Global Journal of Medical Research
Volume 12 Issue 9 Version 1.0 Year 2012
Type: Double Blind Peer Reviewed International Research Journal
Publisher: Global Journals Inc. (USA)
Online ISSN: 2249-4618 Print ISSN:0975-5888

Attitudes of Patients at Disclosure of Their HIV Sero-Positive Status During Post-Test Counselling in a Tiartiary Institution in Northeastern Nigeria

By Dr. Ballah Akawu Denue, Dr. Stella Jacks, Dr. Suleiman Bello, Mrs. Cecilia Akawu, Mal Anas Yusuf Hussaini, & Dr. Oladimeji Adebayo

University of Maiduguri Teaching Hospital, Maiduguri

Abstract - Aim : To document the attitudes of patients at disclosure of their HIV sero-positive status during post-test counselling in a Tertiary institution in North eastern Nigeria. Methods : This cross-sectional descriptive study was carried out among clients that presented for VCT at the HIV clinic at the University of Teaching Hospital. Questionnaire administration took place at the clinic; those that consented to participate in the study were subjected to elaborate pre-test counselling. Blood sample was obtained from each participant. The result of each participant was revealed to them confidentially at post-test counselling in the presence of a trained counsellor and social worker. The attitudes, behaviours and concerns of the patients at post test counselling were observed and documented.

GJMR-J Classification : NLMC Code: QW 168.5.H6, WC 503.7, WD 308

ATTITUDES OF PATIENTS AT DISCLOSURE OF THEIR HIV SERO-POSITIVE STATUS DURING POST-TEST COUNSELLING IN A TIARTIARY INSTITUTION IN NORTHEASTERN NIGERIA

Attitudes of Patients at Disclosure of Their HIV Sero-Positive Status During Post-Test Counselling in a Tiartiary Institution in Northeastern Nigeria

Dr. Ballah Akawu Denue [α], Dr. Stella Jacks [ρ], Dr. Suleiman Bello [ω], Mrs. Cecilia Akawu[¥], Mal Anas Yusuf Hussaini [§] & Dr. Oladimeji Adebayo [χ]

Abstract – Aim : To document the attitudes of patients at disclosure of their HIV sero-positive status during post-test counselling in a Tertiary institution in North eastern Nigeria.

Methods : This cross-sectional descriptive study was carried out among clients that presented for VCT at the HIV clinic at the University of Teaching Hospital. Questionnaire administration took place at the clinic; those that consented to participate in the study were subjected to elaborate pre-test counselling. Blood sample was obtained from each participant. The result of each participant was revealed to them confidentially at post-test counselling in the presence of a trained counsellor and social worker. The attitudes, behaviours and concerns of the patients at post test counselling were observed and documented.

Results : A total of 130 participants were consecutively recruited into this study, with male to female ratio of 1:1.9. The mean age of the participants was 35.72±9.43, the mean age of males was significantly higher than females (40-40±10.58 vs 33.34±7.80; $p<0.05$). Majority of the participants (**69.2%**) were married and **43.9%** had no formal education. It was observed that **51.5%** of the cohort were non-challant at disclosure of their HIV sero-positive status during post- test counselling, **34.6%** were worried, **10.0%** were sad and **3.9%** denied the outcome of their results. Significantly more males (**47.7%**) were non-challant than females (**27.9%**), more females were sad at disclosure of their HIV sero-positive status but fails to reach a significant level (0.095).

Conclusion : This study highlights the need to anticipate actual outcomes of disclosure and concerns of newly diagnosed HIV patients. It is evident from this report that disclosure of HIV status is associated with varying reactions and psychological attitude that need to be addressed for successful patient management and HIV/AIDS preventive interventions.

I. INTRODUCTION

The burden of HIV/AIDS on the health sector and the health professionals that work in it is enormous[1]. Researches conducted in developed and developing countries has shown that Voluntary counselling and testing (VCT) can reduce high risk sexual practices and can decrease rates of sexually transmitted infections[1-4]. In addition, VCT is necessary for directing HIV infected people to antiretroviral therapy, with is becoming increasingly available in Nigeria[5,6]. Voluntary counselling and testing for HIV entails confidential counselling with patients/clients that help them make informed decisions related to HIV testing and risk reduction, it consist of two sessions; one prior to taking the test known as pre-test counselling and one following the HIV test results are given known as post test and follow up counselling. The need to expand HIV voluntary counselling and testing as an integral part of preventive strategies has been advocated[7,8]. Expansion of HIV screening services is a cost effective way of increasing life expectancy and decrease disease transmission especially in sub Saharan Africa [4,9]. Expert attributes delay in seeking medical attention and continued risky behaviour partly due to lack of knowledge of HIV status. Awareness and acceptance of HIV sero-positive status by patients is an important step in both its management and prevention. Effective care and preventive strategy could help overcome the devastating outcome of this disease. Through appropriate response and support to those affected by HIV/AIDS, everyone gains; the family remain intact with steady income or at least no economic loss, the state gains as production by its productive youths targeted by HIV scourge is not disrupted in key sectors[1,3,7-10]. Against this background, this cross sectional study was undertaken to document the attitude of newly diagnosed HIV sero-positive patients at disclosure of their status. Understanding of the attitude of patients will help the caregiver to appropriately respond to the challenges that may hinder effective management during follow up counselling.

II. MATERIALS AND METHODS

This cross-sectional descriptive study was carried out among clients that presented for VCT at the HIV clinic at the university of Maiduguri Teaching Hospital after obtaining an ethical clearance from the

---

Author α : Department of Medicine, University of Maiduguri Teaching Hospital, PMB 1414, Maiduguri, Borno State.

Author σ : Department of Education, University of Maiduguri, PMB 1069, Maiduguri, Borno State.

Author ¥ : Department of Geography, University of Maiduguri, PMB 1069, Maiduguri, Borno State.

Institutions research and ethics committee. Eligibility criteria were; 18 years and above and willingness to participate in the study. Subjects were recruited into the study after given oral/written consent at presentation at the HIV clinic.

Questionnaire administration took place at the clinic, it was administered in English and local languages(Hausa, Kanuri, Bura and Marghi) and translated into English language by trained interviewers/counsellors. The questionnaire covered a range of social issues including marital status, educational background, sexuality and sexual relationships, educational background, social network, past history suggestive of sexually transmitted infections or HIV /AIDS, intravenous drug use and blood transfusion. After the administration of the questionnaire, those that indicated interest to participate in the study were subjected to elaborate pre-test counselling.

Blood samples from the participants that fulfilled the inclusion criteria were collected by venipuncture after scrubbing the area with sterile cotton soaked in methylated spirit from the antecubital vein into ten millilitres of ethylene di tetra acetic acid (EDTA) tubes bottles. Participants were asked to present after 48 hours for the outcome of their result. The result of each participant was revealed to them confidentially at post-test counselling in the presence of a trained counsellor and social worker. Married couples were encouraged to disclose their status to their spouses. The attitudes, behaviours and concerns of the patients at post test counselling were observed and documented. Patients that had concerns were recommended follow up counselling.

Data analysis was carried out using Statistical package for social sciences (SPSS) for window, Chi square test was used to test level of significance. Statistical significance was considered present when the p-value was <0.05.

III. RESULTS

Distribution of the participants by age group and marital status

A total of 130 participants were consecutively recruited into this study, with 86 (66.2%) females and 44 males (33.8%) and male to female ratio of 1:1.9. The mean age of the participants was 35.72±9.43, the mean age of males was significantly higher than females (40-40±10.58 vs 33.34±7.80; p<0.05). However the distribution of the participants within the defined age group based on gender was similar (p>0.05). Majority of the participants (69.2%) were married followed by widows/widowers (20.0%), with female preponderances in comparison to their male counterpart (p<0.05) as shown in Table 1.

Stratification of participants by risky behaviour, reason for VCT and source of support

Of the 130 participants evaluated, 40(30.8%) engaged in extra marital marital or in multiple heterosexual relationship, this trend was similar in both gender. A total of 25 (19.2%) had past History suggestive of sexually transmitted infections(STIs), with similar propenderance in both males and females (p>0.05). Majority of the participants presented at the clinic with symptoms suggestive of HIV infection, VCT was suggested to them as an essential part of their management, 19 (14.6%) presented at the clinic as a result of a sick spause/ died of HIV/AIDS complications, with significantly higher females than males (p<0.05). Significantly more females received support and encouragement from their families and friends when asked at presentation. Males supported themselves more than females, though this fail to reach a significant level (p=0.078), at disclosure all participants agreed to access the available Government HIV Program services as depicted in Table 2.

Categorization of the participants based on educational status

As shown in figure 1, one out of two study participants had no formal education; this was followed by secondary education that had prevalence of 21.5%, then tertiary and primary education with 21.5% and 14.6% respectively.

Classification based on their attitude at disclosure of their sero-positive HIV status

It was observed that 51.5% of the cohort was non-challant at disclosure of their HIV sero-positive status during pos test counselling, 34.6% were worried, 10.0% were sad and 3.9% denied the outcome of their results as shown in figure 2. Significantly more males (47.7%) were non-challant than females (27.9%), while more females were sad at disclosure of their HIV sero-positive status but fails to reach a significant level (0.095) as shown in Table 3.

Table 1 : Distribution of the participants by age group and marital status.

Age (mean±SD,95%CI)		males	females	p-value
35.72±9.43(34.0-37.36)		40.40±10.58(37.19-43.63)	33.34±7.80(31.65-35.0)	0.000
Age Group,	no (%)			
18-25	13	01(2.30)	12(14.0)	0.073
26-35	65	18(40.9)	47(54.7)	0.193
36-45	33	14(31.8)	19(22.1)	0.322
46-55	14	08(18.2)	06(8.80)	0.202
56-65	05	04(9.10)	01(1.1)	0.070
66-75	01	01	00	0
Marital status,	no (%)			
Married	90	40(86.4)	48(55.8)	0.001
Single	12	02(4.60)	10(11.6)	0.325
Widowed	26	03(6.80)	23(26.7)	0.014
Divorced	06	01(2.30)	05(5.80)	0.647

Table 2 : Stratification by risky behaviour, reason for VCT and source of support

	Overall	Males (44)	Females (86)	p-value
Risky HIV behaviour				
Multiple sex partners	40	13 (29.6)	27 (31.4)	0.992
Hx of STDS	25	10 (22.7)	15 29.0)	0.569
IV drug use	0	00	00	-
Blood transfusion	0	00	00	-
Reason for VCT				
Symptomatic of HIV	99	30(90.9)	69(80.2)	0.188
Spouse sick/died of HIV	19	02(4.60)	17(19.8)	0.040
Child died of HIV	03	00	07	
Premarital counselling HCT	09	02(4.60)	03(3.60)	0.999
Source of support				
Self	52	31(59.6)	21(40.4)	0.078
Family/friends	66	20(30.3)	46(69.7)	0.000
Willingness to access support from Government HIV program	130	44(33.9)	86(66.1)	0.000
none	0	0	0	-

Table 3 : Attitude of participants at disclosure of their HIV status.

	Males (44)	Females (86)	p-value
Non challant, no(%)	21(47.7)	24(27.9)	0.040
Worried, no(%)	17(38.6)	48(55.8)	0.095
Sad, no(%)	02(04.6)	12(14.0)	0.182
Denial, no(%)	04(09.1)	02(02.3)	0.193

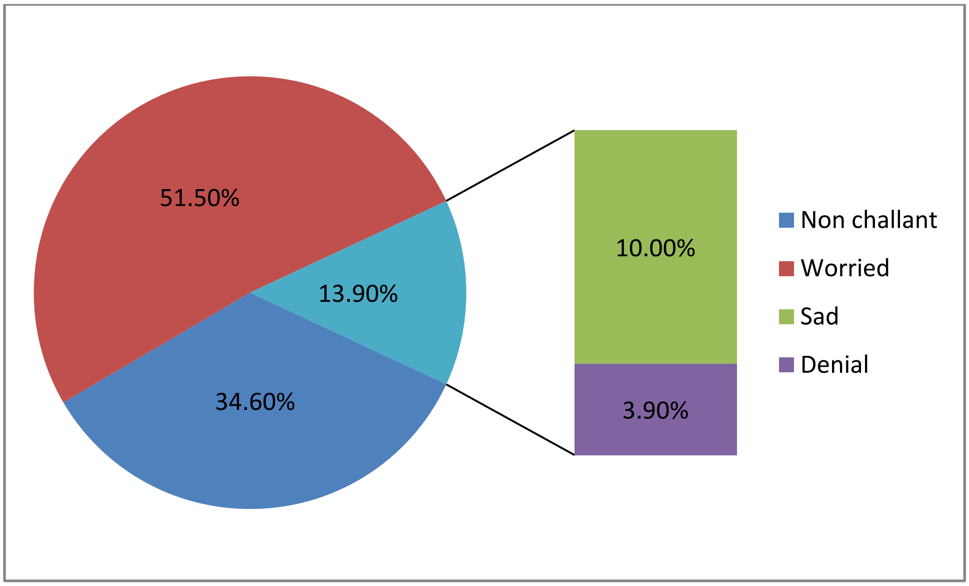

Figure 1 : Attitude of participants at disclosure of their HIV status.

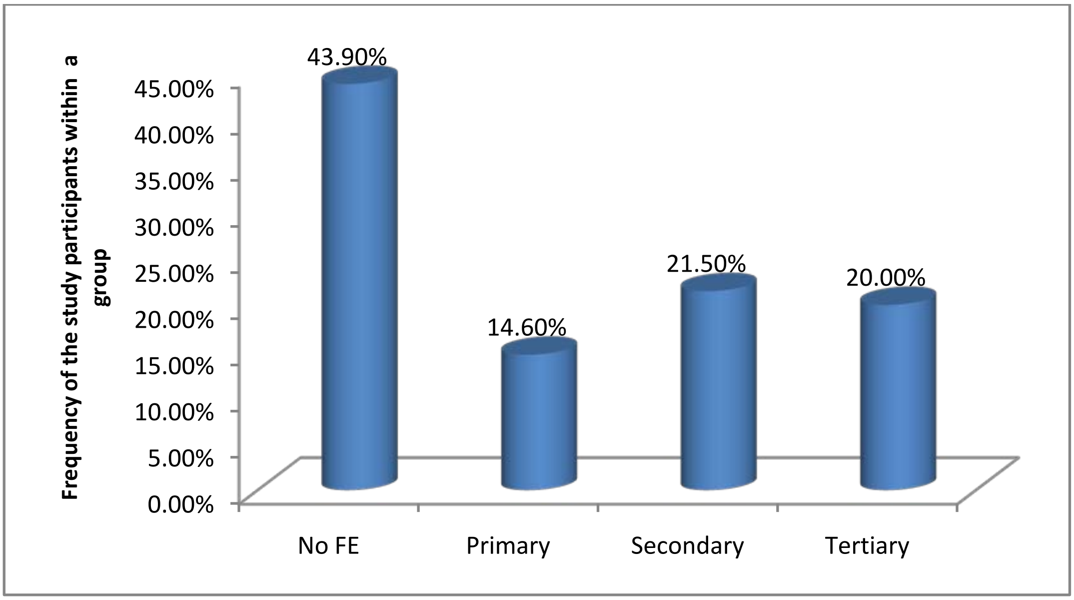

Figure 2 : Classification of participants based on their educational attainment.

IV. DISCUSSION

The prevention and control of human immunodeficiency virus (HIV) infection depends on the success of strategies to prevent new infections and to treat currently infected individuals. Voluntary HIV testing and counselling is an essential step in achieving this goals. It provide the needed information and support to individuals at risk for contracting HIV, enabling uninfected individuals to remain uninfected and those infected to plan for future and prevent HIV transmission to others [11,12]. Knowledge of HIV status may be critical to decision making around both health and sexual risk behaviours, as it will enable HIV-infected individuals to access timely and appropriate treatment, care and support programmes.

However, despite awareness campaign on the need for Voluntary HIV testing and counselling by National agency for the control of AIDS (NACA) and related implementing partners in Nigeria, majority of our cohort 99 (76.2%) were either referred or presented with features suggestive of HIV/AIDS, and VCT was suggested based on their clinical presentation, this trend was similar in both males and females.

Forty (30.8%) and 25 (19.2%) of the study participants had multiple sexual partners outside marriage and past history of sexual transmitted infections (STIs) respectively, with similar frequency in both gender, this observation is a public health concern. Although 50% of our participants had no formal education, almost all of them were aware of HIV infection and its routes of transmission, however their knowledge of HIV/AIDS may have been driven by the suspicion that they may be HIV positive from their illness. Voluntary HIV services place emphasis on HIV status disclosure among HIV-infected clients, particularly to their sexual partners. Many international organizations including UNAIDS, WHO and CDC emphasize the importance of HIV status disclosure [13,14]. Self-disclosure of sensitive information is generally thought to have beneficial effects on an individual's health, lower stress, and lead to better psychological health [15]. Disclosure offers a number of benefits to the infected individuals, partners and the general public [13-15].

Along with these benefits, however, there are a number of potential risks, disclosure is a sensitive issue, often causing psychological distress due to the uncertainty of how people will react [16]. They may experience stigma and rejection related to their HIV status and be less open about their status [17]. Conversely lack of disclosure of HIV status has been associated with personal distress and loneliness [18]

Existing research regarding HIV disclosure has primarily focused on documenting rates of disclosure,[21] predictors of disclosure,[22] issues regarding disclosure to children,[23–25] and individuals to whom PLWHA disclose their serostatus.[24,26] Research on the relationship between disclosure and psychological attitude has produced mixed findings and has been conducted largely in HIV-positive populations from developed countries. Some studies have found an association between disclosure and lower levels of depression,[22,27,28] while other studies have reported higher levels of depression being associated with disclosure of HIV serostatus, [29] and others have reported no association between depression and disclosure.[26,30]

However, disclosure does not always mean, individuals will use the information to protect themselves or others; in fact, some will knowingly place themselves at risk of infection [31]. Other studies have found no association between disclosure and safer sex [32,33].

In this report it was observed that 51.5% of the cohort were non-challant at disclosure of their HIV sero-positive status during pos test counselling, 34.6% were worried, 10.0% were sad and 3.9% denied the outcome of their test results. Significantly more males (47.7%) were non-challant than females (27.9%), while more females were sad at disclosure of their HIV sero-positive status but fails to reach a significant level. Our study is in agreement with a study conducted in South Africa that revealed males were more casual and complacent about the outcome of their HIV results, disclosed their result more often to partner than females [34]. Indeed, expecting rejection due to stigma especially in females is associated with denial, deception, and social withdrawal, which leads to more constricted social networks and low self-esteem [19] The fear of being found out by the community, of disgracing one's self and family, and of mistreatment by health care workers are related indirectly to health seeking intentions and behaviours. Furthermore, social avoidance or rejection can then, of course, hinder peoples' psychological and physical wellbeing [20].

Although, there were few individuals who regretted their decision to consent for Voluntary HIV testing and counselling at disclosure of their HIV status by becoming sad, we were limited by time to determine rates of depression among the study population as most of them returned for their result within 72 hours. Negative consequences or psychological adjustment to learning one is HIV-positive likely takes time.

These findings affirm that disclosure is a complex process with widely varying consequences. Although it may result in greater social support, negative consequences such as feelings of regret and undermining reactions from close friends, intimate partners, and parents have been associated with depression and anxiety

This study highlights the need to anticipate actual outcomes of disclosure and concerns. It is evident from this report that disclosure of HIV status is associated with varying reactions and psychological attitude that need to be addressed for successful patient management and HIV/AIDS prevention interventions.

V. LIMITATIONS

However, results from this study must be viewed within the context of the following limitations. Firstly, the cross sectional nature of this study limits our ability to interpret causal direction in the findings. secondly, the impact of disclosure may not be apparent immediately following the disclosure. It is possible that the Negative consequences or psychological adjustment to learning one is HIV-positive likely takes time. Furthermore positive gains of disclosure may diminish over time and other factors such as stressful life events, medication adverse effects, and symptomatic disease may mitigate the initial effect of disclosure. These factors were not controlled for in this study.

REFERENCES RÉFÉRENCES REFERENCIAS

1. Tawfik, L., Kinoti, S.N., The impact of HIV/AIDS on health systems and health workforce in Subsaharan Africa. The SAHA Project. USAID Bereau for Africa. Office of sustainable development Washington USA. 2003 report.
2. Conelly, D., Variava, Y., Roberts, S., Tsotetsi, T., De silva, MB., Rosen, S., De silva, E., Prevalence of HIV infection and median CD4 count among health care workers in South Africa. SAMJ 2007;97:115-120.
3. Uebel, K., Friedland, G., Pawkinshi, R., Holst, H., HAART for Hospital health care workers- an innovative programme SAMJ 2004; 94:423-427.
4. Sweat M, Gregorich S, Sangiwa G, Furlong C, Balmer D, Kamenga C, Grinstead O, Coastes T. Cost effectiveness of voluntary HIV-1 counselling and testing in reducing sexually transmitted infections in Kenya and Tanzania. Lancet 2000;365(9224):113-121.
5. Ikechebelu, J.I., Udigwe, G.O., Joe-Ikechebelu, N.N., The knowledge attitude and practice of Voluntary counselling and testing for HIV/AIDS among undergraduates in polytechnic in South eastern Nigeria. Nigerian Journal of Medicine 2006; 15:245-249.
6. Iliyasu, Z., Abubakar, I.S., Kabir, M., Aliyu, M.H. Knowledge of HIV/AIDS and attitude towards voluntary counselling and testing among adults. Journal of the National Medical Association. 2006; 98: 1917-1922.
7. HIV Prevention in Maternal Health services programme Guide. UNFPA and Engender Health 2004, pg45.
8. Pool R, Nyanzi S, Whitwort JA. Attitude to voluntary counselling and testing for HIV among pregnant women in rural south west Uganda. AIDS Care 2001; 13(5):605-615.
9. Maman S, Mwanbo J, Hogan NM, Kilonzo GP, Sweat M. Women's barrier to HIV-testing and disclosure: Challenges for HIV-1 Voluntary counselling and testing. AIDS Care 2001; 13(5)595-603.
10. Sule-odua AO, Akindele RA, Ogunledun A, Yinusa AI, Sunmola JM. Prevalence of human immunodeficiency virus amongst patients and

blood donours at University Hospital in Nigeria. J. Med Medical Sci. 1999;1(2):117-119.

11. Allen S, Serufilia A, Gruber V, Kegele S, Van De Pere P, Carael M et al. Pregnancy and contraception use among urban Rwandan women after HIV testing and counselling. American Journal of Public Health. 1993; 83:705-10.
12. Basset MT. Ensuring public health impact of programs to reduce HIV transmission from mothers to infants; the place of voluntary counselling and testing. American Journal of Public Health. 2002;92:347-51.
13. UNAIDS/WHO: Opening up the HIV/AIDS Epidemic: Guidance on encouraging beneficial disclosure, ethical partner counseling& appropriate use of HIV case reporting. UNAIDS/00.42E, Geneva; 2000.
14. CDC: Revised guidelines for HIV counseling, testing and referral. MMWR Morbidity and Mortality Weekly Report 2002, 50:1-57.
15. Collins NL, Miller LC: Self-Disclosure and Liking: A Meta-Analytic Review. Psychological Bulletin 1994, 116:457-475.
16. Clark HJ, Lindner G, Armistead L, Austin B-J. Stigma, disclosure and psychological functioning amount HIV-infected and non-infectedAfrican-American women. Women Health. 2003;38:57–71.
17. Landau G, York A. Keeping and disclosing a secret among people with HIV in Israel. Health Soc Work. 2004;29:116–126.
18. Wiener LS, Battles HB, Heilman N. Public disclosure of child's HIV infection: impact on children and families. *AIDS Patient Care STDS*. 2000;12:485–497.
19. Markowitz FE. The effects of stigma on the psychological well-being and life satisfaction of persons with mental illness. *J Health Soc Behav*.1998;39:335–348.
20. Smith RA, Morrison D. The impact of stigma, experience and group referent on HIV risk assessments and HIV testing intentions in Namibia. *SocSci Med*. 2006;63:2649–2660.
21. Kalichman SC, Nachimson D. Self-efficacy and disclosure of HIV-Positive serostatus to sex partners. *Health Psychol*. 1999;18:281–287.
22. Hays RB, McKusick L, Pollack L, Hilliard R, Hoff C, Coates TJ. Disclosing HIV seropositivity to significant others. *AIDS*. 1993;7: 425–431.
23. Kirshenbaum SB, Nevid JS. The specificity of maternal disclosure of HIV/AIDS in relations to children's adjustment. *AIDS Educ Prev*. 2002;14:1–16.
24. Letteney S, LaPorte HH. Deconstructing stigma: perceptions of HIV seropositive mothers and their disclosure to children. *Soc Work ealth Care*. 2004;38:105 –123.
25. Mellins CA, Kang E, Leu C, Havens JF, Chesney MA. Longitudinal study of mental health and psychosocial predictors of medical treatment adherence in mothers living with HIV disease. *AIDS Patient Care STDS*. 2003;17:407–416.
26. Simoni JM, Davis ML, Drossman JA, Weinberg BA. Mothers with HIV/ AIDS and their children: disclosure and guardianship issues. *WomenHealth*. 2000;31:39–54.
27. Armistead L, Morse E, Forehand R, Morse P, Clark L. African-American women and self-disclosure of HIV infection: rates, predictors, and relationship to depressive symptomatology. *AIDS Behav*. 1999;3: 195–204.
28. Perry SW, Card CAL, Moffatt M Jr, Ashman T, Fishman B, Jacobsberg LB. Self-disclosure of HIV infection to sexual partners after repeated counseling. *AIDS Educ Prev*. 1994;6:403–411.
29. Comer LK, Henker B, Kemeny M, Wyatt G. Illness disclosure and mental health among women with HIV/AIDS. *J CommunApplSocPsychol*. 2000;10:449–464.
30. Derlega VJ, Winstead BA, Greene K, Serovich J, Elwood WN. Perceived HIV-related stigma and HIV disclosure to relationship partners after finding out about the seropositive diagnosis. *J HealthPsychol*. 2002;7:415–432.
31. Serovich JM, Mosack KE: Reasons for HIV disclosure or nondisclosure to casual sexual partners. *AIDS EducPrev*2003, 15:70-80.
32. Kalichman SC, Rompa D, Luke W, Austin J: HIV transmission risk behaviors among HIV-positive persons in serodiscordant relationships. *Int J STD AIDS* 2002, 13:677-682.
33. Crepaz N, Marks G: Serostatus disclosure, sexual communication and safer sex in HIV-positive men. *AIDS Care* 2003, 15:379-387.
34. Skogmar S, Shakely D, lans M, danell J, Andersson R, Tshandu N, Ode'n A, Roberts S, Francois Venter WD: Effect of antiretroviraltreatment and counseling on disclosure of HIV-serostatus inJohannesburg, South Africa. AIDS Care 2006, 18:725-730.

GLOBAL JOURNALS INC. (US) GUIDELINES HANDBOOK 2012

www.GlobalJournals.org