



Demographic variations in the coping ability of people living with HIV/AIDS in Nigeria: implications for counselling

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Abstract

Objective: To determine the coping ability of people living with HIV/AIDS (PLWHA) across demographic variations of gender, duration of living with HIV infection, marital status and living arrangements either with the family or alone.

Method: The research design adopted in this study was descriptive survey. The population consisted of all PLWHA in Nigeria. The sample comprised of 117 PLWHA attending clinic regularly at General Hospital Ilesa, Osun State, Nigeria. The subjects had all been exposed to voluntary counselling and testing (VCT). Only those who consented participated in the study. A structured questionnaire developed for the purpose of this research was used to collect data.

Results: Marital status, living arrangements and gender do not significantly influence coping ability of the PLWHAs ($p > 0.05$); however duration of living with the infection had significant influence on the coping ability of PLWHAs ($p < 0.05$).

Conclusion: The length of period of living with HIV/AIDS had a significant effect on the coping abilities of PLWHA ($p < 0.05$). The results also showed no significant difference in the coping ability of PLWHA by gender, marital status and living arrangements ($p = 0.05$). Developing adaptive coping skills to deal with stress of living with HIV/AIDS may be a particularly effective strategy for improving overall health among the study population and not just on the medical needs.

Key words: Demography, Coping, HIV/AIDS, Counselling

Introduction

Human Immunodeficiency Virus/Acquired Immune Deficiency Syndrome (HIV/AIDS) is an epidemic of grand proportions sweeping through the world at large. The statistics reveal that particularly in Nigeria HIV/AIDS is fast becoming a major health crisis and psychological emergency⁽¹⁾. AIDS has been termed the world's most deadly undeclared war and a profound human tragedy. A UNICEF⁽²⁾ report indicated that the HIV virus and AIDS continue their devastating spread affecting the lives of 16,000 people each day. By the end of year 2004, 20 million people had died, 39.4 million people were living with HIV/AIDS and during the year, 3.1 million died from AIDS related illness⁽¹⁾.

The diagnosis of HIV infection is associated with considerable psychological and social discomfort like anxiety, depression, fear, shame, grief, mourning, guilt, confusion, self pity, fear of death and loneliness⁽³⁾. These emotions are found in all people who test positive to HIV. After HIV/AIDS was first identified, the social responses of

fear, denial, stigma and discrimination spread rapidly, fuelling anxiety and prejudice against people living with HIV/AIDS⁽⁴⁾. Manopaiboon et al.⁽⁵⁾ reported that HIV infected persons experience shame, fear of disclosure, anxiety about the future, and the effects on their family. These emotional reactions get worse over time, as the HIV/AIDS patients witnessed family disintegration, functional decline and loss of spouse or family. In addition, greater anxiety and depression symptoms were associated with women who reported higher stress, used fewer active coping strategies, and perceived less social support⁽⁶⁾.

HIV/AIDS in Nigeria has evolved into a serious public health problem; the evidence suggests that people living with HIV/AIDS in Nigeria experience considerable stigma and discrimination. Investigation of coping efforts among Nigerians living with HIV/AIDS is therefore important at least for some reasons. One, as a construct, coping has emerged out of a distinctly Western tradition, and the degree to which it translates to other cultures such as Nigeria is a potentially important research area. In addition,

little is known about the specific coping strategies used by HIV-infected people or the relationship between these strategies and their psychological well-being. However, there is considerable interest in how people cope with HIV/AIDS.

Being diagnosed with HIV/AIDS produces countless problems. These include stigmatisation and "general prejudice", no known cure, minimally adequate medical care, problems of confidentiality with no one to confide in, bereavement, financial distress (most money is being spent on drugs), and family disintegration⁽⁷⁻⁹⁾.

A person who has tested positive may never have the same quality of life again. PLWHA who have positive and helpful experiences at the time of testing cope with their situations more satisfactorily and are better able to talk about their fears and feelings, and to plan for the future⁽¹⁰⁾.

Quality of life incorporates many aspects of a person's well being, including overall health, oral health, pain, physical functioning and mental health⁽¹¹⁾. About 70% to 90% of HIV/AIDS patients will at one time or the other during the course of the disease can be afflicted by an oral lesion^(12,13). These oral lesions, often multiple, not only affect the quality of life but have a high recurrence rate. These conditions cause pain, discomfort, eating restrictions and provide a constant source of opportunistic infection. The importance of oral health cannot be over emphasized. The many problems arising as a result of HIV/AIDS associated illness/lesions could inevitably lead to the overwhelming psychological trauma and the sense of threat experienced by PLWHA. The frightening, irrational fears and negative discriminatory responses of the society undoubtedly intensify the troubles.

Most research on people living with HIV/AIDS emphasizes medical factors describing transmission and biology. Only a small number of theoretical studies and empirical research have begun to explore how PLWHA cope. This study was conducted to explore the coping abilities of PLWHA across gender, duration of living with the infection, marital status and living arrangements.

This study tested the following hypotheses':

1. There is no significant influence of duration of living with the infection on the coping ability of PLWHA.
2. There is no significant influence of living arrangements on the ability to cope with living with HIV/AIDS.
3. There is no difference in the coping ability of male or female PLWHA.
4. There is no difference in the coping ability of married or single PLWHA.

Materials and Method

The research design employed in this study is descriptive survey. The sample was drawn from all PLWHAs who are being supported in Osun State. Purposive sampling technique was used but only 117 were available and willing to participate in the study. This was above the expected sample size of 65 subjects using a prevalence of 4.4% of HIV/AIDS in Nigeria⁽¹⁴⁾. They had been exposed to voluntary counselling and testing (VCT) to help reduce risky sexual behaviour and empowered to make informed choices about reproductive health. All participants were

regularly attending PLWHA clinic at General Hospital Ilesa, Osun State and had consented to participate in the study. The instrument used for data collection was a structured questionnaire developed for the purpose of this research. It consisted of two sections - A and B. Section A solicited information on demographic variables, while section B elicited responses on patients' coping abilities. Section B of the questionnaire contained twenty-two questions which cut across PLWHA's level of concerns about discrimination and stigmatisation, coping with the illness process, medication, facing loss of loved ones and so on. Using a Likert scale 1 to 5, respondents graded their coping ability on various issues of living with the infection. The Potential scores ranged from 22 to 110. Low scores reflect less concern and less anxiety about the issues while higher scores denote more concerns and lower coping ability. A trained assistant who administered the questionnaire to the respondents collected the data. Data was analysed using SPSS (version 11) statistical software⁽¹⁵⁾. The hypotheses were tested using Chi-square and Mann-Whitney U test.

Result

One hundred and seventeen PLWHAs, 74 (63.2%) females and 43 (36.8%) males participated in this study. Their ages ranged between 15-62years (mean age 36.0 ± 1.01). Sixty four (54.7%) were artisans, 12 (10.3%) were civil servants, 36 (30.8%) were unemployed, and 5 (4.3%) were retirees. Seventeen (14.5%) participants lived alone while 100 (85.5%) lived with family. The duration of living with HIV infection ranged from 1-155 months (mean 14.7 ± 20.8 months). Hence, the majority fell within the first one year of living with the infection.

Table 1 shows the various questions that were asked in the questionnaire. The lowest score was observed for 'attitude of close relation' among 33.3% of the respondents, while 33.3% rated their inability to cope with the fact that 'there is no cure for AIDS' highest (Likert rating 4 and 5 respectively). Forty one per cent showed higher scores for question on 'disinterest in things'.

Testing of hypotheses

The influence of duration of living with HIV/AIDS and coping ability of respondents was tested - hypothesis 1 (**Table 2**). It was revealed that the duration of living with the infection had significant influence on coping ability of PLWHA ($X^2 = 13.6, p = 0.05$). Hence, the more advanced the duration of living with the disease, the better the coping ability. This observation is revealed by the percentage (61.5%) of those who had higher coping scores and living with the disease for less than 2years (**Table 2**).

For hypothesis 2, Living arrangement of either with the family or alone has no significant influence on the coping ability of PLWHAs ($X^2 = 5.3, p \geq 0.05$). (**Table 3**).

For hypothesis 3, a t-test analysis was used to determine the significant difference in the coping ability of male and female PLWHAs. The result revealed that coping ability of males and females are practically indistinguishable. That is, there is no significant difference in the coping ability of male and female PLWHAs (Mann-Whitney U = 1547.50, $p \geq 0.05$). **Table 4** presents the results. For hypothesis 4 the coping ability of married and single PLWHAs was



compared. The results reveal that there was no significant difference in the coping ability of married and single PLWHAs (Mann-Whitney U= 1449.50, p=0.05) (Table 3).

Discussion

The findings from this study revealed that the duration of the infection has significant influence on the coping ability of PLWHAs. That is, as the duration of living with the infection increases the better the coping ability. This finding was in agreement with expected pattern of coping observed in literature. The previous studies had established that the disease condition produces in the patients a period of shock, denial, anger, bargaining (where people will bargain for survival) and finally acceptance where the

person accepts the diagnosis and the eventual death, and might then be able to consider treatment and preventive actions⁽¹⁶⁻¹⁸⁾. It is expected that these different stages would dictate different coping abilities in the respondents. Previous studies have suggested that more symptoms of HIV/AIDS are observed as the clinical stage of the disease increases⁽¹⁹⁻²¹⁾. It is expected that as the disease progresses patients become sick more often, yet their ability to cope become increased due to what Wilson et al⁽¹⁰⁾ termed as “bargaining for survival”. That is the reason why the support being received by the respondents are highly essential. They need to receive medical and psychological support (counselling) from time to time.

Bonuck et al⁽²²⁾ found that PLWHA living alone were likely

Table 1. Responses of subjects in the questionnaire

Questions	Scores					Total N (%)
	1 N (%)	2 N (%)	3 N (%)	4 N (%)	5 N (%)	
The attitude of close relations and associates	39(33.3)	25(21.4)	22(18.8)	23(19.7)	8(6.8)	117 (100)
That you get sick often	12(10.3)	21(17.9)	31(26.5)	44(37.6)	9(7.7)	117(100)
There is no cure for AIDS yet	8(6.8)	10(8.5)	21(18.0)	39(33.3)	39(33.3)	117(100)
That you get tired easily	16(13.7)	15(12.8)	29(24.8)	43(36.7)	14(12.0)	117(100)
Have no appetite for meals	15(12.8)	14(12.0)	40(34.2)	35(29.9)	13(11.1)	117(100)
Gradually getting thinner	15(12.8)	13(11.1)	20(17.1)	39(33.3)	30(25.6)	117(100)
Not having many friends	43(36.7)	9(7.7)	20(17.1)	32(27.3)	13(11.1)	117(100)
You cannot have close contact with the opposite sex	32(27.3)	12(10.3)	16(13.7)	39(33.3)	18(15.4)	117(100)
You might loose your loved ones	21(17.9)	14(12.0)	20(17.1)	35(29.9)	27(23.1)	117(100)
That you might not get married	36(30.8)	16(13.7)	20(17.1)	33(28.2)	12(10.2)	117(100)
Being talked about	29(24.8)	22(18.8)	34(29.1)	23(19.6)	9(7.7)	117(100)
Being made fun of	24(20.5)	22(18.8)	25(21.4)	32(27.3)	14(12.0)	117(100)
Not getting along well with others	32(27.4)	17(14.5)	16(13.7)	39(33.3)	13(11.1)	117(100)
Being criticized by others	27(23.1)	18(15.4)	23(19.6)	40(34.2)	9(7.7)	117(100)
Being left out of things	27(23.1)	22(18.8)	16(13.7)	40(34.2)	12(10.2)	117(100)
Feeling very lonely	28(23.9)	23(19.6)	21(18.0)	36(30.8)	9(7.7)	117(100)
No one with whom to discuss your troubles	30(25.6)	20(17.1)	21(18.0)	32(27.3)	14(12.0)	117(100)
That you worry too much	22(18.8)	21(18.0)	37(31.6)	26(22.2)	11(9.4)	117(100)
Daydream	34(29.0)	19(16.2)	25(21.4)	27(23.1)	12(10.3)	117(100)
Relenting due to discouragement	23(19.7)	24(20.5)	21(18.0)	39(33.3)	10(8.5)	117(100)
Wishing you have never been born	30(25.6)	11(9.4)	24(20.5)	34(29.1)	18(15.4)	117(100)
Disinterest in things	21(17.9)	20(17.1)	16(13.7)	48(41.0)	12(10.3)	117(100)



Table 2: Relationship between duration of living with HIV/AIDS and Coping ability

Coping scores	Duration (months)	
	1-24 N (%)	25 < N (%)
20-50	16 (16.7)	6 (28.6)
51-65	21 (21.9)	11 (52.4)
66-110	59 (61.4)	4 (19.0)
Total	96(100.0)	21 (100.0)

$\chi^2=12.92$, $df=2$, $p=0.001$

Table 3. Coping ability of PLWHA and their living arrangements

Coping scores	Living arrangement	
	Alone N (%)	With family N (%)
20-50	4 (23.5)	18 (18.0)
51-65	8 (47.1)	24 (24.0)
66-110	5 (29.4)	58 (58.0)
Total	17 (100.0)	100 (100.0)

$\chi^2=5.3$, $df=2$, $p=0.07$

to have a higher level of unmet needs than those living with others. Yet, the test of hypothesis 2 revealed no significant relationship between living arrangement conditions of PLWHA and their coping ability in the present study. It has been reported that living with another person, assist the PLWHA in accessing health care for themselves^(23, 24). In the present study, this was not found to be the case; most likely due to the fact that the partners of PLWHA were themselves lacking in their ability (due to socio-economic and other factors common in sub-Saharan Africa) to assist the PLWHAs to care for their health and access health/counselling services. Another possible explanation for this finding might be because previous studies were conducted in the western world and it should be noted that there might be cultural variability in expression, dependence and coping ability hence the results obtained in hypothesis 2.

Unlike in some earlier studies, the tests of hypotheses 3 and 4 of the present study showed no statistically significant differences in the coping ability of PLWHA with respect to gender and marital status. The inference here is that marital status and gender do not influence coping ability to the infection. So, both married and unmarried are equally affected and the same was true for the males and females in this study.

Conclusion

This paper serves to illustrate the effect of demographic variations on the coping ability of PLWHAs. This study has been able to show that duration of living with the disease has significant influence on respondents coping ability. This goes on to buttress the fact that PLWHAs need adaptive coping skills and more psychological support in terms of professional counselling. Furthermore, living

Table 4. Relationship between the coping ability, gender and marital status.

Gender	N	Mean rank	Sum rank	Z	Mann-Whitney U	p
Male	43	60.01	2580.50	-0.246	1547.50	0.81
Female	74	58.41	4322.50			
Marital status						
Single	36	59.24	2132.50	-0.05	1449.50	0.96
Married	81	58.90	4770.50			

arrangement, gender and marital status have no influences on the coping ability of PLWHAs and so, should no longer be given undue emphasis in coping interventions among the study population.

Future, longitudinal studies on coping strategies among PLWHA are needed to examine factors associated with disease progression, coping and quality of life over time. Developing adaptive coping skills to deal with stress of living with HIV/AIDS may be a particularly effective strategy for improving overall health⁽²⁵⁾. This may also be useful in developing an outpatient behaviour-modification/coping effectiveness training program that is both gender-specific and culturally appropriate.

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