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Nature of benefits derived from support groups of people living with HIV and AIDS in Masvingo Province, Zimbabwe

Munatsi Shoko & Ellen Farisai Zvobgo
Nehanda Centre for Gender and Culture Studies, Great Zimbabwe University

Abstract

The study sought to assess the nature of benefits derived from support groups of people living with HIV and AIDS in Masvingo Province. A survey was conducted with 300 support group members. Cluster sampling was used to select participants from Gutu, Zaka, Bikita, Chivi and Masvingo districts of Masvingo Province. A questionnaire was used to collect data which were analysed using Stata version 11. The study revealed that members benefited from support groups by realising improved livelihoods, increased incomes and changed reception from their communities. However, these benefits were being derived more by the most active members of the groups, who were mostly female. Recommendations were made.

Key words: Benefits, HIV and AIDS, support groups, Zimbabwe

Introduction

The HIV and AIDS epidemic has had devastating effects world-wide, leading to deepening poverty, pressure on health services and increased vulnerability among the hardest hit populations (Weiler, 2013). In Zimbabwe, the prevalence of the pandemic has declined over the last decade. The most recent demographic health survey (Zimbabwe Demographic and Health Survey ZDHS, 2010-11) estimates that 15% of people aged 15 to 49 are currently infected with HIV as compared to 18% who were reported as infected in the ZDHS 2005-06 (ZimStat & ICF, 2011). Changes in risky sexual behavior contributed to the decline of Zimbabwe's HIV and AIDS prevalence (Gregson, Gonese, Hallet, Taruberekera, Hargrove et al., 2010; ZNASP, 2011), because a small decrease in the number of people with more than one partner has potential to break the transmission chain (Morris & Epstein, 2011; ZDHS, 2010-11).

It has also been highlighted by other scholars that high mortality and falling HIV and AIDS incidences are attributed to have been the main causes of HIV and AIDS prevalence decline between 1997 (29.3%) and 2007 (15.6%), (ZNASP, 2011; ZimStat & ICF, 2010-11). As a result, it is important to capitalize on the gains that have been made through the inclusion of all stakeholders through the multi-stakeholder approach

that is promoted by the Ministry of Health and Child Care in Zimbabwe (Ministry of Health and Child Care (MoHCC), 2016). In doing this, one of the key stakeholders that have been identified are the People Living with HIV and AIDS (PLWHIV) themselves (NAC, 2011). The possibility to utilize PLHIV in the fight against HIV and AIDS was difficult before the creation of support groups for people living with HIV and AIDS.

The increase in the number of support groups in Zimbabwe since the early 1990s has been driven by People Living with HIV (PLHIV) themselves, especially women living with HIV and AIDS. Auxillia Chimusoro and colleagues set up support groups to share the experiences of living with HIV under Batanai HIV and AIDS Support Organization (BHASO) which was formed in 1996 in Masvingo town, and many more people joined forming several other groups for purposes of maintaining the groups' effectiveness as well as reaching out to more people (NAC, 2011). BHASO now works with over 100 support groups for PLHIV in five districts namely Gutu, Zaka, Bikita, Masvingo and Chivi (NAC, 2011). At present, support groups reach over 60 000 new people with messages on HIV and AIDS every year across Zimbabwe (PEPFAR, 2013). The Zimbabwe National Network of People living positively (ZNNP+) register shows that the number of people registered with support groups in Masvingo province, including old and new members was just over 30 000 in 2011, of which 23 786 were women (NAC, 2011).

Benefits of support groups for PLHIV

Literature shows that there are some studies that have been done to show certain benefits of support groups of PLHIV. A study in the United States of America by Bateganya, Amanyeiwe, Roxo and Dong (2015) found that support groups for people living with HIV and AIDS provide an opportunity to disclose one's HIV status. In South Africa, research done within support groups and on HIV and AIDS risk found that the groups provided supportive relationships of trust and those individuals who benefit from these, tend to have control over their own decisions as a result of better self-esteem (Pronyk et al., 2008). Research that has been conducted with support groups in Manicaland in Zimbabwe has also revealed the groups' capacity to increase HIV and AIDS competency in communities (Campbell, Skovdal, Madanhire, Mugurungi, Gregson & Nyamukapa, 2011). Other studies have reported on the potential of support groups as a platform that reduces women's vulnerability to HIV and AIDS (Gregson, Mushati, Grusin, Nhamo, Schumacher, Skovdal, Nyamukapa & Campbell, 2011).

Islam, Merlo, Kawachi and Lindstrom (2006) who did a literature review on support groups found that within community groups, supportive relationships may also be

created among members who depend on one another for psychosocial support, financial assistance or even spiritual assistance. These benefits from fellow members are not only derived from continued inter-relations, but also from deliberate and organized sessions of group discussions that usually characterize such groups (Helliwel & Putman, 2004).

Purpose of the study

This study sought to investigate the nature of benefits derived from support groups by people living with HIV and AIDS. It is important to bring out the benefits of being in a support group for PLHIV because the groups are providing an opportunity to fight stigma (Mburu, et al., 2013). Also, bringing out the benefits derived from being a member of a support group assists in motivating those PLHIV who are in doubt about the usefulness of joining those groups.

Method

Research design

The study utilised a cross sectional survey design in order to be able to generalise the results from the selected sample population (Creswell, 2014). In this study, the breadth and depth of a cross-sectional survey (Creswell, 2014) helped in providing a description of the trends in benefits derived by members of support groups. The research design employed was useful in providing information on associations between variables (Gray, 2014). The research adopted a quantitative approach which allowed for data to be collected for a large sample.

Sample

The data for the study was collected from the five districts in which BHASO is currently working with support groups for PLHIV namely Zaka, Masvingo, Gutu, Chivi and Bikita. Three hundred support group members aged between 15 and 79 years participated in the study with only 48 of them being male. A simple cluster sampling method was used by picking the names of support groups from a hat choosing 31 support groups so as to get a third of the number of support groups reported by NAC (2011) to be in the province. After selecting the support groups to be included in the study, respondents from each selected support groups were randomly identified by way of picking names from a hat. A maximum of 12 members were chosen from each support group since some of the groups had less than 12 registered members.

Instrumentation

A structured questionnaire was used to collect the data. The questionnaire had three sections on demographic data, psychosocial support and socio-economic support gained from support groups. The questionnaire had structured questions because the researchers wanted to restrict the responses of the respondents to the issues under investigation as well as to limit the time spent during the administration of the questionnaire (Gray, 2014). Questionnaire validation was done by the research team through a pilot study which was carried out among support groups in Masvingo district as is recommended by Bless et al. (2013). Those who participated in the pilot study did not take part in the main study.

Data collection procedure

The administering of the questionnaires was done by BHASO field officers who worked with support group members in the districts after under-going a two day training which was provided by the researchers. The field officers distributed the questionnaires to the respondents and allowed them a few hours to respond to them. Time taken to complete the questionnaires varied between an hour and two hours forty minutes.

Data analysis

Data were analysed using Stata version 11 to obtain descriptive information giving details on the nature of benefits derived from support groups by members living with HIV and AIDS. Data that were analysed were presented using percentages, tables and figures.

Ethical considerations

Ethical clearance for the study was obtained by Batanai HIV and AIDS Support Organisation (BHASO) from the Medical Research Council of Zimbabwe. This clearance covers all research and community engagement work done under the auspices of BHASO. All respondents were guaranteed that their responses would be maintained in confidentiality and informed consent was sought from respondents before they participated in the study.

Results

The purpose of this study was to assess the nature of benefits derived from support groups of people living with HIV and AIDS in Masvingo Province.

Table 1 HIV Status and Reason for Joining Support Group

	Males	Females	Total
HIV positive	39	199	238
Don’t know my status	3	1	4
Sole breadwinners	32	130	162
Reason for joining support group			
I knew I was HIV positive	29	154	183
I suspected that I was HIV positive	6	32	38
I lived with a person who was HIV positive	4	43	47
No response given	9	23	32
Have managed total disclosure of HIV positive status	24	111	135

The results in Table 1 show basic information on the respondents in the study. Almost 80% of the respondents were HIV positive. The majority of the respondents had joined support groups because they knew they were HIV positive. The table also shows that below half of both the males and females who were living with HIV and AIDS had managed to disclose of their HIV positive status.

Emotions of HIV positive members before joining a support group

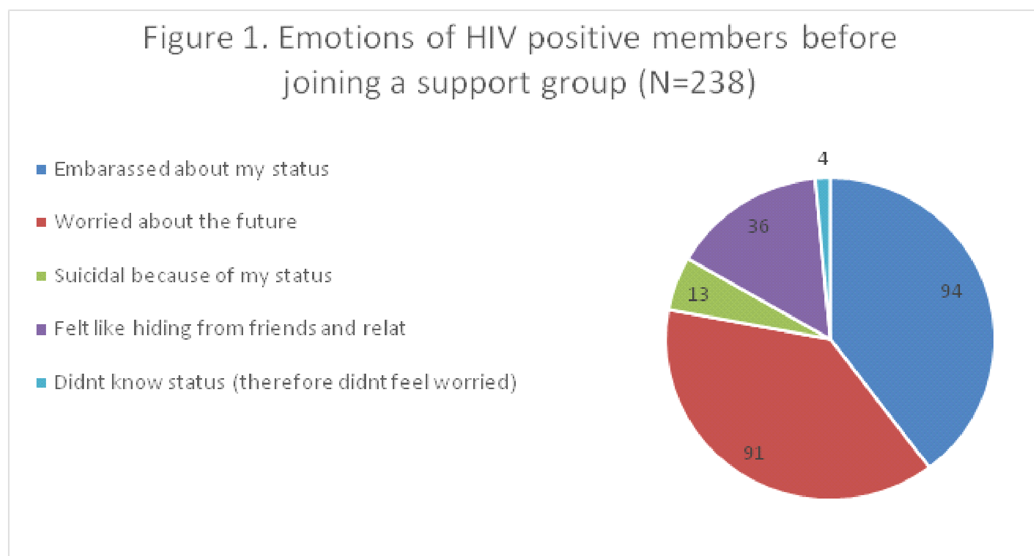
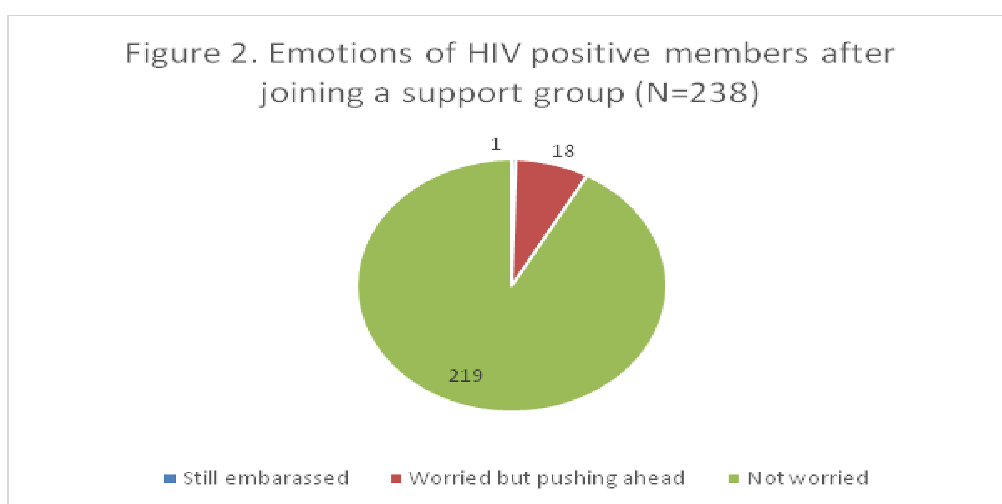


Figure 1 shows that before joining support groups, the majority of the respondents (78%) were either embarrassed of their HIV positive status or worried about their future. A further 15.3% showed that they felt like hiding with shame and sadness. The most worrisome group were the 5.3% who were contemplating suicide as a result of discovering or suspecting that they were HIV positive.

Emotions of HIV positive members after joining a support group



The majority (91.87%) stated that they were no longer worried about their HIV positive status and no longer viewed it as an embarrassment nor did they feel that it was the end of the world. The number of people who were still feeling worried about their future with HIV and AIDS had gone down from 38% of the sample to 23%. Only one respondent still felt embarrassed of their HIV and AIDS status.

Relationship between psycho-social support (PSS) service type and intensity of benefit derived

Those support group members who enjoyed more than one psychosocial support service, reported that they had not only accepted their HIV positive status, but they also improved in Anti Retro-viral Therapy (ART) adherence, and were able to disclose their HIV status. Group oriented provision of information, such as awareness training programmes proved to provide less benefits as compared to information provided directly to the individual. The majority of the participants received both group oriented services as well as individualized services, and it was such members who derived the most benefit.

Interestingly, those members who had reported that they received professional counselling once, (mostly from the testing and counselling Centre) seemed to have derived very low benefits. This was unlike those who received counselling followed up with psychosocial support services including receiving follow-up assistance from community based caregivers.

Community's views on support group members

Table 2Community's View of Individuals Living with HIV and AIDS Due to Support Group Membership N=238

	Frequency	Percentage
I am now appreciated by my children	6	2.5%
I am now appreciated by my partner	9	3.78%
I am now appreciated by my community	47	19.7%
I now appreciate my importance to my family	48	20.2%
Everyone in my community now has a positive perception of me	171	71.8%
My community has a negative perception of me	2	0.8%
Nothing has changed	5	2.1%

Table 2 shows that generally support group members felt an improvement in the perceptions of the community towards them in spite of their HIV and AIDS status.

Table 3 Involvement and Benefits from Support Group Income Generating Projects

Has your involvement in the following IGP improved your ability to cater for your family?	Yes	No	Total
Microfinance	24	0	24
Contributor (mukando)	35	9	44
Livestock pass-on	27	1	28
Irrigation scheme	0	1	1
Buying and selling	12	0	12
Other	1	0	1
Total	99 (93%)	11 (7%)	110 (100%)

The majority (93%) of support group members involved in IGP stated that they had realised an improvement in their ability to cater for their families.

Discussion

The main purpose for carrying out this study was to assess the nature of benefits derived from support groups of people living with HIV and AIDS in Masvingo Province.

Gendered nature of benefits derived from support groups

This study revealed that women dominate support group membership and structures and as such, they tended to reap greater benefits from the support group. The lower participation of men in support groups for PLHIV is probably explained by men's weaker health seeking behavior (Gregson et al., 2011). This is unfortunate, considering the significant importance of support group membership for PLHIV to lead positive lives (Campbell et al., 2013; Gregson et al., 2011; Skovdal et al., 2011).

The involvement of more women in support groups, including those who were HIV negative, can be explained by the fact that they are usually the ones who care for the sick in households. On the other hand, men tend to fail to identify the importance of support groups because they play a less intense role in the care of the sick. A feminisation of care provision to HIV positive people can be noted.

The study revealed that more women than men disclosed their HIV positive status. This finding relates to Skovdal et al.'s (2011) view that men find it harder to disclose their status to their entire social circle. This failure to disclose by men, militates against positive living principles and limits men's ability to tap the benefits that support groups can give them. In a similar vein, Campbell et al. (2013) note that studies in Manicaland highlight that men tend to be a bad influence to each other, while women are usually a good influence to each other.

Support groups and benefits to members

This study found that members in support groups were part of IGPs. IGPs provide individuals with an opportunity to improve their lives as well as to cater for their families. As a direct result, the members feel that their lives are valuable to their families. The availability of such livelihood programmes within support groups also provided members with nutritious food to cater for their dietary requirements. Projects such as livestock pass-on were known for providing participating families with food items as well as with supplementary incomes (Gillespie, 2006). These benefits empower families to not only cope with HIV and poverty, but to also mitigate the chances of future infection for other family members.

Improved adherence to HIV and AIDS treatment is another of the benefits that members derive from being in support groups. As a result of the PSS that members receive from within the support groups, they become more resistant to stigma and begin to appreciate the importance of adhering to treatment. Tarwirei (2005) found that in Mabvuku and Tafara suburbs of Harare, 83.3% of respondents living with HIV opted to join support groups among other things in order to gain support in coping with HIV and adhering to treatment.

Conclusion

Evidence from this study shows that support group membership has a positive impact on the lives of PLHIV who are members in support groups. The benefits that members derived from support groups included access to IGPs, psycho-social support services as well as uptake of health care services. The benefits were more evident among females than males.

Recommendations

On the basis of the findings of this study, the following recommendations are made:

- Efforts should be made to increase men's membership and participation in support groups for PLHIV so that they may also benefit from them.
- More people who are not HIV positive should be encouraged to become members of support groups in order to increase support groups' influence of reducing stigma and discrimination in communities.

References

Bateganya, M., Amanyeiwe, U., Roxo, U., & Dong, M. (2015). Impact of Support Groups for People living with HIV on Clinical outcomes: A systematic review of Literature. Acquir Immune Defic Syndr, 68(3), S368-S374.

Bless, C., Higson-Smith, C., & Sithole, S. L. (2013). Fundamentals of Social Research Methods: An African Perspective (Fifth Edition ed.). Cape Town: Juta.

Campbell, C., Mortein, S., Madanhire, C., Mugurungi, O., Gregson, S., & Nyamukapa, C. (2011). 'We the AIDS People...': How antiretroviral therapy enables Zimbabweans living with HIV/AIDS to cope with Stigma. American Journal of Public Health, 101(6), 1004-1010.

Campbell, C., Scott, K., Nhamo, M., Nyamukapa, C., Madanhire, C., Skovdal, M., . . . Gregson, S. (2013). Social Capital and HIV competent communities: The role of community groups in Managing HIV/AIDS in rural Zimbabwe. AIDS Care, 25(1), 114-122.

Campbel, C., Skovdal, M., & Mupambireyi, Z. (2002). Building adherence-competent communities: Factors promoting children's adherence to anti-retroviral HIV/ AIDS treatment in rural Zimbabwe. Health and Place, 18, 123-131.

Campbell, C., Skovdal, M., Madanhire, C., Mugurungi, O., Gregson, S., & Nyamukapa, C. (2011). “We the AIDS people.”: How Antiretroviral Therapy enables Zimbabweans living with AIDS to cope with stigma. Public Health, 6,1004-1010.

Chambers, R., & Cornway, G. R. (1992). Sustainable rural livelihoods: Practical concepts for the 21st century. Brighton: Institute of Development Studies.

Colvin, M. (2005). Impact of AIDS - The health care burden. In S. S. Abdool Karim, & Q. Abdool Karim (Eds.), HIV/AIDS in South Africa (pp. 86-113). Cambridge: Cambridge University Press.

Cresswell, J. W. (2014). A framework for the study: Research design: Qualitative and quantitative approaches. Los Angeles: Sage Publications.

Denscombe, M. (1998). Surveys: Strategies for social research. The good research guide. London: Open University Press.

Gray, D. (2014). Doing research in the real world (3rd ed.). Los Angeles: Sage.

Gregson, S., Mushati, P., Grusin, H., Nhamo, M., Schumacher, C., Skovdal, M., . . . Campbell, C. (2011). Social Capital and women’s reduced vulnerability to HIV infection in rural Zimbabwe. Population and Revelopment Review, 27(2), 333-359.

Gregson, S., Mushati, P., & Grusin, H. (2011). Social capital and women’s reduced vulnerability to HIV infection in Zimbabwe. Population and Development Review, 37(2), 333-359.

Gregson, S., Mushati, P., & White, P. R. (2004). Informal confidential voting interview methods and temporal changes in reported sexual risk behaviour for HIV transmission in Sub-Saharan Africa. Sexually Transmitted Infections, 80, 36-42.

Gregson, S., Todd, J., & Zaba, B. (2005). Beer halls a focus for HIV prevention activities in rural Zimbabwe. Sexually Transmitted Infections, 32(6),364-369.

Islam, M. K., Merlo, J., Kawachi, I., & Lindstrom, M., (2006) Does it really matter where you live? A panel data multilevel analysis of Swedish municipality-level social capital on individual health related quality of life. Health Economics, Policy and Law, 1(3), 209-235.

Lee, J. (1994) Odds ratio or relative risk for cross-sectional data? International Journal of Epidemiology, 23(1), 201-203.

Lopman, B. A., Nyamukapa, C., & Hallet, T. B. (2009). Role of widows in heterosexual transmission of HIV in Manicaland, Zimbabwe 1998 - 2003. Sexually Transmitted Infections, 85(Suplement 1),41-48.

Mburu, G., Ram, M. S., Bitira, D., Hodgson, I., Mwai, G., Stegling, C., & Seeley, J. (2013). Resisting and Challenging stigma in Uganda: the role of support groups of people living with HIV. Journal of International AIDS Society, 16(Supplement 2), 1-7.

Ministry of Health and Child Care (MoHCC). (2016). Global AIDS Progress Report 2016: Follow up to the 2011 political declaration on HIV/AIDS; Intensifying our efforts to eliminate HIV/AIDS. Harare: MoHCC.

MoHCW. (2009). The national health strategy for Zimbabwe (2009 - 2013) Equity and quality in health: a people‘s right. Harare: Government of Zimbabwe.

MoHCW. (2011). Zimbabwe communications strategy: Supporting the elimination of new HIV infections in children, and keeping mothers and their children alive 2011 - 2015. Harare: Government of Zimbabwe.

Morris, M., & Epstein, H. (2011). Response to Gregson S, Gonese E, Hallet TB, et al. HIV decline in Zimbabwe due to reductions in risky sex? Evidence from a comprehensive epidemiological review. International Journal of Epidemiology, 40(3), 836-850.

NAC, (2011). Zimbabwe national HIV and AIDS strategic plan 2011 - 2015 (ZNASP II) Revitalising our commitment to zero infections, zero deaths and zero discrimination. Harare: National AIDS Council.

Pronyk, P. M., Harpman, T., & Busza, J. (2008a). Can social capital be intentionally generated? A randomized trial from South Africa. Social Science and Medicine, 67,1559-1570.

Pronyk, P. M., Harpman, T., & Morison, A. (2008b). Is social capital associated with HIV risk in rural South Africa? Social Science and Medicine, 66,1999-2010.

Pronyk, P. M., Kim, J., & Abramsky, T. (2008c). A combined microfinance and training intervention can reduce HIV risk in young female participants. AIDS, 22,1659-1665.

Ramjee, G., & Gouws, E. (2002). Prevalence of HIV among truck drivers visiting sex workers in KwaZulu-Natal, South Africa. Sexually Transmitted Diseases, 29(1), 44-49.

Scoones, I. (1998). Sustainable rural livelihoods: A framework for analysis. Sussex: IDS Working Papers 72.

Skovdal, M., & Mwasiaji, W. W. (2010). Building orphan competent communities: experiences from a community-based capital cash transfer initiative in Kenya. Health Policy and Planning, 1-9.

Weiler, G. (2013). Global update on HIV Treatment 2013: Results, Impact and opportunities. Kuala Lumpur: IAS and WHO.

ZIMSTAT, & ICF. (2012). Zimbabwe demographic and health survey 2010 - 11. Calverton, Maryland: ZIMSTAT and ICF Martland Inc.

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