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Quality of life of people living with HIV in Pakistan

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Abstract

Background: With the appreciable increase in life span of people living with HIV (PLWHA), the need for data about their quality of life (QoL) has become realy important. However, very limited studies have been done using the World Health Organization quality of life HIV (WHOQOL-HIV) bref questionnaire for this purpose in our environment.

Objective: This study assessed the QoL of PLWHA) in Pakistan

Methods: A descriptive cross-sectional study design was used. Two hundred fifty-two PLWHA from five health care centers located across Pakistan were consecutively selected. Sociodemographic, medical, data was obtained by administering questionnaire at interview and the WHOQOL-HIV bref was used to assess the QoL of each study participant.

Results: The overall QoL mean scores in the three domains were similar: psychological health, 15.0±2.8; physical health, 15.2±2.5; and spirituality/religion/personal beliefs, 15.7± 3.4. in social relationships (13.2±2.5) and environment (13.1±1.9) domains Lower QoL mean scores were recorded. In the level of independence domain a significant difference in mean QoL scores was noticed among women (14.4±1.9) compared to men (13.9±1.7; p=0.028).

Conclusions: The PLWHA studied appear to have a higher QoL in the spirituality/religion/personal beliefs, physical, and psychological health domains, but a lower QoL in the social relationships and environment domains, which could be an indication of discrimination as well as poor living conditions in their physical environment.

Keywords: Quality of life, PLWHA, HIV, AIDS, WHOQOL-HIV bref

Introduction

Human immunodeficiency virus (HIV) / Acquired immune deficiency syndrome (AIDS) is a chronic infection that affects not only the patients' physical condition, but also their social relations, mental health and financial aspects [1]. AIDS has become a major health problem worldwide since its start in 1981. By the end of 2013 more than 78 million people infected with HIV and people living with HIV reached to 35 million[2]. 780,000 people living with HIV/AIDS (PLWHA) is recorded in china's population according to epidemic estimate. 46.5% and 13.7% were infected through heterosexual transmission and homosexual transmission respectively were reported according to case reports. From 33.1% in 2006 to 76.3% in 2011 the ratio of the cases resulting from sexual transmission has increased [3]. The most prevalent transmission route is Sexual transmission, [4]

Relatively developed economy and cultural values of openness in the province of Zhejiang in china. In

Zhejiang, the most of the patients developed HIV via sexual transmission, and the documented HIV infections have went up to 11,357 by the end of 2012. The HIV prevalence rate among the general population is about 0.01% [5].

In spite of its moderate HIV epidemic, risk factors such as high prevalence of sexually transmitted infections and various entertainment venues providing sex service in main urban areas are driving the epidemic in Zhejiang province [6]. Improving the living and traffic environment of PLWHA local municipality has vital role. . In China, the National Free Antiretroviral Treatment Program (NFATP) started in 2002 has remarkably decrease the mortality of HIV patients, from 27 deaths per 100 person-years prior to treatment [7].

However, given the need of managing HIV/AIDS as a chronic and survivable disease and the medication side effects, opportunistic infections, and the constant stigma and discrimination experienced by the PLWHA, there has been growing concern about PLWHA's overall wellbeing in physical, psychological and socioeconomic domains [8]. In China, widespread discrimination towards PLWHA. Like other countries, China have meet with the challenges of both controlling the epidemic and removing discrimination[9].

The current study assessed the QoL of PLWHA.

Methodology

This was a descriptive, cross-sectional study. PLWHA (252) were consecutively recruited from the following five health care facilities in Pakistan. Sociodemographic, medical, data was obtained by administering questionnaire at interview and the WHOQOL-HIV bref was used to assess the QoL of each study participant. The WHOQOL-HIV bref compromised of 31 questions, 5-point Likert scale was used for each item. These items are divided into six domains. The six domains of QoL are as follows: physical health, psychological health, level of independence, social relationships, environment, and spirituality/religion/personal beliefs. The physical health domain measures pain and discomfort, energy and fatigue, and sleep and rest. The psychological health domain measures positive feelings, thinking, learning, memory and concentration, self-esteem, bodily image and appearance, and negative feelings.

Mobility, daily life activities measures is the independence domain, medications or treatments, and work capacity is dependence component. The social relationships domain includes personal relationships, social support, and sexual activity. physical safety and security, home environment, financial resources, health and social care, accessibility and quality, opportunities for acquiring new information and skills is measure in the environment domain of the questionnaire, also participation in and opportunities for recreation and leisure activities, and physical environment (pollution, noise, traffic, climate, and transport). Forgiveness and blame, concerns about the future, and death and dying was dealing in spirituality/religion/personal beliefs domain in questionnaire.

Data entry and statistical analysis were performed using the statistical package for social science (SPSS) software, version 14.0. The descriptive statistics, such as mean and standard deviation, were used to summarize the score of the QoL. Domain scores were scaled in a positive direction (higher scores denoting a higher QoL). The mean score of items within each domain was used to calculate the domain scores by multiplying by 4, so that scores ranged from 4 (minimum) to 20 (maximum), with higher scores indicating a better QoL. For the analysis of statistical differences between the mean scores of QoL for dichotomous variables, the student t-test was used. <0.05 is the level of statistically significant.

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Results

Total 252 PLWHA participant were selected in the study, out of the 62.7% were females. The mean age of participants was 34.8 years, with a range of 18-58 years. The married respondents constituted more than one-half of the entire sample size (51.6%), while 23.8% were unmarried. Educational status showed that 67.5% of the respondents were educated up to the secondary school level (Table I). Mean score of spirituality/religion/personal beliefs and the psychological domains were high in Qol questionaire, but lower for environment and social relationships. Table II shows a summary of the QoL domain scores. Only in the level of independence domain of the QoL the gender status of the PLWHA showed a significant difference. The results of the Student t-test between gender and domain scores are summarized in Table III.

Table I: SOCIO-DEMOGRAPHIC STATUS

Variables	Categories	N	%
Gender (n=252)	Male	94	37.3
	Female	158	62.7
Marital status (n=252)	Married	130	51.6
	Single	60	23.8
	Widowed	26	10.3
	Divorced	16	6.3
	Separated	12	4.8
	Co-habitation	8	3.2
Educational status (n=252)	Primary	72	28.6
	Secondary	98	38.9
	Tertiary	38	15.1
	None	44	17.5

Table II: Scores Obtained From The Quality Of Life Questionnaire (Whoqol-Hiv Bref) By Domain

Domain	Mean (SD)	Minimum – Maximum
1. Physical health	15.2 (2.5)	4.0 – 20.00
2. Psychological health	15.0 (2.8)	4.0 – 20.00
3. Level of independence	14.2 (1.9)	4.0 – 20.00
4. Social relationships	13.2 (2.5)	4.0 – 20.00
5. Environment	13.1 (1.9)	4.0 – 20.00
6. Spirituality/religion/personal beliefs	15.7 (3.4)	4.0 – 20.00

Table III: Gender and Quality Of Life Scores

Domain	Male Mean (SD)	Female Mean (SD)	p-value
Physical health	15.2 (2.7)	15.2 (2.5)	0.834
Psychological	14.7 (2.8)	15.2 (2.7)	0.204
Level of independence	13.9 (1.7)	14.4 (1.9)	0.028
Social relationship	13.0 (2.5)	13.2 (2.6)	0.354
Environmental	13.0 (1.9)	13.2 (1.9)	0.383
Spiritual/religious/ personal beliefs	16.1 (3.1)	15.4 (3.6)	0.137

Independent samples test

Discussion

In this study, the mean score was highest and similar in the spirituality/religion/personal beliefs, physical, and psychological health domains, indicating a better QoL in these domains. However, the mean scores in the social relationships and environment domains were at the intermediate level. As documented by Ebisabete et al. in a study conducted to assess the QoL of PLWHA in Sao Paulo, Brazil, the results showed that mean scores for social relationships and environment domains fell in the intermediate level, a result observed to be similar with the present study. Also, in a study conducted in Casa da by Fleck et al.

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PLWHA had a better QoL (i.e., physical and psychological health), but worse QoL in the social relationship domain[11] The resulting low level QoL in the social relationships domain could reflect stigmatization and discrimination faced by the participants. Also, issues like personal relationships, sexual activities, and social support of PLWHA can have a negative effect in the social relationship domain. In the current study, women showed a higher QoL score compared to men in virtually all domains and a significantly higher level on the independence domain. However, previous studies have reported lower QoL scores in psychological and environment domains among women[12 13].

The reason for the observed higher QoL scores in women could be due to constant visits and show of concern among the females in our environment. Generally, especially in a country like Nigeria, people tend to be spiritual and religious only when confronted with issues that are beyond them. This could account for the observed high QoL scores in the spirituality/religion/personal belief domain. A paper by Szaflarki et al. reported that one-third of patients with HIV/AIDS believed that their life was better now than before they were diagnosed with HIV. Several factors, including spirituality were associated with believing that life has improved. Szaflarki and his colleagues used path analysis to examine the conceptual model of how spirituality/religion is related to QoL. Ironson et al. in their study to examine the relationship between changes in spirituality/religion post-HIV diagnosis and disease progression, observed that nearly one-half of the patients reported an increase in spirituality/religion following diagnosis and as such, their findings corroborated with those of Szaflarski and his colleagues, confirming that patients become more spiritual/religious after disease diagnosis.

Conclusion

The PLWHA studied appear to have a higher QoL in the spirituality/religion/personal beliefs, physical, and psychological health domains, but a lower QoL in the social relationships and environment domains, which could be an indication of discrimination as well as poor living conditions in their physical environment.

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