
The Psychosocial Effects Of People Living With HIV/AIDS At The Niger Delta University Teaching Hospital Okolobiri, Bayelsa State Nigeria

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ABSTRACT: *The psychosocial effects of the people living with HIV/AIDS have been acknowledged in sociological literature with few or little empirical study to justify its consequences on the affected people in contrast to its biomedical effects. This paper acknowledges that the biomedical consequences of people living with HIV/AIDS (PLWHA) is still essential, but focuses more on the psychosocial effects of PLWHA that aggravate their health conditions. Engel's biopsychosocial model was utilized as analytical framework and a descriptive research design for the study. One hundred and fifty (N=150) respondents participated in the study in a chain-referral technique at the Niger Delta University Teaching Hospital, Okolobiri Bayelsa State using a structured questionnaire as instrument of data collection. Frequency and percentage distribution tables were used to present and analyzed the quantitative data collected for the study using SPSS version 17.0. Findings showed that there were psychosocial effects that aggravate the conditions of PLWHA ranging from depression and perhaps self-destruction arisen from stigmatization, discrimination, denial, loss of relationships and social disarticulation among others. The paper concluded that though the biological determinants of the transmission of the disease need to be emphasized and discouraged among people of the society through campaign and sensitization across board, but more emphasis and attention should be laid on efforts to embrace those already affected with HIV/AIDS by eradicating all forms of stigmatization, discrimination, deprivation through love and supports for them rather than disarticulating them from the members of the society.*

KEYWORDS: HIV/AIDS, stigmatization, loneliness, loss of relationships, social disarticulation and supports

INTRODUCTION

The spread of HIV/AIDS epidemics has increased significantly in Nigeria since the official report of its first case in 1986. Indeed, the results of periodic national surveys among ante-natal clinic attendees showed a progressive increase in the HIV Sero-prevalence rate from 1.8% in 1991; 4.5% in 1996 to 5.8% in 2001 before declining to 5.0% in 2003, and 4.4% in 2005 respectively. Also, according to the 2008 National HIV Sero-prevalence, Nigeria has an HIV prevalence of 4.6%. All the 36 states and the Federal Capital Territory (FCT) have HIV prevalence above 1% with 17 states having HIV prevalence greater than 5%. This translates to about 2.9% people (1.2 million men and 1.73 million women) living with the virus in the country with a number of new cases put at 323,000 adults and 57,000 children. In fact, the infection rates among young people aged 15-19 put at 3.3%; 20-24 at 4.6% and

25-29 years at 5.6% are considered very high. As such, it has been a major key national strategy to direct focus on national HIV prevention efforts in order to address this trend (FMOH, 2010).

Explaining what the acronym AIDS means, Van Dyk (2001) stated that it is referred to as Acquired Immune Deficiency Syndrome, which is caused by a virus called Human Immunodeficiency Virus (HIV) that enters the body from outside. As such and from its biological effects, it is a virus that weakens the body's immune system. In a further explanation, Shernoff *et al* (1998) maintains that HIV/AIDs is spread through three (3) main mode of transmission, namely; (1) Through unprotected sex; (2) Through unscreened blood of the person affected with HIV/AIDs and; (3) Through affected mother to the unborn child. Also, in the course of the illness, there are four phases that features, namely; (1) Primary infection phase; (2) The HIV asymptomatic phase; (3) The HIV symptomatic phase and; (4) The AIDs phase. However, the most vulnerable groups of this infectious disease are women between age 15-30 years, sexually active men with more than one partner, migrants and mine workers, transport workers, commercial sex workers and drug users who share the same needles with affected persons.

According to Bernstein and Van Rooyen (1994), the impact of AIDS within the society is and will continue to be more than merely medical in nature, and that HIV/AIDs are a medical disease is a well-known fact. Despite this, its profound physiological and sociological effects are less acknowledged. Therefore, the profession of sociology generally accept AIDS as a disease with more than mere medical implications (Bernstein and Van Rooyen, 1994).

Again, HIV and AIDS have extended beyond the commonly classified high-risk groups and are now in the general population. According to Federal Ministry of Health (2010), in Nigeria, HIV infection cuts across both sexes and all age groups. The number of HIV positive children is increasing, with mother-to-child transmission as the principal route of infection. The number of the children orphaned by AIDs has increased substantially to an estimated 1.2 million (UNAIDS, 2010; FMOH, 2010). By all indications, HIV and AIDs epidemic has continued to grow largely through heterosexual unprotected sexual relationships, mother-to-child transmission and contaminated blood and blood products. Among the high-risk groups, however, the findings from the 2010 Integrated Biological and Behavioral Surveillance Survey (IBBSS) showed that the most affected group is the Female Sex Workers (FSW) with HIV prevalence of 27.4% for those brothel-based, and 21.1% for non-brothel based; followed by the Men having Sex with Men (MSM) and Injecting Drug Users (IDU) groups with prevalence of 17.2% and 4.2% respectively; while the least affected group is the Transport Workers with HIV prevalence of 2.4% (FGN, 2009; FMOH, 2010).

In specific terms, though Bayelsa State is one of the newest states in Nigeria endowed with rich natural resources with a number of investors, but Bayelsa State remains one of the three topmost states in HIV prevalence in Nigeria with 4.0% prevalence in 2003 before it fell down to 3.8% in 2005 which later rose to 7.2% in 2008. In fact, according to FMOH (2010) because of the high prevalence rate of HIV in Bayelsa State, the state has been rated as the third in HIV prevalence with 9.1% prevalence rate.

However, among other devastating consequences of the prevalence of HIV/AIDs in the state is the psychosocial effect and influences on the victims and their families. These range from stress, denial, low self-esteem, anxiety, depression, stigma, discrimination and trauma which

have been neglected in biomedical and treatment studies involving people with HIV/AIDS. Yet, recent studies have shown that there are significant psychosocial implications of HIV/AIDS pandemic on individuals affected with the diseases ranging from chronic depression and trauma (UNAIDS, 2010). According to UNAIDS (2010), those infected with the disease with its effects of chronic depression and trauma (psychosocial effects) are about twice as likely to die. This is because HIV as an illness affects the person first and foremost at biological level in the form of aggressive virus that compromises immunity, thereafter associated with a profound and authentic psychological engagement of patients themselves and the significant people in their lives

Besides these, HIV infected individuals live in a cultural and social environment as well as political conditions of the State in which they live directly affects their lives. This must have made Psychologists to draw a line between the viral sub-types of HIV and the psychological response of these persons to the disease. For example patience with personality disorder is at higher risk of HIV than others. These mentally ill patients have been found to be involved in HIV risks behaviours and the virus further complicates their ill mental issues (Greene and Serovich, 1998).

Following the psychosocial effects earlier documented by scholars, Busza (1999) stated that HIV/AIDS infected individuals have been rejected by their families, loved ones; as well as their communities. In addition, Ali, Khanani and Menno (1999) adding to this view observed that people tend to display or show negative attitudes in terms of discrimination and denial towards people infected with the disease due to the level of knowledge and awareness they have concerning the disease and the fears of contracting the disease. This affects the psychology of the carriers of this deadly disease and may aggravate the severity of the illness due to the social and psychological effects surrounding such individuals.

Nevertheless, much attention have been made to focus on the biological effects of the disease overtime with less attention been made to focus on the likely effects of the disease across the globe with different agencies to reduce the risks of its biological effects such as National Agency for the Control of Aids (NACA) as well as State Agency for the Control of Aids (SACA), yet considerable attention have not been made to focus on the psychosocial effects of the disease especially in Bayelsa State where the cases of HIV/AIDS prevalence has been reported to be the third position among states in Nigeria (HIV-Counselling and Testing Centre, 2009). This paper however, is made to document the psychosocial effects of people living with HIV/AIDS at the Niger Delta University Teaching Hospital, Bayelsa State through an investigative and empirically analytical form.

Statement of the Problem

All over the world, about three (3) million people died of AIDS related disease and more than 40 million are living with HIV. The disease is identified as a social problem in Nigeria and other parts of the world; again, since its discovery in Nigeria, the disease has eaten deep into the fabrics of our society. Each day about 140,000 people of age 15-24 are infected which include women and young people who term to be more vulnerable and this has claimed many lives, made many children orphans and broken marriage (Ogunjuyigbe *et al.*, 2009). As the burden of the disease increases within communities, individuals living with HIV/AIDS are stigmatized, discriminated, shunned and even experienced sanction and harassment and possibly evidence, because of their infection or association with those living with the disease (Nwanna, 2005).

In Bayelsa State where the prevalence rate has been put at 9.1% (3rd position among all the states in the federation) (FMOH, 2010); the psychosocial effects of the dreaded HIV/AIDS on infected individuals cannot be down played. It has created problems of broken marriages, and made many children orphans because their parents are lost to the deadly disease due to the fact that they suffer more of depression and social disarticulation resulting from discrimination, shock, social denial, emotional trauma and stigmatization. As a matter of fact, the biological consequences are less deadly than the psychosocial consequences because most of the HIV/AIDS victims seldomly commit suicide which is far more than its biological effects. Against this backdrop, many studies have been carried out to examine the effects of HIV/AIDS in different perspective but few have been made to focus on the psychosocial effects of disease especially in Bayelsa State where its prevalence has been reported to be third in Nigeria. This is a gap in sociological literature which this paper will fill and document in the most empirical and investigative manner.

The purpose of the study

1. To ascertain the major ways of contracting HIV/AIDS infection in Bayelsa State.
2. To examine people's perception about people living with HIV/AIDS in Bayelsa State.
3. To investigate the psychosocial effects of people living with HIV/AIDS in Bayelsa State.
4. To examine the coping strategies of people living with HIV/AIDSs in Bayelsa State.

Analytical Framework

The study adopted the theoretical model of biopsychosocial model (BPS). The biopsychosocial model was theorized by Psychiatrist George L. Engel in 1977 at the University of Rochester where he posited that there should be a need for a new theoretical model for medical explanation (Engel, 1977). In this, however, the theoretical model is of the view that both biological (which entails the genetics, blood group or hereditary); psychological (which entails emotions, thoughts, and behaviors); and social (which includes cultural, socio-economical, and socio-environmental) factors play a significant role in human functioning in the context of disease and illness. The model also posits that health conditions are best understood in terms of the combination of three components of the model, namely: biological, psychological and social factors other than purely in biological terms (Engel, 1980).

However, this theoretical model is in contrast with the biomedical model of medicine that suggests every disease process can be explained in terms of an underlying deviation from normal functioning of the body such as a virus, developmental abnormality, gene or injury that results to diseases (Engel, 1980); the model is a technical term for describing mind-body connection in providing explanation for the etiology of diseases and illness (McLaren, 2002).

In providing etiological explanation of diseases in general terms, the three components of the model are described by the proponent of the model. On the biological component of the model, it seeks to provide explanation on how the cause of a particular illness stems from the disequilibrium in the normal functioning of individual's body such as in genetic make-up, genotype or hereditary traits of such individual. The psychological component of the model looks out for the potential psychological causes for a health problem such as emotional

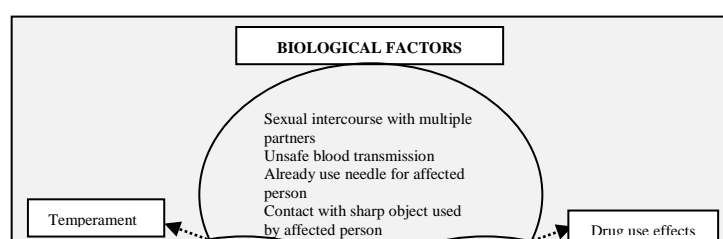
disorder, lack of self-control, and depressing thinking resulting from an illness, while the social component of the biopsychosocial model attempts to investigate how different social factors such as the prevailing cultural practices of the ill person, socioeconomic status, poverty, the prevailing technology, and religious practices that can influence or affect health conditions (Engel, 1977; 1980).

The biopsychosocial model of the HIV/AIDS condition here is seen not just about causation but about how its clinical condition be it biomedical or psychosocial can either be seen narrowly as just biological or more widely as a condition with both psychological and social components which will impinge on the carrier's understanding of the condition and invariably affect the clinical course of the condition. This also implies that the treatment of HIV/AIDS processes will require that the health care professionals address these three components of the model (biological, psychological and social factors) that impacts significantly upon patient's functioning in his/her environment.

As Halligan and Aylward (2006) noted in a philosophical sense of the model, the workings of the body has the capacity to affect the mind, and the workings of the mind in turn can affect the body. This suggests that there is both a direct interaction between the mind and the body as well as indirect effects through intermediate factors of HIV/AIDS as will illustrated in the conceptual framework in figure 1. This also means that it is important to handle the three components of the biopsychosocial model together largely due to patient perceptions of health and threat of the disease, as well as the barriers in a patient's social or cultural environment that appear to influence the likelihood that a patient will engage in health-promoting or treatment behaviours such as the taking of medication, proper nutritional intake or diet as well as engaging in other socio-physical activity in his/her environment without barriers (DiMatteo, Haskard and Williams, 2007).

This also means that the psychosocial factors can cause a biological effect by predisposing the patient to risk factors such as depression that may result to high blood pressure thereby causing damage to the heart which is now biological. In fact, the three components are interwoven, and more often than not the psychosocial effects of people living with HIV/AIDS for example may include outright taking away of ones' life due to the social conditions attached to the disease ranging from acute stigmatization, discrimination and social disarticulation or dejection.

Figure 1: The Conceptual Framework





MATERIAL AND METHODS

The study adopted descriptive survey design using people who have been diagnosed for HIV/AIDS at the Niger Delta University Teaching Hospital, Okoloibiri Bayelsa State. One hundred and fifty ($N=150$) respondents were selected in a chain-referral method (snow ball technique) in a period of one month during the period of testing, diagnosis, treatment and counselling of those who have been diagnosed positive of the disease with the aid of medical practitioners at the Hospital HIV/AIDS Unit. This method was motivated due to the nature and people's perception of the disease in the study area.

In an attempt to collect relevant data from the respondents, an instrument of structured questionnaire was utilized solely to gather quantitative data for the study. The structured questionnaire was designed and structured in such a way that it captured both objective and subjective questions of the subject matter. In addition to this, the quantitative data collected for the study was analyzed using statistical package for social sciences (SPSS Version 17.0) whereas data were presented utilizing frequency and percentage distribution tables. Finally, and due to the general perception of people as well as the people affected with the subject of investigation, all ethical considerations were strictly applied and abide by ranging from informed consent and voluntary participation of the respondents, anonymity, confidentiality as well as assurance of elimination of any form of harm arising from stigmatization and discrimination attached to the people affected with the health condition.

RESULTS AND DISCUSSION

The Socio-Demographic Characteristics of Respondents

Table 1 shows the socio-demographic characteristics of the respondents. On the gender of the respondents, it was revealed that 60% of the respondents were female while 40% were male. This indicates that there were more female HIV/AIDS victims than male as this agrees with Caldwell (1992) studies which asserted that more females than males are infected with HIV/AIDS. In terms of the age of the respondents, the table showed that a large percentage of the respondents (33.33%) between the ages of 26 and 30 years old were more infected with the virus compared to other categories of age group. Though earlier findings by the Federal Ministry of Health (2006) showed that in Nigeria, HIV infection cuts across both sexes and all age groups but seems to be prevalence among youthful age groups than the older population.

On the religious practices of the respondents, it was revealed that more than half percentage of the respondents (80.7%) were Christians compared to other religious affiliations. This suggests that majority of the respondents were dominated by Christianity as their religious affiliation. This could also be attributable to the fact that Christianity as religious affiliation dominated the area to which the study was carried out. In terms of the marital status of the respondents, a large number (46.7%) of the respondents signified single compared to those that indicated married (22.7%). This implies that singles (never-married or ever-married) were more infected with the virus than those that were married.

On the educational characteristics of the respondents, those with secondary school leaving certificates (41.3%) were more than those with tertiary educational qualification and other categories of educational qualification. This suggests that those with lower educational qualification are more vulnerable to the disease than those with higher educational qualification.

Table 1: Distribution of the respondents by socio-demographic characteristics (N=150)

Variables	Frequency	Percentage
Sex		
Male	60	40.0
Female	90	60.0
Age		
15-20	25	16.67
21-25	30	20.0
26-30	50	33.33
30-34	25	16.67
35 and Above	20	13.33
Religion		
Christianity	121	80.7
Africa Traditionalist	25	16.7
Islam	03	2.0
Others	01	1.0
Marital Status		
Single	70	46.7
Married	34	22.7
Divorced	21	14.0
Separated	25	16.7

Educational Qualification		
No formal education	16	10.7
Primary education	43	28.7
Secondary education	62	41.3
Tertiary education	29	19.3
Income Level on Average Per Month		
< 18, 000	32	21,3
18, 000-29, 999	26	17.3
30, 000-39, 999	43	28.7
40, 000-49, 999	21	14.0
50, 000 and Above	28	18.7

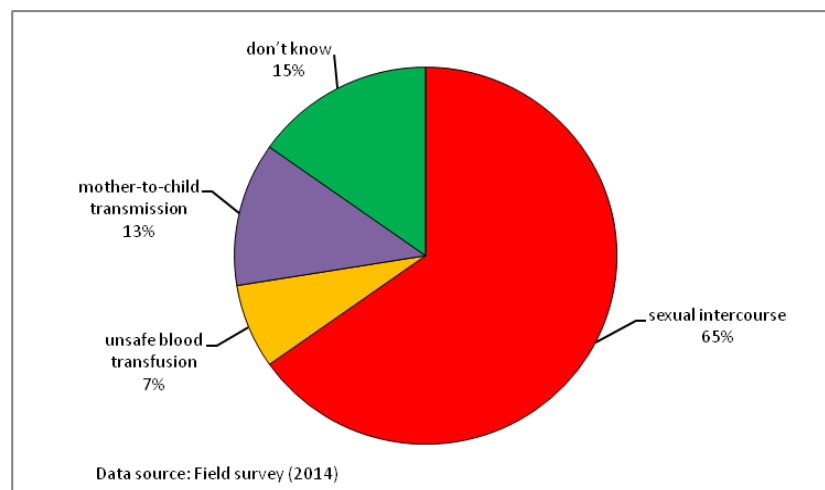
Data source: Field survey, 2014

On the average income of the respondents per month, the table revealed that a large percentage of the respondents (28.7%) earned between 30, 000 and 39, 999 naira as monthly income compared to those who earned less than that or even above. In sum however, those who earned above 18, 000 naira national minimum wage are much higher than those who earned less. Despite this, income level does not really determine the whether one is infected with HIV/AIDS infection or not. It only helps in the maintenance of health of individual infected with the diseases rather than facilitating its cure.

Major ways of contracting HIV/AIDS

Figure 2 reveals the results on the various ways through which HIV/AIDS are contracted by individual victims, it was shown that a large number of the respondents (60.0%) contracted the disease through sexual intercourse compared to other categories of people who indicated unsafe blood transfusion (6.7%), sharp objects (8.0%), mother-to-child transmission (11.3%), while other indicated don't know (14.0%).

Figure 2: Distribution of respondents by major ways of contracting HIV/AIDS (N=150)



This findings however, corroborates Shernoff *et al* (1998) who maintains that HIV/AIDs is spread through three (3) main mode of transmission, namely; (1) Through unprotected sex; (2) Through unscreened blood of the person affected with HIV/AIDs; (3) Through affected mother to the unborn child.

People's perception about people living with HIV/AIDS

Table 2 showed how people perceived those living with HIV/AIDS infection in the study area. Respondents were first asked how they are perceived by the members of the society, it was revealed that a large number of the respondents (52.7%) signified very negatively as well as negatively (45.3%) compared to those who indicated not very negatively. In a further investigation of the perception of people about the people living with HIV/AIDS, respondents were asked how often they were avoided by the people around them, about 53.3% of the respondents indicated that they were always avoided compared to those (40.0%) who said they were never avoided by the members of the society. Indeed, as indicated on the table, more than half of the percentage (50.0% and 21.3%) of the respondents still showed that they don't associate freely with significant people around them (such as family members and friends once they know that they were infected with the virus) as against only a few of them (28.7%) who signified that they associated freely with significant people around them. This suggests that majority of people living with HIV/AIDS are negatively perceived by the members of the society which has a lot of implications on their psychosocial effects.

Table 2: Distribution of respondents by people's perception about PLWHA

Variables	Number (N=150)	Percentage %
How PLWHA are perceived		
Negatively	68	45.3
Not negatively	-	-
Very negatively	79	52.7
Not very negatively	3	2.0
Avoidance based on negative perception of PLWHA		
Always	80	53.3
Sometimes	10	6.67
Never	60	40.0
Association of PLWHA with significant others		
Freely	43	28.7
Not freely	75	50
Not freely	-	-
Somehow freely	32	21.3
Not freely at all		

*Data source: Field survey, 2014 * PLWHA means people living with HIV/AIDS*

Psychosocial effects of people living with HIV/AIDS

Table 3 shows the psychosocial responses to HIV/AIDS positivity among the respondents. Respondents were first asked how they felt when tested positive with HIV/AIDS, it was revealed that a large percentage of the respondents (40.0%) were anxious and feared that they would die of the HIV infection as well as 26.8% of them who were depressed immediately after tested positive of the infection. Also in the table, 13.33% of them indicated that they cried and felt they would be denied by people around them, 16.7% of them felt hopeless, while only 3.3% of them felt guilty that they were tested positive. Based on these results, respondents were further asked whether they disclosed their being tested positive with friends or people around them, a good number of them (53.3%) said yes while 40.0% of them indicated no.

However, for those that have signified yes as to the disclosure of their HIV/AIDS status; the effects of their disclosure were ascertained. It was therefore revealed that large population of the respondents (34.0%) said they were stigmatized, while others indicated that they lost relationships with friends and family members (7.3%), loss of self-identity and respect (5.3%) and dejection (6.3%). These findings were found in line with the earlier studies of Busza (1999) that individuals infected with HIV/AIDS have been rejected by their families, loved ones; as well as their communities. In fact, as and Ali, Khani and Menno (1999) earlier finding stated, people tend to display or show negative attitudes towards individual infected with HIV/AIDS in terms of discrimination and denial due to the level of knowledge and awareness they have concerning the disease and the fears of contracting the disease through body contact.

Table 3: Distribution of respondents by the psychosocial effects of people living with HIV/AIDS

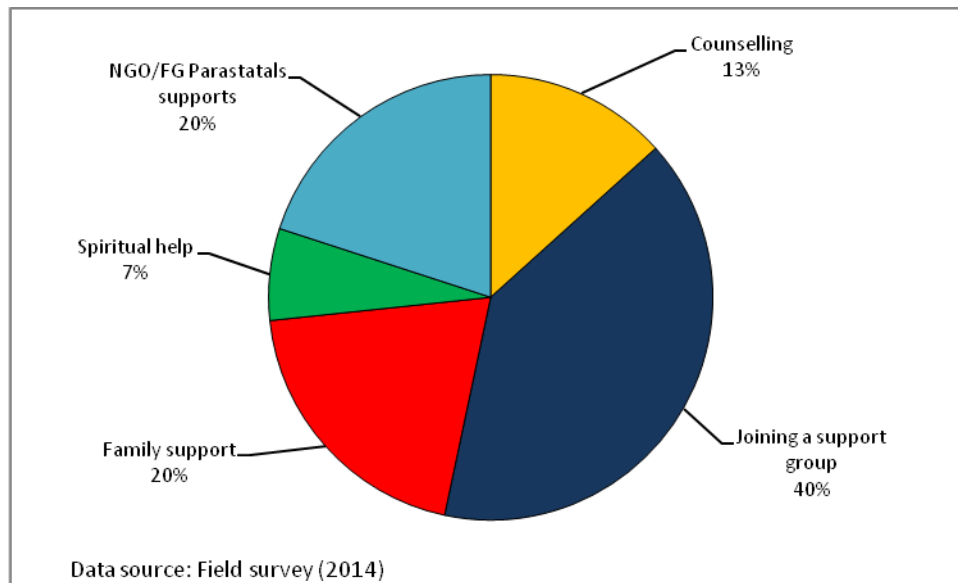
Variables	Frequency (N=150)	Percentage (%)
Feelings when tested positive with HIV/AIDs		
Cried/Denial	20	13.3
Depression	40	26.7
Guilty	5	3.3
Hopeless	25	16.7
Fear Of Death/Anxiety	60	40.0
Disclosure of HIV/AIDS Status		
Yes	80	53.3
No	60	40
Sometimes	10	6.7
Effects of disclosure		
Stigmatization	51	34.0
Loss of relationships with others	11	7.3
Loss of self-identity/respect	08	5.3
Dejection (social disarticulation)	10	6.7

Data source: Field survey, 2014

Coping strategies of the people living with HIV/AIDS

Figure 3 revealed the coping strategies of people living with HIV/AIDS. As indicated in the figure, 13% of the respondents cope with the dreaded disease through counselling from medical practitioners and priests, 40% of them signified that they cope by joining support groups, 20% of them indicated that they cope through family supports, 7% of them said through spiritual assistance (prayers and preaching), while 20% of them said they cope through NGO/FG parastatals supports in terms of free medical assistance or subsidized preventive drugs supplies. This means that people affected with HIV/AIDS could still be managed through various dimensions of coping strategies which would in turn reduce the impact of the psychosocial effects of PLWHA that aggravate their pains more than its biological effects.

Figure 3: Distribution of the respondents by their coping strategies after tested positive of HIV/AIDS (N=150)



CONCLUSION AND RECOMMENDATIONS

It is obvious from this study that there are psychosocial effects suffer by those infected with HIV/AIDS ranging from stigmatization, discrimination, social exclusion or disarticulation, denial by friends, family members due to the fear of contracting the disease through body contact which may not necessarily be true as proven medically. These have been made to be more worrisome than its biological effects. This 'pushes' HIV/AIDS victims to be affected with depression (psychological effects) which may of course lead to biological dysfunction of their body systems that aggravates the situation of their health condition.

In view of the findings of the study, though efforts need to be put in place by individuals in the society to prevent the transmission of the disease through the various ways the disease is contracted such as having unprotected sexual intercourse with multiple partners, unscreened blood transfusion, sharing of sharp objects with infected individual with HIV/AIDS especially by preventing the biological causes of HIV/AIDS such as abstinence from sexual activities with multiple partners or use condoms when having sex; screening of blood before transfusion; and avoidance of sharing of sharp objects with partners or friends, those already affected with the virus need to be cared for without stigmatization, discrimination or deprivation since earlier studies have revealed that it cannot be contracted through social interaction.

Therefore, the stigmatization of those affected can be minimized through campaigning, so that people can continue to live a life, which is productive and full-valued. For a wider outreach of actions, programs cannot be restricted to massive information diffusion but the psycho-educational strategies need to be applied on a small number of target groups. There is the need, not only to increase the medical knowledge but also to enhance the awareness about HIV/AIDs in general. Culture, values, traditional norms and taboos are lost as a consequence of too many HIV/AIDs deaths. The support groups seem to be a very positive way in supporting people how to cope with the situation. The services provided to the families are needed very much and also the wider family should be well-informed and educated in order to provide basic emotional and psycho-social support. Education and support is the most

effective tool that helps people living with HIV/AIDs to live a psychologically well-balanced life. Proper support will also help people with HIV/AIDs to move through the appropriate stages and to reach the acceptance of their status and to cope with all the psycho-social issues in their lives. HIV positive people can use the educational activities to learn to be in charge of their own medical care, and how to protect themselves as well as those around them. They can also disseminate this education to others and help to reduce the stigma within their communities. Through the many changes and challenges, the support of family, friends, communities, and health care professionals which are essential to overall well-being.

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