

Impact of HIV/AIDS on an overseas Filipino worker and his family

Antonio Guido F. VALENCIA and Gary Louie A. NICOMEDES

Department of Family and Community Medicine, Philippine General Hospital, University of The Philippines, Manila, The Philippines

Brief medical background

JD was a 42-year-old male from Cavite, the Philippines who was referred to the Research Institute for Tropical Medicine (RITM) for further management of progressive dyspnea secondary to pulmonary tuberculosis (PTB). As part of the Family and Community Medicine Residency Training Program in our institution, I underwent a rotation at the RITM, where I first met JD on 21 April 2002.

JD was previously diagnosed to have, and treated for PTB, in September 2001. Symptoms resolved during the 6-month treatment period, only to recur 2 weeks after termination of treatment despite good compliance. He developed cough paroxysms with anorexia, fever, and progressive dyspnea 2 weeks prior to this admission.

Personal/social history revealed that JD worked as an overseas Filipino worker (OFW) in Saudi Arabia (1981–1984) and in East Africa (1991–1994). He revealed for the first time to a medical personnel that he was screened to have a positive HIV antibody test in 1995 while trying to renew his OFW contract. JD refused further medical consults.

Upon admission, JD was in mild respiratory distress, with rales on both lung fields. Supportive management was instituted. Further work-up was done to exclude other possible opportunistic infections and for HIV confirmatory testing which was subsequently confirmed positive. He was managed as a case of recurrent PTB; HIV infection category C (or AIDS); and *Pneumocystis carinii* pneumonia. Recurrent PTB was given as assessment due to the recurrence of the PTB

symptoms (cough paroxysms, anorexia, weight loss, fever, night sweats and chills) after completion of the 6-month treatment for PTB with symptom resolution. An assessment of HIV infection category C was given on the basis of a positive HIV confirmatory test and having AIDS indicator conditions (i.e., PTB and *Pneumocystis carinii* pneumonia, Tables 1,2).¹

He was given the appropriate antibiotics. The family was worked-up for PTB. The youngest daughter was screened positive for PTB and appropriate therapy was initiated. JD's wife, ND, was screened negative for HIV, but repeat screening after 6 months was advised.

Brief psychosocial background

JD was married and had two daughters (ages 21 and 17). He was the head of the family and the main decision-maker (Fig. 1). He used to be the breadwinner, took blue collar type jobs, before he became ill in 2002. ND then assumed the breadwinner role. Functional relationships existed among the family members. While in East Africa, JD felt lonely and depressed because his employers maltreated him, and denied him the right to return home. It was there that he began to have multiple unprotected sexual contacts with promiscuous female partners.

After learning that he was HIV positive, he never sought medical consult for fear of rejection. He was asymptomatic during that time. He felt lonely and isolated with his illness. Although he no longer had extramarital affairs upon returning home, he resumed his sexual relationship with ND. For 6 years, he kept his infidelity and HIV status a secret from his family. It was only when the medical problems arose that he revealed it to ND. ND felt betrayed but she tried her best to understand and forgive JD. The couple decided to keep it a secret from their children, fearing that the children might reject him. JD preferred to disclose the secret to his children when he was already dying.

The Biopsychosocial approach was used, with the help of the tools for family assessment, in analyzing

Correspondence: Dr Antonio GF Valencia, Department of Family and Community Medicine, Philippine General Hospital, University of the Philippines, Manila, The Philippines
Email: valenciamd@edsamail.com.ph

Accepted for publication 12 February 2003.

Table 1 USA Centers for Disease Control 1993 classification of HIV infection¹

	Clinical categories		
	A Asymptomatic, or acute HIV infection	B Symptomatic (not A or C)	C AIDS indicator condition
CD4+ T cell level categories			
>500/mm ³	A1	B1	C1
200–499/mm ³	A2	B2	C2
<200/mm ³	A3	B3	C3

Table 2 USA Centers for Disease Control 1993 classification of HIV infection (clinical conditions of categories B and C)¹

Category B clinical condition

- 1 Bacillary angiomatosis
- 2 Candidiasis, oropharyngeal thrush
- 3 Vulvovaginal candidiasis
- 4 Cervical dysplasia
- 5 Oral leukoplakia, hairy
- 6 Herpes zoster
- 7 Idiopathic thrombocytopenic purpura
- 8 Listeriosis
- 9 Pelvic inflammatory disease
- 10 Peripheral neuropathy

Category C clinical condition

- | | |
|--|---|
| 1 Candidiasis of bronchi, trachea or lungs | 13 Burkitt's lymphoma |
| 2 Candidiasis, esophageal | 14 Immunoblastic lymphoma |
| 3 Invasive cervical cancer | 15 Lymphoma of the brain |
| 4 Coccidiomycosis | 16 Pulmonary tuberculosis [†] |
| 5 Cryptococcosis, extrapulmonary | 17 <i>Mycobacterium tuberculosis</i> , extrapulmonary |
| 6 Cryptosporidiosis | 18 <i>Mycobacterium</i> , other species |
| 7 CMV retinitis | 19 <i>Pneumocystis carinii</i> pneumonia [†] |
| 8 HIV dementia (encephalopathy) | 20 Pneumonia, recurrent |
| 9 Chronic herpes simplex | 21 Progressive multifocal leukoencephalopathy |
| 10 Histoplasmosis | 22 Salmonella septicemia |
| 11 Psoriasis | 23 Toxoplasmosis of the brain |
| 12 Kaposi's sarcoma | 24 Wasting syndrome |

[†]AIDS indicator conditions present in the patient. CMV, cytomegalovirus.

and managing this case which involved a family with an OFW afflicted with HIV/AIDS.

Biopsychosocial analysis

The Biopsychosocial approach analyzes the interrelationship of molecular changes, organic pathology, psychological conflicts, family issues, community determinants, and global factors as they are affected by a certain disease entity.^{2,3}

The HIV infection produces a spectrum of disease that progress from a clinically asymptomatic state to

AIDS as a late manifestation. The virus attacks CD4+ lymphocytes which play a central role in immune response. The killing of many CD4+ lymphocytes leads to progressive decline in immunity.¹

As of the end of 2001, an estimated 40 million people worldwide were living with HIV/AIDS.⁴ Understanding HIV/AIDS also requires knowledge about migration. Migration and certain human behaviors are important factors in disease emergence. The AIDS virus started as an isolated infectious disease in rural Africa. Migrants to and from rural Africa came in contact with individuals infected with HIV through unprotected sex, spreading the virus to a more global atmosphere.⁵

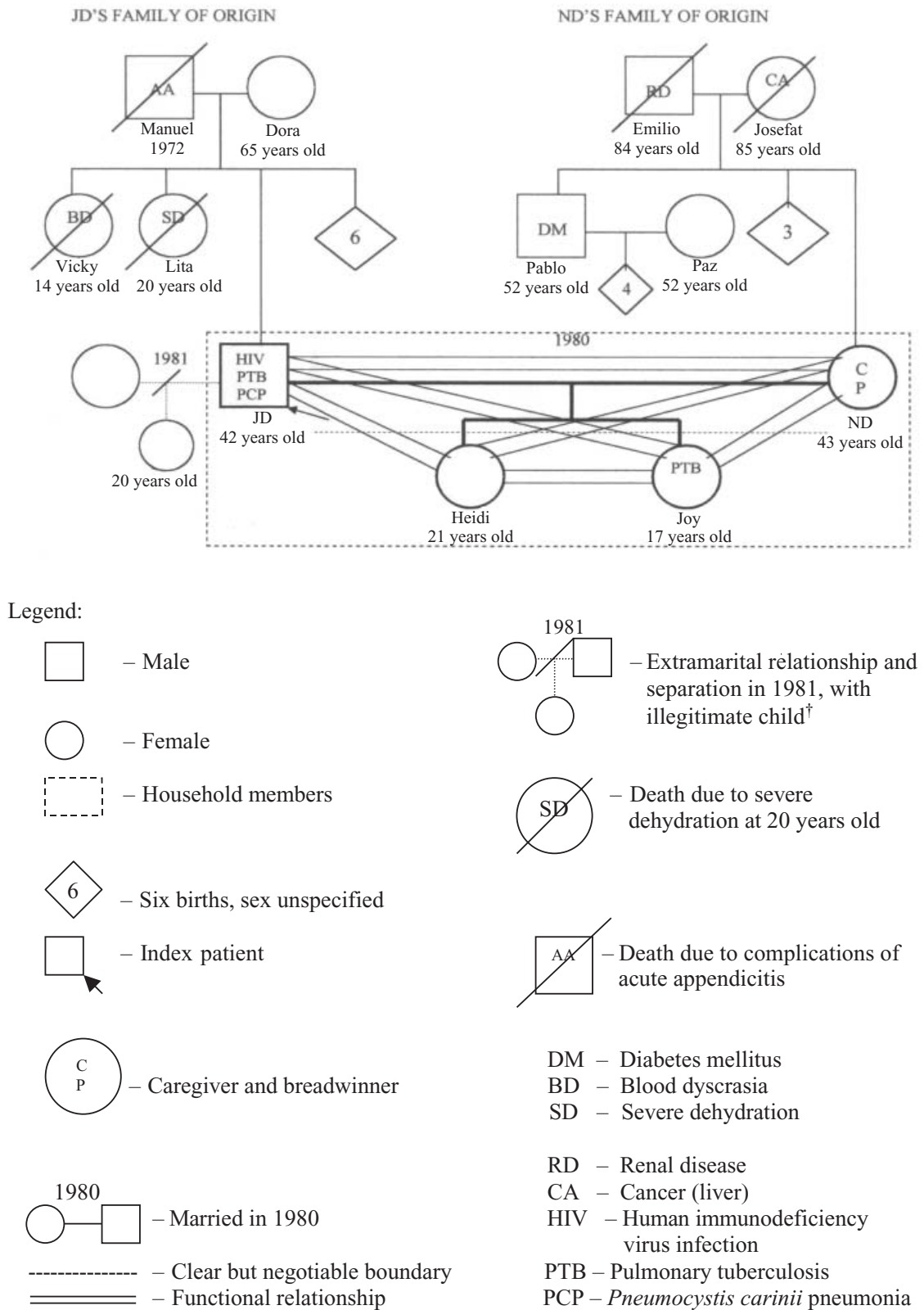


Figure 1 Family genogram and family map. †After 1981, JD never saw the 'other woman' again. In 1988, he learned that he had a daughter with the previous extramarital affair. He searched for the woman and the child for 2 years, but he never found them, and he never received any information about them. JD concluded that the woman no longer wanted him in her life. JD gave up searching for them. Informants (interviewed separately): JD and ND. Main decision-maker: JD.

As of 1998, nearly 7 million OFW were working and living in more than 180 countries worldwide.⁵ Approximately 2293 OFW leave daily.⁵ The Philippine Overseas Employment Administration has reported a total of 636 024 deployed OFW from January to August 2002.⁶

Associated with migration is the adjustment to the environment and culture of the host country. Without their significant others in a foreign land, OFW tend to become home sick. To forget this feeling of loneliness, many of them engage themselves in (unprotected) sexual activities with foreigners or fellow Filipinos abroad.⁵ When they return to the Philippines, they then resume their sexual relationship with their spouses. Thus, HIV/AIDS is spread in the Philippines.

Overseas Filipino workers learn about their HIV status, usually, during the annual physical exam or renewal of their OFW contract.⁵ More often than not, they are asymptomatic. Once the OFW learns that he/she has HIV, fear develops because of the possible rejection from the host country, employer, his/her community, and/or his/her own family. This stigma associated with AIDS prevents infected individuals from coming out for help.⁷

JD was a former OFW who worked in East Africa, where he began to engage in multiple unprotected sexual contacts with foreign prostitutes brought about by his loneliness. Most probably, he acquired the virus during that time. After learning that he had HIV, he kept it a secret from ND for several years (until his immunity progressively declined). He developed a sense of loneliness and guilt. He resumed his sexual relationship with ND. After telling ND about his illness, the issue of possible rejection shifted to his children.

It appeared that the HIV not only decreased JD's CD4+ lymphocyte count or immune response, but it also depleted his self esteem.

Analysis of the tools for family assessment

The tools for family assessment (Table 3) enabled us to identify the problems/issues, as well as plausible solutions.⁸ Aside from the medical problems mentioned above, other identified problems were disclosure of illness to children; guilt and mistrust; and feelings of loneliness.

The family lifeline revealed that JD disclosed his extramarital affairs abroad and medical condition to ND 6 years later after learning that he was HIV positive. He never disclosed to ND his extramarital affair with another Filipina, who allegedly bore him a daughter (Fig. 1). JD had a tendency to keep secrets which he perceived to be potentially disruptive of his

Table 3 Tools for family assessment used in this family case⁸

-
1. Family genogram – a graphic representation of the family structure (family tree, functional chart, family illness/history)
 2. Family map – describes the family system, in terms of relationships among family members, boundaries between generations, presence of conflicts and/or alliances
 3. Family lifeline – significant life/clinical events, and how they were handled, are recorded according to dates of occurrences.
 4. Family resources – (social, cultural, religious, economic, educational, medical (SCREEM)) assessment of family as to its capacity to participate in the provision of health care or to cope with crisis.
 5. Family APGAR – (adaptation, partnership, growth, affection, resolve) screening instrument for family dysfunction; measures the individual's level of satisfaction about family relationships
-

Table 4 Stages of the family life cycle⁹

-
- 1 Unattached young adult
 - 2 The newly married couple
 - 3 The family with young children
 - 4 The family with adolescents
 - 5 Launching family
 - 6 Family in later years
-

family's stability. The family economic, medical, cultural resources revealed the family's unstable finances, inaccessibility of medicines and medical services in JD's own community, and the possible rejection due to the shame attached with AIDS. These factors contributed to further hindrance to disclosure in order to avoid adding problems to the children.

This family was in the launching family stage of the family life cycle (Table 4). Marital and parental issues inherent in this stage include adjustment with the disability of a family member, sexual relationship with spouse, career stagnation, early retirement, and conflicting issues with children.⁹ These factors not only contributed to a possible delay in disclosure to the children, but these also affected the marital relationship as evidenced by both, the guilt and loneliness of JD brought about by his illness, and ND's feelings of mistrust/betrayal upon learning of JD's infidelity and illness.¹⁰ JD's perception that his children had a tendency to bear grudges added difficulty with the disclosure issue.

The tools for family assessment also revealed strengths of the family which aided in the counseling

Table 5 Counseling techniques used for the psychosocial issues^{11,12}

Issue	Counseling technique	Outcome
1. Disclosure of illness to children	'Catharsis-education-action' counseling method	Disclosure done by the couple to their children; forgiveness and acceptance obtained by JD from his children
2. Guilt and mistrust	Intentional family/marital counseling method	Couple relieved of emotional burden; promised to fulfil each other's needs
3. Feeling of loneliness	Rogerian/client-centered technique	JD realized that he was never alone and despite his illness, he was still lucky for all the moral support he received

process, leading to the resolution of the above psychosocial issues. Through the process of counseling, with the help of the tools for family assessment, these strengths were identified/realized by JD and ND (Table 5).^{11,12} The family APGAR (adaptation, partnership, growth, affection, resolve) used to screen for family dysfunction and measure the individual's level of satisfaction about family relationships, revealed a highly functional family. Their family map also revealed clear and negotiable boundaries between generations (Fig. 1). The family social resources revealed the existing smooth interpersonal relationship of their family with extended families and friends/neighbors in their community. Religion, as a family resource, was adequate to give them hope and strength to overcome problems. Adequate education of family members suggested the possibility of an easy facilitation of the family's understanding of the HIV/AIDS issue.¹³

Since the couple was only started on HIV/AIDS education during that time, they were still trying to adjust to this condition. Disclosure to the children was temporarily deferred during that time.⁷

Five months later, news came that JD passed away.

The family was uncertain about the cause of his death but they were certain that he died peacefully. According to ND, several weeks before JD died, the couple contemplated on what transpired during our counseling sessions. Recalling their family's strengths, they finally decided to disclose his illness to their children before it became too late. The children had forgiven and accepted their father, despite his shortcomings and his illness. JD felt relieved of emotional burden during his last days. Acceptance of his death was not difficult for his family.

Conclusion

A family physician's management extends beyond the boundaries of his/her clinical expertise. As family physicians, we can help HIV/AIDS patients out from the darkness of the stigma and go deeper into the implication of this virus to the patient's family and community. The rise of viral load/burden may be beyond medical control, but we can ease or lighten up their psychosocial burden, which, from the patients' viewpoint, would give a sense of great relief.

References

- Philippine National AIDS Council. Clinical management of HIV infection in the Philippines. Manila: Department of Health, 2001
- Engel GL. The biopsychosocial model and the education of health professionals. *Ann. NY Acad. Sci.* 1978; **310**: 169–81.
- Engel GL. The clinical application of the biopsychosocial model. *Am. J. Psych.* 1980; **137**: 535–44.
- National Institute of Allergy and Infectious Diseases Fact Sheet. HIV/AIDS Statistics [Internet]. Bethesda, MD: NIAID; [updated February 2002; cited 11 May 2002]. Available from: <http://www.niaid.nih.gov/factsheets/aidsstat.htm>.
- Marin ML. HIV/AIDS knows no borders. Addressing HIV vulnerability of overseas Filipino workers (OFWs). [Internet]. Manila: Philippine Health Social Science Association; [updated October 2001; cited May 2002]. Available at: http://www.phssa.org/announcements_news/hiv.htm.
- Philippine Overseas Employment Administration. Deployed Overseas Filipino Workers for the year 2002 (January to August 2002). [Internet]. Mandaluyong City: Philippine Overseas Employment Administration; [updated 2002; cited November 2002]. Available at: http://www.poea.gov.ph/docs/Monthly_Deployment_JANUARY_to_AUGUST_2002.xls
- Yoshioka MR, Schustack A. Disclosure of HIV status: Cultural issues of Asian patients. *AIDS Patient Care STDS* 2001; **15**: 77–82.
- Pineda A. Tools for family assessment. *Proceedings of the Orientation Course in Family Medicine*. Makati City: Philippine Academy of Family Physicians, 1999; 36–50.
- Samaniego I. Family life cycle. *Proceedings of the Orientation Course in Family Medicine*. Makati City: Philippine Academy of Family Physicians, 1999; 18–25.

- 10 Beckerman NL, Letteney S, Lorber K. Key emotional issues for couples of mixed HIV status. *Soc. Work Health Care* 2000; **31**: 25–41.
- 11 Clinebell H. *Basic Types of Pastoral Care and Counseling*. Nashville: Abingdon Press, 1984.
- 12 Gillard BE, James RK, Bowman JT. *Theories and Strategies in Counseling and Psychotherapy*. New Jersey: Prentice Hall, 1989.
- 13 Centers for Disease Control and Prevention. Revised guidelines for HIV counseling, testing, and referral. *Morbid. Mortat. Weekly Rep.* 2001; **50**: 1–58.