

TB/HIV/AIDS Infection Coping Strategies in Nigeria

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ABSTRACT

Background: At least 7 out of every 10 persons living with Tuberculosis (TB) and Human immune deficiency virus (HIV) infection in Nigeria's rural communities live below poverty level. Most suffer from malnutrition and die. What coping mechanisms must be designed for households, the primary care units, for the effective management of the pandemic. **Aims and Objectives:** The main aim and objective of this study is to evaluate and determine the cultural, social and economic conditions of TB/HIV/AIDS patients and how they are coping with the disease in a rural community in a developing country using Nigeria as case study. **Materials and Methods:** Given the prevalence of cases of TB/HIV infection in Nigeria's rural communities, a case study of Mbaise rural area in Imo state, South-East Nigeria was developed. Over several weeks, visits to chest clinics and health facilities of 675 active TB/HIV infected patients were made, including interactions and interviews with the patients to study their cultural, social and economic conditions. Focus group consultations, interviews and discussions were held to assess needs and situations using well structured questionnaire. Data was analysed using descriptive statistics and budgetary analysis. **Results:** Negative cultural strains and endemic poverty severely restrict positive household response to the caring of TB/HIV infected patients. In the absence of medical care and welfare, the burden of caring is too heavy for the household to carry. **Conclusion:** There is need for a sustainable, institutionalized programme involving government rural development agencies, community leaders, and rural health professionals in order to achieve poverty alleviation, medical support and awareness of TB/HIV prevention and control methods.

Keywords: Tuberculosis, Human immune deficiency virus, Rural communities, Developing countries, Household, Coped, Nigerian case study

Introduction

TB/HIV infection results in the morbidity and often in the mortality of its victims leading to loss of labor time, declining productivity and reduced income.

Even though TB/HIV control programs like the Directly Observed Therapy Short course (DOTS) and the American Presidential Emergency Program for AIDS Relief (PEPFAR) now cover nearly half of the population of TB/HIV patients, we are nowhere near the target for case detection as only about 30% of people with active TB/HIV infection are currently diagnosed and managed with DOTS/PEPFAR according to the latest WHO estimates.¹

Consider the hurdles that await a rural hill farmer who has persistent cough that he fears may be tuberculosis (TB). Assume that he wants to cure himself, as well as protect his family and community.

So he gets up early and walks to the nearest TB clinic, which could be many miles away across rugged mountains. On arriving

there, he stands in line possibly for several hours- in order to register at the front desk.

After he has registered, the clinic will send him to a laboratory, which may be located somewhere else, where he will line up again to be given another form to fill out and then told to go outside and cough some sputum from his lungs into a plastic cup.

He brings the cup back to the laboratory for analysis, and is told to return the next morning with another sputum sample. When he treks back to the clinic, he hands over the second cup and is told to go outside and produce yet another sputum sample. Then he has to wait for another few hours or to come back after some days for the test results.

And while he is away, his farm goes untended and neighbours gossip about his prolonged absence.(Women-who are generally expected to collect firewood and water, cook, clean, tend to children and livestock and perform other myriad chores- have it even

tougher). So far so bad. But it is just the beginning of our village hill farmer's travails. If he is diagnosed TB positive, he will have to return to the clinic everyday for the next two months to receive directly observed medication from a health worker. If he is diagnosed negative, all well and good.

But will he go that entire border the next time he develops a cough, one that is really TB? Or will he simply ignore the signs the second time around, infecting a dozen other people before dying a painful, wasting death?

Majority of TB patients are also HIV infected patients and they face this same ordeal as they suffer to get diagnosis, treatment or drugs but the precise reason for these failures differ from place to place.

Obstacles may be social stigma, lack of information, poor quality services, simple economics or a combination of these.¹

This study will evaluate the impact of this infection and how households in rural communities of a developing country like Nigeria are coping with it.

Results obtained from this study will be utilized in formulating TB/HIV control programs in the study population.

Materials and Methods

Focus group discussions and interviews were held with 675 active TB/HIV patients in chest clinics and health facilities in the study area to assess the ways they are coping with TB and HIV.

In-depth interviews were subsequently held using a well structured, pre-tested 33-question interview schedule questionnaire which was administered to the 675 subjects, with personal interview conducted for those that can neither read nor write.

The questionnaires were administered by health workers who were previously trained in questionnaire administration techniques.

Data obtained was analyzed using descriptive statistics and budgetary analysis.

Results

The educational and socioeconomic background of the respondents revealed that 340(22.9%) had no formal education while 177(11.9%), 106(7.15%), 52 (3.51%) had primary, secondary and tertiary education respectively.

A total of 301 (20.3%) were married, 347 (23.4%) were single while 7 (4.72%), 12(8.1%), 8(5.4%) were divorced, separated or widowed respectively.

Those that were unwilling to reveal their monthly income was 178 (5.4%) while most of those that revealed their income were 322 (21.7%) and earned between N1,000 to N5000 (US\$7.4 to US\$37.0) per month.

These are shown in Table 1 below

The coping strategies adopted by households suffering from TB/HIV include those that use herbal drugs for treatment of the infection 345(23.2%), those that experience continuing reduction in their budget and expenditure because of ill health 354(23.8%), those that sold their household assets because of the disease 302(20.3%), those that use child labor 276(18.6%), those that obtain financial assistance or remittances from extended family members 177(11.9%), those

that obtained loans from finance sources 192(12.9%), and those that use prayers as a means of coping with the disease was 345(23.2%).

The problems they encounter include unemployment, stigmatization, inability to pay for transportation and medical services, poverty and inaccessibility to loans for business activities.

These are shown in Table 2 below.

In addition, these patients were less able to work to generate income for themselves and their dependants.

These factors posed significant additional economic hardships on these patients and their households, further limiting their access to care. Frequently encountered health needs and problems of people suffering from TB/HIV are weakness (70%) and irritating cough (64%). A total of 86% of them were concerned with lack of love and understanding from immediate family members and community. A total of 94% of them will rather not disclose their TB/HIV status to family members because of the highly infectious nature of TB/HIV.

Majority of family members lacked basic knowledge of TB/HIV and may not be aware that their relatives have TB/HIV but

Table 1: Educational, marital and income profile of the patients

Variables	Subjects (N=675) (%)
Education	
None	340 (22.9)
Primary	177 (11.9)
Secondary	106 (7.15)
Tertiary	52 (3.51)
Marital status	
Single	347 (23.4)
Married	301 (20.3)
Divorced	7 (4.72)
Separated	12 (8.1)
Widowed	8 (5.4)
Income profile per month	
<N1,000	56 (3.78)
N1,001-N5,000	322 (21.7)
N5,001- N11,000	67 (4.52)
N11,001- N21,000	44 (2.97)
N21,001-N23,000	8 (5.4)
No response	178 (12.01)

Table 2: Coping strategies of the patients

Variables	Subjects (N=675) (%)
Use of herbal drugs	345 (23.2)
Reduction in household budget	354 (23.8)
Sale of household assets	302 (20.3)
Use of child labour	276 (18.6)
Family financial assistance	177 (11.9)
Loans	192 (12.9)
Prayers	345 (23.2)

may regard it as ordinary cough or other diseases. If known, they demonstrated unwillingness to care for their relatives.

Concerns with finance, coping with caring and hostile environment was common to all. A total of 80% of households lacked basic hygienic environment to care for TB/HIV patients.

Discussion

The result from his study shows that TB/HIV infection has led to reduction in household incomes of infected families in the study population.

While TB/HIV is not exclusively a disease of the poor, the association between poverty and TB/HIV is well established and widespread.²

Impoverished communities and social groups are at higher risk of infection with TB/HIV compared to the general population due to overcrowded living and working conditions, poor nutrition, ignorance and migration from or to higher risk communities.

Health spending, even if DOTS and PEPFAR services have full coverage and are available, free or subsidized, is also an important additional source of poverty.³

The use of herbal drugs has not helped significantly to improve the health condition of the patients in the study area while they cannot afford modern health care services or participate in the DOTS and PEPFAR program.

All the families studied were affected by catastrophic and impoverishing health spending. This study confirms the notion that the intervention of government, non-governmental organizations (NGOs) and community –based organizations (CBOs) are indispensable in the rural communities to help households cope with the impact of TB/HIV infection. There is need to reduce impoverishment and protect households during periods of financial crisis due to ill health. Furthermore, if households are forced into poverty traps by health shocks because they cannot insure against illness, this phenomenon may have long, as well as short run implications.⁴

Families are often forced to choose between satisfying other basic needs such as education, food and housing or purchasing healthcare and saving loved ones from illness, suffering and shortened life spans.

Conscious of these problems, the 58th World Health Assembly that convened in May 2005 adopted a resolution recognizing the absence in most developing countries of financial protection mechanisms that offer prepayment and pooling of risk to all citizens.

In a call to member states, the assembly requested that experiences be shared among countries on different methods of health financing including the development of social health

insurance schemes, with particular reference to the institutional mechanisms that are implemented to finance health systems.

Nigeria diagnosed the problem of catastrophic and impoverishing out-of-pocket (OOP) health spending and attributed its cause to absence of financial protection, and then proposed systemic therapy through health reform.

The Nigerian National Health Insurance Scheme (NHIS) was then established by the Federal Government of Nigeria via Act 35 of 1999 to provide health care delivery at affordable cost. This program was designed to cover employers of the formal sector, self employed, the poor and the vulnerable group.

The existence of the NHIS, PEPFAR and DOTS programs have their various shortcomings. Presently, the NHIS does not have universal coverage as it is unavailable to the majority of the people in the study area and other rural communities in Nigeria.

Therefore, there is an urgent need to evaluate how patients are coping in rural communities in developing countries which will serve as a guide to future health policy reforms in resource-poor settings of developing countries.

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References

1. Kumaresan J. Stop TB partnership Newsletter (Issue 8: Winter 2002-2003). The newsletter of the global partnership movement to stop TB. <http://www.stoptb.org>.
2. World Health Organization: Addressing poverty in TB control. Options for National TB control programs. Geneva; World Health Organization; 2005 (WHO/HTM/TB/2005.352)
3. Van Doorslaer, E., O'Donnell O, Ranna-Eliya RP, et al. Effects of payments for healthcare on poverty estimates in 11 countries in Asia: an analysis of household survey data. *Lancet* 2006; 368: 1357-1364.
4. Gertler P and Gruber J. Insuring consumption against illness. *Amer Econ Rev* 2002; 92: 51-70.

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