



## Quality Of Life Of Hiv Infected People At Perambalur

### KEYWORDS

HIV/AIDS, Quality of Life.

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### ABSTRACT

Many of the HIV patients struggle with numerous social problems such as stigma, poverty, depression, substance abuse, and cultural beliefs which can affect their Quality of Life not only from the physical health aspect, but also from mental and social health point of view and cause numerous problems in useful activities and interests of the patients. This present study aims to analyze the quality of life of HIV infected persons at Perambalur. WHOQOL-HIV BREF was adopted to collect the data from 44 respondents. The study reveals that Quality of Life was low among the respondents

### INTRODUCTION

Quality of life is defined not only by one's general health but also by psychological well-being and social status. The psychosocial aspects of quality of life may be increasingly important in patients with HIV infection as the disease becomes more chronic in nature during the era of more effective antiretroviral treatment (ART). Studies show that HIV patients often experience a decline in quality of life due to factors other than disease stage and physical condition [1-4], such as poverty, addiction, depression, and violence. Understanding such factors and their influence helps to establish better social services to address multidimensional issues related to quality of life in these patients. However, the measurement of quality of life with its diverse dimensions is complex. The World Health Organization disseminates a standardized quality-of-life instrument specifically adapted for HIV patients (WHOQOL-HIV) which has been widely used and shown to be a valuable tool for evaluating patients' perception of their quality of life.

**PedramRazavi et al. (2012)** conducted a cross-sectional study on 191 HIV/AIDS patient, WHOQOL-HIV instrument was applied to determine quality of life and its associated factors in Tehran, Iran. Student's t-test was used to compare quality of life between groups. Compared to younger participants, patients older than 35 years had significantly lower scores in overall quality of life ( $P = 0.003$ ), social relationships ( $P = 0.021$ ), and spirituality/religion/personal beliefs ( $P = 0.024$ ). Unemployed patients had significantly lower scores in overall quality of life ( $P = 0.01$ ), level of independence ( $P = 0.004$ ), and environment ( $P = 0.001$ ) compared to employed participants.

**Tran (2012)** conducted a study entitled Quality of Life Outcomes of Antiretroviral Treatment for HIV/AIDS Patients in Vietnam and the study discussed the WHOQOL-HIV BREF had a good discriminative validity with patient's disease stages, CD4 cell counts, and duration of ART. In a band score of (4, 20), six domains were moderate; "Environment" had the highest score (13.8±2.8), and "Social" had the lowest score (11.2±3.3). Worse HRQOL were observed in patients at provincial and district clinics. Those patients who were male, had higher educational attainment, and are employed, reported better HRQOL. In reduced regression models, poorer HRQOL was found in patients who had advanced HIV infection and had CD4 cell count <200 cells/mL. Patients reported significantly poorer Physical and Social in the 1st year ART, but moderately

better Performance, Morbidity, Spirituality, and Environment from the 2nd year ART, compared to those not-yet-on ART. Strengthening the quality of ART services at the provincial and district levels, gender-specific impact mitigation, and early treatment supports are recommended for further expansion of ART services in Vietnam. Regular assessments of HRQOL may provide important indicators for monitoring and evaluating HIV/AIDS services.

**BNirmal, (2008)** With developing countries on the wave of a HIV epidemic, issues like quality of life (QOL) have come to fore. We aimed to assess the quality of life in human immunodeficiency virus (HIV)/acquired immune deficiency syndrome (AIDS) patients at antiretroviral therapy (ART) clinic in a tertiary healthcare centre in South India. The study was conducted on 60 HIV/AIDS patients attending ART clinic at a tertiary health hospital, Chennai, South India. QOL was evaluated using the WHO QOL-BREF (Field trial version) instrument using 26 items grouped under 4 domains, namely physical health, psychological well-being, social relationships, and environment on 60 HIV/AIDS patients. Standard error of the difference between means was employed to find out significant difference between domain scores and clinical categories. QOL scores were highest for environmental domain which is 46.19 (0-100 scale). QOL scores were significantly lower among persons with lower CD4 counts ( $P < 0.001$ ). Women had lower QOL scores than men despite having less advanced disease. Patients with better educational background had significantly higher psychological domain scores. Also, a supportive family kept environmental domain scores better ( $P < 0.001$ ). A need for good healthcare support system was perceived. Better education helps the patient to cope with the disease well. Family support is essential for healthier environment.

### Objectives

To analyze the Quality of Life of HIV people.

### Materials and Methodology

The participants were the HIV infected people at Perambalur Government Hospital (20 male and 24 female, N=44). The researcher selected all the 44 respondents for this study and census method was adopted for selecting the respondents. This study is descriptive in nature. A self-prepared interview schedule was used to collect the socio-demographic details along with WHOQOL-HIV BREF (2002) to analyze the Quality of life of the respondents.

Analysis and Discussion

S. No	Particulars	No. of respondents (n:44)	Percentage
1	<b>Age</b>		
	Below 35 years	18	41
	36-40 years	21	48
	Above 41	5	11
2	<b>Gender</b>		
	Male	20	46
	Female	24	54
3	<b>Marital status</b>		
	Married	29	56
	Divorced	1	2
	Separated	2	5
	Widowed	12	27
4	<b>Education</b>		
	Primary	26	60
	Middle	9	20
	Higher Secondary	9	20
5	<b>Occupation</b>		
	Agriculture	9	21
	Coolie	22	50
	NGO	3	7
	Others	10	23
6	<b>Income</b>		
	Rs 1000-2000	35	80
	Rs 2001-3000	3	7
	Rs 3001&above	6	14
7	<b>Type of family</b>	44	100
	Nuclear		

**Table 1**  
Distribution of the respondents by their socio demographic details

The above table reveals that nearly half (48 %) of the respondents were in the age group of 36-40 years, 55 per cent were females. It is clearly evident that female respondents are more vulnerable than male respondents. More than half (56 percent) of the respondents were married, With regard to the educational status of the respondents majority (60 percent) had basic school education. The occupational status of the respondents indicates that half of the respondents (50%) were coolies. A High majority (80%) of the respondent's income were Rs1000 to 2000. All the respondents were from nuclear family. Sexual contact was reported as mode of transmission by the respondents.

S. No.	Age of Diagnosis	No. of Respondents (n:44)	Percentage
1	Below 30 years	15	34
2	31 - 35 years	18	41
3	36 - 40 years	11	25
	Total	44	100

**Table 2**  
Distribution of respondents by their Age of diagnosis of HIV

The above table indicates that 41 per cent of the respondents were diagnosed with HIV at the age of 31- 35 years, 34 per cent below 30 years of age and 25 per cent 36- 40

years of age.

S.No	Quality of Life	No of Respondents	Percentage
1	High	16	36
2	Low	28	64
	Total	44	100

**Table 3**  
Quality of Life of the respondents

Majority (64 %) of the respondents quality of life were low and 36 percent were high. Thus the quality of life of the respondents in this study was found to be low.

S.No.	AGE	N	MEAN	SD	Statistical Inference
1.	Below 35 years	18	94.77	20.00	Df- 2, 41 F- 9.505 Sig- 0.000 p < 0.05 <b>Significant</b>
2.	36 - 40 years	21	93.23	17.66	
3	Above 41 years	5	50.20	36.40	
	Total	44	88.97	24.98	

**Table 4**  
One way analysis of variance between the age of the respondents and quality of life

The above table reveals that there is a significant difference between the age of the respondents with regard to their quality of life.

S.NO.	Educational Status	N	MEAN	SD	Statistical Inference
1.	Primary	26	82.5000	25.17499	Df- 2, 41 F- 2.961 Sig- 0.063 p < 0.10 <b>Significant</b>
2.	Middle	9	92.0000	30.83829	
3.	Higher Secondary	9	1.0467	1.00000	
	Total	44	88.9773	24.98789	

**Table 5**  
One way analysis of variance between the educational status of the respondents and quality of life

The above table reveals that there is a significant difference between the educational status of the respondents and quality of life.

S. No.	Income	N	Mean	SD	Statistical Inference
1.	Rs. 1000 - 2000	35	85.3143	26.85338	Df- 2, 41 F- 1.927 Sig - 0.159 p > 0.05 <b>Not Significant</b>
2.	Rs. 2001 - 3000	3	1.0167	2.88675	
3.	Rs. 3001 and above	6	1.0400	1.26491	
	Total	44	88.9773	24.98789	

**Table 6** One way analysis of variance between income of the respondents and quality of life

The above table reveals that there is no significant difference between the income of the respondents and quality of life.

### Discussion

- Currently, many people are not learning about their HIV status until late in their HIV disease, when they start to develop symptoms or opportunistic infections. At this point, antiretroviral treatment can help improve their health, but not as effectively as when treatment is started earlier.
- Earlier diagnosis is therefore important for both the health of a person living with HIV and for preventing the transmission of the virus.
- Campaigns to improve awareness of HIV risk and encourage people to get tested regularly.
- Making HIV testing a routine part of healthcare to increase the number of people offered an HIV test.
- Linking people who receive a positive diagnosis to accessible and culturally appropriate care and support services is important to ensure that people living with HIV enter the next step of the treatment cascade. Research shows that delays in linkage to medical care after HIV diagnosis are associated with faster disease progression.
- Programs that support people living with HIV to live healthy sexual lives and incorporate prevention as part of their overall health and well-being.
- Public health authorities, social workers, healthcare providers and frontline service providers all have a role to play in making services more accessible and providing people with ongoing care.
- Each organization has a role to play in improving care for people living with HIV, such as policymakers, service providers, healthcare providers and people living with HIV, should help improve services for people living with and at risk of HIV.
- Teaching about HIV Management improves the HIV people to have a better outlook about HIV infection.
- Improving sexual health of HIV people, taking advantage of group and individual therapy and spirituality also improves their quality of life.
- Quality of life is the ability to have quality in love, labor, and leisure, says Bea. People living with HIV deserve those qualities, just like all of us." Thus steps should be taken to improve their quality of life in the long run.
- This study argues for realistic interventions and policy changes designed to reduce the financial and time burden of ART and to reduce logistical barriers, such as simplifying the referral and transfer process, employing patient advocates, and adopting extended and weekend clinic hours.

### REFERENCE

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