Factors Influencing Women to Disclose Their HIV Status to Their Sexual Partners at the Regional Hospital Ngaoundere

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Abstract

Introduction: Only 48% of women living with HIV are receiving ART, leaving a gap of 10,591 women yet to be initiated to ART (Spectrum, 2022). The gap between women yet to be initiated to ART treatment is twice that of men. Assisting women to disclose their HIV status will contribute positively to bridging this gap, as some women refuse to take treatment because they are not willing to disclose their status for reasons like fear of isolation, stigmatization, separation, and intimate partner violence. Objective: The main aim of this study is to determine the patterns and predictors of HIV status disclosure by women to their sexual partners. Method: This study employed a mixed approach. A total of 248 women who began ART treatment between June 2020 and May 2023 were randomly selected. Face-to-face interviews utilized a questionnaire comprising 7 closed-ended questions and 3 open-ended questions. The collected data was organized in a designated spreadsheet, where it was cleaned, cross-verified, and coded before being transferred to the Statistical Package for Social Science (SPSS) version 29 for storage and descriptive analysis. Conclusion: The prevalence of HIV disclosure to partners was 48.8%. Disclosure was higher among older respondents and in the educated than among those who could not read or write. HIV disclosure was also higher in the illiterate respondents involved in polygamous relationships. Women who were diagnosed at the PMTCT services disclosed more (60%) than those tested during sickness (53%) and those who tested through VCT (42%).

Keywords: HIV Disclosure, Ngaoundere, Regional Hospital, Sexual Partner.

Introduction

The total number of people living with HIV (PLHIV) in Cameroon for 2020 was estimated at 504,472 [34]. HIV infection has become a manageable chronic health condition, enabling people living with HIV to lead long and healthy lives. There has been a general downward trend in the prevalence of HIV in the country, moving from 5.4% in 2004 to 4.3% in 2011, 3.4% in 2017 [1, 4], and recently 2.7% in 2018 [2]. Prevalence among women is nearly twice that of men (3.4% vs. 1.9%, [2]. Four out of five new infections are among women aged 15-64. HIV prevalence is highest among women between 35-39 years of age (6.5%) and 40-44

years of age (6.4%); and close to 5% among women aged 45-49 and 50-64. Adolescent girls and young women (AGYW) are equally more affected compared to their male counterparts in the 15-19 age range (0.8%) but have a higher burden in the 20-24 age range (2.4% vs. 1.5%) [4, 2, 5].

The prevention and control of HIV infection depend on the success of strategies to prevent new infections and treat currently infected individuals. HIV testing and counselling services serve as a critical prevention and treatment tool in the control of the HIV epidemic. Within HIV testing and counselling programs, emphasis is placed on the importance of HIV status disclosure among HIV-infected clients [3], particularly to their sexual partners, to have psychological, physical and financial support during treatment. At the antenatal clinic, HIV prevention services are taken more seriously to prevent transmission from mother to child during pregnancy, delivery, and in the post-delivery period during breastfeeding through breast milk [27]. Disclosure is also an important preventive measure because it motivates sexual partners to seek testing services, change risky behaviour, and ultimately decrease transmission of HIV [5, 6]. It also prevents unplanned pregnancy [23]. In addition, disclosure has several potential benefits for the individual, including increased opportunities for social support from the partner and relatives [22, 27, 28], improved access to necessary medical care, including antiretroviral treatment, increased opportunities to discuss and implement HIV risk reduction with partners, and increased opportunities to plan for the future [3, 23].

Long-standing gender inequalities, discrimination, and poverty deny many women and adolescent girls economic autonomy, deprive them of control over their sexual lives, and expose them to the risk of emotional and bodily harm [30]. All these factors can increase the risk of HIV, particularly in sub-Saharan where HIV prevalence among Africa. adolescent girls and young women is more than three times higher than among their male counterparts [3]. In Cameroon, only 48% of women living with HIV are receiving ART, leaving a gap of 10,591 women yet to be initiated into ART (Spectrum 2022). The gap between women not yet initiated on ART treatment is twice that of men. Assisting women to disclose their HIV status will contribute positively to bridging this gap, as some women refuse to take treatment because they are not willing to disclose their status to their partners for reasons like fear of isolation, stigmatization, separation, and any form of violence.

In this study, we assessed the factors affecting the disclosure of HIV status by the woman to her sexual partner in women receiving treatment from the Ngaoundere Regional Hospital, Cameroon. Disclosure of HIV status means releasing information by one person to his or her partner, which can lead to either a positive or negative experience for the woman. The high number of women who refused to be initiated to antiretroviral drugs (ARV) in Adamaoua incited us to carry out this study. This was coupled with the low retention rate of ARV care and treatment observed in women. In 2020 and 2021, the monthly and quarterly retention rates could hardly surpass 75% despite the regular reminder calls made two days before the appointment date by the caseworkers. Many women missed drug dispensation appointments and refused home or community-based ARV delivery under the Differential Service Delivery (DSD) model. DSD is a person-centred approach that simplifies and adapts HIV services across the cascade in ways that both serve the needs of people living with HIV better and reduce unnecessary burdens on the health system. Thev preferred being served through intermediaries and fast-track models of DSD. It became increasingly difficult to carry out routine clinical laboratory examinations like viral load examinations and others. The viral uptake was therefore subnormal in 2020, as low as 30% in women at the PMTCT unit in that period (CDC PEPFAR 2021). This attitude of isolation and hiding in women prompted our curiosity to inquire about their HIV status disclosure.

The prevalence of HIV disclosure by women to their sexual partners in South Nigeria was 74.5% [35]. Duration of marriage, knowledge of the partner's status, and belief in the partner's support if disclosed were the factors contributing to HIV disclosure to the partner. In a systematic review of studies in sub-Saharan Africa, the rate of disclosure to sexual partners ranged from 5% to 97%. [31]. Most women disclosed at the PMTCT services before delivery. Younger age, first pregnancies, knowing someone with HIV, lower levels of internalized stigma, and lower levels of avoidant coping were factors contributing to disclosure. A study in Kenya, reported that the disclosure rate to a partner was at 80% [19], and was higher than in the previous years, suggesting a possible improvement over time. Younger pregnant women appear to be more likely to disclose. This result was different from the study in Uganda where young women were reticent to disclose their status to their partners for fear of loss of emotional and economic support [33]. Also, in a Bangui hospital, 27% of the women did not disclose their status to their partner, against 73% who disclosed, and the main factors associated with non-disclosure of HIV status were the spouse's young age, precarious employment status, and couples living separately [16].

There is not enough research on HIV disclosure by women to their partners in Cameroon. We found just one study by Loubiere S et al., 2009. In conducting this study, we sought to create awareness among service providers and policymakers on the importance of HIV disclosure as a secondary prevention measure in HIV and also bring out the gender aspect in HIV management. Service providers must be diligent when helping women in the process of disclosure to minimize negative outcomes of HIV disclosure to sexual partners. The findings from this study will help healthcare workers (HCWs) to improve HIV prevention services in all treatment centers in Cameroon.

Methods

Study Setting

This study took place at the regional hospital in Ngaoundere, in the Adamaoua region of Cameroon. Ngaoundere is a metropolitan town and the chief town of the Adamaoua region, with a population of about 2 million. The Muslim Fulbe make up the majority of the population, along with Baya and the Tikar tribes. Ngaoundere is a junction town. The regional hospital Ngaoundere is the highest in the referral system for the Adamaoua region, receiving referred patients from the 10 district hospitals and 9 other private hospitals in the region. It has specialized services for the mother and child care, pediatric, surgical, and medical units, as well as a dialysis center and the HIV treatment center. In 2022, the HIV treatment center received 4,885 adult patients and 1,100 pediatric and adolescent patients. The PMTCT unit had 415 mothers, who make up part of the adult patients in the treatment center. 65% of the adult patients in this center were females. It has 28 psychosocial agents, 7 nurses, and two medical doctors caring for the patients.

Study Design

This was a cross-sectional descriptive study since information was generated and collected within a short period. Face-to-face interviews were conducted on 248 women using a questionnaire of 7 closed-ended questions. Four psychosocial case workers who spoke Foufulbe and the local Baya and Tikar languages were trained as interviewers. The training aimed to enable them to understand the sense of the questions and make better translations of the questions to the patients in the local languages. The interviews took place in confidential cubicles, with the patient and the interviewer. This is because the questions were too personal and could invoke moments of emotions and shame in the patient.

Study Population

Only women recruited to care and treatment in the past 36 months, that is, between 2020 and 2022, were included in the study. This was meant to minimize recall bias.

Sampling and Sample Size

The sampling frame was made up of women initiated to care and treatment between June 2020 and May 2023, that is, within 36 months of starting ARV treatment. This was meant to minimize recall bias. The sample size was calculated using a single population size formula for sample size as follows:

$$n \ge \frac{z^2 p q}{d^2}$$

n: the desired sample size, *z*: the standard normal deviation usually set at 1.96 (which corresponds to the 95% confidence level); *p*: the proportion in the target population to have a specific characteristic. If no estimate is available set at 50% (or 0.50); *q*:1-*p*; *d*: absolute precision or accuracy, normally set at 0.05.

This gave a sample size of 248 women. The participants were randomly selected from the cohort of patients assigned to these four caseworkers.

Data Collection and Management

Information collected from the interview was collected in a spreadsheet formulated for the purpose of cleaning, cross-checking, and coded before being transferred to the Statistical Package for Social Science (SPSS) version 29 software for data storage and descriptive analysis. Each patient was assigned an anonymous code on the questionnaire to maintain the confidentiality of the patient's information.

Ethical Considerations

A signed consent or verbal consent was obtained from the patient before administering the questionnaire. The interviewers also explained the confidentiality of the information provided and the importance of the study to the patient and society. The patients were also informed that they were free to stop the process at any time they felt uncomfortable. Permission to use the registers and patient records was obtained from the coordinator of the treatment centre. The patients were ascribed identification numbers, different from their ART codes of the treatment centres as a means to protect the patient's identity and maintain confidentiality.

Results

We considered the age, religion, educational level, type of marriage or relationship, and the entry point of the woman to HIV care as the main characteristics which could influence HIV disclosure to the partner.

The Durbin-Watson test for the independence of variables was 1.930 and at 96%. This was within the standard values of +1 and +3. The standardized residual value was used to test for outliers. The minimum predictive standard residual value was -1.360, and the maximum was 2.561, which was within the normal range for residual values of -3.29 and +3.29. The minimum and maximum residual values obtained in the study show no outliers in the data.

Bivariate Analysis of the Predictors of HIV Disclosure

Pearson's correlation tests ranges from -1 to +1, whereby a positive value indicates that as the independent variable increases, the dependent variable also increases, and vice versa when negative. Table 1 below demonstrates bivariate analysis of independent variables and the dependent variable. This shows there is a strong relationship between the dependent variable and marital status (p < 0.001), as well as the entry points of the patient to HIV care (p < 0.001).

does your	age in years	religion	level of	marital	where were
partner know	at the time of		education	status	you diagnosed
you are	the interview				for the first
taking ART					time

Table 1. Correlation of Variables with HIV Disclosure

Pearson	does your	1.000					
Correlation	partner know						
	you are taking						
	ART						
	age in years	026	1.000				
	religion	.058	.009	1.000			
	level of	.052	.083	023	1.000		
	education						
	marital status	.211	047	.021	.002	1.000	
	Where were	196	056	.037	.022	.055	1.000
	you diagnosed						
	for the first						
	time?						
Sig. (1-	does your		.342	.181	.205	<.001	<.001
tailed)	partner know						
	you are taking						
	ART						

The relationship between HIV status disclosure to partners on the one hand, and religion (p < 0.058 at 95% CL and 5% significance) and level of education (p < 0.052 at 95% CL and 5% significance) was a very low positive correlation. Christians (2) were slightly disclosing more than Muslims (1). HIV disclosure by the women increased with an increase in educational level (+0.052 at 95% CL and 5% significance), and an increase in age

(p>-0.026 at 95% CL and 5% significance). A significant relationship was demonstrated between marital status (p < 0.001 at 95% CL and 5% significance), the entry point where HIV diagnosis was established (p < 0.001 at 95% CL and 5% significance), and HIV disclosure.

Socio-demographic Data

Religion

Religion	number	Per cent
Muslim	130	52.4
Christian	118	47.6
Total	248	100.0

Table 2. Proportion of Christians and Muslim Population

The respondents were between the ages of 14 and 58, with a mean of 28.5 years. 69% of the population of Adamaoua are Muslims, so it was

no surprise that Muslim respondents were more than Christians (Table 2 above).

Marital Status or Type of Relationship

Table 3: Frequency of Ty	ype of Relationship	(Marital Status) by	y Age Group
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Age Group	monogamy	polygamy	widow	divorced/	concubine	single
				separated		
14 - 19yrs	16	15	0	0	6	0
20 - 24 yrs	27	19	8	3	5	0
25 and above	75	40	14	12	7	1
Total	118	74	22	15	18	1

47.5% of respondents were in monogamous relationships, 30% were in polygamy, 9% were widows, 6% were separated or divorced, and 7.2% were concubines.

40% of respondents were tested at PMTCT entry point during antenatal care, 18% at VCT, 32.6% during sickness and other entry points (ICT, blood bank) formed 10%.

Point of Entry of HIV Diagnosis as a Factor Affecting disclosure



Figure 1. Entry Points of HIV Diagnosis According to Age Group

Determinants of HIV Disclosure in Women

Disclosure and Level of Education

In Tables 4 below, 96 women (38.7%) could not read and write, showing the high illiteracy

rate among women in the Adamaoua region. 90 (36.3%) of them attended primary school and could read and write, 56 (22.6%) of them completed secondary school, and 6 (2.4%) either attended university or a professional school.

Level of education	Number of women	No. of women who disclosed their HIV status to their partner	No. of women who did not disclose HIV status	% disclosure
No formal education	96	42	54	44%
primary level	90	52	37	58%
secondary level	56	27	30	48%
university level	6	1	5	17%
TOTAL	248	121	124	48.8%

Table 4. Disclosure Rate According to Level of Education

Disclosure and Age of the Woman

for the youth (20 to 24 years), and 53% for the adult age group (25 years and above).

The rate of HIV disclosure increased with an increase in age; 30% for the adolescents, 47%

Age group	Number disclosed	Number not disclosed	% disclosed
14 to 19 Yrs N=37	11	26	30%
20 to 24 Yrs N=62	29	33	47%
25 Yrs and Above	79	70	53%
N=149			

Table 5. Proportion of Disclosure according to Age

HIV Disclosure and Type of Relationship (or Marital Status)

significant at P value< 0.001 at 95% CL.HIV disclosure was higher in polygamy (55%) than in monogamy (52%). It was low in concubines and widows, (fig. 2 below).

The relationship between marital status and HIV disclosure to the partner was strong and



Figure 2. Rate of Disclosure according to Type of Relationship

HIV Disclosure and Entry Point to HIV Treatment

The rate of disclosure was higher at PMTCT (60%) as compared to VCT (42%) and HIV

testing during sickness (53%). Disclosure was also high for those contacted as index cases and those who tested at the blood bank (77%) (Fig. 2 below).



Figure 3. Proportion of Disclosure According to the Type of Testing

Discussion

This study found that the disclosure rate increased with age, at 30%, 44%, and 58% in the adolescent, youth, and adult age groups, respectively. Similar results were seen in Kenya [19] where older women had lower odds of disclosure to their partners. Among the 11 adolescents who disclosed their status to their partners, 9 were tested with their husbands at ANC, one was through accidental disclosure, and the other told the husband immediately she got home from the hospital. Sharing this information was a source of relief and mutual support for the couple [6, 7, 8, 9, 11, 30]. Thus making male partner involvement essential in HIV disclosure [13, 18].

The respondents' reasons for non-disclosure included fear of being abandoned by the partner (44%) [28], fear of losing financial support from the spouse (28%), and fear of public disclosure, stigmatization, or disgrace (18%) [10, 15, 16, 17, 18, 20, 28].

HIV disclosure was higher in those who could read and write than in those who could not or who had no formal education (table 5 above), [10, 11,]. This could be because they understood the importance of disclosure as a

way of preventing HIV transmission. The rate of HIV status disclosure was as high as 58% for women who had acquired a primary level of education, 48% for the secondary, and only 44% for women who had no formal education. This was similar to the results obtained in a study with women at PMTCT in Tanzania, Uganda, and Ethiopia, where disclosure was higher in women with a secondary or higher level of education than in women with no education [37, 11, 8]. The adolescent girls (14-19 years age group) had the highest rate of illiteracy (57%) and the lowest proportion of secondary school level learners (11%). The culture in Adamaoua promotes early marriages for the girl child, as such parents prepare the girl child for marriage instead of sending her to school. In Ngaoundere, girls marry as early as 14 years. Thus, as many as 37 adolescent girls were recruited in the study. Out of these, 21 (57%) could not read or write. HIV disclosure to partners was lowest in the adolescent age group.

Disclosure was higher in adolescents and youth involved in polygamous marriages (89%) and (63%) than in monogamous relationships (fig. 1 above). This result was different from a study carried out in Uganda where polygamy was a reason for nondisclosure [12]. This could be because it was difficult to know whom to blame in a polygamous union. It could also be because many adolescents and youth were diagnosed with antenatal care (ANC) when their husbands accompanied them during the first visit. High disclosure was also seen in monogamous marriages for those who have attained the secondary level of education in the adult population (63%) [26]. Only 1 out of the 6 (17%) with a university level of education disclosed her status, even though they are all in monogamous marriages. A low disclosure rate was also seen in concubines (30%), similar to a study in Bangui and rural Malawi [11, 14, 15, 17, 25]. It should be noted that trust was the main driver in HIV disclosure among women [36, 6]. "When deciding to disclose, the idea

and feeling of 'trust' come into play in many ways. For example, individuals may only disclose if they feel that the person receiving the disclosure can be trusted to keep their HIV status information private" [36]. Most widows were tested either during the partners' illness or sometime after the death of their partners, leading to low disclosure [27%].

A significant relationship was demonstrated between the entry point where HIV diagnosis was established and HIV disclosure (p < 0.001at 95% CL and 5% significance). The entry point to HIV care and treatment could determine whether the woman can easily disclose her status to her partner or not. The main entry points for women into HIV care and treatment are PMTCT services, (antenatal or postpartum services), voluntary counselling and testing (VCT) services. general consultation services, and others (blood transfusion service, index case testing, and those born with HIV). Disclosure was higher at PMTCT (60%) compared to VCT (42%) and HIV testing during sickness (53%). Other women who did not fall into the above three categories of entry points were tested either as index cases of their husbands (10) or at the blood bank for their transfusion or to donate blood to sick relatives and had a very high disclosure rate at 77%. This could be because they already knew their partner's status [12]. These results also reiterate ANC as an important entry point for women into HIV care. These women are directly linked to PMTCT services to prevent linear transmission to the unborn baby during pregnancy, delivery, and breastfeeding. Partners usually accompany the women during the first ANC to pay for onetime charges. The health personnel use this opportunity to test the partners too. Testing them together is an opportunity for results sharing, thus improving HIV disclosure. It is different in VCT and provider-initiated testing during sickness, whereby the woman has the time to contemplate whether or not to tell the man.

Conclusion

The prevalence of HIV disclosure to partners at the Regional Hospital Ngaoundere was 48.8%. Disclosure was lower in younger respondents below 24 years (30%) than in respondents who were 25 years and above (53%). HIV disclosure to partners increased with an increase in the educational level, with those who could read and write disclosing more (58%) than those who could not (44%). HIV disclosure was also higher in polygamous relationships (55%) than in monogamous marriages (52%). The concubine was the relationship type having the lowest disclosure rate (30%). Most widows (26%) were tested either during their husbands' illness or sometime after the death of their husbands, so they did not have the opportunity to share their status with their partners. Women who were diagnosed during PMTCT services (60%) disclosed more than those tested through provider-initiated counselling during sickness (53%) and those who tested through VCT (42%). We recommend that mental health specialists be deployed to HIV treatment centers to cater to mental health disorders

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[5]. Cameroon Population-Based HIV Impact Assessment, CAMPHIA 2017, Available at https://phia.icap.columbia.edu/wp-content/uploads ranging from depression to all forms of violence suffered by women as an outcome of disclosing their HIV status. The process of HIV disclosure in adults should be developed, and capacity reinforcement in healthcare workers on the use of the disclosure process should also be implemented.

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Conflict of Interest

I declare that there is no conflict of interest.

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