Texila International Journal of Public Health
Volume 4, Issue 4, Dec 2016

Role of Counseling in the Disclosure of HIV Status to Sexual Partners among HIV Positive Women Accessing PMTCT Services in South Nigeria

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Background

HIV infection is still associated with a lot of stigmatization and discrimination, which makes it difficult for infected individuals to disclose their status. Many studies have shown different rates of disclosure of HIV status with average of 71% in the developed world and 52% in the developing world (WHO 2004)). Different reasons were attributed to non-disclosure of HIV status which included fear of abandonment, fear of rejection and discrimination, fear of violence and fear of upsetting family members.

Counseling is integral to guiding the infected persons to disclosure and a study by Alemayehu et al (2014) in Northern Ethiopia support that counseling is important to HIV disclosure. In ANC in Nigeria, opt out counseling and testing is practiced as recommended by WHO which focused on group counseling, it is however recommended that HIV positive individuals should be privileged to have one on one counseling with counselors to avail them of the opportunity to be properly counseled on the benefits of disclosure and other HIV care (FHI, 2008).

Counseling is an intervention that gives one the opportunity to confidentially discuss his or her situation in a dialogue with the aim of helping the person to explore and work out possible solutions in a reasonable manner. Disclosure is essential to achieving good HIV care especially in PMTCT for many reasons. It motivates sexual partners to go for testing, change risky behaviors and provide support to the infected partners as showing in several studies which reported high support rate for infected persons who disclosed their status to their sexual partners. Other benefits are that it increased the opportunities for improved access to appropriate medical treatment and care and to plan HIV risk reduction with sexual partners (WHO, 2004).

Scogmar et al (2006) in the study in South Africa did not show correlation between HIV counseling and disclosure and likewise Adeyemo et al (2011) in Lagos, South west Nigeria reported low disclosure to counseling even though there was improvement in the attitude change towards disclosure after counseling. This study is therefore aimed at determining the role of counseling in the disclosure of HIV status to sexual partners among HIV positive women in PMTCT programme.

Methods

Study setting

This study was conducted in in the health care facilities that offer PMTCT services across the 18 local government areas (LGAs) of Edo state, Nigeria. Edo state is in the south region of Nigeria with 18 local governments in three senatorial districts; Edo North, Edo South and Edo Central senatorial districts. The state has an estimated population of 3, 218, 332 people, made up of 1.640,461 males and 1. 577,871 females and occupies a total land mass of 19, 308.93sq km (NPC 2006). It has 5 tertiary health facilities, 32 secondary health facilities and about 200 primary health care facilities; however PMTCT services are not offered all the health institutions. Data was collected from January to March 2016 in some of the health institutions where PMTCT are offered which included 1 tertiary health institution, 17 secondary health facilities, and 18 primary health care facilities (Edo State MOH 2010).

Study population and study design

The study population was HIV positive women accessing PMTCT programme in the health care institutions. 904 women received PMTCT intervention in the state in a year period from August 2014 to July 2015 as reported in the DHIS. The sample size was calculated using the Kish Leslie formula for descriptive studies, with sample size N generated with formula $N=pqz^2/d^2$. In the review of 25 published papers from January 1990 to December 2001 in sub-Saharan Africa by WHO, the least rate of HIV disclosure to sexual partners in the developing world was 16%, which was used in this study as the prevalence so as to have the estimated minimum size for a good study (WHO, 2004). The sample size then with 10% non-response rate made the final sample size to be 227.

Cross-sectional descriptive study design was used and data was collected from the respondents with the use of structured questionnaires. The questionnaire includes demographic variables, partner characteristics, partnership, disclosure status, disclosure barriers, partner's status, partner's reaction and counseling types. The questionnaire was adapted from different literatures and local settings of the study participants were put into consideration. The questionnaires were applied in an interview session by recruited volunteers, who were well trained on the use of the tool.

Data analysis

The collated data was analyzed using SPSS version 21 software. Exploratory analysis was run to check for missing values and outliers. Descriptive analysis was run on the variables for their frequencies and test of association was assessed with crosstab to check for Chi square value and to assess the P-value for significance of associations. Several dependent variables were cross tabbed with the dependent variables. P-value less than 0.05 were considered to be statistically significant.

The study was approved by the research and ethics committee of the tertiary hospital, Irrua Specialist Teaching Hospital (ISTH) and the Edo state Hospital management board ethical committee. Formal letter of permissions were obtained from the institutions and written consent was obtained from the participants of the study. The right of the participants to withdraw from the interview or not to participate was assured throughout the questionnaire administration period.

Results

255 HIV positive women participated in the study, and most of the participants (33.7%) are within the age range 26 to 30 years, and the highest level of education for majority (40.4%) is secondary school. More (45%) are self-employed, 81.2% are Christians and 93.7% are married.

Table 1. Socio-demographic characteristics of the study participants, Edo state, Nigeria

Age of Respondents		
Age (yrs)	Frequency	Percentage (%)
16-20	6	2.4
21-25	41	16.1
26-30	86	33.7
31-35	53	20.8
36-40	59	23.1
41-45	10	3.9
Level of Education		
Primary	91	35.7

Secondary	103	40.4
Technical	12	4.7
Graduate	32	12.5
Postgraduate	17	6.7
Occupation of Respondents		
Self-employed	115	45.1
Civil servant	16	6.3
Private Establishment	18	7.1
Trader	105	41.2
No Response	1	0.4
Religion		
Christianity	207	81.2
Islam	43	16.9
Others	5	2
Marital Status		
Married	239	93.7
Single	16	6.3
Total	**255**	**100**

Table 2

Respondents' HIV status disclosure to their sexual partners		
HIV disclosure	Frequency	Percentage (%)
Yes	190	74.5
No	65	25.5
Total	255	100
Reasons for Non-disclosure		
Reasons	Frequency	Percentage (%)
Fear of stigmatization	12	4.7
Fear of infidelity accusation	3	1.1
Fear abandonment/rejection	37	14.5
Fear of physical abuse	5	2
Multiple reasons	4	1.6
Other reasons	4	1.6
Status known	190	74.5
Total	255	100
Respondents counseled on HIV disclosure		
Response	Frequency	Percentage (%)
Yes	235	92.2
No	18	7.1
No response	2	0.8
Total	255	100
Types of counseling received		
Response	Frequency	Percentage (%)
Group counseling	34	13.3
One on one	160	62.7
Both	41	16

No response	2	0.8
Not counseled	18	7.2
Total	255	100
Reactions of Partners to Non-disclosure		
Reactions of partners	Frequency	Percentage (%)
Supportive	170	89.5
Indifferent	14	7.3
Abusive	4	2.1
Violent	2	1.1
Total	190	100

Table 3

		HIV status disclosure		
		Yes	No	**Total**
Respondents counseled on HIV disclosure	Yes	176	59	**235**
	No	12	6	**18**
	No response	2	0	**2**
Total		**190**	**65**	**255**
	Value	df	P-value	
Chi- Square	1.29	2	0.526	
Likelihood Ratio	1.75	2	0.418	

		Belief in partners support if status is disclosed			
		Yes	No	No response	**Total**
Respondents counseled on HIV disclosure	Yes	200	30	5	**235**
	No	13	5	0	**18**
	No response	0	0	2	**2**
Total		**213**	**35**	**7**	**255**
	Value	df	P-value		
Chi- Square	74.77	4	0.0001		
Likelihood Ratio	18.23	4	0.001		

		HIV status disclosure		
		Yes	No	**Total**
Types of counseling	Group	24	10	**34**

	One on one	110	50	**160**
	Both	40	1	**41**
Total		**174**	**61**	**235**

	Value	df	P-value
Chi- Square	17.021	2	0.002
Likelihood Ratio	22.924	2	0.0001

		Reactions of partners to HIV disclosure						
		Supportive	Indifferent	Abusive	Violent	No response	Status not disclosed	**Total**
HIV status disclosure	Yes	168	13	4	2	3	0	**190**
	No	2	0	0	0	0	63	**65**
	Total	**170**	**13**	**4**	**2**	**3**	**63**	**255**

	Value	df	P-value
Chi- Square	128.2	2	0.0001
Likelihood Ratio	128.9	2	0.0001

Out of the 255 study participants, 190 (74.5%) have disclosed their disclosed their HIV status to their sexual partners. 235 (92%) of them agreed to have been counseled at the clinic on the benefits and the need to disclose their status to their partners, and 201 (78.7%) of the study participants had one on one sessions with the counselors. The commonest reason for not disclosing HIV status was fear of abandonment and rejection. Out of the 190 participants that disclosed the HIV status to their sexual partners, 89.5% of them enjoyed good support from their partners.

Being counseled on HIV disclosure had strong positive association with the participants' belief that their partners will support them following disclosure of status (P=0.0001). This was truly reflected in the strong positive association of reactions of the partners of participants and the disclosure of HIV status of the participants (P=0.0001).

However, the counseling of participants did not show any association with the disclosure pattern (P>0.05), even though there was a positive association between HIV status disclosure and type of counseling offered to the participants (P= 0.002).

Discussion

The study focused on determining the role of counseling in the disclosure of HIV status to sexual partners among HIV positive women in the PMTCT programme in the south Nigeria. This study assessed the pattern of counseling and its effect on HIV disclosure among these women.

The rate of HIV disclosure to sexual partners was 74.5% in this study, which was higher than the study in Northern Ethiopia with 63.8% disclosure (Alemayehu et al, 2014). However the studies in southern Ethiopia and Uganda showed higher rate of 94.5% and 97% respectively for general disclosure to any person (Deribe et al, 2008; King et al, 2008).

In the study conducted in Northern Ethiopia, there was positive association between pretest counseling for women who knew the HIV status of their partners and disclosure of HIV status. The association could have been influenced by their knowledge of HIV status of their partners, though the type of counseling was not given whether it was one on one or group counseling.

In another study in a teaching hospital in South West Nigeria, counseling contributed to less than 50% of the impact on willingness to disclose HIV status to partners, though type of counseling was not ascertained (Adeyemo et al, 2011). Adeyemo et al however reported that counseling helps more to overcome the fear of disclosure, which supports this study, in which there is strong positive association between counseling and participants' belief that their partners would support them, though it did not show association in its direct relationship in translation to disclosure of their status. Alsoin support of this study, Sethosa et al (2005) in the study in South Africa did not show any correlation between counseling and HIV disclosure in a study that has both HIV positive men and women as study participants. All these points may be due to inadequate number of participants or the composition of participants in different studies.

Considering the above, counseling might have convinced the participants to believe that they would get support from their partners but the results did not show significant translation to the practice of actual disclosure. This was strongly supported in this study as 89.5% of participants who disclosed their HIV status got good support from their partners, and there was demonstration of positive association between the reactions of the partners to the status disclosure and HIV disclosure.

Quality of counseling which in this study was measured by the type of counseling offered through one on one or group counseling could have accounted for this kind of result. Due to the sensitive nature of HIV disclosure, one on one counseling is recommended for all PLHIV, however only 201 (78.7%) received one on one counseling and 18 (7.2%) participants were not counseled on HIV disclosure. This shows poor quality of counseling in the PMTCT setting. To support the effect of one on one counseling on disclosure of HIV status to partners, the study showed a strong association between the types of counseling and HIV

status disclosure with high likelihood ratio (LR-22.9, P=0.002). Not many studies were seen reporting the association between the different types of counseling and HIV disclosure.

Conclusion and recommendation

The quality of counseling offered to HIV positive women during PMTCT through one on one counseling does not only help the women to overcome the fear of being denied support by their partners, but also go a long way in making them to take necessary steps in disclosing their status. This will generate the support needed from the partners for effective PMTCT intervention. It is therefore recommended that all women in the PMTCT programme intervention should be routinely offered one on one counseling on the benefits of HIV status disclosure till they disclose. Counselors must be ready to support them in this process.

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