



A study to examine the relationship between HIV status disclosure and social support among people living with HIV and AIDS aged 18 to 64 years at Bindura provincial hospital OI/ART clinic

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Abstract

The purpose of the study was to examine the relationship between HIV status disclosure and social support among people living with HIV and AIDS aged 18 to 64 years at Bindura Provincial Hospital OI/ART clinic. Descriptive Correlational design was used. A sample size of 236 respondents were chosen into the study using the simple random sampling technique with a rotary method. Data were collected using interviewer-administered questionnaire for a period of four weeks. Statistical software Package for Social Sciences (SPSS) was used to analyse data. Results revealed that 138 (58, 5%) respondents disclosed their HIV sero positive status and hundred nigh teen (86%) respondents received social support. Pearson correlation coefficient ($r=.815;p<.01$) showed a statistically significant strong positive relationship. Social support had an impact of 66, 4% on HIV status disclosure ($R^2=664$). HIV disclosure services should be strengthened in order to promote disclosure among people living with HIV and AIDS.

Keywords: HIV status disclosure, HIV, AIDS, provincial hospital

1. Introduction

Human Immune-virus (HIV) is the virus that causes the disease acquired immune-deficiency syndrome (AIDS). HIV continues to be a major global public health topic, having claimed 35 million so far, World Health Organisation (WHO, 2016). Sub-Sahara Africa has the most serious HIV and AIDS epidemic in the globe. In 2013 an estimated 24,7million people were living with HIV, accounting for 71% of the worldwide total. In the same year there estimated 1.5 million new HIV infection and 1.1 million deaths (UNAIDS, 2016) [30].

According to UNAIDS, 2016 [30], Zimbabwe has the fifth largest HIV prevalence in the Sub-Saharan Africa constituting a rate of 15%. In addition, approximately 1.4 million individuals are apparently living with HIV, and this includes 170 000 children, constituting up to 4% of the global total. Furthermore, HIV and AIDS statistics in Zimbabwe show that the prevalence rate is still very high at 15% as in 2014 (UNAIDS 2016) [30]. About 64 000 deaths which were AIDS related were experienced in the same year. HIV Prevalence in Zimbabwe declined from 15% in 2010 to 13,8% in 2015, however, Zimbabwe is still far away from the elimination of the epidemic as one in five women and one in three men have never tested for HIV (ZDHS, 2015).

Disclosure of HIV status continues to be the main obstruction in the battle against the spread of HIV in sub-

Saharan Africa (Amberbir, Woldemichael, Getachew, Girma Deribe, 2008) [3]. Disclosure of HIV-status is distinctively a selective process that occurs based in cognitive consideration of sincere and confidence of others and perceived determinants and benefits to PLWH (Stutterheim, Shiripinda, Bos, Pryor, Bruin, Wellen, 2011) [29]. One of the major benefits of disclosure can be social support which is an essential or critical resource to deal effectively and successfully with HIV infection (Bos, Kanner, Muri, Janssen, Mayer, 2009) [7]. Social support is an important component or feature of psychological adjustment or modification that can promote well-being for many people living with HIV, but receiving social support is required to disclose HIV status from PLWH (Smith, Rossetto, Peterson, 2008). It has been however noticed that disclosure of one`s HIV status has a positive bearing on social support since it plays a pivotal role in promoting as well as maintaining ART adherence among people living with HIV infection.

Disclosure extremely increases opportunities for obtaining social support, implementation of HIV risk reduction with partners and motivates the partners to seek voluntary counselling and testing (VCT) (Gari, Habte and Markos, 2012). Disclosure of one`s HIV sero-positive results could as well encourage partners to seek HIV testing or reduce hazardous behaviours/conducts, and eventually reduce the spread of HIV (Amberbir, *et al.*, 2008) [3]. They made it

clear that couples are encouraged to have their partners tested based on expected benefits from institutions such as basic healthcare and material support from organizations (Amberbir *et al.*, 2008)^[3]

Nevertheless, the revelation of one's HIV status could result in negative consequences, including the deprivation of societal living. Many PLWHA, after disclosing their HIV status, are victims of discrimination, stigmatization, rejection and sometimes, violent reactions (Seid, Wasie and Admassu, 2012)^[25]. A study conducted in Zimbabwe revealed that HIV infected women were two times less likely to disclose their status in fear of abuse, and divorce (Mucheto, Chadambuka, shambira, Tshimanga, 2009)^[22]. Women, who realised large risk of HIV stigma, were less likely to disclose HIV status to a spouse (Anglewicz and Chintsanya, 2011)^[4].

In Zimbabwe, most strategies for the prevention of HIV transmission are mainly campaigns to raise public awareness of individual behaviour change, Prevention of Mother to Child Transmission among (PMTCT), Antiretroviral Therapy (ART), Voluntary Male Circumcision (VMC) and HIV Testing and Counselling (VCT). However to meet these prevention strategies, HIV status disclosure is very fundamental.

1.1 Problem Statement

Zimbabwe has adopted the fast track concept of the United Nations Program on HIV/AIDS, which aims at ending Aids epidemic by 2030. The set targets that need to be reached by 2020 include the 90:90:90 strategy, that is 90% of people living with HIV should know their status, 90% of people who know their HIV status are put on Anti-Retroviral Therapy (ART) and 90% of people on ART have their viral loads successfully suppressed (ZNNP, 2016) and (ZDHS 2015).

According to the NAC, HIV Framework (2016) the government of Zimbabwe remains committed to achieving zero new HIV infection, zero Aids related deaths and zero stigma and discrimination. HIV prevalence in Zimbabwe declined from 15% in 2010 to 13.8% in 2015. However, Zimbabwe is still very far from elimination of the HIV epidemic as one in five women and one in three men have never tested for HIV (ZDHS, 2015).

The success or failure of these efforts depends on the willingness and ability of HIV positive individuals to directly or indirectly reveal their HIV status and also its links to confidentiality as a human right issue (Obermeyer, Baijail, Peguri, 2011). Studies have shown that disclosure is a paramount important public health goal for a number of additional reasons. Disclosure might cause less social isolation, and help facilitate access to social support, health care and social services. According to research conducted by Serovich (2011), people living with HIV who decide to disclose their HIV status are inclined to feel better emotionally as well as having less amount of stress than individuals who do not disclose. Other benefits of disclosure of HIV status include safe sex practices, having a treatment supporter who can assist in ART adherence than those who do not have (Patel, Ratner, Gore-Felto, Kadzirange, Woek, Katzenstein, 2012)^[24]. Health care givers have a responsibility towards (Adeoye-Agboola, Evans, Hewson and Pappas, 2016)^[1]

However, HIV status disclosure also poses a number of potential risks for individuals. Research conducted by Leonard and Ellen (2008)^[17] indicated that disclosure can complicate life instead of making it easier. They established that disclosure of HIV positive status in certain situations did not yield anticipated social support, but instead caused more worry along with stress. Additionally, the disclosure of HIV positive status does not constantly lead to relief, and may be followed with disappointments. A number of researchers have reported that disclosing one's HIV- sero positive status frequently result with HIV stigmatization and discrimination instead of increasing social support. Individuals will end up isolating themselves as a coping mechanism (Audet, Macgowan, Kipp, 2013)^[6]. Research conducted by Sukmaningrum, (2015) in Indonesia indicated that HIV positive disclosure had the extreme percentage of unaccommodating outcomes from family unit .

However, there is inadequate information pertaining the prevalence and pattern of HIV status disclosure in Zimbabwe and few studies have been done in Zimbabwe pertaining disclosure of status and social support. Therefore, additional local research studies are called for in order to measure the level of disclosure for OI/ART programs among people living with HIV. The researcher was prompted to conduct a study to establish the relationship between HIV status disclosure and social support among people living HIV and AIDS. Focus much into disclosure status to bridge the gaps between HIV/AIDS management and disclosure towards achieving the three zeros, that is, zero HIV related new HIV infection, and zero HIV related deaths and zero stigma and discrimination by 2018.

Therefore, government's efforts are of no effect if people are not willing to be disclose their HIV status. Hence, Disclosure of an HIV-positive diagnosis is a major challenge for PLWHA as they risk negative consequences such as anxiousness, violence, stigma and threats to personal well-being, which make people afraid to divulge their condition. However, this hinders social support which is critical in the management of HIV/AIDS. Thus there is need to establish the relationship between disclosure and social support.

2. Methodology

This study employed a descriptive correlation design. This quantitative non-probability study design allowed the investigator to scrutinise the relationship between HIV status disclosure and social support among PLWHA at Bindura Provincial Hospital. The target population consisted of HIV positive respondents attending OI/ ART clinic at the Bindura Provincial Hospital who was aged 18 -64 years. Data was edited for accuracy, readability, consistence and completeness; thereafter it was coded and then entered into a computer using software SPSS (Statistical Package for the Social Sciences) version 20, 0.

3. Results and Discussion of findings

3.1 Sample Demographics

The sample consisted of 236 respondents living with HIV and AIDS. The study comprised of 103 (43, 6%) males and 133(56, 4%) females as gender/sex distribution. In this study the impression was more women sought HIV treatment than males. Women are more vulnerable than their

male counterparts, the disproportional impact on women can be attributed to several factors such as biological/physiological, social, behavioural, cultural and economic (Gita Ramjee & Brodie Daniel, 2013) ^[12]. The respondents in this study were between the age of 19 and 64 years. The mean age was 35, 5% most of the respondents were between 35 and 44 years, while few were between 55-64 (11%) and those between 18-24 years (13%).

The observed results indicated that the majority of respondents were not formally employed 66 (28%), self-employed 61(25,8%), combination of 1 and 2 were 4 (1,7%), unemployed 46(19,5%), pensioners 5 (2,1%), those who survived by farming were 44 (18,6%) and the house keepers were 10 (4,2%). This could most probably be due to high levels of unemployment in Zimbabwe which is estimated at 92% (Zimbabwe Demographic Survey, 2015) ^[31]. Unemployment has an implication in both HIV status disclosure and social support in the sense that people who are not employed are always mobile seeking to earn a living hence they also have limited time to interaction with members of the society therefore time to disclose and to receive support is also limited.

In case of religion most of the respondents were Christians 99 (41, 9%), apostolic sect accounted for 62 (26, 3%), atheist none and traditional had 38 (16, 1%). A study conducted in Tanzania revealed that on factors associated with intention to disclose to the religious community if HIV- infected, majority were willing to disclose their HIV status to the religious community (Zou *et al.*, 2009).

In terms of where the respondents stay, 29 (12, 3%) were staying in mines while the majority of respondents stayed in urban 110 (46, 6%), communal accounted for 5 (2, 1%) of the respondents, those who stayed in farms were also many this is because Bindura Provincial hospital is surrounded by farms. Those who stayed in urban area in Bindura had benefited from Non-Governmental Organisations (NGO) as compared with those in the same district. This provision promoted HIV status disclosure as it was a prerequisite for this type of support.

Forty four (18, 6%) were staying alone, those women stayed with their husband was 85 (36%), with wife was 109 (46, 2%), parents 5 (2, 1%), brother /sister/cousin were 13 (5, 5%) and 18% of the respondents were staying alone. Those who were staying with their husbands were 85 (36%). These respondents had high chances of receiving support from their spouses; however they were also at risk of facing domestic disputes leading to physical violence. This was also highlighted in the study conducted as consequence of HIV status disclosure. The 109 (46, 2%) of the respondents were staying with their wives, in this regard, once disclosure was done to their wives, they could offer social support as much as possible. Those respondents who stayed with their parents were 5 (2, 1%). This means that they had higher chances of getting support from their parents since their parents can never neglect their children because of the biological bond or component. 13 (5, 5%) respondents indicated that they stayed with brother/sister/uncle hence chances of disclosing and receiving social support would be moderate.

In terms of employment status of the respondents partner`s, unemployment was 100 (42.4%), employed 90 (38.1%) and self-employed 46 (19.6%). It is clear therefore that the

majority of the respondent`s partners were unemployed. Hence they will probably be unable to support their partners.

In terms of the employment status of the respondents `partners, unemployment 100 (42,4%), employed 90 (38,1%) and self-employed were 46 (19,6%). This however may have negative effect on social support since the partner will not be able to sustain his or her family needs particularly those that require money to purchase such as food (Personal communication).

On the knowledge of partners HIV status 104 (44%) of the respondents partners were HIV positive, 31 (13, 1%) also knew the status of their partners which was negative and those who did not know their partner`s HIV status were 53 (22, 5%). Majority of the respondents had their partner who were HIV positive 104 (44%), This is comparable with the study conducted in Ethiopia where they revealed that knowing of the partner, HIV status determines the decision to disclose their status to their partners (Alemayehu *et al.*, 2014). Thirty one (13, 1%) knew their partners HIV status as negative again that shows one`s openness to disclose HIV status, however 53 (22, 5%) were not aware of their partner`s support this shows that there were some people who still did not want to disclose their HIV status.

3.2 HIV status disclosure

In this study it is interesting to note that all respondents received adherence counselling which is the component of disclosure in order to have a treatment bud in order to promote ART adherence among people living with HIV. It is a mandate in Zimbabwe that every client who wants to be tested for HIV must go through counselling sessions that is pre and post counselling then and also ART adherence counselling before and after ART initiation. Counselling is used much in Sub-Saharan Africa. Bott & Obermeyer (2013) ^[8] explained that in Sub Saharan Africa utilisation of HIV and counselling and access to treatment has expanded greatly in the recent years, though the coverage is very low. Majority of the respondents 133(56, 4%) disclosed this means that they had high chances of getting social support. Shushtari, *et al.* 2014 ^[27] found that each person with HIV may decide with whom he/she may want to disclose for requesting for assistance, information and support. Those who did not disclose their HIV status were 98 (41,5%). This means that these respondents were not receiving social support which was important in HIV management. However major benefits of disclosure is social support which is essential for effective coping with HIV infection, to receive social support requires disclosing (Shushtari, *et al.*, 2014) ^[27] The reasons why some of the respondents did not disclose their HIV were, cultural beliefs 65 (27,5%), stigma 50 (21,2%), discrimination 34 (14,4%), divorce 31 (13,1%), rejection 24(10,2%), blame 13 (5,5%), accusation of infidelity 10 (4,2%) and physical violence 7(3%). Respondents who did not disclose their HIV status due to cultural beliefs 65 (27, 5%). This shows that cultural beliefs affected the disclosure of HIV status. In most African countries HIV is associated with witchcraft hence they did not disclose their HIV status. This hindered their chance of receiving social support. Those who feared stigmatisation and cultural beliefs did not receiving support in order to

cope with HIV infection. This was found in Uganda where people living with HIV were more affected by stigma suffered additional burden of losing social support. The emotional and material resources provided by social support are important for people living with HIV (Takada, *et al.*, 2015) and in this study it was not forthcoming. Some people feared divorced 31 (13, 1%) most likely because they wanted to maintain their marriages. The findings were also found in Uganda where 42% feared to be divorced (Kadowa Nuwaha (2009) ^[15]). The respondents did not want to be rejected by their families and they decided not disclose their HIV status to anyone and the rejection accounted for 24 (10%) hence they did not receive support. This was in agreement with findings by Norman *et al.*, 2007 that some of the respondents were rejected following the disclosure of HIV positive diagnosis status to their family members. Accusation of infidelity 10(4, 2%) this is very common in marriage where partners accuse one another of infidelity when infected with HIV instead of accepting the condition and move on with life. Another study with similar findings had found out that (23%) of respondents feared accusation of promiscuity/ infidelity (Kadowa & Nuwaha, 2009) ^[15]. Physical violence 7 (3%) was also another contributing factor of not disclosing HIV status by the respondents. Physical violence had negative effect on HIV disclosure; misunderstanding or conflicts may arise in the family as to how and who brought the HIV infection home. This is in agreement with a study conducted by Norman, *et al.*, (2007). They found that non-disclosure of HIV status was due to fear of stigma, discrimination, self-adjustment to positive diagnosis, fear of being labelled, fear of rejection and being a burden to family members.

For the 133(56,4%) who decided to disclose, there was variation in the length of time taken by the respondents to decide on when to disclose their HIV status, those who disclosed within 1 week or less were 51 (21,6%), up to one month were 43(18,2%) and those who took more than six months were 31 (13,1%). This information showed that HIV status disclosure is a process that one might undergo hence people needed time to disclose their HIV status to anyone. Respondents in this study with a standard level of education were 107 (45, 3%). This revealed the importance of education since all respondents went through adherence counselling they managed to comprehend the importance of disclosure during the counselling process. However, variation of time to disclose showed that disclosure is a selective process where an individual would decide when and who to disclose to. These outcomes support what Eustace & Ilagan (2010) says about disclosure that it is a voluntary or an involuntary where an individual decision about whom to inform about one's sero-status as well as, why, when, where and how to do it.

Those who disclosed their HIV status, 75(31, 8%) disclosed to their spouses, 73(31%) disclosed to their parents, 52 (22%) disclosed to their siblings, 15(6, 4%) disclosed to their children their HIV status, 10 (4, 2%) disclosed to in-laws, 7(2, 9%) disclosed to friends and those who disclosed to their work mates were 4 (1, 7%). Majority of the respondents disclosed their status to their spouse. This is very important because disclosing one's HIV status helps the partners seek HIV testing as well as seeking for treatment. Disclosing to partner promoted respondents to

seek a health living behaviour, which is, eating natural food in order to boost the immune system. Disclosing to spouse also promoted prevention and promoting safe sex. The findings were similar to the study conducted by Deribe *et al.* (2008) ^[3].

In addition, Deribe *et al.* also revealed that disclosure of sero-status increases participation in preventive behaviour, access to support for dealing with HIV related illnesses, influence partners to pursue testing, behaviour modification, thereby culminating in decrease of HIV transmission. Mlambo and Peltzer, (2011) also found that after learning the partner's HIV status, most of the respondents used condoms. Also, 73 (31%) of the respondents disclosed their sero-status to their parents. This is similar to findings by Kadowa and Nuwaha (2009) ^[15] in their study. They found out that 30% of the respondents disclosed to their parents. This showed that quite a number of respondents trusted their parents and realised that parents can feel for their children (Assumption).

The observed 225 respondents (95, 3%) disclosed to their family members as compared to workmates and friends who only constituted only 11 (4, 7%) of the respondents. This could indicate that trusted family members more than anyone for support. A similar study conducted in Iran showed that respondents often disclosed their HIV status to family members, however they highlighted that there were differences about disclosure of HIV status within the family context as family members were perceived as more supportive (Shushtari *et al.*, 2014) ^[27]. Another study in India, also revealed that majority of the respondents did not want to reveal their HIV status to anyone other than spouse and family members (Umesh *et al.*, 2013).

The findings also revealed that those who disclosed their HIV status to siblings were 52 (22%), this is also similar with findings in Uganda which showed that respondents who disclosed to siblings were 34% (Kadowa and Nuwaha, 2009) ^[15]. This study also found out that those who disclosed their HIV status to friends were 4 (1, 7%). This is in contrast with the findings in Uganda where 50% of the respondents disclosed their HIV status to their friends.

On responding to the negative experiences following HIV status disclosure, stigmatization had 34(14, 4%), divorced 13 (5, 5%), abandonment 10 (4, 2%), isolation 5 (2, 1%), discrimination 4 (2, 1%) and the others did not experience the listed negative consequences.

Majority of the respondents who disclosed experienced stigmatization. Stigmatization had great impact since it reduces the moral of people living with HIV. It is difficult to associate with others if an individual is discriminated and it brings loss of confidence in disclosing HIV status. Lack of awareness about the HIV and fear of contracting it from the patient could result in discrimination (Joge *et al.*, 2013) ^[14]. This is one of the reasons why some respondents did not want to disclose their HIV status. In a similar study conducted in Uganda they found out that people with stigma are less likely to disclose their HIV status to their family members as well as friends or to solicit support from them (Welser *et al.*, 2015). Some of the respondents however, experienced divorce 13 (5, 5%) after disclosure. Most the respondents' partners did not have standard education therefore they failed to support their partners instead caused divorce. Kadowa and Nuwaha, (2009) ^[15] in their study

reported that disclosure is associated with discrimination within the family set up. The disclosure can cause couples to separate beds and eventually divorce.

It was noted that some respondents were abandoned by their partners after they disclosed their status. This is also similar to the study conducted in Mbekweni South Africa that after disclosure the respondent experienced abandonment immediately after disclosure and were stigmatised (Norman *et al.*, 2007). Other severe consequences of disclosure of HIV status included marital dissolution, abandonment, blame and denying access to care and physical abuse. All these were the major consequences of HIV status disclosure from the time it was diagnosed to date. Many people associated HIV with promiscuity hence these had negative effects to the respondents in this study. This concurs with a number of studies conducted and they also showed the negative consequences of HIV positive status disclosure. A study done in Uganda and Tanzania showed that HIV status disclosure had the risk of accusation of infidelity especially women (Lugalla *et al.*, 2011) ^[18].

The reactions after disclosure were anger 41(17, 4%), blame for getting the virus 25 (10%), sympathy 51 (21, 6%), those who promised to offer support to the respondents were 45 (19%), and physical violence 19 (8, 1%) The respondents received different reactions from the people they disclosed to. Those who felt angry towards the respondents were 41 (17, 4%). This means that in this study people did not welcome people who were HIV positive. Another negative reaction such as blame for getting the virus were 25 (10, 6%), this is because HIV is associated with promiscuity and often cause physical or verbal abuse up to an extent of punishing the infected person (personal communication). In a study done by Joge *et al.*, (2013) ^[14] highlighted that punishment, verbal fight and horror were predominant immediate reactions after disclosure (Joge *et al.*, 2013) ^[14]

Violence also contributed 19 (8, 1%) of the respondents. This could be a result of failure to accept the HIV infection which might have been caused by religious background of some of the respondents since 38(16, 1%) believed in tradition and also most of the respondents' partners had low educational standard. In a similar study conducted by Maeri *et al* (2016) ^[20] male partners were violent to the females preventing them from accessing ART by forbidding access to health facility, discouraging treatment and destroying their partners HIV medication. In their study women feared physical violence and that they also expressed anxieties around partner abandonment or violence. In the same study male feared their partners labelling them promiscuous (Maeri *et al.*, 2016) ^[20]

In terms of sympathetic reaction 51(21, 6%) expressed sympathy to the respondents. It is essential to get sympathetic reaction as this will reduce psychological distress, promote adherence and strengthen the immune system thereby increase life expectancy. A study by Joge *et al* (2013) ^[14] indicated that husband and wives showed sympathetic reactions to their partners, and this is critical they had to come to terms with reality and care for each other. However of the 45(19, 1%) of respondents were promised by their spouses that they were going to be available for them. This could possibly mean that these respondents were receiving social support most likely

because the people they disclosed to were willing to assist them. This concurred with Kangwende *et al.*, (2009) ^[16] in Mutare they discovered that those who disclosed their HIV status received social support for psychological adjustment to live with HIV infection. This was found to be one of the benefits of HIV status disclosure. Respondents who were encouraged to express their feelings were 54 (22.9%). People who live with HIV often experience severe stress that HIV has no cure, it causes illness failure to look after oneself, loss of employment and premature death. HIV is also associated with stigma and discrimination hence this could bring psychological distress to the respondents. Therefore they needed someone to express their feelings and anxiety (Personal communication). This was similar to a study conducted in Mutare revealed that family, friends and health care workers can provide social support to people living with HIV to be able to cope with HIV care and taking their medication on time (Kangwende *et al.*, 2009) ^[16].

Those who felt obliged to tell 42(17,8%), to these respondents it seems the HIV status disclosure did not come from their innermost heart it could be that the respondents wanted to impress the health care givers or feared that the family members may discover HIV status. This could be attributed to that these respondents wanted to obtain some benefits since Bindura District has Non-Governmental Organisations, which sometimes would offer food and clothes items to the people living with HIV. Therefore, all above mentioned factors could have contributed to sero positive HIV disclosure status among people living with HIV.

Some of the respondents felt that they would be relieved if they could tell someone about HIV sero-positive status, these respondents were 23(9, 7%). In regard those respondents who did not want carry the burden alone, they had positive attitude towards HIV status disclosure since it was going to be easy for them to receive social support (personal communication). Receiving social support can promote ART adherence, in turn, prolong life among people living with HIV.

Those who did not want to risk their health were 13 (5, 5%). This implies that these respondents understood the HIV counselling sessions shared among them by the experts as they were able to relate HIV infection with their health status. They knew the consequences of HIV infection such as deterioration of illness, death, loss of employment as well as discrimination and stigma associated with the disease. This also stressed the importance of education since in this study majority of the respondents had basic education.

Persons who had the right to know what was happening to the respondents were 10 (4, 2%). This most likely indicates that respondents felt that their families had the right to know since most people often receive support from family circle. Therefore the respondents saw no reason to hide their HIV status.

The respondents who disclosed their HIV status because they wanted to get support were 36 (15, 3%). This probably shows that the respondents realised that they can only get social support after HIV status disclosure from different support groups found in the community. This could be a result of the effectiveness of counselling before, during and after ART initiation at the health facility. In a study conducted in Kwa Zulu –Natal South Africa, they also

found that disclosure of one's HIV positive status proved to be beneficial in accessing the much needed support and medical care particularly to those who disclosed when their health was compromised (Mkize *et al.*, 2009).

3.3 Social Support

Those who received social support after disclosure were 119 (86%) and those who did not receive social support after HIV status disclosure were 19 (14%). The majority of the respondents who disclosed their HIV status and received social support were 114 (48, 3%). This was because in the study, it was found out that 131 (56%) of the respondents had basic education, which assisted in understanding the importance of health education. In support of this statement, the study also revealed that 100% of respondents agreed that they attended counselling sessions which were being given at Bindura Provincial Hospital OI/ART clinic. This showed that they really understood the importance of disclosing their HIV status and, in turn, they managed to receive social support.

Some of the respondents 36 (15, 3%) had indicated that they wanted to get social support, hence the reason to disclose their status. However those who did not receive social support after HIV status disclosure were 19(8, 1%), this might be attributed to lack of employment activities among the spouses since the study revealed that 100(42, 4%) of respondents indicated that their partners were not employed, hence they had challenges in supporting their partners at household level. Lack of employment might have caused mobility of the respondents' partners away from their infected partner. This might have contributed to lack of psychological support in search of survival.

The study also revealed 115(48,7%) of the respondents agreed that they had children below 5 years which implies more burden since they had to look after those children below the age 5years while their partners were away in search of survival means. The under 5years are also not able to assist their infected parents. Therefore, social support is crucial in HIV management. On the other hand 68 (28, 8%) and 77 (32, 6%) of the respondents s partner did not acquire formal education and primary education respectively. This could mean that they lacked understanding on the disease progression; hence this can affect the quality of social support in different forms at household level (Assumption).

The study further established that respondents received social from different individuals and organisations, 27 (11, 4%) received support from parents, spouse 57(24, 2%), siblings 14(5, 9%), friends 4(1, 7%), Non-Governmental Organisation 4 (1, 7%), faith based organisation 4(1, 7%) The respondents who received support from their spouse constituted a high number 57 (24, 2%). These were the very people to whom the majority of respondents disclosed to. This is because majority of respondents 152 (64, 4%) were married, therefore they were supposed to disclose to their partners in order to prevent spread of the HIV as well as to promote Prevention of Mother to Child Transmission (PMTCT). This study showed that the spouses had positive attitude towards HIV infection. A study conducted by (Atuyambe *et al.*, 2011) also supported that those who disclosed their HIV status experienced positive and supportive message from some people they disclosed their HIV status. Spouses were the immediate people and close to their partners, therefore they were the ones who offered

immediate support to the respondents. Lynn (2011) in Uganda also highlighted that respondents reported receiving support from their family and friends; there were 17% who reported no change in relationship with their spouses and 66% of the respondents reported positive support. Most of the respondents also received support from their parents that showed a significant role of parents in HIV care. Siblings 14(5, 9%) also gave support to the respondents. Non – Governmental organisation and faith based organisation 4 (1, 7%) also plays a pivotal role in offering support among people living with HIV.

Most of the respondents were encouraged and reminded to take their medication on time. This could have been attributed to disclosure rate which was 138(58.5%). The more an individual discloses HIV status the higher the chances of receiving social support. This could help the respondents to be more relaxed and be loved. In addition, they were supported well by their families, friends, faith based organisation and NGOs. Therefore, taking medication is very critical in HIV care as it improves adherence rate among people living with HIV and their well-being. This was also supported by Atuyambe *et al.*, 2011 in Uganda where most respondents explained that they received encouragement and support. The most common positive reaction was encouragement with 27% and that encouragement leaned towards adherence to HIV antiviral medication and to live a longer meaningful life. WHO, 2013 stated that adherence is second strongest predictor of progression to AIDS and death, after CD4count. Therefore a high level of adherence to ART regimen helps to achieve and maintain viral load suppression and at the same time prevent the development of drug resistance and emergence of OIs.

Financial support had 26 (11%). The reason why they receive financial support could be that some respondents partners were formally employed 90 (38,1%) and self-employed 46 (19%) they were able to financially support their infected partners. The money could be used to pay for hospital bills, transport costs to and from the health facilities and also for food. These results concurred with the study conducted in Malaysia, the study revealed that supportive resources which were available included emotional, financial assistance and that support can come from different sources such as family, friends, neighbours, co-workers and organisations (Ghani *et al.*, 2015)

Findings showed that on 5(2, 1%) received social support. It was possible for the respondents to receive such type of support since they disclosed to different people whom they felt comfortable to. These included NGOs and faith based organisation. Non-Governmental Organisations (NGOs) which are based in Bindura usually assist people living with HIV in District. These Donors usually target the vulnerable groups. Bindura is surrounded by farmers and they also support with food, politicians as well. This was similar with study conducted in Kenya where they found that HIV self-disclosure has been known to offer some rewards for PLWHA that it can result in acquisition of emotional, physical (material forms) financial and societal resources (Serovich *et al.*, 2008).

Those who received psychological support were 23 (19, 3%), this could have been attributed by the fact that 104(44, 1%) of the respondents knew their partners HIV status. This

could probably show that there was open communication about HIV among people living with HIV and their partners therefore hence they managed to receive psychological support through disclosing their HIV status. This study also revealed that 23 (9, 7%) of the respondents were influenced to disclose their HIV status because they felt relieved if they could tell someone therefore they also received social support. This was similar to results found by Wohl *et al.*, 2011 that support resulting from disclosure had positive impact on people living with HIV as it improved the psychological, emotional being of people infected with HIV. It also improved health status of the PLWHA (Wohl *et al.*, 2011).

Most of the Respondents in this study received counselling which is a very crucial element of HIV management some stated that they had children below 5 years and 6 -12years 168 (71, 2%). Some had the responsibility to look after their children in case they get bed ridden due to HIV. It has been realised that in most of the studies that people who disclose their HIV status receive social support and that social support can result in access to social care and improvement on ART adherence (Wohl *et al.*, 2011)

It was observed that some respondents received spiritual support had 9 (3, 8%). This is most probably due to the fact that most people in Zimbabwe are Christians and as such many people normally comfort each other using the word of God (Assumption).

Duration while receiving support varied, 0-3months 5 (2, 1%), 4-6 months 9(3, 8%), 7-9 months 10 (4, 2%), 10-12 months 15(6, 4%) and those who were one year and above 66(28%). This differed most likely because it depends on when the respondents were diagnosed and initiated. Those who had been receiving support one year and above were 66(28%). This showed that they had been receiving antiretroviral therapy for more than a year by the time the study was conducted. Those who received social support for 0-3 years were 5(2, 1%), this might also have been contributed by the fact that some respondents took time to or delayed to disclose their HIV status. People disclose their HIV status when they comfortable to do so. Variation regarding when to disclosed one's HIV status was emphasised by Eustace and Ilagan (2010) where they mentioned that HIV status disclosure is a voluntary process where an individual decide when, where, who and how to disclose their HIV status. Regardless of time the respondents took to disclose their HIV status what was important was they managed to receive social support which is essential in HIV care and management.

On satisfaction with support received, 9(3, 8%) were not satisfied at all, 9 (3, 8%) were slightly satisfied, moderately satisfied were 19 (8, 1%) and those who very satisfied were 63 (26, 7%). Those who were highly satisfied were 63(26, 7%), this could be as a result of the type of support the respondents were receiving. The percentage of the respondent partners who were working was self-employed 90 (38%) and self-employed 46(19%).The partners were in a position to support their infected partners. Amberbir (2008) ^[3] found out that those individuals who usually experience high levels of social support tend to disclose their positive HIV diagnosis more than those who without support do. Some were just generally satisfied. Those who were not satisfied at all 9(3, 8%) This might have been due

to the fact that their partner were not employed hence they were not able to support them. Poor social support can affect the health of the respondent. Almeleh, 2006 discovered that lack of emotional support can result in depression and HIV related stress and this in turn lead to dissatisfaction with social support being offered to PLWHA (Almeleh, 2006).

On responding to suffering from opportunistic infection after ART initiation were 99 (41, 9%) and those who did not suffer from opportunistic infections after ART initiation were 137(58%). These findings were similar to those found in Mozambique where 78% of the respondents highlighted that illness was aggravated by lack of food, when projects that gave people food is over, people would also stop returning to the health centre resulting in poor adherence they would only return to health centre while in the final phase and they eventually die (Groh, *et al.*, 2011) ^[13].

On type of opportunistic infection the respondents suffered on were, tuberculosis 41(17, 4%), diarrhoea 66(28%), pneumonia 16(6, 8%), herpes zoster 35 (14, 8%) and none of the listed opportunistic infections 78(33, 1%). Majority of respondents suffered from diarrhoea 66(28%). This concurred with findings in Uganda where diarrhoeal infection was common among living with HIV, in early antiretroviral therapy diarrhoea accounted for 25,6% and in late ART it was 14,8% (Rubaihayo *et al.*, 2016). In this study tuberculosis infection was at 41 (17, 4%) while a study in Uganda also found out that tuberculosis in early initiation accounted for 18 (7.6%). In terms pneumonia the current study it had 16(6, 8%) and herpes 35 (14, 8%). In Uganda 14% had pneumonia while herpes zoster accounted 6, 5% (Rubaihayo *et al.*, 2016).

Responding on whether the person disclosed to be accompanied to the health centre those who said yes were 63(46%) and those who said no were 75 (54%). The majority of the respondents were not being accompanied to the health centre. This could be that some the respondents' partners were mobile since the study findings established that they were not employed 90 (38, 1) hence that could leave them without time to accompany the respondents. Another contributing factor could be that some the respondents partners were employed 90 (38, 1%), so they could not have time to accompany the respondents. It is interesting to note that some respondents had children under the age of 5 at household level and they could not be accompanied to the health facilities. Those respondents who were being accompanied to the health centre were 63(46%). Some of the respondents' partners 104(44,1%) were HIV positive therefore chances of accompanying their partners to the public health facility were high as they could remind each other at family level.

The study established that 100 (72, 5%) of respondents had acknowledged that they were getting assistance on cooking meals 42(17, 8%), cleaning chores 12(5%), help with care giving 10(4, 2%), give you rides to health providers 8(3, 4%), help the respondents remember 5(2, 1%) and provide financial assistance 15 (6, 4%). These findings were similar to the study conducted in Ethiopia where they observed that there was high agreement between predicted and very positive outcome of HIV status disclosure. Of the 459 respondents who anticipated supportive out come to HIV disclosure, 96. 3% received support from their spouse. The support included assistance with home-related chores, living

accommodation and medical attention (Serovich *et al.*, 2008). In this study it was found out that in regard to general social assistance received by the respondents, it might be due to the fact that some of the respondents had children aged 19 and above 87 (36,9%), these children were capable of helping their parents with household chores. The study also found out that most of the respondents disclosed their HIV status to their family circle; this could result in the provision of social support from individual family members.

3.4 Knowledge of OI/ART

Rating of the importance of taking antiretroviral drugs, the research findings were, very good 118(50%), good 63(26, 7%) and poor 35(14, 8%). Majority of respondents rated very good 118(50%) this showed that they had positive attitude towards taking antiretroviral drugs. This indicated that OI/ART counselling sessions 236 (100%) played a vital role in enabling the people living with HIV to understand and appreciate, in depth, the importance of ART adherence. This was evidenced by 137(58%) of the respondents who did not suffer from opportunistic infections after ART initiation. However some respondents rated poor the importance of taking antiretroviral drugs. It could be due to side effects of ART.

Majority of the respondents received health education 170 (72%), similar findings were identified by (Paxton, 2008) where he mentioned that HIV positive speakers may be a fundamental component of successful AIDS education campaigns. In this study it could be due to counselling sessions which were 100%. Therefore, information giving through health education on every OI ART visit is crucial since it enable the HIV positive people to disclose their status.

In this study, 126(53, 4%) of respondents had accepted that there were aware of the existence of the support groups in the society in which they live. This is similar to the findings obtained by Lyttleton (2010) [19] in Thai where the Researcher had found out that large numbers of support groups were in existence throughout the country, as primary forum at which HIV is negotiated and normalised in Thai society. However, notwithstanding their knowledge on the existence of support group the number of people who did not disclose their status remains high.

Regarding the type of services offered by the support groups, awareness campaign was 69 (29, 2%), horticulture 10(4, 2%), chicken projects 24 (10, 2%), and herbal gardens 9 (3, 8%). This study had identified that the majority of respondents were not aware while 69 (29,2%) acknowledged that they were aware of the HIV campaigns. In support of the awareness campaigns, which the respondents agreed to have done had matched with the findings of similar study that was conducted in Zimbabwe, which revealed that the female condom awareness accounted for 9,5% of uptake. Also, it was revealed in the same study that women with increased level of awareness on the method were likely to use it (Chipfuwa, *et al.*, 2014) [9].

In terms of horticulture, it accounted for 10 (4, 2%). This is in agreement with the findings obtained in Zimbabwe where 39% households grew green vegetable in their gardens and field crops 28% at their households (Gregson, *et al.*, 2014). In this study it was established that 24 (10, 2%) of

respondents were doing chicken project. This was also found in Botswana among people living with HIV who were involved in poultry project that 79% slaughtered chicken for family consumption, 21% to honour guest, 61% of respondents consumed eggs while the remainder used eggs for breeding purposes. 84% of chickens were sold for cash followed by barter 10% (Gabanakgosi, *et al.*, 2013). It was noted that some respondents had herbal gardens, and in a similar study it was found that herbs and bulbous vegetables were grown by 33% of the households (Gregson *et al.*, 2014). Therefore, some individuals have knowledge on the role that nutrition plays in the management of HIV.

However 134 (57%) of the respondents were not aware of the function of the social groups in their communities. This is because 66(27, 9%) of the respondents indicated that they did not receive health education package at every visit to the public health facilities. Also it could be that health personnel did not have adequate time to give a comprehensive health education to the respondents due to shortage and workload hence 110 (46, 6%) were not aware of any support groups. As a result respondents became unaware of the existence and functionality of social support groups in their communities. This further indicates that education and awareness is a challenge in most societies of developing nations.

3.5 Relationship between HIV status disclosure and social support

The research findings showed a positive significant correlation ($r=0.815$; $p<.01$) between HIV status disclosure and social support. The Correlational coefficient shows that the two variables were exponentially increasing together, that is, when HIV status disclosure increased, social support among people living with HIV also increased. The significant regression coefficient indicates a change in social support for every change in disclosure. The study results indicated an $R^2=66,4$ which when expressed as a percentage 66, 4%. This means that the effect of HIV status disclosure to social support accounts for about 66, 4% of the change in social support. This means that 66, 4% of the change in HIV status disclosure was as a result of social support. A positive effect ($b=0,09$; $p<0,01$) represent 0,09 change in the dependent variable disclosure and for every unit change in the independent variable (social support) at 0,01 significant level. The significant standardize coefficient ($B=.815$ $p=0,01$) shows the significance of HIV status disclosure and indicating that disclosure is very critical in promoting social support.

In this study, 119(86%) received social support after HIV status disclosure and 19(14%) did not receive social support after HIV status disclosure. In relation to HIV status disclosure 138(59%) of the respondents disclosed their HIV status and 98(41%) did not. Therefore, this study had established that the number of those people who did not disclose their HIV was likely due to various reasons such as cultural beliefs, stigma, discrimination, blame, rejection, violence, divorce and accusation of infidelity (Personal communication).

4. References

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