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Health-Related Quality of Life and Religious Coping among People Living with HIV/AIDS

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Abstract

Identifying the level of health-related quality of life (HRQoL) and its influencing factors in people living with HIV/AIDS (PLWHA) is extremely important especially in Mizoram as it is experiencing one of the highest prevalent rates of this disease in the whole nation. The study on this regard might help the infected persons and persons working in this field to identify the level of health-related quality of life of PLWHA in comparison with non-PLWHA and the level of correlation with religious coping. This study was an attempt to determine the level of HRQoL of PLWHA in comparison with non-PLWHA and the level of religious coping as a mediating factor. The study employed 2X2 factorial design by comparing People Living with HIV/AIDS and non-infected persons on these two variables including gender comparison. The study was conducted in Aizawl district, Mizoram based on NGOs who are working in this field. The result showed significant difference between PLWHA and non-PLWHA in HRQoL ($p<.01$) but significant positive correlation of HRQoL and religious coping is not obtained based on the data collected for this study.

Keywords*: Quality of Life, HIV/AIDS, Religious Coping.*

Introduction

Acquired Immune Deficiency Syndrome (AIDS) was first recognized as a new disease in 1981 when an increasing number of young homosexual men succumbed to unusual opportunistic infections and rare malignancies (CDC 1981; Greene, 2007). A retrovirus, now termed Human Immunodeficiency Virus Type 1 (HIV-1), was subsequently identified as the causative agent of what has since become one of the most devastating infectious diseases to have emerged in recent history (Barre-Sinoussi et al., 1983; Gallo et al., 1984). Since its first

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identification almost three decades ago, the pandemic form of HIV-1, also called the main (M) group, has infected at least 60 million people and caused more than 25 million deaths (Merson, O'Malley, Serwadda & Apisuk, 2008). Developing countries have experienced the greatest HIV/AIDS morbidity and mortality, with the highest prevalence rates recorded in young adults in sub-Saharan Africa (http://www.unaids.org/).

HIV, or human immunodeficiency virus, is the virus that causes AIDS (acquired immunodeficiency syndrome) and can be transmitted during sexual intercourse; by sharing syringes; or perinatally during pregnancy, childbirth or breastfeeding. Since the first AIDS cases were reported in 1981, HIV/AIDS has been one of humanity's deadliest and most persistent epidemics. Although extraordinary progress has been made in the fight against new HIV cases and AIDS deaths, the HIV pandemic continues. HIV attacks the immune system by destroying CD4+ T cells, a type of white blood cell that is vital to fighting off infection. The destruction of these cells can leave people with untreated HIV vulnerable to life-threatening infections and complications. Today, effective anti-HIV medications allow people with HIV to lead long, healthy lives. (www.niaid.nih.gov)

Health Related Quality of Life

In general, quality of life (QoL or QOL) is the perceived quality of an individual's daily life, that is, an assessment of their well-being or lack thereof. This includes all emotional, social and physical aspects of the individual's life. In health care, health-related quality of life (HRQoL) is an assessment of how the individual's well-being may be affected over time by a disease, disability or disorder (Bottomley, 2002).

Religious Coping

Tix and Frazier (1998) defined religious coping as the "use of cognitive or behavioral techniques, in the face of stressful life events, that arise out of one's religion or spirituality" (p. 411). Religious coping strategies often stem directly from an individual's religious beliefs system and helps them to construct meaning and form interpretations (both positive and negative) of stressful situations and events (Gall and Cornblat, 2002). Moreover, religious coping has been found to be a distinct form of coping separate from secular forms of coping (e.g., cognitive restructuring) (Tarakeshwar and Pargament, 2001). It has been hypothesized that the incorporation of religion into the process of coping provides a source of meaning that may not be as salient or readily accessed during times of distress with secular forms of coping (Krause, 1998).

HRQoL is an important measure that enables healthcare workers to understand patients' perceived satisfaction and perception of illness (Group, W., 1998). PLWH often report poor or moderate Health-Related Quality of Life (HRQoL) that is worse than the general population. This may be related to the psychological and physiological demands of HIV disease and the socio-demographic stressors associated with it. The role of religious coping, religiosity, and social support in the mental and physical dimensions of HRQoL is less known, although recent studies highlight that PLWH rely on spirituality/religion to cope with HIV-associated stressors (Dalmida et al., 2015). People Living with HIV/AIDS

(PLHIV) often report poorer Health-Related Quality of Life (HRQoL) than that of the general population, especially after the diagnosis of HIV. This may be related to the psychological and physiological demands of HIV disease, social stressors, or demographic factors. Religion and spirituality are important social determinants of health and public health, especially in the context of HIV/AIDS and may be used by PLHIV to cope and improve their HRQoL. Religion and spirituality serve as central guiding forces in the daily life of many people, including People Living with HIV/ADS (PLHIV). Growing evidence supports an association between spirituality or religiousness and better health or better quality of life. Some reviews found that most studies identified significant associations between spirituality/religiousness and better health outcomes, including better coping skills and better health-related quality of life (even during terminal illness). The association between spirituality or religiousness and health outcomes may be explained by a number of variables, including coping style, psychological factors and social support. However, more research in this area and among PLHIV is necessary. This is particularly important since HIV is a chronic, highly stigmatized disease and requires significant lifestyle adjustments in order for PLHIV to survive and lead relatively healthy, quality lives (Mueller et al., 2001)

Religious coping plays an important role in the life of PLWHA as Haddad (2011) advocated that they play an essential role in mitigating the epidemic. PLWHs have to deal with their condition each day as well as social pressure like stigmatization and discrimination. Coping with religions seemed to be able to encourage healthy habits and also promotes QoL (Oman & Thoresen, 2002). Apparently, consistent findings across studies were not strong enough to establish the link between religious coping and physical health outcome among PLWHs. Some suggested that it is associated with slower disease progression but some suggested no relationship with immune status (Ironson et al., 2002; Ironson, Stuetzle, & Fletcher, 2006; Kudel, Cotton, Szaflarski, Holmes, & Tsevat, 2011). Despite the fact that findings are not consistent just like what was reported in Cotton et al. (2006a) and other studies like Pargament et al. (2003) and Ironson et al. (2002), it was reported by Cotton et al. (2006b) and Lorenz et al. (2005) that approximately more than half to 80% of the PLWHs in their studies becoming more religious and spiritual and acknowledged the importance of religiosity and spirituality in their lives since their diagnosis. In addition, it is always useful and significant to examine the relationship between religious elements and psychological factors in different context due to the differences across cultures especially studies based on religious coping theories have been largely done in the Western and Christian context. (Pargament et al., 2011)

The purpose of this paper is to identify the degree of health-related quality of life and its association with religious coping among PLHIV in Mizo population. Social and psychological experiences that are significantly related to health outcomes are important components of a research agenda and quality of life is an important outcome measure and includes a sense of well-being, functional health, and engagement in the psychological and social world.

Statement of the Problem

According to Unique Identification Aadhar India, Mizoram population in 2022 is estimated to be 1.27 million (12.7 Lakhs) and it is the second smallest state in India. But Mizoram stands highest in adult HIV/AIDS prevalent rate at sub-national level. The study on this regard might help the infected persons to identify themselves and persons working in this field might be able to gain knowledge from this study about the level of contributing factor this social support can have on these infected persons' quality of life. This study is an attempt to obtain the level of HRQoL and its correlation with religious coping among people living with HIV/AIDS. While the number of PLWH has been increasing day by day in Mizoram, research on this topic has so far been limited. An extensive review of literature found no published articles focusing on correlation of health-related quality of life and religious coping in Mizoram. It is therefore felt necessary to explore this aspect. The overall consideration would not only help satisfy to achieve the theoretical and methodological considerations but would provide foundations for behavioral intervention programs and further extended studies.

Objectives of the Study

Given the theoretical and methodological foundations pertaining to the research problem, the present study has put forward the following objectives:

a) To determine the levels of Health-Related Quality of life (HRQoL) in PLWHA and non-PLWHA.
b) To explore relationship between the degree of Religious Coping and HRQoL among PLWHA and non-PLWHA.
c) To highlight gender differences between the variables under study.

Hypotheses

Following the review of literatures pertaining to Health-Related quality of Life and Religious Coping among PLHIV and the research objectives put forward, it is hypothesized that:

i) The level of HRQoL of PLWHA will be low in comparison to non-PLWHA.
ii) There will be a significant positive correlation between the levels of health-related quality of life and religious coping among PLWHA.
iii) There will be significant gender difference on the variables under study.

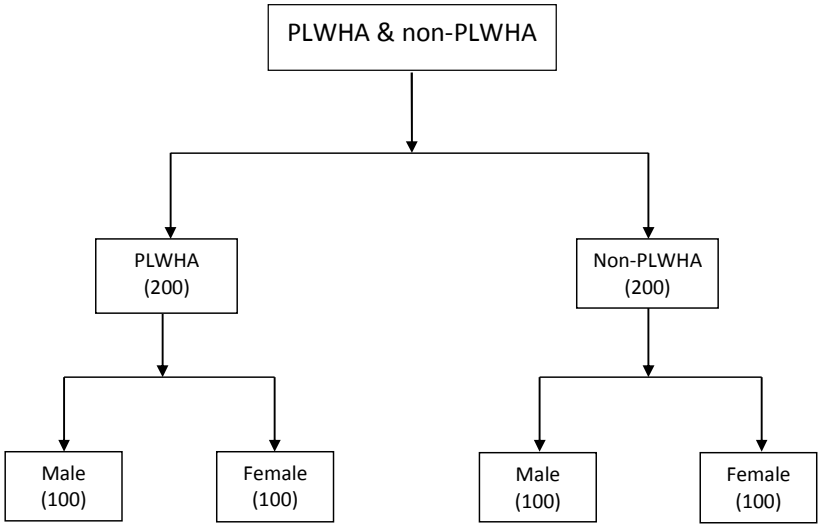
Sample

Purposive random sampling procedure was used for the present study. 200 PLWHAs and 200 non- PLWHAs, 400 in total who were young adults between the ages of 20 to 40 (Sandrock, 2013) from Aizawl district and were willing to participate were selected to serve as subjects for the study. The study was carried out in Aizawl district, in agencies such as ART Plus Centre, Community Care Centre, Integrated Counselling and Testing Centre (ICTC), Care and Support Centre and NGOs within Aizawl district. PLWHA, who were the beneficiaries of these agencies constituted the universe for this study. The non – PLWHA sample was randomly selected based on the above age group.

Design of the Study

To achieve the objectives, the study incorporated two-way classification of the variable of 'Status of Participant' (PLWHA and non-PLWHA) and another two-way classification of variable of 'Gender' (Male and Female) on the dependent variables was employed, to elucidate the level of health-related quality of life and the relationships between health-related quality of life and religious coping.

The sample characteristic table is as follows:



Procedure

The primary data for the study was collected in face-to-face interactions between the participants and the researcher in an optimum environmental setting after informed consent from all participants and formation of good rapport. The researcher took care to see that the respondents provide honest and independent answers to all the questions presented. The anonymity, confidentiality and ethics as cited/formulated by APA, 2003 (American Psychiatric Association) was followed. In order to determine the level of HRQoL in PLWHA, 36 Item Short Form Survey (Ware and Sherbourne 1992) was used and their health status was highlighted. Further, the religious coping status of PLWHA was examined using Brief RCOPE (Pargament 1998). A pilot study was already conducted to ensure participant comprehension.

Psychological Tools

[1] 36 Item Short Form Survey (Ware and Sherbourne 1992): SF 36 consists of 36 items measuring physical and mental health status in relation to eight health concepts such as: physical functioning, role limitations due to physical health, bodily pain, general health perceptions, vitality (energy/fatigue), social functioning, role limitations due to emotional health, general mental health (psychological distress/wellbeing). Responses to each of the SF-36 items are scored and summed according to a standardised scoring protocol (Ware et al 1993), and expressed as a score on a 0–100 scale for each of the eight health concepts. Higher scores represent better self-perceived health. Five of the scales are

'unipolar' (Physical Functioning, Role Physical, Bodily Pain, Social Functioning, and Role Emotional), meaning that they define health status in terms of the absence of disability. The maximum score of 100 is therefore achieved when no disability is reported. The other scales (General Health, Vitality and Mental Health) are 'bipolar' scales, covering both positive and negative health states. The maximum of 100 on these bipolar scales therefore indicates not just the absence of disability, but the presence of a positive state of health.

[2] Brief RCOPE (Pargament, 1998): The Brief RCOPE is a 14-item measure of religious coping with major life stressors. As the most commonly used measure of religious coping in the literature, it has helped contribute to the growth of knowledge about the roles religion serves in the process of dealing with crisis, trauma, and transition. The scale developed out of Pargament's (1997) program of theory and research on religious coping. The items themselves were generated through interviews with people experiencing major life stressors. Two overarching forms of religious coping, positive and negative, were articulated through factor analysis of the full RCOPE. Positive religious coping methods reflect a secure relationship with a transcendent force, a sense of spiritual connectedness with others, and a benevolent world view. Negative religious coping methods reflect underlying spiritual tensions and struggles within oneself, with others, and with the divine.

Data Collection

Each participant received a booklet containing the demographic information (age, educational qualification, and socioeconomic status, number of children, family size, family type and breadwinner), 36 Item Short Form Survey (Ware and Sherbourne 1992) and Brief RCOPE (Pargament, 1998). The booklets were completed with the presence and supervision of the researcher.

Statistical Analyses

Data analysis was done with the help of SPSS 2020.Parametric statistic was employed in this study:

i) Levene's Test and Independent T-test were employed to assess the level of HRQoL among PLWHA and non-PLWHA.
ii) Pearson Correlation Co-Efficient Test was used to assess the correlation between HRQoL and Religious Coping.
iii) Independent T-test was again employed to assess gender difference.

Result

Reliability of Instruments

The reliability and predictive validity of the scales was ascertained to ensure the psychometric adequacy of the scales used for the study. Internal consistency reliability was estimated for each of the scales used in the study using Cronbach's coefficient alpha (Cronbach, 1951). The result shows that 36 Item Scale is 0.93 and Brief RCope is 0.81 in reliability of instrument test. The result is emerged to be satisfactory over the levels of analysis for the whole sample, indicating the trustworthiness of the scales.

Table 1: Levene's Test and Independent T-test to determine significant differences between PLWHA and non-PLWHA in HRQoL and Religious Coping

Scales	Levene's Test	T-Test	Mean Diff.
36 Item Scale (HRQoL)	.98	.000	446.78
Brief RCope	.69	.250	.830

Levene's Test conducted in the above two scales shows equal variances were assumed. Then, the above table further shows that there was a significant difference between PLWHA and non-PLWHA in health-related quality of life ($p<.01$). The mean score also shows that PLWHA were lower in health- related quality of life in comparison to non-PLWHA. But, a significant difference between PLWHA and non-PLWHA in religious coping was not obtained from the data.

Table 2: Pearson Correlation Test between health-related quality of life using 36 Item Scale and religious coping using R Cope

		36 Item Scale	R Cope
36 Item Scale	Pearson Correlation	1	.034
	Sig. (2-tailed)	.	.494
	N	399	399
R Cope	Pearson Correlation	.034	1
	Sig. (2-tailed)	.494	.
	N	399	400

From table 2, we can easily assess that there was no positive correlation between health-related quality of life and religious coping in the subjects under study.

Table 3: Independent T-test to determine significant gender differences between male and female in HRQoL and Religious Coping

Scales	Sig.	Mean Diff.
36 Item Scale (HRQoL)	.000	233.09
Brief RCope	.000	-2.54

Table 3 shows that significant gender difference was obtained in HRQoL ($P<.01$) and also in religious coping ($P<.01$).

Summary of Result

Hypothesis 1 predicted that the level of HRQoL of PLWHA will be low in comparison to non-PLWHA. From the result obtained in this study, it was found out that there was a significant difference between PLWHA and non-PLWHA in health-related quality of life and PLWHA participants scored lower than non-PLWHAs. This finding is

consistent with study conducted by Drewes et al in 2013 which specified that the HRQoL of people with HIV is generally lower than that of the general population. This study is also congruent with the study conducted by Dalmida et al., 2015. Even though 95% of the PLWHA participants in this study were registered ART clients, they still scored lower than non-PLWHA in health-related quality of life scale which means that PLWHA participants felt the presence of health-related problems more than non-infected participants even after ART treatment.

Hypothesis 2 predicted that there will be significant positive correlation between the levels of health-related quality of life and religious coping among PLWHA. But in this study, a positive correlation between health-related quality of life and religious coping was not obtained. The finding is contrast with the finding of Muiller in 2001. The demographic profiles of the subjects showed that 100% of participants in this study were Christian. In the case of our study, it was obtained that many PLWHA patients admitted that they sought comfort and spiritual healing from God through religion, even many of them showed close connection with God and even took part in various religious programmes even though they felt different kinds of physical illness and problems related to their disease.

Hypothesis 3 predicted that there will be significant gender difference in the study. And, there were significant gender differences obtained from the subjects in health-related quality of life and religious coping.

Limitations of the Study

The present study is conducted among Christians and there was no other person with different religion other than Christianity. It made the study limited and made it look like focusing on only one specific religion, but it was very difficult to cover other religion as most of the people in Mizoram are Christians and there was no chance to include other religion to make the study more inclusive. Besides, most of the participants who were available and accepted to participate in this study were old infected patients who did have any kind of hesitation to make connections with others and participating in ritualistic activities. If we can cover newly infected ones, there might be a different result to obtain.

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