HIV SEROSTATUS DISCLOSURE AMONG PREGNANT WOMEN ATTENDING ANTENATAL CARE CLINIC AT USMANU DANFODIO UNIVERSITY TEACHING HOSPITAL, SOKOTO

BY

DR NASIR SADIYA

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DECLARATION

I hereby declare that this research work was carried out by me under the supervision of Dr Tukur Dahiru and Dr Mrs Muazu both of the Department of Community Medicine. Ahmadu Bello University, Zaria. It has not been submitted for any previous application for other degrees or qualifications. Efforts of other researchers in related areas of my work were duly acknowledged and listed in the reference.

_____ _____

Dr Nasir Sadiya Date

CERTIFICATION

This thesis entitled "HIV SEROSTATUS DISCLOSURE AMONG PREGNANT WOMEN ATTENDING ANTENATAL CARE CLINIC AT USMANU DANFODIO UNIVERSITY TEACHING HOSPITAL, SOKOTO" by Dr Nasir Sadiya meets the regulations governing the award of the degree of Master of Public Health of Ahmadu Bello University Teaching Hospital, Zaria and is approved for its contribution to knowledge and literary presentation.

_____ _____

Dr Tukur Dahiru Date

Project supervisor

_____ _____

Dr M N Sambo Date

Head of Department

_____ _____

External Examiner Date

_____ _____

Prof. A A Joshua (B.A, M.A, Ph.D (ABU) Date

Dean Postgraduate School

DEDICATION

This work is dedicated to almighty God for his infinite mercy, guidance and making it possible for me to undertake this programme and also to my husband Alhaji Aliyu Musa Kardi for his patience, understanding and support during this programme.

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I wish to extend special thanks to Almighty Allah in whose mercy and guidance this work has become a reality.

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ABSTRACT

Background: Partner consent and support can substantially enhance adherence to PMTCT interventions. The disclosure of HIV serostatus has adverse sociopsychological consequences and is presently a major public health challenge in many African countries including Nigeria. With increasing uptake of HIV counseling and testing among pregnant women in Nigeria, there has been increasing concern about whether those found to be positive would report the results of the test to their spouses or sexual partners.

This study explores the issues concerning disclosure of HIV status to husband/partners among women attending the antenatal clinic of Usman Danfodio University Teaching Hospital Sokoto.

Objectives: This study is aimed at determining the prevalence, barriers and outcome of HIV serostatus disclosure among pregnant women attending antenatal care clinic at UDUTH and its implications for the prevention of mother-to-child transmission of HIV.

Methodology: The study was a cross-sectional and descriptive study with both quantitative and qualitative component.

Results: The prevalence of HIV serostatus disclosure was 66.7% among HIV Positive women and 82% among HIV negative women. Intent to disclose HIV positive result among HIV women was found to be 65.1%. Only 1(16.7%) of

the participants disclosed her HIV positive result in less than a month from diagnosis. In the remaining disclosure was made between 1 and 11 months. There was no statistically significant relationship between age, educational status, duration of marriage and disclosure, possibly because of the low proportion of the HIV positive participants in the study.

The most important barrier to disclosure found in the study was fear of divorce. The outcome of disclosure was found to positive in the study with about 50% of the participants reporting their husbands as being supportive and 66.6% of the participants were still in relationship with their husbands.

Conclusion: the study revealed that disclosure was high among both HIV positive and negative participants. The most feared barrier to disclosure was fear of divorce and in general a positive outcome followed the disclosure. It is recommended that involvement of male partner should be early in HIV counseling and testing process to reduce or remove the most feared barrier to disclosure.

CHAPTER ONE

1.0 INTRODUCTION

The most effective approach for preventing vertically acquired HIV infection in children is through primary prevention among women of childbearing age and secondly through the prevention of unwanted pregnancy among HIV – infected women and in the prevention of mother – to – child transmission of HIV (PMTCT).[1]

A well functioning, appropriate and accessible voluntary counselling and testing (VCT) services is a prerequisite for conducting successful PMTCT programmes.

(VCT) services enable uninfected individuals to remain uninfected and those infected to plan for the future and prevent HIV transmission to others. Knowing ones status may also enable HIV infected individuals to access timely and appropriate treatment, as well as care and support programmes. Furthermore HIV infected women who know their serostatus are in a better position to make informed choices about their reproductive life and, if pregnant, to access specific interventions such as antiretroviral prophylaxis and infant feeding counselling and support, which can significantly reduce the risk of mother - to - child transmission of HIV.[1,2,3,4]

Disclosure of HIV serostatus to sexual partners is an important prevention goal emphasized by the WHO[5] and the Centre for Disease Control and Prevention (CDC) [6] in their protocol for HIV testing and counselling.

Disclosure refers to informing others of one's HIV positive status. There are different levels of disclosure, they include;

Disclosure to;

- Health care workers for care and support
- Disclosure to families, friends, Co-workers, employers and communities for emotional support.
- Disclosure to partners to prevent onward transmission.
- To general public for "putting a human face" on the epidemic (education, advocacy, money).

Disclosure offers a number of important benefits to the infected individual and to the general public. Disclosure of HIV test results to sexual partners is associated with less anxiety and increased social support among many women.[7] In addition; HIV status disclosure may lead to improved access to HIV prevention and treatment programmes, increased opportunities for risk reduction and increased opportunities to plan for the future. Disclosure of HIV status also expands the awareness of HIV risk to untested partners, which can lead to greater uptake of voluntary HIV testing and counselling and changes in HIV risk behaviours.[8,9] It is clear from the literature that risk behaviours change

most dramatically among couples where both partners are aware of their HIV serostatus.[8,9] In addition, disclosure of HIV status to sexual partners enables couples to make informed reproductive health choices that may ultimately lower the number of unintended pregnancies among HIV-positive women.[8]

Along with these benefits, however, there are a number of potential risks from disclosure for HIV-infected women, including loss of economic support, blame, abandonment, physical and emotional abuse, discrimination and disruption of family relationships as well as stigma, loss of custody of children and property.[10,11] These risks may lead women to choose not to share their HIV test results with their friends, family and sexual partners. This, in turn, leads to lost opportunities for the prevention of new infections and for the ability of these women to access appropriate treatment, care and support services where they are available. In addition there is also loss of greater access to social, psychological, financial and legal support.

After all the above-mentioned obstacles the most heart-breaking phenomena is that pregnant women who are found to be HIV-positive cannot participate fully in PMTCT programs and the most important reason for low participation is non-disclosure of HIV test results to sexual partner. The uptake and adherence to PMTCT programmes is difficult for women whose partners are unaware of their HIV status.

1.2 RATIONALE OF THE STUDY

The most effective approach for preventing vertically acquired HIV infection in children is through primary prevention among women of childbearing age and secondly through the prevention of unwanted pregnancies among HIV – infected women and in the prevention of mother-to-child transmission of HIV(PMTCT).

The optimal uptake and adherence to PMTCT programmes is difficult for women whose partners are either unaware or not supportive of their participation. In Africa, Nigeria inclusive, women lack power to make independent decisions with regard to the safety of their own and their children's health. It is therefore, difficult for HIV positive women to seek social and medical support from care and support programs for themselves and their infants without disclosing their HIV status to their partners.[12]

With increasing uptake of HIV counselling and testing among pregnant women in Nigeria, there has been increasing concern about whether those found to be positive would report the results of the test to their spouses or sexual partners, as the importance of involving partner has increased as we move from PMTCT to PMTCT-Plus. It can therefore be seen that sero status disclosure is one of the factors that account for the success or failure of PMTCT programmes and therefore the need to study the prevalence, outcome and obstacles towards disclosure in order to develop appropriate interventions for increasing

disclosure and thereby improving the uptake and success of PMTCT programs and also this will encourage partners to know there status and take preventive measures if found to be negative.

1.3 GENERAL OBJECTIVE

This study is aimed at determining the prevalence, barriers and outcomes of HIV serostatus disclosure among pregnant women attending antenatal care at Usmanu Danfodio University Teaching Hospital, Sokoto and its implications for the prevention of mother-to-child transmission of HIV.

1.4 SPECIFIC OBJECTIVES

1. To determine the prevalence to HIV serostatus disclosure to sexual partners and other social network members.
2. To determine the barriers of HIV positive serostatus disclosure among antenatal women.
3. To determine the outcome of HIV positive serostatus disclosure among PMTCT women.
4. To determine the implications of HIV positive serostatus disclosure for the prevention of mother to child transmission of HIV.

CHAPTER TWO

2.0 LITERITURE REVIEW

2.1 INTRODUCTION

The HIV epidemic remains one of the greatest challenges to medicine. Sub – Saharan Africa has continued to bear the greatest burden of the HIV and AIDS pandemic, with approximately 63% of the total number of people living with HIV, 65% of the 4.3 million total new infections and 72% of the 2.9 million deaths in 2006. Over the decades, the epidemic, once dominated by infected males has become progressively feminized and in sub – Saharan Africa approximately 57% of adults living with the HIV are women. Over 90% of infection in children is acquired through mother- to-child transmission (MTCT) and as more women contract the virus, the number of children infected has been growing.[18]

Since the first case of AIDS was reported in Nigeria in 1986, the epidemic has continued to rise at an alarming rate; with national HIV sero-prevalence rate of 1.8% in 1991, 5.8% in 2001 and a drop to 4.4% in 2005 and 4.6% in 2008.[19] Most children less than 15 years living with HIV acquire the infection through MTCT. Estimate by the end of 2008 showed that there were a total of 2.95 million people living with HIV/AIDS (Male 1.23, Female 1.72), with 56.681 annual HIV positive births, cumulative AIDS deaths of 2.99 million (Male 1.

38, Females 1.61) with a total of 380.000 new infections (Adults 323.000, Children 57.000).[19]

With the introduction of highly active anti – retroviral treatment in developed countries, there have been a profound improvement in the quality of life and subsequent reduction in mortality of HIV patients.[18] The story is quite different in sub – Saharan Africa where access to HAART is still limited. Therefore primary prevention remains the most effective method of controlling the infection. The most effective approach for preventing vertically acquired HIV infection in children is through primary prevention among women of childbearing age and secondly through the prevention of unwanted pregnancy among HIV – infected women and in the prevention of mother-to-child transmission of HIV (PMTCT).[2]

A well functioning, appropriate and accessible voluntary counselling and testing (VCT) services is a prerequisite for conducting successful PMTCT programmes. HIV counselling and testing provides essential knowledge and support to individuals at risk of contracting HIV, enables uninfected individuals to remain uninfected and those infected to plan for the future and prevent HIV transmission to others. Knowing ones status may also enable HIV infected individuals to access timely and appropriate treatment, as well as care and support programmes. Furthermore HIV infected women who know their serostatus are in a better position to make informed choices about their

reproductive live and, if pregnant, to access specific interventions such as antiretroviral prophylaxis and infant feeding counselling and support, which can significantly reduce the risk of mother - to - child transmission of HIV.[2,3,4]

2.2 DISCLOSURE OF HIV SEROSTATUS

Disclosure in the context of HIV/AIDS occurs when a person's HIV test is revealed to another person. Disclosure of HIV serostatus to sexual partners is an important prevention goal emphasized by the WHO[7] WHO[5] and the Centre for Disease Control and Prevention (CDC) [6] in their protocol for HIV testing and counselling. Disclosure of HIV test result is an important prevention goal for a number of reasons.

The benefits includes expanding and sharing the burden of helping People Living with HIV/AIDS (PLWHA) beyond professional care providers, providing access for care and support programmes, planning for future care, and enhancing quality of life of PLWHAs and their partners. Disclosure is also associated with less anxiety and increased social support among many women, increased opportunities for risk reduction. It also expands the awareness of HIV risk to untested partners, which can lead to greater uptake of voluntary HIV testing and counselling and changes in HIV risk behaviours.[8, 9] In relation to PMTCT, shared confidentiality is considered beneficial in other to prevent unwanted pregnancies and arrest the spread of HIV infection to uninfected partners. Another benefit is in assisting HIV infected women to plan for their

future and their partners, to gain access and adhere to therapeutic regimens such as antiretroviral therapy and replacement feeding for infants.[10, 11] Along with these benefits, however, there are a number of potential risks from disclosure for HIV infected women, including loss of economic support, blame, abandonment, physical and emotional abuse, discrimination and disruption of family relationships as well as discrimination, stigma, loss of custody of children and property.[14,15] These risks may lead women to choose not to share their HIV test results with their friends, family and sexual partners. This, in turn, lead to lost opportunities for the prevention of new infections to their partners and infants, and also loss of ability of these women to access appropriate treatment, care and support services where they are available. In addition there is also loss of greater access to social, psychological, financial and legal support.[10, 16] Generally, prevention of mother – to – child (PMTCT) is one of the strategies that help to prevent HIV infection in infants. Pregnant women should have access to ante natal care in order to participate in PMTCT programs. After all the above-mentioned obstacles the most heart-breaking phenomena is that pregnant women who are found to be HIV-positive cannot participate fully in PMTCT programs due to various reasons.

One of the reasons for the low participation of HIV positive women in PMTCT is the non-disclosure of HIV test results to sexual partner. The uptake and adherence to PMTCT programmes is difficult for women whose partners are

unaware of their HIV status. It has been well documented in Africa that women lack power to make independent decisions with regard to the safety of their own and their children's health. It is therefore, difficult for HIV positive women to seek social and medical support from care and support programs for themselves and their infants without disclosing their HIV status to their partners.[10]

WHO has outlined a four-pronged approach to prevent HIV infection in mothers and their infants. The four elements are: the reduction of HIV transmission to potential mothers; the reduction of unintended pregnancies among women and girls living with HIV; the reduction of mother-to-child transmission of HIV; and the provision of care, treatment and support for mothers and their infants, partners and families. The low rates of disclosure seen in many studies have implications for each component of the strategy, as outlined in Fig. 1. First, disclosure of HIV status between HIV-uninfected women and their sexual partners is necessary to initiate discussions about HIV/AIDS that raise both partners' awareness of the risk of infection and may ultimately lead to behaviour change to reduce HIV risk. Secondly, disclosure can be an important starting point for HIV-infected women to begin discussing the use of contraception with their partners and reduce the number of unintended pregnancies among HIV-infected women. Thirdly, disclosure plays an important role in women's uptake of PMTCT programmes and in their participation in treatment and care and support programmes. In order to benefit

from interventions that can reduce HIV perinatal transmission, women must be willing to be tested for HIV, and if they are HIV-positive they must be willing to accept and adhere to PMTCT prophylaxis. The optimal uptake and adherence to PMTCT programmes is difficult for women whose partners are either unaware or not supportive of their participation. Finally, it has been well documented in Africa that women often lack the power to make independent decisions with regard to their own health care and that of their children.[20, 21] It is therefore difficult for HIV infected women to seek social and medical support from care and treatment programmes for themselves and their infants without first disclosing their HIV status to their partners.

. Role of HIV status disclosure in the prevention of HIV infection in mothers and infants

WHO's four-pronged approach to prevent HIV infection in mothers and infants		Role of women's disclosure of HIV serostatus
1 Reduction of HIV transmission to potential mothers	→	Initiates discussions among sexual partners that can lead to behaviour change
2 Reduction of unintended pregnancies among HIV-infected women and girls	→	Enables HIV-infected women to begin discussing the use of contraceptives with sexual partners
3 Reduction of mother-to-child transmission of HIV	→	Enables HIV-infected women to gain support from partners for participation in pMTCT programmes
4 Provision of care, treatment and support for mothers and their infants, partners and families	→	Enables HIV-infected women to gain support from partners for participation in treatment and support programmes

WHO 04.26

The literature indicates that the rate of disclosure of HIV serostatus is higher among women in U.S. than among women in developing countries, with rates

of 42-100 percent in the U.S. compared with 16-86 percent in developing countries.[18, 19, 20, 21] The lowest rates of disclosure are among pregnant women tested during antenatal care (ANC) in sub-Saharan Africa (16.7 – 32%).[22, 23, 24]

In Nigeria the rate of disclosure ranges between 28% and 89% in different studies across Nigeria.[17, 25, 26,]

Within literature on self-disclosure of HIV serostatus in Africa, the proportion of PLHIVs who report sharing their status with their partners as well as the timing of that disclosure varies widely among studies. At the lowest end of the spectrum, MacNeil, Mberesero, and Kilonzo[27] indicated that 6 months after learning they were HIV-positive, only 26% of married respondents reported having shared their status with their spouse and only 15% of participants said they had informed a boyfriend/girlfriend or other sexual partner of their diagnosis. In a study of 1078 HIV-positive women by Antelman et al.[28] at 2 months after diagnosis only 22% said they had disclosed their condition to their sexual partner, although that proportion steadily increased to 40% after 4 years. Comparable rates were found in Burkina Faso[29] as well as in Kenya.[30] On the other hand, two studies carried out in Tanzania reported closer to two-thirds of participants telling partners of their diagnosis.[31]

A similar project in Lusaka, Zambia found that 47% of women who tested positive had reported their status to their partner within a week of diagnosis.[32]

Beyond the issue of disclosure to sexual partners, the hierarchy of preferred disclosure targets in sub-Saharan Africa appears to be different than in the US, where the most frequent recipients of HIV disclosure are friends.[33]

Similarly, among PLHIVs in Nigeria partners were the first disclosure target of choice, followed by close family members,[26] and whereas 62% of Namibian participants had disclosed HIV test results (either positive or negative) to partners and 55% to family members, only 32% had revealed their results to friends.[34] Antelman et al.[28] found that women who had already disclosed to a female relative were less likely to reveal their status to their partner. Among MacNeil et al.'s [27]participants, parents were the most likely target of diagnosis disclosure. On the other hand, although HIV-infected women in Issiaka et al.'s[29] study reported a low (33%) rate of disclosure to partners, they indicated even lower rates of disclosure to other significant persons in their lives. Farquhar et al. And Galliard et al. found that younger women (under the age of 24 years) were more likely to disclose to sexual partners than older women.[35, 36] Additionally, Farquhar found women of lower socioeconomic status had a higher disclosure rate than women of higher socioeconomic status.[35] Antelman et al. also found that women who had been in relationships for a longer period of time (defined as more than two years) were more likely to disclose than women who had been in relationships for a shorter duration.[28] Issiaka and

colleagues found that women with a higher level of education were more likely to share their results with their partners than women who were illiterate.[29]

The most common barriers to disclosure mentioned by PLHIV included fear of abandonment, rejection and discrimination, violence, upsetting family members, and accusations of infidelity. Women's fear of abandonment was closely tied to fear of loss of economic support from a partner. In these settings where resources are extremely scarce and women's access to resources independent of their partner is uncommon, it is not surprising that fear of losing this instrumental support from a partner is a major consideration when deciding whether to share HIV test results or not.

Majority of the studies reported positive outcomes related to disclosure. Women reported receiving kindness, understanding or acceptance following disclosure in three of the studies. An important finding is that disclosure was not associated with the break-up of marriages. In fact, some studies reported that most marriages survived disclosure.[25, 26]

Negative outcomes included blame, abandonment, violence, anger, stigma and depression.

The issue of serostatus disclosure is sensitive; high stigma in many countries creates a disincentive for people to share their HIV positive status with others. In order to access care and support for HIV infection, however, it is usually necessary to disclose one's status to health care providers and one's family. The

degree of sensitivity around disclosure varies across settings, and consensus has not been reached on standards or procedures regarding when, how and to whom disclosure should occur. In addition, there are not adequate support mechanisms for clients and providers to facilitate disclosure.

2.3 CHALLENGES IN ADDRESSING DISCLOSURE

There are a variety of challenges for clients, policymakers, service providers, partners, families, and communities involved in addressing disclosure. Barriers to disclosure at the client level include both fear of a negative partner reaction and fear of stigma and discrimination, which may be grounded in the experience of witnessing others being mistreated because they are infected with HIV. Clients may fear adverse consequences for their children and/or that health care workers will disclose their HIV status to others without their consent. The negative consequences of disclosure may be harsher for women than for men, in part because women are more economically and socially vulnerable, often dependent on their partners economic status and because there is less societal tolerance for women perceived to have multiple sexual partners than for men.

2.3.1 Challenges for Clients

Many clients disclose because they expect some benefit, but the expected benefits do not always occur. Most women report positive outcomes from disclosing. In some instances, however, women may disclose to their partner expecting support, but find themselves abandoned. Some women encounter

rejection and discrimination and may be accused of infidelity. These challenges may be even more pronounced for marginalized women who often experience discrimination, stigma, and rejection because their sexual behaviour may fall outside of what is traditionally accepted for women. They may be viewed as criminals or outcasts, and their HIV-positive status only further marginalizes them. Despite health education messages about HIV/AIDS, family members may develop avoidant behaviour with their HIV positive family members. For these reasons, the risk of disclosure of a HIV positive test result is significant, and many women resist disclosing their results to anyone.

2.3.2 Challenges for Service Providers

Service providers face a number of practical and professional challenges in addressing disclosure, including the lack of clear policies, guidelines, and tools on disclosure. They have limited time and skills and may be grappling with the silence around HIV within their profession, place of work, and social network. Providers face an ethical challenge: how to address the issue of negative consequences following disclosure, while, at the same time, promoting disclosure, given that most women report positive outcomes.

Providers often lack the interpersonal communication skills to effectively counsel and support clients to disclose, especially women who are within marginalized and vulnerable groups. Providers often do not have the capacity to establish or refer for follow-up and support services following disclosure. Many

providers consider it unethical to facilitate disclosure without the availability of ongoing counselling and support services, and they do not know how to help their clients with conflict resolution after disclosure of positive serostatus.

2.3.3 Challenges for Policymakers

Policymakers face the challenge of balancing confidentiality protections with public health concerns. They must now consider whether legislation should allow breaks in confidentiality for HIV positive clients; whether there should be mandatory partner notification; whether there should be named HIV case reporting for public health reasons; and whether to allow prosecution of individuals for the failure or inability to disclose their HIV positive status.

2.3.4 Practical challenges

Lack of communication skills (partners and providers)

Lack of community and male involvement

Lack of resources

How to establish or refer for follow up and support services following disclosure

How to develop appropriate methods of conflict resolution

2.4 INTERVENTIONS THAT CAN BE USED TO IMPROVE HIV SEROSTATUS DISCLOSURE

2.4.1 Immediate interventions: client level

•Promote disclosure of results to “significant” others when safe to do so

•Promote partner communication and couple counselling

•Encourage male involvement

•Form women support groups

•Promote networks among women and couples

•Promote innovative women empowerment strategies–e.g. micro credit program help to strategies–e.g. micro credit program help to shift gender norms

2.4.2 Immediate interventions: provider level

•Develop/adopt domestic violence screening and referral tools to identify women at risk of negative outcomes

•Assist women to determine potential for negative outcomes

•Based on screening and self-assessment, prepare clients to share their results–Role plays–Planned disclosure–Mediated disclosure

2.4.3 Immediate interventions: provider manager level

•Establish mechanisms for safe record keeping

•Train counsellors to understand the intersection of confidentiality, disclosure, and negative outcomes

•Orient providers at all levels to:–(1)Identify and prioritize clients who will benefit from, or be harmed by disclosure, because women know when it is/is not to safe to disclose to partners. (2)Provide ongoing supportive counselling. (3)Provide knowledge on benefits of VCT, PMTCT and care–Strengthen

linkages with community based services. (4)Foster community awareness of HIV

2.4.4 Immediate interventions: policy maker level

•Policy makers and community leaders should formulate policy on disclosure together

•Policies should address fundamental human rights

•Clarify "confidentiality"–Define confidentiality versus secrecy –Define circumstances that warrant breach of confidentiality –Develop guidelines for promoting 'shared confidentiality'

•Determine culturally specific partner notification policy–Client referral, provider referral, dual referral, and contract referral

•Revise informed consent policies and forms to include options for disclosure

•Establish professional standards for counselling

•Consider legal protection for PLHIV/AIDSA

2.4.5 Community level interventions

•Promote establishment of autonomous self-help group

•Broader community-based initiatives–Address underlying power differentials in gender relations –General efforts to reduce violence against women–Target young men and boys to promote relational development–Identify alternative conflict resolution and change sexual norms.

•Approaches–Translate existing research into action; create local ownership–Conduct new research.

2.4.6 Intermediate and long-term interventions

•Equip providers to recognize and address consequences of disclosure

•Address gender norms and attitudes targeting young men and boys

•Promote community-based programs to reduce stigma

•Conduct intervention linked research

2.4.7 Male involvement

As the preceding suggests, male involvement must be a key element in addressing and eliminating potential negative consequences of serostatus disclosure. Men dominate decision-making in many relationships, and while many women would accept testing, they can return for the result, in many cases, only after discussion with their partner.

In many societies there is already a tendency to blame women for bad fortune, and encouraging women to disclose seropositive status can reinforce this gender inequity.

Mechanisms should be developed for reducing the inequities between partners. Couple counselling and testing would help in this respect, but facilitating couple counselling is not easy in some cultures. Many clinical settings, especially antenatal care settings, are not welcoming to men, and men may actually be ridiculed in some African cultures for attending these clinics with their partners.

Since men are generally more comfortable attending VCT services outside clinical settings, mechanisms need to be found for making PMTCT settings more conducive for testing couples, perhaps by having the room for counselling located away from the antenatal care clinic or co-located with the laboratory.

Couple counselling and testing might improve the rates of disclosure, facilitate communication, increase positive outcomes, and reduce negative outcomes; it may also create the potential for serodiscordant couples to become aware of their discordant status during pregnancy, a situation that might pose risks for a positive woman with a negative partner.

Male involvement is also important for increasing the number of women seeking antenatal care and returning for further visits.

Men often control the resources that are needed to attend ANC clinics. Encouraging male involvement necessitates talking with political and traditional leaders in the community to establish the importance of antenatal care and preventing mother-to-child transmission.

CHAPTER THREE

3.0 METHODOLOGY

3.1 Study Area

Usman Danfodio Uninversity Teaching Hospital is located in Wamakko LGA, within Sokoto metropolis. It is a tertiary institution with 500 bed capacity, serving as a referral centre to several hospitals within the North- western region. It was commissioned in 1989, to provide preventive, curative and rehabilitative services to people living within and around the state. It serves as a training centre for several medical and paramedical courses at both undergraduate and post graduate levels. It provides general and speciality services at various special clinics. Obstetrics and Gynaecology department is one of the specialist departments. The obstetric unit consists of the outpatient clinics (Booking, Antenatal and Postnatal), the labour and obstetric wards.

The booking clinic runs every Wednesday from 1100 to 1530 hours and caters for pregnant women on their first antenatal visit.

The patients are initially given a health talk for about 30 minutes, the content of which include general hygiene, diet, harmful practices in pregnancy, clothing in pregnancy, coitus, breastfeeding, immunization Human immuno-deficiency virus infection (HIV/AIDS) and family planning, usually by nurses and midwives. They are also educated on drug use in pregnancy and early recognition of abnormality with prompt report at the hospital.

PMTCT Clinic

The department offers a comprehensive package on the Prevention of mother to child transmission of HIV (PMTCT) since 2008 to all women attending the booking/antenatal clinic, where voluntary counseling and confidential testing (VCT) is employed by our trained counselors as the entry point to the PMTCT, care and support. The women receive HIV group pretest counseling with provision for individual counseling and offered HIV testing with the option to opt out if they so desire, partner notification and testing is also encouraged. Women who accept the test receive a post test counseling where test results are communicated to them. Those found negative are counseled on how to remain negative and offered a retesting after three months, while the HIV positive clients benefit from interventions aimed at preventing vertical transmission and improving their health with that of their families. The PMTCT and PMTCT plus services are rendered free of charge. The most commonly used antiretroviral combination is Nevirapine, Zidovudine and lamivudine. The PMTCT clinic is covered by three consultants, a nurse, a mentor mother and one record person. The clinic runs on Monday and Friday every week together with ANC. On average 2 HIV positive women are seen per clinic day and about 50 to 60 HIV negative pregnant women attend the clinic.

3.2 Study Methods

The study was designed to have both quantitative and qualitative components.

3.3 QUANTITATIVE COMPONENT

3.3.1 Study design

The study was a cross-sectional and descriptive study.

3.3.2 Study Population

The study population consisted of all pregnant women attending the antenatal clinic of UDUTH.

3.3.3 Inclusion criteria

All pregnant women that have had at least more than two visits (this is to allow them to have enough time to discuss and disclose their serostatus test result) were enrolled in to the study.

3.3.4 Exclusion criteria

Pregnant women attending the clinic for the first or second time were excluded from the study.

3.3.5 Sample size determination

The sample size was estimated using the formula for estimating minimum sample size required in a population < 10,000, adjusted for non – response.

$n_f = n/1 + (n/N)$

Value of n was calculated using the formula for estimating minimum sample required in a population > 10,000.

n- Was calculated using the formula: $n = Z^2pq/d^2$

Where n = sample size

Z = standard normal deviate at 95% confidence level = 1.96

p = prevalence of the factor under study, 89% (0.89) was used, as discovered in a previous study.[17]

q = 1 – p

d = precision/tolerable margin of error = 5% (0.05)

N = average number of targeted population to be studied. On average about 60 women are screened weekly (Wednesday) on each booking clinic, making a total of 240 women in a month. Therefore N = 240

n_f = Minimum required sample size, adjusted for non – response.

Thus, $n = \frac{(1.96)^2 \text{ X } 0.89 \text{ X } 0.11}{(0.05)^2} =$

$\frac{3.8416 \text{ X } 0.0979}{0.0025} =$

n = 150.44

For a population less than 10,000 the sample size is calculated using the formular:

$n_s = n/1 + (n/N)$

$ns = \frac{150}{1 + (150/240)} = 92$

Response rate (R) of 90% will be expected, thus

$n_f = 92/0.9 = 102$

102 study subjects were therefore enrolled into the study.

3.3.6 Sampling Technique

On the average about 50 women attend antenatal clinic during each of the antenatal clinics. The folders of these patients were segregated into those that satisfied the inclusion criteria and those that did not. On average 25 – 30 women satisfied the inclusion criteria per clinic day, they were selected and administered the questionnaire until the required sample size was obtained. Four clinic visits were made in order to obtain the required sample size. On the last day the remaining 12 participants were recruited by balloting.

3.3.7 Method of data collection

Questionnaire method was used as the method of data collection.

3.3.8 Instruments for data collection

A standard semi – structured questionnaire was used to obtain the relevant information from the participants. Appendix I

3.3.9 Research assistants

Three research assistants (resident doctors) were recruited and trained by the researcher. The training was one day training, where the instrument for data collection was discussed extensively. Practical demonstration was also conducted to further train the assistants.

3.3.10 Pre – test

Pre- testing of the questionnaire and FGD guide was done to detect deficiencies and ambiguities. Appropriate corrections and modifications were made.

3.3.11 Data analysis

The questionnaires were checked manually, collated and organized before the data was entered into the computer for further analysis. Statistical Software for Social Sciences (SPSS) version 17 was used. All statistical analysis was set at 5% level of significance (95% confidence interval). P = 0.05.

The indicators used to measure the variables include: percentages, rates, and frequencies. X^2 and t-test were used to test for significance of association between variables.

3.4 QUALITATIVE COMPONENT

3.4.1 Study Population

The study population consisted of all pregnant women attending the antenatal clinic of UDUTH.

3.4.2 Inclusion criteria

All pregnant women that had at least more than two visits (this is to allow them to have enough time to discuss and disclose their serostatus test result) were enrolled in to the study.

3.4.3 Exclusion criteria

Pregnant women attending the clinic for the first or second time were excluded from the study.

3.4.4 Method of data collection

Focus group discussion (FGD) was used to obtain relevant information from the respondents for the qualitative component of the work.

3.4.5 Instruments for data collection

A focus group discussion guide was used to obtain qualitative data from both HIV positive and negative pregnant participants. Appendix II. There were a total of 8 FGD groups. Four for HIV positive and four for HIV negative. The composition of the group was based on age (young/old) and place of residence; urban (living within Sokoto metropolis) and rural (outside Sokoto metropolis). Appendix III. Each group consisted of 8 participants. Discussion was conducted inside the female resident call duty room of UDUTH.

The coordinating team for the FGD consisted of a moderator, note taker for documentation of comments and record keeper for recording. Each session lasted for about 45 minutes.

3.4.6 Data analysis

The qualitative data sets from FGD were retrieved by playing back the recorded tapes and editing the notes documented.

3.5 Ethical consideration

Permission was obtained from the department/ethical committee of UDUTH to carry out the research both the quantitative and qualitative component of the research. Informed consent of the respondents to take part in the study was also obtained, after the full explanation of the purpose of the study. Respondents were given opportunity to opt out when they so wished. All information obtained was treated with utmost confidentiality.

CHAPTER FOUR

4.0 RESULTS

4.1 RESULTS OF QUANTITATIVE STUDY

SOCIODEMOGRAPHIC CHARACTERISTICS OF RESPONDENTS

The study was carried out between January to June, 2012. A total of 102 questionnaires were administered but only 100 were correctly filled and fit for analysis.

Table 1 showed the distribution of the socio-demographic characteristics of the respondents. The age of the respondents ranged from 17 to 42 years with a mean age of 27.45 ± 4.92 years and modal age of 30 years. Most of the respondents were in the 25 – 29 year age group, followed by 30 – 34 years age group with 27 .0%. A lower proportion of the respondents, 3.0% were in the 35 – 39 and 4o– 44 years age group.

The mean parity of the respondents was 2.39 ± 2.20 with a minimum parity of 0 (Primigravida) and maximum of 9. Majority of the respondents 65.0% fell within 0 – 2 parity group, followed by 3 – 5 parity groups with 23.0%. Only one (1.0%) of the respondents fell within 9 – 11 parity groups.

The table also showed that 46 (46.0%) of the respondents had tertiary education, followed by secondary education with 33%, while 16% had Quranic education.

Hausa/Fulani constituted 59 (59.0%) of the respondents. The Igbo tribe was next with 14%, other tribes (Igbira, Zuru, Nupe, etc) also constituted the same

number with the Igbo tribe of 14%. The least tribe was the Yoruba tribe. The two main religions of the respondents were Islam (67%) and Christianity (33%). The mean duration of marriage was 5.96 ± 5.46 years with minimum of 4 months and maximum of 26 years. Majority of the respondents 37 (31.9%) were within the range of 2 – 6 years marriage duration. This is followed by those that are less than one year in marriage with 25% and between 7 – 11 years with 20%.

Table 1: Sociodemographic Characteristics of Respondents

VARIABLES	FREQUENCY (%)
Age (yrs)	n= 100
15-19	5 (5.0)
20-24	20 (20.0)
25-29	42 (42.0)
30-34	27 (27.0)
35-39	3 (3.0)
40-44	3 (3.0)
Parity	n= 100
0-2	65 (65.0)
3-5	23 (23.0)
6-8	11 (11.0)
9-11	1 (1.0)
Educational Status	n = 100
Quranic	16 (16.0)
Primary	5 (5.0)
Secondary	33 (33.0)
Tertiary	46 (46.0)
Ethinicity	
Igbo	14 (14.0)
Hausa	59 (59.0)
Yoruba	13 (13.0)
Others	14 (14.0)
Religion	
Islam	67 (67.0)
Christianity	33 (33.0)
Duration of Marriage (yrs)	
≤ 1	25 (25.0)
2-6	37 (37.0)
7-11	20 (20.0)
12-16	14 (14.0)
17-21	3 (3.0)
22-26	1 (1.0)

Table 2: HIV Screening Profile of Respondents

VARIABLE	FREQUENCY (%)
HIV Screening	n = 100
Yes	97 (97.0)
No	3 (3.0)
Result of HIV Screening Test	n = 97
Positive	9 (9.3)
Negative	77 (79.4)
Not Aware	11 (11.3)
Duration of HIV Seropositivity(yrs)	n = 9
≤1	3 (33.3)
2	0 (0.0)
3	1 (11.1)
4	1 (11.1)
5	4 (44.4)

HIV Screening Profile of Respondents

Ninety – seven (97.0%) of the 100 respondents were screened for HIV at booking. Nine (9.3%) of the 97 respondents that were screened were found to be HIV positive, 77(79.4%) were found to be HIV negative. While 11(11.3%) were unaware of their screening result (the result was not communicated to them by the doctor). (Table 2)

The table also showed that 4(44.4%) out of the 9 respondents that were found to be HIV positive at screening have been diagnosed HIV positive for about five

years. This was followed by the respondents that were diagnosed HIV positive for less a year with 33.3%. (Table 2)

Table 3: Disclosure of HIV Positive Result by Respondents

VARIABLE	FREQUENCY (%)	
Disclosure of HIV positive result	n = 9	
Yes	6	(66.7)
No	3	(33.3)
Disclosure of positive result was made by	n=6	
Self	2	(33.3)
Healthcare worker	4	(66.7)
Positive result disclosure pattern	n = 6	
Husband	5	(83.3)
Mother	1	(16.7)
Time from diagnosis to disclosure/months	n = 6	
1	1	(16.7)
3	1	(16.7)
4	2	(33.3)
11	2	(33.3)

Out of the 9 respondents with HIV positive result, 6(66.7%) had their result disclosed. Two (33.3%) of the 6 respondents that had their result disclosed made it by themselves, while 4 (66.7%) had the disclosure of their positive result made by the healthcare worker.

The result was disclosed to the husbands in 5 (83.3%) of the 6 respondents with positive result, and to the mother in the remaining 16.7%. Four(66.6%) out of 6

respondents that disclose their positive made the disclosure between 4 and 11 months of diagnosis while the remaining made the disclosure between 1 and 3 months.

Table 4: Distribution of Disclosure of HIV Positive Result by Age, Educational Status and Duration of Marriage

VARIABLE	DISCLOSURE OF HIV POSITIVE RESULT		
Age group(yrs)	YES	NO	
20 – 24	0 (0.0)	1 (16.7)	
25 – 29	4 (66.6)	1 (16.7)	P = 0.40
30 – 34	1 (16.7)	0 (0.0)	Fisher
35 – 39	0 (0.0)	1 (16.7)	exact
40 - 44	1 (16.7)	0 (0.0)	$X^2=4.895$
Educational status			
Quranic	1 916.70	0 (0.0)	
Primary	0 (0,0)	0 (0.0)	p = 0.33
Secondary	1 (16.7)	3 (100)	F/E=
Tertiary	4 (66.7)	0 (0.0)	12.457
Duration of marriage(yrs)			
2 – 6	0 (0.0)	2 (66.7)	
7 – 11	1 (16.7)	1 (33.3)	P = 0.33
12 – 16	2 (33.3)	0 (0.0)	F/E= 5.565
17 – 21	3 (50.0)	0 (0.0)	

Table 4 shows the distribution of disclosure of positive result by age group, educational status and duration of marriage.

The table showed that disclosure of HIV positive result was more (66.6%) in the age group of 25 – 29 years, followed by 30 – 34 age groups. There was no

statistically significant difference in the distribution of disclosure of positive result by age (p = 0.4).

Disclosure of positive result was found to be more among respondents with tertiary level of education. The table showed that all respondents with tertiary level of education disclosed their HIV positive result (66.7%), 1 (16.7%) respondent with Quranic level of education disclosed her result but all the 3(100.0%) respondents that did not disclose their positive have secondary level of education. There was no statistically significant difference found in the association between educational status and disclosure of positive result. (p = 0.33). (Table 4)

Disclosure of HIV positive result was also more with increasing duration of marriage or relationship. The highest (50.0%) disclosure was found in women that were between 17 and 21 years of marriage followed by those within12 – 16 years of marriage duration (33.3%). There was no statistically significant difference found in the association. (p = 0.33).

Table 5: Husbands HIV Screening Profile of HIV Positive Respondents

VARIABLE	FREQUENCY (%)
Husband/Partner tested	
Yes	5 (83.3)
No	1 (16.7)
Husband/partners result	
Positive	3 (60.0)
Negative	2 (40.0)

The table showed that only 1(16.7%) out of the 6 husbands of the respondents with HIV positive who discussed result did not agree to be screened. The respondent reported that the reason given by her husband was he is not prone to contacting infections. Five (83.3%) agreed to be screened for HIV.

Three (60.0%) out the 5 of those that agreed to test were for to be HIV positive while the remaining 2 (40.0%) were HIV negative.

Barriers to Disclosure of HIV Positive Result

All the three respondents that reported non disclosure of their HIV positive result gave fear of divorce as their main reason for not disclosing their HIV positive result.

Table 6: Outcome of HIV Positive Result Disclosure/State of Relationship

OUTCOME	FREQUENCY (%)
Husband indiffeent to test result	1 (16.7)
Encouraging and supportive	2 (33.3)
Domestic violence	1 (16.7)
Blame by the husband	2 (33.3)
Current state of relationship	n = 6
Still in relationship with husband	4 (66.6)
Separated	1 (16.7)
Divorced	1 (16.7)

One (16.7%) of the 6 respondents that disclosed their positive result reported that her husband was indifferent to the outcome of the test result.

Two (33.3%) reported that their husbands encouraged and supported them, 1(16.7%) reported domestic violence, while 2 (33.3%) were blamed by their husbands after disclosing their positive result.

Four (66.6%) out of the 6 respondents that disclosed their HIV positive test result were still in relationship with their husbands, 1 (16.6%) was separated and 1 (16.7%) was divorced.

Out of the 4 respondents that are still in relationship with their husbands, two of the husbands tested positive for HIV. Table 6

Table 7: Disclosure of HIV Negative Result by Respondents

VARIABLE	FREQUENCY (%)
Disclosure of HIV negative result	n = 77
Yes	63 (81.8)
No	14 (18.2)
HIV negative result disclosed to whom	n = 63
Husband	55 (87.3)
Mother	8 (12.7)

Sixty – three (81.8%) of the respondent that tested negative disclosed their HIV negative result while 14(18.2%) did not and 55 (87.3%) out of the 63 that disclosed, reported disclosing to their husbands and 8 (12.7%) disclosed to the mother. (Table 7)

Table 8: Intent to Disclose Result if Positive Result by HIV Negative Respondents

DISCLOSURE	FREQUENCY (%)
Intent to disclose	n = 63
Yes	41 (65.1)
No	19 (30.2)
I don't know	3 (4.8)
If no, why would you not disclose	n = 19
Fear of stigmatization	7 (36.8)
Fear of divorce	12 (63.2)

Table 8 shows that 41 (65.1%) of the 63 respondents that disclosed their negative result reported the intent to still disclose their HIV positive result if found to be positive and this also gave a disclosure rate of 65.1% which is similar to that found for HIV positive respondents. Twelve (63.2%) respondents gave fear of divorce as their main reason for not disclosing, while 7 (36.8%) reported fear of stigmatization as their main reason for not disclosing HIV positive result if they are found to be positive. (Table8)

Table 9: Husbands HIV Screening Profile of HIV Negative Respondents

VARIABLE	FRQUENCY (%)
Husband/partner agree to test	n = 55
Yes	24 (43.6)
No	31 (56.4)
Aware of his result	n = 24
Yes	21 (87.5)
No	3 (12.5)
Test result outcome	n = 21
Positive	1 (4.8)
Negative	20 (95.2)
Reasons for not testing	n = 31
No reason	5 (16.1)
No need since wife is HIV negative	11 (35.5)
Was not told to do so	13 (41.9)
Other reasons	2 (6.5)

Twenty four (43.6%) of the respondents reported that their husband agreed to have HIV test done and 21 (87.5%) of them are aware of the result of their husbands and1 (4.8%) out of 21 reported the husband as being HIV positive. Thirteen (41.9%) reported that their husband did not screen for HIV because they were not told to so, 11 (35.5%) felt there was no need to screen since their wives tested negative for HIV and 5 (16.1%) gave no reason for not screening. (Table 9)

Table 10: Implication of HIV Positive Serostatus Disclosure on PMTCT Related Issues

VARIABLE	FREQUENCY (%)
Support in chosen infant feeding option	
Yes	3 (50.0)
No	3 (50.0)
Remind you to take ARVs	
Yes	3 (50.0)
No	3 (50.0)
Willing to allow hospital delivery	
Yes	4 (66.7)
No	2 (33.3)
Agreed to use condom	
Yes	1 (16.7)
No	5 (83.5)
Reminder on ANC follow up	
Yes	3 (50.0)
No	3 (50.0)

Table 10 shows that out of the 6 respondents that disclosed their HIV positive result, 3(50.0%) reported being supported in terms of choosing infant feeding option, being reminded to take antiretroviral drugs (ARV) and antenatal follow up.

Four (66.7%) of the 6 respondents that disclosed their positive result reported willingness by husband to allow hospital delivery. Only 1(25.0%) of the respondent reported the willingness of her husband to use condom.

4.2 RESULTS OF QUALITATIVE STUDY

Eight focused group discussions were held (HIV negative 4 groups and HIV positive 4 groups). The categorizations of the groups are in appendix 111.

Data for the qualitative part of the study was collected through eight focus group discussions.

The respondents were given numbers from R1 to R8, they were encouraged to discuss freely and say their mind.

4.2.1 GENERAL KNOWLEDGE ABOUT HIV SCREENIN TEST

Majority of the respondents in all the groups agreed that all pregnant women were offered HIV screening test as part of their routine antenatal investigations at booking and all those tested are given their result and the result discussed with the doctor in confidence and the HIV positive ones are further counselled on their condition in secret.

To my understanding it is done to all women, no discrimination and the only time you can know of a woman's result is if she comes out of the doctors or the counsellors room crying. R6 a 35 year old para 4 from kware, FGD2.

Honestly everybody is given the test to do but we are told that the test is not compulsory but is for our own benefit and also for the health of our baby. R7 an 18 year old para 2 from Mabera area, FGD7

HIV positive result for most of the respondents who participated in the FGDS means that one is infected and has the disease. HIV negative result means that one does not have the disease.

For me, what I can say from what the doctor told me positive is having HIV and negative means one does not have HIV. So he said to me and I can never forget that YOUR RESULT IS POSITIVE (crying). R5 a 25 year old para 3 from Dange – Shuni area, FGD5.

The opinion of the majority of the respondents on implications or consequences of HIV positive result on their unborn baby and husband is the same. They are of the opinion that HIV can be contracted by the baby if the woman is not on drugs and so also the husband. They also believe that the main reason for doing HIV screening test is to prevent this.

By the time a pregnant woman is told that she is HIV positive the first thing that will come to her mind is that the baby already has the problem but thanks to the drugs we are taking we are told that if we take them religiously our babies will be delivered without the disease. We were also told to tell our husbands to use condom but most men don't like using condom. For me my husband is also positive so he already has the problem. R4, a 33 year old para 2 from old airport area, FGD8

To my own understanding if a woman is HIV positive only God can save her baby and I know the husband can be infected from the woman if he is not the one that gave her the disease. It is important for any HIV pregnant woman to take drugs so that her baby does not get the disease and also the woman if the man is negative should do anything possible so that the man doesn't get it. R3, a 21 year old para 1 from Gawo area. FGD3

Most of the respondents from the rural area believe that one's you tested negative that is all no need to inform anybody even the husband and also the husband does not need to screen. Also most of the HIV negative respondents share the same opinion. Contrary to this opinion most of the HIV positive respondents believe that one should inform her husband of the result so that the husband can equally test because it is possible for the woman to be negative and the man positive.

4.2.2 DISCLOSURE OF HIV POSITIVE TEST RESULT

Most of the FGD respondents felt that it is very important for a HIV positive woman to disclose her positive test result. They unanimously agreed that the result should be disclosed to husband and parents especially the mother because they felt it is only the husband and mother that can keep secret. Few are of the opinion that it should be disclosed to the husband only, parents should not be told about the result because parents tend to get worried about the problems of

their children, so in other not to disturb them they should be left alone. Very few believe that the result should be disclosed to other family members.

*Truly in my own opinion HIV positive result should only be disclosed to the husband and nobody else, please live parents out of this problem. I know if I tell my mother that I am HIV positive she will die of hypertension. God forbid I will not tell her. R6 a 31 year old para 2 HIV positive from Tudun wada area.*FGD 8

If my result is found to be positive, I will definitely tell my husband and my mother because it is only your husband that can keep your secret and it is only the mother that can share both sorrow and happiness with you. R1 a 30 year old para 5 from Kware area.FGD 2

It was agreed by most if not all the respondents that the best person to disclose a HIV positive test result is the health worker. It is the health worker that can break such information without much family problem. Majority said they will be afraid to go back home with such bad information because they do not know what will follow. Some believe that healthcare workers are specially trained in breaking bad news.

Three respondents from different FGD groups said they will go back home and inform their husbands because there should be very good understand between husband and wife. R8 a 37 year old para 4 from FGD 7 said *the day I was told that my HIV test result was positive I went home straight to tell my husband*

because I know for sure that I got it from him, so why should I be afraid of telling him.

4.2.3 OUTCOME OF DISCLOSURE OF HIV POSITIVE RESULT

Majority said, the usual reaction after disclosure of a positive test result by husbands is shock, some can even breakdown. If the man is HIV negative he can decide to divorce or abandon you but if the man is found to be HIV positive he has no option but to support you so that you can keep your secret together. In terms of disclosure to other relations all believe that only few will be supportive most will discriminate and stigmatize.

Thanks be to God almighty, the day I told my husband about my result, he started shedding tears like a boy, so I was the one consoling him. Then he did not say anything. Later in the night he woke me up from sleep and asked me again if what i said in the afternoon was true. I told him yes, and then he said he had wanted to tell me for more than a year now that he was also diagnosed as having the same problem but did not know how to break the news. Now the time has come. He asked for my forgiveness for keeping it a secret for such a long time and since then our life became different now we live like brother and sister no more quarrels. Is it because we know we will soon die (laughter). R4 a 35 year old para 2 from Hajiya Halima area.FGD8

4.2.4 BARRIES TO DISCLOSURE OF HIV POSITIVE RESULT

The reason why most women will not disclose their positive HIV test result did not differ in all the FGD groups and the single most important reason put forward by all the groups is fear of divorce followed by stigma and discrimination. They believe if one is positive and divorced by the husband nobody will accept the woman even her parents talk less of other people in the society.

God forbid, if I am found to be HIV positive I don't think I can ever tell my husband because he will beat the hell out of me and then throw me out of the house because in my village it is assumed that anybody with HIV has cheated or is still cheating on her husband, so nobody will want to associate with her. R1 a 20 year old primigravida from Achida area. FGD 1

I have been diagnosed to be HIV positive for about 8 months now but I am yet to tell my husband because if I tell him he will never allow me to stay in his house and my people will abandon me. R4 a 23 year old para 1 from Gwadabawa. FGD 5

In general all respondents were happy with the test and they all fill that it should be extended to other hospitals so that everybody is given the opportunity to know his or her status and our unborn babies can be saved from contracting the disease.

CHAPTER FIVE

5.0 DISCUSSION, CONCLUSION AND RECOMMENDATIONS

5.1 DISCUSSION

Disclosure of HIV positive result is a complex, difficult and very personal matter. Disclosing one's HIV positive status entails communication about a potentially life threatening, stigmatized and transmissible illness. Choices people make about this are not only personal but vary across different age groups, in different situations and context, and with different partners and may change with time, depending on one's experiences.

The mean age of the participants in the study was 27.45 ± 4.92years. This is similar to that obtained by Sagay et al[25] where the mean age was 29 years. The mean parity of the participants was 2.4 this is similar to that obtained in studies in Nnewi.[37] the place of study being a tertiary health centre could probably be responsible for the high proportion of participants with tertiary education. Islam was the predominant religion and Hausa was the predominant ethnic group. This could be due to the fact that Islam is the predominant religion among the populace in Sokoto.

The rates of HIV serostatus disclosure varies among countries and also within countries.[28,38,39,40]

The HIV disclosure rate of 66.7% among HIV positive women found in this study was comparable to the 67.8% reported by Daniel et al,[26] lower than the rates reported in other parts of Nigeria,[25, 41] and higher than 59% reported among the South African women.[39] Disclosure rate of 82.0% was found among HIV negative women in this study. In HIV negative women, the intent to disclose HIV positive result if found to be positive the disclosure rate was 65.1%. This is closely related to the disclosure rate found in HIV positive women. The rate of disclosure of HIV serostatus is higher among women in U.S – based studies than among women in developing countries with rates of 42 – 100% in the U. S compared with 16 – 86% in developing countries.[42]

Disclosure of HIV positive was made with the help of the healthcare provider in the majority of the participants in this study, however in a study by Sagay et al[25] on partner disclosure of HIV status among HIV positive mothers, the disclosure of HIV positive result was made in about half of the women by themselves. The pattern of disclosure from this study shows that majority of the participants had disclosed to their husbands. This is common trend and is in agreement with other studies done elsewhere. [25,26, 38] also further supported by the result of FGD. R8 a 37 year old para 4 from FGD 7 said *"the day I was told that my HIV test result was positive I went home straight to tell my husband because I know for sure that I got it from him, so why should I be afraid of telling him."*

Disclosure was equally made to the mother. In Nigeria the mothers were more likely to be confided in than fathers with respect to HIV status disclosure.[17, 41]

There was no correlation between the duration of knowledge of test result and disclosure of HIV positive result in this study, but a variance with the findings in a study among women in Ethiopia[43]that reported women who have known their result for a year or more were more likely to disclose their HIV positive test result. This implies that rate of disclosure increases over time as people adjust to their results.

Disclosure was more among women in the age group of 25 – 29 years, this compares well with findings by Farquhar[35] et al and Galliard[36] et al that young women (under the age of 24 years) were more likely to disclose their test result to sexual partners than older women, this finding is similar to the findings in this study . The study also showed that women with tertiary level of education were more likely to disclose their HIV positive test result; this is in agreement with what Issiaka[29] et al findings that women with higher level of education were more likely to share their results with their partner than women who are illiterate.

It was found out from the study that disclosure of HIV positive result was more with increasing duration of marriage however, there was no statistical correlation between the duration of marriage and disclosure of HIV positive

result in this study; this could be due to the low proportion of participants with HIV positive result. This finding is in concordance with the findings in a study by Antelman et al.[28] He reported that the type and duration of relationship between the woman and her partner were major determinants of disclosure. He found that women who had been in relationship for longer period of time (defined as >2 years) were more likely to disclose than women who had been in relationship for a shorter duration.

Majority of the HIV positive participants in this study were aware of their husbands HIV serostatus, and most of the husbands were reported to be HIV positive. This is similar to that obtained in a study in Northern Nigeria.[25] Majority of the HIV negative participants reported their husbands as being HIV negative. The HIV negative participants also reported that most of the husbands that did not screen for HIV were not told to do so and some reported that the husbands felt there was no need to screen since the woman is negative. This implies deficiencies on the part of the healthcare workers.

The identified reasons for nondisclosure of serostatus were fear of stigmatization, divorce/separation, abandonment and violent reactions from the partners.[44, 45]The most important barrier to disclosure reported by the participants in this study was fear of divorce. This finding is further supported by the result of FGD. *God forbid, if I am found to be HIV positive I don't think I can ever tell my husband because he will beat the hell out of me and then throw*

me out of the house because in my village it is assumed that anybody with HIV has cheated or is still cheating on his husband, so nobody will want to associate with her. R1 A 20 year old primigravida from Achida area.FGD 1.

I have been diagnosed to be HIV positive for about 8 months now but I am yet to tell my husband because if I tell him he will never allow me to stay in his house and my people will abandon me. R4 A 23 year old para 1 from Gwadabawa. FGD 5 The findings in this study compares well with the findings of Igwegbe.[37]

Several studies have reported positive outcome following the disclosure of HIV positive result.[24,29,46] Sagay et al reported that 86.9% of the partners were supportive and 5.7% were indifferent to the test result. in another study Suzanne et al reported that majority of the HIV negative women and almost half of the HIV positive women reported that their partners reacted supportively to the disclosure of serostatus.[47] This study showed that the outcome of disclosure was equally positive as 66.6% were still in relationship with their husbands also some reported their husbands as being supportive and encouraging even though there was reported divorce and separation.

In relation to PMTCT the participants reported positive response from their husbands. It is encouraging to note that most of them were supportive in chosen the best infant feeding option, reminder to take ARVs, attend ANC and

permission for hospital delivery. On the issue of the use of condom it was only one respondent that reported her husband has agreed to use condom.

5. 2 CONCLUSION AND RECOMMENDATIONS

5. 2. 1 CONCLUSION

The findings in this study revealed that the prevalence of HIV serostatus disclosure is high in both HIV positive and negative participants. The most important barrier to serostatus disclosure among HIV positive women was fear of divorce. The study also showed that the outcome of HIV positive serostatus disclosure was positive with majority still being in relationship with their husbands and the husbands being supportive. The study showed that the participants reported positive response from their husbands in relation to issues that are supportive for the prevention of mother to child transmission of HIV.

5. 2. 2 RECOMMENDATIONS

In view of the findings in this study, it recommended that, public health education should be intensified to increase the knowledge of HIV, the need and importance of disclosure of both positive and negative test result. This can be achieved through mass media and health talks in the health facilities.

Health promoting activities like the safe practices should be encouraged to reduce the risk of new HIV infection.

Involvement of male partner should be early in the HIV counselling and testing processes as this my bypass or reduce many of the barriers associated with disclosure.

Since fear of divorce is the only identified barrier to disclosure in this study, counselling for serostatus disclosure among women should specifically address this issue.

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APPENDIX I

QUESTIONNAIRE ON

HIV SEROSTATUS DISCLOSURE AMONGST PREGNANT WOMEN ATTENDING ANTENATAL CARE AT UDUTH, SOKOTO

INTRODUCTION

My name is Dr Sadiya Nasir from the Department of Obstetrics & Gynaecology UDUTH, Sokoto. I am conducting a survey on the above subject matter as part of the fulfilment for the award of Masters Degree in Public Health. The study is aimed at knowing whether pregnant women inform their partners and other family members of their test result after HIV test and what followed after such disclosure. The outcome of the study will help in finding ways to overcome problems that follow disclosure of HIV test result.

Your participation is voluntary, and your response will be strictly confidential.

Thank you for the anticipated cooperation.

CONSENT: I agree to take part in the study

a. Yes [ ] b. No [ ]

SECTION A: SOCIO-DEMOGRAPHIC CHARACTERISTICS OF RESPONDENTS

1. Age -------- yrs
2. Parity: ---------
3. Educational status: a. None[ ] b. Quranic [ ]

   c. Primary [ ] d. Secondary [ ] e. Tertiary [ ]
4. Marital status: a. Married [ ] b. Single [ ] c. Divorced [ ]

   d. Separated [ ] e. Widowed [ ]
5. Duration of marriage or relationship ---------- yrs
6. Tribe: a. Igbo [ ] b. Hausa [ ] c. Yoruba [ ] d. Others----------please specify
7. Religion: a. Islam [ ] b. Christianity [ ] c. Others----------please specify

SECTION B: HIV SCREENING AND PATTERN OF DISCLOSURE OF POSITVE RESULT

8. Have you been screened for HIV?

   a. Yes [ ] b. No [ ]

9. If yes, what is the finding? a. Positive [ ] b. Negative [ ] c. Not aware of test result [ ] (pls interviewer should confirm from folder)

10. If Positive duration of HIV seropositivity -------- yrs

11. Have you disclosed your HIV test result a. Yes [ ] b. No [ ]

12. If yes, to whom a. Husband [ ] b. Mother [ ] c. Father [ ] d. Sister[ ] e. Close friend [ ] f. Religious leader [ ]

13. Who disclosed the result: a. Self [ ] b. Healthcare provider [ ]

14. Length of time from diagnosis to disclosure ----------mnts

15. Has your partner agreed to be tested? a. Yes [ ] b. No [ ]

16. If yes, are you aware of his result? a. Yes [ ] b. No [ ]

17. If yes, what is the result? a. Positive [ ] b. Negative [ ]

18. Why has he not agreed to be tested?

    a. No reason [ ]

    b. Not prone to contacting infections [ ]

    c. Afraid of the test outcome [ ]

    d. Already know his status [ ]

    e. Others----------

SECTION C: BARRIERS TO DISCLOSURE OF HIV POSITIVE TEST RESULT

19. Which one among the following do you consider as the most important reason that made you not to have disclosed your HIV positive test result

a. Fear of abandonment [ ]

b. Fear of Rejection [ ]

c. Fear of Stigmatization [ ]

d. Fear of Violence [ ]

e. Fear of upsetting family relation [ ]

f. Fear of Accusation of infidelity [ ]

g. Fear of Loss of economic support [ ]

h. Fear of divorce [ ]

SECTION D: OUTCOME OF DISCLOSURE OF HIV POSITIVE TEST RESULT

20. What was your partners' reaction after disclosing your HIV test result?

a. Husband/partner indifferent to text result [ ]

b. Encouraging/supportive attitude [ ]

c. Domestic violence [ ]

d. Blame by husband/partner [ ]

21. What is the current state of your marriage/relationship after disclosing your HIV positive test result to your husband/partner?

a. Still in relationship with husband/partner [ ]

b. Separated from husband/partner [ ]

c. Divorced [ ]

SECTION E: IMPLICATIONS OF DISCLOSING HIV POSITIVE TEST RESULT ON PMTCT

22. Does your partner support you in terms of chosen the best infant feeding option?

a. Yes [ ] b. No[ ]

23. Does he remind you to take your ARVs a. Yes [ ] b. No[ ]

24. Is he willing to allow you to deliver in the hospital? a. Yes [ ] b. No[ ]

25. Has he agreed to use condom a. Yes [ ] b. No [ ]

26. Does he remind you about ANC follow up a. Yes [ ] b. No [ ]

SECTION F: **PATTERN OF DISCLOSURE OF NEGATIVE TEST RESULT**

27. Have you disclose your HIV negative test result to anybody

a. Yes [ ] b. No [ ]

28. If yes, to whom: a. Husband [ ] b. mother [ ] c. Father [ ]

d. Sister [ ] e. Close friend [ ]

29. Has your partner agreed to be tested a. Yes [ ] b. No [

30. If no, why has he refused to be tested?

a. No reason

b. No need since the wife/partner is HIV Negative

c. Was not told to do so

d. Other reasons----------

31. If yes, are you aware of his result a. Yes [ ] b. No [ ]

32. If yes, what was the result? a. Positive [ ] b. Negative [ ]

SECTION G: INTENT TO DISCLOSE RESULT IF POSITIVE AMONG RESPONDENTS WITH HIV NEGATIVE RESULT

33. Had it been you were found to be positive, would you have still disclose your test result

a. Yes [ ] b. No [ ] c. I don't know [ ]

34. If no, which of the following do you consider as the most important reason for not disclosing your result?

a. Fear of abandonment [ ]

b. Fear of Rejection [ ]

c. Fear of Stigmatization [ ]

d. Fear of Violence [ ]

e. Fear of upsetting family relation [ ]

f. Fear of Accusation of infidelity [ ]

g. Fear of Loss of economic support [ ]

h. Fear of divorce [ ]

Thank you for taking your time.

APPENDIX II

HIV SEROSTATUS DISCLOSURE AMONGST WOMEN ATTENDING ANTE NATAL CARE (ANC) AT UDUTH, SOKOTO.

FOCUS GROUP DISCUSSION GUIDE

S/No of FGD----------

Age – (15 – 29) (30 – 44)

Location – (Urban) (Rural)

S/NO	STEM QUESTION	RESPONDENTS REMARKS
1.	**Is it true that all pregnant women do have HIV testing as part of their routine investigations?**	R1
		R2
		R3
		R4
		R5
		R6
		R7
		R8
2.	**Is it all those that are tested that are shown and informed of their result or only some?**	R1
		R2
		R3
		R4
		R5
		R6
		R7
		R8

3.	**What do you understand by positive or negative result of HIV test?**	R1
		R2
		R3
		R4
		R5
		R6
		R7
		R8
4.	**What in your opinion are the consequences of a positive test result both for your baby and for your partner?**	R1
		R2
		R3
		R4
		R5
		R6
		R7
		R8
5.	**What in your opinion are the implications of a negative result?**	R1
		R2
		R3
		R4
		R5
		R6
		R7
		R8

6.	**Do you think one should disclose the result of her positive test to her husband or partner or even other people like family members?**	R1
		R2
		R3
		R4
		R5
		R6
		R7
		R8
7.	**Who do you think it is appropriate to disclose the result of a positive test to her husband/relations, is it the woman herself or the health care worker?**	R1
		R2
		R3
		R4
		R5
		R6
		R7
		R8
8.	**What do you think will be the reaction of the husband or relations if you disclose to them that you are positive?**	R1
		R2
		R3
		R4
		R5
		R6
		R7
		R8

9.	**What are the reasons why one may not wish to disclose the result of a positive test to his partner/husband and other family members?**	R1
		R2
		R3
		R4
		R5
		R6
		R7
		R8
10.	**If you have disclosed the result of a positive test to your husband and or family members, what was their reaction**	R1
		R2
		R3
		R4
		R5
		R6
		R7
		R8
11.	**Are you happy about this testing of HIV? Would you recommend to others to embrace it or not?**	R1
		R2
		R3
		R4
		R5
		R6
		R7
		R8

APPENDIX III

FGD COMPOSITIONS

FGD	HIV STATUS	AGE GROUP	PLACE OF RESIDENCE
1	NEGATIVE	15 -29	RURAL
2	NEGATIVE	30 - 44	RURAL
3	NEGATIVE	15 - 29	URBAN
4	NEGATIVE	30 - 44	URBAN
5	POSITVE	15 - 29	RURAL
6	POSITIVE	30 - 44	RURAL
7	POSITVE	15 - 29	URBAN
8	POSITVE	30 - 44	URBAN