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Archives of Applied Science Research, 2014, 6 (1):184-191  
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## Psychosocial determinants of self-disclosure of HIV positive status

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### ABSTRACT

*Disclosure of HIV+ status is an important prevention goal and it offers a number of important benefits to the infected individual and to the general public. Disclosure of HIV test result is associated with less anxiety and increased support. HIV status disclosure may also lead to improved access to HIV prevention and treatment programmes, increased opportunities for risk reduction and increased opportunities to plan for the future. This study looked into psychosocial determinants of self-disclosure of HIV+ status; it is a simple survey study seeking for responses from the participants. Self-reporting questionnaire drawn on the factors affecting self-disclosure of HIV+ status. One hundred participants were conveniently selected for the study; five hypotheses were formulated and tested at the significant level of 0.05 using multiple regression method of statistics. The findings about HIV/AIDS, cultural influences, illiteracy level and anxiety, stigma and discrimination were some of the factors identified as militating against self-disclosure of HIV+ status. It is recommended that health education should be used to create aggressive awareness about the benefits of disclosure of HIV+ status.*

**Key words:** Psychosocial determinants, Self-disclosure, HIV status.

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### INTRODUCTION

AIDS remains a highly stigmatized illness throughout the world. AIDS stigma refers to prejudice, discounting, discrediting and discrimination directed at people perceived to have AIDS as well as individuals, groups and communities with which they are associated. The decision to disclose an HIV+ diagnosis can be a stressful and difficult process for women afflicted with the virus. However, because of disclosure's positive impact on social support, it is an important step to decreasing the psychological impact of the disease itself. Practitioners can assist women in disclosing to supportive individuals who will help them navigate a life with HIV.

AIDS is not merely a medical problem; the manner in which the virus is affecting the society reveals the intricate way in which social, economic, cultural, political and legal factors act together to make certain sections of the society more vulnerable, the epidemic exposes the method and the impact of marginalization and inequality in clear terms.

Marginalization groups in the society have little or no access to basic fundamental and human rights such as food, medical services and information. Many of these groups are ostracized by the society at large, and their lifestyles criminalized, making it practically impossible for them to participate in mainstream processes whereby they could

demand their rights. Coupled with this dismal situation, there is minimal awareness about HIV and no real options for safer lifestyle.

Adeokun, Okonkwo and Ladipo (2006) were of the view that the complexity of the HIV/AIDS epidemic stems from its links with all aspects of society and culture. Social and cultural factors affecting not only Ural transmissions but also the success of prevention strategies and the compassion with which people living with the virus are treated. A clear understanding of these factors therefore becomes a point of departure for planning the control of the epidemic. Culture can be defined as the habits, expectations, behaviour, rituals, values, beliefs that human groups develop over time (WHO, 1994); culture is a product of interaction of people, ideas and the physical environment. It determines their feelings and beliefs about death and loss. Culture and tradition therefore influence how people interpret, explain and respond to HIV infection and AIDS. Because HIV infection is attributed to sexual behaviour, some people may hesitate for cultural, religious and moral reasons to consider disclosing their HIV+ status. Adeokun et al (2006) views peoples' belief about disease causation as ultimately influencing their health care-seeking behaviour and efforts to protect themselves from infection.

Many Nigerians believe in supernatural nature of illness. The features of a culture are derived from the component of the demographic and socio-economic composition of the population, which are age, sex, residence, education, marital status and religion, family/social unit and ethical identity. All these features influence people's spatial and sexual mobility, their exposure to infection and their health-seeking and managing responses.

Stigmatization/Discrimination, Level of education, perception about HIV/AIDS, anxiety about HIV/AIDS, attitude about the outcome of disclosure of sero-status, knowledge of HIV/AIDS, gender influence, religion, social background, customs and values have been identified as some of the psychosocial determinants of HIV+ self-disclosure. No doubt from the start of AIDS epidemic, stigmatization and discrimination have fuelled the transmission of HIV and greatly increased the negative impact associated with the epidemic.

HIV-related stigma and discrimination continue to manifest in every country and region of the world, creating major barriers to self-disclosure of HIV+ status thereby preventing further spread of infection, alleviating impact and providing adequate care, support and treatment. The stigma associated with AIDS has silenced open discussion both of its causes and of appropriate responses that has created a strong obstacle for the successful mobilization of government, communities and individuals to respond to the epidemic.

Concealment encourages denial that there is a problem and delays urgent action. Stigma leads to discrimination and other violation of human rights that affects the well-being of people living with HIV/AIDS such as denial of their right to health, work, education and freedom of movement among others (UNAIDS, 2005 & Bradford, 2004).

Transmission of HIV is another psychosocial reason for lack of disclosure of HIV+ status. To Olaleye, Harry and Odaibo (2006), although worldwide, sexual intercourse is the most frequent mode of transmission of which may either be by vaginal, anal or oral sexual intercourse and that globally, 90% of HIV infection is acquired sexually and this has brought a misconception that everyone with AIDS is promiscuous not minding that HIV can be transmitted through blood and blood products, HIV-contaminated needles and syringes, and mother-to-child transmission (UNAIDS, 2004).

Women are particularly susceptible to HIV infection in developing countries, where the male-to-female ratio is less than 1 (WHO) (UNAIDS, 1996) reported that a complex combination of factors ranging from the biology of the virus, to the anatomy of the female genital tract to socio-cultural traditions have increased women's vulnerability to HIV infection.

Adewole, Odutola and Saggay (2006) asserted that large population of women of reproductive age, high birth rates, a tradition of prolonged breastfeeding and a lack of effective intervention aimed at preventing MTCT had added to a high prevalence of HIV among women in Sub-Saharan Africa.

Knowledge and acceptance of HIV/AIDS also determines self-disclosure of the status, although many studies have been carried out to assess the level of knowledge about HIV/AIDS (Olayinka & Osho, 1997, Nasidi & Harry, 2006, Duffy, 1998, Ezeonu & Ezegui, 2001). All agreed that knowledge level is high but acceptance is still very low and it is discovered that the straight jack education about HIV/AIDS does not seem to be very effective rather there would be ways of laying emphasis on benefits of self-disclosure of HIV+ status.

Duffy (1998) reported that knowledge about HIV/AIDS and testing is affected by race as non-Caucasian women had less knowledge and were also more less likely to accept HIV testing and this affects their disclosure while Cartoux, Meda and Perre (1998) were of the view that acceptance of HIV+ status may be affected by cultural factors and the perceived stigma of selection process (labelling) on the women or the fact that these women may be unaware of their risks for infection.

Fear and hostility towards people living with HIV/AIDS (PLWHA) appears to be greatest among heterosexuals that express negative attitudes towards gay people.

The decision to disclose an HIV diagnosis is a complex issue for those infected. Although, research has shown that suppressing difficult emotions and thoughts can be damaging to one's physical and emotional health, sharing an HIV diagnosis with others can also be stigmatizing and potentially damaging due to society's views of the illness.

Negative emotional consequences of disclosure have been shown to include rejection, abandonment and isolation. Nevertheless, disclosure is an issue that all patients face since it is a pre-requisite for proper healthcare and in many cases, necessary for the receipt of appropriate emotional support from others (Ambrose & Seehan, 1991; Anderson, 1992; D'Augelli, 1989; Grieger & Ponterotto, 1988).

### **Conceptual Framework (Fishbein's Theory of Reasoned Action) (TRA)**

This theory has explained and predicted a variety of human behaviour and it is based on the premise that humans are rational and that behaviours being explored are under rotational control. The theory provides a construct that links individual beliefs, attitudes, intentions and behaviour. The key intervention of the model is to alter intention; the behaviour is predicted by a series of mathematical modes that combines the determinants of intention. Intention is determined by the behaviour and their subjective norms i.e. their perception of the degree to which significant others think performing the behaviour is important. (Fishbein & Ajzen, 1975). The attitude component is the product of the beliefs (expectations that performing a specific behaviour will lead to a certain consequence and the individual valuation of that consequence i.e. how good or bad such an outcome would be). The subjective normative component of the model also incorporates an expectancy and value component. It is the product of the expectation that important others will consider the performance of the behaviour important and the value of that person's approval. The theory thus considers both the individual's attitude towards behaviour as well as the influence of social environment as important predictors of behavioural intention. The relative contribution of the two components of the model will in part depend on the behaviour in question, for example, an HIV+ individual will self-disclose his/her sero-status because of social, physical, emotional and financial supports he/she would enjoy from the significant person(s) he/she is disclosing to.

### **Hypotheses**

The following hypotheses were formulated, used and tested at the significance level of 0.05.

- (1) There would be no significant relationship between literacy level and self-disclosure of HIV+ status.
- (2) There would be no significant relationship between knowledge acquired about HIV/AIDS and self-disclosure of HIV positive status.
- (3) There would be no significant relationship between cultural influence and self-disclosure of HIV+ status.
- (4) There would be no significant relationship between anxiety/stigma/discrimination and self-disclosure of HIV+ status.

### **MATERIALS AND METHODS**

The research design was a descriptive survey, non-experimental study. The study was limited to the psychosocial determinants of self-disclosure of HIV+ status.

The study was conducted in Ipetu-Igbomina, Irepodun Local Government of Kwara State, Nigeria. Ipetu-igbomina is a community located in the Kwara-south senatorial district of Kwara state with inhabitants of about 12000 people (NPC, 1996). It is bounded in the north by Omu-Aran, Erinmope and Aran-orin in the south, east by Odo-owa, Oke-ero Local government and to the west by Rore. The inhabitants are predominantly farmers, traders, traders and civil servants respectively. The target population was all males and females in the community age not below 18 years as an adult is responsible for his/her action and decision.

Three Hundred (300) respondents were conveniently selected in the community. The community has the following compounds; Inisha, Oke-omoh, Oke-oba. Odo-oro, Ododofun and Temidire. Fifty (50) participants were selected from each compound conveniently and to ensure that all the compounds were fully represented in the study. The researcher met the Royal father and the Oba-in-Council for their formal permission and informed consent. Since every compound head is a member of Oba-in-Council, this made it easier for dissemination of the programme to every household as the Royal father gave the researcher another appointment day for the administration of the questionnaire since the compound heads must have informed their households. The researcher employed the service of research assistants for the conduct of the study especially since majority of the participants were not literate and for better coverage. All the inhabitants that were available both males and females not below 18 years were qualified for the study but only those fifty that volunteered themselves per compound participated in the study and a total of three hundred respondents were conveniently selected i.e. 50 per compound ( $50 \times 6 = 300$ ).

The instrument used for collection of data from the participants was:

The questionnaire had two sections.

Section A: The Bio-data of the participants while Section B was of Sexual Self-Disclosure Scale (SSDC) adopted the Snell and Belk (1987) using the Likert Scale of 5 to 1 (closed ended questions).

Scores rating scale ranges from 5 to 1 in that order and all closed ended questions. The section B enquired in general knowledge and self-disclosure of HIV+ status. Five research assistants were employed and trained on how to interview and translate the questionnaire into local language (Yoruba) for the non-literate participants, the questionnaire were retrieved immediately from the literate ones in order to ensure no-loss was recorded. All the questionnaires were well completed and fit for analysis.

To ensure the clarity and easy understanding of the questionnaires by both the administrators i.e. research assistants and literate participants, the questionnaires were drawn in simple English language while the research assistants were orientated on how to administer the questionnaires. The questionnaire was an adapted one produced by Snell & Belk (1987) of Sexual Self-Disclosure Scale (SSDS) containing 35 selected items. The reliability coefficient of the instrument was 0.92.

Since the study was community based, the Royal father was formally met by the researcher and gave the researcher an appointment to meet the Oba-in-Council, Oba-in-Council is the collection of the titleholders of the community where all the compound/family heads congregate(s). The researcher met the Oba-in-Council where the purpose of the research was explained and the benefits for both the community and researcher. It was an opportunity for social interaction with the principal members of the community and at that meeting, a general consent was given by the Oba-in-Council for everyone to explain to the members of their compounds and a day and time of administering the questionnaires was fixed. The researchers promised confidentiality and anonymity of information and their cooperation for a successful conduct of the research.

The data were collated and statistical methods used included means, standard deviation and correlation data as presented in tables below.

Table 1 showed the age distribution in percentage as many of the participants i.e. 80(26.67%) were between 26 and 30 years, 60(20%) were 31-35 years of age, 55(18.33%), 36-40 years, 45(15%) were between 21 and 25 years, 20(6.67%) were below 20 years and also 46 and 50 years, 20(6.67%) and 51 years and above were 10(3.33%) while between ages 41 and 45 years 10(3.33%) respectively. Sex distribution of the participants showed that majority 225(75%) were females and 75(25%) were males.

By religious distribution, it showed that majority 210(70%) were Christians while 90(30%) were Moslems by faith. Their education level indicated that majority of the participants 110(36.67%) were non-literates, 60(20%) had only Primary School Certificate, 30(10%) had only College of Education Certificate, 28(9.33%) attended Secondary Schools only, 22(7.33%) were undergraduates, 20(6.67%) were graduates, 20(6.67%) holds Polytechnic Certificates, and 10(3.33%) were Postgraduates. The marital distribution showed that majority 240(80%) were married, 26(8.67%) were widowed 22(7.33%) were Single and Divorced and Separated participants were 6(2%) each. Four hypotheses were used for this study and upon which the results and discussion were based.

## RESULTS AND DISCUSSION

Table 1: Biodata of the participants in percentages

	Frequency	%
Age		
Below 20	20	6.67
21-25	45	15
26-30	80	26.67
31-35	60	20
36-40	55	18.33
41-45	10	3.33
46-50	20	6.67
51 and above	10	3.33
Sex		
Male	75	25
Female	225	75
Religion		
Christianity	280	70
Muslim	90	30
Educational Level		
Non-literate	110	36.67
Primary level	60	20
Secondary	28	9.33
Polytechnic	20	6.67
College of Education	30	10
University		
- Undergraduate	22	7.33
- Graduate	20	6.67
- Post Graduate	10	3.33
Marital status		
Single	22	7.33
Married	240	80
Divorced	6	2
Separated	6	2
Widowed	26	8.67

Hypothesis I: There would be no significant relationship between literacy level of the participants and their self-disclosure of HIV+ status

Table 2 showing Correlation level of Psychosocial factors determining self-disclosure of HIV+ status.

Variables	Self-disclosure of HIV+ status	Literacy level	Knowledge acquired about HIV/AIDS	Cultural influence	Anxiety / Stigma / Discrimination
Self-disclosure of HIV+ status	1.000				
Literacy level	0.0191	1.000			
Knowledge acquired about HIV/AIDS	0.153	-0.220	1.000		
Cultural influence	0.165	-0.356	0.321	1.000	
Anxiety/ Stigma/ Discrimination	0.015	-2.04	0.265	0.416	1.100
Mean	24.3432	1.2331	37.3600	40.3262	28.93224
Standard Deviation	11.2111	0.6166	7.472	8.0652	7.146

Table 2 showed the correlation matrix of psychosocial factors determining self-disclosure of HIV+ status of the participants. Findings from table II indicated that there was a significant relationship between literacy level of the participants and their self-disclosure of HIV+ status ( $PC=0.191$ ,  $P>0.05$ ) which showed that education is a strong determinant of self-disclosure of HIV+ status.

This result supports Lettency (2004) who investigated the perception of stigma and disclosure of HIV+ mothers that disclosure 67 percent had similar socio-demographic characteristics like marital status, race, religion, employment and literacy level while the 33 percent non-disclosers were similar in the bio-data and concluded that the disclosers were highly educated and this informed their exposure with the attendant advantages of disclosure as education enlightens the mind of the elites thereby changing their better perception about life.

The finding of this hypothesis also confirmed Fishbein's theory of Reasoned Action that if an individual knows the benefits of his/her action then he/she will act in the same way in which education and reasoning so it is expected that an individual that is well informed will surely act having known that his action will bring good outcome or benefits. An individual who thinks if he discloses his HIV+ status will get necessary support to remain health and alive or would not be stigmatized and abandoned by the members of the family and society at large would be freely disposed to disclose his HIV+ status but if otherwise, would not be ready to disclose also.

Hypothesis II : There would be no significant relationship between knowledge acquired about HIV/AIDS and self-disclosure of HIV+ status.

The result of the study showed that there is a significant relationship between knowledge acquired about HIV/AIDS by the participants and their self-disclosure of HIV+ status. ( $PC=0.183$ ,  $P>0.05$ ) indicating that the hypothesis was rejected.

The result of the hypothesis further confirmed USAID (2003) which indicates that the change in risk behaviour is particularly great for couples who know their HIV status and who are able to make informed productive health choices and their knowledge helps disclosure which improves their access to care and support programmes.

USAID (2003) further stated in their report that the rate of disclosure of HIV sero-status is higher among women in the United States based studies than among women in developing country studies with rates of 42-100% in the United States compare with 16-84% in developing countries.

The studies also indicate that women often disclose to multiple categories of people, some disclose to partners and family members, others disclose to female confidants and others disclose in their social network. It is also clear that disclosure rates increase over time and the studies concludes that several knowledge acquired by the women in developed countries and available resources as par HIV/AIDS go a long way in exposing the individuals to the disease.

Sarah Gossi (1996) also investigated on "You are HIV-positive; whom do you tell?" He discovered that HIV/AIDS is not only a medical problem, but also social and that the diagnosis carries a stigma that has profound psychological, social and emotional ramifications.

For this reason, when a person is HIV infected, the diagnosis is often a closely guarded secret, even within the family and that the most highly represented populations of infected women are drug users and minority women but their disclosure is dictated by their exposure to different information on HIV/AIDS.

In a related study by Hinshaw and Cicchetti (2000), they studied the degree of Public awareness regarding mental disorder as well as motivation for policy change with particular attention to self-disclosure of mental disorder status, the study concluded that the more knowledge the public acquired on mental disorder the better and easier for them to disclose their mental disorder as the individuals who have acquired knowledge about it will have understanding and passion for the victims and will be readily disposed assisting anyone with the disorder.

In the studies of Sriayanth, Dharmarajan, Read, Jacok, Samuel, Elango, Junarka, Collins, Von-Hook and Bethel (2006) on baseline knowledge regarding HIV infections and transmission among pregnant women in Rural Tanul Nadu, India. It was concluded that at baseline approximately two-thirds (2/3) of pregnant women (758) have not heard of HIV/AIDS and of the one-third (1/3) awareness of HIV, knowledge of how the infection was acquired or transmitted was variable. This result emphasized the relevance of education as par HIV/AIDS as the type of education needed is a specialized type.

Hypothesis III : There would be no significant relationship between cultural influence and self-disclosure of HIV+ status.

Table 2 showed that there was a significant relationship between Cultural influence on the participants and their self-disclosure of HIV+ status ( $PC=0.165$ ,  $P>0.05$ . therefore the hypothesis was rejected.



This result supports the study of Adekun, Okwonkwo and Ladipo (2006) who see people's belief about disease causation as greatly influencing their health care-seeking behaviour and efforts to protect themselves from infections.

Culture is a strong traditional value, belief and habit passed from one generation to the other which determines what disease is, causes, course, show signs and symptoms, prevention, management and implication on the victim and society, the supports, whether emotional, physical or social that the affected would get from the members of the family or society, so if HIV+ state would be disclosed or not is affected by the cultural practices of the society where the individual comes from as it may lead to abandonment, isolation, stigmatization, discrimination even alienation of the affected but if an injury to one is injury to all is the cultural practice, then disclosure will bring physical, emotional, social, spiritual and economic support to the affected.

Hypothesis IV : There would be no significant relationship between anxiety/stigma/discrimination and self-disclosure of HIV+ status.

The result from Table 2 showed that there was a significant relationship between anxiety, stigma and discrimination and self-disclosure of the participants' HIV+ status. ( $PC=0.105$ ,  $P>0.05$ ).

The finding supports Letteny (2004) who investigated the perceptions of stigma and disclosure behaviour of HIV seropositive mothers and concluded that anxiety for rejection and non-acceptance, leading to discrimination and stigmatization hinders people from disclosing their HIV+ status.

In another study in Tanzania by Antelman et al, (2001) it was concluded that women were less likely to disclose to their partners if they were cohabiting, had low wage employment and that disclosure to a female relative was predictive by knowing more than two individuals with HIV/AIDS, full economic dependency on their partner, high levels of social support and prior attendance at a support group meeting as all these must have reduced anxiety, discrimination and stigmatization.

According to Hinshaw and Cicchetti (2000), stigma is at multiple levels (community, social, familiar, individual) through which it operates to dehumanize and delegitimize individuals with emotional disorders and the impact of stigma across development and concluded that the more the society interact with these patients the better they will disclose their mental states and enjoy concern and compassion from the members of the society and with less discrimination and stigmatization.

## CONCLUSION

Disclosure of HIV+ status is an important prevention goal emphasized by the World Health Organization. Disclosure offers a number of crucial benefits to the infected individuals and to the public. Disclosure of HIV test results to sexual partners is associated with less anxiety and increased social support. HIV+ status disclosure may also lead to improved access to HIV prevention and treatment programmes, increased opportunities for risk reduction and increased opportunities to plan for the future.

## Recommendations

Based on the findings in this study, the following recommendations are made:

- There is the need for better awareness to be made on HIV/AIDS especially the needs for disclosure of HIV+ status, benefits accrued to disclosure.
- Creation of more awareness on the disease is needed to deal with all misconceptions about it so that love, passion and empathy should be shown to the affected, which may lead to a better care and management.
- Since level of education, significantly affect disclosure hence, the need for better education facilities for the members of the society to improve the literacy level.
- Members of the family, friends and society should show positive concern and identification with people living with AIDS as this will provide a social support for the victims and they will have a sense of belonging to the family and society.
- Cultural practices isolating people with HIV/AIDS should be discouraged and other cultural practices militating against healthful living also.

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