

The Psychosocial Challenges of People Living with HIV/AIDS in North-West Province of South Africa

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ABSTRACT The present study investigated psychological and social challenges facing PLWHA in Northwest Province of South Africa. 728 participants were sampled for the study; there were 319 (43.8%) female and 409 (56.2%) male, with ages ranging between 19 – 75 years. Data was collected using existing validated scales, with hypotheses tested with Pearson moment correlation and t-test for independent samples, using version 21 of the SPSS statistical software. Results of the study suggested a significant relationship among the psychosocial variables in the study; gender did not significantly predict self-efficacy and self-worth among PLWHA; however, there was a significant gender difference in life satisfaction as women appeared to be more satisfied with life than men did. Participants did not present such reactions as guilt, helplessness, depression, confusion, or despair in the face of diagnosis. It was concluded that most PLWHA in North-West Province of South Africa are adjusting well; without feeling of fear, rejection, frustration and depression. The most important factor in helping PLWHA might be improving their psychosocial well-being and protect them from stigmatization.

INTRODUCTION

All over the world, there has been a steady and unprecedented growth in the body of research on the impact of HIV/AIDS on patients and there is no gain saying the fact that this has been of major concern to governments, non-governmental organizations, health sector, and individuals in different parts of the world. Although, the problem of HIV/AIDS is global, with every nation having its own share, the impact of the pandemic seems to be more in Africa where it was estimated that about twenty-eight million people are living with HIV/AIDS, with Southern Africa having the highest HIV adult prevalence in the world. Well over two thirds of the HIV/AIDS related deaths (18 million, or 72%) are from Africa (World Bank 2002) and almost one in every ten adults in sub-Saharan Africa are HIV positive (UNESCO 2002), although, infection rates in individual countries such as South Africa, Botswana, Malawi, and Swaziland are much higher.

In addition to the above, UNAIDS Report on the global AIDS epidemic (2012) showed that,

globally, 34.0 million people were living with HIV at the end of 2011; and an estimated 0.8% of adults aged 15-49 years worldwide are living with HIV, which implied that young people, the active and most productive group are mostly affected and this has grievous social and economic implications for the society. Although, there is a variance of the burden of the epidemics between countries and regions, sub-Saharan Africa remains most severely affected, with nearly 1 in every 20 adults (4.9%) living with HIV and accounting for 69% of the people living with HIV worldwide (UNAIDS 2012).

The UNAIDS (2012) report, further, indicated that the regional prevalence of HIV infection is nearly 25 times higher in sub-Saharan Africa than other regions of the world. Besides, Africa disproportionately bears the burden of the HIV/AIDS pandemic. Two-thirds of all people infected with HIV live in sub-Saharan Africa, although, this region contains little more than 12 percent of the world's population. In the entire African region, the scourge of HIV/AIDS appears to be even more in South Africa, as statistics has shown (CIA World Fact Book, 2012).

The impact of the disease cannot be over-emphasized both on the patients, significant others in the patients' lives, as well as the society in general. For instance, HIV/AIDS leads to financial, resource and income impoverishment (Barnett and Whiteside 2002), and puts severe strain

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on individuals and households. The psychological stress that is a direct consequence of the impact of HIV/AIDS on individuals and families can compromise school and work performance, family relationships, and the capacity to take care of children, and may also culminate in risk behavior such as alcohol, drug abuse and in unsafe sexual behavior (Coombe 2002).

More often than not, people living with HIV/AIDS experience physiological symptoms such as decrease in weight and energy level, frequent fever (Van Dyk 2005); psychological stress, which includes fear of death, depression, despair, rejection and prejudice (Raniga and Motloug 2013), these challenges may including the stress of real and anticipated losses; stigmatization and rejection from people (family and community members), as well as coping with uncertainty. All of these stressors, if not appropriately managed may become catalysts for unprecedented death and or deterioration in health and may hamper the survival chances of the patient.

In addition, HIV/AIDS is associated with stigma and discrimination in most places and patients (most often than not) have been rejected by their families, loved ones, their communities and even the society at large (Fife and Wright 2000). It is, therefore, needful to understand the psychosocial impact of the disease on the patients because psychological and social factors influence the ability to cope with HIV/AIDS more than the severity of the disease.

Besides, there is a specific individual dynamic in relation with different stages of chronic disease: disclosure and planning the treatment phase; accommodation with the disease stage; and the final, terminal stage.

It is against the background that HIV/AIDS has serious impacts on patients that this study was conducted to investigate the psycho-social impact of the disease on patients within the North-West Province of South Africa, owing to the fact that South Africa has a significantly high prevalence of the disease. In addition, the choice of North-West Province of South Africa as the research setting is informed by: (a) the fact that it is one of the provinces with high prevalence of HIV/AIDS (UNAIDS 2011) (b) Proximity and accessibility to the researchers who are based at the Mafikeng campus of the North-West University.

The significance of this study lies in the fact that: (a) Individual HIV disease happens in the

context of an HIV epidemic; therefore, understanding psychosocial aspects of HIV in patients involves understanding the interrelations between the individual's micro and macro environments. If this is the case, it will then be of immense benefit to the patients as well as the caregivers to understand the dynamics and consequences of the psychosocial variables that impact on the patients, because it is believed that it will help in devising better coping strategies for them. (b) Understanding the psychosocial impact of the disease on patients will equip stakeholders in preparing and harnessing their resources towards providing specific and meaningful support for the patients to cope better and possibly relieve them of some of the psychosocial stresses experienced. (d) The present study will also serve as a primary data source and provide direction for future researches in HIV/AIDS, particularly, in the North-West Province and South Africa as a whole.

Psychosocial Responses to HIV/AIDS

Fabianova (2011), reporting the finding of his study conducted in Nairobi, Kenya, to investigate the psychosocial responses among PLWHA reflected that PLWHA felt uncertain about their lives generally and they have to cope with the situation. They have the feelings of insecurity based on the fear of the future. The adult patients are concerned about their families, job, quality of life and life expectancy, the treatment's outcome and the reaction of the society to their health condition. The situation is very special for children, who have lost their family and home. The HIV positive child must react to this uncertainty and make several decisions to adapt to the current situation. Even if it seems, that the child does not react at all, the non-reaction itself can be the very adaptation to the illness by denying it. These tensions of uncertainty, fear of death, rejection and stigmatization reflect on the patients daily and apparently raise a lot of psychosocial responses of different dimensions and degrees of intensity in the patients.

Fear and Loss

Fear of HIV/AIDS is closely associated with fear of death. It is the fear which most people are trying to fight with by constantly running away

from the idea of self-termination or by inventing a series of comforting ideas (Fabianova 2011). Frensmann, (2000) observed that in most countries with high rate of infected people, the fear is not only with the patients, caregivers, family members, some health practitioners and friends also exercise fear of contracting the disease and therefore isolate and push PLWHA to the margins of the society. They are often forced to leave their jobs; they lose their homes, often their family and friends. They are not given adequate health care and by the provided health care they are confronted with rejection. All of these happen because of an illness which cannot be transmitted by common contact.

For many people finding out about their HIV/AIDS status is the first opportunity, to realize their mortality and psychological vulnerability. They face social isolation due to the inability to perform all daily activities which they used to do. Relationships within the family change more frequently and the attitude of acquaintances and friends changes frequently as well. Many are afraid of the loss of memory, their concentration and ability to make decisions. Mental failure is accompanied by significant behaviour, changes in physiological and psychological processes in the body, which have sometimes permanent effects on health. This persistent extreme burden leads to disruption of relationships with the social environment in the patients.

Anxiety Disorder and Depression

Satir (2006) mentioned that anxiety disorders and depression are among the psychological presentations of PLWHA. They are anxious about their state, stigmatization and rejection from the society, inability to change the circumstances and consequences of HIV infection and loss of physical and financial independence, just to mention a few. This anxiety can eventually lead to depression in the patients (Koutek and Kocourkova 2003).

Grief, Hopelessness and Helplessness Syndrome

Another strong emotion that is linked to loss and feelings of PLWHA is grief. PLWHA often experience sadness because of real or perceived loss of unfulfilled dreams; prestige and self-esteem. Sadness can also be a result of feeling of

nearness of inevitable end. The patient may lose the sense for relationship with parents, children, friends or life partner, as well as with other people. PLWHA tend not to care anymore about things which made them happy, they submit to their fate, usually with little or no hope and wait for the death to come.

Hopelessness and helplessness syndrome include elements of giving up and leaving. The survival mechanism includes the following:

- Painful feeling of helplessness and hopelessness face to face to the situation,
- The subjective feeling of reduced ability to deal with the situation (“it is beyond my strength”),
- Feeling of danger and decreased satisfaction from relationships with others,
- Loss of continuity of the past and future, a reduced ability to hope and trust,
- Tendency to revive and re-construct former deprivations and failures. (Simek 1993 as cited in Bastecky 1993)

Stigma and Discrimination

Probably, the single most important factor in producing and extending the negative psychosocial effect of HIV and AIDS is stigma. Consequently, actions to reduce or protect against stigma may be the most significant step that can be taken to improve the psychosocial well-being of people with HIV/AIDS (Fabianova 2011). People with HIV/AIDS are stigmatized and discriminated against for many reasons, including the following:

- HIV is a slow, incurable disease that eventually results in suffering and death.
- Many people regard HIV as a death sentence.
- The public often poorly understands how HIV is transmitted and is irrationally afraid of acquiring HIV from people infected with it.
- HIV transmission is often associated with violations of social mores regarding proper sexual relationships, so people with HIV are associated with having done something “bad.” For instance, in some cultures, people believe that a woman becomes infected with HIV because she has violated the mourning period after her husband died (Fabianova 2011).

Stigma prevents people from talking about and acknowledging HIV as a major cause of illness and death. Stigma prevents HIV-infected people from seeking counseling, obtaining medical and psychosocial care, and taking preventive measures to avoid infecting others. Prevention behaviors are also stigmatized, and people are reluctant to introduce behaviors that could associate them with the virus, such as use of condoms, certain medications, and infant formula when appropriate. A woman with HIV might want her partner to use a condom but might be reluctant to ask because of the stigma associated with the suggestion of HIV risk (Fabianova 2011).

Stigma and discrimination also occur in the health care setting. Sometimes, HIV-infected patients are denied appropriate care or are segregated from the general hospital population. Health care workers may selectively use universal precautions only with HIV-infected patients. Reasons may include a lack of medical resources, but health care workers' ignorance and stigmatization of HIV can also be factors.

Denial and Frustration Aggression

Some people react to news about their HIV/AIDS status by denying it. For some of them, such refusal may present a constructive way to handle the shock of the diagnosis. However, if this condition persists, the denial can become unproductive, because these people refuse the social responsibility associated with HIV positivity.

Anger and aggression are typical aspects which accompany people in situations of bereavement. Some individuals become angry and aggressive. They are often very upset about their fate. They continuously have the feeling, that they are not treated decently and tactfully enough. Anger can sometimes escalate into self-destruction leading to suicide. Aggression is one of the most frequently reported reactions in frustrating situations. In the frustrating situations, an individual may focus his anger, remorse, indignation, outrage, hostility on other people that are considered as suitable object (Bratska 2001).

Hypotheses

- There will be a significant positive correlation among participants' demographic char-

acteristics; self-efficacy, self-worth and life satisfaction.

- Gender will significantly predict general self-efficacy, self-worth and life satisfaction among participants in the study.

METHODS

Design

The exploratory descriptive survey design was adopted for the purpose of the present study (Rubin and Babbie 2009).

Participants

Participants were 728 PLWHA located within the North-West Province of South Africa. There were 319 (43.8%) female and 409 (56.2%) men. Their ages ranged between 19-75 years ($M = 38.6$; $SD = 36.32$). Distribution according to marital status showed that 359 (49.3%) were never married, while 529 (72.7%) were married at some point in their lives. Looking at participants' educational level 316 (43.4%) had primary education; 137 (18.8%) had secondary education; 35 (4.8%) had tertiary education, while 216 (29.7%) had no education. Inclusion criterion included (a) diagnosis that the individual is HIV positive or has been living with AIDS. (b) Consent to participate in the study (c) independent participation without any fear or prejudice. (d) Participant must be 18 years of age or above.

Sampling Technique and Procedure

This study adopted the non-probability purposive sampling method to select the 728 PLWHA in Mafikeng, Rustenburg, Klerksdorp, Ramathlabama, Phokeng, and Leeudoringstad (that is three urban centers and three rural places), all within the North-West Province of South Africa. The choice of these settings was informed by proximity to the researchers as well as the availability of research participants in the area.

Approval was obtained from the Research Ethics Committee of the school before conducting the study and the consent of participants were also obtained. Only those who consented to participate in the study were included. After obtaining consents and permission, trained research assistants were sent to the study site for

data collection with the help of five trained research assistants, the survey was conducted and at the end of three months, 728 HIV/AIDS patients had been successfully purposively sampled for the study. The average response time to the questionnaire was 6min. A total of 800 questionnaires were administered but only 728 were analyzed. Rests were rejected on the basis of mutilation or incomplete responses.

Instruments

The instrument of data collection was made up of the following validated scales.

General Self-efficacy Scale: This is the 10-item; Likert format scale, which was developed by Schwarzer and Jerusalem (1995) to measure the level of optimistic self-belief of personal capability to cope efficiently and competently with a variety of situations. The scale has been reported to be highly reliable and has been used in a number of studies. For example Schwarzer et al. (1997) reported alpha coefficient of between .79 and .93 in different studies and for this present study a reliability coefficient of .89 was established. Response options on the scale ranged from (1 = Not all true, 2 = Hardly true, 3 = moderately true, 4 = exactly true). A total score was calculated from the 10 items, the range being 10 to 40. A score of 30 is the middle point, so higher scores indicated high general self-efficacy, while lower scores indicate low general self-efficacy.

Life-satisfaction Scale: This is the 5-item; Likert format scale, which was developed by Diener et al. (1985.) to measure how satisfied an individual is with his life. The scale has been reported to consistently show good psychometric properties and has been used in a number of studies. For example Oladipo and Balogun (2012) .79 and for this present study a reliability coefficient of .75 was established. Each item on the scale is scored from 1 to 7 in terms of “strongly

agree” to “strongly disagree.” A total score was calculated from the 5 items, the range being 5 to 35. A score of 20 is the middle point, so higher scores indicate high satisfaction with life, while lower scores indicate low satisfaction with life.

RESULTS

Descriptive analysis done showed that a larger percentage of PLWHA reacted well to their illness status. Only 86.5% of respondents did not have feelings of guilt; 57.2% did not feel helpless; 62.5% did not feel depressed; 66.5% did not have the feeling of confusion and 87.4% did not have the feeling of despair because of their status. In the same vein, an examination of respondents’ distribution based on how high or low on the psychological variables showed that they were high on these variables that is life satisfaction (53.5%), self-worth (53.4%) and general self-efficacy (59.5%).

The first hypothesis was tested with the Pearson moment correlation and the result is presented in Table 1.

Age of participants correlated significantly positively with educational qualification (r = .188***) and marital status (r = .287**) but did not have any statistically significant correlation with self-worth, life satisfaction and general self-efficacy. It is logical that age correlated positively with educational attainment because the older one grows the more advance he is supposed to go as well in educational achievement. There are certain educational levels that are age specific and an individual may not be able to attain such except he attains the required age.

The same explanation holds for the positive relationship between age and marital status. An underage individual is not legally permitted to marry until he/she attains the accepted age of marriage as stipulated by the law or the customs of the society in which the individual involved is living. The older an individual becomes, the

Table 1: summary of correlation matrix showing the relationship among the Psychosocial variables of interest in the study

Variables	Age	Educational qualification	Marital status	Life satisfaction	Self-worth
Educational qualification	.188**				
Marital status	.287**	.076*			
Life satisfaction	.003	-.067	-.010		
Self-worth	-.048	.033	-.069	.013	
General self-efficacy	.037	.003	.052	.197**	-.113**

more the likelihood of being fit for marriage and the more the person (most likely) will begin to think and plan towards marriage.

Correlational analysis also showed a significant relationship between general self-efficacy, life satisfaction ($r = .197^{**}$) and self-worth ($-.113^{**}$). This implies that, an increase in one's general self-efficacy should bring a corresponding increase in the person life satisfaction and self-worth. An individual who perceives himself as having high self-efficacy will also most probably believe in his own ability and this will realistically positively affect the individual's self-worth and invariably life satisfaction as well.

The second hypothesis was tested with the t-test for independent samples and the result is presented in Table 2.

Result of t-test analysis done showed that gender did not significantly predict self-efficacy ($M=11.0; 10.8, t=1.26, p > .05$) and self-worth ($M=7.86; 7.96, t=-.564, p > .05$). However, gender significantly predicted life satisfaction among PLWHA ($M=31.87; 32.06, t=-.410, p < .05$). In other words, PLWHA who were women were shown to be more satisfied with life than their male counterparts. Therefore, the condition of being a male of female does not determine the level of an individual's self-efficacy or self-worth, but it did for life satisfaction among the research participants.

DISCUSSION

This present study investigated the psychological and social consequences of being diagnosed as HIV positive or being an AIDS patient on PLWHA in the Northwest Province of South Africa.

The descriptive analysis of data collected showed that a larger percentage of PLWHA reacted well to their illness status as shown in Figure 1. Most of them did not react to their

status with guilt, helplessness, depression, confusion or despair. This present findings seem to be a deviation from previous research reports of researchers like Satir (2006); Koutek and Kourkova (2003) who mentioned that anxiety disorders and depression (Grief, hopelessness and helplessness syndrome) are among the psychological presentations of PLWHA. Possible explanation for the findings of the present study could be the fact that the participants in this study have been exposed to both medical and psychological treatment, which must have strengthened their coping skill and resilience in the face of the disease. The government, both at the Provincial and National levels has been aggressive in the fight against HIV/AIDS in South Africa and this must have informed the medical and psychological provisions that are put in place to help PLWHA.

The observation of these researchers is that, participants in this study reported that they have been attending clinic sessions regularly and have been taking their drugs. More importantly they have benefited immensely from the social support provided by different NGOs that are within the North-West Province. These may have accounted for the more positive reactions they put up despite their present health status. Some people react to news about their HIV/AIDS status by denying it and for some of them, such refusal may present a constructive way to handle the shock of the diagnosis. However, if this condition persists, the denial can become unproductive, because these people refuse also the social responsibility associated with HIV positivity. In the frustrating situations, an individual may focus his anger, remorse, indignation, outrage, hostility on other people that are considered as suitable object (Bratska 2001). However, when patients have been counselled and psychologically prepared to face the challenges of the diagnosis, they become well-adjusted and react

Table 2: Results of independent t-test analysis comparing males and females on self-efficacy, self-worth and life satisfaction

<i>D.V</i>	<i>I.Vs</i>	<i>N</i>	<i>Mean</i>	<i>SD</i>	<i>df</i>	<i>T</i>	<i>p</i>
Self-efficacy	Male	321	11.0	2.346	726	1.262	P > .05
	Female	407	10.8	2.582			
Self-worth	Male	321	7.86	2.383	726	-.564	P > .05
	Female	407	7.96	2.427			
Life satisfaction	Male	321	31.87	6.764	726	-.410	P < .05
	Female	407	32.06	6.080			

more positively to the situation; this in turn improves their psychological well-being and better coping skills in the face of the disease.

Further, an examination of the psychological impacts of the illness on patients showed that a higher percentage of the respondents have high self-esteem, self-efficacy and life satisfaction. The finding of the present study is at variance with the previous research report of Mawar et al. 2002 who reported decrease in self-esteem of PLWHA because they no longer have confidence in themselves of what they can achieve. In addition, contrary to the previous findings of Fabianova (2011), that PLWHA have feeling of uncertainty and insecurity based on fear of the future, this study found that PLWHA within the Northwest Province of South Africa do not fear, or feeling of insecurity or uncertainty. Possible explanation for this finding may not be unconnected with the level of Medical, Social and Psychological attention given to PLWHA who are located within the North-West Province of South Africa. Being one of the Provinces with high rate of infections, it seems the numerous programs that have been put in place by the Provincial government, NGOs and other such organizations to fight HIV/AIDS and also to educate PLWHA are having positive impact based on the current research report that reflects that PLWHA within the province do not only have courage and hope to face the future, they do not perceived being stigmatized neither do they feel depressed or frustrated because of their health condition.

CONCLUSION

It is concluded that most of PLWHA within the North-West Province of South Africa are adjusting well because they do not have the feeling of fear, rejection, frustration and depression; neither did they perceive stigmatization. Majority of them also showed high self-esteem, self-efficacy and satisfaction with their lives. Probably the single most important factor in helping PLWHA is to take significant steps towards improving their psychosocial well-being; protect them from stigmatization and discrimination as well as provide good social support for them. This in turn will improve their coping skills and invariably positively impact on their overall well-being.

RECOMMENDATION

Although, literature is thin regarding gender difference in life satisfaction among PLWHA, this present study found that more women living with HIV/AIDS reported being more satisfied with their lives when compared with their male counterparts. It is, therefore, recommended that further researches are required to ascertain the causes.

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