

Prevalence, Patterns and Cognitive Barriers to HIV Disclosure Intention Among Treatment-Seeking People Living With HIV

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Abstract

Background: Globally, the patterns, prevalence and cognitive barriers to Human-Immunodeficiency-Virus and Acquired-Immune-Deficiency-Syndrome (HIV/AIDS) disclosure among individuals diagnosed with HIV have continually been a source of concern, especially in developing countries. This been widely linked to most persistent problems thwarting the effort of authorities saddled with responsibilities of curbing the menace of HIV/AIDS in Africa at large. The unabated issues have been a primary global health concern.

Methods: The study was carried out in the Heart to Heart (H2H) unit of Hematology Department of the Ondo State Teaching Hospital, Akure, Ondo State. The study incorporated a blend of a quantitative method (to explore the prevalence of disclosure and its socio-demographic prevalence) and qualitative method (to explore cognitive barriers to self-disclosure of HIV positive status. The quantitative data was gathered from three hundred and ninety (n=390) PLWHA and the qualitative data was gathered from nineteen (n=19) PLHIV.

Results: The prevalence of low-disclosure intention among treatment-seeking people living with HIV/AIDS was pegged at 64.6%. Approximately 70% of the males and 60% of the females are not likely to disclose their HIV positive status. 65% of the PLHIV from monogamy family structure are not likely to disclose their HIV positive status. Anticipated stigmatization, disclosure self-efficacy, mood problems, health locus of control were identified as the major cognitive barriers to disclosure of

HIV positive status.

Conclusion: The study further concludes that anticipated stigmatization, disclosure efficacy, manifested mood problems (anxiety and depressive symptoms), and health locus of control were the implicated cognitive barriers to disclosure among a hospital-based PLHIV. The outcome was similarly Furthermore, the study revealed that the target of disclosure was major to secondary circle i.e. parents and siblings and not towards the primary circle, such as; spouse/girlfriend/boyfriend, children. Implications and recommendations were further discussed.

Key words: HIV; Disclosure; Cognitive Barriers; Qualitative; Prevalence

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INTRODUCTION

Globally, the patterns, prevalence and cognitive barriers to Human-Immunodeficiency-Virus and Acquired-Immune-Deficiency-Syndrome (HIV/AIDS) disclosure among individuals diagnosed with HIV have continually been a source of concern, especially in developing countries. This been widely linked to most persistent problems thwarting the effort of authorities saddled with responsibilities of curbing the menace of HIV/AIDS in Africa at large. The unabated issues have been a primary global health concern, despite lots of efforts in research and clinical intervention programmes (UNAID, 2012). Inclusively, HIV/AIDS is one of the most complicated health problems to disclose to targets of the disclosure being wife, husband, children, siblings, and employers.

Nigeria, as the most popular black nation, has the prevalence of HIV/AIDS rate at 4.1% as reported by the Federal Ministry of Health (FMOH, 2010), invariably indicating that approximately 3.2 millions Nigerians are functioning with HIV/AIDS (UNAIDS, 2013). The dominant HIV figures in term of its prevalence among adulthood (aged 18-49) was reported at 3.1% indicating that 2.8 million PLWHA were between the age 15 and beyond (UNAIDS, 2013), which placed Nigeria as the second-largest figure of people functioning with HIV. In Africa, HIV/AIDS may be considered an epidemic for 1 in every 20 random adults was reported performing with HIV in Africa, which invariably accounted for the 69% global burden of HIV/AIDS in the region (UNAIDS, 2012) significantly. With 4.3% prevalence, Ondo State is ranked among the top ten states with the highest HIV prevalence in Nigeria (NACA, 2014).

According to Olaseni (2018), the major problem of HIV/AIDS in Nigeria is no longer about lack of awareness or inability to access care, but the high rate of non-disclosure by the people living with HIV/AIDS. The World Health Organization (2004) reported that about 94% of Nigerians are aware of HIV/AIDS, yet a high rate of non-disclosure among people living with the virus persists, with the rate far above the 79% recommended benchmark for developing countries. In a study conducted by Olley, Seedat, and Stein (2004), about 78% of the study participants (people living with HIV) reported none or low disclosure of their status.

Self-disclosure has been identified as a major contributing factor in the treatment and management of HIV and AIDS (Salami, Olatunji & Oluboyo, 2006). Disclosure of HIV/AIDS helps in decreasing the possibilities and probabilities of further transmitting the virus to people in their networks (Greene, et al, 2003). On the other hand, people living with HIV who failed to disclose positive status increases the risk of multiple transmission of HIV disease. Disclosure, whether voluntary or involuntary has been identified to increase access to treatment material and social support which consequently improves both the physical and psychological health of PLWHA (Waddell & Messeri, 2006).

Disclosing HIV positive status to one's partner(s) enhances safer-sex practice or behavior through increased condom use behavior (Allen, Fideli, & Zulu, 2003). Disclosure can invariably prevent the rapid spread of HIV and AIDS. Knowledge of a sexual partner HIV status may help both parties in making a more adaptive decision. Disclosure improves general and mental health, such as; reduction of victim's stress, while enhances the rate of social support either actual or perceived (Holt, et al, 1998). It also increase opportunity for social support, influence confidants to seek testing and undoubtedly unclg durable and stable plans to ensure adequate results

in HIV management and prevention (Salami, et al, 2011).

It is, however, imperial to note that the outcome of disclosure is not always positive and costs of exposure can potentially be very substantial. In other words, adverse consequences sequel to disclosure has been reported by several researchers (e.g. Deribe, et al, 2008). It is also not uncommon for PLWHA to be preoccupied with worries about whether or not to disclose, to whom to disclose, how to disclose, and how to manage post-disclosure information about their HIV/AIDS status. The target of whom to disclose HIV positive status is another difficult challenge among PLWHA. In various health care facilities, PLWHA is often encouraged to disclose their status to the spouse, trusted friends, family members, employers, among others. HIV positive status disclosure may consequentially be a double-edged sword. The consequence of disclosure could be expected end and could be an unexpected end. The negative consequence are not limited to broken marriages or relationships, emotional and physical emotional abuses, discrimination and stigmatization, and loss of economic support (Susan, 2006; Laurent, Peeters, & Delaporte, 2007).

Furthermore, disclosing one's HIV/AIDS positive status to crucial relatives could be an immediate or primary concern to PLHIV. Often time, it is a complex action, emotionally stimulated, and tough decision for individuals to make because at one though, there is a desire to isolate oneself or withdraw or refusing to tell anyone. The reasons are not far-fetched because disclosure of own HIV positive status predisposes the victim to discrimination, stigmatization, and rejection by folks such as; friends, family, and members of the community (Ewing, 2003). Disclosure of HIV positive status remained a prerequisite for adequate health care and the ground upon which the needed or expected health, emotional and social supports are meant (Derlega, et al, 2001). Adejumo (2011) reported that age has no significant influence on HIV disclosure intention among people living with HIV in Ibadan, Nigeria.

Nevertheless the aforementioned, few studies have explored this the prevalence, pattern and factors enhancing or hindering it among the Nigerian population. The objective of this research was to investigate the prevalence of disclosure rate in a major health care facility, the pattern of disclosure and explore the major cognitive barriers militating against disclosure intention among PLWHA.

MATERIALS AND METHODS

Study Area/Setting

The study was carried out in the State Government Healthcare facility in Ondo State. The sampled population was reached and engaged in the research in the Heart to Heart (H2H) unit of Hematology Department of the Ondo State Teaching Hospital, Akure, Ondo State. SSH

Akure is a government-owned general hospital in Akure south local government area of Ondo state. The health institution provides HIV/AIDS care significantly to people diagnosed with HIV/AIDS in Ondo state. This setting was considered appropriate for this study because it is the largest and government accredited facility for the treatment and management of HIV/AIDS in the state with over six thousand registered PLWHA. Ondo state is one and has persistently been representing the southwestern state in the top ten states in Nigeria with a high prevalence of HIV/AIDS diagnosis and management.

Research Design

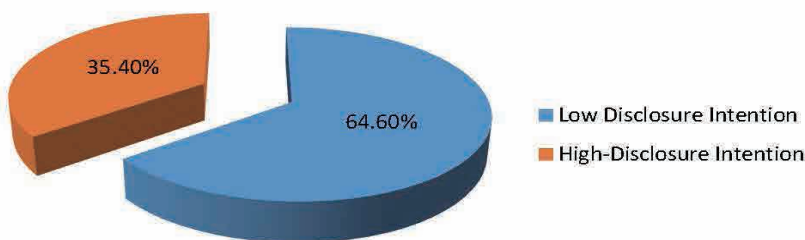
This study was conducted in two stages which utilize the mixed research design (Creswell, 2012). In other words, the study incorporated a blend of a quantitative method (to explore the prevalence of disclosure and its socio-demographic prevalence) and qualitative method (to explore cognitive barriers to self-disclosure of HIV positive status. The qualitative design adopted phenomenology design. The design allows the researcher to explore information from the subject matters on variables key to the subject matters. Focus Group Discussions (FGDs) were conducted among treatment-seeking people living with HIV, excluding AIDs patients). The quantitative design was achieved by adopting a survey-descriptive design. The design enabled the researchers to examine the estimated disclosure prevalence rate among PLHIV.

Participants

The target populations were registered HIV patients attending the clinic at the research settings at the time of data collection. The quantitative data was gathered from three hundred and ninety (n=390) PLWHA and the qualitative data was gathered from nineteen (n=19) PLHIV. The following criteria will be used to recruit participants for this study:

Inclusion Criteria

- Individuals receiving treatment for HIV/AIDS in state general hospital, Akure.
- Participants must be an adult (not less than 18 years).
- Participants who can speak, understand, read and write in the English language.
- Only consented HIV patients from phase one shall be strictly engaged.



The identified 64.6% (n = 252) of the respondents

Sampling Techniques

The sampling technique adopted in the study was purposive sampling techniques. The sampling technique allows the researcher to select appropriate respondents that are qualified to participate in the study.

Procedures

Informal consents were sought from PLWHA who were registered for treatment and follow up management as the stage of conducting the exploratory study among PLWHA through FGDs (HIV/AIDS patients). The essence of the exploratory study was fulfilled as the pull of variables were retrieved through response content analysis (RCA) and were all subject to preliminaries analysis and major and most useful variables shall be retained as the dependent variables to test against the study dependent variable.

RESULTS

This phase presents the results and interpretation of data collected on major cognitive barriers to HIV disclosure intention among three hundred and ninety (390) treatment-seeking people living with HIV in Ondo State, Nigeria. The collected data was analyzed using SPSS package (version 20). The analyzed data revealed the results of the study in three parts; the first part which is the preliminary results were being presented in tier one (an exploratory result of the study) and level two (revealed the prevalence and associated prevalence of non-disclosure intention rates among people living with HIV), The analyses which include; prevalence estimate analysis, chi-square analysis, was therefore presented.

Prevalence of Disclosure Intention

The prevalent rate of disclosure intention among people living with HIV in a hospital-based population was revealed in Table 1.

Table 1
Prevalence of disclosure intention of people living with HIV in a hospital: based population

	N	%
Low Disclosure Intention	252	64.6
High Disclosure Intention	138	35.4

The prevalence of low-disclosure intention among treatment-seeking people living with HIV/AIDS was pegged at 64.6%.

had mean scores of 66.13 (norm) or below as at the time

of data collection. This prevalence rate implies that that 252 of 390 participants had low disclosure intention in a hospital-based population.

Table 2
Prevalence of low disclosure intention according to participants' socio-demographic attributes

	Frequency (n/N)	%
Sex		
Male	54/77	70.1
Female	198/313	63.3
Marital Status		
Unmarried (Single) Respondents	110/156	70.5
Married Respondents	107/180	59.4
Divorced	05/10	50.0
Widowed/Widower	15/25	60.0
Co-habiting	15/19	78.9
Family Structure		
Monogamous	156/242	64.5%
Polygamous	96/148	64.9%
Employment Status		
Unemployed Respondents	131/204	64.2%
Employed Respondents	121/186	65.1%
Education Qualifications		
No Formal Education	24/47	51.1%
Primary Education	06/06	100%
Secondary Education	102/138	73.9%
OND/NCE	72/136	52.9%
B.Sc./HND	42/57	73.7%
Post-graduate	06/06	100%
Duration of Diagnosis		
1 - 5 Years	216/349	61.9%
6 - 10 Years	30/35	85.7%
11 - 15 Years	06/06	100

The results presented in table 2 showed the prevalence of low disclosure intention according to participants' socio-demographic attributes. The prevalence of low intention to disclose one's HIV positive status among a hospital-based population as presented in table 2 revealed that approximately 70% of the males and 60% of the females are not likely to disclose their HIV positive status.

The result also showed that approximately 70% of the unmarried PLHIV are not likely to disclose their HIV positive status. Furthermore, approximately 60% of the married PLHIV are not likely to disclose their HIV positive status. Half (50%) of the divorced PLHIV are not likely to disclose their HIV positive status. It was also shown that approximately 60% of the widower/d PLHIV are not likely to disclose their HIV positive status. The majority (79%) of the PLHIV who were co-habiting is not likely to disclose their HIV positive status.

Looking at the prevalence rate of low disclosure intention according to participants' family structure, it was revealed that about 65% of the PLHIV from monogamy family structure is not likely to disclose their HIV positive status. On the other hand, approximately 65% of the PLHIV from polygamy family structure is not likely to disclose their HIV positive status.

The results also revealed that approximately 60% of the unemployed PLHIV are not likely to disclose their HIV positive status. Approximately 65% of the employed PLHIV are not likely to disclose their HIV positive status.

Regarding the education status, approximately 51% of the PLHIV without formal education are not likely to disclose their HIV positive status. Further prevalence analysis revealed that 100% of the PLHIV with primary school certificate is not likely to disclose their HIV positive status. Approximately 74% of the PLHIV with secondary school education is not likely to disclose their HIV positive status, while approximately 53% of the PLHIV with OND/NCE certificates are not likely to disclose their HIV positive status. The prevalence study revealed that 74% of the PLHIV with B.Sc./HND certificates are not likely to disclose their HIV positive status. Everyone with a postgraduate certificate is not likely to disclose their HIV positive status.

Finally, approximately 62% of the PLHIV with 1 to 5 years of diagnosis knowledge is not likely to disclose their HIV positive status. The result further revealed that approximately 86% of the PLHIV with 6 to 10 years of diagnosis knowledge is not likely to disclose their HIV positive status. Furthermore, it was revealed that 100% of the PLHIV with 11 to 15 years of diagnosis knowledge is not likely to disclose their HIV positive status.

Analysis of Theme 1: Major Cognitive barriers to Disclosure of HIV positive status.

Qualitative results analyzed were derived from participants' responses to reasons for disclosure and non-disclosure of HIV status. Based on responses that are professionally labeled, and subjected to content analysis. The identified constructs implicated as reasons for cognitive barriers to non-disclosure of HIV positive serostatus had not less than 75% value of the Response Content Analysis.

Anticipated stigmatization: The Majority (93%) of the respondents identified anticipated stigmatization as the major reason their HIV positive status remained undisclosed to the circle of target disclosure (i.e. husband, wife, employers, children and friends). Respondents claimed knowledge of their HIV positive status may be a serious threat to the marriage, family, work-sustainability, and relationship with friends accordingly.

“As for me, the reason I insisted not opening up is simple, I cannot die before my death. The name the people call the sickness in Yoruba culture is even not helping issue, when something is called “aruntiogbogun” (meaning, untreatable

sickness), who will want to be associated with such sickness. I don't want people's attitude to send me to the grave before the sickness kill me itself"

(FGD/Group 2/Participant 4/Female/Married)

Disclosure Self-efficacy: In the study, it was further revealed based on the majority (76%) opinion that self-efficacy remained another reason their HIV positive status remained undisclosed to the circle of target disclosure (i.e. husband, wife, employers, children, and friends). The majority of the respondents claimed they do not have the zeal/capability of disclosing their HIV positive status may be a serious threat to the marriage, family, work-sustainability, and relationship with friends accordingly.

"The truth is how can I gather the strength of telling my children or employer that I'm infected with HIV? I just can't! Its better they know through whatever means than me sitting anyone down and disclose my HIV positive status."

(FGD/Group 1/Participant 4/Female/Married)

Manifested Mood Problems (Depression & Anxiety): Substantively among those that had disclosed their HIV positive status, 91% of the study respondents implicated mood problems in the reasons for disclosure of their HIV positive status. Findings had it that the swift and significant changes in the mood of people living with HIV/AIDs at the early knowledge of diagnosis informed the compulsive disclosure they reported.

"Unwillingly, my wife got to know that I'm infected with HIV because she noticed something is not right with me. During that period, I was avoiding having fun with her, I wasn't eating, I couldn't sleep, I stopped attending church. Infact, I was totally depressed.....not happy at all. My mood was affecting her that she was crying always to know what was wrong with me, finally, I have to tell. "

(FGD/Group 2/Participant 5/Male/Married)

"In my case, I don't want to tell him (husband) initially but the way I was behaving was somehow. That I will be crying always, feeling cold and sweating at the same time, breathing hard, and other terrible feelings. He was then curious and I couldn't hide it anymore but to tell him."

(FGD/Group 2/Participant 1/Female/Separated)

Health locus of control: The human nature of attribution negative and automatic thoughts was also implicated in the Focus Group Discussion such that, despite adequate knowledge of what HIV means and how to contract the virus infection, people's belief system strongly influences the perception of the victim to the disclosure of HIV status. In other words, majorly (81%) of the respondents identified peoples' belief system; i.e. anyone who is diagnosed of HIV is promiscuous or had lived a rough lifestyle as the major reason their HIV positive status remained undisclosed to the circle of target disclosure (i.e. husband, wife, employers, children and friends).

"Our people in this part of the world is funny, If I tell my husband and other disclosure target groups you said, they will

start thinking I am a useless woman to have contracted an HIV" She went further to say "people knows that HIV can be infected through simple careless like the use of a needle, but they wouldn't think about they, they will jump into the worst conclusion, I got infected in the process of cheating on my husband".

(FGD/Group 1/Participant 2/Female/Single)

Analysis of Theme 2: Targets of Disclosure (i.e. whom to disclose to?)

The second theme of the Focus Group Discussions explored both the targets of disclosure and potential target of disclosure among participants who had disclosed and participants who are yet to disclose their HIV positive status respectively. Whom they disclose their status to vary depending on motivations, and relational ties. The identified targets of disclosure with full content load include; Spouse (for those married), Partner(s) (for those in a relationship), parents of PLHIV (not spouse's parents), family, friends, health care workers, employers, and spiritual figure.

Findings from the study theme revealed that the majority of the respondents chose and will prefer to disclose to those they shared 50% genes with such i.e. parents. The majority of the respondents assumed their preferred target of disclosure is more unlikely to desert/stereotype against them and more likely to share the negative feelings (shame, fear of labeling, fear of information dissemination, etc.) associated with HIV positive status.

"In my case, when I was like encouraged to bring someone with me to the hospital, I can't think of any other body at that moment to present other than my mother, because my secret is safe with her and she can't find joy telling people around that I have this kind of problem unlike sharing it with other people....."

(FGD/Group 1/Participant 3/Female/Married)

Furthermore, findings also revealed that the majority of the respondents preferred and will prefer to disclose to those they shared 100% genes with such i.e. siblings where parents are not available.

"when I got to know that at least one person must be part of our treatment requirement, I had to involve my brother (sibling of the same parents) that stays here in Akure with me, because the way he (brother) will handle the matter is better than involving my wife, since my children is too young to understand what's going on."

(FGD/Group 2/Participant 5/Male/Married)

DISCUSSION AND CONCLUSION

The study purposed to examine the prevalence, patterns and cognitive barriers to HIV disclosure intention among treatment-seeking people living with HIV in Ono State Nigeria. The study became necessary due to the increasing rate of newly infected cases of HIV in Ondo state, culminated from the effect of the low rate of disclosure of HIV positive status.

The study revealed that the majority of the people living with HIV had low/no intention to disclose their HIV positive status, while a minority had the no intention or low intention to disclose their HIV positive status. In agreement with the study of Olley, et al. (2004) that concluded very low disclosure rate among PLWHA. The study outcome further reveal the stance of Nigeria against the 78% disclosure benchmark of stipulated for a developing nation as Nigeria, according to WHO (2004).

The study revealed that more males were likely to disclose their HIV positive status when compared to their female counterparts. On contrary, the study conducted by Adejumo (2011) reported that age has no significant influence on HIV disclosure intention among people living with HIV in Ibadan, Nigeria. Single PLHIV is less likely to disclose their HIV positive status when compared with counterparts who are either married, divorced, widow/er or co-habiting. The study revealed that majority of the respondents who are gainfully employed are less likely to disclose their HIV positive status when compared to counterparts who are not employed. The study also reviewed that people with 11-15 years of diagnosis knowledge are not likely to disclose their HIV positive status when compared to counterparts with an early year(s) of diagnosis. Conclusively, estimation prevalence results revealed that participants with primary school leaving certificate and postgraduate certificates were less likely to disclose their HIV positive status when compared with participants who were holders of other qualifications.

Like the study of Susan (2006) and Laurent, et al. (2007) that implicated the role of social and psychological on disclosure of HIV positive status, the study further concludes that anticipated stigmatization, disclosure efficacy, manifested mood problems (anxiety and depressive symptoms), and health locus of control were the implicated cognitive barriers to disclosure among a hospital-based PLHIV. The outcome was similarly Furthermore, the study revealed that the target of disclosure was major to secondary circle i.e. parents and siblings and not towards the primary circle, such as; spouse/girlfriend/boyfriend, children, etc.

Implication and Recommendation

This study has implications for theory, practice, policy, and research that were elaborated in this section. The outcomes accentuated some factors that predicted cognitive barriers of disclosure intention among PLHIV. Therefore, programs concerning HIV disclosure intervention should integrate psychology-based intervention strategies (psychotherapy, specifically, psychological inoculation) that will reduce cognitive barriers to disclosure, which thereafter culminate into the expected rate of disclosure among PLHIV.

There is a need for the government and other relevant stakeholders to review and implement existing policies on HIV and AIDS to encourage the virus applicability

to the masses and therefore culminate into the expected increase in disclosure rate. The native name of “HIV” in the research settings is called “arunkogbo-ogun” meaning an “incurable infection” which was identified as one of the major sources of anticipated and social stigmatization. The authority concerned should review the menace and come up with National Re-orientation Programmes (NRP) aimed at changing people’s perception of people living with HIV/AIDS. In other words, public enlightenment programs on HIV/ AIDS should be instituted. Such applications should include a public forum and community talks, radio and dissemination of information and communication materials. The education on HIV/ AIDS in the society should look into the culture of the people. This is because findings revealed that aspects of anticipated stigmatization are embedded in the culture of the people.

There is a need for appropriate authorities like the Nigerian Medical Association and others sponsored body saddled with the battle of HIV/AIDs in Nigeria to re-evaluate the existing programs purposed to aid acceptance of PLWHA. It was discovered that PLHIV declined disclosure intention not because they were stigmatized but because they anticipated stigmatization. Therefore, for an effective result, the focus should also shift towards using psychological inoculation techniques (using blends of anticipated stigmatization, disclosure efficacy, etc.) to remove cognitive barriers to disclosure and therefore culminate into expected disclosure rate among PLWHA.

Limitations of the study

Even though major cognitive barriers to disclosure were discovered in the study, however, the study did not further examine actual disclosure and consequences that follow disclosure of HIV positive status to primary targets. Such disclosure would have been essential to determine and understand the risk and benefit associated with disclosure to primary target such as; sex partners, husbands, wives, and children.

The findings of the study are limited to HIV/AIDs facility in Ondo State and may not be generalized to all the other health care facilities in Nigeria, especially regions with distinct cultural tight (northern and eastern part of Nigeria).

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