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Original article

FACTORS CONTRIBUTING TO NON-DISCLOSURE OF HIV POSITIVE STATUS AMONG SEXUAL PARTNERS ATTENDING ART CLINIC AT KYANAMUKAAKA HEALTH CENTRE IV, MASAKA DISTRICT-UGANDA: A CROSS-SECTIONAL STUDY.

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Abstract

Background:

Globally, it is estimated that non-discloser among HIV-positive clients account for a third of new HIV infections. Positive HIV results disclosure plays a significant role in the successful prevention and care of HIV-infected patients. It provides significant social and health benefits to the individual and the community. Non-disclosure is one of the contextual factors driving the HIV epidemic in Uganda.

Methods:

A cross-sectional study using quantitative and qualitative methods among HIV-positive serostatus sexual partners attending the ART clinic at Kyamukaaka Health Centre IV was done and simple random sampling techniques were used to obtain 60 participants.

Results:

Most participants (56%) thought it was not important to disclose their HIV status to their partner(s). Among reasons for non-disclosure included 51.2% having fears of divorce/separation, 23.3% of accusations of infidelity, 13.9% having fears of loss of support, 6.9% of stigma and discrimination, and 4.7% having fears of violence respectively. Among reasons for disclosure 60.9% thought it was important to disclose so as to get support, 26.1% for the partner to get tested as well, and 13% disclosed to protect their partner(s). The other factors associated with disclosure included 61.5% being aged between 26-35 years, 36(69.2%) being females 28(53.8%) of the respondents had attained a primary level of education 29(55.8%) being married, 12(23.1%) were divorced/separated, 38(73.1%) were in monogamous marriage, while 26.9% were polygamously married.

Conclusion:

Although most participants acknowledged that disclosing their HIV status to their partner was important, a large number of participants had not disclosed their HIV status. There is a need to optimize disclosure merits to enable increased participation in treatment and support programs. Therefore, increasing awareness campaigns on the benefits of HIV-serostatus disclosure among individuals, cultures, and the general public is highly recommended.

Keywords: HIV/AIDS, Disclosure, Uganda, Factors contributing, Submitted: 2023-06-03 Accepted: 2023-06-10

1. Background of the study:

Since the beginning of the epidemic, 84.2 million [64.0–113.0 million] people have been infected with HIV, and about 40.1 million [33.6–48.6 million] people have died of HIV (WHO, 2021).

Globally, it is estimated that non-discloser among HIV-positive clients accounts for a third of new HIV infections (UNAIDS, 2020). The WHO African Region remains most severely affected, with nearly 1 in every 25 adults (3.4%) living with HIV and accounting for more than two-thirds of the people living with HIV world- wide (WHO, 2021)

Worldwide there are over 37.7million of people living with HIV 1.5 million people become newly infected with HIV in 2020 and 680,000 people died from AIDS-related illnesses in the year 2020 and 36.3 million people have died from AIDS-related illnesses since the start of the pandemic respectively (UNAIDS 2020). Globally, 38.4 million [33.9–43.8 million] people were living with HIV at the end of 2021 and an estimated 0.7% [0.6-0.8%] of adults aged 15–49 years worldwide are living with HIV, although the burden of the epidemic continues to vary considerably between countries and regions (WHO, 2021). However, the discloser rates remain low varying from 7%-70% with an average of 30% (Mc Hugh, 2018). Non-disclosure is associated with poor adherence to ART and increases the risk of HIV transmission between sexual partners and is also associated with negative psychosocial effects such as high-stress levels and poor coping skills due to lack of partner support (Adeniyi et al., 2021). Disclosure of HIV-positive status plays an important role in strengthening Art adherence and HIV prevention (Charles J., et al 2020). Disclosure is useful for both the infected individual and the community and also inspires people to seek HIV testing and counseling to change behavior, and decrease the prevalence of HIV, Poor counseling and individual testing were among the gaps noted that have led to non-disclosure (Charles J., et al 2020).

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Globally, disclosure of HIV status was an important variable, as disclosure of HIV status to a sexual partner, close relatives, and friends might benefit people living with HIV/AIDS partners, and society (WHO, 2017). Some of the potential benefits were improving emotional and psychological well-being, early enrolment on antiretroviral therapy, better adherence to therapy, and disclosure to sexual partners may increase HIV testing and reduce the risk of HIV transmission including HIV transmission from the mother to child (Adam et al., 2021).

The magnitude of HIV-positive status disclosure in developing countries is lower than in developed countries (Berhe et al., 2020). This was attributed to the general status of well-being among the respective countries. The magnitude of HIV-positive status disclosure in developing countries ranged from 16.7% to 86% with an average of 49%. This indicates 50% of people living with HIV/AIDS in developing countries disclosed their HIV-positive status to another person. But, in developed countries, the average magnitude of HIV-positive disclosure status was 79% (Berhe al., 2020).

In Africa, over 25.3 people are living with HIV the prevalence disclosure rate was 40%, 36% delayed discloser for over a year, and most disclosed to protect their partners from HIV transmission to receive support and to be honest and trust full (Adeoye et al., 2016). Prevalence of non-disclosure was high as 60% withheld discloser due to fear of abandonment, stigma and discrimination, and accusations of unfaithfulness and partner violence (Mengwai et al. 2020). The lower discloser rates imply that HIV transmission continues to persist among sexual partners in these settings. According to WHO, (2017) the findings suggest that high levels of perceived stigma impact disclosure and HIV treatment which increases the risk of ongoing HIV transmission among clients receiving long-term anti-retroviral therapy.

According to the study conducted in Southwest Ethiopia; of the total respondents, 37.6% had disclosed their HIV-positive status in general (Berhe et al, 2020). Nondisclosure of HIV-positive status

to someone has many consequences like distress, loneliness, social isolation, lack of support, infection from their partners with a new type of HIV strain, refusal to initiate ART, poor adherence to ART, poor utilization of condom, the chance of mother-to-child transmission of HIV (Longinetti et al., 2016).

In South Africa, a higher rate of HIV serostatus non-disclosure to sex partners (25.6%) in comparison to family members (20%) was reported by the participants, and younger age, not living with partners, and alcohol use were significantly associated with non-disclosure of HIV serostatus to sex partners (Oladele et al., 2017). Non-disclosure of HIV serostatus to sex partners was significantly associated with poor adherence to the highly active antiretroviral therapy (HAART), failure to keep clinic appointments, and high viral load at the delivery of the baby (Mengwai et al. 2020). Perceived fear of intimate partner violence, fear of rejection, the guilt of not disclosing at the onset of the relationship, sex partner's non-disclosure of HIV serostatus, and guilt of unfaithfulness were some of the reasons for non-disclosure of HIV serostatus to sex partners (Olaele et al., 2017)

In Tanzania, disclosure rates range from 17% to 55% and only 17% of HIV women disclosed to their status partners (Ismail N, 2021). In Morogoro specifically, the discloser rate is 41% this is mostly from married or cohabitating HIV-positive pregnant attending ANC in Morogoro municipality who had disclosed their HIV serostatus to their partners (Hall-berg D., et al. 2019). Conversely, in East Africa, disclosure rates remain low and estimates average between 25-51% these low disclosure rates are attributed to various factors including stigma and discrimination, fear of partner's reaction, fear of loss of marriage, and being chased from the home, lack of socio and psychological support among many other factors (Baiden et al, 2017). This was found greatly affect HIV prevention and control among the general population.

Interventions to address the negative attitudes towards non-disclosure are necessary to promote HIV disclosure and in turn, better adherence to psychological adjustments therapy and reduction in the risk of HIV transmission among couples. Moderate level of knowledge about the importance of HIV serostatus disclosure. Preventing HIV transmission, the need for care, and upholding the integrity of the relationship (Hall-berg et al., 2019).

In Uganda, although research shows that 42% of the 130,000 new HIV infections between 1996 and 2005 were among married couples, among people who test for HIV in Uganda, only 43% disclose their serostatus to their partners while it is estimated that in many regions of Uganda, up to 90.4% of sexually active females and males respectively do not know the serostatus of any of their sex partners (Kakumba K K., 2018). The disclosure level of 56.3% was documented by the study conducted at the Mityanaa district hospital of Uganda (Kadowa and Nuwaha., 2019)

In Uganda, over 1.5 million people are living with HIV, and from a cross-sectional study using enrollment data from 500 people living with HIV are unaware of their male partner's HIV status and participating in a randomized clinical trial assessing secondary to the distribution of HIV of self-testing kits in Kampala, Uganda 68.2% had not disclosed their HIV status to their partners. Relationship factors, including shorter-term, unmarried, and polygamous relationships are un certainly about partners testing history and were associated with a higher likelihood of a client's non-disclosure of HIV status to their partners. Interventions that facilitate the couple's HIV testing and disclosure, provide counseling to decrease relationship dissolution in serodiscordant couples, and offer peer support for women may increase disclosure (AIDS Journal, 2021). Therefore, this study aimed at identifying the factors contributing to the non-disclosure of HIV-positive status among sexual partners attending the ART clinic at Kyanamukaaka Health Centre IV, Masaka district-Uganda.

2. Methodology:

2.1. Study design:

This study employed a descriptive cross-sectional design as information was generated

and collected at a given point in time and within a short period. Moreso the approach was easier, cheaper, and not time-wasting. Quantitative methods were used since the data collected was numerically documented using figures, graphs, pie charts, and tables.

2.2. Study setting:

Kyanamukaaka Health Centre IV is located in Masaka district, Bukoto central, Kyanamukaaka sub county, Kyantale parish, Kyanamukaaka village. It is bordered by Kalungu district to the north, Bukomansimbi and Mpigi districts to the northwest, Kalangala to the east and the south, and Lwengo district to the west. Latitude is at 0 degrees 21'56 south and longitude is 31 degrees 41' east. It is 2km north of kyabbogo, 5km southwest of Butale, 9km northeast of Masaka regional referral hospital, and 9km southeast of Gulama.

Kyanamukaaka health center four is one of the biggest health centers in the area. It offers a wide range of health care services including RCT services, EMTCT services, HIV/AIDS management services obstetric services, antenatal and postnatal care services, immunization services, general patient management services, and emergency care among others. This study area was selected because it is well-known by the researcher and the problem under the study is prevalent on the ground.

2.3. Study population:

The study focused on HIV-positive sexual partners who attended the ART clinic at Kyanamukaaka Health Centre IV, Masaka district.

2.4. Sample size determination:

The study included a total of 60 respondents, all sexual partners attending the ART clinic at Kyanamukaaka Health Center IV, Masaka District. This sample size was presumed representative enough of the entire study population. The sample size was determined by the use of Kish and Leslie's (1970) formula as stated below: -

$n = \frac{z^2pq}{d^2}$ Where n=Desired sample size (if the target population is greater than 10,000)

z=Standard normal deviation at 95% confidence interval (i.e.1.96).

p=Proportion of the target (which is 50% or 0.5)

q= 1-p (1-0.5=0.5) is the acceptable degree of error (in this case 0.5)

$$n = \frac{z^2pq}{d^2}$$

$$n = \frac{(1.96)^2 \times 0.5 \times 0.5}{(0.5)^2}$$

$$n = 384$$

Since the target population under the study was less than 10.000, the required sample size was then adjusted to a smaller which was estimated as follows;

$$nf = \frac{n}{1 + (n/N)}$$

Where N is the total population=60

$$nf = \frac{384}{1 + (384/60)}$$

$$nf = 60\ respondents$$

2.5. Sampling procedure:

The researcher used simple random sampling techniques. Every participant had an equal chance to participate in the study hence minimizing selection bias. In this sampling technique, the researcher allowed all the potential participants to participate in the study by picking papers from an enclosed box. The box contained pieces of paper containing the words 'YES' and 'NO' written and any respondent who picked a paper with a yes was requested to participate in the study. This process continued until the desired number of participants was obtained.

2.6. Selection criteria:

2.6.1. Inclusion criteria:

The study included all HIV-positive sexual partners attending the ART clinic at Kyanamukaaka Health Centre IV. The study participants were recruited for 2 months (March and April 2022). During this period, a total of 60 eligible respondents were obtained and data were collected using an interviewer-administered questionnaire. This was done on a scheduled basis on different days with participants to allow respondents enough time to even ask where they need clarification before responding.

2.6.2. Exclusion criteria:

All those who did not consent to participate in the study and those with severe mental disorders were excluded.

2.7. Bias:

To minimize bias, a simple random sampling technique was used therefore each individual in a target population had an equal opportunity of being chosen to participate in the study.

Furthermore, before interviewing the respondents, the researcher and his assistants assured respondents that the collected information would be confidential and would only be used for implementational and improved service delivery purposes. To further ensure this, code numbers were used instead of respondents' names as an assurance that no one would know from whom the information was got. This encouraged participants to respond to research questions sincerely hence reducing informational bias.

2.8. Study variable:

The independent variables in the study include some socio-demographics such as age, religion, tribe, educational level, and HIV seropositive status. The dependent variables included the sociocultural, health facility-related, and psychological factors contributing to the non-disclosure of HIV-positive serostatus among sexual partners attending the ART clinic at Kyanamukaaka Health Centre IV.

2.9. Data collection procedures:

After the research proposal, a letter of introduction was taken to the administration of Kyanamukaaka health center four seeking permission to carry out the research.

Research assistants doubling as key informants were trained and briefed and then consulted on days when respondents would be expected to be at the ART clinic. The researcher approached patients attending the ART clinic at Kyanamukaaka Health Centre Four, and explain the objectives, benefits, significance, and risks involved to seek consent to participate in the study. The researcher thereafter administered the questionnaires. The researcher and researcher assistants asked and explained the questions from the questionnaire in the language best understood by the respondents.

2.10. Data management:

Data from the completed questionnaire were extracted and checked to ensure they are complete. Data were cleaned, coded, and entered into the computer. The questionnaire from which data is extracted will be filed and locked safely until the time of data analysis. After data analysis, they were kept for future reference.

2.11. Data analysis:

Data that were collected were analyzed using Microsoft Excel version 2019. The data findings were presented in tables, bar graphs, pie charts, and narrations.

2.12. Ethical consideration:

An introductory letter was taken to the in charge, Kyanamukaaka Health Centre IV, Masaka district seeking permission to carry out the study. A signature of authorization was put on the letter as an indicator of legal permission to carry out data collection.

Verbal consent was obtained from the respondents following an explanation of the study topic and reasons for the study. The respondents were assured of their right to consent.

3. Results:

Out of the 60 respondents, majority 32(61.5%) were aged between 26-35 years, followed by 14(27%) aged between 18-25 years, and the least 6(11.5%) being those aged 46 years and above.

Most of the respondents 36(69.2%) were females and only 16(30.8%) were males.

More than half 28(53.8%) of the respondents had attained a primary level of education, followed by 21(40.4%) who reached the secondary level with the least 3(5.8%) having attained a tertiary level of education.

Majority of the respondents 29(55.8%) were married, 12(23.1%) were divorced / separated, 9(17.3%) were single and only 2(3.8%) were cohabiting respectively.

The bigger majority 38(73.1%) were in monogamous marriage, while only 14(26.9%) reported being in polygamous marriage. (See Table 1).

Out of the 60 respondents, 29 respondents (56%) thought it was not important to disclose their HIV status to their partner(s), while 23(44%) said it was important to disclose their serostatus. In the respondents' communities, the majority of them 42 (81%) people with HIV/AIDs were laughed at and labeled as promiscuous while 10 respondents (19%) were laughed at and labeled as promiscuous. All respondents used the RCT services provided at Kyanamukaaka Health Center IV (see Figure 1)

The majority of the respondents 15 (51.7%) did not think it was important to disclose their status to their partner(s) because of fear of being divorced, 9 respondents (31.1%) had fear of loss of support and 5 respondents (17.2%) feared they would be rejected, while some respondents 14 (60.9%) thought it was important to disclose to get support, 6 respondents (26.1%) thought it was important so that the partner could get tested, 3 respondents (13%) thought it was important to protect their partner (see Table 2).

The majority of the respondents 48 (92.3%) were talked to before testing (pre-test counseling done) while a minority of them 4 respondents (7.7%) were not. All respondents 52 (100%) were provided with post-test counseling before receiving their results. 20 respondents (38%) were sensitized about the importance and need to disclose their status while 32 respondents (62%) were not. 14 respondents (27%) never discussed with their counselor about disclosure of HIV/AIDs while 38 (73%) did not.

The majority of the respondents 35 (67%) sometimes found health workers readily available for counseling when they needed them while 17 respondents (33%) always found the health workers readily available. 41 respondents (85%) sometimes found HIV/AIDs counselors readily available at Kyanamukaaka Health Center IV for pre-test counseling while 7 respondents (15%) always found them readily available.

In Figure 3 above, most of the respondents 43(83%) reported having fears about disclosure of their serostatus to their partners, while only 9(17%) reported having no fears to disclose their status. 20 respondents (38%) ever discussed about HIV/AIDs with their partner(s) well as 32 respondents (62%) never did. The majority of the respondents 27 (51.9%) were aware of their partners' serostatus while 25 respondents (48.1%) were not.

From Table 4 above, more than half of the respondents 22(51.2%) had fears of divorce/separation, followed by 10(23.3%) for accusations of infidelity, 6(13.9%) had fears for loss of support, 3(6.9%) for stigma and discrimination with violence being the least with 2(4.7%) respectively.

The majority of the respondents 16(64%) found out from friends/family, 5 respondents (20%) were told by their partners while only 4 respondents (16%) mistakenly saw their partner's ARVs.

4. Discussion of study findings:

4.1. Demographic data of respondents:

From the study, the majority of the respondents 32(61.5%) were aged between 26-35 years, followed by 14(27%) aged between 18-25 years, and the least 6(11.5%) were those aged 46 years and above. This showed that HIV is commonest among the youth (18-35 years), with the least (11.5%) being the elderly 46 years and above.

Table 1: **respondent's demographic characteristics**

Variable	**Frequency (f)**	**Percentage (%)**
Age of the respondents 18-25 years	14	27
26-35 years	32	61.5
46 years and above	6	11.5
Respondents' gender		
Male	16	30.8
Female	36	69.2
Respondents' level of education		
Primary	28	53.8
Secondary	21	40.4
Tertiary level	3	5.8
Marital status and type of marriage		
Single	9	17.3
Cohabiting	2	3.8
Married	29	55.8
Divorced / separated	12	23.1
Monogamous	38	73.1
Polygamous	14	26.9

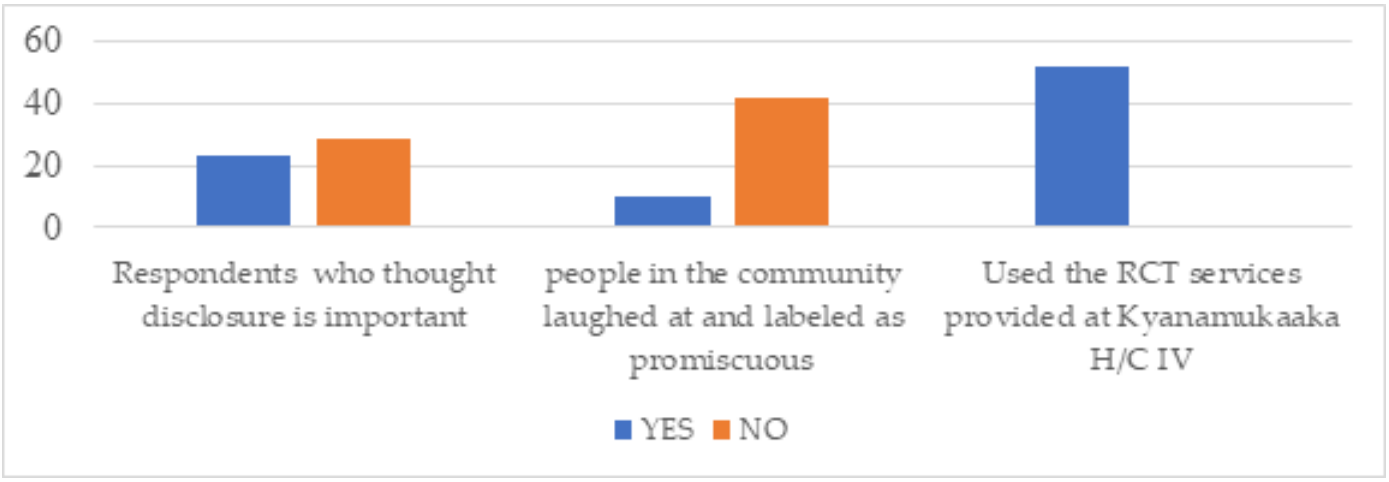

Figure 1: social factors influencing disclosureof HIV serostatus.

Table 2: **respondents' thought on importance of disclosure of status to partner(s).**

Variable	**frequency**	**Percentage (%)**
Reasons why respondents thought it was important. To get support. So that the partner can get tested. To protect my partner. **Reasons why respondents thought it wasn't important.** Fear of being divorced. Fear of loss of support. Would be rejected.	14 6 3 15 9 5	60.9 26.1 13 51.7 31.1 17.2

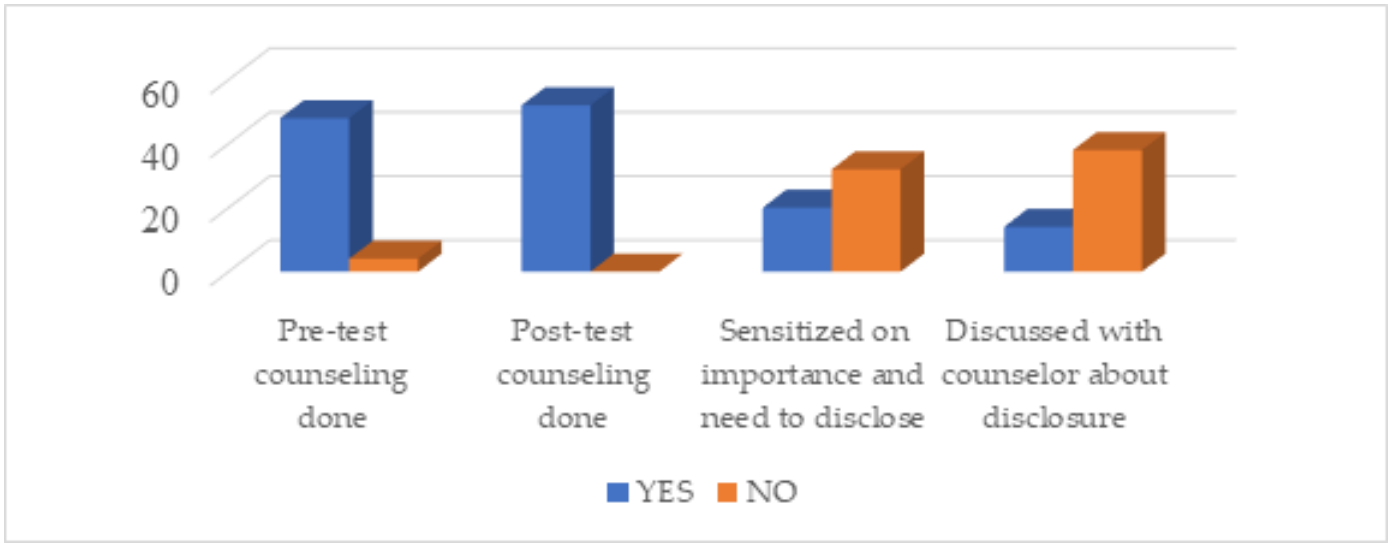

Figure 2: shows health facility factors contributing tonon-disclosure of HIV positive serostatus

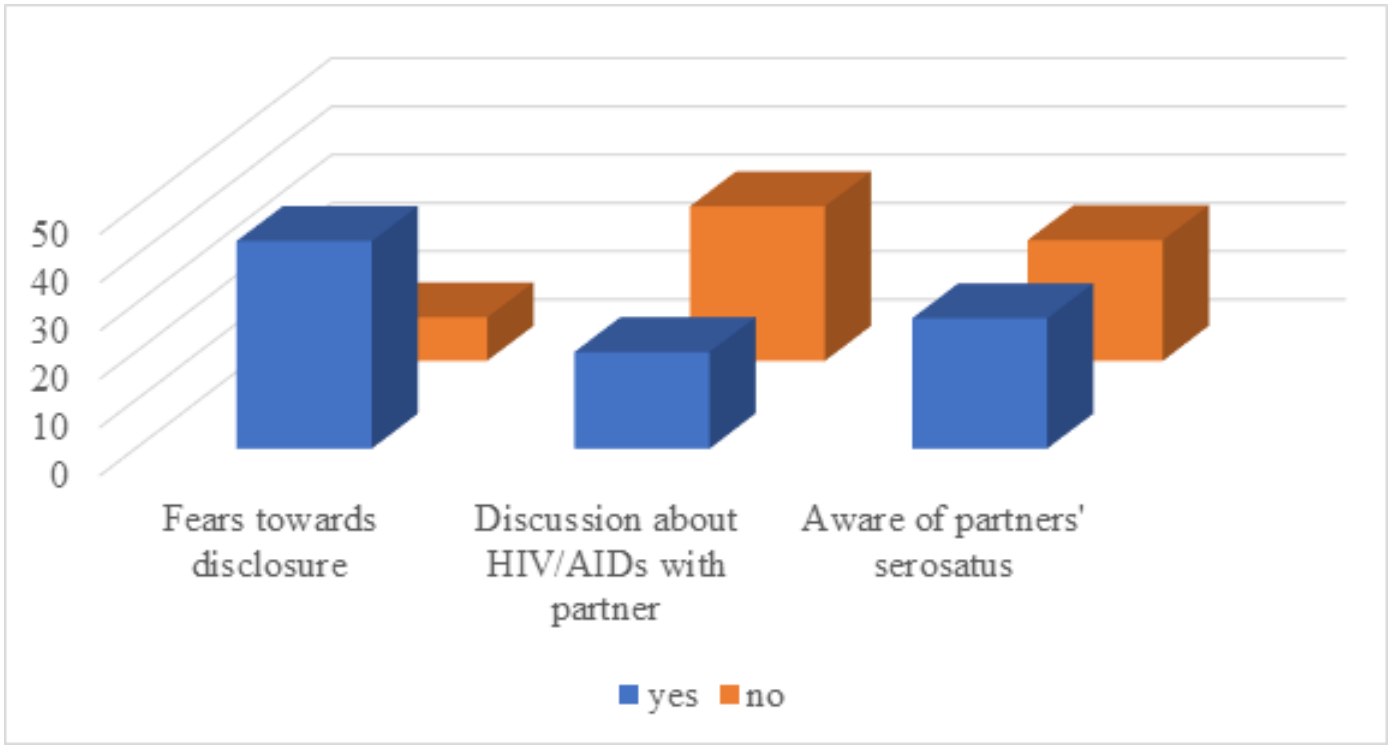

Figure 3: Psychological factors contributing to non-disclosure of HIV positive status among sexual partners attending ART clinic at Kyanamukaaka health Centre IV, Masaka district.

Table 3: showing respondent's fears aboutdisclosing their sero-status to partner(s)

Variable	**Frequency**	**Percentage (%)**
Respondents' fears Violence	2	4.7
Loss of support	6	13.9
Divorce / separation	22	51.2
Stigma and discrimination	3	6.9
Accusation of infidelity	10	23.3

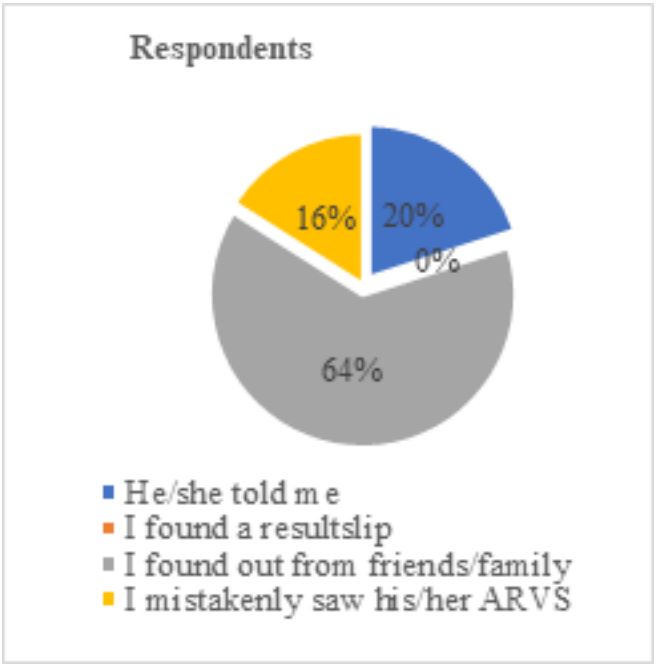

Figure 4: shows how respondents came to know oftheir partners' serostatus.

This could be related to risky sexual lifestyles among the youth that predisposes them more to acquiring HIV than the elderly. Most of these respondents 36(69.2%) were females compared to only 16(30.8%) males and 28(53.8%) of the respondents had attained a primary level of education, 21(40.4%) had reached a secondary level with the least 3(5.8%) having attained a tertiary level of education. Therefore, higher levels of education could have possibly improved one's knowledge of preventive measures for HIV among uneducated individuals.

However, this does not necessarily mean that the educated ones were not infected by HIV. Majority of the respondents 29(55.8%) were married, 12(23.1%) were divorced / separated, 9(17.3%) were single and only 2(3.8%) were cohabiting respectively. The majority being married could be explained by the age of the respondents since most of them were above 18 years and 38(73.1%) were in monogamous marriage, while only 14(26.9%) reported being in polygamous marriage. These findings were in agreement with those by D.I. Adeoye et al, [2016] who reported that the disclosure rate is higher in monogamous families than in polygamy, and the affected member in a monogamous family experiences more positive outcomes than the corresponding member of polygamous homes. Also, married women disclosed more than singles ones with the odds of married reported to be 12 times more than the singles.

4.2. Social factors contributing to non-disclosure of HIV-positive status among sexual partners:

From the study, 29(56%) respondents thought it was not important to disclose their HIV status to their partner(s), and among the reasons for their non-disclosure included 42 (81%) who said people with HIV/AIDs were laughed at and labeled as promiscuous in their communities, 22(51.2%) had fears of divorce/separation, followed by 10(23.3%) for an accusation of infidelity, 6(13.9%) had fears for the loss of support, 3(6.9%) for stigma and discrimination with violence being the least with 2(4.7%). These findings were in line with those by Ngonzi et al, (2019) where the majority of the women who disclosed were comforted (73.9%) and the negative outcomes included accusations of infidelity (24.9%), others were verbally abused (6.8%), some were beaten (5.7%) and a few were chased out of their homes by their husbands and the relatives of their husbands (2.3%).

However, in this study, 23(44%) said it was important to disclose their serostatus because 14(60.9%) disclosed their status to their partner(s) to get support, then 6(26.1%) disclosed so that their partner(s) would get tested as well, and the least 3(13%) thought disclosure would protect their partner(s).

4.3. Health facility-related factors contributing to non-disclosure of HIV-positive status to sexual partners:

From the study, the majority of the respondents 35 (67%) sometimes found health workers readily available for counseling when they needed them which could have possibly affected the rates of HIV-positive status disclosure which were evidenced by 38(73%) respondents who had not discussed the disclosure of their serostatus with their counsellors possibly because of un-availability of the counsellors whenever they could be needed and 32(62%) were not sensitized on the importance and need to disclose their serostatus to partner(s). Other reasons for such findings could have been health workers' attitudes, competencies of the health worker, total time given by the health worker to individual patients, and trust for the confidentiality between the healthcare worker and the patient. These findings were in agreement with other similar studies by 1. Ismail N et al), [2021], Ngonzi et al), [2019], and (Kadowa and Nuwaha), [2019] these findings summarized an important health facility-related factor influencing disclosure of serostatus being poor provision and uptake of HIV couple testing services during which health workers have an opportunity to sensitize the couples and help them reach consensus on testing and disclosure of results. This was linked to inadequate qualified and employed counselors in healthcare facilities.

4.4. Psychological factors contributing to non-disclosure of HIV-positive status to sexual partners:

From the study, most of the respondents 43(83%) reported to have had fears towards disclosure of their serostatus to their partners, 22(51.2%) had fears of divorce/separation, 10(23.3%) for an accusation of infidelity, 6(13.9%) had fears for the loss of support, 3(6.9%) for stigma and discrimination with violence being the least with 2(4.7%) these findings were in line with those by Kadowa and Nuwaha (2019), were among the 139 people who had not disclosed, 63% had sexual partners. The reasons cited for their non-disclosure were fear of divorce and violence 42% for those in sexual relationships, fear of discrimination and stigma 29%, fear of rumor-mongering 21%, fear of accusation of promiscuity/infidelity 23%, and 8% said that they saw no reason to disclose.

5. Conclusions:

The HIV status non-disclosure rate reported in this study is significant. Although most participants acknowledged that disclosing their HIV status to their partner was important, a large number of participants had not disclosed their HIV status. The reasons behind their nondisclosure included the fear of being blamed, the belief that disclosure is against the traditional practice, the fear of divorce, the fear of loss of traditional support, the fear of being abused, and fear of discrimination and stigma, loss of friends, and accusation

of infidelity. And on the other hand, the benefits of disclosure included getting support and encouraging their partner(s) to get tested as well and to protect their partner(s) from getting infected.

6. Recommendations:

The issue of disclosure has not been fully addressed at Kyanamukaaka Health Centre IV, Masaka district. Partner involvement must be encouraged since partners do not seem to be fully involved in discussing matters concerning disclosure.

The findings of this study have provided a basis for the evaluation of the status of disclosure, but more support is required. Researchers need to do more explorative qualitative studies to examine the experiences and challenges faced by partners upon disclosing their HIV status. More analytical studies can be done to assess the factors associated with disclosure, the attitudes toward disclosure, and the knowledge about disclosure.

Stakeholders in the HIV epidemic can conduct more educational forums, increase their advocacy for disclosure, and emphasize the involvement of couples instead of the male or female partner alone. More campaigns should be conducted by health workers with a focus on discouraging the stigma against persons living with HIV.

Creating awareness of the benefits of HIV-sero disclosure in individuals, cultures, and environments. Therefore, disclosure should be the pinnacle of Pre- and Post-counseling and should be considered a seminal concern of healthcare providers of various disciplines who care for persons living with HIV as well as health authorities, municipalities, and community organizations.

7. Study limitations:

Limited funds to support the researcher and research assistants during the whole research process. However, this was overcome by minimizing the few available resources to accomplish this research work.

8. Source of funding:

This research study did not receive any source of funding.

9. Conflict of Interest:

The author declares no conflict of interest.

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