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INFLUENCE OF GENDER ON SELF DISCLOSURE OF HIV/AIDS STATUS BY VICTIMS IN JOS

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ABSTRACT

This study examined the influence of gender on self disclosure of HIV/AIDS status among People living with human immune deficiency virus(PLWHAs) in Jos metropolis. It adopted a 2x2 factorial design. Participants, whose ages ranged from19-65years, comprised of 167 females and 79 males came from various educational backgrounds.The purposive sampling technique was employed in the recruitment of the study participants. The reliability coefficient of the HIV stigma scale used in the study was .96 while the Multidimensional scale of perceived social support had .92-.94. The statistical analysis used was the independent t-test .Result showed that no significant difference was observed in self-disclosure of HIV/AIDS status between gender, [t (244) = -1.469, p>.05].An aggressive, intensive and well funded study on a wider scope in this regard was recommended to government at federal, State and local levels, non-governmental organizations like APIN(Aids prevention initiative in Nigeria), PEPFAR(President's emergency plan for Aids relief), GLOBAL FUND, civil society organisations and other stakeholders.

KEY WORDS:

Politics, health care delivery and child and maternal mortality.

Introduction

Over the years HIV/AIDS has plagued the world with damaging consequences on human life and society. The most worrisome aspects of the disease are issues surrounding it. The latter include stigma and discrimination which are said to exist worldwide, although they manifest themselves differently across countries, communities, religious groups and individuals. Since 1986 when the first case of the Acquired Immune Deficiency Syndrome (AIDS) was reported in Nigeria, the disease has grown to epidemic proportions (Nasidi, Harry, Ajose-Coker , Ademiluyi & Akinyanju, 1986). The prevalence of its causative agent- the Human Immunodeficiency Virus (HIV) was observed to be steadily rising since the early days of the epidemic from 1.8% in 1991 to 5.8% in 2001. Subsequent surveys in 2003 and 2005 revealed a slight downward trend to 5.0% and 4.4% respectively(National AIDS/STDs Control Programme (NASCP) Federal Ministry of Health, Abuja, 2005).

Researchers have reported that disclosure of HIV status varies with regard to the types of relationships (Kalichman, DiMarco, Austin, Luke, DiFonzo, Marks, Bundek, Richardson, Ruiz, Maldonado, Mason 1992, Jeffe, Khan, Meredith, Schlesinger, Fraser, Mundy, 2000). However, there is no consistency among their results. Some of the studies suggest that PLWHA intend to disclose HIV-status to family members more than friends and coworkers for the simple reason that they(family members) would keep it confidential. Whereas, some other studies showed that the disclosure was more towards the friends (Kalichman, DiMarco, Austin, Luke, DiFonzo,. Stempel, Moulton, Moss 1995.). Contrary to other countries, particularly western society, information about social support and disclosure of HIV status is limited in Iran

According to Sagay**,** Musa, Ekwempu, Imade, Babalola, and Daniyan (2006), disclosure is an important public health goal for a number of reasons. First, disclosure may motivate sexual partners to seek testing, change behaviour and ultimately decrease transmission of HIV. Secondly, disclosure may facilitate other health behaviours that may improve management of HIV. Women who disclose their HIV status to partners may be more likely to participate in programmes for prevention of mother to child transmission (PMTCT) than those who don't. Through disclosure of her HIV status, a woman may receive support from her family or others in her social network and may also be able to access available support services. By adequately addressing the emotional, social, and practical problems associated with her HIV positive status she may be more willing to adopt and maintain health behaviours such as cessation of breast feeding or adherence to treatment regimens and other interventions for PMTCT. Some of the barriers to disclosure of HIV status include fear of accusations of infidelity, abandonment, discrimination and violence (Medley. Garcia-Moreno, McGill & Maman). Inspite of these fears and barriers, disclosure of HIV status to sexual partner has been emphasized by WHO (UNAIDS; 1997) and the centre for disease control and prevention (CDC) (Morbidity & Mortality weekly report 2002).

An abundance of research has shown that men and women use different criteria for deciding to open or close their boundaries. Consequently, they tend to depend on different rules to reveal or conceal. The outcome of these rules is that women more than men tend to disclose overall (though there are situations where the reverse is also true). Women more than men also tend to talk about intimate or personal topics with each other. In addition, women prefer disclosing to same-sex friends while men prefer to disclose while engaging in some activity (Caldwell & Peplau 1982; Dindia & Allen 1992).

Jos is a city in the Middle Belt of Nigeria. The city has a population of about 900,000 residents based on the 2006 census. Popularly called "J-town", it is the administrative capital of Plateau State.

The city is located on the Jos Plateau at an elevation of about 1,238 metres or 4,062 feet high above sea level. During British colonial rule, Jos was an important centre for tin mining. In recent years it has suffered violent religious clashes between its Muslim and Christian populations in 2001, 2008, 2010, and 2011. The earliest known settlers of the land that would come to be known as Nigeria were the Nok people (circa 1000 BC), skilled artisans from around the Jos area who mysteriously vanished in the late first millennium.

According to the historian Zangabadt (2006), the area known as Jos today was inhabited by indigenous ethnic groups who were mostly farmers.

Gender

Several researchers have examined the relationship between gender and disclosure; however, results have been equivocal. For example, Jourard found that women disclose more than men (Jourard, 1961; Jourard & Lasakow, 1958; Jourard & Richman, 1963) and that women were more often the recipients of disclosure than men (Jourard & Lasakow, 1958; Jourard & Richman, 1963). As an explanation for these gender differences, Jourard (1971) surmised that the male sex role which "requires men to appear tough, objective, striving, achieving, unsentimental and emotionally unexpressive" (p. 35) may be why men tend to not disclose as much as women. On the contrary, however, other researchers have found no differences in the amount of disclosure by women and men (Doster & Strickland, 1971; Vondracek & Marshall, 1971) and in some cases, found men to disclose more than women (Grigsby & Weatherly, 1983; Stokes, Fuehrer, & Childs, 1980). HIV are typically viewed m relation to others, primarily sexual partners and children (Cohan & Atwood, 1994; Corea, 1992; Welch Cilne, McKenzie, & Glassman, 1992),

Men have a greater need to control their privacy (Petronio, Martin, & Little field 1984; Rosenfeld 1979). Men also report expecting greater negative ramifications when disclosing about life expectations (Petronio and Martin 1986). Men and women who enter into a marital relationship often have to change their personal rules to coordinate with their partners. Thus, although they still maintain the same rules around private information that is personal, once information becomes shared and defined as belonging to the couple collectively, new mutually held rules must be determined. If the couple is not able to agree on ways to mutually manage their shared boundary, conflict might erupt. Deribe et al (2008). in a study to compare rates of HIV/AIDS status disclosure among HIV infected men and women using clinical services in Ethiopia, found out that the rate of disclosure was similar between males and females contrary to reports by Anglewicza, & Chintsanya (2011) and Simbayi, Kalichman, Strebel, Cloete, Henda, & Mqeketo (2007) in studies conducted in Malawi and South Africa respectively, which noted higher rates of disclosure to sexual partners among female participants as

compared to males. Mwanga (2012) reported higher proportion of male participants to have disclosed to their sexual partners in a study conducted among clients in Kisarawe district in Tanzania.

Self-disclosure is an important building block for intimacy; intimacy cannot be achieved without it. We expect self-disclosure to be reciprocal and appropriate. Self-disclosure can be assessed by an analysis of cost and rewards which can be further explained by social exchange theory. Most self-disclosure occurs early in relational development, but more intimate self-disclosure occurs later (wikipedia, the free encyclopedia).

Statement of the Problem

There are so many HIV/AIDS victims in Plateau state and elsewhere in the world who are directly or indirectly experiencing problems associated with the disease which include stigma, anxiety, depression, and hypertension, fear of spousal abandonment, community rejection, abusive and derogatory labels. The culture and or the hereditary traits of people in most cases influences what males and females can do corporately and as individuals in word and in action. This practice places people in dilemma when it comes to issues of necessity and or survival. Accordingly this study sets out to examine the influence of gender onself disclosure of HIV/AIDS status by victims in Jos.

Objectives

The aim of this paper is to investigate the impact of gender on self disclosure of HIV/AIDS status among victims in Jos metropolis. The following objective is defined for the study:

To investigate the influence of gender on self disclosure of HIV/AIDS status by PLWA in Jos.

The study of self disclosure of HIV/AIDS status by victims is gaining attention because the strategic preventive and therapeutic approaches of the disease stem from it mostly. Findings from this paper will undoubtedly go a long way in addressing challenges that have unfortunately affected the control of HIV/AIDS by governments, civil society organizations, communities, spouses and lovers.

It is expected that the study will give government direction on legislation and enforcement of laws in connection with HIV/AIDS appreciation. The result obtained will broaden the literature on the hypothesised variables and open new avenues of research on disclosure of HIV/AIDS status among victims. The research will provide information that will be of major importance in the facilitation of self disclosure of HIV/AIDS by victims.

This paper focuses on the Jos metropolis in Plateau State Nigeria. The AIDS Prevention Initiative (APIN) centre in Jos was the setting where much of the information was collected. Care was taken to capture all genders. We hypothesized that there was going to be significant influence of gender on self disclosure of HIV/AIDS status by people living with the disease.

Conceptual clarification

A review of concepts, theories and studies in relation to gender and HIV/AIDS status disclosure is undoubtedly necessary. Human immunodeficiency virus infection / acquired immunodeficiency syndrome (HIV/AIDS) is a disease of the human immune system caused by infection with human immunodeficiency virus (HIV) (Sepkowitz, 2001). The term HIV/AIDS represents the entire range of disease caused by the human immunodeficiency virus from early infection to late stage symptoms. During the initial infection, a person may experience a brief period of influenza-like illness. This is typically followed by a prolonged period without symptoms. As the illness progresses, it interferes more and more with the immune system, making the person much more likely to get infections, including opportunistic infections and tumors that do not usually affect people who have working immune systems (Sepkowitz , 2001)

HIV is transmitted by three main routes: sexual contact, exposure to infected body fluids or tissues, and from mother to child during pregnancy, delivery, or breast feeding known as vertical transmission (Markowitz, 2007). Kripke (2007) posits that there is no risk of acquiring HIV if exposed to feces, nasal secretions, saliva, sputum, sweat, tears, urine, or vomit unless these are contaminated with blood. It is possible to be co-infected by more than one strain of HIV—a condition known as HIV super infection (van der Kuyl, Cornelissen, 2007).

Gender concept

Gender is the range of characteristics pertaining to, and differentiating between, masculinity and femininity. Depending on the context, these characteristics may include biological sex (i.e. the state of being male, female or intersex), sex-based social structures (including gender roles and other social roles), or gender identity (Udry and Richard,1994,Haig&David,2004;Ann-Maree & Nobelius,2004;World Health Organization,2009)

Sexologist John Money introduced the terminological distinction between biological sex and gender as a role in 1955. Before his work, it was uncommon to use the word *gender* to refer to anything but grammatical categories(Udry & Richard, 1994,Haig & David,2004). However, Money's meaning of the word did not become widespread until the 1970s, when feminist theory embraced the concept of a distinction between biological sex and the social construct of gender. Self-disclosure is a process of communication through which one person reveals himself or herself to another. It comprises everything an individual chooses to tell

the other person about himself or herself, making him or her known. The information can be descriptive or evaluative and can include thoughts, feelings, aspirations, goals, failures, successes, fears, dreams as well as one's likes, dislikes, and favorites (Ignatius, Emmi, Marja and Kokkonen, 2007).Ignatius et, al (2007) also put it that self–disclosure is not simply providing information to another person but sharing information with others that they would not normally know or discover. Self –disclosure involves risk of breaking confidence on the part of the person sharing the information.

A useful way of viewing self – disclosure is the Johari window. The Johari window is a way of showing how much information you know about yourself and how much others know about you. The window contains four panes, as shown below.

Table 1 -.Showing self-disclosure panes between self and others

	Known to self	***Unknown to self***
Known to others	**Open Pane** Known to self and others	**Blind Pane** Blind to self, seen by others
Unknown to others	**Hidden Pane** Open to self, hidden from others	**Unknown Pane** Unknown to self and others

Source: Tim Bochers (1999)

Attribution Theory and HIV Disclosure

Disclosure of an HIV-positive diagnosis can be easily understood in terms of attribution theory as the two factors necessary for making attributions (dispositional factors and situational factors) are likely be involved in this disclosure process. Regardless of whether it is the HIV-positive individual him/herself or a family member with the information, in the case of disclosing one's HIV-positive status, attributions regarding the potential recipient of the information in deciding whether or not to reveal the diagnosis are likely to occur. For example, dispositional factors such as, is the person likely to be supportive of the HIV-positive individual or discloser or is the potential recipient someone who the HIV-positive individual or discloser will have to take care of emotionally, might be considered. Next, how has the person responded in the past to disclosures of distressing information? Likewise, the HIV-positive individual or family member with the information must also entertain situational constraints about the potential recipient of the information that may promote or restrict disclosure. For example, is the person physically healthy or are attributions likely to be made that the potential recipient is too ill and his/her condition may worsen if disclosure occurs?

For the purposes of this analogue study, the attributions a person makes about an HIV-positive individual, the potential recipient of the information, and various factors associated with the HIV-positive individual and his/her relationship with potential recipients of that information in determining whether or not to disclose will be examined. Theoretically, for the HIV-positive person or family members with this information to decide to disclose an individual's HIV-status to a particular person, the available information must first be considered. For example, will consensus, consistency, and distinctiveness be low or high? That is, will all potential recipients of the information react in a similar way? Will the person react like she/he did when other information was disclosed? Will the person regard this information as "news" or is this something he/she has known or suspected for awhile? After this information has been processed, attributions regarding the potential recipient's anticipated response will be made in an effort by the HIV-positive person (perceiver) to create a more predictable world for him/herself In accordance with attribution theory, these attributions will be made on the basis of dispositional factors of the potential recipient (i.e., closeness, attitude toward persons in stigmatized groups) and situational factors (i.e., health, financial assistance).

Disease Progression Theory (Kalichman, 1995)

According to the disease progression theory, individuals disclose their HIV diagnosis as they become ill because when HIV progresses to AIDS they can no longer keep it a secret (Babcock, 1998; Kalichman, 1995). Disease progression often results in hospitalizations and physical deterioration, which, in some cases, mandates individuals to explain their illness (Kalichman, 1995). Holt, Court, Vedhara, Nott, Holmes & Snow(1998) further put it that not only would hospitalization require explanation, but if death is imminent or individuals fear they will need additional assistance to manage their illness, they may disclose as a means of accessing additional needed resources. Delaying disclosure may be a way to normalize their life and protect others from pain (Babcock, 1998).

The relationship between disease progression and disclosure has been substantiated in numerous studies using various indexes of disease progression (Hays et al., 1993; Marks, Bundek, et al., 1992; Marks, Richardson, et al., 1992; Mason, Marks, Simoni, Ruiz, and Richardson, 1995). For example, Marks, Bundek, and colleagues (1992) documented in a study of Hispanic men that as overall symptom severity increased, disclosure to others increased. This trend remained consistent for both overt and less overt symptoms as well as various targets of disclosure such as parents and siblings. Using a sample of symptomatic and asymptomatic men, Hays, McKusick, Pollack, Hilliard, Hoff and Coates, (1993) found asymptomatic men were less likely to disclose their HIV status to family and friends than symptomatic men. Furthermore, disease severity and time since testing for HIV have both been shown to be positively related to disclosure

(Mason et al., 1995). Marks, Bundek, and their collaborators (1992) hypothesized that "illness progression heightens anxiety and need for social support, which may motivate disclosure to significant others"

Consequence theory (Thibaut & Kelly, 1959): The consequence theory of HIV disclosure suggests that the relationship between disease progression and disclosure is moderated by the consequences one anticipates resulting from the disclosure. That is, as the disease progresses, stresses accumulate which result in the need to evaluate the consequences of disclosure. Persons with HIV are likely to reveal to significant others and sexual partners once the rewards for disclosing outweigh the associated costs (Serovich, 2008).

From the foregoing, the consequence theory showcases one's readiness to accept or reject the appeal to disclose based on the merits and demerits of the disclosure Uti et'al (2007) in a study found out that there was a significant difference between genders concerning disclosure of HIV status with the males more willing to disclose their status compared to the females ($p < 0.05$). Fear of breach of confidentiality and discrimination were the most common reasons given. Bouillon et'al (2007) found out that determinants of disclosure to the family, friend or religious network was gender.

Gender and Self Disclosure

Among 705 participants, an equal number of men and women (94.6% men vs. 94.3%, women, $p = 0.876$) indicated that they have disclosed their result to at least one individual and the majority (90.9% men vs. 90.7% women, $p = 0.906$) disclosed their result to their current main partner. It is customary to tell my partner everything was the frequently cited motivator for disclosing (36.3% men vs. 44.6% women, $p = 0.147$). Reasons for non-disclosure varied by gender: men are more tender-hearted about their partners while women are more pragmatic. The individual contextual meaning of fear of partner reaction entirely differs between men and women. Men were concerned about their partner's worry and exposure of their own unfaithfulness. Women feared physical violence and social and economic pressure in raising their children. For men, disclosure of HIV results to a sexual partner was positively associated with knowing the partner's HIV status and discussion about HIV testing prior to seeking services, while for women it was associated with knowing the partner's HIV status, advanced disease stage, attending no more than primary education, being married, and perceiving the current relation as long-lasting. It was finally concluded that there was no significant difference in the proportion of HIV status disclosure among men and women. However, the contextual barriers and motivators of disclosure varied by gender. Therefore future interventions should consider the importance of socially constructed gender roles in the efforts to increase HIV status disclosure (Deribe; Woldemichael; Bernard; Yakob .2009)

Methodology

From a population of 1018, a total of 287 participants were sampled purposively. The study employed the 2x2 factorial design to examine the influence of gender(male and female)on self disclosure (low and high) of HIV/AIDS status by people living with HIV/AIDS(PLWH)

At the end of the exercise 246 questionnaires were collected. Out of this, 79 of the participants were males while 167 of them were females within the age range of 19 to 65 years. Table 4.0 shows the socio-demographic characteristics of participants. The table shows that the majority 167 (67.8%) of the participants were females, while 79 (32.2%) were males. Regarding the highest education attainment of participants, the table revealed that the majority 110 (44.9%) of the participants had tertiary educational qualification; while 16 (6.6%) had informal education, 59 (23.8%) had primary education, and 61 (24.7%) had secondary education.

Table 2: Socio-demographic Characteristics of Participants

	Frequency	**Percentage %**
Gender		
Male	79	32.2
Female	167	67.8
Total	**246**	**100.0**
Highest Educational Attainment		
Informal	16	6.6
Primary	59	23.8
Secondary	61	24.7
Tertiary	110	44.9
Total	**246**	**100.0**

Instruments

The HIV stigma scale and the multidimensional scale of perceived social support were the instruments used in the study

Results

Out of 287 questionnaires distributed, a total of 246 were collected and analyzed. The descriptive and inferential results are presented below:

Table 3: T -test Summary of effect of gender on self -disclosure of HIV/AIDS status among People Living with HIV and AIDS (PLWHAs) .

Variables	Gender	N	Mean	Std	t	Df	Sig	P
Self-Disclosure stigma	Male	80	25.84	3.72	-1.469	244	.144	>.05
	Female	166	26.63	4.38				

Table 3 shows that there was no significant difference in the self-disclosure stigma of the participants gender [t (244) = -1.469, p>.05]. The mean observation shows that male participants reported ($\overline{X}$ = 25.84) self-disclosure, while their female counterpart reported ($\overline{X}$ = 26.63) with a mean difference of 0.789. The hypothesis was therefore not confirmed. There were no gender differences in self disclosure of HIV status. The implication here is that gender does not matter in the choice to disclose or not to disclose HIV/AIDS status. Any gender can disclose far higher than the other depending on some personal or environmental factor(s)

The stated Hypothesis which sought to examine if there was significant influence of gender on self disclosure of HIV/AIDS status was not confirmed. This finding tallies with Kadowa et' al (2009) who in a study on Factors influencing disclosure of HIV positive status in Mityana district of Uganda found out that there was no significant difference in self disclosure between the cases and controls in relation to gender. Similarly, Deribe et' al (2010) came up with the finding that there was no significant difference in the proportion of HIV status disclosure among men and women. However, the contextual barriers and motivators of disclosure varied by gender. Therefore it was concluded that it is important that clinicians, counselors, and health educators underscore the importance of gender-specific interventions in efforts to dispel barriers to HIV status disclosure. Dankoli, Aliyu, Nsubuga, Nguku, Ossai, Tukur et'al (2014) in a study titled HIV disclosure status and factors among adult HIV positive patients in a secondary health facility in North-Eastern Nigeria, 2011, found out that Gender, employment status, educational level, duration of infection and marital status were not found to be significantly associated with disclosure of HIV status. A plausible explanation for this finding is that as men and women in this part of the world (Jos, Nigeria) are virtually economically independent of one another, disclosure and non disclosure of Status to the other makes no difference. No party owes the other a duty to disclose his/her HIV/AIDS status. Makin et al (2007) in their study, found out that less dependence on partners was positively associated with disclosure. This is unlike other societies like in Kenya where research found that women were significantly more likely to notify their partners if they had limited resources or relied on their husband for economic support (Farquhar, Mbori-Ngacha, Bosire, Nduati, Kreiss and John 2001), suggesting that women may feel compelled to disclose to partners to ensure continuing economic support. But the evidence

comparing levels of disclosure by women and men is mixed. Studies from Kenya by Katz et al. (2009) and South Africa by Olley et al(2004) found higher rates of disclosure by women, while other studies have found no significant differences, as in Ethiopia (Deribe, Woldemichael, Bernard and Yakob 2009; Deribe et al. 2008)

Gender could not predict disclosure as demonstrated by Ndayala, Ondigi, Ngige (2015) whose study revealed that the association between disclosure of HIV positivity and the PLWHAs' demographic factors such as gender and level of education was not established. This finding could be attributed to independent lifestyles that are common among couples in this part of the country. This research had challenges in the sense that coverage was poor as only one treatment facility was covered. Also the number of research assistants was limited as only six of them were there to assist in the administration and translation of the instruments used.

Recommendations

A wider coverage and recruitment of more research personnel is highly recommended with support from bodies like APIN (Aids prevention initiative in Nigeria), PEPFAR (President's emergency plan for Aids relief), GLOBAL FUND, civil society organisations and other stakeholders to address challenges encountered in this exercise.

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