Research Article

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Received: 22 July 2022 / Accepted: 22 October 2022 / Published: 5 November 2022

An Impact Assessment of Socio-Medical Approach to Managing Women Living With HIV/AIDS Based on the Opinions of Patients in Heart-To-Heart Centres in Calabar Metropolis, Nigeria

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DOI: https://doi.org/10.36941/ajis-2022-0156

Abstract

Nigerian women living with HIV/AIDS do face social, psychological and physical challenges in their daily lives. The objectives of this study were to determine how elements of the socio-medical approach have contributed to managing their health problems in Calabar metropolis, Nigeria. Six hundred women, aged 15-60 years, were sampled from Hearth-to-Heart Centers for their opinions on the socio-medical approach to managing their condition. The women expressed reasonable satisfaction with the availability and accessibility of socio-medical services: all of them received counselling, 92.2% were counselled on adherence, 81.7% received anti-retro viral services and 64.2% enjoyed family planning services. Some of the routine challenges highlighted by the women were poverty and fear of rejection by society. Also, the use of family planning does hinder their adherence to antiretroviral treatment. Overall, the socio-medical approach has been successful in managing their illness; more women should thus avail themselves of the opportunity of enjoying good health despite their HIV status.

Keywords: *HIV/AIDS, Heart-Heart, Women, Nigeria, drugs*

1. Introduction

The challenges confronting women with human immunodeficiency virus (HIV) and acquired immunodeficiency syndrome (AIDS) are social, psychological, spiritual and physical, all of which must be managed to stabilize the wellbeing of victims (Lambo, 2006). The management of HIV/ AIDS requires a holistic approach to health care and not merely the management of signs and symptoms. The concept of socio-medical approach to the management of HIV/AIDS is derived from comprehensive or holistic view of care which requires collaboration among care givers, namely, doctors, nurses, pharmacists, and social workers, in the management of HIV-related challenges. The use of highly active anti-retroviral therapy and widespread availability of antiretroviral (ARV) drugs have effectively transformed HIV from a rapidly progressing and fatal illness to a chronic, slowly progressing disease (Eneji et al., 2022). Today, persons living with the illness tend to live longer and like all chronic disease conditions, require constant and continuing care (FMOH, 2006).

In Nigeria, the prevalence rate of HIV/AIDS was 4.0% for females and 3.2% for males and heterosexual sex is the primary mode of transmission, with 80-90% rate and women are more at risk (NARHS, 2007). Furthermore, women suffer same complications of AIDS like men along with their biologically specific symptoms of HIV diseases like, frequent infections by vaginal yeast, serious pelvic inflammatory disease and an elevated likelihood of precancerous alterations in the cervix (Fleischman, 2011). In Nigeria, there has been a decentralization of HIV/AIDS services to the Primary Health Centres (PHCs) due to congestion in treatment centres in tertiary and secondary health care institutions. Both human and material resources are well positioned to provide free services for people living with HIV (PLHIV). However, there is general paucity of reliable data on the success of management of women with HIV/AIDS, using socio-medical approach in the Heart-to-Heart centres in Nigeria. There may also be some obstacles in the way women living with HIV/AIDS that prevent them from accessing these services in several locations nation-wide. The objectives of this study were to determine the extent to which socio-medical services are available to women in the Heart-to-Heart centres in Calabar metropolis, Nigeria. Also determined was how much women living with HIV/AIDS have accessed these socio-medical services, what socio-medical challenges are peculiar to them and how satisfied they are with the services applied to managing their condition.

2. Research Methodology

2.1 *Research area*

This research was carried out in the Heart-to-Heart centres located in Calabar Urban of Cross River State, Nigeria, divided into Calabar Municipality and Calabar South local government areas (Archibong et al., 2020). The metropolis has a population of about 371,022 made up of 186,607 males and 184,415 females. It has approximately 40 primary health centres and few private hospitals, offering social and medical services for people living with HIV. Three hospitals (A, B and C) were purposefully selected for the study.

2.2 *Profile of Heart-to-Heart centres*

Heart-to-Heart was established by a committee of health care professionals, social service agencies and volunteers in response to the earliest cases of HIV/AIDS diagnosed in 1991 *(www.volunteermatch.org/search/org64777.jsp).* The project serves as a clearing house for information and support service for HIV/AIDS patients that could not be attended to by other agencies. It has presence in many countries, including Nigeria. In Nigeria, Heart-to-Heart is reputed for friendly and confidential counselling and as testing centres. Records from Nigeria's Federal Ministry of Health (FMH, 2006) indicated that Heart-to-Heart Centres offered free ARVT on ante-natal care for PLHIV in all federal and state health institutions. The outcome of the availability of

these centres has been the increase in accessibility by over four million HIV-positive Nigerians who may not have been able to afford the cost of the HIV services.

2.3 Population of the study

The study population comprised women aged 15 to 60 years who received HIV/AIDS management in the Heart-to-Heart centres from 2007-2013. Altogether, 32,267 females (12424 from Hospital A, 1909 from Hospital B and 17,934 from Hospital C) with HIV/AIDs did receive treatment from the centers. Six hundred of these women were sampled following Yamane (1967) technique for sample size determination. A 25 item questionnaire in two sections (A and B) was developed for the study. Section A contained five items seeking information on the demographics of respondents such as age, marital status, religion and education. Section B consisted of 20 items on 4-point Likert scale that measured the women's opinion on the socio-medical services they received from the Heart-to-Heart centres. Section B was further partitioned into four sub-sections focusing on the availability, accessibility, challenges and successes of the socio-medical variables. To determine the reliability of the questionnaire, 30 copies were administered to women who were not part of the final sample for the study. Their analysis produced reliability estimates of 0.72 - 0.89, implying that the subscales in the instrument were reliable and adequate for use in the study. The questionnaire was supplemented with interview schedules and focus group discussion with staff and patients at the Centers. The resulting data were summarised into frequency and simple percentages, using SPSS version 18.

3. Results and Discussion

As shown in Table 1, majority (26.0%; N = 153) of the respondents were aged 30-34 years, 23.3% (N = 137) were 25-29 years, 18.3% (N = 108) were under 25 years, 13.6% (N = 80) were 35-39 years, 11.0% (N = 65) were 40-44 years and 7.8% (N = 46) were more than 44 years old. Majority of the respondents (45.7%; N = 269) were single, 34.8% (N = 205) were married, 12.4% (N=73) were widowed and 2.4% (N=42) were divorced.

Table 1: Personal/demographic information of the respondents

Variable		N	per cent
Age	Less than 25years	108	18.3
	25 - 29years	137	23.3
	30 - 34years	153	26.0
	35 - 39years	80	13.6
	40-44years	65	11.0
	45years and above	46	7.8
	Total	589	100
Marital status	Single	269	45.7
	Married	205	34.8
	Widowed	73	12.4
	Divorced	42	7.1
	Total	589	100
Religion	Christian	547	92.9
	Islam	28	4.8
	Traditional	14	2.4
	Total	589	100
Highest Education	Incomplete primary	54	9.2
	Complete primary	77	13.1
	Incomplete secondary	107	18.2
	Complete secondary	181	30.7
	Tertiary	160	27.2
	Others	10	1.7
	Total	589	100

N = number of respondents.

Since singles dominated the study population, they would be better off sticking to just one sex partner and ensuring that they persuade their partners to know their HIV status. Also, married women will benefit more in the treatment if their husbands are treated as well. About 93% (N = 547) of the respondents were Christians, 4.8% (N = 28) were Moslems and 2.4% (N = 14) were traditionalists. Majority of the respondents (30.7%; N = 181) had secondary school education, 27.2% (N = 160) had University degrees, 18.2% (N = 107) did not complete secondary school education, 13.1% (N = 77) had primary education, 9.2% (N = 54) did not complete primary school education and 1.7% (N = 10) had other forms of education.

Table 2 shows the opinions of the respondents on knowledge of the availability of socio-medical services in the Heart-to-Heart centres sampled with four options of either "strongly agree (SA), agree (A), disagree (D), or strongly disagree (SD)". Majority of the respondents strongly agreed or agreed that they knew about the specific services rendered in the centres for the care of HIV/AIDS and did not need to travel far distances to have treatment or receive counselling. About 73 and 81% of them strongly agreed that the workers at the Heart-to-Heart centers were friendly and that drugs were given free.

Table 2: The opinion of respondents on the availability of socio-medical services

	SA	A	D	SD
I know about specific services rendered in Heart-to-Heart center	396(67.2)	185(31.4)	4(0.7)	4(0.7)
I do not need to travel far distances to have my treatment	295(50.1)	244(41.4)	44(7.5)	6(1.0)
I receive counseling in the Heart-to-Heart center	395(67.1)	184(31.2)	4 (0.7)	6 (1.0)
The workers are friendly in the centre	431(73.2)	142(24.1)	10(1.7)	6 (1.0)
Drugs are given free for my care	479(81.3)	106(18.0)	4(4.2)	0(0.0)
My condition is better now than before	310(52.6)	207(35.1)	48(8.1)	24(4.1)

The number of respondents for each item is as indicated and percentages are in parenthesis.

A combined 88% strongly agreed or agreed that their conditions were better now than before. This is proof that the support of government and other stakeholders for the Heart-to-Heart centres was enabling the provision of needed services for the successful management of HIV/AIDS challenges. The general opinions of women under study were indicative of their satisfaction with the socio-medical services available in the Heart-to-Heart centres and the number of centers in the metropolis they could go for HIV treatment. Women interviewed spoke strongly that they would have died if the government did not make these services available for their care. The experience of Atim (one of the interviewees) reveals thus:

> *I was like a broom stick in Liberty church and was taken to another church. Another pastor from another church asked somebody to bring me here, to this Heart to Heart Center. So I was brought here. I did not know myself but the staff here took care of me till I became well. I did not pay for anything. The social workers counseled me, doctors sent me to the lab for CD4 count while the nurses encouraged me to take my drugs well.*

Another lady aged 18 years had this to say:

> *I have no mother. I used to sing in the choir in my church. One day I became very sick. I was treated for malaria and typhoid but the more I took the drug, the more I was ill. One day my mummy in church took me for test here (Hospital B) and I tested positive. I fainted and the following day I saw myself in hospital bed ... since then I have been coming here for my care. Drugs are given free. I enjoy the talks because workers are very friendly. Now if I tell people that I am HIV positive no one will 'know.*

Again, some women from FGDs confirmed that availability of services in the heart to heart centres did help them manage their HIV condition well. Some said:

Coming here is not to collect something extra but we are here to mix up with others, share their experiences and gain knowledge. This place is very good. Everything we want to do, like lab test, collection of drugs, family planning and asking questions about our problem is done here. One of the women in the group cuts it; for a long time, I was very sick, my CD4 count was very low but because of the way they take care of people, I started my drugs and now I am very well.

Another woman from the group added:

Exactly what my friend said. The nurses counsel us very well. Ever since I came here and had all these advices I try to follow everything. This is why if I fail to come for this meeting for even one day, I feel very sad. Before now I was getting sick every time. People will give me antimalarial drug from chemists but when I came here and started my drugs you can see how healthy I am. Even doctors take time to check us while Pastor John always prays for, and comforts us.

The women in the group wished that government could bring permanent solution to the HIV/AIDS problem as taking the drugs every day is a big problem. To them, as government has provided other things in the Heart-to-Heart centres, money should be added periodically to help them take care of what they cannot get from the centres.

The importance of availability of treatment centres in the area of information provision and resources regarding management of PLHIV has been previously emphasized (CDCP, 2008). Recent advances in ARV therapies for HIV have improved the safety, tolerability, and effectiveness of treatments leading to adherence and improved health outcomes. Anderson (2005) reported that the availability of complementary medical services is essential for assessment and care of the varied medical problems associated with HIV. According to Plate (2011), the integration and decentralization of HIV/AIDS services increased the availability of HIV/AIDS services to the PLHIV, which in turn, helped the women to manage their condition adequately.

Many of the respondents either strongly agreed or agreed that the society was more intolerant of females living with HIV than men, hence women who test positive conceal their status (Table 3) and that early diagnosis and treatment enhance success of management. Conversely, majority of them either disagreed or strongly disagreed that women should refrain from testing for HIV. Since it was strongly agreed that early diagnosis and treatment enhance success of management, women should not hide their status, but should be courageous in their decision so that they will stay healthy. According to Iwara (2011), poor access to information, fear of rejection, stigmatization and religious believe can affect accessibility of women to socio-medical management of their condition. Despite the presence of some roadblocks, women who accessed treatment centres for their care had renewed hopes. Camp (2006) noted that ARVT was effective when initiated in someone with advanced disease. Thus, women who surmount the problems hindering them from accessing care in the Heart-to-Heart centres, succeeded in managing their status.

In the Focus Group Discussion carried out in Hospital A, the discussants unanimously opined that:

Corning out for treatment in this place (Heart-to-Heart centre), has helped us to be healthy because they will send us to the lab, weigh us, instruct us on feeding, give HIV drugs and drugs to treat us malaria. When we meet each other, we feel encouraged.

In another FGD, some women got worried about women with HIV who refuse to access treatment in Heart-to-Heart centres. Excerpts:

Some women don't want to come here for their care because of fear and shame. There are some when they come here and see others that they know they'll run away because of shame. Another woman from the group commented: "I came and met my daughter in-law here and she ran away because of me". Some other women in the group commented: some women run to church because they think it is witchcraft and when they are almost dying they will rush them to treatment centre. One woman fainted here when she was told that she was positive. When she was well, she said she

was afraid that her husband will not marry her again.

Another respondent from stressed:

> *I used to hide and buy drug at N2000 for two tablets in the chemist because I did not know that drugs were given free. My friend told me about free drugs from Heart-to-Heart centre and I came here. Initially, I refused to start taking the drugs because people said I'll die after taking the drugs. But I was counseled very well here. I saw other people that were taking the drugs and were healthy. I was encouraged. Now who can say that I have HIV?*

Yet another respondent amplified spiritual attachment to what hinders women from accessing care thus:

> *When some test positive, they'll say, it is not my portion and will go away. Some will say I have a programme with my Pastor when I finish I will come back. Unfortunately, most of them will come in a very, very bad state. The viral load becomes very high, overwhelming the blood and the person will come down with severe illness. Most of them, it's the drugs that speak for themselves. When the person comes back to the centre, you counsel, treat and give ARV drugs. Suddenly, the life style that became so low and so bad, begins to pick up and she is encouraged to start coming back for treatment.*

Table 3: Respondents opinion on societal perception and accessibility to care

	SA	A	D	SD
Society is more intolerant of females living with HIV than men.	173(29.4)	199(33.9)	153(26.0)	64(10.9)
Women refrain from testing for HIV	140(24.1)	150(25.4)	179(31.3)	120(20.3)
Women who test positive conceal their status.	214(36.3)	239(40.6)	102(17.3)	34(5.8)
Early diagnosis and treatment enhance success of management.	404(68.6)	151(25.6)	18(3.1)	16(2.7)

The number of respondents for each item is as indicated while percentages are in parenthesis.

As for socio-medical challenges, majority of the respondents either strongly agreed, or agreed that women carry the heavy burden of caring for others affected by HIV/AIDS, that poverty and fear of rejection can hinder HIV/AIDS management in women, those with HIV are prone to gynecological problem, the use of family planning can hinder adherence to ART and that adherence to HIV treatment promotes success of management (Table 4).

Table 4: Opinion on socio-medical challenges faced by women living with HIV/AIDS

	SA	A	D	SD
Women carry heavy burden of caring for others affected by HIV/AIDS	299(38.9)	173(29.4)	125(21.2)	62(10.5)
Poverty and fear of rejection can hinder HIV/AIDs management in women	239(40.6	199(33.8)	102(17.3)	49(8.3)
Women with HIV are prone to gynecological problems	176(29.9)	279(47.4)	91(15.4	34(7.3)
The use of family planning can hinder adherence to ART	167(28.4)	130(22.1)	182(30.9)	110(18.7)
Adherence to HIV treatment promote success of management	372(63.2)	151(25.6)	18(3.1)	18(2.7)

The number of respondents for each item is as indicated while percentages are in parenthesis.

Brashers *et al.* (2003) reported that PLHIV faced both medical and social challenges associated with the disease condition. Women with HIV/AIDS often do face uncertainty in personal, medical and social aspects of their lives and such uncertainty is so stressful that it can affect their quality of life. The PLHIV are often not sure of how other people will react to the news about their HIV status, how old relationship will change and how new relationships will develop (Brashers *et al.*, 2003). Usually, HIV/AIDS is a stigmatized illness because it is blamed on promiscuity, homosexuality and drug use. Gilmore and Somerville (1994) reported HIV/AIDS is stigmatizing because it carries many cultural associations with danger, including attribution of communicability, incurability, immorality and punishment for sin. Thorsen et al. (2008) noted that some communities were more intolerant of

females with HIV/AIDS than that of males.

According to Cardel (2012), while women with HIV or AIDS suffer many of the symptoms as men, there are additional symptoms that generally only women suffer from. For instance, women suffer more headaches, more fatigue and have significantly more abdominal and pelvic complaints. In addition, infections that are common in all women, such as vulvovaginal candidiasis and pelvic inflammatory diseases become more frequent and severe (Cardel, 2012). According to Fleischman (2011), recurrent vaginal infections, pelvic inflammatory diseases and risk of precancerous cervical changes, are often experienced by women living with HIV/AIDS. To further support the quantitative analysis that women's knowledge of socio- medical challenges posed by HIV is significantly related to the success of management of the disease, a single 33-year-old lady lamented thus:

> *I am a graduate working in Abuja but I come to Calabar for my drugs because I don't want anyone to suspect me. As a lady I want to be married one day. I wonder if I will still have children and if I do, whether the children will be negative. I cannot take my mind off this problem even though the ARV drug is helping me to be healthy. It is very frustrating taking this drug every time. When I am with my boyfriend, I hide to take the drug in the toilet. Initially it used to make me very weak with a feeling of vomiting, my skin was rough but I told people that I changed my cream. Now it is better.*

The second respondent in tears said:

> *When I tested positive, my boyfriend in church left me and I was shunned by my friends. I almost died. My father brought me here. My CD4 count was 320. I was started on ARV drugs. I used to vomit and that made me very weak but now my CD4 is high.*

A respondent, 30 years of age bore her mind on her fears:

> *When I received the result of the test, I fainted and I was revived. I felt very bad. My problem was; when my husband hears this, I will be finished; he will not marry me again. He will disgrace me anywhere and there is nothing I will do.*

A 37-year-old widow lamented:

> *My husband died seven years ago after a brief illness. My in-laws have sent me away because they know my status. They accused me of killing their brother. I am the one taking care of my five children. My business is not giving me money like before because I am not strong enough to go to bush market again. Even my menses is not flowing well again and I will like to remarry.*

During the focus group discussion (FGD), the women were very vocal concerning their challenges thus:

> *What brings us often to this place are vaginal itching, rashes and dizziness. Even though they give us Septrine we will still be having itching. We don't know why. Still within the group, a woman with a six-month old baby, in tears said "my husband left me when I was pregnant because of this problem and I am now alone. It is only the church members and this clinic that are helping me". Others echoed that the ARV drugs, sometimes it will stop their period for three months but when given blood medicine and they eat well, it will come back.*

A 46-year-old respondent in Hospital A, who was a HIV positive staff in one of the centres narrated some of the challenges WLHIV face thus:

> *Women are very susceptible to anaemia. This is true (she continued): when a man and woman are living together, and the man test positive while the woman is negative, the woman will remain with the man. She will volunteer, he's my husband, I married him, I will stay. But when the woman tests positive and man negative, about 65 percent of the men will abandon the woman, especially when she is cachectic and very bad. Some of them are sent home with the children and no one knows the financial standing of*

the woman's family. By the time the blood volume and the quality is low, it makes her to be more exposed to OIs. When the haemoglobin becomes so low, their menstruation will cease. But when they start ARV drugs, start eating well their menses will re-establish on its own. Candidiasis is very common in women with HIV. The reason is that men usually have early symptoms when they are infected with Candida organism. The men do not have signs and symptoms but they are capable of transmitting it to women. A wife may be having sex with ten people she does not know because the man may be having sex with other women outside that he may not disclose his status to. Most men when they are reactive they don't accept using condom on their wives, so the women now are at a disadvantage side. With her reduced immunity and everything, see her coming with oral thrush, vaginal thrush, oesophageal thrush. So women are more susceptible to these things. This is why they are advised not to drink alcohol, eat sweet and chewing gum because of oral thrush since microorganisms thrive better in sugar medium. Again, any caffeinated drinks attract reaction of most of their drugs like, pepsi, coke and even chewing of kola because of caffeine. However, they can take fanta and malt because these are mild.

Majority of the respondents either strongly agreed or agreed they were counselled properly in Heart-to-Heart centres, laboratory test was done there before diagnosis were made, compassion and psychosocial care complement medical treatments and that adequate supply of antiretroviral drugs encourage adherence (Table 5). Based on the combination of team members and the services rendered in the centres as agreed by the respondents, it can be suggested that a socio-medical approach to care is necessary in the management of WLHIV. The socio-medical services available at the Heart-to-Heart centres in the study area are summarized in table 6.

Table 5: Respondents' opinion on the application of social-medical approach

Item	SA	A	D	SD
I was counseled properly in Heart to Heart centre	325(43.4)	266(29.3)	12(15.9)	6(3.4)
Laboratory tests are done here before diagnosis is made	403(68.4)	167(28.4)	15(2.5)	4(0.7)
Compassion and psychosocial care complement medical treatments of PLHIV	304(51.6)	260(44.1)	15(2.5)	10(1.7)
Adequate supply of antiretroviral drugs encourage adherence	305(51.8)	161(27.3)	95(16.1)	28(4.8)

The number of respondents for each item is as indicated while percentages are in parenthesis.

Table 6: Descriptive statistics of socio-medical services available at Heart-to-Heart centres and the associated frequency of patronage by the respondents

Variables	Frequency	Percentage (%)
Counseling services	589	100
Adherence counseling services	543	92.19
Anti-retroviral services	378	81.66
STI's services	483	82.00
Family planning services	841	64.17

All the respondents received counselling services, 92.2% were counselled on adherence, 81.7% received anti-retro viral services, 82.0% received STI's services and 64.2% enjoyed family planning services at the centres visited.

Owing to the multifaceted challenges of HIV disease, management requires a collaborative response from people with some varied complementary skills - like counsellors, nurses, doctors, social workers, PLHIV themselves, pharmacists and laboratory scientists (UNAIDS, 2003). All these people work together to ensure a smooth flow of information, resources and services among them, providing a continuum of quality care. Qualitatively, our respondents confirmed that the collaboration of the services was pivotal to the success of management of their condition. A respondent in Hospital A commented:

I like coming here because everything you need is here. They'll explain everything about this disease to you, send you to the lab, weigh you, give you drug free and comfort you.

Another mentioned:

I always come to collect my drugs here so that I will be healthy. The workers are very friendly and kind here. They don't run away from us. Even the doctors take time to check us. I thank the government for training people to know how to help us.

Also a very vocal lady from the FGD confessed:

I used to have stigma but when I came here, I saw that the people didn't run away from me like other people used to; I summoned courage because the workers are very friendly. They are not scared of contacting this disease; rather they counsel us and ask us to obey the rules so that we'll be healthy.

Another respondent from the group cuts in:

I am not here because I want to collect something extra. I am here to mix up with others, share other people's experiences and gain knowledge. When I am here I feel comforted. I was very sick when I came here and my CD4 was very low but because of the way they take care of people, I started my drugs and now I am very well.

A HIV positive staff respondent stated:

In the heart to heart centres, there is a standard operational procedure from Family Health International for PLHIV. This procedure is comprehensive in nature because all the activities are incorporated into the ARV site. HIV disease is a very stigmatizing condition that a patient needs to be encouraged to start and continue the treatment. So, here we take time to counsel them on adherence, general health care and they are treated for OIs. They have free drugs and free laboratory investigations; monitoring of their state of health is done, and some spiritual support as well as follow-up activities are carried out here. Everyone involved in the care of the PLHIV in these centres is specifically trained so that they show compassion on the people. This is the only way they will be encouraged to come back for treatment. Doctors, nurses, pharmacists, laboratory scientists, monitoring and evaluation personnel and social workers work together here. Those who take advantage of the services manage their HIV status successfully.

Sharer (2011) showed that counseling can have significant effects on quality of health, ART adherence, retention in care, reduction in symptom severity and HIV progression. Our results are consistent with those of (Fong *et al,* 2003) that psychosocial care (counseling) was an important factor in determining treatment adherence, which exceeded 80%, with more than 91% of patients achieving undetectable viral load (Fong *et al.,* 2005). This suggests that counseling patients at every point of the HIV management is very crucial if a high quality of life is to be achieved. Without treatment, Althoff et al. (2010) found that most HIV individuals developed immunosuppression, as evidenced by reductions in CD4 T lymphocyte, which caused AIDS-related illnesses and untimely death.

4. Conclusion

The main purpose of the study was to evaluate the effectiveness of socio-medical approach to the management of women living with HIV/AIDS, using the heart to heart centres in Calabar Metropolis, Nigeria. The study population was satisfied with the availability and accessibility of socio-medical services for the management of their condition in the centres. They considered that the more the government and other stakeholders provide support for multidimensional services, the more successful management will be. The comprehensiveness of activities in the centres and the

collaboration of the personnel enhance positive interaction and the success of management of women with HIV/AIDS. Women's knowledge of the HIV/AIDS socio-medical challenges is a key precursor to realising the benefits of socio-medical approach offered at the Centers. While collaboration across multidisciplinary services in the Heart-to-Heart centres should be sustained, women must be encouraged to access these services to enhance success in the management of their challenges. The government should continue giving incentives to the collaborating team so they can keep on showing empathy to the women reporting for treatment.

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