

**NON-DISCLOSURE OF HIV SEROSTATUS TO PARTNERS AMONG HIV
POSITIVE PREGNANT WOMEN ENROLLED ON THE PREVENTION OF
MOTHER TO CHILD TRANSMISSION (PMTCT) PROGRAM AT KATUTURA
ANTENATAL CLINIC, WINDHOEK, NAMIBIA**

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 Economic and Management Sciences at Stellenbosch University*



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DECLARATION

By submitting this assignment 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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ABSTRACT

There are no published studies conducted in Namibia describing the experiences of HIV positive women on HIV disclosure. Exploring and understanding factors affecting disclosure among these women is crucial for health care workers and policy makers to devise ways to increase disclosure rate among women.

The overall aim of the study was to establish factors contributing to HIV non-disclosure to sexual partners among women enrolled on the PMTCT program at Katutura ANC clinic in order to suggest strategies to increase HIV disclosure rate among women in the communities.

The objectives of the study were to identify current level of HIV disclosure among pregnant women, to establish factors contributing to nondisclosure to sexual partners among pregnant women, to determine the proportion of women those have been abused by their sexual partners as a reaction of HIV disclosure and to recommend strategies aimed at increasing HIV disclosure rate among women living with HIV in the communities.

The objectives were met by using a correlational research design with a quantitative approach conducted to collect data from 50 HIV positive pregnant women attending follow-up antenatal care at Katutura Antenatal Care Clinic, Windhoek, Namibia in November 2012.

A self administered questionnaire which primarily consisted of closed ended questions and a limited number of open-ended questions was used to answer the research question.

Ethical approval was sought and obtained from the Ethics Committee of Stellenbosch University. Permission was requested and granted from the Ministry of Health and Social Services (MoHSS) to conduct the study. Study participants who agreed to take part in the study were also given a consent form to sign.

Quantitative data was analysed with assistance from a statistician. Analysed data were presented by using frequency tables, pie charts and bar graphs. Cross tabulations were also used to analyse the relationship between HIV disclosure and other variables. Qualitative data collected by the use of open ended questions were analysed by using a thematic approach and trends were assessed.

Recommendations were to encourage couples to test together in order to prevent negative outcomes as a result of HIV disclosure to partners. HIV positive women that encounter difficulties in disclosing to partners were encouraged to discuss issues on disclosure to family or community members they trust to assist share their HIV serostatus to their sexual partners. Empowerment of women through education and employment opportunities could also lessen women's dependence on men for financial support.

OPSOMMING

Daar is geen gepubliseerde studies in Namibië wat die ervarings van MIV-positiewe vroue oor MIV openbaarmaking uitbeeld nie. Verkenning en begrip van faktore wat 'n uitwerking het op die openbaarmaking onder hierdie vroue is van kardinale belang vir gesondheidswerkers en beleidmakers om maniere te bedink om openbaarmaking koers te verhoog onder die vroue.

Die algehele doel van die studie was om faktore wat bydra tot MIV nie-openbaarmaking aan seksmaats onder vroue wat op die Voorkoming van Moeder tot Kind MIV-program by die Katutura voorgeboorte kliniek geregistreer is te bewerkstellig om ten einde strategieë voor te stel om MIV-openbaarmaking koers te verhoog onder die vroue en in die gemeenskap.

Die doelwitte van die studie was om die huidige vlak van MIV openbaarmaking onder swanger vroue te identifiseer, faktore wat bydra tot nie-openbaarmaking aan seksmaats onder swanger vroue te bevestig, die verhouding van vroue wat mishandel is deur hul seksmaats as gevolg van reaksies terwille van MIV-openbaarmaking te bepaal en strategieë wat gemik is op die verhoging van MIV openbaarmaking koers onder vroue wat met MIV leef in die gemeenskap aan te beveel.

Die doelwitte is bereik deur gebruik te maak van 'n korrelatiewe navorsingsontwerp met 'n kwantitatiewe benadering om data in te samel van 50 MIV-positiewe swanger vroue wat vir opvolg voorgeboortesorg by die Katutura Voorgeboorte kliniek, Windhoek, Namibia in November 2012 opgedaag het.

'N self geadministreer vraelys, hoofsaaklik bestaande uit geslote en 'n beperkte oop vrae is gebruik om die navorsingsvraag te beantwoord.

Etiese goedkeuring is gevra en verkry van die Etiese Komitee van die Universiteit van Stellenbosch. Toestemming is ook gevra van die Ministerie van Gesondheid en Maatskaplike Dienste (MoHSS) en is toegestaan om die studie uit te voer. Studie deelnemers wat ingestem het om deel te neem in die studie is ook 'n toestemming vorm gegee om te onderteken.

Kwantitatiewe data is ontleed met die hulp van 'n statistikus. Ontlede data is met behulp van frekwensie tabelle, sirkeldiagramme en staafgrafieke gedemonstreer. Kruis tabelle is ook gebruik om die verhouding tussen MIV-openbaarmaking en ander veranderlikes te analiseer. Kwalitatiewe data ingesamel deur die gebruik van oop vrae is ontleed deur gebruik te maak van 'n tematiese benadering en tendense is gemeet.

Aanbevelings is om paartjies aan te moedig om saam te toets ten einde negatiewe uitkomst te voorkom as gevolg van MIV openbaarmaking daarvan aan die seksmaat. MIV-positiewe vroue wat probleme ondervind met openbaarmaking aan hulle seksmaats is aangemoedig om kwessies oor openbaarmaking met familie of lede van die gemeenskap wat hulle vertrou te bespreek om sodoende hulp te verkry om hul MIV- serostatus met hulle seksmaats te kan bespreek. Bemagtiging van vroue deur middel van opvoeding en werksgeleenthede kan ook vroue se afhanklikheid van die manne vir finansiële ondersteuning verminder.

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ACRONYMS

- AIDS** - Acquired Immunodeficiency syndrome
- ART** - Antiretroviral Therapy
- CDC** - Centre for Disease Control and Prevention
- DHS** -Demographic Health Survey
- GBV** – Gender based violence
- HCWs**- Health Care Workers
- HIV**– Human Immunodeficiency virus
- MDICP** - Malawi Diffusion Ideational Change Project
- MoHSS** - Ministry of Health and Social Services
- MSM** - Men having sex with Men
- PLHIV** - People Living With HIV
- PMTCT** - Prevention of Mother to Child Transmission
- STI** – Sexually Transmitted Infections
- TB** – Tuberculosis
- UNAIDS** –United Nations Joint Programme on HIV/AIDS
- WHO** - World Health Organisation
- VCT** – Voluntary Counselling and Testing

CHAPTER ONE

INTRODUCTION

1.1 INTRODUCTION

Chapter one (1) presents the background and the significance of the study, study question and specific objectives. The chapter will briefly describe the research methodology and a brief literature review. Study limitations, time frame of the study and an overview of ethical considerations will also be discussed.

1.2 BACKGROUND OF THE STUDY

In 2010, an estimate of about 34 million people were reported to be living with HIV and AIDS worldwide, with about 2.7 million people reported infected in that year alone. Approximately 1.9 million of the new infections reported were from sub-Saharan Africa. Women make up 59% of adults living with HIV in sub-Saharan Africa (UNAIDS, 2011). According to Greig, Jewkes, Msimang and Peacock (2008) for every 10 infected men there are 14 infected women in sub-Saharan African.

Namibia is one of the countries with a high HIV prevalence in sub-Saharan Africa with an HIV prevalence of 18.8%. At Katutura State Hospital, the largest health facility in Windhoek which serves the city's residents, the HIV prevalence of 23.4% was recorded among pregnant women attending ante-natal clinic (MoHSS, 2010).

Prevention of Mother to Child Transmission (PMTCT) was rolled out in March 2002 at the two largest hospitals in Namibia namely Katutura State Hospital and Oshakati Intermediate Hospital. All 35 hospitals and 153 health centres and clinics are now offering PMTCT services. The program includes HIV counselling and testing and provision of adherence counselling and Antiretroviral Therapy (ART) to HIV positive expectant women. This is aimed at preventing maternal transmission of the virus to unborn babies (MoHSS, 2008). Progress on the PMTCT program has been reported with regard to reduction on number of babies born with HIV, and who subsequently die due to AIDS related illnesses. According to a UNAIDS report (2011) there has been an increase in access to the PMTCT services by pregnant women which resulted in 30% decrease in the numbers of newly infected babies with HIV compared to cases reported in 2002 and 2003. Similarly, 20% less AIDS related deaths were reported compared to cases reported in 2005.

HIV disclosure is an important aspect in HIV prevention particularly in PMTCT as there are various benefits associated with it that favours such individuals. The World Health Organisation (WHO) and the Centre for Disease Control and Prevention (CDC) emphasized HIV disclosure as a crucial prevention goal in their protocols for HIV testing and counselling (Medley, Garcia-Moreno, McGill, & Maman, 2004). An individual may disclose to family members, co-workers or friends for social and emotional support or sexual partners for HIV prevention as well as support. It is crucial for pregnant women to disclose to sexual partners for them to explore and adopt safer sexual behaviours to prevent re-infection if they are both infected or avoiding infecting the partner if he is negative.

In addition, HIV disclosure to sexual partners minimise the risk of HIV transmission to the unborn baby during pregnancy, at delivery and during breastfeeding after birth (WHO, 2004). Irrespective of the HIV status of the woman, HIV disclosure is important in PMTCT program as it allows individuals to get support from family or partners and provide an opportunity for couples to decide on the type of preventive measures to take. Disclosure for HIV negative women may motivate their partners to get tested and for HIV positive women it can encourage partners to make informed reproductive health options (Mucheto, Chadambuka, Shambira, Tshimanga & Gombe, 2009).

According to Visser, Neufeld, de Villiers, Makin and Forsyth (2008) disclosure for a pregnant woman can be traumatic as she is preparing for the arrival of her baby and has little time to cope with her diagnosis. Hiding the HIV status can lead to HIV transmission from mother to child perinatally, during birth or during breastfeeding.

Despite several benefits associated with HIV serostatus disclosure, there are a various barriers that prevent women from disclosing to their sexual partners. According to Remien and Bradley (2007) in Reda, Biadgilign, Deribe and Deribew (2012) HIV disclosure is a complex and a personal matter that involves communicating about a potentially life threatening, stigmatized and transmissible infection. Kassaye, Lingerh and Dejene (2005) state there are possible negative consequences that come with HIV disclosure such as blame, physical and emotional abuse, loss of income, stigma and discrimination, abandonment as well as loss of children's custody. These potential consequences may prevent women from disclosing to their sexual partners leading to negative health consequences to the affected women, sexual partners and children.

Nondisclosure can further negatively affect the general health of people living with HIV (PLHIV) and pregnant women in particular as they are disempowered to negotiate for safer sex putting them at risk of re-infection with HIV. Fear of violence or when violence is present, adherence to ART which prevent the virus from mother to child is impeded. Barriers to HIV disclosure such as blame, fear of abuse, abandonment and rejection can also prevent women to seek related treatment, care and support where they are available (Medley et al. 2004).

1.3 MOTIVATION OF THE RESEARCH PROJECT

HIV is not just a virus, it is also an illness that affects social and human relationships. It can bring out both positive and the negative reactions in how people treat one another. Unfortunately so far negative reactions have outweighed the positive as HIV has become a scourge of unfair discrimination and stigma and violence against people known or suspected to have the virus (Jossel, 2009).

This study sought to understand the attitudes and knowledge of gender based violence, barriers to disclosure and outcome of disclosure among HIV positive pregnant women. The results of the study may assist health care workers (HCWs) to understand the complexity of HIV disclosure, promote disclosure among HIV positive pregnant women and non pregnant women alike to disclose to sexual partners. Ssali, Atuyambe, Tumwine, Segujja, Nekesa, Nannungi, Ryan and Wagner (2010) state that HIV disclosure has been promoted by health care workers at the

clinic as it reduces the risk of HIV transmission to sexual partners and encourages untested partners to seek HIV counselling and testing. It can also help couples to explore and adopt preventive behaviours such as condom use.

There are no similar published studies done in Namibia on disclosure before, therefore understanding the rationale for disclosure and non-disclosure is the key to HIV prevention among women with HIV and the entire population in general.

Key findings and recommendations made from the study will advise the Ministry of Health and Social Services (MoHSS)' Directorate of Special Programs (HIV and AIDS, TB, STI and Malaria), policymakers, donors and all other stakeholders with comprehensive information to devise strategies aimed at reducing gender based violence (GBV) associated with HIV disclosure among HIV positive women in Namibia.

1.4 PROBLEM STATEMENT

A large number of HIV positive pregnant women were observed who have not disclosed their results to sexual partners at the Katutura State Hospital. Some of the women who have not disclosed to partners have revealed to health care workers a number of barriers that hinder them from disclosure. These range from fear of rejection, loss of financial support, violence and being accused as the ones' who brought the disease in the family. Although health care workers encourage women to disclose to sexual partners they lack adequate skills to assist and counsel women experiencing difficulties with disclosure.

This study therefore aimed to answer the following question: What are the factors contributing to HIV non-disclosure to sexual partners among HIV pregnant women enrolled on the PMTCT program at Katutura Antenatal Care Clinic?

1.5 STUDY AIM

The overall aim of the study was to establish factors contributing to HIV non-disclosure among women enrolled on the PMTCT program at Katutura ANC clinic in order to suggest strategies to increase HIV disclosure rate among women living with HIV in the communities.

1.6 OBJECTIVES

The study had the following objectives:

- To identify current level of HIV disclosure among women at Katutura ANC.
- To establish factors contributing to non-disclosure to their sexual partners among pregnant women.
- To determine the proportion of women that has been abused by their sexual partners as a reaction of HIV disclosure.
- To recommend strategies aimed at increasing HIV disclosure rate among women living with HIV in the communities.

1.7 RESEARCH METHODOLOGY

A brief summary of research design and methodology used in this study is described. A more detailed account of the research approach and design employed in this study will be discussed in chapter three (3).

1.7.1 Research design

Quantitative research is a research strategy that employs quantification in the collection and analysis of data, while qualitative research is a research that emphasize on collecting words (Bryman, 2012). Qualitative research is a broad approach to studies of social phenomena. Bryman (2012) further states that in qualitative studies the researcher is flexible and can change the direction in the course of the investigation much more easily than in quantitative studies. He further states that the advantage of qualitative research is that it is critical, interpretive, and naturalistic and draws on multiple methods of data collection (Marshall & Rossman, 2006). Hence, quantitative and qualitative research methods were used in the study to establish factors contributing to HIV non-disclosure among HIV pregnant women to their partners.

1.7.2 Population and sampling

The target population of this study was all HIV positive pregnant women who attended antenatal care at Katutura Antenatal Care clinic (ANC) in Windhoek health district during the study period. Five (5) clients per day were selected by employing simple random sampling. The sample size consisted of (n=50) pregnant women who were randomly selected, met the criteria and voluntarily agreed to take part in the study.

1.7.3 Measuring instrument

A self-administered questionnaire, consisting of closed ended questions and limited number of open ended questions was used to collect information from participants in this study. The questionnaire was based on the study objectives. Numerical and categorical questions were used.

1.7.4 Pilot study

The questionnaire used in the study was pre-tested and piloted using (N=5/10%) clients from Katutura Antiretroviral Therapy (ART) Clinic to test the feasibility of the study methodology as well as the reliability, validity and cultural sensitivities of the questions. Information collected during the piloting and pretesting process was used to revise the questions and was not analysed in the main study.

1.7.5 Instrument validity and reliability

Prior to data collection, the questionnaire was given to two research experts who looked at the validity, reliability as well to authenticate the criterion of the questionnaire. A statistician was also consulted throughout the study for input.

1.8 DATA COLLECTION

Data was collected using a self-administered questionnaire given to participants who agreed to take part in the study. The questionnaire was written in English and translated into Oshiwambo language, the main language spoken in the study area. The researcher assisted study participants who needed clarifications with the questions.

1.9 ETHICAL CONSIDERATIONS

Ethical approval was obtained from Stellenbosch University Ethical Committee (Appendix B). Permission to conduct the study at Katutura ANC Clinic was sought and obtained from the Permanent Secretary of Ministry of Health and Social Services (MoHSS) (Appendix C). Additional permission was obtained from the office of the Superintendent of the Katutura Intermediate Hospital (Appendix D). Informed consent was obtained from all participants who took part in the study (Appendix E). Participants were assured of anonymity and confidentiality during the entire process of the study. Due to sensitivity of both HIV disclosure and gender based violence, with permission of study participants, counselling was provided to study participants that were emotional after the study as well as those who needed further counselling on HIV disclosure and GBV. Study participants were assured of confidentiality and therefore data collection was done in a separate room provided by the Nurse in-charge at the clinic. More details on the ethical considerations are explained in Chapter three (3).

1.10 LIMITATIONS OF THE STUDY

The quantitative method employed in this study could not get more in-depth information from either women or/and health care workers. Two open ended questions were, however, included in the questionnaire to allow study participants to state their views and opinions on disclosure of HIV status to sexual partners. Another limitation is that only women from 18 to 45 years of age were recruited to take part in the study as per legally stipulated age in the Namibian Constitution. Women from more age groups could provide diverse data representing the general population. The study focused on women and thus could not get views and opinions of their partners on HIV disclosure. The study sample was small and hence does not represent HIV positive pregnant women living in Namibia. Therefore, results could not be generalised to the entire population. Study participants were from semi urban areas. Results could have depicted a broader understanding of HIV disclosure should it have come from both urban and rural areas. Another limitation for this study is that its focus on factors contributing to HIV nondisclosure among pregnant HIV positive women excluded non-pregnant women.

1.11 OUTLINE OF CHAPTERS

This thesis is structured as follows.

Chapter 1: Introduction

The first chapter provides the background to the study, significance of the study and study question and objectives. It also described the research methodology, a brief literature review, study limitations, time frame and an overview of ethical considerations.

Chapter 2: Literature review

The second chapter describes an overview of the research problem by collecting various literatures on HIV disclosure and GBV.

Chapter 3: Research methodology

The third chapter explains the methodological aspects, study design, data collection and the instruments used in the study.

Chapter 4: Reporting results

This chapter presents data analysis, interpretations and confer the results of the study.

Chapter 5: Conclusions and recommendations

This chapter summarises key findings, conclusion and recommendations of the study.

1.12 CONCLUSION

HIV disclosure is an important element in HIV prevention as it allows partners to make informed decisions regarding their partners and their own health. Disclosure of HIV test results to sexual partners encourage partners to seek HIV counselling and testing, an entry point into HIV treatment, care and support services. As a result of disclosure awareness of HIV transmission risk is increased and couples are able to communicate sexual and reproductive health issues and ultimately reduce risk of HIV transmission (King Katuntu, Lifshay, Packel, Batamwita, Nakayiwa et al., 2008).

Chapter two (2) will present findings of some literature reviewed by the researcher to better understand the research question and approach

CHAPTER TWO

LITERATURE REVIEW

2.1 INTRODUCTION

Goddard and Melville (2005) described a full literature study as an ample study which is part of the research process. The purpose of literature review is to look at the work of other researchers from various sources. Chapter two (2) will describe the findings of various literatures conducted on factors that either influence or hinder HIV disclosure among PLHIV and women in particular who are the focal target group for this study. The chapter covers the global HIV epidemic, overview of HIV and AIDS in Namibia, HIV disclosure, benefits and motivators of disclosure. This chapter will further explain factors influencing HIV disclosure, barriers of disclosure, the relationship between GBV and HIV disclosure and interventions suggested by other researchers to enhance disclosure to partners.

2.2 GLOBAL HIV PANDEMIC

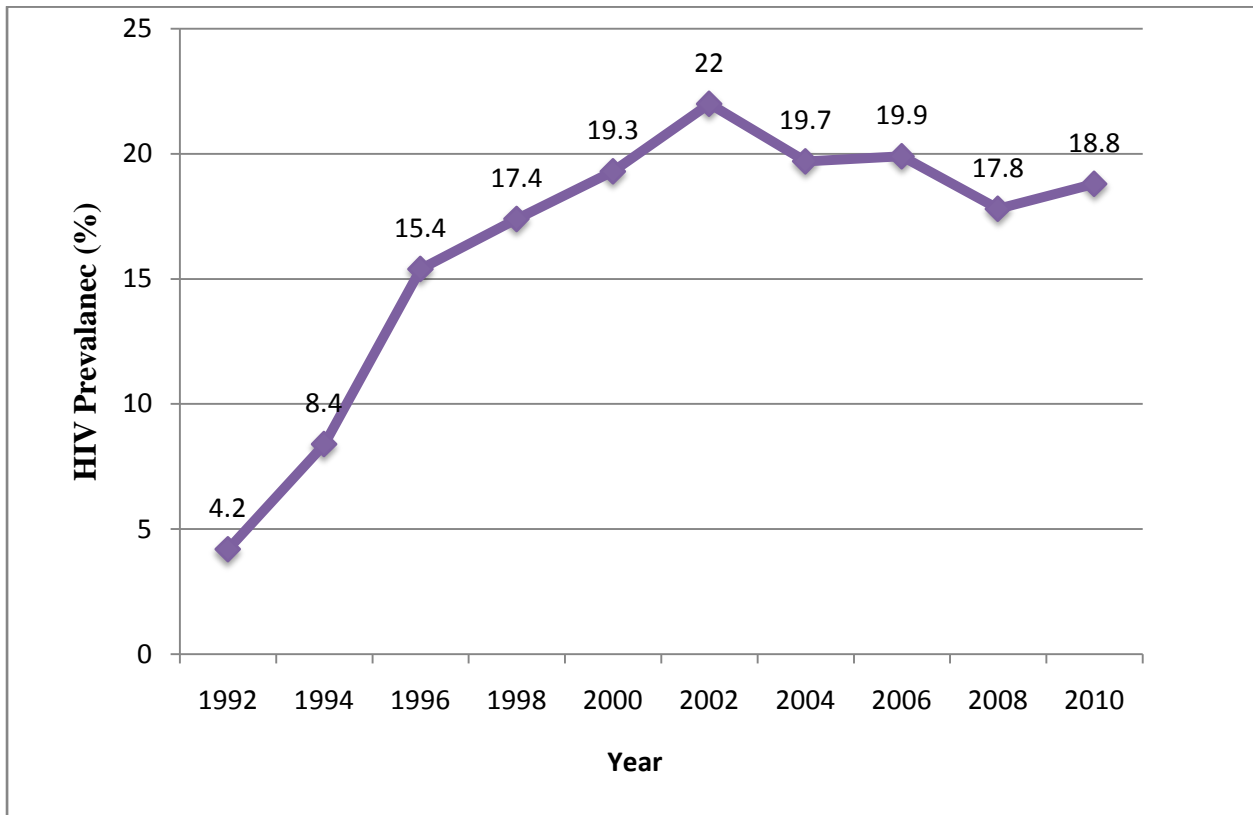
About 34 million people at the end of 2010 were living with Human Immunodeficiency Virus (HIV) in the world. HIV is a virus that causes Acquired Immunodeficiency Syndrome (AIDS). Sub Saharan Africa remains the region which is hardest hit by the epidemic. In 2010 alone, 2.7 million people were reported to be infected with HIV and about 70% of the newly infected people were from sub-Saharan African region. Although there was a decline in the number of newly infected people in 2010 compared to 3.1 million in 2001, the epidemic remains a major health and human developmental challenge throughout the world (UNAIDS 2011).

2.3 HIV AND AIDS IN NAMIBIA

The first case of HIV was diagnosed in Namibia in 1986 and to date, like other southern African countries, the country has a generalised HIV epidemic mainly transmitted through heterosexual sex (UNAIDS & MoHSS, 2011). According to the National sentinel survey conducted in 2010, the country reported HIV prevalence of 18.8% among pregnant women (MoHSS, 2010) (figure 2.1).

Figure 2.1

Prevalence of HIV in Pregnant Women in Namibia



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

Studies conducted in the country show the main drivers of the epidemic are multiple and concurrent partnerships, intergenerational sex, transactional sex, low and inconsistent condom use, low levels of medical male circumcision, low risk perceptions of HIV infection, alcohol abuse and mobility and migration patterns (USAID, 2009). Other factors fuelling HIV are decreasing numbers of people in marital and cohabitating relationships and increasing numbers of key populations most at risk of HIV such as Men having sex with Men (MSM) and sex workers. Women are particularly vulnerable to HIV due to gender inequalities and prevalent gender based violence (UNAIDS and MoHSS, 2011) (table 2.1).

Table 2.1
Namibia population and HIV and AIDS estimates

Indicator	Value
Total Population	~ 2.2 million (2011)
Estimated number of PLHIV	178 000 (2009)
Adult HIV Prevalence	13.1% (2009)
HIV prevalence among pregnant women	18.8% (2010)
PLHIV receiving ART (2009/2010)	75 681 (Mar 2010) Adults 88%, Children >95% @CD4200; (Adults 73%, Children 82% @CD4 350)

Source: UNAIDS and MoHSS, 2011

2.4 HIV DISCLOSURE

Mckeown (2003, p.6) defines HIV disclosure as “an act of informing another person or persons of the HIV status of an individual”. He further explained disclosure can take place in various contexts such as within personal relationships (to sexual partners, children, friends and other family members), in the workplace (to the employer, co-workers and clients), to health care providers, in an institutional setting as well as to the public via media. This study will focus on the self disclosure of HIV positive pregnant women to sexual partners.

HIV disclosure is a decision making process and not an outcome (WHO, 2004). Kimberly (1995) in WHO (2004) adopted a framework which describes the process of HIV disclosure. The framework consists of six (6) steps that involve dilemmas, barriers and decisions at each step:

- Adjustment to the diagnosis: Individuals may require help in adjusting to the diagnosis and achieving a personal acceptance of such diagnosis.
- Evaluation of personal disclosure skills: HIV positive individuals assess whether they have necessary skills to enable them to disclose to others.
- Evaluating appropriateness of disclosure: An individual takes an inventory of all social networks and decides who to disclose to, taking into consideration aspects such as role of the person to be disclosed to as well as the physical distance from the recipient to such recipients.

- Evaluation of circumstances for disclosure: Individuals evaluate various circumstances or factors that may prevent them from disclosing.
- Anticipating reactions of potential recipients: Individuals weigh the expected benefits and expected reactions from individuals to be disclosed to.
- Identification of motivators of disclosure: Individuals explore motivators of disclosing to each recipient.

Various studies found different rates of disclosure among women to partners. Kilewo et al. in Medley et al (2004) found 77.8% of women did not disclose their serostatus to partners 18 months after being tested. Another study done in Kenya by Galliard and colleagues (2000) cited in Medley (2004) found 76.1% of HIV positive pregnant women who reported non-disclosure to partners two months after being tested had no intentions of disclosing to partners. Pregnant women disclose at different stages either during pregnancy or after birth. A study done by Brou, Djohan, Allou, Ekouevi, Viho and LeroyDesgrées-du-Loû (2007) reported 55.7% of women disclosed their serostatus before giving birth, 17% disclosed soon as after giving birth and 19% disclosed before recommencement of sexual activities.

2.5 BENEFITS OF HIV DISCLOSURE

HIV disclosure may benefit the infected individuals, their partners and the general public (Visser et al., 2008). Disclosure in infected individuals and partners may reduce the risk of HIV transmission in two ways. Firstly, prospective partners may decline to engage in sexual activities or may agree to take part in very low risk activities with individuals that have disclosed. Secondly, those who agree to have sex are likely to use condoms. Individuals with HIV are therefore encouraged to disclose their HIV serostatus to prospective partners in order to reduce the risk of HIV transmission (Pinkerton & Galletly, 2007).

Ssali et al. (2010) have drawn attention to the majority of people living with HIV and AIDS (PLWHA) currently have access to ART services. HIV has now become a chronic disease and not a terminal disease as it has been in the past. In general, HIV serostatus disclosure among couples is encouraged as it promotes safer sexual behaviours, lowers HIV transmission, decreases stigma associated with living with HIV and endorses access to treatment, care and support. Pregnant women diagnosed with HIV are especially encouraged to disclose to their partners as doing so prevents further transmission to themselves, their unborn babies as well as their sexual partners (WHO, 2004). According to Kassaye et al. (2005) disclosing ones HIV test result to a sexual partner is the key factor in HIV/AIDS prevention interventions. They further state disclosure allows people to adapt HIV prevention behaviours and seek treatment services.

Medley et al (2004) further emphasize the importance of HIV disclosure on family planning as it allows couples to make informed reproductive health decisions and subsequently reduce the number of unplanned pregnancies among women. HIV disclosure to sexual partners also helps PLWHA to share the burden and support one another. These benefits are further reiterated by Katz, Kiarie, John Stewart, Richardson and John (2011) sharing HIV results

among partners heightens risk reduction behaviours by increasing communication regarding HIV and sexual health which in turn results in condom use and testing of partners.

HIV disclosure also enables partners to plan their future including adhering to ART and replacement feeding for the babies. Adherence to ART is an important goal for optimal health for PLHIV as it leads to a strong immune system that is capable of preventing opportunistic infections. According to Brou et al. (2007) sexual partners of women who have disclosed their status are more likely to undergo HIV testing than the sexual partners of women who have not disclosed their status compared to those that were not disclosed to are reluctant to take action.

HIV disclosure also has positive effects to the community as a whole. Disclosure may reduce stigma among community members towards PLHIV. Support from groups of PLHIV can increase disclosure to family members (Ssali et al., 2010).

2.6. MOTIVATORS OF DISCLOSURE

A study by Simoni (1995) cited by the WHO (2004) report found concerns over ones' health and ethical responsibility were major reasons why women disclosed to sexual partners. Visser et al. (2008) found among women who disclosed to sexual partners, 30% citing a sense of responsibility to the relationship. Out of these women, 9% disclosed because the partners are fathers of their unborn babies. In a study conducted in Seattle and Los Angeles in USA, men who disclosed to partners feared to be imprisoned as a result of non-disclosure, while others cited just disclosure as a legal issue motivated them to disclose (Gorbach, Galea, Amani, Shin, Celum, Kerndt & Golden, 2004). A study by Kadowa and Nuwaha (2009) shows individuals who have seen someone disclosing in public may get motivated to disclose. They claim openness to disclosure increases self-efficacy and that perceived negative outcomes of disclosure may after all not be real.

2.7 FACTORS INFLUENCING HIV DISCLOSURE

Individuals' decisions to disclose are influenced by various and complex factors. Thus, it is important to examine each factor individually and appreciate their roles in HIV disclosure.

2.7.1 Socio-economic factors

Several socio-demographic factors may influence an individual's decision to disclose. Numerous studies found factors such as age, gender, length of time since diagnosis, relationship status and partner type, awareness of partners' status and economic status as some of the factors influencing disclosure.

2.7.1.1 Gender

A study conducted in South Africa on disclosure among HIV positive men and women found women who were involved in casual sex were twice more likely to disclose than men in similar relationships (Andrinopoulos, Mathews, Chopra, Eisele, Thomas, 2012). These findings were supported by Olley et al. (2004) in Deribe,

Woldemichael, Wondafrash, Haile and Amberbir (2008) who highlighted females were more likely to disclose than their male counterparts.

Contrary to some studies, Skogmar, Shakely, Ians, Danell, Andersson, Tshandu, Ode'n, Roberts and Francois Venter (2006) in Deribe et al. (2008) argue men were more likely to disclose their sexual status compared to women. Another study done by Anglewicz and Chintsanya (2011) using secondary data collected from a longitudinal study done by Malawi Diffusion Ideational Change Project (MDICP) between 1996 to 2006 in Malawi found in 2006, women were less likely to disclose to their partners or to anyone compared to men.

2.7.1.2 Relationship duration and partner type

A number of studies indicated women who are either married or in steady relationships were more likely to disclose to sexual partners than the unmarried ones. This is attributed to the notion that women in steady relationships might feel more comfortable to reveal their serostatus to partners as they have been together for years. It is indicated by Maman (2001) in Visser et al. (2008) women in trusting and long-term relationships found it easier to disclose to sexual partners and to family members as they expect their partners and family members to support them after disclosure. Visser et al. (2008) affirm disclosure to partners was more likely to take place with married couples. Duru et al. (2006) in Lugalla, Madihi, Sigalla, Mrutu (2008) state disclosing becomes easier when couples have been together for a long time, as they become comfortable with an HIV positive status. Disclosure was likely to take place in long term relationships than in casual relationships such as in one-night stands. A study conducted in South Africa by Andrinopoulos et al. (2011) found disclosure to steady sexual partners was 2.7% higher than among casual partners.

2.7.1.3 Educational level

Türmen (2003) notes education or knowledge about sex may be a definite determinant of HIV risk. Educational level is shown to have an impact on HIV disclosure among PLWHA. Some studies reveal educational levels may influence both the individual intending to disclose as well as the recipient of disclosure. Issiaka et al. (2001) in Medley et al. (2004) indicated women with a higher educational level have a higher disclosure rate compared to women with minimal or no form of education. However, Visser et al. (2008) affirm women with partners who attained higher level of education reported a higher disclosure rate than those with partners with low or no education at all.

2.7.1.4 Awareness of partner's status

Several studies documented that awareness of partner's HIV results may have an impact on the women's decision to disclose to partners. Studies conducted by D'Angelo, Abdalian, Sarr, Hoffman and Belzer (2001), Derosa and Marks (1998) and Duru, Collins and Ciccarone (2006) in Sullivan (2011) found women who do not know their partners' status were less likely to disclose to partners than those who are aware of their partners' status. This is supported in a cross sectional study carried out by Deribe and colleagues (2008) in southwest Ethiopia which affirmed that nondisclosure was found among 98% of respondents who did not know their partners HIV status. According to Andrinopoulos et al. (2011) it is not the HIV status that influence the decision to disclose, but rather

the knowledge of the partner's status. This is because when individuals disclose, they need to discuss as couples their own HIV status and only thereafter more disclosure is expected.

Contrary to some studies Sowell et al. (2003) cited in Rice, Comulada, Green, Mayfield Elizabeth, & Rotheram-Borus(2009) pointed out fear of rejection from HIV negative partners was cited as a reason for nondisclosure among HIV positive women in serodiscordant relationships.

2.7.1.5 Length of time since diagnosis

Deribe et al. (2008) affirms communication between partners before testing is crucial in disclosure of HIV as it prepares partners for the results and assists them to disclose. Some studies have looked at the relationship between the length of time from diagnosis to disclosure and the rate of disclosure. Among these studies some found as length of time from diagnosis increases the rate of disclosure also increases (Medley et al., 2004). A study conducted by Antelman and colleagues in Tanzania (2001) in Medley et. al (2004) found disclosure to sexual partners among women attending ANC increased from 21% within two months after diagnosis to 41% four (4) years later. Women who have known their HIV status for longer period are found to be more likely to disclose (Rice, Comulada, Green, Arnold, & Rotheram-Borus, 2009).

Studies conducted in Tanzania by Maman et al. (2003) and Nsabagasani and Yoder (2006) uncovered women tested during the pregnancy in PMTCT programs were less likely to disclose than those tested at Voluntary Counselling Testing (VCT) centres. Women tested at VCT centres have usually discussed their intention of getting tested with partners and perceived themselves at risk of HIV which consequently facilitates disclosure. Women offered HIV testing during pregnancy may not perceive they are at risk of HIV, may not have been prepared to undergo HIV testing and may not have discussed testing with partners. For those reasons, whatever the outcome of the test, such women will have difficulties in disclosing to their partners (Lugalla et al., 2008). A study done by Kilewo et al. (2001) in Medley (2004) also found similar results that indicate 77% of pregnant women enrolled in perinatal care trial had not disclosed to sexual partners 18 months from time of diagnosis. That study shows the longer the time after diagnosis, the higher the rate of HIV disclosure.

Contrary to some studies Medley et al.(2004) in Wodi (2005) stated pregnant women attending free standing ANC sites were more likely to disclose their HIV serostatus compared to those tested at Voluntary Counselling and Testing (VCT); this promote adherence to treatment and lessen the risk of mother to child transmission.

2.7.1.6 Age

Age has been pointed out by several researchers as a factor that influences HIV disclosure. A study conducted in eastern Uganda revealed low rates of disclosure among younger women compared to older women. In this study women between the age of 36 and 43 had a higher disclosure rate than younger women (Ssali et al., 2010). A case control study conducted in Uganda by Kadowa & Nuwaha (2009) found similar but varying results from some of the studies. The study shows the mean age for women who disclosed was 38 compared to 31 who did not follow suit.

Contrary to the findings in these studies, research by Farquhar et al. (2000) and Galliard et al. (2000) cited Medley et al. (2004) found younger women particularly those under the age of 24 years were more likely to disclose to sexual partners than older women.

2.7.1.7 Economical status

Women that are dependent on men for financial support have been noted to disclose to their partners for several reasons. According to Visser, Neufeld, De Villiers, Makin and Forsyth (2008) a woman who lives with her partner and solely gets financial support from him might be likely to disclose to her partner due to fear of being abandoned, while a woman who resides with family members may get support from them and is less likely to disclose. According to (Kadowa & Nuwaha, 2009) financial support was reported by 35% of participants as the main reason for HIV disclosure to sexual partners. According to Visser et al.(2008), 4.8% of women disclosed to prepare their partners for a potentially HIV-positive baby or to obtain support from partners in preventing transmission to the infant. A study by Farquhar in Kenya (2000) cited in WHO (2004) found women with lower socio-economic status reported a higher disclosure rate compared to women from higher socio-economic status. On the contrary, Medley et al. (2004) expressed women's financial dependence on their partners may be a barrier for disclosure. These women may not disclose to partners as they fear losing support from partners if they do so.

2.8 BARRIERS TO HIV DISCLOSURE

Along with numerous and diverse benefits associated with HIV disclosure, there are potential risks associated with disclosure among HIV-infected women. These risks includes loss of economic support, abandonment, physical and emotional abuse, blame, discrimination and disruption of family relationships. These potential risks may lead to lost opportunity of HIV prevention as such women may choose not to disclose to anyone (WHO, 2004). Similarly Medley et al. (2004) identified various barriers to HIV disclosure among women such as fear of accusation of infidelity and fear of loss of financial support. Ssali et al. (2010) cited fear of discrimination and stigmatization, fear of emotional and physical abuse, and anticipated disruption of relationships as some of the barriers to HIV disclosure among women.

DeMatteo et al. (2002) in Lugalla et al. (2008) found HIV disclosure may negatively change relationships; leading to issues such as divorce, abandonment of sexual partners and separation. Medley et al. (2004) highlighted a study done in Tanzania showed about 46.4% of women who did not disclose expressed fear of divorce as a barrier to disclosure. However, about 91.7% of women who disclosed reported continuation of relationships. Ssali (2010) cite nondisclosure as a result of fear of rejection, inaccessibility of disclosure target and unwillingness to upset the disclosure target.

2.9 GENDER BASED VIOLENCE AND HIV DISCLOSURE

Gender-based Violence (GBV) “refers to all forms of violence that happen to women, girls, men and boys because of the unequal power relations between them” (MGECW, 2010, p. 29). Gender based violence is defined in a PEPFAR report (2006, p.5) as “any act that results in or likely to result in, physical, sexual, psychological harm, or

suffering to women, including threats of such acts, coercion or arbitrary deprivation of liberty, whether occurring in public or a private life". Kimberly and Serovich (1996) in Visser et al. (2008) claim that GBV originates from several factors such as traditions and beliefs, customs, illiteracy and limited education, unequal power relations and the low status of women in society.

Several studies report the apparent relationship between GBV and HIV transmission among women. A study conducted in South Africa reported women with violent sexual partners have a 50% greater chance of contracting HIV than those who are living in harmony. Another study conducted in Tanzania cited young HIV infected women were 10 times likely to report violence than the HIV negative ones. Violence may also prevent women living with HIV from accessing appropriate HIV information, being tested and adhering either to PMTCT prophylaxis or to antiretroviral therapy (PEPFAR, 2006).

Gender Based Violence (GBV) is one of the barriers to disclosure among HIV positive women to their sexual partners. In Namibia, there are certain cultural norms and beliefs that promote GBV; for example it is an accepted norm for women to be abused in relationships including marriages. Married women report violence when they disclose their HIV status to spouses, when they propose condom use and refuse sexual intercourse even in cases when they know that their husbands have been unfaithful (James, Mafundikwa & Chakare, 2011).

Various factors associated with unequal prevalence of HIV between men and women in Sub Sahara Africa have been noted. According to Robinson (2004) Dunkle, et al. (2004); Martin and Curtis, (2004); Eaton, et al., (2003); Mill and Anarfi, (2002) in Wodi (2005) socio-economic factors such as women's financial dependency, limited education opportunities, sexual violence and lack of political will are some of the issues that contribute the apparent higher HIV prevalence among women.

There are also biological implications associated with violence and putting women at a higher risk of HIV infection. A woman for example who is sexually abused may sustain physical vaginal trauma such as lacerations that can increase the risk of acquiring HIV (Shamu, Abrahams, Temmerman, Musekiwa & Zarowsky, 2011). A study carried out by Greig et al. (2008) has expressed a similar view that physical and sexual violence perpetrated against women has contributed to an increased risk of women to contract HIV. It is evident there is a vicious cycle between HIV transmission and GBV among women. Just as GBV increases the risk of HIV acquisition among women, there is a reported increase of gender based violence among HIV infected women and it also aggravates other forms of gender discrimination (Macdonald, Lafreniere, Billings, Colombini and Maman, 2011).

In the context of HIV disclosure Medley et al. (2004) have reported different studies that were conducted in Africa which have shown high numbers of women who did not disclose their serostatus to partners due to fear of violence. Although disclosure is proven to be crucial in the prevention of HIV transmission as it results in couples choosing safer sex practices, high number of women choose not to disclose for a number of reasons. Approximately 16 to

86% of women in developing countries do not disclose to sexual partners due to violence or fear of violence associated with disclosure (WHO, not dated).

Contrary to literature showing negative reactions as a result of disclosure, Brou, Djohan, Becquet, Allou, Ekouevi, Viho and Desgrées-du-Lou (2007) have a different view. They found among HIV positive women who disclosed their serostatus to partners, about 82.1% confirmed their partners understood and provided moral support as a result of disclosure. In another study conducted in Tanzania about 57% of women who tested HIV positive and disclosed to their partners, reported positive outcomes such as support and understanding from their partners (UNAIDS/UNFPA/UNIFEM, 2004).

2.9.1 Types of GBV

Physical abuse is defined as “the use of physical force against someone in a way that injures or endangers that person” (WHO, 2004). Sexual abuse is referred to as “any sexual act, attempt to obtain a sexual act, unwanted sexual comments or advances, or acts to traffic, or otherwise directed against a person’s sexuality using coercion, by any person regardless of their relationship to the victim, in any setting including but not limited to home and work” (WHO, 2010). Sexual violence can be perpetrated by either strangers, family members, intimate partners or individuals in authority (PEPFAR, 2006). Andersson, Cockcroft and Shea (2008) expressed that trauma as a result of either forced sex or dry sex with an infected partner increases the woman’s risk of transmission; in these instances women have no power to negotiate safer sex.

Financial abuse, also referred to as economic exploitation, occurs in various ways such as when the abuser withholds basic needs such as food, clothes, medications or shelter (Helpguide.org). A study conducted in Uganda revealed women were afraid to request for permission or money from their partners to visit HIV counselling and testing centres; while some women were banned from visiting such centres (Medley et al., 2004).

Emotional abuse, also known as psychological cruelty, includes verbal abuse such as yelling, name-calling, blaming, and shaming (Helpguide.org). According to (WHO, 2004), emotional violence involves behaviours such as belittling and intimidation, preventing her from seeing friends and family, withholding resources or taking away her money.

2.10 INTERVENTIONS

The importance of HIV disclosure in the reduction of HIV transmission has been emphasized in this chapter. Low rates of HIV disclosure among pregnant women have been highlighted and a need to strategise measures to increase disclosure cannot be overlooked. The body of literature has recommended various measures that need to be employed to promote HIV disclosure in both communities and health care settings. According to Kadowa and Nuwaha (2009) special attention should be put on counselling and supporting those who test in ANC/PMTCT clinics, those who have not been started on ART as well as those that express fears to disclose in order to increase the rate of disclosure to partners.

Counsellors need to be thoughtful when providing counselling to HIV positive women at all times. They should encourage client referral instead of health care provider referral. Client referral is less likely to result in violence as opposed to health care referral (Iliyasu, Abubakar, Babashani & Galadanci, 2011). King et al. (2008) suggested that clients who fear disclosing their HIV status should be thoroughly counselled, all reasons for anxiety should be explored and where it was necessary clients could be referred to relevant services. According to Allen, Meinzen-Derr, Kautzman, et. al. (2003) and Mcgrath, Celentano, Chard, et al. (2007) in Sullivan (2011) couple counselling and group interventions for serodiscordant couples have been shown to lead to an increase in condom use.

The role of counselling in HIV disclosure has also been emphasized in studies by De Rosa (1998) cited in (WHO, 2004) which found disclosure increased with the frequency of counselling sessions when health care workers (HCWs) discussed disclosure issues at HIV clinics. These studies demonstrate that continuous counselling of PLHIV enhances disclosure to partners.

2.11 CONCLUSION

Chapter two (2) presents an overview of HIV globally and in Namibia, in particular. Major drivers that fuel the epidemic in Namibia are highlighted. The chapter also explores various existing studies carried out around the subject of HIV disclosure and presents aspects of disclosure including the importance of disclosure, factors that influence disclosure and motivators of disclosure. It also describes various barriers of disclosure and the effects of GBV on disclosure.

Studies have shown disclosure to sexual partners may result in a number of benefits including access to HIV testing, treatment, care and support, safer sexual behaviours and support among couples. Literature also shows that although a high rate of disclosure has been reported by most African women, some women face challenges that prevent them from disclosing such as fear of GBV including rejection and abandonment, loss of financial support and divorce. Chapter 3 presents research methodology employed in this study.

CHAPTER THREE

RESEARCH METHODOLOGY

3.1 INTRODUCTION

This chapter illustrates the method and the design used to answer the research question. The research goal and specific objectives have been described.

3.2 RESEARCH QUESTION

A research question is defined as by Kerlinger (1979, p. 17) in Christensen, Johnson and Turner (2011) as “an interrogative sentence or statement that asks: what relation exists between two or more variables”. In this study the researcher investigated the question: What are the factors contributing to nondisclosure of HIV serostatus to sexual partners among HIV pregnant women enrolled on the PMTCT program at Katutura Antenatal Care Clinic?

3.3 GOAL OF THE STUDY

The overall goal of the study was to investigate factors which contribute to nondisclosure of HIV serostatus to sexual partners among HIV pregnant women enrolled on the PMTCT program at Katutura Antenatal Care Clinic in order to suggest strategies to increase HIV disclosure rate among women in the communities.

3.4 RESEARCH OBJECTIVES

The specific objectives for this study are:

- To identify current level of HIV disclosure among women at Katutura ANC.
- To establish factors contributing to non disclosure among pregnant women to their sexual partners.
- To determine the proportion of women that has been abused by their sexual partners as a reaction of HIV disclosure.
- To recommend strategies aimed at increasing HIV disclosure rate among women living with HIV in the communities.

3.5 RESEARCH METHODOLOGY

According to Degu and Yigzaw (2006) study design “is the process that guides researchers on how to collect data, analyze and interpret observations”. Research approach and design used in this study will be placed in context of the problem statement and objectives.

3.5.1 Research design

Research design refers to the plan that specifies the procedures to be used in answering the research question (Christensen et al., 2011). The plan indicates aspects such as how data will be collected and analysed.

A correlational study measures two variables to determine the level of the relationship between the variables (Christensen et al., 2011). One of the advantages of correlational research it enables measurement of various variables (Cohen and Manion 1995). The main weakness of a correlational study though, is when there is a relationship between two variables then one presumes that one variable causes the other (Christensen et al., 2011).

They further define quantitative research as a study that collects numerical data from study participants to answer the research question; Qualitative research collects non-numerical data to answer (Christensen et al., 2011). They defined qualitative research as an interpretive research approach that relies on multiple types of subjective data and investigates people in particular situations in their natural environments” (Christensen et al., 2011). The strength of qualitative research is data collected are an understanding and description of individuals and group of individuals with similar characteristics. The main disadvantage of qualitative studies is that findings made from the study cannot be generalised to the general population because they are based on a local data (Christensen et al., 2011). Thus, a descriptive correlational design with a quantitative approach was used in this study to identify factors that influence study participants to disclose to sexual partners.

3.5.2 Study population, sampling and inclusion criteria

A population is a full set of elements from where participants taking part in the study are selected, while a sample is a set of elements that are selected from the target population (Christensen et al., 2011). The target population for this study are the total number of HIV positive women from the study area registered on the PMTCT program during the period of data collection. The sample size was (N=50) women that are HIV positive and enrolled on the PMTCT program between the ages of 18-49 years old.

Simple random sampling is a sampling method that gives an equal opportunity for everyone to be included in the study sample. Random sampling method is a favoured sampling method as it produces a representative sample (Christensen et al., 2011). According to Fisher, Foreit, Laing, Stoeckel and Townsend (2002) simple random sampling is best suited for use with relatively small population with an easy sampling frame. A simple random sampling method was therefore preferred as a sampling method to select study participants. Every 10th client was selected that came for scheduled visit at the PMTCT department.

The inclusion criteria for the study were pregnant HIV positive clients between the ages of 18-49 that were enrolled onto the PMTCT program at the Katutura ANC Clinic. The women must have not been referred from another health facility, must be revisiting the clinic, have voluntarily agreed to take part in the study and signed an informed consent form. An exclusion criterion was all pregnant women that are HIV negative, as well as positive women visiting the clinic for the first time. Another exclusion criterion is HIV positive and negative women that are younger than 18 years and older than 49 years.

3.5.3 Measurement instrumentation

Participants were given self-administered questionnaires with categorical and numerical questions to answer. The questionnaire consist of closed ended questions and a minimal number of open ended questions aimed at establishing factors that influence HIV disclosure among pregnant women to their sexual partners. A questionnaire is a self-report data collection tool that is filled in by the study participants. This tool is used to collect study participants' perceptions and opinions of participants and give self report demographic information (Christensen et al., 2011).

English based questionnaire was translated into Oshiwambo language; spoken among women attended at the clinic. This was therefore done to ensure study participants were not conversant in English could understand the content of the questionnaire. Consequently, a back translation was done on the Oshiwambo translated questionnaire to ensure that translation correctly captured the meanings. Consent forms were also translated in Oshiwambo language for the same purpose.

Validation of the data collection tool was done and approved by the Stellenbosch Ethical Committee.

The questionnaire was broken down into three sections, namely, section A, B and C respectively.

SECTION A-SOCIO-DEMOGRAPHIC CHARACTERISTICS

This section aimed to collect information on study participant's age, gender, ethnicity, marital status, physical address, formal education level, duration of current relationship, duration of knowing HIV status and monthly income. The questionnaire also collected information on partner's HIV status as well as partner's employment status.

SECTION B-ATTITUDES AND KNOWLEDGE OF GENDER BASED VIOLENCE

This section was aimed at measuring study participants' attitudes and knowledge towards gender based violence. Study participants were asked whether they know about gender based violence, whether they know or witnessed someone who has been abused and information sources where they hear mostly about gender based violence. They were also asked how strongly they agree to statement "GBV is a big problem in Namibia".

Factors contributing to GBV

Major factors contributing to GBV in Namibia were explored such as women's financial dependence on men, alcohol abuse, and lack of respect for women, as well as traditional and cultural beliefs.

SECTION C-BARRIERS AND OUTCOMES OF HIV DISCLOSURE

Various questions were asked to collect information from study participants on importance of HIV disclosure.

Motivation and reasons for HIV disclosure to sexual partners

Study participants were asked whether they disclosed their HIV status to anyone and whether they informed their sexual partners about their HIV status. Reasons which inspired study participants to disclosure to sexual partners were explored and reasons for nondisclosure were established.

Open ended questions

The questionnaire consists of a total of two open ended questions. These questions collected information on reactions of partners after disclosure as well as recommendations on measures that need to be put in place to assist women when disclosing their HIV status to partners.

3.5.4 Pilot study

A pilot study is a run-through of the complete experiment with a small number of participants. Pilot testing of questionnaires is crucial as the process identifies unclear and ambiguous questions, or any other difficulties that might be experienced in completing the questionnaires (Christensen et al., 2011). The questionnaire was pilot tested using (n=5/10%) of HIV positive women receiving treatment, care and support at Katutura ART Clinic. Pilot study helped the researcher to validate the questionnaire, and ascertain its appropriateness and its user-friendliness. Two questions in the questionnaire were not culturally sensitive and the researcher altered the questions appropriately. Information obtained from the pilot study was not included in the final analysis of the study.

3.5.5 Validity and reliability

According to Messick (1989) in Christensen et al. (2011, p.145) validity is defined as “the accuracy of the inferences, interpretations, or actions made on the basis of the test scores”.

Content validity is defined by Christensen et al. (2011) as validity based on the judgement of degree of tasks, items or questions on an instrument to ensure that it sufficiently represent the construct’s domain. Face validity is referred to as a “prima facie judgement of whether the items appear to represent the construct and whether the test or the instrument looks valid” (Christensen et al., 2011, p.146).

Measuring content and face validities, certain standards were adhered to when designing the questionnaire. Existing literature was reviewed prior to questionnaire design to ensure that the researcher can have a broader knowledge on what has already been studied on the subject as well as content validity. This judgement need to be done by a team of experts in the subject matter. The questionnaire was designed was discussed with the study supervisor. A medical officer that specialises in the HIV field also reviewed the questionnaire to look at the content validity. A statistician also reviewed the questionnaire to look at whether the information that will be collected can be analysed.

Reliability is referred to stability or consistency of scores (Christensen et al., 2011). The use of pilot study was a measure put in place to ensure reliability of the data collection tool.

3.6 DATA COLLECTION

Data collection is a process in research aimed at gathering information from the sample to answer the research (Bryman, 2012). Verbal permission to collect data was requested from the Nurse in-charge of the Katutura ANC clinic as well as the Nurse Manager for Maternity Unit at the Katutura Intermediate Hospital. Study participants were randomly sampled while waiting to be seen by health care workers. Since clients visiting the clinic for follow-up visits were only seen on certain days of the week namely Mondays and Wednesdays, these were the only days data collection could be done. The Nurse in-charge allocated a room within the PMTCT department for data collection to ensure study participants’ privacy and confidentiality.

A consent form in English and Oshiwambo were given to study participants after verbal consent has been obtained. Study participants were given adequate time to read the consent form, for areas that needed clarifications, the

researcher were available to answer all questions. Upon signing the consent form study participants were given the questionnaire to fill in according to the language they understand best. They were given enough time to complete the questionnaire and were advised to ask for clarifications should there be a question that needed to be clarified. The researcher who was fluent in both English and Oshiwambo was available when participants were filling in the questionnaire and provided clarifications to all study participants. Most participants completed the questionnaires in 15-25 minutes.

Completed questionnaire were stored at the researcher's residence in a lockable cupboard where accessibility was solely available to the researcher to maintain confidentiality. Completed consent forms were stored separately from the questionnaire to maintain anonymity. Data collection was completed in 4 weeks during the month of November 2012.

3.7 DATA ANALYSIS

Data collected during a research study was analysed to answer the research question. Quantitative data collected using questionnaires were cleaned, coded and entered into statistical software called SPSS statistical software version 18. According to Christensen et al. (2011) statistical software make quantitative data analysis simpler as the program performs all the calculations. Cross tabulation is a table used to depict data that are in cells formed from intersection of two categorical variables (Christensen et al., 2011). Frequency tables, bar graphs and pie charts were used to ensure efficient summary of all collected. Percentages were used to display findings to clearly compare various figures. The findings are displayed in bar graphs, pie charts and tables. A detailed of data collected is discussed in the chapter four.

3.8 ETHICAL CONSIDERATIONS

Christensen et al. (2011, p. 94) define research ethics as “a set of principles that assist the community and researchers in deciding how to conduct ethical research”. It is crucial ethical principles are adhered to by the researcher throughout the study. Approval to conduct research was sought and obtained from the Stellenbosch University Ethical Committee before commencement of the study. Permission was sought from the Permanent Secretary of Ministry of Health and Social Services (MoHSS) in Namibia to conduct the study at the health facility.

Obtaining informed consent from study participants is done when the researcher fully informs study participants about all the aspects of the study. These aspects include the aim and objectives of the study, benefits, and implications of participating in the study and incentives if any. After information is given to participants, they voluntarily made an informed decision whether or not to take part take part in the study (Christensen et al., 2011). Participants had the right to refuse to take part in the study or withdraw at any time during the study without any consequences. Participants signed a consent form after a verbal consent has been obtained.

Christensen et al. (2011) assert preferably the consent form should be written in an easy to understand and in a layman's language. Ensuring that participants who are not conversant in English clearly understand the consent form, it was translated into Oshiwambo. This is done to ensure participants to feel relaxed and less threatened when

filling in the questionnaire. It also motivated research participants to complete the questionnaires. Participants were also informed that information collected will solely be utilised to suggest various strategies that can reduce GBV as a result of HIV disclosure.

As a professional nurse and a qualified HIV Counsellor, the researcher provided counselling to all study participants about effects of gender based violence on disclosure. Participants with GBV and disclosure issues were referred to a professional social worker that is based at the Katutura Intermediate Hospital for further counselling. The ANC clinic is a department of the hospital, and referral could easily be made to the hospital. These study participants were also referred to the Women and Child Protection Unit to get professional assistance. This is a special Unit in the Namibian Police which is in close proximity and within a walking distance from the ANC clinic.

Confidentiality, anonymity and privacy are critical issues that need to be maintained in research. Confidentiality in the context of research refers to as an agreement with researchers about what will be done with the data collected from study participants (Christensen et al., 2011). Prior to data collection process participants will informed that the information they will give will only be known by the researcher to maintain confidentiality during as well as after the study.

Anonymity in research means “keeping the identity of the research participants unknown” (Christensen et al., 2011, p. 124). Anonymity is attained when the researcher cannot connect information collected from study with specific research participants (Christensen et al., 2011). In order to ensure anonymity during the study, participants were not required to provide their names or addresses during the data collection process. According to Christensen et al (2011) privacy on the other hand is defined in the context of research as controlling other people’s access to data collected about a person. In order to ensure privacy of study participants, interviews were conducted in a safe and secure room with a door that can be closed to ensure privacy.

Electronic data are stored on a password-protected computer and network drives. This data is only accessible to the researcher. Hard copies of the questionnaires are stored in locked cupboards at the researcher’s residence when not in use for data entry or analysis. The key to the cupboard is safely stored and only the researcher has access to the key. This data will be destroyed after three (3) years (Davis, 2012). Data findings and recommendations were discussed with health care workers at the facility. An academic report is generated upon completion of data analysis and submitted to the Stellenbosch University, Africa Centre for HIV/AIDS Management. Another copy of the report of the study will be submitted to the Ministry of Health and Services, Research Unit in Namibia as it is required from the researcher.

3.9 CONCLUSION

A descriptive correlational design with quantitative approach was employed in this study. A sample of (n=50) were randomly selected to participate in the study. A pilot study was done prior to the data collection process. Upon completion of data collection of data collection process, quantitative data obtained by closed ended questions data

was entered and analysed with SPSS statistical software by a statistician. Qualitative data obtained from open ended questions were grouped in trends and analysed in themes by the researcher.

This chapter described the research methodology applied in this study. Ethical aspects were adhered to during the course of the study were described. The next chapter will present the results of the study.

CHAPTER FOUR

REPORTING RESULTS

4.1 INTRODUCTION

This chapter presents results of data collected from HIV positive pregnant women with the use of the self-administered questionnaire. Data collected in this study were mainly quantitative, with minimal open ended questions. Quantitative data are presented in the form of, bar graphs, pie-charts and frequency tables. According to Corbin (1997), cited in Marshall and Rossman (2006) analysis of qualitative data is a process that search for general statements about correlations and underlying themes. Thus, qualitative data collected by use of open-ended questions were analysed by use of a thematic approach.

4.2 STATISTICAL ANALYSIS

SPSS statistical software version 18 was used to analyse quantitative data collected in this study. A statistical software (Christensen et al., 2011) ensure that the process of analysing quantitative data is simpler compared to methods used in previous years as it does all of the calculations. Qualitative data derived from two open-ended questions were analysed by use of a thematic analysis. Qualitative data were themed into various categories to generate general statements. Bryman (2012) describes the purpose of themes in qualitative data analysis which is to provide the researcher the basis theoretical understanding of data that make theoretical contribution to the literature relating to the research focus.

4.3 SECTION A - SOCIO-DEMOGRAPHIC CHARACTERISTICS

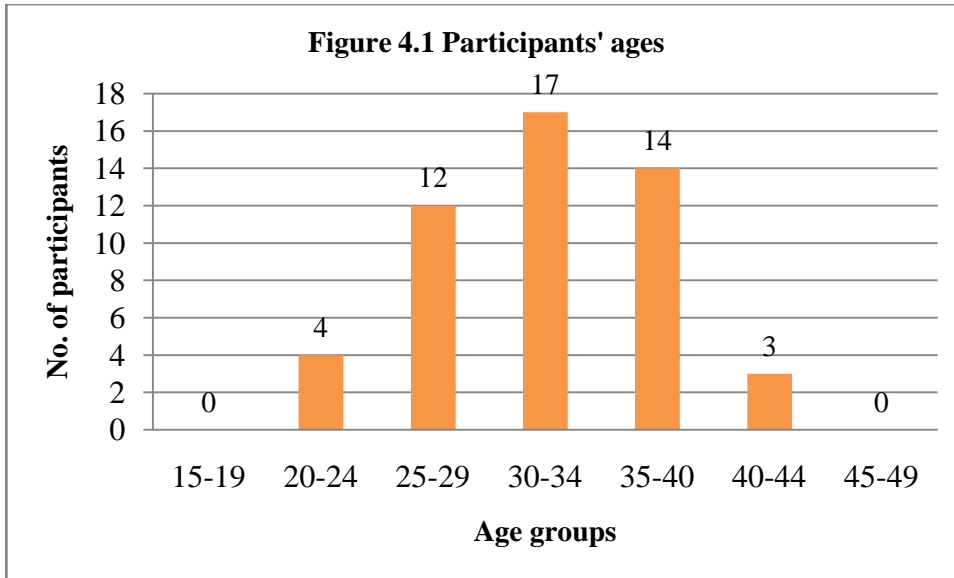
Various socio-demographic characteristics provide the background of the respondents participating in this study.

4.3.1 Variable 1: Gender

All respondents were females as they were the target group for the study. The total number of respondents was (n=50/100%). The study did not intend to recruit male participants, therefore no males were recruited.

4.3.2 Variable 2: Age

All participants responded to this question. Majority of participants (n=17/34%) were between the ages of 30-34, followed by women in the age range of 35-39 years (n=14/28%). The lowest number of participants were in the range of 40-44 (n=3/6%). There were no participants recruited in the age group of 15-19 and 45-49 years. This can be justified by the National Sentinel Survey (2010) which found that women between the age of 30-34 and 35-39 age groups reported the highest HIV prevalence. The age group of 30-34 had a 29.6% and 35-39 reported 29.7% HIV prevalence (figure 4.1).



4.3.3 Variable 3: Marital status

The majority of participants were single (n=30/60%), followed by those that are living together with partners (n=14/28%) as shown in table 4.1. Five respondents were married, while one participant was widowed. According to the LAC report published in 2010, the rate of marriage in Namibia is low and most children are born outside of marriage. Partners living together but not married also known as cohabitation, was reported to be ranging from 15% for women and 13% for men in the latest Demographic Health Survey (DHS) report of 2006-2007 (MoHSS, 2006) (Table 4.1).

Table 4.1 Marital status

Marital status	n	%
Single	30	60
Married	5	10
Living together but not married	14	28
Widowed	1	2
Total	50	100

4.3.4 Variable 4: Education levels

Majority of participants (n=31/62%) completed their junior secondary school, while only (n=4/8%) achieved tertiary education as their highest level of education. There were (n=3/6%) participants who had not attended school at all. Education is important for women to know their rights and to get formal jobs in order to increase their standards of living (NPC, 2008).

There are significant variations in ratios between girls and boys enrolled in schools in Namibia. In rural areas, the boy ratio is higher compared to girl ratio compared to urban areas. Generally, the main cause of school drop-out among girls is teenage pregnancy. The rate of teenage pregnancy among secondary school learners is 5% compared to 45% among primary school drop-outs and girls with no education at all. Girls who did not finish primary education are likely to get in risky sexual activities by dating men 10 or more years older than them (NPC, 2008) (Table 4.2).

Table 4.2 Education level

Education level	n	%
None	3	6
Primary school (grade 1-7)	8	16
Junior secondary school (gr 8-10)	31	62
Secondary (grade 11-12)	4	8
Tertiary education	4	8
Total	50	100

4.3.5 Variable 5: Employment status

Most of the participants, (n=33/66%) were unemployed. Those that were employed, (n=11/22%) were formally employed, while (n=6/12%) were self-employed as indicated in table 4.2. Monthly income for participants that are either formally employed or self-employed will be shown in table 4.4. The high unemployment rate among participants concurs with Mwinga (2012), who state that the current unemployment rate in Namibia stands at 51.2%, which is one of the highest unemployment rates in the world (Table 4.3).

Table 4.3 Employment status

Employment status	Number	%
employed	11	22
self-employed	6	12
unemployed	33	66
Total	50	100

4.3.6 Variable 6: Estimated monthly income

The highest number of participants, (n=33/66%) were not getting any form of monthly income. Participants that were employed (n=12/24%) are receiving a monthly income between 0-999 Namibian dollars while (n=5/10%) receive an income between 2000-2999 Namibian dollars per month (Table 4.4).

Table 4.4 Estimated Monthly Income

Monthly income	Number	%
Nil	33	66
0-999	12	24
1000-1999	5	10
2000-2999	0	0
Total	50	100

4.3.7 Variable 7: How long have you known your HIV status?

Majority of participants, (n=28/56%) indicated that they have known their HIV serostatus for two years or less.

The rest of the participants have known their HIV serostatus for longer than two years where (n=11/22%) reported duration of 3-5 years. One participant did not respond to this question and was therefore reported as presented in Table 4.5

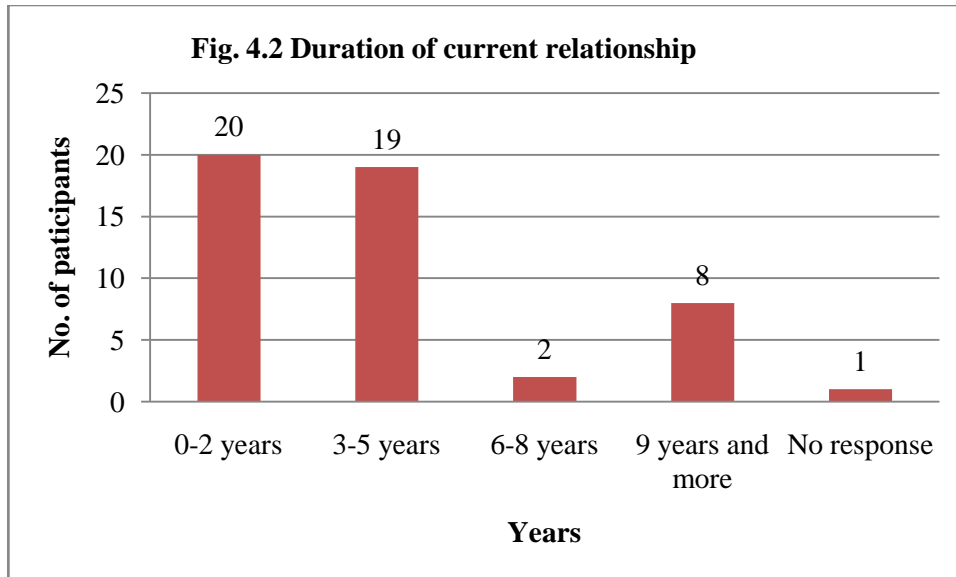
Table 4.5 Duration of knowing own HIV status

Duration of knowing own HIV status	Number	%
0-2 years	28	56
3-5 years	11	22
6-8 years	6	12
9 years and more	4	8
No response	1	2
Total	50	100

4.3.8 Variable 8: How long have you been in your current relationship?

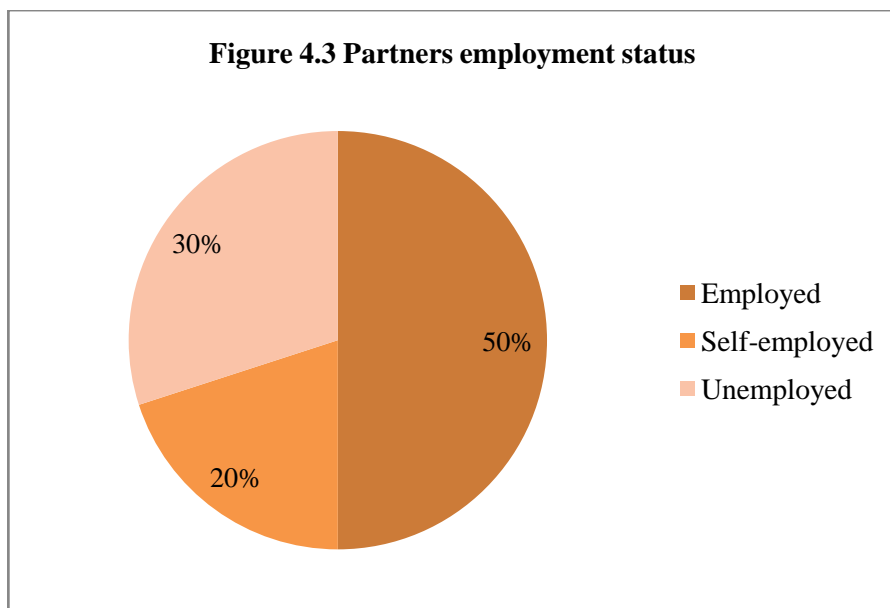
A total of (n=49/98%) of participants responded to this question. Most participants have been in their current relationships for less than five (5) years, with (n=20/40%) participants reported to be in their current relationships for less than two (2) years, while (n=19/38%) reported 3-5 years. Few participants have been in their current

relationships for more six (6) years and more, (n=8/16%) reported nine (9) years and more while (n=2/4%) reported a duration of 6-8 years in their current relationships. One participant did not respond to this question (Figure 4.2).



4.3.9 Variable 9: Partner’s employment status

Most participants (n=25/50%) responded that their partners are employed, (n=10/20%) stated that their partners are self employed while (n=15/30%) stating that their partners are unemployed (figure 4.2).



4.3.10 Variable 10: Partner’s HIV status

As shown in table 4.7 the response rate for this question was (n=50/100%). Participants who reported their partners were HIV positive were (n=23/46%), while those with HIV negative partners were (n=6/12%). Some participants (n=21/42%) reported not knowing their partners’ HIV status. Among participants who indicated knowledge of their partners’ HIV status, (n=26/90%) disclosed to partners.

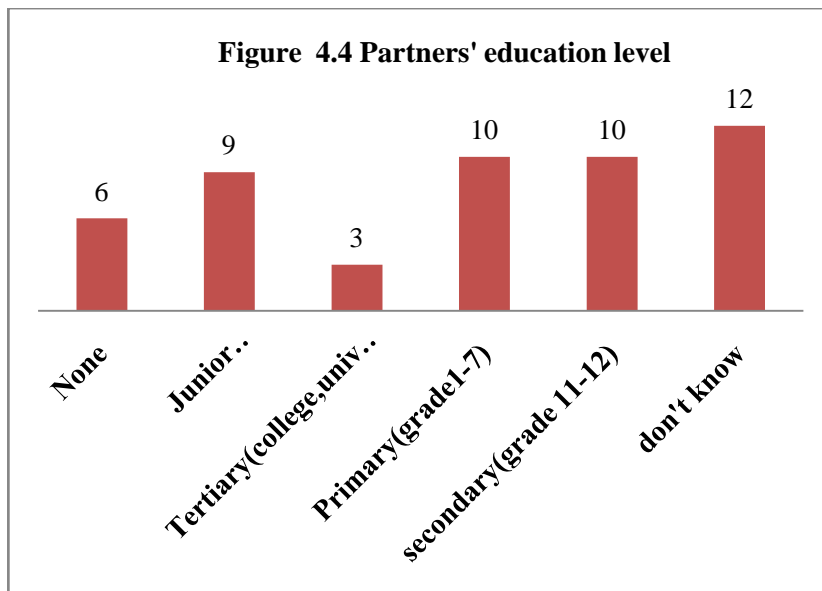
Serodiscordant relationships are prevalent in most African countries. Although results from study only show 12% of participants in serodiscordant relationships, studies conducted elsewhere in Africa show relatively higher rates of discordant relationships. A cohort study carried out in 14 African countries by Eyawo, de Walque, Ford, Gakii, Lester and Mill (2010) found the rate of HIV positive women in heterosexual serodiscordant stable companionships was at 47%, higher than the rate in this study (Table 4.6).

Table 4.6 Partner’s HIV status

Partner’s HIV status	Number	%
HIV positive	23	46
HIV negative	6	12
don't know	21	42
Total	50	100

4.3.11 Variable 11: Partners’ education level

Majority of participants (n=12/34%) indicated that they do not know the partners highest level of education. Of those who know their partners’ education level, (n=3/6%) indicated tertiary education and (n=6/12%) stated that their partners have not attended any formal education at all as shown in Figure 4.4.

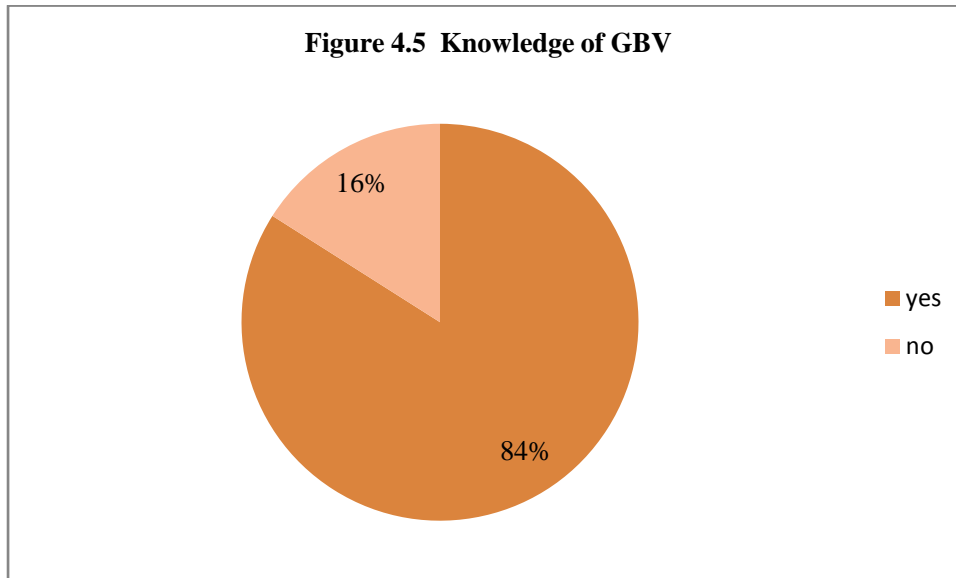


4.4. SECTION B - ATTITUDES AND KNOWLEDGE TOWARDS GENDER BASED VIOLENCE (GBV)

This section presents results of outcomes of variables under this section as outlined below.

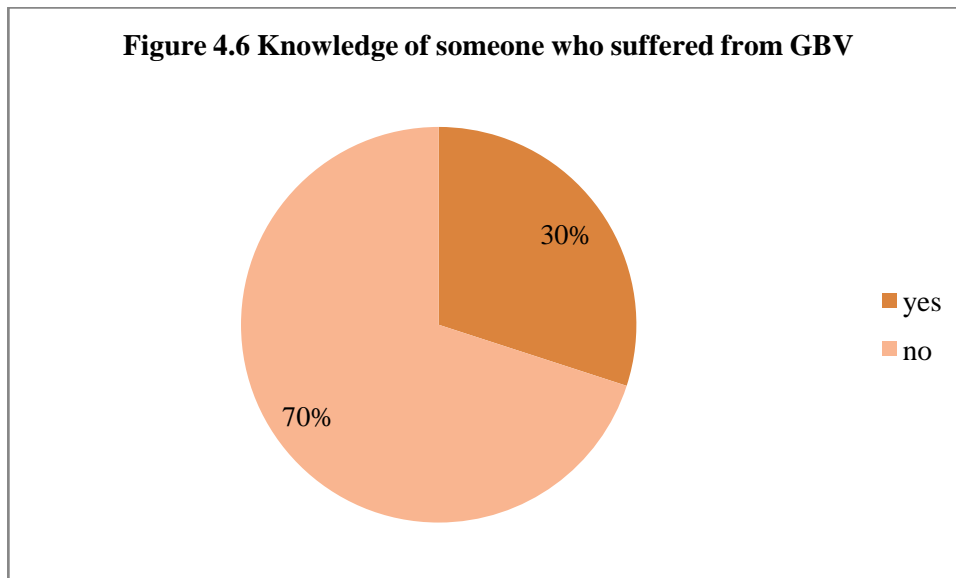
4.4.1 Variable 12: Do you know about gender based violence?

All participants (n=50/100%) responded to this question. Majority of the participants (n=42/84%) indicated their knowledge of GBV, while (n=8/16%) stated that they do not know about GBV (Figure 4.5).



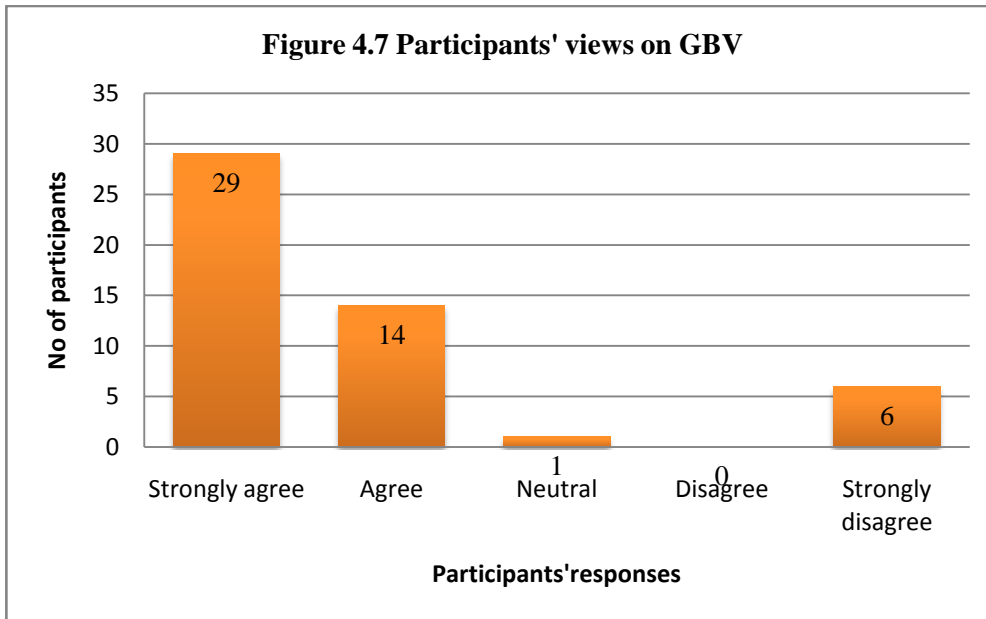
4.4.2 Variable 13: Do you know someone suffering or suffered from GBV?

A vast number of participants (n=35/70%) indicated that they are not aware of someone suffering or suffered as a result of GBV. However, (n=15/30%) stated that they know someone who is either suffering or suffered as a result of GBV (Figure 4.6).



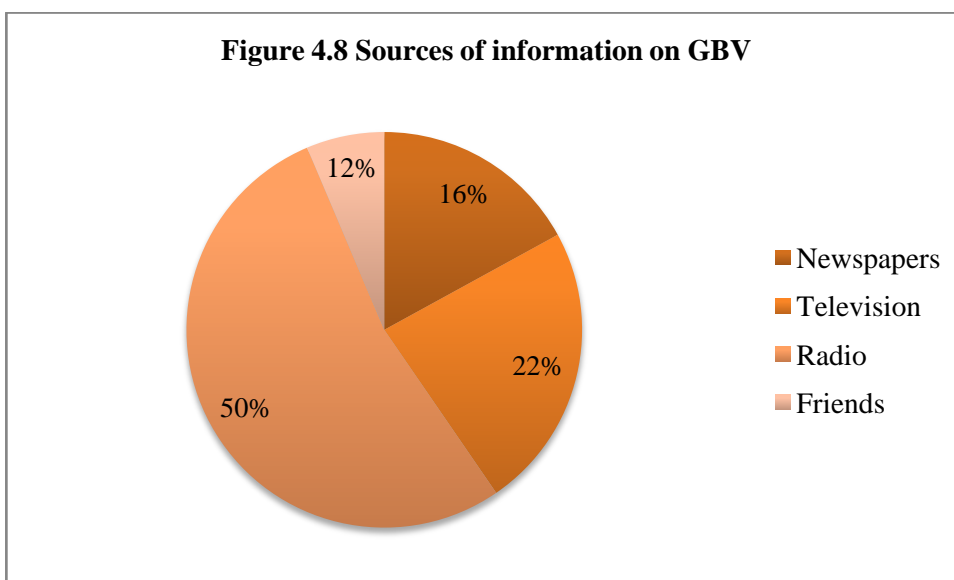
4.4.3 Variable 14: Do you agree or disagree with the following statement “Gender Based Violence is a big problem in Namibia”

The majority of participants (n=43/86%) are in agreement that the GBV is a major problem in Namibia, whereby (n=29/58%) strongly agree with the statement while (n=14/28%) agree with the statement. One participant (n=1/2%) neither agree nor disagree with the statement. However, (n=6/12%) strongly disagreed with the statement. According to Hubbard, Coomer and Holt (2008) GBV is a common predicament in Namibia, where one in five women is believed to be in an abusive relationship (Figure 4.7).



4.4.4 Variable 15: Which of the following is the common source of information on gender based violence?

As indicated in the figure 4.7, radio is the common source of information on GBV (n=25/50%), followed by television with (n=11/22%). Some participants (n=8/16%) reported newspapers as the source of information while (n=6/12%) reported friends as source of information on GBV (Figure 4.8).



4.4.5 Variable 16: Which one of the following form of violence did you witnessed/heard most?

Majority of participants (n=17/34%) stated physical abuse as the common form of GBV they either heard or witnessed, followed by emotional abuse which was reported by (n=15/30%) of the participants. Not getting financial support from the partner also known as financial abuse was reported by (n=10/20%) of the participants. Sexual abuse was reported by the least number of participants (n=8/16%) as indicated in Table 4.7.

Table 4.7 Types of GBV

Type of GBV	n	%
Physical Abuse	17	34
Emotional Abuse	15	30
Sexual Abuse	8	16
Financial Abuse	10	20
Total	50	100

4.4.6 Variable 17: What do you think is the major cause of gender based violence in Namibia?

As indicated in table 4.8 the majority of participants (n=22/44%) indicated alcohol abuse as the major cause of GBV in Namibia, while (n=21/42%) expressed that women's dependence on men for financial support is the major contributor to GBV in the country. A minimal number of participants (n=5=10%) blamed cultural and traditional beliefs as major causes of GBV, while (n=1/2%) participant reported the origin of GBV is lack of respect for women as illustrated in Table 4.8.

Table 4.8 Causes of GBV

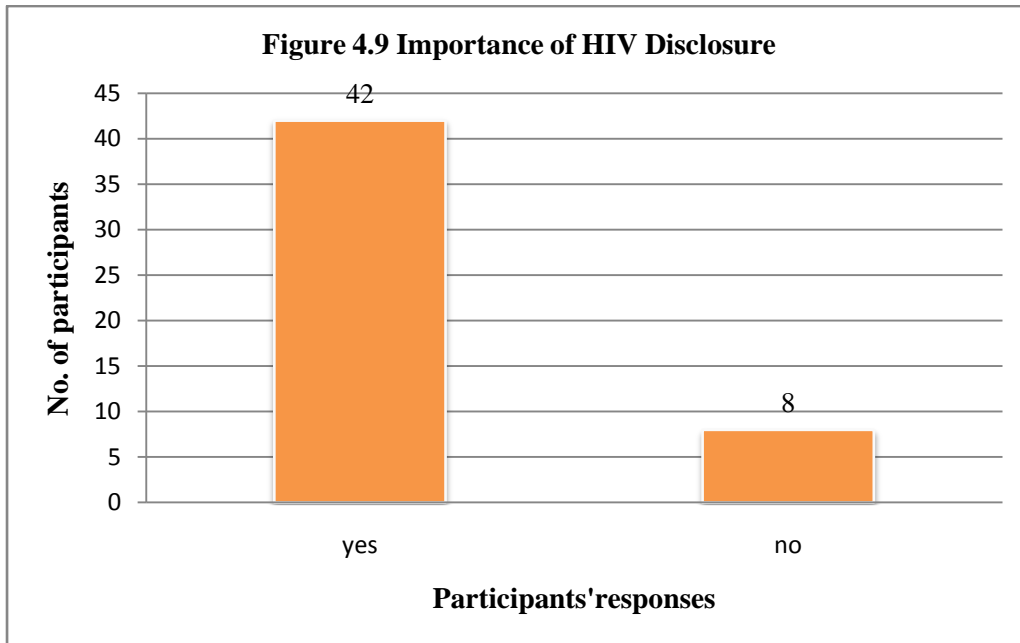
Major cause of GBV	n	%
Alcohol and substance abuse	22	44
Cultural and traditional beliefs	5	10
Lack of respect for women	1	2
women's dependence on men for financial support	21	42
Do not know	1	2
Total	50	100

4.5. SECTION C- BARRIERS TO DISCLOSURE AND OUTCOME OF DISCLOSURE

The results of various variables under this section are summarised according to the sequence in the questionnaire.

4.5.1 Variable 18: Do you think it is important to disclose HIV status?

The majority of the participants (n=42/84%) indicated the importance of disclosing HIV serostatus, while (n=8/16%) did not think HIV serostatus disclosure is crucial. Perceived importance of HIV disclosure may encourage participants to disclose their HIV status (Figure 4.9).



4.5.2. Variable 19: Did you tell your HIV result to anyone?

As shown in Table 4.9, all participants (n=50/100%) responded to this question. Majority of participants (n=47/94%) indicated that they have disclosed their HIV serostatus, while (n=3/6%) had not disclosed to anyone. The questionnaire did not attempt to explore other different categories of individuals to who participants disclosed to except to sexual partners. The information on figure 4.9 illustrates the number of participants who disclosed their status to sexual partners versus those who did not disclose.

Disclosure rate differs in various studies conducted in Sub Sahara Africa and elsewhere. A study by Deribe et al. (2008) found 94.5% of women disclosed at least to one person.

Gender was also found to influence disclosure. Olley et al. (2004) in Deribe et al. (2008) highlighted females were more likely to disclose than their male counterparts.

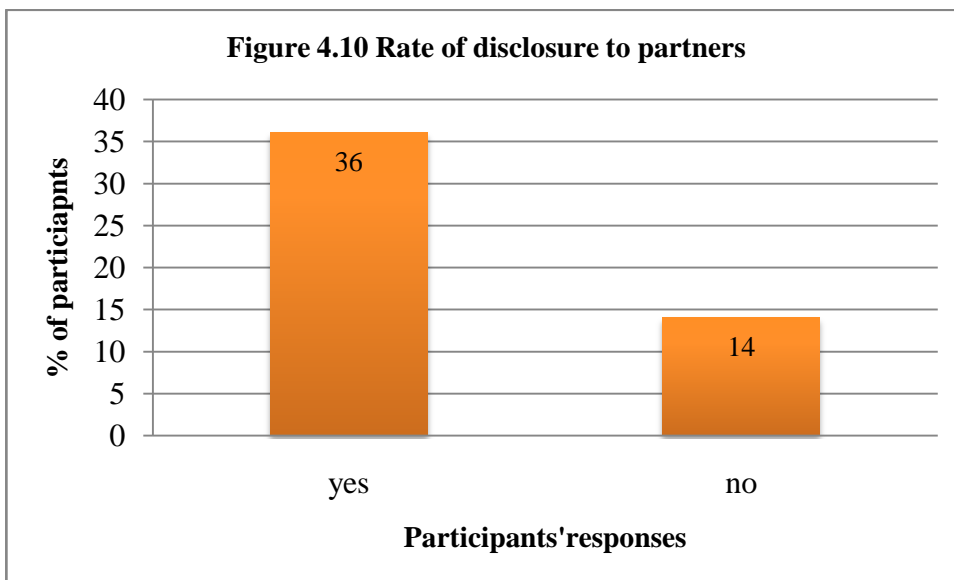
Table 4.9 Rate of HIV disclosure

Disclosed HIV status to someone	n	%
Yes	47	94
No	3	6
Total	50	100

4.5.3 Variable 20: Did you tell your partner about your HIV results?

It is interesting to see that majority of participants disclosed to their partners (n=36/72%). However, there is a considerable number (n=14=28%) of participants who did not disclose to sexual partners. By comparing the number of participants who disclosed to partners and table 4.10; it is clear that a relatively higher number (n=11/22%) of participants disclosed to other people than their sexual partners (Figure 4.10). There was no provision given for participants to identify individuals they disclosed to except to sexual partners, therefore it was unclear to which other people they disclosed to.

A similar study by Kassaye et al. (2005) showed comparable results whereby 69% of women disclosed to sexual partners. Another study conducted in Ethiopia by Gari, Habte and Markos (2010) showed 87.5% of women disclosed to partners.



4.5.4 Variable 21: What motivated you to disclose to partner?

As shown in table 4.11, participants who disclosed (n=36/72%) were further asked the main reason or what motivated them to disclose to sexual partners. Majority of participants (n=18/50%) indicated getting support from partners as the main reason for disclosure. Furthermore, the sense of responsibility of not wanting to infect the partner and fear of God rated by (n=5/14%) each as the main reason for disclosing to partners. Reasons such as not

wanting to be legally accused was mentioned by (n=4/11%), while another (n=4/11%) reported that they were tested as couples and were given their HIV test results at the same time, therefore they had no difficulties to disclose (Table 4.10).

The results concurs with observation by Visser et al. (2008) that women who depends on partners for financial support might be likely to disclose to their partners due to fear of being abandoned. Noting that the unemployment rate among participants in this study is above 60%, it is likely that majority of participants depend on their partners for financial support a possible motivator for disclosure.

Another study by Andrinopoulos et al. (2011) found that PLHIV may be concerned about their partners' health and feel a sense of responsibility which may increase disclosure.

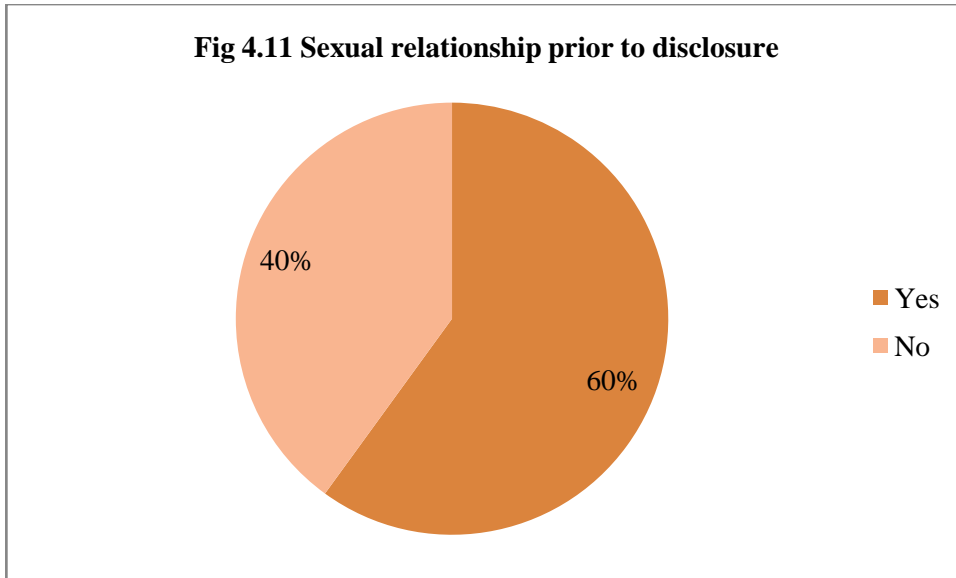
Table 4.10 Reasons for disclosure

Main reason for disclosure	n	%
To get support from him	18	50
Do not want to infect him	5	14
Fear God and do not want to hide such things	5	14
Do not want to be legally accused	4	11
Usually share secrets		3
Others	4	11
Total	36	100

4.5.5 Variable 22: Did you have a sexual relationship with your partner before telling him your results?

As shown in Table 4.11, 30 participants (n=30/83%) responded to this question. Majority of participants (n=18/60%) of those who disclosed indicated they had sexual relationships with their partners prior to disclosure. Participants who did not have sexual relationships with partners were (n=12/40%)

A study by Deribe et al. (2008) revealed 14.2% of participants had sex with their partners before disclosing their HIV status. Another study by Ciccarone et al. (2003) cited in Sullivan (2011) found 13% of women engaged in at least one encounter of unprotected sex without disclosing in serodiscordant relationships.



4.5.6. Variable 23: If you did not disclose, what are the reasons for delayed disclosure and nondisclosure?

Participants who did not disclose to sexual partners were further asked to state the primary reason for delayed or nondisclosure. There was only one participant who cited fear of being killed by partner as a result of disclosure. Majority of participants cited fear of rejection or abandonment as the main reason for not disclosing to sexual partners. Other participants indicated barriers to disclosure such as fear of physical abuse (n=4/29%), being accused of unfaithfulness (n=2/14%), partner might get angry (n=1/7%). There was no participant who mentioned that partner might tell others about the woman’s HIV status after disclosure.

Several studies found varying barriers to HIV among women in Africa. Medley et al. (2004) identified barriers such as fear of accusation of being unfaithful and fear of loss of financial support. Ssali et al. (2010) cited fear of discrimination and stigmatization, fear of emotional and physical abuse, and anticipated disruption of relationships as some of the barriers to HIV disclosure among women (Table 4.11).

Table 4.11 Reasons for delayed/non-disclosure

Reason for delayed disclosure/nondisclosure	n	%
He might get angry with me	1	7
He might hurt me physically	4	29
Kill me	1	7
Tell other people about it	0	0
He might think I have been unfaithful	2	14
He might leave me	6	43%
Total	14	100

4.5.7. Variable 24: Open-ended question: What were your partner's reactions when you disclosed?

All participants (n=34/100%) who disclosed to partners responded to this question. The majority of the respondents (n=21/62%) indicated positive outcomes after disclosure. The major theme that emerged from responses is that partners were supportive and accepted their HIV status, encouraged to live healthier by using condom use and reduction of stress, accept what God has given them and promised to live together for the rest of their lives as well as disclosure from partners. One participant said "He accepted it and said we will be together no matter what" while another one said "He was fine, accepted and told me that he was tested in 1999. He also apologised to me". Other related comments were mentioned by other participants.

Various studies found similar positive outcomes as a result of HIV disclosure. King et al. (2009) cited improved partner relationships, relief from worry, initiation of condom use, reduction of sexual partners, testing and disclosure of sexual partners and accessing treatment, care and support services for partners and self. Sullivan (2011) affirm disclosure to sexual partners open up opportunities for couples to make informed decisions including condom use, an important component in HIV prevention. In another study conducted in Tanzania about 57 % HIV positive women who disclosed to partner reported positive outcomes such as support and understanding from their partners (UNAIDS/UNFPA/UNIFEM, 2004).

Although a vast number of participants reported positive experiences with disclosure to partners, there were participants (n=13/38%) cited negative outcomes as a consequence of disclosure. Negative reactions from partners ranged from shock, depression, denial, rejection and abandonment, blame and anger. One participant said "He left me and the baby and went to other women".

A study by Visser et al. (2008) found overall, negative reactions experienced by women as a result of disclosure to partners ranged from anger, disbelief, blame, denial, fearful, anger and sadness.

4.5.8 Variable 25: Open-ended question: Do you think there is a need for measures to be put in place to assist women when informing their partners about their HIV status, if YES please explain below?

This question was responded by (n=41/82%) participants. Participants suggested various measures to assist women when disclosing to partners. Three predominant themes generated from participants responses were: promotion of couple counselling, the role of health care workers in disclosure and promotion HIV information awareness sessions.

Majority of participants (n=20/49%) of those who responded to the question recommended for partners to get tested together as couples. It is suggested that couples to be either be tested at health facilities or at homes to facilitate disclosure. "Partners need to be tested together, that way they all get their results at the same time from the counsellor" claimed one participant. Similar comments were reiterated by other participants.

Another theme that emerged was the role of health care workers in assisting women to disclose to partners. This recommendation was cited by (n=5/12%) of the participants. It was emphasized men lack information on HIV and AIDS and women find it difficult to disclose to partners or convince partners to become tested and HCWs can play

a major role in disseminating information on HIV among all men. This can be done conducting mass campaigns for men, at workplace and places where men mostly gather for recreational purposes such as bars and sport venues. One participant said: “Before you disclose, bring him to the hospital so that the nurse can talk to him”.

The third theme was on the role family members and community support system in disclosure cited by (n=9/22%) of participants. Participants suggested women finding difficulties in disclosing to sexual partners to seek the presence and support from trusted family members and community leaders such as pastors when disclosing to partners to facilitate communication and alleviate negative outcomes of disclosure.

The rest of the participants (n=7/17%) indicated no measure to assist women when disclosing. One participant said “No, there is no need. A woman is a strong being”.

Makin et al.(2008) suggest providing support to women around disclosure issues is a crucial component in any PMTCT program as such support will ultimately increase disclosure and subsequently decrease transmission of HIV from mother to the baby as well as to sexual partners.

4.6 CONCLUSION

This chapter presented results and findings of the study. Quantitative data were presented by use of graphs, pie charts and frequency tables, while a thematic analysis was employed to analyse qualitative data.

Generally, the rate of disclosure among participants was high. Disclosure rate to partners was 72% among study participants. The majority of participants disclosed to sexual partners cited desire to get support from sexual partners as the main reason for disclosure. Chapter 5 will present an outline of objectives that were met during this study and recommendations.

CHAPTER 5

CONCLUSIONS AND RECOMMENDATIONS

5.1 INTRODUCTION

The study was conducted to establish factors contributing to HIV nondisclosure to sexual partners among women enrolled on the PMTCT program at Katutura ANC clinic, Windhoek. Although the study sample was little and findings could not be generalised, the study produced useful findings that could be used to formulate further strategies aimed at promoting disclosure particularly among pregnant women. Chapter five (5) presents conclusions made from the study by discussing findings study objectives drawn from the chapter four (4). Recommendations aimed at increasing disclosure to sexual partners among women are also presented.

5.2 CONCLUSIONS

The specific objectives set for this study were:

- To identify current level of HIV disclosure among women at Katutura ANC.
- To establish factors contributing to non disclosure among pregnant women to their sexual partner.
- To determine the proportion of women those have been abused by their sexual partners as a reaction of HIV disclosure
- To recommend strategies aimed at increasing HIV disclosure rate among women living with HIV in the communities

The study objectives were met and findings are summarised as follow:

The findings from the study show a significant number (n=42/84%) of participants know the importance of disclosure and (n=47/94%) of the respondents disclosed their HIV status. Those who disclosed (n=36/72%) did it to sexual partners, while (n=14/28%) did not disclose. Although the number for women who disclosed is higher than those who did not disclose, non-disclosure among HIV positive pregnant women may result in further HIV transmission to current and potential partners as well as to the babies.

A study by Deribe et al. (2008) found 95% of women disclosed their HIV status and 90% disclosed to sexual partners. A similar study by Kassaye et al. (2005) showed comparable results whereby 69% of women disclosed to sexual partners.

Various factors contributing to nondisclosure of HIV serostatus to sexual partners were found. Fourteen (n=14/28%) participants who did not disclose to partners cited various barriers to disclosure. Majority of participants (n=6/43%) indicated fear of being abandoned and rejected by partners as a result of disclosure, while (n=4/29%) cited physical abuse a result of disclosure.

Some barriers to disclosure cited by participants who did not disclose were also confirmed by participants who disclosed to sexual partners. Among participants (n=34/72%) who disclosed to partners, (n=13/38%) got negative

reactions from partners which ranged from shock, depression, denial, rejection and abandonment, blame and anger.

Studies conducted in some African countries show while fears of negative outcomes as a result of disclosure are genuine, these outcomes are less than anticipated. Medley et al. (2004) found while 4-28% experienced negative outcomes such as blame, violence, abandonment and stigma as a result of disclosure, 19-73% reported positive outcomes such as kindness, understanding and acceptance after disclosure. This study therefore found that although most women disclose, there is a considerable number of women who do not disclose fearing abuse and other negative outcomes.

The study found GBV is a major problem in Namibia; however, participants who disclosed to partners did not cite any form of physical violence as a result of disclosure. Other forms of violence such as rejection and abandonment were experienced by some women after disclosure.

5.3 RECOMMENDATIONS

Various recommendations were made from the findings of the study and are presented.

5.3.1 Promotion of Couple Counselling

The study found the promotion of couple counselling was suggested by most participants who took part in the study. When couples are tested together they will receive results at the same time and disclosure will not be required.

5.3.2 Women empowerment through education

The study found most participants had a low level of education which as a result led to high unemployment rate among women who took part in the study. It was also found the majority of women depend on their partners for financial support which was cited as the main reason for disclosure. Women's dependence on men for financial support has also been linked to non-disclosure in some studies.

Medley et al. (2004) state women's financial dependence partners may be a barrier to disclosure, as they fear losing support from partners if they do so.

It is therefore crucial to empower women through education to ensure that they are financial stable. There is a need for Ministry of Education and MoHSS to jointly devise programs intended to promote education among girls and reduce teenage pregnancy at both urban and rural areas. It is also important to provide financial support to women to start their own businesses.

5.3.3 Promotion of HIV and AIDS awareness campaigns targeted for men

The findings from the study show a significant number of women do not know their partners' HIV status. It is not clear whether partners are not tested or did not disclose to them. It also emerged from the study there is a need for

HIV and AIDS awareness campaigns target to men to empower them with information on HIV and AIDS including the importance of HIV disclosure.

5.3.4 Health care workers role on disclosure

It has emerged from this study health care workers can play a pivotal role in facilitating disclosure particularly among women. Since there are no specific courses for health care workers on adult disclosure, the MoHSS and partners need to develop a course on disclosure in order to equip health care workers with skills to assist clients with disclosure issues.

5.3.5 Involvement of a trusted family or community member to mediate disclosure

The study findings suggest women experiencing barriers to disclosure need to contact a trusted individual to mediate disclosure between couples. These suggestions are reiterated by WHO (2004) which propose for mediated disclosure. This is done when either the counsellor mediates disclosure between couples at the clinic or when the client identifies a trusted family member to mediate disclosure.

5.4 FURTHER RESEARCH

Further research is needed to assess the effectiveness of couple counselling as a strategy aimed at reducing negative outcomes of disclosure such as violence, blame, abandonment and denial.

There is a need to conduct a study with a larger sample, where more health facilities are selected to allow comparison of findings.

This study identified factors contributing to non-disclosure among women; further research is needed to investigate factors contributing to HIV nondisclosure among both men and women.

The study discovered barriers to disclosure among women on the PMTCT program, further research is needed to investigate factors contributing to nondisclosure among women tested at VCT centres.

5.6 CONCLUSION

This study identified factors contributing to HIV nondisclosure to sexual partners among women enrolled on the PMTCT program at Katutura ANC clinic. The study found a high rate of disclosure to partners among study participants. The results of the study show that most participants disclosed to partners to get support. Barriers to disclosure were noted among some participants including fear of abandonment, rejection and physical violence. In view of the findings the study formulated recommendations that could be utilised to increase rate of disclosure among women. These include couple counselling, empowerment of women through education and employment, creating awareness among men on issues of HIV and AIDS and involvement of either a trusted family or community members to mediated disclosure.

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APPENDICES

Appendix A – Questionnaire

Nondisclosure of HIV serostatus to partners among HIV positive pregnant women enrolled on the Prevention of Mother to Child Transmission (PMTCT) Program at Katutura Antenatal Clinic, Windhoek

KINDLY COMPLETE THE QUESTIONNAIRE BY PLACING A X IN THE BOX

SECTION A -SOCIO-DEMOGRAPHIC CHARACTERISTICS

1. Age

- | | |
|--------------------------------|--------------------------------|
| <input type="checkbox"/> 15-19 | <input type="checkbox"/> 20-24 |
| <input type="checkbox"/> 25-29 | <input type="checkbox"/> 30-34 |
| <input type="checkbox"/> 35-39 | <input type="checkbox"/> 40-44 |
| <input type="checkbox"/> 45-49 | |

2. Gender

- | | |
|-------------------------------|---------------------------------|
| <input type="checkbox"/> Male | <input type="checkbox"/> Female |
|-------------------------------|---------------------------------|

3. Present physical address.....

4. Marital Status

- | | | | |
|----------------------------------|----------------------------------|--|-----------------------------------|
| <input type="checkbox"/> Single | <input type="checkbox"/> Married | <input type="checkbox"/> Living together but not married | <input type="checkbox"/> Divorced |
| <input type="checkbox"/> Widowed | | | |

5. Ethnicity

- | | |
|------------------------------------|--------------------------------------|
| <input type="checkbox"/> Oshiwambo | <input type="checkbox"/> Damara>Nama |
| <input type="checkbox"/> Herero | <input type="checkbox"/> Tswana |
| <input type="checkbox"/> Caprivi | <input type="checkbox"/> Kavango |

Others

6. Formal education level

- None Primary (grade 1-7)
 Junior Secondary (grade 8-10) Secondary (Grade 11- 12)
 Tertiary (college, university, polytechnic etc) don't know

7. Employment status

- Employed Self-employed Unemployed

8. if you are employed or self employed, what is your estimated monthly income? (please tick the appropriate figures)

- 0-999 1000-1999 2000-2999
 3000-3999 4000-4999 5000-6999 7000 and more

9. How long have you known your HIV status

- 0-2 years 3-5 years 6-8 years 9 years and more

10. How long have you been in your current relationships?

- 2 years and less 3-5 years 6-8 years 9 years and more

11. Partner's employment status

- Employed Self-employed Unemployed

12. Partner's HIV status..... (To be obtained from participant if known)

- HIV positive HIV negative don't know

13. Partner's educational level

- None Primary (grade 1-7)
- Junior Secondary (grade 8-10) Secondary (Grade 11-12)
- Tertiary (college, university, polytechnic etc) do not know

SECTION B - ATTITUDES AND KNOWLEDGE TOWARDS GENDER BASED VIOLENCE (GBV)

14. Do you know about gender based violence?

Yes No

15. Do you know someone suffering or suffered from Gender Based Violence?

Yes No

16. Do you agree or disagree with the following statement "Gender Based Violence is a big problem in Namibia" ? (Please circle one appropriate answer only)

1	2	3	4	5
Strongly disagree	Disagree	Neutral	Agree	Strongly Agree

17. Which of the following is the common source of information on gender based violence?

Newspapers

Television

Friends

Radio

18. Which one of the following forms of violence did you witness/heard most?

Physical Violence

Emotional Violence

Sexual Violence

Financial Violence

19. What do you think is the major cause of gender based violence in Namibia?

Alcohol and Substance Abuse

Cultural and traditional beliefs

Lack of respect for women

Women's dependence on men
for financial support

Don't know

Others..... (Please
specify)

SECTION C-BARRIERS TO DISCLOSURE AND OUTCOME OF DISCLOSURE

20. Do you think it is important to disclose HIV status?

Yes No

21. Did you tell your HIV result to anyone? Yes No

22. Did you tell your partner about your HIV results?

Yes No

(If **Yes**, **continue** to the next question, if **No**, skip to **Question 25**)

23. Please mark the most appropriate answer, which of the following reasons motivated you to disclose to partner?

I want to get his support

I do not want to infect him

I fear God and do not want to
hide such things

I do not want to get legally
accused

We usually share secrets in our
relationship

Others (Specify)

24. Did you have a sexual relationship with your partner before telling him your results?

Yes

No

25. Please tick the most appropriate answers, If I tell my partner about my HIV results, He might:

get angry with me

hurt me physically

kill me

tell other people about it

think I have been unfaithful

leave me?

26. What were your partner's reactions when you disclosed?

27. Do you think there is a need for measures to be put in place to assist women when informing their partners about their HIV status, if YES please explain below?

THANK YOU FOR COMPLETING THIS QUESTIONNAIRE!

Questionnaire- Oshiwambo translated

OSHIWEDWAPO A – OMAPULAAPULO

Omaimbo haa imbi ovakainhu ve li momateeleleo ve na ombuto yoHIV, nove li koshi yetonatelo lokukelela okaana kaha kwatwe kombuto yoHIV pokaklinika kaKatutura koomeme, ve li momateelelo moVenduka va lombwele ovaholike vavo kutya ove na ombuto.

KWAFENGE U NYAMUKULE OMAPULO ELI MOMBAPILA OMU TOTULA OKA X MOKAKOLOLO AKA UWETE KE LI MONDJILA.

OSHIWEDWAPO A – OMAUKWATYA OYE

1. Eedula doye

- | | |
|--------------------------------|--------------------------------|
| <input type="checkbox"/> 15-19 | <input type="checkbox"/> 20-24 |
| <input type="checkbox"/> 25-29 | <input type="checkbox"/> 30-34 |
| <input type="checkbox"/> 35-39 | <input type="checkbox"/> 40-44 |
| <input type="checkbox"/> 45-49 | |

2. Oukashike ko okanhu

- | | |
|-------------------------------------|------------------------------------|
| <input type="checkbox"/> Omulumenhu | <input type="checkbox"/> Omukainhu |
|-------------------------------------|------------------------------------|

3. Ondjukifi.....

4. Oukwatya wohombo

- | | | |
|--|--|--|
| <input type="checkbox"/> Inandi hombolwa | <input type="checkbox"/> Onda hombolwa | <input type="checkbox"/> Ohatu kala pamwe ndee inatu hombola |
| <input type="checkbox"/> Otwa hengana | <input type="checkbox"/> Omufiyekadi | |

5. Oukwamunghoko

- | | |
|---|---|
| <input type="checkbox"/> Omuwambo | <input type="checkbox"/> omudamara/nama |
| <input type="checkbox"/> Omuhherero | <input type="checkbox"/> Omutswana |
| <input type="checkbox"/> Omucapivi | <input type="checkbox"/> Omukavango |
| <input type="checkbox"/> Ominghoko dimwe (Omukwashike.....) | |

Twikila ke pandja la landula

6. Ouhongelwa woye

- Inandi ya koskola Oprima (ondodo 1-7)
 Osekondele yopedu (ondodo 8-10) Osekondele (Ondodo 11- 12)
 Elongo lopombada Kandishishi

7. Oilonga

- Ohandi longo Ohandi longo paumwene Ihandi longo

8. Ondjabi yokomwedi (didilika mokakololo aka keli mondjila)

- 0-999 1000-1999 2000-2999

 3000-3999 4000-4999 5000-6999 7000 ile idulepo

9. Omanyamukulo oye owa kala waashi efimbo lifike peni?

- Eedula 0-2 Eedula 3-5 Eedula 6-8 Eedula 9 ile didulepo

10. Omuholike woye owa kala naye efimbo lifike peni?

- Eedula didule mbali 2 ile dishona Eedula 3-5 Eedula 6-8
 Eedula 9 ile didulifepo

11. Onghalo yoilonga yomuholike woye

- Oha longo Oha longo kuye mwene Iha longo

12. Omanyamukulo ombuto omuholike woye..... (taa yandjwa komukulukadi)

- Okuna Ombuto yoHIV Kena mbuto yoHIV Kandi shishi

Twikila kebandja la landula

13. Ouhongelwa womuholike woye

- Ke na sha Oprima (Ondodo 1-7)
 Osekondele yopedu (ondodo 8-10) Osekondele (Ondodo 11-12)
 Elongo lopombada (okollege, university, polytechnic) Kandi shishi

OSHITOPOLWA B – OMALIHUMBATO NESHIIVO LOMAHEPEKO OPAKAUKWASHIKE KO OKANHU

14. Ou shi omahepeko opakaukwashike ko okanhu Ehenol Ayee

15. Ou shi omunhu ha hepekwa komulumenhu waye? Ehenol Aayee

16. Oto tu kumwe ile ito tu kumwe netumbulo e li “Omahepeko opakaukwashike ko okanhu okwa ninga mahapu moNamibia” (Tenda enyamukulo eli lili mondjila)

1 2 3 4 5

Itandi tu kumwe Itandi tu kumwe Ondili pokati Ohandi tu kumwe Ohandi tu kumwe neenghono

17. Openi houdu omahepeko opakaukwashike kookanhu?

- Moifo kundaneke
 Moradio yomudidimbe
 Kookaume/kookahewa
 Koradio
 Pamwe pelili (Openi?).....
 Inandishiuda nale

Twikila ke pandja la landula

18. Owaudile/wamonene oludi lonhumba li na sha nomahepeko oukashike ko okanhu eli pedu?

Ehepeko lokolutu	Eheno <input type="checkbox"/>	Aaye <input type="checkbox"/>
Ehepeko lokomwenyo	Eheno <input type="checkbox"/>	Aaye <input type="checkbox"/>
Okukwata keenghono	Eheno <input type="checkbox"/>	Aaye <input type="checkbox"/>
Itapewa oimaliwa komuholike waye	Eheno <input type="checkbox"/>	Aaye <input type="checkbox"/>

19. Oshike u wete tashi eta omahepeko opaukashike kookanhu?

- Elongifo lomalodu noingangamifi
- omifyuululwakalo
- Odino yovakainhu
- Ovakainhu tava hupu movaholike vavo
- Oietifi yomahepeko ikwao (Ngaashi?).....
- Kandi shi shi

OSHIPOLWA C-OINIMA TAYI IMBI OMUNHU A LOMBWELE VAKWAO OMANYAMUKULO AYE OMBUTO YO HIV

20. Owete tuu sha fimana okulombwela omunhu kutya oto lumbu nombuto yoHIV?

Eheno Aaye

21. Omatomelo ashike haa etifa omunhu alombwele ovanhu kutya otalumbu nombuto yoHIV?

Opo umone omavatelo	Eheno <input type="checkbox"/>	Aaye <input type="checkbox"/>
Oshinakuwanifwa shopaukriste	Eheno <input type="checkbox"/>	Aaye <input type="checkbox"/>
Oumbada wokupangulwa	Eheno <input type="checkbox"/>	Aaye <input type="checkbox"/>

22. Ouna ouwalombwela kutya otolumbu nombuto yoHIV?

Eheno Aaye

23. Owalombwela omuholike woye kutya otolumbu nombuto yoHIV?

Eheno Aaye

(Ngee oweshininga, **twikila kepulo talilandula**, ngee hasho, **indakepulo 27**)

Twikila kepanja la landula

24. Oshike shekutwa omukumo ulombwele omuholike woye omayamulo oye oHIV?

Onda hala a vatelenge Ehenol Aaye

Inandihala kumu pa ombuto Ehenol Aaye

Ame omutiliKalunga inandihala ndimuholeke Ehenol Aaye

Inandihala okukapangulwa paveta Ehenol Aaye

Ohatu lilombwele oiholekwa alushe Ehenol Aaye

Omatomelo amwe (Ngaashi)

25. Omwaya pamwe pamilele nomuholike woye manga inomulombwela kutya otolumbu nombuto yoHIV?

Ehenol Aaye

26. Ngee ondalombwele omuholike wange kutya ohandilumbu nombuto yoHIV ota:

handukilenge Ehenol Aaye

denge nge Ehenol Aaye

dipaa nge Ehenol Aaye

ka lombwela ovanhu vamwe Ehenol Aaye

ota katya onda li novalumenhu vamwe Ehenol Aaye

fiyenge po Ehenol Aaye

27. Omalihumbato omuholike woye okwa li ngahelipi eshi we mu lombwela kutya otolumbu nombuto yoHIV?

TANGI UNENE ESHI WANYAMUKULA OMAPULO!

Appendix B – Ethical Approval: University of Stellenbosch



UNIVERSITEIT•STELLENBOSCH•UNIVERSITY
jou kennisvennoot • your knowledge partner

Approval Notice

Response to Modifications- (New Application)

18-Sep-2012

Shiyoleni,

Mirjam N

Stellenbosch,

WC

Protocol #: HS815/2012

A Study on nondisclosure of human immunodeficiency virus serostatus to partners among HIV positive pregnant women enrolled on

Title:

the prevention of mother to child transmission program.

Dear Ms Mirjam Shiyoleni,

The **Response to Modifications - (New Application)** received on **03-Sep-2012**, was reviewed by members of **Research Ethics Committee: Human Research (Humanities)** via Expedited review procedures on **27-Sep-2012** and was approved.

Please note the following information about your approved research protocol:

Protocol Approval Period: **18-Sep-2012 -17-Sep-2013**

Standard provisions

1. The researcher will remain within the procedures and protocols indicated in the proposal, particularly in terms of any undertakings made in terms of the confidentiality of the information gathered.
2. The research will again be submitted for ethical clearance if there is any substantial departure from the existing proposal.
3. The researcher will remain within the parameters of any applicable national legislation, institutional guidelines and scientific standards relevant to the specific field of research.
4. The researcher will consider and implement the foregoing suggestions to lower the ethical risk associated with the research.

You may commence with your research with strict adherence to the abovementioned provisions and stipulations.

Please remember to use your **protocol number** (HS815/2012) on any documents or correspondence with the REC concerning your research protocol.

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.

After Ethical Review:

Please 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). Annually a number of projects may be selected randomly for an external audit.

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

This committee abides by the ethical norms and principles for research, established by the Declaration of Helsinki, the South African Medical Research Council Guidelines as well as the Guidelines for Ethical Research: Principles Structures and Processes 2004 (Department of Health).

Provincial and City of Cape Town Approval

Please note that for research at a primary or secondary healthcare facility permission must be obtained from the relevant authorities (Western Cape Department of Health and/or City Health) to conduct the research as stated in the protocol. Contact persons are Ms Claudette Abrahams at Western Cape Department of Health (healthres@pgwc.gov.za Tel: +27 21 483 9907) and Dr Helene Visser at City Health (Helene.Visser@capetown.gov.za Tel: +27 21 400 3981). Research that will be conducted at any tertiary academic institution requires approval from the relevant parties. For approvals from the Western Cape Education Department, contact Dr AT Wyngaard (awyngaar@pgwc.gov.za, Tel: 0214769272, Fax: 0865902282, <http://wced.wcape.gov.za>).

Institutional permission from academic institutions for students, staff & alumni. This institutional permission should be obtained before submitting an application for ethics clearance to the REC.

Please note that informed consent from participants can only be obtained after ethics approval has been granted. It is your responsibility as researcher to keep signed informed consent forms for inspection for the duration of the research.

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 **Included Documents:**

Letter of Permission

Questionnaire

Interview Schedule

Admin Review

Participant Information sheet

DESC Appl

Research Proposal

Consent Form

REC Application

Sincerely,

Winston Beukes

REC Coordinator

Research Ethics Committee: Human Research (Humanities)

Investigator Responsibilities

Protection of Human Research Participants

Some of the 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 protocols 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 RECs 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 protocol and all amendments; all informed consent documents; recruiting materials; continuing review reports; adverse or unanticipated events; and all correspondence from the REC

8. Reports to Sponsor. When you submit the required reports to your sponsor, you **must** provide a copy of that report to the REC. You may submit the report at the time of continuing REC review.

9. 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.

10. 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.

11. 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.

**Appendix C- Permission to conduct
research from Ministry of Health and
Social Services**

9 - 0/0001



REPUBLIC OF NAMIBIA

Ministry of Health and Social Services

Private Bag 13198
Windhoek
Namibia

Ministerial Building
Harvey Street
Windhoek

Tel: (061) 2032552
Fax: (061) 222558
E-mail: tkakili@yahoo.com

Enquiries: Ms. T. Kakili

Ref: 17/3/3

Date: 23 July 2012

OFFICE OF THE PERMANENT SECRETARY


Ms. M.N. Shiyoleni
P.O.BOX 26903
Windhoek

Dear Ms. Shiyoleni

Re: A study on non disclosure of HIV serostatus to partners among HIV positive pregnant women enrolled on PMTCT programme at Katutura ANC Clinic.

1. Reference is made to your application to conduct the above-mentioned study.
2. The proposal has been evaluated and found to have merit.
3. **Kindly be informed that permission to conduct the study has been granted under the following conditions:**
 - 3.1 The data to be collected must only be used for completion of your Master's Degree in HIV and AIDS;
 - 3.2 No other data should be collected other than the data stated in the proposal;
 - 3.3 A quarterly report to be submitted to the Ministry's Research Unit;
 - 3.4 Preliminary findings to be submitted upon completion of study;
 - 3.5 Final report to be submitted upon completion of the study;
 - 3.6 Separate permission should be sought from the Ministry for the publication of the findings.

Yours sincerely,


2012/7/23
MR. ANDREW NDISHISHI
PERMANENT SECRETARY
MINISTRY OF HEALTH AND SOCIAL SERVICES

"Health for All"

Appendix D: Permission to conduct research from Katutura Intermediate Hospital



Republic of Namibia

Ministry of Health and Social Services

Private Bag 13215
WINDHOEK
Namibia

Intermediate Hospital Katutura
Independence Avenue
WINDHOEK

Telephone (061) 203 4004
Telefax (061) 222706

Enquiries: Dr. N. T. Amagulu

Date: 29 August 2012

Ms. Miriam Shyoleni
P. O. Box 26903
Windhoek

RE: PERMISSION FOR RESEARCH AT ANC CLINIC FOR MS. M. SHYOLENI

This office hereby grant you permission to do a study on non disclosure of HIV serostatus to partners among HIV positive pregnant women enrolled on PMTCT programme at Katutura ANC clinic.

Thank you.

Yours in Health,

A handwritten signature in black ink, appearing to be 'N. T. Amagulu', written over a horizontal line.

DR. N. T. AMAGULU
CHIEF MEDICAL OFFICER
PARAMEDICAL SERVICES



Appendix E– Participant Informed Consent: English



UNIVERSITEIT • STELLENBOSCH • UNIVERSITY
jou kennisvennoot • your knowledge partner

STELLENBOSCH UNIVERSITY CONSENT TO PARTICIPATE IN RESEARCH

A STUDY ON NONDISCLOSURE OF HIV SEROSTATUS TO PARTNERS AMONG HIV POSITIVE PREGNANT WOMEN ENROLLED ON THE PREVENTION OF MOTHER TO CHILD TRANSMISSION (PMTCT) PROGRAM AT KATUTURA ANTENATAL CLINIC, WINDHOEK

You are asked to participate in a research study conducted by **Mirjam Ndapandula Shiyoleni** (*Mphil in HIV Management*) from the **Africa Centre of HIV/AIDS Management** at **Stellenbosch University**. Results of this study will be contributed to a mini-thesis. You were selected as a possible participant in this study because you are a pregnant woman with a known HIV positive result and between the ages of 18-49 years.

1. PURPOSE OF THE STUDY

The purpose of this study is to establish effects of Gender based violence on HIV disclosure to partners among women enrolled on the PMTCT program in order to suggest strategies to reduce Gender Based Violence in the communities

2. PROCEDURES

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

The researcher will provide you with information on effects gender based violence and HIV disclosure before taking part in the study. There are various questions in the questionnaire that you are requested to answer. These questions are divided in three groups such as socio-demographic information, knowledge and attitudes of gender based violence, HIV status disclosure as well as outcome disclosure. Some questions are multiple choice questions where possible answers are provided. There are also those questions that will require responses from you in your own words. The researcher will read each questions possible answers to the questions and ask you to answer the questions.

The researcher requests you to answer all questions truthfully as your information will be kept confidential. The questionnaire will take about 20-25 minutes to complete.

3. POTENTIAL RISKS AND DISCOMFORTS

There might be some questions that the researcher will ask you that may cause discomfort in answering them. Should such a situation occur, kindly inform the researcher so that he/she can provide necessary support and counseling. The researcher can refer you to a social worker or to the Women and Child Protection Unit should you require further counseling and support. You have a right to terminate your participation in the study at anytime during the process if you feel discomfort in any way.

4. POTENTIAL BENEFITS TO SUBJECTS AND/OR TO SOCIETY

There are no direct benefits that you will receive from this research. However there are indirect benefits as findings from the study will be used by government, donors and other stakeholders to come up with ways to address gender based violence as a result of HIV disclosure. These strategies will assist HIV positive women who face difficulties in disclosing their HIV positive status to their partners

5. PAYMENT FOR PARTICIPATION

You will not receive any form of incentive for taking part in this study.

6. 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 of questionnaires and no names will be used. Information collected will be stored in a lockable cupboard and the key will be safely be kept by the researcher. The researcher will be the only person with access to the information collected.

The report will be forwarded to Africa Centre for HIV/AIDS Management at Stellenbosch University as the institution where the researcher is pursuing her studies.

7. 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.

8. IDENTIFICATION OF INVESTIGATORS

If you have any questions or concerns about the research, please feel free to contact Mirjam N. Shiyoleni (Principal Investigator) at shiyoleni@yahoo.com or on cell number: 0811285464, Flat Number. 19 Kwelea Court, Mandawas Street, Khomasdal, Windhoek, or Prof. Elza Thomson (Study Supervisor) at elzathomson@gmail.com or on cell +2721 555 4991.

9. 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; 021 808 4622] at the Division for Research Development.

SIGNATURE OF RESEARCH SUBJECT OR LEGAL REPRESENTATIVE

The information above was described to me: by Mirjam Ndapandula Shiyoleni in English and I am in command of this language or it was satisfactorily translated to me. I 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.

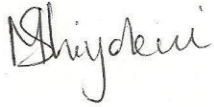
Name of Subject/Participant

Signature of Subject/Participant or Legal Representative

Date

SIGNATURE OF INVESTIGATOR

I Mirjam N. Shiyoleni declare that I explained the information given in this document to _____ . She was encouraged and given ample time to ask me any questions. This conversation was conducted in English.



Signature of Investigator

Date

Participant Informed Consent: Oshiwambo translated version

**OSHIPUTUDHILO SHOPOMBANDA SHASTELLENBOSCH
EZIMININO LYOKUKUTHA OMBINGA MOMAPEKAAPEKO**

EKONAKONO LYOKUTALA OMAIMBO HAGA IMBI AAKINTU YE LI MOMATEGELELO TAYALUMBU NOOMBUTO YOHIV, NOYE LI KOHI YETONATELO LYOKUKELELA OKANONA KAA YA KWATWE KOMBUTO YOHIV POKAKLINIKA KAKATUTURA KOOMEME, YE LI MOMATEELELO MOVENDUKA YA LOMBWELE AAHOLIKE YAWO KUTYA OYE NA OMBUTO.

Oto pulwa nesimaneko opo u kuthe ombinga momapekaapeko taga ningwa kuMirjam Ndapandula yaShiyoleni ngoka e li omunasikola koUniversiti yaStellenbosch ti ilongele onkatu yopombanda mekondjitho lyomukithi gwo-HIV/AIDS. Omapekaapeko ote ga ningi pamwe nomulongi gwe Omuprofessora Elza Thomson. Iizemo yomapekaapeko ngaka otayi ka longithwa moku mu pethitha onzapo monkatu yopombanda. Oto indilwa nee ngeyi opo u kuthe ombinga molwashoka owu na omauyelele ngoka taga pumbiwa opo omuntu a vule okukutha ombinga.

10. ELALAKANO LYOMAPEKAAPEKO

Elalakano lekonakono ndika okutala omaudhigu haga ningilwa oomeme ye li momategelelo noye li koho yetonatele lyokukelela okanona kaa ka kwatwe kombuto yoHIV, ngele taahololele aaholike yawo kutya oyamonika ombuto yoHIV. Omapekaapeko ngaka otaga kawatela opo pumonike omikalo tadhivulu okushunitha pevi omahapeko haga ningilwa aakintu moshigwana.

11. OMILANDU

Ngele owi iyamba u kuthe ombinga momapekaapeko muka otatu ke ku pula iinima tayi landula:

Oto ka pewa elandulathano lyomapulo ngoka wa pumbwa okuyamukula to udhitha mombaapila ndjoka to pewa, notashi ke ku kutha konyala ominute omulongo nantano sigo omilongo ndatu. Kambadhala wu gandje uuyelele wu li mondjila ngaashi tashi vulika.

12. OMAUPYAKADHI NGOKA HASHI VULIKA GA HOLOKE

Kapu na naanaa uupyakadhi wa sha wa tegelelwa wu ka holoke molwokukutha ombinga kwoye momapekapeko muka, ashike otashi vulika omapulo gamwe wu ga mone ko ga fa omawinayi unene noitoo vulu oku ga yamukula. Otashi vulika aantu yamwe ya ka kale ye wete okuyamukula omapulo taku ya manene po ethimbo lyawo.

4. OMAUWANAWA KAAKUTHIMBINGA NENGE KOSHIGWANA

Omayamakulo ngoka to ka gandja itage ku kwathele ongoye awike, ashike omayamakulo ngaka otaga ka kwathela oshigwana ashihe notaga ka kwathela wo aalongekidhi yomilandu opo ya hwepopaleke omahepeko haga holoka omolwa okwiilolola kwaakiintu kutya oyena ombuto yoHIV. . Ekuthombinga lyoye ota li ka kwathela wo aaningi yomapekapeko yu uve ko omaudhigu ngaka, nokwee tapo omikalo dhilwe dhokukelela omahepeko taga ningilwa aakintu taya lumbu nombuto moshigwana.

5. ONDJAMBI MOLWEKUTHOMBINGA MEPEKAPEKO NDIKA

Ito ka pewa ondjambi yasha mokukutha ombinga momapekaapeko ngano.

6.OKWAAHOLOLA UUYELELE WOYE MBU TO GANDJA

Uuyelele auhe to ka gandja momapekapeko ngaka otawu kala oshiholekwanima thiluthilu noitawu ka gandjwa nande okulye, kakele owala kungoye mwene nenge papitikilo lyoye, nenge ngele owa pumbiwa kompango. Itatu ka longitha nando edhina lyomuntu mombapila ndji wa yamukula, otatu longitha owala oonomola. Kapu na nando ogumwe ta ka tseye kutya owa yamukula shike. Oombapila adhihe ndhi dha yamukulwa otadhi kala dha patelwa mokaskopa koshitenda mombelewa yanakupekapeka. Nakupekapeka oye owala e na oshipatululo shombelewa ndjoka, osho wo shokaskopa mu mwa patelwa oombapila. Iizemo yomayamakulo otayi ka shangwa momushangwa ngu tagu ka tuminwa komuprofessora Thomson, ashike itamu ka shangwa nando edhina lyomuntu.

7. OKUKUTHA OMBINGA NENGE OKUTINDA

Oto vulu okukutha ombinga nenge okutinda okukutha ombinga momapekapeko ngaka. Ngele owi iyamba okukutha ombinga, oto vulu okwiikutha mo kehe ethimbo nopwaa na nando egeelo lyasha. Oto vulu wo okutinda okuyamukula omapulo ngoka u uvite inoo hala oku ga yamukula ndele e to tsikile okuyamukula ngoka wa hala. Omupekapeki ota vulu okukwiindika waa tsikile we nokugandja uuyelele ngele oku wete sha pumbiwa.

8. OMAUYELELE GOONAKUNINGA OMAPEKAPEKO

Ngele owu na omapulo nenge omagwedhelepo gasha, oto vulu okudhengela koonomola tadhi landula: Ms Mirjam Ndapandula Shiyoleni, koemailed shiyoleni@yahoo.com nenge kongodhi yosheendelela 081 128 5464 onomola yegumbo, 19, Kwelea Court, Mandawas Street, Khomasdal, movenduka, nenge omukuluntu meilongo omuprofessor Elza Thomson, koemailed elzathomson@gmail.com nenge kongodi yosheendelela ko +2721 555 4991.

9. UUTHEMBA WOYE NAKUKUTHOMBINGA

Oto vulu wu hulithe po okugandja uuyelele pwaa na egeelo lyasha. Ito vulu okuningilwa nando oshipotha shasha shaashi wa tokola kutya ino hala we okukutha ombinga momapekapeko ngaka. Ngele owu na omapulo gasha ge na sha nuuthemba woye onganakukuthombinga momapekapeko ngaka, oto vulu okuninga ekwatathano naMee Maléne Fouché koiimeila nenge kongodhi ndjika [mfouche@sun.ac.za; 021 808 4622] koshitopolwa shomapekapeko.

ESHAINOKAHA LYANAKUKUTHOMBINGA NENGE LYOMUKALELIPO GWE

Uuyelele auhe onde u yelithilwa, _____ ku Mirjam Ndapandula Shiyoleni mOshiwambo, elaka ndyoka ndu uvite. Onda pewa wo ompito opo ndi pule omapulo nonda yeelwa lela komayamukulo ngoka nda pewa.

Otandi gandja epitikilo lyandje lyokukutha ombinga momapekapeko ngaka. Onda pewa wo okopi yombaapila ndji.

EDHINA LYANAKUKUTHOMBINGA

ESHAINO LYANAKUKUTHOMBINGA

Esiku_____

ESHAINOKAHA LYANAKUNINGA OMAPEKAPEKO

Otandi gana kutya onda gandja omauyelele ge na sha nombapila ndjino ku _____. Okwa li a tsuwa omukumo nokwa pewa ethimbo lya gwana lyokupula omapulo. Oonkundathana ndhino odha ningwa melaka lyOshiwambo nodha tolokolwa melaka lyOshiingilisa ku _____.

ESHAINOKAHA:

ESIKU

Appendix F: Proof of Authentic translation of English-based questionnaire into Oshiwambo



HAGE G.GEINGOB HIGH SCHOOL
AIM HIGH

PO BOX 62974 WANAHEDA • C/O MONTE CHRISTO& OMUNGWINDI STR•
TEL: 061 - 211893/4/5•FAX 061- 265724

20 August 2012

Enquiries: Mrs T. Iiyambula
Contact: +264 816020848

To: Research Ethical Committee (Human Research)
University of Stellenbosch
Stellenbosch

Re: Authentic Translation of English-based informed consent form into Oshiwambo Language

Dear Sir/Madam

This letter serves to inform your institution that the Oshiwambo translated informed consent is a true authentic translation from the original informed consent that is in English. The translated informed consent has been reviewed by Mrs T. Iyambula, Oshiwambo language teacher at the above mentioned school.

Do not hesitate to contact our institution should you have any queries.

Yours sincerely

T. Iyambula(Oshindonga Teacher)





HAGE G. GEINGOB HIGH SCHOOL

AIM HIGH

PO BOX 62974 WANAHEDA • C/O MONTE CHRISTO & OMUNGWINDI STR •
TEL: 061 - 211893/4/5 • FAX 061 - 265724

25 June 2012

Enquiries: Mrs. T. Iiyambula
Contact: 0816020848

Ethical Committee
University of Stellenbosch
Stellenbosch
South Africa

Re: Authentic Translation of English-based questionnaire into Oshiwambo language

Dear Sir/Madam

The letter serves to inform your institution that the Oshiwambo translated questionnaire is a true authentic translation of the English language. The translated questionnaire has been reviewed by Mrs. T. Iiyambula, Oshiwambo language teacher at the above mentioned school.

Do not hesitate to contact our institution should you have any queries.

Yours faithfully

