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SOCIAL SUPPORT AND QUALITY OF LIFE IN INDIVIDUALS WITH INJECTIONS DRUG USE HAVING COMORBID HIV/ AIDS INFECTION

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ABSTRACT

The objective of the present study was to investigate the predictive association between Social Support from Significant Others, Family, and Friends and Quality of Life (QOL) in individuals with comorbid substance use disorders and HIV/AIDS infection. The participants of the current study comprised of 150 males with Injection Drug Use (IDU) having comorbid HIV/AIDS infection, which were selected from a treatment unit of SACP (Sindh Aids Control Program) in Karachi. Participants' age ranged from 18 to 58 years (Mean=29.7, SD=6.74). The measures used along with Demographic Information Sheet include: Urdu version of Multi-dimensional Scale of Perceived Social Support (MSPSS) (Rizwan & Aftab, 2009) and WHO-Quality of Life Scale (WHOQOL-BREF) (Khan, Akhter, Ayub, Alam & Laghari, 2003). The results of Multiple Regression Analysis reflect social support from all three sources i.e. significant others, family and friends to be significant predictors of quality of life. Thus it is concluded that provision of social support to individuals with IDU having comorbid HIV/AIDS is crucial in enhancing their QOL.

Keywords: *Quality of Life, Injection Drug Users, Social Support, HIV/AIDS*

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INTRODUCTION

The epidemic of HIV/AIDS as driven by injection drug use (IDU) (EI-Bassel, Shaw, Dasgupta, & Strathdee, 2014) is rapid and has escalated enormously in past few years (Grassly et al., 2003). According to an estimate by UNAID (2011), out of 16 million people who inject drugs, about 3 million are living with HIV. This indicates that IDU is the major source and risk factor for HIV/AIDS transmission and this rate is alarmingly high in people with ID use in Eastern Europe and Central Asia. As compared to general population, the individuals with IDU and comorbid HIV/AIDS in Pakistan are extremely marginalized and stigmatized population. The adverse impacts on the social, physical, psychological health and overall quality of life along with a decreased chance of survival in individual with IDU are attributed to the concomitant HIV/AIDS (UNODC, 2013).

The World Health Organization (1997) defines Quality of Life (QOL) as an individual's appraisal of life situations with regard to their goals, objectives and aspirations within the value system and cultural context. It is a multifaceted concept that is influenced in an intricate manner by an individual's physical and psychological health, social ties, degree of individuality, beliefs and their link to significant environmental features (World Health Organization, 1997). The QOL of an individual is impacted by their culture, norms, values, beliefs, ethnicity, as well as their physical, social and environmental circumstances. Therefore, it varies from person to person and is regarded as rather a very subjective concept (Rapley, 2007). For an increased comprehension and to assess the impacts of a long term illness on health and associated QOL in a more lucid manner, the QOL in the context of a long term illness is regarded as 'Health-related Quality of Life' (HRQOL) as in long term diseases, all aspects of an individual's life are affected (Ferrans, Zerwic, Wilbur, & Larson, 2005).

There is scarcity of studies with regard to QOL estimation of people with IDU having comorbid HIV/AIDS infection. Most of the work done on this population is limited and mostly focused on recruitment in drug rehabilitation treatment programs (Litwin, Soloway, & Gourevitch, 2005). Studies suggest that in contrast to the general population people with IDU are more vulnerable to develop HIV positive and consequently become more prone to develop various psychological issues (Buckingham, Schrage, & Cournos, 2013; Kaplan et al., 1995; World Health Organization, 2008). As the individuals with IDU who are HIV/AIDS positive face multitudinous issues such as social disapproval, social prejudice and stigma (Bal et al., 2003). Thus, these people apparently live in such

environmental situations which are not suitable for the betterment of QOL. Most of them suffer from financial strain and are not educated as indicated in multiple studies that found characteristics of individuals with substance use disorder with HIV include low socioeconomic status, lower educational levels, ethnicity, sexual orientation, poor social network, psychological issues, homelessness, trauma history (Burnam et al., 2001; Lundgren & Delgado, 2008; Orwat et al., 2011). Hence, it can be inferred rationally that individuals with IDU specifically with a dual diagnosis of HIV/AIDS positive suffer from physical and psychological consequences which can impact their QOL. The spread of HIV in IDU population due to the sharing of infected needles is attributed to insufficient resources, lack of education and inadequate social support (Ahmed, Long, Huong, & Stewart, 2015). The individuals with IDU are more susceptible to develop HIV/AIDS and various other social and health problems (Potvin, Sepehry, & Stip, 2006). Due to the increased susceptibility of HIV infection the management of disease becomes challenging (Johnson, Cunningham, Williams, & Cottler, 2003). In order to assist individuals to defy and face their illness, social support is one of the major aspects in this context (Hansen et al., 2009).

Social support is referred as "the perception or experience that one is loved and cared for by others, esteemed and valued, and part of a social network of mutual assistance and obligations" (Taylor, 2007, pg. 145). Since social support allows individuals to share their issues with others therefore it is an essential element for individuals who suffer from distressing issues (Tan & Karabulutlu, 2005). Social support is composed of functional and structural factors. The functional factors comprised of perceived level of received support i.e. emotional and substantial support. The structural factors include size of a person's social synergistic network, the reciprocity of support and its quality thereof (Goebert, 2009). Both of these aspects are significant for a person's welfare and are more generally categorized as perceived (subjective) and received (objective) support (Aranda, Cataneda, Lee, & Sobel, 2001).

Existing evidences suggest inadequate social support to be associated with psychological distress (Costa & Gouveia, 2013) and poor quality of life (Helgeson, 2003). Nonetheless, incorporating social supportive networks improves physical and mental health (Cohen 2004; Uchino 2004) and enhances well-being (Taylor, Chatters, Hardison, & Riley, 2001). A generalized positive state of mind and mental wellbeing is contributed by inclusion in social networks which promotes general health and consequently improves QOL (Pasmaney, 2009). The issue of social support in individuals with IDU having HIV/AIDS has not been studied

much. The supportive role of social network and its accessibility in individuals with IDU is jeopardized by the requirements of support and social stigma due to the HIV/AIDS. An old study documents that individuals with IDU need significant amount of support from their social networks however their increased need for support might burden their supportive networks. The provision of support from others may also be restricted because of their inability to reciprocate the support, conversely they might refuse the support altogether. It is also suggested by researches that the people with IDU who acquire HIV/AIDS through needle sharing significantly and equivalently depend on the support provided by their relatives and by those who are non kin (Johnston et al., 1995).

Betterment in physical, psychological, social and environmental domains of QOL in individuals with IDU is related with social support. The notion of perceived support among individuals with IDU is associated with concurrent reduction in substance use. Thus social support is positively associated with increased adherence to treatment and improved levels of QOL (Lin, Wu & Detels, 2011). A study done on males with IDU having HIV/AIDS also indicated that improved levels of QOL by lowering levels of psychological distress was achieved by provision of social support (Jia, Reid, Findley, & Duncan, 2004).

In a nutshell, it can be logically inferred based on existing literature that quality of life can be improved by the provision of social support and may contribute in reducing the precariousness in individuals with IDU having comorbid HIV/AIDS. In indigenous settings the aspects of social support and QOL in individuals with IDU having HIV/AIDS has not been studied much hence there is an increased need to pay attention to this critical issue so that an understating about the challenges caused by the dual impacts of the substance use and HIV/AIDS on individual as well as society could be understood. Findings of this study would benefit the affected individuals, related professionals and families in terms of provision of awareness regarding social support which ultimately improve their quality of life. Contemplating this gap in existing literature, the current study is an attempt to examine the predictive association between social support and QOL in individuals with IDUs with HIV/AIDS.

It is hypothesized that:

1. There would be a significant predictive association between social support from significant others, family and friends and quality of life in individuals with injection drug use (IDU) and HIV/AIDS infection.

METHOD

Participants

The sample of the current study comprised of 150 individuals with Injection Drug Use (IDU) having comorbid HIV/AIDS infection. The site for conducting the study was HIV/AIDS clinic in Karachi, which is outpatient sponsored unit of Sindh Aids Control Program (SACP). The age range of participants was between 18 to 58 years (Mean age = 29.7, SD = 6.74). The demographic characteristics of the entire sample are presented in Table 1.

Measures

Demographic Information Sheet

The demographic form obtained the information regarding the personal and socio demographic characteristics, such as age, marital status, family structure formal educational level, number of children and employment status.

Multi-Dimensional Scale of Perceived Social Support

Multi-Dimensional Scale of Perceived Social Support (MSPSS) (Zimmet, Dehlem, Zimmet, & Farly, 1988) is a short, 12-item, self-report questionnaire rated on a 7 point Likert scale ranging from *very strongly disagree (1)* to *very strongly agree (7)*. It has three subcomponents namely support from Significant Others (SO) (Items 1, 2, 5, and 10), Family (FA) (Items 3, 4, 8, and 11) and Friends (FR) (Items 6, 7, 9, and 12). It is a reliable and valid instrument to assess social support with reported internal reliability as .88. The present study used the Urdu translated version of MSPSS (Rizwan & Aftab, 2009) The Cronbach's alpha (Table 2) was .86, and .77, .88, .88 for the subdomains of significant others, family and friends, respectively in the current study

WHOQOL- BREF

The Urdu version of WHOQOL- BREF (Khan, Akhter, Ayub, Alam & Laghari, 2003) was used in current investigation to measure quality of life. It is a 5-point Likert scale having 26 items, 24 questions incorporate four main domains as physical health, psychological health, social function and environmental domain, and the other two questions are related to quality of life and satisfaction of overall

health. The facet of physical health includes areas such as energy, pain, sleep mobility, activities, medication, work; psychological facet includes self-esteem, spirituality, concentration, feelings; social relationship includes support, sex, relationship, and environmental facets measures finance, home, leisure, safety, information. The scores on the instrument are scaled in a positive direction indicating that higher score shows better QOL. The Cronbach's alpha values obtained in the present study for four domains were .84, .78, .63, and .68 for physical, psychological, social and environmental aspect respectively (Table 2). In the present study cumulative score of all four domains is used.

Procedure

Initially the research synopsis was approved by the Advanced Studies and Research Board (ASRB), University of Karachi. After approval, permission to collect data from SACP authorities was sought. After getting the permission, the participants were approached and were elaborated about the significance and rationale of the research. The voluntary participation from the participants was sought and their concerns were duly addressed regarding the confidentiality of the data. After taking their consent the participants were instructed about filling of research instruments including demographic sheets and the questionnaires. For better understanding and to reduce any ambiguity, oral instructions and feedback was also provided by the examiner. After the collection of data researcher individually thanked all participants for their time and cooperation.

Statistical Analysis

The scoring of all the measures used in the study was done according to the standardized procedure. The data interpretation was made possible by using the Multiple Regression Analysis. Descriptive statistics was also employed. The Statistical Package for Social Sciences (version 25) was used for analyses.

RESULTS

Table 1
Summary of the Demographic Characteristics of the Sample

Variables	*f*	*%*
Age		
18-29	69	46.00
30-58	81	54.00
Education		
Not educated	74	49.33
Below Matriculation	51	34.00
Matriculation and above	25	16.67
Monthly Income		
0-13,999	89	59.33
14,000-29,999	59	39.33
30,000+	2	1.33
Marital Status		
Married	67	44.67
Unmarried	76	50.67
Divorced	5	3.33
Widower	2	1.33
Employment Status		
Employed	99	66.00
Un-Employed	51	34.00
Family		
Nuclear	11	7.33
Joint	139	92.67

Table 2
Descriptive Statistics and Cronbach's Alpha of all the Measures

Scales and Sub-scales	*M*	*SD*	*α*
WHOQOL- BREF	56.9	14.23	.91
Physical Domain	34.64	19.44	.84
Psychological Domain	32.72	17.35	.78
Social Domain	34.89	22.63	.63
Satisfaction with Environment	34.98	13.51	.68
Multidimensional Scale of Perceived Social Support (MSPSS)	3.43	1.23	.86
Significant Other Scale	4.60	1.62	.77
Family Scale	3.70	1.79	.88
Friend Scale	1.98	1.47	.88

Table 3
Summary of Standard Multiple Regression Analysis with Social Support from Significant Others, Family and Friends as Predictors of QOL in Individuals with IDU having Comorbid HIV/AIDS Infection

Predictor	R^2	ΔR^2	*F*	*Sig.*
Social Support Sources	.45	.44	40.45	.00*

*p <.05

Table 4
Coefficients of Standard Multiple Regression Analysis with Social Support from Significant Others, Family and Friends as Predictors of QOL in Individuals with IDU having Comorbid HIV/AIDS Infection

Model	*B*	*SE B*	*ß*	*t*	*Sig.*
Constant	30.62	2.77		11.05	.00*
Significant Others	.69	.15	.31	4.63	.00*
Family	.47	.14	.24	3.31	.00*
Friends	.85	.16	.35	5.32	.00

*p <.05

DISCUSSION

The present study aimed at investigating the predictive association between social support from significant others, family, and friends and quality of life in individuals with comorbid substance use disorders and HIV/AIDS infection. The results reveal that three predictors explained 44% variation in the scores of quality of life (Table 3). The analysis found that social support from all three sources i.e. significant others, family and friends (Table 4) predicted quality of life in individuals with IDU having comorbid HIV/AIDS infection.

The findings of the present study are consistent with the previous studies which suggested a positive association between social support and QOL (Liu et al., 2016). These findings may be attributed to the discrimination and self-isolation faced by the marginalized group of population in any society which creates gap in social networks and renders the communication as ineffective hence impacting the QOL. In general, it has been seen that the involvement in groups and seeking support brings improvement in health and physical status which consequently impact QOL. The individuals with IDU face stigma and discrimination due to their drug use. When substance use is coupled with the status of being HIV positive the burden of social marginalization multiplies (Paxton *et al*., 2005). Hence, drug use may be exacerbated due to the increased social marginalization, inadequate health

resources, lack of income or employment, isolation and prejudice. As they are not only rejected by their families but society as well, therefore they are economically and social disadvantaged. Thus, the quality of life of individuals with IDU having HIV positive is impacted by the social stigma experienced due to dual diagnosis of substance use and HIV positive status. The better health and social outcomes can be aided for them by the help, comfort and camaraderie of relatives. By providing more access to resources, such as association with peers, relatives, family and help in the professional setting such as assistance through counseling, these individuals can be provided with adequate support (Knowlton et al., 2004). Moreover, they can also benefit from these resources when informed about the ways to address and utilize this support.

The QOL in individuals with IDU having comorbid HIV/AIDS can also be impacted by the comorbid opportunistic infections such as Hepatitis B & C and Tuberculosis, non-compliance and delayed access to treatment due to social marginalization (Moore et al., 2004). In this context social support can be regarded as the most potent source for increasing compliance and reducing distress associated with HIV (Holstad, Pace Ak, & Ura, 2006). Social support provides them a sense of security and resilience that results in improving their sense of well-being and eventually quality of life.

Our findings are suggestive of positive association between social support from significant others, family and friends and QOL. These findings are consistent with previous studies which supported the positive role of social support from the afore-stated sources for enhancing quality of life for people with psychological distress (Bronowski & Zaluska, 2008; Mahmoud, Berma, & Gabal, 2017) and mental and health related QOL in HIV infected individuals (Burgoyne & Renwick, 2004). The better perception of social support from alternate caregivers and close relationships could be owed to the fact that living in a collectivistic culture our lives mostly revolve around relationships and in this context the adequacy of social support as provided by the close relationships is notable. Social support is considered to be the one of the significant protective factors in buffering negative effects of substance use (Moos, 2007). This indicates that the unfavorable outcomes that adversely impact the QOL are potentially reduced by the provision of social support. Another possible explanation is that we live in a culture where family ties are stronger and the individuals live in a close and intricate network of relationships which plays a significant role in provision of social support. Majority of the participants in the study belonged to a joint family set up. Thus the results point toward the possibility that when individuals with IDU having comorbid

HIV/AIDS would be surrounded and felt supported by their family (including, parents, siblings, children, spouses) their QOL would be improved.

In conclusion it can be endorsed that social support from significant others, family and friends contribute positively to the QOL in individuals with injection drug use (IDU) and comorbid HIV/AIDS in Pakistani cultural context. The findings indicate that this marginalized population can benefit from provision of social support from close relationships, family and friends. A general sense of well-being and improved levels of QOL can be achieved if these individuals feel supported by their environment which would also help in reducing the stigma and social discrimination. Thus, individuals would not only benefit from a reduced distress associated with the comorbid conditions but would also be able to manage the unfavorable outcomes when provided with the social support. In the context of Pakistani culture there is a scarcity in investigation regarding social support and QOL especially in individuals with IDU having HIV/AIDS. Thus findings of the current study contribute towards a theoretical framework for future investigations. Due to the small sample size the generalizability of the results to whole population is limited. Therefore future studies with much larger sample size should be conducted to increase generalization of results.

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