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Rates, Factors, Timing and Outcomes of HIV Status Disclosure Among Patients Attending the Special Treatment Clinic of the National Hospital Abuja Nigeria

Olutayo Folashade Martins[1, *], Hipoletus Cyprian Ngong[2], Iliya Sarki Dongs[2], Kingsley Cyprian Ngong[3]

[1]Department of Public Health, Federal Medical Centre Yola, Nigeria

[2]Department of Public Health, College of Medicine, International University Bamenda, Republic of Cameroon, Central Africa

[3]Department of Clinical Pharmacy and Pharmacy Administration, University of Maiduguri, Maiduguri, Nigeria

Email address:

tymartins@yahoo.com (O. F. Martins), trulyyoursco@yahoo.co.uk (H. C. Ngong), iliya_dongs@yahoo.com (I. S. Dongs), i4kingsley@yahoo.com (K. C. Ngong)

[*]Corresponding author

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Abstract: Disclosure of private information is likely to be emotional and complex, and even more so in the context of disclosing one's HIV status, which involves sensitive, potentially life-changing information and the possibility of invoking stigmatization and discrimination. The objective of the study was to determine the prevalence, factors, timing and outcomes of HIV status disclosure among HIV positive patients receiving care at the Special Treatment Clinic of the National Hospital Abuja, Nigeria. The study was a descriptive cross sectional involving 240 conveniently sampled HIV positive patients enrolled in care. A self-administered structured questionnaire was used for data collection. Data was analyzed with the SPSS version 16. Tools used for analysis included descriptive statistics and Chi square test. Results showed that majority of respondents 228 (95.0%) had disclosed their HIV status, of which most 121 (50.4%) had disclosed to their sexual partners. A significant association was seen between level of education and status disclosure; $x^2 = 0.001$. A significant association ($x^2 = 0.001$) was seen between timing of status disclosure and age and also between level of education and timing of status disclosure ($x^2 = 0.001$). Overall majority 122 (53.3%) of respondents received positive reaction from the first person to whom they first disclosed their HIV status. Minority 2 (0.9%) experienced violence and majority 136 (56.7%) had no intention of further disclosure of their status. With most respondents experiencing positive responses to their HIV status disclosure; indicating clear benefits, minority experiencing negative reactions and a significant proportion having no intention of further disclosure, more studies are needed for wider recommendation on how to manage disclosure issues.

Keywords: HIV Status Disclosure, Rates, Timing, Factors, Outcomes, Nigeria

1. Introduction

Despite concerted global efforts, the epicenter of the HIV/AIDS scourge is still deeply rooted in Sub Saharan Africa. Laments have been made that a mammoth 65% of cases is recorded in the region which is home to only 10% of the world population [1]. The prevalence in Nigeria was quoted at 4.1% in 2010, representing a drop from 4.6% in 2008 [2]. This raises the question of whether the values may only signify a reduction in accessing notifying services and low disclosure rates. In its global HIV/AIDS response progress report, the WHO; Joint United Nations Program on HIV/ AIDS asserts that the global trend is slowly being reversed [3]. Though 1.8 million mortality rates quoted represents a value lower than previous estimates [3], is still unacceptably high. To put these mortality figures in a better perspective to a world whose politics and foreign policies are greatly influenced by the activities of terrorists and economic

implications, for HIV, the World Trade Centre goes down at least once daily.

As the epidemic enters its third decade with no absolute cure in sight, a lot of focus is being drawn to the bulk load of stable patients generated (fortunately not mainly by new infections) by effective Highly Active Anti-Retroviral Treatment (HAART). This is because the accumulating pool of sero-positives, engendered by the conversion of a previously uniformly fatal disease into a chronic one has to be safeguarded to give meaning to the medical community's quest for improving both morbidity and mortality. It means that rehabilitation of this hitherto moribund segment of the society in this new chapter of the AIDS saga becomes imperative. This informs the wisdom of encouraging disclosure, one of the cornerstones of social management since the apparent proportion of the affected will increase drastically to effectively accommodate the infected. To underpin this important coming of age, the prefix beneficial has been added to signify that if disclosure is properly considered and managed, it will help in the long term management of the clients/patients, increase safer sex practices and reduce both horizontal and vertical transmission of the virus.

Therefore, some governments have considered whether the principles of confidentiality and informed consent contribute to the spread of HIV. There is a concern that these principles allow a person who is HIV positive to keep his or her status confidential, and refuse to share it with sexual (or drug-injecting) partners, family members or the community.

In the context of HIV/AIDS, disclosure refers to the act of informing any individual or organization of the sero-status of an infected person, or it refers to the fact that such information has been transmitted, by any means, by the person him or herself, or by a third party, with or without consent [4]. Beneficial disclosure is disclosure that is voluntary; respects the autonomy and dignity of the affected individuals; maintains confidentiality as appropriate; leads to beneficial results for those individuals, and for their families and sexual and drug-injecting partners; leads to greater openness in the community about HIV/AIDS; and meets the ethical imperatives of the situation where there is need to prevent onward transmission of HIV [4].

The prevalence of denial, stigma, discrimination and secrecy dictates a clear and urgent need to "open up" the HIV/AIDS epidemic. UNAID report states that it is neither feasible nor desirable to force people to get tested; to disclose their status or to change their behavior. This would require the creation of a health "police" state requiring vast amounts of resources [4]. This report also maintains that it would drive further underground the very kinds of behavior that are already hidden and need to be changed [4]. Hence the urgent need to encourage, provide incentives for and persuade volitional disclosure. This will cement a self-policing spirit while carefully applying disincentives to denial, stigmatization, discrimination and secrecy.

Volitional disclosure to pre-diagnosis sexual contact could be the difference between accessing care or otherwise. Anecdotal reports of spouses who discover that their significant others were seropositive and sometimes even on drugs years later abound in practice. With this background in mind, it is apparent that appropriate disclosure will reveal the true epic proportion of the pandemic.

The objective of the study was to determine the prevalence, factors, timing and outcomes of HIV status disclosure among HIV positive patients receiving care at the Special Treatment Clinic (STC) of National Hospital Abuja, Nigeria.

2. Materials and Methods

This study was a descriptive cross-sectional survey that used quantitative method to determine disclosure rates, various outcomes, timing and factors influencing status disclosure among clients at the STC of the National Hospital, Abuja. The Hospital is a tertiary health facility initially conceived to carter for the needs of women and children in Nigeria and the West African sub-region with a view to reducing the mortality rates and to carry out extensive research into the peculiar causes of women and children related diseases in Africa. However, in order for vast majority of Nigerians to benefit from the state of the art infrastructures and equipment in the hospital, the scope of its operations was expanded to accommodate male patients. Hence, initially christened "National Hospital for Women and Children," it graduated into the "National Hospital, Abuja" on the 10th of May, 2000. The Hospital is a melting pot of referral cases, fresh cases, executive patients and the masses alike and therefore gives a scout picture of the health situation in Nigeria. It has the Special Treatment Clinic (STC) which caters for sexually transmitted diseases with a primary focus on HIV/AIDS. The unit sees an average of 1500 clients every month, offering free comprehensive care.

The clinic is manned by the Departments of Family Medicine and Clinical Microbiology with ancillary support from the nurses, a Monitoring and Evaluation unit, Hospital Assistants and support groups. Clients are seen as outpatients from Mondays to Thursdays while those requiring admissions are admitted to the appropriate wards. This study took place from1st February to 31st March 2012.

2.1. Population of the Study

The population of the study consisted of HIV positive clients receiving care at the National Hospital, living within and beyond the environs of Abuja.

2.2. Eligibility Criteria

To be included in this study the participants had to meet the following eligibility criteria: Agreed willingly to participate and signed a consent form, aged above 18 and below 58 years, diagnosed HIV positive at least one year ago and at most ten years ago, aware of his/her seropositive status, in a relationship with at least one sexual partner, and regularly utilizing the index clinic from which the population

was taken as the health facility providing their HIV treatment. Patients excluded from this study were those; aged below 18 years and above 58 years, admitted in a facility due to HIV related morbidity and those who expressed unwillingness to participate and refused to sign the informed consent form.

2.3. Sample Size

A convenience sample size of 240 was taken as representative of the 1500 clients seen each month at the STC.

2.4. Sampling Technique

Non-probability purposive sampling method was employed in order to recruit clients as respondents for the study.

2.5. Data Collection

An interviewer administered structured questionnaire was used for data collection. Questionnaires contained mainly of close-ended questions. The questionnaire was divided into two sections. Section A was aimed at exploring the demographic profile of the participants. Section B contained factual questions that determined the morbidity profile as well as disclosure issues.

The contents of the questionnaire were reviewed by a group of experts which included three public health consultants and two experts in infectious diseases. The experts agreed the contents of the questionnaires was valid and reflected the study objective. Pilot interviews were conducted before commencing the actual study interviews. Thirty people infected with HIV but not within the study sample were interviewed after a schedule outpatient visit at the facility. This helped identify deficiencies in the questionnaire, estimate the probable length of interview, and indicate any logistical problems that could potentially arise during the main interviews.

2.6. Ethical Clearance

Ethical clearance was obtained from the ethical research committee board of the National Hospital Abuja. An informed, written and signed consent was obtained from each respondent.

2.7. Data Analysis

Data was analyzed using the Statistical Package for Social Sciences (SPSS) version 16.0. Tools used for analysis included frequencies and Chi square test. Test of significance was at α level 0.05.

3. Results

3.1. Socio-demographic Characteristics of Respondents

Majority 118 (49.2%) of respondents in this study were between the ages of 29 years to 38 years. Most 147 (61.2%) were female, majority 158 (65.8%) had attained tertiary level of education and majority 157 (65.4%) were married (Table 1)

Table 1. *Demographic data of the clients (n=240).*

Variable	Frequency n=240	Percent %
Age group (years)		
18-28	21	8.7
29-38	118	49.2
39-48	79	33.0
49-58	22	9.1
Gender		
Male	93	38.8
Female	147	61.2
Educational level		
No formal education	4	1.6
Primary	11	4.6
Secondary	67	27.9
Tertiary	158	65.8
Marital status		
Single	61	25.4
Married	157	65.4
Divorced	10	4.1
Widowed	10	4.1
Separated	2	0.8

3.2. Prevalence of HIV Status Disclosure of Respondents

Majority of respondents 228 (95.0%) had disclosed their HIV status, of which most 121 (50.4%) had disclosed to their sexual partners (Table 2).

Table 2. *HIV status disclosure and trends associated with disclosure (n=240).*

Variable	Frequency	Percent %
Apart from to Healthcare professionals, Have you disclosed you status?		
Yes	228	95.0
No	12	5.0
If yes, to who did you confide in?		
No Response	11	4.6
A family member	100	41.7
My sexual partner	121	50.4
Religious leader	6	2.5
My herbalist	2	0.8
Who will you not particularly want to disclose your status to?		
No Response	52	21.7
A family member	60	25.0
My sexual partner (spouse, girlfriend/boyfriend)	33	13.7
Religious leader	17	7.1
My herbalist	8	3.3
Colleagues/Associates	70	29.2

3.3. Association Between HIV Status Disclosure, Age, Gender, Level of Education and Marital Status

No significant association was seen between gender and status disclosure; $x^2 = 0.07$. No significant association was seen between age and status disclosure ($x^2 = 0.69$) and likewise no significant association between marital status and status disclosure ($x^2 = 0.35$). A significant association was seen between level of education and status disclosure; $x^2 = 0.001$ (Table 3).

Table 3. *Association between HIV status disclosure, age, gender, level of education and marital status (n=240).*

Variable	Apart from Healthcare professionals, Have you disclosed you status?			P value
	Yes (%)	No (%)	Test	
Gender				
Male	91 (97.8)	2 (2.2)	X^2	0.07
Female	137(93.2)	10(6.8)		
Age group (years)				
18-28	19(90.5)	2(9.5)		
29-38	114(96.6)	4(3.4)	X^2	0.69
39-48	75(94.9)	4(5.1)		
49-58	20(90.9)	2(9.1)		
Educational level				
No formal education	4(100.0)	0(0.0)		
Primary	9(81.8)	2(18.2)	X^2	0.001*
Secondary	61(94.0)	4(6.0)		
Tertiary	154(98.7)	2(1.3)		
Marital status				
Single	59(96.7)	2(3.3)		
Married	149(94.9)	8(5.1)		
Divorced	8(80.0)	2(20.0)	X^2	0.35
Widowed	10(100.0)	0(0.0)		
Separated	2(100.0)	0(0.0)		

Chi square test (x^2), Significant at $p < 0.05$

3.4. Timing of HIV Status Disclosure

Majority of respondents in this study disclosed their HIV status immediately after getting tested and knowing their status, irrespective of their gender, age, level of education or marital status (Table 4). A significant association ($x^2 = 0.001$) was seen between timing of status disclosure and age and also between level of education and timing of status disclosure ($x^2 = 0.001$).

Table 4. *Timing of HIV status disclosure (n=228).*

Variable	How long after your diagnosis did you disclose your status to anyone?						P value
	Immediately (%)	In days (%)	In weeks (%)	In months (%)	In years (%)	Test	
Sex							
Male	59(64.8)	6(6.5)	7(7.6)	11(12.1)	8(8.7)	X^2	0.16
Female	67(48.9)	25(18.2)	10(7.3)	17(12.4)	18(13.1)		
Age group (years)							
18-28	11(52.4)	4(19.0)	0(0.0)	2(9.5)	3(14.3)		
29-38	53(46.5)	22(19.3)	10(8.8)	17(14.9)	12(10.5)	X^2	0.001*
39-48	44(58.7)	2(2.6)	5(6.7)	13(17.3)	11(14.7)		
49-58	16(80.0)	2(10.0)	2(10.0)	0(0.0)	0(0.0)		
Educational level							
No formal education	0(0.0)	2(50.0)	0(0.0)	2(50.0)	0(0.0)		
Primary	1(11.1)	6(66.7)	0(0.0)	1(11.1)	1(11.1)	X^2	0.001*
Secondary	31(50.8)	7(11.5)	5(8.1)	7(11.5)	10(16.4)		
Tertiary	90(57.7)	17(10.9)	13(8.3)	21(13.5)	15(9.6)		
Marital status							
Single	31(52.5)	9(15.3)	3(5.1)	7(11.9)	9(15.3)		
Married	80(53.7)	19(12.8)	13(8.7)	21(14.1)	16(10.7)		
Divorced	3(37.5)	3(37.5)	0(0.0)	1(12.5)	1(12.5)	X^2	0.47
Widowed	6(60.0)	0(0.0)	2(20.0)	2(20.0)	0(0.0)		
Separated	2(100.0)	0(0.0)	0(0.0)	0(0.0)	0(0.0)		

Chi square test (x^2), Significant at $p < 0.05$

3.5. Outcomes of Disclosure

Overall majority of respondents received positive reaction from the first person to whom they first disclosed their HIV status; 122(53.5%) met with understanding while 87(38.1%) received support. Minority 2(0.9%) experienced violence (Table 5). Most 220(96.5%) respondents admitted that disclosing their status had been helpful though majority 136(56.7%) had no intention of further disclosure of their status (Table 5).

Table 5. *Outcomes of disclosure.*

Variable	Frequency	Percentage
What was the reaction of the person you first disclosed to? (n=228)		
Understanding	122	53.5
Avoidance	11	4.8
Violence	2	0.9
Support	87	38.1
Anger	4	1.7
Divorce	2	0.9
Has disclosing our status been helpful in living with HIV? (n=228)		
Yes	220	96.5
No	8	3.5
How many (more) people do you intend to disclose to? (n=240)		
None	136	56.7
1-2	50	20.8
3-4	22	9.2
>4	32	13.3

4. Discussion

4.1. Prevalence of HIV Status Disclosure

WHO reported that rates of disclosure in studies from developing countries are notably lower than in developed countries and ranged from 16.7% to 86%. Among studies reported, an average rate of status disclosure was 49% [5]. A status disclosure rate to sexual partners of 50.4% seen in this study is within the range reported by WHO. A lower disclosure rate (18.6%) than that seen in this study was reported in conducted in North central Nigeria [6]. While higher disclosure rates of 50.9% and 61.5% have been reported within Nigeria. [7, 8]

4.2. Association Between HIV Status Disclosure, Age, Gender, Level of Education and Marital Status

Many factors may influence the disclosure of a positive HIV status. These include age, sex, race, relationship status, religion, culture, educational level and awareness of the partner's status. Influences of age, gender, relationship status and level of education were determined in this study.

No significant association seen between age and status disclosure indicates that among the respondents in this study, disclosure of their HIV status had no association with their ages. This is unlike the report of O'Brein in which younger people were more likely to disclose to their sexual partner than older people. It was also reported that participants older than 22 disclosed most often to sexual partners or an immediate family member, while participants older than 35 seemed more willing to disclose to a friend [9]. Another study however found out that women younger than 24 years of age are more likely to disclose than older women and specifically to their sexual partners [10].

The results of a study completed in Uganda study again showed and association between age and status disclosure and reported the mean age of those who disclose are 38 years and 31 years for those who never disclose [11].

Studies by Gaskin have investigated two aspects to of education when attempting to determine whether education influences HIV status disclosure. The first is the educational level of the individual i.e. the academic achievement level and secondly, the knowledge of HIV/AIDS and educational opportunities the individual has access to [12].

A significant association seen between level of education and status disclosure indicates HIV status disclosure of respondents in this study was associated with their level of education. This is similar to reports of Gaskin where it was reported that individuals were less likely to disclose their HIV status if they had tertiary education [12]. Influences of level of education on HIV status disclosure have again been reported in a study conducted in Southwest Ethiopia, where it was reported that individuals with higher education are more likely to disclose their HIV status than those with a basic education or those who are illiterate [13]. However, other studies have noted that there is no significant difference in disclosure rates with regards to a level of education [11, 14], these reports are in contrast to the findings of this research.

The relational status of individuals may influence the willingness to share or not share their HIV status, according to Gaskins, people do not always disclose to their partner's and disclosure is also influenced by the number of partners. As the number of partners' increase, the rate of disclosure decreases [12]. No significant association found between marital status and status disclosure in this research is unlike the finding of Gari and his group who found that married women were more likely to disclose to their sexual partners than women in cohabitating relationships [14]. According to Chaudoir and his group disclosure rates were higher to steady partners in comparison to those who have casual partners [15]. This was supported by the finding of O Brein who found that disclosure was significantly higher to steady partners. This rate also increases according to the stage of the disease, where individuals who are ill are more likely to disclose [9].

4.3. Timing of HIV Status Disclosure

Variations in time of disclosure of ones' HIV status is not a unique finding to this study alone. A study in Southwest Ethiopia found that the diagnosis to disclosure time varied from one day to two years [13]. Majority of respondents in this research had disclosed their HIV status immediately after getting tested and knowing their status is similar to findings of another study reported that 59% of women disclose soon

after diagnosis to one other individual [16]. Variations in time of disclosure were seen in a study conducted in Ogun state, Nigeria; 17.3% disclosed their HIV status on the day of receiving their test results, 15,5% within two weeks, 9.7% in two to four weeks and 8.3% in one or more months [7]. Still looking at the findings of Visser which showed an association between the timing of disclosure and gender [16], no association was seen between timing of disclosure and gender in this research.

4.4. Outcome of Disclosure

Common barriers to disclosure include fear of discrimination, stigmatization, fear of blame, rejection and abuse and lack of understanding of the disease [10, 12]. On disclosure majority of respondents in this received positive reaction from the first person to whom they first disclosed their HIV status while only a minority experienced violence. This high level of positive outcomes could be as a result of better knowledge and awareness of HIV/AIDS in recent years and so there is less ignorance with resultant reductions in unwarranted fears of contracting the disease. Similar positive outcomes were reported in a study conducted among PLWHAs assessing care in Ilorin, North central Nigeria [6]

A study conducted in Johannesburg, South Africa, reported that almost all respondents who had disclosed their statuses to family members were shown acceptance and received moral support [17]. Positive outcome for most individual have been reported in a study conducted in North east Ethiopia [18]. Again, a study in India reported positive outcomes following disclosure among most respondents such as kindness, understanding and acceptance [19].

Minority of respondents in this study experienced negative reactions such as violence. Negative outcomes among minority of respondents were reported in a study conducted in India, such outcomes included; blame, abandonment, violence, anger and stigma [19]. Majority respondents in this study indicating no intention of further disclosure of their status could be attributed to fear of such negative outcomes.

Some limitations of this study include the use of a convenience sample. With the questionnaire as the tool of data collection, a lot depended on the truthfulness of respondents. The use of interviewer administered questionnaires (due to the literacy level of some respondents) and lack of anonymousity may have further affected the responses of respondents.

5. Conclusion

Most respondents experienced positive reactions to disclosure indicating clear benefits of HIV status disclosure. Minority received negative reactions to their status disclosure and a noted majority had no intention of any further disclosure. More studies are thus needed for wider recommendation on how to manage disclosure issues.

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