SOCIAL SUPPORT AND ITS HEALTH- RELATED OUTCOMESAMONG RESIDENTS OF JIMMA CITY, SOUTHWEST ETHIOPIA

BY:

SEMIRA KASIM

A THESIS TO BE SUBMITTED TO JIMMA UNIVERSITY COLLEGE OF SOCIAL SCIENCE AND HUMANITIES, DEPARTMENT OF SOCIOLOGY IN PARTIAL FULFILLMENT OF THE REQUIREMENT FOR MASTER OF ART IN SOCIOLOGY AND SOCIAL POLICY

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SCHOOL OF GRADUATE STUDIES

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APPROVAL SHEET
School of Graduate Studies

Jimma University

As thesis research advisors, we here by certify that we have read and evaluated this thesis prepared, under our guidance, by Semira Kasim, entitled Social Support and its Health-Related Outcomes at Jimma City, Southwest Ethiopia.   We recommend that it be submitted as fulfilling the thesis requirement Sociology and Social Policy

Bisrta Tesfa (MA)	Signature	Date
Major Advisor	_____	_____

As members of Board of Examiners of the MA thesis open defense examination, we certify that we have read, evaluated the thesis prepared by Semira Kasim and examined the candidate. We recommended that the thesis could be accepted as fulfilling the thesis requirement for the Degree of Master of Art in Sociology and Social Policy.

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BIOGRAPHICAL SKETCH

The author, Semira Kasim Ababulgu, was born on 15 June 1984 in Jimma Town, Jimma Zone of Oromia Regional State. She attended her elementary and junior secondary schools at Hamle 19 elementary and junior then secondary school at Jimma high school.

Following the completion of her secondary education, she joined Ethiopia Adventist collage in 2006 and graduated with BA Degree in Community Development and Leadership on July 01, 2009. After graduation, she was employed by child fund incorporated in Shashemene as community development officer. Later she joined Land Olakes International Development based at Addis Abeba as Nutrition and Livelihoods Zonal Coordinator until she joined the graduate studies program of Jimma University collage of sociology to pursue a graduate study leading to a Master of Art in Sociology and Social Policy.

ACKNOWLEDGEMENTS

LIST OF ABBREVIATIONS AND ACRONYMS

ANOVA   Analysis of Variance

ART   Antiretroviral Therapy

CD4   Cluster of Differentiation 4

CDC   Center for Disease Control

HAART   Highly Active Antiretroviral Therapy

HIV/AIDS   Human Immunodeficiency Virus/Acquired Immuno-Deficiency Syndrome

PLWHA   People Living With HIV/AIDS

SPSS   Statistical Package for Social Sciences

SPS   Social Provisions Scale

WHO   World Health Organization

TABLE OF CONTENTS

LIST OF TABLES

ABSTRACT

Evidence shows that social support is vital in maintaining good health and that socially isolated people get sick more often and have a more difficult time recovering from an illness. Social and psychological circumstances can cause long-term stress. Continuing anxiety, insecurity, low self-esteem, social isolation and lack of control over work and home life have powerful effects on health. This is because our immune system is influenced by stress that comes due to social isolation. Thus, in this study, attempts were made to bring a light about social support and its health related outcomes in Jimma City. The study used a cross sectional research design in order to collect the necessary data. The target population for this study was all households who were residing in Jimma City. For this study, three kebeles were selected randomly from the total of 17 kebeles of the city. The total numbers of household of three kebeles were 4951, out of which a sample of 370 households were selected using systematic random sampling technique. Data were collected from three kebeles (Hermata, Ifa Bula and Bore) of Jimma City found in Oromia Regional State through questionnaires and interview. Then, the study employed descriptive and inferential method of data analysis. The findings demonstrated that households were "some of the times" get the four distinct types of social support such as emotional, Informational/advices, instrumental, and appraisal type of support. This data revealed that an emotional and informational type of social support were the most acknowledged type of support among the participants and appears to be more forthcoming in households in times of illness in the study area. In relation to household members who has been sick in the last 2 years, all (100.0%) participants replied that at least one member of their household has been sick in the past two years. Therefore, the results indicated that all household members in the study area need health related social support in times of illness. The results further showed that the majority of respondents, 100.0%, 93.6% and 84.9% of household heads revealed that relatives, friends and neighbor were respectively the first, the second and third source of social support in the study area. Finally, the finding of the study indicated that most of the respondents (96.7%, 100.0% and 98.4%) from Hermata, Bore and Ifa Bula kebeles were disclosed that the available social support had significant contribution for the household's health status. Therefore, community based social support should be encouraged by stakeholders to improve the health related outcomes of households in the study area.

Keywords: Social Support, Sources of support, health related outcome

1. INTRODUCTION

1.1. Background of the study

Social support is a complex concept, consisting of the structural characteristics of social networks and the functional support that they provide (Lansdowne, 2011). Lansdowne also reported that the components of emotional, informational, instrumental support and social support could influence health outcomes in a variety of ways, including building self-esteem, coping abilities, improving knowledge, and understanding of available health, support services and encouraging healthy behaviors. The growing recognition of the role that social factors play in the health status of individuals has heightened attention to the connection between health and social services, particularly for vulnerable populations. Social support includes real or perceived resources provided by others that enable a person to feel cared for, valued and part of a network of communication and mutual obligation. It is vital to the quality of life of people in many different situations, including where illness or health disorder is already present. Studies of later life in particular have shown how vital social support is in promoting well-being (Bury and Holme, 1991).

Different studies have gone on to examine the impact of social support among various vulnerable populations, by looking to determine the mechanistic processes at play, seeking an understanding of the behavioral, psychological, biological processes along the pathway between social support and health outcomes (Jolene, 2011). Social support affects health in three ways: by regulating thoughts, feelings and behavior to promote health; by fostering an individual's sense of meaning in life; and by facilitating health-promoting behavior (Callaghan and Morrissey, 1993).

Many studies underpin the importance of social support in reducing stress and providing other health benefits. It is vital in maintaining good health and that socially isolated people get sick more often and have a more difficult time recovering from an illness. This is because our immune system is influenced by stress. Stress compromises our immune system and makes us more susceptible to infectious diseases (Parkinsonian, 2016).

The health care scholars have agreed that social support is a multidimensional construct with different types or kinds of social support. Social support as interpersonal transactions and look it

as an individual perception about the adequacy or availability of different types of support. An individual needs a set of relationships over the course of life and that all these relationships are necessary for well-being and lack of social support may adversely affect health (Wang et al., 2003). Social and psychological circumstances can cause long-term stress. Continuing anxiety, insecurity, low self-esteem, social isolation and lack of control over work and home life have powerful effects on health. Such psychosocial risks activate a cascade of stress hormones that affect the cardiovascular and immune systems.

Close relationships support individuals not only in their ability to cope with stress or adversity, but also in their efforts to learn, grow, explore, achieve goals, cultivate new talents, find purpose and meaning in life. But, research on social support has conceptualized health primarily in terms of the presence or absence of negative outcomes associated with acute and chronic stress (Feeney and Collins, 2014). This narrow focus has limited our understanding of the many ways in which social relationships can promote or hinder positive human health and well-being. One reason for this is that research on social support has not been well integrated with the literature on positive well-being, which shows that positive health endpoints are not simply the opposite of negative ones, and that optimal health is not simply the absence of mental and physical illness (Feeney and Collins, 2014).

Processes of social exclusion and the extent of relative deprivation in a society have a major impact on health and premature death. The harm to health comes not only from material deprivation but also from the social and psychological problems of living in poverty.

1.2. Statement of the Problem

Quite a bit research in the area of social network support and health outcomes has been conducted in many countries around the world; however, most of the research has been conducted on social support and its health related outcomes were relatively less (Rao et al., 2012). In Ethiopia also, research works on social support is mostly focused in connection with HIV/AIDs. The perceived social support among HIV patients enrolled in care in rural Ethiopia indicates that social support significantly enhances physical and mental health for persons with human immunodeficiency virus (Alan et at., 2015). The effect of social support, perceived social support, depression symptoms, and stigma on adherence and treatment outcome of highly active antiretroviral therapy at Zewditu

Memorial Hospital and her findings indicate that perceived social support was significantly associated with both adherences to HAART and self-confidence on the ability to take medication properly (Hibret, 2012).

Social supports and stressors among kin caregivers who were caring for HIV/AIDS affected orphans and vulnerable children in Addis Ababa (Hibret, 2012). In this study, social support was viewed as a buffer and the results indicate a low level of social support and a high level of stress (Meseret 2015). The barriers and facilitators to ART adherence and social support were found to be an independent predictor of adherence (Amberbir et al. 2008). The effects of depressive symptoms and perceived SS on weight gain and CD4 cell and found progression SS had positive effect on weight and CD4 cell progression (Hibret, 2012). Another study conducted by Tigist Shiferaw (2015), focused on social support in connection with chronic diseases and the relationship between self-efficacy; social support and self-management among chronic illness patients and her study findings highlight the role of self-efficacy and social support in predicting chronic disease self-management.

In the above listed research works, social support was examined relative to the adherence to ART medication, physical health, and quality of life. Based on these studies, we can see that social support is associated with improvement in access and adherence to ART, medication uptake, retention in care, physical functioning, CD4 cell progression, body weight of PLWHA, and mortality, in which all are focused on stress-buffering effects of social support and not integrated with positive well-being (Diener et al., 2006, Keyes, 2007).

Although social support and health have been major concepts in a number of research studies over the past decades, the influence of social support on health still appears to be inconclusive. Social support benefits individuals not only in their ability to cope with stress or adversity, but also in their efforts to learn, grow, explore, achieve goals, cultivate new talents, find purpose and meaning in life. The effects of social supports on positive well-being were not getting much emphasis and there are dearth's of information on the research work done in the country.

Thus, in this study, attempts were made to bring a light about social support and its health related outcomes integrated with positive well-being in Jimma City.

1.3. Objectives

1.3.1. General Objective

The general objective of this study was to make assessment on the role of social supports to health-related outcomes of households in Jimma City.

1.3.1   Specific objectives

➢   To explore the types of social support households, get in times of illness.

➢   To identify the sources of social support for households in times of illness.

➢   To learn how households, conceive social support and its health-related outcomes.

1.4.   Significance of the Study

This research was going to examine the influence of social support on health-related outcomes and may serve as a spill out for further research in the area. It can also bring social support to theme of public health policy makers, scholars and other concerned bodies in order to draft appropriate prevention and effective control approaches to improve health conditions.

2. LITERATURE REVIEW

2.1. Social Support

Although the construct of social support was first conceptualized by social scientists in the late 1970s (Berkman & Syme, 1979), the definition of the concept varies widely among researchers and their study context (William, Barclay, & Schmeid, 2004). Social support is generally defined 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). Conceptualizations of social support have also focused on the source of support, which can vary from family, spouse, friend, coworkers, doctor, and community ties/affiliations.

Social support refers to those aspects of social relationships that provide a sense of self-worth and offer resources in tackling life's troubles (Elston *et al.,* 2004). It is the individual belief that one is cared for and loved, esteemed and valued and belongs to a network of communication and mutual obligations (Parkinsonian, 2016). It acts as a powerful mediating factor in a range of physical and mental health problems. It is a micro level process or set of processes that mediate a causal sequence that takes us from the structural position and social networks people inhabit to resulting health-related outcomes. These outcomes might be psychological, physiological or behavioral in character. It also defined as the provision of psychological and material resources intended to benefit an individual's ability to cope with stress (Cohen, 2004).

The Conceptualizations of social support have also focused on the source of support, which can vary from family, spouse, friend, coworkers, doctor, and community ties/affiliations. House, Landis, and Umberson (1988) outlined the following four broad types of social support, which are still extensively used in research conducted today are informational support, instrumental support, emotional support and appraisal support. Informational support involves the provision of information, education, or guidance for use in managing personal and health-related problems. Instrumental support (also referred to as tangible support) involves the provision of tangible assistance, in the form of financial aid, material goods, labor, time, or any direct help. Emotional support involves the provision of empathy, affection, love, trust, encouragement, listening, and care from members of an individuals' social network. Appraisal support (also referred to as

affiliative support and social integration) involves the number of social relationships an individual has with others that have mutual interests. This type of support also provides affirmation and feedback (Jolene, 2011)

Social scientists have long been interested in the link between societal processes and individual outcomes. The founders of sociology were interested in how social integration affected suicide rates (Durkheim 1987/1951), how the social organization of labor relations impacted worker experience (Marx and Engels 1964), how religious principles translated into individuals' work ethics (Weber 1930), how modern society impacted mental health (Simmel 1950), how mental health institutions shaped individual inmates (Goffman 1961) or how the social system impacted health care utilization (Parsons 1951). All addressed issues of health, illness, and healing in one way or another, yet medical sociologists have tended to pay less attention to the distal forces of societal level institutions, focusing instead on the more proximate micro- and meso-level determinants of individual health. Comparative research provides an important lens to understand variation in the relationship between society and individuals, as it illuminates how different social organization may lead to a different lived experience across contexts.

Studies of the causal role of social support make a distinction between the availability of social support, perceived support and the delivery of support when it is most needed, for example, following a major life event. Such support can act as a direct and positive influence in promoting good health and its opposite, social isolation, can lead to poor health. But social support can also operate indirectly by protecting (acting as a buffer) in the presence of stress. Considerable work is currently under way to understand the biological mechanisms (through the immune system, hormonal pathways or neurotransmitters) that might explain the connections between social and psychological experiences and their impact on the body and health (Elston *et al.,* 2004).

Social integration can operate at a number of levels, from whole societies to local communities. Social networks can be examined in terms of day-to-day support or in terms of wider community participation or inclusion (Elston *et al.*, 2004). Both formal and informal support networks have been seen as a central component of an individual's social capital, a valuable resource that contributes to better health chances (Cattell, 2001).

2.2 Health

Health is a state of complete physical, mental, and social well-being, not merely the absence of disease and infirmity. The definition is holistic and they present three major interrelated components of health as physical, social and mental. Physical is the physiological or biological component of the definition. It simply implies the maintenance of homoeostasis. This is often used to infer a soundness of the body (WHO, 1940). The social represents the behavioral aspect of human health. A member of society is being in the network of social interaction and being able to fulfil social roles and expectations. If an individual is not active in the social network, it represents a form of social pathology an abnormality, which is an infraction on the norms and values of society. The social also incorporates the spiritual dimension. The spiritual aspect could be personal to the individual by connecting to the world of reality and divinity (Larson, 1999). The WHO's definition of health, medicine has treated individuals' social beings whose health is affected by social behavior and interaction.

The mental indicates the psychological, emotional and mental status of the individual. Emotional apathy, fixation and mal adjusted personality constitute a part of the manifestation of illness. Huber *et al*. (2011) observed that the mental aspect of health signifies the possession of a sense of coherence, which includes the subjective faculties enhancing the comprehensibility, manageability, and meaningfulness of any circumstances. The Physical implies that, most often, disease represents a malfunction of a part of the body system or an intrusion of harmful organisms such as a virus or parasite. This may cause a breakdown of the individual affected. This physiological aspect is the most important biomedical criterion in the determination of health. For someone to be healthy, his/her biological components must be in order. A major diagnosis procedure involves a determination of what could be wrong with any component of the body or detection of any intrusion of any anti-body by tracing the pathways of the disease from underlying causes to pathology in the human body system and examination of any emerging of symptoms (WHO, 1948).

In addition, Saracci (1997) also submitted that the WHO's definition of health is problematic and it should be reconsidered. He observed that the definition equates health with happiness that a disruption of happiness could be regarded as a health problem. He further argued that the WHO's definition reflects that health is boundless. Huber *et al. (*2011) also opined that the WHO's

definition is problematic because it impliedly declares people with chronic diseases and disabilities definitively ill. The definition further minimizes the role of the human capacity to cope autonomously with life's ever changing physical, emotional, and social challenges and to function with fulfilment and a feeling of wellbeing with a chronic disease or disability. Despite several decades of criticisms, the WHO has not reviewed the definition. The idea of a definition is to present a holistic view that is meaningful not only for individuals but also as a definitive tool in scientific investigation. The idea is not to advance an operational perfection that is unchangeable. Perhaps, there is yet a review because there has not been a more holistic and measurable alternative definition of health.

Decades of research studies have found that Social support helps us feel better, cope with challenges, help to improve health including physical health, psychological health and overall wellbeing. This means that having access to adequate social support is essential to a healthy life. Much research links social support to several health outcomes (Motl, McAuiey, Snook and Gilottoni, 2009). Some of the many health outcomes of social support include psychological adjustment, improved efficacy, better copping with upsetting events, resistance to diseases, recovery from diseases and reduced mortality.

There is a feedback loop between social support and morbidity, where each can impact on the other. Social networks can work to encourage integration and maintain an individual's health, which in turn allows them to further participate in social activities and act in a supporting role in the networks of others (Sluzki, 2010), but recurrent illness can impact the availability and quality of support (Cohen, 2004) with increased disability leading to decreased social interaction and further accelerated decline in health (Mendes de Leon et al., 2001). It should be noted that there is potential for behavioural and psychological processes to affect each other, for example, a stress response may result in poor health behaviours (Uchino, 2006). As well, behavioural and psychological processes may impact the type of support an individual receives or their perceptions of that support (Uchino, 2006).

Social support works to strengthen existing network relationships and extend network ties; to reduce isolation and promote connectedness; to increase self-esteem and coping abilities; to develop new skills and encourage productive participation; and to promote and enhance collective

problem solving and reciprocal support (Stansfeld, 1999). social networks and interpersonal relationships have a substantial impact on our physical health and psychological well-being (Burleson et al., 1994; Cohen et al., 2000; Shaw and Gant, 2002; Goldsmith, 2004; Goldsmith and Albrecht, 2011; Thoits, 2011). Controlling for known determinants of morbidity and mortality, a number of studies have shown that people with low social support levels have a higher risk of mortality compared to people who have stronger and more satisfying support networks (Berkman and Syme, 1979; Cohen et al., 2000). In addition to being positively correlated with health, positive types of social network support can reinforce health behavior change, while negative types of social network influence can undermine health behavior change (Revenson et al., 1991; Amick and Ockene, 1994; Goldsmith, 2004). For example, having a large number of peers who smoke cigarettes may negatively affect the success rate of a patient's quitting attempts.

2.2.1 Theoretical models linking social support to health outcomes

There are several proposed models to show how social support is linked to health-related outcomes. Lansdowne, (2011) categorized the models into two general categories; stress-related models and direct-effect models. Stress-related models suggest that social support is only or primarily important during times of stress and that it works to decrease stress-related cardiovascular activities (elevated heart rate, increased blood pressure), which influences long-term health outcomes (Uchino, 2004). The buffering model proposes that social support diminishes the negative effects stress on a person's life and health, buffering the pathogenic influence of stressful events (Stansfeld, 1999 and Uchino, 2004). The stress-prevention model proposes that increased social networks result in increased resources and reduced exposure to stressful life events (Lansdowne, 2011).

Direct-effect models suggest that social support is effective in influencing health outcomes regardless of stress levels. The social control hypothesis proposes that social networks can directly influence a person to improve health behaviors through peer pressure and social norms or indirectly influence individuals by providing an individual with social roles that lead to greater sense of purpose and reason for life and thus a reason to maintain their health (Cohen, 2003).

The social networks & social support conceptual model: is another model shows how supportive connections between people influence physical, mental and social health. The model consists of

five hypothesized relationships between social networks providing social support and health. It also illustrates several ways a network may influence health. (Srensen et al., 2011)

Therefore, this mode is more preferable for this study because the proposed models suggest that how supportive connections between people influence physical, mental and social health.

Conceptual Model for the Relationship of Social Networks & Social Support to Health (See Figure 9.1)
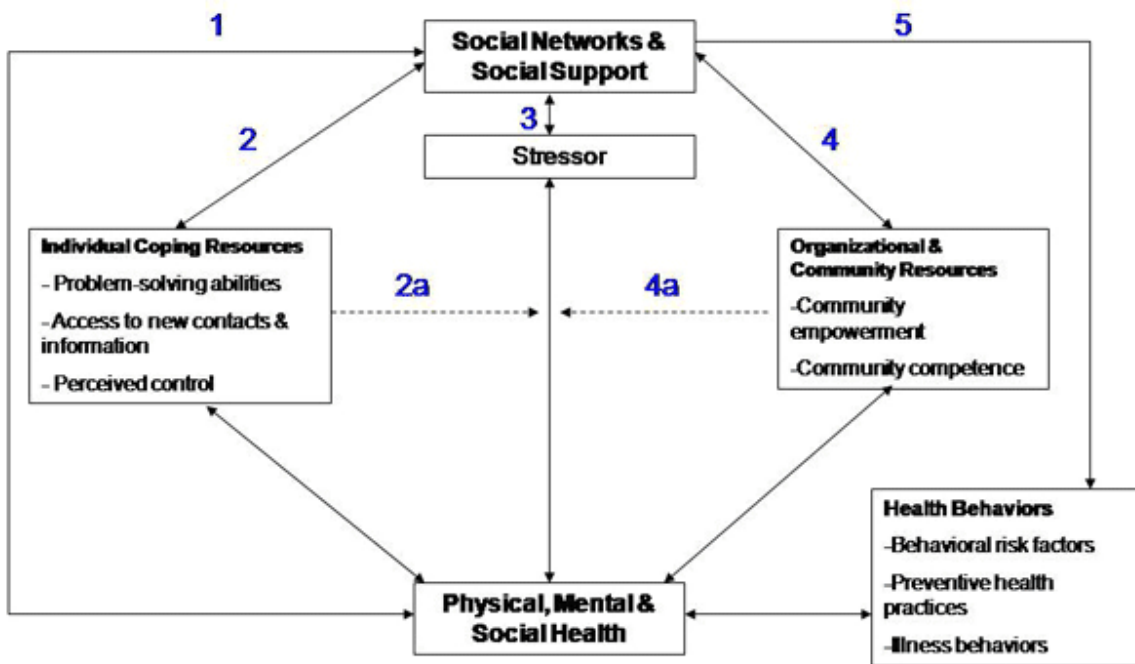
3. RESEARCH METHODOLOGY

3.1. Description Study Area

Jimma is located at the Southwestern part of Ethiopia, 352 kms away from the national capital, Addis Abebe. It is located at 9°26'N latitude, 41°8'E longitude and at an altitude of 1210 m. The mean annual maximum and minimum rainfall is 760 mm and 710 mm respectively (Belay et al., 1998). The mean annual maximum and minimum temperatures are 34 and 18 °C, respectively (Berhe et al., 2012). The city has a total population of 201,223 (of which 49.76% female) residing in 17 kebeles of it (Jimma Health Office Report, 2014).

3.2. Research Design

The researcher used a cross sectional research design in order to collect the necessary data on social support and its health related outcomes in Jimma City. A descriptive, exploratory design was used in this study. This design was chosen to learn more about the topic and explore possible directions for further research. The study was employed both quantitative and qualitative approach.

3.3. Sources of Data

Both qualitative and quantitative data was obtained primarily from household survey and in-depth key informant interview. Moreover, secondary data is used as supplementary. Documented information related to the study is reviewed. Efforts have been made to review the existing literature and documents. Books, Journals, statistical abstracts are assessed. Internet websites is explored so as to collect up-date information about the subject area of the study.

3.4. Study Population, Sample Technique and Size

3.4.1. Study Population
The population for this study were 4,951 households who were residing in Hermata, Bore and Ifa Bula kebeles of Jimma City. The household sizes in the study area were 2016, 1656 and 1279 for Hirmata, Ifa Bula and Bore kebeles respectively.

3.4.2. Sampling Technique and Sample Size

Sample size determination was the technique of electing the number of observations to include in a sample. The sample size was an important feature of any study or investigation in which the aim was to make inferences about the population from a sample. In general, the sample size used in a study was determined based on the cost of data collection and based on sufficient statistical power (Kish 1965, Robert 2004).

For quantitative study, first, three kebeles were selected randomly from the total of 17 kebeles of the city and these represent 17.6% of the kebeles. The selected three kebeles have twelve clusters which implies that four clusters for each kebeles. Out of these twelve clusters, three were selected randomly (one from each kebeles). The total number of household of three kebeles were 4951 out of which the sample was calculated 370 by using the below formula.

$$n = \frac{N}{1 + N(e^2)} \dots\dots\dots\dots\dots\dots\dots\dots\dots\dots\dots\dots\dots.(1)$$

Where, 'n' is the sample size, 'e' is the level of precision and 'N' is the total population.

Based on a simplified formula of Yamane (1967) using 95% confidence level and P = 0.05, from the total population (4951) of the selected three kebles the sample size (370) was calculated. Following this the sample size of each kebeles (Hirmata, Ifa Bula and Bore) were proportionally determined as 151, 124 and 95 households by considering their original values (2016, 1656 and 1279) respectively.

For qualitative study, key informant interview was conducted in three kebeles namely Hirmata, Ifa Bula, and Bore kebeles. A total of six key informant interviews was conducted; two from each kebeles. Four women and two men from kebeles who had an experience in working in social support services were key purposively selected for the qualitative in-depth interview.

3.5. Inclusion and Exclusion Criteria

The inclusion criterion for the study participants were households, either male or female, living in the study area and above 18 years of age, issues which might not met these criteria were considered as exclusion.

3.6. Methods of Data Collection and Tools

For quantitative study, quantitative data were collected in the study area with the assistance of data collectors. Social support scale was used to assess the study participants' social support. The questionnaire contains demographic characteristics, social support type, and source of social support and health outcomes. The questionnaires were translated into Afaan Oromo and Amharic. The questionnaires were administered with an average face-to-face interview time of 32 minutes. In total, 370 interviews were effectively conducted. Participants were 151 Hermata, 124 Ifa Bula and 95 Bore Kebeles. Based on the prepared questionnaires,

For qualitative study, key informant in-depth interview was employed to explore the participants' perceived importance and barrier of social support and its health-related outcomes. A key informant in-depth interview guide which was prepared following through review of literatures was used by the interviewer. The guide composes of items which explore; types of social support available for the people in need, major sources of social support and perceived benefit of social support.

3.7. Methods of Data Analysis

For quantitative data, the collected data from questionnaires and interview were analyzed, and presented by the combination of quantitative and qualitative data analysis method. Based on the nature of the basic questions developed, and the data collected from the respondents regarding current types and sources of social support and its health related outcomes in Jimma city; the following data analysis method were employed using Statistical Package for Social Sciences (SPSS) version 21. To analyze, the respondents' demographic characteristics descriptive statistics like frequency and percentage was used, while One Way ANOVA was carried out to determine the significance level of differences in the responses of household heads from Hermata, Bore and

Ifa kebeles on types of social support. The One Way ANOVA (F-test) looks at the F-statistic, F-distribution and degrees of freedom to determine the p value (probability) which was used to determine the mean difference between the respondents on the subject studied by comparing mean scores of respondents. The association of responses between household heads from Hermata, Bore and Ifa kebeles on sources of social supports and health related outcomes were analyzed through χ 2-test. Moreover, information and/or opinion reported by respondents through the open ended questions and the key informant interview organized and interpreted through a content analysis mainly by clustering the information into sub-themes to triangulate it properly.

For qualitative data, data from in-depth interview were recorded by voice recorder and it was transcribed verbatim and then translated to English Language by the researcher. The transcripts were read and checked repeatedly for verification and codes were subsequently assigned. Notes taken during the field work was used in the analysis. Following the codes grouped in to sub-theme, the investigator identified the emergent themes through repeated reading. The statement was grouped by code once the themes were established; the transcripts were read repeatedly to ensure the appropriate reflected theme. Thus, the finding is presented in narratives by thematic areas.

3.8. Ethical Consideration

Data were collected from three kebeles (Hermata, Ifa Bula and Bore) of Jimma City found in Oromia Regional State. Before commencing the study, every respondent was clearly have told about the purpose of the study. The research work was carried out after receiving verbal consent of each participant and confidentiality issue was thoroughly addressed. Questioner was developed in English but translated in to Amharic and/or Afan Oromo, as it is suitable for the respondents.

3.9. Scope of the Study

The study was limited and conducted in three randomly selected kebeles of Jimma city due to financial and time constraints. Moreover, the findings of this study was represented only the residents in these kebeles. Social support brings several impacts and consequences on the health conditions of individual lives. The study mainly focused on the various forms of social support to assess the respondent's social relationship and the related health outcomes.

3.10. Limitation of the Study

Social support was not static, but rather a dynamic aspect of a person's lifecycle, and so a single measurement in time may not be an accurate assessment (Bruhn, 2009 cited in Lansdowne 2011). This study was used a cross-sectional design, which not passes to establish a temporal relationship between social support and health outcomes.

4. RESULTS AND DISCUSSIONS

This chapter deals with the analysis, presentation and interpretation of the data gathered from the respondents through questionnaires, interviews and document analysis. Thus, the quantitative as well as qualitative analysis of data was incorporated into this chapter. The qualitative part is complementary to the quantitative analysis.

4.1. Response Rate

The data was collected from a total of 370 respondents. A total of 370 copies of questionnaires were distributed to households from Hermata (151), Ifa Bula (124) and Bore (95) kebeles. The return rate of the questionnaires was 370 (100.0%) specifically, 151 (100.0%) from Hermata, 124 (100.0%) from Ifa Bula and 95 (100.0%) from Bore Kebele households respectively.

4.2. Characteristics of Respondents

The households' respondents from the three kebeles were asked to indicate their background information. The details of the responses were given in Table 1 and discussed as follows:

As shown in Table 1 below, the data of the study revealed that 45.0%, 35.8% and 35.5% of household respondents from Hermata, Bore and Ifa Bula kebele were male, while 55.0%, 64.2% and 64.5% of household head respondents from Hermata, Bore and Ifa Bula kebele were females respectively. This implies that, females were household members who stay at home during the survey period as compared with male. That is why the chance of sampling female household heads were more than males and used as a unit of analysis.

A chi-square test analysis was also used to see the relationship between the three kebeles in terms of categorical variables such as sex of household head. The result revealed that there was statistically significant difference between the three kebeles in case of sex proportion at $X^2=3.320$ and at P=0.190 (P>0.05) probability level. This implies that, females were household members who stay at home during the survey period due to responsibility for child care and home management as compared with male. Findings strongly suggest that caregivers with less support were reported to have a significantly higher burden than those with stronger social support. Thus

social support from families, friends and others was beneficial for caregivers, providing access to resources, information and knowledge.

The three kebeles (Hermata, Bore and Ifa Bula) study participant's religious composition indicates that 53.0 % of study participants were followers of Muslim, 26.8 % were Orthodox, 19.5 % were Protestants and the lingering 0.67 % were followers of other faiths. The dominance of Muslim in the study area might be due to the wide spread of Muslim in the study area. The result of Chi-square-test was not significant as the p-value is greater than 0.05 (p>.05), X^2 (3) = 4.430, p=0.619. The result revealed that there was statistically significant difference between the three kebeles in case of religion composition.

Education is a key factor that influences the types of support required and health related outcomes. Regarding educational status about 42.3%, 51.2% and 68.4% of sample respondents from Hermata, Bore and Ifa Bula kebele were primary school completed. Similarly, 34.8%, 23.5% and 12.3% of Hermata, Bore and Ifa kebele household heads were secondary school completed respectively. About 12.3%, 8.5% and 5.1% of cases in same order had diploma and above while only 10.6%, 16.8% and 14.2% of the household heads were illiterate and showing that, education level of HHs in the study area is dominated by primary completed.

The marital status of the households illustrates that the majority 89.4%, 87.4% and 88.4% of household heads from Hermata, Bore and Ifa Bula kebele were married respectively. However, 6.0%, 8.4% and 5.6% of household heads from Hermata, Bore and Ifa Bula kebele were unmarried in same order. However, only 4.6%, 4.2% and 5.1% households from Hermata, Bore and Ifa kebeles were separated/divorced/widowed. This implies that married household heads are likely to use the different types of support in time of illness. Household heads responses from the three kebeles on their marital status were statistically significant different among the 370 respondents at χ2 = 2.082; P=0.912(P<0.05) probability level.

Pertaining to occupation of household heads, a few proportions of respondents numerically 14.6%, 9.5% and 5.6% of respondents were employed (self-employed, government and private institution employees) from Hermata, Bore and Ifa Bula kebele respectively. However, the majority (85.4%, 90.5% and 94.4%) of respondents from Hermata, Bore and Ifa Bula kebele were unemployed respectively. Thus, the types of occupation observed at Jimma city were dominated by

unemployed. So, it implies that awareness about health related supports are usually characterized by self-employed, government and private institution employed workers, but not by unemployed households). Regarding characteristics of in-depth interview participants, all six participants were married, four of them were women while two of them were men respectively.

Table 1: Part 1 section 1 respondents' responses on some categorical demographic characteristics

Item	Response Categories	Location						Over all
		Hermata		Bore		Ifa Bula		(%)
Sex		Freq.	%	Freq.	%	Freq.	%	
	Male	68	45.0	34	35.8	44	35.5	39.5
	Female	83	55.0	61	64.2	80	64.5	60.5
Religion	Muslim	79	52.3	50	52.6	67	54.0	53.0
	Orthodox	40	26.5	26	27.4	33	26.6	26.8
	Protestant	29	19.2	19	20.0	24	19.4	19.5
	Other	3	2.0	0	0.0	0	0.0	0.8
Education	Primary(1-8)	64	42.3	49	51.2	85	68.4	54.6
Level	Secondary (9-12)	53	34.8	22	23.5	15	12.3	11.9
	Collage/University	18	12.3	8	8.5	7	5.1	5.9
	Illiterate	16	10.6	16	16.8	17	14.2	27.6
	Married	125	82.8	75	78.9	108	87.1	88.4
Marital	Unmarried	9	5.9	8	8.4	7	5.6	6.5
Status	Separated/Divorced/ Widowed	17	11.3	12	12.6	9	7.3	2.2
Occupation	Employed	22	14.6	9	9.5	7	5.6	10.3
	Unemployed	129	85.4	86	90.5	117	94.4	89.7

The other two demographic profiles such as age and monthly income of the HHs in the study area were presented in Table 2. The results indicate that the highest age (78.0 years) and the lowest age (18 years) of the respondents were recorded in Hermata and Bore kebele respectively. The average age of household heads from Hermata, Bore and Ifa Bula kebele were 42.07±11.98, 41.87±12.26 and 42.39±11.77 years respectively with grand mean of   42.12±11.85. The average age range households were between 41.87±12.26 and 42.39±11.77. This entails most of surveyed households are economically active and they replied that they are well aware of their health status and identifying source and types of social support available to improve health related out comes in the study area.

Income is one of the important economic parameters that affect not only the quality of social support, but also other socio-economic parameters of households and improve health related outcomes (WHO, 2006). Accordingly, household heads income level was not significantly (P > 0.05) affected by households' residence area (kebeles). Considering the income level, the highest (1275.2 EBR) mean value of income was recorded in Hermata kebele and the lowest (1057.30EBR) mean level was found in Ifa Bula kebele with grand mean of 1165.0 EBR (Table 2). This difference in income level may result due to the nature of kebeles that Hermata is more of business area than I/Bula.

Number of close friend and relatives are a simple parameter but extremely important, since most of the social relationship at household level are controlled by any change in its size. In the current study, the number of close friend and relatives of the household member at the three kebeles had grand mean of 2.17±0.95. The analysis of variance results indicated that number of close friend and relatives were not significantly affected by study kebeles (Tables 2). Considering the main effect of household heads residence area, the highest (6.0) and the lowest (1.0) number of close friends and relatives were recorded in all three kebeles (Table 2). Hence, the observed mean number of close friends and relatives in the study area currently measured varied between minimum mean values of 2.14±0.92 (Hermata kebele) to maximum mean values of 2.21±1.02 (Bore kebele).

Table 2: Part 1 section 2 respondents' responses on some continuous demographic characteristics

Items		Mean	Std. Deviation	Minimum	Maximum	F-value	p-value
Age of respondent	Hermata	42.07	11.98	20.00	78.00	0.05	.94
	Bore	41.87	12.26	18.00	74.00		
	Ifa Bula	42.39	11.77	20.00	70.00		
	Total	42.11	12.00	18.00	78.00		
Monthly income	Hermata	1275.20	1131.47	200.00	6000.00	1.48	.225
	Bore	1130.50	981.54	200.00	5000.00		
	Ifa Bula	1057.30	1050.53	300.00	5000.00		
	Total	1165.0	1069.06	200.00	6000.00		
Number of close friends	Hermata	2.14	0.92	1.00	6.00	0.16	0.84
	Bore	2.21	1.02	1.00	6.00		
	Ifa Bula	2.17	0.95	1.00	6.00		
	Total	**2.17**	**0.95**	**1.00**	**6.00**		

4.3. The Extent and types of Social Support Households Get in Times of Illness

People sometimes look to others for companionship, assistance, or other types of support. These are still extensively used in research conducted today and summarized as informational support, instrumental support, emotional support and appraisal support. Next were some questions deals with how often the different types of social support that was available to household members were improving health related outcomes (Table 3).

Item 1 of table 3 shows, how often someone (relatives, neighbors, friends and others) help the household members if they were confined to bed. Hence, the mean value 2.93 ± 0.91, 2.91 ± 0.86 and 2.92 ± 0.99 were obtained from Hermata, Bore and Ifa Bula kebeles household responses respectively with 2.92 ± 0.92 weighted mean values. This finding revealed that instrumental and emotional type of support was sometime available to households when they were confined to bed. The result obtained from One Way ANOVA is not significant as the p-value is greater than 0.05 ($p>0.05$), $f_{(2, 67)} = 0.016$, $p=0.98$). Thus, the groups mean indicates that household respondents'

views from the three kebeles (on average) showed that such type of support was sometime help most of the households in the study city. In line to this finding Peveler, & Moss-Morris (2009) reported that since individuals do not live in a vacuum one of the incorporate pathway in intervention of health related problem is that of social support in the form of instrumental and emotional type of support.

Item 2 in the same table 3 presents and asks, the types and frequency of support available to family members from someone they can count on to listen to them when they need to talk. Thus, the mean value of (M = 2.93, SD = 0.92, 2.89, SD = 0.87 and M = 2.94, SD = 1.00) obtained from responses of household heads from Hermata, Bore and Ifa Bula kebeles respectively with weighted mean value of (WM = 2.92, SD = 0.93). This all mean value indicated that sometimes social interaction and attachment that a person has with others was a type of social support available to the households in the study area. The result obtained from the One Way ANOVA test (0.056) is less than the Table value (1.96) at p<0.05 which denotes that there was no statistically significant difference between the mean values of the three group of respondents. This means that social interaction and attachment that a person has with others was sometime was available to the households to improve health related outcomes in the study Area. This is in agreement with the results of (Hibret, 2012) and (Meseret, 2015) both social network size and frequency of contact were associated with health related outcomes improvement.

Item 3 of table 3 also shows the frequency of someone to give a good advice during a crisis for the households in Jimma City. Accordingly, the analyzed mean values (M = 3.21, SD = 0.77, M = 3.31, SD = 0.97 and 3.11, SD = 0.1.24) are found from Hermata, Bore and Ifa Bula kebele household head responses respectively with weighted mean value 3.20, SD = 1.00. This result indicated that advice type of support during crisis that available to the household members was not in a greater frequency to improve health related to cognitive function in the study city. This is in disagreeing with the finding of Alan *et al.* (2015); Hendryx *et al*. (2009) who reported prospective follow-up showed higher levels of emotional support predictive of better health related outcomes such as cognitive performance. Moreover, the analysis of variance result (F-value = 0.998) is less than the table value (1.96) at (P> 0.05). This confirms that there is no a statistically significant mean scores difference between the responses of the three groups. This ANOVA result revealed

that advice type of support during crisis was sometime available to most the households in the study Area.

As shown in Table 3, item number 4 is concerned with the frequency of someone to take the household members to the doctor if they needed it. Hence, the response rate of the household heads from Hermata, Bore and Ifa Bula Kebele using the means score value were (M = 3.70, SD = 0.750, M = 3.64, SD = 0.97 and M = 3.21, SD = 1.11) respectively with grand mean of (WM = 3.52, SD = 0.98) showed that "most of the time" instrumental type of support was available to the households in the study Area. The result concurs with the finding of Parkinsonia (2016); Tigist (2015) who reported perceived family support and perceived friend support both significantly positively associated with health related outcomes. However, the result obtained from the ANOVA-test was showed a statistically significant difference between the three groups response rate as the p-value is less than 0.05 ($p< .05$), f (2, 367) = 10.027, p=.000. The observed difference may have come from the fact that the households from Ifa Bula kebele use such types of support less frequently than Hermata and Bore kebeles households.

As indicated by Table 3, item number 5, the mean value of 4.11± 1.043, 3.47±1.19 and 3.0170± 1.23 of household responses from Hermata, Bore and Ifa Bula kebeles respectively with (3.63±1.23) weighted mean value. From this, one can conclude that most of the times support available to household heads were from someone who shows them love and affection. Therefore, such type of emotional support was frequently available to the households to improve health related outcomes in the study district. Similar to this finding Hwang *et al*. (2009) reported that perceived access to emotional support associated with better health. However, the result obtained from the analysis of variance was showed a statistically significant difference between the three groups response rate as the p-value is less than 0.05 ($p< .05$), t (2, 367) = 23.497, p=.000. The observed difference may have also come from the fact that the households from Hermata and Bore kebeles obtain such types of support more frequently than Ifa Bula households.

Item 6 of table 3 shows the extent of someone to have a good time with households during the time of illness. Instrumental support (also referred to as tangible support) involves the provision of tangible assistance, in the form of financial aid, material goods, labor, time, or any direct help. Hence, the response rate of the three groups using the mean score value of households from

Hermata, Bore and Ifa Bula on the former social support were (3.24±0.91, 3.51±1.06 and 2.89±1.28) respectively with weighted mean of (3.19±1.11). The weighted mean (3.19) indicated that instrumental type of social support was not always the type of support that households get in times of illness to improve their health crisis. However, One Way ANOVA was showed that there was a statistically significant difference at the $p < .05$, between the three groups on availability of such types of social support during the times of health crisis (illness). This is in disagreeing with the finding of Tolane (2011) and Mendes et al. (2001) who stated that instrumental support strongly associated with increased risk of disability.

Similarly, item 7 of table 3, the response rate of the three groups on the frequency of someone to give information to help household members from Hermata, Bore and Ifa Bula kebeles in order to understand a situation in times of illness were (3.38±1.27, 3.10±1.21 and 3.33±1.09) respectively with weighted mean value of 3.30±1.20. In this case, the combined mean including the weighted mean values were revealed that such types of information social support were sometimes, households get in times of illness to alleviate health related out comes. The result of One Way ANOVA was showed that there was no a statistically significant difference at the $p > .05$ level between the three groups on availability of an informational support to help household members' in understanding such unhealthy situation in the study area. The result concurs with the finding of Hendryx et al (2009), social network, social support and activity level positively correlated with better recovery; interaction between social support and activity level, with activity level more important for those with low social support.

As indicated by item 8, the mean value of 3.19± 1.20, 3.32±1.06 and 2.96± 1.18 of household responses from Hermata, Bore and Ifa Bula kebeles respectively with (3.15±1.17) weighted mean value. These all mean value indicated that households were "sometimes" obtained informational support by someone who talked to their problems in times of illness. Therefore, such type of informational support was "some of the times" available to the households in the study district. However, the result obtained from the analysis of variance was not showed a statistically significant difference between the three groups response rate as the p-value is greater than 0.05 $(p > .05)$, $f(2, 367) = 2.73$, $p = .066$. The observed similarity may have also come from the fact that the households from the three kebele obtain such types of support equally and in same frequency. Parallel to this findings, Sewart *et al.* (2009) reported that a significant decrease in loneliness,

increased support-seeking behaviors, increased coping skills, increased self-esteem and self-confidence through development of social skills,

Item 9 in the same table presents, the extent of someone who hugs your household members during the time of illness. So, the mean value of (M = 3.30, SD = 1.19, M = 2.84, SD = 1.33 and 2.77, SD = 1.27) obtained from responses of households from Hermata, Bore and Ifa Bula Kebeles respectively with weighted mean value of (WM = 3.00, SD = 1.28). This weighted mean value indicated that an emotional type of social support was sometimes available to households in times of illness. Similar results were also observed with the finding of Solomon (2004) and Tigist (2015) who reported perceived family support and perceived friend support both significantly positively associated with health related outcomes such as cognitive function. The result obtained from One Way ANOVA is significant as the p-value is less than 0.05 (p<0.05), f (2,367) = 7.365, p= .001). This implies that there is a statistically significant difference between the response rates of the three groups of respondents.

As shown in Table 3, item number 10 concerned the frequency of someone to get together with for relaxation. Accordingly, the mean score value obtained from the household heads from Hermata, Bore and Ifa Bula kebeles were (M = 3.34, SD = 1.27, M = 3.16, SD = 1.21 and M = 3.33, SD = 1.10) respectively with the weighted mean of (M = 3.31, SD = 1.20). Combined mean score values indicate that appraisal type (relaxation) support was sometimes available to the households under study. The finding coincides with the finding of Irwin *et al*. (2008) who reported that the perceived family support and perceived friend support both significantly positively associated with health related outcomes such as relaxation (cognitive function). The result of One Way ANOVA showed there was no a statistically significant difference (f= 1.062, df= 2,367, p= .347) in mean score value between the three groups of respondents at 5% significance level. This means that there is a consensus among the respondent groups about frequency of such emotional support availability among respondents in the three kebeles.

Table 3: **Part 2 section 1 response rate on the extent and types of social support households get in times of illness**

Item	Kebeles	Mean	Std. Dev	F-value	P-value
1. Someone to help you if you were confined to bed	Hermata	2.93	0.91	0.016	0.98
	Bore	2.91	0.86		
	Ifa Bula	2.92	0.99		
	WM*	2.92	0.92		
2. Someone you can count on to listen to you when you need to talk	Hermata	2.93	0.92	0.05	0.95
	Bore	2.89	0.87		
	Ifa Bula	2.94	1.00		
	WM	2.92	0.93		
3. Someone to give you good advice about a crisis	Hermata	3.21	0.77	0.99	0.37
	Bore	3.31	0.97		
	Ifa Bula	3.11	1.24		
	WM	3.20	1.00		
4. Someone to take you to the doctor if you needed it	Hermata	3.70	0.80	10.03	0.00
	Bore	3.64	0.97		
	Ifa Bula	3.21	1.11		
	WM	3.52	0.98		
5. Someone who shows you love and affection	Hermata	4.11	1.04	23.49	0.00
	Bore	3.47	1.19		
	Ifa Bula	3.17	1.28		
	WM	3.63	1.23		
6. Someone to have a good time with	Hermata	3.23	0.91	9.04	.000
	Bore	3.51	1.06		
	Ifa Bula	2.89	1.28		
	WM	3.19	1.11		
7. Someone to give you information to help you understand a situation	Hermata	3.38	1.27	1.06	.347
	Bore	3.16	1.21		
	Ifa Bula	3.33	1.10		
	WM	3.31	1.20		
8. Someone to confide in or talk to about yourself or your problems	Hermata	3.19	1.20	2.73	0.066
	Bore	3.32	1.06		
	Ifa Bula	2.96	1.18		
	Total	3.15	1.17		
9. Someone who hugs you	Hermata	3.30	1.19	7.36	0.00
	Bore	2.84	1.33		
	Ifa Bula	2.77	1.27		
	WM	3.00	1.28		
10. Someone to get together with for relaxation	Hermata	3.34	1.27	1.062	0.347
	Bore	3.16	1.21		
	Ifa Bula	3.33	1.10		
	WM	3.31	1.20		

Key: Mean value ≥ 4.50= All of the Time, 3.50-4.49= Most of the Time, 2.50-3.49= some of the time, 1.50-2.49= A Little of the time and ≤ 1.49= None of the Time at $p>0.05$, fcr= 1.96, df = (2,367)

* Weighted mean

Item 11 of table 4 below also shows the frequency of someone to prepare meals if the household members were unable to do it for themselves. Accordingly, the analyzed mean values (M = 3.19, SD = 1.20, M = 3.32, SD = 1.06 and 2.96, SD = 1.18) are found from Hermata, Bore and Ifa Bula kebeles household head responses respectively with (3.15, SD = 1.15) weighted mean value. This result indicated that practical help with routine activity /instrumental/ type of support during unhealthy period was sometime available to the household members in the study Area. This is not in line with the finding of Mendes *et al.* (2001); Seeman *et al.* (2001) who reported that instrumental support strongly associated with increased risk disability. Besides, the analysis of variance result (F-value = 2.73) is greater than the table value (1.96) at (P> 0.1). This confirms that there was a statistically significant mean scores difference between the responses of the three groups. This ANOVA result revealed that the frequency of such type of support during health problem was not uniformly available to the households in the study Area

Item 12 Table 4 shows the other types of social support/ emotional and appraisal/ households get in time of illness such as advice they really want from someone else. With regard to this item, the mean value 3.74± 1.07, 2.93±1.10 and 3.27± 1.18 were obtained from households of Hermata, Bore and Ifa Bula responses respectively with 3.38± 1.17 weighted mean values. This finding revealed that an advice type of social support was not always households get in time of illness to improve their health related outcomes in the study area. This is in agreement with the results of Cornwell and Waite (2009), individuals who were socially connected and reported high levels of perceived report had a 70% chance of reporting very good or excellent health. The result obtained from One Way ANOVA is significant as the p-value is less than 0.05 (p<0.05), f (2, 367) = 16.541, p=0.000). The observed difference may arise due to the fact that the households from Hermata kebeles obtain such types of support more frequently (M = 3.74) than Bore and Ifa Bula kebeles households.

Item 13 of table 4 shows the frequency of someone to do things to support the household members to get their mind of appraisal and informational support in time of illness. Thus, the analyzed mean values (M = 2.98, SD = 1.36, M = 3.19, SD = 0.99 and 2.92, SD = 1.23) are found from Hermata, Bore and Ifa Bula kebele household head responses respectively with (3.01, SD = 1.23) weighted mean value. This result proved that appraisal and informational type of social support was "sometime" available to households in time of illness in the study Area. Further, the analysis of

variance result (F-value = 1.387) is less than the table value (1.96) at (P> 0.05). This confirms that there was no a statistically significant mean scores difference between the responses of the three groups. This ANOVA result revealed that the frequency of such type of support during health problem was sometime available to the households in the study Area. Similarly, Tigist (2015) and Tolane (2001) stated reported that social disengagement significantly associated with probability of cognitive decline; as number of social ties increased the probability of cognitive decline was reduced.

Item 14 in table 4, shows the frequency of someone to help with daily chores if the household members in time of illness. Hence, the response rate of the household heads from Hermata, Bore and Ifa Bula Kebele using the mean score values were (M = 2.72, SD = 1.03, M = 2.85, SD = 1.30 and M = 3.00, SD = 1.08) respectively with grand mean of (WM = 2.85, SD = 1.12) showed that instrumental type of social support was sometimes households get in time of illness in the study Area. However, the result obtained from the ANOVA-test was showed a statistically significant difference between the three groups' response rate as the p-value is less than 0.05 (p< 0.05). The observed similarity reveled that such type of support was sometime available to the households in the study area. Opposite to this finding Cornwell and Waite (2009) reported that individuals who did not perceive themselves to be isolated had an 85% chance of reporting very good or excellent health.

Item 15 in the same table presents, the extent of someone to share the most private worries and fears of households during the time illness. So, the mean value of (M = 3.86, SD = 0.99 and M = 3.42, SD = 1.20 and 3.85, SD = 1.13) obtained from responses of households from Hermata, Bore and Ifa Bula Kebeles respectively with weighted mean value of (WM = 3.74, SD = 1.11). This weighted mean value indicated that an appraisal type of social support was sometime available to households in times of worries and fears. However, this finding was not in accord with Cornwell and Waite (2009) reported that individuals who did not perceive themselves as to be isolated had an 85% chance of reporting very good or excellent health. The result obtained from One Way ANOVA is significant as the p-value is less than 0.05 (p<0.05), f (2,367) = 5.548, p= .004). This implies that there is a statistically significant difference between the response rates of the three groups of respondents.

Pertaining to item 16 of table 4 presents, the frequency of someone to turn for suggestions about how to deal with a personal health problem of households in times of illness. Therefore, the mean value of (M = 3.46, SD = 1.04, M = 3.39, SD = 1.07 and 3.02, SD = 1.21) obtained from responses of households from Hermata, Bore and Ifa Bula Kebeles respectively with weighted mean value of (WM = 3.30, SD = 1.12). This weighted mean value indicated that an appraisal type of social support (suggestion) was sometime available to households in times of personal health crisis. Table 2 also showed a significant difference between the response rates of households from the three sample Kebeles. The f-cal = 5.789 and t-crit = 1.96 which is greater than the alpha (α) of 0.05. Therefore, there was a significant difference between the response rates of the three groups of respondents.

With respect to item 17 of table 4, it asks the frequency of someone to do something enjoyable with households in time of illness. Accordingly, the mean score value obtained from Hermata, Bore and Ifa Bula kebeles household responses were (M = 2.67, SD = 0.95, M = 2.95, SD = 1.20 and M = 3.23, SD = 1.10) respectively with the weighted mean of (M = 2.93, SD = 1.10). Combined mean score values indicate that an appraisal and emotional support was sometime household get in time of illness. Similar to this finding Kidds and Shahar (2008) reported that secure attachment positively associated with subjective health. However, analysis of variance was showed that there was a statistically significant difference at the $p < .001$ level between the three groups on availability of an appraisal and emotional support such making enjoyable in times of illness f (2, 367) = 9.209, $p < .001$. Despite reaching statistical significance, the actual difference in mean scores between groups was quite small.

Finally, item 18 and 19 of table 4 shows the extent of someone who understands households' problems and to love and make households feel wanted. Hence, the response rate of the three groups using the mean score value of households from Hermata, Bore and Ifa Bula on the former social support were (3.79±0.98, 3.57±1.19 and 3.42±1.14) respectively with weighted mean of (3.61±1.10). Similarly, the response rate of the three groups on the later social support was (3.08±1.12, 3.16±1.14 and 2.79±1.09) respectively with weighted mean value of 3.00±1.12. In both cases the weighted mean value revealed that such types of an appraisal support and emotional support were sometimes, households get in times of illness. However, One Way ANOVA was showed that there was a statistically significant difference at the $p < .05$ level between the three

groups on availability of an emotional support such understanding household members' problems, love and make them to feel wanted in times of illness. However, Kidds and Shahar (2008) stated that social involvement negatively associated with loneliness; secure attachment positively associated with subjective health; self-esteem negatively associated with loneliness, feeling trapped, suicidal ideation, and substance use; self-esteem positively associated with subjective health.

Table 4: Part 2 section 2, response rate on the extent and types of social support households get in times of Illness

Item	Kebeles	Mean	Std. Dev	F-value	P-value
11. Someone to prepare your meals if you were unable to do it yourself	Hermata	3.19	1.20	2.73	0.1
	Bore	3.32	1.06		
	Ifa Bula	2.96	1.18		
	Total	3.15	1.15		
12. Someone whose advice you really want	Hermata	3.74	1.07	16.54	0.00
	Bore	2.93	1.10		
	Ifa Bula	3.27	1.18		
	Total	3.38	1.17		
13. Someone to do things with to help you get your mind off things	Hermata	2.98	1.36	1.39	0.25
	Bore	3.19	0.99		
	Ifa Bula	2.92	1.23		
	Total	3.01	1.23		
14. Someone to help with daily chores if you were sick	Hermata	2.72	1.03	2.33	0.09
	Bore	2.85	1.29		
	Ifa Bula	3.01	1.08		
	Total	2.85	1.12		
15. Someone to share your most private worries and fears with	Hermata	3.86	0.99	5.55	0.00
	Bore	3.42	1.20		
	Ifa Bula	3.85	1.13		
	Total	3.74	1.11		
16. Someone to turn to for suggestions about how to deal with a personal peroblems	Hermata	3.46	1.04	5.79	0.00
	Bore	3.39	1.07		
	Ifa Bula	3.02	1.21		
	Total	3.29	1.12		
17. Someone to do something enjoyable with	Hermata	2.67	0.95	9.21	0.00
	Bore	2.95	1.20		
	Ifa Bula	3.22	1.11		
	Total	2.93	1.10		
18. Someone who understands your problems	Hermata	3.79	0.98	4.13	0.02
	Bore	3.57	1.19		
	Ifa Bula	3.42	1.14		
	Total	3.61	1.10		
19. Someone to love and make you feel wanted	Hermata	3.08	1.12	3.51	0.03
	Bore	3.16	1.14		
	Ifa Bula	2.79	1.09		
	Total	3.00	1.12		

Key: Mean value ≥4.50= All of the Time, 3.50-4.49= Most of the Time, 2.50-3.49= some of the time, 1.50-2.49= A Little of the time and ≤1.49= None of the Time at p>0.05, fcr= 1.96, df = (2,367)

The hierarchy of relations varied by type of support provided. The percentages of the respondents reporting the four top ranked types of support by source are shown in Table 5 bellow. It is suggested that social support is most effective when the type of support provided matches a person's life events (Uchino, 2004). The types of social support available to the households such as financial, material, psychological and/or advice and love and care were expressed in terms of three sample kebeles (Hermata, Bore and Ifa Bula) from where the sample households were selected. Regarding items 1 of table 5, the majority of respondents, 100.0% from Hermata, 100.0% from Bore and 100.o% from Ifa Bula kebele confirmed that the common types of social support households obtained was psychological/advice type support (Table 5). Moreover, 98.4%, 72.1% and 82.5% of household heads from Hermata, Bore and Ifa Bula kebele reported that love and care was the second type of social support households get in times of illness. Further, 52.8% from Hermata, 80.2 % from Bore and 39.5% Ifa Bula kebele respondents were replied that material was the third type of social support households accessed in times of illness. However, 13.4%, 20.9% and 25.4% of the respondents from Hermata, Bore and Ifa Bula kebeles respectively revealed that financial was the least type of social support households obtained in times of illness.

Therefore, psychological/advice (100.0%), love and care (84.33%) material (57.5%) and financial (19.9%) were the types of social support households get in times of illness in order of their importance. The results obtained from chi-square tests showed that there is no a significant association (at 5% significance level) between the three group of respondents on accessibility to financial, material and psychological type of support to get treatment.

Table 5: Multiple responses rate on types of social support households get in times of illness

Items	Response rate	Kebeles			Over all total		X ^{2}-value
		Hermata	Bore	Ifa Bula			
Types of social support							
Financial	Frequency	17	18	29	64		
	Percent	13.4	20.9	25.4	19.6		
Material	Frequency	67	69	45	181		
	Percent	52.8	80.2	39.5	55.4		
Psychological/advice	Frequency	127	86	114	327		Ns
	Percent	100.0	100.0	100.0	100.0		
Care & support	Frequency	125	62	94	281		
	Percent	98.4	72.1	82.5	85.9		
Over all total	Frequency	127	86	114	327		
	Percent	38.8	26.3	34.9	100.0		

Key: ns = none significance at 5% significance level

In relation to household members who has been sick in the last 2 years, all (100.0%) of the household heads in each kebele (category) said "Yes". This implies that most of the household members in the study area were not free of health problems in the last 2 years. Therefore, the results indicated that all household members in the study area need health related social support in times of illness.

Item 2 of table 6 asks that if sample households response to item1 is "Yes", they further inquired that had you access to any type of support to get treatment? Accordingly, table 6 shows, 93.4%, 94.7% and 94.4% of household heads from Hermata, Bore and Ifa Bula Kebels were respectively reported that we had got any type of social support to get treatment. Only, 6.6%, 5.3% and 5.6% of the respondents from Hermata, Bore and Ifa Bula kebeles respectively proved that we had not obtained any type of social support to get treatment in times of illness. Hence, it was seen in the study area that a great majority of the community access to any type of social support to get treatment. So, it had a significant contribution for the household's health status. The results obtained from chi- square tests showed that there is no a significant association (at 5% significance level) between the three group of respondents on accessibility to any type of support to get treatment.

Table 5: Response rates of respondents on health status, availability of social support to prevent future health and whether or not households get treatment in times of illness

Item	Response categories	Hermata(N = 151)		Bore(N = 95)		Ifa Bula(N = 124)		F-value
		Freq.	Percent	Freq.	Percent	Freq.	Percent	
1.Is there someone who has been sick in the last 2 years in your household	Yes	151	100.0	95	100.0	124	100.0	NC
	No	-	-	-	-	-	-	
	Total	151	100.0	95	100.0	124	100.0	
2.If your response to item1 is "Yes", have you got any type of support to get treatment?	Yes	141	93.40	90	94.70	117	94.4	0.23^{ns}
	No	10	6.6	5	5.3	7	5.6	
	Total	151	100.0	95	100.0	124	100.0	

Key: NC = Not computed, ns = non-significant

If households' response is no or did not get any type of support, how did households cover the health cost was another question. Accordingly, the majority of respondents, 100% from Hermata, 100% from Bore and 66.0% Ifa Bula kebeles confirmed that personal payment were the sources of finance to cover the health cost in times of illness respectively. Moreover, 57.1% of Hermata, 66.7% of Bore and 60.0% of Ifa Bula kebele household heads revealed that borrowing from somebody were the sources of finance to cover the health cost in times of illness respectively. However, 14.3% of Hermata, 33.3% of Bore and 40.0% of Ifa Bula kebele respondents confirmed that traditional medicine was used without financial cost in times of illness.

This shows that the types of financial sources that households used in the study area were personal payment (85.7%), borrowing from somebody (75.6%) and traditional medicine (29.2%) to cover the health cost respectively. The results obtained from chi- square tests showed that there is no a significant association (at 5% significance level) among the three group of respondents on the sources of finance to cover the health cost during health problems.

Table 6: Multiple responses rates of respondents on sources of finance for households to get treatment in times of illness

Items	Response rate	Kebeles			Over all total	X²-value
		Hermata	Bore	Ifa Bula		
Sources of support						
personal payment	Frequency	7	3	5	15	
	Percent	100	100	66	86.7	
Borrowing from some body	Frequency	4	2	3	9	
	Percent	57.1	66.7	60	61.3	Ns
Traditional medicine	Frequency	1	1	2	4	
	Percent	14.3	33.3	40.0	87.6	
Over all total	Frequency	7	3	5	15	
	Percent	46.7	20.0	33.3	100.0	
	Percent	42.0	23.7	34.3	100.0	

Key: Ns = none significance at 5% significance level

4.4. Sources of social support for the households during the time of illness

Common source of social support for households from Hermata, Bore and Ifa Bula kebeles is indicated in Table 8. The results show that the majority of respondents, 100.0% of household heads revealed that relatives were the first source of social support in all three kebeles. Moreover, 93.1, 94.6% and 93.5% of respondents from the three kebeles reported that their common source of social support were friends respectively. While, 91.6%, 85.1% and 76.6% of participants from Hermita, Bore and Ifa Bula kebele respectively proved that social support from neighbor was the households got support in the study Area. To study the difference between households in Hermata, Bore and Ifa Bula kebeles on sources of social support, chi – square test was made. Table 6 shows the Pearson chi-square results indicates that households from the three kebeles were not statistically different from where they had got the social support (X^2 = 1.738, df = 1, N = 195, P >0.05).

Table 7: Multiple responses rate on social support households get in times of illness

Items	Response rate	Kebeles			Over all total	X ^{2}-value
		Hermata	Bore	Ifa Bula		
	Percent	46.7	20.0	33.3	100.0	
Sources of social support						
From relatives	Frequency	131	74	107	312	
	Percent	100.0	100.0	100.0	100.0	
From neighbor	Frequency	120	63	82	265	Ns
	Percent	91.6	85.1	76.6	84.9	
From friends	Frequency	122	70	100	292	
	Percent	93.1	94.6	93.5	93.7	
Over all total	Frequency	131	74	107	312	
	Percent	42.0	23.7	34.3	100.0	

Key: ns = none significance at 5% significance level

4.5. Households perception on social support and its health-related outcomes

With the association between social support and health outcomes established, this study is now looking to determine how households conceive social support and its health-related outcomes (Table 9). Thus, item 1 of this table, showed that, 91.4%, 82.1% and 81.7% of household respondents' from Hermata, Bore and Ifa Bula kebeles respectively were conceive and evaluate the contribution of social support they had got for their health outcome as high contribution. But 8.6%, 17.9% and 18.3% of household head respondents from the three kebeles conceived that the contribution of social support they accessed had moderate contribution for their health related outcome. The calculated chi- square tests result showed that there was a statistically significant association (at 5% significance level) between the three groups of respondents' perception on the contribution of social support in improving health-related outcomes.

With regard to item 2, most of the respondents (96.7%, 100.0% and 98.4%) from Hermata, Bore and Ifa Bula kebeles indicated that the available social support had significant contribution for the household's health status. Whereas 3.3% and 1.6% of the respondents from Hermata and Ifa Bula kebeles respectively perceived that the available social support had not a significant contribution for the household's health status in the study area. The chi- square tests at (P 0.172 >0.05) level of significance showed that there was no a statistically significant association between the

respondents' responses on significant contribution of social support for the household's health status.

Item 3 of table 9 asks who can really count on to help you in order to feel more relaxed when household members are under pressure in times of illness. Hence, 51.0%, 61.0% and 62.9% of respondents from household of Hermata, Bore and Ifa Bula kebeles respectively disclosed that relatives were the first really count on to help the households in order to feel more relaxed when they were under pressure in times of illness. Moreover, 33.1% of Hermata, 25.3% of Bore and 21.0% of Ifa Bula Kebele household heads confirmed that friends were the second source of help for households to feel more relaxed when you are under pressure in times of illness. However, 15.9%, 13.7% and 16.1% of participants from Hermita, Bore and Ifa Bula kebele respectively proved that social help from neighbor was the least where households got support in order to feel more relaxed when they were under pressure in times of illness in the study area.

To examine the difference between households from the three kebeles about Who can really count on to help the household members in order to feel more relaxed when they were under pressure in times of illness, chi – square test was used. Households responses from the three kebeles were not statistically different (P > 0.05) on sources of social support depend on.

A question on item 4 was raised concerning the available social support in preventing households from fear of future health cost needs. Accordingly, higher percentage (96.0%, 98.9% and 98.4%) of respondents from Hermata, Bore and Ifa Bula kebeles conceived that the availability of social support was suitable in preventing households from fear of future health cost needs. However, only 2.43% (4.0%, 1.1% and 1.6% Hermata, Bore and Ifa Kebele household heads) of them said the availability of social support was not suitable in preventing households from fear of future health cost needs. The results obtained from chi- square tests showed that there was no a significant association (at 5% significance level) between the three group of respondents.

Table 8: Households perception on social support and its health-related outcomes

Item	Response categories	Hermata(N = 151)		Bore(N = 95)		Ifa Bula(N = 124)		F-value
		Frequency	percent	Frequency	Percent	Frequency	Percent	
1. How do you evaluate the contribution of the support you have got for your health outcome?	High	138	91.4	78	82.1	85	81.7	6.416**
	moderate	13	8.6	17	17.9	19	18.3	
	Low	-	-	-	-	-	-	
	Total	151	100.0	95	100.0	124	100.0	
2. Do you think social support has significant contribution for the household's health status"?	Yes	146	96.7	95	100.0	122	98.4	3.523^{ns}
	No	5	3.3	-	-	2	1.6	
	Total	151	100.0	95	100.0	124	100.0	
3. Who can you really count on to help you feel more relaxed when you are under pressure in times of illness	From relatives	77	51.0	58	61.0	78	62.9	6.058^{ns}
	From neighbor	24	15.9	13	13.7	20	16.1	
	From friends	50	33.1	24	25.3	26	21.0	
	Total	151	100.0	95	100.0	124	100.0	
4. Is availability of social support preventing from fear of future health cost needs	Yes	145	96.0	94	98.9	122	98.4	2.624^{ns}
	No	6	4.0	1	1.1	2	1.6	
	Total	151	100.0	95	100.0	124	100.0	

4.6. The types and source of social support and perception of social support of participants from finding of in-depth interview

Finding of qualitative study indicated that there were different type and source of social support available for people in need. The study participants of qualitative study indicated different type of

social support available for the sick individuals which included: emotional, instrumental, informational, etc. As per the report by the participants these care can be delivered by household members (including siblings, spouse, and children), neighborhoods, religious fathers, local supporting groups including local non-governmental organizations, health care professionals, and health facilities.

A. Social support from family members

A 48-year-old woman from Ifa Bula kebele indicated that:
"Some of the sick individuals are supported by their mother and another by their father. Most of the time mothers and fathers are humble for their family and it is usually both that take great role in taking caring of the family members. In case if both are older and dependent it is the other family members who are take care of them. I believe that older people are emotionally strong to care of one. There words are more supportive that drug treatment and they calm down and give hope for someone who is highly affected by the illness."
The same woman reported that her husband is supportive for her and she acknowledged that he was get involved in supporting other too. She verbalized that:

"He (husband) is very helpful for the whole family and taking example in my case, my husband is supportive in all regard while I and other family member became sick. He supported us emotionally not to worry much. He arranged every of the activity and the medical services that family members need to seek. Furthermore, he supported us to be strong by praying to God and he usually plays religious music to let us feel healthy and well. There are several similar husbands in the community which are supportive for the ill."

B. Social support from friends and neighborhood

Aside of social support from family member, all study participants of in-depth interview reported that their friends and neighborhoods as a source of care support. As a societal means of living it is common in Ethiopia that friends and neighborhood visit the sick individual and provide necessary encouragement and different type of care.   A 45-year-old woman from Hermata kebele reported:
"I do have several neighbors and friends in my neighbor. I have lived in this area since my birth. This helped me in getting together with others easily. Whenever we encounter an event either bad

or good, it is our neighbor and nearby friends that shares our feeling. For example, whenever family members become sick it is the neighbor that facilitate and helps us in taking to the health facility and support us either emotionally and financially. Whenever I don't have money on my hand I will borrow or take from my friends in the neighborhood. Similarly, if someone encounters illness during the night time, we usually call the neighborhood and visit the hospital. We do the same thing when they encounter the same problem."

C. Social support from workplace

Some of the study participants had a gratitude for their employee and workmate for their emotional, financial, and instrumental supports. A 48 years old male patient from Bore kebele reported that:

"My colleagues are very friendly and they usually visit me whenever I encountered an illness. They usually take short walk from my office to my house. I have four office mates. They usually come together and pass several times with me. The time I do have with them is interesting and helped me in forgetting my pain and illness."

Another woman from the Hermata kebele reported that:
"Following my diagnosis of diabetic mellitus, I was discouraged and felt very sad and depressed. Whenever I met my friends of work place I told them that I was diagnosed with the disease. Although they felt confused a bit they encouraged me by giving advice and they helped me to accept the problem positively. I was felt that everything is ended and my life is no more worse. I thought that everything is worthless and useless. My friends encouraged by giving me an example of people affected by the problem and who are living healthy with care and health life practice. They pray for me and told me to continue to pray which helped me in enjoying the rest of my life with happiness. I am really blessed to have such lovely friends."

D. Physical and informational support from health professionals

The other type of support reported by the participants was physical and information support by health professionals. The participants reported that different type of professionals including physicians, nurses, other type of care workers were involved in delivering, supporting and helping

the affected people at health facility. This is very important for those who have a problem in obtaining care because of lack of someone closer to them. A 42 years' woman reported that:

"There are several health professionals who are helping the sick people. Most of them are compassionate and respecting the patient although few are not. To tell you my experience in this regard I had got illness some three months back and I was admitted in a hospital. I have got a nice doctor and nurses there. If I suggest anything or if he suggests something, it's usually very effective and every time I see him he's very attentive. He was curiously following my condition and gave me necessary information on my condition. The nurses were also responsive for their work. Every time they come to my bed room and gave me medication on time. Other than medication they were supporting me emotionally and gave me necessary information regarding my illness."

E. Social support from religious leaders and local organization

In-depth interview participants reported that there are local organizations either faith based or not which deliver social support for the local community. Some of those organizations are involved in delivering spiritual and emotional support for their members. Some other was involved in delivering financial service for the needy in addition to their primary goal. A 43 years old man who is Muslim in religion stated that:

"Religious fathers are very helpful for people in delivering overall rounded support, they usually go to someone's home for caring prayer and other religious rituals for the sick. The advice and emotional support they provide gives hope and a feeling of worthy for the individual. The 'dua' they make is a mercy for the individual and install hope during encounter of serious health related problem."

5.   CONCLUSION AND RECOMMENDATION

5.1 Conclusion

Based on the findings of the study the following conclusions are made:

The study provided current examples of the type and source of social support households get in times illness grounded in a specific context of urban area of Jimma City. The data indicate that household heads in the study area perceive the receipt of four distinct types of social supports. Although the sources varied by type of support provided, the role of household members and number of close friend was prominent in all the narratives.

The types of support were discussed in terms of the helping activities they comprised. This finding revealed that emotional, Informational/advices, instrumental type of support were sometimes available to households in times of illness and when they were confined to bed. However, an emotional and informational type of social support were the most acknowledged type of support among the participants and appears to be more forthcoming in households in times of illness in the study area.

In relation to household members who has been sick in the last 2 years, all (100.0%) of the household heads in each kebele (category) said "yes". This implies that most of the household members in the study area were not free of health problems in the last 2 years. Therefore, the results indicated that all household members in the study area need health related social support in times of illness. Certain relationships were of particular importance and include the most frequently (overall)-mentioned sources—relatives, neighbors, and friends. The results show that the majority of respondents, 100.0% of household heads revealed that relatives were the first source of social support in the study area.

The types of social support available to the households were financial, material, informational and/or advice and love and care. Therefore, informational/advice (100.0%), love and care (85.9%) material (55.4%) and financial (19.6%) were the types of social support households get in times of illness in order of their importance. The study further showed that the types of financial sources that households used in the study area were personal payment and borrowing from somebody (80.0%) and traditional medicine (26.7%) to cover the health cost.

The relationship between social support and health related outcomes is incredibly complex, with the various components of social support linked to health outcomes through a range of behavioral and psychological pathway and various integrated biological mechanisms. This study is now looking to determine how households conceive social support and its health-related outcomes. Therefore, 91.4%, 82.1% and 81.7% of household respondents' from Hermata, Bore and Ifa Bula kebeles respectively were conceive and evaluate the contribution of social support they had got for their health outcome as high contribution for health-related outcomes.

5.2 Recommendations

Based on the analysis and major findings the following recommendations were forwarded.

The four most frequently-mentioned types included: emotional, informational/advices, appraisal type of support, as well as the instrumental/provision of resources and material goods. Sources varied by type of support and most frequently included and most frequently (overall)-mentioned sources are relatives, neighbors, and friends. Examples depicting the content of each type of support and culturally-specific issues that can inform community-based social support interventions training should be provided to all households by stakeholders to improve health related outcomes of the study area.

Health care scholars have agreed that health is a multidimensional construct with different types or kinds of functions. The role-function of health is defined as performance of social roles with maximum expected output, whose negative consequence leads to clinical causes that need further diagnosis and medication. Therefore, the area health office cannot solve alone the health problems of the household residents of the district due to its huge resource requirement. Therefore, the area health office needs to involve other partners from the private sector and other donor agencies in the improvement of the health related outcomes and health conditions of the community.

Health workers need to be encouraged continue community mobilization through group discussions about the need for the supportive role of family, friends, neighbors, and other members of the community in times of illness. Replication of this approach deserves further consideration.

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Appendix

Jimma University College of Social Sciences and Humanities
Department of Sociology and social work

Introduction

The objective of this discussion is to collect data from community representatives. Since you are part of the community, the researcher recognizes that your answer is most relevant to the purpose of this study.

Dear respondent, I am going to ask you about your relationship with other people. Please tell me how much each statement describes your situation. The information obtained will only be used for this academic purpose. Thank you in advance for your cooperation.

Section I. Background Information:

1. Age _____

2. Sex _____

3. Religion _____

4. Educational level _____

5. Marital status _____

6. Employment status _____

7. Monthly income _____

8. About how many close friends and close relatives do you have (a person you feel at ease with and can talk to about what is on your mind)? Write in number of close friends _____ and close relatives: _____

Section II - Social Support Survey Instrument

Next are some questions about the support that is available to you.

People sometimes look to others for companionship, assistance, or other types of support. How often is each of the following kinds of support available to YOU if you need it?

		None of the Time	A Little of the time	Some of the time	Most of the Time	All of the Time
1	Someone to help you if you were confined to bed	1	2	3	4	5
2	Someone you can count on to listen to you when you need to talk	1	2	3	4	5
3	Someone to give you good advice about a crisis	1	2	3	4	5
4	Someone to take you to the doctor if you needed it	1	2	3	4	5
5	Someone who shows you love and affection	1	2	3	4	5
6	Someone to have a good time with	1	2	3	4	5
7	Someone to give you information to help you understand a situation	1	2	3	4	5
8	Someone to confide in or talk to about yourself or your problems	1	2	3	4	5
9	Someone who hugs you	1	2	3	4	5
10	Someone to get together with for relaxation	1	2	3	4	5
11	Someone to prepare your meals if you were unable to do it yourself	1	2	3	4	5
12	Someone whose advice you really want	1	2	3	4	5
13	Someone to do things with to help you get your mind off things	1	2	3	4	5

14	Someone to help with daily chores if you were sick	1	2	3	4	5
15	Someone to share your most private worries and fears with	1	2	3	4	5
16	Someone to turn to for suggestions about how to deal with a personal problem	1	2	3	4	5
17	Someone to do something enjoyable with	1	2	3	4	5
18	Someone who understands your problems	1	2	3	4	5
19	Someone to love and make you feel wanted	1	2	3	4	5

Section III. Social support questioner

1. Is there someone who has been sick in the last 2 years in your household?

   1) Yes   2) No

2. If your response to Qn #1 is "Yes", have you got any type of support to get treatment?

   1) Yes   2) No

3. If your response to Qn #2 is "Yes", what type of support have you got?

   1) Financial   2) material   3) Informational/Advice   4) Love and Care

4. If your response to Qn. #2 is "No", how did you cover the health cost?

   1. Personal payment   2) Borrowing from some body   3) Traditional medicine

       4) Stay at home

   5) Others (specify) _____

5. If your response to Qn #2 is "Yes", from where have you got the support?

   1) From relatives   2) from neighbors   3) from friends   4) Health institutions

   5) others (specify) _____

6. On whom are you commonly depending in times of illness?

   1) From relatives   2) from neighbors   3) from friends   4) Health institutions

   5) others (specify) _____

7. How do you evaluate the contribution of the support you have got for your health outcome?

   1) High   2) Moderate   3) Low   4) None

8. Do you think social support has significant contribution for the household's health status"?

   1) Yes   2) No

9. Who can you really count on to help you feel more relaxed when you are under pressure in times of illness?

   1) Relatives   2) Neighbors   3) Friends   4) Other (specify)

10. Is availability of social support preventing from fear of future health cost needs?

   1) Yes   2) No

11. If your response to Qn. #10 is yes, how?

Annex IV: In-depth interview questions

1. What types of social support is available or delivered for the community? (Probe: financial and non-financial support)

   _____

2. What are the major sources of social support for the community given in relation to maintaining health and wellbeing and when this support is delivered? (Probe: local community, social organizations, NGOs, when service is given)

   _____

3. How do you perceive the importance of social support for the wellbeing of the society? (Probe: in maintaining social cohesion, preventing illness, improving health and maintaining livelihood)

   _____

4. How do you evaluate the importance of social support in relation with health outcomes (Probe: in improving disease condition, in bringing emotional wellbeing and preventing stress)

   _____