THE ROLE OF SELF-EFFICACY, POSITIVE THINKING AND OPTIMISM ON QUALITY OF LIFE AMONG HIV PATIENT IN UNIVERSITY COLLEGE HOSPITAL (UCH) AND ADEOYO MATERNITY HOSPITAL IN IBADAN.

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ABSTRACT
Quality of Life of HIV patients has not only been recognized as a health problem, but a development challenge, throughout the world with Nigeria on the alarming rate. The purpose of this study is to investigate the influence of role of self-efficacy, positive thinking and optimism on quality of life among HIV patient in university college hospital (UCH) and Adeoyo maternity hospital in Ibadan. This study adopted an ex-post facto design. A total number of one hundred and fifty one (151) participants were selected by the researcher using purposive sampling technique. A structured questionnaire consisted of demographics and scales were used to collect data in this study. Five hypotheses were formulated and tested using bi-variate and multi-variate statistical techniques. The result showed that, there was joint effect of 58% of Self-Efficacy, Positive Thinking, and Optimism on quality of life ($F(3,151)=24.99$, $R=.58$, $R^2=.32$, $P<.05$). There was significance differences in Self Efficacy of Low and High respondents ($t(149)=-7.94$, $p<.05$), on dating relationship. There is no significant differences between Patients with High Positive and Low Positive Thinking on dating relationship ($t(147)= -.50$, $p>.05$), There is also no significant differences between Patients with High optimism and Low optimism on dating relationship ($t(149)=.35$, $p>.05$), Gender, Age, Religion, Educational Qualification and Marital Status jointly predict Quality of life. ($F(5, 151) =4.11$, $R=.35$, $R2=.12$, $p<.05$).furthermore, Age ($B= -.40$, $\beta = -.16$, $t= -1.92$, $p< .05$), and gender ($B= -12.35$, $\beta = -.32$, $t= -4.00$, $p< .05$) independently predict Quality of Life while Religion ($B= .10$, $\beta = .14$, $t= 1.77$, $p> .05$), Educational Qualification ($B= 1.12$, $\beta = .06$, $t= .73$, $p> .05$), and Marital Status ($B= 2.29$, $\beta = .10$, $t= 1.21$, $p> .05$), did not independently predict quality of life. It was concluded in this study that there was significant role of self-efficacy, positive thinking and optimism on quality of life, hence it is highly recommended that health psychologists, and social workers need to mount intervention programmes designed to enhance self-efficacy which in the long run affect positive thinking, optimism of patient with HIV so as to achieve a healthy quality of life.
Key words: Quality of life, HIV/AIDS, Self-Efficacy, Positive Thinking and Optimism

INTRODUCTION
Human immunodeficiency virus (HIV) infection and Acquired immunodeficiency syndrome (AIDS) is one of the serious public health problems with severe impact on various facets of human life (Mweemba, 2008). At present, in the world, around 35 million people are suffering from HIV/AIDS (WHO, 2004). Every year 2.5 million people are infected by this virus (WHO, 2004). Nigeria has the third highest number of people estimated to be living with HIV/AIDS in the world (3.6 million as at the end of 2003), after South Africa and India (HIV/AIDS, 2005). Nigeria's epidemic is characterized by one of the most rapidly increasing rates of new HIV/AIDS cases in West Africa (USAID, 2000). Current projections show an increase in the number of new AIDS cases from 250,000 in 2000 to 360,000 by 2010. As a result of the epidemic, the crude death rate in Nigeria was about 20 percent higher in 2000 than in 1990. In 2001 alone, 170,000 adults and children died of AIDS. At the end of 2001, UNAIDS estimated that 1 million children orphaned by AIDS were living in Nigeria. Bearing the alarming increase of HIV/AIDS pandemic in developing countries, and the limited accessibility and availability of highly active anti-retroviral therapy (HAART), the majority of HIV/AIDS patients continue to suffer with the disease, with a serious impact on their quality of life (Geurtsen, 2010).

In more recent years, the concept of quality of life has attracted the attention of many social researchers and health care providers, and the concept has broadened. Traditionally, researchers of economics, medicine, and the social sciences have been interested in the concept of quality of life as a measure of the social effects of policies and practice. However, the approach of each of these disciplines has varied in their conceptualization and measurement of quality of life (Cummins, 2005). Quality of life is a multi-dimensional concept. There is a lack of

universally agreed definition of QOL (Basavaraj, Navya, and Rashmi, 2010). WHO defines QOL as "individual's perceptions of their position in life in context of the culture and value systems in which they live and in relation to their goals, expectations, standards and concerns". This broader definition of QOL by WHO indicates that QOL is a subjective feeling. Schalock (2000) defines QOL as "a concept that reflects a person's desired conditions of living related to eight core dimensions of one's life: emotional wellbeing, rights, interpersonal relationships, material wellbeing, personal development, physical wellbeing, self-determination and social inclusion". Many HIV patients battle numerous social problems such as stigma and depression, which affect their QoL in terms of their physical, mental, and social health (Semba, Martin, Kempen, Thorne, and Wu, 2005). QoL is an indicator of not only how well an individual functions in daily life, but also how the individual's perceptions of health status influence his or her life (Chan I, Li, Chung, Po, and Yu, 2004).

Phillips (2006) postulate that quality of life is a multifaceted phenomenon determined by the cumulative and interactive impacts of numerous and varied factors like housing conditions, infrastructure, access to various amenities, income, standard of living, satisfaction about the physical and social environment. According to Phillips (2006), the two indicators of quality of life which are subjective and objective are pointing to two different things. Subjective indicator focuses on pleasure as the basic building block of human happiness and satisfaction of quality of life. However, the objective indicator on the other hand, focuses on a radically different perspective. To those who are working with this indicator, the important question to ask at the individual level are whether people are healthy, well fed, appropriately housed, economically secure and well educated or not rather than whether they feel happy. In Nigeria, QoL has been found to be determined by education, income, family support, HIV serostatus, and patient age (Odili, Ikhuronian, Usifoh, and Oparah, 2011). The present study is interested in looking at variables that can help increase HIV patient quality of life. Hence, this study will considered self-efficacy, positive thinking and optimism on quality of life.

Self-efficacy is defined as peoples believe about their capability to produce designated levels of performance that exercise influence over event that affect their life (Bandura, 1997). According to Bandura (1997), there are four main sources of information that influence perception of self- efficacy. These are: mastery experience, vicarious experience, verbal persuasion or similar sources of social influences, and physiological and affective states. Self-efficacy has been positively associated with better health status outcomes in a range of conditions relevant to rehabilitation. There is some evidence suggesting a positive association between quality of life and self-efficacy. However, this relationship has not been investigated among HIV patients. Self-efficacy has become a vital element in a variety of fields such as sociology, psychology, health and education because higher self-efficacy has been shown to be related to better health, and social integration (Schwarzer and Fuchs, 1995).Researchers are curious to find out what affects self-efficacy, its influence on a variety of behaviours, and how it can be enhanced. It has been claimed to have a predictive nature, with positive self-efficacy linked with successful accomplishment of tasks (Gecas, 1989; Bandura, 1977, and 1994). Bradley and Corwyn (2001) proposed that environment stimulates or encourages one's behavior such as self-efficacy. Bandura (1995) explains that self-efficacy plays an important role in determining one's capacities to organize and execute courses of action required to produce given attainments. It influences the choices people make, courses of action they pursue, amount of stress and anxiety that one experiences as he or she is involved in the activity. A strong sense of efficacy encourages people to do well in many ways. They can approach difficult tasks as challenges and maintain strong commitment (Pajares, 2006). If the people face failure, they will attribute it to insufficient efforts and lack of knowledge. On the other hand, people with low self-efficacy always assume that tasks are tough and avoid indulging in it meaning with low self-efficacy feel contraceptive is hard to use and they avoid using it. They have little or no idea on how to resolve it by using the best choice

Positive thinking is another psychological factor that has been linked to quality of life. McGrath (2004) defined positive thinking as a generic term referring to an overall attitude that is reflected in thinking, behavior, feeling and speaking. Positive thinking is a mental attitude that admits into the mind; thoughts, words and images that are conducive to growth, expansion and success. According to Seligman, (2006), positive thinking is a mental attitude that admits into the mind thoughts, words, and images that are conducive to growth and success. Positive psychology is a new dimension that focuses on positive thinking, positive emotions and positive behavioral qualities that enhance human potential in various domains such as work, coping with stress and health. By thinking positively, we perceive the stress as less threatening, are able to cope with it effectively. Positive thinking is a manner of thinking that puts emphasis on processing thoughts in a more desirable way.

Positive thinkers encounter circumstances with optimism and if they encounter stressful situations they appraise it as controllable and use coping strategies that are functional, efficient and problem focused. Positive thinkers feel that life is going well, their goals are being met, and resources are adequate (Carver & Scheier, 1998; Cantor et al., 1991). Negative thinking is thoughts that imply criticism or devaluation of self. These thoughts dominate the perception of a depressed person. People who think negatively do not expect things to go as planned therefore anticipating bad outcomes. Their coping with daily stressors becomes dysfunctional and they develop psychological and physical health problems. Historically, psychologists have been solely focused on negative mental states leading to pathology and disorder. The influence of positive thinking, positive emotions on quality of life and health outcomes was generally neglected.

Optimism is another variable used in this study to influence quality of life. Optimism refers to the belief that one's outcome from psychological and sociological situations will be positive rather than negative. This refers to the self-serving belief that favorable situations are likely to occur in the face of any circumstance. Optimists are more likely than pessimists to believe that good outcomes are attainable and bad outcomes are avoidable. As a result optimists exert greater effect towards attaining desired outcomes, whereas pessimists reduce or withdraw effort and eventually fail at achieving set goals. Peterson (2000) asserted that optimism can be referred to as a global expectation that more desirable things than undesirable things will happen in the future. This expectation is stable and seldom changes across situations in the lives of individuals with this characteristic (Peterson, 2000). Dispositional optimism has been associated with a reduced risk, for various physical disorders, including a lower risk for various physical disorders (Ruis-Ottenheim, van der Mast, Zitman, Giltay, 2012).

Carr (2007) mentions that people having a pessimistic explanatory style tend to develop more depression when confronted with stressful events or health challenges. A great number of researchers have given to the task of finding how optimism works, sometimes as a protective variable, sometimes as a perilous antecedent of an individual's coping style. Many say that in case individual get sick, optimism is useful for psychological adjustment. Research has shown that individuals with optimistic outlooks are better liked by others and are socially rejected less often; have fewer negative social interactions; have longer-lasting friendships; and experience lesser social alienation and anxiety

Most Research have not really looked at how individual who are faced with HIV/AIDS can effectively cope or mechanisms that patients with HIV can personally use in coping with the illness in other to result to a positive quality of life. Hence this study sought to fill this gap in knowledge by looking at the role of self-efficacy, positive thinking and optimism on quality of life among HIV patients.

HYPOTHESES

1. Self-efficacy positive thinking and optimism will jointly and independently influence quality of life among HIV patient in Ibadan

2. Patient with high self-efficacy will significantly score higher on Quality of Life than Patients with Low Self-Efficacy
3. Patient with high positive thinking will significantly score higher on Quality of Life than Patients with Low positive thinking
4. Patient with high optimism will significantly score higher on Quality of Life than Patients with Low optimism
5. Demographic factors (age, sex, marital status, and educational attainment.) will independently and jointly predict quality of life among HIV patient in Ibadan

METHOD

Research Design

This study employed an ex-post facto design; this is because the variables of interest, self-efficacy, positive thinking, optimism and quality of life had already occurred in nature prior to the commencement of the study. Therefore, the researcher collects the necessary data needed for the study in order to draw inferences about these variables in association with the dependent variable which is of interest.

Research Setting

This study was carried out at two different hospitals in Ibadan north local government, namely, University College Hospital (UCH) and Adeoyo maternity hospital. University College Hospital Ibadan is a government owned teaching hospital located at Queen Elizabeth Road, Ibadan, Oyo State, while Adeoyo maternity Ibadan is a state government owned specialised service hospital located at Yemetu Adeoyo, Ibadan, Oyo State. These two hospitals are approved by the federal government as HIV/AIDS treatment centres.

Participants

The study population focused on patients who were diagnosed of HIV/AIDS and were receiving their palliative care from the hospital. A total of one hundred and fifty one (151) participants were sampled and used for the study. Their gender reveals that 60(39.7%) are male while 91(60.3%) are female. Mean age of the respondents is 32.07 with a standard deviation of 7.75. Their religious affiliation shows that 73(48.3%) are Christian 77(51.0%) are Muslim and 1 (.7%) is from other religions. Respondent educational qualification revealed that 26(17.2%) have primary/secondary education, 42(27.8%) are NCE/OND holders, 58(38.4%) are Degree/HND holders, 21(13.9%) are MSc holders and 4(2.6%) are PhD holders. Respondent marital status shows that 80(53.0%) are single, 48(31.8%) are married, 16(10.6%) are divorced/separated and 7(4.6%) are widowed.

Sampling Technique

This study employed purposive and accidental sampling techniques. In purposive sampling, the choice of individuals diagnosed with HIV/AIDS were selected in the selected hospitals; in accidental, HIV/AIDS patient that come in for anti-retroviral drugs or medical check-up at the hospitals were selected for participation in the study.

Ethical Consideration

Ethical approval was duly processed and obtained from Oyo State Ethical Review Board.

Research Instrument

A structured self-administered questionnaire was adopted for this study; this questionnaire was divided into five sections:

Section A: This section measured demographic variables such as age, sex, religion, marital status and educational attainment.

Section B: Quality of life was measured with the English version of the World Health Organization Quality of Life Questionnaire-Short Version (WHOQoLBREF). The questionnaire consists of 26 items in four domains. The four domains of QOL are physical health domain, psychological health domain, social relationships domain and environmental domain. The mean score will be transformed from 4 – 20 range. The Higher the scores, the better is the Quality of life. It will be score as 1= Not at all, 2 = Not much, 3 = moderately, 4 = A great deal, 5 = completely. In this study a Cronbach Alpha of 0.94 was obtained for this scale.

Section C: These sections measure Self efficacy. This variable was captured using the 10-item scale developed by Schwarzer and Jerusalem (1993). The response format was 1= not at all true, 2 = hardly true, 3 = moderately true, and 4 = exactly true. According to the authors, GSE had positive criterion-related validity coefficients ranging from .65 to .98 with favourable emotions, dispositional optimism, and work satisfaction. It had negative criterion-related validity coefficients ranging from -.52 to -.86 with depression, anxiety, stress, burnout, and health complaints (Schwarzer & Jerusalem, 1993). In samples drawn from 23 nations, GSE had Cronbach's Alpha that ranged between .76 and .90 (Schwarzer & Jerusalem, 1993). High score indicated high self-efficacy whereas low score indicated low self-efficacy. In this study a Cronbach Alpha of 0.85 was obtained for this scale.

Section D: These sections measure Positive Thinking. This variable was measure with a 28 item positive scale developed by Ingram and Wisnicki (1988). The format of the scale range from 1 = always, 2 = often, 3 = sometimes, 4 = rarely, 5 = Never. The Reliability of the scale is 0.88 and in this study a Cronbach Alpha of 0.94 was obtained for this scale.

Section E: These section will measures Optimism with the Revised Life Orientation Test (LOT-R). The LOT-R (Scheier, Carver, & Bridges, 1994) is a test developed to measure self-reported dispositional optimism, being a reduced and revised version of the Life Orientation Test – LOT (Scheier & Carver, 1985). The test includes 10 items: three statements about optimism (items 1, 4 and 10), three on pessimism (items 3, 7 and 9) and four distractor items (2, 5, 6, 8) whose scores are not computed. Subjects answer the statements indicating their level of agreement on a five-point Likert scale, ranging from strongly disagree to strongly agree. The negative scores on the test need to be inverted for the statistical analysis, so that values close to five always indicate a higher degree of optimistic expectations of the individual. LOT-R has good internal consistency (alpha coefficient ranging from .70 to .80) (Scheier, Carver, & Bridges, 1994).

Research Procedure

Firstly, the researcher sought permission from the two hospital management in which it was granted after four weeks of consideration. The next step the researcher took was to visit the HIV counselling unit to inform the participants on the purpose and objectives of the study. During the interaction, the researcher assured the entire participants that their responses will be confidential. The researcher prepared one hundred and sixty (160) copies of the questionnaire in which one questionnaire was given to each participant with the assistance of a health nurse. Directions on how to complete the questionnaire were explained by the researcher. Some participants filled the questionnaires on the spot while some participants promise to return the questionnaire on a later day. Administration and collection of the questionnaires took five weeks. A total number of 151 questionnaires were retrieved while 9 were not returned as participants gave excuses that they could not find the questionnaires. Finally, the collected questionnaires were subjected to statistical analysis.

Statistical Analysis

The collected data was first checked for its adequacy and then analysed using the statistical package for Social Sciences (SPSS) version 20. Hypotheses one and five were analysed using the multiple regression analysis while hypotheses two, three and four were analysed with t-test for independent samples.

RESULTS

Descriptive Analysis

Table 1: Summary Showing Descriptive Analysis of the Demographic Factors

Variables	N	%	Mean (X)	SD	p
Gender					
Male	60	39.7	81.15	17.09	
Female	91	60.3	70.31	18.68	**<.01**
Total	**151**	**100**	74.62	18.78	
Age			32.07	7.76	**>.05**
Religion					
Christian	73	48.3	72.67	18.33	
Muslim	77	51	76.08	18.99	**>.05**
Other	1	0.7	104.00	.	
Total	**151**	**100**	74.62	18.78	
Educational Qualification					
Primary/Secondary	26	17.2	72.62	15.48	
NCE/OND	42	27.8	77.19	17.35	
Degree/HND	58	38.4	74.41	21.54	**>.05**
MSc.	21	13.9	72.14	19.09	
Ph.D	4	2.6	76.50	10.25	
Total	**151**	**100**	74.62	18.78	
Marital Status					
Single	80	53	74.90	19.17	
Married	48	31.8	73.42	18.45	
Divorced/Separated	16	10.6	70.63	16.07	**>.05**
Widowed	7	4.6	88.71	19.58	
Total	**151**	**100**	74.62	18.78	

From the descriptive result, it is observed that there are 60 (39.72%) male respondents and 91 (60.3%) female respondents whose mean age is 32 years. This shows female respondents were almost double the distribution of male respondents. Also, 73 (48.3%) are

Christians while 77(51%) are Muslims and 1(.7%) of the respondent is from other religion. Twenty Six (17.2%) of the respondents had primary/secondary school educational qualifications while 42(27.8%) respondents had NCE/OND educational Qualification while 58(38.4%) are Degree/HND holders and 21(13.9%) respondents had MSc. Educational Qualification and 4(2.6%) of the respondents had Ph.D educational Qualification. Eighty (53%) of the respondents were single, 48(31.8%) were married, 16(10.6%) divorced/Separated and 7(4.6%) were Widowed at the time of the study. It should be noted that all respondents indicated information for these demographic information.

Test of Inter-Variable Correlations

Before the test of research hypothesis, the relationship existing among the variables is examined and the result is present below:

Table 2: Summary Showing Pairwise Inter-variable Correlations using Pearson Product Moment Correlations

Variables	1	2	3	4	5	6	7	8	9	**Mean**	**SD**
1. Gender	1									1.60	.49
2. Age	-.083	1								32.07	7.75
3. Religion	.063	.087	1							1.52	.51
4. Educational Qualification	.216**	.236**	.115	1						2.56	1.02
5. Marital Status	.034	.390**	.064	.174*	1					1.66	.85
6. Self-Efficacy	-.152	-.186*	.132	.081	.050	1				24.61	6.44
7. Positive Thinking	-.034	.086	.086	-.008	.092	.038	1			66.70	21.99
8. Optimism	.061	-.026	.107	.050	.104	-.095	.660**	1		20.17	6.89
9. Quality Of Life	-.283**	-.074	.118	-.014	.046	.584**	.109	.006	1	74.61	18.78

Hypothesis one stated that, Self Efficacy, Positive Thinking and Optimism will independently and jointly predict Quality of Life. The hypothesis was tested using multiple regression analysis. The result is presented in table 3.

Table 3: Summary Table of Multiple Regression showing independent and joint prediction of Self Efficacy, Positive Thinking and Optimism on Quality of Life.

Predictors	**B**	***β***	**T**	**Sig**	**R**	**R^2**	**F**	***P***
Self-Efficacy	1.67	.57	8.42	< .05	.58	.34	24.99	< .05
Positive Thinking	.06	.08	.88	> .05				
Optimism	.02	.01	.11	> .05				

Results from table 3 partially supported the alternate hypothesis ($F(3,151)=24.99$, $R=.58$, $R^2=.32$, $P<.05$). This infers that Self-Efficacy, Positive Thinking, and Optimism jointly accounted for about 32% of the variance observable in HIV patients' quality of life. Further, the independent contribution of self-efficacy was significant ($\beta = .57$; $t = 8.42$; $p < .05$) while that of positive thinking and optimism were not significant [($\beta = .08$; $t = .88$; $p > .05$) and ($\beta = .01$; $t = .11$; $p > .05$) respectively].

Hypothesis two stated that Patient with high self-efficacy will significantly score higher on Quality of Life than Patients with Low Self-Efficacy. The hypothesis was tested using t-test for Independent Sample. The results is presented in table 4

Table 4: Summary of t-test table showing the influence of Self-Efficacy on Quality of Life.

Variable		N	$\overline{X}$	S.D	t	df	P
Low Self-Efficacy	75	64.33	13.49				
				-7.94	149	<.05	
High Self-Efficacy	76	84.76	17.77				

Hypothesis two stated that, Patient with high self-efficacy will significantly score higher on Quality of Life than Patients with Low Self- Efficacy. The above results fully supported the hypothesis (t(149)=-7.94, p<.05), Also, the means score of patients with high self-efficacy ($\overline{X}$ =84.76, SD=17.77) was higher than patients with low self-efficacy ($\overline{X}$ =64.33, SD= 13.49) on Quality of Life. Therefore hypothesis two was accepted and confirmed.

Hypothesis three stated that Patients with High Positive Thinking will significantly score higher on Quality of Life than Patients with Low Positive Thinking. The hypothesis was tested using t-test for Independent Sample. The results are presented in table 5.

Table 5: Summary of t-test table showing the influence of Positive Thinking on Quality of Life.

Variable		N	$\overline{X}$	S D	t	df	P
Low Positive Thinking	91	73.79	20.11				
				-.50	147	>.05	
High Positive Thinking	58	75.39	16.53				

Hypothesis three stated that, Patients with High Positive Thinking will significantly score higher on Quality of Life than Patients with Low Positive Thinking. The above results negate the hypothesis (t(147)= -.50, p>.05), Also, the means score of the patients with high positive thinking ($\overline{X}$ =75.39, SD=16.53) was lower than patients with low positive thinking ($\overline{X}$ =73.79, SD= 20.11) on Quality of life. Therefore hypothesis three was rejected.

Hypothesis four stated that Patient with High Optimism will significantly score higher on Quality of Life than Patient with Low Optimism. The hypothesis was tested using t-test for Independent Sample. The result is presented in table 6.

Table 6: Summary of t-test table showing the influence of Optimism on Quality of Life.

Variable		N	$\overline{X}$	SD	T	df	P
Low Optimism	93	75.04	19.85				
				.35	149	>.05	
High Optimism	58	73.93	17.06				

Hypothesis four stated that, Patient with High Optimism will significantly score higher on Quality of Life than Patient with Low Optimism. The above results negate the hypothesis (t(149)=.35, p>.05). Additionally, the means score of patients with high optimism ($\overline{X}$ =73.93, SD=17.06) was low than patients with low optimism ($\overline{X}$ =75.04, SD= 19.85) on Quality of Life. Therefore hypothesis four was rejected.

Hypothesis five stated that, demographic factors will independently and jointly predict on Quality of life. The hypothesis was tested using multiple regression analysis. The results is presented in table 7.

Table 7: Summary of Multiple Regression Showing the independent and joint prediction of Demographic Factors on Quality of Life.

Predictors	B	*B*	t	P	R	R^2	F	*P*
Gender	-12.35	-.32	-4.00	<.05				
Age	-.40	-.16	-1.92	< .05	.35	.12	4.11	< .05
Religion	5.10	.14	1.77	> .05				
Educational Qualification	1.12	.06	.73	> .05				
Marital Status	2.29	.10	.1.21	>. 05				

Hypothesis five stated that, demographic factors will independently and jointly predict on Quality of life. The above results shown that that gender independently (B= -12.35, ***β*** = -.32, t= -4.00, p< .05), predict Quality of Life. In other words, gender shared (B=-12.35) unstandardized regression coefficient and (β=-.32) standardized regression coefficient which indicated that gender independently contributed (32%)) indirect variance on quality of life.

In addition, Age independently (B= -.40, ***β*** = -.16, t= -1.92, p< .05), and gender (B= -12.35, β = -.32, t= -4.00, p< .05) predict Quality of Life. This suggests that age contributed (B=-.40) unstandardized regression coefficient and (***β*** = -.16) standardized regression coefficient on Quality of Life. That is, (16%) indirect variance on quality of life can be accounted for by age. Conversely, Religion (B= .10, ***β*** = .14, t= 1.77, p> .05), Educational Qualification (B= 1.12, ***β*** = .06, t= .73, p> .05), and Marital Status (B= 2.29, ***β*** = .10, t= 1.21, p> .05), did not independently and insignificantly predict Quality of life.

Moreover, Gender, Age, Religion, Educational Qualification and Marital Status (F(5, 151) =4.11, R=.35, R^2=.12, p<.05) jointly predict Quality of life. This suggests that the multiple regression coefficients of the five demographic factors shown the relationship strength of 35% on Quality of life. Also, these variables jointly accounted for 12% variance in Quality of life while the remaining 88% variances are attributed to other alienated factors which are not considered in this study. Hence, the results partially supported the hypothesis.

DISCUSSION

The first hypothesis which stated that Self Efficacy, Positive Thinking and Optimism will independently and jointly predict Quality of Life was supported. The finding was in line with Shelley and Pakenham (2004) investigated the association between self-efficacy, optimism and positive thinking on quality of life among 164 in patient in an urban hospital. The result showed that there was a joint effect of self-efficacy, optimism and positive thinking on quality of life among this sampled respondent. Another similar study by Cohen and Pressman (2006) examined self-esteem, optimism perception and positive thinking among 85 tuberculosis patients. It was found that self-esteem independently influence quality of life while optimism perception and positive thinking did not influence quality of life among the sampled patients.

The second hypothesis which stated that Patient with high self-efficacy will significantly score higher on Quality of Life than Patients with Low Self-Efficacy was supported. This study was in line with study done by Jane, Cramm, Strating and Nieboer (2013) examined influence of general self-efficacy on quality of life outcomes over time among adolescents with type I diabetes or juvenile rheumatoid arthritis. The result shows that adolescents' data showed adolescent with high general self-efficacy and changes in general self-efficacy predicted quality of life. Another study done by Abraham, miller, Birgen, and kilbourne (2014) who examined Self-Efficacy and Quality of Life among People with Bipolar Disorder. The result found that higher levels of self-efficacy were associated with higher mental and physical HRQoL

The third hypothesis which stated that Patients with High Positive Thinking will significantly score higher on Quality of Life than Patients with Low Positive Thinking was not supported. The finding is in line with the study done by Chida and Steptoe (2008) where they conducted a meta-analysis of the prospective studies examining the association between positive well-being and quality of life in both healthy and diseased populations. The study found a negative relationship between quality of life and positive wellbeing. Another similar study done by De Reave (2009) examined differences between 120 patients who have high positive thinking on quality of life among some patient in a specialised hospital. The study found no significant differences between patient with low and high positive thinking on their quality of life.

The fourth hypothesis which stated that Patient with High Optimism will significantly score higher on Quality of Life than Patient with Low Optimism was not supported. This study was Boman and Yates (2001) found students with high levels of optimism did not adjust better to high school than student with low optimism even when accounting for depression and anxiety. Another similar study done by Kung et al. (2006) who found that optimism does not have associated with quality of life in survivors of thyroid cancer than those with head and neck cancer

The fifth hypotheses which stated that demographic factors will independently and jointly predict Quality of life was partially supported. This study was in line with study done by Akinyemi, Owoaje, Popoola and Ilesanmi (2015) who examined some socio demographic factors on quality of life among adults in a community in south west Nigeria. The study found that age, gender, marital status, and educational qualification jointly predicted quality of life among the sampled respondent. Yet another study done by Jane Mathilde Strating and Nieboer, (2013) also found that age and gender independently have a positive effect on quality of life of HIV patient.

Conclusion

Based on the findings of this study the following conclusions were made; it was concluded in this study that there was joint influence of self-efficacy, positive thinking and optimism on the quality of life of the respondent. It was also concluded that patient with high self-efficacy have high quality of life compare with patient with low self-efficacy. Furthermore there were no significant differences between patient who have high positive thinking and low positive thinking on their quality of life. Also there was differences of patient with low optimism and patient who high optimism on their quality of life. The joint effect of Gender, Age, Religion, Educational Qualification and Marital Status has influence on quality of life of the respondent. Only gender and age have independent contribution on quality of life while Religion, Educational Qualification and Marital Status do not have any independent influence on quality of life

Recommendation

With reference to the findings of this study, it is recommended that in order to effectively maintain a healthy quality of life among HIV patients. It is highly recommended that health psychologists, and social workers need to mount intervention programmes designed to enhance self-efficacy which in the long run affect positive thinking, optimism of patient with HIV so as to achieve a healthy quality of life. The study also recommend that training should be encouraged from time to time through improving individuals' affective perception of their own through increased self-efficacy and raising motivation to solve daily challenges, and belief in their abilities which in the long run improve their quality of life . Government and NGOS should intensify training and facilities required to boost the quality of life of patients by engaging the services of experience clinical psychologist in training and developing the coping skill required for patient to have a better quality of life.

Limitation of the study

One of the major limitations of this study is the sample size used. It is still relatively small, the fact still remains that it did not represent the totality of HV patient in Ibadan, Oyo state,

Nigeria. Thus, a note of caution needs to be sounded when generalizing the study's findings. Another limitation of this study is inability to get the participants to fill the questionnaire as the researcher always wait for longer hours before having access to this participant. Lastly, the budget at the disposal of the researcher placed a constraint in order to sample from different hospitals. Lastly, time constraints were also a major limitation in this study

Suggestions for further study

It is highly suggested that future researchers should try to focus on the following areas: Replication of this study for further validation, increase the number of participant to be sampled, as the present population was not too large. Future study can also include different terminal illness from different government teaching hospitals across Nigeria order than the ones used in this study. More Studies can also be done on more psychological variables that can influence quality of life among HIV patient.

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