

GENDER AS PREDICTOR OF ATTITUDE TOWARDS HIV COUNSELLING TESTING AMONGST ROAD SAFETY PERSONNEL IN IMO STATE, NIGERIA

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Abstract

This study examined gender difference in attitude towards HIV Counselling and Testing (HCT) amongst Federal Road Safety Personnel (FRSC) personnel in Imo state exposed to Emotional Intelligence Therapy (EIT). Pretest-posttest control group quasi experimental design with 2x2x2 factorial matrix was adopted for the study. One hundred participants (Male=60; Female=40) with age range of 24 to 40 years (\bar{x} =23.01; SD=1.12) were purposively drawn from two units of FRSC Imo Sector Command. Attitude towards HIV Antibody Testing Scale ($r=0.89$) was used for data collection. The data derived from the pre and post treatment assessments were subjected to Analysis of Covariance using pre-test scores as covariates. Results show that EIT was potent for modifying HCT attitude of the treated group in comparison with the control group [F (1, 99) =82.14, $P<0.05$]. Gender and educational status have significant influence on treatment outcomes ($t=1.53$; DF= (1, 99), $P=<0.05$) and (F (1, 99) =45.08; $P<0.05$) respectively. Based on these findings, EIT is recommended therapy for improving HCT attitude among women in high HIV risky occupation in Nigeria. The outcomes have implications for programmers to be gender sensitive in development, implementation and evaluation of HIV intervention.

Globally, the pandemic of HIV and AIDS have continued to constitute serious health and socio- economic challenges for more than two decades. In developing countries, such as Nigeria, it has reversed many of the health and developmental gains over the past three decades as reflected by indices such as life expectancy; birth and infant mortality rate among others. The epidemic has also facilitated the re-emergence of disease conditions such as pulmonary tuberculosis and other opportunistic infections. As at the end of 2010, about 33.3 million persons were estimated to be infected with HIV globally. Of these, 22.5 million (i.e. 68% of the global total) were in sub-Saharan Africa, and about 2.98 million in Nigeria. Nigeria has the second highest number of people living with HIV in the world after South Africa (Joint United Nation Actions on AIDS, 2010; National Agency for control of AIDS, 2010). A growing risk group that has received insufficient attention in HIV epidemic is women. HIV sero-prevalence survey using ante natal clinic attendee in Nigeria showed highest prevalence among women aged 25-29 years (5.6%). Thus, this figure is greater than the national prevalence of 4.1 %. Similarly, the proportion of people with AIDS who

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are women has grown dramatically over the past decade (Federal Ministry of health, 2010).

Federal Road Safety Commission is one of the occupations in Nigeria listed as both a high risk group and a key “bridging” gap acting as a conduit for the spread of HIV into the wider populations (Akinawo,1998; Raufu, 2002; Nwokoji & Ajuwon, 2004).Assessment of the trends and characteristics of road traffic accidents in Nigeria conducted by Ezenwa (2010) using data from police records show that there has been an increase in the fatality rates, injury and death rates per 100,000 populations. The number of accidents also increased by 10.4%, injured cases increased by 43%, cases of deaths increased by 110.6%, and total casualties increased by 57.1%. The mortality pattern showed that for every five fatal accident, one death occurred in the accident scene. This provides a clearer picture of the working condition of FRSC personnel being the commission charged with providing immediate attention to accident victims in Nigeria. This is in addition to heterosexual sex which accounts for about 80% of transmission route in Nigeria (National Agency for control of AIDS, 2010).

A concern is despite the documented benefits of HCT in optimal HIV health care utilization, recent data indicate that a significant proportion (77 %) of Nigerians including women in FRSC do not know their HIV sero-status. Negative attitude towards HCT has been identified as a major barrier to HCT uptake. Aday and Andersen (1974) opined that the ‘predisposing factor’ for HCT services include demographic characteristics such as age, social structures, occupational and educational status. This study therefore, examines gender differences in attitude towards HCT amongst FRSC personnel in Imo state exposed to Emotional Intelligence Therapy (EIT). Emotional Intelligence Therapy (EIT) was purposely selected for the study because it has a well reported potential to contribute to positive health outcomes.

Emotional Intelligence is a non-cognitive intelligence that involves an array of emotional, personal, social abilities and skills that influence an individual’s ability to cope effectively with environmental demands and pressures (Bar-On & Parker 2000). Emotional intelligence is defined as the ability to use emotions adaptively (Salovey & Mayer, 1990). According to Salovey and Grewal (2005), individual vary in their ability to process information of an emotional nature. Emotional intelligence competencies can either be inherited or acquired in therapy which is unlike Intelligent Quotient (Schuttle, Malouff, Hall, Haggerty, Cooper, Golden & Dornheim, 1998; Ciarochi, Scott, Deane, & Heaven, 2003). The purpose of using Emotional Intelligence therapy is to stimulate the emotional competencies of participants to enable them accurately assess the benefits of HIV counselling and Testing. Emotional Intelligence Training also has capacity to make the participants become empathic to person (s) living with HIV (PLHIV). Thus, through positive attitude towards HCT stigma and discrimination of PLHIV would be brought to

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minimal. Components of Emotional Intelligence therapy according to Dunn (2003) consists of self-awareness stimulation, self-regulation, empathy, creativity, innovation, motivation and good decision making skill. Other researchers conceptualized EI therapy as learner-centred activities (Giaconia & Hedges 1982); identifications of individuals' strengths and weaknesses, (Topping, 1998; Sluijsmans, Dochy & Moerker, 1999) and Role play activity (Jaeger, 2003; Reilly, 2005). The efficacy of Emotional Intelligence therapy in improving attitude towards health services has been supported by qualitative and quantitative research conducted in a variety of settings throughout the world (Robichhaud, Michel & Conway 2003; Adeyemo, 2004; Essien, Meshack & Ekong, 2005; Animasaun, 2005; Ofole & Falaye, 2011).

Purpose of Study

This study is designed primarily to examine the effectiveness of Emotional Intelligence Therapy (EIT) on modifying attitude towards HIV counselling and testing of Federal Road Safety Commission personnel in Imo state. In addition, the moderating effects of the participants' gender and levels of education on the study outcome will be investigated.

Hypotheses

The following three null hypotheses were tested at 0.05 level of significance

1. There is no significant difference in the HCT attitude mean scores of group treated and the control group.
2. There is no significant difference in the HCT attitude mean scores of males and female treated
3. There is no significant difference in the HCT attitude mean scores of treated group with high and low HIV educational status.

Methods

Research Design

The design adopted for the study is a pretest-posttest, control group, quasi-experimental with 2x2x2 factorial matrix. The columns consist of the Emotional Intelligence Therapy group (EIT) and the Control Group (CG). While the rows were made up of the study's moderating variables; gender (male and female) and levels of educational status (high and low levels).

Population, Sample and Sampling Technique

The target population for this study is three hundred and ten (310) FRSC personnel serving in Imo state. This command is one out of the forty-four Sector Commands of the Federal Road Safety Commission (FRSC) in Nigeria. The Commission was established by the government of the Federal Republic of Nigeria vide Decree 45 of 1988 as amended by Decree 35 of 1992 and 2007 also known as FRSC Act cap 141 Laws of the Federation (1990), with effect from 18th February 1988. The Commission is charged with providing prompt attention

and care to victims of road traffic accidents among other functions. Imo sector command is under zone RS9 which also comprises Ebonyi, Enugu, and Abia states. Imo sector command has units located in Owerri, Okigwe, Njaba and Orlu.

One hundred respondents (males =60; Females=40) with age range of 24 to 40 years, mean of 23.01 and standard deviation of 1.12 were purposively drawn from two units of FRSC using probability proportional to size sampling technique (PPST). Sixty four percent of the study participants were married while forty-six were single. Forty-seven per cent (47%) of the respondents have high educational level while fifty-three (53%) has low level as measured by their academic qualifications. The participants

Instrumentation

The instrument used to measure the dependent variable (HCT attitude) is a self report paper and pencil scale by Boshamer and Bruce (1999). It has two sections namely; section A and B. Section A sought information about the respondents' demographic characteristics such as their age, gender, rank, educational qualifications, and marital status. While section B is a 22- item scale with five sub-scales namely; trust and support about HIV testing; general concerns about testing; fears about HIV antibody testing; fears about confidentiality of HIV antibody testing; and friends concerns about HIV antibody testing. The scale contains 4-point Likert-type items in which higher scores indicate positive HCT attitude. The instrument was reported valid by Peltzer, Mpofu, Baguma, and Lawal (2002) who used it to examine the HIV testing attitude of adults whose age ranged between 17 and 44 in four African countries including Nigeria. For the present study the test-retest reliability of $r=0.89$ was obtained after two weeks interval during the pilot study by the researchers.

Procedures

Prior to the intervention, the researchers obtained the consent of the Sector and Units Commanders. The units were thereafter randomly assigned to the experimental condition (Experimental and control group). Respondents who satisfied the study inclusion criteria were exposed to eight sessions of Emotional Intelligence Therapy which lasted for one and half hours per session. The control group took part in the pre-test and post test but were not treated. They were compensated with a lecture on work ethics. Summary of the treatment package conceptualized based on Dunn (2003) is presented below;

Summary of Sessions

- Session I: General orientation and administration of instruments to obtain baseline data
- Session ii: Therapeutic goal and benefits of EIT in HIV prevention care and support
- Session iii: Self awareness /emotional mastery training

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- Session iv: Empathy/ sensitivity training
- Session v: Influence/communication skill training
- Session vi: Stimulating positive emotions towards HIV/AIDS by direct teaching.
- Session vii: Modifying attitude towards HIV/AIDS by direct teaching
- Session viii: Self control/conflict management training.
- Session ix: Adaptability/innovation competencies training.
- Session x: Administration of Questionnaires (ATHTS) AND Termination of ‘Therapy

Data Analysis and Results

Analysis of Covariance (ANCOVA) was used to determine the effectiveness of the independent variable (EIT) on the dependent variable (HCT attitude).The choice of ANCOVA was based on the fact that the study is a quasi experimental design which has a non randomised sample. ANCOVA also enables the inclusion of those covariates that are not part of the main experimental manipulation but have influence on the dependent variables. Secondly, t-test statistics was used to test the third hypotheses.

Hypothesis One

Hypothesis one predicted no significant difference in the HCT attitude of group treated and the control group. This hypothesis was tested using ANCOVA at 0.05 level of significance. The findings are presented on tables1- 3 below.

Table 1: Analysis of Covariance (ANCOVA) using EIT and Control group

Source of variation	Sum of Squares	DF	Mean Square	F	P	Remark
Rows	216.04	1	261.04	82.14	<0.05	Sig
Columns	423.19	1	423.19	14.06	>0.05	NS
Interactions	182.50	1	182.50	3.21	>0.05	NS
Within	889.21	96	8.08			

Result on Table 1 above show that there was significant difference in the HCT attitude scores of the experimental group and the control group. Hypothesis 1 is therefore rejected (F (1, 99) =82.14, P<0.05)

Table 2: Unadjusted X-Mean and Adjusted Y-Mean Based on Treatments (Rows) and Gender (Columns)

Groups	Male			Female		
	NO	X-X	Y-X	NO	X-X	Y-X
Emotional intelligence therapy (EIT)	34	32.11	37.24	22	39.10	42.12
Control Group (CG)	26	30.22	30.23	18	24.07	25.12

Table 3: Rows and Columns of Adjusted Y-Means for Comparison

Groups	Male	Female
EIT	37.24 (a) n=34	42.12 (b) n=22
CTG	30.22 (c) n=26	25.12 (d) n=18

Tables 2 and 3 above present the unadjusted x-means and adjusted y-means of participants' scores on treatment (row) and sex (columns). It reveals an increase in adjusted y- means of the treated group's scores. This is evidence that the therapy improved the HCT attitude of participants in the experimental group. On the contrary, there was no improvement in the adjusted y-means of the control group.

Hypothesis Two

Hypothesis two predicted no significant difference in the HCT attitude mean scores of male and female exposed to treatment. This hypothesis was tested using t-test at 0.05 level of significance. The findings are presented on tables 4 below.

Table 4: T-Test Showing the HCT Attitude of Male and Female Treated

Variables	N	df	X	SD	t	P	Remark
Male	60	99	44.21	7.01	1.53	2.11	Sig
Female	40		12.00	2.22			

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The result from table 4 above shows that $t=1.53$; $DF=48$, $P=0.59$, since the calculated value was greater than the table value, the null hypothesis was therefore rejected. It implies therefore, that gender significantly influence treatment outcomes.

Hypothesis Three

Hypothesis three predicted no significant difference in the HCT attitude mean scores of treated group with high and low educational levels. This hypothesis was tested using ANCOVA at 0.05 level of significance. The findings are presented on tables 5 and 6 below.

Table 5: Analysis of Covariance Based on Treatments and Educational Level

Source of Variation	Sum of squares	df	Mean squares	F	P	Remark
Rows	311.60	1	311.60	45.08	<0.05	S
Columns	82.00	1	82.00	0.11	>0.05	Ns
Interaction	111.12	1	111.12	1.01	>0.05	Ns
Residual	8238.18	99	9.24			

Result on Table 5 above show that there was significant difference in the HCT attitude scores of the treated group based on educational levels. Since the calculated F is greater than the table value at 0.05 level of significance, the null hypothesis was therefore rejected ($F(1, 99) = 45.08$; $P < 0.05$). This implies that educational levels significantly influence HCT attitude scores of the treated group.

Table 6: Unadjusted X-mean and adjusted Y-mean based (Rows) and levels Education (Columns).

Groups	High educational level			Low educational level		
	NO	X-X	Y-X	NO	X-X	Y-X
Male	24	25 .17	28.12	36	28.23	30.10
Female	18	29.50	30.32	22	28.19	38 .20

Table 6 above shows the adjusted Y-mean scores of the treated groups (high and low level of educational status). It shows that the adjusted y-means scores of the group with low level of education

(68.30) was higher than those with high level of education (58.44) .It implies therefore, that the group with low level of education had superior treatment gains over their counterpart with higher educational status.

Discussion

The results obtained in this study indicate the effectiveness of Emotional Intelligence Therapy in improving attitude towards HIV counselling and testing amongst FRSC personnel in Imo state. The first hypothesis which predicated no significant difference in the HCT attitude of the treated group and the control group was rejected. This finding reveals that EIT improved the attitude of participants treated when compared with that of the control group. This result corroborates with previous findings researchers (Kiehn, Swales 1995; Slaski & Cartwright, 2003; Essien, Meshack & Ekong, 2005; Animasaun, 2005; Ofole & Falaye, 2011). In their studies using diverse target populations they reported that an enhanced emotional Intelligence competencies stimulates individuals' perceptual speed to accurately assess services that would benefit them and others unlike their counterpart with low EI. The outcome is also in tandem with several theoretical researches that considered emotional intelligence to be the answer to the variance not accountable for by cognitions as measured by intelligent quotient (Mayer, Caruso, & Salovey 1999; Goleman, 1998; Kaufman, 2000; Lam & Kirby, 2002; Joseph & Tamera, 2005).

The finding is plausible given that exposure of the participants to Emotional Intelligence Training may have stimulated their emotional intelligence competencies and have made them to become self aware of the implications of being involved in HIV risky behaviours. It is also possible that EIT have empowered the participants with pro-social skills of coping with the demands of changing environment occasioned by the scourge of HIV. Instead of resorting to ineffective and antisocial behaviours of denial, avoidance and aggressiveness, they became proactive and changed their attitude unlike their counterpart in the control group (Bora, 2003; Roy, 2004; Animasaun, 2005).

Similarly, the second hypothesis which predicted that gender will not significantly influence treated outcome was also rejected. This implies that gender significantly influence participants' performance on HCT attitude. This finding is corroborative of, Wang, Stanton, Fang, Liang, Liu, Lin and Yang (2007). However, other researchers (Robertson, Stein & Thomas, 2006; Sohn & Chun, 2007) report contrary findings. This outcome is not surprising, substantial evidence shows that women display superior emotional intelligence competencies in diverse settings when compared with their male counterpart (Schuttle, et al., 1998; Macintyre, Rutenberg, Brown & Karim, 2004). This result is plausible, because women are reported to have emotional intelligence competencies more than the males in the following areas; expressive, emphatic,

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socially sensitive and are genuinely interested in their welfares and that of others (Eagley & Johnson 1990).

The third hypothesis which stated that there is no significant differences in the HCT attitude mean scores of the treated group based on educational level was rejected. This finding supports that of Brown, Lourie, Flanagan and High (1998), Slovic, (2000) who reported that participants with low educational level gained significantly in therapy when compared with their counterpart with high educational level. However, some researchers such as Adebajo, Mafeni and Moreland (2002), Adebola, Adedimeji, Omololu, & Oluwole (2007) and Aremu, (2009) found a contrary result. There are many possible reasons for this outcome; firstly, there is likelihood that the cohort with high educational level may have knowledge in other areas that is not related to HIV and HCT (Joint United Nation Actions on AIDS, 1998). Secondly, their educational attainment may also have inhibited therapy gain among this group. Another variable which perhaps influenced the study outcome was the participants' self-esteem. Rhodes and Wood (1992) opined that individuals with high educational level have high self-esteem which culminates to negative attitude to health services. He asserted that such people are less easily persuaded than those with moderate or low self self-esteem. Participants with high educational statues may also have been affected by unrealistic optimism-having an illusory belief of using their knowledge to control the possibility of HIV infection by for instance, believing that washing the genitals immediately after sexual intercourse would prevent HIV infection.

Recommendations and Conclusion

This study has therefore, provided empirical evidence based on which Emotional Intelligence is recommended as a potent therapy for the modifying attitude towards HCT. Based on the study's outcome, it is imperative that HCT counsellors and policy makers should put gender into considerations in all aspects of HCT programming. Similarly, messages promoting HCT services should be designed to easily be comprehended by both educated and non educated audience.

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