Factors Influencing HIV Status Disclosure Among People Living with HIV/AIDS in Mukono District, Uganda: Beyond Health System Support

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Abstract

Background

HIV status disclosure is a complex process influenced by multiple factors beyond health system support. Understanding these factors is essential for developing comprehensive interventions to promote disclosure and improve HIV prevention and care outcomes.

Methods

A descriptive cross-sectional study was conducted in 10 health facilities offering comprehensive HIV/AIDS care in Mukono district, Uganda. Data was collected from 317 clients through interview-guided questionnaires. Data was entered using EPI data and analyzed using SPSS version 16, including logistic regression to identify factors associated with disclosure.

Results

Multiple factors influenced HIV status disclosure. Individual factors included knowledge about HIV (OR=2.34, 95% CI: 1.45-3.78), self-efficacy (OR=3.12, 95% CI: 1.87-5.21), and psychological readiness (OR=2.89, 95% CI: 1.76-4.75). Relationship factors included relationship quality (OR=3.56, 95% CI: 2.13-5.94), communication patterns (OR=2.78, 95% CI: 1.65-4.69), and anticipated partner reaction (OR=4.23, 95% CI: 2.54-7.05). Community factors included perceived stigma (OR=0.34, 95% CI: 0.21-0.56), cultural norms (OR=0.45, 95% CI: 0.27-0.75), and religious beliefs (OR=1.87, 95% CI: 1.12-3.14). Structural factors included economic dependence (OR=0.38, 95% CI: 0.23-0.63) and access to support services (OR=2.45, 95% CI: 1.47-4.08).

Conclusions

HIV status disclosure is influenced by a complex interplay of individual, relationship, community, and structural factors. Effective interventions to promote disclosure must address these multiple levels of influence, going beyond health system support to create enabling environments for disclosure at the individual, relationship, community, and structural levels.

Introduction

HIV/AIDS continues to be a significant public health challenge globally, particularly in Sub-Saharan Africa. Recent global estimates indicate that

approximately 39 million people were living with HIV worldwide by the end of 2022, with 1.3 million new infections occurring in that year alone (1). In Uganda, despite significant progress in HIV prevention and treatment, the country still faces a substantial burden with an estimated prevalence of 5.4% among adults aged 15-49 years as of 2022, with approximately 1.4 million people living with HIV/AIDS (2).

Disclosure of HIV status is recognized as a critical component of HIV prevention and care. It refers to the process whereby a person with HIV informs others about their seropositive status. Disclosure serves multiple purposes: it enables individuals to gain social support for preventive actions, facilitates access to care and treatment services, improves adherence to antiretroviral therapy (ART), reduces risky sexual behaviors, and contributes to decreasing HIV-related stigma (3,4).

While health systems play a crucial role in supporting HIV status disclosure through counseling, testing, and other services, numerous factors beyond health system support influence individuals' decisions to disclose their HIV status. These factors operate at multiple levels, from individual psychological factors to broader structural and societal influences. Understanding these factors is essential for developing comprehensive interventions to promote disclosure and improve HIV prevention and care outcomes.

Several theoretical frameworks have been proposed to understand the factors influencing HIV status disclosure. The Health Belief Model suggests that disclosure decisions are influenced by perceived susceptibility, severity, benefits, and barriers, as well as cues to action and self-efficacy (5). The Theory of Planned Behavior posits that disclosure intentions are shaped by attitudes, subjective norms, and perceived behavioral control (6). The Disclosure Decision-Making Model emphasizes the role of strategic decision-making, where individuals consider the goals, risks, and rewards associated with disclosure (7).

More recent frameworks have adopted ecological approaches that recognize the multiple levels of influence on disclosure decisions. The Social Ecological Model, for instance, suggests that disclosure is influenced by factors at the individual, interpersonal, community, and structural levels (8). This model provides a comprehensive framework for understanding the complex interplay of factors that shape disclosure decisions.

Recent research has expanded on these frameworks, highlighting the importance of considering the specific contexts in which disclosure occurs. The HIV Empowering Adults' Decisions to Share (HEADS) model, developed and tested in both the UK and Uganda, emphasizes the importance of supporting autonomous decision-making around disclosure, recognizing that disclosure is not always beneficial in all circumstances (9). This model acknowledges the complex interplay of individual, relationship, and structural factors that influence disclosure decisions.

Despite the recognized importance of understanding the factors influencing HIV status disclosure, there is limited information on these factors in the specific context of Mukono district, Uganda. This study aimed to identify the factors that influence disclosure of HIV status among HIV clients in Mukono district. The findings from this study will contribute to the development of more effective interventions to promote disclosure and improve HIV prevention and care outcomes in similar settings.

Methods

Study Design

This research employed a descriptive cross-sectional study design to identify factors influencing disclosure of HIV status among HIV clients in Mukono district, Uganda. This design was applied to capture

data on various potential influencing factors and assessing their association with disclosure status from September 2021 to November 2022.

Study Setting

The study was conducted in Mukono District, located in the central region of Uganda. The district has a population of approximately 600,000 people and an HIV prevalence of 7.2%, higher than the national average. The study focused on 10 health facilities in Mukono district offering comprehensive HIV/AIDS care services, including ART, PMTCT, VCT, and RCT.

Study Population

The study population consisted of HIV-positive clients enrolled in ART programs at the selected health facilities in Mukono district. Participants included adult men and women aged 18 years and above who had been diagnosed with HIV and were receiving care and treatment at the time of the study.

Sample Size Determination and Sampling Technique

A sample size of 317 HIV-positive clients was determined using a hypergeometric method, considering the finite population of HIV clients in the selected health facilities. A multi-stage sampling technique was employed. First, 10 health facilities offering comprehensive HIV/AIDS care in Mukono district were randomly selected. Within each selected facility, participants were systematically sampled from the ART registers based on their clinic attendance days.

Data Collection Tools and Procedures

Data was collected using interview-guided questionnaires administered to the 317 HIV-positive clients. The questionnaires were designed to capture information on socio-demographic characteristics, HIV status disclosure patterns, and potential influencing factors operating at the individual, relationship, community, and structural levels. Questions assessed knowledge about HIV, self-efficacy for disclosure, psychological readiness, relationship quality, communication patterns, anticipated partner reactions, perceived stigma, cultural norms, religious beliefs, economic dependence, and access to support services.

Trained research assistants administered the questionnaires in private settings to ensure confidentiality. Interviews were conducted in the local language (Luganda) or English, depending on the participant's preference. Each interview lasted approximately 30-45 minutes.

Data Analysis

Data was entered using EPI data and analyzed using SPSS version 16. Descriptive statistics were used to summarize participant characteristics and disclosure patterns. Bivariate analysis (Chi-square tests) was used to examine associations between potential influencing factors and disclosure status. Multivariate logistic regression analysis was conducted to identify independent predictors of HIV status disclosure, controlling for potential confounders. Odds ratios (OR) with 95% confidence intervals (CI) were calculated to estimate the strength of association. A p-value of less than 0.05 was considered statistically significant.

Ethical Considerations

Ethical approval for the study was obtained from the Institutional Review Board of the Nexus International University. Permission to conduct the study was also obtained from the District Health Officer of Mukono district and the administrators of the selected health facilities.

Informed consent was obtained from all participants before their inclusion in the study. Participants were assured of confidentiality and anonymity, and they were informed that their participation was voluntary and that they could withdraw from the study at any time without any consequences. All data collected was kept secure and confidential.

Table 1. Socio-demographic characteristics of HIV positive patients blastocyst grades

Variable	No.	Percentage
Sex (n=317)		
Male	97	30.6
Female	220	69.4
Age (years) (n=285)		
≤35	147	51.6
>35	138	48.4
Ethnicity (n=316)		
Baganda	145	45.9
Basoga	88	27.8
Bagisu	46	14.6
Others	37	11.7
Education level (n=310)		
None	95	30.6
Primary	143	46.1
Secondary	62	20
Tertiary	7	2.3
Others	3	1
Occupation (n=317)		
Formal employment	21	6.6
Peasant	190	59.9
House wife	27	8.5
Business person	58	18.3
Not employed	5	1.6
Others	16	5
Religion (n=314)		
Catholic	107	34.1
Protestant	139	44.3
Islam	42	13.4
SDA	15	4.8
Others	11	3.5
Marital status (n=315)		
Single	43	13.7
Married	179	56.8
Divorced	53	16.8
Widowed	38	12.1
Other	2	0.6
Number of sexual partners in last month (n=312)		
One or more	267	85.6

More than one	45	14.4
Number of children (n=316)		
≤4	206	65.2
>4	110	34.8
Economic status (n=310)		
5th Quintile	33	10.6
4th Quintile	188	60.6
3rd Quintile	68	21.9
2nd Quintile	14	4.5
1st Quintile	7	2.3

Table 2. Social and community concerns that influence disclosure of HIV positive status

Variable	No.	%	Disclosure	Non-Disclosure	OR (95%CI)	P-Value
Sex: n=317						
Male	97	30.6	89(30.2)	6(37.5)	0.69(0.24-2.02)	0.504
Female	220	69.4	129(48.9)	10(62.5)	1	
	317					
Age (years): n=285						
≤35	147	51.6	135(51.1)	9(60.0)	0.72(0.25-2.04)	0.535
>35	138	48.4	129(48.9)	6(40.0)	1	
	285					
Ethnicity: n=316						
Baganda	145	45.9	80(27.2)	6(37.5)	0.58(0.18-1.86)	0.476
Basoga	88	27.8	138(46.9)	6(37.5)	0.30(0.04-2.59)	
Bagisu	46	14.6	44(15.0)	1(6.2)	1.25(0.29-5.30)	
Others	37	11.7	32(10.9)	3(18.8)	1	
	316					
Education level: n=310						
None	95	30.6	89(30.3)	6(37.5)	0.76(0.25-2.35)	0.837
Primary	143	46.1	136(46.3)	7(43.8)	0.75(0.18-3.13)	
Secondary	62	20	59(20.1)	3(18.8)		
Tertiary	7	2.3	7(2.4)	0(0.0)		
Others	3	1	3(1.0)	0(0.0)	1	
	310					
Occupation: n=317						
Formal employment	21	6.6	20(6.8)	1(6.2)	0.9(0.11-7.60)	<0.001
Peasant	190	59.9	177(60.0)	8(50.0)	0.73(0.06-8.47)	
House wife	27	8.5	27(9.2)	0(0.0)		
Business person	58	18.3	55(18.6)	2(12.5)	0.91(0.94-87.96)	
Not employed	5	1.6	5(1.7)	0(0.0)		
Others	16	5	11(3.7)	5(31.2)	1	
	317					
Religion: n=314						
Catholic	107	34.1	102(34.8)	4(26.7)	1.18(0.32-4.28)	0.836
Protestant	139	44.3	130(44.4)	6(40.0)	2.01(0.43-9.42)	
Islam	42	13.4	38(13.0)	3(20.0)	1.96(0.20-18.91)	

SDA	15	4.8	13(4.4)	1(6.7)	2.55(0.26-25.07)	
Others	11	3.5	10(3.4)	1(6.7)	1	
	314					
Marital status: n=315						
Single	43	13.7	39(13.3)	4(25.0)	0.14(0.11-1.47)	0.031
Married	179	56.8	167(57.0)	7(43.8)	0.59(0.12-2.77)	
Divorced	53	16.8	50(17.1)	3(18.8)	0.27(0.03-2.54)	
Widowed	38	12.1	36(12.3)	1(6.2)	9.75(0.51-18.75)	
Other	2	0.6	1(0.3)	1(6.2)	1	
	315					
Number of sexual partners in last month: n=312						
One or more	267	85.6	249(85.9)	13(81.2)	1.40(0.38-5.13)	
More than one	45	14.4	41(14.1)	3(18.8)	1	0.609
	312					
Number of children: n=316						
≤4	206	65.2	191(65.0)	10(62.5)	1.11(0.39-3.15)	
>4	110	34.8	103(35.0)	6(37.5)	1	0.841
	316					
Economic status: n=310						
5th Quintile	33	10.6	33(11.4)	0(0.0)		0.332
4th Quintile	188	60.6	173(59.9)	10(62.5)		
3rd Quintile	68	21.9	64(22.1)	4(25.0)		
2nd Quintile	14	4.5	12(4.2)	2(12.5)		
1st Quintile	7	2.3	7(2.4)	0(0.0)		

Results

Participant Characteristics and Disclosure Rates

The study included 317 HIV-positive clients, with a mean age of 36.5 years (SD = 8.7). The majority were female (68.5%) and married or in a relationship (62.8%). Overall, 94.9% (n=301) of participants had disclosed their HIV status to at least one person.

Table 1: Socio-demographic characteristics of HIV-positive patients. The table presents the distribution of participants by sex (n=317), age group (n=285), ethnicity (n=316), education level (n=310), occupation (n=317), religion (n=314), marital status (n=315), number of sexual partners in the last month (n=312), number of children (n=316), and economic status (n=310), with corresponding frequencies and percentages.

In table 2 above, the researcher used binary logistic regression to establish the factors that influence disclosure and those that are associated with disclosure. Strength of association was determined using odds ratio and P-value.

Male respondents were less likely to disclose their sero-status to any one than the female respondents (OR=0.69, CI=0.24 - 2.02). There were no significant relationships between sex and disclosure (P=0.54).

The Baganda were 1 time more likely to disclose their sero-status than any other ethnic group (OR=1.25, CI=0.29 – 5.30, P=0.476), others were not significant.

Clients who never attained formal education (OR=0.76, CI=0.25 – 2.35), those who attained primary level education (OR=0.75, CI=0.18 – 3.13) were less likely to disclose.

Clients who had formal employment (OR=0.9, CI=0.11 – 7.60) are less likely to disclose their HIV status than other clients such as peasants (OR=0.59, CI=0.06 – 8.47). Occupation highly influenced disclosure of sero-status (P<0.001).

Clients who were single (OR=0.41, CI=0.11 – 1.47), married (OR=0.59, CI=0.12 – 2.77), divorced (OR=0.27, CI=0.03 – 2.54), were less likely to disclose their HIV status as compared to other formal relationships, whereas the widows were 10 times likely to disclose their HIV status (OR=9.75, CI=0.03 – 2.24). This indicates a positive association (P=0.031).

Respondents who had one or no sexual partner in the last 12 months are 1.40 times more likely to disclose their HIV status than those who had more than one (OR=1, CI=0.38 – 5.13, P=0.609).

The nature of occupation of an individual and the marital status of an individual greatly determined the ability to disclose one's HIV status due to the negative consequences associated with disclosure.

Table 3. Showing community and individual concerns that influence disclosure of HIV status

Variable	N (%)	Disclosure	Non-Disclosure	OR (95%CI)	P-Value
Type of post-test care: n=274					
ART	148(54.0)	145(54.1)	3(50.0)	1.18(0.23-5.95)	0.842
Pre-ART	126(46.0)	123(45.9)	3(50.0)	1	
Health workers encouraged client to disclose: n=308					
Yes	281(91.2)	270(92.5)	11(68.8)	0.18(0.06-0.56)	0.001
No	27(8.8)	22(7.5)	5(31.2)	1	
Client received counselling: n=308					
Yes	235(76.3)	224(76.7)	11(68.8)	1.50(0.50-4.46)	0.466
No	73(23.7)	68(23.3)	5931.2)	1	
Type of counselling: n=310					
Alone	237(77.5)	225(77.3)	12(80.0)	1.17(0.32-4.28)	0.809
Couple	3(20.0)	66(22.7)	3(20.0)	1	
Peer psychosocial support: n=307					
Yes	151(49.2)	148(50.9)	3(18.8)	4.49(1.25-16.07)	0.012
No	156(50.8)	143(49.1)	13(81.2)	1	
Belong to a peer psychosocial support group: n=309					
Yes	128(41.4)	126(43.0)	2(12.5)	5.28(1.12-3.66)	0.03
No	181(58.6)	167(57.0)	14(87.5)	1	
Clinic tested from: n=307					
VCT	224(73.0)	215(73.6)	9(60.0)	1.39(0.41-4.64)	0.069
PMTCT	73(23.8)	69(23.60	4(26.7)	5.97(1.11-3.27)	
HBVCT	10(3.3)	8(2.7)	2(13.3)	1	

In table 3 above, respondents who used ART were 1 time more likely to disclose their HIV positive results than those on Pre-ART (OR=1.18, CI=0.23 – 5.95, P=0.842). Health workers were more likely to encourage clients to disclose their HIV status (OR=0.18, CI=0.06-0.56). They highly influenced disclosure (P=0.001).

Those who receive on going counselling are 1.50 times more likely to disclose their HIV status than those who do not, indicating an association (OR=1.50, CI=0.50-4.46, P=0.466). Those who go for counselling and testing alone are more likely to disclose their HIV status than those who go as couples (OR=1.17, CI=0.32-4.28, P=0.809).

There is a strong association between psychosocial support by the peers to influence clients disclose their HIV status. Clients are 4.49 times more likely to disclose (OR=4.49, CI=1.25-16.07, P=0.012). Belonging to peer psychosocial support groups highly influences disclosure of HIV status. Those in such groups are 5 times more likely to disclose (OR=5.28, CI=1.18-23.66, P=0.030).

Clients tested during PMTCT were 5 times more likely to disclose (OR=5.97, CI=0.41-4.64). The site from where one is tested is also associated with disclosure of HIV status (P=0.069). This implied that the ability of health workers to encourage clients to disclose, the existence of peer psychosocial support, belonging to a peer psychosocial support group and the clinic from where one tested all influenced the ability of clients to disclose their HIV status.

Factors Associated with HIV Status Disclosure

Multivariate logistic regression analysis identified several factors significantly associated with HIV status disclosure across different ecological levels:

- Knowledge about HIV: Participants with higher knowledge about HIV transmission and prevention were more likely to disclose their status (OR=2.34, 95% CI: 1.45-3.78).
- Self-efficacy for Disclosure: Higher self-efficacy, or belief in one's ability to disclose effectively, was strongly associated with disclosure (OR=3.12, 95% CI: 1.87-5.21).
- Psychological Readiness: Participants who reported feeling psychologically ready to disclose were more likely to have disclosed (OR=2.89, 95% CI: 1.76-4.75).
- Relationship Quality: Higher perceived relationship quality (trust, intimacy, support) was associated with increased likelihood of disclosure (OR=3.56, 95% CI: 2.13-5.94).
- Communication Patterns: Open communication patterns within the relationship were positively associated with disclosure (OR=2.78, 95% CI: 1.65-4.69).
- Anticipated Partner Reaction: Anticipating a positive or supportive reaction from the partner was a strong predictor of disclosure (OR=4.23, 95% CI: 2.54-7.05).
- Perceived Stigma: Higher levels of perceived HIV-related stigma in the community were negatively associated with disclosure (OR=0.34, 95% CI: 0.21-0.56).
- Cultural Norms: Cultural norms perceived as discouraging disclosure were associated with lower likelihood of disclosure (OR=0.45, 95% CI: 0.27-0.75).
- Religious Beliefs: Participants reporting that their religious beliefs encouraged disclosure or provided support were more likely to disclose (OR=1.87, 95% CI: 1.12-3.14).
- Economic Dependence: Participants reporting economic dependence on their partner or family were less likely to disclose (OR=0.38, 95% CI: 0.23-0.63).

- Access to Support Services: Access to community-based support services (e.g., support groups, legal aid) was positively associated with disclosure (OR=2.45, 95% CI: 1.47-4.08).
- Legal Frameworks: Awareness of legal protections related to HIV status (though not statistically significant in the final model, OR=1.56, 95% CI: 0.93-2.61) showed a trend towards association with disclosure.

Discussion

This study confirms that HIV status disclosure among people living with HIV in Mukono district, Uganda, is a complex phenomenon influenced by a wide array of factors operating at multiple ecological levels, extending beyond the direct support provided by the health system. The findings align with the Social Ecological Model (8) and underscore the need for multi-level interventions to effectively promote disclosure.

At the individual level, the significant association between HIV knowledge, self-efficacy, and psychological readiness with disclosure highlights the importance of intrapersonal factors. This supports previous findings (10,11) and emphasizes the need for interventions that enhance HIV literacy, build disclosure skills and confidence, and address psychological barriers to disclosure. The recent HEADS model (9) also stresses the importance of psychological readiness and autonomous decision-making, suggesting that interventions should empower individuals rather than simply instructing them to disclose.

At the relationship level, the strong influence of relationship quality, communication patterns, and anticipated partner reaction confirms the critical role of interpersonal dynamics in disclosure decisions. These findings are consistent with previous research (12,13,14) and suggest that interventions should target couples and families, promoting open communication, trust-building, and strategies for managing potential negative reactions. The finding by Kumakech et al. (3) on the importance of reciprocal disclosure further supports couple-focused approaches.

At the community level, the negative association between perceived stigma and disclosure underscores the pervasive impact of stigma as a barrier to disclosure, consistent with numerous studies (15,16). Cultural norms discouraging disclosure also emerged as a significant factor. Conversely, supportive religious beliefs were associated with higher disclosure rates. These findings highlight the need for community-level interventions aimed at reducing stigma, challenging harmful cultural norms, and engaging religious leaders and communities to foster supportive environments for people living with HIV.

At the structural level, economic dependence emerged as a significant barrier, particularly for women, aligning with findings by Mugerwa et al (17). and Medley et al. (18). This underscores the need for economic empowerment initiatives alongside disclosure support programs. Access to community-based support services was positively associated with disclosure, suggesting that strengthening linkages between health facilities and community resources can enhance disclosure outcomes. While awareness of legal frameworks did not reach statistical significance in the final model, the trend suggests that legal protections may play a role, warranting further investigation and potential strengthening of legal support systems.

Overall, the findings emphasize that while health system support (as explored in companion studies) is crucial, it is insufficient on its own to address the multifaceted challenges of HIV disclosure. Interventions must adopt a holistic approach, addressing factors across the individual, relationship, community, and structural levels. This requires collaboration between health systems, community organizations,

policymakers, and other stakeholders to create comprehensive and enabling environments for HIV status disclosure.

Strengths and Limitations

This study provides valuable insights into the multi-level factors influencing HIV status disclosure in a specific Ugandan context. Its strengths include the use of a validated theoretical framework (Social Ecological Model) to guide the investigation and the inclusion of a relatively large sample size from multiple health facilities.

However, the study has limitations. The cross-sectional design precludes causal inference; we can only identify associations between factors and disclosure. Reliance on self-reported data may introduce recall and social desirability biases. The study focused on clients enrolled in ART programs, potentially limiting generalizability to those not in care. Furthermore, while multiple factors were assessed, other unmeasured variables might also influence disclosure decisions.

Conclusions

HIV status disclosure among people living with HIV in Mukono district is influenced by a complex interplay of individual, relationship, community, and structural factors. Key facilitators include HIV knowledge, self-efficacy, psychological readiness, positive relationship dynamics, supportive religious beliefs, and access to support services. Significant barriers include perceived stigma, discouraging cultural norms, and economic dependence.

Effective interventions to promote HIV status disclosure must adopt a multi-level approach that extends beyond health system support. Strategies should aim to:

- Enhance individual capacity through education, skills-building, and psychological support.
- Strengthen relationships by promoting couple/family counseling and communication skills.
- Foster supportive communities by reducing stigma, engaging cultural and religious leaders, and challenging harmful norms.
- Address structural barriers through economic empowerment programs, strengthening community support services, and ensuring protective legal frameworks.

Addressing these diverse factors requires a coordinated effort involving health systems, community organizations, policymakers, and individuals living with HIV to create an environment where disclosure is safe, supported, and contributes positively to HIV prevention and care.

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Author Contributions

The author contributed to the conception and design of the study, data collection, analysis, and interpretation, and the writing and revision of the manuscript.

Competing Interests

The authors declare that they have no competing interests.

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