Original article

Determinants and outcomes of disclosing HIV-sero positive status to sexual partners among women in Mettu and Gore towns, Illubabor Zone southwest Ethiopia

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Abstract

Background: Disclosing one's HIV test result to a sexual partner is an important factor in HIV/AIDS prevention interventions. Disclosure of one's HIV status enables for improved access to prevention and treatment programs provides increased opportunities for risk reduction and helps in planning for the future. An assessment of the barriers and outcomes for disclosure is necessary to enhance HIV test result disclosure among couples.

Objective: This study is aimed at determining the rate, barriers and out comes of HIV positive status disclosure among sexual partners.

Method: A cross sectional study was conducted in Mettu and Gore towns of Illubabor Zone, south west Ethiopia. Sixty-seven women living with HIV out of which 42(62.7%) reported to had sexual partners and were eligible for the study and were interviewed. A structured questionnaire was used for data collection.

Results: Overall 69% of the women reported that they had shared their HIV test results with their partners. Among the women who did not disclose their HIV status 62.5% said that it was due to fear of partner's reaction (fear of abandonment, rejection and accusation of infidelity). But 75.9 % of HIV positive women who disclosed their result reported positive partner's reaction. Most (81.3%) women who had prior discussion about HIV and HIV testing with their partners have disclosed their results ($P<0.005$). Condom use was also found to be high among couples that disclosed their HIV/status than those who did not do so ($P<0.05$).

Conclusion: This study indicates that the outcomes of disclosure are encouraging. The anticipated partner reactions and the reality discovered by the study were different. Therefore it is important to assure HIV-positive women that the benefits of disclosure out weigh the potential risks. A large-scale study on the subject is also recommended. [*Ethiop.J.Health Dev.* 2005; 19(2):126-131]

Introduction

The most effective approach for preventing vertically acquired HIV infection in children is through primary prevention among women of childbearing age and secondly through the prevention of unwanted pregnancies among HIV-infected women and in the prevention of mother-to-child transmission of HIV (PMTCT) (1).

A well functioning, appropriate and accessible voluntary counseling and testing (VCT) service is a prerequisite for conducting successful PMTCT programmes. HIV testing and counseling provides essential knowledge and support to individuals at risk of contracting HIV, enables uninfected individuals to remain uninfected and those infected to plan for the future and prevent HIV transmission to others. Knowing ones HIV status may also enable HIV infected individuals to access timely and appropriate treatment, as well as care and support programmes. Further more HIV infected women who know their serostatus are in a better position to make informed choices about their reproductive lives and, if pregnant, to access specific interventions such as antiretroviral prophylaxis and infant feeding options (1, 4, 5, 6).

Despite the benefit of VCT, the low rate of disclosure of HIV serostatus has limited the effectiveness of VCT programs. Disclosure of HIV test results to a sexual partner is an important prevention goal for a number of reasons. The benefit includes expanding and sharing the burden of helping People Living with HIV/AIDS (PLWHA) beyond professional care providers, providing access for care and support programmes, planning for future care, and enhancing the quality of life of PLWHAs and their partners. In relation to PMTCT, shared confidentiality is considered beneficial in order to prevent unwanted pregnancies and arrest the spread of HIV infection to uninfected partners. Another benefit is in assisting HIV infected women to plan for their future and their partners, to gain access and adhere to therapeutic regimens such as anti retroviral therapy (ART) and replacement feeding for infants (7,8).

Along with these benefits, however, there are a number of potential risks resulting from disclosure for HIV infected women including loss of economic support, blame, abandonment, physical and emotional abuse, discrimination and stigma, as well as a loss of custody of children and property (9, 10, 11, 12, and 13). These risks may lead women not to disclose their serostatus, with friends, families and partners. This intern leads to a loss of opportunities for the prevention of new infections to their partners and infants. In addition there is a loss of greater access to social, medical, psychological, financial and legal support (3, 7).

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AIDS- related stigma and discrimination directly hamper the effectiveness of Anti-AIDS responses. Stigma and concerns about discrimination constitute a major barrier to people seeking HIV testing and directly affect the initiation of protective behavior. Silence around HIV can prevent the use of condoms or can lead HIV positive women to continue with breast-feeding their children for fear of being identified (4, 14).

For example, Menschen fur Menschen Foundation, in its HIV/AIDS prevention and care programme, has been implementing nevirapine and replacement feeding provision services for HIV positive women and their infants. The program is run in four health centers, one hospital and, recently also, in many clinics throughout four woredas in Illubabor zone. According to 2004, 3rd quarter report of the programme, some 1861 pregnant women have attended antenatal care services in the five health institutions since the commencement of the programme. Six hundred seventy (36%) pregnant women were tested for HIV and 37(5.5%) were found to be HIV positive. Among the HIV positive pregnant women only 4(10.8) women and 6(16.2%) infants took nevirapine. Two mothers were willing not to breast feed their infants and adhered to replacement feeding.

Generally, prevention of mother to child transmission (PMTCT) is one of the strategies that help to prevent HIV infection in infants. Pregnant women should have access to ante natal care (ANC) in order to participate in PMTCT programs. Moreover women who have access to ANC should have access to VCT, short course ART and replacement feeding. But the situation in Ethiopia is different, as most women have no access to antenatal care, VCT services and PMTCT programmes.

In the presence of limited access to VCT the number of pregnant women who are willing to be tested would be very low. Even though some of them have HIV tests, a very small number of women return to receive their test results. The rest do not return at all.

After all the above-mentioned obstacles the most heart-breaking phenomena is that pregnant women who are found to be HIV-positive cannot participate fully in PMTCT programs due to various reasons.

One of the causes for the low participation of HIV positive women in PMTCT programmes is the non-disclosure of HIV test results to a sexual partner. The uptake and adherence to PMTCT programmes is difficult for women whose partners are unaware of their HIV status. It has been well documented in Africa that women lack power to make independent decisions with regard to the safety of their own and their children's' health. It is, therefore, difficult for HIV positive women to seek social and medical support from care and support programs for themselves and their infants with out disclosing their HIV status to their partners (7).

Therefore, this study is aimed at determining the rate, barriers and outcomes of HIV serostatus disclosure to sexual partner, which is one of the factors that account for the success or failure of PMTCT programmes. In addition to this, methods to minimize the negative outcomes of disclosure are discussed.

The object of the study was to determine the rate, barriers and out comes of HIV sero positive status disclosure to sexual partners among women in relation to PMTCT in Mettu and Gore towns, October 2004.

Methods

The study was conducted in Mettu and Gore towns in Illubabor Zone. Mettu and Gore are located 600KM and 618KM, south west of Addis Ababa. Menschen fur Menschen started its VCT and PMTCT programs in four woredas of Illubabor zone (Mettu, Gore, Yayu hurumu and Bedele) since Sept.2003. A total of 6003 volunteers were tested and 505(8.4%) were found to be HIV positive up to Sept. 2004. Out of these 102 female volunteers were found to be HIV positive in Mettu and Gore towns.

A cross sectional study was conducted from Sept. 15 to Oct. 10, 2004 to determine the rate, barriers and outcomes of disclosure among HIV positive women in Mettu and Gore towns.

The study subjects were all the HIV positive women living in Mettu and Gore towns during the study period. A review of the VCT register was done and 102 HIV positive women were identified. Among the 102 HIV positive were females 11(10.8%) were already dead, 7(6.8%) have changed their place of residence and no information could be gathered about five of them. The rest 79(77.5%) were contacted through their counselors and 67(74.5%) volunteered to participate in the study.

The target groups were HIV positive women who have sexual partners in Mettu and Gore towns during the study period. A rapid assessment was done among 67 and 42 reported to have sexual partner during the study period and were thus, eligible for the study.

Data were collected using a structured and pre-tested questionnaire by counselors and home based care givers. The questionnaire included information as to whether or not the women have told their test results or test to their partners, barriers of disclosure and outcomes of disclosure. Some of the other factors identified include socio-demographic characteristics of both the women and their partners, the duration of relationship, prior discussion about HIV and HIV test, the condition of their

relation ship prior to the test, current use of condom, type of partner. All these were included in the questionnaire.

Results

A total of 67 female PLWHAs were interviewed in Gore and Mettu towns. Forty-two (62.7%) reported to have sexual partners and were thus, eligible for the study. Most (24(57.18%)) of the women are in the age range of 25 to 34 years. Twenty-eight (66.72%) of the respondents have non-regular sexual partners. Over half of the respondents are Oromos by ethnicity (57.2%), merchants (54.76%) by occupation and orthodox-christians (54.8%) by religion. Twenty-four (57.18%) of the women have attended primary or secondary school. (Table1).

It was found out that 29 (69%) of the women disclosed their test results to their sexual partner. As can be seen from Table 1, illiterate women were more likely to disclose their test results than educated ones (P<0.025). Likewise prior discussion about HIV and HIV test was found to have a statistically significant association with disclosure in that who had prior discussion were found to disclose their test results (P<0.005). Even if it is not statistically significant the length of diagnosis was also found to have some impact on disclosure (P<0.25). In that women who know their result for>1 year were most likely to disclose than those who know for a duration of one year or less.

Although it is not statistically significant, women who have non-regular sexual partners were not likely to disclose their status than who have regular sexual partners (cohabiting & spousal). Partner's age, partner's education, duration of relationships with partners, having multiple sexual partners were analyzed using the multivariate analysis method and were not found to have significant effect on disclosure.

Condom use is higher among those who disclosed their results than those who did not (p<0.05) Table2.

Eleven (26.19%) women said they did not disclose their results. The most common barriers to disclosure mentioned by the women include, fear of abandonment (31.3%), fear of stigma and rejection (25%), fear of confidentiality (25%), fear of embarrassing family members (12.5%) and fear of accusations of infidelity (6.2%). This is shown in Table 3.

Of the 29 women who disclosed their test results 22 (75.9%) women reported positive out comes related to disclosure. Women reported receiving kindness or acceptance following disclosure. Even if the fear of most women to disclose is break-up of relations, disclosure was not associated with abandonment. In fact, all of the women in this study survived disclosure.

But some 7(24.1%) of the respondents reported negative out comes following status disclosure. All were blamed and their partners felt sad for their result for getting tested without their consent. None of the women reported physical violence. (Table4).

Table 1: **Socio-demographic characteristics of respondents in Gore and Mettu towns, Illubabor Zone, Oct. 2004.**

Variable (N=42)	Total n	HIV sero positivity Disclosed n (%)
Age (years)		
15-19	2	2 (100)
20-24	8	6 (75)
25-29	12	8 (66.7)
30-34	12	9 (75)
35-39	6	4 (66.7)
40-44	1	0 (0.0)
45-49	1	0 (0.0)
Ethnicity		
Oromo	24	16 (66.7)
Amhara	10	7 (70.0)
Guragehe	4	3 (75)
Tigre	2	1 (50)
Kefa	2	2 (100)
Occupation		
Merchant	23	17 (73.9)
Housewife	9	6 (66.7)
Farmer	4	2 (50)
Government employee	2	2 (100)
Housemaid	2	1 (50)
Others	2	1 (50)
Religion		
Orthodox	23	15 (65.2)
Protestant	15	11 (73.3)
Muslim	4	3 (75)
Educational		
Illiterate	18	16 (88.9)
Literate	24	13 (54.2)

Discussion

The disclosure rate in this study was 69%, which is less than other study (15). This study shows that a considerable proportion of women living with HIV/AIDS did not disclose their sero status to their sexual partners. Those who do not disclose their status are less likely to use condoms than those who do (P<0.05). As is the case with many women in Ethiopia, the participants of this study do not have much power to decide when, how and with whom to have sexual relations. These decisions are left to men. Thus the sexual partners of those women who do not disclose their HIV-positive status continue to be at risk for HIV transmission.

Women who hold prior discussions about HIV and HIV test are more likely to disclose their status than who do have not discuss the matter with partners (P< 0.05). This might be due to the fact that women who have prior discussion have the chance to raise issues related to HIV and testing. In addition it would be easier for them to

Table 2: **Factors associated with disclosure of HIV status, and condom use among HIV positive Women in Gore and Metu towns, Illubabor Zone, Oct. 2004**

Variable (N=42)[a]	Total n	HIV sero positivity Disclosed n (%)	X^2	P-value
Discussion before test (HIV)				
Yes	32	26 (81.3)		
No	10	3 (30.3)	9.36	P<0.005
Current use of condoms				
Yes	31	24 (77.4)	3.88	P<0.05
No	11	5 (45.5)		
Types of partner				
Non-regular	28	18 (64.3)		
Spousal	8	7 (87.5)	1.59	P<0.5
cohabiting	6	4 (66.7)		
Partner age (years)				
≤ 30	10	8 (80.0)		
> 30	29	19 (65.5)	0.73	P<0.5
Partner education				
Illiterate	1	0 (0.0)		
Literate	40	28 (70.0)	0.078	P<0.5
Duration of relation				
≤ 2 years	24	18 (75.0)		
> 2 years	18	11 (61.1)	0.93	P<0.5
Relationship before test				
Smooth relation	10	8 (80.0)		
with disagreement	32	21 (65.6)	0.74	P<0.5
Duration of test & test result				
≤ 1 year	28	18 (64.3)	2.37	<0.25
> 1 year	10	9 (90.0)		

Table 3: **Barriers to HIV status disclosure among non-disclosers in Gore and Mettu towns, Illubabor Zone Oct. 2004 (N=16)**

Barriers to disclosure	No	%
Fear of abandonment	5	31.3
Fear of stigma & rejection	4	25.0
Fear of confidentiality	4	25.0
Fear of shaming family	2	12.5
Fear of accusation of infidelity	1	6.2
Total	**16**	

Table 4: **Outcomes of disclosure among disclosers in Gore and Mettu towns, Illubabor Zone, October 2004 (n=29)**

Outcomes of disclosure	No	%
Receiving kindness	15	51.7
Acceptance	7	24.1
Blame	7	24.1
Total	**29**	

The duration of knowledge of test results has some impact on disclosure even if it is not significant. Women who have known their results for more than one year were more likely to disclose. This implies that disclosure rate increases over time as people adjust to their results.

Although it is not statistically significant women who have smooth relations with their partners are more likely to disclose their status. Thus, in order to safeguard women most at risk for negative out comes following disclosure, they should be identified for counseling through the use of screening tools. The screening tools enable to ask women about prior communication with their partners regarding HIV and HIV testing, prior experience of violence and anticipated reactions of partners to HIV status disclosure. Based on the result of the screening, counselors may discuss to find out alternative options to disclosure, identify various methods of disclosure, and make decisions on whether or not to disclose or to postpone disclosure for the time being (7).

The most common barrier to disclosure mentioned by the participants is fear of abandonment. Women's fears of abandonment were mainly a question of economic support and social value. In a setting where women's access to resources independent of their partner is uncommon, disclosure is a question of survival and thus the negative outcomes.

The other mentioned barrier to disclosure is stigma and rejection. In places where HIV is considered as divine

punishment and a result of moral misconduct, stigma and discrimination are very strong. It has been suggested that people are more concerned about the social consequences of HIV including issues of death, sex, misbehavior (sin), blame, shame and stigma, than with the technical facts about HIV/AIDS (14). It is, therefore, important to initiate-mass education to de-stigmatize the disease and deal with underlying gender norms social attitudes about HIV/AIDS and violence against women, in order to create a favorable environment for the women to disclose their results.

The National HIV/AIDS Counseling Manual pays due attention for the disclosure of HIV status to partners. Therefore, counselors should stick to the manual and help women to disclose their results safely. Counseling tools such as role-playing may also be useful to help women develop self confidence and the communication skills they need to share HIV test results safely with their partners. Moreover, HIV positive women's organizations are becoming increasingly visible (4). Associations like "Tesfa Goh" Ethiopia and "Tilla" an association of women living with HIV/AIDS are also effective in encouraging individuals to share their HIV test results with others and in reducing the stigma associated with HIV counseling and testing. In addition, those associations may help women to discuss their results with-partners. Providing follow up counseling is another method, which enhances the disclosure of HIV test results. Otherwise, innovative ways of involving men in PMTCT programs should be sought so that women are not blamed or isolated if they are found to be sero positive. This might be possible by inviting men during ANC to come with their partners and go through safest way of counseling for disclosure i.e. couple counseling.

The access and acceptability of HIV testing and counseling is the "passport" for all individuals to discover and take advantages of important preventive and care services. In addition, disclosure is one way for HIV positive women to participate fully in effective PMTCT programs. Enhanced support services for HIV-positive women and individualized approaches to post test counseling help women to disclose their results safely. In addition, efforts should be made in properly utilizing the limited available resources in order to save the lives of innocent victims (infants) from HIV/AIDS.

The disclosure of HIV status is associated with supportive and favorable responses. Therefore it is important to assure HIV positive women that the benefits out weigh the potential costs. However, individual approaches to post test counseling, establishing and strengthening HIV positive women's associations, initiating community-based programmes to de-stigmatize HIV/AIDS and skill-upgrading for counselors are important means to ensure the safety of women who want to disclose their HIV serostatus to their sexual partners.

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