



## HEALTH-RELATED QUALITY OF LIFE, WORK PRODUCTIVITY, AND ASSOCIATED FACTORS AMONG PATIENTS WITH TYPE 2 DIABETES MELLITUS ON ANTI-DIABETIC MEDICATIONS: A CROSS-SECTIONAL STUDY IN NORTH CENTRAL NIGERIA

<sup>1\*</sup>Giwa, H. B., <sup>2</sup>Babatunde, M. O., <sup>1</sup>Jamiu, O. M., <sup>3</sup>Giwa F. S. and <sup>1</sup>Giwa, A

<sup>1</sup>*Department of Clinical Pharmacy and Pharmacy Practice, Faculty of Pharmaceutical Sciences, University of Ilorin, Ilorin, Kwara State, Nigeria*

<sup>2</sup>*Myway Pharmacare Pharmacy, Number 120 Isolo Quarters, Akure, Ondo State, Nigeria*

<sup>3</sup>*Faculty of Pharmacy, Tehran University of Medical Sciences, Tehran, Iran*

\*Author for correspondence: [hbfgiwa@yahoo.com](mailto:hbfgiwa@yahoo.com) 07043502592

---

### ABSTRACT

Diabetes mellitus poses a major public health challenge in Africa, particularly in Nigeria, due to its high morbidity, mortality, and economic impact, which are worsened by its chronic nature and related complications. The aim of this study was to assess the health-related quality of life (HRQoL), work productivity, and associated factors among patients with Type 2 Diabetes Mellitus (T2DM) receiving anti-diabetic medications at a secondary health facility in Ilorin, Kwara State, North Central Nigeria. A cross-sectional study through convenient sampling was conducted in patients registered in the last ten years (10) from (May 2013 to August 2023). Participants were drawn after a sample size of 304 participants was calculated. Informed consent was obtained from all participants, and ethical approval was granted by Ethics and Research Committee of the Institution (Approval ID: ERC /MOH/2023/04/102). Data on health-related quality of life were collected using the EQ-5D-5L and EQ-VAS instruments, while the Work Productivity and Activity Impairment (WPAI) questionnaire was used to assess changes in work productivity. Statistical analysis involved both descriptive and inferential methods, with results presented in tables. Of the 304 participants included, 108(35.5%) were female, 196(64.4%) were male. Majority fell within the age group of 55-65 years old (39.5%). Majority 140 (46%) were in the lower middle income (\$39-130) category. Biguanide plus sulphonyl urea combination therapy recorded the highest usage (71.1%). Overall loss of productivity and activity impairment as outcomes of work productivity was found to be 24.8% and 33.6%. The mean EQ-5D utility scores and EQ-VAS scores were  $0.7033 \pm 0.1525$  and  $63.57 \pm 17.16$ . Factors such as older age, presence of complications and comorbidities, and higher overall productivity loss are significantly associated with lower HRQoL scores. Conversely, being employed and having a good monthly income are significantly associated with better. Health-related quality of life of individuals with type 2 diabetes, as measured by EQ-5D utility and EQ-VAS scores. Results highlight the importance of socioeconomic and clinical factors in influencing the quality of life of patients with type 2 diabetes.

**Keywords:** EQ-VAS, EQ-5D-5L, HRQoL, Nigeria, Quality of life, T2DM, WPAI

---

### INTRODUCTION

Diabetes is a chronic, metabolic disease characterised by elevated levels of blood glucose (or blood sugar), which on the long run results into serious damage of the heart, blood vessels (WHO, 2023). In 2019 WHO

estimated that 415 million people were living with diabetes globally, this is estimated to be 1 in 11 of the world's adult population. 46% of people living with the disease are undiagnosed and this figure is

expected to reach 640 million by 2040. It was reported that the prevalence of diabetes also varied by sex (adult) with 13.7% of men and 11.7% of women in US. In Nigeria it was reported that there is higher prevalence of type 2 diabetes in females compared to males which is attributed to both biological and psychosocial predictors (Tella *et al.*, 2021). The World Health Organization (WHO) defines quality of life (QoL) as an individual's subjective evaluation of their life circumstances, encompassing their cultural context, values, goals, expectations, and concerns (Orley, 1995), while health-related quality of life is defined as the valuation of life duration, adjusted for the impact of impairments, functional limitations, personal perceptions, and social opportunities, all of which are influenced by disease, injury, treatment, or policy (Patrick and Erickson 1993). The main aspect in a HRQoL study is how the manifestation of an illness or treatment is experienced by an individual (Patrick and Erickson 1993). The EQ-5D (EuroQol 5-Dimensions) questionnaire is widely used to score patient preferences and generate index values. However, work productivity is a measure of how efficiently and effectively a worker or group of workers produce goods and services. (Hubens, *et al.*, 2021).

Studies have shown that there is a paucity of comprehensive evidence on health-related quality of life (HRQoL), work productivity, and their determinants among patients with type 2 diabetes mellitus (T2DM), particularly in the Nigerian context. (Ababio *et al.*, 2017). There are several studies highlighting assessments in health-related quality of life in the Ethiopian context. For instance, Aschalew *et al.*, (2020) found that higher HRQoL was associated with exercising, adherence to a recommended diet, foot care, moderate alcohol consumption, and the absence of

comorbidities. Conversely, older age, unemployment, and being single or widowed were significantly associated with lower HRQoL. Similarly, Gebremedhin *et al.*, (2019) reported that age, disease duration, and fasting blood glucose levels were inversely associated with all domains of HRQoL ( $p < 0.001$ ), while body mass index (BMI) also showed an inverse relationship. A study conducted in Addis Ababa by Degu and Wondimagegnehu (2019) further indicated that diabetic nephropathic pain negatively impacted HRQoL. Likewise, a more recent study from Iran revealed that individuals living with diabetes experienced reduced work efficiency and increased absenteeism, resulting in substantial declines in overall work productivity (Ebrahimipour *et al.*, 2021). Type 2 Diabetes Mellitus (T2DM) is a growing public health concern in Northern Nigeria, where limited access to healthcare, poor disease awareness, and socio-economic challenges compound its impact. Studying Health-Related Quality of Life (HRQoL) and productivity loss among individuals living with T2DM is essential to understanding the full burden of the disease in this region. HRQoL assessments reveal how diabetes affects patients' physical functioning, psychological well-being, social relationships, and ability to perform daily activities. This is especially important in Northern Nigeria, where cultural and economic factors often influence health-seeking behavior and treatment adherence (Gureje, *et al.*, 2023).

By highlighting the multidimensional impact of T2DM, HRQoL and productivity studies provide evidence to inform more effective, patient-centered care models, guide resource allocation, and shape public health interventions tailored to the unique needs of Northern Nigeria's population (Kass *et al.*, 2023). This study aims to present a

comprehensive analysis of the HRQoL, work productivity, and potential factors in patients with type 2 diabetes mellitus that are on anti-diabetic therapy.

## METHODOLOGY

### Study Setting

This study was conducted in Ilorin, the capital of Kwara State in the North-Central geopolitical zone of Nigeria. As of the 2012 census, the population of Ilorin was officially recorded at 1,084,681, with a notable annual growth rate of 3.22%. The city spans an area of 765 square kilometers and is geographically situated at coordinates 8°30'N latitude and 4°32'E longitude. The General Hospital Ilorin boasts a multidisciplinary team of specialists and 600 bed spaces, providing comprehensive care to patients from Kwara and neighboring states, including Oyo, Osun, and Kogi. Previously serving as a temporary site for the University of Ilorin Teaching Hospital, this well-equipped secondary health facility is strategically located in the Ilorin West Local Government Area, with geographical coordinates 8°32'14.298'N and 4°38'50.327'E." The prevalence of type 2 Diabetes mellitus in general hospital is 5.2%. (Adeloye *et al.*, 2017)

### Study design

The study employed a cross-sectional design, with participants recruited through convenient sampling.

### Study Population

The study population comprised of patients aged 18-70 years diagnosed with Type-2 Diabetes Mellitus and registered at the General out-patient clinic and Endocrine clinic of General Hospital, Ilorin in the last ten 10 years (May 2013 to August 2023) and still attending the facility for checkup. All type 2 diabetes patients aged over 18 years, who presented for treatment at General Hospital Ilorin and had been diagnosed for

more than six months, and provided informed consent were included in the study. Inpatients and individuals with any long-term or temporary psychiatric conditions were excluded.

### Sample size

Sample size was determined by a formula prescribed by (Araoye,2003), and 304 participants were included in the study.

### Data collection

#### Data collection tools

Data collection was facilitated through the use of self-completed questionnaires, specifically the EQ-5D-5L (Sprangers,2022) and the Work Productivity and Activity Impairment Questionnaire: General Health version (WPAI:GH) ((Ebrahimipour *et al.*, 2021). The instruments measure Health related quality of life and work productivity respectively.

Work Productivity and Activity Impairment Questionnaire: General Health version (WPAI:GH) was used to estimate change in work productivity. Concerning validity, similar questionnaire which is the WHO Student Drug Use Survey Model Questionnaire has been validated and used in Abeokuta, a Nigerian setting (Adelakun *et al.*,1989). WPAI:GH is a self-completed questionnaire that has 6 questions. This is an instrument for measuring health-related productivity changes. It has a recall of 7 days and also visual analogue scale (VAS) ranges from 1-10. The VAS was used to measure the degree of patients' health on that specific day the data was collected.

Question 1: Currently employed/self employed

Question 2: Hours missed due to health problem.

Question 3: Hours missed due to other reasons.

Question 4: Hours actually worked.

Question 5: Degree health affected productivity while working using a scale 1-10 (VAS Scale).

Question 6: Degree health affected regular activities (unpaid).

These were used to calculate four outcomes for work productivity:

- a. Work time missed/Absenteeism (%) =  $Q2/(Q2+Q4)$
- b. Impairment of work (%) /presenteeism =  $Q5/10$
- c. Activity impairment (%) /unpaid work =  $Q6/10$
- d. Overall work impairment =  $Q2/Q2+Q4 + [(1-(Q2/Q2+Q4)) (Q5/10)]$

EQ-5D-5L: It consists of 2 parts; first part is EQ-5D-5L descriptive system that measures health-related quality of life across 5 domains (mobility, self-care, usual activities, pain/discomfort, and anxiety/depression). Each dimension has 5 levels: no problem, slight problem, moderate problem, severe problem and extreme problem. The EQ-5D-5L requires respondents to simply mark X on the scale to indicate how their health was on that day and then to write the number marked on the scale in the box provided. Final result can be a 1-digit or a 5-digit number, or combination of the two. The 5-digit number shows a description of the patient's health state.

The second part is EQ visual analogue scale (EQ-VAS) in which respondents were asked to rate their health on a 20cm vertical visual analogue scale from 0-100 with end points labelled "best health you can imagine" and "worst health you can imagine".

### Data collection procedure

Data collection took place on Mondays and Wednesdays, which were the designated clinical days for Endocrinology clinic. Patient data collection was facilitated through collaboration with the Consultant Endocrinologist. A designated space within

the consultation room was provided for interviews, and the Endocrinologist would direct patients who gave informed consent to this area after their consultations. The questionnaires were self-administered and written in English. For participants who were not literate, trained interviewers administered the questionnaires by translating them into the respondents' native language.

### Data Analysis and Ethical approval

#### Data were analysed using SPSS version 22.0.

Descriptive statistics (means, frequencies, percentages, and standard deviations) were used to summarize socio-demographic, clinical, EQ-5D-5L, EQ-VAS, and WPAI data. **Pearson correlation** assessed associations between socio-demographic/clinical variables and HRQoL scores, while **Spearman correlation** was used to examine relationships between EQ-5D-5L, EQ-VAS, and work productivity outcomes. Also included were chi-square tests, which are used to compare observed data with expected data—specifically to determine whether any differences are due to chance or reflect a significant relationship between the variables studied or a difference between groups (McHugh, *et al.*, 2013). Ethical approval was sought and obtained from the Ethics and Research Committee of the Institution (Approval ID: ERC /MOH/2023/04/102).

## RESULTS

### Socio demographic Profiles

Out of the 304 participants 35.5% (108) were male while 64.5 % (196) were female ( $p = 0.315$ ,  $X^2=64.718$ ) The participants' age ranged from 18-70 years. No participant has age below 35 years. ( $p=0.353$ ,  $X^2=.186.552$ ).

The participants' time diagnosed was grouped into two; 6 months to < 5 years and 5-10 years. Fifty-seven-point nine percent

the participants were diagnosed within 6 months to less than 5 years while 42.1% were diagnosed within 5-10 years ( $p=0.294$ ,  $X^2=65.41$ ). The monthly income of the participants was rated as low (below ₦30,000/39\$), lower middle (₦ 30,000-/39\$-100,000/130\$), lower upper

(₦100,000/130\$-200.000/260\$) and High (above ₦200,000/\$260), considering Nigeria's minimum wage. Forty six percent had lower middle income, 21.7% had lower upper income, and 22.4% had low income and 9% had high income  $p= (0.444$ ,  $X^2=121.531$ ). As shown on table I

**Table I: Socio-demographic characteristics of patients with T2DM attending General Hospital Ilorin (n=304).**

| Characteristic    | Category          | Frequency (N) | Percentage (%) | p-value | $X^2$   |
|-------------------|-------------------|---------------|----------------|---------|---------|
| Sex               | Male              | 108           | 35.5           | 0.315   | 64.718  |
|                   | Female            | 196           | 64.5           |         |         |
| Age               | 18-24             | -             | -              | 0.353   | 186.552 |
|                   | 25- 34            | -             | -              |         |         |
|                   | 35-44             | 22            | 7.2            |         |         |
|                   | 45-54             | 54            | 17.8           |         |         |
|                   | 55-65             | 120           | 39.5           |         |         |
|                   | 65-70             | 108           | 35.5           |         |         |
| Marital status    | Single            | 6             | 2.0            | 0.301   | 127.547 |
|                   | Married           | 220           | 72.4           |         |         |
|                   | Divorce/separated | -             | -              |         |         |
|                   | Widow/widower     | 78            | 25.7           |         |         |
| Education status  | Informal          | 114           | 37.5           | 0.330   | 187.805 |
|                   | Primary           | 48            | 15.8           |         |         |
|                   | Secondary         | 34            | 11.2           |         |         |
|                   | Tertiary          | 108           | 35.5           |         |         |
| Employment status | Employed          | 74            | 24.3           | 0.733   | 109.983 |
|                   | Self-employed     | 174           | 57.2           |         |         |
|                   | Unemployed        | 56            | 18.4           |         |         |
| Time diagnosed    | 6 month- 5 years  | 176           | 57.9           | 0.294   | 65.413  |
|                   | 5-10 years        | 128           | 42.1           |         |         |
| Monthly income    | Low               | 68            | 22.4           | 0.444   | 121.531 |
|                   | Lower middle      | 140           | 46             |         |         |
|                   | Lower upper       | 66            | 21.7           |         |         |
|                   | High              | 30            | 9.9            |         |         |

### Clinical characteristics

Diabetes complications reported by the participants varied from leg ulcers, neuropathy, nephropathy, and retinopathy. 57.9% of the participants had no complications. Neuropathy was the major

complication (32.9%), while the least common complication was observed in 1.3% ( $p=0.033$ ,  $X^2=281.68$ ) of the participants who had both neuropathy and retinopathy.

The comorbidity of participants varied from Arthritis, benign prostate hypertrophy

(BPH), chronic kidney disease (CKD), human immunodeficiency virus (HIV), hypertension and related diseases (HTN), hepatitis B (HBsAg), hyperlipidaemia and hyperthyroidism. 31.6% of the participants had no comorbidity, hypertension was the major comorbidity, (44.1%) while the least common comorbidity was observed in 0.7% of the participants who had hyperlipidaemia, hypertension and arthritis. ( $p<0.001$ ,  $X^2=1022.129$ )

In the study, most of the participants were on a combination of different classes of anti-

diabetic medications. Few participants were on monotherapy. Biguanide plus sulphonyl urea combination recorded the highest usage (71.1%), while the least usage (0.7%) was observed for some other combinations ( $p<0.001$ ,  $X^2=830.917$ )

Non-pharmacological treatments were exercise 4.6%, dietary 38.8%, and dietary exercise 38.2% while 18.4 % were not following non-pharmacological treatments. These are presented in table II below. ( $p=0.142$ ,  $X^2=200.142$ )

**Table II: Clinical characteristics of patients with T2DM attending General Hospital Ilorin (n=304)**

| Characteristic     | Category                | Frequency (N) | Percentage (%) | p-value | $X^2$    |
|--------------------|-------------------------|---------------|----------------|---------|----------|
| Complications      | Leg Ulcer               | 2             | 0.7            | 0.033   | 281.68   |
|                    | Neuropathy              | 100           | 32.9           |         |          |
|                    | Nephropathy             | 20            | 6.57           |         |          |
|                    | None                    | 176           | 57.9           |         |          |
|                    | Retinopathy             | 2             | 0.7            |         |          |
|                    | Retinopathy, Neuropathy | 4             | 1.3            |         |          |
| Comorbidity        | Arthritis               | 8             | 2.6            | 0.000** | 1022.129 |
|                    | BPH, HTN, HBsAg         | 4             | 1.3            |         |          |
|                    | CKD                     | 4             | 1.3            |         |          |
|                    | HIV                     | 4             | 1.3            |         |          |
|                    | HTN                     | 134           | 44.1           |         |          |
|                    | HTN, HbsAg              | 2             | 0.7            |         |          |
|                    | HTN,                    | 6             | 2.0            |         |          |
|                    | HYPERLIPIDEMIA          |               |                |         |          |
|                    | HTN, ARTHRITIS          | 16            | 5.3            |         |          |
|                    | HTN, CKD                | 14            | 4.6            |         |          |
|                    | HTN,                    | 2             | 0.7            |         |          |
|                    | HYPERTHYROIDISM         |               |                |         |          |
|                    | HYPERLIPIDEMIA          | 10            | 3.3            |         |          |
|                    | HYPERLIPIDEMIA          | 2             | 0.7            |         |          |
|                    | HTN, ARTHRITIS          |               |                |         |          |
|                    | NONE                    | 96            | 31.6           |         |          |
|                    | ULCER                   | 2             | 0.7            |         |          |
| Current medication | Biguanide               | 26            | 8.6            | 0.000** | 830.917  |
|                    | Biguanide, sulphonyl    | 216           | 71.1           |         |          |

|                             |                           |     |      |       |         |
|-----------------------------|---------------------------|-----|------|-------|---------|
| Non-Pharmacological therapy | urea                      |     |      |       |         |
|                             | Biguanide, sulphonyl      | 2   | 0.7  |       |         |
|                             | urea, DPP-4, Insulin      |     |      |       |         |
|                             | Biguanide, sulphonyl      | 14  | 4.6  |       |         |
|                             | urea, DPP-4               |     |      |       |         |
|                             | Biguanide, DPP-4          | 4   | 1.3  |       |         |
|                             | Biguanide, Insulin        | 6   | 2.0  |       |         |
|                             | Biguanide, SGLT2          | 2   | 0.7  |       |         |
|                             | Biguanide, sulphonyl      | 18  | 5.9  |       |         |
|                             | urea, Insulin             |     |      |       |         |
|                             | Biguanide, sulphonyl      | 2   | 0.7  |       |         |
|                             | urea, SGLT2               |     |      |       |         |
|                             | DPP-4, Biguanide, Insulin | 4   | 1.3  |       |         |
|                             | Sulphonylurea, Insulin    | 6   | 2.0  |       |         |
|                             | Sulphonyl urea            | 4   | 1.3  |       |         |
|                             | Dietary                   |     |      |       |         |
|                             | Exercise                  | 118 | 38.8 | 0.142 | 200.142 |
|                             | Exercise, dietary         | 14  | 4.6  |       |         |
|                             | None                      | 116 | 38.2 |       |         |

<sup>a</sup> Definition of all abbreviations BPH-Benign Prostatic Hyperplasia, HTN-Hypertension, CKD-Chronic Kidney Disease, HIV- Human Immune -deficiency Virus, DPP-4 -Dipeptidyl Peptidase 4 Inhibitors, SGLT2 I- Sodium-Glucose Co-Transporter 2Inhibitors, HbsAg- Hepatitis B surface antigen.

**Overall EQ-5D Index scores and EQ-VAS scores of patients** 0.7033±0.1525 and 63.57±17.16 summarized on table III below.

The overall mean EQ-5D utility scores and overall mean EQ-VAS scores were

**TABLE III: Overall mean EQ-5D Index scores and mean EQ-VAS scores of patients with T2DM attending General Hospital Ilorin (n=304)**

| ITEM                     | MEAN    | STANDARD DEVIATION |
|--------------------------|---------|--------------------|
| <b>EQ-5D INDEX SCORE</b> | 0.7033  | 0.1525             |
| <b>EQ-VAS SCORE</b>      | 63.5724 | 17.1606            |

#### **Relationship between socio-demographic information/clinical characteristics and Health-related quality of Life.**

Relationship between the socio-demographic data, clinical characteristics and utility scores were established using Pearson correlation test. Age, Employment

status and Monthly income were significant at p value of 0.016, 0.035 and 0.025 respectively. Clinical characteristics such as complication, co morbidity and medication were as significant as presented on table V below.

**Table IV: Relationship between Socio-demographic, Clinical characteristics, EQ-5D utility scores using Pearson correlation for patients with T2DM attending General Hospital Ilorin (n=304).**

| Socio-demographic, Clinical characteristics |                         | R        | Sig   |
|---------------------------------------------|-------------------------|----------|-------|
| Sex                                         | Male                    | -0.056   | 0.497 |
|                                             | Female                  |          |       |
| Age                                         | 18-24                   | -0.314*  | 0.016 |
|                                             | 25-34                   |          |       |
|                                             | 35-44                   |          |       |
|                                             | 45-54                   |          |       |
|                                             | 55-64                   |          |       |
|                                             | 65-70                   |          |       |
| MARITAL STATUS                              | Single                  | 0.084    | 0.302 |
|                                             | Married                 |          |       |
|                                             | Widow/Widower           |          |       |
|                                             | Divorce/Separated       |          |       |
| EDUCATION STATUS                            | Informal                | -0.084   | 0.301 |
|                                             | Primary                 |          |       |
|                                             | Secondary               |          |       |
|                                             | Tertiary                |          |       |
| EMPLOYMENT STATUS                           | Employed                | 0.171*   | 0.035 |
|                                             | Self-employed           |          |       |
|                                             | Unemployed              |          |       |
| TIME DIAGNOSED                              | 6 month- 5 years        | -0.036   | 0.662 |
|                                             | 5-10 years              |          |       |
| MONTHLY INCOME                              | Low                     | 0.093*   | 0.025 |
|                                             | Lower middle            |          |       |
|                                             | Upper middle            |          |       |
|                                             | High                    |          |       |
| COMORBIDITY                                 | HTN                     | -0.981** | 0.002 |
|                                             | HIV                     | -1.000** | 0.000 |
|                                             | CKD                     | -1.000** | 0.000 |
|                                             | ULCER                   | -1.000** | 0.000 |
|                                             | Arthritis               | -0.577   | 0.423 |
|                                             | HTN + CKD               | -0.639   | 0.122 |
|                                             | HTN + Arthritis         | -0.966** | 0.002 |
|                                             | HTN + HYPERLIPIDEMIA    | -0.837** | 0.005 |
|                                             | BPH + HTN + HbsAg       | -1.000** | 0.000 |
|                                             | NEUROPATHY              | -0.871** | 0.000 |
| COMPLICATION                                | NEHPROPATHY             | -0.706*  | 0.023 |
|                                             | NEURO + NEPHROPATHY     | -1.000** | 0.000 |
| MEDICATION                                  | SULPHONYLUREA           | -0.261   | 0.832 |
|                                             | BIGUANIDE               | 0.912**  | 0.000 |
|                                             | BIGUANIDE +SULPONYLUREA | 0.811**  | 0.000 |
|                                             | BIGUANIDE +DPP-4        | -0.993   | 0.073 |

|                                   |         |       |
|-----------------------------------|---------|-------|
| BIGUANIDE +SULPONYLUREA + DPP-4   | 0.910** | 0.002 |
| BIGUANIDE +SULPONYLUREA + INSULIN | 0.693   | 0.084 |
| BIGUANIDE +DPP-4 + INSULIN        | 1.000** | 0.000 |
| SULPHONYLUREA + INSULIN           | 1.000** | 0.000 |
| BIGUANIDE + INSULIN               | 1.000** | 0.000 |

\*Correlation is significant at the 0.05 level (2-tailed)

\*\*Correlation is significant at the 0.01 level (2-tailed)

**Means and standard deviation of the four outcomes of work productivity and activity impairment for patients with T2DM attending General Hospital Ilorin(n=304).**

21.0419±24.8157%, and 33.6184±24.4556% for work time missed, impairment of work, overall work productivity loss and activity impairment respectively as shown in table VI

The four outcomes of WPAI were 7.9857±12.0931%, 15.9868±19.9868%,

**Table VI: Mean and standard deviation for WPAI Outcome for patients with T2DM attending General Hospital Ilorin (n=304).**

| WPAI OUTCOME                     | MEANS   | STANDARD DEVIATION |
|----------------------------------|---------|--------------------|
| Work time missed                 | 7.9857  | 12.0931            |
| Impairment of work %             | 15.9868 | 19.9868            |
| Overall work productivity loss % | 24.8157 | 21.0419            |
| Activity impairment %            | 33.6184 | 24.4556            |

**Relationship between health-related quality of life and loss of productivity**

The WPAI outcomes versus mean EQ-5D utility scores/EQ-VAS scores were used to establish the relationship between health-related quality of life and loss of productivity using Spearman correlation coefficient. Work time missed and activity

impairment had positive and negative correlation with EQ-5D respectively. Work time missed, impairment of work and overall work had a positive correlation with EQ-VAS scores while activity impairment had a negative correlation with EQ-VAS. The results are presented in the table VII below:

**Table VI: Association between health-related quality of life (Mean EQ-5D-5L and EQ-VAS scores) and productivity using spearman rank order correlation coefficient**

|                            | EQ-5D-5L SCORES |         | EQ-VAS SCORE |         |
|----------------------------|-----------------|---------|--------------|---------|
|                            | R               | p-value | R            | p-value |
| <b>WORK TIME MISSED</b>    | 0.227**         | 0.005   | 0.221**      | 0.006   |
| <b>IMPAIRMENT OF WORK</b>  | 0.100           | 0.220   | 0.200*       | 0.014   |
| <b>OVERALL WORK</b>        | 0.127           | 0.120   | 0.216**      | 0.008   |
| <b>ACTIVITY IMPAIRMENT</b> | -0.706**        | 0.000   | -0.661**     | 0.000   |

\*\* Correlation is significant at the 0.01 level (2-tailed)

\* Correlation is significant at the 0.05 level (2-tailed)

## DISCUSSION

The results from present study showing that majority of participants were within the age of 55-65 years is similar to results from previously carried out studies, in Enugu (Nwatu *et.al.*, 2019), Port-Harcourt (Okpuruka *et.al.*, 2022), Oshogbo (Adijat,*et.al*, 2021) and Ikorodu, Nigreja (Adeunmi *et.al*, 2022). The prevalence of diabetes which was found to be highest in females and lowest in males could be due to the sedentary lifestyles of females which encourage them to be overweight and have higher BMI (Diabetes Mellitus Predisposing factors). This was similar to gender distribution reported by IDF 10<sup>th</sup> edition (IDF 2021) and study done in Port-Harcourt Nigeria (Okpuruka *et.al.*,2022) with females and males having a prevalence of 52% and 48% respectively.

Majority of the participants having informal education (highest frequency), were inconsistent with a study carried out by Abubakar, (2014),in the Southern part of Nigeria where the majority of the participants had tertiary education and small number of participants had informal education. Also inconsistent with study done in Enugu (Nwatu,*et.al.*,2019) where most of the participants also had informal education. This was because in Nigeria, the percentage of literates was found to be higher in the Southern part of the country than in the Northern part as reported by (Tamornpark,2022) and (National Literacy Survey 2010).

Findings showing that a greater number of study participants had an income of between ₦30,000/\$39 -100,000/\$130. This is because the present minimum wage of the country is set at ₦30,000 (\$39) per month (wage indicator, 2023). The index study revealed a statistically significant difference in the distribution of complications ( $p = 0.033$ ,  $\chi^2$

$= 281$ ) and comorbidities ( $p < 0.001$ ,  $\chi^2 = 1022.13$ ). This comorbidity and complications have further affected participants quality of life. Some developed as complications due to chronic nature of type-2 DM (macrovascular and microvascular) while some are not related to diabetes. Complications reported are neuropathy 32.9%, nephropathy 6.6%, retinopathy 0.7%, neuropathy and retinopathy 1.3%. These were similar to what was observed by (Sendekie,*etal.*,2022). These could be explained based on diabetes's effect on the kidney, causing scarring of the kidney which could lead to water retention and consequently result in raised blood pressure. Because diabetes is chronic, it could later affect the small blood vessels, arterioles, and venules causing stiffening and malfunction of the blood vessels which could further increase the chances of developing hypertension. Thus, diabetes patients are prone to nephropathy, neuropathy, and retinopathy as a result of damage to the blood vessels and nerves in organs such as the eyes.

The most prevalent comorbidity in this study was hypertension and related heart diseases, affecting 44.1% of the participants. Conversely, 31.6% of the participants reported no comorbidities or complications. The high prevalence of hypertension as a comorbidity observed in this study is consistent with findings from similar studies conducted in various regions of Nigeria.: Jos (Jelinek *et.al.*,2017) reported 63.8%; Uyo (Abubakar,2014) reported 40%; Ekiti (Okobiah,2020) reported 68.3%; Portharcout (Okpuruka *et.al.*, 2022) reported 89.5%; and in other Africa country, Uganda (Zare *et.al*,2020).reported 76.9%.Furthermore there was also an observed statistically significant difference in distribution of participants medication ( $P < 0.001$ ,  $\chi^2 = 1022.13$ ).

The socio-demographic information and clinical characteristics are both known as determinant of health-related quality of life. The effects of socio-demographic information on HRQOL were established by estimating the means of EQ-5D index scores and EQ-VAS scores across different categorical groups. The mean EQ-5D utility scores and overall mean EQ-VAS scores for this study are  $0.7033 \pm 0.1525$  and  $63.57 \pm 17.16\%$ ; a similar study done in Berjand (Zare, *et.al* 2020). using the same instrument had  $0.89 \pm 0.13$  and the mean score of EQ-VAS was  $65.22 \pm 9.32$ ; a study in Northwest Ethiopia (Adibe, *et.al.*, 2018) had overall EQ-5D-5L utility and EQ-VAS scores to be  $0.56 (\pm 0.11)$  and  $56.7 (\pm 10.1)$  and study done in China (Wonget.al, 2020). had overall EQ-5D-5L utility and EQ-VAS scores to be  $0.75 \pm 0.006$ ,  $69.25 \pm 0.63$  respectively. The slight difference could be because health system, health expenditures per capita, political system, social culture, economic growth, and patient characteristics differ for different counties.

The results reveal a significant negative correlation between EQ-5D utility scores and age, such that scores decreased with increasing age ( $r = -0.314$ ,  $p = 0.016$ ), as confirmed by Pearson correlation analysis. This is consistent with the study done in Nigeria where an increase in age leads to a decrease in utility scores hence decrease in health-related quality of life (Abedini *et.al*, 2020). Also consistent with the study done in China (Issa and Baiyewu 2006). where different age groups 18-44, 45-64, and 65 above had EQ-5D utility mean scores  $0.95 \pm 0.1$ ,  $0.98 \pm 0.17$ ,  $0.80 \pm 0.26$  in decreasing order as age progresses, and the study done in Birjand (Allyhiani,*et.al.* ,2022) found mean score for quality of life in the older age groups to be lower than younger groups. The decreasing trend as the age progresses could be because as people age other chronic diseases and diabetes

complications set in and since growth follow sigmoid curve, human body reaches maximum growth and starts declining/degenerating. In this study, employed participants had the best EQ-5D index mean score and EQ-VAS mean score while unemployed had the least. Pearson correlation is significant at p-value of 0.035. This similar to study done in Birjand (Allyhiani,*et.al.*, 2022) where employed people had the best utility score. Also, similar to study done in Iran where mean EQ-VAS scores were higher in employed subjects (Wong,*et.al.*, 2020). Employed patients in developing countries have more opportunities to have a better socioeconomic status but in Nigeria due to poor remuneration of government workers, self-employed people have a better socioeconomic status which is reflected in the utility and VAS scores.

Findings show participants with low income have the lowest EQ-5D utility mean scores and Pearson correlation is significant at a p-value of 0.025. This is consistent with studies done in Nigeria (Ashutosh *et.al.*, 2017).) where people with low income had poor quality of health.

Association between comorbidity and HRQOL using Pearson correlation shows strong negative correlation which is significant in participants with Neuropathy, and nephropathy and those participants with neuropathy and nephropathy.

Association between complication and HRQOL using Pearson correlation shows a strong negative correlation which is significant in most identified complications except in participants with Arthritis and those with chronic kidney disease combined hypertension. This shows that as HRQOL increased complication and comorbidity decreased.

This study shows that the majority of the participants are on combination of Biguanide and Sulphonyl urea (sulphonylurea used as second line anti-diabetic). This is consistent with study done by (Sakamaki *et.al.*, 2006) and with (. Javanbakht *et.al.*, 2012).). This could be due to strong marketing, effectiveness, drug availability, high tolerability, promising effects, and price. The association between patients' anti-diabetic medications and HRQOL using Pearson correlation shows a strong positive correlation that is significant in all the nine categories of anti-diabetic prescription patterns identified in this study except for participants on Sulphonylurea as monotherapy, Biguanide combined with Sulphonylurea and insulin, and participant on Biguanide combine with DPP-4. This could be a result of sulphonylurea being a monotherapy and the prices of insulin and DPP-4 which could cause non-adherence.

Productivity change is always in form of loss of activity in disease state. The study measures the loss of productivity in the participants. The mean percentage of time missed/absenteeism and Impairment of work/presenteeism are found to be 7.99% and 15.99% respectively. The mean percentage of overall work productivity lost (absenteeism presenteeism) is 24.89% and activity impairment/unpaid work is 33.62%. These findings are inconsistent with a study done in Turkey using the same instrument (Satman *et al.*, 2012) where the percentage work missed, impairment of work, overall work productivity, and activity impairment were found out to be 24%, 15% 39%, and 31% respectively. The difference in the value could be due to factors such as attitude to work, working conditions, employment age, wage, and environmental conditions which are different in the two countries.

Association between EQ-5D scores, EQ-VAS scores, and four outcomes of

productivity loss was established using Spearman rank order correlation coefficient. EQ-5D and EQ-VAS show a significant strong negative correlation ( $p < 0.000$ ) for activity impairment and overall work productivity. The negative correlation indicates that as EQ-5D scores increase (participants attaining better health), activity impairment decreases and overall work productivity increases. This is because, in disease state, it's difficult to attain full potential. Also, time to visit the hospital to seek medical intervention results in the loss of reasonable hours of work.

According to recent data (Take-profit.org, 2023), the minimum wage in Nigeria is approximately \$38.984 per month. This study found a mean overall work productivity loss (OWPL) of 24.89%, comprising both absenteeism and presenteeism. Based on this finding, the estimated monthly loss due to diabetes is approximately \$9.703, representing 24.89% of the minimum monthly wage.

The estimated prevalence of Type II diabetes in Nigeria is approximately 5.7% of the country's population, which is projected to be 224,588,394 individuals (Àkànle., 2024).). This translates to a substantial burden of 12,801,538 individuals living with Type 2 diabetes mellitus in Nigeria.

The estimated monthly monetary loss in Nigeria due to Type II diabetes is approximately \$124,213,323.214. This calculation is based on the average overall work productivity loss per individual (\$9.703) multiplied by the estimated number of individuals living with Type II diabetes (12,801,538). On an annual basis, the total economic burden of Type II diabetes in Nigeria is estimated to be \$1,490,559,878.56.

## LIMITATION

The study population may not be fully representative of all individuals with type 2 diabetes, particularly those in rural or underserved areas

## CONCLUSION

Type 2 Diabetes Mellitus (T2DM) significantly impairs health-related quality of life (HRQoL) and results in substantial productivity losses. This study highlights the crucial role of sociodemographic, clinical factors, and medications in determining HRQoL outcomes.

## REFERENCES

Ababio GK, Bosomprah S, Olumide A, Aperkor N, Aimakhu C, Oteng-Yeboah A, Agama J, Chaplin WF, Okuyemi KS, Amoah AGB, Ogedegbe G. Predictors of quality of life in patients with diabetes mellitus in two tertiary health institutions in Ghana and Nigeria. *Niger Postgrad Med J.* 2017 Jan-Mar;24(1):48-55. doi: 10.4103/npmj.npmj\_3\_17. PMID: 28492210.

Abedini, M. R., Bijari, B., Miri, Z., Shakhsemampour, F., & Abbasi, A. (2020). The quality of life of the patients with diabetes type 2 using EQ-5D-5 L in Birjand. *Health and Quality of Life Outcomes*, 18(1) 18. <https://doi.org/10.1186/s12955-020-1277-8>

Abubakar, S.K. (2014). Assessment of Health-Related Quality of Life of Type II Diabetes Mellitus Patients Attending General Out Patient Clinic of the Jos University Teaching Hospital, Jos. (Fellowship of the college in family medicine). University of Jos.

Adelekan ML, Odejide OA. The reliability and validity of the WHO student drug-use questionnaire among Nigerian students. *Drug Alcohol Depend.* 1989 Dec;24(3):245-9. doi: 10.1016/0376-8716(89)90062-8. PMID: 2606001.

Adeloye, D., Ige, J.O., Aderemi, A.V., et al. (2017) Estimating the prevalence, hospitalisation and mortality from type 2 diabetes mellitus in Nigeria: A systematic review and meta-analysis. *BMJ Open*, 7(5), e015424. <https://doi.org/10.1136/bmjopen-2016-015424>

Adewumi, O.O., Oladele, E.O. & Jegede, O.S. (2022). Risk factors and Prevalence of Diabetes Mellitus among Residents of Lagos, Nigeria. *African Journal of Health, Safety and Environment* Vol: 3 (1): 35-43. <https://doi.org/10.52417/ajhse.v3i1.19>

Adibe, M. O., Anosike, C., Nduka, S. O., Isah, A. (2018). Evaluation of Health Status of Type 2 Diabetes Outpatients Receiving Care in a Tertiary Hospital in Nigeria. *PharmacoEconomics Open*, 2:337–345. <https://doi.org/10.1007/s41669-017-0056-x>

Adijat O.A., Folakemi E., Adejumo A., Atolagbe James E. (2021). The Prevalence and Risk Factors of Diabetes Mellitus among Civil Service Workers in Osogbo, Osun State, Nigeria. *J Hypertens Manag* 7:062. <https://doi.org/10.23937/2474-3690/1510062z>

Àkànlé (2024). Background country report on Nigeria within the migration system of West Africa.

Allyhiani, M., Kurdi, A., Abdulaziz, A., Faqeh, S., Alhajjaji, A., Alansari, S., Althaqafi, A., Alzaman, N., & Ali, M. (2022). Prescribing patterns of antidiabetic in type 2 diabetes and factors affecting them. *Saudi Pharmaceutical Journal* 2(30), 112-119. <https://doi.org/10.1016/j.jsps.2021.12.019>.

Alshayban, D. & Joseph, R. (2020). Health-related quality of life among patients with type 2 diabetes mellitus in Eastern Province, Saudi Arabia: A cross-sectional study. *PLOS ONE*. <https://doi.org/10.1371/journal.pone.0227573>

Aschalew AY, Yitayal M. &MinyihunA. Health-related quality of life and associated factors among patients with diabetes mellitus at the University of Gondar referral hospital. *Health Qual Life Outcomes*. 2020; 18:62. <https://doi.org/10.1186/s12955-020-01311-5>

Ashutosh, K., Ipseeta, R., & Sandeep, R. (2017). Assessment of prescription pattern of Antidiabetic Drugs in the Outpatient Department of a Tertiary Hospital. *International Journal of Clinical Endocrinology and Metabolism*. ISSN: 2640-7582.

Asiimwe D., Godfrey O. Mauti G. O., & Kiconco R. (2020). Prevalence and Risk Factors Associated with Type 2 Diabetes in Elderly Patients Aged 45-80 Years at Kanungu District. *Hindawi Journal of Diabetes Research* Volume 2020 (5). <https://doi.org/10.1155/2020/5152146>

Degu H, Wondimagegnehu A, Yifru YM, Belachew A. Is health related quality of life influenced by

diabetic neuropathic pain among type II diabetes mellitus patients in Ethiopia? *PLoS ONE*. 2019; 14(2): e0211449. <https://doi.org/10.1371/journal.pone.0211449>

Ebrahimipour, H., Keyvanlo, Z., Miri, H.H., Yousefi, M., Ariafar, M., Rezazadeh, A., Pourahmadi, E., (2021). Productivity Loss of Diabetes in Iran (South Khorasan Province). *Journal of Research and Health*. 11(6), 403-412. <https://doi.org/10.32598/jrh.11.6.1780.1>

Gebremedhin T, Workicho A, AngawDA. Health-related quality of life and its associated factors among adult patients with type II diabetes attending Mizan Tepi University Teaching Hospital, Southwest Ethiopia. *BMJ Open Diabetes Res Care*. 2019;20(7(1):e000577. doi: 10.1136/bmjdr-2018-000577. PMID: 30899526; PMCID: PMC6398819.

Gureje, O., Adebayo, K., Olley, B. O., & Bello, T. (2023). Social support and medication adherence as predictors of quality of life among patients with diabetes and hypertension in Nigeria. *BMC Endocrine Disorders*, 23(1), 69. <https://doi.org/10.1186/s12902-023-01329-y>

Hubens, K., Krol, M., Coast, J., Drummond, M.F., Brouwer, W.B.F., Uyl-de Groot, C.A., & Hakkaart-van Roijen, L. (2021). Measurement Instruments of Productivity Loss of Paid and Unpaid Work: A Systematic Review and Assessment of Suitability for Health Economic Evaluations from a Societal Perspective. *Value in Health: the journal of the international society of Pharmacoeconomics and Outcomes Research*, 24(11):1686-1699. <http://doi.org/10.1016/j.jval.2021.05.002>

Issa B. A and Baiyewu O. (2006). Quality of Life of Patients with Diabetes Mellitus in a Nigerian Teaching Hospital. *Hong Kong J Psychiatry*, 16:27-33

Javanbakht, M., Abolhasani, F., Mashayekhi, A., Baradaran, H. R., & Jahangiri noudesh, Y. (2012). Health related quality of life in patients with type 2 diabetes mellitus in Iran: a national survey. *PloS one*, 7(8), e44526. <https://doi.org/10.1371/journal.pone.00445>

Jelinek, H.F., Osman, W.M., Khandoker, A.H., Khalaf, K., Lee, S., Almahmeed, W. & Alsafar, H.S. (2017). Clinical profiles, comorbidities and complications of type 2 diabetes mellitus in patients from United Arab Emirates. *BMJ Open Diab Res Care*, 5(427). <https://doi.org/10.1136/bmjdr-2017-000427>

Kassa, G. M., Arowojolu, A. O., & Berman, P. (2023). Productivity loss due to non-communicable diseases in Nigeria: Evidence from the Nigeria Living Standards Survey. *The Lancet Global Health*, 11(6), e940–e951. [https://doi.org/10.1016/S2214-109X\(23\)00139-2](https://doi.org/10.1016/S2214-109X(23)00139-2)

McHugh ML. The chi-square test of independence. *Biochem Med (Zagreb)*. 2013;23(2):143-9. doi: 10.11613/bm.2013.018. PMID: 23894860; PMCID: PMC3900058.

Morgan UM, Etiobong E. (2020). Quality of life of patients with diabetes mellitus attending a tertiary hospital in Uyo, South-South Nigeria. *Niger J Med*. 31, 163-7. DOI: 10.4103/NJM.NJM\_94\_21. <https://www.njmonline.org>

Nwatu, C.B., Onyekonwu, C.L., Unaogu, N.N., Onyeka, T.C., Onwuekwe, I.O., Ugwumba, F., Nwachukwu, C.V., Nwutobo, R.C. (2019). Health related quality of life in Nigerians with complicated diabetes mellitus – a study from Enugu, South East Nigeria. *Nigeria Journal of Medicine*, 28(2). <https://doi.org/10.4103/1115-2613.278574>

Okobia, O. S. (2002). The Educational Imbalance between the Northern and Southern States of Nigeria: A Re-Direction of Educational Policies. (Award). Delta State University Abraka, Nigeria.

Okpuruka P.O., Anarado A.N., Nwonu E., Chinweuba A., Ogbonnaya N.P., Opara H.C., Anetekhai C.J. (2022). Health-related quality of life (HRQOL) of patients with type 2 diabetes mellitus and people without diabetes at a tertiary hospital in Port-Harcourt, Rivers State, Nigeria. *Int J Med Health Dev*, 27:151-9. DOI: 10.4103/ijmh.IJMH\_20\_21. <http://www.ijmhdev.com>

Okurumeh, A.I., Akpor, O.A., Okeya, O.E., & Akpor, O. B. (2022). Type 2 diabetes mellitus patients' lived experience at a tertiary hospital in Ekiti State, Nigeria. *Sci Rep* 12,8481. <https://doi.org/10.1038/s41598-022-12633-3>

*Oncol*. 2002; 41:229-37.

J. World Health Organization: Programme on Mental Health. *Journal of Mental Health*. 1996;5(3):319-22.

Patrick DL, Erickson P. Health status and health policy: quality of life in health care evaluation and resource allocation. New York. Oxford University Press. 1993.

Sakamaki H, Ikeda S, Ikegami N, Uchigata Y, Iwamoto Y, Origasa H, Otani T., & Otani, Y. (2006). Measurement of HRQL using EQ-5D in patients with type 2 diabetes mellitus in Japan. *Value in Health: the journal of the international Society for Pharmacoeconomics and Outcomes Research*, 9(1), 47-53. <https://doi.org/10.1111/j.1524-4733.2006.00080.x>

Satman I, Akalin S & S. (2012). The Loss of Work Productivity in Type 2 Diabetes Mellitus in Turkey. Presented at Society for Endocrinology BES 2012, Harrogate, UK. *Endocrine Abstracts* 0029p669. <https://www.endocrine-abstract.org/ea/0029/ea0029p669>

Sendekie A K., Dagnew E M., Tefera B B., Belachew E A. (2022). Health-related quality of life and its determinants among patients with diabetes mellitus: a multicentre cross-sectional study in Northwest Ethiopia. *BMJ Open*, 13(1). <http://dx.doi.org/10.1136/bmjopen-2022-068518>

Sprangers MA. Quality-of-life assessment in oncology. Achievements and challenges. *Acta*

Staquet MJ, Hays RD, Fayers PM. Quality of life assessment in clinical trials. New York: Oxford University Press. 1998.

Tamornpark, R., Utsaha, S., Apidechkul, T., Panklang, D. (2022). Quality of life and factors associated with a good quality of life among diabetes

mellitus patients in northern Thailand. *Health and quality of life outcomes*, 20(1), 81. <https://doi.org/10.1186/s12955-022-01986-y>

Tella, E.E., Yunusa, I., Hassan, J.H., Chindo, I.A., & Oti, V.B. 2021. Prevalence, Contributing Factors and Management Strategies (Self-Management Education) of Type 2 Diabetes Patients in Nigeria: A Review. *Int J Diabetes Clin Res*, 8 (3):148. <https://doi.org/10.23937/2377-3634/1410148>

Wong, E.L Y., Xu, R.H., & Cheung, A. W. L (2020). Measurement of health-related quality of life in patients with diabetes mellitus using EQ-5D-5L in Hong Kong, China. *Quality of Life Research: an international journal of quality-of-life aspects of treatment, care and rehabilitation*, 29(7), 1913-1921. <https://doi.org/10.1007/s11136-020-02462-0>

World Health Organization. (2023). *Diabetes*. <https://www.who.int/news-room/fact-sheets/detail/diabetes>

Zare, F., Ameri, H., Madadzadeh, F., & Reza Aghaei, M. (2020). Health-related quality of life and its associated factors in patients with type 2 diabetes mellitus. *SAGE open medicine*, 8, 2050312120965314. <https://doi.org/10.1177/2050312120965314>

Araoye, M. O. (2003). Sample size determination in research methodology with statistics for health and social sciences. Nathadex Publishers, Ilorin, 115-121