ASSESSMENT OF PSYCHO-SOCIAL AND ECONOMIC ADAPTATION AMONG PEOPLE LIVING WITH HIV/AIDS IN KADUNA STATE NIGERIA

BY

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DECLARATION

I declare that the work in thisthesisentitled "**Assessment of Psycho-Social and Economic Adaptation Among People Living with HIV/AIDS in Kaduna State, Nigeria"** has been carried out by AlhajiAbdullahi Umar in the Department of Physical and Health Education. The information derived from literature has been duly acknowledged in the text and a list of reference provide. No part of this dissertation was previously presented for another degree or diploma at this or any other institution.

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CERTIFICATION

This thesisentitle "**ASSESSMENT OF PSYCHO-SOCIAL AND ECONOMIC ADAPTATION AMONG PEOPLE LIVING WITH HIV/AIDS IN KADUNA STATE, Nigeria** by AlhajiAbdullahi UMAR meets the regulation governing the award of masters of Health Education of Ahmadu Bello University, Zaria and is approved for its contributions to knowledge and literacy presentation.

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DEDICATION

This research is dedicated to my caring mother; H.R Abdullahi; my obedient children M.T Abdullahi K. U Abdullahi, R. Abdullahi, A. Abdullahi and my beloved wife F. Jibirin.

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ABSTRACT

The purpose of the study wasto assess psycho-social and economic adaptation among people living with HIV/AIDS(PLWHA) in Kaduna State. The research design that was used for this study was an ex-post facto research design. The population for this study was 268,903. A stratified random sampling procedure was used to divide Kaduna State into three (3) existing senatorial districts (3 Strata). Random sampling procedure was used to sample2/3 of the Local Government Areas (LGAs), 5 LGAs from each senatorial district (stratum). Purposive sampling procedure was used to select a Health Care Facility (HCF)from each selected Local Government Area (LGA). A total of 384 copiesof the questionnaire were purposively administered and retrieved from the respondents. Proportionate sampling procedure was used in sampling the respondent, the sample size for Kaduna North was 116 respondents, while for Kaduna Central was 173respondents and for South Senatorial Districts was 95 respondents. Frequency countsand percentages were used to describe demographic characteristics of the respondents. Mean and Standard Deviation wereusedtoanswer the research questions.Inferential statistics of one sample t-test was used to test Hypotheses 1-3, while inferential statistics of two sample t- tests was used to test Hypotheses 4-6.The findings of the study revealed that psychological adaptation was significant (P= 0.00) among people living with HIV/AIDS in Kaduna State, sociological adaptation was significant (P=0.00) among people living with HIV/AIDS in Kaduna State. While male and female living with HIV/AIDS do not significantly differ (P=0.105) and (tcal= 0.943) in their economic adaptation in Kaduna State.On the basis of the findings of the study the following conclusion were drawn: that people living with HIV/AIDS adapted to both their psychological and sociological conditions in Kaduna State, male and female living with HIV/AIDS do not differ in their economic adaptation and gender difference in Kaduna State. The following recommendations were made;PLWHA adapt to their psychological variablessuch as emotional distress (anger, anxiety, depression) and sociological variables such as trust, acceptance, disclosure, interaction among others, therefore HIV/AIDS counselingby health care providers, counselors and psychologistsshould be sustained and there is need for civil society organizations (CBOs) to come to the door step of PLWHIV/AIDS to organize them to form a support groups, so as to ensure their involvement in planning and development of behavioural change activity relating to stigma and discrimination, as this wouldimproved their life. Male and Female living with HIV/AIDS do not differ in their economic adaptation. Therefore, there is the need for government to strengthen the policy environment that empower cPLWHA support group in order to close the gap in access to treatment and social support to infected male and female living with HIV/AIDS in Kaduna State.

LIST OF ABBREVIATIONS

ABC	– Abstinence Be Faithful Condom use
AIDS	- Acquired Immune Deficiency Syndrome
ANC	- Antenatal Care
ART	- Antiretroviral Therapy
ARV	- Antiretroviral
BBFSW	- Brothel and non Brothel Female Sex Workers.
FMOH	- Federal Ministry of Health
FSW	- Female Sex Works
HAART	- Highly Active Antiretroviral therapy
H C F	- Health Care Facility
HIV	- Human Immunodeficiency Virus
IDU	- Intravenous Drugs Users
KADSACA	- Kaduna State Agency for the control of AIDS
MSM	-Male Sex with Male
NEWPLWHA	- Network of People Living With HIV/AIDS
PABA	- People Affected by HIV/AIDS
PLWHA	- People Living With HIV/AIDS
SDS	- Social Determinant of Stigma

SMT	- Stigma Mental Illness
STD	- Sexually Transmitted Disease
STI	- Sexually Transmitted Infection

OPERATIONAL DEFINITION OF TERMS

- **Adaption**; Is the adjustment of people living with HIV/AIDS to improve psychological, cultural, sociological or economical challenge.
- **Economic adaptation:** Refers to financial aids, social support, assessing to household with People Living with HIV/AIDS and medical service to infected person.
- **Psychological adaptation:** Adjustment from negative behavior such as anger, anxiety, depression and moodiness of people living with HIV/AIDS to positive
- **Psychosocial**: Is the psychological and social aspect of management of people living with HIV/AIDS
- **Sociologicaladaptation**: The adjustment to the demands, restrictions and morals of Society where people living with HIV/AIDS will live in harmony. Social adaptation sees us having satisfying social interactions and relationships.
- **Socialsupport**: Is the assistance, care for people living with HIV/AIDS mostly supportive social network, which can be emotional, tangible or compassion.
- **Stigma and discrimination**: This is the prejudice negative attitude, abuse and maltreatment directed at people living with HIV/AIDS

TABLE OF CONTENT

CHAPTER ONE		**Page(s)**
1.1	Introduction.	1
1.1	Background of the study	1
1.2	Statement of Problem	5
1.3	Purpose of the Study	6
1.4	Research Questions	7
1.5	Hypotheses	8
1.5.1	Major Hypothesis	8
1.5.2	Sub-Hypothesis	8
1.6	Basic Assumptions	9
1.7	Significance of the study	9
1.7.1	Delimitation of the Study	11
CHAPTER TWO		
2.0	Review of Related Literature	12
2.1	Introduction	12
2.2	Concept of HIV/AIDS	12
2.2.1	Mode of Transmission of HIV/AIDS	13
2.2.2	Treatment of HIV/AIDS	14
2.2.3	Symptoms	17
2.3	Conceptual framework	18
2.4	Empirical Review	19
2.4.1	Psychological Impact of HIV/AIDS	20
2.41.1	Self Stigma Among People Living With HIV/AIDS (PLWHA)	21
2..4.2	Sociological Impact of HIV/AIDS	21
2.4.2.1	Culture, sexual Religious and Legal Issues and poverty of PLWHA	22

2.4.2.2Proper Counseling and Social Support for People Living With HIV/AIDS 23

2.4.2.3 Prevention 25

2.4.4Economical Impact of HIV/AIDS 27

2.5Psychological Adaptation of adaption people living with HIV/AIDS 28

2.5.1 Removing Stigma and Resistance to Change 29

2.6. Sociological Adaptation of adaption people living with HIV/AIDS 30

2.6.1 Silent among PLWHIV/AIDS 31

2.7 Economic Adaptation of people living with HIV/AIDS 31

2.7.1 Family Socio – Economic Statues as a Determinant of Economic Adaptation 32

2.7.2 Nutrition and HIV/AIDS 32

2.8 Psychological Adaptation and Gender Deference among people living with HIV/AIDS 31

2.9 Sociological Adaptation and Gender Deference among people living withHIV/AIDS 36

2.9.1 Feature of Culture and Sexuality in HIV/AIDS era 37

2.10 Economic Adaptation and Gender Deference among people living withHIV/AIDS 41

2.11 The Care for people living with HIV/AIDS 42

2.11.1 Health Education and Promotion 44

2.11.2 Right of People Living With HIV/AIDS (PLWHA) 45

2.11.3 General Recommendation for Taking Care of Your Self 48

2.11.4 Trend in Management 49

2.12 Implication to Public Heath 50

2.12.1 Loss to Man Power and Economic Growth 51

2.13 Psychosocial support for people living with HIV/AIDS 51

2.13.1 Physiological and Psychological Effects of Exercise Intervention in HIV Disease 53

2.14 Summary 54

CHAPTER THREE 58

3.0 Methodology 58

3.2 Research Design 58

3.3 Population of the Study 58

3.4 Sample and Sampling Procedure 58

3.5 Instrumentation 62

3.6 Validity of Instrument 63

3.7 Procedure for Data Collection 63

3.8 Procedure for Data Analysis 64

CHAPTER FOUR 65

4.1 Introduction 65

4.2 Result 66

4.3 Discussion 74

CHAPTER FIVE 75

5.1 Summary 78

5.1.2 Summary of Major Findings 78

5.2 Conclusion 79

5.3 Recommendation 79

REFERENCES 81

LIST OF TABLE

Table 3.1	Summary of sampled Local Government Areas (LGAs) and Health Care Facilities (HCF) From the Three Senatorial District of Kaduna State	62
Table 4.1	Demographic Characteristics of the Respondents	66
Table 4.2	Mean Score and Standard Deviation of Responses of People Living With HIV/AIDSon Psychological Adaptation	68
Table 4.3	Mean Score and Standard Deviation of Responses of People Living With HIV/AIDS on Sociological Adaptation	69
Table 4.4	Mean Score and Standard Deviation of Responses of People Living With HIV/AIDS on Economical Adaptation	70
Table 4.5	Summary of one Sample t-test Analysis on Psychological Adaptation of PeopleLiving With HIV/AIDS	70
Table 4.6	Summary of one Sample t-test Analysis on Sociological Adaptation of People Living With HIV/AIDS	71
Table 4.7	Summary of one Sample t-test Analysis on economical Adaptation of People Living With HIV/AIDS	71
Table 4.8	Summary of two Sample t- test Analysis on psychological Adaptation Between Male and Female Living With HIV/AIDS	72
Table 4.9	Summary of two sample t-test Analysis on Sociological Adaptation Between Male and Female Living With HIV/AIDS	72
Table 4.10	Summary of two Sample t-test Analysis on Economical Adaptation BetweenMale and Females Living With HIV/AIDS	73

CHAPTER ONE

INTRODUCTION

Background of the study

Globally, the pandemic of human immunodeficiency virus (HIV) and acquired immune deficiency syndrome (AIDS) has continued to pose serious health and socio – economic challenges. (Afolabi, Afolabi, Odewale&Olowookers, 2013).There were 23 million new HIV infection globally, showing a (33%) decline in the number of new infections from 3.4 million in 2001. HIV/AIDS in Africa was one of the most important global public health issues of our time, and perhaps, in the history of mankind. In Africa, AIDS was one of the top causes of death.While only comprising slightly fewer than (15%) of the total population of the world, Africans account for nearly (70%) of those who live with HIV and were dying of AIDS (AIDS in Africa, 2014). However, Southern Africa exhibits pandemic-level HIV infection rates, with extreme levels in the countries of Botswana, Lesotho, South Africa, Namibia, Zimbabwe, Swaziland, and Zambia. By contrast, some countries in North Africa have HIV prevalence rates lower than most cities in the United State of America. Countries in Western Africa include Senegal, the Gambia, Cape Verde, Guinea-Bissau, Guinea, Sierra Leone, Liberia, Côte d'Ivoire, Ghana, Togo, Benin, Cameroon, Nigeria, and the landlocked states of Mali, Burkina Faso and Niger (AIDS in Africa,2014).

Similarly, United Nation (2015) reported that, Nigeriawas the second highest HIV/AIDS burden in the world with 3.4 million living with the virus in 2014. The figure represents (4.1%) national prevalence rates as found from the United Nation Programmeon AIDS(UNAIDS).According to United Nation Programme on AIDS (2016), at November 2015 in every region of the world there were three or four countries that were devastated with the epidemic. For example in sub-Saharan Africa just three countries – Nigeria, South Africa and Uganda account for 48% of all new HIV infections. World Health organization (2016), documented that 37 million people were living with HIV in 2016 globally. However,HIV

prevalence by United Nation Programmed on AIDS (UNIADS) in Nigeria was3.2% among the adult population, giving a total of 3.4 million Nigerians living with HIV **(**Nigerian Health Watch, 2016).In Nigeria, Kaduna state rank among the worst hit by HIV/AIDS with approximately 400,000 people living with the virus (Adeoti& Dung, 2012).Kaduna State has a prevalence of 9.2% and only 24% of children has access to antiretroviral drugs (Abubakar, 2015).

Peter, kamath, Adrews, and Monappa, (2014), found that HIV infection has been viewed as chronic disease which was manageable with lifelong highly active anti-retroviral therapy (HAART). However, the long term toxicities of currently available antiretroviral drugs combine with HIV/AIDS profound impact on individuals, psychological, social, physical and economical well – being associated with poor adherence to active anti-retroviral therapy (ART) and higher rate of discontinuation of treatment among people living with HIV/AIDS (PLWHA). This may act as significant barriers to National AIDS control program goals.

HIV/AIDS were one of the most destructive diseases mankind has ever faced. It brings with profound psychological, social, economic and public health consequences and has become one of the world most serious health and development challenges (Internet HIV and AIDS Stigma and Discrimination, 2014). Some of these challenges include AIDS related stigma and discrimination which refers to prejudice, negative attitudes, abuse and maltreatment directed at people living with HIV/AIDS (PLWHA). The consequences of this stigma and discrimination were wide – ranging for example, being shunned by family, peers and the wider communities, poor treatment in health care facilities and education settings, psychological damage, and a negative effect on the success of HIV testing and treatment (Internet HIV and AIDS Stigma and Discrimination, 2014). This informed the need for research in psychological, sociological and economic adaptations.

The poor psychological adaption was often as a result of stigma that leads to depression, anxiety, stress and felling of hopelessness of people living with HIV/AIDS (Hult, wrubel, Bransrom, Accree&Tedlie, 2012). Sometimes, HIV infection and related opportunistic infections can also directly impact the brain and nervous system. This may lead to problems in memory, thinking, and behavior and can be a challenge to a person's mental health. In addition, some medicines used to treat HIV may have side effects that affect a person's mental health (United State Department of Health and Human Services, 2017). However, many factors influence the way people living with HIV/AIDS (PLWHA) experience and communicate their pain. These factors can be categorize as both psychological and emotional (Mikan, 2011). As well chronic pain in people living with HIV/AIDS was often associated with psychiatric illness and substance abuse (Melin, 2013 &Mikan, 2011). Drugs abuse also enhances the spread of HIV/AIDS by depressing judgment and making addict engage in high risk sexual behavior (National Reproductive Health, HIV/AIDS Prevention Care Project, 2009). So the need to stop stigma is the responsibility for all, so that the tomorrow of PLWHA would be looking better.

Within the past decade, tremendous advances in the fight against HIV have resulted in declining mortality rate and improved life expectancy of those infected. Despite these advances, there continue to be strong social barriers such as HIV – related stigma that negatively affect HIV testing, disclosure, access to care, and health status of populations that may be at risk of infection (Emmanuel, 2010). Despite increased HIV/AIDS awareness and the limited ways it was contracted, social isolation remains a reality for many with HIV. Fear of social stigmas makes disclosing one's HIV status to friends and family a concern for many with the infection. Determining when to share one's HIV status and whom to share it with can be a stressful decision due to fear of others' reactions (Brown, 2017)).Additionally fear – base HIV campaigns have been known to intensify discriminations, as HIV remains a highly stigmatized condition. One in three people diagnose with the virus would have experienced HIV – discrimination at certain point in their lives. However, regrettably people living with HIV/AIDS (PLWHA)were often discriminate against because of (often unfounded) fear of infection which was negatively associated with promiscuity and drugs addiction (Musawa, 2013).

Sexes for survival greatly reduce women's ability to freely choose when sex should take place or to negotiate safe sex. There was evidence from all regions globally that the major driving force behind sex work, whether commercial or occasional, was economic opportunity. Sex work that was poverty driving was likely to encourage greater risk taking behavior, such as man – use of condom with client (Elhadji, 2001). Poverty and limited availability of health care facilities were major barriers to health care service in resources poor countries. For people living with HIV/AIDS (PLWHA), economic and geographic factors were compounded by social stigma and decrease mobility making delivery of public health service an even greater challenges (Ogojo, Stuar, Kidana& Wube,2013). With subsistence agriculture as predominant occupation of the indigenes of Kaduna State, the poverty level in the state was higher than the average for the country. Most of the people

living with HIV/AIDS were very poor and find it difficult to feed or even transport themselves to the hospital. This makes it quit difficult for them to access extra care service (ante-retroviral and some laboratory support) provided free of charge, courtesy of donor and government support. Quite a number of clients have had to be discharged without receiving special treatment and care and most were treated without paying their hospital bills (Adeoti& Dung, 2012).

Despite higher response to antiretroviral therapy (ART) among people living with HIV/AIDS (PLWHA), HIV continues to disproportionally affect people in Nigeria and other developing countries. If any, there were few pertinent studies that explore both psychos – social and economic adaptation among people living with HIV/AIDS in Nigeria. Monjok, Smesry, and James (2010), documented that relevant research studies were needed to thoroughly understand the consequences of stigma and discrimination at the levels and its effect on HIV prevention, treatment and care as it was directly related in the different socio – cultural setting in Nigeria. Therefore, this study was design to address and analyze four gabs: first psychological related factors, second – sociological related factors, third economic related factors and fourth the setting in Kaduna State and there after suggest to legislatives and planners to develop appropriate and timely intervention program that would encourage prompt accessibility to treatment and supporting Network of people living with HIV/AIDS (PLWHA) by reviewing the right of PLWHA to action.

1.2 Statement of Problem

The researcher was a peer educator trainer (a National Youth Service Corps (NYSC) member who was trained to train school children by forming anti-HIV/AIDS club on prevention of HIH/AIDS). On an outreach visits, the researcher interact with the members of network of people living with HIV/AIDS support group and observed that people living with HIV/AIDS (PLWHA) have been psychologically affected and predispose to stigma and discrimination, denied respect and acceptance by the community, family, friends and love ones. These lead to poor adaptive rate, pain, trauma and increase unequal income opportunities, food insecurity, and inaccessibility to health care services and to link with support groups. This scourge has been inflicting pain and grief, causing fear and uncertainty, encouraging the spread of the epidemic and threatening the economy. So far, there was no single document that investigates the psychological, sociological and economic adaptations of people living with HIV/AIDS (PLWHA) in Kaduna State. These issues raises above motivated the researcher to conduct a research on psycho-social and economical adaptation among people living with HIV/AIDS (PLWHA) in Kaduna State.

People living with HIV/AIDS (PLWHA) were known to have great emotional need and require enormous support for coming to term with dire afflicting status. Some of the feeling that PLHWA experience include, shock or anger at being positively diagnose with HIV, fear of isolation by family and friends and worries about infecting other. By bearing such a heavy emotional burden was surprised that depression was twice as common in PLWHA compare to the general population (Oppong, 2012). Kaduna state was yet to legislate on the stigmatisation and discrimination of people living with HIV/AIDS and people affected by AIDS (PABA) (Ejembi, 2010). This was a driving force that had an implication on the psychological, sociological and economic adaptation of people living with HIV/AIDS in Kaduna State.

1.3 Purpose of the study

The purpose of this study was to investigate the psycho-social and economic adaptation of people living with HIV/AIDS in Kaduna State. The specific purposes were to assess:

1. Psychological adaptation of people living with HIV/AIDS in Kaduna State
2. Sociological adaptation of people living with HIV/AIDS in Kaduna State
3. Economic adaptation of people living with HIV/AIDS in Kaduna State
4. Whether psychological adaptation would differ among gender of people living with HIV/AIDS in Kaduna State.
5. Whether sociological adaptation would differ among gender people living with HIV/AIDS in Kaduna State.
6. Whether economic adaption would differ among gender of people living with HIV/AIDS in Kaduna State**.**

1.4 Research Questions

The study wasconducted to answer the following questions;

1. What is the psychological adaptation of people living with HIV/AIDS in Kaduna State?
2. What is the sociological adaptation of people living with HIV/AIDS in Kaduna State?
3. What is the economic adaptation of people living with HIV/AIDS in Kaduna State?
4. Would psychological adaptation differ among gender of people living with HIV/AIDSadaptation in Kaduna State?
5. Would sociological adaptation differ among gender of people living with HIV/AIDS adaptation Kaduna State?
6. Would economic adaptation differ among gender of people living with HIV/AIDS condition in Kaduna State

1.5 Hypotheses

On the basis of the research questions, one major and six sub-hypotheses were formulated for the purpose of this study

1.5.1 Major Hypothesis:

People living with HIV/AIDS do not significantly adapt to psychological, sociological and economic adaptations in Kaduna State.

1.5.2 Sub-Hypotheses

1. The psychological adaptation of people living with HIV/AIDS is not significant in Kaduna State.
2. The sociological adaptation of people living with HIV/AIDS is not significant in Kaduna State.
3. The economic adaptation of people living with HIV/AIDS is not significant in Kaduna State.
4. There is no significant difference between males and female living with HIV/AIDS in their psychological adaptation in Kaduna State.
5. There is no significant difference between males and female living with HIV/AIDS in their sociological adaptation in Kaduna State.
6. There is no significant difference between males and female living with HIV/AIDS in their economic adaptation in Kaduna State.

1.6 Basic Assumptions

The basic assumptions of the study were as follows;

1. If psychological adaptation of People living with HIV/AIDS (PLWHIV/AIDS) is Positive, they would effectively cope with their condition.
2. If sociological adaptation of People living with HIV/AIDS (PLWHIV/AIDS) is positive, this would create better understanding of themselves in Kaduna State.
3. If economic adaptation of People living with HIV/AIDS (PLWHIV/AIDS) is positive, they would cope with their medication.
4. If psychological adaptation betweengenders of people living with HIV/AIDS is positive, they would enjoy doing things with others.
5. If sociological adaptation between genders of people living with HIV/AIDS is positive, they would share time with people.
6. If economical adaptation between gender of people living with HIV/AIDS is positive, theywouldnot default to treatment.

1.7 Significance of the study

It is expected that the result of the research work be useful to:

- Researchers; May add to the existing literature that could be useful to other researchers.
- Government; May help Government to understand how people living with HIV/AIDS were treated in the health care setting by medical practitioners. As well it may help government to see the blue print of the recommendation made that were specific and relevant intervention programmers' that would alleviate the problem of people living with HIV in Kaduna state. It would help Government to implement issues that were read and pass into law by policy makers.
- Medical practitioners; May help medical practitioners to understand how people living with HIV/AIDS were neglected and often stigmatize by the general public, So

that they would counsel them to developed positive emotions and self esteem. May help them to understand the dangers associated with defaulting to treatment and advocate for follow up, tracking and monitoring services.

- Heath Educators; May help health educators to advocate on behavioural change to the general public on dangers associated with stigmatizing people living with HIV/AIDS, so that they would accept, love and take care of them. It would help health educators to advocate on proactive intervention programmed that would promote the better understanding of people living with HIV/AIDS.
- Nongovernmental Organisation; May encourage Nongovernmental organizations to give more psycho-social support to person infected with HIV/AIDS. It would help them to understand that psychosocial and palliative support services were poorly developed in Kaduna state, so that they would advocate for better support services in term of Nutrition, access to health care facilities, incentive and encourage people living with HIV/AIDS to join support group.
- International Organisation; it would help international organizations such as (World Health Organisation, United Nation International Children Emergency Fund, United Nation Development Programme and United Nation Programme on AIDS) to understand how devastating HIV/AIDS was in Kaduna state and provide more technical and financial assistance to the state. .

1.8 Delimitation of the Study

The study was delimited to assessment of psychosocial and economical adaptations among adaption people living with HIV/AIDS in Kaduna State.

CHAPTER TWO

Review of Related Literature

2.1 Introduction

Available research finding and relevant studies related to psycho-social and economic adaptation among people living with HIV/AIDS (PLWHA) in Kaduna state were reviewed and presented in this chapter. The review was made under the following subtitles.

2.2 Concept of HIV/AIDS

2.3 Conceptual framework

2.4 Empirical Review

2.5 Psychological Adaptation of psychosocial adaptations of adaption people living with HIV/AIDS

2.6 Sociological Adaptation of psycho=social of adaptations among adaption people living with HIV/AIDS

2.7 Economic Adaptation of psycho-social of adaptations among adaption people living with HIV/AIDS

2.8 Psychological Adaptation and Gender Deference among people living with HIV/AIDS

2.9 Sociological Adaptation and Gender Deference among people living with HIV/AIDS

2.10 Economic Adaptation and Gender Deference among people living with HIV/AIDS

2.11 The Care for people living with HIV/AIDS

2.12 Implication on Public Heath

2.13 Psycho-social support for people living with HIV/AIDS

2.14 Summary

2.2 Concept of HIV/AIDS

Definition: HIV stands for human immunodeficiency virus and AIDS refers to acquired immune deficiency syndrome(National Reproductive Health, HIV/AIDS Prevention Care Project, 2009). According to AIDS in Africa impact (2004), the first documented case of AIDS was on the 5th of June, 1981 in the United State of America and five people were infected with the disease. However, there were reported (but not documented) cases of occurrence of HIV in 1959, but not much information was gathered on the event (AIDS in Africa – Impact, 2004). However, the first confirm case ofAIDS in Africa was reported in 1984, in Nairobi, Kenya. In Nigeria, the first case was diagnosed in 1986 (Abdu, 2006).

HIV was a virus that infects human being and course a lowering of the body immune system. This makes it impossible for the body to fight certain infection (National Reproductive Health, HIV/AIDS Prevention Care Project, 2009). The organ that HIV infects was the immune system and central nervous system. However, the main target of the HIV was the T helper lymphocyte. The T helper was an important cell in the immune system. It coordinates all other immune cells, as such any damage or loss of the T helper cell seriously affects the immune system. HIV attacks the T helper lymphocyte because it has protein CD4 on its surface, which the virus needs to get into the cell (AIDS in Africa – Impact, 2004).

The number of people living with HIV/AIDS has increase from 31.7 million in 2003 to 35.3 in 2013, as a result of: Continuing infection, people living with HIV AIDS general population growth. The global prevalence rate (0.8 per cent) has leveled since 2001. The number of people newly infected has declined in the last decade, in 2012, the number of AIDS related death – 1.6 million fell down from peak of 2.2 million in the mid-2005, due the spread availability of antiretroviral therapy (ART), since its introduction in 1996. At the end of December, 2009, since the advent of highly active antiretroviral therapy (HAART) in 1996, it estimated that HAART has saved an estimated 14.4 million life Worldwide (G F S, 2014).

Nigeria has the second largest HIV epidemic globally; in 2012 there were an estimated 3.4 million people living with HIV in Nigeria in 2010 National HIV prevalence in Nigeria was estimated at (4.1%) among general population (United Nation program on AIDS, 2014).

New number of people who were newly infected with HIV was continuing to decline in most parts of the world. There were 2.1 Million new infections in 2013, a decline of (38%) from 2001 when there were 3.4 Million new infections. Progress in stopping new HIV infection among children has been dramatic. In 2013, 240,000 children were newly infected globally. This was (58%) lower than in 2002, the year with the highest number, when 580,000 children became infected with HIV. Providing access to antiretroviral drugs for pregnant women living with HIV has averted more than 900,000 new HIV infections among children since 2009 (Abubaka, 2015).

2.2.1 Mode of Transmission of HIV/AIDS

HIV was a minute and can replicate (reproduce) itself several times once it found a suitable host to recite. In early 1980s, AIDS was initially identified as homosexual disease. Today however heterosexual was the primary mood of transmission (WHO, 2004). However, there were three basic mode of transmission from an infected person to another. They were sexual intercourse, unprotected penetrative intercourse with someone who was infected and infected blood and blood product, through donation of semen (artificial insemination) skin graft, organ transplant take from someone who was infected, sharing of unsterilized injection that has been previously used by infected person and from infected mother to her baby, (this may be during the cause of the pregnancy, at child birth and through breast feeding), (National Reproductive Health HIV/AIDS Prevention Care Project, 2009).

According to pennintong (2007), some (80 %) of HIV infection in Nigeria were Transmitted by hetero sexual sex. factors contributing to this include lack of information about sexual health and HIV, low-level of condom use and high level of sexually transmitted infections

(STDs) such as Chlamydia and gonorrhea which make it easier for the virus to be transmitted. Blood transfusion were responsible for (10%) of all HIV infection. There was highly demand of blood because of rood traffic accidents, blood loss from surgery and child birth, and anemia from malaria, blood was not routinely tested for HIV, and a recent study found that (4%) of all donors in Lagos were HIV positive.The remaining (10%) of HIV infection were acquired through other routes such as mother-to-child transmission, homosexual sex and injection drugs used (Pennintong, 2007). Summarily the transmission of HIV was mainly through exchange of bodily fluid like blood, semen and vaginal secretions. HIV cannot be transmitted by mere contacts and social interaction with a person who was infected. There were lots of myths and misconception about mode of transmission but we need to know about them to be able to dispel them. However, there were so many ways of protecting oneself and others from HIV infection. Essentially modes of prevention were in response to mode of transmission of HIV. A good knowledge of mode of transmission would enable one to protect oneself and the others (National Reproductive Health HIV/AIDS Prevention Care Project, 2009).

2.2.2 Treatment of HIV/AIDS

At present there was no cure for HIV/AIDS. However, HIV and AIDS could be manage through healthy living, use of anti- retroviral drugs, treatment of opportunistic infections, care and support(National Reproductive Health, HIV/AIDS Prevention Care Project, 2009).

AIDS in Africa impact (2004), reported that antiretroviral treatment usually elongates the lifespan of an HIV positive person; it involve the use of certain drugs called anti-retroviral drugs (some time called anti HIV drugs). These drugs called antiretroviral, help the immune system by directing it on possible techniques of dealing with the virus. This was however not a cure for the disease. One common ART drugs was Azidothymidine (AZT), it was however been recommended that a minimum of three antiretroviral drugs should be taking at a time for effective action, what was known as highly active antiretroviral therapy (HAART or

combination therapy (ART). A Standard (ART) consists of the combination of at least three antiretroviral (ARV) drugs to maximally suppress the HIV virus and stop the progression of the disease. Huge reduction has been seen in the rate of death and suffering when use was made of potent ARV regimen, particularly in early stage of the disease (WHO, 2013).

National Agency for the Control of AIDS (NACA) (2014), documented that, the World Health organization (W H O) report has made it clear that expanded access to antiretroviral therapy (ART) can reduce HIV transmission at population level, significantly reduced orphan – hood, help in preserving families. In 2010, WHO and UNAIDS lunch treatment 2.0 strategy which promote radical simplification of antiretroviral therapy, with accelerated treatment scale up and full integration with prevention, in order to reach universal access. World Health Organisation(WHO) lunch in July 2013 new guideline with recommendation on ART for adult and Adolescents (NACA, 2014). All these would make sure that people living with HIV/AIDS (PLWHA) has access to ART and their lives could be better as the disease was kept at bay. With antiretroviral therapy (ART) a patient has long life deprive of complication of HIV. At around (30%) and with over 600,000 on ART in Nigeria, all hands were on deck to up this number. National Agency for the Control AIDS would continue to be reference point in the fight against HIV/AIDS in the country and continent (NACA, 2014). The HIV/AIDS situation in Nigeria has undergone a lot of transformation after a long period of denial. Sero prevalence sentinel survey were conducted among antenatal clinic (ANC) attendees consider to be homogenous community of person with steady sexual partners.

The study population was made up of 36,427 consecutive pregnant women, aged 15 – 49 years, attending antenatal clinic in 160 selected cities across 36 state and FCT of Nigeria. Fifty eight percent of the attendees were aged 20 – 29 years with the least population of (2.4%), aged 40 – 49 years most of women were married (96.4%) and this makes the population fairly homogenous in all zones. The socio – economic characteristic of respondents were used to compare their level of access to health care service from

antiretroviral therapy (ART) site and government hospitals. Awareness about location of health facilities was generally high (79%) among respondent but higher among males urban dweller and those in highest wealth class. About (60%) of rural people living with HIV/AIDS (PLWHA) and (55.2%) of those in the lowest wealth class reported illness compare with (49.4%) of these in urban resident and (47.4%) of those in the highest wealth class. However, PLWHA in urban areas utilized government hospital more than those in the lowest wealth class, travelled long distance to ART site. People living with HIV/AIDS in lowest wealth class female face catastrophic health expenditure (67. 6%) and (55.5%) of their monthly income respectively.

Social inequalities were observed in subsidized HIV – treatment programme in Nigeria. Expansion of ART site in rural area and decentralization of HIV care at government hospital will reduce travelled distance and transport cost to ensure universal access to health care service among people living with HIV/AIDS (PLWHA). The study found the HIV prevalence was higher in North Central Zone (7.5%) followed by South-South zone (6.5%). The North West Zone has the lowest prevalence of (2.1%) (NACA, 2010). The epidemic has grown beyond the high risk groups (in which earlier described) to affect general population. Base on these figures, an estimated 3.1 million people in 2010, harboring the second highest number of people living with HIV/AIDS in the world, second to South Africa (United Nation Programmed on AIDS, 2014).

According to the Federal Ministry of Health (2010), there was no concrete evidence of unequal distribution of burden of HIV in Nigeria, including among groups about who little was known men sex men (MSM) and Intravenous Drugs Users (IDU). female sex worker (FSW) still bears the brunt of the epidemic in Nigeria, HIV prevalence levels among brothel and non-brothel female sex worker (BFSW) as high as (46%) in Benue and Nasarawa state, state incidence also have high HIV prevalence among anti-natal clinic (ANC) attendees (12.7% and 7.5% respectively) used as proxy for general population, Federal Ministry of

Health ANC 2010. Male sex with male in the Federal Capital Territory were also severely affected, with almost one out of every three respondents tested positive for HIV in 2010, which was particularly worrisome as most of those samples in this group were under age of 25 years.

However, with the National launching of elimination of mother to child transmission of HIV and prompted in the state Government, the gap in anti natal care attendance, HIV testing and counseling during and antiretroviral therapy for HIV positive pregnant women would be closed (Abubakar, 2015).

The Kaduna State AIDS control agency has embarked on a number of reforms to fast-track ending the AIDS epidemic in the state." Giving the unacceptably high prevalence of HIV of 9.2% in the state, we determined to close all the gaps in the HIV/AIDS response in the state. Closing the gap means empowering and enabling all people, everywhere, to access the services they need. By closing the HIV testing gap, the 300,000 people who were unaware of their HIV-positive status in the state can begin to get support. By closing the treatment gap, all the 600,000 people living with HIV would have access to life-saving medicine. By closing the gap in access to medication for children, all children living with HIV would be able to access treatment, not just the (24%) who have access today. By closing the access gap, all people can be included as part of the solution (Abubakar, 2014).

2.2.3 Symptoms of HIV/AIDS

The major sign and symptoms were severe, unexpected weight loss (up to 10%)of total body weight), fever lasting for more than one month, chronic diarrhea lasting for more than one month, persistence severe fatigue, skin rash, mouth ulcers/infection, swollen gland, persistent cough lasting more than 3 months (check for tuberculosis) (National Reproductive Health HIV/AIDS Prevention Care Project, 2009). However, HIV can cause a worsen malnutrition due to decrease food intake; increase care and support help break the vicious cycle by helping individual improve, maintain, manage system, boost immune response and improve

adherence (Gaikwad, Gari, Suryawanshi, Garg,, Singh, & Gupta, 2013).National Reproductive Health HIV/AIDS Prevention Care Project (2009)documented that, the only way to determine if somebody has HIV/AIDS was through a test for infection. Therefore, only early diagnoses, detection and follow-up treatment were the answers to fighting the virus and preventing the virus from killing. HIV/AIDS still does not have a cure as at today and can still kill and open the body to other opportunistic infection that can killed (confirming your status early, 2014).

2.3 Conceptual framework

Conceptual framework has been useful in the depiction and analysis in complicated health programmers' especially those determined by social and biological factors such as malnutrition and infectious disease in developing countries (Weiser, Young, Cohen, Kushel, Tsai, Tien, Hatches, Frongillo&Banberg 2011). However, observation highlight inadequacies in the individualistic and structural models were offered, followed by the theory of structuration as a possible complementary conceptual base for designing HIV/AIDS stigma – reduction interventions (Misir, 2013).

A new Bio psychosocial model have been suggested, that takes into account all relevant determinants of health and disease and that supports the integration of biological and social factors in assessment, prevention and treatment of diseases. Bio-psycho-social model (BPSM) was a general model or approach stating that biology, psychology (which entail thought, emotion and behaviour) and social (Socio-economic, Socio environment and cultural) factors, all play significant role in human functioning in the context of disease or illness. The biological model serves as incentive for any study of how psychological and social factors influence the development, course and outcome of a disease, giving rise to the development inter disciplinary field, particularly the field of health psychology (Mladen, Jasminka, Damir, 2009).

2.4 Empirical Review

Approximately 9.7 million people in –low and middle income countries were receiving ART, an increase of (50%) from 2010(GFS, 2014).Availability of anti – retroviral therapies has transformed AIDS into managerial chronic condition and improve well – being among PLWHA in developed countries. However, in developing countries such transformations were yet to occur due to socio – economic system and environmental constraint (Adedimeji, Alawode&odutolu, 2010). A considerable amount of research has been conducted in many countries on the variable related to psychological well – being of different population of PLHHA. 10 current researches confirm that social support from significant social network members can promote positive psychological adjustment in people living with HIV. Great number of amount of social support have shown to be associated with less negative and more positive effect in people living with HIV/AIDS who were satisfied with the amount of support available to them tend to experience less psychological distress, a higher quality of life, and more self esteem, where as those who perceived low levels of social support experience increase distress (Olaleye, 2013). Whereas, Wouters (2012), stress that large scale introduction of antiretroviral therapy (ART) in developing world has transform HIV/AIDS into manageable chronic condition. HIV/AIDSwere one of the most important public heath challenges facing Nigeria today. Recent evidence reveals that the adolescent population made up a large portion of (3.7 %) reported prevalence rate among Nigeria aged 15 -49 years. School base sexual health education therefore, becomes an important tool towards fighting these problems (Gospel, Papadopolous, Ochien, Ali, 2014).

2.4.1 Psychological Impact of HIV/AIDS

People living with HIV/AIDS (PLWHA) were known to have great emotional need and require enormous support for coming to term with dire afflicting status. Some of the feeling that PLHWA experience include, shock or anger at being positively diagnose with HIV, fear of isolation by family and friends and worries about infecting other. By bearing such a heavy emotional burden was surprised that depression was twice as common in PLWHA compare to the general population (Oppong, 2012). However, in addition to being a disease that was associated with a number of physical malfunction and progressive discomfort like, pain shortness of breath, altered sexual functioning and disfigurement, HIV/AIDSwas also a highly stigmatise disease. This stigma can lead to a progression of other grievous psycho – social stressors including unemployment, homelessness financial doldrums and the breakup of relationship. This in turn can cause further depression along with a number of other psycho– social problems (Desquibet, et. al, 2002).There was paucity of effective interventions to reduce stigma, there was no shortage of conceptual framework intending to offer a comprehensive understanding of stigma, ranging from socio- cognitive model at the individual level to structural model at macro level.However, observation highlight inadequacies in the individualistic and structural models were offered, followed by the theory ofstructuration as a possible complementary conceptual base for designing HIV/AIDS stigma – reduction interventions(Misir, 2013).

2.4.1.1 Self Stigma Among People Living With HIV/AIDS (PLWHA)

Shitu, Issa, Olanrewaju, Odeinger, Sanni and Aderibebe (2014), reported that there was internalized stigma significantly impacts the lives of depressed people living with HIV/AIDS (PLWHA). Nevertheless, there was paucity of data on the context, domains and demographic correlate of internalized stigma among people living with HIV/AIDS. This was a hospital bases cross sectional, descriptive study of one hundred and seventy depressed people living with HIV/AIDS. The PHQ – 9 was classified as minimal, mild, moderate and severe. The

three key of social determinant of stigma (SDS) were assessed and associated with stigma sought. A modified version of stigma mental illness (SML) was used as their measure of their self stigma. The prevalence of depress disorder was (57%). The spectrum of stigma was as follows, 103 (60.69), minimal 33 (19.4%), mildly, 19(11.2%), moderately and 15 (8.8%) severely stigmatized. There was a strong association between stigma and age, educational level, monthly income, stressful life event as well as self – stigma was common phenomenon in depressed people living with HIV/AIDS. Therefore, it was not possible to mange people living with HIV/AIDSwithout considering the high context in which they were embedded.

Even though stigma and discrimination remain formidable obstacle to the national HIV/AIDS response and great impediment to access care and support services, tremendous but often coordinated effort have continued to address these issue. People living with HIV/AIDS and key stake holders have been mobilized and empowered to challenge this at institutional and community levels as well as decrease self – stigmatization and improve self-esteem of PLWHA (NACA, 2010). Psycho – social challenges include anxiety, depression, and social support impact up on all domain of Health related quality of life (Peter & Kamath, 2014). Therefore, in order to developed effective HIV risky behaviour reduction intervention strategies and further decrease spread of HIV/AIDS, it's important to access the prevalence of psychosocial problem and HIV risky behaviour in PLWHA (Gerbi,Haptemarijam, Robnett, Nganwa&Temeru 2012).

2.4.2 Sociological Impact of HIV/AIDS

It has been recognized that HIV was a social disease, and the outcome of sexual behaviour. It emerges that poverty and the quest for survival provide the best behaviour that tend to enhance the spread of this disease particularly among vulnerable groups include young ladies, individuals from breaking homes, migrants, unemployed, deprived or street children among others. Increase rate of HIV has therefore, been inextricably linked to socio-economic factors (mainly poverty) that place women at disadvantage position. Alleviation of poverty and

women emancipation programs may contribute positively towards effective HIV control and or prevention (Dibua, 2009).With sociological discourse people sexual practice has become an area of particular interest as sociologist attempt to contextualize sexuality as multifaceted social experience rather than as psychological and psychoanalytic (Babantunde& Ake, 2015). However, HIV and AIDS was one of the most complicates and bewildering social challenges faced by contemporary societies due to its strong ties with sexual and societal stigmatized behavior. Hence, contracting HIV may lead to difficult to self – esteem coping, social Isolation, and poor psychological wellbeing (Oppong, 2012).

2.4.2.1 Culture, sexual Religious and Legal Issues and poverty of PLWHA

Cultural, sexual, religious and legal influence often makes discussion about sexual practice, preferences, sexual desires, the number and type of sexual partners, and the use of birth control difficult. In addition, there was often a ‘’clock of silence‘’ related to sexual practice and to illicit drugs use. Such subjects were often taboo and associated with embarrassment, Shame, guilt and rejection. The additional fear of HIV/AIDS as a fatal illness compounds the problem of discussing that difficult subject. In some societies the use of condom as a method of birth control (as well as controls of transmission) was not sanction by religious leaders. The cultural norms of silence regarding sexual practice, preferences and desire can be problematic. This sexual practice may include men having sex with men, sexual abuse, child abuse, and heterosexual intercourse (Lindsey, 2001).

Dibau, (2009), found that vulnerability of females to sex could assume to account for the increase level of sexually transmitted diseases including HIV transmission among them. However, observation in the study area were that women, especially those of child bearing age in these areas live below subsistence level, hence relieve on the quick or immediate source of money for personal, family and social support.

The women vulnerability model took from extremely convincing reason – biological, epidemiological, socio-cultural and structural indicating that heterosexual women were more

likely susceptible then were heterosexual men to HIV infection. Significant feminist scholarship on gender inequalities and general power dynamic has been essential in documenting that women were embedded in contest and relationship in which HIV risk was heightened. However, in more generalized epidemic, women and men may be infecting each other in far more balanced number than vulnerability paradigm suggested (Higgins, Hoffman, Dworkin, 2011).On addition to their socio-economic and cultural vulnerability, many women were married to or sexually partner of men who also have sexual contact with prostitutes. On the other hand, men generally become sexually active several years before marriage during each period they have free women (often single mothers) and sometimes prostitutes with multiple sex partners, and through this free women STD's including HIV awere contacted and subsequently transferred (Dibau, 2009).

Denial of a discomfort with homosexuality was another aspect of masculinity that can increase HIV risk for men, several HIV research has found that traditionally male gender roles can influence risky heterosexual behaviour against women, and perpetual violence against women, another strong HIV risk factor for women. Even when women worldwide follow the ABC commandments of remaining abstinent until marriage, being faithful to a single partner and using condom, they could be susceptible to HIV from their husband because of a nearly universal sexual double standard and men's greater access to extramarital sex (Higgins & Hoffman, 2001).

2.4.2.2 Proper Counseling and Social Support for People Living With HIV/AIDS

The HIV infected person and his/her family require further counseling and support following the initial meeting such support help to improve their quality of life as well as to enhance their ability to cope and make informed decisions about ongoing care. Such counseling and support may include encouraging the people living with HIV/AIDS to join a peer group to learn where and how to access services, to find educational resources, and to obtained

treatment(Lindersy, 2001).The psycho-social pathways underlying associations between benefit finding and quality of life were poorly understood (Brand, Barry &Ghallghes, 2014).

The irrational and often exaggerated fear associated with HIV/AIDS (even by nurses and midwife) can be directly address through education programmes based on sound medical, social and psychological knowledge. To be successful such programme must be sustained and supported over a period of time. Knowledge about HIV/AIDSwas constantly expanding, and nurses and care givers must be continually updated through continuing education programmes. They can then take important role of educating others. That means they can advocate, not only for universal precaution, but also for universal tolerance and knowledge about AIDS (Lindsey, 2001).

Effective and dignified care can only be given where respect and compassion for others was the Norms. Looking inward to examine and challenge long held beliefs, values, assumptions and attitudes would go a long way to providing compassion and respectful care. Such cares can then be demonstrated to others. When health care were provided with both knowledge and compassion, it makes the difference between misery and isolation, and the provision of comfort in setting of dignity and respect (Lindesay, 2001).

The relationship between HIV and nutrition was multi-faced and multi directional. HIV can cause or worsen malnutrition due to decrease food intake, increased energy requirements, and poor nutrient absorption. Malnutrition, in turn, further weakens immune system, increases susceptibility to infection, and worsens the disease impact. Nutrition, care and support help to break this vicious cycle by helping individuals improve, maintain, or slow down the decline nutritional status, manage systems, boost immune response, and improve adherence. However, consumption of proper nutrients, which can be enhance by knowledge of importance of good nutrition for people living with HIV/AIDS and proper dietary practices and support on already – compromised immune system would improve life (Gaikwad&Giri, 2013).

One of the major challenge in managing the affairs of HIV/AIDS in Kaduna State was the organise private sector. The organised private sector was not doing much in supporting the HIV control. If you look at the support that was coming from other international partners of course, these were countries that their private sector supports most of their activities. But in Nigeria it was not the case particularly in Kaduna state. Kaduna state provide free testing and counseling, give free antiretroviral drugs to those who have been tested and found positive and take strategic means in preventing HIV/AIDS from mother to child transmission. All these were provided free in Kaduna state (Mudashir, 2013).

One of the most difficult aspects of caring for PLWHA was deciding when to stop active treatment and to begin prepares the person and his family for dying. In practice, the boundaries between the two activities were often indistinct, with a terminal tandem. The decision to stop treatment requires considerable skill and sensitivity. Where ever possible should be taking by health care professional, the PLWHA family members and loved ones often difficult to decide when aggressive medical treatment should end and when palliative care may began (Lindsey, 2001). The status of psycho – social adaption was main influential factor for quality of life. The correlation between psycho – social adaptation and quality of life has been studied previously (Zhang, 2012). Studies within the past decade, tremendous advance in fight against HIV have resulted in declining mortality rate and improved life expectance of those infected (Emanuel, 2014).

2.4.2.3 Prevention of HIV/AIDS Resistant Strength

Preventive measures aimed at reducing the transmission of HIV infection havebeen known for over two decades. Yet the number of people infected with HIV was estimated at 38.6 million with some 41 million new infections yearly, about 1,400 new infections occurring everyday world wide. Approaches towards reducing this ugly trend would include eliminating drug use and/or needle sharing for intravenous drug users, to reduce the frequency of substance in situations where there would be risk for unprotected sex and

maintaining preventive strategy that reduce sexual risk for others while under the influence of alcohol and other illicit drugs. (Garbati& Abbas 2011).Prevention of HIV infection has been primarily through abstainers and needle exchange programmes, it was a key strategy to the spread of the disease (Musawa, 2014). Therefore, if prevention strategy would continue to be compromised, if fear, ignorance, intolerance and discrimination against HIV infected person persist, nurses and midwife have a responsibility to help normalize HIV so that the mode of transmission and prevention can be addressed without emotional and attitudinal overly that limit open dialogue about AIDS (Lindsey, 2001). HIV can cause or worsen malnutrition due to decrease food intake, increased energy requirements, and poor nutrient absorption. Malnutrition in turn further weakens immune system, increase susceptibility to infection, and worsen the disease impact. Nutrition, care and support help to break this vicious cycle by helping individuals improve, maintain, or slow down the decline nutritional status, manage systems, boost immune response, and improve adherence. However, consumption of proper nutrients, which can be enhance by knowledge of importance of good nutrition for PLWHA and proper dietary practices and support on already – compromised immune system would improve life (Gaikwad et. al 2013).

Even when women worldwide follow the ABC commandments of remaining abstinent until marriage, being faithful to a single partner and using condom, they could be susceptible to HIV from their husband because of a nearly universal sexual double standard and men's greater access to extramarital sex (Higgins & Hoffman, 2001). However, there was no confirmation of status, even in polygamous marriage'' said YakubuAbubakar, Director HIV/AIDS control Bauchi State Agency for the Control of AIDS, TB, Leprosy and malaria (Okafor, 2014).In Nigeria most people do not know their status skiptical in carrying out tests until they get sick due to the spread of the virus Therefore, knowing ones HIV status can go a long way in curbing this pandemic especially in timely HIV treatment and care, and somewhat reduces the risk of onward transmission. (Musawa,2014).

2.4.3 Economical Impact of HIV/AIDS

The poverty experience by women and men in developing countries has been aggravated by increasing global economic inequalities. But men gender relations and unequal access to economic resources have made women poorer than men. Poverty and wealth inequalities between men and women can fuel the transmission as women engage in unsafe sex in exchange for money, housing, food or education. Macro – economic policies which have resulted in diminished resources for social spending have not only created conditions that heighten vulnerability and risk, but have also impacted unequally on women and men. In many communities women have a key role in ensuring economics security for their families (Bako, Mohammed and Lar, 2014).

Olalaye, Fedelis, and Olanrewaju (2013) investigated the magnitude of social inequalities in access to subsidise health care service among people living with HIV/AIDS (PLWHA) in Nigeria. Structured interview were conducted with 1065 PLWHA selected from 60 communities base on support groups in 12 local government area across three (3) Nigeria state and federal capital territory, using multi – stage cluster sampling method. Data were collected on socio – economic characteristic of respondent, awareness about location of health facilities, current health status, distance to facilities, and utilization and expenditure on health care. The socio-economic characteristics of respondents were used to compare their level of access to health care service from antiretroviral therapy (ART) site and government hospitals. Awareness about location of health facilities was generally high (79%) among respondent but higher among males urban dwellers and those in highest wealth class. About (60%) of rural people living with HIV/AIDSand (55.2%) of those in the lowest wealth class reported illness compare with (49.4%) of these in urban resident and (47.4%) of those in the highest wealth class.However, people living with HIV/AIDSin urban areas utilized government hospital more than those in the lowest wealth class, travelled long distance to antiretroviral therapy site. People living with HIV/AIDS in lowest wealth class female face

catastrophic health expenditure (67.6%) and (55.5%) of their monthly income respectively. Social inequalities were observed in subsidized HIV-treatment programme in Nigeria. Expansion of antiretroviral therapy (ART) site in rural areas and decentralization of HIV care at government hospital will reduce travelled distance and transport cost to ensure universal access to health care service among PLWHA.

There were need to focus on the economic aspect of the epidemic, attention and resources to be directed towards the economic empowerment of households and individuals. The Establishment of cooperatives would help prevent and raise household from poverty as they organize their selves into skills training cooperatives and rotating, saving, and created association's people living with HIV/AIDS(PLWHA) need to be accompanied by training in various trades. This would equip individuals with the ability to diversity their livelihood activities thereby preventing them from falling into destitution (Bako, Mamman&Laah, 2014).

2.5 Psychological Adaptation of people living with HIV/AIDS

People living with HIV/AIDS (PLWHA) were known to have great emotional need and require enormous support for coming to term with dire afflicting status. Some of the feeling that PLHWA experience include, shock or anger at being positively diagnose with HIV, fear of isolation by family and friends and worries about infecting other. By bearing such a heavy emotional burden was surprised that depression was twice as common in PLWHA compare to the general population (Oppong, 2012). However, in addition to being a disease that was associated with a number of physical malfunction and progressive discomfort like, pain shortness of breath, altered sexual functioning and disfigurement, HIV/AIDS was also a highly stigmatized disease. This stigma can lead to a progression of other grievous psycho – social stressors including unemployment, homelessness financial doldrums and the breakup of relationship. This in turn can cause further depression along with a number of other psycho– social problems (Desquibet, et. al, 2002).

There was a high prevalence of unsafe sex among people living with HIVAIDS receiving antiretroviral therapy (ART) at the hospital. Factor associated with sexual risk behaviour were law education level, non adherence to ART, alcohol consumption before sex and the duration of antiretroviral therapy. It was important to strength the implementation of secondary prevention among this population of group (Yaya et. al, 2014). However, psychological factors that may put adolescents in increase risk of STI's include a general sense of vulnerability and desire to try new sexual and substance (drugs) experimentation. Also the willingness to take risk, including changing sexual partner often or having of encounter sexually transmitted infections (STIs) including HIV/AIDS. College students might be at risk because they tend to sexually adventurous, often with multiple partners and do not use condom consistently (shifaraw&Alemu, 2014).Therefore, in order to live an adaptive life despite HIV infection, patient need to negotiate between the demand of chronic illness and their goals of living a ''normal'' life. In order to enjoy sustainable physical health, social support and financial independence, patient have to work on a number of areas that requires persistence efforts. These were treatment related stress and relationship with significant other (Chang & Chung, 2007).

2.5.1 Removing Stigma and Resistance to Change

Stigma and discrimination means loss of dignity and self-esteem on the part of the sick person. Therefore, the duty of community was make sure these issues or cases of stigma and discrimination were dealt with. Secondly, investment in anti – stigma campaigns and message was worthwhile (Nyawasha, 2009).Fear, ignorance, and confusion about the finer details of HIV/AIDS were major causes of stigma surrounding HIV infection. Awareness creation was often not enough to erase those emotions. At time the eagerness to create awareness can result in a message distortion, as was the case when the image most people associated with AIDS was death. In this atmosphere, the efficiency of the proposed behaviour change, the motivation of project staff, and the futility of behaviour change in the light of absence of cure

for AIDS make people resist the superficial prescription for behaviour change such as (''A B C''), which promote Abstinence, Being faithful, and condom use. What was becoming clear was that the objective and method of intervention must be credible for people to ascribe to them. To achieve that level of communication calls for sustained period of training of target population to allow them to understand the logic for feasibility of the modified practice being suggested to them (Adeyi, &Kanki, 2006). However, in order to develop effective HIV/AIDS risk behavior reduction strategies and further decrease the spread of HIV/AIDS, it would be important to access prevalence of psycho – social problem and HIV/AIDS risky behaviour in people living with HIV/AIDS (Girbe&Haptemarijam, 2012).

2.6 Sociological Adaptationof living with HIV/AIDS

HIV and AIDS were one of the most complicates and bewildering social challenges faced by contemporary societies due to its strong ties with sexual and societal stigmatized behavior. Hence, contracting HIV may lead to difficult to self – esteem coping, social Isolation, and poor psychological wellbeing (Oppong, 2012).

However, low and middle income countries, the availability and uptake of HIV testing have increase considerably in recent years. Yet a large proportion of people infected with HIV were still unaware of their status, and despite high level of testing in some context (internal care clinic for example) population were at risk HIV infection were not reached. Maximum coverage of those populations requires more innovation appropriate and cost effective approaches (G F S, 2014). But according to the United Nation Development program (UNDP) in adequate information, misinformation, and superstitious beliefs had in the past acted synergistically to fuel discrimination, stigmatization of people living with HIV/AIDS(PLWHA) and self stigma (United National Development Programme, 2005). This was contradicting because we still experience such problems even today.

Other targets include reducing the annual number of new HIV infections by more than (75%) compared to 2010 cases in 2020, and achieving zero discrimination. The targets were firmly

based on an approach to leaving no one behind that was grounded in human rights and, if achieved, would significantly improve global health outcomes. Massive and widespread progress has been made in responding to HIV and many lessons have been learned in how to program efficiently and effectively to produce the best results for people (Abubakar, 2015).

2.6.1 Silent on HIV/AIDS

United Nation News Centre (2008), reported that, the United Nation secretary general Banki Moon 'says stigma remain single most important barrier to public health action. It was a main reason why too many people were afraid to see a doctor to determine whether they have the disease, or to seek treatment if so. It help make AIDS the silent killer because people were fear of the social disgrace of speaking about it, or taking easy available precautions. Stigma was a chief reason why AIDS epidemic continues to a devastate societies around the world.

The reluctant to talk about AIDS within marriage and between generations, the public Health response to a sexuality transmitted epidemic. Many Nigerians believe that fertility associated disease were in special category, treatable of AIDS, also was perceived as linked to witchcraft. The alien images of AIDS add to its stigma and encourage the perception of AIDS as retribution for those who engage in immoral activities (Adeyi&Kanki, 2006). Whereas, contrarily, the silent around HIV/AIDS has been broken, some deep rooted cultural practices that been identify to the spread of the disease have been brought to the front banner and address so the harmless practice should be adopted (UNDP, 2010).

2.7 Economic Adaptation of adaption people living with HIV/AIDS

The socio economic impact of the epidemic include, loss of job and in ability to get a new one, discrimination reduced earning capacity and reduce productivity among others and increase economic and social vulnerability of woman and children (Ejembi , 2010).Oladipo (2006), found that in Nigeria many of those people living with HIV/AIDS were now unemployed, having been sacked or denied employment base on their status. Example was bound of millions of people living with HIV/AIDS battling extreme poverty. As well add on

that, poverty account for 70 per cent of reason why people living with HIV/AIDS do not adhere to their drugs. Unemployment and poverty affect people living with HIV/AIDS capacity to undergo routine test, eat good food and transport to the care center, because the average people living with HIV/AIDS were poor. Even when you were not paying for the drugs, you need to move yourself to the point of treatment you need the nutritional support, which was core component of any anti – retroviral therapy. If you were not eating well no matter all the treatment, it would not have any impact.

Financial Constraint and HIV/AIDS, If not poor before contracting HIV, Contracting the infection can lead to financial hardship for a variety of reasons, and people living with HIV/AIDS may not be able to afford the taking time off work or away from farm or business. Going to health facility may result in out of pocket expenses associated with travel, child care, clinic fees, lab test and so on. If impoverished, people living with HIV/AIDS may have to choose between accessing treatment and starving/being able to feed their family (Internet science treatment writers, 2013).

2.7.1 Family Socio – Economic Statues as a Determinant of Economic Adaptation

Family, care givers face numerous challenges in care provision, the most prominent ones being financial, food provision, stress and stigma. Consequently, they adopt copying strategy to ensure economic endurance, psycho social well being and spiritual support (Kathum, Mugenda& Kerri,2014) where as on the level of house hold, AIDS result in both loss of income and increase spending on health care by household. The income effect of it lead to spending reduction as well as a substitution effect away from education and toward health care and funeral spending (Internet economic impact of HIV/AIDS, 2014).

Poverty and the effect of HIV and AIDS follow a divesting cycle relationship, as poverty increase so does the risk of infection with HIV and other sexually transmitted disease. HIV infection lead to increase medical cost and decrease household labour availability, which

limit already vulnerable household abilities to cope with disease leading to more deeply entrenched poverty (Internet HIV/AIDS,2014).

2.7.2 Nutrition and HIV/AIDS

The HIV epidemic combine with drought, food, soaring food price, decade of conflict, economic decline and cut in social services, have over whelmed families in may part of sub – Saharan Africa, living them with few copying mechanism. Weight loss and low micronutrient levels were associated with increase progression of AIDS in adult living with HIV. This crisis in Africa has underscored the dire nutritional need of all children who were HIV/AIDS, such as orphans and those living in household with infected family members. Other live with HIV infracted parents who can no longer provide food for their families (United Nation International Children Emergency Fund, 2012).

Meeting immediate food, nutrition and other basic needs was essential if HIV/AIDS affected households were to live with dignity and security. Providing nutritional care support for people living with HIV/AIDS was important part of caring at all stages of the disease (Food and Agricultural organization, 2013). Therefore, all hand should be on decks as ensuring access to adequate, affordable food and nutrition was certainly one of the fundamental role of government and, indeed, of civilization itself (Sheeran, 2008).

For many people living with HIV/AIDS (PLWHA) they were no financial position to access treatment and manage the virus (Ogojo&Steur, 2013), it has been estimated at the end 2012, just under 10 million PLWHA had access to antiretroviral therapy (ART) in low and middle income countries. In many circumstance, people informed of their HIV positive status were not adequately link with appropriate services, thus preventing immediate enrolment in care service (GFS, 2014). Therefore, there were need to focus on the economic aspect of the epidemic, attention and resources to be directed towards the economic empowerment of households and individuals. The Establishment of cooperatives would help prevent and raise household from poverty as they organize their selves into skills training cooperatives and

rotating, saving, and created association's people living with HIV/AIDS (PLWHA) need to be accompanied by training in various trades. This would equip individuals with the ability to diversity their livelihood activities thereby preventing them from falling into destitution (Bako, Mamman&Laah, 2014).

Empowerment of people living with HIV/AIDS: Micro credit facilities should be made available for people living with HIV/AIDS and if possible jobs should be created for them (Anozie, 2011). This would assist them in prompt and continuous treatment, so that they can avoid been default. However, Programmes can promote economic opportunities for women such as, though microfinance and other micro – credit, vocation and skills training and other incomes generation activities, protect and promote their inheritance right, and expert efforts to keep girls in school (WHO, 2015). People living with HIV/AIDS should be encouraged to enrol with social group to receive proper information on living positively, share experiences and entitlement for them (Anozie, 2011).

2.8 Psychological Adaptation and Gender Difference among people living withHIV/AIDS

Gender refers to difference in social roles relation between man and women generally, role were learned through socialization and very widely among cultures. Gender role were also affected by age, class, race, ethnicity and environments. The gender dimensions that were relevant to HIV/AIDS include economics, legal, cultural, religion, political and sexual status of women. Some of the gender inequalities do not increase the vulnerability of women to HIV/AIDS but also becomes factors that fuel the spread of epidemic (Tigawalana, 2010). Sexual behaviour among people receiving antiretroviral therapy (ART) was a major public health concern not only because of risk of HIV transmission but also the potential risk of transmission of resistant strains (Yaya, et. al, 2014).

Kalichman (1999), reported that men and women living with HIV/AIDS who experience difficult maintaining safer sex practices, their sex partners as well as themselves at considerable risk for sexually transmitted infections. Psychological correlates of continues

risk behaviour was investigated, a sample of 203 HIV – positive men and 129 HIV – positive women recruited from infectious disease clinic and AIDS service agencies. The study show that (42%) of men and (42%) of women reported at least one occasion of unprotected anal or virginal intercourse in the preceding six months. Unprotected intercourse frequently occurred outside a long time relationship and with partner who were not known to be HIV infected. Similarly to population at primary risk, HIV-infected men and women reported alcohol and drugs use including use before sexual episode. However, the association between substances used and unprotected sex was modest for men and absent for women. Contrary to previous research, emotional distress and maladaptive coping were not related to continued sexual risk. Interventions were urgently needed to support men and women living HIV/AIDS in maintaining long term-safer sex practices. Israel, Prantis, Lubega, Balma, Muhammed and Koopman (2007), found that considerable evidence suggested that people with HIV disease were significantly more distress than the general population; yet psychiatric disorders were commonly under detected in HIV care settings. The prevalence of three stress-related psychiatric diagnosis depression, post traumatic stress disorder (PTSD), and acute stress disorder (ASD), among vulnerable population of HIV-infected patient. Among approximately 350 patients attending two contrary based HIV primary care clinic, 210 participants were screened for diagnostic symptoms criteria for depression, PTST and ASD standardized screening measure used to asses for the disorders include the back depression inventory the post traumatic stress checklist, and Stanford acute stress questionnaire. High percentage of HIV infected patient meet screening criteria patient meet screening criteria for depression (38 percent) PTSD (34 percent, and ASD (43 percent) thirty eight percent screen positively for two or more disorder, women were more likely to meet system criteria for ASD then me (55 percent vs. 38 percent).

Furthermore, 173 clients enroll were interviewed using structured survey questionnaire as follows. The relationship between HIV risk behaviour and social and cognitive factor among

transgendered females (male – female transgender) (n = 25) in comparison with homosexual or bisexual male (n=122) and heterosexual female (n=26). Transgender female engage in risk behaviour than the other groups in terms of the number of sex partners in the past 30 days and past six months, commercial sex activities and having a steady sex partner who inject drugs. Adverse socioeconomic condition and transgender specific risk behaviour such as injecting hormones in relation to HIV risk behaviour must be targeted by future intervention study (Nemoto, Luke, Mamo, chin, patric 1999).

2.9 Sociological Adaptation and Gender Differences among people living with HIV/AIDS

HIV/AIDS has becomes a major challenge to gender equality and the advancement women's vulnerability to HIV/AIDS also increase some risk for men. Prevailing vies about masculinity and manliness encourages men to demonstrate sexual powers by having multiple sexual partners, and by consuming alcohol and other substances that may lead to risk taking and violence. An HIV – related illness in the family affect men and women differently, and its impact also varies depending on instances, when men falls ill there would be likely to be drop in disposal be household income. In culture where women, the primary sources of food for the household, if a woman becomes ill there would be more likely to be a problem with food security. The direct provision of care for the young or the sick would often seen primary as women's responsibility, and many girl were withdraw from school to assist with household tasks which were considered unacceptable for men (Elhadj, 2001)**.**

Women have increase in ability to negotiate safer sex. In spite of having knowledge of their extra-marital sexual interactions, women were often unable to protect themselves of power within relationships create by culture, economics and emotional dependent (w – Zakato, 2008). However, norms related to masculinity,sex homophobia, stigmatise men having sex with men, and make them and their partners vulnerable to HIV (WHO, 2015).

Elhadj (2001) reported that all over the world, there were strong social pressures to ensure that women and girls remain ignorant about gender safer sex, sexuality and relationship as

well as HIV/AIDS. They lack access to relevant information resources and opportunities to develop skills need to apply that information to avoid HIV infection. Boys also have limited to accurate information because of the common assumption that they were already knowledgeable about sex or would learn about it from their peers.

2.9.1 Feature of Culture and Sexuality in HIV/AIDS era

The features of culture drive from the components of the demographic and socioeconomic composition ofpopulation. The most important demographic and socioeconomic features were age, sex, residence, education, marital status, and religion, family social unit, and ethnic identity. These features influence the spatial and sexual mobility of people, their exposure to infection, and their health care- seeking and managing responses.

Age, the onset of sexual feelings, the timing of marriage, sexual debut, and ability to cope with the demand of sexuality all relate to the age of individual (Adeyi&Kanki, 2010).

Gender norms related masculinity can encourage men to have more sexual partners and older men to have sexual relations with much younger women. In some settings, this contributes to higher infection rates among young women (15 – 24 years) compared to young men (WHO, 2015).

Sex, the sexual domain was marked by some of the adverse inequalities between sexes, including unequal sexual negotiating powers, the different timing of marriage by sex, the practice of polygamy, and the age group between spouses within polygamous unions all sustain these inequalities. So total was the dominance of man that may be considered to have only duties and responsibility and no rights (Adeyi&kank, 2006) .

Sexual violence was also common, including rape and defilement. In some instances, men who were infected with HIV believed that virgin can “cleanse” them of HIV. A number of young girls have reported forceful initiation into sex by older sexual partners. Sexual violence can also occur in work place even among educated women, Job hiring, promotion and to avoid dismissal, fear of violence lead to acceptance of sex and lack of protection. Therefore,

women in Africa need protection and this can be done by addressing gender inequalities. Women need a fair share of treatment (Tigawalan, 2010). HIV/AIDS programs can address harmful norms and stereotype including by working with men and boys to change norms related to fatherhood, sexual responsibility, decision making and violence and by providing comprehensive, age- appropriate education for young people and address gender norms (WHO, 2015).

Type of marriage may influence the sexual practices within each type and thus affect the potential exposure to risk of HIV infection within marriage. The link operates through differential age at marriage between monogamous and polygamous woman, the length of postpartum sexual abstinence, and lactation amenorrhea (Adeyi&kanki, 2006.)

Pennington (2007) found that many girls get marriage between the age of 12 and 13 and there was usually large gap between husband and wife, young married girls ware at risk of contracting HIV from their husband as it would be acceptable for men to have sexual partners outside marriage and some men have more than one wife (polygamy). Integration sex was common in Africa. Young girls have sex with older men (sugar daddies) for money, gift or status. Even culturally, women were found to marry men who were much older than them and more sexually experience thus exposing them to the risk of HIV. There was a danger of young women seeking sexual satisfaction outside marriage, thus exposing them to risk of HIV (Tigawalana, 2010). Within polygamy or outside of marriage, young girls were often the preferred and possibly the easier target of old men. The public health implication shows up in the differential levels of infection between young males and young females in some population (Adeyi&Kanki, 2010). Women have increase in ability to negotiate safer sex. In spite of having knowledge of their extra-marital sexual interactions, women were often unable to protect themselves of power within relationships create by culture, economics and emotional dependent (w – Zakato, 2008). In many African cultures, there were tolerances for multiple sexual partnerships, including extramarital sex by men. Marriage and monogamous

relationship do not protect women; ironically unmarried women would be more protected than a married one because of the unfaithfulness of men. There was common saying such as AIDS can meet you in your bedroom. In polygamous societies, a man can have many sexual partners but a woman has to be faithful to one'. A woman who has been paid a bride-price was even more vulnerable to HIV (Tigwalara 2010).

Education was one of the most potent acquired socioeconomic characteristics was by itself not always the predictor of risk exposure. In combination with other lifestyle issues – such as opportunity for travelling, type of employment, and access to cash income – though, it was closely related to the dynamics of HIV infection, prevention, and management in a population. In effect, both a negative and a positive feedback loop operate between education and the epidemic. (Adeyi&Kanki, 2010). Studies in Africa and elsewhere indicate that students of higher institution were exposed to many risk behaviour including substance use, sexual coercion and unsafe sex which predispose them to sexually transmitted diseases including HIV/AIDS (Girbe&Bodad, 2013). However, the university environment offers great opportunity for HIV high risk behaviour, including unsafe sex and multiple partnerships. Despite recently gained declined of overall incidence of HIV infection, still significant proportion of youth population were HIV positive (Shferaw, Alemu, Assef, Tesfaye, Gilbermedlih& Amare, 2014).

Adeyi and Kanki (2010), found that (29.2%) of university students in their study had sexual relation during travel outside of Nigeria. Sex tourism has potentials implications for the spread of HIV, the development of confections with HIV – 1 and HIV – 2 and the increase in HIV subtypes found in Nigeria. Giving the better education of those involved however, they may be able to monitor their health, maintain high level of condom use, and experience fewer episodes of STD's. This circumstance would likely limit the public health significant of sex tourism for Nigeria's epidemic yet a large cluster of HIV infected returning female sex tourist into an area of origin could have devastating effect on the course of epidemic in the area

However, law condom use among female students was quite troubling because women were more likely than men to be infected with HIV during sexual intercourse. The environment affects great opportunity for HIV high risk behaviours including unsafe sex and multiple sex partner (Shiferaw et. al, 2014).

Residence and migration in urban or rural areas helps to determine people economic and social options, opportunities, and limitation. It also creates the context for developing the coping mechanisms for sexual need, satisfaction and consequences. Expansion in the entertainment industry resulted in the creation of the drinking bars, brothels, and rooming houses in large town where rural urban migrants, single men and married men all have access to sex for cash. In effect both urban and rural areas offer challenge and opportunities for HIV prevention and management. Nigeria significant in county flows between regions and between rural and urban areas has implication for spread of HIV/AIDS. Such movement can be effectively reducing urban – rural differential in HIV/AIDS prevalence. However, a combination of the popularity of air travel and downtown of the Nigeria female including well educated yet unemployed female easily drawn into foreign sex, as well peace keeping operations by Nigerian soldiers at various times have produced other distinct strands of net transfer of infection to Nigeria. The lifestyle of peace keeping officers was characterized by high levels of multiple sexual partners, low condom use and exposure to blood transfusion in line of duty. As well the impact of male labour migration affects both sexuality of mobile males and females with whom they have sex ration create (Adeyi&Kanki, 2010).

Gender – related barriers in access to service prevent women and men from accessing HIV prevention, treatment and care women may face barriers due to their lack of access to and control over resources child care responsibilities, restricted mobility and limited decision making power. Socialization of men may mean that they would not seek HIV services due to a fear of stigma and discrimination, losing their job and of being perceived as “weak” or “unmanly”. Programs can improve access to services of women and man by removing

financial barriers in access to service bring services closer to the community including in health care settings (WHO, 2015).

Religion plays a major role in both social behaviour and health belief system. Religion and modernization were modifying some of the sexual excesses of males within traditional sexual codes, yet this modification may be in the contributing to an increase in the use of sex workers other feature of family formation have a potential impact on the epidemic. In the past, the universality of marriage and the early timing of marriage serve as safety nets for reducing the incidence of premarital sex and promiscuity. Mate selection process was now less autocratic and allows greater sexual experimentation between consenting adults than in the past. The formation of social units provides the setting within which the interaction of culture, sexuality and risk of HIV infection take place. So compel were these interactions that an assumption of a static and predictable role of social and cultural factors in the epidemic was likely to be invalid. As with other social and demographic variable, the epidemic can alter the structure and functionality of a family, yet the family was also the frontline unit for caring for people infected with or affected by HIV (Adeyi&kank, 2006).

2.10 Economic Adaptation and Gender Differences among people living with HIV/AIDS

Socioeconomic factors indirectly influence the individual's decision to indulge in HIV/AIDS risk behaviours. Poverty was considered a major factors influencing indulgement in heterosexual exposure and hence to HIV risk factors. The female sex observed to be more vulnerable to unprotected sexual exposure and hence to HIV infection. Basically, because there were prevailing culture constraining them to opt out for sex for economic reason or for the gratification of other materials needs and protection. The males were on the other hand reported to be motivated by fun (Dibua, 2009). The poverty experience by women and men in developing countries has been deepened by increasing global economic in equalities. This global economics order has increase the vulnerability of developing countries to HIV/AIDS both in term of infection and impact (Elhadj, 2014).

The majority of people living with HIV/AIDS (PLWHA) in developing countries do not have access to treatment for opportunistic infections, or necessary dietary and food supplements to strength the immunes system. Such situation impacts seriously upon women because some of the poorest countries women outnumber men among those infected. Gender inequalities in access to medical treatments and health services also limit women's access to HIV/AIDS treatments, care and supports, including anti- retroviral therapies. In many part of the world men may be also have difficulty accessing HIV/AIDS services because these services were typically serve women, such as pre – marital and family planning clinics (Elhadj, 2004). Sex – for – survival greatly reduces women's ability to freely choose when sex should take place or to negotiate safe sex. There was evidence from all regions globally that the major driving force behind sex work, whether commercialor occasional, was economic opportunity. Sex work that was poverty – driving was likely to encourage greater risk taking behaviour, such as man – use of condom with clients (Elhadj, 2001).

Lack of education and economics security affect millions of women and girls, whose literacy levels were generally lower than men and boys. Many women, especially those living with HIV, loss their homes, inheritance, possession, livelihoods, even their children when their partner dies. This force many women to adept survival strategies that increase their chances of contracting and spreading HIV. Therefore educating girls make them more equipped and safer sexual decision would reduce the spread of the epidemic (Shifaraw&Alemu; 2014). Programmes can promote economic opportunities for women (e.g though microfinance and other micro – credit, vocation and skills training and other incomes generation activities, protect and promote their inheritance right, and expert efforts to keep girls in school(WHO,2015).

2.11 The Care for People Living With HIV/AIDS (PLWHA)

Ogojo and Stuer (2013) reported that in most developing countries, community based organizations (CBO's) play major role in delivering care and support to people living with

HIV/AIDS (PLWHA). A key outcome of CBO involvement in HIV intervention has been the facilitation of community – level access to services, particularly in area where public systems were either inadequate or absent. Partnership with CBO's stems from their understanding of, respect for and connection with communities.

The National Strategic Framework (NEF) 2005 – 2009 period witness the gradual change in perception and reality of requiring regular and sustainable care and support. The national response include systematically developing policies and guidelines that promote minimal package and standard of care and support service and provide common policy framework for the operations of all key stakeholders including Federal, State and Local Government. The policies and guidelines promotes the continuum of care strategy for PLWHA and their families and link specialist and professional care to community and home base care (HBC). Civil Society Organizations (CFOs). Faith Based Organizations (FBOs), Community Based Organizations (CBOs), and associations, networks and support groups of people living with HIV/AIDS to the challenge (National Agency for the Control of AIDS, 2010).However, there was inadequate capacity for psychosocial support services in the Kaduna State. Psychosocial, nutritional and palliative support services were poorly developed. Most antiretroviral therapy (ART) treatment centers lack follow-up, tracking and monitoring services, which make drug adherence and compliance difficult and the emergence of resistance strains a major problem. As well, there was poor capacity building in income generation strategies for PLWHA (Ejembi, 2010).

2.11.1 Health Education and Promotion

People living with HIV/AIDS should receive proper counseling on how to take their medication, consequences of not taking their drugs; they should be taught how to practice hygiene. However, due to lack of appetite, people living with HIV/AIDS should be encouraged to eat small but frequently and drink lots of water, also food supplements should be administered to them free of charge (Anozie, 2011) As well a combination of strategies health education, psycho-social intervention ware needed in addressing the need for people living with HIV/AIDS (Ogbuji&Oke, 2010).

Nevertheless, in the face of epidemic, education can generate hope because of its potential to work at three levels where AIDS related intervention was needed:

1. While there was yet infection: by providing knowledge that would inform self-protection; fostering the development of a personally held, constructive value system; including skills that would facilitate self- protection; promoting behaviour that lower infectious risk; and enhancing capacity to help others to protect themselves against risk;
2. When infection has occurred: by strengthening ability to cope with personal and/ or family infection; promoting care for those that were infected; helping young people to stand up for human right that were threatened by their HIV/AIDS condition; and reducing stigma, silence, shame, discrimination;
3. When AIDS has brought to death: by helping coping with grieve and loss, in the recognition of life after death of family members and in assertion of personal rights (Kelly, 2000)

Care: Changing the therapy if patient has severe antiretroviral (ARV) drug side effect. Patient who suffers from extreme side effect of antiretroviral (ARV) drugs should be given alternative antiretroviral therapy (ART) drug to reduce suffering (Anozie, 2011). In order to care for people living with HIV/AIDS, the institution of Human Virology, Nigeria has embarked on a campaign to sensitize health care providers on the importance of

pharmacovigelence and need to record side effect of anti- retroviral drugs. Participant at the session noted that they have observed client with side effect but the sensitization has encourage them to report them (Ukpabia, 2010). Intervention to support adherence in regions should be directed at all factors in order for patients to be adhere and persists to the treatment, and ultimately for the health and quality of life (Lyimu, Bruin, Boogard, & Hospers, 2012).

HIV Counseling and Testing: Garbati, Abbas, Yusuf and Kabrang4 (2011), stress that HIV counseling and testing (HCT) services and de-stigmatizations targeted at different level of population would help place many of those infected into treatment and care service. However, being tested positive does not mean automatic death sentence anymore, because there were modern "anti – retroviral drugs" available to combat the HIV/AIDS virus. Immediately consults with your doctor for the reconfirmation of your test result, and there after your doctor would also send you to government designated HIV/AIDS treatment centre where you would get final reconfirmation of your test result, if still tested positive, immediately, you would begin to get medical attention that would prevent the virus from ravaging and destroying your body immune system. But please note that only early diagnosis, detection and follow-up treatment was the answer to fighting the virus and preventing the virus from killing you and your beloved partners, running away from been tested would be dangerous, so get Dr. Greg HIV/AIDS Home Test Kit privately in your home or office confirm your status early, so that we can altogether prevent the spread of the virus. HIV/AIDS still does not have cure as at today and it can still killed or open the body to other opportunistic disease that can also easily killed (Confirming your HIV status early, 2014).

2.11.2 Right of People Living With HIV/AIDS (PLWHA)

Despite compelling evidence that reducing stigma, promoting human rights, promoting greater involvement of people living with HIV/AIDS and gender mainstreaming, Strengthen HIV/AIDS control, Nigeria achievements in this regard remain slow and hesitant. More than two decade of the first case of HIV in Nigeria, violation of human rights of parsons infected

was still rampart and stigma remains pernicious and pervasive. This situation was compounded by attitudes and approaches which discriminate against widow and parson orphaned by AIDS. Furthermore, the approaches of the national response under the lost National Strategic Framework appears to accentuate the differential access to information, services and participation by marginalized segments of the population and those with high vulnerability to HIV infection including woman, young people, and parson who engage in transactional sex or same sex relationship. These situations call for strong focus on advancing human right in the context of the national response, demanding, among others vigorous promotion of relevant policy and legal frameworks (NACA, 2010). Human rights violations affect people living with HIV in the workplace and affect their access to housing and education. Even more critical was community ownership and leadership in the AIDS response. Where communities have taken charge, the impact has been significant (Abubakar, 2014).

Sources report that under the legal framework in Nigeria, the protection of right of people living with HIV/AIDS relies on constitutional right to freedom from discrimination and national HIV/AIDS policies and guideline(Immigration and Refuse Board of Canada, 2014).

The 2009 National policy on HIV/AIDS state that Nigeria was committed to reducing stigma and discrimination and protecting the right of people living with HIV/AIDS. Similarly sources state that there were no National laws in place specifically for the protection of people living with HIV/AIDS from discriminate in base on HIV status (Immigration and Refuge Board of Canada, 2014).Nigeria has glut of policies and guidelines on the right of people infected and affected by HIV/AIDS. The drafted 2009 HIV policy was perhaps the most ambitions and comprehensive. The country was also a signatory to many regional and international commitments and convents human rights. Yet minimal progress, if any, has been made in addressing the human right and legal issues surrounding HIV/AIDS. This stems principally from the fact that, in Nigeria, official policy documents do not constitutes law and

cannot be enforced in court of law. They were for administrative tools and guidelines that provide direction for Government action. And add-on that protection of the right of PLHWA and PABA were not on the priority radar screen of law enforcement agencies (NACA, 2010).

Policy Making and Development: Policies that protect people living with HIV/AIDS in places of employment, schools and immigration laws should be developed (Anozie, 2011).

The introduction of 2009 National policy on HIV/AIDS developed by National agency for the control of AIDS to regulations and guiding principles for the control of HIV/AIDS 'state that the people living with HIV/AIDS in Nigeria experience stigma and discrimination that remain pervasive. The network of HIV/AIDS support groups whose objective was to advocate for right of people living with HIV/AIDS in Nigeria indicated in Nigeria, 'there was spread societal discrimination against people living with HIV/AIDS ' media report that part of the Nigeria population varies people living with HIV/AIDS (PLWHA) as "morally corrupt VOA. 10 July, 2012 or 'immoral' global post 25 July, 2012. Country report for 2012 state that in Nigeria, 'HIV/AIDS was seen as the result of immoral behavior and punishment for homosexual activities' (Immigration and Refuse Board of Canada, 2014). For this the president of Nigeria, Good luck Jonathan, has signed a new anti-discrimination bill to into law that protects the right and dignity of people living with HIV. The HIV/AIDS Anti – discrimination Act 2014 makes it illegal to discriminate against people based on their HIV Status. It also prohibits any employer, individual or organization from requiring a person to take an HIV test as a precondition for employment or access to services. It would hoped that the new law would create a more supportive environment allowing people living with HIV to carry on their lives normally as possible. More than three million people were living with HIV in Nigeria (Network of PLWHA, 2015).

Kaduna State was yet to legislate on the stigmatization and discrimination ofpeople living with HIV/AIDS(PLWHAs) and people affected by AIDS (PABAs), the activities by Government, civil society organization (CSO) and private sectors on stigma reduction were

limited. There was limited involvement of PLWHA in the training and development of behavioural change communication (BCC) activities relating to stigma and discrimination. The number of programs on stigma reduction targeting the special need group were very few (Ejembi, 2010). Whereas, Abubakar(2014), affirm that, Kaduna State was determined to transform the vision of zero new infections, discrimination and zero AIDS-related deaths into concrete milestones and endpoint. This was by revolutionizing HIV prevention politics, policies and practice, shifting the debate from HIV prevalence to incidence, enabling to identify transmission hot sports, empowers people, particularly young people to demand and own the response.

2.11.3 General Recommendation for Taking Care of Your Self was Given Below

- The body needs extra rest. Try to sleep for eight hours every night. Rest when you were tired.
- Try not to worry too much stress can harm the immune system. Relax with people you love, your family, your children and your friends.
- Be kind to yourself try to keep a positive attitude, feeling good was part of being healthy
- Take light exercise. Chose a form of exercise that you enjoy.
- Find support and get advice. Ask for advice from health workers. Many medical problems can be treated.
- Stop smoking. It may damage the lungs and many other part of the body
- Alcohol was harmful to the body, especially liver. It increase vulnerability to infection and destroys vitamins in the body, under the influence of alcohol you may forget to practice safe sex.
- Avoid unnecessary medicines. They often have unwanted side effects and can interfere with food and nutrition. If you do take medicine read the instruction carefully (FAO, 2013).

2.11.4 Trend in Management

Since 2003, World Health Organisation (WHO) also recommend the antiretroviral (ARV) use for the prevention of infection, particularly for pregnant women, young children and key population that may be at risks? Countries were now following to adapt and implement these recommendations within own epidemiological settings. WHO was working to improve scaling up of ARV use in developing countries by optimizing drugs and diagnostics and enhancing community engagement (WHO, 2013).Despite these achievements, the present HIV program was no optimal in three important areas. First there was concern whether the current treatment strategy was most efficient. Research suggests that alternative policies such as universal testing and immediate treatment of all HIV infected patient (UTT) and targeting specific risks group would be more efficient than the present program. Second concern exist regarding the quality of distribution on antiretroviral Therapy(ART) across population groups, recent review show that, men and children have less access to treatment than women. Third, there was concern about the program feasibility giving the severely limited capacity for health system (Baltussen, Mikisen, Tromp, Hurting, Byskov, Olsen, Baerek, Hontelez, Sing &Norheim, 2012).

*Therefore, in order to developed effective HIV/AIDS risky behaviour reduction strategies and further decrease the spread of HIV/AIDS it's important to access the prevalence of psycho – social problem and HIV/AIDS risky behaviour in PLWHA (Gerbi&Haptemarijam, 2012).

Already, Kaduna State has reached more than one hundred thousand people with life-saving treatment in the state and increasingly able to refine efforts and be more precise in ability to reach people who might otherwise be left behind through HCT outreaches and engagement of CSOs.' With this attention to location and population we were able redistribute opportunities to improve access. On this World AIDS Day countries were implementing the UNAIDS Fast-Track Strategy, and together with front-loaded investments we can expect to close the gaps to

essential services faster. This means resources can go further to reach more people with life-changing results. With the sustainable Development Goals, the world has entered a new era of innovation and integration. There was a greater understanding of how the global goals ware interconnected and a better appreciation for moving forward together. Ending the AIDS epidemic means that adolescent girls and young women have access to education and appropriate HIV and sexual and reproductive health services. It means key populations, such as female sex workers (FSWs), male sex with male (MSM), people who inject drugs and transgender people, have full access to health services delivered with dignity and respect and it also means that every child was born free from HIV, and that they and their mothers not only survive but thrive. This was an exciting time in the AIDS response. In line with the state government's restoration master plan of having disease-free State and productive citizenry, we have what it takes to break the AIDS epidemic as we have already bent the trajectory' (Abubakar, 2015).

2.12 Implications on Public Health

Globalization can be cited as the primary cause of disease distribution and incidence of modern epidemics. An associated phenomenon was the drugs needed to treat emerging and re-emerging reach of people in poor countries, often the most needed affordable treatment. Globalization presents both challenges and opportunities, however, that can be harnessed to balance some of the in equalities in period of health emergencies such as HIV epidemic (Adeyi,&kanki, 2006). The heavy burden of HIV/AIDS on about three million Nigerian infected with the virus, their families and communities, and the country. HIV/AIDSwas one of the greatest public health challenges in the country, it was reversing many health and development gains of recant past including maternal and under five mortality rate and placing unprecedented stress on already over burden health care system (NACA, 2010). By killing off mainly adults, AIDS Seriously weakens taxable population, reducing the resource available for public expenditure such as education and health services not related to

AIDSresulting in increase pressure for the state finance and slower growth of economy (Internet economic impact of HIV/AIDS, 2014).

2.12.1 Loss to Man Power and Economic Growth

A healthy work force was essential to building and maintaining competitiveness in today's global market place. HIV and its resulting opportunistic infections predominantly affect adults between the age of 25 and 50, in the prime of their productive years. In some countries in sub-Saharan Africa as many as one in every four adults have HIV/AIDS. These result in frequent employment absence because of personal illness of the obligation to care for sick family members. It also means an overall reduced investment in productive asserts because cash income was diverted to other expenses such as health care and burial (Internet HIV/AIDS, 2014). These means people living with HIV/AIDS would not only be unable to work, but would also require significant medical care. The forecast was that this would probably course a collapse of economies and societies in country with significant AIDS population (Internet economic impact of HIV'', 2014).Therefore, the economic and social impact of HIV and AIDS can negate, and even undo, hard worn development gain, hindering economic growth and destroying families and communities (Internet HIV/AIDS,2014).

2.13 Psycho-Social Support for People Living With HIV/AIDS

Epidemiological studies highlight the importance of social support in attenuating the impact of stressful events and reducing incidence of disease. Social support generally defines in terms of availability of people whom the individual trust, who can be relied upon and who make person feel valued and care for (Adedimeji, Adedimeyi, &Odutolu, 2010).However,

According to Nyawasha (2009), psycho – social support can be define as an ongoing process of meeting the social, mental and spiritual needs, which were considered essential element for positive human development. And add on that people living with HIV/AIDS (PLWHA) needs support so that they can effectively deal with their emotional and psychological problem. They need society to look after them and a community should be ready to play this

significant and central role. While little information were available on the cost of psychosocial support for HIV/AIDS in resources poor settings. Such care was either infrequently provided, has not been documented or was provided as part of overall care and support of people living with HIV/AIDS (PLWHA) (e.g. by way of care service and palliative care) as studied by (W H O, 2014).

However, psychosocial support addresses the ongoing psychological and social problems of HIV infected individuals, their partners, families and care givers (WHO, 2014). As well community level intervention\n target only health related and psycho – social needs of PLWHA and their households. Although these efforts tend to produce some immediate benefit for clients, the benefit was often lost over time, as other important need come to the fore (Ogojor&Stuer, 2014).People living with HIV/AIDS with good social support were adhered to HAART. There would be need to educate and train family, care givers on stigma reduction and how to care and support their HIV positive relatives (Afolabi, Odewale&Oluwakere, 2013). As well according to Dr. Tom Decroo at HIV and Health system pre –meeting held before AIDS 2012 in Washington D.C ‘’people living with HIV/AIDS can be involve with psycho-social support talks, in treatment literacy and impotently in accompanying a referral and tracing other patients who were lost to follow up’’ (Internet treatment writers,2013) . The status of psycho – social adaption was main influential factor for quality of life. The correlation between psycho – social adaptation and quality of life has been studied previously (Zhang, 2012). Studies within the past decade, tremendous advance in fight against HIV have resulted in declining and improved life expectance of those infected (Emanuel, 2014).

In Nigeria and indeed Kaduna state various public and private organisation including Civil Society Organisation (CSO’s), Faith Base Organisation (FBO’s),community base organisation (CBO’S) have responded in different ways to mitigate the impact of this pandemic. These efforts range from prevention to care treatment and support for those

infected and affected by the disease. What was important was to access whether the effort were achieving desired result and the conduct of relevant research operations reach to generate relevant date for improvement of programme and service (Ejembi, 2006).

One of the major challenge in managing the affairs of HIV/AIDS in Kaduna State was the organise private sector. The organised private sector was not doing much in supporting the HIVcontrol. If you look at the support that was coming from other international partners of course, these were countries that their private sector supports most of their activities.

Therefore, "to end the AIDS epidemic by 2030 as part of the Sustainable Development Goals would require investment, commitment and innovation to be accelerated. The Fast-Track approach: Front-loads investments, focuses on the locations, populations and program that deliver the greatest impact, catalyzes innovation for people who need it most, engages local leadership for targeted, sustained and accountable responses, creates new partnerships, stands firm on human rights and delivers results that leave no one behind. Fast-Track would change the lives of millions of people in the Country and Kaduna State in particular. We have a fragile window of opportunity – just five short years to break the epidemic"(Abubakar, 2015).

2.13.1 Physiological and Psychological Effect of Exercise Intervention in HIV Disease

People with HIV can slow down their HIV infections and improve their health by doing four things: eating a healthy diet, managing stress levels effectively, getting sufficient sleep and getting some regular exercise. A study by department of health and environmental control in South Caroline's shows that patient who exercise three to four times per week were less likely to developed AIDS than those who did no exercise at all. It not only slowed HIV progression, but increase blood count as well. Add on that when you start exercising, there were number of things to considered, including your current level of fitness, where you were in your HIV/AIDS treatment and which type of exercise was appropriate and enjoyable for you. If you start doing something which was too extraneous, you would not enjoy it and

chances were that you would abandon all exercising effort. So the choice of exercise was crucial. Exercise can play a big role in controlling some of the side effect of HIV'' (Internet exercise & HIV, 2009).

The use of both aerobic and resistance exercise has been shown to improve physiological parameters, such as strength, endurance, time to fatigue, and body composition in HIV infected population. Exercise has also been used successfully to treat Psychological condition such as depression and anxiety that were common in HIV infected individual (Dudgeon, Phillips, BOOP&Hanel, 2004). There was growing evidences to support aerobic exercise been safe and effective for HIV infected individual. In 2012 Botros et.al reported that the nutritional counseling and exercise can be effective in treating HIV-related fat redistribution and metabolic abnormalities and can improve body composition, strength and fitness in people living with HIV/AIDS (PLWHA). Gomes et.al investigated the effects of physical exercise in perception of life satisfaction (Using the life satisfaction index) and non immunological functioning in people living with HIV/AIDS, concluded that a moderate intensity physical exercise programme improves life satisfaction for PLWHA and had no adverse immunological effect (Pullen, 2014).

Why Exercise was Good for PLWH: There were number of reason why exercise was beneficial to everyone, including people living with HIV positive. Exercise increase stamina, decrease body fat and total cholesterol, which increase HDL, the good cholesterol. It reduces resting heart rate. It also increases lung ability to absorb oxygen. It decreases the incidence of some cancers as well as general anxiety, tension and depression (Internet exercise & HIV, 2009).

2.14 Summary

The review of related literature found that prompt and effective treatment has dramatically ly increased the life expectancy of people living with HIV/AIDS (Peter & Kamath, 2014, Musawa, 2013 &Oladayo, 2014.). But the poor psychological adaptation was often as a result of stigma that leads to depression, fear, anxiety and felling of hopelessness of PLWHA (Hult, Wrubel, Branstrom, Accree&Tedlie, 2012). However, not only the discovery that one was infected with HIV lead to fear of progression to AIDS and fear of dying, it also creates anticipation of negative social reaction among People living with HIV /AIDS (Monjok, 2010 , Musawa, 2013 &Gerbi&Haptemarijam, 2012). Gerbi and Haptemarijam (2012). As well bodies of work have agreed that stigma and discrimination were barriers to the prevention treatment as well as fear of the negative perception of the disease (Musawa, 2013, NACA, 2010 &Lindersyl, 2001). Therefore, it would be of important to access the prevalence of psychosocial problem and HIV/AIDS risky behaviour in people living with HIV/AIDS (PLWHA).

Whereas, on the economic adaptation tremendous studies has agreed that contracting HIV/AIDS can lead to economic hardship, loss and denial of gainful employment as well as financial difficulties in accessing treatment, adequate nutrition and to leave an adaptive life despite HIV infection and collapse of economic (Ejimbe, 2010 & Interne science treatment writer, 2013.) Therefore, PLWHA should be encouraged to joint social groups (Anozie, 2011 &Gandema, 2002). However, patient engagement has become important in health care delivery (Berallo&Graffigna, 2014 &Anozie, 2011). Gender play important role in the determination of disease and frequency of disease among males and females living with HIV/AIDS (WHO, 2015). It was widely assumed that males were more responsible for the spread of the disease than female due to masculinity, polygamy high income, and indulging in drugs and alcohol leading to more sex partner, sexual violence, and sex without condom respectively. While most women were at disadvantages regarding education, welfare/income

that make them more vulnerable and at risk of spreading and contracting STIs including HIV/AIDS as a result of failure take the right decision. But women utilise health care services and access to social sport more the men (Dibua, 2009, Tigawalana, 2010, Elhadji, 2001 & WHO, 2015). Significantly intervention should address psychosocial, sociological, economic and other systematic issues that negatively influence the well being of people living with HIV/AIDS and Government need to strength policy environment that empowers people living with HIV/AIDS support groups (Adedemeji&Alawale, 2010 &Anozie, 2011 & NACA, 2010). However, the organise private sector were not doing much in supporting HIV control in Kaduna State (Mudashiru, 2013). But contrarily Ejimbi (2006), found that private sector have responded in different ways to mitigate the impact in Kaduna State. However, existing intervention to harness treatment through food security were limited. (weise, et. al, 2011).

In conclusion, majority of people living with HIV/AIDS were demoralise and neglected due to stigma and discrimination against that lead to physical, psychological, emotional and social discomfort. These lead to dementia, homelessness, disfigurement and financial constraint, unemployment, food insecurity and failure in treatment. In addition, psycho-social context was a driving force that impacted on the economic adaptation among people living with HIV/AIDS (PLWHA). Therefore, there were the needs to thoroughly understand psycho – social impact of burden of disease so that the required support can be address. These means the focus should be holistic in order to achieve a greater impact. The study review here was geographically limited and also limited studies found in the context that addresses both psycho-social and economic adaptation. These were what make this study to be unique.

Finally, there was the need for this study to adopt Bio psychosocial model that wouldbe useful in determine the psycho-social and economic adaptation among people living withHIV/AIDS in Kaduna State, Nigeria. The study further recommends the review andstrengthens policy that would save guard and support Network of people living withHIV/AIDS (NEWPLWHA) in Nigeria and decentralization of ART centers across KadunaState in order to reach out to the door step of people living with HIV/AIDS. However, therewould be the need for moral re-engineering by inculcating moral values that focuses onhuman right and violation of human right and dignities and sense of entrepreneurship to theyounger generation, so that they would grow up with a sense of sympathy, compassion,respect and more entrepreneur, This call for curriculum modification, altered rolls that haveto be adopted by teacher and education. This means all hard should be on deck tosynergisticallytackle the menaces of HIV/AIDS in Kaduna state.

CHAPTER THREE

Methodology

3.1 Introduction

The main purpose of the study was to assess the psychosocial and economic adaptation of people living with HIV/AIDS (PLWHA) in Kaduna State. To achieve this purpose, this chapter describes the research design, population, sample and sampling procedure, research instrument, validity of instrument, procedures for data collection and analysis**.**

3.2 Research Design

The research design that was used for this study was an ex-post facto research design. The ex-post facto design was adequate because the information required was available with the respondents, therefore, cannot be manipulated by the researcher. According to Nunes (2010), ex-post facto or after the fact research is a category of research design in which the investigation start after the fact has occurred without interference from the researcher.

3.3 Population of the Study

The population of this study consists of all people living with HIV/AIDS in the three (3) SenatorialDistricts of Kaduna state with a total of 268,903 (Kaduna State Ministry of Health, 2016)

3.4 Sample and Sampling Procedure

The sample size consists of 384 respondents. This Sampled table used was in line with the suggestions of Krejcie and Morgan (2006), who recommended that population sample size of 384, could be adequate for population of 268, 903.

The multi- stage sampling procedurewasused for the purpose of this study, which includes;stage 1

Stratified sampling procedure; for the purpose of data collection, the researcher used the three (3) already existing Senatorial districtsforming three3 strata. These three (3) Senatorial Districts include;

Kaduna North Senatorial District which include the following eight (8) Local Government Areas (LGAs), namely Kudan, Makarfi, Ikara, SabonGari, Soba, Kubau, Lere and Zaria. The Central Senatorial District with seven (7) LGAs, namely, Igabi, Giwa, BirninGwari, Kauru, Chukun, Kaduna North and Kaduna South. While, the South SenatorialDistrictcomprise of eight (8) LGAs namely, Jaba, Jama'a, Kajuru, Kaura, Sanga, Kachia, Kagarko and ZangonKataf. Hence, Kaduna State comprised of twenty three (23) LGAs.

Stage 2

Randomsampling was used to sample the two third(2/3) of the local Government Areas (5 LGA), from each senatorial district (stratum).This is in order to get a reasonable sampled size from each senatorial district (Stratum). The names of the twenty three LGAs were written on pieces of papers, squeezed, and then place them in three (3) different boxes representing the North, Central and South Senatorial Districts. Using deep hand method, three trained research assistants were assigned to picked five (5) papers from each box, a paper picked would be squeezed and return to the same box, sharked vigorously to ensure randomization, this means all LGAs were included. The names of LGAs picked from each box were the study areas. Therefore, a total of 15 LGAs were selected for the purpose of this study. However, the stratum were named (A, B and C) to represents North, Central and south senatorial districts respectively. According to Ibrahim and David (2004), simple random sampling is the simplest form of probability sampling. To select a sample, researcher should make a list of all units in the population, from which to draw a sample, decide on the size of sample and select the required number sampling unit.

Stage 3

Purposive or convenient sampling was use to select a health care facility from each selected Local Government Area (LGA). The selected health care facilities for Kaduna North include General Hospital Saminaka, General Hospitals Makarfi, General Hospitals Ikara, Rural HospitalsPanbeguwa and Rural Hospitals Maigana. While the selected health carefacilitiesfor Kaduna central senatorial district were General Hospitals Amina, General HospitalsRigasa, Yusuf Dan Tsoho Memorial Hospitals Kaduna, Rural HospitalsGiwa and General HospitalsKawo. The Southsenatorialdistrict consists of General Hospitals Kwoi, General Hospitals Kafanchan, Rural Hospitals Kagarko, Rural Hospitals Doka and Rural HospitalsIdon.

Stage 4

The proportionate sampling technique was used to sample the respondents as follow:

Observed population per LGA x sample size = sample

Cumulative of population from the 3 senatorial district (stratum)

Stratum A (Kaduna North Senatorial District)

Lere	21,604 x 384 268903	= 31
Kubau	8,400 x 384 268903	= 26
Makarfi	9,542 x 384 268903	= 14
Soba	19,133 x 384 268903	= 27
Ikara	12,651 x 384 268903	= 18
Total		= 116

Stratum B (Kaduna Central Senatorial District)

Chikun	$\frac{24,024}{268903} \times 384$	= 34
Giwa	$\frac{18,686}{268903} \times 384$	= 27
Igabi	$\frac{28,068}{268903} \times 384$	= 40
Kaduna South	$\frac{26,251}{268903} \times 384$	=38
Kad. North	$\frac{23.335}{268903} \times 384$	= 34
Total		= 173

Stratum C (Kaduna South Senatorial District)

Kajuru	$\frac{7,232}{268903} \times 384$	= 10
Jaba	$\frac{10,137}{268903} \times 384$	= 14
Kachia	$\frac{15,936}{268903} \times 384$	= 23
Kagarko	$\frac{15,719}{268903} \times 384$	= 22
Jama'a	$\frac{18,184}{268903} \times 384$	= 26
Total		= 95

D Total for A, B and C =384

Table 3.1Summary of sampled Local Government Areas (LGAs) and Health Care Facilities (HCF) From the Three Senatorial District of Kaduna State

Sen. Dest.	Sampled LGAs	Sampled HCF	Population	Sampled Size
Kaduna North	Lere	G.H Saminaka	21,604	31
	Kubau	R.H Pambeguwa	18,400	26
	Makarfi	G.H Makarfi	9,542	14
	Soba	R.H Maigana	19,133	27
	Ikara	G.H Ikara	12,651	18
Kaduna Central	Chikun	G.H Amina	24,024	34
	Giwa	R.H Giwa	18,686	27
	Igabi	G.H Rigasa	28,068	40
	K. South	YDMHK	268903	38
	Kad. North	G.H Kawo	23,335	34
Kaduna South	Kajuru	R.H Idon	7,233	10
	Jaba	G.H Kwoi	10,137	14
	Kachia	R.H Doka	15,936	23
	Kagarko	R.H Kagarko	15,719	22
	Jama'a	G.H Kafanchan	18,184	26
TOTAL	15	15	268,903	384

3.5 Instrumentation

The research instrument used for this study was a close-ended questionnaire. Some of the items were adapted from (Njoku, 2015), while some items generated from relevant literature reviewed for this study. The questionnaire was structured in to four (4) sections (A, B, C and D). Section A contains six (6) items on demographic information of the respondents. Section B contains ten (10) items on psychological adaptation of people living with HIV/AIDS. Section C contains ten (10) items on sociological adaptation of people living with HIV/AIDS. Section D contains ten (10) items on economic adaptation of people living with HIV/AIDS (PLWHA). Hence, the questionnaire used for data collection for this study consists of thirty six (36) items. To respond to the various items in the questionnaire, a modified 4 point Likert Scale was used as follows:

Strongly Agree	SA	4
Agree	A	3
Disagree	D	2
Strongly Disagree	SD	1

Hence, the acceptance mean scores is 2.5 which show level of positivity of the response per item, while any number that falls below the mean score of 2.5 reveals the level of negativity of the item. The distance between each of the modified likertscals was 2.5.

3.6 Validity of Instrument

To validate the research instrument for content and face validity, five jurors from the Department of Physical and Health Education and Health related department were given copies of the questionnaire for vetting. Based on the suggestions made by these jurors, some of the items were removed and some of the items were modified before the research instrument was used for data collection**.**

3.7 Procedure for Data Collection

The administration of the questionnaire was conducted by the researcher and his three (3) trained research assistants per health care facility, who have been trained for this purpose of distributing and retrieving of the questionnaire from the respondent. The researcher and his trained research assistants administered the questionnaire purposively to the respondents who visits the health care facility for their routine treatment until the required number of subject was collected from the 15 sampled health care facilities treating HIV/AIDS in Kaduna State has been reached. However, the researcher and his trained research assistants interpret the structured statements to the subjects who cannot read or do not understand the statement. The respondents complete the questionnaire at the spot and returned it immediately.

3.8 Procedure for Data Analysis

To analyse the data collected for this study, the following statistics were used

1. Descriptive statistics of frequency and percentage (%) were used for demographic data
2. Mean and standard deviation were used to answer the research questions
3. Inferential statistics of one sample t- test was used to test HOs 1-3.
4. Inferential statistic of two sample t- test was used to test HOs 4-6.

CHAPTER FOUR

RESULTS AND DISCUSSION

4.1 Introduction

The purposes of this study were to assess the psycho-social and economic adaptation among people living with HIV/AIDS in Kaduna state. The research design that was used for this study was an expose facto research design. The population of the study was268,903 people living with HIV/AIDS in Kaduna state. The sample consists of three hundred and eighty four (384) respondents. Purposive sampling was used to distribute 384 questionnaires and retrieved same from the respondent who were people living with HIV/AIDS in Kaduna state by the researcher and his 3 train research assistance per health facility.

The demographic characteristics on psychological, sociological and economical adaptations were age, gender, marital status, level of education. The subjects were classified into frequency and percentage for each of this variableHowever, the presentation in the chapter was done on sectional basis in line with the research objectives and questions of the study. These sections of the chapter contained answer to the research questions, test of the studies hypotheses and discussion of the studies finding from the data. Mean and standard deviation were used to answer the research questions, one sample t-test was employed to test hypotheses 1-3 and 2 sample t- tests was used to test hypotheses 4-6 formulated for this study. The psychological variables considered in the study were emotional variables such as anger, anxiety, distress depression among others, while sociological variables were social support, interaction with people, acceptance, encouragement among others and economic variables were access to treatment, income, social relief, saving, among others. To respond to the various items on the questionnaire a modified 4 point likert scale was used as follow: strongly agree SA (4.00-3.50), Agree A (3.49-2.50) Disagree D (2.49 – 1.50) and strongly

disagree SD (1.49 – 1.00). The acceptance means score was 2.5 which indicate level of positively of response per item.

4.2 Results

Table 4.1Demoographic Characteristicsof theRespondents

Variables	Responses	Frequency	Percentage
Ages Range	(a)15-19 years old	23	5.9
	(b) 20-24 "	25	6.5
	(c) 25-29 "	48	12.5
	(d) 30-34 "	60	15.6
	(e) 35-39 "	89	23.1
	(f) 40-44 "	78	20.3
	(g) 45-49 "	41	10.6
	(h) 50& Above "	20	5.2
Total		384	100
Gender	(a) Male	205	53.3
	(b) Female	179	46.7
Total		384	100
Marital Status	(a) Married	79	20.5
	(b) Single	109	28.3
	(c) Divorced	34	8.8
	(d) Widow /Widower	100	26
	(e)Separated	62	16.1
Total		384	100
Level of Education	(a) Not Educated	95	25.5
	(b)Islamiyya	23	5.9
	(c)Primary 133		34.6
	(d) Secondary	80	20.8
	(e) Tertiary	50	13
Total		384	100

Observation in Table 4.1 above reveals that majority 89 (23.1%) of the respondents were between ages 35-39 years and respondents age of 40-44 were 78 (20.3%) in numbers. The rest of the subject 60 (15.6%, 48; 12.5% 20; 5.2%) were lesser in numbers. With regard to gender, the malerespondents were more 205 (53.3%) than female counterpart (179; 46.7%). The majority of respondents 109 (28.3%) were not married, but single. The table above also shows that quite a number of widows/widowers 100 (26%) responded to the research

instrument. The married respondent who made themselves available was not as many as 79 (20.5 %).

Classification in Table 4.1 above level of education indicated that majority of the respondents 133 (34.4%) obtained primary school living school certificate. However, the Table also shows that many respondents were not educated 95 (25.5%). The rest of the respondents were80 (20.8%) 50(13%) 23 (59%) certainly not as many as earlier classification.

4.2.1 Answering Research Question 1:

What is the psychological adaptation of people living with HIV/AIDS in Kaduna State?

Table 4.2 Mean Score and Standard Deviation of Responses of People Living With HIV/AIDS on Psychological Adaptation

S/N	Item	Mean	Standard Deviation
1.	I sometimes get upset for being Stigmatize and let my emotion go away	3.31	.94736
2.	I feel a lot of emotional distress such as anger, anxiety and depression and find myself expressing this feeling	3.39	.82896
3.	I admit to that I cannot deal With it I am just trying	3.32	.92665
4.	I imagine that the virus it's just outside My body	3.47	.79446
5.	I pretend it's not part of me	3.34	.85806
6	I tell myself it does not matter Being tested positive	3.55	.73864
7.	I think of people enjoying doing things With me despite my status	3.39	.83523
8.	I do dream about things other than Being tested positive	3.30	.88350
9.	I have gained assertiveness	3.42	.80087
10.	I do not have trouble sleeping	3.57	.79177
	Aggregate mean score	3.41	.841

A careful look at Table 4.2 above shows that psychological adaptation with I do not have trouble sleeping (X= 3.57, SD= .79177) having highest mean as a factor indicating positive psychological adaptation. However, the respondents agree with I sometime get upset for

being stigmatised and let my emotion go away (X= 3.31, SD = .94736) with a lower mean scores but meet the criteria for the average mean score of 2.50 that indicate positive response.

4.2.2 Answering Research Question 2:

What is the sociological adaptation of people living with HIV/AIDS in Kaduna State?

Table 4.3 Mean Score and Standard Deviation of Responses of People Living With HIV/AIDS on Sociological Adaptation

S/N	Item	Mean	Standard Deviation
1.	I try to get advice from someone about what to do	3.48	.84562
2.	I put my trust in GOD because he sustain life	3.58	.72562
3.	Someday someone will be here to help me manage condition of living with it	3.53	.75380
4.	Someone is encouraging me to see my doctor and take my medication	3.20	.93685
5.	I feel very conformable in social in social gathering like naming, marriage and religious gathering despite my status	3.36	.84952
6.	Friend accept me and interact with me despite being tested positive	3.54	.76717
7.	I try to be around other people for interaction in order to leave happily	3.18	.99864
8.	My family involves me in decision making despite my status	3.19	1.01747
9.	People share time with me regardless of my status	3.08	1.03779
10.	I talk to someone who could do something about living with it	3.35	.89565
	Aggregate mean score	3.33	.882

Observation on Table 4.3 above reveals that sociological of respondents with I put my trust in GOD because He sustain life (X= 3.58, SD= .72567) with the highest mean score. However, the respondents agree with people share time with me despite my status (X= 3.08, SD= 1.037) with lower mean but within the positive range of the acceptance mean score of 2.5.

4.2.3 Answering Research Question 3:

What is the economical adaptation of people living with HIV/AIDS in Kaduna State?

Table 4.4 Mean Score and Standard Deviation of Responses of People Living With HIV/AIDS on Economical Adaptation

S/N	Item	Mean	Standard Deviation
	My family members support me for medication	3.01	1.05832
	I receive reimbursement from medical scheme for medication	3.23	.96314
	I receive support from friends and relatives for my needs	2.99	1.080755
	I trade to make some money for my upkeep and Medication	3.51	.71166
	I reduce my expenses in order to cope with my my dieting.	3.45	.82243
	I am contentment with little money I made from my source of income.	3.26	.95654
	I joint support group to access treatment	3.30	.95726
	I receive social relief to survive	3.31	.94736
	I borrow from money lenders to cope with My medication	3.39	.82896
	I use cash and saving to overcome all my expenses such transportation and dietary supplement like fruit	3.32	.92665
	Aggregate mean score	3.28	.926

Available data in Table 4.4 indicated that economic adaptation with I receive support from friends and relative for my needs (X= 2.99, SD= 1.08744) having a lower mean but within the acceptance mean score of 2.50 indicating passivity of response. The response I trade to make some money for my upkeep and medication (X= 3.51, SD= .71166) having mean. Therefore, the result showed a positive economical adaptation of the respondents. .

4.2.4 Test of Hypotheses 1

The psychological adaptation of people living with HIV/AIDS is not significant in Kaduna State

Table 4.5 Summary of one Sample t-test Analysis on Psychological Adaptation of People Living With HIV/AIDS

Variable	N	Mean	SD	DF	t-value	P
Psychological Adaptation	**384**	**3.41**	**0.840**	**383**	**80.978**	**0.00**

t= (384) = 80.978 P< 0.05 significance.

The result is significant, the null hypothesis is rejected.

Data in table 4.5 above reveals that the observed value of t=Cal is 80.978 > t=crit. is 1.96. This means subject significantly adapt to their psychological adaptation situation. The observed level of significant was lower than 0.05 ($p < 0.05$). These means significantly adapt by their psychological adaptation of the situation. This observation was a good evidence to reject the null hypotheses that the psychological adaptation of people living with HIV/AIDS is not significant in Kaduna State.

4.2.5 Test of Hypotheses 2

The sociological adaptation of people living with HIV/AIDS is not significant in Kaduna State.

Table 4.6 Summary of one Sample t-test Analysis on Sociological Adaptation of People Living With HIV/AIDS

Variable	N	Mean	SD	DF	t-value	P
Psychological Adaptation	**384**	**3.35**	**0.882**	**383**	**77. 918**	**0.00**

t= (384) =77.918 P< 0.05 significance.

Null hypothesis is rejected.

The result in Table 4.6 above indicated that the observe value of t-cal=77.918 > t-crit. =1.96 df 383). The observed level of significant was lower for the test was lower than 0.05 ($p < 0.05$). Therefore, observation was also a good evidence to reject the null hypotheses that the psychological adaptation of people living with HIV/AIDS is not significant in Kaduna State.

4.2.6 Test of Hypotheses 3

The economical adaptation of people living with HIV/AIDS is not significant in Kaduna State.

Table 4.7 Summary of one Sample t-test Analysis on economical Adaptation of People Living With HIV/AIDS

Variable	N	Mean	SD	DF	t-value	P
Psychological Adaptation	**384**	**3.28**	**0.926**	**383**	**71.918**	**0.00**

Careful observation of Table 4.7 above shows that the result was significant difference exist to the economical adaptation of people living with HIV/AIDS t-cal=46.942 > t-crit. =1.96, df383.) However, the observed levels of significance for the test was lower than 0.05 (p>0.05). Hence, the null hypothesis that the economic adaptation of people living HIV/AIDS was not significant in Kaduna State was rejected.

4.2.7 Test of Hypotheses4

There is no significant difference between male and female living with HIV/AIDS in their psychological adaptation in Kaduna State.

Table 4.8 Summary of two Sample t-test Analysis on psychological Adaptation Between Males and Females Living With HIV/AIDS

Variable	N	Mean	SD	DF	t-value	P
Males	**205**	**3.43**	**0.81**	**383**	**56.083**	**0.00**
Females'	**179**	**3.38**	**0.83**			

t= (384) =56.083 P< 0.05 significance.
Null hypothesis is rejected.

Result in Table 4.8 above indicated that the observed value of t-cal=56.083 > 1.96, df, 383. This means that the t-calculated was higher than the critical value. However, the observed levels of significance for the test was lower than 0.05 (p < 0.05). Therefore, subject difference significantly exist bet males and females living with HIV/AIDS in their psychological adaptation. Hence, the null hypotheses that the psychological adaptation between male and female living with HIV/AIDS is not significance in Kaduna State was rejected. The deference was in favour of males having a mean score of 3.43.

4.2.8 Test of Hypotheses 5

There is no significant difference between male and female living with HIV/AIDS in their sociological adaptation in Kaduna State.

Table 4.9 Summary of two sample t-test Analysis on Sociological Adaptation Between Males and Females Living With HIV/AIDS

Variable	N	Mean	SD	DF	t-value	P
Males	**205**	**3.35**	**0.91**	**383**	**46.942**	**0.00**
Females'	**179**	**3.31**	**0.85**			

t= (384) =46.942 P< 0.05 significance.
Null hypothesis is rejected.

Result in Table 4.9 above indicated that the observed value of t-cal= 45.942 > t- crit. = 1.96, df 383. The value of the calculated value was higher than the value of critical value. This means subject difference significantly exist between male and female living with HIV/AIDS in their sociological adaptation. However, the observed levels of significance for the test was lower than 0.05 (p< 0.05). These observations was a good evidence to reject the null hypotheses which stated that there is no significance difference between male and female living with HIV/AIDS in their sociological adaptation in Kaduna State is rejected. The deference was in favour of means having a mean score of 3.35.

4.2.9 Test of Hypotheses6

There is no significant difference between male and female living with HIV/AIDS in their economic adaptation in Kaduna State.

Table 4.10 Summary of two Sample t-tests Analysis on Economical Adaptation Between Males And Females Living With HIV/AIDS

Variable	N	Mean	SD	df	t-value	P
Males	**2053.30**		**0.83**	**383**	**0.943**	**0.105**
Female	**179**	**3.30**	**0.95**			

t= (384) =0.943, P $\leq$ 0.05 significance.
Null hypothesis is retained.

The result in the Table 4.10 above indicated that the observed value of t- cal 0.943 < t- crit. =1.96, df 383.This means, the value of the calculated value was less than the critical value.

The observe level of significance was at ($p>0.05$).The null hypotheses that stated that there is no significance difference between male and female living with HIV/AIDS in their economic adaptation and gender deference is therefore retained. This observation was good evidence to retain the null hypotheses.

4.3 Discussion

The demographic characteristicsof the respondents were organize and presented to include age, gender, marital status, and level of education. Observation in Table 4.1 reveals that majority, 89 of the respondents were between ages 35-39 years and respondents' age of 40-44 were 78 in number. The rest of the subject 60, 48, 20 were not as many as the earlier ages described. With regard to gender, the male respondents were more 205 than female counterpart 179. The majority of respondents 109 were not married, but single. The table shows that quite a number of widows/widowers 100 responded to the research instrument. The married respondent who made themselves available were not as many as 62.

The analysis of data collected for answering the research questions, result in Table 4.2 shows that psychological adaptation with I do not have trouble sleeping having the highest mean as a factor indicating positive psychological adaptation. However, the respondents agree with I sometime get upset for being stigmatize and let my emotion go away with a lower mean than the rest of the scores but is above the average mean score of 2.50 that indicate positive response.

A careful look at the result in Table 4.3 reveals that sociological adaptation of response with I put my trust in GOD because He sustain life having the highest mean score. Furthermore, the respondents agree with people share time with me despite my status, having lower mean but within the positive range of the acceptance mean score of 2.5

Available data in Table 4.4 indicated that economic adaptation with I receive support from friends and relative for my needs having a lower mean score of the acceptance mean score of 2.50 indicating passivity of response. The responses with I trade to make some money for my upkeep and medication having higher mean than the other economical variable. Therefore, the result showed positive economical condition of the respondent's because of having a higher mean score that was far above the acceptance mean score of 2.50.

From the analysis of data collected for the study and test of hypotheses, it was result in Table 4.5shows that psychological adaptation of people living with HIV/AIDS was positive. However, the observed levels of significance for the test was lower than 0.05 ($p< 0.05$). Although other studies such asMusawa (2014) oppong (2012) Higgins and Hoffman reveals that depression was twice as common in people living with HIV/AIDS (2001). Some of the feeling that people living with HIV/AIDS experience include shock or anger at being positively diagnose with HIV, fear of isolation by family and friend and worries about infecting others (Desquibet et. al, 2002 & Emanuel, 2010 &Musawa, 2014, &oppong, 2012). The finding was inline with chang and chung (2007) who reported that in order to live an adaptive life despite HIV infection patient need to negotiate between the demand of chronic illness and their goal of living a normal life. This means people living with HIV/AIDS have adapted to their psychological situation in Kaduna State.

The result in Table 4.6 shows that sociological adaptation of people living with HIV/AIDS was positive. However, the observed level of significance of the test was lower than 0.05 ($p< 0.05$). UNDP (2010) affirm that inadequate information, misinformation, and superstitious beliefs have in the pass acted synergistically to fuel discrimination, stigmatization of people living with HIV/AIDS. This mean people's living with HIV/AIDS has overcome such problems. In order to enjoy physical health, social support and financial independence patient have to work on a number of areas that require persistence effort. These were treatment related stress and relationship with significant others (chang&chung, 2007).

The analysis of the result on economic adaptation of people living with HIV/AIDS in Table 4.7 reveals that people living with HIV/AIDS have positive adaptation to their economic adaptation. However, the observed levels of significance for the test was lower than 0.05 ($p< 0.05$). The establishment of cooperatives would help prevent and raise household from poverty as they organize themselves into skills training, cooperatives and rotating saving, and created associations of people living with HIV/AIDS need to be accompanied by training in

various trade. This would equip individual with ability to diversify their livelihood activities (Bako, Mamman&Laah, 2014).

From the respondents point of view on psychological adaptation and gender difference of people living with HIV/AIDS. The finding of the study in table 4.8 shows that male and female living with HIV/AIDS significantly differs to their psychological adaptation. However, the observed level of significance of the test was lower than 0.05 ($p< 0.05$). This was not in conformity with Kalichman (1999) who reported that psychological correlate of continues risk behaviours were investigated, a sample of 203 HIV positive men and 129 HIV positive women from infections disease clinic and AIDS service agency. The study shows that (42%) of men and (42%) of women reported taking risk. Tigawalana (2010) documented that some of the gender inequalities do not increase the vulnerability of women to HIV/AIDS but also become factors that fuel the spread of the epidemic.

The analysis on sociological adaptation and gender difference of people living with HIV/AIDS reveals that male and female living with HIV/AIDS significantly differ to their sociological adaptation and gender difference in table 4.9. Therefore, the null hypotheses which stated that male and female living with HIV/AIDS do not significantly differ in their sociological adaptation was therefore rejected. However, the observed levels of significance for the test was lower than 0.05 ($p< 0.05$). This was in conformity with WHO (2015) who documented that socialization of men may mean that they would not seek HIV services and share with others due to a fear of stigma and discrimination, losing their job and of being perceived as weak or unmanly and Elhadji (2001) reported that all over the world, there were strong social pressures to ensure that women and girls remain ignorant about gender safer sex, sexuality and relationship as well as HIV/AIDS. Significant feminist scholarship that women were embedded in contest and relationship in which HIV risk was heightened (Higgina, Hoffman, Dworkin, 2011).

From the result on the economical adaptation and gender difference in Table 4.10 indicate that male and female living with HIV/AIDS do not significantly differ ($p > 0.05$) to their economical adaptation. This means male and female livings with HIV/AIDS do not significantly differ in their economic adaptations in the test of hypotheses. Therefore, the null hypotheses which stated that there is no significant difference between male and female living with HIV/AIDS in their economic adaptations was retained. This was not contrary with Bako, Mamman and Laah (2014) who reported that there were need to focus on the economic aspect of the epidemic, attention and resources to be directed toward the economic empowerment of households, individuals, men and women who were in need. Programmes can improve access to services of women and men by removing financial barriers in access to service, bring service closer to the community including in health care setting (WHO, 2015). But according to Adeyi and Kanki (2006), globalization present both challenges and opportunities, however, which can be harnessed to balance some of the inequalities between men and women in period of health emergencies such as HIV/AIDS epidemic.

CHAPTER FIVE

Summary, Conclusion and Recommendations

5.1 Summary:

The main purpose of the study was to assess the psycho-social and economic adaptation among people living with HIV/AIDS in Kaduna State. To achieve this purpose six (6) research question and six (6) research hypotheses were formulated for the study. The questionnaire which was employed as instrument used to gather information for the study contains four 4 major sections: Demographic characteristic of respondents, Psychological, sociological and economical adaptations of people living with HIV/AID respectively.

5.1.1 Summary of Major Findings:

The major findings of the study were:

- Psychological adaptation was significant ($p < 0.05$) among people living with HIV/AIDS Kaduna State
- Sociological adaptation was significant ($p < 0.05$) among people living with HIV/AIDS Kaduna State
- Economical adaptation was significant ($p < 0.05$) among people living with HIV/AIDS Kaduna State
- Male and female living with HIV/AIDSsignificantly differ in ($p < 0.05$) in their psychological adaptation Kaduna State.
- Male and female living with HIV/AIDSsignificantly differs ($p < 0.05$) in their sociological adaptation Kaduna State.
- Male and female livings with HIV/AIDS donot significantly differ ($p > 0.05$) in their economic adaptation.

5.2 Conclusion

On the basis of the finding in of the study, the following conclusions were drawn:

- People living with HIV/AIDS have psychological adaptation in Kaduna State.
- People living with HIV/AIDS have sociological adaptation in Kaduna State
- People living with HIV/AIDS have economic adaptation in Kaduna State
- Male and female living with HIV/AIDS differs in their psychological adaptation in Kaduna State.
- Male and female living with HIV/AIDS differs in their sociological adaptation in Kaduna State.
- Male and female livings with HIV/AIDS do not differ in their economical adaptation in Kaduna State.

5.3 Recommendations:

On the basis of conclusion drawn, the following recommendations were made:

1. Concerning the psychological adaptation of people living with HIV/AIDS (PLWHA) in Kaduna State it was concluded PLWHA adapt to their psychological adaptation variables. Therefore, it was recommended that HIV/AIDScounseling should be sustaining to archive great impact on overcoming emotional distress, such as anger, anxiety and depression. And continuity ineducating community members to stop stigmatization of HIV infected person be sustain.
2. Civil society organization should continue to put more effort in order to reach out to the door step of people living with HIV/AIDS (PLWHA) to organized them to form a support groups, so as to ensure their involvement in planning and development behavioural change activities relating to stigma and discrimination as well as inassisting them to get more packages that would improved their life's at thegrass root level.

3. Government should continue to strength the policy environment that empowers people living with HIV/AIDS support groups in order to close the gap in treatment by ensuring all HIV/AIDSinfected person enable everywhere access treatment services.

4 There were the need for more advocacies on the danger of drugs and alcohol especially during social event to HIV infected persons so that should practice safe sex if they cannot abstained as well as on how to promote gender equalities as a basis for human rights advancement.

5 Also mass media need to intensify effort to ensure the dissemination of the correct and appropriate information on dangers associated with defaulting or non adherence to treatment / antiretroviral therapy of persons infected with HIV/AIDS. This was in order to avoid transmission of resistance strength a major problem among males and females living with HIV/AIDS.

6 Government should empower people living with HIV/AIDS as poverty and wealth inequalities between men and women can fuel the transmission, as some infected men and women engaged in unsafe sex practices in exchange of money as a result of sugar daddy and sugar mommies syndrome which need to be stopped.

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