



## **Psychosocial Correlates of HIV Status Disclosure among Persons Living with HIV in Ibadan Metropolis, Oyo State, Nigeria**

**\*Jamiu, Mahmood Suleiman; \*Abdulkareem, Mansoor Olayinka; \*\*Issah, Abolaji Yusuf; & \*\*\*Salihu Nurudeen Oganija**

*\*School of Education and General Studies, College of Arabic and Islamic Legal, Studies Ilorin, Ilorin. Kwara State, Nigeria. \*\*Computer Science Department, College of Arabic and Islamic Legal, Studies Ilorin, Ilorin. Kwara State, Nigeria. \*\*\*Guidance and Counselling Unit, Quality Assurance Section, Ilorin West I G E A, Kwara State Nigeria*

### ***Abstract***

*HIV status disclosure to ART remain issues of concern to health related professional, most especially counselling psychologists in the field of STI/HIV/AIDS as many of the Persons living with HIV hardly adhere to ART and some of them are experiencing psychological related issues which are impeding their HIV positive status disclosure. This informed the direction of this study to examine psychosocial factors as correlates of HIV status disclosure among Persons living with HIV in Ibadan metropolis, Oyo State, Nigeria. The study adopted descriptive survey research design of correlational type and structured questionnaires (stigmatization, social support, self-concept, depression, disclosure and adherence scale) were used to gather information. Multistage sampling procedure was adopted which involved the use of simple random sampling technique to select three (3) APIN/PEPFAR Clinics Ibadan metropolis and purposive sampling technique was used to select (150) Persons living with HIV from each of the selected clinics. The data collected were analysed using frequency count,*

*Pearson Product moment correlation and Multiple Regression Statistical Tool, and tested at 0.05 level of significance. The result revealed that self-concept ( $\beta= 0.423$ ;  $t = 4.324$ ;  $p<0.05$ ), stigmatization ( $\beta= -0.389$ ;  $t = -3.762$ ;  $p<0.05$ ), depression ( $\beta= 0.531$ ;  $t = 4.341$ ;  $p<0.05$ ) and social support ( $\beta= 0.618$ ;  $t = 5.277$ ;  $p<0.05$ ) made significant independent contribution to HIV status disclosure among Persons living with HIV. The result also indicated that psychosocial factors (self-concept, depression, stigmatization and social support) had significant joint contribution to HIV status disclosure among Persons living with HIV ( $F_{(4,140)}= 9.012$ ;  $p<0.05$ ). The study concluded that psychosocial factors had significant relative and joint contribution to HIV status disclosure among Persons living with HIV. Therefore, it was recommended that counselling psychologists and health related professionals should take cognisance of self-concept, depression, stigmatization and social support in the development of any intervention to improve and help people living with HIV through disclosure.*

**Keywords:** *Psychosocial, Factors, HIV, Disclosure, Correlates and persons living with HIV*

## **Introduction**

Disclosure of positive HIV status is typically difficult and fraught with concern and fear regarding the outcomes of the disclosure, which has some bearing on the motivation to disclose among PLHIV. While certain psychological and social assets can buffer or ameliorate the worry, disclosure remains a salient issue for PLHIV, and in adhering to ART which is other to improve their quality and longevity of life. Since there is yet to be a proven or known cure for HIV infection. Human's physical health,

mental health, emotional life and social life which comprises relationships, attitudes, cultural values and the influences of family, school, peers and community all affect psychosocial wellbeing. PLHIV are also influenced by their capacity for independence and self-management, understanding and knowing how to limit and cope with psychosocial factors that are impeding on disclosing of their HIV status. Such factors may include any or combinations of stigma, isolation, discrimination,

anger, self-esteem, vulnerabilities linked to orphan hood, poverty, illness and abuse, coping with death and bereavement, educational challenges or cognitive impairment, and disclosure to others for emotional and practical support.

HIV status disclosure are very significant in treating, controlling and promoting healthy and happy living among PLHIV to the extent that they can go about living their life in a very fulfilling, purposeful, joyous, prosperous and prolonging manner. The negative effects of HIV can be suppressed to a possible near zero level and prevent it from crossing the threshold level of been HIV infection to AIDS-related complex or full-blown AIDS through volitional disclosure of HIV status by the PLHIV which will offer them opportunity to access supports. However, it is very saddening that the rate of HIV status disclosure among PLHIV in Nigeria remain very low.

Despite that ART is free and can be easily accessed through out the Nation's designated health centres and Nigerian Government enactment into law, an act that made provisions for prevention of HIV and AIDS-based discrimination and protects the fundamental human rights and dignity of people living with and affected by HIV and AIDS in Nigeria. With the intent of identifying, understanding and proffering solutions to issues on HIV status disclosure. One will be very motivated to ask why is it still difficult for PLHIV to disclose their HIV status and even though doing so inherently have immeasurable benefits that will help to promote their overall healthy living and prolong life expectancy. The reasons are not far fetch considering the reality that Nigeria as a nation like other African countries have it in their cultural and religious structures that HIV is God's retribution for sexual promiscuities among human race and whoever is infected with HIV is treated with disdain. According to Balogun (2017) being HIV positive attracts stigma, discrimination and violence because of fear of the unknown source of HIV, the generally poor knowledge of HIV transmission and the association of HIV to death.

The Human Immune Virus (HIV) has created a vast challenge throughout the world and across all human race. A report by UNAIDS (2012) shows that, at end of the year 2012, approximately, 34 million people around the world are living with HIV/AIDS. The epidemic continues to be more severe in Africa than anyother country in the world. Almost half of the deaths from Acquired immune deficiency syndrome (AIDS) related illness in 2012 occurred in Africa and 1.1million people are living with HIV with Marked regional variations. AIDS is oneof the most destructive epidemics the world has ever witnessed. Presently

an estimated 33.4 million people are living with HIV worldwide, nearly two-thirds of these live in sub-Saharan Africa. Antiretroviral therapy (ART) has shown to delay progression to AIDS, resulting in a greater and more sustained virology and immunologic response and improve survival (HIV/AIDS Prevention and Control Office, 2012).

Appropriate use of antiretroviral therapy (ART) has improved the health of many PLHIV, who otherwise may have died due to the HIV infection. Notably, But, the antiretroviral regimens are often complicated and can include varying dosing schedules, dietary requirements and adverse effects. Adherence is a major predictor of the survival of PLHIV and poor adherence to treatment remains a major obstacle in the fight against HIV. From the perspective of service delivery, treatment non-adherence undermines the efficient distribution of resources and huge expenditure by international organizations including the United States President's Emergency Plan for AIDS Relief (PEPFAR), the Global Fund and the World Bank (Pennington, 2007).

Sasaki, Kakimoto, Dube, Sikazwe, Moyo et. al (2012) interventions that focused on improving HIV status was tailored to the demands that are experienced by the patients with that specific illness. As a result, it is important for health care providers to assess those factors that impact negatively on HIV patients. Significantly, to improve disclosure, the health care providers should first ascertain treatment readiness, otherwise treatment may be given to patient who are not ready to follow the regime. In addition, patients should be advised on how to take their treatment. Burkhart and Sabaté (2003) patients who show less than 80% compliance require increases adherence support knowledge regarding the effect of anti-retroviral medication on viral load.

## **THEORETICAL BACKGROUND**

Globally, young people constitute more than half of those infected by HIV with reports estimating that over 6000 youth get infected with HIV every day (USAID, 2011). This increasing number of young people getting infected means there are more young people being initiated into treatment programs. Behaviours associated with adherence such as taking doses at the same time every day, following food restrictions and skipping doses because of irregularity in routines remain a challenge to youth living with HIV (Reisner, Mimiaga, Skeer, Perkovich, Johnson et al., 2009).

Human Immunodeficiency Virus (HIV) infection remains one of the ten leading causes of death in Nigeria and the social stigma associated with this disease compounds the problem. Recent estimates suggest that Africa has about 1.7 million of the global 2.5 million individuals newly infected in 2007. Antiretroviral therapy is indicated for all patients with obvious AIDS defining illness (WHO stage 4) and those with CD4 count less than 200/mm. However, the current view is that ART should be initiated when the CD4 count is 350/mm<sup>3</sup> for effective care.

Stigma associated with HIV/AIDS infection is underpinned by many factors, including lack of understanding of the illness, misconceptions about how HIV is transmitted, lack of access to treatment, irresponsible media reporting on the epidemic, the incurability of AIDS, prejudice and fears relating to many socially sensitive issues including sexuality, disease and death, and drug use. Stigma can lead to discrimination and other violations of human rights which affect the well-being of PLHIV in fundamental ways. In countries all over the world, there are well-documented cases of PLHIV being denied the right to healthcare, work, education, and freedom of movement, among others. Global consensus on the importance of tackling AIDS-related stigma and discrimination is highlighted by the Declaration of Commitment adopted by the United Nations General Assembly Special Session on HIV/AIDS in 2001. The Declaration states that confronting stigma and discrimination is a prerequisite for effective prevention and care, and reaffirms that discrimination on the grounds of one's HIV status is a violation of human rights.

### **HIV Status Disclosure Scale**

The HIV Status Disclosure Scale was developed by Dima, Stutterheim, Lyimo and De Bruin (2014). The scale was developed to measure the HIV/AIDS status disclosure of Persons living with HIV/AIDS. The scale has a variety of items with different response scales and formats and consists of 8 items. Two sample items are: 1). "When did you learn about your HIV diagnosis?" and 2). "Have you disclosed your HIV status to anyone, excluding health care professionals? The developers reported reliability of 0.88. The researcher re-validated the scale via a pilot.

### **Concept of HIV Status Disclosure**

The act of informing another person such as a sexual partner, friend or family member, of one's HIV status is called disclosure. This act of disclosure

can be done by the person him/herself or by another person such as a service or health provider. There are many contexts in which disclosure can take place, such as: disclosure within close or personal relationships (to close family members, sexual partners or spouses and friends); disclosure to service or health care providers (doctors, nurses, dentists, social workers, counsellors and insurance); disclosure at the workplace (to an employer, among employees, clients); disclosure in other institutional settings like prisons and schools; and disclosure to the public through the media (Ontario Advisory Committee on HIV/AIDS, 2003). While there are many contexts in which disclosure occurs and more relevant, and useful information concerning HIV status disclosure. Contextually, the focus here is on self-disclosure to treatment or sexual partner, due to the significance and potential for HIV transmission to take place in such settings and the social, legal and ethical obligations to disclose one's status under different circumstances.

Depending on the context and the circumstances, disclosure of positive HIV status may be easier or more difficult due to fear of rejection. Many people may have difficulties to disclose their HIV positive status to their potential sexual partners than to closer friends or family members. Some reports have suggested that disclosure to casual sexual partners may be more difficult due to the conditions in which these casual sexual relationships take place, which often do not give time for conversation to know each other better. Under such conditions, individuals often tend to assume on non-verbal disclosure signals, which may not be reliable (OACHA, 2003).

### **Factors Influencing HIV Positive Status Disclosure**

Numerous factors have been associated with status disclosure. They range from demographic factors, socio-economic to cultural and religious factors.

**Age:** Studies have demonstrated that younger age is associated with disclosure of HIV status to the sexual partners. Farquhar et al. (2000) conducted a cross-sectional study in Kenya, Nairobi; where they looked at 104 HIV positive pregnant women tested during antenatal care. They found that 65.0% of women disclosed their status to their partners and disclosure was associated with age. Women aged less than 24 years old were more likely to disclose their status to their sexual partners. In another study on PLHIV in USA, O'Brien, Richardson-Alton, Ayoub, Magnus, Peterman et al. (2003) discovered that younger participants disclosed their HIV status to either the sexual partners or a

close family member, compared to older participants who tended to disclose their status to a friend. Also, in a cross-sectional study conducted by Gaillard, Verhofstede, Myanyuma, Claeys, Chohan et al. (2000), 331 HIV positive pregnant women enrolled in antenatal trial in Mombasa, Kenya; women aged less than 22 years had higher disclosure rate compared to their older counterparts. Contrarily to the above studies, Kadowa and Nuwaha (2009) in a case control study conducted in Uganda among PLHIV, showed that participants aged less than 31 years never disclosed their HIV status and the mean age of disclosure was 38 years.

**Gender:** HIV/AIDS disproportionately affects marginalized populations such as women as reported in Botswana AIDS Impact Survey AS IV (2013) results in which females in Botswana have a relatively high prevalence rate of 19.2% compared to 14.1% of males. Türmen (2003) consequentially mentioned that these women may be ill-treated if they disclose their HIV positive status to their male sexual partners due to gender imbalances and discrimination in many communities. Violence against women is a global epidemic that encourages high rates of HIV infection among women, they face a higher risk of HIV infection through forced sex than consensual sex. Violence and the fear of violence against women can discourage them from seeking HIV testing services, negotiating on safe sex practices or disclosing their HIV status to their sexual partners (BONELA, 2008; BONELA, 2009).

In a study conducted in South Africa among PLHIV by Skogmar, Shakely, Lans, Danell, Andersson et al. (2006), males were found to disclose their result more often to their partner than their female counterparts. In contrast, another South African study on self-disclosure among recently diagnosed HIV positive individuals by Olley, Seedat and Stein (2004) revealed that being male was associated with non-disclosure of HIV status. Deribe, Woldemichael, Wondafrash, Haile and Amberbir (2007) mentioned the prevalence of HIV/AIDS is disproportionately high among groups that already suffer from a lack of human rights protection, social and economic discrimination, or marginalization in terms of legal status. Women are likelier than men to experience negative consequences, such as violence, when they disclose their HIV status. In a cross-sectional observational study conducted by Pranita, Dasgupta and Saha, (2007) of all the HIV/AIDS patients admitted to the school of tropical medicine hospital in Kolkata, India, 16.6 % of women reported negative outcomes following disclosure of their HIV positive status, compared

to 11.5 % of men. The main reasons for non-disclosure among PLHIV in Southern India were relatively good health and emotional status, denial of diagnosis, fear of rejection, limited knowledge of and belief in strategies to live positively with HIV, unacceptability of condoms and safer sex, and women's economic dependency and lack of power in sexual situations.

### **Time between HIV diagnosis and disclosure**

Parsons, Schrimshaw, Bimbi, Wolitski, Gómez et al. (2005) a challenging issue for many persons living with HIV is the timing of disclosure. If it is not done relatively early, it can become more difficult as time goes on and can cause significant disruption to an ongoing relationship if the disclosed-to partner feels betrayed due to the lack of an earlier disclosure. HIV positive persons who have thought through a disclosure plan and have a consistent strategy for managing disclosure are less likely to engage in risky sexual behaviours than those who do not disclose or have inconsistent disclosure strategies.

Disclosure of HIV positive status generally becomes easier the longer someone has been living with the virus, as such individual becomes more comfortable with the HIV positive status. In a study by Deribe, Woldemichael, Wondafrash, Haile and Amberbir (2008), it was found that disclosure was made as early as the same day and late as two years after learning about HIV positive status through diagnosis. Most of the participants (73.0%) disclosed on the day of receiving test result, 74 (12%) within two weeks, 55 (9%) in 2 to 4 weeks, 27(4%) in 1 to 4 months and 12 (2%) greater than 4 months.

Furthermore, Serovich (2001) described HIV/AIDS status disclosure through the examination of the disclosure methods. For instance, she typologically developed and depicted five primary categories of HIV status disclosure among men namely, point-blank disclosure, indirect disclosure, stage-setting, buffering, and seeking similar disclosure. Thus, it is apparent that the validity of the theories and measures employed in HIV/AIDS disclosure research raises further questions, making it difficult for researchers and care providers to pursue potential clues that are critical in supporting the disclosure needs of their clients.

### **Characteristics of HIV disclosure**

The characteristics of HIV disclosure comprise experiencing an event, communicating something, timing, contextual environment, protecting someone, relationship status and improving something or being therapeutic.



***Experiencing an event:*** Disclosure occurs when a certain life event that influences the feeling(s) or thought(s) of disclosing or not disclosing it to others is experienced. In the context of disclosing HIV-positive status, the PLHIV is faced with an infection that feature venereal shame, self-stigmatizing and life-threatening, and there are needs to decide how, when, where, what and to whom to disclose or not to disclose.

***Communicating something:*** Without a meaningful exchange of information, disclosure cannot be said to have happen. Therefore, the quality of communication in HIV status disclosure has to do with PLHIV telling someone about been diagnosed to be positive to HIV infection. Since HIV is a life-threatening and tagged as shameful infection that nobody is aware of or suspecting until it reaches the symptomatic or AIDS-related complex clinical stage. HIV status disclosure constitutes freeing oneself from the burden of keeping the positive HIV status as secret by PLHIV, which is such a burning issue. Eustace and Ilagan (2010) mentioned others to have defined this process as catharsis or the opportunity to ventilate feelings by talking to someone. The process involves making the decision to communicate which is both difficult and personal. Since the communication process has to do with divulging sensitive topic such as positive HIV status which is influenced by individual and social factors.

***Timing:*** Timing in the context of HIV status disclosure by PLHIV refers to the social meaning of why and when such individuals living with HIV/AIDS decide to divulge their positive HIV status to others. As time goes on, PLHIV tend to accept and be more open about their illness. But still struggle to overcome the difficult inherent in making decision on when and whom to inform about their HIV positive status. Eustace and Ilagan (2010) stated that, empirical evidence indicates that disclosure becomes easier the longer someone has been living with the HIV infection, because they become more open and comfortable with the HIV status or can no longer hide the symptoms. However, the longer PLHIV hold out on disclosing their HIV status, the riskier it might get in terms of maintaining trusting relationships. On delaying the time of disclosure, their partners may feel betrayed and increase the possibility of losing the relationships.

***Contextual environment:*** The contextual environment is extremely important in HIV disclosure ad non-disclosure. It portrays the setting and potential contextual factors that promote or discourage disclosure. PLHIV, their families

and communities, as well as their socio-cultural fabrics and political norms, all of which constitute the environment. In such environment where HIV stigma is widespread, the PLHIV is less like to experience non-disclosure of their HIV positive status. Rutledge (2007) conversely stated that disclosure can occur only if the person feels secure, in control and in a comfortable environment.

***Protecting someone:*** Eustace and Ilagan (2010) persons living with HIV may choose to disclose or experience non-disclosure of their status owing to their feeling, sense of responsibility to protect their partners and social networks, and in some sense to protect themselves. From this context, disclosure can be defined as another reason-focused process. This sense of protection can come in different ways. While some PLHIV may disclose their status to their partners so that they can be able to accurately make decision about their relationship, some sees it as avenue to fulfil their disclosure responsibility. Adversely, while some PLHIV recognise their partners' right to know, they may still fail to disclose believing that, if they are engaging in safer sex behaviours, there is no need to inform them. As regard self-protection by PLHIV, if they consider themselves to have a very low viral load, meaning they are having reduction in the possibility of transmitting the infection to the partners, they are less likely to disclose.

***Relationship status:*** Eustace and Ilagan (2010) stated that there are patterns and limitations inherent in the decision-making process been undergo by PLHIV in disclosing their HIV status to others. In the process, the attribute of relationship status featured selection of who to disclosure to, with a view preserve their privacy. Some PLHIV may be secretive about who they disclose to and may not disclose to everyone. Mostly, PLHIV engage in disclosing their HIV positive status to selected close friends and family members, healthcare workers, employers, others in the community and sometimes, to their amorous relationship partner(s).

***Improving something or being therapeutic:*** HIV status disclosure to significant others such as family and friends is therapeutically significant in gaining social support and coping with HIV infection since it tends to increase enrolment, initiation and adherence to ART by PLHIV. It was stated in Eustace and Ilagan (2010) that disclosure to friends are most likely and friends have been found to be very supportive. In addition, disclosures to mothers and sisters have been reported more often than fathers and brothers, and are perceived as the most supportive family members. As regard disclosure to the extended

family, they are viewed to be more supportive than all immediate family members except for mothers.

### **PURPOSE OF THE STUDY**

The general purpose of this study was to investigate psychosocial factors as correlates of HIV status disclosure among PLHIV in Ibadan metropolis, Oyo State, Nigeria. The following specific objectives were addressed in this study:

1. To examine the pattern of significant relationship between psychosocial factors (self-concept, depression, stigmatization and social support) to HIV status disclosure among Persons living with HIV in Ibadan metropolis.
2. To examine the joint contribution of psychosocial factors (self-concept, depression, stigmatization and social support) to HIV status disclosure among Persons living with HIV in Ibadan metropolis.

### **RESEARCH QUESTIONS**

1. What is the pattern of significant relationship that exist between psychosocial factors (self-concept, depression, stigmatization and social support) to HIV status disclosure among Persons living with HIV in Ibadan metropolis?
2. What is the joint contribution of psychosocial factors (self-concept, depression, stigmatization and social support) to HIV status disclosure among Persons living with HIV in Ibadan metropolis?

### **METHODOLOGY**

This study adopted descriptive survey research design of correlational type.

The study adopted multi-stage sampling procedure. The first stage involved the use of simple random sampling technique to select three (3) PEPFAR/APIN clinics in Ibadan metropolis, where Persons living with HIV are accessing antiretroviral treatments. The three (3) selected PEPFAR/APIN clinics are; Adeoyo Maternity Teaching Hospital, Yemetu; Moniya Health Care Centre, Moniya and Oluyoro Catholic Hospital, Oluyoro Oke-Offa.

The second stage involved the use of purposive sampling technique to select 50 persons living with HIV each from the three (3) selected PEPFAR/APIN clinics in Ibadan Metropolis. The sample size for the study is 150 persons living with HIV.

## ANALYSIS AND RESULTS

The researcher used Pearson Product Moment Correlation (PPMC) to check the significant relationship among the variables and Multiple Regression was used to check the joint contribution and relative contribution of the variables. Data were analysed using frequency counts and percentage. Section A deals with the socio-demographic information of the respondents, section B presents the analysis of the research questions.

### Section A: Socio-demographic information of the respondents

**Table 1: Socio-demographic characteristics of the respondents**

Variables	Frequency	Percentage (%)
<b>Gender</b>		
Male	29	20.0
Female	116	80.0
<b>Age</b>		
18-30	20	13.8
31-40	69	47.6
41-50	34	23.4
50 and above	22	15.2
<b>Ethnicity</b>		
Yoruba	132	91.0
Igbo	2	1.4
Hausa	2	1.4
Others	9	6.2
<b>Marital status</b>		
Single	24	16.6
Married	116	80.0
Others; divorced, widowed and separated	5	3.4
<b>Educational status</b>		
No formal education	5	3.4
Primary School Certificate	37	25.5
Secondary School Certificate	68	46.9
Tertiary	35	24.1

Table 1 revealed the socio-demographic characteristic of the respondents: The result reveals that female respondents dominated the study with 116 (80.0%) while the rest 29 (20.0%) were male. The result also shows that Majority 69 (47.6%) of the respondents was within same age range of 31 to 40 years. The result indicated that majority 132 (91.0%) of the respondents were from Yoruba ethnic background. The marital status information reveals that majority 116 (80.0%) were married and still living with their husbands. The information collected on the respondents' educational attainment reveals that majority 68 (46.9%) of them were secondary school certificate holders.

**Research question one:** What is the significant relationship between psychosocial factors (self-concept, depression, stigmatization and social support) and HIV status disclosure among Persons living with HIV in Ibadan metropolis? This was analysed using Pearson Product Moment Correlation statistical tool and the result is presented in the Table 2:

**Table 2: Correlation Matrix showing the Relationship between Psychosocial Factors (Self-concept, Depression, Stigmatization and Social Support) and HIV Status Disclosure.**

Variables	Mean	SD	1	2	3	4	5
Self-concept	47.99	10.773	1.000				
Depression	18.61	3.058	-.041	1.000			
Stigmatization	12.46	2.010	-.073	.971*	1.000		
Social-support	12.32	2.411	.019	.917*	.795*	1.000	
Disclosure	17.04	2.635	.455*	.481*	.403*	.546*	1.000

\*\* . Correlation is significant at the 0.01 level (2-tailed).

\* . Correlation is significant at the 0.05 level (2-tailed).

Table 2 reveals the inter-correlational matrix between the between psychosocial factors (self-concept, depression, stigmatization and social support) and HIV status disclosure among Persons living with HIV in Ibadan metropolis, Oyo State, Nigeria. The result reveals that depression ( $r = .481, p < 0.05$ ),

stigmatization ( $r = .403, p < 0.05$ ) and social support ( $r = .546, p < 0.05$ ) positively and significantly correlated with HIV status disclosure while Self-concept ( $r = -.455, p < 0.05$ ) was negatively and significantly correlated with HIV status disclosure among Persons living with HIV in Ibadan metropolis.

**Research question two:** What is the joint contribution of psychosocial factors (self-concept, depression, stigmatization and social support) to HIV status disclosure among Persons living with HIV in Ibadan metropolis? This was analysed using multiple regression statistical tool and the result is presented in Table 3:

**Table 3: Summary of Regression for the Joint contribution of Psychosocial Factors (Self-Concept, Depression, Stigmatization and Social Support) to HIV Status Disclosure.**

**R = .549**

**R (adjusted) = .301**

**R<sup>2</sup> (adjusted) = .286**

**Standard error of estimate = .335**

Model	Sum of Squares	Df	Mean Square	F	Sig.	Remark
Regression	6.808	4	2.269	20.272	.000 <sup>b</sup>	Sig
Residual	15.785	140	.112			
Total	22.593	144				

Table 3 shows the joint contribution of psychosocial factors (self-concept, depression, stigmatization and social support) to HIV status disclosure among Persons living with HIV in Ibadan metropolis, Oyo State, Nigeria. The result shows that psychosocial factors (self-concept, depression, stigmatization and social support) yielded a coefficient of multiple correlations (R) of 0.301 and multiple correlations square of 0.286. This shows that about 30.1% (Adj.R<sup>2</sup>=0.301) of the total variance of HIV status disclosure among Persons living with HIV in Ibadan metropolis, Oyo State, Nigeria was accounted for by the linear combination of psychosocial factors (self-concept, depression, stigmatization and social support) while the remaining 69.9% could be assigned to other estranged factors not considered in this study.

The result in the Table 3 also indicated that psychosocial factors (self-concept, depression, stigmatization and social support) had significant joint contribution to HIV status disclosure among Persons living with HIV in Ibadan metropolis, Oyo State, Nigeria ( $F_{(4,140)} = 9.012$ ;  $p < 0.05$ ).

## **DISCUSSION OF FINDINGS**

The paper examined the influence of psychosocial factors (self-concept, depression, stigmatization and social support) on HIV status disclosure among Persons living with HIV in Ibadan metropolis, Oyo state, Nigeria. The pattern of relationship that exist between the variables of the study was examined and the result revealed that depression, stigmatization and social support positively and significantly correlated with HIV status disclosure while Self-concept negatively and significantly correlated with HIV status disclosure among Persons living with HIV in Ibadan metropolis. This finding corroborates finding of Ojikutu, Pathak, Srithanaviboonchai, Limbada, Friedman Li (2016) that found in their study that there was significant relationship between stigma and HIV status disclosure among PLHIV. They further reported that the higher the level of perceived stigma, the lesser the rate of HIV status disclosure among PLHIV. Poindexter and Shippy (2010) found that PLHIV exercise full disclosure of HIV status, educating themselves and sharing with others about their experiences of being HIV positive as means of resisting HIV-related stigma they are encountering. Also, Tshisuyi (2014) found that fear of blame, fear of abuse and casual relationships are major factors that influenced HIV status disclosure which is consistent with the finding of this study.

## **CONCLUSION**

The conclusion of this study is based on findings that have been established through this study. The following conclusions were made:

The findings of the study revealed that depression, stigmatization and social support positively and significantly correlated with HIV status disclosure while self-concept was negatively and significantly correlated with HIV status disclosure among People living with HIV in Ibadan metropolis, Oyo state, Nigeria.

The result of the findings also revealed that self-concept, stigmatization, depression and social support made significant independent contribution to HIV

status disclosure among People living with HIV in Ibadan metropolis, Oyo State, Nigeria.

Furthermore, the findings of this study revealed that psychosocial factors (self-concept, depression, stigmatization and social support) contributed about 30.1% to HIV status disclosure among People living with HIV in Ibadan metropolis, Oyo State, Nigeria

## CONCLUDING REMARKS

In the light of the findings, it is hereby suggested that researches should be carried out across other states in the country in other to expand the generalization of the finding of this study. Some other factors such as fatalistic belief, health care provider's attitude and concordant etc. that can influence disclosure to treatment among people living with HIV/AIDS on treatment should also be considered by other researchers.

## REFERENCES

- Balogun, A. 2017. *Exploring the use of Healthcare Services and Antiretroviral Therapy among HIV Positive Men Who Have Sex with Men (MSM) in Nigeria: A Qualitative Study*. PhD thesis, University of Sheffield.
- Balogun, K. LO. 2014. Knowledge and attitude towards antiretroviral therapy and adherence pattern of HIV patients in southwest Nigeria. ISSN 1996-9783. *International Journal of Infection Control* 2014, v10:i3. doi: 10.3396/IJIC.v10i3.024.14
- Botswana Network on Ethics, Law, and HIV/AIDS. 2008. *The Botswana Review of Ethics, Law and HIV/AIDS*. 2(1): 71-83
- Botswana Network on Ethics, Law, and HIV/AIDS. 2009. *The Botswana Review of Ethics, Law and HIV/AIDS*. 3(1): 17-44
- BIAS IV 2013. Statistical Report – Botswana AIDS Impact Survey IV 2103. [www.statsbots.org.bw/files](http://www.statsbots.org.bw/files)
- Burkhart, P. V. & Sabaté E. 2003. Adherence to long-term therapies: Evidence for Action. *Journal of Nursing Scholarship* 35 (3):207.**
- Deribe, K., Woldemichael, K., Wondafrash, M., Haile, A. & Amberbir, A. 2007. Disclosure experience and associated factors among HIV positive men and women clinical service users in Southwest Ethiopia. *BMC Public Health*. [Online], Available: <http://www.ncbi.nlm.nih.gov/pubmed/18312653> [2010, April 21].
- Deribe, K. K., Woldemichael, K., Wondafrash, M., Haile, A., & Amberbir, A. 2008. Disclosure experience and associated factors among HIV positive men and women, clinical service users in South West Ethiopia. Jimma: Ethiopia [outline], Available: <http://creativecommons.org/licenses/by/2.0> [05/07/2007].
- Dima, A. L., Stutterheim, S. E., Lyimo, R. & De Bruin, M. 2014. Advancing methodology in the study of HIV status disclosure: The importance of considering disclosure target and intent. *Social science & medicine* 108, 166-174, 2014.
- Eustace, R. W., & Ilagan, P. R. 2010. HIV disclosure among HIV positive individuals: A concept analysis. *Journal of Advanced Nursing*, 66(9), 2094–2103.



- Farquhar, C., Ngacha, D., Bosire, R., Nduati, R., Kreiss, J. & John G. 2000. Prevalence and Correlates of Partner Notification Regarding HIV-1 in an Antenatal Setting in Nairobi, Kenya. XIII International AIDS Conference, Durban, South Africa.
- Gaillard, P., Verhofstede, C., Mwanjumba, F., Claeys, P., Chohan, V., Mandaliya, K., Bwayo, J., Plum, J. & Temmerman, M. 2000. Exposure to HIV-1 during delivery and mother-to-child transmission. *AIDS* 14 (15). 2341-2348, 2000.
- HIV/AIDS Prevention and Control Office. 2012. Effect of nutritional factors on adherence to antiretroviral therapy among HIV-infected adults: a case control study in Northern Ethiopia. *BMC Infectious Diseases* 13: 233.**
- Kadowa, I. & Nuwaha, F. 2009. Factors influencing disclosure of HIV positive status district of Uganda. *African Health Sciences* 9 (1):26-33. [Online], Available: Olley, B.O., Seedat, S. & Stein, D. J. 2004. Self disclosure of HIV status in recently diagnosed patients with HIV in South Africa. *Africa Journal of Reproductive Health*, 8 (2):71-76. <http://www.ncbi.nlm.nih.gov/pubmed/20842239> [2011, May 16].
- O'Brien M., Richardson-Alton, G., Ayoub, M., Magnus, M., Peterman, T. & Kissinger, P. 2003. Prevalence and Correlates of HIV serostatus Disclosure, *Sexually Transmitted Diseases*, 30, 731-735.
- Ontario Advisory Committee on HIV/AIDS. 2003. Disclosure of HIV-Positive Status to Sexual and Drug-Injecting Partners (A Resource Document).
- Ojikutu, B. O., Pathak, S., Srithanaviboonchai, K., Limbada, M., Friedman, R., Li, S., Mimiaga, M. J., Mayer, K. H., Safren, S. A., & HIV Prevention Trials Network 063 Team 2016. Community Cultural Norms, Stigma and Disclosure to Sexual Partners among Women Living with HIV in Thailand, Brazil and Zambia (HPTN063). *PLoS ONE* 11(5): e0153600. doi:10.1371/journal.pone.0153600
- Reisner, S. L., Mimiaga, M. J., Skeer, M., Perkovich, B., Johnson, C. V. & Safren, S. A. 2009. A review of HIV anti-retroviral adherence and intervention Studies among HIVinfected youth. *Top HIV Med.* 17 (1):14-25, 2009.**
- Rutledge, S. E. 2007. Enacting Personal HIV Disclosure Policies for Sexual Situations: HIV-Positive Gay Men's Experiences. *Qualitative Health Research* 17 (17), 1040-1059. doi.org/10.1177/1049732307306931
- Sasaki, Y., Kakimoto, K., Dube, C., Sikazwe, I., Moyo, C., Syakantu, G., Komada, K., Miyano, S., Ishikawa, N., Kita, K. & Kai, I. 2012. Adherence to antiretroviral therapy (ART) during the early months of treatment in rural Zambia: influence of demographic characteristics and social surroundings of patients. *Annals of Clinical Microbiology Antimicrobials* 11 (1), 34, 2012. doi: 10.1186/1476-0711-11-34**
- Serovich J. M., 2001. A test of two HIV disclosure theories. *AIDS Education and Prevention*, 13(4), 355-364, 2001.
- Skogmar, S., Shakely, D., Lans, M., Danell, J., Andersson, R., Tshandu, N., & Francois Venter, W. D. 2006. Effect of antiretroviral treatment and counselling on disclosure of HIV-serostatus in Johannesburg, South Africa. *AIDS Care*, 18(7), 725-730.
- Parsons, J. T., Schrimshaw, E. W., Bimbi, D. S., Wolitski, R. J., Gómez, C. A. & Halkitis, P. N. 2005. Consistent, inconsistent, and non-disclosure to casual sex partners among HIV seropositive gay and bisexual men. *AIDS* 19:S87-S97, 2005.
- Pennington, J. 2007. HIV & AIDS in Nigeria. Avert HIV/AIDS International. Retrieved November 31, 2007 from [www.avert.org/aidsnigeria.htm](http://www.avert.org/aidsnigeria.htm)**
- Pranita, T., Dasgupta, A. & Saha, B. 2007. Disclosure Among People Living with HIV/AIDS. *Indian Journal of Community Medicine* 32(4), 280, 2007.

- Poindexter, C. C. & Shippy, R. A. 2010. HIV diagnosis disclosure: Stigma management and stigma resistance. *Journal of Gerontological Social Work*, 53(4), 366-81.
- Tshisuyi, E. T. 2014. Disclosure of HIV Positive Status to Sexual Partners Among Pregnant Women in a Health District of Botswana. Stellenbosch University. <http://scholar.sun.ac.za>
- Türmen, T. 2003. Gender and HIV/AIDS. *International Journal of Gynaecology and Obstetrics* 82 (3):411-418, 2003.
- UNAID 2012. World AIDS Day Report. Geneva, Switzerland.**
- USAID 2011. How to Investigate Adherence to Antiretroviral Therapy. An Indicator-Based Approach (2011; 115 pages). USA.**