Disclosing HIV Serostatus to sexual partners among HIV infected women in Kisil DistricT, Kenya: A qualitative study

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SUMMARY

Study objective: As the rates of HIV infection continues to soar in many parts of the world, concerted efforts have been mounted on counseling to help HIV infected individuals disclose their serostatus to their sexual partners. However, various studies have continued to show few seropositive women disclosing their status to their sexual partners and this has become an important impediment to the efforts made in HIV prevention and treatment. The study aimed at establishing factors that influence women's decision to disclose HIV serostatus to their sexual partners.

Methods: The study was a qualitative study conducted in Kisii district hospital, western Kenya among 87 purposively selected HIV infected women enrolled at a Patient Support Center and 8 key informants. Focus group discussions and key informants interviews were used to collect the data. Aspects of disclosure that were assessed included; the prevalence of disclosure, the reasons that enhanced/ de-enhanced disclosure, the reaction of the sexual partner after being disclosed to and the intent to disclose among women who had not disclosed. Data was analysed by Text-based Beta Softwares

Results: Out of the 87 participants 59 had disclosed their HIV serostatus to their sexual partners. Of those participants who had not disclosed (28) 19 had no intention of ever disclosing. Main factors that enhanced disclosure were a feeling that a partner needed to know or to gain the partner's support while factors that exhibited disclosure were expressed as; fear of being abandoned by the sexual partner, being accused of infidelity or the possibility of the sexual partner withdrawing his economic support.

Conclusion: The reasons given by the study participants are of public health importance as they may have limited most women to appropriate health care or ability to engage in safer sexual behaviours, which are both tantamount to HIV/AIDS control effort.

Key words: Disclosure, HIV serostatus, sexual partners, HIV infected women, Kenya

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Introduction

One of the main strategies for control and prevention of Human Immunodeficiency Virus (HIV) infection is disclosure of seropositive status to sexual partners. This is because sexual partners of HIV infected individuals are a high-risk population for HIV acquisition (1). Moreover, disclosure motivates sexual partners for early uptake of voluntary HIV testing and counseling as well as change in risky sexual behaviors (2). It also enables couples to make informed reproductive health choices that may reduce the number of unintended pregnancies among HIV positive women as well as uptake and adherence to Prevention of Mother-To-Child Transmission (3, 4). In addition, disclosure may lead to important social support among women by their sexual partners and this can mitigate the negative effects of emotional stress, an important factor to improved access to HIV treatment and care (5).

However, despite these benefits, the rate of HIV serostatus disclosure among sexual partners is wanting particularly among seropositive women. Previous studies show disclosure rates ranging from 16-84% in developing countries and 58-100% in developed countries (6). Several factors tangled in social, economic and cultural lives of most women influence their decision to disclose. For instance, in developing countries, early marriages, low level of education and childbearing disproportionately impact on women's occupation. This leads to lack of economic dependency, an aspect which negatively influences on disclosure as most women fear rejection, that may apparently be compounded by lose of economic support from the partner (7)

Gender inequality embedded in socio-cultural factors is also a vital element influencing disclosure. HIV infected women in most African societies, are rejected and erroneously perceived as the main transmitters of HIV infection. This negative depiction outweighs the benefits associated with disclosure and has provided the basis for many HIV infected women not disclosing their serostatus (8).

There is an urgent need therefore, to determine the precise reasons and barriers influencing disclosure of serostatus to sexual partners among HIV infected women especially today when there is an increasing proportion of HIV infected women (8.3%) and a high rate (17-23%) of discordant couples in Kenya (9). No recent studies have been done among HIV infected women in Kenya, and the few available (10, 6) were conducted only among antenatal mothers.

Methods

Study area

The study was conducted in April 2008 at Kisii district hospital, an urban hospital situated in Kisii Central district, western Kenya. The district has a total population of 542,972 persons (248,945 males and 273,252 females) and is served by 54 health facilities (5 hospitals, 20 health centers and 27 health clinics), which are either private or government owned. HIV prevalence rate is 5.1% among females and 3.2% among males. The pandemic have strained massively the district health sector with about 50% of hospital beds being occupied by HIV/AIDS patients as well as the social sector due to an increased number of widows and orphans.

Study site

Kisii district hospital has a catchment population of about 280,000 persons both within the district and its

environs. The doctor-patient ratio is nearly 1:35,000. It is the only tertiary hospital in the district and the only hospital with a HIV Patient Support Center (PSC) offering free medical care and a feeding programme for malnourished HIV infected adults and infants. In a month PSC serves an average of 960 patients (children and adults) (11).

Study design

This was a qualitative study. The study participants were HIV infected women recruited from PSC. The inclusion criteria was all HIV infected women with sexual partner (s) aged 18 years and above and willing to participate in the study.

Study procedures and data collection

We conducted Focus Group Discussions (FGDs) and Key Informants Interviews (KIIs) for triangulation. The study took 12 days. The FGDs comprised 9-11 purposively selected participants based on the eligibility criteria. A total of 87 participants that encompassed 8 groups were formed based on age (18-30 years versus above 30 years) and marital status (married versus not married). The grouping was meant to facilitate free and frank responses among the participants.

Recruitment was conducted after the respondents had received clinical services. Detailed explanations on the nature and purpose of the study were provided to each and every respondent and asked if they were willing to participate. Upon giving written informed consent, they were invited into a private room for discussion. Each discussion session began after 9-11 eligible consenting participants had been identified.

A moderator, an assistant and a note taker conducted each FGD by use of an open-ended interview guide. Discussions were initiated by formal introductions of both the study team and the participants followed by a clear explanation of the interview format.

The following themes were then studied:

1. HIV related characteristics of the respondents (duration since the respondent knew her HIV status, duration lived with the sexual partner as well as the sexual partners serostatus))
2. Disclosure of HIV status to sexual partner(s).
3. Reasons for and against disclosure of seropositive status to the sexual partners.
4. Response of the sexual partner upon learning the serostatus of the respondent.
5. Intention of disclosing to the sexual partners for respondents who had not disclosed.

The moderator put forward non-leading questions to highlight each theme and participants were asked to discuss honestly their own experiences, knowledge and thoughts. All the responses were tape-recorded verbatim and simultaneously hand written. Each session lasted approximately one hour.

Key informant interviews were conducted for with 8 purposively selected respondents (2 clinical officers, 4 nurses and 2 social health workers). The selection was based on their involvement in treatment and counseling. The interviews were free conversations guided by an interview guide and centered on their perception on factors that discouraged HIV positive women from disclosing their serostatus to their sexual partners. They were done in English and conducted in the morning before the key informants attended the patients to avoid disruption of work. The responses of the interviews were recorded in process.

Data analysis

All the tape-recorded materials were transcribed at the end of every interview day while hand written notes

were elaborated on initial observation and subsequently appended to the transcripts. At the end of the study period, all the narratives (transcripts and notes) were typed and translated into English for analysis. Two translators who were natives of the study area and familiar with the local language conducted the translation.

Ethical considerations

The study was approved by the research ethics committee of Maseno University and by the Medical Superintendent of Kisii district hospital where the study was conducted. All the respondents were clearly informed about the objective of the study and only those who provided consent were considered eligible to participate. Identification of the respondents were kept anonymous and confidentiality was ensured in all the information given by the respondents.

Results

Socio-demographic and HIV related characteristics of the respondents

A total of 87 HIV positive aged between 19-61 were interviewed. Of all the participants in the study, 37 [42.5%] were married, 58 [66.7%] had attained primary level of education and 26 [29.9%] were in formal employment. About two thirds [(54) 62.1%] had known their seropositive status for over six months. All the participants conceded on receiving post-test counseling on disclosure. The majority [(42) 48.3%] attested their sexual partners were also HIV seropositive.

Disclosure of HIV status

It was established that, 59 [67.8%] of the study's participants had disclosed their HIV serostatus to their sexual partners. We further assessed what enhanced their disclosure as well as the reasons that made some women not having disclosed.

The specific narratives were then reviewed for main themes (study themes) and how the themes were patterned. They were then coded using thematic codes consistent with the study objective. Text-based Beta Softwares were used for analyzes (12). The information corresponding to both the main themes and sub themes were then presented in illustrative quotes.

Reasons for disclosing to sexual partners

Participants who had disclosed felt that HIV infection was a collective liability between a woman and her sexual partner hence a partner needed to know of the other's HIV serostatus. The following are some of the statements that exemplified the situation: *"I got to tell him so that I can ask him whether it's him who brought it",* said one participant. "W*hy won't I tell him? Is he also not infected"?* Asked another participant*". "Men are the ones who bring this disease. When do women get time to roam about"?* A young participant articulated in futility. Others said they disclosed since they suspected their partners were also ailing from the same illness or to motivate them to take a HIV test. A few more said they disclosed so as to get the partner's support or to freely access health care. Others said they disclosed because their partners suspected they may have been tested while some disclosed to avoid their sexual partners knowing their HIV test results from others: *"If you don't tell him, he will finally find out and it will be chaos"* said one participant.

Reasons for not disclosing to sexual partners

Participants (both who had disclosed and those who had not) affirmed that disclosure of seropositive status

to sexual partners was not easy. One participant expressed this in futility. *"Disclosure doesn't come in a snap. One has to contemplate foremost on the well being of the children who would remain if we happen to die and whatever would become of their education"*.

Other participants who had not disclosed to their sexual partners expressed fear as the main reason; including, fear of being abandoned, being accused of infidelity, withdrawal of economic support, fear of being chased out or being beaten. *"Most of the time we go with our husbands so that we can be tested and told together. I lied to him that I had refused to be tested so that we could go with him and be told together*" said one participant.

A key informant corroborated these findings. *"In this district,* d*isclosure is not really easy with women, but we do assist them. Whenever the woman has tested HIV positive and desires to tell the sexual partner, but fears the consequences, we advice the woman to act as if she has not been tested. She is supposed then to persuade her partner to go for HIV testing. If the partner concedes to go, testing is done again for the woman, but this time together with the sexual partner. This way, the man often does not react negatively towards her".* Another key informant said disclosure was still a problem in the district because stigma was still high in the community.

Intention of disclosing to sexual partner

Those who had not disclosed said they had no intention of ever disclosing to their sexual partners. One participant noted: *"I didn't know my husband was suffering from HIV. When he died, other men came in and we had sex. Later I was diagnosed with HIV, but I have never told them and I'm not planning to. I do not want to scare them. It's confidential".* Another participant attested this by saying, "*My husband is the one who brought it, so I would never tell him I'm also HIV infected. I don't care about him"*

Response of the sexual partner towards disclosure

Participants who had disclosed said they had positive experiences related to disclosure. Majority said their partners had supported them from the time they disclosed their HIV status. One participant stated: "*If there is love, between the two of you, then there is support. As for me, all has been well".* However, a few participants said they got negative experiences from the sexual partners. Some said since they informed their partners that they were HIV infected, their relationships had turned to the worse. They had been beaten, sometimes avoided and verbally abused. "*My sex partner has refused to support me completely. He has denied the fact that we are sick. He has refused to go for HIV test and refused me to take the medicine. He declines to even use condoms. He beats me when I insist on using them and forces me into sex without them. I'm now pregnant!"* said a 22-year-old participant amidst tears. Two participants said they had been chased out while another two were continuously accused of infidelity. One participant said her sexual partner abandoned her in the VCT centre after discovering she was HIV positive and have never seen him since then.

Discussion

This study showed that, seropositive women who disclosed their serostatus to their sexual partners do so for various reasons. The reason that surfaced strongly was a feeling that a partner needed to know. On further probing, it emerged that the participants felt the sexual partner was the cause of the infection thus they were venting their anger. This implied an act of retribution that may only be reprimanded through counseling. Those who said they disclosed to get support may have feared the upheaval of HIV infection thus anticipated to get support from their sexual partners. Some of the reasons given for disclosure in our study are similar to those reported in other studies. For instance in Nigeria (13) disclosure of seropositive status was in the hope of getting economic, spiritual, emotional and social supports from confidants. Another study (5) in India also found disclosure as a mean to elicit various forms of support while other respondents felt they had a responsibility to disclose or because they needed the sexual partner to also go for HIV testing.

Disclosure was said to be a difficult endeavor by the respondents who had not disclosed Most feared being abandoned, being accused of infidelity, while a few feared the partner acting violently towards them. This finding may stem from gender inequality. In most societies, women who are HIV infected are perceived as the main transmitters of HIV infection hence accused of infidelity and often abandoned (14). This negative depiction could have abdicated women in our study from disclosing to their partners. It could also be the core reason why most respondents who had not disclosed said they had no intention of ever doing so.

This finding is consistent with those reported in a review of studies among women in developing countries (6). According to 14 studies conducted in Africa, the most common barriers to disclosure were found to be fear of abandonment, fear of rejection, fear of discrimination, fear of violence and fear of being accused of infidelity.

This study found that, most women who disclosed to their sexual partners had their partners support. However, a small proportion of women said the partners were either avoiding them or were verbally abusive. This indicates that, the perception and anticipated fears the respondents had on disclosing seropositive status to their sexual partners were not often realized. A review of studies in developing countries (15) had findings consistent with our study. Among 20 studies focusing exclusively on HIV infected women, 18 reported at least one positive outcome following disclosure to the sexual partner. The common ones were support, acceptance and kindness. In most of these studies, relationships still lingered on well even after the women had disclosed. This was consistent with our study as most respondents said they remained together in harmony with their sexual partners in spite of disclosure. This results are inconsistent with a study in Maryland, USA, which found higher rates of negative responses (rejection, physical and sexual assault) among HIV infected women who had disclosed their seropositive status to their sexual partners (16).

Limitations of the study

The study had a few limitations in that number of participants involved in both focus group discussions and key informants interviews may not be a

representative of all HIV infected women in the district. Moreover, The study relied solely on self-reported data, that could not be verified. In this case, there was the potential of over-reporting disclosure as the discussion was done in an open focus group setting.

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