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How reliable are self-reports of HIV status disclosure? Evidence from couples in Malawi

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ABSTRACT

Introduction: The majority of research on human immunodeficiency virus (HIV) disclosure utilizes the perspective from a single individual, which cannot be substantiated in the absence of supporting data such as from a primary partner.
Objectives: The objectives of this study were to evaluate: (1) the extent to which self-reported HIV disclosure was confirmed by a primary partner; (2) individual and relationship-level predictors of self-reported versus confirmed disclosure; and (3) whether confirmed disclosure was a stronger predictor of correctly assessing a partner's HIV status compared to self-reported disclosure.
Methods: As part of an 8-wave longitudinal study from 2009 to 2011 in southern Malawi, 366 individuals (183 couples) were interviewed about their primary relationship (wave 3), individually tested for HIV (wave 4), and then asked whether they disclosed to their primary partner (wave 5).
Results: While 93% of respondents reported that they disclosed, only 64% of respondents had confirmed reports from their partner. Having communicated with partner about HIV was positively associated with self-reported disclosure; this association remained significant but became more precise in the models for confirmed disclosure. Confirmed disclosure, but not self-report, was a significant predictor of correctly assessing a partner's HIV status. Being male, having lower perceived partner infidelity, having higher relationship unity, and testing HIV-negative were positively and significantly associated with correct assessment. Dyadic data from two partners provide an improved measure of disclosure as compared to a single individual's self-report and could be used to identify behavioral and biomedical opportunities to prevent HIV transmission within couples.

1. Introduction

In sub-Saharan Africa, the success of human immunodeficiency virus (HIV) prevention and treatment depends upon high levels of disclosure to sexual partners. HIV disclosure facilitates the adoption of safer sex behaviors, partner HIV testing, social support, and engagement in HIV care and treatment programs (Brou et al., 2007; Loubiere et al., 2009; Simoni and Pantalone, 2004; Stirratt et al., 2006; Wong et al., 2009). Disclosure to primary partners may encourage disclosure to other relatives and friends, who can provide emotional and economic support necessary for coping and accessing health services (Suzan-Monti et al., 2013). Even for those who test negative—the majority of in sub-Saharan Africa—disclosure provides an important opportunity for couples to communicate about risk reduction approaches that might not occur otherwise (Crepaz and Marks, 2004; Desgrees-Du-Lou et al., 2007). Disclosure of negative results has the potential to increase trust and intimacy, and strengthen relationship quality, which is associated with many positive health outcomes in couples (Lewis et al., 2006). Despite these benefits, disclosure of positive results can invite stigma, abandonment, discrimination, violence, and emotional distress (Obermeyer et al., 2011). Thus, decisions on when, how, and to whom to disclose are often described as a complex calculus weighing the perceived risks and benefits (Black and Miles, 2002).

Research on individuals who disclose to their sexual partners suggests that socio-economic and relationship factors play an important role. Demographic factors related to non-disclosure include lower socio-economic status, being unmarried, and younger age (Anglewicz and Chintsanya, 2011; King et al., 2008; Wong et al., 2009). Relationship dynamics such as couple

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communication around HIV may facilitate disclosure, while other factors related to power imbalances may interfere with disclosure (Katz et al., 2009; Maman et al., 2001, 2003). Indeed, women who worried about relationship dissolution, loss of economic support, and intimate partner violence were less likely to disclose to sexual partners (Maman et al., 2001, 2003; Medley et al., 2004). Decisions to disclose may also depend on beliefs about whether a partner's HIV status is similar or different to one's own. In seroconcordant positive partnerships, disclosure may be higher if partners expect to rely on each other for social support and coping with HIV/AIDS. Conversely, in serodiscordant partnerships, disclosure may be lower as these relationships are more prone to violence and dissolution following disclosure, especially for HIV-positive women (Maman et al., 2003, 2002; Porter et al., 2004). While studies have shown that HIV-negative individuals are more likely to disclose to partners than HIV-positive individuals (Anglewicz and Chintsanya, 2011), little research has examined whether couples' discrepancy in HIV status itself predicts disclosure.

To date, most research on HIV disclosure has relied upon self-reported data from the perspective of a single individual (e.g., see Medley et al., 2004; Obermeyer et al., 2011; Simoni and Pantalone, 2004), and thus cannot be substantiated in the absence of other data (Olley et al., 2004; Venkatesh et al., 2011). First, the reliability of disclosure reports may be affected by differences in perceptions around what is 'disclosure', which can occur though verbal and non-verbal gestures or behaviors (Wong et al., 2011). Second, as with other sensitive measures around sexuality and HIV/AIDS, disclosure reports are subject to social desirability bias. In sub-Saharan Africa, intentions to disclose are conflicted between the perceived ethical responsibility of protecting a partner and concerns of abandonment and violence (King et al., 2008; WHO, 2003). Thus, those who believe they will be morally judged for placing their partner at risk for HIV may be more likely to over-report disclosure. Finally, disclosure is a bi-directional process involving both a transmitter and receiver and thus, a single partner's account cannot capture both sides of the interaction.

Without an objective measure of disclosure such as direct observation, couples studies offer a novel opportunity to assess the reliability of self-reports by using partners' confirmatory accounts. Indeed, two couples studies from sub-Saharan Africa provide evidence that respondents may not disclose even when they say they do. Among married couples from Malawi, 85% of HIV-positive men and 93% of HIV-positive women who reported disclosing had their spouse's confirmation (Anglewicz and Chintsanya, 2011). In a study from Kenya, men were more likely to confirm their partner's reports of disclosure (93%) as compared to women (71%) (Katz et al., 2009). However, these two studies did not evaluate respondents' reports of their partner's HIV status following disclosure, which would provide stronger evidence that disclosure occurred.

If confirmed reports of disclosure are less prone to error than an individual's self-report, they should result in better assessments of a partner's HIV status. At the same time, knowledge of test results may not completely explain perceptions of a partner's HIV status. Research from sub-Saharan Africa suggests that people use locally adaptive strategies to socially diagnose HIV/AIDS in their communities. For example, in rural Malawi, Watkins (2004) found that people rely on the physical signs of AIDS and information from their social networks to assess who is HIV-positive. Also in Malawi, spouses were more likely to incorrectly perceive their partner was HIV-positive if they suspected partner infidelity even after adjusting for previous HIV tests and couple communication around HIV (Anglewicz et al., 2008). Furthermore, there are widespread beliefs regarding the idea of a shared HIV status among married couples, which may not reflect a partner's actual HIV status (Lingappa et al., 2008; Njau et al., 2011). As more people test for HIV, these diagnostic techniques will evolve to blend beliefs about HIV with knowledge of partner's HIV status obtained through disclosure (Reniers and Helleringer, 2011).

In this study, we utilized a longitudinal couples dataset of women and their male partners who were separately tested for HIV and then asked four months later whether they disclosed to their primary partner. This design allowed us to circumvent three common methodological limitations observed in previous studies: (1) the inability to control for the timing of testing and when the disclosure occurred; (2) the reliance on self-reported HIV status in the absence of serostatus biomarkers; and (3) the inability to assess the reliability of self-reported disclosure. Our objectives were three-fold. First, we examined the extent to which self-reported disclosure was confirmed by a partner and whether rates of disclosure differed by gender (objective 1). In accordance with classical test theory (Lord and Novick, 1968), we expected that a multi-item measure of disclosure (i.e., confirmed disclosure) would be more reliable than a single-item measure from one partner (i.e., self-reported disclosure). Second, using separate models for the two disclosure outcomes, we compared the patterns of associations between individual and relationship factors with self-reported versus confirmed disclosure (objective 2). Third, we investigated whether there were differences in correct assessment of a partner's HIV serostatus using both self-reported disclosure and confirmed disclosure (objective 3). We hypothesized that if confirmed disclosure was a better measure of disclosure, our confidence intervals would be smaller and more precise (objective 2) and respondents would more accurately report on their partner's HIV serostatus (objective 3).

2. Methods

2.1. Participants and procedures

The data were from *Tsogolo la Thanzi* (TLT; "Healthy Futures" in Chichewa), a prospective cohort study that took place from 2009 to 2011 in the Balaka district of southern Malawi. TLT was designed to study how young women and their male partners who have grown up during the HIV/AIDS epidemic make decisions about marriage, childbearing, and sexual behavior. The TLT cohort consisted of approximately 1500 women aged 15–25 who were randomly selected from a household listing of all residents living within a 7-km radius of the Balaka town center. The women were given enumerated tokens and could recruit up to three romantic male partners (e.g., husbands and boyfriends) to participate in the study. Recruiting up to three partners allowed women to enroll secondary partners; however, it not was expected that all women would enroll multiple partners. A romantic partner was defined for respondents as "any relationship that was sexual as well as any relationship where you felt affectionate towards someone even if it was not a sexual relationship". Male partners who were interested in participating in the study could present the token at the TLT research center to enroll. The use of enumerated tokens allowed for the verification of each male participant as a named partner and the ability to identify his female partner in the sample, which has been a successful approach in other studies (Helleringer and Kohler, 2007).

The TLT baseline sample consisted of 1505 randomly selected women and 616 of their male partners (2121 individuals)—as shown in Fig. 1. As noted earlier, several steps were required for male partners to make it into this sample: (1) the women needed to report on the male partner in the survey, (2) give the token to the named male partner, and (3) the male partner needed to present the token at the research center and be matched to a woman in the study. Of the 1505 women at baseline, 17.5% reported on zero