WEST AFRICAN JOURNAL OF MEDICINE

ORIGINAL ARTICLE

Status Disclosure among People Living With HIV/AIDS in Ilorin, Nigeria

La divulgation du statut des personnes vivant avec le VIH / SIDA à Ilorin, Nigeria

A. K. Salami*†, A. Fadeyi‡, J. A. Ogunmodede†, O. O. Desalu†

ABSTRACT

BACKGROUND: **HIV/AIDS is a disease that is characterised by discrimination and stigmatisation particularly in Africa.**

OBJECTIVE: **To determine rate of disclosure of HIV status among People Living with HIV/AIDS (PLWHA) in Ilorin, Nigeria.**

METHODS**: A semi-structured, interviewer administered questionnaire containing 40 items was used to collect information from persons living with HIV/AIDS accessing treatment at the University of Ilorin Teaching Hospital, Ilorin, Nigeria. Information on patients' socio-demography and life-style history, HIV medical history and HIV status disclosure was obtained from the patients.**

RESULTS: **A total of 253 patients participated in the study. Their ages ranged between 26 and 58 years. Majority were females, 58.5% and 41.5% were males. The disclosure rate was 39.5%. As many as 60.5% of the respondents had not disclosed their HIV status to anybody. The disclosure was to the spouses, in 18.6% of the instances and to relatives or friends or co workers in another 20.6% of cases. There was a significant difference. The knowledge of their spouses on HIV/AIDS status correlated with disclosure rate, r=0.237, p=0.02. Female sex, intact family and monogamy correlated well with high disclosure rate.**

CONCLUSION: **HIV status disclosure rate among PLWHA in Ilorin is low. Female sex and monogamous marital status are positive predictors of disclosure. There is need to ensure effective disclosure counselling for the unmarried; single/ separated, patients in polygamous marriages and males member of the society. WAJM 2011; 30(5): 359–363.**

Keywords: **HIV status, disclosure, rate, Ilorin.**

RÉSUMÉ

CONTEXTE: Le VIH / sida est une maladie qui se caractérise par la discrimination et la stigmatisation en particulier en Afrique.

OBJECTIF: Pour déterminer le taux de divulgation de la séropositivité chez les personnes vivant avec le VIH / sida (PVVIH) à Ilorin, Nigeria.

MÉTHODES: Un questionnaire semi-structuré, l'interviewer administré contenant 40 articles a été utilisé pour recueillir des informations auprès des personnes vivant avec le VIH / sida l'accès au traitement à l'Université d'Ilorin CHU, Ilorin, Nigeria. Information sur l'histoire des patients socio-démographie et le style de vie, les antécédents médicaux du VIH et la divulgation du statut VIH a été obtenu à partir des patients.

RÉSULTATS: Un total de 253 patients ont participé à l'étude. Leurs âges varient entre 26 et 58 ans. Femelles étaient majoritaires, 58,5% et 41,5% étaient des hommes. Le taux de la divulgation était de 39,5%. Autant que 60,5% des répondants n'avaient pas révélé leur statut sérologique à personne. La divulgation était aux conjoints, dans 18,6% des cas et à des parents ou des amis ou des collègues de travail dans un autre 20,6% des cas. Il y avait une différence significative. La connaissance de leurs conjoints sur le VIH / SIDA état corrélé avec le taux de divulgation, r = 0,237, p = 0,02. Femme sexe, famille intacte et la monogamie est bien corrélée avec le taux de la divulgation de haut.

CONCLUSION: Taux de VIH chez les PVVIH la divulgation du statut à Ilorin est faible. Le sexe féminin et monogame l'état matrimonial sont des prédicteurs positifs de la divulgation. Il est nécessaire de veiller à ce conseil une divulgation efficace pour les célibataires; simple / séparés, les patients dans des mariages polygames et membres mâles de la société. **WAJM 2011; 30 (5): 359–363.**

Mots-clés: Statut VIH, la divulgation, le taux, Ilorin.

Departments of Medicine and Medical Microbiology, University Of Ilorin, PMB 1515, Ilorin, Nigeria.
***Correspondence:* Dr. Salami AK, P.O. Box 4470, Ilorin, Nigeria**
E-Mail : salkaz2000@yahoo.com E-Mail Addresses: FA: abayomifadeyi@yahoo.com OJA: ayodeleogunmodede@yahoo.com DOO: femuy1967@yahoo.co.uk

Abbreviations: ARV, Antiretroviral; **HAART,** Highly Active Anti-retroviral Therapy; **PLWHA,** Person living with HIV/AIDS; **PMTCT,** Prevention of mother to child transmission; **VCT,** Voluntary Counselling and Testing.

INTRODUCTION

HIV/AIDS pandemic at present is enormous; 33.4 millions people of the world population were infected as at the end of 2008.[1] In that year, there were 2.7 million new infections and 2.0 million deaths globally.[1] In sub-Saharan Africa, where 22.4 million of the infected people reside, there were about 1.9 million new infections and 1.4 million AIDS-related deaths in year 2008 alone. And Nigeria, the giant of Africa due to her population, has an estimated 3.1% of her adults between ages of 15–49years living with HIV/AIDS with approximately 170,000 deaths from AIDS in 2007.[2] The HIV epidemic in Nigeria has taken its toll on the citizenry as the average life expectancy of Nigerians has dropped from 53.8 years for women and 52.6 years for men in 1991 to 46 and 47 respectively by the year 2007.[3]

The adverse impact of HIV/AIDS on the world is on the increase because of the high frequency of new infections as against the primary goal of HIV control/ prevention programme. One very important tool for the HIV control is Voluntary Counselling and Testing (VCT). This is because VCT has been associated with reduced risky behaviours with attendant advantage of prevention of HIV transmission and infection.[4] Furthermore, VCT is known to aid early detection and management of newly infected persons facilitating their integration into the other aspects of the control programme including treatment with HAART. Therefore, satisfactory control of HIV spread is only achievable when a well planned and efficient VCT programme is in place.

A major contributor to the success of any VCT and indeed HIV control programme is disclosure of status to spouse, trusted family member or close associate. However, infected patients may not be too eager to disclose such sensitive information like this because of the risks of abandonment, physical violence, and feelings of shame, worry, fear, or rejection,[5] but on the other hands its merits are overwhelming. Disclosure of one's HIV status may motivate sexual partners to seek testing, change risky behaviour and ultimately decrease HIV transmission rate.[5–7]

In addition, disclosure may facilitate other health behaviours that may improve the outcome of overall HIV management. For example, women who disclose their status to spouses are more likely to participate in the prevention of mother to child transmission (PMTCT) of HIV programmes.[5,8] Similarly, disclosure of HIV status may result in an individual's opportunity to receive support from his family members or other people in his social network in addition to having access to other available support services elsewhere.[8] Furthermore, disclosure followed by adequate handling of the emotional and social sequelae of such action often results in patients being more willing and indeed finding it easier to adopt and maintain healthy behaviours such as adherence to treatment regimens.[9] Also disclosure often provides and increases opportunities to receive social support, which may help individuals cope and recover from physical illness, and attenuate depressive symptomatology associated with HIV status test result notification.[8–10]

Person living with HIV/AIDS have been accessing care from the UITH, Ilorin for more than five years under a FGN/ PEPFAR sponsored programme. Rate of disclosure of HIV status among these patients has not been assessed since the commencement of HAART in this hospital despite its importance. This informed the decision to determine HIV status disclosure rate among PLWHA who are accessing care at our centre.

SUBJECTS, MATERIALS, AND METHODS

This study was a descriptive cross sectional survey conducted at the HAART clinics of the University of Ilorin Teaching Hospital in June 2009 and is part of the research on adherence to anti-retroviral drugs. Person living with HIV/ AIDS attending this clinic were routinely counselled on every aspect of their disease including adherence and disclosure at every clinic visit.

Patients with HIV/AIDS who had been diagnosed and accessing treatment in the hospital for at least six months were recruited into the study after obtaining their consent. The patients were educa-

Table 1: Socio-demographic Characteristics of the Respondents

Variable	Number (%)
Age	
26 – 30	65 (25.7)
31 – 35	66 (26.1)
36 – 40	52 (20.6)
41 – 45	35 (13.8)
46 – 50	20 (7.9)
51 – 55	9 (3.6)
56 – 60	6 (2.4)
Sex	
Female	148 (58.5)
Male	105 (41.5)
Marital Status	
Married	138 (54.5)
Widowed	31 (12.3)
Single	60 (23.7)
Separated	24 (9.5)
Religion	
Christianity	98 (38.7)
Islamic Religion	143 (56.5)
Others	12 (4.7)
Occupation	
Civil servants	30 (11.9)
Security	15 (5.9)
Trading	58 (22.9)
House wife	25 (9.9)
Students	13 (5.1)
Artisans	31 (12.3)
Driving	13 (5.1)
Nursing	4 (1.6)
Media	2 (0.8)
Unemployed	11 (4.3)
Farming	7 (2.8)
Teaching	33(13.0)
Clergy	11 (4.3)

Table 2: Distribution of Patients by the Year of Diagnosis and Commencement of HAART

Year	Number (%)	
	Diagnosed	HAART Commencement
≤1	37 (14.6)	77 (30.4)
2	54 (21.3)	37 (14.6)
3	60 (23.7)	47 (18.6)
4	50 (19.8)	55 (21.7)
≥5	52 (20.6)	37 (14.7)
Total	**253 (100)**	**253 (100)**

ted on the general purpose of the study and the need to respond correctly to questions in the questionnaire which was anonymous. They were told that their participation was voluntary and that they could withdraw from the study at any time if they so desired. They were assured of the confidentiality of information supplied.

A semi-structured, trained interviewer-administered questionnaire was used to collect information from them. The interviewers were the resident doctors in the hospital. Details of socio-demographic data and HIV medical history including time and reaction at diagnosis disclosure of HIV status to spouse, sexual partner and members of patient's social network (friends, relatives or co-workers) were obtained at recruitment. Information on knowledge of HIV sero-status of spouse, sexual partner, enjoyment of confidentiality during consultation and other relevant information were also obtained.

All information obtained was imputed into SPSS software version 15 for statistical analysis. Disclosure was correlated with a number of factors including age, sex, marital status, type of marriage, occupation, religion, number of years since diagnosis, number of years on treatment, confidentiality during consultation, perceived benefit from antiretroviral (ARV) drugs and presence of reaction to ARV's using the Spearman's correlation.

RESULTS

The socio-demographic characteristics of the patients are presented in Table 1. A total of 253 patients participated in this study. Their age ranged between 26 and 58 years. Majority, 148 (58.5%) were females while 105 (41.5%) were males. More than halve, 138 (54.5%) of the patients were married and gainfully employed.

Many, 216(85.4%) of the respondents had been diagnosed for more than one year and a significant proportion, 176 (69.6%) had also been on HAART since then (Table 2). The feelings of the patients at notification of their HIV sero (positive) status varied from feeling of; sadness, 77 (30.4%), surprise, 37 (14.6%), to acceptance, 25 (9.9%) among others (Table 3).

More than a half, 153 (60.5%) of the respondents had not disclosed their HIV status to anybody while 47, (18.6%) had disclosed to their spouses and 52 (20.6%) to members of their social network, Table 4. Of these social network disclosures 46, (18.2%) were to relatives, five, (2.0%) to friends and two, (0.8%) to co-workers. As many as 157 (62.1%) of the respondents did not know the HIV status of their spouses while 41 (16.2%) had an HIV positive spouse and 40, (15.8%) had HIV negative spouses, Table 4. Majority, 228 (90.1%) of these patients enjoyed confidentiality during clinic consultation.

The patients' knowledge of their spouses or sexual partners' HIV status correlated (Spearman's co-efficient SC = 0.237, p=0.020) well with disclosure, Table 4. Similarly, as presented in Table 5, disclosure was associated with sex, (SC =0.316, p= 0.001). Women disclosed their HIV status more than men. The marital status of the respondents correlated negatively with disclosure (SC= –0.223, p=0.026). The disclosure rates were highest among married respondents as against singles, separated or widows. Women in monogamous marriages were more likely to disclose their HIV status than those in polygamous marriages (SC=0.488, p=0.000). Furthermore, occupation (SC=0.323, p=0.001), duration of treatment for HIV (SC=0.278, p=0.050) and confidentiality during consultations (SC= -0.216, p=0.029) among others were good predicting factors for disclosure HIV status.

Table 3: Respondents Feelings at Notification of Results of HIV Positive Tests

Patients Feeling	Number (%)
Felt Sad	77 (30.4)
Afraid	22 (8.7)
Surprised	37 (14.6)
Not Surprised	26 (10.3)
Confused	17 (6.7)
Depressed	13 (5.1)
Can't Believe	12 (4.7)
Acceptance	25 (9.9)
Disappointed	7 (2.8)
Shocked	16 (6.3)
Don't want to comment	1 (0.4)
Total	**253 (100.0)**

Table 4: Disclosure of Status and Knowledge of HIV Status of Spouse

Variable	Number (%)
Respondent Disclosure Type	
To Spouse	47 (18.6)
Other Acquaintances	53 (20.9)
Non-Disclosure	153 (60.5)
Total	**253 (100.0)**
Knowledge of Spouse HIV Status	
HIV Positive Spouse	41 (16.2)
HIV Negative Spouse	40 (15.8)
Don't know HIV Status of Spouse	15 (5.9)
Don't want to respond to question	157 (62.1)
Total	**253 (100.0)**

Table 5: Factors influencing HIV status disclosure based on Spearman's Correlation

Variable	Spearman's Co-efficient Correlation	p-value
Age	–0.049	0.631
Sex	0.316	0.001
Religion	0.091	0.369
Occupation	0.323	0.001
Marital Status	–0.223	0.026
Type of family	0.488	0.000
Year of diagnosis	0.058	0.567
Feelings on diagnosis	–0.222	0.027
Years on treatment	0.278	0.050
Reaction to HAART	0.111	0.276
Concurrent diseases	0.273	0.006
Confidentiality	–0.219	0.029

DISCUSSION

HIV Status Disclosure Rate

The rate of HIV status disclosure, as found in this study was 39.5%. This is similar to 46.2% reported by Brou *et al*[11] in Cote d'Ivoire but far lower than the average of 79.0% observed for the developing world by the World Health Organisation[5] (WHO) in their review of 2004. However, recent findings in some parts of Africa have shown far higher disclosure rates comparable to what obtained in the developed world. For instance, Wong *et al*[12] in South Africa found a disclosure rate of 87.0% while Deribe *et al*[13] in Ethiopia reported a disclosure rate of 94.5% and Salami *et al*[14] reported a disclosure rate of 70% from Nigeria.

The difference between disclosure rates in these reports and ours may be related to the characteristics of the studied population. Most of our respondents were females who were in polygamous marriages and fear of being labelled as being sexually loose. In addition the fear of discrimination and societal rejection with a possible threat of divorce might have made most of them to keep their status to themselves. Also some of these women, especially the single and separated ones, who are in employment and as such not dependent on spouse or family for sustenance may chose not to disclose their status to anybody. These reasons could partly explain why most of them preferred disclosing their status to friends and co-workers instead of their spouses.

High level of illiteracy and ignorance among others could also contribute to this low level of disclosure amongst our clients since they didn't appreciate the contribution of this practise to their care. Reluctance in adapting to behaviours that are less risky especially amongst those with high level of awareness about HIV/AIDS is another limiting factor to status disclosure.[14] Therefore, it is important that PLWHA in Ilorin are given effective and adequate counselling on values of HIV status disclosure to spouses and immediate family members if the spread of this virus is to be tamed and new infections avoided.

The readiness of most of our clients to disclose their status to members of their social network than to their spouses was at variance with the experiences of Wong *et al*[12] and Salami *et al,*[14] both of whom observed the spouse to be the focus of the disclosure in their respective studies. However, our finding was consistent with that of MacNeil and Lie[15] from Tanzania. This perhaps suggests that the category of person(s) an infected individual chose to disclose his/her HIV status to may sometimes not be important because it may probably represent a break-point in time in the patient's ability to keep the information to him/herself and he /she just want to confide in someone available.

Predictors of HIV Status disclosure

We did not evaluate the reasons why HIV positive patients in Ilorin failed to disclose their status to relevant quarters in this study report. However, previous studies[5,9,10,13,14] have identified the risks of abandonment, physical violence and feelings of shame, worry, fear, or rejection as important contributors to patients' reluctance in disclosing their HIV status. To adequately address this problem therefore, there is a need for local researches to establish the factors responsible for our patients' reluctance to disclose their HIV status.

Our study however identified some factors that could promote or discourage disclosure of patients' HIV status in our environment. Some of these factors could be used indirectly to predict drug compliance and potential defaulters could be identified early and encouraged along. Female gender for instance correlated positively with disclosure unlike what was reported in South Africa [15] and hence, an indicator of willingness to disclosing one's HIV status. A long year of treatment with anti-retroviral drugs is another good predictor of higher disclosure rates among PLWHA. This observation is in tune with similar reports[15-17] that found higher disclosure rates with longer duration of time on HAART programme. Furthermore, married as against single, separated parents or widows and monogamy as opposed to polygamy were other positive predictors of disclosure. These findings are not unexpected since a single, separated parent or widows may be willing to remarry and not willing to disclose their status. Similarly, information sharing in a monogamous family is expected to be good and less accompanied by adverse reactions as may occur with polygamy where envy potentially exists.

Confidentiality in HIV Status Disclosure

The importance of confidentiality in enhancing disclosure was equally demonstrated in our study and this was in keeping with the work of De-Rosa and Marks[18] who found the rates of disclosure to increase with the number of times a health professional discussed issues of disclosure with an infected individual in a relaxed and secured consulting room.

Conclusion

In conclusion, HIV status disclosure rate among PLWHA in Ilorin is a far cry from the WHO projected rate for the developing world like Nigeria. There is therefore an urgent need to raise the awareness of the local community about the values of status disclosure to comprehensive treatment package of person living with HIV/AIDS.

REERENCES

1. UNAIDS/WHO: AIDS epidemic update. 2009. UNAIDS/09.36E/ JC1700E. http://data.unaids.org/pub/ Report/2009/2009_epidemic_update_ en.pdf
2. UNAIDS.Report on the global AIDS epidemic. 2008. http://www.unaids.org/ en/knowledgeCentre/HIVData/ GlobalReport/2008/2008_Global_ Report.asp
3. WHO.WHO African Region: Nigeria.2008. http://www.who.int/ countries/nga/areas/hiv/en/index.html
4. Group VH-CaTES. Efficacy of voluntary HIV-1 counselling and testing in individuals and couples in Kenya, Tanzania and Trinidad: a randomised trial. *The Lancet,* 2000; **356:**103–112.
5. World Health Organization. Gender Dimensions of HIV Status Disclosure to Sexual Partners: Rates, Barriers and Outcomes: A Review Paper. Geneva, Switzerland: World Health Organization; 2004.
6. Serovich JM. A test of two HIV disclosure theories. *AIDS Educ Prev* 2001; **13:** 355–364.
7. Medley A, Garcia-Moreno C, McGill S, *et al.* Rates, barriers and outcomes of HIV serostatus disclosure among

women in developing countries: implications for prevention of mother-to-child transmission programmes. *Bull World Health Organ.* 2004; **82:** 299–307.

8. Cohen S. Psychosocial models of the role of social support in the aetiology of physical disease. *Health Psychol* 1988; **7:** 269–297.
9. Waddell EN, Messeri PA. Social support, disclosure, and use of antiretroviral therapy. *AIDS Behav.* 2006, **10:** 263–272.
10. Hays RB, Turner H, Coates TJ. Social support, AIDS-related symptoms and depression among gay men. *J Consult Clin Psychol.* 1992; **60:** 463–469.
11. Hermann Brou, Gérard Djohan, Renaud Becquet, Gérard Allou, Didier K Ekouevi, Ida Viho, Valériane Leroy, Annabel Desgrées-du-Loû, Ditrame Plus Study Group. When Do HIV-Infected Women Disclose Their HIV Status to Their Male Partner and Why? A Study in a PMTCT Programme, Abidjan. PLoS Med. 2007; 4): e342. http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2100145/?tool=pmcentrez
12. Wong LH, Van Rooyen, Modiba P, Richter L, Gray G, McIntyre JA, *et al.* Test and Tell: Correlates and Consequences of Testing and Disclosure of HIV Status in South Africa (HPTN 043 Project Accept). *J Acquir Immune Defic Syndr.* 2009; **50:** 215–222.
13. Kebede Deribe, Kifle Woldemichael, Mekitie Wondafrash, Amaha Haile and Alemayehu Amberbir. Disclosure experience and associated factors among HIV positive men and women clinical service users in southwest Ethiopia. BMC Public Health. 2008; **8:** 81 http://www.biomedcentral.com/1471-2458/8/81.
14. Salami AK, Araoye MA, Adamu UG. Knowledge, risk perception and willingness of relatives of patients to submit to voluntary HIV counseling and testing. *Afri J Clinical Experiment Microbiol.* 2006; **7:** 57–64.
15. MacNeil JM, Mberesero F, Kilonzo G. Is care and support associated with preventive behaviour among people with HIV? *AIDS Care.* 1999; **11:** 537–546.
16. Antelman G, *et al.* Predictors of HIV-1 status disclosure:A prospective study among HIV-infected pregnant women in Dar es Salaam,Tanzania. *AIDS.* 2001; **15:** 1865–1874.
17. Van der Straten A, *et al.* Couple communication, sexual coercion and HIV risk reduction in Kigali,Rwanda. *AIDS.* 1995; **9:** 935–944.
18. De Rosa C, Marks G. Preventive counselling of HIV-positive men and self-disclosure of status to sex partners: new opportunities for prevention. Health Psychology. 1998; **17:** 224–31.