

Nature and Extent of HIV Self Disclosure by Seropositive Adults in HIV Support Groups in Nairobi County, Kenya

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ABSTRACT

New treatment regimens in HIV management have led to the rapid growth in the numbers of People living with HIV (PLWHIV). Disclosure rates among this group remains low which limits their ability to access necessary support resulting in early progression to death and increased risk of infection and low uptake of protection among sexual partners. Understanding the predictors of sero-positive disclosure to sexual partners can be a step toward devising targeted strategies aimed at promoting HIV testing and disclosure thus enhancing HIV prevention and risk reduction efforts. This study was a descriptive survey involving 232 PLWHIV drawn from HIV support groups in the area selected through non-proportionate systematic random sampling. Multiple logistic regression and Chi-square tests were used to establish the predictors and relationships of self disclosure of seropositive status by PLWHIV to sexual partners. Data was collected using interviewer administered questionnaires, key informant interviews and Focus Group Discussions (FGDs). Quantitative data was analyzed generating descriptive and inferential statistics. Qualitative data was analyzed using content analysis with the use of verbatim quotes to highlight the respondents' voices. Study results showed that the general HIV disclosure rates were high (92.2%), but only 50.5% had disclosed to a sexual partner. Consistent disclosure to all sexual partners was low (29%) and this was mainly involved regular partners. Generally, PLWHIV had a positive perception of HIV self disclosure. Results point to high levels of anticipated stigma and discrimination from all support structures by PLWHIV. However, only 48% of PLWHIV recorded high levels of enacted stigma and discrimination. It was concluded that PLWHIV anticipated high levels of enacted stigma and discrimination from their social networks after disclosure. This acted as a barrier to HIV self disclosure. However, these fears did not translate into high levels of actual enacted stigma and discrimination. The study recommended that initiating income generating activities for the PLWHIV, consistent training and counseling on the management of self stigma and promotion of strategies of living positively with the disease can promote effective self disclosure of sero-positive status to sexual partners.

KeyWords: HIV self-disclosure, Support Groups, Seropositive adults

1.1 Background to the study

HIV disclosure is considered as the act of telling or communicating one's Human Immune-Deficiency Virus (HIV) status to someone else. This has gained prominence in recent years due to the renewed focus on HIV testing and disclosure as a preventive and risk reduction strategy in national HIV programs (Centre for Disease Control and Prevention (CDC), 2003). Disclosure is a reasoned process whereby the costs and benefits to oneself and others are weighed (Stutterheim, Shiripinda, Bos, Pryor, Bruin, Nellen, Kok, Prins, 2011). It is often characterized as a dilemma; on one hand, it can promote health, support, and psychological well being; on the other it can lead to stigmatization, rejection and other negative social interactions (ibid). Disclosure of a positive HIV diagnosis is an important aspect in the management of HIV/AIDS and thus its' predictors need to be researched to inform policy on HIV management.

Kenya is home to one of the world's harshest HIV and AIDS epidemics. An estimated 1.5 million people are living with HIV; around 1.2 million children have been orphaned by AIDS; and in 2009, 80,000 people died from AIDS related illnesses (UNAIDS, 2010). Moreover, HIV continues to have devastating effects on the population in general. Kenya's HIV prevalence peaked in 2000 and the latest figures show dramatic reduction from 7.4% in the 2007 KAIS study to around 5.6% in 2012 (NASCOP, 2013). The decline is thought to be partially due to an increase in education, awareness and high death rates. However, many PLWHIV in the world (5.2 Million) have access to HIV treatment thus translating into fewer AIDS-related deaths (UNAIDS,

2009) leading to a rise in the number of PLWHIV.

Although HIV positive adults receiving therapy have hope for the future, they still have fears about disclosing their sero-positive status to others and infecting someone with HIV (Birungi, Mugish, Nyombi, Evelia and Nyinkavu, 2008). In spite of the numerous efforts that have been made to increase universal access to HIV treatment; minimal efforts have been made on the promotion of sero-positive disclosure to sexual partners. If HIV self disclosure among this group is not promoted, it is likely to bring down the gains that have been made in the fight against HIV. Understanding the predictors of HIV disclosure can help promote the practice among sexual partners by PLWHIV.

Literature shows that despite knowing their HIV positive status, a large proportion of PLWHA engage in unprotected sex with HIV negative partners or partners of unknown status putting them at risk of getting infected (Sarna, A., et al. 2009; NASCOP, 2007; Simbayi, Kalichman, Strebel, Cloete, Henda & Mqeketo, 2007 and Diamond & Buskin, 2000). Interventions for PLWHA have mainly focused on their medical needs with little attention given to the role of their HIV disclosure in preventing the spread of the disease. Increasing numbers of people in Kenya find themselves in sexual relations without knowing the sero-status of their partners. In Kenya about 78% of sexual partners report a partner of unknown status (NASCOP, 2007) with 6% in discordant relationships. Studies show low rates of disclosure of a positive HIV diagnosis to sexual partners (Sarna, A., et al. 2009 and NASCOP, 2007). Only 37% of the respondents in a Kenyan study disclosed their HIV status to sexual partners (Sarna, A., et al. 2009). According to the 2007 KAIS only 35 % of the partners disclosed their HIV status to their sexual partners in the year prior to the study (NASCOP, 2007).

Lack of knowledge of sero-status of sexual partners increases the risk of HIV infection (Hart, Wolitski, Purcell, Parsons, Gomez & Team, Parsons, Schrimshaw, Bimbi, Wolitski, Gomez & Halkitis, 2005). In addition, Kenya has witnessed an upsurge of discordant couples. In the 2007 KAIS study, 57.5% of women and 56.4 % of men reported having unprotected sex with at least one partner of HIV-discordant or unknown HIV status 12 months prior to the study (NASCOP, 2007). In the study, almost half (45%) of married couples reported having a sexual partner who was not currently infected (ibid). A study carried out in Mombasa among PLWHIV showed that 62% of the respondents reported having unprotected sex with regular partners of HIV-negative or unknown HIV status (Sarna, et al. 2009).

HIV disclosure rates to sexual partner's remains low in Kenya. In a Mombasa study, only 37% of the respondents disclosed their HIV status to sexual partners (Sarna, et al., 2009). Results from the 2007 KAIS show that very few respondents were aware of their sexual partners' HIV status with over two thirds (78%) reporting a partner of unknown status (NASCOP, 2007). There are many barriers to HIV disclosure, among them being fear of rejection, discrimination, stigmatization, and loss of an intimate relationship (Oyore, 2009). Although the advent of antiretroviral treatment brought hopes that the stigma and discrimination surrounding HIV would reduce, there is no conclusive evidence to support this hope (Gruskin, Ferguson & O, Malley, 2007). There is need for further research on how various factors including HIV stigma and discrimination determine disclosure to sexual partners by PLWHIV.

This study was conducted in Huruma location of Central Division, Nairobi. It targeted people who are aware of their HIV status and were receiving some support for the same. Nairobi has the second highest HIV prevalence rates of 7% which is above the national HIV prevalence of 6.3%. It has the highest percentage (73.8%) of people who had ever tested for HIV and received the results. Thus, more people in the area are aware of their HIV status than in any other part of the country. Overall, the

Nairobi city is highly populated with 1,533,139 females and 1,605,230 males making a total of 3,138,369 people (Republic of Kenya, 2010). There is therefore need, to investigate the nature and extent of sero-positive status disclosure to propose practical strategies that can promote the practice among sexual partners.

1.2 Statement of the problem

Recent statistics show that an estimated 1.5 Million people are living with HIV in Kenya (UNGASS, 2010). Results from the 2008-09 KDHS show that 6.3% of Kenyan adults aged 15-49 are infected with HIV. Moreover, the provision of Highly Active Antiretroviral therapy (HAART) has led to an increase in the number of PLWHA. Some are young, with plans to marry, have children and engage in unprotected sex with multiple sexual partners. Safe sex is rare and contributes to increased infection rates especially among couples. To make matters worse, Kenya's AIDS epidemic is mainly hetero-sexually transmitted ().

Being HIV positive is highly stigmatized and consequently the dominant public opinion on HIV/AIDS universally is that HIV is associated with promiscuity (Kathryn, & Trang, 2002; Wiener, Battles, & Wood, 2007). As such, this view prevents self disclosure. Disclosure of an HIV-positive diagnosis has also been associated with feelings of anxiety, fear of harm/violence, stigma, discrimination and threats to personal well-being which make people afraid to disclose. It is thus difficult for PLWHIV to freely disclose their positive status and overcome the stigma and discrimination enacted or anticipated from their immediate social support

structures.

Many PLWHAs engage in sexual relations with people of unknown or negative sero-status without disclosure thus putting them at risk of HIV infection (Clarke, Gibson, Barrow, James, Abel & Barton, 2010; Sethosa and Peltzer, 2005 and Vu, Andrinopoulos, Mathews, Chopra, Kendall & Eisele, 2012). Studies display lower spousal HIV disclosure rates in Sub-Saharan Africa (Vu et al, 2012; Sethosa and Peltzer, 2005) yet literature indicates that earlier studies on HIV disclosure have mainly been conducted among homosexuals and heterosexuals in developed countries (Marks & Crepaz, 2001). Few studies have focused on HIV disclosure among heterosexuals in the developing countries. The current study analyzed the predictors of HIV self-disclosure among heterosexuals in Nairobi in order to address this gap and add to the body of knowledge on the issue. Positive prevention is about helping PLWHIV to acknowledge that they have a crucial role in controlling the HIV epidemic by: avoiding knowingly transmitting HIV to others, testing and disclosing their status to sexual partners (International HIV/AIDS Alliance, 2003). Understanding the predictors of HIV self-disclosure to sexual partners can help to suggest practical interventions and policy recommendations that can promote the practice.

1.4 Objectives

1. Examine the extent and nature of HIV self disclosure by sero-positive adults.
2. Analyze the relationship between PLWHIVs' individual factors and HIV self disclosure to sexual partners.
3. Explore the relationship between stigma and discrimination and self disclosure of sero-status by PLWHIV to sexual partners.

METHODOLOGY

2.1 Research design

The study employed a descriptive survey research design which is a present-oriented research that seeks to accurately state what is happening at that given point in time. The research design was considered appropriate because it seeks information on perceptions, attitudes and also to study social conditions, relations and behavior of PLWHA (Gall, Borg, & Gall, 1996). It seeks to obtain information that describes existing phenomena by asking individuals about their perspectives, attitudes, behavior, or values (Mugenda and Mugenda, 2003). The study examined the PLWHIVs' socio-demographic and cultural factors, sexual behavior, stigma and discrimination (enacted and anticipated), community based support structures and their influence on self disclosure of a sero-positive diagnosis to sexual partners.

2.2 Target population

The target population included all adults who had been diagnosed HIV positive, were aware of their HIV status and belonged to an HIV community based support group in Nairobi. The sample was obtained from this population through the 17 identified HIV support groups which deal with PLWHA within Central Division, Huruma location in Nairobi County.

FINDINGS OF THE STUDY

3.1.1 Respondents' gender

Individuals are treated differently depending on their sex and this may affect the decision on HIV self disclosure. Results presented in the table 3.1 indicate that in the 72.6% (n=167) of the PLWHIV in the selected support groups were females and 27.4% (n=63) were males. This finding is consistent with a study carried out in western Kenya which found that those seeking Psychological support to deal with their HIV infection were primarily female (72%) (Shacham, Reece, Ong'or, Otieno, Monahan and Ojwang, 2008). Results indicate that females were more likely to belong to the HIV support groups than males. A summary of the PLWHIVs' demographic factors is presented in Table 3.1 (Here)

3.1.2 Respondents' age

The results presented in the table 4.1 show that most of the respondents were in the 35-44 age category (39.2%), followed by 25-34 (23.0%) and then 45-54 (22.1%) age category. The other age groups recorded percentages of less than ten percent with the youngest group (15-24) represented by 5.6% and oldest age group (55-64) was represented by 9.2% of the population. Most (82.2%) of them were in the reproductive age range of 15-49 years. The mean age of respondents was 39.97 and the median was 40 years. The mean and the median were virtually similar indicating a normal distribution.

3.1.3 PLWHIVs' marital status

Results presented in Table 4.1 indicate that 28.6 % of respondents were widowed, 27.7% married, 26.4% had separated, 13% single and 4.3% divorced. The distribution of PLWHIVs' marital status exposed a high proportion (72%) of respondents who were not currently married. On probing during the FGDs, the PLWHIV

reported that some of their partners had already passed away due to the HIV disease while others especially the women had been deserted by their partners on discovering that they were infected. The majority (72.3%) of the PLWHIV in the study area were not currently living with their sexual partners. This may make them prone to engaging in casual sexual relations thus leading to the fast spread of the disease. This is supported by studies which report that HIV prevalence by marital status is highest among widowed respondents (44.4%) and the lowest among those who had never been married (2.4%) (KNBS and ICF-Macro, 2010 & Centre for Prevention and Disease Control, 2009).

3.1.4 Respondents' employment status

Table 3.1 presents a distribution of the occupation structure of the respondents. From table 4.1, it is observed that 54.7% of the respondents were self-employed, 21.1% were formally employed, 13% were in casual employment and 9.4 % were unemployed while 0.4% had retired. Over half of them (54.7%) were self employed. It is important to note that the percentage of those who were employed in the formal sector in this segment of the population (21.1%) was far less that the percentage reported in Nairobi province in general (56.6%), (KNBS and ICF-Macro, 2010).

Most of the PLWHIV in the area reported that they had been encouraged and enabled to start income generating activities by their support groups. On probing for occupation, the PLWHIV reported that they engaged in small business projects like selling of charcoal, hawking, selling of vegetables and shoe repair work. This means that a high proportion of the PLWHIV in the study area were not in formal employment. This is illustrated by the following extracts from the FGDs:

"We do table banking that is for saving and credit among the members".

(Respondent No., X₁).

"We make beads, mats for sale and we save money in our support group. If one of us is sick we contribute Kshs. 20 to get ambulance to access the hospital".

(Respondent No., X₂).

3.1.5 Person living with the respondent

The person the respondent lived with was thought to influence the decision on disclosure of a sero-positive diagnosis by PLWHIV. The way the person living with the PLWHIV treated them can act as a measure of how other people would react to their disclosure. Results presented in Table 3.1 showed that over half of the respondents (53.9%) of the respondents were living alone with their children; 27.6% with a partner, husband or wife; 8.2% alone; 5.6% with parents; 3% with siblings and 2% with uncle or aunt. The results revealed that a high proportion of respondents lived with someone.

3.1.6 Respondents' level of education

Education of individuals was believed to influence the decision on self disclosure. It showed that 69.8% of the respondents had attained primary level of education, 23.3% secondary and 6.9% tertiary, college or university. Results indicate that over two thirds had only attained primary level of education. This is consistent with the results from the 2008-09 KDHS which show that the level of education increases with the wealth index (), yet the study sample was predominantly made up of PLWHIV from low income households. Low education attainment is often associated with residence in the informal settlements in Kenya.

3.1.7 Personal beliefs of PLWHIV on HIV/AIDS

The distribution of the respondents' beliefs on HIV/AIDS disclosed a high proportion of those who believed AIDS is real. Over two thirds (62%) of the respondents' believed that HIV is a disease that is real while 38% did not. Results indicate that although most of the PLWHIV involved in the study were receiving some form of support from the groups less than half (44.4%) believed that HIV can be managed with good medication and diet while 55.6% did not believe so. This means the underlying population of PLWHIV in the study area was dominated by individuals with wrong beliefs on the effect of medication and diet on HIV.

Over two thirds (78%) of the respondents did not believe that opportunistic infections led to death of PLWHIV. This result indicates that most of the PLWHIV in the study area held the wrong belief about what killed PLWHIV. The results further indicate that 66% of the respondents believed that HIV is not normal while 34% believed so. The other beliefs included that: HIV was a curse, a bad disease and a disease that one could not understand cited by one respondent each. These results mainly indicate that majority of the PLWHIV in the study area had negative beliefs about HIV disease and this may affect their ability to disclose to sexual partner.

3.1.8 PLWHIVs' perceived benefit of knowing HIV status

Results of the benefits of knowing their HIV status are presented in Table 4.2. Results show the PLWHIV felt that the benefit of knowing sero-positive status was to: prevent re-infection (74.5%), live positively (63.2%), start medication (57.6%), initiate behavior change (19.9%), plan for the future (16.5%) and prevent mother-to-child transmission (6.9%). Results indicate that most of the PLWHIV disclosed their sero-positive status due to the personal benefits expected from the disclosure more than the concern for others.

Table 3.2 (Here)

3.1.9 PLWHIVs' knowledge of sexual partners' sero-status

Of the respondents who knew their partners' serostatus (N=106), 81.1% of them reported that their sexual partner was HIV positive while 18.9% reported that their partners were HIV negative. The distribution of respondents' sexual partners HIV status indicated that most of the PLWHIV were both HIV positive (concordant) followed by those where only one partner was HIV positive (discordant). This means the underlying population of sexually active PLWHIV in the study area was mainly composed of concordant couples. However, it is important to note that the rates of discordant couples in this population is more than three times (18.9%) the rates reported in the recent KDHS for the general population (6%), (.). This means many couples are at risk of heterosexual transmission of HIV unless they practice safer sex with the PLWHIV.

3.1.10 Source of information of sexual partners' HIV status

The respondents who knew their sexual partners' HIV status were further asked to state how they came to know this. Over two thirds (67%) of the respondents reported that they went for VCT together, 29.2% were told by their partners, 1.9% learnt from physical symptoms and 1.9% were told by someone. Results indicate that couple testing is popular among the PLWHIV in this area. One of the respondents participating in a FGD said:

"I informed him that I was positive and advised him we go to the VCT center together and he also tested positive, though I did not tell him immediately".

(Respondent No., X₃).

3.11 PLWHIVs' knowledge of sexual partners' HIV status

The PLWHIV who reported that their current sexual partners had been tested were asked if they knew their partners' serostatus. Knowledge of partners' serostatus was believed to encourage disclosure as literature indicates that HIV infected individuals are more likely to disclose to partners whom they know are HIV positive than to HIV negative or of unknown sero- status partner (Niccolai, et al., 2006). Almost all (98.2%) of the PLWHIV reported knowing their current sexual partners serostatus. It is however important to note that although HIV disclosure to current sexual partners was high most of them only disclosed to regular partners. Those in casual relations were rarely disclosed to yet the sexual encounters were not always protected. The PLWHIV were also noted to practice serial monogamy¹ where partners were exchanged frequently. Results indicate that most of the PLWHIV who were currently sexually active knew their sexual partners' serostatus.

3.12 Knowledge of PLWHIV on HIV re-infection prevention

Knowledge on ways of preventing re-infection among PLWHIV was assumed to increase uptake of safer sex practices among them. Knowledge of methods of preventing re-infection among PLWHIV showed varied proportions. The respondents cited that they would use condoms (81.3%, n=187), abstain (54.3%, n=125) and avoid sharing contaminated sharps (44.3%, n=102) to avoid re-infection. The most known method was condom use, followed by abstinence and then not sharing contaminated sharps.

DISCUSSION OF RESULTS

4.1 Individual attributes of PLWHIV and HIV status self disclosure

Majority of the respondents in the study were: female, had attained primary level of education, self employed and lived alone with their children. A large proportion of the PLWHIV in the study were not currently living with their sexual partners which put many of them at risk of engaging in casual sexual encounters. The PLWHIV reported that some of their partners had died from the illness while others especially the women had been deserted by their spouses. In the study however, not living with a sexual partner did not influence decision on disclosure to sexual partners.

This study did not demonstrate an association between disclosure of HIV positivity and the PLWHIVs' demographic factors such as sex, age, marital status, level of education, and time taken before disclosure. This result contradicts other studies which reported rates of disclosure varied between the different genders and level of education (Issiaka, et. al. 2001; Daniel, et al., 2004 and Kim, et al., 2007). The results are however in agreement with a study by Arthur, et al., 2007 who did not find any significant differences in rates of HIV disclosure by gender. The results indicated a notable difference in disclosure rates between the genders; females were more likely to disclose than males. This finding is consistent with the finding of Ngula and Miller, 2010 who reported that HIV positive men were less likely to disclose. These differences were mainly motivated by the need of women to disclose in order to access emotional and financial support which is consistent with findings of Stutterheim et al., 2011 and Miller and Rubin, 2007. This is in spite of the finding that women have more to fear than men should their diagnosis be known (Issiaka, 2001). The result point to the importance of economic empowerment efforts specifically tailored for women in HIV disclosure promotion efforts.

Although the results indicate that majority of the PLWHIV in the study were receiving support in coping with the HIV disease; many still held negative beliefs about it. The results however indicate that in spite

¹ This is the practice of having one partner for a given period of time then moving on to get another one. This is necessitated by death of spouse, abandonment, divorce or separation mainly due to the illness.

of this the respondents felt it was important to know one's sero-positive status. Knowledge of sero-status was deemed necessary to help one to: live positively, initiate behavior change, start medication, plan for the future and prevent mother-to child transmission of HIV. The study demonstrated an association between the challenge of financial constraints and self disclosure of sero-status to the sexual partners. This was consistent with Makin et al. 2007 who found that less dependence on partners was positively associated with disclosure. Ciccarone et al., 2003 and Crepaz et al., have also associated lower incomes with non-disclosure. This implies a need to initiate income generating activities and other economic support mechanisms for PLWHIV to promote disclosure.

The results point to delayed timing of HIV disclosure to sexual partners with over a third having taken over one year before disclosing to any sexual partner. Delay in seropositive increases the period of uninformed disclosure which exposes the sexual partners to risk of HIV infection. From the qualitative data, it was established that most of the PLWHIV practised serial monogamy as they kept changing partners due to being abandoned by their partners on discovering their sero- positive status or death of spouse. There is need to promote antecedent disclosure as research has shown that disclosure can most likely prevent new HIV infections when it takes place prior to sex, since it can lead to safe sex behaviors (Duru et al. 2006). Timing of HIV disclosure to sexual partners is therefore an important factor to consider in HIV disclosure promotion strategies.

4.2 The rates and Nature of disclosure

The general HIV disclosure was high (92%) but only slightly over half (50.5%) of the PLWHIV had ever disclosed their sero-status to sexual partners. This is worrying even though the proportions of those who had ever disclosed to any sexual partners were higher in this study than those reported in other studies carried out in Kenya (NASCO, 2007; Arthur et al. 2007 and Sarna et al., 2009). Consistent disclosure to sexual partners was low. Only about a third of the PLWHIV reported that they always disclosed their seropositive status to all sexual partners. Consistent disclosure to all sexual partners is important in effective prevention of new HIV infections and re-infections. Although most of the PLWHIV were both HIV positive (concordant) it is important to note that the rates of discordant couples in this population was more than three times the rates reported in the general population. Without disclosure, the sexual partners are at risk of getting infected or re-infected.

4.3 Enacted stigma and HIV disclosure

Self disclosure of a positive HIV diagnosis has been known to have negative effects on the PLWHIV. Moreover, negative reactions following sero-status disclosure to friends and other loved ones often exacerbate feelings of distress and isolation among PLWHIV (Cheryl, et al., 2008) and this may discourage disclosure. Generally, over two thirds of the PLWHIV felt that they had ever been stigmatized and discriminated. They reported that they experienced: isolation, desertion, separation from spouse, being spoken ill of and being excommunicated by their in-laws after sero-positive disclosure. The HIV positive females were more likely to experience many forms of stigma and discrimination than their male counterparts. The selected statements used to compute enacted stigma and discrimination levels among PLWHIV showed that on overall, over half of the PLWHIV recorded low levels of enacted stigma and discrimination. The results showed that PLWHIVs' perceived level of enacted stigma and discrimination did not determine their disclosure despite being mentioned as a key determinant of HIV self disclosure in many studies (Makin et al., 2007). A slight difference in the rates of disclosure was noted; the PLWHIV who reported that they had suffered low levels were more likely to disclose than those who recorded suffering high levels of stigma and discrimination.

4.4 Anticipated levels of stigma and discrimination and HIV self disclosure

The anticipated negative reactions from the community support structures promoted non-disclosure. The result is consistent with research findings which indicated that individuals were less likely to reveal their HIV positive status if they anticipated negative outcomes from the sexual partners (Simoni, 2005; Issiaka et al., 2001). The negative consequences expected from sexual partner included: anger, physical violence, divorce and separation or desertion. The anticipated outcomes of disclosure to community members included: being spoken ill of, avoidance, not being invited to social functions, desertion and being denied work. The outcomes expected from neighbours' were: avoidance, denial of physical contact, not being invited to social functions and treating their children badly. From the interactions with friends the PLWHIV anticipated: denial of financial support, not being invited to functions, termination of friendship and being spoken ill of.

The negative effects expected from family members were: denial of financial support, isolation, physical abuse, not being involved in their activities and abandonment. The anticipated consequences from the religious group were: being demonized as promiscuous, as sinners, isolation or excommunication. The PLWHIV agreed that disclosure would make the employer/clients to: avoid physical contact with them, dismiss them from work, demote them, and send them on early retirement and denial of Medicare support.

The study therefore, suggests a need for development and implementation of a training module on

stigma reduction information and interventions that are especially aimed at reducing self stigma among PLWHIV. A work place policy that clearly outlines the provisions and treatment of PLWHIV and one that promotes equal treatment of all the workers should be designed in a consultative forum and implemented in all work units. This can help reduce the fear of negative consequences of disclosure from the workplace.

Results however point to the fact that in spite of the high rates of anticipated negative outcomes from the social support structures following a seropositive disclosure; this did not translate into high levels of enacted negative outcomes for PLWHIV. This result is consistent with the findings of Issiaka et al., 2001 who reported, that while some who disclose record negative outcomes from disclosure, in actual fact most of the people in the PLWHIVs' support network are more likely to be sympathetic and supportive.

CONCLUSION

The general HIV disclosure was high (92%) but only slightly over half (50.5%) of the PLWHIV had ever disclosed their sero-status to sexual partners. Disclosure to current regular sexual partner was high (97.2%). Over two thirds (62.1%) of the PLWHIV had disclosed to a health provider or counselor followed by a friend (44%). Consistent disclosure to all sexual partners was low: only about a third of the respondents (29.9%) of the PLWHIV reported that they always disclosed their positive status to all sexual partners. Disclosure was more likely to occur among regular partners or spouses than in casual relations. Disclosure was motivated by the need to: reduce stress; access medical or financial or emotional support; get emotional release; make those they lived with to understand them; explain their behavior like taking drugs; protect their family members from worrying and others felt a perceived duty to inform.

Majority of the respondents in the study were: female, had attained primary level of education, self employed, living alone with their children and not currently living with their sexual partner. Many still held negative beliefs about the HIV disease. Knowledge of serostatus of current sexual partner (92%) and knowledge of the methods of preventing HIV re-infection was high. The PLWHIV exhibited delayed timing of HIV disclosure to sexual partners with over a third having taken over one year before disclosing. Most of the PLWHIV had been aware of their sero-positive status for 1-5 years (44.0%).

Results of chi-square test indicated that most of the demographic characteristics of PLWHIV namely: age categories ($p=0.921$), education level ($p=0.464$), time taken before disclosure ($p=0.762$) and the duration since testing HIV positive ($p=0.442$) were not significant. The chi-square test result showed that financial constraints ($p=0.003$); personal beliefs of PLWHIV on HIV [HIV is real ($p=0.005$), HIV can be managed with medication and diet ($P=0.000$) and HIV does not mean automatic death $p=0.007$] were significantly related to HIV disclosure. Results revealed a significant relationship between the employment status ($p=0.000$), financial constraints ($p=0.003$) and knowledge of current partners' serostatus ($p=0.011$) and HIV self disclosure to sexual partners by PLWHIV.

Further analysis using the Multiple Logistic Regression showed that employment status ($p=0.001$); disclosure in order to access emotional and financial support ($p=0.02$); financial constraints ($p=0.020$) and the method of finding out HIV status determined HIV self disclosure to sexual partners (0.012). The results however showed that the personal beliefs of PLWHIV on the HIV disease did not determine HIV self disclosure to sexual partners. These views included HIV: [can be managed ($P=0.094$); is real ($P=0.578$) and it does not mean automatic death ($P=0.982$)]. Knowledge of current sexual partners' serostatus did not determine HIV self disclosure to sexual partners ($P=0.031$). Overall, over two thirds (63.5%) of the respondents had a positive perception but it was not significantly related to HIV self disclosure and its practice with sexual partners ($p=0.788$).

Most of the cultural factors were found to relate to seropositive disclosure to sexual partners. Results indicated a significant relationship between the gender roles expected of women like taking care of household chores ($p=0.000$); being submissive to husbands ($p=0.011$); bearing children ($p=0.012$) and taking care of children ($p=0.000$) and HIV self disclosure to sexual partners. The roles expected of women in sexual relations ($p=0.000$) and the expected reactions of women leaving the man after disclosure ($p=0.020$) were significantly associated with HIV self disclosure to sexual partners. The expectation that male sexual partners would react to disclosure by: taking the matter to the council of elders ($p=0.039$), leaving children behind ($p=0.031$), resorting to domestic violence ($p=0.007$) and deserting the woman ($p=0.012$) were found to be related with HIV self disclosure to sexual partners.

The study established that the taboos related to mens' sexual relations namely: incest ($p=0.002$); homosexuality ($p=0.000$), masturbation ($p=0.001$) and rape ($p=0.000$) were related to HIV self disclosure to sexual partners. There was no significant relationship between infidelity ($p=0.546$) and defilement by women ($p=0.308$) and self disclosure to sexual partners. Results of Chi-Square test of significance show that there is a significant relationship between incest ($p=0.001$); lesbianism ($p=0.000$); rape by women ($p=0.000$) and HIV self disclosure to sexual partners. The cultural rite that was found to be associated with disclosure was that of wife inheritance ($p=0.002$). Chi-Square results show a significant relationship between the community's view that

HIV was a punishment for past mistakes ($p=0.019$) and self-disclosure of serostatus to sexual partners.

The Multiple Logistic Regression analysis results showed that the cultural roles of women in sexual relations ($p=0.087$) and communities view of HIV as a punishment for past mistakes (0.065) did not determine HIV disclosure. Fear of exclusion from wife inheritance and fear of domestic violence from the male partner determined HIV self disclosure to sexual partners [$(p=0.002)$ and $(p=0.005)$] respectively. This study relied upon self-reports of PLWHIV from registered HIV support groups in an urban slum. Further research among PLWHIV who are not members of registered support groups based in a rural setting using a triangulated approach would allow from varied perspectives on HIV disclosure in those contexts.

LIST OF TABLES

Table 3.1 Demographic data of PLWHIV

Characteristic Variable	Frequency	Percent (%)
Sex (N=230)		
Female	167	72.6
Male	63	27.4
Age group (N=231)		
15-24	13	5.6
25-34	53	23.0
35-44	93	39.2
45-54	51	22.1
55-64	21	9.2
Employment status (N=220)		
Self employed	29	54.7%
Formally employed	122	21.1%
Casual employment	47	13.0%
Unemployed	21	9.4%
Retired	1	0.4%
Marital status (N=212)		
Single	30	13.0
Married	64	27.7
Separated	61	26.4
Divorced	10	4.3
Widowed/er	66	28.6
Who respondent lived with (N=232)		
Parents	13	5.6
Brother/sister/cousin	7	3.0
Uncle/aunt	4	1.7
Partner/spouse	64	27.6
Alone without children	19	8.2
Alone with children	125	53.9

Table 3.2 Benefits of knowing ones' seropositive status

Benefit of knowing serostatus	Frequency	Percentage (%)
Prevent re-infection	172	74.5
PMTCT	16	6.9
Plan for the future	38	16.5
Live positively	146	63.2
Start medication	133	57.6
Initiate behavior change	46	19.9

**Multiple responses allowed

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