

Special Issue on Population  
and Health

**j**ournal of Social  
Development  
in Africa

Volume 28. No: 1. 2013

ISSN 1012-1080

**Journal of Social Development in Africa**  
**Volume 28. No 1. 2013**

**CONTENTS**



---

**EDITORIAL**

---

**Social development, population and health**

**Articles**

**Introduction**

*Akim J. Mturi*



5

**Determinants of age at first marriage in sub-Saharan Africa: A comparative study of Uganda and South Africa.**

9

*Natal Ayiga & Veronica Rampagane*

**Developmental local governance and service delivery in South Africa: Progress, achievements and challenges.**

37

*Bornwell C. Chikulo*

**Migration into Rustenburg local municipality between 1996 and 2001.**

65

*Moses Kibet*

**Determinants of age at first marriage in Addis Ababa, Ethiopia.**

81

*Eshetu Gurmu & Ruth Mace*

**Factors influencing the high dropout rate of the girl child from education in South Africa: A case study of black women in North-West province, South Africa.**

111

*Karabo Mhele & Natal Ayiga*

**Psychological predictors of perceived quality of life among people living with HIV/AIDS in South West Nigeria.**

139

*Peter O. Olapegba & Erhabor S. Idemudia*

**Street children in Mafikeng, North-West province: A qualitative study of social experiences.**

161

*Erahabor S. Idemudia, Keitumetse Kgokong & Patricia Kolobe*

**Do religious beliefs influence use of contraception among currently married women in Nigeria?**

187

*Godswill N. Osuafor & Akim J. Mturi*

**Notes for Contributors**

# Psychological predictors of perceived quality of life among people living with HIV and AIDS in South West Nigeria

Peter O. Olapegba<sup>1</sup> & Erhabor S. Idemudia<sup>2</sup>

## Abstract

*This study examined the dynamics of perceived social support and self-esteem in predicting perception of quality of life among People Living with HIV/AIDS (PLWHA) in South West Nigeria. One hundred and fifty nine (159) PLWHA selected using the purposive sampling technique participated in the study; the sample was made up of 46 males and 113 females, aged between 19 and 72 years. Data were collected using a structured questionnaire. The result of the multiple regression analysis showed that perceived social support and self-esteem significantly jointly predicted perceived quality of life among PLWHA ( $p < .05$ ). Self-esteem significantly independently predicted perceived quality of life ( $p < .05$ ) while perceived social support did not significantly predict perceived quality of life. A *t*-test indicated no gender differences in perception of quality of life. The study therefore concluded that psychological interventions are required to shore-up the self-esteem of PLWHA alongside social support to enable them to cope better and be more optimistic and positive in their perception of quality of life.*

## Keywords:

Social support, self-esteem, perceived quality of life, PLWHA, Nigeria, psychological.

<sup>1</sup>. Post-Doctoral Fellow, Department of Psychology, Ipelegeng Child & Family Centre, North West University, Mafikeng, South Africa. (Corresponding author). Email: hanpet70@yahoo.com

<sup>2</sup>. Professor, Department of Psychology, Ipelegeng Child & Family Centre, North West University, Mafikeng, South Africa. Email: sundayidemudia@yahoo.com

## Introduction

The discourse on the HIV and AIDS pandemic has gone beyond the issue of finding medical cure, a vaccine and ordinary prevention, to fast becoming holistic in outlook to accommodate issues such as positive living conditions, wellbeing and quality of life of people living with the condition. This is logical in view of the fact that a significant proportion of people living with the condition are in the prime of their lives and form the critical mass of the economically productive cohort of any given country's population. The social phenomena of stigma and discrimination against PLWHA have done much in undermining the psychological state and overall quality of life of infected persons. PLWHA have experienced ostracism, repression and rejection by society and in many instances by members of their own families. These experiences have further compounded the trauma of living with the condition and as such have tended to negatively affect their perception of society and the world around them.

In the words of Merson (1993), "fear, stigmatization and discrimination against PLWHA have undermined the ability of individuals and families to protect themselves and provide the necessary support and reassurance to those infected". Many efforts by the international community have gone into promoting the medical wellbeing of infected persons, and yet, the experience in most developing nations points to the fact that there is still relatively high mortality among infected persons, and this may not be unconnected with attitudinal dispositions of the people involved. This calls for a paradigm shift or a widening of the scope of care to include infected persons' perception and expectations of quality of life. This concern was implied in the London Declaration on AIDS (1988) which posited that negative treatment of PLWHA tends

to undermine public health and must be avoided considering that health comprises physical, mental and spiritual states. In a similar development, the United Nations Centre for Human Rights (1989) reaffirmed the need to appreciate the public health rationale in promoting the wellbeing of HIV infected persons.

### **Perceived Quality of Life**

Research activities in recent years have focused on quality of life in relation to many health conditions– HIV and AIDS inclusive (Kohli, Sane, Kumar, Paranjape and Mehendale (2005). However, for any intervention to be effective in medically enhancing quality of life, the caregivers ought to take into consideration the disposition/ perceptions of the patients/clients as well as the perceived and/or real social support that is available. According to Healthy People (2010), improving the quality of life of a population is a major policy goal, and as such organisations such as the United Nations (UN), World Health Organization (WHO) and governments of various nations are heavily involved in activities aimed at improving the quality of life of PLWHA. Several authors and researchers have over the years attempted to define the concept ‘quality of life’ either as a construct or as a domain-specific phenomenon in terms of specific ailment(s). Harding (2001) has defined quality of life as aspects of a person’s well-being (physical, psychological, social), as well as aspects of the environment and a person’s standard of living.

Up until two decades ago, the concept of quality of life had been approached from the objective/medical point of view with emphasis placed on observable and quantifiable indicators. The perception of the individual under assessment was not seen as an important consideration; rather, an established criterion was used to determine a person’s quality of life. In recent times, however,

findings from research endeavours have emphasized the importance of the perception of the individual in arriving at an objective assessment of their quality of life. The findings of these studies have led to a rethink in respect of the definition of the concept of quality of life, to ensure that it included the subjective domain.

In an attempt to come up with a more comprehensive definition, The World Health Organization Quality of Life (WHOQOL) Group (1994, 1995) as well as Bonomi, Patric, Bushnell, and Martin (2000) more or less defined quality of life as individuals' perception of their position in life in the context of the culture and value systems in which they live and in relation to their goals, expectations, standards and concerns. This definition, though broad, has placed the concept of quality of life within the purview of individuals and their values, including the dynamics of their interaction with the immediate environment. It then follows that; there may be cultural and contextual differences in people's perception of quality of life. The individual nature of quality of life was further corroborated by the assertions of Diener, Suh, Lucas and Smith (1999) and Wallander and Varni (1998) who suggested that a positive self-appraisal of health might mitigate the deleterious effect of illness on quality of life. Diener et al., (1999) found that life satisfaction was predicted by subjectively interpreted health, which was influenced by both negative affects and object health. Consequently, they concluded that if people appraise their health positively, the adverse impact of illness on life satisfaction/quality of life would likely be mitigated.

### **Models of Illness**

The WHO (2001) (cited in Edwards, Patric, and Topolski, 2003) identified the medical and social models, as a framework for understanding illness and medical conditions. The medical model

sees illness more as a problem of the individual, as a result of trauma or adverse health conditions for which professional help is needed. This model will see HIV infection as the sole responsibility of the infected and how he or she adjusts and adapts to the conditions could be a function of perception with implications for overall quality of life. The social model, on the other hand, views illness as primarily attributable to societal dynamics which may be beyond the individuals; in which case the society would be expected to play a certain role in mitigating the effect of the illness on the affected. In the case of HIV and AIDS, society would be expected to provide social support, compassion and understanding to buffer the infected in order to enhance their adjustment. If the supports are in place, then the perception of quality of life may be enhanced as adjustment to the condition improves.

In the social model, quality of life will be measured by self-report taking into consideration the values, expectations and prevailing environmental factors. All these taken together with the medical indicators will likely provide a more comprehensive picture of the quality of life of a PLWHA. In a study on quality of life, Edwards et al., (2003) reported that self-rating and contextual variables significantly predicted quality of life among adolescents. This finding was corroborated by Duracinsky et al., (2012) who found that patients living with HIV made spontaneous reference to the importance of their general health and that slight improvements or declines in perception had an important impact on quality of life.

---

### **Social Support**

Duracinsky et al., (2012) have identified social relationships as constituting a very important component of quality of life. The

authors explain that, in their study, HIV patients identified quality of relationships with partners, family and friends as being very important to quality of life. This is in addition to support from significant others, feeling socially acceptable despite illness, stigma (real or imagined) worries over rejection and loneliness. These disclosures reveal the importance of social support in enhancing quality of life among PLWHA, the amount and quality of support received will influence their perception of the condition and that is likely to affect overall quality of life. Patients with quality social supports are likely to be less pessimistic and helpless in their assessment of the condition and as such will be more positive and functional in society. On the other hand, lack of social support may have the potential of diminishing the quality of patients' lives.

Social support has been found to play a key role in coping with, and adjustment to, adverse situations; patients in various health conditions have shown quicker recovery and adherence to medication when the social supports received were adequate. Dumont and Provost (1999) described social support as a multidimensional concept which includes support received from friends, family, strangers, and animals. The support is classified as information, emotion and instrument. These components of social support are expected to act in consonance as a buffer for the patients in coping with the condition and adhering to the treatment regimen. Farmer and Farmer (1996) depicted social support as a process of social change which contributes to the development of a person in respect of his/her values, behavioural patterns and social cognition. Stated otherwise, social support is seen as care, value and guidance provided by family, peers, community members and significant others to stabilize one of their own (Dollete & Matthew, 2006).

In confronting the HIV and AIDS pandemic, social support



should therefore, be considered as a veritable tool through which HIV patients will receive pertinent information through social interactions, actual assistance and a feeling of belonging in a social network that provides, loves, cares and understands. The needed social support in the fight against the HIV and AIDS pandemic may be provided on both formal and informal platforms; the informal level will include close family members, friends, spouses and colleagues while the formal platforms would include government agencies, non-governmental organizations, self-help groups and policy frameworks. In a study assessing quality of life of HIV-infected persons in Pune, India, Kohli et al., (2005) reported that marital status significantly affected quality of life, with married patients reporting better quality of life possibly because of the support they got from their spouses. A major submission from the study by Kohli et al., (2005) was the need for psychological intervention for the HIV-infected individuals especially women who have been shown to have less social support available.

### **Self-esteem**

Apart from social support which constitutes an external resource available for PLWHA to improve their quality of life, there are certain factors internal to the individuals that can mediate the impact HIV infection on overall perception of quality of life. One of such internal factors is self-esteem, which was defined by Freshbach and Weiner (1991) as a positive or negative value based on one's own attributes. Empirical studies over the last few decades have shown that self-esteem is an important factor which contributes to health and quality of life (Evans, 1997). Zimmerman (2000) reported results from studies showing that subjective well-being significantly correlates with high self-esteem, and that self-esteem

shares significant variance in both mental well-being and happiness. This was corroborated by Olapegba (2008) who reported that self-esteem is a predictor of perception of quality of life among Nigerians. Similarly, Olapegba (2005<sup>a & b</sup>) in two separate studies, reported that self-esteem predicted mental health and coping among PLWHA in Nigeria. These findings corroborate a submission by Garmezy (1984) and Glick and Zigler (1992) that while low self-esteem led to maladjustment, high self-esteem seemed to contribute to better well-being or perceived quality of life as the case may be.

Considering the centrality of perception in arriving at the overall assessment of quality of life and the importance of social support and self-esteem in shaping perception, this study investigated the role of self-esteem and perceived social support in predicting the perception of quality of life among persons living with HIV. Specifically, the study addressed two questions: first, does perceived social support predict the perception of quality of life of persons living with HIV and AIDS? Second, does self-esteem significantly predict perception of quality of life?

## **Method**

### *Design*

The study was cross-sectional in design, and it investigated the independent and joint influence of perceived social support and self-esteem on the perception of quality of life among PLWHA and to also establish whether there was any gender difference in perception of quality of life.

### *Sample*

One hundred and fifty nine (159) PLWHA receiving treatment, care and support from a Non Governmental Organization (NGO)

in South West Nigeria were conveniently sampled to participate in the study. The relatively small sample frame was a function of the fact that PLWHA constitute a sensitive and vulnerable population; factors such as ethical considerations involved and the challenges associated with status disclosure, played a key role in arriving at the sample size. The demographic characteristics of the sample are listed in Table 1 below. The participants were reached through the zonal offices of the NGO in question, with the assistance of the zonal coordinators.

**Table 1: Demographic characteristics of the sample**

Sex	Male	46 (29.3%)
	Female	113 (70.7%)
Age	Mean	29.52
	Standard Deviation	7.96
Marital Status	Single	69 (43.4%)
	Married	65 (40.9%)
	Widowed	20 (12.6%)
	Separated	5 (3.1%)
Religion	Christianity	122 (76.7%)
	Islam	33 (20.8%)
	Unspecified	4 (2.5%)
Education	No formal education	32 (20.1%)
	Primary	19 (12.0)
	High School	83 (52.2%)
	First Degree	24 (15.1%)
	Postgraduate	1 (6.0%)
Habitation type	Live alone	65 (42.2%)
	Live with partners	58 (37.7%)
	Live with friends	7 (4.6%)
	Live with parents	13 (8.4%)
	Live with other relations	11 (7.1%)

## *Instruments*

A structured questionnaire made up of four sections was used for data collection; this comprised the demographic section and three valid scales. For participants who could not speak the English Language, the Yoruba translation of the questionnaire was used.

Section A

This section tapped *demographic information* of the study participants. The information requested included age, gender, marital status, religion affiliation, and level of education attained.

Section B

This section utilised the '*perceived quality of life scale*' which was developed by Olapegba (2009). It is a 22-item Likert-format scale with 5 point response options which range from strongly agree (5) to strongly disagree (1); the scoring pattern indicates that the higher one scores, the better the perception of quality of life. The scale has a Cronbach Alpha of .87 with split half reliability of .84 and correlation between forms of .68.

Section C

Section C utilised the Zimet, Dahlem, Zimet, and Farley (1988) '*multidimensional social support scale*'. The scale contains 12 items with 7 points response options in the Likert format, the options range from very strongly disagree 1 to very strongly agree 7. A higher score denotes higher perception of social support. Canty-Mitchell and Zimet (2000) reported Cronbach Alpha Coefficient of .93 for the scale.

Section D

This section used the Rosenberg (1965) '*self-esteem scale*', generally viewed as the standard against which

other measures of self-esteem are considered. It is a 10-item measure of global self-esteem, on a 4 point continuum ranging from strongly agree to strongly disagree. In scoring the items, 5 negatively worded items were reversed. Rosenberg reported Cronbach Alpha of .77, Shahani, Dipboye and Philips (1990) .80, Hagborg (1993) .88 and Olapegba (2008) .68.

### *Procedure*

Data collection for this study was, as noted earlier, through the use of a structured questionnaire. As noted earlier, accessing potential respondents was made possible through a Non-Governmental Organization (NGO) involved in the care, support and counseling of persons living with HIV and AIDS in South West Nigeria. The NGO has a network of offices in various states of the federation. Having complied with necessary ethical requirements and with agreement that the identities of the participants and the organization would not be compromised, approval was granted by the NGO for the researchers to approach participants within the premises of the organizations in four of the south west states with the assistance of the coordinators. Informed consent of the participants was sought after explaining the nature of the study with additional information that participation was entirely voluntary and that participants reserved the right to withdraw at any time they felt inclined to do so. The questionnaire was administered to those who consented to participating in the study.

The respondents were reminded that there were no right or wrong answers, and were encouraged to be as honest as possible in their responses. It was stressed to them that confidentiality and anonymity were guaranteed as there was no way their respective

responses could ever be traced back to them as individuals. Those who requested to take the questionnaire home with them, were allowed to do so, with the proviso that they would drop the completed questionnaire at the office by a specified date. Four research assistants who at the time were postgraduate students, assisted in the administration of questionnaires. The exercise was done within a period of three weeks.

### *Statistical Analysis*

Multiple regression analysis was used to estimate the independent and joint contribution of perceived social support and self-esteem on the perception of quality of life, while a t-test of independent means was used to test for gender differences in the perception of quality of life among PLWHA. The Statistical Package in Social Sciences (SPSS) software was used for the data analysis.

### **Result**

In response to the first and second research questions, the results summarised in table 2 revealed that when perceived quality of life was regressed against perceived social support and self-esteem, there was a significant joint influence of the independent variables on the dependent variable ( $R = .40$ ;  $R^2 = .16$ ;  $F(141), 13.76$ ;  $p < .05$ ). The two variables jointly contributed 16% of the variance to perceived quality of life. Meanwhile, only self-esteem significantly influenced perceived quality of life ( $Beta = .38$ ;  $t(df 146) = 4.99$ ;  $p < .05$ ) while perceived social support showed no significant influence ( $Beta = .13$ ;  $t(df 146) = -1.62$ ;  $p > .05$ ).

The finding relating to the joint influence of social support and self-esteem is in consonance with the theoretical postulations of the WHO (2001) and Edwards et al., (2003) which are predicated on the social model of illness which posits that society is expected to play certain roles in mitigating the impact of illness on the affected individuals. If the immediate environment provides the much needed social support for PLWHA, this, coupled with positive self-esteem, will serve as some sort of buffer for the infected and enhance their perception of quality of life. These observations are consistent with the assertion by Duracinsky et al., (2012) that patients living with HIV made spontaneous reference to the importance of their general health while a change in perception can lead to a dramatic change. Edwards et al., (2003) similarly affirmed that self-rating and contextual factors have a marked impact on quality of life. It can then be surmised that psychological intervention is required to strengthen social support; at the same time, it is critically important to promote efforts aimed at enhancing self-esteem of HIV patients to facilitate improved quality of life.

Considering the individual influence of self-esteem on perception of quality of life, it is obvious that the self-esteem of individuals has a major role to play in their perception. This finding is consonant with literature on self-esteem and individual health; for instance, Zimmerman (2000) found a high correlation between self-esteem and subjective well-being and happiness. Several empirical studies done both in the western world and parts of Africa that have investigated the influence of self-esteem on coping and mental health of persons living with HIV/ and AIDS as well as other health conditions, have consistently reported high positive correlations between the variables (Olapegba, 2005; Glick & Zigler, 1992; Garmezy, 1984).

It is however, rather interesting to note in the current study

that social support on its own did not seem to independently predict perception of quality of life contrary to what literature suggest. Be that as it may, if one considers the cultural context of the study, the finding might not be that surprising after all. Nigerian culture is essentially collectivist in nature, a feature which is very pronounced in the south west part of the country, ensuring that social support is an integral part of the lives of the people. In this culture, it is often taken for granted that both the immediate and extended family members are obligated to look after a sick relation, irrespective of the nature of the patient's health condition. Thus, sick people do not necessarily go out to actively look for social support; rather they assume it is always available. Meanwhile, this finding should not be viewed as a totally isolated instance; Kimberly and Serovich (1996) reported in a study conducted in the United States that social support was not related to quality of life in HIV infections. The authors attributed this to uncertainty regarding the extent to which others are perceived as supportive and who it is that is perceived to be supportive.

Gender difference was not found to be an issue in respect of the perception of quality of life among people living with HIV. Both male and female infected persons showed a similar pattern in terms of their perception of quality of life. Although the females score showed a slightly higher mean, the difference was not statistically significant to warrant particular attention. The conclusion therefore, was that both males and females required about the same level of social support and self-esteem to cope effectively with their health condition. This finding further confirms the inconclusive nature of research on gender differences in perceived quality of life; there has been no agreement in literature as to the nature and direction of gender differences.



The findings of the current study are at variance with those of Cederfjall, Langius-Eklof, Lidman & Wredling (2001), who reported that HIV infected women scored lower on perceived quality of life than their male counterparts. This may however, have been a function of the nature of the sample generated for the study; the women in that study were significantly younger than the men and were largely infected through heterosexual transmission, while the men were largely infected through homosexual/bisexual contacts. In a similar research project, Farooqi and Rasul (2011) found that females reported better overall quality of life compared to males. The variances in results from study to study may be attributed to a number of factors, including socio-cultural characteristics and values of the population of study. For instance, Farooqi & Rasul's study was conducted in Pakistan; Cedetfjall et al.'s study was done in Sweden, while the current study was conducted in Nigeria. Disparities in findings may also be attributable to certain characteristics of the illness that may not have been considered in some of the studies but not in others, issues such as progression of the illness, onset and quality of medical care.

## **Conclusion**

The study established that self-esteem is a strong factor in how individuals, particularly PLWHA, perceived the notion of quality of life. The belief and evaluations people held of themselves determined, to a large extent, who they are, what they can do and what they can become (Burns, 1982). As indicated in the reviewed literature, when people held a positive opinion about themselves and their abilities, they tended to be positive in their outlook towards life and as such this positively helped their perception quality of life. In the light of this finding, it is imperative that psychological interventions be

provided to shore up, alongside social support, the self-esteem of PLWHA to enable them cope better and be more optimistic and positive in their perception of quality of life.

### **Limitations of Study**

The sample size for the study was rather small, which may limit generalizability of the findings. The sample size, however, will not render the findings invalid considering the rigour put into the design and methodology. In addition, the current study was purely quantitative, and as such it did not allow for information that might have been peculiar to individual participants. Further research may wish to employ the qualitative method to ensure collection of more robust, individualised data.

### **References**

- Bonomi, A. E., Patrick, D. L., Bushnell, D. M., and Martin, M. 2000. Validation of the United States' version of the World Health Organization Quality of Life (WHOQOL) instrument. *Journal of Clinical Epidemiology*, 53, 19 – 23.
- Burns, R. 1982. *Self-concept development and education*". London: Holt, Rinehart & Winston.
- Canty-Mitchell, J., and Zimet, G. T. 2000. Psychometric properties of the Multidimensional Scale of Perceived Social Support in urban adolescents. *American Journal of Community Psychology*, 28, 391-400.
- Cederfjall, C., Langius-Eklof, A., Lidman, K., & Wreding, R. 2001. Gender differences in perceived health-related quality of life among patients with HIV infection. *AIDS patient Care STDS*, 15 (1); 31-39.
- Diener, E., Suh, E. M., Lucas, R. E., and Smith, H. L. 1999. Subjective well-being: Three decades of progress. *Psychological*

*Bulletin*, 125, 276 – 302.

Dollete, M., Steese, S., Phillips, W., and Matthews, G. 2006. Understanding girls' circle as an intervention on perceived social support, body image, self-efficacy, locus of control and self-esteem. *Girls' Circle Association: A Project of The Tides Center*.

Dumont, M., and Provost, A. M. 1999. Resilience in adolescents: Protective role of social support, coping strategies, self-esteem, and social activities on experience of stress and depression. *Journal of Youth and Adolescence*, 28 (3), 343 – 363.

Duracinsky, M., Acquadro, C., Herrmann, S., Berzins, B., Le Coeur, S., Kholi, R., Ban, B., Ferro doLago, R., and Chassany, O. 2012. The development of PROQOL-HIV: an international instrument to assess the health-related quality of life of persons living with HIV/AIDS. *Journal of Acquired Immune Deficiency Syndrome*, online edition. DOI: 10.1097/QAI.0o13e318245.

Edwards, T. C., Patrick, D. L., and Topolski, T. D. 2003. Quality of Life of Adolescents with Perceived Disability. *Journal of Pediatric Psychology*, 28, (4), 233 – 241.

Evans, D. R. 1997. Health promotion, wellness programs quality of life and marketing of psychology. *Canadian Psychology*, 38. 1 – 12.

Farooqi, Y. N. & Rasul, F. 2011. Gender differences in perceived quality of life of patients suffering from obsessive-compulsive disorder. *Pakistan Journal of Psychological Research*, 26 (1). <https://www.pjprnip.edu.pk/pjpr/index.php/pjpr/article/view/47>. Retrieved on 2012-10-22.

Farmer, T.W.& Farmer, E.M. 1996. The social relationships of students with exceptionalities in mainstream classrooms: Social network centrality and homophily. *Exceptional Children*, 62, 431 – 450.

Feshbach, S., and Weiner, B. 1991. *Personality* (3<sup>rd</sup>ed.). Lexington, Ma: D. C. Health.

Garnezy, N. 1984. The study of stress and competence in children: a building block For developmental psychopathology. *Child Development*, 55, 97 – 111.

Glick, M., and Zigler, E. 1992. Premorbid competence and the courses and outcomes of psychiatric disorders. In Rolf, J., Maste, A. S., Cicchetti, D., Nuechterlein, K. H. and Weintraub, S. Eds. *Risk and Protective Factors in the Development of Psychopathology*. Cambridge University Press, Cambridge, pp. 497 – 513.

Hagborg, W. J. 1993. The Rosenberg Self-Esteem Scale and Harter's Self Perception: Profile for Adolescents: A Concurrent Validity Study. *Psychology in the Schools*, 30, 132-136.

Harding, L. 2001. Children's quality of life assessment: A review of generic and health related quality of life measures completed by children and adolescents. *Clinical Psychology and Psychotherapy*, 8, 76-96.

Healthy People.2010. Disability and secondary conditions. Retrieved March 28, 2012, from [www.jpesy.oxfordjournals.org](http://www.jpesy.oxfordjournals.org).

Kimberly, J. A., and Serovich, J. M. 1996. Perceived social support among persons living with HIV/AIDS. *American Journal of Family Therapy*, 24, 41-53.

Kohli, R. M., Sane, S., Kumar, K., Paranjape, R. S., and Mehendale, S. M. 2005. Assessment of Quality of Life among HIV-Infected Persons in Pune, India. *Quality of Life Research*, 14, 1641 – 1647.

Merson, M. 1993. *Discrimination against HIV infected people or people with AIDS, WHO/GPA*, Speech to Commission on Human Rights, Geneva, 18 August.

Olapegba, P. O. 2005. Coping among People Living With HIV/AIDS (PLWHA): The influence of social support, self-esteem, locus of control and gender. *African Journal for the Psychological Study of Social Issues*, 8 (1). 114-120.

Olapegba, P. O. 2005. Predicting Mental Health of People Living with HIV/AIDS (PLWHA): The Role of Psychosocial Factors. *Journal of Human Ecology*, 18 (1). 69-72.

Olapegba, P. O. 2008. Psychosocial Factors and Environmental Adaptation as Predictors of Aggressive Tendency and Perceived Quality of Life among People Living near refuse Dumpsite, Lagos, Nigeria. *Unpublished PhD Thesis*, Dept. of Psychology, University of Ibadan, Nigeria.

Olapegba, P. O. 2009. Perceived Quality of Life: Towards a Generic Measure in Nigerian Culture. *Ibadan Journal of the Social Sciences*, 7 (2), 137-142.

Rosenberg, M. 1965. *Society and the Adolescent Self-Image*. Princeton, N. J: Princeton University Press.

Shahani, C., Dipboye, R. L., & Phillips, A. P. 1990. Global Self-Esteem as a Correlate of Work-Related Attitudes: A Question of Dimensionality. *Journal of Personality Assessment*, 54(1&2), 276-288.

The London Declaration on AIDS Prevention. 1988. World Summit of Ministers of Health. Retrieved April 6, 2012 from [www.whqlibdoc.int/hq/1988/WHO\\_GPA\\_INF\\_88.6.pdf](http://www.whqlibdoc.int/hq/1988/WHO_GPA_INF_88.6.pdf)

United Nations Centre for Human Rights. 1989. UN Commission on Human Rights' 1989. Report on the Situation of Human Rights in Iran. Retrieved on April 6, 2012 from [www.iranrights.org/english/document-374.php](http://www.iranrights.org/english/document-374.php).

Wallander, J. L., and Varni, J. W. 1998. Effects of paediatric chronic physical disorders on child and family adjustment. *Journal of Child Psychology and Psychiatry*, 39, 29 – 46.

WHOQOL Group. 1994. The development of the World Health Organization Quality of Life Assessment Instrument (the WHOQOL). In J. Orley & W. Kuyken (Eds.), *Quality of life assessment: International perspectives*. Berlin: Springer-Verlag.

WHOQOL Group.1995. The World Health Organization Quality of Life Assessment

(WHOQOL): Position paper from the World Health Organization. *Social Science and Medicine*, 41, 1403-1409.

World Health Organization. 2001. *International Classification of Functioning, Disability, and Health (ICF)*. Geneva, Switzerland: World Health Organization.

Zimet, G. D., Dahlem, N. W., Zimet, S. G., and Farley, G. K. 1988. The Multidimensional Scale of Perceived Social Support. *Journal of Personality Assessment*, 52: 30-41.

Zimmerman, S. L. 2000. Self-esteem, personal control, optimism, extraversion and the subjective well-being of Midwestern University Faculty. *Dissertation Abstract International B: Science and Engineering*, 60 (7-B), 3608.