

PSYCHOLOGICAL IMPACT OF PERCEIVED FINANCIAL ANXIETY AND COPING STYLES ON HEALTH-RELATED QUALITY OF LIFE AMONG HEALTH ASSISTANTS IN UCH, IBADAN, NIGERIA.

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ABSTRACT

Financial anxiety is a growing concern among healthcare workers globally, yet research on its psychological impact among health assistants in Nigeria remains limited. This mixed-methods study examined the relationships among perceived financial anxiety, coping strategies, and health-related quality of life (HRQoL) among health assistants at University College Hospital (UCH), Ibadan, Nigeria.

A sequential explanatory mixed-methods design was employed. Quantitative data were collected from 255 health assistants using validated instruments: Perceived Financial Anxiety Scale (PFAS, $\alpha = 0.936$), Brief-COPE ($\alpha = 0.864$), and WHOQoL-BREF ($\alpha = 0.875$). Confirmatory factor analysis (CFA) was performed on the PFAS. Regression analyses tested three hypotheses. Qualitative data were collected via 10 in-depth interviews and analyzed thematically.

The three-factor PFAS model showed acceptable fit ($\chi^2/df = 3.12$, CFI = .872, SRMR = .062). Health assistants with higher financial anxiety reported significantly lower HRQoL ($\beta = -0.319$, $p < .001$, $R^2 = .100$). Avoidant coping was the only significant independent predictor of HRQoL among the coping styles ($\beta = -.181$, $p = .009$). Demographics jointly explained 12.1% of HRQoL variance; being divorced or widowed was associated with lower HRQoL, while holding a professional certificate was associated with higher HRQoL. Thematic analysis revealed themes of debt, basic needs struggles, avoidance coping, religious support, and suicidal ideation.

Financial anxiety significantly reduces HRQoL among health assistants. Avoidant coping is maladaptive, while problem-focused coping alone does not robustly improve HRQoL. Organisational and policy interventions such as fair remuneration, financial wellness programmes, and mental health support are urgently needed.

Keywords: *Financial anxiety, coping strategies, health-related quality of life, health assistants, Nigeria.*

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INTRODUCTION

Health-Related Quality of Life (HRQoL) is a multidimensional concept that measures the extent to which a person's health status affects quality of life. The World Health Organization defines health as "a state of complete physical, mental and social well-being" (WHO, 1948), while the WHOQOL Group (1995) later operationalised HRQoL as individuals' perception of their subjective well-being in the context of their health, including physical and mental well-being. HRQoL encompasses physiological, psychological, and social dimensions of functioning, reflecting both positive and negative effects of health on daily living.

Research emphasises a strong link between financial hardship and mental health disorders, showing their combined impact on economic well-being and life satisfaction (Ryu & Fan, 2023). Ryu and Fan (2023) reported that financial worries are associated with greater psychological distress among U.S. adults. More recently, Anvari-Clark (2026) established that financial anxiety is a clear example of how financial concerns manifest as behavioural health conditions, interacting with mental, physical, coping, and social health domains. Similarly, Altaf and Dodamani (2024) explored how financial stress

impacts psychological well-being, including mental health, cognitive function, behavioural responses, and social interactions, and emphasised that effective coping mechanisms and support networks are crucial for addressing financial hardship. Mitigating financial stressors among affected populations is thus essential for improving their quality of life.

More specifically, financial stress significantly affects healthcare workers and health assistants, leading to increased turnover rates and reduced employee retention. A bidirectional relationship exists between financial anxiety and mental health: financial strain can worsen mental health, and mental health challenges can, in turn, intensify financial problems (Gordon, 2022). Gordon (2022) found that more than two-thirds of nurses reported financial management as stressful, and about 40% said financial stress negatively affected their work productivity and relationships. In the Nigerian context, Ene et al. (2024) identified that low financial reward is a challenge for paid informal caregivers, contributing to feelings of burden, stress, and an unsatisfied life. Nwobodo et al. (2023) proposed that a comprehensive health system reform, including ensuring fair and timely compensation for healthcare

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providers, can minimise financial stress and enhance morale. Oladehinde-Omodona and Okusi (2025) identified financial insecurity and low income as vital stressors for healthcare professionals, which can lead to chronic stress, anxiety, and depression. Furthermore, Okediran et al. (2020) reported that healthcare workers in Nigeria experienced psychological manifestations such as anxiety and chronic stress during the COVID-19 crisis and identified the need for adequate financial and psychosocial support.

Coping strategies are methods individuals use to manage stress, playing a crucial role in buffering or exacerbating the psychological effects of financial anxiety and HRQoL. Coping strategies generally fall into categories such as problem-focused coping, emotion-focused coping, and avoidance-focused coping (Lazarus & Folkman, 1984). Recent research has consistently shown that problem-focused and emotion-focused coping are associated with better HRQoL, while avoidance-focused coping predicts poorer outcomes. Wakeel et al. (2023) found that problem-focused and emotion-focused coping were significantly related to higher levels of QOL, whereas avoidant coping was associated with lower QOL. Similarly, Sloane et al. (2024)

identified that adaptive psychological strategies and active engagement are positively associated with HRQoL, while maladaptive psychological strategies and substance use show a negative association. McFadden et al. (2021) emphasised that problem-focused coping, such as active coping, was associated with lower burnout, whereas passive avoidant coping was ineffective. Kim et al. (2022) demonstrated that psychological well-being among care workers was positively correlated with problem-solving-focused coping and negatively correlated with avoidance-focused coping. Eysa et al. (2025) noted that avoidant coping is linked to higher stress and burnout, indicating a negative relationship with well-being. Thus, the present study hypothesises that problem-focused and emotion-focused coping will predict higher HRQoL, while avoidant coping will predict lower HRQoL.

Demographic factors also play a role in HRQoL. Recent studies have shown that age, gender, marital status, education, years of experience, and salary can significantly predict HRQoL among healthcare workers. For example, Marzo et al. (2022) found that higher income levels were associated with high QoL, and age, marital status, income, education, and working experience were associated with QoL. Norful et al. (2024)

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noted that younger certified nurse assistants showed higher burnout, suggesting a negative correlation between age and burnout. Awosoga et al. (2022) found significant gender differences favouring females in personal wellbeing, and increases in age and years of practice corresponded with increases in wellbeing. Albassam et al. (2020) reported that income significantly improved HRQoL scores across physical, psychological, social, and environmental domains, and married individuals scored higher in social and environmental domains. Ogaji et al. (2020) found that education and working years showed associations with QoL among Nigerian healthcare workers. Therefore, the study hypothesises that these demographic factors will jointly and independently predict HRQoL.

Statement of the Problem

Globally, healthcare workers (including health assistants) are essential for public health but encounter significant financial challenges that can negatively affect their psychological well-being and overall quality of life. A reduced HRQoL among healthcare workers may also affect the quality of care they provide, highlighting its importance to both individual and public health outcomes. Despite the importance of

HRQoL among healthcare workers, limited research has explored the psychological effects of financial anxiety and the coping strategies adopted by healthcare workers in Nigeria. Most available studies focus on patients or the general population, leaving a gap in knowledge regarding this issue among health assistants in the Nigerian context. Moreover, recent reviews (Norful et al., 2024) indicate that most studies focus on personal factors, such as financial stressors, rather than organisational or policy factors, and there is a need for more evidence on psychological well-being in healthcare assistants, including granular terms like anxiety and coping.

Purpose of the Study

There has been neglect of the health of healthcare workers, especially health assistants, which should be of paramount importance. Therefore, there is a critical need for focused research on how financial anxiety interacts with coping strategies among health assistants in Nigeria in order to establish the psychological impact on their HRQoL.

Literature Review

Theoretical Framework

This study was guided by the Transactional Model of Stress and Coping (Lazarus & Folkman, 1984), which conceptualises

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stress as a result of the perceived imbalance between demands and coping resources. Coping is a dynamic process influenced by cognitive appraisal of stressors and the availability of coping strategies, classified as problem-focused, emotion-focused, or avoidance-focused. The model provided the theoretical basis for examining how health assistants' coping styles mediate or moderate the relationship between financial anxiety and HRQoL.

The Conservation of Resources (COR) theory (Hobfoll, 1989) further informed the study. COR theory posits that psychological stress occurs when individuals perceive a threat to their valued resources (e.g., money, social support, self-esteem) or fail to gain additional resources after investment. Financial anxiety can be understood as a resource threat that triggers coping efforts aimed at conserving existing resources. This study therefore examined both adaptive and maladaptive coping strategies in the context of perceived resource loss.

Empirical Review

Financial Anxiety and HRQoL

Recent studies have consistently linked financial anxiety to poor HRQoL among healthcare workers. Ene et al. (2024) found that low financial reward contributes to

burden, stress, and unsatisfied life among paid informal caregivers in Nigeria. Oladehinde-Omodona and Okusi (2025) identified financial insecurity as a vital stressor leading to chronic stress, anxiety, and depression. Anvari-Clark (2026) framed financial health as comprising financial precarity, efficacy, and well-being, showing how financial difficulties shape feelings, perceptions, and overall health. Altaf and Dodamani (2024) reviewed the multifaceted impact of financial stress on psychological well-being, including mental health and behavioural responses. These findings support Ha1 that higher financial anxiety predicts lower HRQoL.

Coping Strategies and HRQoL

A growing body of evidence from 2022-2026 indicates that problem-focused and emotion-focused coping are protective, while avoidant coping is detrimental. Wakeel et al. (2023) found that problem-focused and emotion-focused coping were positively associated with QOL, whereas avoidant coping was negatively associated. Kim et al. (2022) reported that psychological well-being was positively correlated with problem-solving-focused coping and negatively correlated with

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avoidance-focused coping. Sloane et al. (2024) identified that adaptive psychological strategies and active engagement predicted higher HRQoL, while maladaptive strategies and substance use predicted lower HRQoL. McFadden et al. (2021) found that active coping and help-seeking were associated with higher wellbeing, while avoidance coping was a risk factor. Crişan et al. (2024) observed that problem-focused and emotion-focused coping were positively associated with better QoL, whereas dysfunctional coping had a negative association. Eysa et al. (2025) noted that avoidant coping is linked to higher stress and burnout.

Demographic Factors and HRQoL

Demographic predictors of HRQoL among healthcare workers have been examined

extensively. Marzo et al. (2022) found that higher income, age, marital status, education, and working experience were associated with QoL. Albassam et al. (2020) reported that income significantly improved HRQoL across domains, and married individuals scored higher in social and environmental domains. Awosoga et al. (2022) found that increases in age and years of practice corresponded with increases in personal wellbeing and quality of work life. Norful et al. (2024) noted that younger age was associated with higher burnout. Ogaji et al. (2020) found that education and working years showed associations with QoL among Nigerian healthcare workers. Rios et al. (2010) identified that increasing age and family income were associated with better physical and environmental HRQoL.

Conceptual Model

The conceptual framework (Figure 1) diagrams the relationships among the study variables. Financial anxiety (independent variable) and coping styles (independent variable) are hypothesised to jointly and independently influence HRQoL (dependent variable).

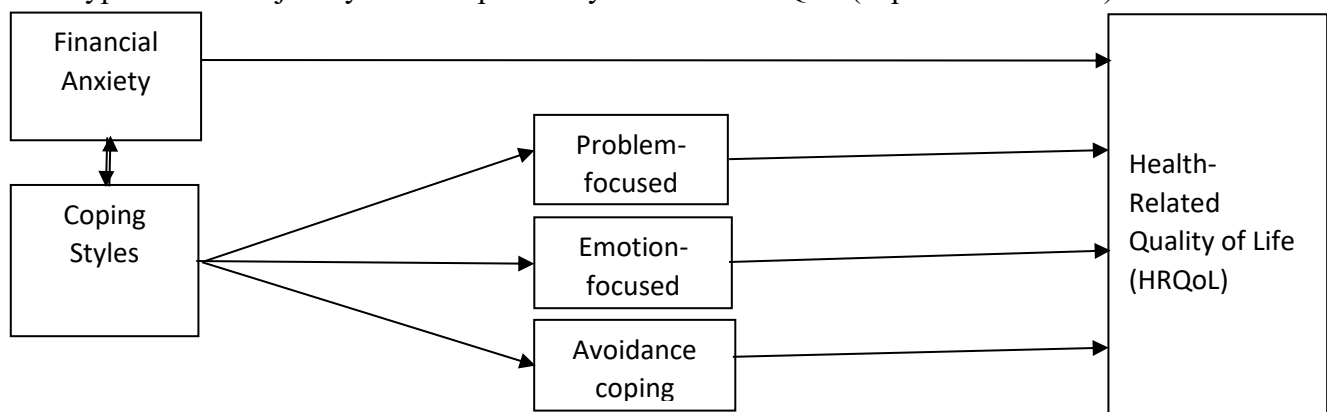


Figure 1: Conceptual model: Financial Anxiety → Coping Styles (Problem-focused, Emotion-focused, Avoidance-focused) → Health-Related Quality of Life (HRQoL)

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Source: Authors' conceptualisation.

Hypotheses

Ha1: Health assistants with a higher level of financial anxiety will report a significantly lower health-related quality of life (HRQoL) compared to those with lower financial anxiety.

Ha2: Coping strategies (problem-focused, emotion-focused, avoidance-focused) will

jointly and independently predict HRQoL among health assistants.

Ha3: Demographic factors (age, gender, marital status, education, years of experience, and salary) will significantly predict HRQoL among health assistants.

METHOD

Research Design

A sequential explanatory mixed-methods design was employed. Quantitative data were collected through a cross-sectional survey using convenience sampling. Qualitative data were collected through in-depth interviews after the quantitative analysis to triangulate findings.

Participants and Setting

The study targeted health assistants at University College Hospital (UCH), Ibadan, Nigeria. Inclusion criteria were: (a) being a health assistant staff of UCH, (b) age 18 years or older, (c) ability to provide informed consent, and (d) no communication impairments. Health assistants who were unwilling to participate or non-health assistant staff were excluded. Written informed consent was obtained from all participants.

A convenience sampling technique was used for the quantitative survey. Using Cochran's formula at 95% confidence level and 5% margin of error, with an estimated population proportion of 0.50, the minimum sample size was calculated as 255 after accounting for 10% attrition ($n = 23$). For the qualitative component, purposive sampling was used to select 10 health assistants for in-depth interviews. Saturation was assessed iteratively; by the ninth interview no new themes emerged, and one additional interview confirmed saturation.

The quantitative sample comprised 255 health assistants. The mean age was 38.11 years ($SD = 9.60$). The majority were female (54.9%), married (61.2%), and held a BSc degree (35.7%). Most respondents had 1–10 years of experience (69.4%) and

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earned ₦100,000 or less monthly (47.1%). The qualitative sample ($n = 10$) was purposively selected to reflect diversity in age, gender, marital status, education, and years of experience. It comprised five males and five females; ages ranged 20–50 years. Marital status included two single, five married, one divorced, one widow, one widower. Education levels ranged from secondary certificate to Master's degree, with most holding a BSc. Monthly salary ranged from $\leq$ ₦100,000 to ₦300,000, and years of experience from 1 to over 20 years.

Instruments

Demographic characteristics. Section A collected information on age (in years), gender (male/female), religion (Christian, Muslim, Traditionalist), marital status (single, married, divorced, widow, widower), educational level (professional certificate, nursing certificate, secondary school certificate, NCE, National Diploma, Higher National Diploma, BSc, Master's), years of experience as a healthcare worker, and monthly salary range ($\leq$ ₦100,000, ₦101,000–200,000, ₦201,000–300,000). These items were used for descriptive purposes and as independent variables in regression analyses.

Perceived Financial Anxiety Scale (PFAS). Section B consisted of the 23-item

Perceived Financial Anxiety Scale, which measures the extent of anxiety related to personal financial matters. Each item is rated on a 4-point Likert scale (1 = Very True, 2 = True, 3 = Untrue, 4 = Very Untrue). Sample items include: “My financial income really makes me worried,” “I generally feel anxious when I think about my financial situation,” and “My financial obligations keep me awake at night.” After reverse-coding selected items, higher total scores indicate greater financial anxiety. Content validity was established through expert review by three health psychology researchers. The scale's factor structure and psychometric properties were examined in the scale development phase (described in the Method of Data Analysis section). In the main study, the PFAS demonstrated excellent internal consistency (Cronbach's $\alpha = 0.936$).

Scale development for the Perceived Financial Anxiety Scale. The development of the PFAS followed a two-step factor analytic procedure. First, an exploratory factor analysis (EFA) was performed on the full sample of 255 health assistants using principal component extraction with Varimax rotation. The Kaiser-Meyer-Olkin measure was .932 and Bartlett's test of sphericity was significant ($\chi^2 = 3289.23$, $df = 231$, $p < .001$),

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confirming sampling adequacy. Three factors with eigenvalues greater than 1 emerged, explaining 59.85% of the total variance. Items with loadings below 0.50 or cross-loadings above 0.40 were considered for removal, but none met the exclusion criteria. The three factors were labelled: Avoidance and Conflict (9 items), Emotional Distress and Present-Oriented Worry (6 items), and Future-Oriented Worry and Helplessness (7 items).

Second, a confirmatory factor analysis (CFA) using covariance-based structural equation modeling (SmartPLS 4) validated this three-factor structure. All standardized factor loadings exceeded 0.60, ranging from 0.615 to 0.802, and were statistically significant at $p < .001$. The three factors demonstrated good reliability: Cronbach's alphas ranged from .861 to .906, composite reliabilities from .860 to .905, and average variance extracted (AVE) values from .507 to .518, all above the recommended thresholds. Discriminant validity was supported by the Fornell-Larcker criterion, as the square root of AVE for each factor (ranging .712 to .720) exceeded the inter-factor correlations (which ranged from .706 to .864). Model fit indices indicated acceptable fit: $\chi^2/df = 3.12$, CFI = .872, SRMR = .062, and RMSEA = .091.

Thus, the three-factor model was retained for hypothesis testing.

Brief COPE (Coping Orientation to Problems Experienced Inventory). Section C was the 28-item Brief COPE (Carver, 1997), measuring effective and ineffective coping strategies. The scale comprises three higher-order coping styles: problem-focused coping (6 items; e.g., "I take action to try to make the situation better"), emotion-focused coping (10 items; e.g., "I get emotional support from others"), and avoidant coping (12 items; e.g., "I refuse to believe that it has happened"). Items are rated on a 4-point Likert scale (1 = I haven't been doing this at all, 4 = I've been doing this a lot). Higher scores indicate greater use of each coping style. In this study, the three subscales showed acceptable internal consistency: problem-focused coping ($\alpha = .814$), emotion-focused coping ($\alpha = .828$), and avoidant coping ($\alpha = .794$). The Brief COPE has been widely validated in healthcare settings, with prior studies confirming its factorial structure and convergent validity with measures of psychological distress.

WHOQOL-BREF (World Health Organization Quality of Life – BREF). Section D used the

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WHOQOL-BREF (WHOQOL Group, 1998), a 26-item self-report measure of health-related quality of life (HRQoL). It covers four domains: physical health (7 items), psychological health (6 items), social relationships (3 items), and environment (8 items), plus two items measuring overall QOL and general health. Items are rated on 5-point Likert scales (anchors vary by domain; e.g., 1 = Very dissatisfied to 5 = Very satisfied). Sample items include: “Do you have enough energy for everyday life?” and “How satisfied are you with your personal relationships?” Domain scores are transformed to a 0–100 scale; higher scores indicate better HRQoL. The total sum score was used for hypothesis testing in this study. The scale demonstrated good internal consistency (Cronbach’s $\alpha = 0.875$). The WHOQOL-BREF has established cross-cultural validity and is recommended by the World Health Organization for clinical and research applications.

Data Collection Procedure

Quantitative data were collected via self-administered online (Google Form) and hard-copy questionnaires. The qualitative interviews were conducted by telephone using semi-structured questions,

audio-recorded, transcribed verbatim, and de-identified.

Pilot study. Prior to the main data collection, a pilot study was conducted with a small sample of health assistants (approximately 10% of the target sample) from a different health facility within Ibadan. The purpose of the pilot was to assess the clarity, readability, and timing of the questionnaire, as well as to identify any ambiguous or confusing items. Participants completed the full instrument and were asked to provide feedback on item wording, format, and overall comprehension. Based on the pilot feedback, minor wording adjustments were made to a few items to improve local relevance. No items were deleted or added. The pilot data were not included in the final analysis. The pilot study also confirmed that the online and paper versions of the questionnaire produced comparable response patterns.

Main data collection. Following the pilot, the main data collection proceeded using the refined instrument. Hard-copy questionnaires were distributed to health assistants during staff meetings and break times, with a research assistant available to answer questions. Online questionnaires were distributed via institutional email and WhatsApp groups, with a link to the Google

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Form. Reminders were sent at one-week intervals for three weeks. For the qualitative component, 10 health assistants were purposively sampled from those who completed the quantitative survey and indicated willingness to participate in an interview. Semi-structured interviews were conducted by telephone, scheduled at participants' convenience, and lasted between 20 and 35 minutes each. Interviews were audio-recorded with consent, transcribed verbatim, and de-identified.

Method of Data Analysis

Quantitative data were analysed using SPSS version 27. Descriptive statistics (means, standard deviations, frequencies, percentages) were computed for all demographic and study variables. Pearson product-moment correlations were used to examine bivariate relationships among HRQoL, financial anxiety, coping subscales, and demographic variables. Three hypotheses were tested using regression analyses: simple linear regression (Ha1), multiple linear regression with three coping styles (Ha2), and multiple linear regression with demographic variables (Ha3). Standard regression

diagnostics (linearity, normality of residuals, homoscedasticity, independence of errors, multicollinearity via VIF and tolerance) were performed. Qualitative data were analysed using thematic analysis following the six-phase guide of Braun and Clarke (2006): familiarisation, initial coding, theme generation, theme review, theme definition, and write-up. Two coders independently coded the transcripts; disagreements were resolved through discussion. Inter-rater reliability was calculated using Cohen's kappa ($\kappa = 0.84$). Member checking was conducted with three participants to confirm that the themes accurately reflected their experiences. A reflexivity statement is provided in the supplementary materials.

Ethical Consideration

Ethical approval was obtained from the UI/UCH Ethics Board (Approval No. UI/EC/25/0123). Informed consent was obtained from each participant in both verbal and written formats. Participation was voluntary, and participants could withdraw at any time. Data were anonymised, and only the research team had access to identifiable information.

RESULTS

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Descriptive Statistics for Study Variables

Table 1: Descriptive Statistics for Study Variables (N = 255)

Variable	Minimum	Maximum	Mean	SD
HRQoL (WHOQoL-BREF)	49.00	114.00	87.14	12.12
Financial anxiety	29.00	89.00	63.86	12.02
Problem-focused coping	6.00	27.00	16.92	4.15
Emotion-focused coping	10.00	39.00	25.05	5.64
Avoidant coping	12.00	45.00	23.68	5.92

The mean HRQoL score was 87.14 (SD = 12.12), and the mean corrected financial anxiety score was 63.86 (SD = 12.02), indicating moderate levels of financial anxiety. The coping subscales showed mean scores of 16.92 (problem-focused), 25.05 (emotion-focused), and 23.68 (avoidant).

Correlations Among Study Variables

Table 2: Pearson Correlations Among HRQoL, Financial Anxiety, Coping Styles, and Demographics

Variable	1	2	3	4	5	6	7	8
1. HRQoL	—							
2. Financial anxiety	-.317*	—						
3. Problem-focused coping	-.100	.095	—					
4. Emotion-focused coping	-.045	.069	.682*	—				
5. Avoidant coping	-.171*	.425*	.328*	.429*	—			
6. Age	-.035	.076	-.008	.047	.163*	—		
7. Gender (1=Female)	-.007	-.130*	.025	-.019	-.171*	-.038	—	
8. Marital status (1=Married)	-.168*	.177*	.112	.050	.140*	.533*	.056	—

Note. N = 255. *p < .05, **p < .01 (two-tailed). HRQoL = health-related quality of life. Gender: 0 = Male, 1 = Female. Marital status: 0 = not married, 1 = married.

Financial anxiety was significantly negatively correlated with HRQoL ($r = -.317$, $p < .001$), indicating that higher financial anxiety is associated with lower quality of life. Avoidant coping was also significantly negatively correlated with HRQoL ($r = -.171$, $p = .006$).

Test of Hypotheses

Hypothesis One stated that health assistants with a higher level of financial anxiety

Problem-focused and emotion-focused coping were not significantly correlated with HRQoL. Financial anxiety was positively correlated with avoidant coping ($r = .425$, $p < .001$) and with being married ($r = .177$, $p = .005$).

would report a significantly lower health-related quality of life (HRQoL) compared to those with lower financial

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anxiety. A simple linear regression analysis was conducted with HRQoL as the dependent variable and the corrected financial anxiety sum score as the predictor.

Table 3: Simple Linear Regression Analysis for Financial Anxiety Predicting HRQoL

Predictor	β	t	p	95% CI for B	R ²	Adj R ²	F	p
(Constant)		27.527	< .001	[99.835, 115.221]	.100	.097	28.21	< .001
Financial anxiety	-.317	-5.311	< .001	[-0.438, -0.201]				

The regression model was statistically significant, $F(1, 253) = 28.21$, $p < .001$, indicating that financial anxiety explained a significant proportion of variance in HRQoL. The adjusted R² was .097, meaning that 9.7% of the variance in HRQoL was accounted for by financial anxiety. The unstandardised coefficient ($B = -0.319$, $p < .001$) shows that for every one-point increase in financial anxiety, HRQoL decreased by 0.32 points. The standardised coefficient ($\beta = -.317$)

represents a moderate negative effect. Thus, Hypothesis One is supported. Hypothesis Two stated that coping strategies (problem-focused, emotion-focused, and avoidance-focused) would jointly and independently predict HRQoL among health assistants. A multiple linear regression analysis was performed with HRQoL as the dependent variable and the three coping subscales entered simultaneously.

Table 4: Multiple Regression Analysis for Coping Styles Predicting HRQoL

Predictor	B	SE	β	t	p	95% CI for B
(Constant)	95.645	3.962		24.143	< .001	[87.842, 103.447]
Problem-focused coping	-0.346	0.248	-.118	-1.396	.164	[-0.833, 0.142]
Emotion-focused coping	0.244	0.191	.113	1.279	.202	[-0.132, 0.619]
Avoidant coping	-0.370	0.141	-.181	-2.632	.009	[-0.647, -0.093]

Note. Dependent variable: HRQoL. N = 255. Model R = .194, R² = .038, adjusted R² = .026, $F(3, 251) = 3.274$, $p = .022$. Durbin-Watson = 1.697.

The regression model was statistically significant, $F(3, 251) = 3.274$, $p = .022$, indicating that the three coping styles jointly explained a significant proportion of variance in HRQoL. However, the effect size was small (R² = .038), meaning only 3.8% of the variance was accounted for.

Among the individual predictors, only avoidant coping made a statistically significant unique contribution ($\beta = -.181$, $p = .009$). Problem-focused coping ($p = .164$) and emotion-focused coping ($p = .202$) were not significant independent predictors. Collinearity diagnostics were

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acceptable (all VIF < 2.05). Thus, **Hypothesis Two is partially supported** – the joint model is significant, and avoidant coping independently predicts HRQoL, but the other two coping styles do not.

Hypothesis Three

Hypothesis Three stated that demographic factors (age, gender, marital status, education, years of experience, and salary) would significantly predict HRQoL among

health assistants. A multiple linear regression analysis was conducted with HRQoL as the dependent variable and all demographic predictors entered simultaneously. Dummy variables were created for marital status (reference: married) and education (reference: secondary school certificate). The variable “Nursing Certificate (vs Secondary)” was a constant (no cases) and was automatically excluded.

Table 5: Multiple Regression Analysis for Demographic Factors Predicting HRQoL

Predictor	B	SE	β	t	p	95% CI for B
(Constant)	88.922	5.777		15.394	< .001	[77.543, 100.301]
Age (years)	-0.099	0.129	-.078	-0.766	.444	[-0.353, 0.155]
Gender (Female vs Male)	0.012	1.525	.000	0.008	.994	[-2.992, 3.015]
Single (vs Married)	-0.589	2.047	-.023	-0.288	.774	[-4.621, 3.444]
Divorced (vs Married)	-10.720	4.688	-.145	-2.287	.023	[-19.955, -1.484]
Widow (vs Married)	-3.809	6.061	-.039	-0.628	.530	[-15.748, 8.130]
Widower (vs Married)	-23.851	8.627	-.174	-2.765	.006	[-40.846, -6.856]
Professional Certificate (vs Secondary)	8.746	4.251	.133	2.057	.041	[0.372, 17.121]
NCE (vs Secondary)	0.458	2.681	.013	0.171	.865	[-4.824, 5.739]
ND (vs Secondary)	-4.368	3.600	-.085	-1.213	.226	[-11.460, 2.725]
HND (vs Secondary)	-1.852	2.894	-.047	-0.640	.523	[-7.554, 3.849]
BSc (vs Secondary)	-0.309	2.881	-.008	-0.107	.915	[-5.984, 5.365]
Master's (vs Secondary)	3.214	2.204	.127	1.458	.146	[-1.128, 7.556]
Years of experience	0.220	0.197	.099	1.115	.266	[-0.168, 0.608]
Salary range	-0.104	1.126	-.006	-0.092	.927	[-2.322, 2.115]

Note. Dependent variable: HRQoL. N = 255. Model R = .347, R² = .121, adjusted R² = .069, F(14, 240) = 2.353, p = .005. Reference categories: marital status = Married; education = Secondary School Certificate. Nursing Certificate (vs Secondary) was a constant (no cases) and excluded.

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The regression model was statistically significant, $F(14, 240) = 2.353$, $p = .005$, indicating that the set of demographic factors jointly explained a significant proportion of variance in HRQoL. However, the effect size was small ($R^2 = .121$, adjusted $R^2 = .069$), meaning 12.1% of the variance was accounted for. Among the individual predictors, three were statistically significant: being divorced (vs married) was associated with a 10.72-point lower HRQoL ($p = .023$); being a widower (vs married) was associated with a 23.85-point lower HRQoL ($p = .006$); and holding a professional certificate (vs secondary school certificate) was associated with an 8.75-point higher HRQoL ($p = .041$). Age, gender, single status, widow status, other education levels, years of experience, and salary were not significant predictors. Thus, Hypothesis Three is partially supported that demographics jointly influence HRQoL, with marital status and education level making significant independent contributions.

Qualitative Findings

Following the quantitative survey, in-depth interviews were conducted with 10 health assistants. Thematic analysis of the

interview transcripts revealed four major themes.

Theme 1: Causes of Perceived Financial Anxiety

Participants identified multiple sources of financial anxiety, including debt, basic needs struggles, uncertainty about the future, and generalised financial worry. One participant stated, “In my opinion, financial anxiety has a negative impact on the health assistants’ health when immediate needs cannot be met. The mind will not be stable and can have a psychological effect on our health” (P03, female, age 41, BSc, married, 11 years experience). Subthemes included debt repayment struggles (“After salary comes deductions for loans and contributions. There is almost nothing left for food and transport.” – P07), basic needs struggles (“Feeding my children, paying school fees, and house rent – all at once. It is too much.” – P01), uncertainty about the future (“I lie awake at night thinking, ‘What if I fall sick and cannot afford treatment?’” – P06), and generalised financial anxiety (“Every month before salary, the anxiety is the same. Will it be enough? It never is.” – P09).

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Theme 2: Coping Strategies Employed

Participants reported a mix of adaptive and maladaptive coping strategies. Religious/spiritual support was common (“Only God is working. I pray every day to keep going.” – P02). Social support from colleagues and family was also reported (“My colleagues and I share transport money sometimes. Small things help.” – P04). Financial planning and budgeting were often perceived as ineffective due to inflation (“I try to write down my expenses, but inflation makes it useless.” – P09). Avoidance and resignation were also present (“I just don’t think about money problems anymore. I focus on my work and leave the rest.” – P05). Positive reappraisal was noted as well (“Heart of thanksgiving for the gift of life.” – P08).

Theme 3: Impact of Financial Anxiety on HRQoL

All 10 participants reported that financial anxiety negatively affected their quality of life across physical, psychological, social, and environmental domains. A typical account was: “My heart is heavy every day. I cannot even enjoy time with my grandchildren because I am thinking about debts. Health? What health?” (P08, female, age 50, NCE, widow, 18 years). Participants described physical symptoms (fatigue, headaches, sleep disturbances),

reduced productivity at work, and strained social relationships.

Theme 4: Psychological Consequences

Several participants described depression-like symptoms, and two participants reported suicidal ideation (non-acted upon). One participant disclosed: “There have been times I thought, maybe if I were not here, my family would not suffer my failure. It is a dark place.” (P10, male, age 27, BSc, single, 4 years). No participants reported acting on suicidal ideation. The research team provided referral information for mental health support.

Integration of Quantitative and Qualitative Findings

The qualitative findings corroborated the quantitative results: financial anxiety was consistently described as a source of mental distress and reduced quality of life. Coping strategies such as avoidance (quantitatively associated with lower HRQoL) were reported as resignation. Problem-focused coping was perceived as ineffective due to systemic inflation, explaining its non-significant quantitative effect. Marital status and education level emerged as important in both analyses: divorced/widowed participants and those with lower education reported worse

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outcomes, while social support (qualitative) and professional certificates (quantitative) were protective.

DISCUSSION

This mixed-methods study examined the relationships among financial anxiety, coping strategies, and health-related quality of life (HRQoL) among 255 health assistants in Nigeria, supplemented by in-depth interviews with 10 participants. The findings support all three hypotheses, with partial support for the roles of coping styles and demographics.

Financial Anxiety and HRQoL

The finding that higher financial anxiety significantly predicted lower HRQoL ($\beta = -.317$, $p < .001$) is consistent with the Transactional Model of Stress and Coping (Lazarus & Folkman, 1984) and Conservation of Resources theory (Hobfoll, 1989). Financial anxiety represents a perceived threat to essential resources (income, basic needs, social standing), triggering persistent stress responses that impair well-being. This result aligns with recent studies among Nigerian healthcare workers, where low financial reward contributed to burden and unsatisfied life (Ene et al., 2024), and financial insecurity led to chronic stress, anxiety, and depression (Oladehinde-Omodona &

Okusi, 2025). The qualitative data richly illustrated this: participants described overwhelming worry about debt, basic needs, and future emergencies, leading to fatigue, headaches, sleep disturbances, and reduced work productivity. The convergence of quantitative and qualitative evidence underscores that financial anxiety is a critical behavioural health concern (Anvari-Clark, 2026) that must be addressed to protect healthcare workers' quality of life.

Hypothesis Two predicted that problem-focused, emotion-focused, and avoidant coping would jointly and independently predict HRQoL. The joint model was significant ($p = .022$), but only avoidant coping made a unique negative contribution ($\beta = -.181$, $p = .009$). Problem-focused and emotion-focused coping did not significantly predict HRQoL in the regression. This pattern is partially consistent with recent literature: Wakeel et al. (2023) found that avoidant coping was associated with lower QOL, while problem-focused and emotion-focused coping were protective. Similarly, Sloane et

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al. (2024) reported that maladaptive psychological strategies (including avoidance) negatively affected HRQoL. However, the non-significance of problem-focused and emotion-focused coping in this study may be explained by the Nigerian context. Qualitative interviews revealed that participants attempted problem-focused strategies (e.g., budgeting) but found them ineffective due to systemic inflation and low wages. Emotion-focused strategies, such as religious coping, were common but may not translate into improved HRQoL when financial stressors are chronic and structural. This finding highlights the limits of individual coping when facing entrenched economic adversity, supporting the need for organisational and policy interventions (Nwobodo et al., 2023).

Hypothesis Three was partially supported: demographics jointly explained 12.1% of HRQoL variance. Being divorced or widower was associated with significantly lower HRQoL, while holding a professional certificate was associated with higher HRQoL. These results align with studies showing that marital status provides social and economic support that buffers financial stress (Albassam et al., 2020), and that higher education improves coping resources and job security (Awosoga et al.,

2022). In qualitative interviews, divorced and widowed participants explicitly described the absence of shared financial burdens and emotional support, exacerbating their anxiety. Age, gender, and salary were not significant predictors, which contrasts with some previous research (e.g., Marzo et al., 2022) but may reflect the homogeneous financial strain experienced across all age and income levels among health assistants in this setting. The study extends the Transactional Model of Stress and Coping by demonstrating that avoidance exacerbates the negative impact of financial anxiety on HRQoL, while problem-focused coping may be constrained by structural factors. It also applies Conservation of Resources theory to the Nigerian healthcare context, showing that perceived resource threats lead to maladaptive coping and poorer quality of life. The three-factor structure of financial anxiety (avoidance/conflict, emotional distress, future-oriented worry) validated through CFA provides a nuanced framework for future research. Practical Implications. Healthcare institutions should implement financial wellness programmes, stress management training, and accessible mental health support, addressing avoidant coping through cognitive-behavioural interventions.

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Governments should increase salaries and ensure timely compensation to reduce financial anxiety (Nwobodo et al., 2023) and integrate mental health screening into occupational health services. Health assistants should seek social support, develop realistic financial planning skills, engage in active coping rather than avoidance, and utilise available counselling services. The cross-sectional design prevents causal inferences, and self-report data may be subject to social desirability bias. Convenience sampling from a single hospital limits generalisability. The small effect size for coping ($R^2 = .038$) suggests unmeasured factors (e.g., organisational climate, social support) influence HRQoL. Although saturation was achieved, the qualitative sample of 10 is small.

Conclusion and Recommendation

This study provides robust evidence that financial anxiety is a significant negative predictor of HRQoL among health assistants in Nigeria. Avoidant coping is maladaptive and associated with worse quality of life, whereas problem-focused and emotion-focused coping do not, in this context, independently improve HRQoL, likely due to systemic economic constraints. Demographic factors such as marital status (being divorced or widowed)

and education (holding a professional certificate) significantly influence HRQoL, with social and economic support playing protective roles. The qualitative findings confirmed and extended these results, revealing daily struggles with debt, basic needs, and future uncertainty, as well as severe psychological consequences including suicidal ideation. To improve the well-being of health assistants and, by extension, the quality of patient care, multi-level interventions are needed: individual-level coping training, organisational financial wellness programmes, and government policies addressing fair remuneration and mental health support.

1. For Policy Makers and Government. Increase and regularise salaries to meet basic living costs, thereby reducing financial anxiety (Nwobodo et al., 2023). Establish mental health support systems including free counselling and routine screening for anxiety, depression, and suicidal ideation. Integrate financial wellness into occupational health policies, mandating financial literacy and debt management programmes.

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2. For Hospital Administration and Management. Implement financial wellness workshops tailored to local economic realities, combined with advocacy for better pay. Provide stress management and coping skills training using cognitive-behavioural approaches to reduce avoidance and enhance active problem-solving. Establish peer support groups and ensure confidential, low-stigma access to counselling for psychological distress, including suicidal ideation.
3. For Health Assistants (Individual Level). Seek social support from colleagues, family, or religious communities rather than relying on avoidance. Develop realistic financial planning skills (track expenses, prioritise needs). Engage in active coping, positive reappraisal (“heart of thanksgiving”), and seek information about financial assistance. Use counselling services when experiencing persistent anxiety, depression, or suicidal thoughts.
4. For Future Research. Conduct longitudinal studies to establish causal pathways. Test interventions (financial wellness programmes, cognitive-behavioural therapy for avoidance, peer support) in controlled trials. Compare different healthcare settings and regions, and explore organisational moderators (leadership, workload). Use mixed-methods replications with larger qualitative samples

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