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Perceived Stigmatization, Fear of Social Consequences, and Spousal HIV Serostatus Disclosure Among Married Couples in Makurdi Metropolis, Nigeria

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Abstract

Background: Despite widespread expansion of antiretroviral therapy (ART) and HIV counseling services in Nigeria, HIV-related stigmatization and fear of adverse relational repercussions continue to impede serostatus disclosure within marital unions.

Objective: This study examined the lived emotional experiences, perceived stigmatization levels, support group participation, and anticipated social consequences influencing spousal HIV serostatus disclosure among married individuals living with HIV in Makurdi Metropolis, Benue State, Nigeria.

Methods: A facility-based descriptive cross-sectional survey was conducted across five comprehensive ART centers in Makurdi Metropolis. Structured questionnaires were administered via systematic sampling to 347 HIV-positive married partners. Data were analyzed using STATA 12 via univariate frequencies, bivariate Pearson chi-square (χ^2) tests, and multivariate binary logistic regression modeling at $\alpha = 0.05$.

Results: While 84.73% (n = 294) of respondents had disclosed their status to their spouses, 75.8% discovered their seropositivity only after marriage, 88.5% experienced initial emotional distress

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upon diagnosis, and 67.3% felt distressed when others learned of their status. Only 38.9% (n = 135) belonged to an HIV support group, primarily citing stigma concerns. Among non-disclosers, primary barriers included fear of accusation of infidelity (29.4%), fear of losing livelihood/economic support (29.4%), fear of divorce (17.6%), fear of abandonment (17.6%), and fear of physical violence (5.9%). Bivariate analysis confirmed a statistically significant relationship between perceived stigmatization and spousal disclosure ($\chi^2 = 5.4146$, $p < 0.05$). In multivariate logistic regression controlling for HIV knowledge and partner status awareness, respondents who were indifferent to community stigma were over three times more likely to disclose to their spouses than those who perceived stigma to be high (OR = 3.2832, z = 2.33, p = 0.020), while those perceiving low stigma exhibited 2.32 times higher odds of disclosure (OR = 2.3210, p = 0.238).

Conclusion: Heightened perception of HIV-related stigma and fear of socio-economic and marital sanctions significantly constrain spousal disclosure in Makurdi Metropolis. Scaling up stigma-reduction interventions, community support groups, and couples-centered counseling is essential to safeguard relationships and curb intra-marital transmission.

Keywords: HIV/AIDS, Stigmatization, Spousal Disclosure, Social Consequences, Married Couples, Makurdi Metropolis, Benue State

1. Introduction

1.1 Background of the Study

Human Immunodeficiency Virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS) remain among the most heavily stigmatized medical conditions globally, presenting profound psychosocial and interpersonal challenges beyond physiological morbidity (Joint United Nations Programme on HIV/AIDS [UNAIDS], 2001; Simbayi et al., 2007). In sub-Saharan Africa, which accounts for roughly 71% of the global HIV burden, heterosexual transmission within stable married or cohabiting relationships represents a major driver of new infections (Allen et al., 2003; UNAIDS, 2017). Within Nigeria which carries the second-largest HIV epidemic worldwide, Benue State in North-Central Nigeria records one of the highest prevalence rates at 5.3%,

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necessitating effective secondary prevention strategies among married couples (Benue State Agency for the Control of AIDS [BENSACA], 2025; Federal Ministry of Health [FMoH], 2025).

Voluntary serostatus disclosure to a marital partner is widely endorsed by global health agencies as a pivotal mechanism for negotiating condom use, promoting antiretroviral therapy (ART) adherence, and preventing mother-to-child transmission (Kalichman & Nachimson, 1999; World Health Organization [WHO], 2004). However, for many individuals diagnosed with HIV, the immediate threat is not the clinical progression of the virus itself, but rather the pervasive fear of discrimination, social rejection, and relational breakdown accompanying disclosure (Fatula, 2013; Paxton, 2002). Exploring how stigma and anticipated social consequences interact within local communities is therefore vital to ensuring that infected spouses have safe, supportive pathways to disclose and access care (Almeleh, 2006; Medley et al., 2004).

1.2 Statement of the Problem

Despite substantial expansion of HIV counseling, testing, and free ART programs across Benue State, persistent stigma continues to undermine epidemic control efforts (BENSACA, 2025; FMoH, 2025). Individuals living with HIV frequently confront workplace discrimination, loss of economic entitlements, social ostracization, and judgmental moralizing, which foster deep psychological reluctance to reveal their diagnosis even to intimate marital partners (Fatula, 2013; Rintamaki et al., 2006). When married individuals conceal their seropositivity out of fear of divorce, physical violence, or accusations of infidelity, they often engage in unprotected marital intercourse and hide medication regimens, thereby accelerating viral transmission and compromising clinical outcomes (Chesney & Smith, 1999; Stein et al., 2003).

Although international literature recognizes stigma as a barrier to HIV care, empirical quantitative evidence quantifying the exact magnitude of perceived stigma, support group isolation, and specific marital fears among HIV-positive spouses in Makurdi Metropolis remains scarce. Without isolating how perceived stigmatization statistically alters the odds of spousal disclosure relative to other cognitive factors, anti-stigma interventions in North-Central Nigeria risk remaining overly generic and clinically ineffective.

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1.3 Objectives of the Study

The primary objective of this study was to investigate the influence of perceived stigmatization and anticipated social consequences on HIV/AIDS serostatus disclosure among married partners in Makurdi Metropolis, Benue State. Specifically, the study sought to:

1. Assess the emotional reactions, timing of diagnosis, and support group participation of HIV-positive married partners in Makurdi Metropolis.

2. Identify the specific socio-economic and relational fears inhibiting spousal disclosure among non-disclosing married respondents.

3. Examine the bivariate and multivariate statistical relationship between perceived stigmatization levels and spousal HIV status disclosure.

2. Literature Review

2.1 Conceptualizing HIV-Related Stigmatization

In foundational sociological theory, Goffman (1963) defined stigma as an attribute that is deeply discrediting, reducing the bearer from a whole and usual person to a tainted, discounted one. Extending this framework to public health, Link and Phelan (2001) conceptualized stigma as the co-occurrence of labeling, stereotyping, separation, status loss, and discrimination exercised within unequal power structures (Parker & Aggleton, 2003). Within the context of HIV/AIDS, stigma operates across three distinct dimensions: enacted stigma (overt acts of discrimination, ostracism, and abuse), perceived or felt stigma (the internalized shame and anticipation of rejection), and courtesy stigma (prejudice extended to family members and associates) (Alvidrez et al., 2008; Herek, 2002; Rüsch et al., 2005).

Historically, HIV stigma has been fueled by fear of contagion, misconceptions regarding transmission routes, and moral judgments linking infection to perceived sexual deviance or promiscuity (Alonzo & Reynolds, 1995; Bogart et al., 2008). Because HIV is initially an invisible condition, infected individuals face an ongoing psychological burden of information management-deciding whether to conceal their diagnosis to preserve social credibility or disclose it at the risk of severe interpersonal penalties (Corrigan & O'Shaughnessy, 2007; Holzemer et al., 2009).

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2.2 Stigma, Relational Consequences, and Spousal Disclosure

Empirical research across sub-Saharan Africa consistently demonstrates an inverse relationship between perceived HIV stigma and serostatus disclosure to sexual partners (Greeff et al., 2008; Simbayi et al., 2007). In a multi-country African study, Greeff et al. (2008) established that intense community stigma discourages disclosure because infected individuals view revelation as an unacceptable personal and social hazard. Similarly, Vanable et al. (2006) found that frequent stigmatizing experiences disrupt psychological adjustment, lower self-esteem, and impair antiretroviral medication adherence (Kang et al., 2006; Rintamaki et al., 2006).

For married individuals-and particularly economically dependent women in resource-constrained settings-the anticipated consequences of spousal disclosure are acute. Reviews by the World Health Organization (2004) and Medley et al. (2004) document that primary barriers to partner disclosure include fear of abandonment, loss of financial support, accusations of marital infidelity, divorce, and intimate partner violence (Buseh & Stevens, 2006; Maman et al., 2003). Notably, while empirical reviews indicate that actual negative reactions following disclosure are often fewer than initially feared (Medley et al., 2004), the subjective anticipation of catastrophic marital loss remains a powerful deterrent to transparency (Derlega et al., 2000; Serovich & Mosack, 2003). Conversely, participation in peer support groups provides psychological validation, coping skills, and social solidarity that empower individuals to overcome internalized stigma and navigate safe disclosure (Almeleh, 2006; Brashers et al., 2004; Norman et al., 2007).

2.3 Theoretical Framework: Consequence Theory and Disease Progression Theory

This investigation is grounded in two complementary frameworks: Serovich's (2001) Consequence Theory of HIV Disclosure and Kalichman's (1995) Disease Progression Theory. Drawing upon Social Exchange Theory (Thibaut & Kelley, 1959), Consequence Theory posits that individuals living with HIV weigh the anticipated rewards of disclosure-such as emotional support, medication adherence assistance, and relief from secrecy-against the expected costs, including stigma, divorce, violence, and economic loss (Derlega et al., 1998; Serovich, 2001). Disclosure occurs only when perceived relational rewards outweigh anticipated social punishments. Complementing this cost-benefit calculus, Disease Progression Theory asserts that as HIV progresses toward symptomatic illness or hospitalization, individuals can no longer conceal their condition and are compelled to

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disclose to mobilize physical care and family support (Babcock, 1998; Holt et al., 1998; Marks et al., 1992).

3. Methodology

3.1 Study Setting and Design

This study was conducted in Makurdi Metropolis, the capital city of Benue State in North-Central Nigeria. A facility-based descriptive cross-sectional survey design was adopted to examine the psychosocial, emotional, and stigma-related determinants of spousal HIV status disclosure among married clients accessing antiretroviral care (Mugenda & Mugenda, 2003).

3.2 Sampling Technique and Sample Size

A multi-stage sampling procedure was utilized. First, health facilities in Makurdi Metropolis were stratified into tertiary and secondary care levels (Primary Health Care centers were excluded due to the absence of comprehensive ART services). Using simple random sampling, one tertiary facility-Federal Medical Centre (FMC), Makurdi-and four secondary comprehensive ART sites-General Hospital Makurdi, Family Support Program (FSP) Clinic, Madonna Hospital, and Wadata PHC were selected. Based on Benue State's 5.3% HIV prevalence rate ($p = 0.06$), a 95% confidence level ($Z = 1.96$), and a 2.5% margin of error ($d = 0.025$), a sample size of 347 HIV-positive married respondents was determined and recruited via systematic random sampling from active clinic registers.

3.3 Data Collection and Statistical Analysis

Ethical approval was granted by the Department of Health Planning, Research and Statistics, Benue State Ministry of Health, and written informed consent was obtained from all participants. Data were collected using a structured, pre-tested questionnaire assessing timing of diagnosis, emotional responses to seropositivity, perceived community stigmatization (categorized as High, Low, or Indifferent), support group membership, motivations for disclosure, and specific fears driving non-disclosure. Data were analyzed using STATA version 12 across three stages: univariate frequency distributions, bivariate Pearson chi-square (χ^2) tests, and a multivariate binary logistic regression model predicting spousal disclosure (1 = Disclosed, 0 = Not Disclosed) at $\alpha = 0.05$.

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4. Results

4.1 Diagnosis Timing, Emotional Reactions, and Support Group Participation

Table 1 summarizes the diagnostic timeline, emotional responses to serostatus awareness, support group participation, and disclosure motivations or barriers among the 347 married respondents.

Psychosocial / Stigma Indicator	Response Category	Frequency (n)	Valid Percent (%)
Timing of HIV-Positive Diagnosis	Before marriage	84	24.2
	After marriage	263	75.8
Spousal HIV Status Disclosure	Yes (Disclosed)	294	84.7
	No (Not Disclosed)	53	15.3
Initial Feeling Upon HIV Diagnosis	Bad / Distressed	307	88.5
	Indifferent	30	8.6
	Good	10	2.9
Feeling When Others Know HIV Status	Bad / Distressed	233	67.3
	Indifferent	81	23.2
	Good	33	9.5
Membership in HIV/AIDS Support Group	Yes (Member)	135	38.9
	No (Non-Member)	212	61.1
Primary Reason for Disclosing (n = 316)	To reduce spread of HIV	193	61.1
	To receive psychological/emotional support	75	23.7
	To receive general/tangible support	21	6.6
	So spouse can take caution	17	5.4
	Freedom to take drugs/attend clinic	5	1.6
	Nurse counseled me to disclose	4	1.3
	Other reasons	1	0.3

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Primary Fear Among Non-Disclosers (n = 34)	Fear of accusation of infidelity	10	29.4
	Fear of loss of means of livelihood	10	29.4
	Fear of divorce	6	17.6
	Fear of abandonment	6	17.6
	Fear of violence / physical abuse	2	5.9

Note. Data from Author's Fieldwork (2018), N = 347. Sub-item valid totals reflect respondents answering conditional follow-up items.

As shown in Table 1, over three-quarters of respondents (75.8%, n = 263) discovered their HIV-positive status after marriage, whereas 24.2% (n = 84) knew their status prior to marriage. Receiving a positive diagnosis provoked acute negative emotion among 88.5% (n = 307) of participants, and 67.3% (n = 233) reported feeling distressed when other people became aware of their seropositivity. Notably, nearly two-thirds of respondents (61.1%, n = 212) did not belong to any HIV/AIDS support group, largely reflecting fear of public identification and stigmatization. Among the 38.9% (n = 135) who joined support groups, 67.7% reported that group membership enhanced their treatment adherence and disclosure confidence.

Among disclosers, the predominant motivation was preventing onward HIV transmission to their spouse (61.1%), followed by securing psychological and emotional support (23.7%) and general support (6.6%). Conversely, among non-disclosing respondents providing specific barriers, the most cited fears were accusation of marital infidelity (29.4%) and loss of livelihood or economic support (29.4%), followed by fear of divorce (17.6%), fear of abandonment (17.6%), and fear of physical violence (5.9%).

4.2 Bivariate Association Between Perceived Stigmatization and Spousal Disclosure

Table 2 presents the bivariate cross-tabulation between respondents' perceived level of HIV-related stigmatization and spousal serostatus disclosure.

Perceived Level of Stigmatization	Disclosed n (%)	Not Disclosed n (%)	Total (N)	Chi-Square (χ^2)	P-value
Low Stigmatization	30 (90.91)	3 (9.09)	33	5.4146*	$p < 0.05$

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High Stigmatization	190 (81.55)	43 (18.45)	233
Indifferent to Stigmatization	73 (91.25)	7 (8.75)	80
Total Valid Cases	293 (84.68)	53 (15.32)	346

*Note. *Statistically significant at α = 0.05 (Reject H0). One missing stigma response excluded (n = 346).*

Bivariate Pearson chi-square analysis revealed a statistically significant relationship between perceived level of stigmatization and spousal disclosure ($\chi^2 = 5.4146$, $p < 0.05$), leading to the rejection of the null hypothesis. Specifically, non-disclosure was more than twice as prevalent among respondents who perceived stigmatization to be high (18.45%, 43/233) compared to those who perceived stigmatization to be low (9.09%, 3/33) or were indifferent to stigma (8.75%, 7/80).

4.3 Multivariate Binary Logistic Regression Analysis

To isolate the independent effect of perceived stigmatization while controlling for cognitive and relational covariates identified as significant in bivariate screening, a binary logistic regression model was estimated (Table 3).

Predictor Variable & Category	**Odds Ratio (OR)**	**z-Statistic**	**P-value**	**Statistical Interpretation**
Perceived Level of Stigmatization				
High Stigmatization (RC)	1.0000	-	-	Reference Category
Indifferent to Stigmatization	3.2832*	2.33	0.020	3.28× higher odds of disclosure (Significant)
Low Stigmatization	2.3210	1.18	0.238	2.32× higher odds of disclosure (Non-sig.)
Knowledge of Partner's HIV Status				
Yes (Aware) (RC)	1.0000	-	-	Reference Category
No (Unaware)	0.1206*	-5.17	0.000	87.9% lower odds of disclosure (Significant)
Belief That Disclosure Reduces Spread				

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Yes (RC)	1.0000	-	-	Reference Category
No	0.2123*	-3.26	0.001	78.8% lower odds of disclosure (Significant)
General Knowledge About HIV/AIDS				
Knowledgeable (RC)	1.0000	-	-	Reference Category
Not Knowledgeable	0.6504	-0.95	0.343	35.0% lower odds of disclosure (Non-sig.)

*Note. RC = Reference Category. *Statistically significant at $p < 0.05$. Dependent variable: Spousal Disclosure (1 = Yes, 0 = No).*

Holding partner status awareness, prevention beliefs, and HIV knowledge constant, respondents who reported indifference toward community stigmatization were over three times more likely to disclose their HIV status to their spouses compared to those who perceived stigmatization to be high (OR = 3.2832, z = 2.33, p = 0.020). Similarly, respondents who perceived stigmatization to be low exhibited more than twice the odds of spousal disclosure relative to the high-stigma reference group (OR = 2.3210, z = 1.18, p = 0.238), though this positive association did not reach statistical significance in the adjusted model. Additionally, lacking knowledge of a spouse's HIV status (OR = 0.1206, $p < 0.001$) and doubting that disclosure curbs HIV transmission (OR = 0.2123, p = 0.001) significantly depressed the odds of spousal disclosure.

5. Discussion

The findings of this study provide compelling empirical confirmation of Serovich's (2001) Consequence Theory within an urban North-Central Nigerian setting. Although overall spousal disclosure among clinic-enrolled married respondents in Makurdi Metropolis reached 84.73%, psychological distress and perceived community stigma remain pervasive: 88.5% experienced negative emotional shock upon diagnosis, 67.3% felt distressed when others knew their serostatus, and 67.3% (233/346) perceived societal stigmatization to be high. Consistent with studies across South Africa, Ethiopia, and Tanzania (Greeff et al., 2008; Simbayi et al., 2007; Zou et al., 2009), perceived stigmatization significantly shaped disclosure behavior ($\chi^2 = 5.4146$, $p < 0.05$).

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Crucially, multivariate logistic regression revealed that psychological resilience against external judgment-manifested as indifference to community stigma-increased the odds of spousal disclosure more than threefold (OR = 3.2832, p = 0.020) compared to individuals experiencing high perceived stigma. This aligns with Buseh and Stevens (2006) and Kang et al. (2006), who noted that internalizing societal stigma amplifies fear of rejection and paralyzes interpersonal communication, whereas emotional detachment from public prejudice enables individuals to prioritize marital health and treatment adherence (Rintamaki et al., 2006; Vanable et al., 2006).

Furthermore, the specific barriers articulated by non-disclosing spouses-fear of infidelity accusations (29.4%), loss of economic livelihood (29.4%), divorce (17.6%), abandonment (17.6%), and domestic violence (5.9%)-mirror the structural and gendered vulnerabilities documented by Medley et al. (2004) and the World Health Organization (2004). Because 75.8% of respondents discovered their seropositivity after marriage, revealing a positive diagnosis threatens marital trust and financial survival, particularly for women lacking independent economic security (Maman et al., 2003; Peterson et al., 2006). Finally, the low rate of support group enrollment (38.9%) indicates that fear of courtesy and enacted stigma deters patients from accessing peer networks that could otherwise strengthen coping self-efficacy and facilitate assisted disclosure (Almeleh, 2006; Norman et al., 2007).

6. Conclusion and Recommendations

6.1 Conclusion

Perceived stigmatization and anticipated socio-economic consequences significantly constrain spousal HIV serostatus disclosure among married couples in Makurdi Metropolis. While altruistic concern to prevent spousal infection motivates the majority of disclosers, high perceived stigma-coupled with fears of infidelity accusations, economic dispossession, divorce, and violence-continues to deter vulnerable spouses from revealing their diagnosis. Dismantling both community-level stigma and internalized fear is therefore indispensable for strengthening secondary HIV prevention in Benue State.

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6.2 Recommendations

1. Integrate Stigma-Reduction and Resilience Training into ART Counseling: Healthcare providers in Makurdi facilities should incorporate structured psychosocial counseling that builds emotional resilience against external stigma and equips married clients with safe disclosure communication skills.

2. Expand Confidential Peer Support Groups: Facility managers and non-governmental partners should establish confidential, community- and faith-based support groups to raise participation well above the current 38.9% level, providing safe spaces for peer mentorship and adherence support.

3. Implement Assisted Partner Notification and Couples Counseling: Counselors should offer voluntary assisted partner notification and facilitated couples testing sessions to mitigate fears of infidelity accusations, abandonment, and intimate partner violence during disclosure.

4. Enact Workplace and Socio-Economic Protections: State policymakers and legal aid organizations should enforce anti-discrimination laws protecting people living with HIV from wrongful termination and economic dispossession, reducing livelihood-related barriers to spousal transparency.

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