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Burden of Depression and Quality of Life Among Elderly People Living with HIV/AIDS in Ibadan, Nigeria: A Cross-Sectional Study

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Abstract:

The growing population of elderly people living with HIV/AIDS (PLWH) faces a dual burden of managing HIV alongside age-related challenges, including depression, which significantly impairs quality of life (QoL). Yet empirical data addressing these intersecting issues among older Nigerians remain scarce. This cross-sectional study examined QoL and depression burden among 230 elderly PLWH (aged ≥50 years) attending two tertiary HIV clinics in Ibadan, Nigeria, identified perceived factors associated with depression, and determined independent predictors of poor QoL. Data were collected using the modified WHO Quality of Life–BREF (WHOQOL-BREF), the Geriatric Depression Scale (GDS-15), and a self-developed perceived-factors instrument. Descriptive statistics, Chi-square tests, and binary logistic regression were employed. Results showed that 46.1% of participants reported low QoL, while 44.3% experienced clinically significant depression (mild: 34.3%; moderate: 9.1%; severe: 0.9%). Marital status, education, residence type, duration since HIV diagnosis, healthcare access, suicidal ideation, and stigmatisation were significantly associated with depression ($p < .05$). Binary logistic regression identified lack of healthcare access (OR = 2.046, $p = .017$), stigmatisation (OR = 2.477, $p = .014$), suicidal ideation (OR = 3.125, $p = .013$), and moderate-to-severe depression as independent predictors of poor QoL. Integrated mental health services, stigma-reduction programmes, and equitable healthcare access are urgently needed within HIV care settings.

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Introduction

The advent of antiretroviral therapy (ART) has changed the face of HIV/AIDS from a death sentence to a chronic manageable disease and has led to significantly longer life expectancy and a rapidly expanding population of older people living with HIV. The role of people aged 50 and older living with HIV (PLH+) is expected to increase to more than half of all PLH+ by 2030 and will be tripled by 2040 globally (Dakum et al., 2020; Rodes et al., 2022). In 2022, the world had an estimated 39.0 million people with HIV (World Health Organization [WHO], 2023). HIV/AIDS prevalence among people in Nigeria in 2023 was estimated at 1.9 million, and older adults (as per HIV definitions) made up over 13% of this population (Archibong & Goshen, 2023; Dakum et al., 2020).

The physiological changes associated with long-term viral infection and ART use in older adults with HIV are accompanied by the natural biological phenomenon of ageing, which results in a distinct and unique burden of accelerated immune senescence, systemic inflammation, and an increased risk for comorbidities like hypertension, diabetes mellitus, and cardiovascular disease (Nakanjako et al., 2024; Webel et al., 2021). A heavy psychosocial burden rests on top of this physical one. HIV infection causes changes in the hypothalamic-pituitary-adrenal axis and neuroinflammation, leading to vulnerability to depression and other depressive disorders (Akadiri et al., 2024). PLWH who experience depression face decreased adherence to ART, premature disease progression, and higher morbidity and mortality rates (Fuenmayor & Cournos, 2022; He et al., 2023).

The prevalence of depression among PLWH is estimated to be around 28% (95% CI [22%, 33%]) which is significantly higher than HIV-negative populations (Ahmed et al., 2023). Reported prevalence in Nigeria varies from 16.3% to 72%, due to the heterogenous population, study settings and diagnostic tools used (Adedeji et al., 2023; Ogunsola et al., 2021). In sub-Saharan Africa, an estimated 3.63 million older PLWH are thought to suffer from major depression (Lofgren et al., 2021). Even with such warning signs, this population is largely invisible in the national health policy and programming. Most HIV clinics in Nigeria do not have full-time mental health professionals and a significant stigma associated with both HIV and mental illness is a major barrier to seeking care (Dakum et al., 2020 and Egbe et al., 2020).

Quality of life (QoL) is a multi-faceted phenomenon that includes physical, psychological, social and environmental dimensions of wellness. Among older PLWH, depression is a key factor that lowers the quality of life via social isolation, cognitive impairment, adherence to treatment, and susceptibility to opportunistic infections (Gakumo et al., 2020; Pendet et al., 2020). This relationship is further complicated by structural and psychosocial factors such as stigmatisation, poor living conditions, poverty and poor access to services, which exacerbate the links between poor mental health and a low QoL and vice versa (Brown & Adeagbo, 2021; Wang et al., 2021).

Although a lot of studies have been conducted on HIV and ageing in sub-Saharan Africa, there is limited empirical research that specifically focuses on the burden of depression and QoL among the elderly PLWH in Nigeria, and very few studies have utilized multivariate approach to determine independent predictors of poor outcomes. The current study was thus aimed at: (a) evaluating the level of QoL and depression among elderly PLWH living in two tertiary HIV clinics in Ibadan; (b) identifying perceived sociodemographic and

psychosocial factors associated with depression; and (c) determining independent predictors of poor QoL.

Methods

Study Design and Setting

A descriptive cross-sectional design was employed. Data were collected between June and July 2024 at two tertiary HIV clinics in Ibadan, Oyo State, Nigeria: the Infectious Disease Institute (IDI) Clinic, College of Medicine, University of Ibadan/University College Hospital (UCH), and the HIV Clinic, Adeoyo Maternity Teaching Hospital. The UCH IDI Clinic serves approximately 400 patients per week, of whom an estimated 75% are aged ≥50 years. The Adeoyo HIV Clinic serves approximately 350 patients per week, with roughly 64% aged ≥50 years.

Participants

The target population comprised all community-dwelling elderly individuals aged ≥50 years living with confirmed HIV/AIDS and attending the study clinics during the data collection period. Participants were eligible if they were aged ≥50 years and provided written informed consent. Individuals aged under 50 years or unwilling to participate were excluded. Sample size was determined using the Kish–Leslie formula, applying a prevalence estimate of 16.3% for depression among PLWH from a Nigerian reference study (Adedeji et al., 2023), a 95% confidence level (Z = 1.96), and a margin of error of 5%. A calculated sample of 210 was inflated by 10% for non-response, yielding a final target of 230 participants, proportionally distributed across sites (UCH IDI: n = 130; Adeoyo: n = 100).

Measures

Data were collected using a structured, interviewer-administered questionnaire comprising four sections. Section A elicited sociodemographic and clinical characteristics. Section B employed a modified version of the WHOQOL-BREF comprising 15 items across physical, psychological, and social domains, scored on a five-point Likert scale and transformed to a 0–100 scale; participants scoring below the sample mean were classified as having low QoL. Section C used the GDS-15, a validated 15-item dichotomous (Yes/No) instrument yielding scores of 0–4 (normal), 5–8 (mild), 9–11 (moderate), and 12–15 (severe depression). Section D contained a self-developed 11-item scale assessing perceived factors influencing depression (e.g., stigmatisation, loss of social support, healthcare access barriers).

Both the WHOQOL-BREF and GDS-15 are internationally validated instruments. The self-developed instrument underwent expert review by specialists in psychiatric nursing and psychometrics, and was translated into Yoruba with back-translation to English to ensure semantic equivalence. A pilot test on 23 participants (10% of the sample) at Jericho Specialist Hospital, Ibadan, yielded Cronbach's alpha (α) coefficients of .787, .712, and .722 for the WHOQOL-BREF, GDS-15, and perceived-factors scale, respectively, all exceeding the accepted threshold of .70 (Stensen, 2022).

Procedure

Following ethical approval and site permission, trained research assistants approached eligible clinic attendees in waiting areas and invited them to a private space for informed consent and data collection. Administration was interviewer-led to accommodate varying literacy levels. All questionnaires were reviewed immediately for completeness. Participants whose GDS-15 scores indicated depression (score > 4) were referred to

attending physicians for clinical evaluation and, where indicated, onward mental health referral.

Data Analysis

Data were analysed using IBM SPSS Statistics Version 22. Sociodemographic characteristics, QoL distribution, and depression levels were summarised using frequencies and percentages. Chi-square (χ^2) tests were used to examine bivariate associations between independent variables and depression level (Objectives 2 and 3) and QoL category (Objective 4), with significance set at $p < .05$. Binary logistic regression was subsequently employed to identify independent predictors of poor QoL (dependent variable: 1 = low QoL, 0 = high QoL), incorporating all variables that achieved significance in bivariate analysis as covariates. Results are presented as adjusted odds ratios (ORs) with 95% confidence intervals (CIs).

Ethical Considerations

Ethical approval was obtained from the University of Ibadan/UCH Ethics Committee and the Oyo State Hospital Management Board Ethics Review Committee. Written informed consent was obtained from all participants. Anonymity was ensured through serial coding; no personal identifiers were collected. Participation was entirely voluntary, with the right to withdraw at any stage without consequences for clinical care.

Results

Sociodemographic Characteristics

A total of 230 participants were enrolled (response rate = 100%). Table 1 presents demographic and clinical characteristics stratified by study site. The majority of participants were aged 50–60 years (65.7%), female (63.9%), and married (54.8%). Secondary education was most prevalent (40.0%). Half the sample (50.0%) were traders, and 60.4% reported a monthly income below ₦100,000. Most participants (45.7%) had been diagnosed with HIV for over 10 years, and 80.9% reported very often or always having access to healthcare facilities.

Table 1 Sociodemographic and Clinical Characteristics of Participants Stratified by Study Site (N = 230)

Characteristic	UCH IDI n (%) (n = 130)	Adeoyo n (%) (n = 100)	Total n	Total %
Age group (years)				
50–60	87 (67.0)	64 (64.0)	151	65.7
61–70	35 (26.9)	28 (28.0)	63	27.4
71–80	7 (5.4)	7 (7.0)	14	6.1
81–90	1 (0.8)	1 (1.0)	2	0.9
Gender				
Male	47 (36.2)	36 (36.0)	83	36.1
Female	83 (63.8)	64 (64.0)	147	63.9
Marital status				
Married	72 (55.4)	54 (54.0)	126	54.8
Widowed	38 (29.2)	29 (29.0)	67	29.1

Divorced	20 (15.4)	16 (16.0)	36	15.7
Education level				
None/Primary	44 (33.8)	30 (30.0)	74	32.2
Secondary	52 (40.0)	40 (40.0)	92	40.0
Tertiary	34 (26.2)	30 (30.0)	64	27.8
Monthly income				
< ₦100,000	80 (61.5)	59 (59.0)	139	60.4
₦100,000–₦299,999	44 (33.8)	39 (39.0)	83	36.1
≥ ₦300,000	6 (4.6)	2 (2.0)	8	3.5
Duration since HIV diagnosis				
< 1 year	3 (2.3)	2 (2.0)	5	2.2
1–5 years	35 (26.9)	27 (27.0)	62	27.0
6–10 years	33 (25.4)	25 (25.0)	58	25.2
> 10 years	59 (45.4)	46 (46.0)	105	45.7

Note. Frequencies may not sum to column totals due to small proportional rounding.

Quality of Life and Depression Burden

Table 2 summarises QoL and depression outcomes. Nearly half of participants (46.1%) reported low QoL. Overall, 44.3% experienced depression of any severity: mild (34.3%), moderate (9.1%), or severe (0.9%).

Table 2 Distribution of Quality of Life and Depression Levels Among Elderly PLWH (N = 230)

Outcome	n	%
Quality of Life		
High quality of life	124	53.9
Low quality of life	106	46.1
Level of Depression (GDS-15)		
Normal (score 0–4)	128	55.7
Mild (score 5–8)	79	34.3
Moderate (score 9–11)	21	9.1
Severe (score 12–15)	2	0.9

Note. GDS-15 = Geriatric Depression Scale-15; PLWH = people living with HIV/AIDS.

Factors Associated With Depression

Table 3 presents Chi-square analyses examining associations between sociodemographic and psychosocial variables and depression levels. Marital status (χ^2 =

19.664, p = .016), education level (χ^2 = 23.842, p < .001), residence type (χ^2 = 16.732, p = .031), duration since HIV diagnosis (χ^2 = 17.086, p = .028), stigmatisation (χ^2 = 19.110, p < .001), healthcare access (χ^2 = 30.027, p < .001), suicidal ideation (χ^2 = 18.396, p < .001), and receipt of family support (χ^2 = 13.279, p = .002) were all significantly associated with depression level. Participants without formal education had the highest rates of mild depression (63.6%), while those recently diagnosed (< 1 year) reported exclusively mild or moderate depression. Variables including age, gender, religion, occupation, residential setting, income, CD4 count/viral load status, healthcare provider behaviour, smoking, alcohol intake, and sedentary lifestyle were not significantly associated with depression (all p > .05).

Table 3 Association Between Sociodemographic and Psychosocial Factors and Depression Level (N = 230)

Variable	Normal n (%)	Mild n (%)	Mod/Sev n (%)	χ^2	p
Marital status				19.664	.016*
Married	75 (59.5)	43 (34.1)	8 (6.3)		
Divorced	18 (50.0)	8 (22.2)	10 (27.8)		
Widowed	35 (52.2)	27 (40.3)	5 (7.5)		
Education level				23.842	< .001*
None/Primary	28 (37.3)	38 (50.7)	9 (12.0)		
Secondary	56 (60.9)	25 (27.2)	11 (12.0)		
Tertiary	44 (68.8)	16 (25.0)	4 (6.3)		
Residence type				16.732	.031*
Flat	66 (68.0)	26 (26.8)	5 (5.2)		
Face-to-Face	39 (42.9)	39 (42.9)	13 (14.3)		
Duration since diagnosis				17.086	.028*
< 1 year	0 (0.0)	4 (80.0)	1 (20.0)		
> 10 years	59 (56.2)	38 (36.2)	8 (7.6)		
Stigmatisation				19.110	< .001*
No	104 (58.4)	65 (36.5)	9 (5.1)		
Yes	24 (46.2)	14 (26.9)	14 (26.9)		
Healthcare access				30.027	< .001*
Not often	5 (41.7)	5 (41.7)	2 (16.7)		
Always	61 (61.0)	26 (26.0)	13 (13.0)		

Suicidal ideation				18.396	< .001*
No	122 (60.4)	64 (31.7)	16 (7.9)		
Yes	6 (21.4)	15 (53.6)	7 (25.0)		

*Note. Mod/Sev = combined moderate and severe depression categories. *p < .05.*

Predictors of Poor Quality of Life

Chi-square analysis identified residence type (p = .022), duration since HIV diagnosis (p = .005), lack of healthcare access (p = .011), receipt of family help (p = .047), stigmatisation (p < .001), suicidal ideation (p = .016), and lifestyle (p = .003) as significantly associated with QoL at the bivariate level. These variables, alongside depression level, were entered as covariates in the binary logistic regression model.

In the adjusted model (see Table 4), four variables emerged as independent predictors of poor QoL. Lack of healthcare access was associated with approximately twice the odds of poor QoL (OR = 2.046, 95% CI [1.14, 3.68], p = .017). Stigmatisation conferred a 2.5-fold increase in odds of poor QoL (OR = 2.477, 95% CI [1.20, 5.11], p = .014). Suicidal ideation was the strongest predictor: individuals reporting such thoughts were more than three times as likely to report poor QoL (OR = 3.125, 95% CI [1.28, 7.64], p = .013). Moderate depression (OR = 2.331, p = .013) and severe depression (OR = 3.052, p = .011) were both significant independent predictors relative to normal depression, while mild depression did not independently predict poor QoL (p = .114). Residence type, diagnosis duration, family help, and lifestyle did not retain significance in the adjusted model (all p > .05), suggesting their bivariate effects were mediated through the dominant predictors.

Table 4 Binary Logistic Regression: Independent Predictors of Poor Quality of Life Among Elderly PLWH (N = 230)

Variable	B	SE	Wald	df	p	OR	95% CI
Lack of healthcare access (yes vs. no)	0.716	0.299	5.737	1	.017*	2.046	[1.14, 3.68]
Stigmatisation (yes vs. no)	0.907	0.369	6.054	1	.014*	2.477	[1.20, 5.11]
Suicidal ideation (yes vs. no)	1.139	0.457	6.223	1	.013*	3.125	[1.28, 7.64]
Moderate depression (vs. normal)	1.518	0.423	5.405	1	.013*	2.331	[1.02, 5.33]
Severe depression (vs. normal)	2.142	0.289	6.321	1	.011*	3.052	[1.19, 7.82]
Mild depression (vs. normal)	0.433	0.126	0.322	1	.114	0.921	—

*Note. OR = odds ratio; CI = confidence interval; SE = standard error. Reference categories: no stigmatisation, no suicidal ideation, no lack of healthcare access, normal depression. *p < .05.*

Discussion

This study revealed a high prevalence of depression and reduced QoL in the elderly HIV clients in tertiary HIV clinics in Ibadan, Nigeria. Almost half of the participants had poor QoL, with more than 44% clinically significant depressive symptoms. These results are

similar to the pooled prevalence of depression among older people living with HIV (PLWH) in sub-Saharan Africa, which ranges between 9% and 42.2% (Molapo et al., 2025) and also similar to the depression prevalence of 38.5% on an earlier clinical cohort in Ibadan (Oyapero et al., 2023).

The high prevalence of depression among those with a recent HIV diagnosis, none of whom had a normal GDS-15 score, confirms data from around the world that people in the first few months immediately after HIV diagnosis experience high-intensity psychological distress, fear, disruption of identity and existential uncertainty (Barger et al., 2023; Mwangala et al., 2021). The finding that longer duration of diagnosis was associated with lower rates of depression is consistent with the trajectory of adaptive coping found in the HIV ageing literature, in which individuals' rates of depression and psychosocial adjustment decrease over time (Mwangala et al., 2021). This longitudinal dynamics is missing from a cross-sectional design and thus the importance of prospective follow-up studies.

Stigmatisation was one of the most powerful variables related to depression and QoL in both bivariate and multivariate analyses, which was supported by a large body of literature in Nigeria and other parts in sub-Saharan Africa (Brown & Adeagbo, 2021; Egbe et al., 2020; Tadesse et al., 2024). Stigma can act as a psychological stressor, leading to social isolation and disempowerment, as well as avoidance of care for psychological distress, which increases psychological distress and decreases life satisfaction (Wang et al., 2021). The fact that it remained a significant independent predictor of poor QoL even when taking into account demographic and clinical factors further highlights the need for structural and community-level interventions which focus on changing stigmatising attitudes.

In a multivariate model, suicidal ideation was the most robust independent predictor of poor QoL, with over threefold increase in the odds of poor QoL. This discovery is consistent with the previous study by Egbe et al. (2020) and other studies in the world that have shown that suicidal ideation is the most extreme manifestation of depression, with the symptoms of emotional withdrawal, loss of functioning, and significantly reduced life satisfaction (Pendet et al., 2020; Sahinoglu et al., 2024). The results strongly suggest routine suicide risk screening should be a part of HIV care, and clinical pathways for urgent mental health referral should be created and resourced at the HIV clinic level.

Poor health care access was independently related to poor QoL (OR = 2.046), consistent clinical engagement was a protective factor. Regular contact is important for timely detection and management of physical and psychological comorbidities, for adherence to ART and for professional social scaffolding (Ku et al., 2021). Mobile outreach and community-based care are potential strategies to address gaps in access in environments where elderly PLWH may have issues with transportation, disability, and/or financial concerns.

A nonintuitive result was the relation between the two bivariate assessments of family support and depression and poorer QoL; these relations were not found in the multivariate analyses. Other, similar paradoxical results have been reported (Hankebo et al., 2023) and may be due to the reverse causal relationship (family support is mobilised in response to already compromised well-being) or may be due to the lack of quality or timeliness of the informal care provided to achieve psychological benefit. Qualitative research will be needed to understand these relational dynamics contextually in the Nigerian culture.

In the adjusted model, all of the structural sociodemographic factors (gender, age, religion, income and residential setting) were not independent predictors of QoL. There is a growing understanding that in populations with similar structural vulnerabilities, such as older people living with HIV in clinical settings in Nigeria, factors related to access and psychosocial stressors are likely to have a more immediate impact on QoL than sociodemographic factors (Mwangala et al., 2021).

Conclusion

This study provides empirical evidence that elderly PLWH in Ibadan, Nigeria carry a substantial and under-addressed dual burden of depression and impaired QoL. Lack of healthcare access, stigmatisation, suicidal ideation, and moderate-to-severe depression were the primary independent predictors of poor QoL. These findings signal urgent priorities for integrating mental health screening and care within Nigerian HIV services, implementing evidence-based stigma-reduction interventions, and ensuring equitable healthcare access for elderly PLWH. Nurse-led psychosocial support programmes, multidisciplinary geriatric HIV clinics, and community outreach models represent actionable pathways through which these priorities can be operationalised.

DECLARATIONS

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Ethical Approval: Granted by the University of Ibadan/UCH Ethics Committee and the Oyo State Hospital Management Board Ethics Review Committee.

Informed Consent: Written informed consent was obtained from all participants.

Data Availability: Data are available from the corresponding author upon reasonable request.

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