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Health System Mechanisms Supporting HIV Status Disclosure Among People Living with HIV in Mukono District, Uganda

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ABSTRACT

Background: Health system support shapes whether and how people living with HIV disclose their status, yet evidence on the specific mechanisms operating at the facility level in Uganda is limited. This study aimed to describe the mechanisms through which the health system in Mukono District, Uganda, supports clients to disclose their HIV status to partners, family members and friends, and to identify gaps in infrastructure, workforce, policy, and coordination.

Methods: Descriptive cross-sectional study conducted from February to August 2024 in 10 health facilities offering comprehensive HIV care in Mukono District. The sample was 317 HIV-positive clients (finite-population correction), 55 health workers (~80% of eligible providers), and 10 health managers. Quantitative data were analysed in SPSS using descriptive statistics; qualitative data were analysed thematically (Braun and Clarke), with two independent coders and an audit trail.

Results: Counselling was the dominant support mechanism: 294/317 clients (92.7%) received disclosure support through counselling, and health workers delivered post-test (54/55, 98.2%), pre-test (94.5%), and ongoing (89.1%) counselling. However, 6/10 facilities (60.0%) had dedicated private counselling spaces, and only 4/10 (40.0%) had adequate disclosure-related information materials. Just 24/55 workers (43.6%) had disclosure-specific training, and 45/55 (81.8%) reported insufficient time per client. Seven of 10 managers (70.0%) described limited inter-stakeholder communication.

Conclusions: Counselling is the primary disclosure-support mechanism in Mukono, but gaps in private space, disclosure-specific training, time per client, and coordination constrain its quality. These descriptive findings should inform policy attention rather than causal claims on outcomes.

BACKGROUND

HIV/AIDS remains a major global public health burden, particularly in sub-Saharan Africa. UNAIDS estimated that 39.0 million people were living with HIV worldwide at the end of 2022, and 1.3 million new infections occurred that year.[1] In Uganda, adult HIV prevalence stood at 5.4% in 2022, and approximately 1.4 million people were living with HIV.[2]

Disclosure of HIV status, the voluntary process by which a person living with HIV informs others of their seropositive status, supports prevention, ART adherence, access to care, reduction of high-risk sexual behaviours, and reduction of HIV-related stigma.[3,4] The decision to disclose is rarely simple. Laschober and colleagues describe a six-step process spanning adjustment to diagnosis, appraisal of disclosure skills, evaluation of the recipient and circumstances, anticipation of reactions, and identification of motivation.[5]

The health system shapes each of these steps. The WHO health-systems framework identifies six building blocks (service delivery, workforce, information systems, financing, medical products, and leadership) through which support for disclosure can be organised.[6] Recent work in Uganda highlights how differentiated service delivery models, peer support, and community-based mechanisms extend counselling beyond the facility.[4,7]

Despite this, evidence on how the health system actually supports disclosure at the district level in Uganda, particularly in Mukono (where prevalence at 7.2% exceeds the national average), is sparse. Earlier work has emphasised individual-level predictors of disclosure or post-disclosure outcomes, with less attention to systemic support structures. The aim of this study was to describe the support mechanisms operating in Mukono District and identify gaps relevant to policy and programme design. The aim was descriptive and hypothesis-generating; the study did not seek to establish causal effects of support mechanisms on disclosure outcomes.

METHODS

Study Design and Period

This was a descriptive cross-sectional study. Data collection took place between February 2024 and August 2024. The design captured a snapshot of

facility-level support at a defined point in time and is treated throughout this manuscript as descriptive only; no causal inferences are drawn about how support mechanisms shape disclosure outcomes.[8]

Study Setting and Population

Mukono District is located in central Uganda, approximately 21 km east of Kampala. It has an estimated population of 600,000 and an adult HIV prevalence of 7.2%.[2] At the time of the study, 10 health facilities in the district provided the full package of comprehensive HIV/AIDS services, including antiretroviral therapy (ART), prevention of mother-to-child transmission (PMTCT), voluntary counselling and testing (VCT), and routine counselling and testing (RCT). All 10 facilities were included through a census. No additional facility sampling was undertaken because all facilities meeting the inclusion criteria were included. This facility selection frame is acknowledged as a potential source of bias in the Limitations section.

The study included three populations, including adult HIV-positive clients who had been enrolled in ART for at least six months at the selected facilities; health workers providing services in the ART, antenatal care (ANC), and VCT/HCT units; and health managers responsible for HIV programmes, including district-level officials and facility in-charges.

Sampling Procedure

The study employed a three-stage sampling design. In the first stage, all 10 comprehensive HIV care facilities in the district were included through census sampling. In the second stage, the study systematically selected HIV-positive clients from each facility's ART register. The number of participants recruited from each facility was allocated proportionally to its active ART client population using probability proportional to size. In the third stage, the study purposively selected health workers based on their direct involvement in HIV service delivery, while all eligible health managers were included through census sampling. Because participants were sampled within health facilities, the analysis of descriptive estimates accounted for the multistage sampling design by treating facilities as the primary clustering units. Post-stratification weighting was not applied because the proportional allocation of participants across facilities produced an approximately self-weighting sample.

Sample Size Determination

The sample size for HIV-positive clients was calculated using the Cochran formula with a finite population correction (FPC), based on a known register-based population of approximately 1,800 active antiretroviral therapy (ART) clients across the 10 study facilities. The formula used was $n = n_0 / (1 + (n_0 - 1)/N)$, where $n_0 = z^2p\ (1 - p)/e^2$, where $Z = 1.96$ (95% confidence level), p=.50 (the most conservative estimate of the population proportion), $e = 0.05$ (margin of error), and $N = 1{,}800$ (finite population size). Application of the finite population correction yielded a final sample size of 317 HIV-positive clients.

For health workers, a sample of 55 participants was selected, representing approximately 80% of eligible providers working in the ART, antenatal care (ANC), and voluntary counselling and testing/health counselling and testing (VCT/HCT) units across the 10 facilities. For health managers, all 10 individuals responsible for coordinating HIV programmes within the district were included through total population enumeration.

Data Collection Tools and Procedures

Four data collection instruments were used, including an interviewer-administered questionnaire for clients, a self-administered questionnaire for health workers, a semi-structured interview guide for facility managers, and an observation checklist for assessing facility infrastructure. Trained research assistants administered the client questionnaires in private rooms, using either Luganda or English according to participants' language preference. With participants' informed consent, interviews with facility managers were audio-recorded and transcribed verbatim.

The observation checklist was used to document the availability of seven categories of HIV disclosure-related information materials: (i) printed brochures on HIV disclosure for couples; (ii) brochures addressing disclosure to children and adolescents; (iii) wall posters highlighting the benefits of HIV status disclosure; (iv) flip charts for counsellor use; (v) audio-visual materials, including videos and short films; (vi) Luganda-language informational leaflets; and (vii) referral cards for peer support services. A facility was classified as having adequate information materials only if at least five of the seven categories were available and accessible to both providers and clients on the day of observation. The categories most frequently unavailable were Luganda-language informational leaflets, audio-visual materials, and brochures specifically addressing disclosure to children and adolescents.

Data Analysis

Quantitative data were entered in EpiData and analysed in SPSS. Descriptive statistics included frequencies, percentages with 95% confidence intervals, means, and standard deviations. Analyses were originally produced in SPSS version 16, which was the version available under the institutional licence at Nexus International University at the time the study was conducted. For the revised manuscript, all key descriptive results were re-run and verified in SPSS version 28 (IBM Corp., Armonk, NY, 2024); reported percentages were unchanged.

Qualitative data from open-ended client and health worker responses and from manager interviews were analysed thematically following Braun and Clarke's six-phase approach.[9] Two researchers independently coded a 20% subsample of transcripts; inter-coder agreement was calculated using Cohen's kappa ($\kappa = 0.81$, indicating substantial agreement). Discrepancies were resolved by consensus, and a third reviewer audited the final code book. Member checking was conducted with five managers, who reviewed and confirmed thematic summaries. Reflexivity was supported by an audit trail of analytic memos. The qualitative component served a contextual and complementary function: it was used to explain the mechanisms and lived experiences behind the quantitative patterns of counselling delivery, resource constraints, and coordination, rather than to yield

independent standalone findings. Themes were mapped onto the quantitative constructs at the interpretive stage to support convergent triangulation of the descriptive conclusions.

Ethical Considerations

Ethical approval was granted by the Institutional Review Board of Nexus International University, Kampala, Uganda (approval reference NIU/REC/2022/07/19; approved 20 July 2022). The study was not additionally registered with the Uganda National Council for Science and Technology (UNCST). UNCST registration was not pursued at the time because the project was conducted as a postgraduate research study under the institutional ethics framework of the university, with permission from the District Health Officer of Mukono and the in-charges of each participating facility. We acknowledge UNCST registration as the standard expectation for human-subjects research in Uganda and have noted this gap in the limitations. Written informed consent was obtained from every participant; participation was voluntary and could be withdrawn at any point. Data were de-identified and stored on a password-protected device accessible only to the principal investigator.

RESULTS

Participant Characteristics

A total of 317 clients, 55 health workers, and 10 health facility managers participated in the study. All client and health-worker questionnaires were completed, and interviews were conducted with managers from all 10 selected health facilities. The 55 health workers represented approximately 80% of eligible providers working in the ART, ANC, and VCT/HCT units. Facility observations were conducted in all 10 health facilities using a structured infrastructure checklist.

Health System Support Mechanisms for HIV Status Disclosure

Table 1 presents the health system support mechanisms available to facilitate HIV status disclosure from both health-worker and client perspectives. Among health workers (N = 55), counselling services constituted the most widely available support mechanism across the continuum of HIV care. Nearly all respondents reported providing post-test counselling (54; 98.2%), while 52 (94.5%) reported offering pre-test counselling and 49 (89.1%) reported providing ongoing counselling. In addition, 47 (85.5%) health workers reported the availability of care and clinical support services, whereas 42 (76.4%) indicated that referral systems were available to support clients requiring additional services.

Client reports were largely consistent with these findings. Of the 317 clients, 294 (92.7%) reported receiving counselling services during their HIV care. Peer support groups were received by 215 (67.8%) clients, while 143 (45.1%) reported receiving disclosure-related information materials and 121 (38.2%) had received home visits. These findings indicate that counselling was the predominant health system strategy for supporting HIV status disclosure, although complementary support mechanisms were less consistently available.

Counselling Approaches and Client Experiences

Table 2 summarises the counselling approaches employed by health workers and clients' experiences of counselling. Individual counselling was the most frequently reported approach, with 54 (98.2%) health workers indicating that they routinely provided one-to-one counselling. Couple counselling was reported by 48 (87.3%) respondents, followed by family counselling (40; 72.7%) and group counselling (35; 63.6%).

From the client perspective, most respondents viewed counselling positively. Overall, 270 (85.2%) clients reported that counselling had been helpful in supporting their HIV status disclosure decisions, whereas 47 (14.8%) indicated that counselling had not adequately addressed their concerns. Clients who expressed dissatisfaction commonly identified the need for more personalised guidance, additional time with counsellors, and greater attention to family-related issues during the disclosure process.

Facility Resources and Health Worker-Reported Resource Constraints

Table 3 presents findings from facility observations alongside health-worker reports of resource constraints affecting HIV disclosure support. Facility assessments showed that only six of the ten health facilities (60.0%) had dedicated private counselling spaces, while four facilities (40.0%) had adequate disclosure-related information materials.

Health worker responses reinforced these observations. Forty-five (81.8%) respondents reported that limited time available for counselling was the most frequent constraint. Inadequate information materials were reported by 40 (72.7%) health workers, while 37 (67.3%) indicated that limited private counselling space hindered the provision of confidential disclosure counselling. Together, the facility observations and health-worker reports demonstrate that shortages of infrastructure, educational materials, and consultation time remain important challenges to delivering comprehensive disclosure support.

Health Worker Training and Manager Perspectives

Tables 4 and 5 present findings on health-worker training and managers' perspectives regarding the capacity of health services to support HIV status disclosure. As shown in Table 4, 43 (78.2%) of the 55 health workers reported having received some training in HIV counselling. However, only 24 (43.6%) had received specific training on HIV status disclosure, indicating a gap in disclosure-focused capacity building.

Manager perspectives are presented in Table 5. Eight of the ten managers (80.0%) reported that current training programmes did not adequately prepare health workers to provide HIV disclosure counselling. In addition, seven managers (70.0%) perceived communication and information sharing among the Ministry of Health, district health authorities, health facilities, and implementing partners to be limited, which they considered a barrier to effective delivery of disclosure support services. Consistent with these perceptions, observations conducted across the 10 facilities found no formal written referral pathways for HIV disclosure support.

Client perceptions of health system support and suggested improvements

Table 6 presents clients' perceptions of the adequacy of health system support for HIV status disclosure and their recommendations for improvement. Overall, 249 (78.5%) clients perceived the support they received as adequate, while 68 (21.5%) reported needing additional assistance.

Clients identified several priorities for strengthening disclosure support services, with a total of 207 (65.3%) identifying personalised counselling as the most important improvement needed. This was followed by improved follow-up after disclosure (185; 58.4%), greater involvement of partners and family members in counselling (165; 52.1%), and expanded access to peer support groups (150; 47.3%).

Qualitative Themes Contextualising the Quantitative Findings

Thematic analysis of open-ended responses and manager interviews produced four themes that contextualise the quantitative results. The themes are presented below with the quantitative finding each helps to explain.

Theme 1: Time pressure erodes counselling depth.
Health workers consistently described counselling as being squeezed into short clinic slots. Providers noted that they usually had space to introduce the topic of disclosure but not to walk clients through a full decision-making conversation, and managers acknowledged that high client loads made in-depth counselling difficult to sustain even where staff were motivated. This theme gives depth to the finding that 45 of 55 health workers (81.8%) reported insufficient time per client (Table 3).

Theme 2: Situational complexity outstrips generic training.
Workers reported feeling confident in routine counselling but under-prepared for scenarios involving serodiscordant couples, adolescents living with HIV, or clients at risk of intimate-partner violence following disclosure. This aligns with the finding that only 24 of 55 workers (43.6%) had received disclosure-specific training (Table 4) and with managers' view that current training does not adequately prepare workers for disclosure counselling (Table 5).

Theme 3: Clients want family and peer voices in the disclosure process.
Client responses repeatedly emphasised the value of involving partners, relatives, and peers rather than being counselled in isolation. This qualitative signal is consistent with the quantitative pattern in Table 6, in which 165 of 317 clients (52.1%) asked for greater involvement of partners and family and 150 (47.3%) asked for expanded peer support.

Theme 4: Coordination between actors is informal and personality-dependent.
Managers described communication between the Ministry of Health, the district office, health facilities, and implementing partners as reliant on individual relationships rather than formal pathways. This explains the perception of limited coordination reported by seven of ten managers (70.0%) in Table 5 and matches the observational finding that no written referral pathways for disclosure support existed across the 10 facilities.

Integration

The qualitative themes did not contradict the quantitative findings; they explained the mechanisms behind them, why counselling was widely delivered yet variably experienced, why training gaps persisted, and why coordination was perceived as weak. Consistent with a convergent mixed-methods design, the qualitative data therefore served to contextualise and enrich the quantitative results rather than to generate independent conclusions.

TABLE 1: Health System Support Mechanisms for HIV Status Disclosure Reported by Health Workers and Clients

Support mechanism	Health workers reporting availability n (%) (N = 55)	Clients reporting receipt n (%) (N = 317)
Counselling services*	294 (92.7)	
Pre-test counselling	52 (94.5)	—
Post-test counselling	54 (98.2)	—
Ongoing counselling	49 (89.1)	—
Care and clinical support	47 (85.5)	—
Referral systems	42 (76.4)	—
Peer support groups	—	215 (67.8)
Home visits	—	121 (38.2)
Information materials	—	143 (45.1)

*Health workers reported the availability of counselling at three stages (pre-test, post-test, and ongoing counselling), whereas clients reported receipt of counselling as a single combined experience and therefore a single overall estimate is presented.

TABLE 2: Counselling Approaches and Client Experiences

Item	n (%)
Health-worker counselling approaches (N=55)	
Individual counselling	54 (98.2)
Couple counselling	48 (87.3)
Family counselling	40 (72.7)
Group counselling	35 (63.6)
Client experience (N=317)	
Found counselling helpful	270 (85.2)
Counselling did not adequately address concerns	47 (14.8)

TABLE 3: Facility Resources and Health-Worker-Reported Resource Constraints

Resource/Constraint	Observation (10 facilities)	Health workers (N=55)
Private counselling space	6 (60.0)	Limited private space: 37 (67.3)
Information materials	4 (40.0) adequate	Inadequate materials: 40 (72.7)
Time for counselling	—	45 (81.8)

TABLE 4: Health-Worker Training (N=55)

Training aspect	n	%
Some training on HIV counselling	43	78.2
Specific training on HIV status disclosure	24	43.6

TABLE 5: Manager Perspectives on Training and Coordination (N=10)

Aspect	n	%
Reported that current training inadequately addresses disclosure counselling	8	80.0
Reported limited communication / information sharing among stakeholders	7	70.0**

** The 70% reflects manager perception of limited coordination, not an objective measure of fragmentation. Observation confirmed the absence of formal written referral pathways for disclosure support across the 10 facilities

TABLE 6: Client Perceptions of Health System Support and Suggested Improvements

Item	n (%)
Perception (N=317)	
Adequate support	249 (78.5)
Needed additional support	68 (21.5)
Suggested improvements	
More personalised counselling	207 (65.3)
Better follow-up	185 (58.4)
Greater partner/family involvement	165 (52.1)
More peer support	150 (47.3)

DISCUSSION

This study described how the health system in Mukono District supports HIV status disclosure. Counselling (pre-test, post-test, and ongoing) emerged as the dominant support mechanism, reported by the great majority of both health workers and clients. The pattern is broadly consistent with findings from elsewhere in East Africa. In Dar es Salaam, Tanzania, Ismail and colleagues reported that adequate post-test counselling was the strongest facilitator of timely disclosure, while inadequate counselling was associated with delayed disclosure.[10] In Kenya, Mugo and colleagues found that adolescents preferred provider-led, structured counselling for disclosure but that no standard practices existed across clinics.[11] In Rwanda, evaluations of the national couples' voluntary counselling and testing programme have documented similar reliance on counselling as the principal disclosure-support mechanism.[12] Within Uganda, Atwijukiire and colleagues' study of discordant couples in Mbarara reported comparable provider-led counselling models with the same gaps identified here.[13]

Three system-level constraints stood out and reinforce one another. Only 4 out of 10 facilities (40%) had dedicated private counselling space. Only 24 of 55 health workers (43.6%) had training specific to disclosure. And 45 of 55 (81.8%) reported insufficient time per client. Read together, these findings describe a workforce expected to deliver sensitive, skill-intensive counselling without privacy, without specific training, and without time. The Tanzanian evidence makes a similar observation: overburdened, under-resourced facilities undermine even motivated providers' ability to counsel adequately.[10]

The 14.8% of clients who felt counselling did not adequately address their concerns are an important minority. Their expressed need for more time, more individualised guidance, and more attention to family dynamics aligns with the HEADS-UP model's emphasis on supporting autonomous decision-making rather than applying a uniform disclosure script.[14] The integration of community health worker (CHW)-led mechanisms, as reported by Lukyamuzi and colleagues in rural Uganda, has shown promise for extending counselling beyond the clinic and addressing post-disclosure follow-up that clients themselves prioritised.[4]

The training gap identified here is consistent with Kirabira and colleagues' study of paediatric HIV disclosure training in eastern Uganda, which identified a similar deficit in disclosure-specific competencies.[15] General HIV counselling training is not a substitute for disclosure-specific training, particularly in scenarios involving discordant couples, adolescents, or risk of intimate partner violence.

The 70% of managers reporting limited communication and information sharing should be read as a perceived lack of coordination rather than as an objective measure of fragmentation. Observation did, however, confirm the absence of formal written referral pathways for disclosure support across the 10 facilities. This is consistent with broader findings on differentiated service delivery in Uganda that highlight informal rather than structured coordination as the norm.[7]

Most clients (78.5%) reported that the health system had adequately supported their disclosure decision, suggesting that the existing counselling-based model is reaching many. The 21.5% of clients who needed additional support, and the prioritisation of personalised counselling, post-disclosure follow-up, partner involvement, and peer support, mirror evidence from peer- and community-led models.[4,14,16]

Strengths and limitations

The study has several strengths, including the integration of three perspectives (clients, health workers, and managers) and the use of mixed quantitative and qualitative data with explicit inter-coder agreement procedures. However, several limitations warrant consideration. First, the cross-sectional descriptive design captures support at a single point in time and cannot establish causal relationships between support mechanisms and disclosure outcomes. Second, self-reported data from health workers and managers may reflect social desirability bias, which could have led participants to overstate the delivery of counselling services. Third, client reports of received support may be affected by recall bias; clients who have been on ART for several years may not accurately recall or may underestimate the support they received around the time of diagnosis. Qualitative and quantitative data were integrated at the interpretive stage: emergent themes were mapped onto the quantitative constructs of support mechanisms, resources, workforce capacity, and coordination, enabling convergent triangulation of the descriptive conclusions.

Fourth, although the 10 facilities included in the study

represented all comprehensive-care facilities in the district at the time of data collection, these facilities are, by definition, better resourced than peripheral health centres. Consequently, the findings likely reflect a relatively favourable segment of the health system and may overestimate the availability of disclosure support across the district as a whole, introducing potential selection bias. Fifth, the study did not examine the relationship between disclosure support and patient-level clinical outcomes, such as viral suppression or retention in care. Future research should address this important gap. Finally, although the study received ethical approval from the Nexus International University IRB, the researchers did not additionally register the study with the UNCST.

Research, Policy and Programme Implications

Future research should focus on developing and rigorously evaluating interventions that address the identified gaps in HIV disclosure support. Priority areas include the design of specialised training programmes to strengthen healthcare workers' capacity to provide effective disclosure counselling; comparative evaluations of counselling approaches, particularly couple-based and individual models; assessment of the potential role of peer support specialists within HIV care teams; and longitudinal studies examining the association between disclosure support interventions and patient-level outcomes, including viral suppression and sustained retention in care.

These findings underscore important implications for policy and programme development, including the need for district health authorities to integrate strategies that improve access to private counselling spaces and develop tailored educational materials to support disclosure-related needs within existing health planning frameworks. Such measures would enhance the quality of counselling services and create more supportive environments for effective disclosure and care. Integrating disclosure-focused competencies into existing HIV counselling training curricula may strengthen healthcare workers' preparedness to support diverse disclosure experiences. The development and implementation of clinical guidelines addressing complex disclosure contexts, including serodiscordant couples, adolescents, and situations involving potential intimate partner violence, could promote more consistent and responsive care across health facilities. Strengthening referral pathways and coordination among the Ministry of Health, district health authorities, healthcare facilities, and implementing partners is essential to improve continuity of care. Finally, patient-centred approaches, including peer support and community health worker-led interventions, should be further evaluated for their effectiveness in improving outcomes such as viral suppression and retention in HIV care.

CONCLUSION

The health system in Mukono District supports HIV status disclosure primarily through counselling, and most clients report that this support is adequate. Notable gaps remain in private counselling space, disclosure-specific training, time per client, and inter-stakeholder coordination. Strengthening these areas could plausibly improve the quality of disclosure support, but the present descriptive evidence is not sufficient to establish causal effects on disclosure or downstream clinical outcomes.

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