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SOCIODEMOGRAPHIC FACTORS AND COPING ABILITIES OF PARENTS OF CHILDREN WITH SICKLE CELL DISEASE IN IBADAN, OYO STATE, NIGERIA

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Vol. 3. Issue 1.
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ABSTRACT

Sickle Cell Disease (SCD) is one of the most common genetic disorders in sub-Saharan Africa, with Nigeria bearing a substantial share of the global burden. This study examines the sociodemographic factors and coping abilities of parents of children with SCD in Ibadan, Oyo State, Nigeria. Specifically, it determines the sociodemographic profile of parents, identifies their coping abilities, and examines the relationship between sociodemographic factors and coping abilities. A cross-sectional descriptive design was employed, drawing on data from 244 parents attending Adeoyo Maternity Hospital and Oni Memorial Children's Hospital, obtained through structured questionnaires measuring sociodemographic characteristics and coping strategies. Descriptive statistics and Pearson correlation were used for analysis. Findings show that most parents were aged 30 to 39 years, married, and moderately educated, with the majority earning between 100,000 and 150,000 naira monthly. Parents reported extensive use of problem-focused strategies, including information-seeking, planning, and consulting healthcare providers, alongside emotion-focused strategies such as prayer and positive reframing. Age was the only sociodemographic variable significantly associated with coping ability ($r = -.278$, $p < .01$), with older parents reporting fewer active coping behaviours; gender, marital status, education, and income showed no significant link. The study concludes that coping ability among parents of children with SCD is shaped more by age-related psychological resources than by socioeconomic status. Age-sensitive psychosocial interventions are recommended to strengthen coping capacity in this population.

Vol. 3. Issue 1.
ISSN: 3115-6940
EISSN: 3115-6932

INTRODUCTION

Sickle Cell Disease (SCD) is one of the most pervasive genetic blood disorders in sub-Saharan Africa, representing a major public health challenge in Nigeria (United Nations General Assembly, 2009). An estimated 150,000 children are born with sickle cell anaemia in Nigeria every year, the highest number of any country (Adegoke & Kuteyi, 2012; Bello-Manga et al., 2024). The chronic and often unpredictable nature of SCD has profound physical, emotional, and socio-economic consequences for affected children and their families. Among the most severely affected are caregivers, primarily parents, guardians, and close relatives, whose daily lives revolve around managing the recurring health crises and complex psychosocial demands imposed by the illness.

Caregiving in the context of chronic illness transcends basic medical attention. It encompasses emotional reassurance, financial support, decision-making, and the coordination of health services. For caregivers of children with SCD, this role involves frequent hospital visits, crisis management, and constant vigilance against infections and complications. The stress associated with these responsibilities often leads to significant psychosocial strain, including emotional distress, disruption of family life, and loss of income (Ohaeri & Shokunbi, 2002; Adegoke & Kuteyi, 2012). In developing contexts like Nigeria, where healthcare systems are under-resourced and social support structures are weak, caregivers frequently experience psychological exhaustion and diminished quality of life.

Empirical studies have documented the psychosocial dimensions of caregiving in chronic diseases. In south-western Nigeria, caregivers of children with SCD in Ado-Ekiti reported substantial financial, interpersonal, and psychological problems, with many losing income because of the time spent on caregiving (Adegoke & Kuteyi, 2012). Similarly, Alabi et al. (2023) observed that frequent hospitalisation, emergencies, and hospital bills contributed significantly to caregiver distress in Ogun State. These findings suggest that the psychosocial burden of caregiving is multidimensional, comprising emotional, social, and economic components that interact dynamically with cultural and environmental factors.

In the Nigerian cultural context, mothers often assume the primary caregiving role, which amplifies gendered emotional and economic strain. In some African settings, mothers are blamed for a child's SCD, which can result in stigma within the family and community (Marsh et al., 2011), and caring for a child with SCD has been linked to marital disharmony among caregivers in Ogun State (Alabi et al., 2023). Caregivers also struggle with inadequate public awareness and persistent stigma surrounding SCD; caregivers in Kaduna, for example, reported stigma related to carrying the sickle trait and having a child with SCD, as well as challenges with their children's schooling (Bello-Manga et al., 2024). Additionally, the financial cost of frequent medical appointments, blood transfusions, and medications imposes an economic burden that further aggravates stress levels, particularly among low-income families in Ibadan Metropolis.

Despite these challenges, caregivers employ diverse coping mechanisms to manage the demands of SCD care. Coping strategies are broadly categorised as problem-focused or emotion-focused, depending on whether the caregiver attempts to change the stressor itself or regulate emotional responses to it (Lazarus & Folkman, 1984). In Nigeria, coping behaviours frequently reflect cultural and spiritual values, and religion has been described as a major source of coping and support for caregivers of children with SCD (Bello-Manga et al., 2024). However, such strategies may not always be sufficient to offset the psychosocial toll of chronic caregiving. Effective coping requires emotional resilience and tangible support systems, yet many caregivers operate in conditions where institutional and community resources are minimal.

The city of Ibadan, Oyo State, represents a relevant context for this inquiry. As one of Nigeria's largest urban centres, Ibadan combines features of modern healthcare infrastructure and deep-rooted traditional

Vol. 3. Issue 1.
ISSN: 3115-6940
EISSN: 3115-6932

beliefs. The city's healthcare institutions, including Adeoyo Maternity Teaching Hospital and Oni Memorial Children's Hospital, where this study was conducted, provide specialised care for children with SCD. Nevertheless, caregivers in these settings face recurring difficulties in balancing treatment obligations with economic realities. Their experiences reveal an urgent need for interventions that address not only clinical outcomes but also psychosocial well-being. Understanding these experiences is therefore critical to designing culturally sensitive support programmes that enhance coping and resilience among caregivers.

Research on caregiver burden has traditionally emphasised medical or behavioural outcomes, often neglecting the psychosocial dimensions that underlie effective caregiving. Studies show that the demands of caring for a child with SCD can disrupt family routines and interactions and lead caregivers to neglect other family members (Adegoke & Kuteyi, 2012). Consequently, examining sociodemographic factors alongside coping abilities provides a fuller view of the caregiving experience. In Ibadan, such analysis is essential to inform the development of targeted psychological counselling, social support networks, and health policies aimed at alleviating the multifaceted strain borne by caregivers of children with SCD.

This study is grounded in Lazarus and Folkman's (1984) Transactional Model of Stress and Coping, which conceptualises stress as a dynamic interaction between individuals and their environment. The model posits that stress arises when individuals perceive external demands as exceeding their coping resources. Two central processes define this framework: cognitive appraisal and coping efforts. Through cognitive appraisal, individuals evaluate whether a situation is threatening, manageable, or benign. Coping, in turn, represents the behavioural and cognitive strategies deployed to manage the stressor (Lazarus & Folkman, 1984).

In the context of this study, caregivers of children with SCD continually appraise their circumstances (hospital visits, crises, financial demands) and engage in coping strategies ranging from seeking social support to employing religious faith. The transactional model provides a lens for understanding how variations in perception, socio-economic conditions, and cultural beliefs influence caregivers' psychological responses. It also aligns with the study's emphasis on adaptive and maladaptive coping, thereby offering a theoretical foundation for analysing the relationship between sociodemographic factors and coping ability among caregivers in Ibadan.

Numerous empirical studies have investigated the psychosocial experiences of caregivers of chronically ill children. In Ogun State, south-western Nigeria, stress was higher among female caregivers, caregivers of low socio-economic class, single parents, and older caregivers, and frequent hospitalisation and the high cost of care placed significant strain on families (Alabi et al., 2023). Similarly, caregivers in Ado-Ekiti reported that caring for a child with SCD led to loss of income, borrowing to meet treatment costs, and neglect of other family members (Adegoke & Kuteyi, 2012).

Findings also demonstrated that the coping mechanisms of mothers of children with SCD in Ibadan varied according to the type of stressor: financial and disease-related stressors were met with confrontation, whereas family sources of stress were complained about, accepted, or avoided (Olley et al., 1997). In a qualitative study in Kaduna, religion was identified as a major source of coping and support for caregivers, although families still felt ill-equipped to manage the condition (Bello-Manga et al., 2024).

While international studies have expanded understanding of caregiver burden, localized research remains sparse, particularly within the Ibadan context. The few existing studies tend to aggregate psychosocial data without linking it explicitly to coping mechanisms. This gap underscores the need for an integrated analysis of both the psychosocial stressors and coping capacities of caregivers in Nigeria's unique socio-cultural environment. By situating this investigation within

Vol. 3. Issue 1.
ISSN: 3115-6940
EISSN: 3115-6932

Ibadan, the study contributes empirical evidence on how environmental, cultural, and economic factors interact to shape caregiver well-being.

STATEMENT OF THE PROBLEM

Caregivers of children with Sickle Cell Disease in Ibadan face persistent psychosocial and economic challenges that compromise their mental health and caregiving efficiency. Frequent hospital admissions, high medical expenses, and the unpredictability of crises exacerbate stress and anxiety. Many caregivers experience chronic fatigue, depression, and social isolation, yet have limited access to psychological counselling or structured support systems. Although previous research has identified the presence of caregiver stress, less attention has been devoted to understanding how caregivers cope with these pressures within the sociocultural realities of Ibadan. Consequently, there is a lack of empirical data on how sociodemographic factors shape coping abilities in this population. Addressing this knowledge gap is essential for developing culturally relevant psychosocial interventions that enhance caregivers' resilience and improve the overall management of SCD.

RESEARCH OBJECTIVES AND QUESTIONS

The study sought to:

Determine the sociodemographic profile of parents of children with Sickle Cell Disease in Ibadan.

Identify the coping abilities adopted by parents of children with Sickle Cell Disease.

Examine the relationship between sociodemographic factors and coping abilities among parents of children with Sickle Cell Disease.

The study addressed the following research questions:

What are the sociodemographic characteristics of parents of children with Sickle Cell Disease in Ibadan?

What coping abilities do parents of children with Sickle Cell Disease employ?

How do sociodemographic factors relate to the coping abilities of parents of children with Sickle Cell Disease?

SCOPE OF THE STUDY

This study focused on parents of children diagnosed with Sickle Cell Disease who attended two government-owned health facilities in Ibadan Metropolis, Oyo State: Adeoyo Maternity Teaching Hospital and Oni Memorial Children's Hospital. The study was limited to parents directly responsible for the daily care and decision-making of children with SCD. Variables investigated were sociodemographic characteristics (gender, age, marital status, level of education, and income) and coping abilities. The findings contribute to a better understanding of how sociodemographic factors shape coping among parents in Ibadan, providing evidence for interventions that promote caregiver well-being.

METHODOLOGY

RESEARCH DESIGN

The study employed a cross-sectional descriptive survey design, in which data were collected from respondents at a single point in time to describe their sociodemographic characteristics and coping abilities and to examine the relationships between these variables. This design was appropriate for identifying patterns of coping across a diverse population of parents.

Population of Study

The population comprised the 1,104 parents (mothers and fathers) of children diagnosed with Sickle Cell Disease who attended Adeoyo Maternity Teaching Hospital and Oni Memorial Children's Hospital, Ibadan. Mothers are often the primary caregivers in Nigerian households and bear much of the emotional, physical, and financial responsibility associated with SCD management; in this study, 166 (68.0%) of the respondents were mothers and 78 (32.0%) were fathers.

Vol. 3. Issue 1.
ISSN: 3115-6940
EISSN: 3115-6932

SAMPLE AND SAMPLING TECHNIQUE

The required sample size was computed with the Taro Yamane formula, $n = N / [1 + N(e)^2]$, using the population of 1,104 parents and a margin of error (e) of 0.05, which gave a minimum sample of 294. A total of 244 parents completed the questionnaire and were included in the analysis. A sample of 244 from this population corresponds to a margin of error of approximately 5.7% at the 95% confidence level. A multi-stage sampling procedure was used. First, local government areas in Ibadan Metropolis with a higher documented caseload of SCD were purposively selected. Second, from the facilities providing SCD care in these areas, Adeoyo Maternity Teaching Hospital and Oni Memorial Children's Hospital were selected by simple random sampling (balloting). Third, eligible parents in each facility were selected by systematic random sampling from the facility register: the sampling interval (k) was obtained by dividing the number of eligible parents at the facility by its proportional quota, and every kth parent was selected until the quota was filled. Parents were eligible if they had a child with a confirmed diagnosis of SCD and were directly responsible for the child's daily care and gave written informed consent.

RESEARCH INSTRUMENTS

Two instruments were used for data collection.

Demographic Information Questionnaire (DIQ): developed by the researcher to collect data on respondents' gender, age, marital status, level of education, source of income, and monthly income. Coping Strategies Inventory (CSI): coping was measured with 24 items adapted from the CSI (Tobin et al., 1989), comprising eight problem-focused items (e.g., information-seeking, planning, and consulting healthcare professionals), eight emotion-focused items (e.g., prayer, positive reframing, and emotional expression), and eight avoidant items (e.g., withdrawal and denial). This article reports the problem-focused and emotion-focused items. Items were rated on a five-point scale (5 = strongly agree, 4 = agree, 3 = neutral, 2 = disagree, 1 = strongly disagree), and item scores were summed to give a total coping score, with higher scores indicating greater use of coping strategies.

VALIDITY AND RELIABILITY OF INSTRUMENTS

The instruments were reviewed for face and content validity by experts in social work and healthcare, whose feedback guided their refinement. A pilot study was conducted to assess whether the items were clear, relevant, and culturally appropriate for the Ibadan context, and the wording of items was refined in light of the pilot responses. Internal consistency was assessed with Cronbach's alpha, with $\alpha \geq .70$ taken as acceptable; for the coping scale in the present sample ($N = 244$), $\alpha = .78$, indicating acceptable internal consistency.

Procedure for Data Collection

Data were collected after ethical approval had been granted on 26 September 2025, within the approval period of 19 September 2025 to 18 August 2026. Trained research assistants administered the questionnaires face-to-face to parents at the two hospitals; each session took approximately 30–45 minutes, allowing participants sufficient time to respond.

Method of Data Analysis

Data were analysed with the Statistical Package for the Social Sciences (SPSS), version 25.0. Frequencies, percentages, means, and standard deviations were used to summarise the respondents' sociodemographic characteristics and their responses to the coping items. Pearson's correlation was used to examine the relationship between each sociodemographic variable and the total coping score, with significance set at $p < .05$. Each sociodemographic variable was coded in the order of its response options on the questionnaire: gender as a dichotomous variable (male, female), and age group, level of education, and monthly income as ordered categories from lowest to highest. Because gender is dichotomous, its Pearson coefficient is

Vol. 3. Issue 1.
ISSN: 3115-6940
EISSN: 3115-6932

equivalent to the point-biserial correlation coefficient, which is the appropriate measure of association between a dichotomous and a continuous variable. For age, education, and income, which are ordered categories, Pearson's r was used to estimate the direction and approximate strength of the association between category rank and coping score. Marital status is a nominal variable, so its coefficient has no directional meaning and is reported only to indicate whether any association was present. All coefficients for categorical variables are therefore interpreted with caution.

Ethical Considerations

Ethical approval for the study was granted by the Oyo State Research Ethics Review Committee, Ministry of Health, Ibadan (Ref. No. AD 13/479/489; NHREC assigned number NHREC/OYOSHRIEC/10/11/22) on 26 September 2025, for the period 19 September 2025 to 18 August 2026. Before participation, parents were briefed on the purpose, procedures, risks, and benefits of the study, and written informed consent was obtained. Participation was voluntary, participants were informed of their right to withdraw at any stage without penalty, no names or other identifying information were recorded, and the data were anonymised before analysis.

RESULTS

This section presents the results of the quantitative survey (N = 244) organised around the three research questions guiding this study.

RESEARCH QUESTION ONE: SOCIODEMOGRAPHIC PROFILE OF RESPONDENTS

TABLE 1

Sociodemographic Profile of Parents of Children Living with Sickle Cell Disease (N = 244)

Vol. 3. Issue 1.
ISSN: 3115-6940
EISSN: 3115-6932

VARIABLE	CATEGORY	FREQUENCY	PERCENT (%)
Gender	Female	166	68.0
	Male	78	32.0
Age Group	Under 20 years	1	0.4
	20–29 years	70	28.7
	30–39 years	90	36.9
	40–49 years	64	26.2
	50 years and above	19	7.8
Marital Status	Married	169	69.3
	Divorced/Separated	36	14.8
	Widowed	39	16.0
Level of Education	Primary Education	26	10.7
	Secondary Education	121	49.6
	Tertiary Education	97	39.8
Source of Income	Self-employed	130	53.3
	Salaried employment	67	27.5
	Informal trading	37	15.2
	Support from spouse/family	4	1.6
	Government or NGO assistance	6	2.5
Monthly Income	Less than ₦50,000	41	16.8
	₦50,000 – ₦100,000	56	23.0
	₦100,000 – ₦150,000	98	40.2
	₦150,000 – ₦200,000	28	11.5
	₦200,000 and above	21	8.6

Note. Field Survey, 2026

Of the 244 respondents, 166 (68.0%) were female (mothers) and 78 (32.0%) were male (fathers). Table 1 also shows that the largest group of respondents (36.9%) were aged 30–39 years, followed by those aged 20–29 years (28.7%), placing the majority of parents within their socially and economically active years. Regarding marital status, 69.3% were married, while a combined 30.7% were widowed, divorced, or separated, indicating that nearly a third of respondents managed caregiving without a spouse present in the

Vol. 3. Issue 1.
ISSN: 3115-6940
EISSN: 3115-6932

household. Educational attainment was moderate to high, with 49.6% having completed secondary education and 39.8% holding tertiary qualifications. Over half of the respondents (53.3%) were self-employed, and monthly income was concentrated in the ₦100,000–₦150,000 bracket (40.2%), while 16.8% earned below ₦50,000, situating most parents within Nigeria's low-to-middle income bracket.

Research Question Two: Coping Abilities Employed

Table 2

Coping Abilities Employed by Parents of Children with Sickle Cell Disease (N = 244)

STATEMENT	SA (%)	A (%)	N (%)	D (%)	SD (%)
I try to find out more information about my child's condition.	48.4	47.1	2.9	1.2	0.4
I plan ahead to manage my caregiving responsibilities effectively.	41.8	53.7	0.4	4.1	–
I actively look for resources (e.g., support groups, NGOs).	25.0	52.0	9.8	8.6	4.5
I talk to healthcare professionals about my child's health needs.	32.0	60.7	7.0	0.4	–
I make a list of things I can do to solve problems as a caregiver.	38.1	57.4	1.6	2.9	–
I seek advice from other caregivers with SCD experience.	48.0	48.4	1.2	2.5	–
I try to improve my caregiving skills through learning/training.	46.3	48.4	1.2	3.7	0.4
I set goals to manage caregiving stress and follow through.	25.8	65.6	2.9	3.3	2.5
I pray or meditate to cope with the emotional burden of caregiving.	50.0	43.9	1.2	4.9	–
I talk to someone close about how I feel.	33.2	61.1	0.4	4.1	1.2
I try to stay positive even when things are difficult.	50.8	45.9	0.8	0.4	2.0
I remind myself that I'm doing my best for my child.	61.9	36.5	0.8	0.4	0.4
I try to find comfort in religious or spiritual beliefs.	38.1	52.0	1.2	8.6	–
I express my emotions instead of keeping them bottled up.	41.0	52.9	0.4	4.5	1.2
I use humour to make myself feel better about the situation.	37.7	49.6	5.7	4.9	2.0
I look for emotional support from friends or family members.	25.4	47.5	5.3	19.7	2.0

Note. Field Survey, 2026

Table 2 shows that parents draw on a wide combination of problem-focused and emotion-focused coping strategies rather than a single dominant approach. Problem-focused behaviours were strongly endorsed: 95.5% agreed or strongly agreed that they actively seek information about their child's condition, 95.5% plan ahead for caregiving tasks, and 92.7% consult healthcare professionals. Emotion-focused strategies were equally prominent, with 93.9% praying or meditating to manage emotional burden, 96.7% trying to stay positive, and 98.4% affirming they are doing their best for their child. Overall, the pattern indicates a

Vol. 3. Issue 1.
ISSN: 3115-6940
EISSN: 3115-6932

caregiving population that is highly engaged with both practical problem-solving and emotional self-regulation.

Research Question Three: Relationship between Sociodemographic Factors and Coping Ability

Table 3

Pearson Correlation between Sociodemographic Factors and Coping Ability (N = 244)

SOCIODEMOGRAPHIC VARIABLE	R-VALUE	P-VALUE	DECISION
Gender	0.031	0.630	Not significant
Age	-0.278	< .001**	Significant
Marital Status	-0.062	0.332	Not significant
Level of Education	-0.069	0.284	Not significant
Monthly Income	-0.105	0.100	Not significant

Note. ** Correlation is significant at the 0.01 level (2-tailed). Coping ability = total coping score. Gender is dichotomous (r is a point-biserial coefficient); age, education, and income are ordered categories coded from lowest to highest; marital status is nominal, so its coefficient has no directional meaning. Field Survey, 2026.

Table 3 shows that age was the only sociodemographic variable significantly related to coping ability, and the relationship was negative ($r = -.278$, $p < .001$): older parents reported using fewer active coping strategies than younger parents. Gender, marital status, educational attainment, and monthly income showed no statistically significant relationship with coping ability, suggesting that psychological and relational resources associated with age, rather than socioeconomic status generally, more strongly shape coping ability in this population.

Discussion of Findings

The sociodemographic profile of respondents in Table 1 situates most parents within Nigeria's low-to-middle income bracket, a pattern that mirrors the wider empirical literature on SCD caregiving in Nigeria, where low socioeconomic status has been linked to delayed diagnosis and constrained healthcare-seeking behaviour (Egbunu et al., 2023). The prevalence of self-employment and informal livelihood among respondents parallels findings from Ogun State, where caregivers from lower socioeconomic backgrounds reported moderate to severe psychosocial burden linked to financial strain (Alabi et al., 2023). Comparable financial pressure has also been documented among SCD caregivers outside Nigeria, underscoring that the economic weight of caregiving is a near-universal feature of SCD management even where healthcare systems differ substantially (Besser et al., 2024).

The concurrent use of problem-focused and emotion-focused coping strategies shown in Table 2 is consistent with research on caregivers of children with other chronic conditions, where active information-seeking and structured caregiving routines have been associated with more positive coping orientations (Arslan Şahbaz & Cankurtaran, 2024). The prominence of prayer and spiritual coping reflects a pattern reported among Nigerian caregivers: in Kaduna, religion was described as a major source of coping and support for caregivers of children with SCD (Bello-Manga et al., 2024), and in Ibadan, mothers' coping mechanisms varied with the type of stressor they faced (Olley et al., 1997). That parents in this study drew on both strategies simultaneously, rather than relying on one exclusively, affirms the Transactional Model of Stress and Coping, which conceptualises coping as a dynamic process

Vol. 3. Issue 1.
ISSN: 3115-6940
EISSN: 3115-6932

mobilising both problem-solving and emotional regulation in response to appraised stress (Lazarus & Folkman, 1984), a pattern similarly observed among caregivers at Mulago Hospital in Uganda (Shamirah, 2023).

The finding in Table 3 that age, rather than education, income, or marital status, was the only variable significantly associated with coping ability is a notable departure from assumptions that commonly link socioeconomic advantage to adaptive coping. It is, however, consistent with findings from Ogun State, where caregiver age had a significant effect on burden and coping levels and stress was higher among older caregivers (Alabi et al., 2023). This suggests that psychological and relational resources associated with younger age, rather than demographic status alone, may better explain variation in coping ability among this population, a view broadly consistent with research on caregiver characteristics and psychological distress among informal caregivers in Nigeria (Muomah et al., 2021). It also implies that interventions targeting coping ability may be more effective when tailored to caregiver age group than when targeted by income or education level alone.

CONCLUSION

This study set out to examine the sociodemographic factors and coping abilities of parents of children with Sickle Cell Disease in Ibadan, Oyo State, Nigeria. The findings show a caregiving population that is predominantly married, moderately educated, and situated within a low-to-middle income bracket, and that draws simultaneously on problem-focused strategies such as information-seeking and planning, and emotion-focused strategies such as prayer and positive reframing, to manage the demands of caregiving. Age, rather than gender, education, income, or marital status, emerged as the only sociodemographic factor significantly associated with coping ability, with older parents reporting fewer active coping behaviours. These findings point to a caregiving population that is coping resourcefully but would benefit from structured, age-sensitive psychosocial support, particularly for older parents and those without spousal support, who appear more vulnerable to reduced coping capacity.

RECOMMENDATIONS

Based on the findings of this study, the following are recommended:

Healthcare facilities managing SCD should design coping-support programmes stratified by caregiver age, given that older parents reported fewer active coping strategies than younger parents.

Hospitals and community organisations should establish peer mentoring schemes pairing younger, more actively coping parents with older parents to share adaptive strategies.

Social welfare units at SCD clinics should link parents, particularly the self-employed and informally employed, to subsidised treatment schemes to ease the financial pressure shaping caregiving.

Declarations

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Use of artificial intelligence: The author used an AI assistant (Claude, Anthropic) to support drafting, language editing, revision of the manuscript in response to editorial comments, and checking of references. All content, data, and interpretations were reviewed and verified by the author, who takes full responsibility for the manuscript.

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Vol. 3. Issue 1.
ISSN: 3115-6940
EISSN: 3115-6932

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