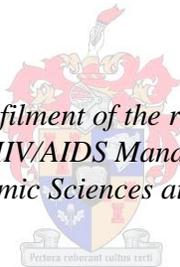


**Factors that influence HIV positive individuals attending anti-retroviral therapy (ARV) clinic at Katutura Hospital (Windhoek, Namibia) to disclose or not to disclose their HIV status to their sexual partners.**

by  
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*Assignment presented in fulfilment of the requirements for the degree of Master of Philosophy (HIV/AIDS Management) in the Faculty of Mangement and Economic Sciences at Stellenbosch University*



Supervisor: Prof. JCD Augustyn

April 2014

## **DECLARATION**

By submitting this thesis electronically, I declare that the entirety of the work contained therein is my own, original work, that I am the sole author thereof (save to the extent explicitly otherwise stated), that reproduction and publication thereof by Stellenbosch University will not infringe any third party rights and that I have not previously in its entirety or in part submitted it for obtaining any qualification.

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20 January 2014

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## Abstract

There have been new infections of HIV despite campaigns aimed at arresting the further spread of the epidemic particularly the new infections. This study sought to investigate whether HIV positive individuals disclose their status to their sexual partners. The study looked at both longtime partners and casual partners. The overall aim was to find the factors that contribute to non-disclosure or to disclosure to sexual partners by HIV positive individuals.

The specific objectives were to identify prevailing levels of HIV sero-status disclosure among people living with HIV who were attending the ARV clinic; to identify people living with HIV's attitude towards HIV status disclosure; to establish factors contributing to disclosure or non-disclosure among people living with HIV; to establish if there is a difference between disclosure rates between 'long time' sex partners and casual/'once-off' sex partners and to provide guidelines to counsellors on how to educate HIV positive people on disclosure. The objectives were achieved by using a quantitative research design through the use of questionnaires targeting 50 HIV positive individuals attending the ARV clinic at Katutura Hospital in Windhoek Namibia. The questionnaire was self-administered and consisted of close-ended questions and one open-ended question which helped collect the quantitative data. The quantitative data was then analyzed using statistical tools (graphs, tables and charts).

Results showed that HIV positive individuals are aware of the importance of disclosure. The results showed that majority of the participants did not disclose for fear of abandonment. Some did not disclose because they thought that their partner was also already infected. As for casual sex partners, some did not disclose because they wanted 'to infect someone since they were also infected by someone'. Some said that they were drunk and hence did not disclose. Participants disclosed because they wanted moral support, they did not want to infect their partners and that they wanted their partners to get tested as well.

One of the recommendations was that there is a need to encourage couple counselling in cases of married couples or 'live-in' couples to reduce the need for disclosure. It was also recommended that HIV/AIDS health workers need special training to enhance their skills on how to educate HIV positive individuals about disclosure. The link between risky sexual behavior and alcohol abuse was highlighted and it was recommended that there is a need to educate people, particular teenagers, the link between the two.

## Opsomming

Die doel van hierdie studie was die bepaling van die mate waartoe persone wat MIV-positief is en klinieke bywoon hulle MIV-status bekendmaak. Die studie is by die Katutura hospitaal in Windhoek, Namibië gedoen en 50 MIV-positiewe pasiënte is as steekproef gebruik.

‘n Vraelys wat die pasiënte self ingevul het is in die studie gebruik en data is op ‘n beskrywende wyse ontleed. Resultate het aangetoon dat MIV-positiewe pasiënte wel bewus is van die belangrikheid om hulle MIV-status bekend te maak. Laasgenoemde pasiënte doen dit egter nie, hoofsaaklik uit vrees vir stigma, diskriminasie en verwerping. Sommige pasiënte maak ook nie hulle status bekend nie omdat hulle bloot aanvaar dat die persoon met wie hulle saambly ook MIV-positief is en die bekendmaking van status dus onbelangrik is.

Een van die belangrikste aanbevelings wat in die studie gemaak word is dat getroude paartjies aangemoedig moet word om MIV-voorligting by te woon, hulle te laat toets en hulle status bekend te maak. Dit word ook verder aanbeveel dat MIV/Vigs-gesondheidswerkers spesiale opleiding moet kry in hoe om persone wat MIV-positief is te oorreed om hulle MIV-status bekend te maak.

Die studie sluit af deur te wys op die belangrike verwantskap tussen seksuele risikogedrag en die misbruik van alkohol. Daar word sterk gepleit dat die gemeenskap, en veral tienerjariges, bewus gemaak moet word van hierdie gevaar.

## **Acknowledgements**

Firstly I would like to thank my supervisor Prof JCD Augustyn for guiding and advising me during the production of this piece. Thank you Prof for the patience. Secondly, to my wife Catherine, your encouragement meant a lot to me during the course of this study. I won't be away from home now. To my son Munyaradzi, I say, now we can watch football together. Thanks for giving me the score lines for the games that I missed. To my three year old son, Taurai, there is a big difference between indiscriminately hitting the computer keyboard with your hands and typing. Thanks anyway for 'trying' to help me with the typing of this manuscript.

To my mother, I don't have words to thank you. Mashoko ndamashaiwa mhai. Dai baba varipowo vaona basa iri.

Lastly, many thanks go to my good friend Douglas Chiwara who muted the idea that I pursue this route. Thanks mate. Ndazvipedza wena.

## **Dedication**

This thesis is dedicated to my late father Robin Samatanga who passed on midway through this work. I hope you will like it even though it has nothing to do with your beloved 'Theorem of Pythagoras'.

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## **ACONYMS**

**AIDS** - Acquired Immunodeficiency syndrome

**ART** - Antiretroviral Therapy

**HCT**: HIV Counselling and Testing

**HIV**: Human Immunodeficiency Virus

**MoHSS** - Ministry of Health and Social Services

**PLHIV**: People Living With HIV

**PMTCT**: Prevention of Mother to Child Transmission

**SSA**: Sub-Saharan Africa

**UNAIDS** –United Nations Joint Programme on HIV/AIDS

**WHO** - World Health Organization

## **Chapter One**

### **Introduction**

#### **1.1 Introduction**

Chapter one presents the background to the study, the significance thereof, the research question and aims and objectives. This chapter will also present a brief description of the research methodology and a brief literature review, both of which will be explained in detail in subsequent chapters in the assignment. Other aspects that will be presented are ethical considerations, time frame and the limitations of the study.

#### **1.2 Background to the study**

Namibia is a vast country with a population of 2.1 million people (2011 census). It has a population density of 25 inhabitants per square kilometre making it the country with the second lowest population density in the World (2011 census). This creates some logistical challenges in the way the country responds to the epidemic in terms of planning and organisation.

As of 2010, UNAIDS (2011) estimates that there are about 34 million people living with HIV/AIDS in the World of which about 60% live in sub-Saharan Africa. In the same year (2010) Namibia had a prevalence rate of 18.8%, up from 17.8% in 2008 (UNAIDS 2011). These figures show a sharp decline from the prevalence rate of 22% in 2002. There is an apparent peak in the prevalence rate (29.7%) among the 35-39 years age group and 29.6% among the 30-34 year age group. This represents the most productive age group which could have their lives cut short if no interventions are implemented. However in the past four years, there has been a tendency for the prevalence rate to move towards the older age group of 40-45 (UNAIDS 2011). This is attributable to the higher accessibility of anti-retroviral drugs (ARV) by more and more people around the country.

On the prevention front, Namibia has made strides in the provision of HIV counselling and testing (HCT) both in state hospitals and as stand-alone facilities. In 2011 alone, the Namibian government established 33 new HCT delivery points which brings to 275 the number of facilities in the country (UNAIDS 2011). These are measures aimed at increasing the number of people who get tested for HIV after which they may seek treatment. UNAIDS (2011), estimates that 67% of adults are on ARV treatment up from 56% in 2007. Of these 31% are men and 59% are women. Prevention of HIV transmission from mother to child (PMTCT) has been running since 2002 and to date 35 hospitals and 153 health centres offer these facilities to pregnant women (Shiyoleni, 2013). There were 67,219 pregnant women who made ante-natal care visits to health care facilities in 2010/2011. Of these 56,948 (85%) were counselled and got tested for HIV. The number of new HIV infection among these tested women was 5,045 (9.4%). In total, there were 9,304 HIV positive maternity clients in the year under review. Out of these, 8,864 (96%) received ARV to reduce the chances of the virus getting transmitted from the mother to the unborn child. According to UNAIDS (2011), this roll out of PMTCT

programmes in Namibia has had a 30% decrease in the number of babies who acquire HIV vertically (from their mothers).

The above figures paint a hopeful picture for the future. However, there have been new infections that are reported annually. In Namibia 9,300 new HIV cases were reported in 2010/2011 amounting to 0.44% of the population. Of these 919 (10%) were mother to child transmissions and 40% were among the 15-45 age group which is sexually active. Namibia has a high occurrence of multiple and concurrent sexual partnerships which has been identified as a big driver of the spread of HIV in the country (UNAIDS, 2002). The thinking is that even HIV positive people still indulge in risky sexual behaviours thereby exposing more people to the virus.

HIV counselling and testing (HCT) programmes place emphasis on post- test disclosure among HIV positive people to their current or future sexual partners. The sexual partners of the infected individuals may advocate for the use of condoms as a means of protection. They may also be encouraged to go for an HIV test themselves in order to ascertain their own HIV status. Having known one is HIV positive, they may then opt to access treatment regimens of ARV. Deribe, Woldemichael and Wonndafrash (2008) say that in Ethiopia, the prevalence rate of HIV among married couples is 2.1% and of these, 85% are discordant. The study also found out that the majority of these couples do not mutually know their HIV status. UNAIDS (2002) recognise that disclosure of HIV positive status to sexual partners and family members would help the infected person to cope psychologically and emotionally. This has the potential to enable the individual to live a healthy productive life. Disclosure also potentially leads to other behaviours that may be beneficial in the fight against and management of HIV/AIDS. An example is when a husband discloses his status to the wife. When pregnant, the woman may seek access to PMTCT. Disclosure may also give an individual some confidence to act as a 'community HIV/AIDS activist'. In the process, more people may come forward to get tested and maybe disclose their status to the community and their sexual partners. Disclosing one's HIV positive status to a partner has also been shown to increase adherence to ARV treatment (Deribe et al. 2008). The reason is that once one's status is known, an individual will not need to 'hide' when taking their medicines. A partner may also even remind the partner to take their medicines thereby reducing chances of forgetting.

Disclosure, though having many benefits, is also characterised by problems. Deribe et al. (2008) reckon that in Ethiopia, disclosure is demonstrated more in 'steady/permanent/regular' partners than in 'casual/once off/unfamiliar' partnerships. This could be because of fear of rejection or being embarrassed that the partner would 'spread' the word of the HIV positive status. Disclosing one's status to a sexual partner may also lead to divorce, physical and emotional abuse, loss of economic support and a general disruption of the family fabric (Tadese, Megabiaw and Wubshet, 2008).

In Namibia, research on disclosure has been confined to women attending PMTCT programmes. Disclosure by both men and women who are HIV positive has not been studied and this research seeks to bridge that gap. Tom (2012) did a study on HIV positive people's attitude, knowledge and perception about disclosure. She found out that 73% of the participants had disclosed their status to their sexual partners and of these 60% had disclosed within one week of knowing their status. Tom (2012) also found out that the majority (68%), had knowledge about the importance of disclosing their status. The setting was however in a private clinic. This study is set in a public institution where majority of the people is poor and mostly with minimal levels of education.

### **1.3 Significance of the study**

The present study would investigate the factors that discourage some HIV positive from disclosing their status to their sexual partners. The study would also explore shortcomings, if any, among HIV/AIDS counsellors on how to educate HIV positive people about disclosure. The ability to disclose one's HIV positive status to sex partners would empower the latter to protect themselves or at least to make informed choices about their sexuality. By this, the rate of new infections may be reduced. For partners who have been together for a long time, disclosure by one may encourage the other to go for HCT so that they may have a 'new start'. The study would also help policy makers in formulating legislation that is aimed at wilful transmission of HIV by HIV positive people. The study may also help policy makers to intensify the campaigns on disclosure particularly to sex partner.

### **1.4 Statement of the Research Problem**

Non-disclosure by HIV positive individuals has been reported worldwide (Tom, 2012). In some cases, the individuals disclose to their medical doctors or any other health service providers like nurses and pharmacists but not to their sexual partners (Deribe et al., 2008). However, some individuals do disclose their status to both their health providers and sexual partners. The factors that discourage HIV positive individuals to disclose their status include fear of rejection, fear of loss of financial support violence and stigma and discrimination. People disclose their status because they may need moral and social support, they may need financial support from family members and sexual partners. Disclosure is also done to protect the sexual partners of the infected individuals. With such benefits associated with disclosure, some people still do not disclose their status to their sexual partners. At the same time, some HIV people do disclose their status.

For these reasons, this study seeks to answer the following question: What are the factors that influence HIV positive individuals to disclose or not to disclose their status to their sexual partners?

### **1.5 Aim of the Study**

The aim of the study is to identify factors that influence HIV positive individuals to disclose or not to disclose their status to their sexual partners.

### **1.6 Objectives of the study.**

The objectives of the study are the following:

- To identify prevailing levels of HIV sero-status disclosure among people living with HIV who are attending the ARV clinic.
- To identify people living with HIV's attitude towards disclosure.
- To establish factors contributing to disclosure or non-disclosure among people living with HIV.
- To establish if there is a difference in disclosure rates between 'long time' sex partners and 'once off' partners.
- To provide guidelines to counsellors on how to educate HIV positive people on disclosure

### **1.7 Research Methodology**

This is a summary of the design and methodology used in the study. The full description will be presented in the third chapter of this assignment

#### **1.7.1 The Research Design**

According to Christensen, Johnson and Turner (2011), a quantitative research is a study that collects numerical data to answer a research question. It has an advantage in that the data so collected can be generalised to the entire population. This is unlike the qualitative research design which collects non-numerical data and whose findings can only be related to a particular group of subjects (Christensen et al. 2011). This is why the quantitative design was chosen over the qualitative one.

The study would be a cross-sectional study making use of questionnaires which would be distributed to patients attending ARV clinic at Katutura Intermediate Hospital (KIH) in Windhoek Namibia. A field worker, with the help of an individual living with HIV at the clinic would be identified and used as the people who would recruit the participants for the study. This would help minimize fear of stigma and discrimination amongst the participants. This questionnaire would be formulated based on the literature and using personal knowledge of the author. The official language in Namibia is English and all the people have a good command for the language. As such, the questionnaires would be in English. In the event that some participants fail to understand some questions, the field worker would help them by explaining.

### **1.7.2 Study Population and Sampling**

Christensen et.al (2011) defines a population as a full set of elements from where participants taking part in a study are selected while a sample is a set of elements selected from the target population. In this study, the target population are all HIV positive individuals attending Katutura anti-retroviral clinic. The sample size was 50 individuals of which 25 were males and 25 were females.

All HIV positive men and women who are visiting the ARV clinic not for the first time were included. The study considered only those patients who voluntarily chose to take part. The process and the purpose of the study were verbally explained to the potential participants by a nurse or counsellor after which those willing to take part would be handed the questionnaire. The patients visiting the clinic for the first time would be excluded since the assumption is that they only knew their HIV status recently.

### **1.7.3 Measuring Instrument**

A self-administered questionnaire with open and closed questions was used to collect information from all the participants (Addendum A). The questions were formulated based on the aims and objectives of the study.

### **1.8 Data Collection**

Data was collected using a self-administered questionnaire which was given to all participants who volunteered to take part in the study. The questionnaire was in English since it is the official language of Namibia.

### **1.9 Ethical Considerations**

Ethical clearance was obtained from the University of Stellenbosch Research Ethics committee (REC), (Addendum B). Permission was sought from and granted by the permanent secretary of the Namibian ministry of health and social services to conduct the study at the Katutura ARV clinic (Addendum C). Further permission was granted by the Katutura Intermediate Hospital medical superintendent to conduct the study at the ARV clinic (Addendum D). Informed consent forms were given to the participants to sign before they completed the questionnaires (Addendum E).

### **1.10 Limitations of the study**

The study used the quantitative method of research which meant that participants could not give in depth explanations about their feelings towards HIV disclosure. The study also had limitations in that it focused on Katutura ARV clinic only which is in an urban area of Windhoek the capital city of Namibia. As such, views from the rural people were not considered. The study also did not include other private ARV clinics in Windhoek where private patients go for services.

## **1.11 Outline of Chapters**

### **Chapter 1**

This is the first chapter and gives the general background to the study and the significance thereof. It gives summaries of the research design, research question and the justification for conducting the study. It also gives the ethical issues and how they were considered. The chapter also indicates the duration of the study and the limitations that the study had.

### **Chapter 2**

This chapter gives a critical literature view which will shed light on what is currently known in the field of HIV disclosure and also what other academics have done in this field.

### **Chapter 3**

This chapter gives the aspects of the research design that were employed and these include data collection, data analysis and the data collection instrument used.

### **Chapter 4**

This fourth chapter presents the outcome of the study. This is the data analysis and the implications thereof.

### **Chapter 5**

The final chapter gives a conclusion to the findings and makes recommendations to the relevant authorities on what has to be to mitigate the issues of non-disclosure by HIV positive individuals.

## **Chapter 2**

### **Literature Review**

#### **2.1 Introduction**

The review of literature is to focus on what other researchers have done and found in the area of HIV disclosure with special reference to factors that influence people living with HIV to disclose or not to disclose their status to their sexual partners. Chapter 2 will critically look at some studies done by other academics about HIV status disclosure to sexual partners. This will include factors that act as barriers and those that motivate disclosure.

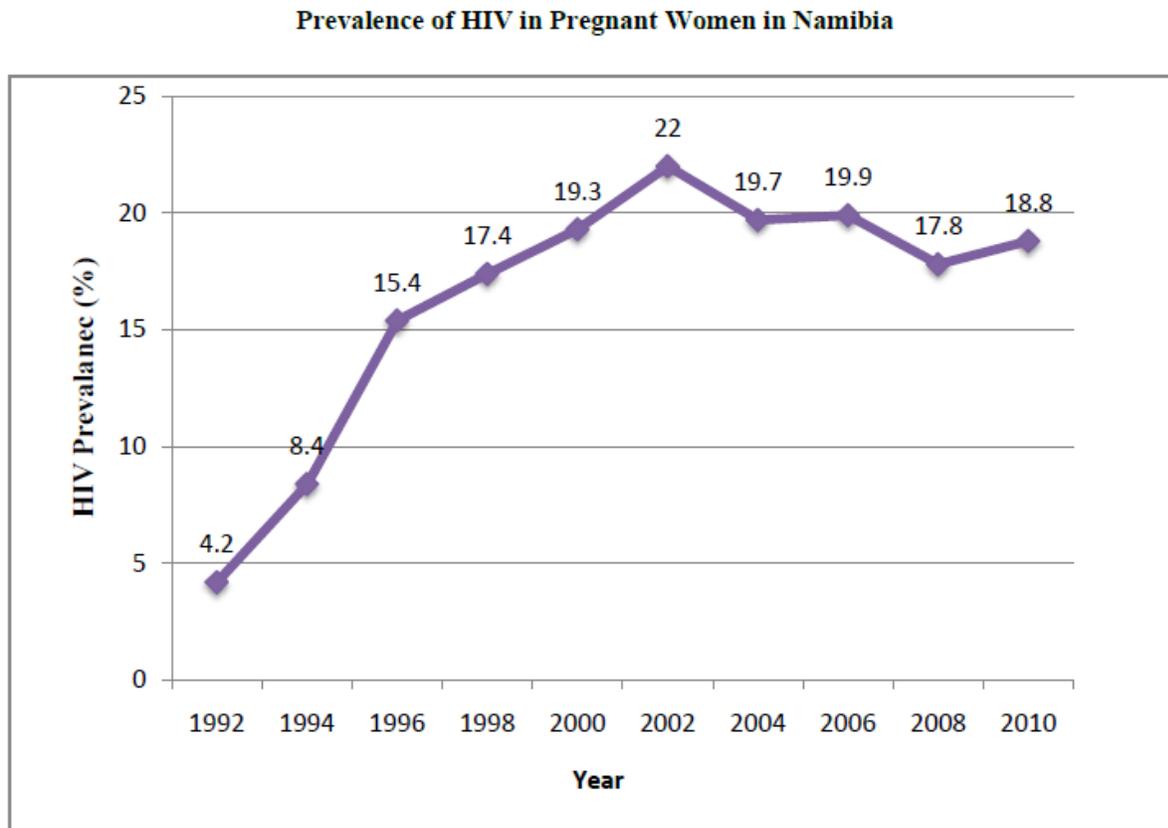
#### **2.2 HIV as a global epidemic**

UNAIDS (2011), estimated that about 34 million people were living with HIV/AIDS. Of these, 20 million are in Sub-Saharan Africa (SSA). This shows that though SSA has just about 10% of the world's population; it is home to about 62% of the world's HIV/AIDS cases (UNAIDS 2011). In this region (SSA), 59% of infected adults are women. The UNAIDS (2008) report showed, however, that there was a 'levelling' in terms of the prevalence rates in 2008. This could be attributed to the rollout of highly active anti-retroviral drugs (HAART) which prolong the lives of infected individual. The same report also highlighted that there was a decline in infections rates from 3 million in 2001 to 2.7 million in 2007, representing 0.9%. Though this represents a positive development, there are also 7500 new infections occurring everyday globally. Of these new daily infections, 50% occur in young people of 25 years and below (UNAIDS 2010). This is means that many young people get infected in the prime of their working lives thereby potentially reducing the most productive workforce. This has the potential to impact negatively on the economy of a nation. UNAIDS (2008) also estimated that about 420 000 children under the age of 15 were infected and that 290 000 of these had died of AIDS. In total, 2.1 million children live with HIV/AIDS and about 15 million children have lost one or both parents due to AIDS(UNAIDS 2010). Of these, 11.6 million of the orphans live in Africa. The described scenario above shows that there is a need for concerted efforts in the fight against the epidemic ranging from prevention drives to care and treatment.

#### **2.3 The Epidemic in Namibia**

Namibia has a population of 2.1million people and covers an area of 825, 418 square kilometres making it the second most sparsely populated country in the world (UNAIDS, 2012). The first case of HIV in Namibia was diagnosed in 1986 and since then, the country now has a generalised epidemic transmitted primarily through heterosexual sex (UNAIDS, 2012). The HIV prevalence rate stood at 4.2% in 1992 and steadily rose to 22% in 2002. The prevalence rate then fell to 19.7% in 2004 and it stood at 18.8% in 2010 (UNAIDS, 2012). According to UNAIDS (2009), the main drivers of the epidemic are multiple and concurrent partnerships, intergenerational sex, low and inconsistent condom use, low risk perceptions, alcohol and drug abuse and mobility and migration

patterns. Figure 2.1 depicts the trends of the prevalence of the epidemic in Namibia among pregnant women from 1992 to 2010.



Source: MoHSS report of the 2010 National HIV Sentinel Survey, November 2010

**Figure 2.1: Prevalence of HIV Pregnant Women in Namibia.**

From Figure 2.1 it is clear that there was a steep rise from in the infection rate from 4.2% in 1992 to 22% in 2002. The rate dropped from the 22% to 19% in two years in 2004. Such drop is attributable to changes in people's attitudes and a general understanding of the epidemic which led to safer sex practices. It was also at that time that PMTCT was introduced in Namibia. The rise from 17.8% in 2008 to 18.8% in 2010 is because of the rollout of ARV treatment throughout the country, which has meant that more people are living longer. Table 2.1 shows Namibia's population with relation to the HIV estimates gathered by UNAIDS.

**Table 2.1 Namibia population and HIV/AIDS estimates. (UNAIDS 2011)**

<b>Indicator</b>	<b>Value</b>
Total population	2.2million(2011)
Estimated number of PLHIV	178 000
Adult prevalence	13.1%(2009)
HIV prevalence among pregnant women	18.8%(2010)
PLHIV receiving HAART	75 681(2010)

HIV disclosure is an act of informing another person or persons of the HIV status of an individual (Mckeown, 2003). Mckeown (2003) goes on to outline contexts in which disclosure can take place. These are at the workplace (to the employers, to clients or to colleagues), to personal relationships (sexual partners, friends, parents etc.), to health service providers like a doctor or nurse. For purposes of this assignment, disclosure occurs when an HIV positive person discloses their status to a sexual partner. The world health organisation (WHO, 2004), adopted a six step framework under which HIV disclosure takes place.

- Adjusting to the ‘news’ of the diagnosis: upon receiving their results, individuals have to achieve a state of personal acceptance where they accept that they are HIV positive and that it cannot be changed.
- Evaluation of personal disclosure skills: here, an individual assesses themselves to see if they have the necessary skills to disclose the news to other people.
- Evaluating appropriateness of disclosure; at this stage, the HIV positive individual looks at all their networks, social, professional and personal, and then decides on whom to disclose to.
- Circumstances for disclosure: at this stage the individual weighs the pros and cons for disclosure.
- Reactions from recipients: an individual figures out the expected reactions from recipients, he/she also weighs the benefits of disclosing in the first place.
- Motivators for disclosure: the individual looks at each potential recipient and figures out why it is important to disclose to that recipient.

Besides these six steps, UNAIDS (2000), explains that disclosure is a major decision that can have negative consequences on both the individual and those around him/her, be they sexual partners, relatives or workmates. This is as a result of stigma that is attached to the epidemic. The fear of rejection coupled with fear of being stigmatised and discriminated against has led to only a few people getting HIV test and then disclosing their status to other people. In Cape Town, South Africa, Simbayi, Kalichman, Strebel, Cloete, Henda and Mqeketo (2007) found that 42% of HIV positive men and women surveyed reported that they had had sex without disclosing to their partners. Tom (2012), found that 73% of HIV positive patients attending a private clinic in Windhoek.

Namibia, had disclosed their status to their sexual partners. The commonest reason for disclosing was that the participants needed help. Deribe, Woldemichael and Wonndafrash (2008) did a study on 705 people taking ARV in South West Kenya and found that the majority (94.5%) disclosed their result to at least one person and that 90.8% disclosed to their current partner. Among those who did not disclose to their sexual partners, 54% feared rejection and negative reaction. Research results indicate that the disclosure rate ranges from 45-99%. WHO (website: [www.who.int](http://www.who.int)), says that there are higher disclosure rates in the developed world (42-100%), than in developing countries (16.7-86%). Sub-Saharan Africa has the lowest average disclosure rate of 16.7% - 32%.

#### **2.4 HIV Disclosure: The Benefits**

Tom (2012) says that disclosing one's HIV status benefits both the individual and the general public. The benefits are derived in two ways. Firstly, when an HIV positive individual has disclosed their status to a sexual partner, the later has a choice of refusing to engage in sexual intercourse with the former and secondly, if the two individuals agree to have sex, there is a likelihood that they would use condoms as a method of prevention (Deribe et al., 2008). This helps in reducing the spread of HIV. Disclosure by a man to his wife means that in the event that the woman fall pregnant, they are likely to get tested and then enrol into PMTCT programmes. Disclosure also helps sexual partners by encouraging them to also go for an HIV test. Once an individual discloses to their sexual partner (after engaging in unprotected), the partner is likely to decide to get tested as well (Tom, 2012). After getting tested and the results are positive, the individual may access HAART before opportunistic infections set in. UNAIDS (2004), state that disclosure helps individuals to adhere to their ARV drugs. Once an individual has disclosed their status, they will be 'free' to take their ARV drugs anywhere anytime. Some HIV positive individuals 'hide' when taking their medicines such that when they go for a visit, they may abscond due to 'fear' of getting 'caught'.

#### **2.5 Barriers to Disclosure**

##### *Stigma and discrimination*

Stigma and discrimination have been associated with reduced disclosure rates (UNAIDS 2008). Maman, Mbwambo, Hogan and Weiss (2003), found out that some HIV positive individuals in Dar es salaam, Tanzania, feared that if they disclosed their status they would face rejection from other people and be labelled as promiscuous people. In that study, some PLWHAs said that they would be looked at as gays 'who must pay for being involved in such disgusting acts' is they disclosed their status. Some PLWHAs believe that disclosing their status may lead to discrimination with regards to getting jobs (Sowell and Seals, 2003). In that study, one male man said 'If I disclose my status and a company comes to our village looking for workers, they will not recruit me, it's better to keep quite'

*Gender Based violence and other undesirable outcomes*

Studies conducted about disclosure by women have shown that fear is the commonest barrier to disclosure. In fact, Sowell and Seals (2003), concluded that HIV positive women have greater difficulty in disclosing their status than HIV positive men. The fear that women have in disclosing their status is based on stigmatization by the community, accusations of infidelity, loss of economic support. Medley and Kennedy (2003) found that women in the developing world feared losing their children if they disclosed their status. The same study also noted that women feared being subjected to physical and emotional violence by their sex partners or the partner's relatives. In their study, Maman et al. (2003) found out that some women being chased away from their family houses by their partners or by the partner's relatives in cases where the husband had died. In Uganda, some women did not disclose their status since they feared abandonment by relatives, verbal abuse and being labelled a 'prostitute' (Kadowa and Nuhwa, 2009).

*Gender and the power dynamics thereof*

Some socio-cultural norms ascribed to women disempower them from disclosing their HIV status, be it to their partners or to family members (Medley and Kennedy 2004). These include their incapability of negotiating safe sex and difficulty in accessing healthcare. The general dependence of women on men, caused by gender dynamics, disempowers from making decisions relating to their sexuality which increases their vulnerability to HIV infection (Sowell et al., 2003). Maman, Mbawambo, Hogan and Weiss (2003), found out that disclosure was easier for Tanzanian women than it was for men. In that study, 53% of the interviewed men notified their partners before they went HCT compared to 33% for the women. In some societies, particularly many in Sub-Saharan Africa, women are perceived as the 'hosts' of HIV and other sexually transmitted infections (Tom, 2012). This perception coupled with some women's lack of education, itself a result of gender imbalances, exposes the women to the social and economic challenges of the epidemic. These issues of masculinity and femininity have led men to being 'excusable' if they indulge in multiple and concurrent partnerships. On the other hand, these issues have disempowered some HIV positive women from disclosing their HIV status to their partners.

**2.6 Motivators for Disclosure**

There are situations that motivate an individual to disclose their status to their sexual partners. WHO (2009) says that an individual may disclose their HIV positive status when they are in need of social and financial support to cope with the diagnosis. They do this as a way of alleviating the stress that is associated with not disclosing. The need for medical help also motivates an individual to disclose their status to sexual partners. Kadowa and Nuhwa (2009) say that in the Mityana district of Uganda, poor health and concern for one's sexual

partner's health motivates HIV positive individuals to disclose their status to sexual partners. In their study, Gaskin (2011), found out that HIV positive rural African American men disclosed their HIV status in order to relieve stress. They also found out that disclosure was motivated by the need to get moral, emotional and financial support from friends and relatives including sexual partners. Mayfield, Rice and Flannery (2008) found in his study that some HIV positive people disclose their status in order to help others. This is done as a way of encouraging more people to get tested and know their status and in the process help to fight stigma and discrimination. The clinical stage of the disease also has an effect on how and when an HIV positive person discloses their status to sexual partners. Deribe et.al (2008) and Kadowa and Nuhwa (2009) found out that people who have lived long periods of time with the virus were more likely to disclose than those newly infected ones. It was also found out that individuals with clinical symptoms of AIDS were more willing to disclose their status than those with latent infections (Deribe et al., 2008). Deterioration in one's health has also been shown to motivate disclosure. This is according to research done by Maman et al., (2003) in Tanzania and Sowell et al., (2003) in southern United States of America which found out that some HIV positive people disclose their status when their health starts to deteriorate. They do this in order to get social support and/or financial support to pay for their medical expenses. Some studies done showed that communication about HIV/AIDS issues between sexual partners is a motivator for disclosure. According to Gaskin (2011) and Mayfield et al., (2008), partners who held communication about HIV/AIDS prior to testing were more willing to disclose their status to their partners and to family members.

## **2.7 Factors that influence Disclosure**

Common factors that have been found to influence disclosure around the world are gender, duration of a sexual relationship, level of education, awareness of partner status, length of time post diagnosis and age of an individual.

In studies done by Deribe et al., (2008) and Tom (2012), it found out that women who are involved in casual sex were more likely to disclose their status than men who are also involved in casual. This is the gender dimension of HIV disclosure which, in this writer's view, is based on masculinity where men feel that disclosing one's status is a sign of weakness. WHO ([www.who.int](http://www.who.int)), also says that women are more willing to disclose their status to sexual partners than their male counterparts. However, Deribe et al., (2008) did a study in South West Ethiopia and found that more men had disclosed their status than women.

Tom (2012) found that in Namibia, disclosure is directly linked to the level of education of an individual. She found out that individuals who had completed high school seemed more likely to disclose than those who did not. This was also found by Simbayi et.al (2007) in Cape Town, South Africa. On the contrary King, Katuntu, Lifshay and Parke (2008) did not find any link between educational level and the willingness to disclose.

King et.al (2004), Simbayi et al., (2007) and Shiyoleni (2013), found that women who were married were more likely to disclose their status than those in casual relationships. King et al., (2008) and Simbayi et al., (2007) also found the same trend for married men. This could be explained by the trust that builds over the years of marriage. Deribe et al., (2008) found that the longer sexual partners have stayed together, the more likely they are to disclose to one another. In Namibia, Tom (2012) also found out that married couples and co-habiting couples had higher rates of disclosure.

The length of time that an individual has known their status also influences disclosure. WHO ([www.who.int](http://www.who.int)) states that the longer an individual has known his/her status, the more likely they are to disclose their status to their sexual partners. This, according to Deribe et al., (2008), is because the individual has developed coping skills and has accepted their status. Kadowa et al., (2009) found out that disclosure increased from 21% within 2 months after diagnosis to 41% four years later. Masupe (2011), found that, in Botswana, disclosure was high (90%) among people who had known their status for more than year.

The age of an individual has also been found to influence an individual's willingness to disclose their HIV status. Kadowa and Nuhwa (2009) found out that the mean age of highest disclosure rates is 38. This study also found out that women in the age group 36-43 had higher disclosure rates than younger women. In Namibia, Tom (2012), found no link between disclosure and age of recipients.

## **2.8 Rates of Disclosure**

Studies done around the world at different times and different settings have shown that not all HIV positive people disclose their status to their sexual partners. However, Medley and Kennedy (2004) concluded that the disclosure rates were lower in developing countries than in the developed world. In their document, WHO (2009) summarised that world-wide disclosure rates ranged between 42% and 100%. This is different from Shah and Shah (2000) who put the rates at 30% to 93%. Medley and Kennedy (2004) did a meta-analysis focussing on 15 studies done in the developing world. Of these, 14 were done in Sub-Saharan Africa. The rates ranged from 16.7% to 86%. WHO (2009), state that disclosure rates are higher among women in the developed world than they are among women in the developing world. They give an average disclosure rate of 71% and a range of 42% to 100% among women in the developed world and a rate of 52% and a range of 16% to 86% among women in developing countries. The lowest rates were reported for women in Sub-Saharan Africa with a range of 16.7% to 32%.

Individual studies done in different settings have given different rates of disclosure but all falling within the range stated by WHO (2009). Tom (2012), did a study in Namibia and found out that a majority of the respondents (73%), disclosed their status to their sexual partners but these disclosures were done at different times ranging from one day to two years. Stein, Kenneth, Sullivan, S, Savetsky and Suzette (2004) did a study and found out that only 40% of the participants had disclosed their status to sexual partners. In a study done in

South Africa, Olley and Seedat (2004) found out that 78% had not disclosed their status to partners and that 46% did not know the HIV status of their sexual partners. Wong and Van Rooyen (2009) did a study in the Soweto and KwaZulu-Natal areas of South Africa and found out that 89% of respondents had disclosed their status to partners and relatives and of these, 82% were willing to know their partners' status.

## **2.9 Outcomes of Disclosure**

According to WHO (2004), studies done both in the developing and developed world settings show that HIV disclosure is associated with positive outcomes. These outcomes include increased social support, acceptance, decreased anxiety and strengthened relationships. Medley (2004) did an analysis on 17 peer-reviewed journals and found out that negative outcomes were much fewer than initially anticipated and that few disclosures led to marriage breakdowns. On the contrary, disclosure was seen to promote relationships. Kilewo, Massawe and Lyamura and Semali (2001) reported that 91.7% of women reported positive outcomes like moral support from their partners, and 14.6% received violent reactions. Of this 14.6%, 3.5% reported that they were chased away from home and 2% were physically assaulted. In India, Shah and Shah (2000) reported that of the 52 women participants, 12 were beaten or abused by their in-laws, 18 were banned from carrying out house hold duties. In the same study, 30 women received positive reactions from their partners.

The next chapter will discuss the research methodology.

## **Chapter 3**

### **Research Methodology**

#### **3.1 Research Design**

The study was a cross-sectional study making use of questionnaires which were distributed to patients attending ARV clinic at Katutura Intermediate Hospital (KIH) in Windhoek Namibia. A field worker, with the help of an individual living with HIV at the clinic were identified and used as the people who would recruit the participants for the study. This helped minimise fear of stigma and discrimination amongst the participants. These questionnaires were formulated based on the literature and using personal knowledge of the author. The official language in Namibia is English and all the people have a good command for the language. As such, the questionnaires were in English. In the event that some participants failed to understand some questions, the field worker helped them by explaining. A quantitative research method was used. According to Christensen et al., (2011), quantitative research is a study that collects numerical data to answer a research question. It has an advantage in that the data so collected can be generalised to the whole population. This is unlike qualitative research which collects non-numerical data and whose findings can only be related to a particular group of subjects. (Christensen et al., 2011). This is why the quantitative approach was preferred to the qualitative one. Fifty respondents were targeted and the study involved 25 of each sex to have a balanced view from both sexes.

#### **3.2 Study population, inclusion and exclusion criteria**

Christensen et al., (2011) defines a population as a full set of elements from where participants taking part in a study are selected while a sample is a set of elements selected from the target population. In this study, the target population were all HIV positive individuals attending Katutura anti-retroviral clinic. The sample size was fifty individuals of which 25 were males and 25 were females.

All HIV positive men and women who are visiting the ARV clinic not for the first time were included. The study included only those patients who voluntarily chose to take part. The process and the purpose of the study were verbally explained to the potential participants by a nurse or counsellor after which those willing to take part were handed the questionnaire. The patients visiting the clinic for the first time were excluded since the assumption is that they only knew their HIV status recently.

#### **3.3 Sampling and Data Collection methods**

The study used the random sampling technique. This, according to Christensen et al., (2011), is a favoured sampling method as it produces a representative sample. Fifty participants attending the ARV clinic at Katutura Intermediate Hospital were recruited for the study.

A field worker was incorporated in the study. In order to improve confidence among the prospective participants, the field, before the start of data collection, recruited one individual who is living with HIV to be present during the recruitment process of the participants. This individual was one of the individuals who attend the ARV clinic at Katutura Hospital. This person together with the field worker selected the participants for the study. The study participants were selected randomly and given consent forms on which they had to sign. The field worker and the assistant approached the patients who had been served. They explained to the prospective participants the purpose of the study and that the participation is voluntary. The HIV positive person also assured the prospective participants of the confidentiality of the whole process. Questionnaires were then handed over to those that had accepted to take part in the study. The choice was given to the participants on whether to fill it in the treatment area or a private area of their choice. A cardboard box was made available where the participants placed the questionnaires after completion. This cardboard box was sealed all round except for an opening just big enough for the questionnaire to fit in.

### **3.4 Data Analysis**

The data was collected using the questionnaires and was used to answer the research question. The quantitative data from the questionnaires was then be coded and presented using statistical instruments like graphs, tables and pie charts statistical software that enabled easy data analysis.

### **3.5 Ethical Considerations**

Research ethics is a set of principles that assist the community and researchers in deciding how to conduct ethical research (Christensen et al., 2011). Permission was sought from the University of Stellenbosch Ethical Committee, Ministry of Health and Social Services in Namibia before the study begins. Before the participants are handed the questionnaires, informed consent was sought from them (Addendum E). This was done by a field worker who was recruited for the research project. Objectives, purpose and benefits of the study were explained to every participant individually. The participants were assured that there was confidentiality guaranteed. After agreeing to take part in the study, the participants were then asked to fill in the consent forms. This consent form, according to Christensen et al., (2011), should be written in a way that can easily be understood.

Results of the study are presented in the following chapter

## Chapter 4

### Results and Discussion

#### 4.1 Introduction

This chapter reports the results of the data collected from 50 HIV positive individuals attending ARV clinic at Katutura Hospital in Windhoek, Namibia. The data was collected using quantitative methods by way of a questionnaire which was given to the participants to complete. In the questionnaire, there was an open ended question for which participants were free to write their opinions. The data is presented in bar graphs, tables and pie charts. The data from the open ended question will be coded and analysed using a thematic approach, which according to Christensen et al., (2011) is a tool used in qualitative research which searches general statements about correlations and underlying themes.

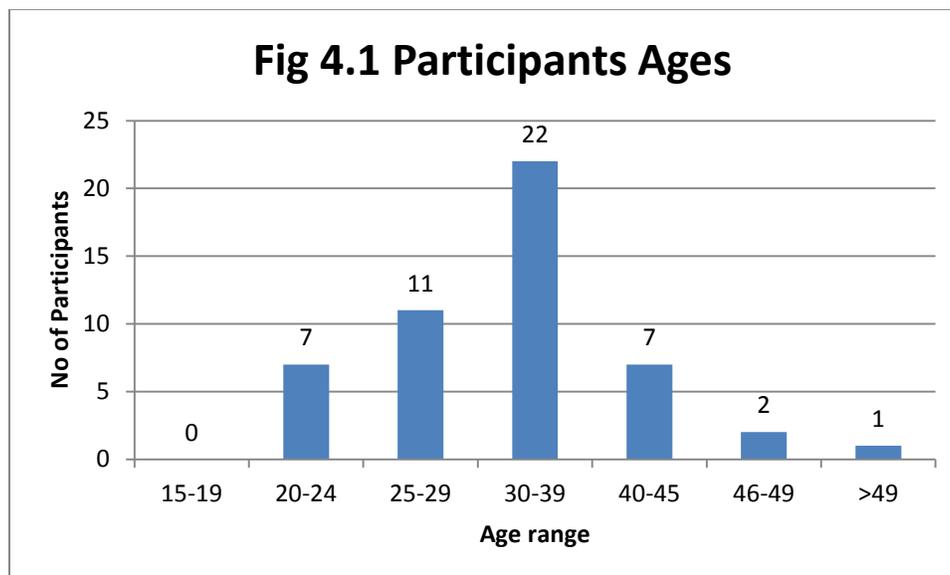
#### 4.2 Section A of the Questionnaire- Socio-demographic Characteristics

This section of the questionnaire looked at participants' backgrounds

##### 4.2.1 Variable 1- Age

All the participants responded to this question and the majority (n=22/44%) were of the 30-39 age range. There were 0 (n=0/0%) participants of the 15-19 age group. The 40-49 age group had seven participants (n=7/14%). There were 11 participants in the 25-39 age group (n=11/22%) and seven in the 20-24 age range (n=7/14%). There was only one participant whose age was above 49 (n=1/2%) and the 46-49 age range had 2 participants (n=2/4%).

The data is represented in Figure 4.1 below.



**Figure 4.1: Participants' Ages**

This data is in agreement with UNAIDS (2011), which says that the highest HIV prevalence in Namibia occurs in the 30-35 age group.

#### 4.2.2 Variable 2-Gender

The study selected 50 (n=50) participants and there were 25 (n=25) females and 25 (n=25) males.

#### 4.2.3 Variable 3-Marital Status

The results showed that the majority of participants were single (n=23/46%) followed by those that live together but not married (n=15/30%). Those that reported to be married were nine (n=9/18%) and 3 (n=3/6%) reported that they were widowed. The Legal Assistance Centre (LAC) reported in 2010 that the rate of marriages in Namibia is low and that more children are born out of wedlock than those born of married couples (LAC 2010). The Demographic Health Survey (DHS) done by the Ministry of Health and Social Services in 2006 found out that co-habitation among Namibians 14% for women and 15% for men (MoHSS 2006). The results of this study match those done by LAC and the MoHSS. These results are shown in Table 4.2

**Table 4.1 Variable 3 Marital Status**

<b>Marital status</b>	<b>n</b>	<b>%</b>
Married	9	18
Single	23	46
Living together but not married	15	30
Widowed	3	6
<b>Total</b>	<b>50</b>	<b>100</b>

#### 4.2.4 Variable 4-Level of Education

There were 0 (n=0/0%) who reported that they had never received formal education. Participants who received up to grade 8-10 were the majority (n=21/42%). Those with grade 1-7 level numbered seven (n=7/14%) and those with tertiary education were 13 (n=13/26%). These results are represented in Table 4.2. Though the thrust of this paper was not to check the differences in education levels between men and women, it was found out that there were more women with lower education than men. The spread of HIV has been linked to levels of education (UNAIDS 2006). In this study, just like what UNAIDS observed, the majority of participants were with lower levels of grade 8-10.

**Table 4.2 Levels of Formal education**

<b>Level of formal education</b>	<b>n</b>	<b>%</b>
None	0	0
Primary (grade 1-7)	7	14
Junior High School (grade 8-10)	21	42
Senior High School (grade 11-12)	9	18
Tertiary Education	13	26
<b>Total</b>	<b>50</b>	<b>100</b>

#### 4.2.5 Variable 5-Employment Status

The majority of the participants (n=23/46%) were unemployed and 16 (n=16/32%) were formally employed. There were 11(n=11/22%) who reported that they were self-employed. The high rate of unemployment evidenced in this study conforms well to a study by Mwinga (2012), which put the unemployment rate in Namibia at 51.2%. The data is represented in Table 4.3

**Table 4.3 Employment Status**

<b>Employment Status</b>	<b>n</b>	<b>%</b>
Employed	16	32
Unemployed	23	46
Self-employed	11	22
<b>Total</b>	<b>50</b>	<b>100</b>

**4.2.6 Variable 6- Monthly Income**

Majority of the participants, 21 (n=21/42%) fell in the range of 0-500 Namibia dollars per month. This includes the unemployed who, according Table 4.3 constitutes the majority of the participants. Participants who earned between 501 and 1000 Namibian dollars were four (n=4/8%) and those that earned 1001-1500 were nine (n=9/18%). There were 3 (n=3/6%) who reported earning between 1501 and 2000 Namibia dollars. There were five (n=5/10%) who were earning 2001-5000 Namibian dollars and eight (n=8/16) who reported earning more than 5000 Namibian dollars. Table 4.4 represents this information.

**Table 4.4 Monthly Incomes**

<b>Monthly Income (in Namibian dollars)</b>	<b>n</b>	<b>%</b>
0-500	21	42
501-1000	4	8
1001-1500	9	18
1501-2000	3	6
2001-5000	5	10
>5000	8	16
<b>Total</b>	<b>50</b>	<b>100</b>

**4.2.7 Variable 7-How did you get to know you HIV status?**

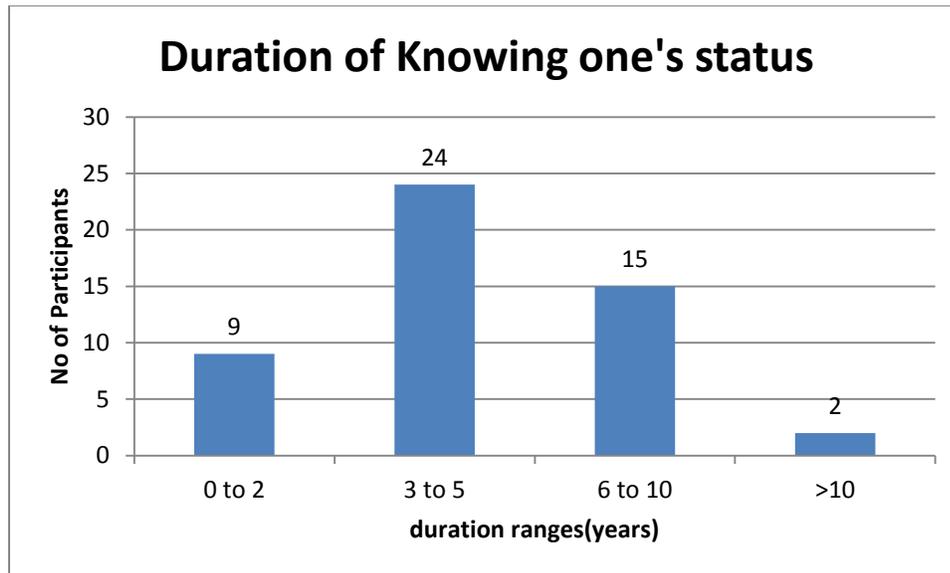
All the respondents answered this question. The majority, (n=27/54%) reported that they voluntarily went for the test and 0(n=0/0%) reported that they were neither forced nor convinced by their partners. There were 14, (n=14/28%), respondents who fell sick and were advised by their doctors to get tested. The other nine (n=9/18%), fell sick and decided, on their own, to get tested. These results differ from those done by the MoHSS in Namibia in 2010 which put rate of voluntary counselling and testing at 30.6%. It seems people are now aware of the importance of getting tested. There are, however, some who still wait until they fall sick to decide to get tested. Table 4.5 illustrates these results.

**Table 4.5 Ways through which respondents got to know their status**

How did you get to know you HIV status	n	%
Fell sick and Doctor recommended it	14	28
Voluntarily went for HIV test	27	54
Fell sick and decided to get tested on my own	9	18
Partner convinced me to get tested	0	0
Partner forced me to get tested	0	0
<b>Total</b>	<b>50</b>	<b>100</b>

#### **4.2.8 Variable 8-For how long have you known your HIV status**

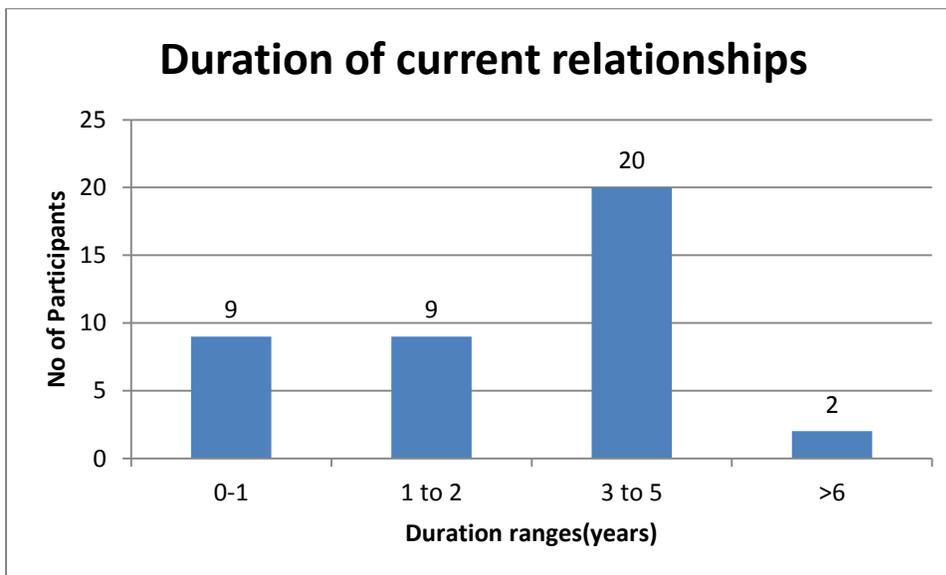
Majority of the participants reported that they had known their status 3 to 5 years ago (n=24/48%) and those that had known it in more than ten years were two (n=2/4%). Nine (n=9/18%) reported that they know their status for between 0 and 2 years. Those that had known their status for years between 6 and 10 were 15 (n=15/30%). This information is represented in Figure 4.2



**Figure 4.2: Duration of knowing one’s status**

**4.2.9 Variable 9-Duration of current relationship**

Majority of the participants reported that they had been in their current relationships for 3-5 years (n=20/40%). Those that had relationships of two years and below numbered 18 (n=18/36%). There were 10 (n=10/10%) who reported that they had more than six years in their current relationships. Two participants did not respond to this question and it is not known whether they are not in any relationships or they just did not want to respond. The data is presented in Figure 4.3



**Figure 4.3: Duration of current relationships**

#### 4.2.10 Variable 10-What is your current partner's HIV status

Majority of respondents, 30 (n=30/60%) reported that their partners were HIV positive and 10 (n=10/20%) said that they did not know their partners' status. Those that had HIV negative partners were 10 (n=10/20%). Deribe et al., (2008) did a study in which 42% of the participants reported discordant couples. These results differ with those from this study. Shiyoleni (2013) did a study in Namibia on pregnant HIV positive women attending ante-natal clinic and found that 12 % were in discordant relationships. These results seem to tally with those from this study. The results are represented in Figure 4.4

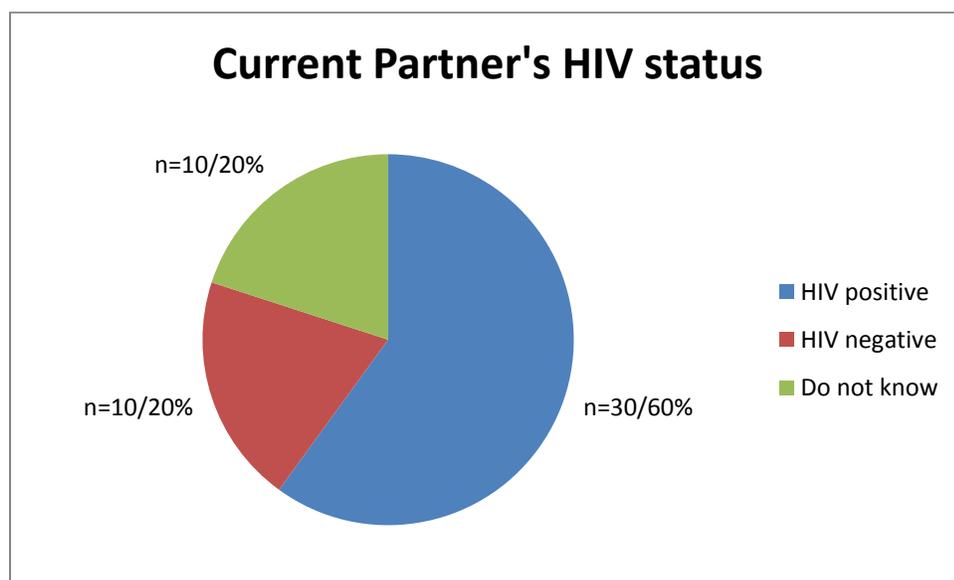


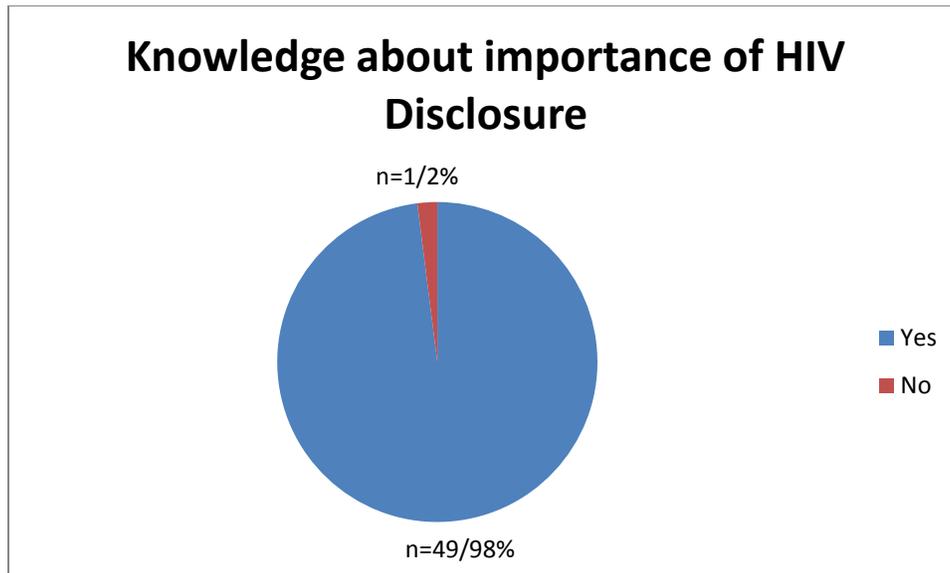
Figure 4.4: Current partner's HIV status

#### 4.3 Section B: Barriers to and outcomes of HIV Disclosure

This section looked at the factors that encourage or discourage HIV status disclosure to sexual partners. It also looks at outcomes of disclosure and the results are listed below.

##### 4.3.1 Variable 11-Do you think HIV disclosure to sexual partners is important?

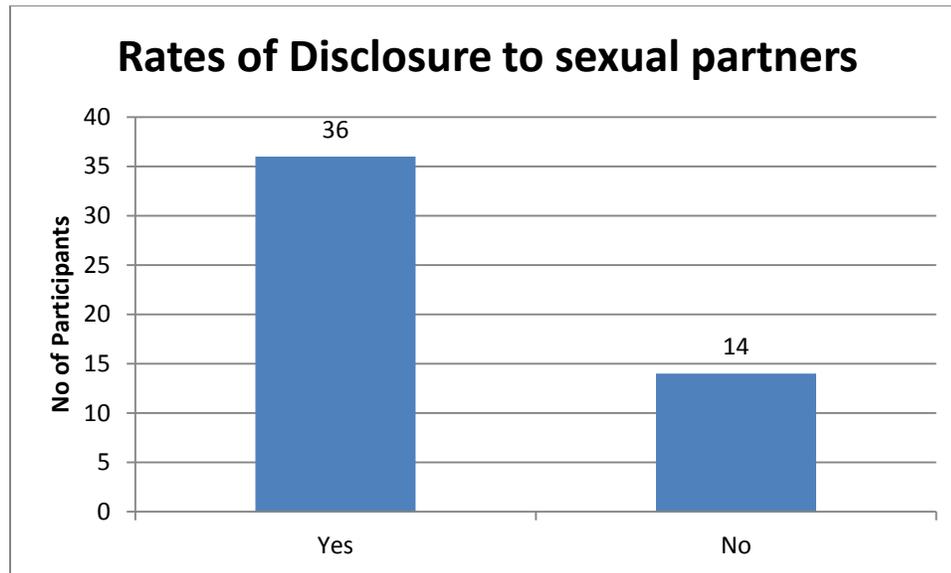
Majority of the participants, 49 (n=49/98%) reported that they view HIV status disclosure to sexual as important. Only one (n=1/2%) said that they did not think that disclosure is important. This may be an indication that education on importance of disclosure is taking root in the general population in Namibia. Figure 4.5 shows this information. Tom (2012) did a study in Windhoek Namibia and also found that participants were aware of the importance of disclosure. In that study, 68% of the participants said that it was important to disclose one's status.



**Figure 4.5: Knowledge about importance of HIV disclosure**

#### **4.3.2 Variable 12a (i): Did you disclose your status to your sexual partner when you got to know your status?**

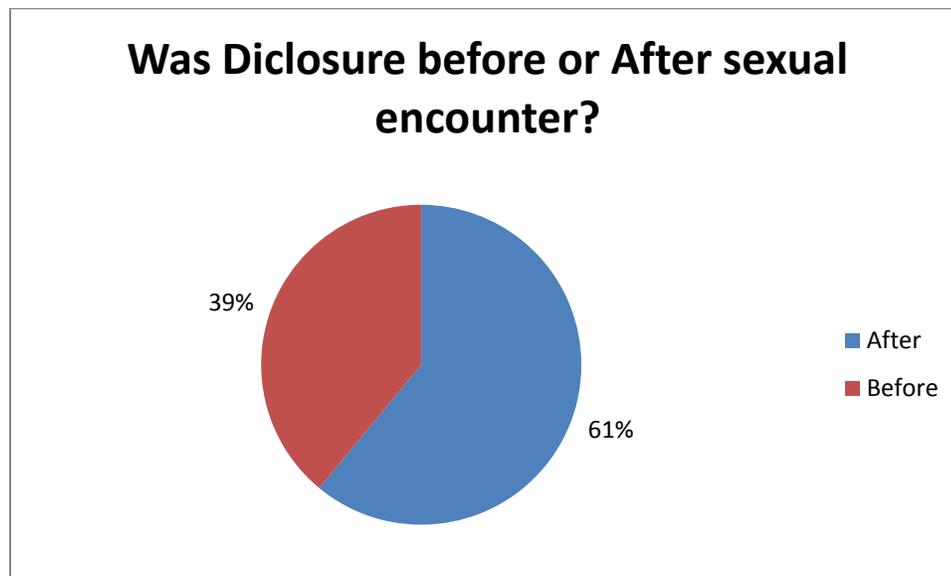
Majority of the participants, 36(n=36/72%) disclosed their results to their sexual partners and 14(n=14/28%) reported that they did not disclose to their sexual partners. Exactly the same results were obtained by Shiyoleni (2013) in Namibia, where 72% of women had disclosed their status to partners and 28% had not. In Ethiopia, Gari and Habte (2010) found that 87.5% of women had disclosed to their partners. These results compare well with those of this study. It may mean that, generally, people are willing to disclose their status to their sexual partners. Figure 4.6 describes this information. Tom (2012) found that 73% of participants had disclosed to their sexual partners in Namibia. All the three studies show similar results with this current study.



**Figure 4.6: Rates of disclosure to sexual partners**

#### **4.3.3 Variable 12a (ii) - Did you disclose before or after a sexual encounter**

There were 36 (n=36) participants who reported that they disclosed their status to their sexual partners (Figure 4.11). Of these 36 participants, 22 (n=22/61%), did not disclose before a sexual encounter with their partners. There were 14 (n=14/39%) who reported that they disclosed to their partners before any sexual encounter. This mirrors well with Shiyoleni (2013), who found that 60% of women only disclosed after a sexual encounter and that 40% disclosed before having sex with their partners. However, Deribe et al., (2008) found that 14.8% of women did not disclose to partners prior to having sex. This present study looked at both men and women which may explain the differences in results. Figure 4.7 presents this information.



**Figure 4.7: Was disclosure before or after sexual encounter?**

#### **4.3.4 Variable 13: How long did it take you to disclose?**

Of the 36 (n=36) participants who had disclosed their status to sexual partners, 18 (n=18/50%), had disclosed in less than a day. There were 16 (n=16/44%) disclosed within one week of knowing their status. Two (n=2/6%) reported that they disclosed after one month. Tom (2012) found out that 60% disclosed within one week. In a study done by Kadowa (2009), in the Mityana district of Uganda, 78% of the people had disclosed within one week. These results show similarity with those of this current study. Table 4.6 represents this information.

**Table 4.6 time taken before disclosure**

<b>Time Taken to disclose</b>	<b>N</b>	<b>%</b>
Less than 1 day	18	50
Within one week	16	44
After one Month	2	6
After six months	0	0
After one year	0	0
<b>Total</b>	<b>36</b>	<b>100</b>

#### **4.3.5 Variable 14: Reasons for not disclosing HIV status**

Of the 14 (n=14) participants who had not disclosed their status, nine (n=9/65%) reported that they feared that their partner would leave them if they disclosed their status. There were three (n=3/21%) who said that they thought that their partner was already infected and there was no need therefore to disclose to them. The remainder, two (n=2/14%), reported that they feared that their partners would deny them sex. Tom (2012) identified fear of abandonment as a leading cause of non-disclosure at 56%. This gives a good relationship to this current study. Table 4.6 represents this data

**Table 4.7 Reasons for non-disclosure**

<b>Reasons for non-disclosure</b>	<b>n</b>	<b>%</b>
My partner would leave me	9	65
I thought my partner was already infected as well	3	21
My partner would deny me sex	2	14
My partner would tell other people	0	0
My partner would think that I was not faithful	0	0
<b>Total</b>	<b>14</b>	<b>100</b>

#### **4.3.6 Variable 15: Reasons for disclosing**

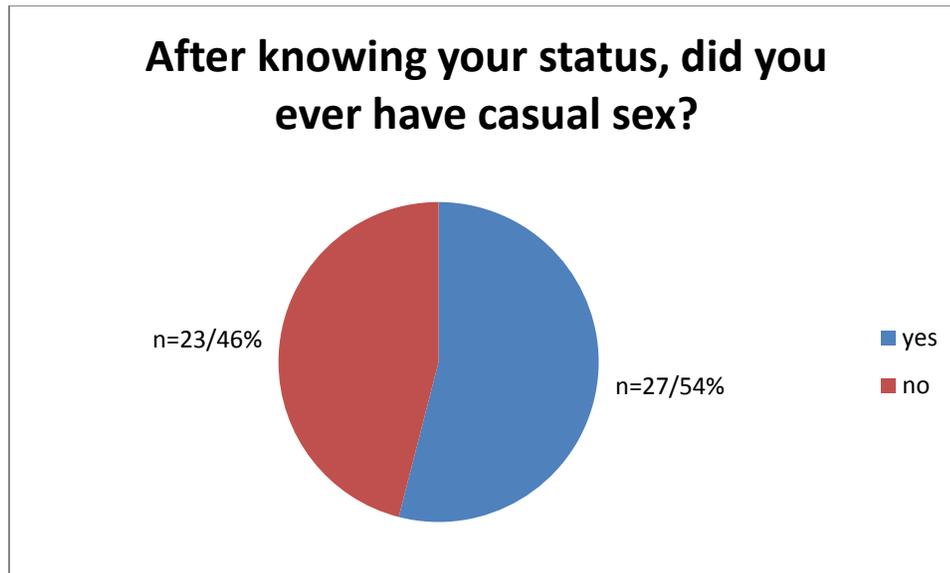
There were 36 (n=36), participants who had disclosed their status to their sexual partners (Figure 4.11). Of these, 19 (n=19/53%) reported that they disclosed because they wanted their partners to get tested as well. There were nine (n=9/25%) said that they disclosed because they did not want to infect their partners. There were eight (n=8/22) who said that they wanted moral support from their partners. This relates with what Kadowa et.al (2009) found in Uganda that 28% disclosed because they wanted moral support from their partners. Tom (2012) also found that 27% disclosed because they were responsible and did not want to infect their partners. Table 4.8 shows this information.

**Table 4.8 Reasons for disclosing**

<b>Reason for disclosure</b>	<b>n</b>	<b>%</b>
I wanted moral support	8	22
I did not want to infect my partner	9	25
I wanted my partner to get tested as well	19	53
I was encouraged by a health worker	0	0
<b>Total</b>	<b>36</b>	<b>100</b>

#### **4.3.7 Variable 16: After knowing your status did you have sex with a ‘once off partner/ one night stand partner**

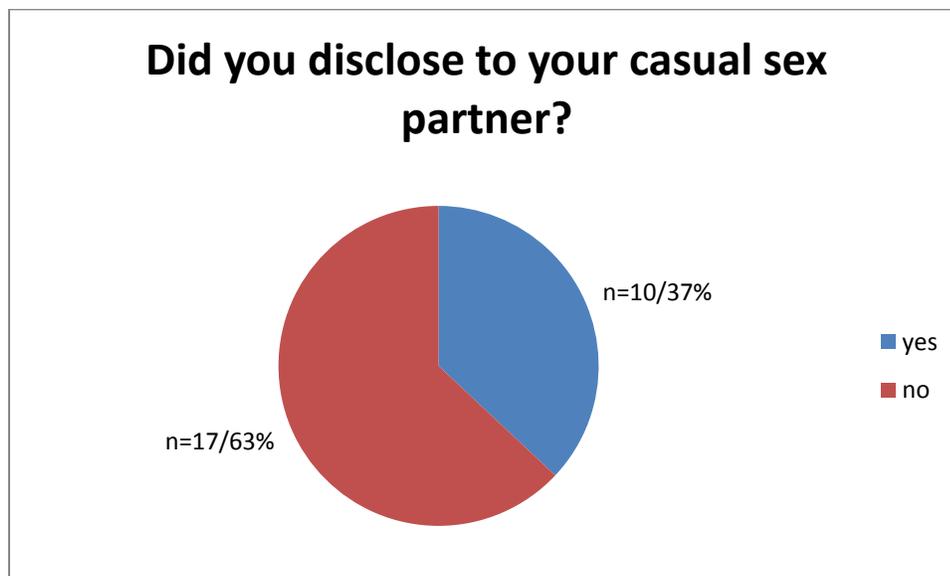
This question sought to find out whether HIV positive individuals do indulge in casual sex with partners they have not known for a long time. There were 27 (n=27/54%) who reported that they had had sex with ‘once off’ partners. The other 23 (n=23/46%) said that they had not. (Purcell, Mizuno and Metsch, 2006) found similar results that 56% of HIV positive Afro-American men indulged in casual sex. These results are represented in Figure 4.8



**Figure 4.8: After knowing your status, did you ever have casual sex?**

**4.3.8 Variable 17: Did you disclose to your casual partner?**

This question sought to find out if HIV positive individuals do disclose their status to casual sexual partners or not. Of the 27 participants who said that they had casual sex, 10 (n=10/37%) reported that they had disclosed their status before the sexual encounter. The other 17 (n=17/63%) said that they did not disclose their status. In their study done in Cape Town South Africa, Simbayi et.al (2007) found that 42% of HIV positive men and women reported that they had had sex with a partner to whom they had not disclosed their status. The results are represented in Figure 4.9



**Figure 4.9: Did you disclose to your casual sex partners?**

#### 4.3.9 Variable 18: Reasons for not disclosing?

There were 17 (n=17) participants who reported that they had not disclosed their status to casual sex partners (Figure 4.9). Of these, four (n=4/24%) reported they did not disclose because they feared that their partner would refuse them sex. Interestingly, four (n=4/24%), said that they did not disclose because they also wanted to infect their partners since they, themselves, had been infected by someone else. There seems to be a sense of revenge. There are not studies that have been done to test whether some people wilfully infect other people as a form of revenge. There were seven (n=7/41%) who reported that they were drunk and as such did not disclose their status. This concurs with findings by Fisher, Simoni and Chaudoir (2007) which say that alcohol increases risks of contracting HIV. Table 4.9 represents this data. The other two (n=2/11%) said that they did not get time to disclose their status.

**Table 4.9: Reasons for not disclosing**

<b>Reasons for not disclosing</b>	<b>n</b>	<b>%</b>
My partner would deny me sex	4	24
I wanted to infect my partner since I was also infected by someone	4	24
I was drunk	7	41
There was no time to do so	2	11
My partner would tell other people	0	0
<b>Total</b>	<b>17</b>	<b>100</b>

**4.3.10 Variable 19: Reasons for disclosing**

There were 10 (n=10) who reported that they had disclosed their status to a casual sex partner (Figure 4.9). Of these, six (n=6/60%) reported that they disclosed because they wanted their partner to use protection (condoms). There were three (n=3/30%) who said that they did not want to infect their partners. There was one (n=1/10%) who reported that they disclosed after being asked about their status. None said that their conscience forced them to disclose. Table 4.10 represents this information.

**Table 4.10: Reasons for disclosing**

<b>Reasons for disclosing</b>	<b>n</b>	<b>%</b>
I feared I would infect my partner	3	30
I wanted my partner to use protection	6	60
My conscience forced me to do	0	0
My partner asked me about my status	1	10
<b>Total</b>	<b>10</b>	<b>100</b>

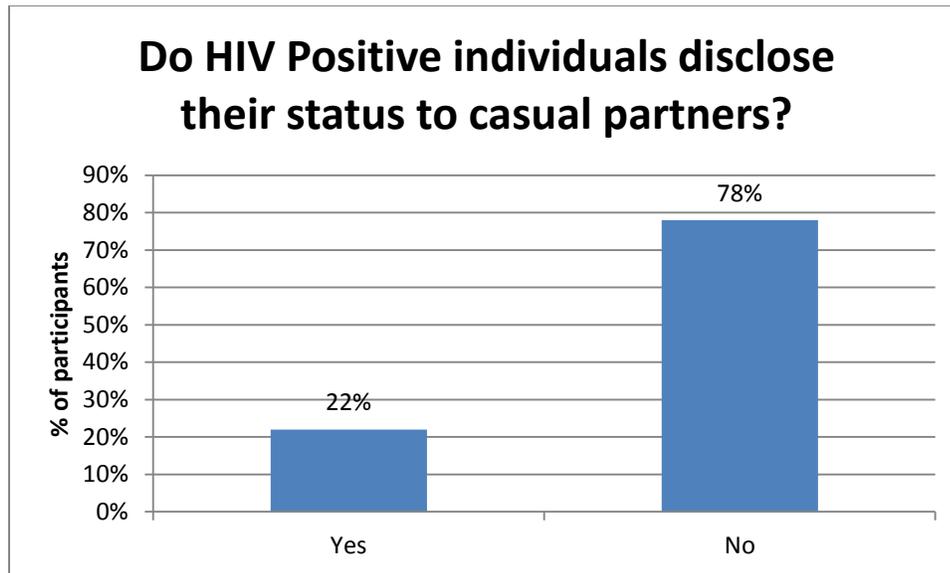
**4.3.11 Variable 20: Open ended question- What was the reaction of your partner when you disclosed your status (from question 14a)**

This was an open ended question in which participants who had disclosed their status to their partners were asked about the response from the partner after disclosing their status. Figure 4.6 shows that 36 participants (61%) disclosed their status to people who were their sexual partners at the time they got to know of their status. Of these 36 participants, the majority, 27 (n=27/75) reported that they received positive outcomes after disclosure. The commonest theme that came out was that partners accepted the situation and promised to be supportive to the other partner. Some were willing to go and get tested as well and there was an element of encouraging each other to adopt a positive and healthy living. One participant said ‘He said it was fine and counselled me and he promised to help me take my pills’. The other said, ‘the reaction was not bad, she said she wants to also know her status before sleeping me’.

These results show similarities with other studies done elsewhere. Tom (2012), found in a study done in Namibia that 66% of participants reported positive outcomes. In a study done by Shiyoleni (2013), in Windhoek, Namibia, 62% of participants reported receiving positive response from their partners. In Ethiopia, Gari and Habte found that 72% of participants got positive outcomes after disclosure. There were also some negative outcomes in this study where, nine (n=9/25%) of the participants received such outcomes. The major theme that emerged was, anger, abandonment name-calling, disbelief and blame. One participant said, 'he was very angry with and he accused me of being a prostitute but he forgot that he was having many girlfriends'. Another one said 'she threw hot water at me and she took our kids to her mother'. 'He was very shocked and could not believe it; he was putting the blame on me for having sex with other men'. Deribe et al., (2008), Shiyoleni (2013), Tom (2012), all found that negative outcomes ranged from anger, abandonment, blame, sadness and denial.

#### **4.3.12 Variable 21: In your opinion, do HIV positive individuals disclose their status to their 'once off/casual' partners?**

All the 50 participants responded to this question. The answer was supposed to be a yes or no. The majority of 39 (n=39/78%) responded with a no and n=11(22%) said yes. This means that the majority believe that HIV positive individuals do not disclose their status to casual sexual partners. This agrees with Tom (2012) who found that disclosure rates increase with the length of time a couple has been in a relationship. In other words, the longer a couple have stayed together, the easier it is for one to disclose to the other. This study did not look at the reasons why disclosure rates are low in casual sexual relationships. Figure 4.10 represents this information.



**Figure 4.10: Do HIV positive individuals disclose their status to casual sex partners**

The following chapter presents conclusions drawn from the study and the recommendations made.

## Chapter 5

### Conclusions and Recommendations

#### 5.1 Introduction

This chapter presents the conclusions drawn from the findings listed in Chapter 4 in relation to the aims and objectives of this study. It also gives recommendations based on these findings to policy makers and other stakeholders. This thrust of the study was to establish factors that influence HIV positive individuals attending the Katutura ARV clinic to disclose or not to disclose their status to their sexual partners. Though this was a relatively small sample of 50, the findings give a glimpse of such factors and the study could be used to strategize ways of improving disclosure rates among people living with HIV.

#### 5.2 Conclusions drawn from the findings

The study set out its specific objectives as follows:

- To identify prevailing levels of HIV sero-status disclosure among people living with HIV who are attending the ARV clinic.
- To identify people living with HIV's attitude towards disclosure.
- To establish factors contributing to disclosure or non-disclosure among people living with HIV.
- To establish if there is a difference in disclosure rates and factors that influence disclosure/non-disclosure between 'long time' sex partners and 'once off' partners.
- To provide guidelines to counsellors on how to educate HIV positive people on disclosure

The study met all the set objectives and the findings are summarised below:

The study showed that there were relatively high levels of disclosure by HIV positive individuals. This is shown by 36 (n=36/72%) who said that they had disclosed to their sexual partners compared to 28(n=14/28%) who said that they did not. This is similar to a study by Shiyoleni (2013) who found that 72% of the participants disclosed to their partners in Namibia. Another study in Ethiopia by Gari (2010) showed that 87.5% of respondents reported that they had disclosed to their sexual partners. Tom (2012) found that 73% of the respondents in her Namibian study had disclosed their status to partners. This study also found that HIV positive individual have a positive attitude towards disclosure with 49 (n=49/98%) reporting that they know the importance of disclosing one's status to sexual partners and 1, (n=1/2%) saying that disclosure is not important. This relates well to Shiyoleni (2013) who found that 84% of participants knew the importance of disclosing one's status to partners. In Tom (2012)'s study, 68% of the respondents reported that it is important to disclose one's status.

The study also found out some factors that influence disclosure or non-disclosure to sexual partners by HIV positive individuals. For disclosure, it emerged that majority of respondents disclosed their status

because they wanted their partners to get tested as well. This is an interesting development as it shows that more and more people now realise the importance of knowing one's HIV status. A sense of responsibility also came out as 25% of those that disclosed did so in order to 'protect' their partners. They did not want to infect their partners. This was also found by Deribe (2008) where 32% of respondents disclosed in order to not to infect their partners. There were 22% who disclosed so that they could get moral support. Kadowa (2009) also found that 28% of the respondents did so in order to get moral support from partners.

For non-disclosure, an interesting point came out. Majority of the participants (65%) feared that their partners would leave them. This is the fear of abandonment which was also found to be 56% by Tom (2012). Some participants, (14%) feared that their partners would deny them sex. Twenty one per cent (21%) did not disclose because they thought that their partners were also infected. This seems to suggest ignorance on the part of these respondents since they assumed that once you have sex with an HIV infected person you are automatically also infected. These factors were also found by Deribe et al., (2008), Shiyoleni (2013) and Kadowa et al., (2009).

This study also sought to find out if there is a difference in (i) disclosure rates and (ii) factors that influence disclosure/non-disclosure between long time sex partners and casual/once-off partners. There was a relatively big difference between the disclosure rates. For long standing partners, the disclosure rate was 72% and 28% did not disclose while 37% disclosed to casual sex partners and 63% did not disclose. These results are similar to those by Tom (2012), Deribe et.al (2008) and Kadowa et al., (2009), who found that the longer the sexual relationship the more likely partners are to disclose their status. Majority of the casual partners (41%) did not disclose because they were 'drunk' and majority of the long standing partners did not disclose because they feared that their partner would leave them. In casual relationships, 24% said that they did not disclose because they wanted to infect their partners since 'they were also infected by someone'. In both types of relationships, some participants did not disclose because they feared that they would be denied sex by their partners. There were 24% for casual partners and 14% for long standing relationships.

## **5.3 Recommendations**

### **5.3.1 Education on Couple Counselling**

Some results from this study suggest that participants went for an HIV test on their own without their sexual partners at the time. This leads to some individuals not disclosing their status to their partners for reasons outlined in this study. Some participants (20%) said that they did not know their partners' HIV status. It seems there is a need for relevant authorities to embark on a programme to educate all people who intend to get an HIV test to bring along their current sexual partners so that they are tested together. This will remove the need to for disclosure. Institutional HIV/AIDS counsellors could be used as agents of these educational programmes.

### **5.3.2 Focus on HIV/AIDS Health workers**

A casual discussion with the head of Katutura ARV clinic (Sister Ilovu) showed that counsellors at the clinic do not have any training on HIV disclosure. The line ministry could introduce a course in which HIV/AIDS counsellors are trained on how to educate clients on HIV disclosure. Though the majority of the participants (98%) knew the importance of disclosure some did not disclose which may suggest lack of skills on how to disclose.

### **5.3.2 Alcohol Abuse**

The results from this study show that 41% of participants who engaged in casual sex did not disclose because they were 'drunk'. Namibia AIDS Awareness, on their website, site alcohol abuse as a one of the leading risk factors to HIV infection. There is, therefore, a need for policy makers and community leaders to educate people, particularly young people, about the dangers of alcohol abuse in relation to general health issues and HIV infection in particular.

### **5.3.3 Live and Let Live**

An interesting point that came out of this study is that some individuals did not disclose their status to casual sex partners because 'they wanted to infect them since they were also infected by someone'. It is likely that this line of thought is brought about a need for revenge. HIV positive individuals need to be intensively counselled so that they understand the disease and forget about how they contracted the disease. The individual bitterness is best addressed by employing well trained counsellors who will advise on the dangers of 'cross-infection'.

### **5.3.4 Economic empowerment of the infected**

It emerged that some participants did not disclose their status because they feared that their partner would abandon them. Authorities could put in place income generating programmes deliberately targeting HIV infected individuals so that they become economically independent. Economic factors

have been identified as factors that increase the vulnerability to HIV infection especially among women. These programmes could be small farming projects.

#### **5.4 Further Research**

This study focussed on both men and women and the themes that came out cannot be attributable to either sex. Further research should focus on individual sexes in order to find out how each sex views issue of disclosure. Majority of participants (78%) reported that they think casual sex partners do not disclose their statuses to each other. There is a need to conduct further research in order to know why these individuals do not disclose their status.

A research study focussing on all ARV clinics will give a larger sample and such a study may give a more balanced perception about issues of HIV disclosure/non-disclosure.

#### **5.5 Conclusion**

HIV status disclosure plays a pivotal role in the fight against HIV/AIDS. It helps reduce the spread of the virus and also helps those who are infected to adhere to their treatment programmes. When an infected individual discloses their status to their sexual partner, the partner may request that they use condoms consistently and persistently. Such disclosure may also motivate the sexual partner to get tested. In the event that the partner is also infected, they can seek medical treatment before the onset of opportunistic infections. After disclosing one's status, PLHIV will have ease with which to take their ARV medication. There will not be any need to hide or skip a dose.

This study, like others sited herein, showed that majority of people who disclosed their status to their partners received positive outcomes. This serves to show that, despite popular belief that there are always negative outcomes; disclosure is associated with moral and social support. HIV status disclosure can act as a kingpin in the realisation of the UNAIDS goal of zero discrimination, zero HIV/AIDS related deaths and zero new infections. What needs to be done, as alluded to in the recommendations section, is that HIV/AIDS health workers are trained so that they have skills to educate people about disclosure and the importance thereof.

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Any other way-----  
-----  
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9. For how long have you known your status: 0-2years  3-5years  6-10years  >10years

**10. For how long have been in your current relationship:** 1 year and less  1-2years  3-5years  >6years

**11. For how long have you been in the relationship with your current partner:** 1 year and less  2-3years  4-6years  7-9years  >10years

**12. What is your current partner's HIV status:** HIV Negative  HIV positive  don't know

**Section 2: Attitudes towards and knowledge about HIV disclosure.**

**13. Do you know the importance of disclosing one's HIV status to sexual partners?** Yes  No

**14(a) upon knowing your HIV status, did you disclose it to the person who was your sexual partner at that time?** Yes  No  if your answer is yes, was it before you had any sexual encounter with him/her or it was after? It was before  it was after

**14(b): How long did it take you to disclose your status?** Less than one day  within one week  after one month  after 6 months  after 1 year

**15. If your answer is NO, I did not disclose because:**  my partner would leave me

I thought my partner was also already infected.

My partner would deny me sex

My partner would tell other people

My partner would think that I have not been faithful

Other (please explain)-----  
-----  
-----

16. **If your answer was YES in 14, I disclosed because:**  I wanted moral support
- I did not want to infect my partner
- I wanted my partner to get tested as well
- I was encouraged by the health worker to do so
- Other(please specify)-----
- 

17. **Since you got to know your HIV status, did you ever have sex with a ‘once off’ partner or a casual partner:** yes  No

18. **If YES, did you disclose your status to the sexual partner:** Yes  No

19. **I disclosed because:**  I feared I would infect the partner
- I wanted the partner to use protection
- My conscience forced me to do so
- The partner asked me about my status
- Other(specify)-----
- 

20. **I did not disclose because:**  My partner would refuse me sex
- I wanted to infect my partner since I was also infected by someone
- I was drunk
- There was no time to do so
- My partner would tell other people
- Other(specify)-----

21. **What was the response/reaction by your partner when you disclosed your status?**

22. **In your opinion, do HIV positive disclose their status to their ‘once off’/”one night stand partners?**

## Addendum B: Ethical Approval: Stellenbosch University



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jou kennisvennoot • your knowledge partner

### Approval Notice Response to Modifications- (New Application)

29-Oct-2013  
Samatanga, Fortune F

**Proposal #:** HS993/2013

**Title:** Factors that Influence HIV positive Individuals attending anti-retroviral therapy (ARV) clinic at Katutura Hospital (Windhoek Namibia) to disclose or not to disclose their HIV status to their sexual partners.

Dear Mr Fortune Samatanga,

Your **Response to Modifications - (New Application)** received on **18-Oct-2013**, was reviewed by members of the **Research Ethics Committee: Human Research (Humanities)** via Expedited review procedures on **29-Oct-2013** and was approved.  
Please note the following information about your approved research proposal:

Proposal Approval Period: **29-Oct-2013 -28-Oct-2014**

Please take note of the general Investigator Responsibilities attached to this letter. You may commence with your research after complying fully with these guidelines.

Please remember to use your **proposal number (HS993/2013)** on any documents or correspondence with the REC concerning your research proposal.

Please note that the REC has the prerogative and authority to ask further questions, seek additional information, require further modifications, or monitor the conduct of your research and the consent process.

Also note that a progress report should be submitted to the Committee before the approval period has expired if a continuation is required. The Committee will then consider the continuation of the project for a further year (if necessary).

This committee abides by the ethical norms and principles for research, established by the Declaration of Helsinki and the Guidelines for Ethical Research: Principles Structures and Processes 2004 (Department of Health). Annually a number of projects may be selected randomly for an external audit.

National Health Research Ethics Committee (NHREC) registration number REC-050411-032.

We wish you the best as you conduct your research.

If you have any questions or need further help, please contact the REC office at 0218839027.

**Included Documents:**

Revised DESC form  
Research proposal  
Desc form  
REC Application  
Informed consent form  
Permission letter  
Letter of response  
Revised Informed consent form  
Revised Research proposal  
Questionnaires  
Revised REC Application  
Permission letters

Sincerely,

Susara Oberholzer

# Investigator Responsibilities

## Protection of Human Research Participants

Some of the general responsibilities investigators have when conducting research involving human participants are listed below:

1. Conducting the Research. You are responsible for making sure that the research is conducted according to the REC approved research protocol. You are also responsible for the actions of all your co-investigators and research staff involved with this research. You must also ensure that the research is conducted within the standards of your field of research.

2. Participant Enrollment. You may not recruit or enroll participants prior to the REC approval date or after the expiration date of REC approval. All recruitment materials for any form of media must be approved by the REC prior to their use. If you need to recruit more participants than was noted in your REC approval letter, you must submit an amendment requesting an increase in the number of participants.

3. Informed Consent. You are responsible for obtaining and documenting effective informed consent using **only** the REC-approved consent documents, and for ensuring that no human participants are involved in research prior to obtaining their informed consent. Please give all participants copies of the signed informed consent documents. Keep the originals in your secured research files for at least five (5) years.

4. Continuing Review. The REC must review and approve all REC-approved research proposals at intervals appropriate to the degree of risk but not less than once per year. There is **no grace period**. Prior to the date on which the REC approval of the research expires, **it is your responsibility to submit the continuing review report in a timely fashion to ensure a lapse in REC approval does not occur**. If REC approval of your research lapses, you must stop new participant enrollment, and contact the REC office immediately.

5. Amendments and Changes. If you wish to amend or change any aspect of your research (such as research design, interventions or procedures, number of participants, participant population, informed consent document, instruments, surveys or recruiting material), you must submit the amendment to the REC for review using the current Amendment Form. You **may not initiate** any amendments or changes to your research without first obtaining written REC review and approval. The **only exception** is when it is necessary to eliminate apparent immediate hazards to participants and the REC should be immediately informed of this necessity.

6. Adverse or Unanticipated Events. Any serious adverse events, participant complaints, and all unanticipated problems that involve risks to participants or others, as well as any research related injuries, occurring at this institution or at other performance sites must be reported to Malene Fouch within **five (5) days** of discovery of the incident. You must also report any instances of serious or continuing problems, or non-compliance with the REC's requirements for protecting human research participants. The only exception to this policy is that the death of a research participant must be reported in accordance with the Stellenbosch University Research Ethics Committee Standard Operating Procedures. All reportable events should be submitted to the REC using the Serious Adverse Event Report Form.

7. Research Record Keeping. You must keep the following research related records, at a minimum, in a secure location for a minimum of five years: the REC approved research proposal and all amendments; all informed consent documents; recruiting materials; continuing review reports; adverse or unanticipated events; and all correspondence from the REC

8. Provision of Counselling or emergency support. When a dedicated counsellor or psychologist provides support to a participant without prior REC review and approval, to the extent permitted by law, such activities will not be recognised as research nor the data used in support of research. Such cases should be indicated in the progress report or final report.

9. Final reports. When you have completed (no further participant enrollment, interactions, interventions or data analysis) or stopped work on your research, you must submit a Final Report to the REC.

10. On-Site Evaluations, Inspections, or Audits. If you are notified that your research will be reviewed or audited by the sponsor or any other external agency or any internal group, you must inform the REC immediately of the impending audit/evaluation.

**Addendum C: Permission from MoHSS**



*Republic of Namibia*

***Ministry of Health and Social Services***

Private Bag 13215  
**WINDHOEK**  
Namibia

Intermediate Hospital Katutura  
Independence Avenue  
**WINDHOEK**

Telephone (061) 203 4107  
Telefax (061) 222706

Enquiries: Sr. C. Kambonde

Date: 06 August 2013

**Mr. Fortune Samatanga**  
**P. O. Box 10746**  
**Khomasdal**  
**Windhoek**

**RE: PERMISSION FOR RESEARCH AT ARV CLINIC FOR MR. F. SAMATANGA**

This office hereby grants you permission to do a study on factors that influence HIV positive individuals attending antiretroviral therapy (ARV) Clinic at Katutura Intermediate Hospital (Windhoek) to disclose or not to disclose their HIV status to their sexual partners.

Thank you.

Yours in Health,

*Kade*

*cc: cren*

**SR. C. KAMBONDE**  
**CHIEF CONTROL REGISTERED NURSE**  
**NURSING ADMIN**



**Addendum D: Approval Letter from Katutura Hospital**



*Republic of Namibia*

***Ministry of Health and Social Services***

Private Bag 13215  
WINDHOEK  
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*Kade*

*accren*

**SR. C. KAMBONDE**  
**CHIEF CONTROL REGISTERED NURSE**  
**NURSING ADMIN**



## Addendum E. Consent Forms



UNIVERSITEIT • STELLENBOSCH • UNIVERSITY  
jou kennisvenoot • your knowledge partner

### **STELLENBOSCH UNIVERSITY CONSENT TO PARTICIPATE IN RESEARCH**

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**Research Study Topic:** *Factors that Influence HIV positive Individuals attending anti-retroviral therapy (ARV) clinic at Katutura Hospital (Windhoek Namibia) to disclose or not to disclose their HIV status to their sexual partners.*

You are asked to participate in a research study conducted by Fortune Samatanga (MPhil HIV/AIDS Management) from the Africa Centre for HIV/AIDS Management at Stellenbosch University. The results of this study will contribute towards a mini-thesis. You were selected as a possible participant in this study because the study is soliciting views from people living with HIV/AIDS.

#### **1. PURPOSE OF THE STUDY**

This study seeks to establish the factors that empower or disempower people living with HIV/AIDS to disclose their status to their sexual partners.

#### **2. PROCEDURES**

If you volunteer to participate in this study, we would ask you to do the following things:

A field worker will explain to you the reasons behind this study including the benefits of disclosing your status to sexual partners before you take part in the study. You will be given a questionnaire and this questionnaire contains questions in multiple choices form and some are questions where you have to write down your own opinions. The questions are divided into categories, from socio-demographic characteristics to attitudes towards HIV disclosure. In this study the researcher wishes that you answer the questions truthfully and to the best of your ability. The process of completing the questionnaire will take about 10-15 minutes.

#### **3. POTENTIAL RISKS AND DISCOMFORTS**

There might be some questions in the questionnaire that may make you feel uncomfortable in answering. In the event that this happens, the researcher will refer you to a counselor who is also resident at Katutura hospital who will offer you counseling. If the discomfort is overwhelming and you feel like not continuing with the study, you are free to terminate your involvement.

#### **4. POTENTIAL BENEFITS TO SUBJECTS AND/OR TO SOCIETY**

There are no direct benefits that you will derive from the results of this study. However, the results will be sent to ministry of Health and other donors and other stakeholders will have access to the results. This will help them

formulate policies that will enable people to disclose their status openly thereby reducing stigma and discrimination against people living with HIV/AIDS.

#### **4.1 PAYMENT FOR PARTICIPATION**

You will not receive any form of payment from participating in this study.

#### **5. CONFIDENTIALITY**

Any information that is obtained in connection with this study and that can be identified with you will remain confidential and will be disclosed only with your permission or as required by law. Confidentiality will be maintained by means of coding the questionnaires. The questionnaires will have no names on them and the researcher will not ask for your name at all. The data collected from you will be stored in a lockable cabinet at the researcher's house. Only the researcher and his supervisor will have access to your information.

#### **6. PARTICIPATION AND WITHDRAWAL**

You can choose whether to be in this study or not. If you volunteer to be in this study, you may withdraw at any time without consequences of any kind. You may also refuse to answer any questions you don't want to answer and still remain in the study. The investigator may withdraw you from this research if circumstances arise which warrant doing so

#### **7. IDENTIFICATION OF INVESTIGATORS**

If you have any questions or concerns about the research, please feel free to contact: Fortune Samatanga. E-mail: [fortsamatanga@yahoo.com](mailto:fortsamatanga@yahoo.com) cell: +264812303716. House number 4779 Meass Street Khomasdal Windhoek. The study leader Prof Johan Augustyn at [jcda@sun.ac.za](mailto:jcda@sun.ac.za) cell: 0836263081 phone:0283164667

#### **8. RIGHTS OF RESEARCH SUBJECTS**

You may withdraw your consent at any time and discontinue participation without penalty. You are not waiving any legal claims, rights or remedies because of your participation in this research study. If you have questions regarding your rights as a research subject, contact Ms Maléne Fouché [[mfouche@sun.ac.za](mailto:mfouche@sun.ac.za); 021 808 4622] at the Division for Research Development.

#### **SIGNATURE OF RESEARCH SUBJECT OR LEGAL REPRESENTATIVE**

The information above was described to me by Fortune Samatanga in English and I, the participant is in good command of this language or it was satisfactorily explained to me. I the participant was given the opportunity to ask questions and these questions were answered to my satisfaction.

*I hereby consent voluntarily to participate in this study I have been given a copy of this form.*

Name of Subject/Participant

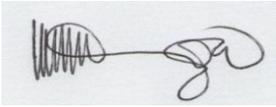
\_\_\_\_\_  
Name of Legal Representative (if applicable)

\_\_\_\_\_  
Signature of Subject/Participant or Legal Representative

\_\_\_\_\_  
Date

**SIGNATURE OF INVESTIGATOR**

I declare that I explained the information given in this document to \_\_\_\_\_ [*name of the subject/participant*] and/or [his/her] representative \_\_\_\_\_ [*name of the representative*]. [He/she] was encouraged and given ample time to ask me any questions. This conversation was conducted in English by Fortune Samatanga



\_\_\_\_\_  
Signature of Investigator

\_\_\_\_\_  
Date