Gender And Antiretroviral Drug Effects On The Hive-self Efficacy And Health Locus Of Control Of Patients Living With Hive/Aids

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Introduction

The HIV-AIDS epidemic is perhaps one of the greatest challenges to countries of the world today. Since it was first diagnosed in 1981, it has become a significant threat to everybody throughout the world irrespective of gender and sexual orientation. The widespread of the disease especially in the African continent has become a major source of concern to government and non-governmental agencies and others concerned with curtailing the pandemic disease. In fact in hard hit areas of Africa, infection rate has been higher in teenage groups than that of adult (Hopkins, 2000). In 2008 alone, an estimated 3 million people in the region became newly infected (Avert, 2009). The situation in Nigeria is fast becoming an unprecedented crisis. The incidence of HIV-AIDS was first reported in 1985 among commercial sex workers (prostitutes) in Lagos and Anambra states. Since then the epidemic has been on the increase. For instance, in September 1991, the Federal Ministry of Health reported a prevalence rate of 0.66% out of the total population. However by the end of December 1992, the number has increased to 552 cases nationwide (Salami, 2002).

As the epidemic rages unhindered, Nigeria has moved from a prevalence rate of 1.8% of the total population in 1993 to 5.8% of the total population in 2001 (USAID, 2005). At the moment, only two states out of 37 states of the federation (including the Federal Capital Territory) have a prevalence rate of less than 2.0%. In fact the HIV/AIDS prevalence trends by state from 1991 to 2005 indicates that many states of the federation have prevalence rates above the national 5.8% rate (see the table below).

As indicated in the data above, the prevalence rate shows clearly that over 4 million Nigerians are living with HIV-AIDS (National HIV/AIDS and Reproductive Health Survey (NARHS) 2003). More recent trends show that approximately 170,000 people died of HIV-AIDS in 2007 alone (UNAIDS, 2008). This development should be a major concern to all sundry. This concern becomes more aggravated when viewed against the background that chronic illness such as HIV-AIDS are usually incurable, and from the perspective that the group most affected by the pandemic disease...
falls between the productive age (20 to 24 years); with a prevalence rate of 5.6% (NARHS, 2003). This explains why medical care efforts are directed at curtailing the disease, showing its progression and managing symptoms related to it.

However, most chronic illness requires adherence to some type of treatment regimen, and typically involves self-cure on the part of the patients. In addition to this, chronic illness bears some degree of stigmatization. The extent of which the stigmatization plays a role in affecting the health status of the patients largely depends on the particular conditions of the patients and on associated factors such as whether the person is perceived as being responsible for acquiring the disease or whether the disease is communicable.

The development of Highly Active Antiviral Therapy (HAART) has lead to a significant lengthened survival period of millions of people living with HIV-AIDS (Siegal & Lekas, 2002). Today, HIV-AIDS is defined from both a clinical and policy perspective as a chronic condition (Siegal & Lekas, 2002). However several features of the disease make the management of such a condition profoundly different from other chronic illnesses such as diabetes, asthma, arthritis etc. Firstly, adherence to antiretroviral regimens is complex and often poor due to their rigid dosing schedules, dietary guidelines and side effects. This problem is extremely concerning; given that intermittent non-adherence to HIV therapy can lead to drug resistance stains of the virus (Chesney, Chambers, Taylor, Johnson & Folkman 2003). Secondly, daily self-monitoring takes a distinct approach with HIV-AIDS compared to a chronic condition like diabetes. People with diabetes can monitor their blood sugar levels throughout the day and can use the information to alter their health behaviors if necessary. This is not the case with people living with HIV/AIDS. There is no test they can self administer that can provide them with immediate feedback which they can use to make adjustment to the way they manage their illness. Another serious issue that makes the management of the disease very complex and at times even renders the HAART ineffective is stigmatization. HIV/AIDS stigma persists and discrimination and social ostracism experienced by many infected individuals is unlike the negative attitudes faced by persons with other chronic conditions. In a survey conducted by Levine et al (2006) on stigmatization and perception of people, generally on the disease a good percentage of the people polled had several misconceptions regarding transmission of HIV/AIDS which are likely associated with enduring stigma attached to the illness.

As at now, the only hope for a better health condition for people living with HIV/AIDS strictly lies on adherence to the HAART. However adherence to therapy, or the extent to which a patients behavior coincide with medical advice mutually negotiated between the health professional and the patients, is a universal challenge with all illness and in all age groups (Siegal & Lekas, 2002); and its most often determined by the belief which the affected patients have on the efficacy of such a drug at ensuring his/her general well-being. The present study therefore attempts to determine the effects of gender and antiretroviral drug on HIV-self efficacy and health locus of control of patients living with HIV/AIDS. This is based on the premise that psychological constructs such as self-efficacy and locus of control play a role

<table>
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<th>ND</th>
<th>ND</th>
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<td>ND</td>
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<td>8.4</td>
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</table>
in adaption to chronic illnesses such as arthritis, asthma, diabetes etc (Cross, et al 2005).

One variable shown to influence behavior is self-efficacy (Bandura, 1977). Self-efficacy is defined as a person’s belief in his/her ability to perform a specific behavior or task in the future. It is the beliefs of confidence individuals have in their ability to execute courses of action (Bandura, 1977, 1986, and 1989). Efficacy expectations are proposed to influence initiating behavior, how much effort will be applied to attain an outcome, and the level of persistence applied to the task in the face of difficulties and setbacks (Bandura, 1977).

Although, a lot of research outcome has demonstrated that self-efficacy plays a role in wide range of life situations (Chelsea & Vosvick, 2005), however little research effort has examined factors associated with self-efficacy of managing HIV/AIDS. Attention to such issue may provide information into how to improve self-efficacy in this population and subsequently contribute to improve adherence rates (Chelsea&vovick, 2005). This becomes imperative when viewed against the backdrop that despite governments efforts at assuring elongation of the survival period of this population through the provision of highly active antiretroviral therapy (HAART) a lot of them die at early stage of diagnosis due to non-adherence to HAART as a result of lack of belief in its efficacy at ensuring longevity of life on the one hand, and due to stigmatization and other related matters that are beyond the scope of this paper on the other hand.

Furthermore, self-efficacy has been noted to be behavior specific and as such, can be altered through education program. Also, enhance self-efficacy has been associated with improved health and reduced health care costs in areas affected by those specific behaviors (Chandiwana, 2002).

However, the way self-efficacy is measured has been found to influence the strength of self-efficacy performance relationships (Moritz, Feltz, Fahrbach, and Mark, 2000). Thus, it is suggested that researchers should seek to develop self-efficacy measure specific to the behavior domain of their research focus. This explains the choice of domain specific self-efficacy (i.e. HIV- self-efficacy) in the present study.

HIV-self-efficacy is defined as a coping resource that reflects the strength of the HIV patients’ beliefs in the effectiveness of their ability to adhere to their treatment regimen (Marc, 2007). There are ways in which HIV-self efficacy serves to promote health. It enhances the patients' beliefs in their treatment regimen, which thus encourages them to adhere to it, thereby making them abstain from various unhealthy and health-damaging habits such as smoking, drinking of alcohol etc. HIV-self efficacy affects every phase of personal change. According to Bandura and Ramachandran, (1994), the greater the HIV self-regulatory the more successful an HIV/AIDS patient attains success in reducing health impairing habit into his/her regular life style (Bandura & Ramachaudran, 1994).

Viral infections are among the most formidable conditions in the primary care setting, causing a wide range of illnesses that are difficult to treat. Developing antiviral medicines has been difficult because most drugs that kill viruses also damage the host cells (Lorig, et al 1996). However since the first antiviral drug amantadine (symeterel) was released in 1966, encouraging process has been made in this area (Lorig, et al, 1996).

Hogg et al, (1998) reported that combination of antiretroviral regimes have revolutionized the treatment of HIV infection, which has resulted in dramatic reduction in morbidity, mortality, and health care
Effective antiretroviral therapy (ART) consistently results in sustained suppression of HIV ribonucleic acid (RNA) replication, resulting in gradual increase in white blood cell (CD4) counts, sometimes to normal level (Lorig, et al, 1996).

Although antiretroviral therapy does not eradicated the virus, as viral replication continues in lymphoid tissue despite suppressive treatment (Furtado & Zhang, 1999), however, durable suppression of viral replication and the accompanying increase in white blood cell (CD4) count, reverse HIV disease progression, even in persons with advanced HIV infection (Hogg et al, 2001). But despite these advantages, ART poses a number of challenges. Many of the effective regimens are complex, have major adverse effects, and can be difficult for patients to adhere to, and eventually (though not inevitably) lead to antiretroviral drug resistance (Chesney et al, 2003). These problems continue to limit the effectiveness of ART and present major challenges in managing HIV infection. However, it is being proposed in the present study that psychological constructs like domain specific self-efficacy and locus of control will come to the rescue, and this is based on the premise that the two constructs have been found to play a role in adaption to chronic illness (Cross, et al 2005) and they have also been found to be associated with improved health (Chelsea & Vosvick 2005).

Locus of control is a personality trait that was introduced by Rotter in 1966 in the context of his social learning theory. Locus of control is defined as an individual’s general expectancy of the outcome of an event as being either within or beyond her or his personal control and understanding (Rotter, 1966). According to him, an individual with an external locus of control personality traits tends to control, and attributes the outcomes of the event to chance, luck or under control of powerful others. On the other hand, a person with an internal locus of control personality trait tends to believe that the event is contingent upon her or his behavior or her or his own relatively permanent characteristics. Health locus of control refers to the degree to which individuals’ belief that their health factors are controlled by either internal or external factors. External beliefs are premised on the notion that ones’ health outcome is under the control of the powerful others (that is medical professionals) or as determined by fate, luck or chance. Internal beliefs characterize one’s health condition as being the directed result of ones actions.

In the psychological literature, there is ample evidence that locus of control is a fundamental and stable personality trait, with clear behavioral consequences. For instance, in recent decades, a great deal of research has linked internal locus of control to positive health beliefs and behaviors (De Boone & Brabander, 1993). Recently too, Spector et al (2002) report impressive evidence as to the impact of locus of control on well-being and psychological well-being in the context of a large international study that involved geopolitical entities across five continents. Furthermore, it is widely accepted now that health-related locus of control is significantly associated with a variety of the health behaviors and outcomes. For example, internal locus of control has been associated with knowledge about disease (Patel et al, 2006), ability to stop smoking (Lorig et al, 1996) and adherence to medical regimen among others (Lindsey & Rapoff, 2007). The importance of locus of control beliefs on health makes crucial our need to understand the constructs. If their development is understood, parents, caregivers, school officials and medical professionals can become more aware of the circumstances that might lead to the adoption of a particular locus of control belief (Mackey, 1999). By conducting this study, we offer two contributions to the literature. First, we test for the robustness of the antiretroviral drug effect on individual’s health behavior. Secondly, we explore whether or not the performance impact of the antiretroviral drug on individuals personality traits (self-efficacy and locus of control) is different for all people vis-à-vis people living with HIV/AIDS.
Another variable considered by the present study is gender. Gender in virtually all societies of the world defines an individual's identity. From birth, people are treated differently because of genitalia. Gender according to Morin et al. (2005) may be seen as the product of psychological imprinting, social learning, and language. It has a profound influence on our intrapsychic, legal, and political lives (Castenda & Glover, 2004). According to Irving & Kirsch, (1996) men and women are different in ways that go beyond their reproductive systems, hormones, and bone structure. They are different at cellular levels and these differences may influence the amount of medicine they need to treat disease; at times they may have the same disease, but they may have different symptoms. Their disease may progress differently and they may respond differently to treatment. In the light of the above reported differences in male and female, a number of studies have given credence to gender as an important construct in health-related issues, especially HIV-self efficacy and health locus of control (Castenda et al., 2004). The present study therefore attempts to determine whether gender and antiretroviral drug have any effect on the HIV-self efficacy and health locus of control of patients living with HIV/AIDS. What further gives impetus to this question raised by this study is the research finding of Cross, March, Lapsley, Byrne, & Brooks (2005) which indicated that construction of masculinity greatly influences men's well-being more than their female counterpart. Going by this research finding, it is plausible to believe that psychological traits such as self-efficacy and locus of control would greatly be influenced by gender.

Methods

Design

The survey research design was employed. This method allows the researcher to ascertain the effect of the independent variables on the criterion variables without necessarily manipulating the behavior of the respondents.

Participants

The participants for the study comprise of all the registered HIV/AIDS patients in University College Hospital, Oyo State, Ijebu Ode General Hospital, Ogun State, Lagos State University Teaching Hospital, Lagos, and recognized people living with HIV/AIDS sub-group at Raise of Hope Foundation, Ijebu-Ode, Ogun State. The stratified random sampling technique was adopted in selecting three states within south-west Nigeria, this was followed by random selection of 312 registered HIV/AIDS patients from the above motioned health institutions and sub-group.

Instrumentation

Three instruments were used to collect data for the study. The instruments were described below:

HIV-Self Efficacy Scale (HSES)

The HIV-self Efficacy Scale (HSES) developed by Lorig, Strewait, Ritter, Gonzalez, Laurent & Lynch (1996) was used to collect data on HIV-self efficacy of participants. The scale assesses HIV-specific self-efficacy based on 10-items on a ten-point scale ranging from 1 (not sure at all) to 10 (totally sure). Scores range from 10 – 1000 with higher scores indicating higher HIV-self efficacy. The psychometric properties of the instrument were reported by Shively, Smith, Borman and Guilford (2002). Sample items of the scale include “How sure are you that you can keep from getting discouragement when nothing
seems to make a difference” “take your prescriptions medication at the appropriate timing”; “take your medication everyday as they are prescribed” etc.

A pilot study that consisted of 50 samples of patients living with HIV/AIDS conducted outside the scope of the study revealed a co-efficient alpha of 0.83. However, internal consistency of 0.878 co-efficient alpha was revealed in the present study.

Health Locus of Control Scale (HLCS)

The health Locus of Control Scale (HLSC) developed by Wallston, Wallston, Gordon, Korplan & Shiviley (1997) was employed. The scale assesses health related behaviors locus of control. Participants responded by indicating their truthfulness to the 11 – item statement using a 6-point scale, each external item is scored from 1 (strongly disagree) to 6 (strongly agree) with the internal items reversely scored. Samples items from the scale include: “if I can take care of my self, I can avoid illness and “Good health is largely a matter of good fortune”.

A co-efficient alpha of 0.54 was obtained from a pilot study of 50 samples of HIV/AIDS patients conducted outside the scope of the study. The HLC demonstrated internal consistency with alpha reliability ranging from 0.40 to 0.54 and 8 week test retest reliability co-efficient of 0.71.

Antiretroviral Drug Usage Scale (ADUS).

Antiretroviral Drug Usage Scale (ADUS) developed by the researchers was also used to collect data on the level of usage of antiretroviral drug by patients living with HIV/AIDS. It is a 4-item scale that assesses how long or not the patient has been on antiretroviral drug. Sample item of the scale includes: “For how long have you been using antiretroviral drugs?” Options in the scale include: “Not yet, 0 – 5 months, 6 -12 months, I year and above”.

Procedure

The scales were personally administered on the participants by the researchers with the assistance of HIV/AIDS patients’ coordinators at the various health institutions. All the scales were administered and collected back immediately upon completion. The data obtained from the instruments were analyzed using student t-test statistics (independent) and analysis of variance (ANOVA) with significant level fixed at 0.05.

Results

The results in table 1 indicated that there is no significant gender difference in hiv-self efficacy of patients’ living with hiv/aids. The calculated t-value of 0.235 is less than the critical t-value of 1.960 at 0.05 level of significant. Thus, the null hypothesis of no significant gender difference in HIV-self efficacy of patients living with HIV/AIDS was accepted. Thus, HIV-self efficacy is not gender specific.

<table>
<thead>
<tr>
<th>Group</th>
<th>N</th>
<th>Mean</th>
<th>Std</th>
<th>Md</th>
<th>Df</th>
<th>t-cal</th>
<th>t-cri</th>
<th>P</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male</td>
<td>135</td>
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<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Female</td>
<td>177</td>
<td>66.486</td>
<td>19.544</td>
<td>0.507</td>
<td>310</td>
<td>0.235</td>
<td>1.960</td>
<td>&gt;.05</td>
</tr>
</tbody>
</table>

Table 1: Independent t-test statistics of Significant gender difference in HIV-self efficacy of patients’ living with HIV/AIDS.
The results in table 2 revealed that there is a significant gender difference in the health locus of control of patients living with HIV/AIDS. The calculated t-value of 2.804 is greater than the t-critical value of 1.906 at 0.05 level of significance. The null hypothesis which stated that there is no significant gender difference in the Health Locus of control of patients living with HIV/AIDS was therefore rejected.

It can be observed from table 3 above that the computed f-ratio of 1.700 is not significant at 0.05 alpha level $F_{3,308} = 1.700$; (P<0.05). The result indicated that there was no significant effect of antiretroviral drug use on the HIV-self efficacy of patients living with HIV/AIDS. Thus, the earlier postulated hypothesis was confirmed.

The table above revealed that the computed f-ratio of 2.810 is significant at 0.05 level of significance $F_{3,308} = 2.810$; (P<0.05). The result above revealed that there is a significant effect of the level of antiretroviral drug usage on the health locus of control of patients living with HIV/AIDS. The earlier stated null hypothesis that there will be no significant effect of the level of antiretroviral drug usage on the health locus of control of patient living with HIV/AIDS was by the finding of this study rejected. However to determine the direction of significant among the subset posthoc analysis was carried out. The result is presented in the table below.

The result in table 5 above revealed two subsets. In the first subset, patients who have not started using antiretroviral drugs, those that have been on it for between 6 to 7 months and those that have been on it within a year and above have similar mean scores on health locus control.

**Table 2: Independent t-test statistics of significant gender difference in the health locus of control of patients living with HIV/AIDS**

<table>
<thead>
<tr>
<th>Group</th>
<th>N</th>
<th>Mean</th>
<th>Sd</th>
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<th>t-cal</th>
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<tr>
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<td>40.037</td>
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**Table 3: Analysis of Variance (ANOVA) of the effect of the level of antiretroviral drug usage on HIV-self efficacy of patients living with HIV/AIDS.**

<table>
<thead>
<tr>
<th>Source</th>
<th>Sum of Square</th>
<th>Df</th>
<th>Mean square</th>
<th>F</th>
<th>Sig.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Between groups</td>
<td>1793.386</td>
<td>3</td>
<td>597.795</td>
<td>1.700</td>
<td>.167</td>
</tr>
<tr>
<td>Within Groups</td>
<td>108277.486</td>
<td>308</td>
<td>351.550</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>110070.872</td>
<td>311</td>
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<td></td>
<td></td>
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</table>

**Table 4: Analysis of Variance (ANOVA) of effects of the level of antiretroviral drug usage on the health locus of control of patients living with HIV/AIDS**

<table>
<thead>
<tr>
<th>Source</th>
<th>Sum of Square</th>
<th>Df</th>
<th>Mean square</th>
<th>F</th>
<th>Sig.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Between groups</td>
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<td>158.947</td>
<td>2.810</td>
<td>.040</td>
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<td>Within Groups</td>
<td>17421.841</td>
<td>308</td>
<td>56.564</td>
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<td></td>
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<tr>
<td>Total</td>
<td>17898.654</td>
<td>311</td>
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</tbody>
</table>

**Table 5: Scheffe test of Homogeneous Subset for health Locus of Control be level of antiretroviral drugs**

<table>
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<th>Antiviral drug</th>
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<td>1 year and above</td>
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<td>36.8243</td>
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<td>6 – 12 months</td>
<td>88</td>
<td>38.4659</td>
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<tr>
<td>Not yet</td>
<td>81</td>
<td>39.1235</td>
</tr>
<tr>
<td></td>
<td>1</td>
<td>2</td>
</tr>
</tbody>
</table>
of control. This was found to be significantly different from the second subset with those who have not yet started, those on the drugs between 0 to 5 months, as well as those who have been on it for between 6 – 12 months. Patients who have been on the antiretroviral drugs for between 0 – 5 months as well as those on the drug for over a year stood out in both groups with those who have been on the drugs for between 0 – 5 months having greater locus of control than those who have been on the drugs for over a year. This implies that patients who are just introduced to the drugs are more internally controlled than those who have been on the drugs for long time.

Discussions

The result of the first hypothesis revealed that HIV-self efficacy of patients living with HIV/AIDS is not gender based. By implication, patients’ belief in their ability to adhere to treatment regimen is not gender specific. This finding, although runs contrary to the researchers expectation, corroborates the finding of Brook, Bryne, Cross, March & Lapslley (2005) who in a related study on the effect of gender on self-efficacy of arthritis patients which is also a chronic health condition reported that gender and age have no significant influence on the self-efficacy of the sample used for the study. The finding also strengthened the research outcome of Bandura (1991) who in a study on the influence of gender and adherence to medication events monitoring systems (MEMS) which involved 130 men and 32 women reported no difference in adherence based on gender.

The finding of this study also revealed that there is a significant gender difference in the health locus of control of patients living with HIV/AIDS, with male HIV/AIDS patients having a higher health locus of control than their female counter part. The finding is not surprising. Castaneda and Burns-Gover (2004) affirmed that constructions of masculinity greatly influenced men’s well-being. Also, Preau et al (2005) in a study on health related quality of life and health locus of control beliefs among HIV-infected patients established that male participants exercise higher health locus of control than their female counterpart. Again, when viewed against the submission of Bangberg et al (2006) that gender may be an important issue when studying relations between attachment and social functioning and the reported effect (Altice, Mostashari & Friedland, 2001) of Stigmatization on health status of patients living with HIV/AIDS. The present finding could be as a result of male HIV/AIDS patients having a strong resistance against stigmatization and the will power to live a positive life while making the best out of life as a whole.

The third finding of the present study which is very surprising and also revealing indicated that level of antiretroviral drug usage will not have effect on HIV-self efficacy of patients living with HIV/AIDS. The implication of this research outcome is that the level of usage of antiretroviral drug has no significant influence on the HIV-self efficacy of patients living with HIV/AIDS. This result contradicts previous research findings (Marc, 2007; Morin et al, 2005; Preau et al 2005) on the effect of HAART generally on health self-efficacy of patients living with HIV/AIDS. The plausible explanation for the variation in the research finding here may be attributed to the relatively low accessibility to antiretroviral drugs by an average Nigerian HIV/AIDS patient; and the stress associated with getting the drugs. From personal interaction we had with few of them that appeared friendly and hopeful and the comments of some of them to the items of the questionnaire (particularly the one designed to measure their level of usage of
antiretroviral drugs); it appears that they have little access to antiretroviral drugs due to the high cost of procuring the drugs (although they are professed to be free by various governmental and non-governmental agencies). Furthermore, it also appear from their personal comments that the stress associated with getting the drugs from various teaching hospitals (even when patients can afford it) is enormous. Although, several reports (Hunter, 2003) have indicated that access to health care varies tremendously by socioeconomic status, level of education, employment and geographic location; but all these cannot be substantiated with evidence since it is beyond the scope of the present study. However, subsequent study may beam research light on the accessibility of patients living with HIV/AIDS to antiretroviral drugs and the relationship of this on their HIV/AIDS-self efficacy.

Another plausible reason for the variation in finding could be attributed to the effect of stigmatization on patients' health system and belief. This is one major problem being faced by this category of people in most countries of the world (Hunter, 2003), especially 3rd world countries where HIV/AIDS stigma persists (Levine et al, 2006). However, which ever way it goes, the finding of the present study needs further investigation.

This study also revealed that there is a significant effect of the level of antiretroviral drug usage on the health locus of control of patients living with HIV/AIDS. This finding is not amazing. Locus of control is generally considered as attribution dimension that has linked with a host of other behaviour; and in recent time a deal of research has also linked locus of control (especially internal locus of control) to positive health behaviours (Spector et al, 2002; Patel et al, 2006; Lindsey & Rapoff, 2007).

While considering the direction of the significant table 5 above revealed that those newly introduced to the antiretroviral drug have better locus of control (internal) than their counterpart that have been on the drug for quite some time. The plausible explanation for this could be that those that are just being introduced to the drugs are more optimistic than their counterparts who have been on the drugs for quite some time without possible physical changes in their health condition. They are not only eager, they are also full of hope about what the future holds for them and this high expectation level could possibly have significant influence on their health locus of control.

Implications of the Findings

The findings of this study underscore the need for caregivers, government and other HIV/AIDS right advocacy groups/agencies to focus more on educating the populace about the disease rather than focusing on the distribution of drugs. This is necessary so as to reduce the stigmatization of people living with the disease since the level of antiretroviral drug usage was found by the present study not to have significant effect on the HIV-self efficacy of patients living with HIV/AIDS. The awareness programme should be organized along side with series of counselling and psychotherapeutic workshops that will be geared towards improving important psychological traits such as locus of control, self-efficacy and a host of others in people living with HIV/AIDS (PLWHA). These programmes are expected to increase their adherence to treatment regimen (Antiretroviral drug therapy) and subsequently their HIV-self efficacy and Health Locus of Control.

References


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