Influence of Information Behaviour On the Quality of Life of Women Living with HIV in South-West, Nigeria

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Abstract- Human immune-deficiency virus infection continues to ravage human lives globally. Women, continue to experience higher new infection rate, morbidity, mortality and their quality of life (QoL) is adversely in various dimensions for which they need adequate information behaviour. This study investigated the influence of information behaviour on the quality of life of women living with HIV and receiving HAART. Data was collected from three study centers, using a self- developed questionnaire with a reliability index of 0.85. Average weighted mean of (x=2.61) showed a generally good quality of life. Respondents' information behaviour with average weighted mean of 2.31 which fell below the criterion mean of 2.5. Information behaviour had a significant, overall influence on the Quality of Life of WLH (*Adj.* R^2 =0.131 $F_{(3, 319)}$ = 17.243, p<0.05.*)* . Relative information seeking,(R^2 = 0.108, β = 0.29, P<0.05, t (323) =5.51), information avoidance was negatively significant *(*R^2 = 0.016, β = -0.09, p< 0.05, t (323*)* = *-2.25*). Information use had no significant influence on quality of life of WLH (R^2 = 0.001, β = 0.3, P<0.05, t (323) = 0.53).

Respondents should be encouraged to use available information and stop avoiding information that can improve their QoL.

Index Terms- HAART, Information seeking, Quality of Life, Women living with HIV

I. Introduction

Quality of life has been described as the ability to enjoy normal activities of life such as eating, sleeping, moving from one place to the other, eliminating and social interactions with others (MedicineNet, 2016). It can also be explained as a subjective multidimensional evaluation of one's functioning and well-being in day to day life. WHO (2002) explained that QoL is the way an individual perceives their position in life in the context of culture and value systems in which they live and in relation to their goals, expectations, standards and concerns. Chronic illnesses like kidney disease, heart problems and HIV infection often have adverse effect on the quality of life of those affected.

The gender profile of HIV/AIDS pandemic has changed from what it was thirty years ago, when the infection was mainly seen in men injecting drugs and homosexuals. The infection is now hetero-sexual, affecting both male and female and globally and nearly half of the 35.3 million people living with HIV currently are women and one in every two new infections occurs among women (United Nations Joint Programme on HIV/AIDS (UNAIDS), 2016). The gender profile of women infected with HIV in Nigeria follows the global pattern. New infection among Nigeria women as at 2014 was 123,601 as compared with 103,917 among men. Estimates show that this new infection occurs more in the age-group of 15-24 women than the male counterpart, and they constitute up to 64% of new infection shown in the country (Federal Ministry of Health ,National HIV/AIDS Reproductive Health Survey, 2015; Avert, 2017).This reveals that women are becoming more infected and vulnerable to HIV infection than men.

The quality of life of women living with HIV has been adversely affected by the disease in various dimensions .These women have a lot of challenges socially physically and psychologically that they find hard to cope with. These challenges however can be drastically reduced if they have access to the right and relevant information relating to their status, available human and material resources that will enable them to cope and thereby enjoy a relative quality of life. Ability of women living with HIV (WLH) to seek and use correct and relevant information is considered as their information behaviour and this may sometimes be problematic to them. This study explored the influence of how WLH seek, use and sometimes avoid information on their quality of life.

II. QUALITY OF LIFE OF WOMEN LIVING WITH HIV

The QoL of WLH in essence, means how they perceive their physical appearance, general health, social relationships, and level of independence in taking life decisions and acceptance in the society. Many WLH may perceive their life coming to an end when they receive the positive result of their HIV test. Some are perplexed while others feel that the stigma and discrimination that follow acknowledgement of their HIV status will bring shame, guilt, loneliness, ostracisation and sometimes violence from their spouses, sexual partners and even family members (Folasire, Irabor & Folasire, 2012; Silveira, Silveira & Muller, 2016).

WLH have demonstrated poorer functioning and greater disruptions of their physical and psycho-social well-being (Folasire *et al.*, 2012; Van, Aguirre, Sama & Bretch, 2002). Low level of literacy, unemployment, financial dependency, and social boundations' can contribute significantly to lower QoL in WLH (Anand, Puri &Mathew 2012). Bhat, Cherian, Bhat, Chapman, Lukose and Patwardhan (2015), found that there is high

prevalence of psychiatric disorders, high level of stress, discrimination, low social support and low income earnings among WLH as a result ill health, loss of job and inability to meet the rising cost of health care (Ghakhar, Kamali and Holodiniy, 2015). Poor adherence to the use of ART, high risk sexual behavior and reduction to free access to drugs constitute problems that can reduce the QoL of these women. Violence and rejection from intimate partners or husbands and significant ones like the in-laws also contribute significantly to poor QoL (Orza *et. al.*2015; Bhat *et al.* 2015). Lipodystrophy which is an alteration in the shape of women receiving ART lowers their self esteem and enhances poor perception of body image which leads to stigmatization (Ghakhar, Kamali & Holodniy, 2015).

Constant worry, stress and anxiety also contribute to poor QoL. (Folasire *et. al.* 2015; Silveira *et. al*. 2016). Cleary and Wilson (1995) suggested that use of alcohol is associated with risky sexual behaviour that often affects the QoL of people living with HIV as people under the influence of alcohol will practice unprotected sex and alcohol may make them forget to take their drugs and there could be drug interaction with alcohol, leading to ineffectiveness. A study in Cameroon revealed poor physical health and frequent unsafe sex, leading to unintended pregnancies, abortions and premature deaths and subsequently poor QoL (Marcellin, Bonono, Blanche, Carrieri, Spire, Koulla-Shiro *et. al*. 2010).

Conversely, a high level of education, employment and good economic status can enhance their QoL. This means the WLH that are educated or reasonably employed can access information and treatment and thereby have a reasonable QoL (Adedimeji & Odutolu, 2007, Folasire *et. al*, 2012, Mutabazi-Mwesigire, Katamba, Martin, Seeley & Wu, 2015) WLH who have adequate social care and support tend to have higher level of QoL than those who do not. Social support can be given by husband, lover, friend or family members, healthcare workers and some non-governmental organisations (Folasire *et al*. (2012).

The use of ART by WLH has been mentioned by various authors as a significant method of improving their QoL (Adedimeji & Odutolu, 2007; Da costa *et .al.* 2014; Silveira et al 2016; Trans, 2012). Availability and consistent use of HAART have greatly enhanced the QoL of WLH to the extent of their desiring sexual relations and motherhood (Gombachika & Soundby, 2013). Wani and Sankar (2017) however found in their study that men living with HIV tend to enjoy more social support by the family and friends than WLH. This is culturally determined as infected men are more accepted than women. In order to have and enjoy a better quality of life and to cope with the numerous challenges these women require adequate, relevant and correct information**.**

III. INFORMATION BEHAVIOUR OF WOMEN LIVING WITH HIV

Women living with HIV often seek information about their condition in order to understand the infection, diagnosis, treatment options and the prognosis. They seek and use information about social support, reproductive issues, nutrition and use of highly active antiretroviral therapy (HAART). The totality of human behaviour in relation to sources and channels of information, including both active and passive information seeking and use is considered as information behaviour (Wilson, 2000). Fear of stigmatization and discrimination often prevent them from seeking information but deterioration in health often lead the victims to seek needed information. The way people seek, use and sometimes avoid available information is considered their information behaviour.

Sources of information seeking by WLH vary according to their level of literacy. In the study conducted at Nigerian Navy Reference Hospital, Ojo, Ibadan, PLWHA prefer seeking information from Television/radio (73 %,) support groups (69%) while 20% sought information from HIV/AIDS campaigns and 11% from traditional healers. Females living with HIV tend to seek information more than male their male counterparts, while 65% of women actually consulted traditional healers. Those with higher educational background tend to seek information from support groups (92%) literature, books and internet (Soremekun & Shonowo, 2013). Health care providers and communities such as churches were also identified as sources of information (Modeste & Majeke, 2014, Zukoski *et. al*. ,2011). Other sources include the health workers, media, internet, friends and other people living with HIV (Stonbraker, 2016). Some however, were not sure of internet as a reliable source of information (Yusuf, 2012). The sources of information tend to affect their quality of life because of the type and quality of information they will get.

Using available information is multi-factorial. Stonbraker et. al. (2015) found association between non use of information and the presence of co- morbidities. Low socio-economic factor, decreased cognitive ability, information overload, poor health, and low literacy were significantly associated with non use of information. On the other hand WLH with high level of literacy were associated with information use (Almeida & Veira, 2009; Wawrzyniat, et. al. 2013). When these women refuse to use or avoid using available information, their quality of life deteriorates fast and often leads to death.

Sweeny, et. al. (2000) described information avoidance as not merely the opposite of information seeking but rather a motivated decision to remain ignorant. People avoid information for various reasons. People may deliberately not pay attention to information particularly when such information may undermine their wellbeing (Chaplin & Dean, 2015; Sallee, 2014). Unpleasant life experiences like HIV motivates people to forget about information seeking and use (Anderson & Huddeston, 2012). Finally, Neben (2015) stipulated that incongruent information that does not synchronize with a person former knowledge and beliefs becomes a threat leading to psychological defense and eventual avoidance of information.

IV. METHODOLOGY

This study adopted descriptive survey to measure and analyse the variables under consideration. The study population was 3018 WLH attending special clinics in three tertiary institutions in South-west, Nigeria. Multistage sampling was employed to select 341 respondents among the population. A self structured questionnaire was used to obtain data about quality of life and information behaviour of respondents. The questionnaire was validated and reliability index using Chronbach alpha coefficient for quality of life was 0.85 and information behaviour 0.86. Ethical clearance was obtained both from Babcock University

Health Research Ethics Committee and from the respective institutions. Informed consent was obtained from respondents ensuring the confidentiality, anonymity and participation was voluntary. Research assistants were trained to assist in data collection. Data was collected over a period of six weeks. 341 questionnaires were distributed and 323 were retrieved and validated for analysis, making 95% return rate. Analysis involved both descriptive and inferential statistics of multiple linear regressions at 5% level of confidence. Participant's quality of life and information behaviour were graded using Likert"s scale.

V. RESULTS AND DISCUSSION

Table1: Demographic Characteristics of Respondents

Variable		Frequency (n)	Percentage (%)
Age	18-25	54	16.7
	26-30	25	7.7
	31-35	69	21.4
	36-40	94	29.1
	41-45	49	15.2
	46-49	32	9.9
	Total	323	100
Ethnicity	Yoruba	276	85.4
	Igbo	23	7.2
	Hausa	20	6.2
	Missing	4	1.2
	Total	323	100
Marital Status	Married	233	72.1
	Divorced	20	6.2
	Single	50	15.5
	Widowed	16	5.0
	Missing	4	1.2
	Total	323	100
Educational Qualification	Non formal	30	9.2
	Primary	61	18.9
	Secondary	152	47.1
	Tertiary	80	24.8
	Total	323	100
Occupation	Self-Employed	244	75.5
	Civil Service	52	16.1
	Unemployed	17	5.3
	Others (Traders)	10	3.1
	Total	323	100

Respondents were across the age spectrum of 18-49 years and (72.1%) were married and (15.5%) were single. Respondent's educational background were tertiary (24.8%), secondary (47.1%) and primary (18.9%), while few had no formal education. Furthermore, majority were self –employed (75.5%) while (16.1%) were civil servants. Majority of respondents have been living with HIV from 6 to 10 years, however (42.2%) of respondents represent new or emerging infected incidences of less than 5 years. This implies that despite various awareness programmes, women are still getting infected as corroborated by (UNAIDS, 2016; Avert 2017).

Table 2: Quality of life of Women Living with HIV

Items	**A 3 F**	**NA 2 F**	**D 1 F**	**x**	**SD**	**AM**

	(%)	(%)	(%)			
Physical Indicators: Please indicate how these items apply to you						
I am able to carry out my daily chores at home	304 (94.1)	6 (1.9)	13 (4.0)	2.90	0.41	
My appetite is good	297 (92)	6 (1.9)	20 (6.2)	2.86	0.50	
I am happy with my appearance.	296 (91.6)	6 (1.9)	21 (6.5)	2.85	0.51	
I am satisfied with my ability to work	296 (91.6)	6 (1.9)	21 (6.5)	2.85	0.51	**Average Mean 2.73**
I am happy about my weight.	283 (87.6)	6 (1.9)	34 (10.5)	2.77	0.62	
I enjoy my social life	280 (86.7)	6 (1.9)	37 (11.5)	2.75	0.65	
I get enough sleep	268 (83)	10 (3.1)	45 (13.9)	2.69	0.70	
Physical pain does not prevent me from carrying out my daily chores	243 (75.2)	28 (8.7)	52 (16.1)	2.59	0.75	
I experience pain regularly	239 (74)	28 (8.7)	56 (17.3)	2.57	0.77	
I am not often tired	219 (67.8)	32 (9.9)	72 (22.3)	2.46	0.83	
Social Support: Please state how these items apply to you.						
Am accepted by my husband or partner	308 (95.4)	-	15 (4.6)	2.91	0.42	
Health workers answer my questions about my health	301 (93.2)	6 (1.9)	16 (5.0)	2.88	0.45	
I am satisfied with my overall quality of life	274 (84.8)	15 (4.6)	34 (10.5)	2.74	0.63	
I receive adequate support from health workers	273 (84.5)	5 (1.5)	45 (13.9)	2.71	0.70	**Average Mean 2.51**
Am satisfied with the relationship with my spouse	273 (84.5)	-	50 (15.5)	2.69	0.72	
Am satisfied with my sexual life	258 (79.9)	-	65 (20.1)	2.60	0.80	
I get support from family members	211 (65.3)	50 (15.5)	62 (19.2)	2.46	0.80	
Health workers help me to look for financial help	179 (55.4)	99 (30.7)	45 (13.9)	2.41	0.72	
I get good support from my friends	159 (49.2)	115 (35.6)	49 (15.2)	2.34	0.73	
Family member help with daily chores when I am unable to do them	178 (55.1)	42 (13)	103 (31.9)	2.23	0.90	
When I am sick friends bring me to the hospital	114 (35.3)	126 (39)	83 (25.7)	2.10	0.78	
Family members support me financially to buy drug	137 (42.4)	57 (17.6)	129 (39.9)	2.02	0.91	
Average Weighted Mean				**2.61**	**0.67**	

Source: Field survey, 2018
KEY: A=Agree, NA=Neither Agree Nor Disagree. D=Disagree
Decision Rule; if mean is ≤ 1.49 = Poor; 1.5 to 2.49 = Fair; 2.5 to 3 = Good
Criterion mean =2.5

Table 2 revealed the quality of life of respondents using physical and social parameters. Physical indicators showed a mean score of (X=2.73) and social support (X=2.51). The average weight mean (x=2.53) showed that their QoL was generally good, as (94.1%)

were able to do their daily chores and (92%) had good appetite. With respect to social support, (95.4%) agreed that they were accepted by their husbands or partners while (35.3%) said that friends were ready to take them to hospitals if they become sick. The average weighted mean of *(M* = 2.61 was higher than the criterion mean of 2.5 indicating that the quality of life of women living with HIV in South West Nigeria was generally good. This finding can be linked to the fact that these women were using ART and the use of ART by WLH has been mentioned by various authors as a significant method of improving their QoL (Silveira et al 2015; Adedimeji & Odutolu, 2007; Da costa *et .al.* 2014; Trans, 2012).

Table 3: Information Behaviour of WLH in South-West, Nigeria

S/N	Items Information Seeking Behaviour	HE 3 F(%)	ME 2 F(%)	LE 1 F(%)	X	SD	
1	Television programs on how I can maintain physical strength	286(88.5%)	-	37(11.5%)	2.77	0.64	
2	Internet sources on how to achieve safe pregnancy	126(73.1%)	44(13.6%)	43(13.3%)	2.60	0.71	
3	Colleagues on how to maintain physical strength	238(73.3%)	17(5.3%)	68(21.1%)	2.53	0.82	Average Mean: 2.50
4	Peer groups on how to achieve social support	208(64.4%)	32(9.9%)	83(25.7%)	2.39	0.87	
5	Colleagues who are well adjusted on how to cope with HIV status	209(64.7%)	86(26.6%)	28(8.7%)	2.38	0.88	
6	Seminars and workshops about my status	189(58.5%)	57(17.6%)	77(23.8%)	2.35	0.84	
7	Family members about social support	187(57.9%)	50(15.5%)	86(26.6%)	2.31	0.87	
Information use: Information I get about my status helps me to:							
8	Take my drugs regularly	297(92%)	6(1.9%)	20(6.2%)	2.86	0.50	
9	Cope in times of depression	284(87.9%)	-	39(12.1%)	2.76	0.65	
10	Maintain my physical strength	277(85.8%)	-	46(14.2%)	2.72	0.70	Average mean 2.58
11	Seek for financial support	216(66.9%)	55(17%)	52(16.1%)	2.51	0.76	
12	Abstain from unsafe sexual relations	229(70.9%)	15(4.6%)	79(24.5%)	2.46	0.86	
13	Seek social support from my family and friends	174(53.9%)	31(9.6%)	118(36.6%)	2.17	0.94	
Information avoidance Behaviour							
14	I interpret information to suit my own belief about social support	127(39.3%)	41(127%)	155(48%)	1.91	0.93	
15	I read books and pamphlet about maintaining physical wellbeing	120(37.2%)	39(12.1%)	164(50.8%)	1.86	0.93	Average mean: 1.85
16	I attend seminars or talks where information is given about my status	109(33.7%)	51(15.8%)	163(50.5%)	1.83	0.90	
17	I may forget information that does not synchronize with my belief about child bearing	107(33.1%)	41(12.7%)	175(54.2%)	1.79	0.91	
	Average weighted mean				**2.31**	**0.81**	

Source; Field survey, 2018
Key : HE=High Extent, ME=Moderate Extent , LE=Low Extent

Decision Rule ; if mean is ≤1.49=Low Extent ; 1.5 to 2.49=Moderate Extent; 2.5 to 3=High Extent
Criterion mean=2.5

Table 3: Showed that most of the WLH in South-West, Nigeria had inclination towards Information seeking and Information use rather than information avoidance. Out of the three indicators of information behaviour, Information Use had the highest mean score (x= 2.58), followed by Information Seeking Behaviour (x =2.50), while Information Avoidance Behaviour (x =1.85) had the least mean score. The overall mean score of 2.31 falls below the criterion mean of 2.5 and this clearly showed that information behaviour of WLH was not adequate. Although they sought and used information, they also avoided information.

Table 4: Summary of Regression Analysis on the influence of Information Behaviour on Quality of Life of WLH

Model		Sum of Squares	Df	Mean Square	F	Sig.
1	Regression	973.723	3	324.574	17.243	**0.000[b]**
	Residual	6004.721	319	18.824		
	Total	6978.444	322			

R= 0.374
R Square = 0.140
Adjusted R Square = 0.131

Source: Field survey, 2018

Table 4. Revealed that Information behaviour had a significant, positive influence on the Quality of Life of WLH in South-West, Nigeria *(Adj.* R^2 =0.131 $F_{(3, 319)}$ = 17.243, p<0.05*)*. This suggests that Women Living with HIV in South-West, Nigeria were inclined to seek and use information but still exhibit information avoidance in some aspect of their quality of life. The hypothesis that Information behaviour has no significant influence on the Quality of Life of WLH in South- West, Nigeria was rejected. Therefore information behaviour has significant influence on the Quality of Life of WLH in South-West, Nigeria.

Table 5: Relative Influence of Information Seeking, Information Use and Information Avoidance on the Quality of Life of WLH

Model		Unstandardized Coefficients		Standardized Coefficients	T	Sig.
		B	Std. Error	Beta		
1	(Constant)	44.521	2.087		21.328	.000
	Information Seeking Behaviour	.297	.054	.328	5.517	.000
	Information Use Behaviour	.033	.061	.034	.537	.592
	Information Avoidance Behaviour	-.094	.042	-.128	-2.251	.025

a. Dependent Variable: Quality of Life

Source: Field survey, 2018

Table 5 showed that Information Seeking Behaviour and information avoidance behaviour had significant relative influence on quality of life of WLH in South-West, Nigeria. Information Seeking Behaviour had a weak positive significant influence on Quality of Life of WLH,(R^2 = 0.108, β = 0.29, P<0.05, t (323) =5.51) meaning that improved Information Seeking Behaviour can lead to better Quality of Life of WLH. Information avoidance behaviour had a negative but significant influence on the quality of life of WLH (R^2 = 0.016, β = -0.09, p< 0.05, t (323) = -2.25). This implies that increased information avoidance behaviour among WLH would negatively impact their quality of life. Finally, Information use behaviour had no significant influence on the quality of life of WLH (R^2 = 0.001, β = 0.3, P<0.05, t (323) = 0.53). This means that information use by WLH did not significantly improve their quality of life. Consequently, the hypothesis that the relative contribution of information seeking and information avoidance on the quality of life of WLH in South West Nigeria is not significant was rejected; while the hypothesis that information use did not have a relative significant influence on the quality of life of WLH in South West Nigeria was accepted. Therefore information seeking and information avoidance have significant influence on Quality of Life of WLH in South-West, Nigeria while information use did not significantly influence their Quality on Life.

The findings in this study revealed a positive influence of information behaviour on the QoL of WLH in South west Nigeria. This finding is in consonance with what Stonbraker *et. al.* (2017) found in their study that the ability of the individuals living with HIV/AIDS to effectively manage their health is dependent on the successful acquisition and use of health information. QoL improves when WLH are able to use their drugs effectively and take good nutrition to maintain health based on the use of available information. This was also confirmed by Folasire *et. al.* (2014) that a better quality of life is enjoyed by participants who had better health seeking behaviour and attitude to treatment which occurs because they have information. St. Jean (2012) found that information behaviour actually predicted the quality of life of participants. On the other hand, Garbutt (2014) found that

information behaviour did not influence the quality of life of respondents.

The findings on the combined relative influence of information seeking, use and avoidance on the QoL of WLH revealed that information behaviour had positive influence on the QoL of respondents. Information seeking had a weak positive significant influence and information avoidance had a negative influence on the QoL. These indicate that increased information seeking can lead to improved QoL, while increased information avoidance can lead to poor QoL. Information use had a relative insignificant influence on QoL of WLH. This implies WLH were not using information to improve their QoL. This finding is in consonance with what Almeida and Vieira (2009) found in their study that though many of their respondents actually need information but they do not use available information because they find it difficult to use or they did not understand how to use it in taking their medications correctly and this often affect their QoL.

VI. Conclusion

The quality of life of women living with HIV is often adversely affected by the infection, though with the advent and use of HAART, their quality of life has improved to a certain extent. However in order to sustain and continue the improvement in the quality of life, they require adequate information behaviour in order to cope with this chronic disease and enjoy a relative quality of life and such information must come from veritable sources. WLH require simple, correct and relevant information that will enable them to access and use their drugs and practice good nutrition that will ultimately affect their quality of life. Health care providers must intensify efforts in provision of relevant and accurate information and encourage them to use available information and stop avoiding information that can improve their quality of life.

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