

## ORIGINAL ARTICLE

# Predictors of disclosure of sero-status to sexual partners among people living with HIV/AIDS in Ogun State, Nigeria

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## Abstract

**Introduction:** Disclosure may reduce the transmission of HIV by raising awareness and decreasing risky behavior, thus status disclosure is an issue to be addressed for HIV prevention and treatment. The objective of this study was to determine the prevalence and determinants of HIV status disclosure to sexual partners among People Living with HIV/AIDS (PLWAs) in Ogun state, Nigeria.

**Materials and Methods:** This study is an analytical cross-sectional study. A sample of people living with HIV/AIDS attending secondary health facilities in Ogun State were recruited into the study.

**Results:** Of the total 637 interviewed, 324 (50.9%) indicated that they have disclosed to their main sexual partner. About 44.6% of the respondents reported that they do not know their partner's HIV status, while 30.3% had a negative partner and 25.1% with HIV-positive partners. Among the participants who disclosed their HIV status, 17.3% disclosed on the day of receiving test result, 15.5% within two weeks, 9.7% in 2 to 4 weeks, 8.3% in 1 or more months. Predictors of disclosure were individuals who were married [OR = 4.52, CI = 2.06–9.92] living within monogamous family [OR = 1.67, CI = 1.10–2.53], had anticipation of partner's support before disclosure [OR = 3.68, CI = 2.36–5.76] with knowledge of partner's sero-status either positive [OR = 4.08, CI = 2.62–6.35] or negative [OR = 2.49, C.I = 1.59–3.90] and had a low self-esteem [OR = 0.61, CI = 0.42–0.89].

**Conclusion:** Disclosure rate was low in this African population. The study implies that PLWAs especially those having a difficult family life should be supported to make effective decisions to disclose their status. HIV sero-status should be addressed in behavioral interventions like counseling on positive living and a multidisciplinary approach to develop positive self-esteem through follow-up counseling.

**Key words:** Disclosure, sexual partners, sero-status, people living with HIV/AIDS, HIV/AIDS, Nigeria

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## Introduction

Nigeria has a HIV sero-prevalence of 4.6% and accounts for the second largest population of people living with HIV/AIDS (PLWHA) worldwide.<sup>[1]</sup> Sub-Saharan Africa has approximately 10% of the world's population. Infection with the human immunodeficiency virus (HIV) is a global pandemic and the commonest route of infection in the developing world is heterosexual intercourse.<sup>[2]</sup> One way

to reduce the spread of HIV may be to encourage infected individuals to communicate their disease status to their sexual partners. Disclosure may reduce the transmission of HIV by raising awareness and decreasing risky behavior.<sup>[3,4]</sup>

Some people living with HIV infection may generally

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conceal their HIV status from people in their lives, not just their sex partners. In addition, people who do not disclose their HIV status may have had adverse experiences related to previous disclosures, including loss of social support, loss of employment, violent reactions and other forms of discrimination.<sup>[5]</sup> People who fail to disclose their HIV status may merely lack a sense of efficacy for being able to effectively disclose their HIV status, especially to their sex partners.

Self-disclosure of sensitive information is generally thought to have beneficial effects on an individual's health, lower stress, and lead to better psychological health.<sup>[6]</sup> In the case of HIV/AIDS, individuals who disclose their status are in a better position in terms of reproductive choices as well as psychosocial support. In addition, disclosure facilitates other behaviors that may improve the management of HIV. Studies also indicate that individuals who disclosed their results have better adherence to ART treatments.<sup>[7]</sup> Furthermore, women who disclose their status to their partners may be more likely to participate in Prevention of Mother To Child Transmission (PMTCT) programs.<sup>[3,8]</sup> Moreover, disclosure may increase opportunities to receive social support, which may help individuals cope and recover from physical illness, and attenuate depressive symptoms due to HIV-related physical symptoms.<sup>[7,9,10]</sup>

Disclosure of HIV positive status increases opportunities of obtaining social support, implementation of HIV risk reduction, improving access to treatment and motivating partners for Voluntary Counseling and Testing. Thus status disclosure is an issue to be addressed for HIV prevention and treatment. The objective of this study is to determine the prevalence and determinants of HIV status disclosure to sexual partners among People Living with HIV/AIDS (PLWAs) in Ogun State, Nigeria.

## Materials and Methods

### The study area

The study was conducted in Ogun State which is one of the 36 states in Nigeria. Ogun State was created in February 1976 out of the old western state. It is also known as the Gateway and the capital is Abeokuta. It is located in the South West Zone of Nigeria with a total land area of 16,409.26 square kilometers and a population of 3,507,735 with growth rate of 2.83% per annum (2006 National Census).

It is situated on the rain forest belt of the country, sharing international boundary with the Republic of Benin to the West and other Nigeria State: Lagos State to the South, Ondo State to the East and Oyo State to the North. Its populace belongs to the Yoruba ethnic group, comprising mainly the Egbas, Yewas, Aworis, Eguns, Ijebus and Remos.

The state has twenty (20) Local Government Areas, with each LGA headed by an executive chairman. It is divided

into 8 geo-political zones, 3 senatorial districts, 9 federal and 26 state constituencies.

This study was conducted in all the four General Hospitals offering VCT, PMTCT, ART and treatment of opportunistic infection services in the State. Data were collected from January 15, 2007 to March 15, 2007. The study was carried out within the Medical units of the four General Hospitals in the National HIV/AIDS Control program in Ogun State including those referred from all parts of the States were enrolled in the study.

However a total of 637 participants were recruited into the study.

### Study instrument

The independent variables include socio-demographic characteristics (age, sex, income, education, religion, marital status, occupation, place of residence), illness-related factors (stage of disease, duration of test result, discussion about HIV), service-related factors (HIV status of partner, fear of partner's reaction, and ART), psychosocial factors (social support, depression, active substance and alcohol use), and behavioral factors (number of partner, self-esteem, perceived severity, and perceived public opinion).

Single multiple response choice questions were asked to determine patterns of disclosure: "Have you told your main sexual partner that you are HIV-positive?" If an individual did not disclose to their sexual partner, the reasons for non-disclosure were probed.

A set of 17 Likert scale questions addressing self-esteem and perceived public opinion were grouped into a composite index, 7 questions for negative self-esteem and 10 questions for negative public attitude. Example of one such question for negative self-esteem is "I feel I am not as good a person as others because I have HIV;" for public attitude, "I worry that people may judge me when they learn I have HIV;" "In many areas of my life, no one knows that I have HIV." Response categories ranged from 1 to 4, for strongly disagree to strongly agree. The composite index was calculated as the mean of the Likert scale questions under each category combined, dichotomized into a variable indicating high self-esteem and perceived positive public attitude.

The questionnaire was pre-tested on 20 clients in Institute of Human Virology, Olabisi Onabanjo University, Sagamu and necessary adjustments were made. Trained data collectors explained the aim of the study, obtained informed consent, and interviewed each respondent privately. All information were obtained under anonymity and the data was collected by trained personnel on clinic days.

### Ethical consideration

Ethical clearance was obtained from the Olabisi Onabanjo Teaching Hospital Ethics Board. Confidentiality on respondent's information was maintained. Written informed consent was also obtained from the study participants. A consent information sheet/form including information on confidentiality was designed which was used in seeking informed consent from healthcare facilities and individual respondents after explaining thoroughly the purpose, objectives, procedure and methodology of the study to them. Respondents were informed that they were free to withdraw from the research at any point if they so wished. Permission of the State Ministry of Health, HIV/AIDS Control Division were obtained before the commencement of the study.

### Data analysis

To describe patient characteristics, we calculated proportions and medians. For categorical variables, we compared proportions using chi-square tests and, when appropriate, Fisher's exact test. Chi-square was used to determine association between categorical variables and a *P* value of less than 0.05 was considered significant. Data were presented in tabular form.

A logistic regression model was produced with disclosure and non-disclosure as outcome variable identifies associated factors. All explanatory variables that were associated with the outcome variable in bivariate analyses and have a *P*-value of  $\leq 0.05$  were included in the logistic models.

## Results

A total of 637 were interviewed, 204 [32%] were males and 433 [68%] were females. Majority [42.4% and 42.9%] of the participants were aged 20–39 yrs and 40–59 yrs respectively with 25 (3.9%) being teenagers-15–19 yrs. The commonest level of education attained by the participant was secondary education [41.4%], tertiary education [20.9%], Primary education [23.5%] and [14.1%] were illiterates. Four hundred and thirty four [68.1%] were married and 85 [13.1%] were Singles. Majority 63.0% were unskilled workers and 14.4% were Professional workers with 429 [67.5%] coming from a monogamous family background. The socio-demographic characteristics of the participants are summarized in Table 1.

### Disclosure of HIV status

Participants were relatively recently diagnosed HIV positive since HAART was introduced in these centers about one year prior to this research work. Only 104 [16.3%] were on antiretroviral therapy. In terms of their health status, nearly half (53.4%) of the sample reported having physical symptoms associated with HIV infection such as fever, headache, weight loss, diarrhea, abdominal pains, vomiting etc with an average of four current symptoms experienced. Among the 637 participants, 44.6% of the

respondents reported that they do not know their partner's HIV status, while 30.3% had a negative partner and 25.1% had HIV-positive partners. Of these, 324 (50.9%) indicated that they have disclosed their HIV status to their main sexual partner.

Disclosure was made as early as one day and late as two years after learning sero-status. Among the participants who disclosed their HIV status, 17.3% on the day of receiving test result, 15.5% within two weeks, 9.7% in 2 to 4 weeks, 8.3% in 1 or more months. Reasons for non-disclosure among those respondents who did not disclose their test results to their partner (*n* = 313) were “fear of separation/divorce” (37.7%), “my partner might be afraid of catching HIV from me” (25.5%), “fear of accusation of infidelity” (7.1%), “fear of being labelled a bad person” (5.0%), “no enough time to discuss because my partner works in other place” (6.1%), “fear of physical abuse” (9.2%), and other reasons (4.2%). Only 59.8% of respondents anticipated partner's support before disclosure.

### Factors associated with disclosure to main sexual partners

There was no statistically significant difference in the rate of disclosure between the male and female respondents OR = 1.04 [C.I = 0.73–1.47]. Significantly more respondents who were married disclosed their sero-status when compared to the singles and others OR = 9.05 [C.I = 1.87–59.91]. Disclosure rate was higher among those in monogamous family type when compared with the polygamous OR = 1.87 [C.I = 1.32–2.60]. The higher the level of education the higher the disclosure rate OR = 0.48 [C.I = 0.27–0.86].

Knowledge of the HIV status of one's partner was also associated with, partner disclosure. Respondents who did not know the HIV status of their main partner were statistically significantly more likely not to disclose their status to their partners [ $X^2 = 82.15$ , *P* = 0.00]. Level of self-esteem was also another factor independently associated with disclosure. Respondents with a higher level of self-esteem were 56.7% less likely to disclose their result compared to those with a low level of negative self-esteem [ $X^2 = 13.31$ , *P* = 0.00]. However, there was no difference in disclosure rate between respondents who believe that public opinion about HIV/AIDS was positive when compare with those who believe that public opinion was negative [ $X^2 = 1.68$ , *P* = 0.13]. The respondents who anticipated support from partners before disclosure when compared to those who did not [ $X^2 = 57.12$  *P* = 0.00]. This is shown in Table 2 below.

In the Table 3 shows multiple logistic regression model, five variables were found to be independently associated with disclosure. Predictors of disclosure were individuals who were married [OR = 4.52, CI = 2.06–9.92] living within monogamy family [OR = 1.67, CI = 1.10–2.53],

**Table 1: Disclosure rate and socio-demographic characteristics**

	Number n = 637 (%)	Disclosure rate N (%)	P value	Unadjusted Odds Ratio (95% CI)
<b>Age</b>				
<20 yrs	25 (3.9)	19 (76.0)	0.026	0.37 (0.11–1.13)
20–39 yrs	273 (42.9)	124 (45.4)		1.34 (0.76–2.34)
40–59 yrs	270 (42.4)	133 (49.3)		1.19 (0.68–2.09)
≥0 yrs	69 (10.8)	37 (53.6)		1.00
Total	637 (100.0)	324 (50.9)		
<b>Sex</b>				
Male	204 (32.0)	105 (51.5)	0.45	1.04 (0.73–1.47)
Female	433 (68.0)	219 (50.6)		1.00
<b>Marital status</b>				
Single	85 (13.3)	20 (23.5)	0.0001	1.69 (0.31–12.09)
Married	434 (68.1)	270 (62.2)		9.05 (1.87–59.91)
Separated	50 (7.8)	13 (26.0)		1.93 (0.33–14.54)
Divorced	17 (2.7)	9 (52.9)		6.19 (0.84–56.61)
Widow	38 (6.0)	10 (26.3)		1.96 (0.32–15.41)
Widower	13 (2.0)	2 (15.4)		1.00
Total	637 (100.0)	324 (50.9)		
<b>Family type</b>				
Monogamy	429 (67.3)	240 (55.9)	0.00	1.87 (1.32–2.60)
Polygamy	208 (32.7)	84 (40.4)		1.00
<b>Level of education</b>				
Nil	90 (14.1)	38 (42.2)	0.05	0.48 (0.27–0.86)
Primary	150 (23.5)	76 (50.7)		0.68 (0.41–1.12)
Secondary	264 (41.4)	130 (49.2)		0.64 (0.41–1.00)
Tertiary	133 (20.9)	80 (60.2)		1.00
<b>Occupation</b>				
Professional	92 (14.4)	52 (56.5)	0.3	0.99 (0.40–2.47)
Skilled	94 (14.8)	53 (56.4)		0.99 (0.40–2.45)
Unskilled	401 (63.0)	198 (49.4)		0.75 (0.33–1.67)
Students	20 (3.1)	4 (20.0)		0.19 (0.04–0.82)
Unemployed	30 (4.7)	17 (56.7)		1.00

had anticipation of partner's support before disclosure [OR = 3.68, CI = 2.36–5.76] with knowledge of partner's sero-status either positive [OR = 4.08, CI = 2.62–6.35] or negative [OR = 2.49, C.I = 1.59–3.90] and had a low self-esteem [OR = 0.61, CI = 0.42–0.89].

## Discussion

The general level of disclosure in this study was low; 50.9% disclosed to at least one person. This is comparable to other studies in Africa. The rate of HIV disclosure varies across different studies ranging from 27%–69%.<sup>[11–15]</sup> Most participants in this study were diagnosed less than a year before study and are still at the early stage of the disease. Several studies have shown that many HIV-infected individuals delay disclosure until their disease has progressed. This might be because as the disease progresses, individuals find that they require emotional or material assistance from family, or it may simply reflect the fact that it becomes difficult to conceal their illness from their partners at a late disease stage.<sup>[16–18]</sup> Specifically, illness severity and length of time since

HIV diagnosis have been shown to be positively correlated to disclosure.<sup>[19]</sup> The lower rate of disclosure in this study may also be attributed to the fact that there is still an inadequate knowledge about treatment services and nature of the disease in the study population. The presence of peer counselors which encourage disclosure and adherence to ART in the Hospital should be encouraged. A structured program such as support group formation to ensure adequate information is passed across to all PLWAs should be developed.

The study shows that those from a monogamous family type, married and educated were more likely to disclose their sero-status to their partners while the gender of the participants were not significantly associated with disclosure. This is similar to findings of several other authors. In a study conducted in Tanzania, a short duration of relationship, polygamous marriage, working out of home, not knowing someone with HIV and lower income were negatively associated with disclosure.<sup>[20]</sup> One study<sup>[21]</sup> found that women with higher education are more likely to disclose their result to their sexual partner than women who are illiterate. In a

**Table 2: Disclosure rate and HIV-related characteristics**

	Total No (%)	Disclosure Rate No (%)	P value
<b>Sero-status of partner</b>			
Positive	193 (30.3)	134 (69.4)	0.00
Negative	160 (25.1)	102 (63.8)	
Don't Know	284 (44.6)	88 (31.0)	
<b>HIV knowledge</b>			
Adequate	488 (76.6)	257 (52.7)	0.06
Not adequate	149 (23.4)	67 (45.0)	
<b>Self esteem</b>			
High	247 (38.8)	140 (56.7)	0.00
Low	390 (61.2)	184 (47.2)	
<b>Living with partner</b>			
Not living with Partner	165 (25.9)	73 (44.2)	0.03
Living with partner	472 (74.1)	251 (53.2)	
<b>Anticipated partner's support after disclosure</b>			
Yes	470 (73.8)	281 (59.8)	0.00
No	167 (26.2)	43 (25.7)	
<b>Attitude towards public opinion on HIV/AIDS</b>			
Good	102 (16.0)	35 (34.3)	0.13
Bad	535 (84.0)	289 (54.0)	

study conducted in South Africa, males were found to disclose their result more often to partner than females.<sup>[22]</sup> In contrast, another South African study<sup>[23]</sup> revealed that male sex is associated with non-disclosure of HIV status.

The low level of disclosure in this study raises the possibility of transmission risk if condoms were not used and may limit the beneficial aspect of disclosure, making negotiating safer sex difficult and perhaps putting the partner at risk of infection or re-infection.<sup>[24]</sup> The fact that most of the participants take a long time before disclosing their HIV-positive status may lead to difficulty in negotiating safer sex and risk reduction plans. Furthermore, the study found that those that have more than one main sexual partner were less likely to disclose their status. Numerous factors have been associated with status disclosure. Research on partnership variables has demonstrated that regular partners are more likely to disclose their sero-status than casual partners.<sup>[25]</sup> Factors beyond partnership can influence disclosure as well.

Another important findings in this study is the fact that HIV-infected individuals are more likely to disclose to a partner whom they know is HIV-positive than to an HIV-negative or unknown sero-status partner. The results of this study are in agreement with many others.<sup>[26-28]</sup> This study showed that it is not only knowing HIV positive status that is associated with disclosure, but knowing negative status is

**Table 3: Multivariate analysis- predictors of disclosure**

Age	Adjusted OR (95% C.I)
<20 yrs	1.03 (0.29–3.68)
20–39 yrs	1.43 (0.72–2.85)
40–59 yrs	1.22 (0.63–2.36)
≥0 yrs	1.00
<b>Marital status</b>	
Single	1.24 (0.48–3.23)
Married	4.52 (2.06–9.92)
Separated	1.39 (0.52–3.73)
Divorced	3.0 (0.86–10.51)
Widow/Widower	1.00
<b>Family type</b>	
Monogamy	1.67 (1.10–2.53)
Polygamy	1.00
<b>Level of education</b>	
Nil	0.63 (0.32–1.22)
Primary	0.87 (0.5–1.52)
Secondary	0.68 (0.41–1.12)
Tertiary	1.00
<b>Sero-status of partner</b>	
Positive	4.08 (2.62–6.35)
Negative	2.49 (1.59–3.90)
Don't Know	1.00
<b>HIV knowledge</b>	
Adequate	1.15 (0.75–1.76)
Not adequate	1.00
<b>Self-esteem</b>	
High	0.61 (0.42–0.89)
Low	1.00
<b>Living with partner</b>	
Not living with partner	1.33 (0.82–2.16)
Living with partner	1.00
<b>Anticipated partner's support after disclosure</b>	
Yes	3.68 (2.36–5.76)
No	1.00

significantly associated with HIV status disclosure as well. This indicates that what matters is not the HIV status of the partner but rather knowledge of his/her status. It can also be implied that individuals who know their partner's HIV status have at least had a discussion about HIV testing; this would help them to anticipate their partner's reaction towards disclosure.

The study shows that substance use and low self-image of the respondents were significantly barriers associated with disclosing one's HIV infection status Supporting people to make effective decisions to disclose their HIV sero-status should be addressed in behavioral interventions like counseling on positive living and a multidisciplinary approach to develop positive self-image through follow-up counseling.<sup>[29-31]</sup> Another factor associated with disclosure was anticipated social support from partners. This has been reported by many studies. Individuals with high social support tend to disclose their result more often than those

without such support.<sup>[12,32]</sup>

The study concludes that PLWAs especially those having a difficult family life should be supported to make effective decisions to disclose their status. HIV sero-status should be addressed in behavioral interventions like counseling on positive living and a multidisciplinary approach to develop positive self-esteem through follow-up counseling.

The results of this study should be interpreted cautiously. First, the study was conducted among service users in selected secondary health facilities. This setting may underestimate the disclosure rate. The study was also limited in that it relied on self-report, and is therefore subject to reporting bias. The effect of social desirability bias and telescoping bias may be other potential limitations in this study. It would have been preferable to interview HIV-positive individuals who do not seek services, but considering ethical and practical issues, it was not possible in this study. Our findings have implications for interventions with PLWHA in a typical African population.

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