

Research Article

Disclosure of HIV Status among Clients Accessing Care at A Tertiary Health Facility in Sagamu, Southwestern Nigeria

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Abstract: HIV/AIDS remains an important health and development issue in sub-Saharan Africa, Nigeria inclusive. A major driver of its spread is the secrecy, associated with a positive test result. We therefore assessed the pattern of HIV status disclosure among people living with HIV attending care and treatment centre at a tertiary health facility in Sagamu, Ogun State, Nigeria. A cross-sectional, descriptive study was carried out among adult clients at the Anti-Retroviral Treatment and Care centre, Olabisi Onabanjo University Teaching Hospital, Sagamu, Ogun State, Nigeria. Data was collected with the aid of semi-structured, interviewer-administered questionnaires. Data were analyzed using IBM SPSS version 18. Relevant descriptive statistics were calculated and presented as frequencies and proportions. Participants' informed consent was obtained prior to commencement of the study. A total of 500 PLWHA were recruited into the study. The mean age of respondents was 32±5.5 years. Males were 355 (71%) of respondents, while females were 145 (29%); 73.7% were married and 48.1% were traders. Disclosure rate among respondents was 76%; of these 51.3% disclosed their HIV status to sexual partners. Some reasons for non-disclosure included: fear of discrimination and stigmatization; fear of divorce; domestic violence and perception of HIV infectivity. Disclosure was high among respondents. Counselling and support of clients should be sought by healthcare providers, in order to improve the rate and promptness of status disclosure among people living with HIV.

Keywords: Adults, disclosure, HIV, status, sagamu

INTRODUCTION

The control of HIV/AIDS has assumed an international, development platform in the last few years, with its inclusion in the attainment of the UN Millennium Development Goals. A target of the sixth goal is to have halted and begun to reverse the spread of HIV by 2015. According to WHO (2014), about 2.1 million new infections occurred in 2013, with over two-thirds being in sub-Saharan Africa, even though new infections fell by about 40% in the last one and a half decade. The importance of HIV/AIDS to sustainable growth and development has made it to be captured in the recently launched Sustainable Development Goals. A major driver of the spread of HIV infections in sub-Saharan Africa is the social stigma, as well as the real or perceived discrimination against people living with HIV. This has been shown to fuel the observed secrecy as regards disclosure of sero-status and HCT results to intimate partners and significant others, among PLHIV. Disclosure of HIV status is an integral part of the preventive strategies. It also plays a great role in

achieving 'universal access to treatment for HIV/AIDS' as proposed in target 6B of the sixth MDG (United Nations, 2008). Studies among pregnant women have shown disclosure to be associated with treatment adherence and outcomes, especially as regards prevention of mother-to-child transmission (Duff *et al.*, 2010; Kuonza *et al.*, 2010; Duff *et al.*, 2012). The importance of disclosure as well as social support, to proper utilization of antiretroviral therapy is well documented by the Community Health Advisory and Information Network (CHAIN) survey conducted in New York. The study showed that disclosure within households, among friends and acquaintances was the premise on which the strong positive association between social support and the use of combination therapies, including Highly Active Anti-retroviral Therapy, was based (Waddell and Messeri, 2006). Disclosure has been studied by various researchers within and outside Nigeria, with widely varied results (Sow, 2013; Amoran, 2012; Udigwe *et al.*, 2013; Salami *et al.*, 2011). In Ilorin, north-central Nigeria, 39.5% of the adult PLHIV studied, had disclosed their

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status to at least one person (Salami *et al.*, 2011). A study of partner disclosure of HIV status among 570 positive mothers in Jos, north-central Nigeria, found 89% of respondents to have disclosed their status to their partners (Sagay *et al.*, 2006). Amoran (2012) reported a sero-status disclosure rate of 50.9% to sexual partners among PLHIV attending secondary health facilities in Ogun State, southwest Nigeria. In Ethiopia, 72.6% of the 334 adults surveyed disclosed their HIV status to sexual partners (Erku *et al.*, 2012) as different from findings of another study carried out in southwest Ethiopia, where 94.5% of respondents had disclosed their status to at least one person (Deribe *et al.*, 2008). A cross-sectional study of disclosure to sexual partners among PLHIV at a regional hospital in Togo, West Africa, reported 60.9% of respondents having disclosed their HIV status to sexual partners (Yaya *et al.*, 2015). In Kumasi, Ghana, disclosure of HIV status was found to be 86% and associated with increased condom use (Ncube *et al.*, 2012).

The teaching hospital in Sagamu is a major contributor to evidence-based care and support of people living with HIV, irrespective of age, sex and other socio-demographic characteristics. The treatment center draws clients from many locations within and outside Ogun State and provides a comprehensive care and support package for clients. There is no documented research work on sero-status disclosure among HIV-positive clients in the tertiary center in Sagamu, Ogun State. This study therefore assessed the pattern of HIV disclosure among adult clients accessing care at the treatment center in Olabisi Onabanjo University Teaching Hospital, Sagamu, Ogun State, Nigeria.

METHODS

Sagamu is a peri-urban Local Government Area (LGA), strategically located in a transit zone between Lagos, the commercial capital of Nigeria and other parts of the southwest, southeast and south-south regions of the country. It has a multi-ethnic population and a thriving commercial township, due to its closeness to Lagos and other destinations, visited by traders. The LGA has several Primary Health Care (PHC) facilities, one secondary health facility (Ode-Lemo Comprehensive Health Center) and a tertiary health facility, which is, Olabisi Onabanjo University Teaching Hospital. The teaching hospital serves as a training center for both undergraduate and postgraduate medical and allied health sciences. It also offers specialized care to the public, including prevention, care, treatment and support for People Living with HIV.

A cross-sectional descriptive study was carried out among adult clients, accessing care at the Anti-Retroviral Treatment center, situated within Olabisi Onabanjo University Teaching Hospital, Sagamu, Ogun State, southwest Nigeria. Only returning clients, i.e.

those who had at least two previous clinic visits, were eligible for participation in the study. This was to ensure that only those who had been offered counseling and psychological support services were recruited into the study. A total of 500 adults enrolled into the study, selected through consecutive recruitment throughout the month of January 2012. Data was collected with the aid of validated, semi-structured, interviewer-administered questionnaires, pre-tested at the ART Treatment Centre in Ijebu-Ode. The questionnaire contained items on respondents' socio-demographic data, disclosure status, reasons for disclosure or non-disclosure. Four trained research assistants, with a minimum of secondary education, conducted the interviews.

Data analysis was carried out using IBM Statistical Package for the Social Sciences (SPSS 18.0) version 18. Descriptive statistics were calculated and presented as frequencies and proportions. Chi square test was used to determine association between categorical variables. Level of significance was set at $p < 0.05$. Ethical approval was obtained from the Health Research and Ethics Committee of Olabisi Onabanjo University Teaching Hospital, Sagamu. Permission was also obtained from the facility / clinic manager prior to commencement of the study. Respondents' informed consent was obtained prior to participation in the study. Participation was entirely voluntary, with participants free to withdraw from the study at any stage. It was made known to them that refusal to participate in the study would not affect the quality of services received from health workers at the study site. Strict confidentiality was ensured throughout the course of this research.

RESULTS

Socio-demographic characteristics: Respondents were aged between 18 and 55 years, with the modal age group being 31-40 years, accounting for 40% of respondents. The mean age of respondents was 32 ± 5.5 years. Males were 355 (71.0%) of respondents, while females were 145 (29.0%). Most (80.0%) of study participants were of Yoruba ethnicity; 15.0% were Igbo; 3.5% were Hausa, while other ethnic minorities accounted for 1.5% of respondents. Majority (73.7%) of respondents were married, with only 18.2% being single. Trading was the most common occupation (48.1%) among respondents. Christians made up 62.0% of respondents and 53.3% were from monogamous homes (Table 1).

Respondents' treatment history: Among respondents, 110 (22.0%) were diagnosed within the last 12 months; 319 (63.8%) had HIV Counseling and Testing (HCT)

Table 1: Socio-demographic characteristics of respondents

Variable	Frequency (n = 500)	Percentage
Age (years)		
< 20	33	6.50
21-30	189	37.8
31-40	200	40.0
41-50	57	11.5
51 and above	21	4.20
Sex		
Male	355	71.0
Female	145	29.0
Marital status		
Single	91	18.2
Married	369	73.7
Divorced/separated	28	5.60
Widowed	12	2.50
Occupation		
Housewife/unemployed	19	3.70
Traders	240	48.1
Artisans	161	32.2
Civil servants	80	16.0

Table 2: Pattern of disclosure

Variable	Frequency (n=500)	Percentage
Disclosure		
Yes	380	76.0
No	120	24.0
To whom	N = 380	
Sexual partner	195	51.3
Parents	66	17.4
Siblings	74	19.4
Children	41	10.9
Religious leaders	4	1.00
Promptness of disclosure		
Same day	187	49.3
Within four weeks	84	22.1
one to six months	81	21.3
Seven to twelve months	18	4.80
Greater than one year	10	2.50

Table 3: Reasons for disclosure and non-disclosure

Variable	Frequency (n = 380)	Percentage
Reasons for disclosure		
To protect partner(s)	104	29.8
Emotional/psychological support	74	21.3
Spiritual convictions	54	15.3
Financial support	21	6.0
Reasons for non-disclosure (N = 120)		
Fear of discrimination / stigmatization	41	34.5
Fear of divorce/domestic violence	30	25.0
Partner's suspicion of infidelity	12	10.3
Issues of confidentiality	22	18.1
Poor perception of HIV infectivity	15	12.1

carried out at the point of awareness of their status; client-initiated HCT was the means of retroviral screening for 294 (58.8%) respondents. Multiple sexual partners were reported among 223 (44.6%) of respondents. Three hundred and fifty (70.0%) respondents had already commenced highly active antiretroviral therapy; 150 (30.0%) were yet to commence antiretroviral drugs; 395 (79.0%) had completed adherence counseling with a treatment partner, while 105 (21.0%) were undergoing counseling.

Disclosure of HIV sero-status: Three hundred and eighty (76.0%) of the respondents had disclosed their

status to another person. Of these, sexual partners were the most frequent (51.3%) recipients of the information; only 4 (1.0%) respondents disclosed their status to religious leaders. 187(49.3%) of respondents disclosed the information on the same day they knew their status, only 10 (2.5%) waited for more than 12 months, before disclosure (Table 2).

Respondents' reasons for disclosure of HIV sero-status included: to protect sexual partners (29.8%); a need for emotional and psychological support (21.3%); only 21 (6.0%) disclosed for the perceived financial benefit that may accrue. Among the respondents who did not disclose their status to anyone, 30 (25.0%) felt they would be subject to domestic violence and divorce; 12 (10.3%) expressed the fear of their partner accusing them of infidelity; 22 (18.1%) had concerns about the ability of the recipient to ensure strict confidentiality (Table 3).

Factors associated with disclosure were sex ($p = 0.032$), experience of HCT ($p = 0.045$), completion of adherence counselling ($p = 0.001$) and number of sexual partners ($p = 0.002$).

DISCUSSION

The proportion of male respondents (71%) in this study is much higher than 41.5% reported by Salami *et al.* (2011) in Ilorin, 40.4% in Ethiopia (Erku *et al.*, 2012) and 49.9% in southwest Ethiopia (Deribe *et al.*, 2008). The modal age of respondents (31-40 years) in this study, buttresses previous findings in medical literature showing that youth and economically productive people are most affected by HIV. This is similar to findings from Togo (Yaya *et al.*, 2015), Ethiopia (Erku *et al.*, 2012), Nnewi, southeastern Nigeria (Udigwe *et al.*, 2013) and Jos, northern Nigeria (Sagay *et al.*, 2006). The proportion of housewives and unemployed respondents in this study is far lower than findings from Ethiopia (Erku *et al.*, 2012).

Disclosure of HIV status among respondents in this study (76%) is similar to the proportion reported by Erku *et al.* (2012) but lower than findings from Jos (Sagay *et al.*, 2006), Gombe, where 97.5% had disclosed their status (Dankoli *et al.*, 2014), Nnewi, where 90.5% had disclosed their status (Udigwe *et al.*, 2013) and southwest Ethiopia (Deribe *et al.*, 2008). It is however higher than findings from Ilorin, where only 39.5% disclosed their status (Salami *et al.*, 2011), Ogun State (Amaran, 2012), Togo, where 60.9% disclosed their status (Yaya *et al.*, 2015).

Disclosure to sexual partners accounted for 51.3% of all forms of disclosure, a finding different from previous studies (Dankoli *et al.*, 2014; Yaya *et al.*, 2015; Deribe *et al.*, 2008; Erku *et al.*, 2012), but similar to findings from Ogun State, where 50.9% had disclosed to main sexual partners (Amaran, 2012) and Kenya (Roxby *et al.*, 2013). A disclosure rate of 80% reported in a multi-country study, among patients accessing care in Tanzania, Kenya and Namibia, is quite higher than what was found in our study

(Bachanas *et al.*, 2013). This is important because studies have shown continued sexual intercourse between partners without disclosure of positive HIV status, even when sero-discordance is present (Ciccarone *et al.*, 2003) and a low use of condoms within marriage (Bauni and Jarabi, 2003). This greatly increases the vulnerability of the partners to HIV infection. Ncube *et al.* (2012) reported over 40% of the respondents having had sex after knowing their HIV status, with two-thirds of them, having regular sexual partners, including sero-discordant ones. Unprotected anal or vaginal sex was reported among 51% of respondents with regular partners. Bachanas *et al.* (2013), reported a prevalence of 77% for condom use among HIV-positive patients attending clinical care in three sub-Saharan African countries.

Promptness of disclosure in this study was slightly different from that documented in previous research works. The proportion of respondents who disclosed their status within 24 hours in this study is much higher than 17.3% reported by Amoran (2012) among clients utilizing secondary health facilities in Ogun State. Findings on disclosure time are similar to those reported from Ethiopia in which 29% of respondents delayed disclosure of their status (Erku *et al.*, 2012). Roxby *et al.* (2013) reported 60% of disclosures to sexual partners being carried out in the first 72 hours following HIV testing among sero-positive antenatal clients in Kenya. The proportion of disclosures within a month in Kenya is slightly higher than was reported in our study. This may be due to the fact that Roxby *et al.* (2013) recruited only pregnant women into their study, who saw a great need for disclosure, because of their unborn child. Bearing in mind the fact that HIV is a multi-dimensional issue, involving not only PLHIV but also families, friends and significant others, researchers have proposed the need for involvement of these people in the process of screening, counseling, care and support of infected persons, including antenatal care clients (Nyondo *et al.*, 2014; O’Gorman *et al.*, 2010; Walcott *et al.*, 2013). A need for counseling and professional support by health workers to facilitate disclosure is documented in literature (Hardon *et al.*, 2013). Delay in disclosure may also be associated with a perceived lack of communication skill, by people living positively (Erku *et al.*, 2012). Regular clinic visits and attendance at support group activities may help to build the confidence and relational skills of people living with HIV. Couple HIV Counselling and Testing has been advocated as a means of overcoming the barriers to timely disclosure of serostatus (Walcott *et al.*, 2013).

The reasons for non-disclosure in this study are similar to those previously reported in literature including fear of discrimination or stigmatization, concerns about the confidentiality of their HIV status, partner’s suspicion of infidelity and breakdown of their marriage or other forms of sexual relationship (Erku *et al.*, 2012; Deribe *et al.*, 2008). The issue of non-

disclosure is not limited to adults alone. With improved HIV prevention, care and support programs, many children are living positively with HIV infection into adolescence and early adulthood, making it an important task for caregivers to disclose their sero-status to them. Brown *et al.* (2011), in a study of disclosure of HIV status to infected children in Lagos, reported the following as the reasons for non-disclosure by care-givers: children’s limited understanding of HIV infection; fear of disclosure to their peers; fear of disclosure to family friends and members of the extended family; fear of psychological disturbance of the child; a strategy to avoid being blamed for the child’s sero status. The World Health Organization developed clear guidelines to assist health workers provide the necessary professional support to families that have children living with HIV infection. It recognizes that disclosure is a very important aspect of curtailing the spread of HIV infection and also enhances the optimal wellbeing of people living positively, as well as their families (WHO, 2011).

CONCLUSION

Disclosure of HIV status in this study was high; mostly to sexual partners and least to religious leaders. Fear was a major cause of non-disclosure. Due to the importance of disclosure to effective control of HIV infection, all perceived barriers must be addressed adequately. All forms of discrimination based on real or perceived HIV status, must be halted and sanctioned as much as possible. The various documents and conventions addressing discrimination and stigmatization should be enforced.

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