations while 55% does not receive support from their siblings.

***Table 2:*** *Distribution of respondents by knowledge of older adults about HIV/AIDS.*

| Knowledge of HIV/AIDS | Frequency | Percentage % |
|---|---|---|
| **What are your sources of information about your health?** | 43 | 35.8 |
| Health care workers | 35 | 29.2 |
| Mass Media | 31 | 25.8 |
| Church/Mosque | 11 | 9.2 |
| Friends/family/neighbour | | |
| Others specify…… | | |
| **How long have you been diagnosed of the illness** | | |
| One week ago | | |
| A month ago | 40 | 33.3 |
| Two months ago | 70 | 58.3 |
| A year ago | 10 | 8.3 |
| Others specify …….. | 0 | 0 |
| **Through which means did you think you got infected** | | |
| Unsafe sexual behaviour | 27 | 22.5 |
| IV drug use | 32 | 26.7 |
| Contaminated blood transfusion | 19 | 15.8 |
| Hyperdemic needles | 31 | 25.8 |
| Others specify ……. | 11 | 9.2 |
| **How often do you take your medication** | | |
| Always | 22 | 18.3 |
| Never | 49 | 40.8 |
| Sometimes | 44 | 36.7 |
| Others | 5 | 4.2 |
| **Do you adequately receive support from your siblings or close family relations** | | |
| Yes | 54 | 45 |
| No | 66 | 55 |
| I can't say | 0 | 0 |

***Table 3:*** *ANOVA showing the impact of counselling services on well-being of HIV infected older adults in Ibadan.*

| | Sum of Squares | df | Mean Square | F | Sig. |
|---|---|---|---|---|---|
| **Between Groups** | 763.329 | 3 | 254.443 | 128.06 | 0 |
| **Within Groups** | 129.295 | 117 | 0.613 | | |
| **Total** | 892.623 | 120 | | | |

## *Testing of research hypotheses*

**Hypothesis one:** There is no significant impact of counselling services on the general well-being of HIV Infected older adults in Ibadan.

From the Table 3 presented above it showed that, there is a significant impact of counselling services on the general well-being of HIV Infected older adults in Ibadan. The results showed that, f-ratio is greater than the f-table (f-cal 3,117=128.058 $p<0.05$). The results reject the null hypothesis and accept the alternate hypothesis which states that, there is a significant impact of counselling services on the general well-being of HIV Infected older adults in Ibadan.

The result is in tandem with the findings of Temmerman, that, the aim of counselling HIV-infected older adult to be to help them cope with the disease and prepare for the future, reduce the sexual risk behaviours and enable them (and possibly partners) to make informed choices about health. Similarly, (UNAIDS, 2001) opined that, comprehensive counselling for HIV infected women will help prevention of mother-to-child HIV transmission [14].

Additionally, Sherr provides a review of papers presented at the 11th International HIV/AIDS Conference in Vancouver, Canada in 2006 on the psychosocial aspects of older adults [15]. Despite this focus, Sherr reports that the major thrust of papers was directly associated with counselling service towards addressing perinatal transmission (or the prevention thereof). She went on

to state, "there were 165 presentations covering pregnancy—149 on mothers, 11 mentioning fathers, and 9 mentioning siblings". Sherr also reported that there were no papers addressing evaluation of interventions from a qualitative or psychosocial perspective. Finally, this report addresses the fact that counselling was not put forward directly as an intervention, "despite the need for it to underpin HIV testing and the contribution of therapeutic counselling to HIV adjustment" [15].

**Hypothesis two:** There is no significant impact of financial support from the centre on the general well-being of HIV Infected older adults in Ibadan

From the Table 4 presented above it showed that, there is a significant impact of financial support on the general well-being of HIV Infected older adults in Ibadan. The results showed that, f-ratio is greater than the f-table (f-cal 3,117=64.821 $p<0.05$). The results reject the null hypothesis and accept the alternate hypothesis which states that, there is a significant impact of financial support on the general well-being of HIV Infected older adults in Ibadan.

The results supported the findings of De Cock Cartoux that adequate financial support from family members services enhances positive psychological experiences of HIV-infected older adults related to HIV testing and decision-making.

Furthermore, Mofenson and McIntyre [16] opined that financial support is a pivot towards improving acceptability of testing and prevention of HIV interventions. The result is also in tandem with the findings of WHO [17] adequate financial support from family members improves the drug compliance and consistent visit to a nearby health care facilities in most sub-urban areas in the country.

Manopaiboon [17] found that these financial support sometimes got worse over time as the older adults witnessed family disintegration, financial decline and loss of a spouse. These will generate emotional instability among HIV-infected financial support and their families have to make important decisions about possible pregnancy termination, consenting to ART and methods of feeding the new born [18-20].

Additionally, Norton [19] contend that, financial support from family members should be involved in making adequate diagnosis and treatment options and make fully informed choices. Asera [18] also make a similar point that HIV education will be interpreted through an emotional filter of fear and vulnerability, resulting in misunderstanding and poorer comprehension through family therapy sessions.

**Hypothesis three:** There is no significant impact of companionship from peers on the general well-being of HIV Infected older adults in Ibadan.

Based on the results presented in Table 5, it is shown that, there is a significant impact of companionship from peers on the general well-being of HIV Infected older adults in Ibadan. The results showed that, f-ratio is greater than the f-table (f-cal 3,117=32.506 $p<0.05$). The results reject the null hypothesis and accept the alternate hypothesis which states that, there is a significant impact of companionship from peers on the general well-being of HIV Infected older adults in Ibadan.

The results supported the findings of Sarni that, older adults with infected with HIV/ADIS are more vulnerable to HIV/AIDS infections broadly due to economic and social reasons due to poor information access, financial constraints and companionship.

According to UNAIDS, poor companionship support from peers have contributed to the high HIV infection rate among older adults in Nigeria [1]. These include sexual networking practices such as polygamy, high prevalence of untreated sexually transmitted diseases, low condom use, poverty, low literacy, poor health status, low status of women, stigmatization and denial HIV infection risks among women.

Okoye [21] maintained that the direct correlation between companionship support of older adults and the prevalence of HIV/AIDS in Ibadan. She maintained that education is a liberating force; it ensures mobility and development of one's potentials. Ajomale, older adults in Nigeria are mostly based in the rural areas and most of these rural women have not attained even the minimum level of formal education but enjoys maximum companionship support from neighbors and family members [22]. Oyinlola found that, companionship support has significant effect of psychosocial well-being of older adults presented with the burden of illnesses in developing countries [8].

Furthermore, the study corroborates that of Zuberi that every community usually create a community service centre capable of catering for old people who may have lost the ability to cope with daily living [23]. The community centre according to him usually organises and arranges necessary care for the old people when all their families and relatives have gone to work.

**Hypothesis four:** There is no significant impact of information access from the clinic on the general well-being of HIV Infected older adults in Ibadan

The results presented in Table 6 shows that there is a significant impact of information access from the clinic on the general well-being of HIV Infected older adults in Ibadan. The results showed that, f-ratio is greater than the f-table (f-cal 3,117=120.655 $p<0.05$). The results reject the null hypothesis

***Table 4:*** *ANOVA showing the impact of financial support from the centre on the general well-being of HIV infected older adults in Ibadan.*

| | Sum of Squares | df | Mean Square | F | Sig. |
|---|---|---|---|---|---|
| **Between Groups** | 32.88 | 3 | 10.96 | 64.821 | 0 |
| **Within Groups** | 859.743 | 117 | 4.075 | | |
| **Total** | 892.623 | 120 | | | |

***Table 5:*** *ANOVA showing the impact of companionship from peers on the general well-being of HIV infected older adults in Ibadan.*

| | Sum of Squares | df | Mean Square | F | Sig. |
|---|---|---|---|---|---|
| **Between Groups** | 60.021 | 3 | 20.007 | 32.506 | 0 |
| **Within Groups** | 181.216 | 117 | 0.859 | | |
| **Total** | 241.237 | 120 | | | |

***Table 6:*** *ANOVA showing the impact of information access from the clinic on the general well-being of HIV infected older adults in Ibadan.*

| | Sum of Squares | df | Mean Square | F | Sig. |
|---|---|---|---|---|---|
| **Between Groups** | 60.021 | 3 | 20.007 | 120.655 | 0 |
| **Within Groups** | 181.22 | 117 | 0.859 | | |
| **Total** | 241.24 | 120 | | | |

and accept the alternate hypothesis which states that, there is a significant impact of information access from the clinic on the general well-being of HIV Infected older adults in Ibadan.

The findings is supported with the findings of Togonu-Bickersteth and Akanni, which revealed the social dimensions of care for the elderly through improved information and communication strategies [24]. She recommended that, provision of comprehensive information services (reading of newspaper, electronic system of communication with the care professionals, chatting with friends and relations afar-of through the internet) have a great significant influence on their general well-being) because, it was perceived that, they feel loved and their sense of belonging is however socially restored. In the same study, she posited that, provision of emergency call services in the elderly who are diagnosed with terminal illnesses and also on life support in old people's home. This will enhance quick and prompt action to care.

Furthermore, Oyinlola and Folaranmi found that, information needed by the aged on HIV/AIDS is important for the wellbeing of older persons [9]. The study explains the impact of Information Education Communication (IEC) materials about the illness on wellbeing of older adults in development countries.

Adesina found that, older person's soles rely on health information gathered through newspaper, health education from public health nurses during clinic days, education materials in a resource constraints environment.

## Conclusion and Recommendation

Geriatrics, known as the care of the elderly (≥ 65 years), is fraught with multiple pathologies. These illnesses or disabilities can be categorized into 'age-determined', which are as a result of the inevitable changes associated with the aging process, or 'age-related' which result from an accumulation of risk factors such as poor nutrition, cigarette smoking, excessive alcohol intake, lack of exercise and unprotected exposure to multiple sexual partners. The latter group can therefore be slowed down or prevented by a healthy lifestyle and adoption of health promotion measures while the former group of morbidities are to a large extent inevitable. Human immune deficiency virus (HIV) infection in the elderly fall into the latter category. However, due to delayed diagnosis, HIV-infected elderly patients generally have more advanced disease than do younger patients at the time of diagnosis. Also, mortality rates within 1 year of acquired immune deficiency syndrome (AIDS) diagnosis are substantially greater in older versus younger patients (Centers for Disease Control and Prevention, HIV/AIDS surveillance report, 2006). There are no manifestations of HIV-1 disease that are unique to the elderly. However, some prominent symptom complexes and AIDS-defining illnesses frequently associated with the elderly HIV infection include peripheral neuropathy, weight loss, HIV associated esophageal candidiasis, wasting, and HIV-associated dementia (HAD).

Based on the findings, it is hereby recommended that:

1. The religious leaders should be involved in the campaign for the improvement of care and support for older adults with HIV/AIDS in the country.
2. The mass media should also help in public enlightenment, most especially in rural areas to increase awareness on mode of transmission of HIV/AIDS among older adults.
3. Social workers and geriatricians should be actively involved in provision of psychosocial support for HIV infected older adults.
4. There is a need for psychosocial intervention programme that will encourage prevention of HIV.
5. There is need to adopt international social work and HIV/AIDS programme of the United Nations for the benefit of older adults residing in underserved communities.

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