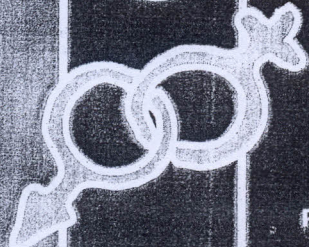


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PERCEIVED HIV STIGMATIZATION, HIV/AIDS COGNITION AND PERSONALITY AS CORRELATES OF HIV SELF- DISCLOSURE AMONG PEOPLE LIVING WITH HIV IN IBADAN, NIGERIA

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Abstract

The relationship between perceived HIV stigmatization, HIV/AIDS cognition, personality and HIV self-disclosure (HSD) was investigated. The influence of age and gender on these was also examined. PLWHA (N421) in Ibadan, Nigeria participated in the cross-sectional study. A positive relationship of extraversion ($r=-.738$, $df=421$, $P<.05$), HIV cognition ($r=-.621$, $df=421$, $P<.05$), neuroticism ($r=-.212$, $df=421$, $P<.05$) and agreeableness personality traits ($r=-.155$, $df=421$, $P<.05$) with HSD was observed. A $2 \times 2 \times 2 \times 2$ factorial analysis showed that old females, with low perceived stigmatisation, but with good HIV cognition ($n=23$, $\bar{X}=18.2$, $SD=3.8$) were most likely to disclose their status. Perceived stigmatisation, HIV cognition, and personality jointly predicted HSD ($R^2=.52$; $F(3,418) = 7.66$ $P <.05$). Negative HIV cognition, perceived stigmatization, openness and conscientious personality traits are major barriers to HSD. Non disclosure remains an enormous barrier to the fight against HIV and AIDS. Policies and actions should therefore focus on these issues in HIV prevention, care and support.

Key words: HIV self-disclosure, Stigmatisation, personality, psychosocial factors, HIV self-disclosure, Nigeria.

Introduction

In Nigeria, an estimated 4.6 percent of the population are living with HIV and AIDS (UNGASS, 2010). Although HIV prevalence is much lower in Nigeria than in other African countries such as South Africa and Zambia, the size of Nigeria's

population (around 149 million) meant that by the end of 2009, there were about 2.98 million people living with HIV. AIDS is not only claiming so many lives, about 192,000 in 2009, Nigeria's life expectancy has declined significantly. The average life expectancy was 54 years for women and 53 years for men in 1991 (UNGASS, 2010). However, in 2009 these figures had fallen to 48 for women and 46 for men (CIA, 2010). HIV transmission has been linked to HIV non disclosure (Galletly & Pinkerton, 2006; Rubin, 2007; and Ogundahunsi, Daniel, & Oladapo, 2007). Understanding the psychological factors related to HIV/AIDS disclosure among people living with HIV/AIDS (PLWHA) to others is a critical issue for HIV prevention and care efforts (Rubin, 2007).

HIV self disclosure is the tendency of an individual to be free to autonomously discuss his/her HIV status with a sexual partner, family, or units of a society. Unfortunately, the potential for rejection, abandonment, physical and emotional abuse and other adverse consequences create substantial barriers to disclosing HIV status (Rothenberg & Paskey, 1995). HIV disclosure is a complex issue since quite often disclosure of status is also linked to disclosure of other clandestine behaviours (such as same sex activity, injection drug use, or any HIV risk behaviour (Adejumo, 2004). The link between situational or dispositional factors and health behaviour is documented in literature (Elwood & Carter, 2003). It is therefore necessary to investigate the relationship between psychological factors and HIV self-disclosure from a sub-Saharan Africa perspective.

Data throughout the world suggests that failure to disclose HIV status is related to three major problems. First, substantial numbers of new HIV infections could occur among partners of HIV-positive persons who do not disclose their status (Mohammed & Kissinger, 2006; and Barnes, 2007). Second it could also hinder access to ante-retroviral therapy (Sullivan, 2005; Ogundahunsi, Daniel, & Oladapo, 2008). Third, failure to disclose could hinder social support required for mental health (Derlega et al, 1993; Pennebaker et al, 1993).

Numerous factors have been associated with HIV status disclosure. HIV-infected individuals are more likely to disclose to a partner whom they know is HIV-positive than to an HIV-negative or unknown sero-status partner (Niccolai et al, 2006; Marks and Crepaz, 2001). A short duration of relationship, polygamous marriage, working out of home, not knowing someone with HIV and lower income were negatively associated with disclosure in a study conducted in Tanzania (Antelman, 2001). Self efficacy and social support have also been found to be positively associated with HIV disclosure (Kalichman & Nachimson, 1999; Degefa, 2003).

Similarly, there is documented evidence linking gender with HIV status disclosure. In a study conducted in South Africa, males were found to disclose their result more often to partner than females (Skogmar, 2006). In contrast, another South African study revealed that male sex is associated with non-disclosure of HIV status (Olley, Seedat, & Stein, 2004). However, relatively little is known about the relationship between perceived stigmatisation, HIV/AIDS cognition, and personality on one hand and HIV self disclosure.

As reported by Olley, Seedat, & Stein, (2004), data indicate that HIV positive patients do not disclose their serostatus, and in fact may be ignorant of their sexual partners' serostatus. Perry et al for example found that almost a third of HIV positive men and women had not disclosed their serostatus to their present or past sexual partners (Perry et al, 1994). Stein et al found that 40% of sexually active men and women living with HIV in a community sample had not disclosed their HIV status to their sexual partners (Stein, 2003). In a community sample, Kalichman and Nachimson found that 41% of HIV positive persons had not disclosed their serostatus with their sexual partners (Kalichman & Nachimson, 1999). Another study involving 206 HIV positive men of mixed sexual orientation revealed that 48% had not disclosed their serostatus with their sexual partners. Consistent with these findings, a recent report of 105 revealed that HIV positive men did not disclose their sero positive status with their at risk sexual partners (Marks & Crepez, 2001). Looking at these, effective HIV disclosure decision-making is a difficult challenge facing most people living with HIV-AIDS, particularly within the context of their sexual relationships.

As at 2003, 31 states in the USA had statutes making sexual contact without disclosure a criminal offence (Marks, Richardson & Crepez, 2002). Also in many states in the USA, health professionals are mandated to report to the appropriate authorities HIV-seropositive individuals who have unprotected sex without informing their partners of their HIV infection. Civil liberty lawyers contend that these statutes may actually hamper disclosure by opening up the possibility of later arrest. These psychosocial, practical, and legal barriers may contribute to the refusal of many individuals with HIV to divulge their serostatus to sexual partners.

The role of perceived stigmatisation, HIV/AIDS cognition, and personality on one hand and HIV self disclosure has not been well documented in literature. Individuals with extraversion personality type had been found to be more willing to disclose their status to their sex partner (Costa, 2007). Hennessy also reported the relationship between personality and HIV disclosure

in a USA study (Hennessy, 2010). Other studies also suggest that of men who are HIV-positive with positive cognition, only between 42% and 48% report disclosing their serostatus to sexual partners before engaging in unprotected intercourse (Ciccarone et al, 2003, Marks & Crepaz, 2001). These suggest that a possible link between psychological factors and HIV self disclosure.

As defined in Encarta Dictionary, to stigmatize an individual is to label the person as socially undesirable, or label somebody as unacceptable. The concept, cognition means the mental faculty or process of acquiring knowledge by the use of reasoning, intuition, or perception. Personality on the other hand has been defined as the totality of someone's attitudes, interests, behavioural patterns, emotional response, social roles, and other individual traits that endure over long periods of time (Encarta Dictionary, 2008).

The goal of this study is to assess the relationship between HIV disclosure among PLWHA and psychological factors namely; perceived stigmatisation, HIV cognition, and personality. Specifically, the objectives of the study are to:

- i. discover if psychological factors (perceived stigmatisation, HIV cognition, and personality) will have any relationship with HIV disclosure among PLWHA and
- ii. examine if there will be differences in the factorial combinations of the influences of psychosocial factors (age and gender) on HIV status disclosure.

Method

This correlational study adopted a cross-sectional design. The independent variables were perceived stigmatization, HIV cognition and personality. The dependent variable was HIV self disclosure. This design was also used in a similar study conducted by Rubin, (Rubin, 2007).

The study was conducted in four centres for PLWHA in Ibadan, Oyo State, Nigeria. The centres were; Adeoyo Maternity Hospital, Ibadan, APIN/PEPFAR units at St. Mary Hospital, Eleta, Ibadan, Family Health and Population Action Council, Ibadan, and Association for Reproductive and Family Health (AFRH), Ibadan. Ibadan city. These sites were selected because of their focus and involvement in caring for PLWHA.

PLWHA in the centres participated. Prospective participants were required to fulfil an inclusion-exclusion criteria including:

1. Diagnosed as HIV positive before the study
2. Currently registered with any of the four centres caring for PLWHA in Ibadan
3. English literate and

4. Personally willing to participate after an informed consent process

Even though about 765 PLWHA were fully registered at the Centres, only about 500 of them fulfilled the inclusion criteria, and were purposively included as participants. Of these, 421 questionnaires were correctly filled and returned, representing 84.2 % response rate. These were made up of 278 (66%) females and 143 (34%) males. The participants' age ranged between 23 and 52 years with a mean age of 34 years.

Instruments: Data was collected with the use of an 80-item self-report questionnaire made up of five sections. The 8-item Section A was designed to tap information about respondents' socio-demographic characteristics. Such information included: gender, age, marital status, religion, HIV disclosure status, educational background, and vocation/profession. Section B had 10 items. It contained the HIV self disclosure scale developed by Kalichman & Nachimson (Kalichman & Nachimson, 1999). The scale is designed in a Likert format with responses ranging between strongly agree and strongly disagree. Kalichman (2000) reported a Cronbach alpha of .85 (Kalichman, 2000), but a re-validation during this study yielded a Cronbach alpha of .79. The norms established during this study was (N= 421, \bar{X} =28.6, SD= 13.5). The higher the score on the scale, the higher disclosure rate, and vice versa.

Section C of the questionnaire developed by Berger et al, (2001) had 40 items designed to obtain information on HIV perceived stigmatization. The self-report Likert-type instrument has four graduated responses ranging from strongly agree to strongly disagree. It had a reliability coefficient of .96; a re-validation yielded an alpha coefficient of .79. The mean obtained was (N= 421, \bar{X} =99.2, SD= 4.8). Any score below the mean implies low perceived HIV stigmatization.

Section D of the questionnaire had the 10 item personality inventory developed by Rammstedt and John (2007). It required the respondents to rate their personality on five traits: extraversion, neuroticism, agreeableness, conscientiousness and openness to experience. The authors reported a Cronbach alpha of .86, but a re-validation yielded an alpha coefficient of .85. The reliability reported for each of the sub-scales include; openness (.79), conscientiousness (.82), extraversion (.89), agreeableness (.74), and neuroticism (.86). A revalidation of the sub-scales produced the following reliability values; openness (.75), conscientiousness (.80), extraversion (.89), agreeableness (.72), and neuroticism(.81). The short version personality inventory has a 5-point rating scale with responses ranging from strongly agree to strongly disagree. To interpret an individual's score, any score

above the mean for each of the subscales indicate a higher predisposition to the personality trait being assessed, and vice versa. The norms obtained during the study were; openness (\bar{X} =7.3, SD=2.1), extraversion (\bar{X} =6.7,SD=2.0), agreeableness (\bar{X} =6.2,SD=2.1), and neuroticism (\bar{X} =6.0,SD=2.0).

Section E was a 12 -item self report scale developed by D. Shah to measure HIV cognition among PLWHA. It has a 5-point graded responses ranging from "had thought very frequently" to "had thought very occasionally". The developer reported a reliability coefficient of .91. A re-validation during this study yielded an internal coefficient of .90. Any score above the mean and standard deviation (N = 421, \bar{X} =38.2, SD= 20.5) is interpreted as good HIV cognition, vice versa (Shah, Thornton, & Burgess, 1997).

Data Collection: The researcher obtained permission from the Department of Psychology, University of Ibadan, to conduct the study. Being a vulnerable group, the researcher thereafter sent the protocol for further institutional review and ethical approval from the State Ministry of Health Research Ethics Committee, which was granted following due ethical review process. The researcher also discussed the protocol with the management of the selected hospitals. Each of the Centres' management ascertained that the research is of minimal psychological or physical harm (if any at all); the respective institutions thereafter gave permission to conduct the study.

At the centres, the medical records of the participants were reviewed to identify potential participants that meet the inclusion-exclusion criteria. While the participants waited at the clinics to see their physicians, the researcher discussed the purpose of the study and gave the questionnaires to prospective participants, including a detailed informed consent document. Only willing and consenting PLWHA in attendance at the clinics were recruited as research participants. They were allowed to read the questionnaire and respond accordingly. This took an average of 30 minutes.

A total of 500 of them fulfilled the inclusion criteria in the four Centres, and were purposively included as participants. Of these, only 421 questionnaires were correctly and completely filled. Completed questionnaires were sorted, coded, and entered into the Statistical Package for Social Sciences for data analysis.

Results

Table 1: 2x2x2x2 factorial Table showing influence of gender, age, perceived stigmatization, and HIV cognition on HIV self disclosure.

Gender	Age	Perceived Stigmatisation	HIV Cognition	Interaction of variables	Level of HIV Disclosure			Rank on \bar{X}
					n	\bar{X}	SD	
Male	Young	Low	Poor	MYLP	42	10.9	2.4	15 th
			Good	MYLG	4	10	1.0	16 th
		High	Poor	MYHP	17	12.3	4.3	14 th
			Good	MYHG	28	13.9	4.9	12 th
	Old	Low	Poor	MOLP	18	12.7	4.6	13 th
			Good	MOLG	6	16.6	5.1	8 th
		High	Poor	MOHP	9	17.7	4.4	3 rd
Good	MOHG		19	17.8	4.1	2 nd		
Female	Young	Low	Poor	FYLP	41	14.8	5.0	11 th
			Good	FYLG	17	17	4.6	5 th
		High	Poor	FYHP	23	16	4.9	9 th
			Good	FYHG	40	17.2	5.0	4 th
	Old	Low	Poor	FOLP	64	15.5	5.0	10 th
			Good	FOLG	23	18.2	3.8	1 st
		High	Poor	FOHP	16	16.8	4.7	6 th
			Good	FOHG	54	16.8	4.6	6 th
Total					421			

Table 1 revealed the influence of gender, age, perceived stigmatization, and HIV cognition on HIV self disclosure among PLWHA in this study. It could be observed that those who were females, old, low on perceived stigmatisation, but with good HIV cognition recorded the highest mean (n=23, \bar{X} =18.2, SD=3.8) on HIV self disclosure. The group with the second most likely tendency to disclose their HIV status are those who are males, old, with high scores in perceived HIV stigmatization, but good in HIV cognition (n=19, \bar{X} =17.8, SD=4.1). Male respondents who are old, with high scores in perceived stigmatisation, but with poor HIV cognition (n=9, \bar{X} =17.7, SD=4.4) ranked third on HIV self disclosure. Also young male PLWHA with high levels of perceived HIV discrimination and poor HIV cognition ranked fourteenth (n=17, \bar{X} =12.3, SD=4.3). Young male PLWHA with low levels of perceived HIV discrimination and poor HIV cognition ranked fifteenth (n=42, \bar{X} =10.9, SD=2.4). The group with the least likelihood of disclosing their HIV status include young male PLWHA with low levels of perceived HIV discrimination and good HIV cognition (n=4, \bar{X} =10, SD=1.0).

Table 2: Pearson correlation Table showing relationship between Personality, Perceived HIV stigmatisation, HIV cognition and HIV Disclosure

	HSD	PS	HC	O	C	E	A	N
HSD	1.0	-.392	.621**	-.549	-.044	-	.155**	.212

						.738**		
PS	-.392	1.0	.153**	.141**	.350**	.364**	.379**	.425**
HC	.621**	.153**	1.0	.197**	.141**	.194**	.236**	.259**
O	-.549	.141**	.197**	1.0	.208**	.138**	.136**	.202**
C	-.044	.350**	.141**	.208**	1.0	.235**	.256**	.268**
E	.738**	.364**	.194**	.138**	.235**	1.0	.218**	.302**
A	.155**	.379**	.236**	.136**	.256**	.218**	1.0	.308**
N	.212**	.425**	.259**	.202**	.268**	.302**	.308**	1.0

**Correlation is significant at the 0.01 level.

Key: HSD=HIV self disclosure, PS=Perceived HIV stigmatisation, HC=Health Cognition, O= Openness, C= Conscientiousness, E= Extraversion, A=Agreeableness, N=Neuroticism

Table 2 above shows that extraversion yielded the strongest significant positive relationship with HIV self disclosure ($r=.738$, $df=421$, $P<.05$). It means that as a PLWHAs' predisposition towards extraversion increases, the individual's tendency to disclose his/her HIV status also increases. This was followed by HIV cognition ($r=.621$, $df=421$, $P<.05$). Neuroticism ($r=.212$, $df=421$, $P<.05$) and agreeableness personality characteristics ($r=.155$, $df=421$, $P<.05$) also showed significant, but weak positive relationship with HIV self disclosure. However, openness personality characteristic showed the strongest significant inverse relationship with HIV self disclosure ($r=-.549$, $df=421$, $P<.05$), followed by perceived stigmatisation ($r=-.392$, $df=421$, $P<.05$), and lastly conscientious personality ($r=-.044$, $df=421$, $P<.05$) with the weakest relationship.

Table 3: Regression Table showing personality characteristics and psychological factors as predictors of HIV self disclosure

Predictor variables	Beta	SEB	R ²	R ² Cum	T	P	F	P
Personality Variables								

Openness to experience	3.23	.103	.05	.05	1.41	NS	6.63	<.05
Conscientiousness	2.47	.019	.05	.10	1.47	NS		
Extraversion	2.80	.012	.36	.46	3.95	<.05		
Agreeableness	-1.89	-.065	.11	.57	2.20	<.05		
Neuroticism	-2.08	.010	.15	.72	2.60	<.05		
Psychological factors							7.66	<.05
Perceived HIV Stigmatization	-3.48	-.035	.03	.03	-.59	NS		
HIV cognition	-1.90	-.201	.32	.35	3.48	<.05		
Personality	.236	.091	.16	.52	2.67	<.05		

Table 3 shows that the five personality factors jointly predicted HIV self disclosure; ($R^2=.72$; $F(5,416) = 6.63$; $P<.05$). Extraversion, ($R^2 = .36$; $F(3,418) = 3.95$, $P<.05$), neuroticism, ($R^2=.15$; $F(5,416) = 3.95$, $P<.05$), and agreeableness ($R^2=.11$; $F(1,420) = 2.20$, $P<.05$) also had significant independent effect in predicting HIV self disclosure. However, conscientiousness, ($R^2=.05$; $F(1,420) = 1.47$, $P>.05$), as well as openness to experience, ($R^2=.05$; $F(1,420) = 1.41$, $P>.05$) had no significant influence in predicting HIV self disclosure. The value of R square (R^2) indicated these. The R^2 indicates the amount of contribution of the independent variables to the prediction of the dependent variables. Thus, extraversion contributed 36% to HIV self disclosure, neuroticism contributed 15%, agreeableness accounted for 11% of the variation in HIV self disclosure, and the five personality trait jointly contributed 72% to HIV self disclosure. Table 3 also shows that perceived stigmatisation, HIV cognition, and personality significantly jointly predicted HIV self disclosure ($R^2=.52$; $F(3,418) = 7.66$ $P <.05$), explaining 52% of the variance in HIV self disclosure. In terms of significant independent influence in predicting HIV self disclosure, HIV cognition contributed mostly, yielding 32%. Perceived HIV stigmatization contributed 3%, while personality accounted for 16% variance in HIV self disclosure. This means HIV cognition independently predicted HIV self disclosure most significantly.

Table 4: T-test Table showing gender and age differences on HIV self disclosure

Gender	N	\bar{X}	SD	Df	T	P
Male	143	1.34	.47	419	-5.66	>.05
Female	278	1.52	.48			
Age						

Young	212	14.4	4.8	419	-3.82	<.05
Old	209	16.2	4.9			

Table 4 results indicate that males and females were not significantly different on their score in HIV Self Disclosure $t(420) = -5.66, p < 0.5$. While the mean score of male PLWHA was $\bar{X} = 1.34$, female PLWHA had a mean score of $\bar{X} = 1.52$ in the study. The hypothesis stating that there is a significant mean difference between young and old PLWHA on HIV disclosure was therefore not confirmed.

The hypothesis stating that there will a significant difference between young and old PLWHA on HIV disclosure was supported $t(419) = -3.82; P < .05$. The means score of young was ($\bar{X} = 1.44$) while that of old was ($\bar{X} = 1.62$). This means old people living with HIV disclosed better than younger ones. Table 4 revealed that the number of young people living with HIV was ($n = 212$) while old people was ($n = 209$).

Discussion

The results from the present study show that only HIV cognition and personality (extraversion, agreeableness, and neuroticism) had significant positive relationship with HIV self disclosure, but HIV cognition was more related. Perceived stigmatization and personality (openness and conscientiousness) had inverse relationship with HIV disclosure. Males were not significantly different from females in HIV Self Disclosure, but old PLWHA were more willing to disclose their HIV status than young PLWHA. It was also discovered that old females with low perceived stigmatisation, but with good HIV cognition were most likely willing to disclose their HIV status followed by older males with high scores in perceived HIV stigmatization, but good in HIV cognition. On the other hand, individuals that are most unlikely to disclose their HIV status are young male PLWHA with low levels of perceived HIV discrimination and good HIV cognition, followed by young male PLWHA with low levels of perceived HIV discrimination and poor HIV cognition.

The significance of HIV cognition in HIV self disclosure in this study might be due to the connectedness between cognition, perception, reasoning and knowledge. Elwood & Carter, (2003) had earlier found that perception of illness influence individual health behaviour, especially attitude and tendency to seek health care (Serovich, 2001). It is also in agreement with the finding of Ciccarone et al (2003) as well as Marks and Crepaz (2001), where they discovered that of men who are HIV-positive with positive cognition, only about half of them disclose their serostatus to

sexual partners before engaging in unprotected intercourse. An individual's mental reasoning or perception about a specific situation is more likely to influence the individual's mental evaluation, attitude, and behaviour related to the event. This means that if an individual sees HIV infection as challenging but surmountable; with a basic understanding of the aetiology, course, treatment and prognosis of the infection, such an individual is likely to make a meaningful cost-benefit analysis of HIV disclosure. With this the individual will make sound decision based on adequate information and personal motivation to disclose HIV status irrespective of the challenges.

In agreement with earlier findings (Niccolai et al, 2006, Olley, Seedat, & Stein, 2004), people who believe that PLWHA are stigmatised in a society are very unlikely to disclose their HIV status to either their sex partners, employer, or members of their society. Going by this, information about HIV infection is believed to be private and confidential; which if revealed, could lead to rejection and stigmatization (Rothenberg, & Paskey, 1995). Yet when HIV status is not disclosed to sexual partners, safer sexual practices may not be followed, and further spread of the disease may thereby result. This may be further explained by failure of many governments to legislate and enforce the protection of PLWHA in work places where co-workers and employers often discriminate against PLWHA. In many other cases employers often feel reluctant to engage PLWHA. Even when already actively employed in an organisation, employers often sack staff known to be HIV positive either as a result of the fear of infecting fellow employees or fear of reduced productivity. In some other societies, employers may also have the fear that consumer satisfaction and patronage may reduce drastically if consumers or members of the society discover that an organisation's services were provided by PLWHA.

It is interesting to note that even though personality was significantly related to HIV disclosure, openness and conscientious personality traits rather had an inverse relationship. Openness to experience is about being inventive or curious versus being cautious or conservative. People with high scores in openness are expected to have appreciation for emotion, adventure, unusual ideas, curiosity, and variety of experience. Similarly, conscientiousness is about being efficient or organised versus being easy going or careless. Conscientious individuals have a tendency to show self discipline, act dutifully, and aim for achievement; planned rather than spontaneous behaviour. Since an individual's personality is a major predictor of his/her dispositions, characteristics and behaviour, therefore PLWHAs who are conservative and emotional; as well as those who are self

disciplined and resist spontaneous behaviour would more likely be cautious in disclosing their HIV status. Hennessy (2010) also reported that personality characteristics constitute a major factor in HIV disclosure (Hennessy, 2010).

This also probably explains why extroverts, agreeable and neurotic PLWHA were more willing to disclose their HIV status as supported by the findings of Costa et al (Costa et al, 2007). Extroverts tend to seek stimulation in the company of others, agreeable individuals compassionate and cooperative rather than suspicious or antagonistic towards others, neurotic people have a tendency to experience unpleasant emotions easily. These reasons might have accounted for the positive disposition of PLWHA with these traits to disclose their HIV status.

Males were not significantly different from females in HIV Self Disclosure, but old PLWHA were more willing to disclose their HIV status than young PLWHA. This contradicts the findings of Skogmar et al (2006), where they observed males to be significantly more willing to disclose their HIV test result to their sex partners than females. The above finding further explains the wide variations in gender role and gender awareness in many parts of Africa. In south west Nigeria where this study took place, there is no significant gender difference in people's tendency to discriminate against PLWHA. Similarly, whether male or female the society discriminates against PLWHA, hence the similarity in the participants' stance on HIV status disclosure.

Conclusion

One of the major contributions of this study to HIV/AIDS literature is that factorial combination of certain psychological and socio-demographic factors yield differences in willingness to disclose HIV status. For instance, it was discovered that old females with low perceived stigmatisation, but with good HIV cognition were most likely willing to disclose their HIV status. This implies that PLWHA with these characteristics are more likely to wilfully disclose their HIV status. It also further confirms the finding that older age, perceived stigmatisation and HIV cognition are critical in predicting HIV disclosure. Older PLWHA would be more willing to disclose their HIV status probably because of maturation, experience and reduced sexual activity. Similarly, PLWHA with the perception that they suffer less discrimination will be more willing to disclose their status because they are likely to still feel acceptable by members of the society, hence will be dis-inhibited to disclose their HIV status. On the other hand, young male PLWHA with low levels of perceived HIV discrimination and good HIV cognition are most

unlikely to disclose their HIV status because of perceived emotional insecurity, immaturity, and fear of rejection.

It could therefore be concluded that negative HIV cognition, perceived stigmatization are major barriers to HIV self disclosure among PLWHA. These factors as well as personality are related to HIV status disclosure. Extroverts will be more willing to disclose their HIV status while PLWHA with high disposition towards conscientiousness and openness to experience personality will be more unwilling to disclose their HIV status. Serovich (2001) also found that fears of rejection and abandonment, discriminating treatment such as eviction or termination of employment, retribution, violence, and other forms of abuse are significant disincentives and barriers to revealing one's HIV diagnosis persist (Serovich, 2001).

HIV non disclosure remains an enormous barrier to the fight against HIV and AIDS. The lesson learnt here is that social stigma in term of prejudice , discrimination and other forms of stigmatization are major barriers to HIV disclosure. A re-focussing of HIV/AIDS prevention programmes on these factors by policy relevant policy makers, programme planners in governmental and non-governmental organisations is critical not only for HIV prevention, but the care and support of PLWHA.

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