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Knowledge, Awareness and Utilization of HIV Support Groups Among People Living with HIV in A Primary Health Centre in Nigeria

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Abstract- Background: ***HIV support groups provide psychosocial support, education, and adherence support for people living with HIV (PLHIV). This study assessed the level of HIV-related knowledge, awareness, and utilization of support groups among PLHIV attending a primary health centre in Nigeria. Methods: A cross-sectional descriptive study was conducted among 112 PLHIV accessing care in a primary health centre in Nigeria. Data were collected on socio-demographics, HIV knowledge, awareness and utilization of support groups using an interviewer-administered, semi-structured questionnaire and analyzed using SPSS version 25. Statistical significance was set at $p < 0.05$. Results: The mean age of the respondents was 41.8 ± 13.5 years; 81.3% were female, 63.4% were married. Many of the respondents (53.6%) had fair HIV-related knowledge, while 46.4% had high knowledge. Awareness of support groups was high (82.1%) and primarily from healthcare providers (72.3%). Active utilization was low as only 37.5% participated actively, and 23.2% had good utilization levels. Conclusion: Utilization of HIV support groups remains suboptimal despite high awareness and fair knowledge. Targeted education and addressing logistical barriers are needed to enhance participation.***

Keywords: HIV, Support Groups, Knowledge, Awareness, Utilisation, Psychosocial Support, Primary Health Care, Nigeria

I. INTRODUCTION

Human Immunodeficiency Virus (HIV) infection continues to pose one of the most significant global public health and development challenges of the 21st century. Despite substantial progress in antiretroviral therapy (ART) scale-up, people living with HIV (PLHIV) continue to face persistent health, psychosocial, and economic burdens that negatively impact their quality of life and treatment outcome [1].

Nigeria bears one of the highest burdens of HIV globally, with an estimated 1.9 million people living with the virus and a national prevalence of 1.4% among adults aged 15–49 years [2]. Regional variations exist, with the South-South zone recording the highest prevalence (3.1%), followed by North Central (2.0%) and South East (1.9%) zones [3]. Women remain disproportionately affected, with prevalence nearly twice that of men (1.9% vs. 0.9%) [4].

Beyond the biomedical aspects, PLHIV frequently experience significant psychosocial challenges, including depression, stigma, discrimination, social isolation, and difficulties with status disclosure and ART adherence [5], [6]. These psychosocial issues contribute to poor health-seeking behaviour, suboptimal treatment adherence, and increased risk of HIV transmission. In response, psychosocial support interventions have gained prominence as essential components of comprehensive HIV care. Among these, HIV support groups have been identified by the World Health Organization (WHO) as a valuable strategy for optimising the continuum of HIV care [7].

An HIV support group is defined as a voluntary, small group of individuals who share a common condition (in this case, HIV) and come together for mutual help, emotional support, information sharing, and coping skill development [8]. These groups

typically offer emotional support, informational resources on treatment and healthy living, peer networking, stigma reduction, and practical assistance such as adherence counselling, nutritional education, and economic empowerment opportunities [9], [10]. Empirical evidence demonstrates that participation in support groups is associated with improved ART adherence, better viral suppression, enhanced quality of life, reduced depression, and increased self-efficacy among PLHIV [11]– [13].

Despite these documented benefits, utilisation of HIV support groups remains suboptimal in many resource-limited settings, particularly in sub-Saharan Africa. Studies have reported utilisation rates ranging from as low as 6.8% to as high as 71%, influenced by factors such as awareness, logistical barriers, socio-demographic characteristics, and service quality [11], [14], [15].

In Nigeria, while facility- and community-based support groups have been established through initiatives such as the Global HIV/AIDS Initiative Nigeria (GHAIN) project under PEPFAR, there is limited empirical data on the level of awareness, knowledge and utilisation of these groups, especially within primary health care settings in the South East region [16].

Most existing studies have focused on urban tertiary facilities or general populations, leaving a significant knowledge gap regarding primary health centre attendees in semi-urban and rural communities like Neni, Anambra State. Understanding the current levels of HIV-related knowledge, awareness of support groups, and actual utilisation patterns is critical for designing targeted interventions to improve psychosocial support services at the primary care level, where most PLHIV receive routine care.

Furthermore, recent systematic reviews have highlighted the growing emphasis on cognitive-behavioural and family-based interventions for adolescents and young people living with HIV in sub-Saharan Africa, underscoring the need for context-specific psychosocial support programmes [5], [17].

This study therefore aimed to assess the knowledge of HIV, awareness of the existence of support groups, and the level of utilisation of HIV support groups among people living with HIV attending a primary health centre in Neni, Anambra State, Nigeria.

Findings from this study are expected to provide evidence for strengthening support group interventions within primary health care systems in Nigeria and similar settings.

II. METHODS

Study Design: This study employed a descriptive cross-sectional design to assess the knowledge of HIV, awareness of the existence of HIV support groups, and the level of utilization of these support groups among people living with HIV (PLHIV) attending a primary health care facility.

Study Setting: The study was conducted at the Centre for Community Medicine and Primary Health Care, Neni, which is an affiliate facility of the Nnamdi Azikiwe University Teaching Hospital (NAUTH), Nnewi, Anambra State, Nigeria. Anambra State is located in the South East geopolitical zone of Nigeria.

Neni is a semi-urban community in Anaocha Local Government Area. The facility provides comprehensive primary health care services, including antiretroviral therapy (ART) for adults, children, and prevention of mother-to-child transmission (PMTCT) services, supported by the Institute of Human Virology Nigeria (IHVN).

The HIV clinic operates twice weekly, and HIV support group meetings are held on the first Saturday of every month. This site was selected because it is a functional primary health centre with an established HIV support group program serving a large number of PLHIV in the region.

Study Population: The target population consisted of all people living with HIV/AIDS (PLHIV) aged 15 years and above attending the antiretroviral therapy clinic at the study facility.

Inclusion and Exclusion Criteria: Participants were included if they were PLHIV (adolescents and adults) attending the ART clinic, had been diagnosed with HIV for at least three months, and provided informed consent. Individuals who were too ill to participate were excluded from the study.

Sample Size Determination: The minimum sample size was calculated using Cochran's formula for sample size determination in finite populations for descriptive studies: $n = Z^2pq/d^2$ where $Z = 1.96$ (at 95% confidence level), $p = 0.07$ (proportion of PLHIV utilizing support groups from a previous study [11]), $q = 1 – p = 0.93$; $d = 0.05$ (margin of error). This yielded an initial sample size of 100, which was adjusted upward by 10% to account for non-response, resulting in a final sample size of 112 participants.

Sampling Technique: Consenting eligible PLHIV attending the ART clinic were consecutively sampled and recruited until the required sample size of 112 was achieved.

Data Collection Instrument: Data were collected using a semi-structured, interviewer-administered questionnaire adapted from literature [18]. The instrument consisted of five sections including socio-demographic characteristics, disease-related variables (time since diagnosis, mode of transmission, disclosure status), HIV-related knowledge, awareness of HIV support groups, and utilization of HIV support groups (participation, frequency, duration, barriers, reasons, and perceived benefits).

The questionnaire was originally prepared in English and administered in either English or Igbo language, depending on participant preference.

Training of Research Assistants: Six research assistants (medical students and clinic staff) were trained over two days on the study protocol, questionnaire administration, ethical conduct, and data quality. The training emphasized confidentiality, cultural sensitivity, and accurate translation into the local language.

Pretesting: The questionnaire was pretested on 10 PLHIV at a similar primary health centre in a neighbouring community to assess clarity, flow, and cultural appropriateness. Necessary modifications were made based on feedback before the main study.

Data Collection Procedure: Trained research assistants administered the questionnaires through face-to-face interviews in a private consultation room within the facility to ensure confidentiality.

Verbal informed consent was obtained from each participant after a detailed explanation of the study purpose, risks, benefits, and the right to withdraw at any time. Each interview lasted approximately 15–20 minutes.

Data Management and Analysis: HIV knowledge was assessed using 30 questions covering transmission, prevention, and treatment. Correct responses were scored 1 and incorrect/don't know responses scored 0.

Knowledge levels were categorized as: High (>18), Average/Fair (10–18), and Low (<10). Awareness and utilization sections used dichotomous and multiple-response items. Data were checked for completeness and accuracy before entry into IBM Statistical Package for the Social Sciences (SPSS) version 25.0. Descriptive statistics (frequencies, percentages, means, and standard deviations) were used to summarize socio-demographic characteristics, knowledge levels, awareness, and utilization patterns.

Ethical Considerations: Ethical approval was obtained from the Nnamdi Azikiwe University Teaching Hospital Health Research Ethics Committee (NAUTHHREC). The study was conducted in accordance with the principles of the Declaration of Helsinki. Participation was voluntary, and confidentiality was maintained by using anonymous codes instead of names. No incentives were provided.

III. RESULTS

A total of 112 questionnaires were administered and all were fully completed and retrieved, yielding a response rate of 100%.

Table 1: Socio-Demographic Characteristics of Respondents (n = 112)

Variable	Category	Frequency (n)	Percentage (%)
Gender	Male	21	18.8
	Female	91	81.2
Age (years)	18–27	19	17.0
	28–37	13	11.6
	38–47	39	34.8
	48–57	22	19.6
	58–67	19	17.0
Marital Status	Single	25	22.3
	Married	71	63.4
	Separated	6	5.4
	Cohabiting	1	0.9
	Divorced	1	0.9
	Widowed	8	7.1
Education Level	None	3	2.7
	Primary	25	22.3
	Secondary	64	57.1
	Tertiary	19	17.0
	Graduated	1	0.9
Occupation	Civil Servant	13	11.6
	Trader	55	49.1
	Professional	4	3.6
	Vocational	17	15.2
	Student	18	16.1
	Unemployed	5	4.5

Table 1 shows that the mean age of the respondents was 41.91 ± 13.56 years (range: 18–67 years). The largest proportion of participants (34.8%) were aged 38–47 years. The majority were female (81.3%), of Igbo ethnicity (95.5%), and Christians (97.3%). Most respondents were married (63.4%), had attained secondary education (57.1%), and were engaged in trading (49.1%).

Table 2: Disease-Related Characteristics of Respondents (n = 112)

Variable	Category	Frequency (n)	Percentage (%)
Time Since Diagnosis	< 5 years	18	16.1
	5–10 years	32	28.6
	10–15 years	44	39.3
	15–20 years	10	8.9
	> 20 years	8	7.1
Mode of Transmission	Heterosexual	63	56.3
	Mother-to-child	10	8.9
	Blood transfusion	8	7.1
	Unknown	28	25.0
	Others	3	2.7
Disclosed Status to Partner	Yes	85	75.9
	No	27	24.1
Status of partner	Positive	63	56.3
	Negative	35	31.3
	Unknown	14	12.5

Table 2 shows that 39.3% of respondents had been diagnosed with HIV for 10–15 years, while 56.3% reported heterosexual contact as the mode of transmission. The majority (75.9%) had disclosed their HIV status to their partners, and 56.3% were in sero-concordant relationships.

Table 3: Level of HIV-Related Knowledge Among Respondents (n = 112)

Knowledge Level	Frequency (n)	Percentage (%)
Average/Fair	60	53.6
High	52	46.4

Table 3 shows that slightly more than half of the respondents (53.6%) had average/fair HIV-related knowledge, while 46.4% demonstrated high knowledge. No respondent had low knowledge.

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Table 4: Awareness of HIV Support Groups (n = 112)

Variable	Category	Frequency (n)	Percentage (%)
Ever Heard of HIV Support Groups	Yes	92	82.1
	No	20	17.9
Source of Information (n=92)	Healthcare Provider	81	72.3
	Fellow Patients	11	9.8
Benefit of Support Group Activities	Improves knowledge of HIV	47	42.0
	Encourages healthy living	24	21.4
Believes knowledge of support groups and activities is sufficient	Yes	60	53.6
	No	52	46.4
Wants to know more about support groups	Yes	92	82.1
	No	20	17.9

Table 4 shows that the awareness of the existence of HIV support groups was high, with 82.1% (n = 92) of respondents reporting that they had heard of such groups. The main source of information was healthcare providers (72.3%). The majority (82.1%) expressed a desire to know more about support groups and their activities.

Table 5: Utilization of HIV Support Groups (n = 112)

Variables	Frequency	Percentage
Participates actively in activities of the support groups		
Yes	42	37.5
No	70	62.5
Frequency of attending HIV support group		
None	67	59.8
1-8 times a year	19	17
> 8 times a year	16	14.3
Utilization Level		
Good	26	23.2
Poor	86	76.8
Barriers for participating in a support group (multiple response)		
Doesn't think would benefit from their services	10	8.9
Already well supported by friends and relations	1	0.9
Location is not favorable	6	5.4
Doesn't know about their services	38	33.9
Doesn't know about its existence	20	17.9
Doesn't understand what a support group is or does	2	1.8
Time constraints due to work/other commitments	2	1.8
Money/transport problems	21	18.8
Fear of being ill, discriminated or stigmatized	3	2.7
Reasons for participating in a support group (multiple response)		
Close to where I live	3	2.7
Provision of my needs	21	18.8
Provision of social and emotional support	13	11.6
To know more about HIV	37	33.0
To help spend time	32	28.6
To be informed on trends and facts pertaining HIV	11	9.8
To have a network of	27	24.1

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people to discuss with		
Impact of support group (multiple response)		
Improved my knowledge about HIV	16	14.3
Improved my ability to disclose my status without feeling uneasy	35	31.3
Improved my self esteem	10	8.9
Helped me to live a healthier and more productive life	32	28.6
Developed new and worthwhile relationships	38	33.9
Feels supported emotionally and socially	16	14.3
Supported financially	17	15.2

Table 5 shows that only 37.5% (n = 42) of respondents reported active participation in support group activities. Overall, 23.2% (n = 26) were classified as having good utilization, while 76.8% (n = 86) had poor utilization. Among those who participated, the most common reasons included gaining more knowledge about HIV (33.0%) and having a network of people to discuss with (24.1%).

Major barriers to participation were lack of knowledge about the services offered (33.9%), money/transport problems (18.8%), and not knowing about the existence of the groups (17.9%). Participants who utilized the groups reported several benefits, including improved HIV-related knowledge (31.3%), development of new relationships (33.9%), emotional and social support (28.6%), and improved ability to disclose their status (14.3%).

Table 6: Association Between Awareness and Utilization of HIV Support Groups (n = 112)

Utilization Level	Aware (n = 92)	Not Aware (n = 20)	Total	χ^2	p-value
Good	25 (27.2%)	1 (5.0%)	26	4.53	0.033*
Poor	67 (72.8%)	19 (95.0%)	86		
Total	92 (100.0%)	20 (100.0%)	112		

Table 6 shows that there was a statistically significant association between awareness of support groups and utilization ($\chi^2 = 4.34$, $p = 0.037$).

IV. DISCUSSION

This study assessed the knowledge of HIV, awareness, and utilization of HIV support groups among 112 people living with HIV (PLHIV) attending a primary health centre in Nigeria. The findings generally revealed moderate HIV-related knowledge, high awareness of support groups, but notably low utilization rates. Slightly more than half of the respondents (53.6%) had only average/fair HIV-related knowledge, while 46.4% demonstrated high knowledge.

This finding is consistent with previous studies conducted among PLHIV in resource-limited settings, which reported suboptimal comprehensive knowledge despite regular contact with healthcare services [19], [20].

The moderate knowledge level in this study, despite a relatively high literacy rate (74.1% with secondary education and above), may be attributed to time constraints among the predominantly working-age population (mostly traders), leading to limited engagement with health education sessions. This gap is concerning because adequate HIV knowledge is essential for preventing super-infection, promoting safer sexual practices, and enhancing adherence to antiretroviral therapy (ART) [21], [15].

Awareness of the existence of HIV support groups was relatively high (82.1%), with healthcare providers serving as the primary source of information (72.3%). This aligns with findings from Chiegil [9], who reported 78.2% awareness of support services among PLHIV in Northern Nigeria.

The high awareness in this study is likely due to the institution-based nature of the support groups and routine counselling provided at the facility. However, despite this high awareness, only 37.5% of the participants reported active participation in support group activities, and just 23.2% were categorized as

having good utilization. This discrepancy between awareness and utilization mirrors findings from Mbah et al. [11], who reported low support group attendance (6.8–16.3%) across multiple African countries despite established programs. Recent systematic reviews on mental health interventions for young people living with HIV in sub-Saharan Africa have similarly highlighted the gap between service availability and actual uptake, emphasizing the need for culturally adapted, community-informed interventions [5], [6].

The low utilization observed in this study can be attributed to several barriers identified by participants, including lack of knowledge about the specific services offered (33.9%), transportation and financial constraints (18.8%), and time limitations due to work commitments (common among traders). These findings are consistent with literature highlighting logistical and socio-economic barriers to participation in HIV support groups in sub-Saharan Africa [10], [14], [5].

The recent cessation of USAID and PEPFAR allocations has further exacerbated these challenges, leading to service disruptions and reduced access to psychosocial support in many regions [5]. The statistically significant association between awareness and utilization observed in this study however provides empirical support for the hypothesis that increasing awareness is a critical first step toward improving utilization. This finding is also consistent with the literature identifying awareness as a key modifiable determinant of health service utilization [10], [14].

Among those who participated in the support groups, reported benefits included improved HIV knowledge, emotional and social support, formation of new relationships, and better status disclosure. These positive outcomes support existing evidence on the value of peer support groups in enhancing psychosocial wellbeing and quality of life among PLHIV [11], [8], [13].

A recent systematic review demonstrated that peer-support interventions significantly improve ART adherence at 3 months (RR = 1.06, 95% CI: 1.01–1.10) and retention in care at 12 months (RR = 1.07, 95% CI: 1.02–1.12), further validating the clinical utility of such programmes [13].

The findings also align with emerging evidence on family-based and cognitive-behavioural interventions for adolescents living with HIV, which have shown promising results in improving mental health outcomes and treatment adherence [15], [17].

This study has several limitations. The cross-sectional design limits causal inference, while the self-reporting of data may be subject to social desirability and recall bias. Additionally, the study was conducted in a single facility in a rural area, which may limit generalizability to other settings or populations not attending regular HIV care. The relatively small sample size (n = 112) may also limit the statistical power to detect significant associations between socio-demographic variables and support group utilization. Future studies should employ larger, multi-centre designs to validate these findings and explore the effectiveness of specific interventions to improve support group uptake.

V. CONCLUSION

This study revealed moderate HIV-related knowledge, high awareness, but low utilization of HIV support groups among PLHIV attending a primary health centre in Nnewi, Nigeria.

While healthcare providers play a crucial role in creating awareness, significant barriers such as transportation costs, time constraints, and inadequate information about group services hinder active participation. Strengthening support group programs through targeted education, addressing logistical barriers, introducing flexible (including online) meeting options, and integrating income-generating activities could therefore significantly improve utilization.

Enhanced participation in HIV support groups has the potential to improve psychosocial wellbeing, ART adherence, and overall quality of life of PLHIV in primary healthcare settings in Nigeria and similar resource-limited contexts. Given the evolving global HIV funding landscape and the documented benefits of peer-support interventions, policymakers should

therefore prioritize domestic financing for psychosocial support programmes and integrate them into the broader healthcare systems to ensure long-term sustainability.

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