



PSYCHOSOCIAL PROBLEMS OF ADULTS LIVING WITH HIV/AIDS IN JOS, NORTH CENTRAL NIGERIA

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ABSTRACT: *Introduction: HIV is a major global public health issue. People living with HIV and their families have a wide variety of problems including psychosocial problems which need to be addressed. Methods: This is a descriptive cross-sectional study carried out to identify and measure the psychosocial needs of adult PLWHA attending two hospitals in Jos, Nigeria. Results: There was a total of 390 respondents interviewed. The mean age was 33.4 ± 7.7 years and 245 (62.8%) respondents were females while 145 (37.2%) were males. In all, 360 (92.7%) reported disclosing their status while 338 (86.7%) reportedly received counselling for disclosure. Most respondents, 224 (77.8%), disclosed their status to their partners while only 61.5% know their partner's HIV status. Also, over 4% reported no preventive/protective measures for their partners. Most respondents (92.1%) desire spiritual support and the preferred source of Spiritual support for the majority (63.4%) of the respondents is their pastor or Imam while some (16.5%) would rather relate with their God directly. Conclusion: In conclusion, although counselling for disclosure and disclosure to partners was high, spiritual support and involvement in care and support groups were low. There is a need to sustain and strengthen psychosocial support for PLHA in order to meet these needs thus improving their quality of life.*

KEYWORDS: HIV/AIDS, Psychosocial needs, Disclosure, Stigma.



INTRODUCTION

HIV continues to be a major global public health issue, having claimed 36.3 million [27.2–47.8 million] lives so far. There were an estimated 37.7 million [30.2–45.1 million] people living with HIV at the end of 2020, over two-thirds of whom (25.4 million) are in the WHO African Region. In 2020, 680 000 [480 000–1.0 million] people died from HIV-related causes and 1.5 million [1.0–2.0 million] people acquired HIV. (1)

The Government of Nigeria indicates a national HIV prevalence in Nigeria of 1.4% among adults aged 15–49 years. Previous estimates indicated a national HIV prevalence of 2.8%. (2) The Joint United Nations Programme on HIV/AIDS (UNAIDS) and the National Agency for the Control of AIDS (NACA) estimate that there are 1.9 million people living with HIV in Nigeria in 2019 and an estimated 3.1 million people living with HIV/AIDS (PLWHA) in 2017 thus making Nigeria one of the countries with the highest number of people living with HIV/AIDS in the world. The PLWHA and their families have a wide variety of problems including psychosocial needs.

Nigeria has the second-largest HIV epidemic in the world. (3) Although HIV prevalence among adults is much less (2.8%) than other sub-Saharan African countries such as South Africa (18.8%) and Zambia (11.5%), the size of Nigeria's population means 3.1 million people were living with HIV in 2017. The adult prevalence of HIV/AIDS gradually increased from 1.8% in 1991 to 5.8% in 2001, dropped to 5.0% in 2003 (4) and further dropped to 4.4% at the end of 2005. (5)

Nigeria is the 10th most populous nation in the world and the largest in Africa thus the spread of the disease has grave consequences for the country, continent & the world. The Nigerian epidemic has different phases with different states and geopolitical zones in the country recording different prevalence rates. Some are above the national average while others are below it but the worst-hit geopolitical zone is the Northcentral zone with a prevalence of 7.0%. Jos North Local Government Area is located in this zone. The prevalence of HIV/AIDS in Jos is 7.7% (2003) (4). Although there are no available estimates of the number of PLWHA in Jos, a study carried out by the Plateau State AIDS Control Agency (PLACA) showed that 26,374 people tested positive for HIV infection out of 122,253 that were screened in health facilities in the state from 1999 to 2004 (5).

PLWHA and their families have a wide variety of problems that manifest in various degrees in the community, workplace, and health setting. Comprehensive care and support services must include medical care for everyone, psychological support, socioeconomic support, rights/legal support and involvement of PLWHAs.

All PLWHA have medical needs and should receive medical care regardless of gender or age. The needs include counselling and testing for diagnostic purposes (including dedicated programs of voluntary counselling and testing), prophylaxis of opportunistic infections, management of HIV/AIDS-related illness control of tuberculosis and management of sexually transmitted infections, management of HIV disease with ART, palliative care, access to drugs related to HIV/AIDS including drugs for opportunistic infections, cancer related to HIV/AIDS and antiretroviral drugs; interventions to reduce the mother-to-child-transmission of HIV; support systems such as function laboratories and drug management systems; nutritional



support; health education measures; adequate universal precautions in clinical settings and post-exposure prophylaxis.

Apart from medical needs, PLWHA also has psychological needs. This includes initial and follow-up counselling services that help to meet the emotional and spiritual needs of PLWHAs and their families and to assist in disclosure, including psychosocial support through support groups, Post-test clubs and other peers, volunteer or outreach approaches within communities. For effective and efficient care and support services, these psychosocial needs should be identified and quantified. A systematic review of a number of North American and Australian studies which focused on the linkages between psychological well-being, social support and coping confirmed strong associations between these domains in both men and women. (6) The importance of this cannot be overemphasised as another study carried out in the USA (7) showed that psychological distress, symptoms of anxiety and depression are common among adult PLWHA. Another study in Kenya (8) showed that support of close family relations and care shown by communities and religious fellowships helped meet the emotional, social and spiritual needs of AIDS patients. Similar studies in Nigeria showed that the needs perceived as most important psychosocial needs by HIV/AIDS patients were not met by their most valued sources of social support. (9)

The psychosocial needs of PLWHA are enormous while resources available for care and support services in Nigeria are grossly inadequate. Available resources should be allocated based on proper planning and resource utilization for optimal results. This requires knowledge of the peculiar psychosocial needs of PLWHA.

There are a number of governmental and non-governmental healthcare institutions offering care and support to PLWHA in Jos North L.G.A. However, available documentation of psychosocial needs and care and support services received by PLWHA in this L.G.A. is scarce. This study, therefore, hopes to contribute to generating information that may serve as bases for sound planning and optimal allocation of available resources in the fight against HIV/AIDS in Jos North L.G of Plateau state and other similar settings in Nigeria.

Aim and Objectives

Aim:

To assess the psychosocial needs and support of adults living with HIV/AIDS attending healthcare institutions in Jos, North Central Nigeria.

Specific Objectives

1. To describe issues pertaining to disclosure of HIV status among adult PLWHA in these institutions in Jos, North Central Nigeria.
2. Determine the level of spiritual needs and support among these clients.
3. Determine the level of psychosocial support of adults living with HIV/AIDS attending healthcare institutions in Jos, North Central Nigeria.



METHODOLOGY

Study area

This study was carried out in the Faith Alive Hospital (owned by a non-governmental organization – Faith alive Foundation) and Plateau State Specialist Hospital (owned by the Plateau State Government) both located in Jos North Local Government Area of Plateau State, North Central Nigeria. FAH was established in 1996 and has an estimated patient load of over 4,000 while the PSSH is a well-staffed training centre for general medical practice in Plateau State with over 120-bed capacity and over 1,720 adult PLWHA (over 750 adults on ART).

Study Populations

The study population consists of adult PLWHA between the ages of 15-49 years, who have been confirmed positive for HIV/AIDS and receive care and support from FAH and PSSH.

Study Design

This is a hospital-based descriptive cross-sectional study.

Sampling Process/Technique

Every 4th patient visiting the HIV clinic gives consent for the interview using a systematic sampling technique. When a patient declines to consent, the next patient who consents to be interviewed is then selected until the sample size is attained.

Sample Size

Total sample size = 388.

Data Collection

Informed consent was obtained either verbally or in writing. Afterwards, self-administered questionnaires were distributed to the patients for responses if the patient was literate enough. Where the patient needed any assistance or is illiterate the researcher, assisted by trained assistants, was on hand to administer the questionnaires.

Data Collection Instruments

Self-administered (for literate clients) and interviewer-administered (for non-literate clients) semi-structured questionnaire was used to collect information on socio-demographic characteristics and psychosocial needs of adult PLWHA. The instrument was pre-tested by the researcher at ECWA Evangel Hospital HIV Clinic.

Data Analysis

Data analysis was done using SPSS 11.0 edition. Frequencies were generated and the test statistic was Chi-Square for proportions with a level of significance set at $P < 0.05$.

Validity

The instrument (questionnaire) was pre-tested at the HIV clinic of the ECWA Evangel Hospital, at Jos North LGA to ensure that questions were easily understood and measured what



they were intended to measure. Difficult or ambiguous questions were either restructured or removed. The research assistants selected for the study were trained adequately.

Ethical Considerations

Ethical Review Committee of PSSH and the Research and Grants Department of FAH gave ethical approval and permission to carry out this study. Informed consent was sought and obtained from all patients either in writing or verbally. Confidentiality was ensured as names were not required from Respondents.

RESULTS

Table 1: Sociodemographic Characteristics of Respondents

Variables	N	n%
Age category		
<19 years	4	1%
20-29 years	129	33.10%
30-39 years	165	42.30%
>40 years	92	23.60%
Marital status		
Never married	114	29.20%
Married	162	46.70%
Separated	12	3.10%
Divorced	18	4.60%
Widowed	64	16.40%
Education		
None	13	33.20%
Quranic	3	0.80%
Primary	67	17.20%
Secondary	147	37.70%
Tertiary	160	41.10%
Occupation		
Higher professional	5	1.30%
Lesser professional	180	46.20%
Skilled manual	69	17.70%
Partly skilled occupation	55	14.10%
Unskilled	81	20.80%



Religion		
Christianity	365	93.60%
Islam	23	5.90%
Others	2	0.50%
Sex		
Male	145	37.20%
Female	245	62.80%
Duration of illness		
<12 months	194	49.7%
12 months and above	196	50.3%
Facility		
FAH	199	51%
PSSH	191	49%
Total	390	100%

A total of 390 respondents were interviewed, 245 representing 62.8% were females and 145 (37.2%) were males. The mean age was 33.4 ± 7.7 years with a minimum age of 16 years and a maximum of 49 years. The age group 30-39 has the highest proportion (42.3%) followed by 20-29 (33.1%) – together they make up 75.4% of the respondents.

There were 199 (51%) respondents from FAH and 191 (49%) respondents from PSSH. Lesser professionals (46.2%) constituted the highest proportion of respondents like Civil Servants, teachers, clerks while the least proportion (1.3%) were higher professionals like Lecturers, doctors, bankers or engineers. Concerning the duration of illness, 49.7% were diagnosed less than 12 months prior to the study while 50.3% of the respondents were diagnosed at least 1yr before the study. The majority of the respondents (46.7%) were married. This is followed by those who have never married (29.2%) then widowed (16.4%), divorced (4.6%) with separated as the least 3.1%. Over 78% have at least a secondary school education. Distribution by religion shows that 93.6% of the respondents were Christians while 5.9% were Muslims.

Table 2: Disclosure Issues

Disclosed HIV status	N (%)
Yes	360(92.3%)
No	30 (7.7%)
Total	390 (100%)
To whom disclosure was made	N (%)
Family	300 (88.8%)
Friends/Neighbors	16 (4.7%)
Pastor/Imam	11 (3.3%)
Employer	2 (0.6%)
All above	8 (2.4%)



Others	1 (0.3%)
Total	338 (86.7%)
Disclosed HIV status by Marital status	
Never married	105 (92.1%)
Married	169 (92.9%)
Separated	12 (100%)
Widowed	58 (90.6%)
Divorced	16 (88.9%)
Total	360 (92.3%)

Disclosure rate is very high: 92.3% among the respondents. Disclosure by Marital Status reveals that respondents who separated are most likely to disclose their status (100%) to any person they choose than other categories of respondents. ($X^2 = 1.64$, $p = 0.802$).

Table 3: Disclosure and Partner Issues

Disclosure to partner	N (%)
Yes	224 (77.8%)
No	64 (22.2%)
Total	288 (100%)
Knowledge of partner's status	
Yes	185 (61.5%)
No	116 (38.5%)
Total	301 (100%)
Relationship with sexual partner	
Casual acquaintance	36 (13.3%)
Steady boy/girlfriend	61 (22.6%)
Husband/wife	173 (64.1%)
Total	270 (100%)
Counseling for disclosure	
Yes	338 (86.7%)
No	52 (13.3%)
Total	390 (100%)
Precaution to prevent infecting HIV negative partners	
Abstinence	50 (19.3%)
Condom	198 (76.4%)
None	11 (4.2%)
Total	259 (100%)

In all 224 (77.8%) disclosed their status to their partners out of the 338 (86.7%) that received counselling for disclosure while only 61.5% know their partner's HIV status. Over 4% reported no preventive/protective measures for their partners.

**Table 4: Disclosure/Knowledge by Sex**

All Disclosure by sex	Yes	No	Total	X ²	P-value
Male	133 (91.7%)	12 (8.3%)	145 (100%)	0.111	0.440
Female	227 (92.7%)	18 (7.3%)	245 (100%)		
Total	360 (92.3%)	30 (7.7%)	390 (100%)		
Disclosure to partner by sex	Yes	No	Total	X ²	P-value
Male	93 (86.1%)	15 (13.9%)	108 (100%)	6.94	0.006
Female	131 (72.8%)	49 (27.2%)	180 (72.8%)		
Total	224 (77.8%)	64 (22.2%)	288 (100%)		
Knowledge of partner's status by sex	Yes	No	Total	X ²	P-value
Male	84 (74.3%)	29 (25.7%)	113 (100%)	12.66	0.000
Female	100 (53.7%)	87 (46.3%)	187 (100%)		
Total	185 (61.5%)	116 (38.5%)	301 (100%)		

Females are more likely (92.7%), to disclose their status to whoever they choose than males (91.7%). ($X^2 = 0.111$, $p = 0.440$).

Male respondents are significantly more likely to disclose their status to their partners than their female respondents. ($X^2 = 6.94$, $P = 0.006$). Male respondents are significantly more likely to know their partner's status than the females. ($X^2 = 12.66$, $P = 0.000$).

Table 5: Disclosure to/Knowledge of Partner Status by Marital Status

Disclosure to partner by marital status	Yes	No	Total	X ²	P-value
Never married	48 (63.2%)	28 (36.8%)	76 (100%)	38.16	0.000
Married	151 (90.4%)	16 (9.6%)	167 (100%)		
Separated	5 (62.5%)	3 (37.5%)	8 (100%)		
Widowed	13 (52.0%)	12 (48%)	25 (100%)		
Divorced	7 (58.3%)	5 (41.7%)	12 (100%)		
Total	224 (77.8%)	64 (22.2%)	288 (100%)		
Knowledge of partner's status by marital status	Yes	No	Total	X ²	P-value
Never married	43 (51.8%)	40 (48.2%)	83 (100%)	40.79	0.000
Married	128 (7.75%)	41 (24.3%)	169 (100%)		
Separated	2 (25.0%)	6 (75.0%)	8 (100%)		
Widowed	9 (33.3%)	18 (66.7%)	27 (100%)		
Divorced	3 (21.4%)	11 (78.6%)	14 (100%)		
Total	185 (61.5%)	116 (38.5%)	301 (100%)		

The highest proportion in terms of marital status to disclose their status to their partners is the married (90.4%) while the least is the widowed (52.0%). ($X^2 = 38.16$, $p = 0.000$). In terms of knowledge of partner's status by marital status, married people are significantly more likely to know their partner's status than other categories of respondents. ($X^2 = 40.79$, $p = 0.000$). (Table 5).

**Table 6: Desire Spiritual/Psychosocial Support**

Desire spiritual support	N (%)
Yes	359 (92.1%)
No	31 (7.7%)
Total	390 (100%)
Preferred source of Spiritual support	
Pastor/Imam	177 (63.4%)
Family	11 (3.9%)
God/Jesus	46 (16.5%)
Friends/Colleagues/Health workers	45 (16.1%)
Total	279 (100%)
Receive spiritual support from hospital	
Yes	285 (73.1%)
No	105 (26.9%)
Total	390 (100%)
Involvement in association of PLWHA (Support group)	
Yes	102(26.2%)
No	288 (73.8%)
Total	390 (100%)
Felt hopeful in spite of diagnosis	
Yes	251 (64.4%)
No	139(35.6%)
Total	390 (100%)

Most respondents (92.1%) desire spiritual support preferably from their pastor or imam (63.4%) or from their personal relationship with God directly (16.5%). The rest depend on friends/colleagues/health workers (16.1%) and family (3.9%). Most respondents (73.1%) reported the availability of spiritual support in their respective hospitals. Concerning involvement in the association of PLWHA (Support group), only 26.3% of the respondents are involved in an association of PLWHA or support groups while 64.4% reportedly felt hopeful with time and counselling.

Table 7: Received Counseling for Disclosure by Hospital

	Yes	No	Total	X²	P-value
FAH	165(82.9%)	34(17.1%)	199 (100%)		
PSSH	173(90.6%)	18(9.4%)	191 (100%)	4.95	0.018
Total	338(86.7%)	52(13.3%)	390 (100%)		

Respondents are more likely to receive counseling for disclosure from PSSH than FAH.

($X^2 = 4.95$, $P = 0.018$).

**Table 8: Desire Spiritual/Psychosocial Support by Hospital**

Spiritual support by hospital	Yes	No	Total	X ²	P-value
FAH	153 (76.9%)	46 (23.2%)	199 (100%)	2.99	0.053
PSSH	132 (69.1%)	59 (30.9%)	191 (100%)		
Total	285 (73.1%)	105 (26.9%)	390 (100%)		
Involvement in association of PLWHA					
FAH	47 (23.6%)	152 (76.4%)	199 (100%)	1.35	0.147
PSSH	55 (28.8%)	136 (71.2%)	191 (100%)		
Total	102 (26.2%)	288 (73.8%)	390 (100%)		

Respondents attending FAH are more likely (76.9%) to receive spiritual support than those attends PSSH (69.1%). ($X^2 = 2.99$, $P = 0.053$).

Regarding involvement in the association of PLWHA by the hospital, respondents attending PSSH are more likely to belong to an association of PLWHA than those attending FAH.

($X^2 = 1.35$, $P = 0.147$).

DISCUSSION

This study was carried out to assess the psychosocial needs of adults living with HIV/AIDS attending healthcare institutions in Jos, North Central Nigeria. The respondents were almost equally divided between FAH and PSSH. The mean age of the respondents was 33.4 ± 7.7 years with the youngest patient being 16 years old and the oldest being 49 years old. The majority (75.4%) of the respondents are between 20-39 years of age. This is slightly lower than that during the 2003 National HIV seroprevalence survey in which those between ages 20-39 years make up 87.8% of the total number of respondents (10). The single largest age group in this study is age group 30-39 (42.3%) as against 27.9% obtained for the same age group in the National Survey. The group 20-29 years is the second largest (33.1%) but in the National survey this group makes up 59.9% (the largest) of the respondents. In both cases, the most affected age groups also make up the most productive age groups. With time this will impact negatively on the home, the community and the nation with severe social and economic consequences. It will certainly slow down and eventually reverse the development gains achieved in recent years if not properly checked.

There were 145 (37.2%) male and 245 (62.8%) female respondents respectively. In both facilities, the proportion of female patients is higher than males. This is also the case nationally and globally. The estimated number of women living with HIV in Nigeria is 1,900,000, which is 57.6% of the total number of adults (3,300,000) living with HIV (11). Women also comprise about half of all people living with HIV worldwide. In Sub-Saharan Africa where the epidemic is worst, they make up 57% of people living with HIV and three-quarters of young people infected on the continent are young women aged 15-24 years (12). Gender equity issues should be taken into consideration in the design of HIV prevention and care programs. Females are about twice as likely as a male to contract HIV from an infected partner in unprotected heterosexual intercourse. In addition to this biological vulnerability is the prevalent condition



of gender inequality, economic and social dependence on men, inadequate access to education and employment opportunities among others.

Regarding occupation, most of the respondents were lesser professionals, a group that includes civil servants, teachers, and clerks while the least occupational group is higher professionals including doctors, lecturers, accountants, bankers and engineers among others. Higher professionals are probably better able to take care of themselves in terms of awareness, prevention and care of HIV while among lesser professionals there is a reasonable level of awareness but the financial requirement for taking care of themselves outside these settings may be the reason why most patients opt for these centres where care is free. This is, however, not very clear.

With regards to the duration of illness, about half the total number of respondents were diagnosed less than a year ago. More of these were in PSSH as it is relatively a newer facility compared to FAH.

Most of the respondents were married. This is followed by those who have never married, then widowed, then divorced and finally the least is separated. Curiously, it would be worth finding out how married people contracted the virus as this is even lower than that obtained during the 2003 National HIV seroprevalence sentinel survey in which 96.6% were married (13). Understandably, the National Survey respondents were pregnant women attending Ante Natal clinics in various sites in the nation, hence these are more likely to be married in a socio-cultural setting like Nigeria.

About 78% of the respondents had at least a secondary school education. This is much higher than the 57.1% reported for the North Central zone in the 1999 National Demographic Health Survey (NDHS 2000) in Nigeria (14). It is also higher than 51.8% obtained during the 2003 National HIV seroprevalence sentinel survey (15). It is, however, lower than that (90%) observed in another study in South Western Nigeria in 1995 (16). This is not surprising since Jos North LG is a metropolitan area with a concentration of enlightened/educated people from various parts of the state and beyond. In this study, almost all the respondents were Christians (93.9%). Could this be reflective of the true distribution of the disease by religion? Is it possible that this reflects the level of awareness amongst adherents of the various religions? Religious leaders and community leaders certainly have a role to play in the prevention and care of PLWHA.

This study found out that the disclosure rate was very high (92.3%) among respondents. This is higher than the 86% disclosure rate obtained for a study in London HIV Clinic (17). Most disclosures were to family members. This is probably because these are also the caregivers. Only 2 respondents disclosed their status to their employers. Lack of disclosure to employers may not be unconnected with the fear of stigma and discrimination or even outright sack in some cases.

However, only three-quarter of respondents disclosed their status to their partners and this is significantly more likely among married couples and the male sex. The fact that the overall disclosure rate for the female sex is higher, therefore, implies that some females may prefer to disclose their status to somebody older than their partners. The reason for this is not known (even though stigma and discrimination cannot be ruled out). Counselling for disclosure was given to most of the respondents.



Knowledge of partners' status is significantly associated with being male or married. About 38.5% of respondents do not know their partners' status. This is higher than 26% obtained for the London study above.

Most respondents described the relationship between them and their partner as husband and wife while 13.3% said their sexual partners are casual acquaintances. The latter implies that these people engage in sex with people they do not have a steady relationship with. This is more likely among the female respondents. 76.4% reported the use of condoms during sex compared with 73% in the London Study. However, it is not known whether condom use was correct and consistent.

About three-quarters of the respondents reported availability of spiritual support at their facility even though a higher number expressed a desire for such support. This confirms other studies reported that psychosocial counselling without spiritual support is not enough such as reported in a study in Zambia (18). The Zambian study suggested that integration of pastoral/spiritual counselling in psychosocial counselling courses had amazing results. Those attending FAH are, however, more likely to receive spiritual support than those attending PSSH while the reverse is reportedly the case for psychosocial support groups. This may be a reflection of the importance people attach to their spiritual beliefs.

CONCLUSION

In conclusion, this study reveals that follow up counselling for disclosure was very high as well as disclosure rates. However, about a third did not know the HIV status of their partners and over 13% of respondents described their partners as casual acquaintances with whom they did not have a steady relationship. This has implications for the spread of the disease. Even though most who desire spiritual/emotional support were able to access same at their facilities, participation in the psychosocial support groups and planning activities for PLWHA was rather poor. This needs to be sustained and further strengthened.

RECOMMENDATIONS

1. There is a need to place greater emphasis on the provision of psychosocial services as part of comprehensive support services for PLWHA in healthcare institutions.
2. Given the high proportion of Christian HIV infected persons, there is a need to create awareness among Christian religious leaders, churches and umbrella church organisations on the psychosocial, human right and legal needs of HIV infected persons.
3. PLWHA should play a key role in planning and delivery of psychosocial support services for PLWHA. This will contribute to the relevance of the programs and their sustainability.
4. There is a need to involve community leaders in the provision of psychosocial support for PLWHA.



5. There is a need to raise awareness regarding adequate and efficient psychosocial support services for adult PLWHA at all levels of educational institutions.

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Conflict of interest

The authors declare that there is no conflict of interest in carrying out this study.

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