

**SOCIO-ECONOMIC IMPLICATIONS OF DISCLOSING HIV STATUS IN
GABORONE, BOTSWANA**

**Onalenna Thebeyadira
(24620564)**

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degree of M.Cur in Nursing Sciences**

Mafikeng Campus, North-West University

Supervisor : Prof Ushotanefe Useh

Co-Supervisor : Dr Lufuno Makhado

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DECLARATION

I, the undersigned declare that, “**SOCIO-ECONOMIC IMPLICATIONS OF DISCLOSING HIV STATUS IN GABORONE,BOTSWANA**” is my original work and that all the sources used have been indicated and acknowledged by means of complete references. I have not previously submitted it for obtaining any qualification at any other university.

Signature:

Onalenna Thebeyadira

Date: -----

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ABSTRACT

Introduction: The prevalence of HIV and AIDS in Botswana is high with disclosure remaining a problem.

Purpose: To evaluate socio-economic implications of disclosing HIV status among People Living with HIV (PLWH) receiving care at selected infectious disease control centres in Gaborone, Botswana.

Design: The design for this study is a cross sectional study design.

Method: Three hundred and ten participants were conveniently sampled in this study. A self-administered questionnaire was used to collect data.

Results: Three hundred and ten questionnaires were completed, 99 were males and 211 were females. Majority were educationally below junior certificate and by status, single. Majority disclosed status to family member (45.2%). PLWH aged between 25 and 68 disclosed. The most common reasons for disclosure of HIV among PLWH attending care and treatment included wanting the sexual partner, family, friend to hear the information from them (95.3%) and the most common reason for non-disclosure of HIV among PLWH attending care and treatment is fear that the partner/family/friend would ask questions that the respondent was not prepared to answer (98%). The most cited reactions to disclosure from partners/family/friend are that the sexual partner/family/friend comforted the person living with HIV (90%).

Conclusion: The study identified that PLWH tend to disclose to their family members rather than their partners, and this might lead to high chances of transmission of HIV. PLWH experience psychosocial and emotional support from family members whereas their partners tend to reject, abandon, stigmatise and discriminate after disclosure of their HIV status. The longer the individual lives with HIV the higher the acceptance, leading to HIV status disclosure.

KEY CONCEPTS

Disclosure, Partner, Family member, Non-Disclosure, Socio economic status

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LIST OF ABBREVIATIONS

AIDS	: Acquired Immune Deficiency Syndrome
ART	: Antiretroviral treatment
BGCSE	: Botswana General Certificate of Secondary Education
BJC	: Botswana Junior Certificate
BONELA	: Botswana Network on Ethics, Law and HIV/AIDS
CDC	: Centres for Disease Control and Prevention
GDHMT	: Gaborone District Health Management Team
HAART	: Highly Active Antiretroviral Therapy
HIV	: Human Immunodeficiency Virus
PMTCT	: Prevention of mother-to-child transmission
PLWH	: People living with HIV
SPSS	: Statistical Package for the Social Sciences
UNAIDS	: The Joint United Nations Programme on HIV/AIDS
WHO	: World Health Organisation

CHAPTER 1

INTRODUCTION

1.1 BACKGROUND TO THE STUDY

Human Immunodeficiency Virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS) remain major global health care priorities as their prevalence still remains high and the number of people living with HIV (PLWH) continues to increase (UNAIDS,2012). HIV and AIDS is no longer regarded as a new syndrome but a chronic illness (UNAIDS, 2012). Even though the prevalence of HIV and AIDS is still high and there is free antiretroviral therapy, quite a number of PLWH still do not disclose their status to their sexual partners and significant others.

At the end of 2011, it was estimated that between 31.4 and 35.9 million people are living with HIV (PLWH), with an estimated 0.8% of adults aged 15-49 years worldwide living with HIV. The burden of the epidemic continues to vary considerably between countries and regions (Akinyemi, 2013). Sub-Saharan Africa remains the most severely affected with nearly 1 in every 20 adults (4.9% live with HIV and account for 69% of the people living with HIV worldwide, Akinyemi, 2013). The prevalence varies geographically between countries and regions. Botswana is severely affected with a prevalence rate among adults aged 15 to 49 at 24.8% (UNAIDS, 2012) and it is the second highest in the world, following after Swaziland (UNAIDS, 2012).

Regardless of the high prevalence of HIV in Botswana, disclosure still remains a major problem (Akinyemi, 2013). The average rate of disclosure is around 49% in developing countries, including Botswana, while in developed countries the rate is about 79% (Mukwaya, 2011). In response to this rate of disclosure which is below average in developing countries, preventative and treatment strategies were initiated to reduce HIV transmission (Akinyemi, 2013) .The strategies available are Prevention of Mother-to-Child Transmission, safe male circumcision and provision of anti-retroviral drugs and prophylactic treatment for those who might accidentally get exposed to the infection (Botswana Aids Impact Survey IV, 2013).

The need for effective strategies in the prevention and management of HIV infection has led to the implementation of programmes such as prevention of mother-to-child transmission (PMTCT, WHO, 2013), safe male circumcision (SMC) (Krieger & Heyns, 2009) and HIV testing and counselling (WHO, 2013). Within HIV testing and counselling programmes, emphasis is placed on the importance of HIV status disclosure among HIV infected clients, particularly to their sexual partners (Brooks, Martin & Veniegas 2004). The Prevention of mother-to-child transmission and safe male circumcision, programmes have resulted in a reduction of 50% new infections annually among adults and adolescents in Botswana between 2001 and 2012 (UNAIDS, 2013).

Disclosure is an important strategy for HIV prevention as well as HIV management (Turan, Miller, Bukusi, Sande & Cohen 2008). It enables PLWH to access HIV care and treatment programmes and creates awareness in sexual partners on safer sex behaviour practices (Turan et al, 2008). People living with HIV who disclose their HIV status tend to receive care and socio-economic support from sexual partners, family, friends and community which in turn reduces post-infection depression (Brooks, Etzel, Hinojos, Henry & Perez 2005). Disclosure helps in adherence to treatment (Brooks et al, 2005).

Disclosing one's status can be very difficult, as people treasure privacy and confidentiality, resulting from fear of stigma, blame, rejection from their partners and family members as well as violence against them (Wong, Rooyen, Modiba, Richter, Gray, McIntyre, Schetter & Coates 2009). Furthermore, non-disclosure inhibits the preventative measures and HIV management and increases cross-infection between sexual partners as well as family members.

As of 2013, 63 countries have given consent to at least one specific legal provision that allows for the prosecution of HIV non-disclosure exposure and or transmission (UNAIDS, 2013). Criminalisation of key populations also remains widespread and 60% of countries report having laws, regulations or policies which present obstacles to effective HIV prevention, treatment care and support for key populations and

vulnerable groups (UNAIDS, 2013). In Canada PLWH had a legal duty under the criminal law to disclose their status to sexual partners before sexual contact that poses a realistic possibility of HIV transmission (UNAIDS 2012). In my view, legislation on HIV status disclosure in Sub Saharan Africa, including Botswana, has not yet been implemented due to PLWH rights issues. This is in spite of the reality that Sub Saharan Africa is the worst affected by the pandemic.

Therefore this study sought to determine the level of HIV status disclosure and to determine and describe determinants of disclosure among PLWH receiving care and treatment. There is an assertion that individuals with a higher level of education are more likely to disclose, which often results in safer sexual practices (Medley, 2004). According to Mwanga (2012), women fear to disclose their HIV status more than men, particularly those who are less educated or have low socio-economic status due to fear of stigma, discrimination, rejection, physical violence and denied socio-economic support.

1.2 PROBLEM STATEMENT

In Botswana, the majority of PLWH find it difficult to disclose their status to partners and relatives whereas HIV status disclosure is a preventative measure for HIV/AIDS transmission. The practice of disclosure in Botswana does not include partners. Partners are not included in treatment, though as part of the treatment plan, patients are told to bring their partners to the treatment centre. There are different anecdotal reasons for lack of disclosure like fear of rejection and abandonment. There is limited evidence about the level of disclosure, factors influencing disclosure and reactions to disclosure as perceived by people living with HIV in Botswana who have disclosed.

This study identifies empirical factors influencing disclosure among PLWH in Botswana. This is important as it assists in the prevention strategy of the spread of HIV infection, promotes access to care and treatment, psychosocial support, and reduces stigma and discrimination. It also facilitates promotion of adherence to treatment. As the prevalence remains high, this study aims to determine and describe the magnitude of HIV status disclosure and associated factors that hinder

or influence disclosure amongst people living with HIV/AIDS attending care and treatment centres in Gaborone, Botswana.

1.3 PURPOSE OF THE STUDY

The purpose of this study is to determine and describe the socio-economic implications of disclosing HIV status at a selected treatment centre in Gaborone, Botswana.

1.4 OBJECTIVES

The objectives of this study are to:

- Determine the rate of disclosure among PLWH attending care, treatment and support in Gaborone, Botswana.
- Establish the reasons for disclosure and non-disclosure of HIV among PLWH attending care and treatment in Gaborone, Botswana.
- Describe reactions to disclosure from partners and family members as perceived by PLWH who had disclosed.
- Determine the influence of socio-economic status towards HIV status disclosure.

1.5 SIGNIFICANCE OF THE STUDY

The potential findings of this study may inform health policy, assist advocates of rights for PLWH and assist administrators who seek to develop guidelines about factors influencing disclosure among PLWH. This will also inform the counselling and preventive strategies and interventions. Contact slips should be issued for PLWH just like other sexually transmitted infections. Partner notification should be promoted as the study revealed that there is no disclosure to sexual partners due to fear of negative outcomes.

Awareness of HIV should be promoted among sexual partners to reduce stigma and discrimination, this could help eliminate rejection. Promotion of counselling and support groups in the prevention of stigma and discrimination, rejection amongst sexual partners after disclosure should be emphasised as this could promote

positive outcomes from sexual partners leading to disclosure and prevention of HIV transmission.

Campaigns on HIV status disclosure to partners should be done in the community just like safe male circumcision and prevention of mother-to-child transmission. The importance of disclosing one's status before marriage should be encouraged in the community as it can promote partners to practice safe sexual health to prevent transmission of the virus from one individual to the other.

1.5.1: Policy

At the moment there is a challenge from organisations on ethics, law and rights of PLWH regarding policy on disclosure of HIV and AIDS in care and treatment in Botswana. It is hoped that the outcome of this study shall assist with empirical information in developing policies that will assist Ministry of Health and the government of Botswana in this regard, without violating the rights of PLWH.

1.5.2: Clinical and Practice

The findings would be important to a number of stakeholders in the prevention of HIV transmission that include Gaborone District Health Management Team (GDHMT), the HIV/AIDS Prevention Division of the Botswana Ministry of Health. A booklet in the indigenous language in the studied area shall be developed to assist with disclosure and HIV counselling. This, to a great extent, is envisaged to assist with breaking the barriers of care and HIV disclosure.

1.5.3: HIV and AIDS legislation and advocacy

There is minimal law with regards to intentional transmissions of HIV to partners. It is hoped that the findings in this study might be used to inform advocates of human rights in Botswana on the rights of people concerning laws and intentional transmission of the HIV to sexual partners and family members in Gaborone, and by extension Botswana. Legislation to this effect might be enacted for this purpose.

1.5.4: Counselling and Prevention

The outcome of this study may contribute to the prevention strategy in the management of HIV and AIDS.

DEFINITION OF CONCEPTS

Disclosure: Refers to communicating confidential patient information to significant others in accordance with legal guidelines (Stedman's Medical Dictionary, 2005). In this study disclosure is regarded as the act of informing another person of the HIV positive status.

Partner: Someone's husband or wife or the person someone is in a sexual relationship with. (Merriam-Webster dictionary). Partner in the study means spouse (husband or wife).

Family member: A person related by descent or marriage to another. Family member in the study means father, mother, brother and sister.

Non-Disclosure: The act of not revealing or uncovering information. In this study non-disclosure is the act of not informing another person of the HIV positive status of an individual.

Socio-economic status: Socio-economic status in the study means concerning occupation, level of education, level of income and regularity of income to the extent that this determines one's standing relative to others and the ensuing spending patterns.

1.7 STUDY OUTLINE

- Chapter 1: Introduction
- Chapter 2: Literature review and conceptual framework
- Chapter 3: Research methods
- Chapter 4: Results
- Chapter 5: Discussion, Conclusion, Recommendations and Limitation of study

1.8 SUMMARY

Globally, Sub Saharan Africa and Botswana still have high prevalence of HIV and AIDS (UNAIDS 2012). Regardless of the high prevalence, disclosure still remains a problem. Even though disclosure is an important strategy for HIV prevention and management, disclosing one's status can be very difficult. The major reason for this behavioural tendency is that people need privacy and confidentiality resulting from fear of stigma, blame and rejection from partners and family members as well as violence (Wong et al, 2009). This study therefore sought to investigate the level of HIV status disclosure and determinants of disclosure among PLWH receiving care and treatment in Gaborone, Botswana.

CHAPTER 2

LITERATURE REVIEW AND CONCEPTUAL FRAMEWORK

2.1 INTRODUCTION

The following search engines: Google Scholar, Science Direct and Scopus databases were used to identify relevant literature for review. Literature was investigated using the following keywords HIV/AIDS, HIV status disclosure, legislation on HIV, HIV statistics, UNAIDS reports and WHO reports. Minimal research on HIV status disclosure patterns has been done in Botswana and this study sought to fill this gap.

Literature was reviewed under the following sub-headings:

- i) The rate of disclosure among PLWH attending care, treatment and support;
- ii) Reasons for disclosure and non-disclosure of HIV;
- iii) Reactions to disclosure from partners/family members as perceived by PLWH; and
- iv) The influence of socio-economic status to disclosure.

HIV disclosure is defined as the act of informing another person or persons of the HIV-positive status of an individual (Hoe, McKeown, Stoltz, Sobota & Trow 2003).

2.2 THE RATE OF DISCLOSURE

The rates of HIV status disclosure in studies from developing countries are notably lower than rates reported from the developed world (Medley, Garcia-Moreno, McGill & Maman 2004). These rates range from 16.7% to 86% (Medley et al, 2004). The higher rate might be as a result of effective awareness campaigns about the HIV pandemic in developed countries. This has most effectively reduced the stigma and prejudice against people living with HIV and AIDS in the developed world, in contrast to the experiences in the developing world. The level of socio-economic and

educational status might also be factors that compel the affected to disclose their HIV status.

Recent studies have reported 49% disclosure rates by current and steady partners in developing countries, a rate that is considerably less than the average rate reported from studies conducted in developed countries which was 79% (Kadowa,& Nuwaha 2009). There is a dearth in literature that seeks to establish the rate of disclosure and sexual behaviour patterns between long standing sexual partnerships in Gaborone, Botswana.

The lowest disclosure rates were among pregnant women who tested positive in antenatal care (ANC) in sub-Saharan Africa (16.7%-32%). The duration of relationship prior to pregnancy might influence disclosure. Multiparous women in longstanding and steady relationships might find it easier to disclose than their younger counterparts (Issiaka, Cartoux, Zerbo, 2001).

A number of studies have reported that rates of disclosure are generally low, in different populations (Makin, Forsyth, Visser, Sikkema, Neufeld & Jeffery 2008). In a review of 17 studies from developing countries, 15 from Africa, the rates of disclosure 2 weeks to 4 years after diagnosis ranged from 16.7% to 86% (Makin et al, 2008). Studies in South Africa reported similarly low rates of disclosure, for example, only 36% of participants in rural settings of 55 women had disclosed their positive status 5 months after diagnosis (Makin et al, 2008). The reason could be that these women were still getting to know their partners since the longer the duration of the relationship, the higher the chances of disclosure.

2.3 REASONS FOR DISCLOSURE AND NON-DISCLOSURE OF HIV STATUS

In the view of this researcher, so many factors might influence HIV and AIDS disclosure. These factors could include the current level of HIV awareness, gender and the societal context, its norms and perceptions relative to infection status. Identifying factors associated with disclosure is very important as a high proportion of PLWH never disclose (Deribe, Woldemichael, Wondafrash, Haile & Amberbir 2007).

In addition, the following factors are associated with HIV positive status disclosure: the type of partnership (for example: main or regular partnership), casual partnerships (Niccolai, Linda, King, Dentremont, Danielle, Pritchett & Ellen 2006).

The fact that single parenting is now a common phenomenon in Botswana society, (unlike the traditional cultural partnerships where a man and woman were married for a long time in the past), there is now freedom in the choices that individuals make. Such individuals also claim personal rights to privacy and non-interference in the running of their personal affairs. This phenomenon of single parenting apparently might have a tremendous impact on disclosure. Illness severity and the length of time since one's diagnosis have been positively correlated to disclosure (Deribe et al, 2007). Stigmatisation and prejudice against persons that are HIV positive might be responsible for their refusal to disclose in the early phases of the illness. On the other hand, it is common to disclose when the symptoms are obvious and the person is in a debilitating state.

Women with higher educational attainments are more likely to disclose their status to sexual partners than women who are illiterate (Issiaka et al, 2001). The level of education might not, in the above study, be the singular factor but the relative independence of the women and their non-reliance upon male partners for economic support could as well be seen critical attributes. It would be interesting to separate HIV education from qualifying how women actualise disclosure patterns and set trends in Gaborone. Illness severity and level of education appear to have a positive influence on HIV status disclosure.

HIV infected individuals are more likely to disclose to a partner whom they know is HIV positive than to an HIV negative or unknown sero status partner (Niccolai et al, 2006). This might emanate from the trust and common support structure of the individual and group. Many international organizations including UNAIDS, WHO and CDC emphasize the importance of HIV status disclosure (UNAIDS, 2013). However, despite the benefits cited above, the disclosure rate in Botswana and some developing countries remains very low.

2.3.1 AGE AND HIV STATUS DISCLOSURE

Factors influencing HIV status disclosure range from age, sex of individual, socio-cultural, socio-economic and religious factors. Studies have demonstrated a contradiction between any perceived connection of age and disclosure. According to Medley et al (2004), 65% of women disclosed their status to partners and those aged less than 24 years old were more likely to disclose their status to their sexual partners (Tshisuyi, 2014).

Younger PLWH tend to disclose their HIV status to either sexual partners or family members compared to older PLWH who only apparently disclose their status to friends (Gaillard, Melis, Mwanyumba, Claeys, Mungai & Mandaliya 2000). Women aged less than 22 years had higher disclosure rate compared to their older counterparts (Gaillard et al, 2000). PLWH aged less than 31 years never disclosed their HIV status and the mean age of disclosure was 38 years. PLWH aged 30-39 years disclosed more as compared to the elderly (Ogbozor, 2016). From these different studies, one gleans different findings but the common thread is identified by Tshisuyi (2014) who reported that age does not have an established significance on HIV status disclosure.

2.3.2 GENDER AND HIV STATUS DISCLOSURE

According to Mwanga (2012), 55% of married men disclose their HIV test results to their spouses while only 34% of married women disclose their HIV test results to their spouses. Women are much less likely to disclose their HIV positive status to their spouses or sexual partners as reported in Mwanga (2012). The reasons for this discrepancy are not known. It might be because of factors such as the general dependence of women on their male partners for security and social support which they are most likely to lose should they disclose their status.

Women with long-standing relations are more likely to disclose their status than those engaged in shorter term relations or who have had multiple sexual partners (Mwanga, 2012). Turan et al (2008) reported that women often get ill-treated if they disclose their HIV status to their male sexual partners due to physical attributes,

gender imbalances and pervasive discrimination, especially in the developing world. Studies from developing countries have reported that women do not share their HIV test results with anyone (10%-78%) as compared to studies on women in developed countries where figures between 3%-10% have been reported (WHO,2004).

The fear of violence directed at women often discourages them from seeking HIV testing services, negotiating safe sex practices or disclosing their HIV status to their sexual partners (Tshisuyi, 2014). Males were found to disclose their HIV status more as compared to females in South Africa (Strongman et al, 2006:1). Olley, Seedat & Stein (2004) also found out that males did not disclose their HIV status. Women are more likely than men to experience negative consequences such as violence directed at them when they disclose their HIV status, and this stands as a plausible reason for their non-disclosure (Tshisuyi, 2014). Unequal gender relations, as evident from the findings above, negatively influence HIV status disclosure in developing countries and this fact could shape the emerging results from this study in Gaborone.

Pranita, Dasgupta & Saha (2007) reports that in Kolkata, India 16,6% of women reported negative outcomes like rejection, abuse following disclosure of their HIV positive status as compared to 11.5% of men. The main reasons for non-disclosure in India were denial of diagnosis, fear of rejection, limited knowledge of and belief in alternative strategies of living positively with HIV, unacceptability of the use of protective condoms and safe sex, women's economic dependency on male partners and lack of decisive power in sexual situations. Medley et al (2004) indicates that women feared accusations of infidelity, abandonment, discrimination and violence then tend not to disclose their HIV status. Between 3.5% and 14.6% of women reported experiencing a violent reaction from a partner after disclosure. Low socio-economic status of women is also a contributing factor to non-disclosure (Akpa, Oulsegun & Aganaba 2011). Fear of negative outcomes cumulatively lead to non-disclosure of HIV status.

In some societies, males do not report sick in hospitals. When unwell, therefore men often report for treatment later than women. By that time, they are often at an

advanced stage of HIV and present with severe opportunistic infections. According to Akinyemi, (2013) disclosure was reported at 52.1% in men in the age group 30-50 years and at 80.5% among women of the same age group. Disclosure was lowest among men and women below 30 years. In contrast, disclosure is higher in women than among men aged 30-50 years.

The study revealed that women more than men seemed to disclose their status in order to relieve themselves of the psychological burden of being HIV positive and as such get quality care from health workers (Akinyemi, 2013). In some societies men sometimes disclosed more often than women because they could not hide their medication from partners/relatives. When they get critically ill they would not be able to keep their hospital visits secret and this fact compels them to disclose their status (Akinyemi, 2013). Disclosing for both men and women maybe too late to achieve its purpose because of unsafe sexual intercourse which makes women more vulnerable to HIV infection (Akinyemi, 2013). Gender therefore is non-significant attribute in HIV status disclosure.

2.3.4 MARITAL STATUS AND HIV STATUS DISCLOSURE

The marital state of an individual influences their willingness to disclose or not to disclose their HIV status. Married women are more likely to disclose to their sexual partners than women in cohabiting relationships (Klopper, 2011). Rates of disclosure are higher between steady partners as compared to those who have casual partners (Klopper, 2011). According to Ogbozor, (2016) spousal disclosure is higher among married than single respondents. The rate of disclosure also increases according to the stage of the disease. Individuals who are severely ill are more likely to disclose than those who are asymptomatic (Akinyemi, 2013).

According to Deribe et al (2007) and Tshisuyi (2014), it has been established that stable partnerships are more inclined towards disclosure than those in unstable partnerships or relationships. A short relationship, polygamous marriage, working out of home, not knowing someone with HIV and lower income were negatively associated with disclosure in an empirical investigation by Tshisuyi (2014).

Disclosure to sex partners is more likely in longer term, romantic relationships than in casual relationships such as one night stands or anonymous partners (Gari,Hubte & Markos,2010). Long term relationships positively influence HIV status disclosure.

2.3.5 EDUCATIONAL LEVEL AND HIV STATUS DISCLOSURE

Evidence reveals that the higher the level of education, the higher the possibility of disclosure for both men and women (Akinyemi, 2013). According to Akinyemi (2013) disclosure was 77% in men with secondary education and above than women (62.5%) with the same level of education. Tshisuyi (2014) also emphasizes that participants with a higher education level were more likely to disclose their HIV status than those with a lower education level. It therefore seems that level of education positively influences disclosure in both men and women.

Studies on HIV positive women in Ethiopia and Uganda have reported that there is no association between disclosure and level of education (Tshisuyi, 2014). Kadowa et al (2009) indicated that there is no significant difference between the cases and controls of HIV status disclosure in relation to education level.

2.4 REACTIONS TO DISCLOSURE

Reaction to disclosure could either be positive or negative.

2.4.1 POSITIVE OUTCOMES OF HIV STATUS DISCLOSURE

Disclosure of HIV positive status to sexual partners, friends or relatives is useful for the prevention and care of HIV and AIDS. It is an important strategy for HIV prevention as it enables HIV positive individuals to access HIV care and treatment programmes, thereby creating awareness in sexual partners on safer sex practices. It also helps couples to make informed reproductive health choices by reducing

unwanted pregnancies. Individuals receive care and socio-economic support from sexual partners, family, friends and community (Galletly, 2009). Positive outcomes act as determinants for disclosure.

Disclosure to sexual partners promotes safer sex practices by preventing new infections and re-infections to partner, reducing the risk of mother-to-child transmission, increasing social support which reduces depression. It also helps in adherence to treatment (Quinn, 2008). According to Mussie, Alemseged, Abrhet and Henock (2014) disclosure to sexual partners enables couples to make informed reproductive health choices resulting on reduction of unplanned pregnancies among HIV positive couples which reduces the risk of transmission from mother-to-child.

Studies indicate that individuals who disclose their status have better adherence to antiretroviral treatment (ART) treatment than those who do not (Deribe et al, 2007). Individuals with high social support also tend to disclose their status more often than those without the necessary social support (Sanders, Mekonnen, Messele, Wolday, Dongo-Zetswa, Degefa and Dukers, 2003).

2.4.2 NEGATIVE OUTCOMES OF HIV DISCLOSURE

Disclosing one's HIV status can lead to negative outcomes. Possible negative outcomes could be rejection, abandonment, stigma and discrimination. Negative outcomes act as barriers towards HIV status disclosure (Medley, 2004). Higher proportions of people living with HIV/AIDS never disclose and Mussie et al (2014) further indicates that non-disclosure of HIV positive status to sexual partners is due to lack of communication skills, fear of loss of confidentiality, fear of accusation for infidelity and fear of abandonment. These reasons are similar to those established in studies done in different developing countries like Uganda, South Africa, Tanzania and Kenya on people living with HIV/AIDS (Medley, 2004). Stigma and discrimination lead to a lower rate of disclosure (Medley, 2004).

Short duration of relationship, polygamous marriages, working out of home, not knowing someone with HIV and lower income negatively affect HIV status

disclosure, as PLWH with the above attributes can be rejected after disclosing their HIV status. (Antelman, 2001). Lower self-efficacy is associated with non-disclosure in women (Kalichman, 1999). Empirical evidence suggests that delayed disclosure or non-disclosure of individuals with HIV continue to practise unsafe sexual behaviour and high risk drug-sharing behaviour (Eustace, 2010). This behaviour is due to fear of rejection, abandonment, isolation, stigma and discrimination as well as lack of psychological and emotional support after disclosing one's HIV status. HIV/AIDS is considered to be a socially degrading illness which results in the stigmatisation of an individual who is HIV positive.

Despite the fact that disclosure is considered to be important as it increases emotional and social support, it may place an individual at an increased risk of abuse and discrimination when disclosing HIV status, more especially to partners and this is common when both individuals are unaware of each other's status (Chaudoir, 2011).

2.5 CULTURAL BELIEFS ON HIV STATUS DISCLOSURE

Some societies believe HIV/AIDS is caused by witchcraft, a tendency which affects disclosure (Mwanga, 2012). A study undertaken in Zimbabwe reveals that traditional healers told people that HIV was not a virus, but a misfortune caused by unhappy spirits. Therefore the diagnosis of unhappy ancestors or bewitching leads to non-disclosure of the true health status of a person, misleading the PLWH (Mwanga, 2012).

According to a study in Rwanda, the social structure shows that a man takes a primary responsibility and dominates in their households. This encourages multiple sexual partners for men who are even married, while women tend to be obedient and faithful (Dada-Adegbola, 2004). The man is more likely to refuse to use condoms and assault the woman when they refuse to have sex with them (Dada-Adegbola, 2004).

Many men think that it is a wife's duty to have sex with her husband, because these men perpetuate a patriarchal ideology that predisposes them towards seeing women as sex objects (Dada-Adegbola, 2004). This leads to violence when the wife refuses to abide by the husband's rules. Violence at home is also directly and indirectly associated with men's increased vulnerability to HIV (Dada-Adegbola, 2004). Violence or the fear of violence is also considered to be a barrier to women seeking HIV testing and for those who seek testing, it acts as a barrier to disclosure of their HIV status to their partners (Dada-Adegbola, 2004).

Cultural norms in many an African society consider that promiscuity is acceptable in men, combined with the encouragement to drink alcohol or abuse drugs which culminate in high risk sexual behaviour (Klopper, 2011). Derivative from this observation, individuals are less likely to disclose their HIV status if they have multiple sexual partners and are more likely to engage in unprotected sex (Klopper, 2011).

2.6 THE ASSOCIATION BETWEEN SOCIO-ECONOMIC STATUS AND HIV STATUS DISCLOSURE

Women with low socio-economic status tend not to disclose their HIV status to their spouses since they depend on their spouses for economic and social support (Kadowa, 2009). They fear rejection, loss of economic support, physical violence and social and economic pressure in raising children alone once they are abandoned by their male partners (Makin et al, 2008). According to Wong et al, (2009) a majority of men have more socio-economic power than women. Therefore men tend to disclose as they do not fear rejection or being discriminated by women. Therefore socio-economic status has a negative influence on HIV status disclosure.

2.7 CONCEPTUAL FRAMEWORK

HIV status disclosure to partners plays a very important role in either allowing or not allowing unsafe sexual or drug sharing behaviour to occur, thus helping in reducing the behaviours that spread HIV (Serovich, 2001). Disclosure of one's status helps PLWH to access social support from family and improved physical health (Derlega, Metts, Petronio, and Marulis, 1993 as reported by Serovich (2001). The current study adapts the consequence theory of HIV disclosure which suggests that disease progression influences disclosure through an individual's perception of the consequences anticipated as a result of disclosure (Serovich, 2001).

2.7.1 CONSEQUENCE THEORY

The consequence theory of HIV disclosure indicates that the relationship between disease progression and disclosure is moderated by the consequences one anticipates from the disclosure (Serovich, 2001). According to Serovich (2001), PLWH tend to disclose their HIV status once the rewards for disclosure outweigh the costs.

2.7.2 DISEASE PROGRESSION THEORY AND CONSEQUENCES MODEL OF HIV DISCLOSURE

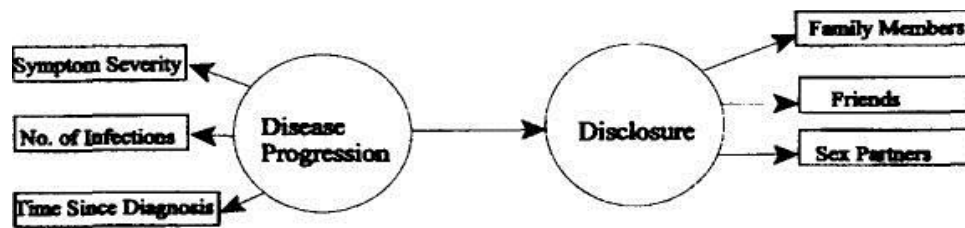
As the disease progresses it leads to consequences. Consequences consist of rewards and costs. As people living with HIV experience higher rewards they tend to disclose. When individuals disclose they experience either positive or negative reactions from the people they are disclosing to (Serovich, Mosack 2003).

Serovich et al (2003) reported that positive reactions lead to positive outcomes which are psychosocial and emotional support, including adherence to treatment that results ultimately in prevention of HIV transmission. Negative reactions lead to negative outcomes which are rejection, abandonment, isolation, stigma and discrimination, non-adherence to medication, lack of psychosocial support and

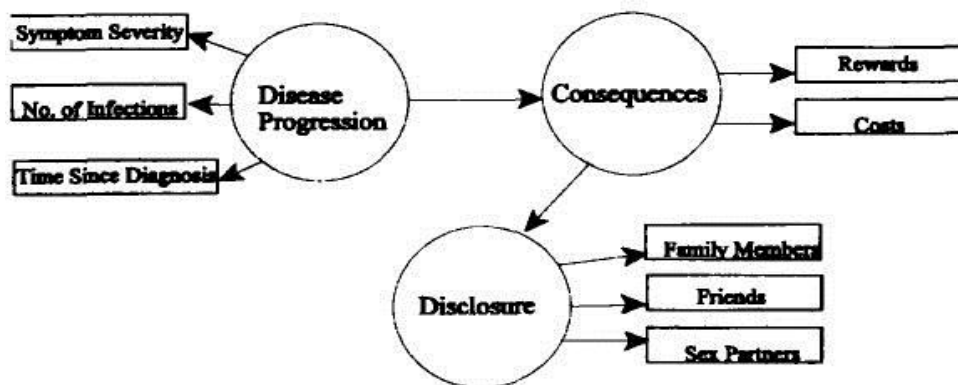
emotional support which leads to non-disclosure of one's HIV status to sexual partners and family members. These attributes lead to unending cycles in the transmission of HIV (Serovich et al, 2003).

Prevention of HIV/AIDS transmission in Botswana can be overcome by implementing HIV/AIDS status disclosure to sexual partners, family members and friends. This can lead to adherence to medication (Highly Active Antiretroviral Therapy), safe sexual behaviour, emotional and psycho-social support by partners and family members and reduction of stigma. This helps in the eradication of HIV/AIDS transmission which is the positive outcome as indicated by the conceptual framework below.

Figure 1: Disease Progression Theory



Consequences Model of HIV Disclosure



Serovich, J.M, Lim, J and Mason, T.L, 2008

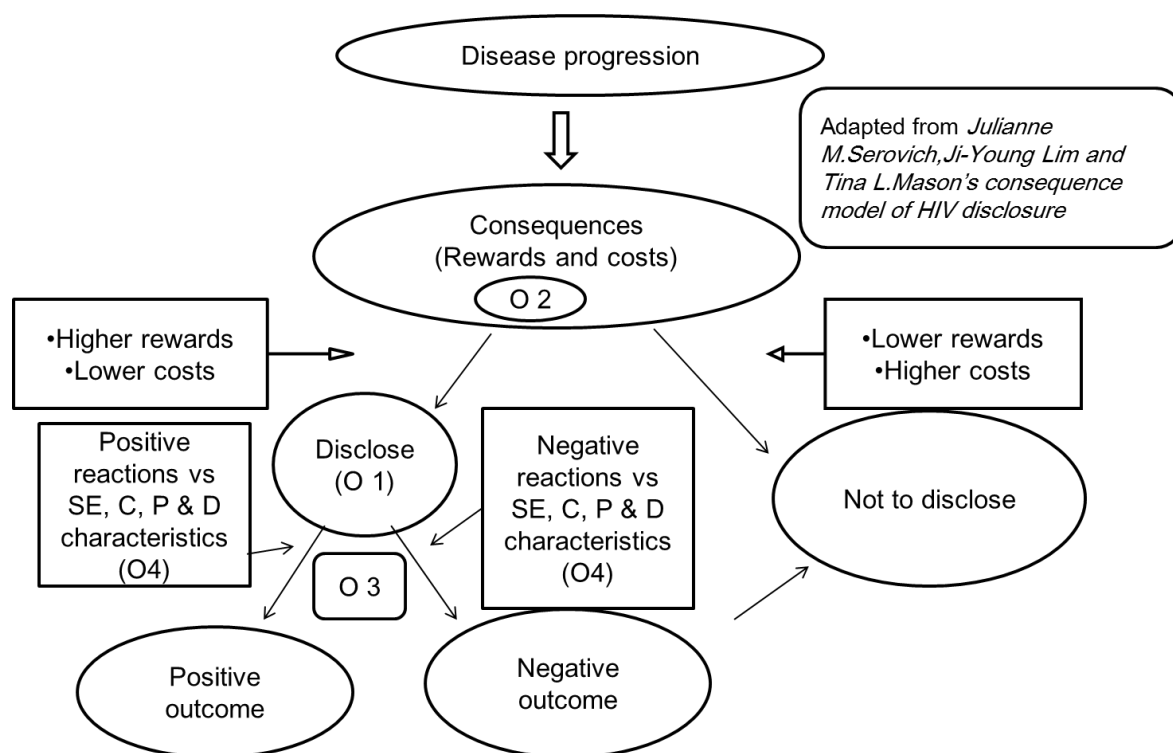
Positive outcomes lead to HIV disclosure. The person can be given medical attention and be provided with medical information. Emotional benefits include the acquisition of social support and acceptance, including prevention of transmission of the virus and adherence to medical treatment. Disclosure leads to either positive reactions or negative reactions from partners or family members. Negative reactions lead to costs associated with non-disclosure by PLWH while positive reactions lead to rewards linked also to disclosure by PLWH.

Prevention of HIV/AIDS transmission in Botswana can be overcome by implementing HIV/AIDS status disclosure to sexual partners, family members and friends. This can lead to adherence to medication (HAART), safe sexual behaviour, emotional and psycho-social support by partners and family members and reduction of stigma

therefore help in the eradication of HIV/AIDS transmission which is the positive outcome as demonstrated by the conceptual framework below.

Figure 2: Conceptual Framework

As the disease progresses or PLWH experience recurrent number of infections they experience consequences in the form of rewards and costs. Rewards are benefits like psychosocial support and emotional support while costs consist of risks like rejection and stigma. When benefits outweigh risks PLWH tend to disclose.



Key: **SE**-Socio-economic, **D**-Demographic characteristics; **C**-Cultural, **P**-Psychosocial

2.8 LEGISLATION ON HIV STATUS DISCLOSURE

In many countries, the intentional infection of a person with HIV is considered to be a crime (UNAIDS, 2012). Some countries or jurisdictions, including some areas of the U.S (Model Penal Code 211.2, 1985), have enacted laws expressly to criminalize HIV transmission or exposure, charging those accused with criminal transmission of HIV (UNAIDS, 2012). Other countries, including the United Kingdom, charge the accused under existing laws with such crimes as murder (UNAIDS, 2012).

There are two sections of the offences against the Person Act 1861 in England, Northern Ireland and Wales, Section 18 for allegations of intentional transmission and Section 20 for allegations of reckless transmission. Section 18 states:

“Whosoever shall unlawfully and maliciously by any means whatsoever wound or cause any grievous bodily harm to any person ...with intent, to do some ... grievous bodily harm to any person...shall be guilty of an offence, and being convicted thereof shall be liable ... to imprisonment for life.”

Section 20 states “Whosoever shall unlawfully and maliciously wound or inflict any grievous bodily harm upon any other person, either with or without any weapon or instrument, shall be guilty of a misdemeanor, and being convicted thereof shall be liable ... [and] shall be guilty of imprisonment for not more than five years” (UNAIDS, 2012).

The Supreme Court of Canada in a “case of Mabior versus D.C 2012” decided that people living with HIV had a legal duty under the criminal law, to disclose their HIV positive status to sexual partners before having sex that poses a realistic possibility of HIV transmission (UNAIDS, 2012). A person could be convicted of aggravated sexual assault if there is evidence of not disclosing their status in such circumstances (UNAIDS, 2012).

As recommended by the Global Commission on HIV and the law, several countries have begun reviewing HIV non-disclosure, exposure and transmission laws, restricted their application or dropped them altogether (UNAIDS, 2013). According to UNAIDS Report (2013) four African countries namely Congo, Guinea, Senegal and Togo have since 2010 restricted the use of criminal laws solely to cases of intentional transmission.

In order to provide support to countries in this area, UNAIDS has recently published a new guidance note on ending overly-broad criminalisation of HIV non-disclosure, exposure and transmission (UNAIDS, 2013). The gap is, there is a challenge to people not living with HIV as it focuses more on protecting rights and confidentiality of PLWH by health authorities.

Laws concerning HIV disclosure in some countries in Sub Saharan Africa are yet to be implemented due to human rights issues. Human rights issues act as a barrier to HIV prevention as disclosure laws work against the efforts of public health leaders to reduce HIV infections even though Sub Saharan is the most affected by the pandemic. Therefore more research is needed on HIV status disclosure to raise awareness.

“According to the Sexual Offences and Related Matters Amendment Act of South Africa, No. 32 of 2007, after the alleged commission of sexual offence the victim carries out compulsory HIV testing and is provided with Post Exposure prophylaxis. The victim is entitled to apply for compulsory HIV testing of alleged sex offender (Le Roux-Kemp, 2013). Any person who with malicious intent or negligently discloses the results of any HIV tests in contravention of section 37 of Sexual Offences and Related Matters Act, is guilty of an offence and is liable to a fine or imprisonment for a period not exceeding three years (Sect 38(1) (b) Sexual Offences and Related Matters Act (Le Roux-Kemp, 2013).”

According to Section 2.7.1 of the National Guidelines on HIV testing and counselling of the Ministry of Health of Botswana, stipulates that

“HIV test results should be disclosed only to the patient or client, unless the patient or client is a minor or is mentally challenged or consents to a third party being present at the time of disclosure. Disclosure of the results to anyone else should only be done with the patient’s or client’s consent which should be documented. Disclosure of HIV status to children should be informed by a thorough assessment of the child’s knowledge level of HIV and AIDS issues and level of maturity.”

Partner Disclosure 2.7.2.of the same document indicates:

“All patients or clients - regardless of their HIV status should be empowered and encouraged to inform their sexual partner/s about their HIV test results. For HIV positive clients who are reluctant or fearful to disclose their results, the service provider should offer additional, on-going counselling to help the client inform the partner. The service provider may inform the client’s sexual partner/s about the HIV test results in the presence of the client and only upon the client’s request. Sexual networks can be uncovered through contact tracing and partner notification, resulting in more people obtaining knowledge of their HIV status and accessing HIV prevention, treatment, care and support services.”

According to the government of Botswana Public Health Act .2013 sect 116(7)

“Health care workers may disclose a person’s HIV status without consent in three circumstances:

1. To sexual contact or caregiver if after a reasonable period they have not made such a disclosure themselves
2. After the death of the person (section 115)
3. Where there may be disclosure to other Health care workers directly involved in the care of the patient.”

Botswana Network on Ethics, Law and HIV /AIDS(BONELA) have been set to challenge the Public Health Act (No. 23 of 2013), which includes laws on HIV disclosure. BONELA regards disclosing HIV status to sexual partners as violation of rights of people living with HIV. There are issues of concerns, thus the rights of HIV negative people are not taken into consideration, and hence they are at risk of contracting HIV without being aware. Furthermore, it is through the disclosure of HIV status by PLWH that this preventive measure can be implemented with ease. Therefore there is a need for a study on HIV status disclosure to be conducted in Botswana.

2.9 GAPS IN LITERATURE REVIEW

Author(s)	Titles and objectives	Setting	Outcomes	Gaps in study in researchers opinion
Oladimeji Akeem Akinyemi March 2013	A comparative analysis of HIV serostatus disclosure patterns among men and women in Gaborone city council, Botswana. Objective: To compare the patterns of HIV serostatus disclosure among men and women.	Gaborone city council, Botswana	Disclosure more common in women than in men.	There is need for research on influence of disclosure on adherence to antiretroviral therapy. Men targeted awareness programmes, universal education, economic empowerment needed to reduce spread of HIV infection.
CeridwynElzarKlopper December 2011	Factors influencing HIV status disclosure. Objective: To investigate the factors which influence the disclosure of a person's HIV positive status.	Cape Metropolitan area.	Stigma was identified as a major factor which influences HIV disclosure to others as well as the fear of rejection and blame.	More research needed to determine effectiveness of couple counselling which may reduce blame and rejection, and determine whether multiple counselling sessions would improve disclosure rates and reduce the time from diagnosis to disclosure, especially to sexual partners.
Jamilla A. MwangaBaso	HIV serostatus disclosure and associated factors among people living with	Kisarawe District Hospital, Tanzania	PLWHA have difficulties in disclosing their HIV status to others for fear of negative	Women should be empowered psychologically to overcome

November 2012	HIV/AIDS attending care and treatment centre in Kisarawe District Hospital, Tanzania Objective: To assess the magnitude of HIV status disclosure and explore determinants of disclosure among people living with HIV/AIDS attending care and treatment centre at Kasarawe District Hospital.		consequences which affects the tempo of HIV prevention.	consequences of disclosure. Coverage of provision of education and counselling on disclosure after receiving HIV positive results should be increased. Community awareness about the importance of disclosure to reduce stigma and discrimination should be done.
Isaac Kadowa and Fred Nuwaha 2009	Factors influencing disclosure of PLWH in Mityana district of Uganda. Objective: To identify factors associated with disclosure among PHAs in Mityana district of Uganda.	Mityana district of Uganda	Reasons for non-disclosure are fear of divorce and violence, fear of discrimination and stigma, fear of accusation of promiscuity/infidelity.	HIV counselling and testing including disclosure of results should be promoted in community HIV programmes. Post care clients need to be trained to improve skills on interpersonal communication regarding disclosure. Need for on-going counselling for PLWH
Regina Mlobeli E Dlakshulu 2007	HIV/AIDS Stigma An investigation into the perspectives and experiences of PLWA.	Khayelitsha Cape Town South Africa	The experiences of discrimination and stigma often originate from the fear and perceptions of PLWHA as immoral or living dead. They suffer	Research needed on experiences of families having HIV positive members and the experiences of health care

	Objective: To identify the nature of HIV/ AIDS related stigma felt by PLWA in Khayelitsha.		rejection, felt shame, guilt, hopelessness and useless. The stigma leads to withdrawal, depression,HIV status nondisclosure	workers dealing with HIV positive people about the stigma related to HIV/AIIDS
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CHAPTER 3

RESEARCH METHODOLOGY

3.1 INTRODUCTION

This chapter outlines the research method that was used in this study. It consists of study design, study setting, target population and sampling plan, instrumentation, data collection, data analysis, and ethical considerations.

3.2 STUDY DESIGN

A descriptive cross sectional study design was used in this study to determine and describe the socio-economic implications of disclosing HIV status in Gaborone, Botswana.

3.3 STUDY SETTING

The study was conducted in Gaborone, in selected treatment centre. The centre was selected purposively because it is a referral centre. Gaborone is the capital and largest city of Botswana. It is located in the south eastern corner of Botswana, about 124km from the South African border. The total population is 231 626(based on 2011census).

FIGURE 3 MAP OF BOTSWANA



3.4 TARGETED POPULATION AND SAMPLING PLAN

3.4.1 PARTICIPANTS

The population for this study was PLWH aged eighteen years and above, attending care and receiving treatment at a selected health centre in Gaborone.

3.4.2 SAMPLING AND SAMPLE SIZE

Convenience sampling was used for the study as participants happened to be in the right place at the right time (Burns & Grove 2009). Research participants were those present at the treatment centre on the days that the research was conducted and they provided requisite information for this study. Sample size was calculated using Raosoft computer software. Population size of PLWH in selected treatment centres was 1600 at 95% confidence level, and desired sample was 310.

3.5 INSTRUMENTATION

A self-administered questionnaire was used in this study. The Derlega, Winsted, Greene, Serovich and Elwood (2002) questionnaire was adapted for data collection in this study. The instrument was adapted from a study that explored the decision making attributes of HIV positive women regarding disclosing their serostatus to their children and the child's perceived immediate and long term reactions towards disclosure. Changes made from the tool adapted are disclosure of PLWH to partners, family members and friends instead of HIV positive women disclosing their serostatus to their children. The adapted tool was in English and was translated into Setswana and back-translated to English for validation purposes. The tool is divided into 4 sections: Section 1 of the instrument measured Demographic characteristics of PLWH; Section 2: Reasons for disclosure; Section 3: Reasons for Non-disclosure; and Section 4: Reactions to disclosure (see Appendix 1 for the English and 2 for the Setswana versions of the questionnaire instrument respectively).

3.6 DATA COLLECTION

An information session was conducted by the researcher during which people living with HIV were recruited for the study before consent forms were provided to them (see Appendix 1) for statement of information for participants in the study). PLWH were then provided with a consent form that sought their permission to participate in the study. Only those who agreed to participate in the study were asked to sign the consent form, and questionnaires were administered to them by the researcher.

3.6.1 VALIDITY

The validity of an instrument determines the extent to which it actually reflects the abstract construct being examined (Burns & Grove 2009). The questionnaire that was administered was assessed for content coverage and relevance by three experts in research which are HIV experts, instrument developers and biostatistician.

3.6.2 RELIABILITY

The reliability of a measure denotes the consistency of measures obtained in the use of a particular instrument and indicates the extent of random error in the measurement method (Burns & Grove 2009). Cronbach's alpha was used for computing correlation values among the questions on the instrument. A computer programme was used whereby Cronbach's alpha splits all the questions on the instrument and computes correlation values for them all. The tool was found to be reliable for the study, especially the reasons for disclosure and non-disclosure (Cronbach $\alpha=0.88$) and the reliability of the reactions to disclosure was at Cronbach's alpha 0.84.

3.6.3 PILOT

A pilot study is conducted on a lesser version of the proposed larger study to refine the steps in the research process (Burns and Grove 2009). The researcher was able to determine the strengths and weaknesses of the measuring instrument. A pilot study was conducted before the main study with 5 participants at a different selected treatment centre to test the questionnaire for validity, reliability and feasibility of the methodology of the study. The results obtained from the pilot study proved the ability of sampled population to understand the questionnaire without further elucidation from the researcher. Eligibility criteria were applied as participants were not forced to participate. Participants from this pilot study were excluded from the main study and the data obtained from pilot study did not form part of the final analysis of the main study.

3.6.3 PROCEDURES FOR DATA COLLECTION

The data was collected by the researcher. Convenience sampling was used for the study whereby the questionnaires were administered to participants before their routine treatment. The study was explained to participants and they were assured that their participation was voluntary and that anonymity and confidentiality would be maintained. Approval from each treatment facility was sought from facility managers through the parent Botswana Ministry of Health. The researcher went to selected treatment centre for three weeks administering questionnaires and completed questionnaires were put in a sealed box and sent for analysis by a statistician.

3.7 DATA ANALYSIS

Statistical Package for the Social Sciences (SPSS) (IBM 21) was used for data analysis. Descriptive statistics, frequencies, percentages and (Means and Standard Deviations ($X \pm SD$)) was used to describe participants and socio-demographic information. The association between demographic data and disclosure of HIV status to anyone was determined through Chi square. Level of disclosure was determined by use of proportions or odds ratios. The level of significance was set at 0.05.

3.8 ETHICAL CONSIDERATIONS

Ethical approval to this study was sought from the North-West University ethics committee before the commencement of the study. This was granted on 18 May 2014. (Please refer to Appendix C). In Botswana permission was sought from Ministry of Health and from the management of the centres where research was conducted. The application was processed by ministry of health ethics committee. The rights and dignity of the participants was protected through their consent, together with the researcher's assurance of confidentiality and anonymity. A consent form was provided to ask permission from participants. Participant's identity remained anonymous in presentations, reports and publications of the study and anonymity which is the right to self-determination was maintained in the study (De Vos et al, 2005). Names of participants were not printed anywhere in the study, both in questionnaire and in results. They were given codes. The records were kept safe. Participants were provided with an information sheet containing purpose of study, procedures, risk involved, benefits of the study to the participants and their right to withdraw from the study.

3.9 SUMMARY

A descriptive cross sectional study design was used in this study. The targeted population was PLWH aged eighteen years and above, attending care and treatment in a treatment centre in Gaborone. Convenience sampling and a self-administered questionnaire was used in this study. Only those who agreed to participate in the study were asked to sign the consent form, and then given a questionnaire to complete and return. Statistical Package for the Social Sciences (SPSS) (IBM 21) was used for data analysis. This study protected the rights and dignity of the participants as consent was sought, confidentiality and anonymity was ensured.

CHAPTER 4

RESULTS

4.1 INTRODUCTION

The results of the study are presented according to the set objectives.

This study was guided by the following objectives:

- Determining the rate of disclosure among PLWH attending care, treatment and support in Gaborone, Botswana.
- Establishing the reasons for disclosure and non-disclosure of HIV among PLWH attending care and treatment in Gaborone, Botswana.
- Describing reactions to disclosure from partners/family members as perceived by PLWH who had disclosed.
- Determining the influence of socio-economic status on reactions to disclosure.

4.2 DEMOGRAPHIC CHARACTERISTICS OF PARTICIPANTS

Three hundred and ten participants completed the questionnaire. All questionnaires were returned in this study and ensured 100% participation. The demographic data is presented in Table 4.1

4.2.1 GENDER OF PARTICIPANTS

The majority of PLWH (68.1%; 67.3%) were females in the two groups of those who disclosed and those who did not disclose. There was no significant difference between the two groups in terms of gender ($p=0.896$).

4.2.2 LEVEL OF EDUCATION

About 53% of PLWH who disclosed did not have junior certificate while about 41% of PLWH who did not disclose their HIV status were without Junior certificate which was a significant difference ($p=0.048$).

4.2.3 MARITAL STATUS

Most PLWH who disclosed their HIV status were single (61.4%), followed by married PLWH (26.2%), while about 37% of PLWH who never disclosed were single with a significant difference between the two groups ($p>0.001$). The mean age for PLWH who disclosed was found to be 41.54 ($SD=1.609$) and for those who did not disclose was 34.82 ($SD=8.261$) with a statistical difference of $p>0.001$.

4.2.4 EMPLOYMENT STATUS

Most employed PLWH disclosed their HIV status (41.7%), while (36.4%) employed PLWH did not disclose, followed by unemployed PLWH (40.8%) disclosed and (41.4%) unemployed PLWH did not disclose, whereas (17.5%) self-employed PLWH disclosed and (22.2%) self-employed PLWH did not disclose their HIV status. There was no significant difference between employment status regarding disclosure.

4.2.5 NUMBER OF YEARS LIVING WITH HIV

Number of years living with HIV also significantly differed ($p=0.026$) within these two groups, thus 9.10 ($SD=4.826$) and 7.76 ($SD=5.147$) for PLWH who disclosed and those who did not disclose respectively.

Table 4.1: Demographic data of Participants

Variable		Did you disclose your HIV status to anyone?		X ² (p-value)
		Yes (n=210)	No (n=98)	
Gender	Male	67 (31.9%)	32 (32.7%)	.896
	Female	143 (68.1%)	66 (67.3%)	
Level of education	BJC	111 (52.9%)	40 (40.8%)	.048
	BGCSE	53 (25.2%)	40 (40.8%)	
	Graduate	39 (18.6%)	16 (16.3%)	
	Postgraduate	7 (3.3%)	2 (2.0%)	
Marital Status	Single	129 (61.4%)	36 (36.7%)	.000
	Married	55 (26.2%)	24 (24.5%)	
	Cohabited	20 (9.5%)	32 (32.7%)	
	Separated	1 (0.5%)	3 (3.1%)	
	Divorced	5 (2.4%)	3 (3.1%)	
		Mean (%)	t (p-value)	
		Disclosure		
Employment Status	Employed	88(41.7)	36(36.4)	0.531
	Self-employed	37(17.5)	22(22.2)	
	Unemployed	86(40.8)	41(41.4)	
Age		41.54 (9.609)	34.82 (8.261)	0.000
Number of years living with HIV		9.10 (4.826)	7.76 (5.147)	0.026

4.2.4 RATE OF DISCLOSURE

About 68% (n=211) of participants had disclosed their HIV status while about 32% (n=99) never disclosed their status (Table 4.2).

Table 4.2 level of disclosure			
		Frequency	Percent
Have you disclosed your HIV status to anyone?	Yes	211	68.1
	No	99	31.9
	Total	310	100.0

4.2.5 TO WHOM DISCLOSURE WAS MADE

Most of the PLWH had disclosed to a family member (66.4%; n=140), followed by partner (28.4%; n=60), relative (3.3%; n=7) and friend (1.9%; n=4) respectively as shown in Table 4.3.

Table 4.3 If yes(Who did you disclose to?)				
Have you disclosed your HIV status to anyone			Frequency	Per cent
Yes	Valid	Partner	60	28.4
		Family member	140	66.4
		Relative	7	3.3
		Friend	4	1.9
		Total	211	100.0

4.3 REASONS FOR DISCLOSURE

Table 4.4 shows the most cited reasons for disclosure of HIV among participants are wanting the sexual partner, family, friend to hear the information from them: *I did not want to keep secrets from this sexual partner/family/friend* (95.3%), *I wanted the sexual partner/family/friend to know what was wrong with me* (91.5%), *I wanted to prepare the sexual partner/family/friend for what might happen* (91%), *I think the sexual partner/family/friend was mature enough to know* (91%) and *I rely on this sexual partner/family/friend for emotional support* (89.1%).

Table 4.4

Items	1 n (%)	2 n (%)	3 n (%)	4 n (%)	5 n (%)
1. I wanted my sexual partner/family/friend to hear the information from me.	7(3.3)	0.0	1(0.5)	2(0.9)	201(95.3)
2. This partner/family/friend had a right to know.	10(4.7)	0.0	2(0.9)	10(4.7)	189(89.6)
3. I wanted to reassure this sexual partner/family/friend.	8(3.8)	2(0.9)	5(2.4)	13(6.2)	183(86.7)
4. I wanted to prepare this sexual partner/family/friend for what might happen.	6(2.8)	0.0	2(0.9)	11(5.2)	192(91)
5. I wanted this sexual partner/family/friend to know what was wrong with me.	8(3.8)	0.0	3(1.4)	7(3.3)	193(91.5)
6. This sexual partner/family/friend needed to know how sick I was or could become.	5(2.4)	0.0	5(2.4)	13(6.2)	188(89.1)
7. I wanted to get this sexual partner/family/friend to get the support he/she needed.	4(1.9)	2(0.9)	6(2.8)	14(6.6)	185(87.7)
8. I did not want to keep secrets from this sexual partner/family/friend.	4(1.9)	0.0	2(0.9)	4(1.9)	201(95.3)
9. This sexual partner/family/friend could handle the truth.	7(3.3)	1(0.5)	9(4.3)	8(3.8)	186(88.2)
10. I thought this sexual partner/family/friend was mature enough to know.	10(4.7)	0 0	2(0.9)	7(3.3)	192(91)
11. I felt like I could not hide it anymore.	11(5.2)	0 0	1(0.5)	14(6.6)	185(87.7)
12. I rely on this sexual partner/family/friend for practical support. (E.g. help around the house).	19(9.0)	6(2.8)	14(6.6)	11(5.2)	161(76.3)
13. I rely on this sexual partner/family/friend for emotional support.	8(3.8)	3(1.4)	9(4.3)	3(1.4)	188(89.1)
14. I was worried that this sexual partner/family/friend might overhear information about my diagnosis.	39(18.5)	3(1.4)	3(1.4)	8(3.8)	158(74.9)
15. This partner/family/friend kept asking me questions about my being sick.	83(39.3)	5(2.4)	11(5.2)	17(8.1)	95(45)
16. I did not think about telling this partner/family/friend: I just blurted it out.	98(46.4)	2(0.9)	11(5.2)	5(2.4)	95(45.0)

Key: 1-Not at all a factor; 2-somewhat a factor; 3-Moderately a factor; 4-A factor; 5-Very Much A Factor

4.4 REASONS FOR NON DISCLOSURE

The reasons for non-disclosure of HIV among participants are presented in Table 4.4

Table 4.5 Reasons for non-disclosure of HIV status among PLWH

Items	1 n (%)	2 n (%)	3 n (%)	4 n (%)	5 n (%)
1. This sexual partner/family/friend deserves to have a carefree lifestyle as possible.	2(2.0)			3(3.0)	94(94.9)
2. I do not want this sexual partner/ family/ friend to worry about me.	2(2.0)	1(1.0)	1(1.0)	3(3.0)	92(92.9)
3. I do not want to scare this sexual partner/family/friend.	1(1.0)	1(1.0)	6(6.1)	11(11.1)	80(80.8)
4. I do not want this sexual partner/ family/ friend to be hurt by the reactions of others.	7(7.1)	3(3.0)	11(11.1)	16(16.2)	62(62.6)
5. I want to protect sexual partner/ family/ friend so others will not hurt him/her because of my status.	13(13.1)	5(5.1)	9(9.1)	11(11.1)	61(61.6)
6. This sexual partner/family/friend does not need to be burdened.	2(2.0)	-	1(1.0)	2(2.0)	93(94.9)
7. I want to keep this information from the sexual partner/family/friend as long as possible.	2(2.0)	-	-	1(1.0)	96(97)
8. This sexual partner/family/friend is not ready to know.	2(2.0)		1(1.0)	3(3.0)	93(93.9)
9. It would be too stressful for me to tell this sexual partner/family/friend.	3(3.0)		-	3(3.0)	93(93.9)
10. This sexual partner/family/friend cannot handle the truth right now.	3(3.0)		-	4(4.0)	92(92.9)
11. This sexual partner/family/friend is not mature enough to know.	2(2.0)		1(1.0)	4(4.0)	92(92.9)
12. I fear this sexual partner/family/friend might tell others of my HIV status.	5(5.1)		-	2(2.0)	92(92.9)
13. My diagnosis is personal.	2(2.0)		-	1(1.0)	96(97)
14. This sexual partner/family/friend does not need to know how sick I am or could become.	2(2.0)		1(1.0)	7(7.1)	89(89.9)
15. This sexual partner/family/friend does not have any reason to know.	2(2.0)		-	3(3.0)	94(94.9)
16. I am afraid this sexual partner/ family/ friend will ask too many questions.	1(1.0)		-	2(2.0)	96(97)
17. I am afraid this sexual partner/ family/ friend will ask questions that I am not prepared to answer.	-		2(2.0)	-	97(98)
18. I am afraid this sexual partner /family/ friend will be angry with me.	5(5.1)		8(8.1)	12(12.1)	73(73.7)
19. I am afraid I will have to tell this sexual partner/family/friend how I contracted HIV.	5(5.1)	1(1.0)	-	-	93(93.9)
20. I am afraid this sexual partner/family/friend will lose respect for me.	17(17.2)	6(6.1)	12(12.1)	15(15.2)	49(49.5)

Key: 1-Not at all a factor; 2-somewhat a factor; 3-Moderately a factor; 4-A factor; 5-Very Much A Factor.

4.5 REACTIONS TO DISCLOSURE

Reaction of participant to disclosure is presented in Table 4.6. It was evident that the most strongly endorsed reactions to disclosure from partners/family/friend are the sexual partner/family/friend comforts me(90%), while the least was the sexual partner/family/friend asks questions about how the diagnosis will affect his/her life(48.1%) and the sexual partner/family/friend is shocked or stunned(46.4%). See Table 4.6 for details.

Table 4.6 Reactions to disclosure

Items	1 n (%)	2 n (%)	3 n (%)	4 n (%)	5 n (%)
1. Hugs me.	50(23.7)	-	12(5.7)	8(3.8)	141(66.8)
2. Is worried about me or the family.	61(28.9)	2(9)	7(3.3)	10(4.7)	131(62.1)
3. Comforts me.	7(3.3)	2(0.9)	4(1.9)	8(3.8)	190(90)
4. Asks questions regarding the meaning of HIV/AIDS or the meaning of my being sick.	68(32.2)	5(2.4)	6(2.8)	10(4.7)	122(57.8)
5. Starts to cry to show emotional distress.	114(54)	49(1.9)	13(6.2)	18(8.5)	62(29.4)
6. Tells me it is going to be okay.	12(5.7)	3(1.4)	6(2.8)	8(3.8)	182(86.3)
7. Is shocked or stunned.	95(45)	-	10(4.7)	8(3.8)	98(46.4)
8. Asks whether other people were or are HIV-positive (e.g. child, father, sibling).	110(52.4)	2(1.0)	7(3.3)	6(2.9)	85(40.5)
9. Is fearful about the future.	99(46.9)	2(9)	11(5.2)	8(3.8)	92(43.1)
10. Asks questions about how the diagnosis will affect his/her life.	94(44.8)	2(1.0)	6(2.9)	7(3.3)	101(48.1)
11. Feels sorry for me.	38(18.0)	-	7(3.3)	1(0.5)	165(78.2)
12. Asks whether she/he is HIV positive.	74(35.1)	-	10(4.7)	5(2.4)	121(57.3)
13. Does not seem to understand what this means.	80(37.9)	2(9)	6(2.8)	9(4.3)	114(54.0)
14. Tells me that she/he is scared.	110(52.1)	3(1.4)	6(2.8)	5(2.4)	87(41.2)
15. Responds with anger. Anger at the infecting person: "God; you."	151(71.6)	5(2.4)	3(1.4)	3(1.4)	49(23.2)
16. Is physically upset(e. g shaking, complained of stomach ache)	137(64.9)	2(0.9)	6(2.8)	6(2.8)	60(28.4)
17. Is in denial or disbelief.	109(51.9)	6(2.9)	8(3.8)	5(2.4)	82(39.0)
18. Told someone else about my HIV status.	118(55.9)	20(9.5)	10(4.7)	5(2.4)	58(27.5)
19. Appears disinterested or bored.	142(67.3)	6(2.8)	8(3.8)	10(4.7)	45(21.3)
20. Tries to change the subject.	142(67.3)	3(1.4)	4(1.9)	5(2.4)	57(27.0)
21. Becomes violent.	169(80.1)	2(0.9)	3(1.4)	7(3.3)	30(14.2)
22. Does not want to touch me because she/he was scared she/he might get it.	159(75.4)	2(0.9)	8(3.8)	2(0.9)	40(19.0)
23. Rejects me or tells me to leave.	170(80.6)	-	3(1.4)	1(0.5)	37(17.5)

Key: 1-Not at all a factor; 2-somewhat a factor; 3-Moderately a factor; 4-A factor; 5-Very Much A Factor

4.7SOCIO-ECONOMIC STATUS TO DISCLOSURE

There was no significant difference between employment status regarding disclosure see Table 4.7.

		Mean (%)		t (p-value)
		Disclosure		
Employment Status	Employed	88(41.7)	36(36.4)	0.531
	Self employed	37(17.5)	22(22.2)	
	Unemployed	86(40.8)	41(41.4)	

4.7 SUMMARY

Three hundred and ten PLWH participated, 99 were males and 211 were females. The majority had attained educational qualifications below junior certificate and were single. A majority of PLWH disclosed to family member (45.2%). PLWH aged between 25 and 68 disclosed the most frequently. The most cited reason for disclosure of HIV among PLWH attending care and treatment include wanting to retain the sexual partner, seeking solace from the family, and for the friend to hear the information from the infected member (95.3%). The most cited reason for non-disclosure of HIV among PLWH attending care and treatment is the fear that the partner/family/friend would ask questions that the respondent was not prepared to answer (98%). The most significant reactions to disclosure from partners/family/friend are the sexual partner/family/friend comforts the affected respondent (90%).

CHAPTER 5

DISCUSSION, CONCLUSION, RECOMMENDATIONS AND LIMITATION OF STUDY

5.1 INTRODUCTION

This chapter discusses the socio-economic implications of disclosing HIV status in Gaborone, Botswana, presents the conclusion and suggests recommendations based on the findings of the study. The purpose of this study was to determine and describe the socio-economic implications of disclosing HIV status at a selected treatment centre in Gaborone, Botswana.

5.2 RATE OF DISCLOSURE

The results of this study found that 68% have disclosed their HIV status mostly to family members. These findings in the study concur with those of Makin et al (2008) which indicate that in a review of 17 studies from developed countries, 15 from Africa, the rate of disclosure to sexual partners ranged between 16.7% and 86%. However, differences in disclosure are determined by different demographics such as age, gender, employment status, relationship status, educational level and the number of years one has been living with HIV.

5.2.1 GENDER

The current study revealed that more females disclosed than males. The outcome in this study might have been skewed by the fact that in the sample, more females took part in this study than males. The other study indicates that the gender of participants has no significance towards disclosure as indicated by Akinyemi (2013), revealing that more women than men disclosed their status in order to relieve themselves of the burden of being HIV positive and as such get quality care from health workers and men disclosed more often than women because they could not hide their medication from partners/relatives. Men were also compelled to disclose because they were critically ill or they would not be able to keep their hospital visits a secret from their partners.

5.2.2 AGE

The study also revealed that age has no influence on disclosure. This finding is in contrast with those of Kadowa et al (2009) who found that respondents who were more than 25 years of age were more likely to disclose to sexual partners than respondents younger than 25 years. The difference might be that the sample size differed, 278 research participants were interrogated in Kadowa (2008) and place of the study was in Uganda while this study was in Gaborone. Selection of study participants differed because for Kadowa only clients who had known their HIV status for at least 12 months were invited to participate whereas for this study participants who were available on the occasions that the researcher visited clinic sites took part in the study.

The difference in the findings might also be due to the fact that in Kadowa's study, a case control design was used to compare 139 PLWH who had disclosed to 139 PWH who had not disclosed regarding socio-demographic characteristics, sexual behaviour, individual experiences and perceptions about disclosure whereas in this study cross sectional study design was used to determine and describe the socio-economic implications of disclosing HIV status.

5.2.3 LEVEL OF EDUCATION

The study revealed that there was a significant association between level of education and disclosure of HIV status ($P=0.048$). This finding is in contrast with those of Kadowa (2009) who found that there was no significant difference between level of education and disclosure. The findings of Ogbozor (2016) also indicate that education level has no impact on HIV status disclosure. The difference might be due to the different study settings and sample size. Recommendation is that level of education should have been measured on knowledge of HIV status disclosure rather than as an academic construct. An individual can be educated academically but not on HIV status disclosure.

5.2.4 EMPLOYMENT STATUS

The findings of the study revealed that there is no significant implication of socio economic status regarding HIV status disclosure. This is in contrast to the study findings of Akinyemi (2013) who concludes that women of lower socio-economic status disclose more often while men of high socio-economic status disclose less. This also contradicts with Ogbozor (2016) who indicates that self-employed participants had highest disclosure rate and unemployed had least disclosure rate.

5.2.5 MARITAL STATUS

Table 1 revealed that single individuals disclosed more as compared to married people, cohabiting people, separated people and divorced people. This concurs with Akinyemi (2013) who indicates that disclosure is high in single men and women as compared to married people because a majority of adults in Botswana are not married. These findings are in contrast to those of Kadowa et al (2009) which indicate that respondents who were married disclosed their HIV status to their sexual partners more than single and partners who never married. The reason might be due to the strength of their relationship, feelings of responsibility and the confidence they have in each other, including their communication skills. The difference in findings might be due to the study setting, the different lifestyles in Uganda which are not the same as in Botswana, as most people in Uganda are married (Kadowa et al 2009).

5.2.6 NUMBER OF YEARS LIVING WITH HIV

Table 1 showed that the number of years one has been living with HIV positively influence disclosure. An individual who is newly diagnosed is less likely to disclose because she/he is going through denial and anxiety compared to someone who has been living with HIV for a long time and reached the stage of acceptance and awareness about HIV. The findings were consistent with Mwanga (2012) who indicates that the longer the period one has been living with HIV, the higher the chance of disclosure.

5.3 REASONS FOR DISCLOSURE

It was evident in this study that multiple factors exist that influence PLWH to disclose their HIV positive status. Most participants felt that it is important to be transparent to their partners or family members by being open and avoid keeping secrets hence they disclosed their HIV positive status. Openness, accountability and good communication skills amongst participants acted as paramount factors positively influencing HIV-positive status disclosure. PLWH needed inner peace and stress free life as keeping secrets steals an individual's inner peace, as they have to hide treatment and medical records all the time and cover up their tracks. The findings were in contrast to those reported by Serovich (2008) indicating that PLWH tend not to disclose because their secret provides them with rewards like pleasures, satisfaction and gratification that they ultimately enjoy.

Honesty in terms of being trustworthy, loyal, fair and sincere were indicated by participants as factors of great importance as they trusted and relied on their sexual partners/family member/friend for emotional and psychosocial support. This concurs with Galletly (2009) who indicates that PLWH disclose for emotional and psychosocial support from the people that they are disclosing to PLWH disclosed to their sexual partners/family member/friend as they have faith, hope and believe that their sexual partners/family member/friend have the right to know their status. This corresponds with Niccolai et al (2006) who indicate that HIV infected individuals are more likely to disclose to a partner whom they trust.

As knowledge is power, PLWH disclosed to their sexual partner, family member and friend in order for them to be informed and be prepared for what might happen in the future. This could assist them not to panic but to accept and give emotional and psychological support when the need arises (Galletly, 2009).

As the disease progresses, PLWH tend to disclose in order to get the emotional and psychosocial support from their sexual partner, family member and friend. This is in line with findings of Serovich et al (2008) who indicate that as the disease progresses it leads to consequences consisting of rewards and costs. As PLWH aim for higher rewards like psychosocial and emotional support they tend to disclose.

5.4 REASONS FOR NON-DISCLOSURE

Participants did not disclose for fear of negative outcomes which relates to possible rejection, abandonment, isolation, stigma and discrimination and potential loss of psychosocial and emotional support. Respondents did not want to be bothered and were secretive about their status hence they never disclosed.

There was lack of communication skills, lack of trust and dishonesty towards their sexual partner, family member and friend. This corresponds with Mussie (2014) who identified that non-disclosure of HIV positive status to sexual partners is due to lack of communication skills, fear of loss of confidentiality, fear of accusation of infidelity and fear of abandonment. Thus the combination of these factors demoralises PLWH to disclose, and thus makes them more secretive which also places barriers with regard to HIV prevention.

Participants feared stigma and discrimination they did not want to suffer blame and rejection as they feared for their marriage and relationship breakdown which potentially can lead to isolation (divorce or separation). However, fear for stigma and discrimination were highlighted in this study as some of the factors inhibiting disclosure. This was also emphasized by Medley (2004), that stigma and discrimination lead to a lower rate of disclosure.

Participants feared violence from their sexual partners, family member and friends; therefore they never disclosed. This also corresponds with Chaudoir et al (2011), who reveal that disclosure may place an individual at an increased risk of abuse, violence and discrimination as this is common when both individuals are unaware of each other's status.

5.5 REACTIONS TO DISCLOSURE

This study identified that the most common reactions to disclosure from partners, family member and friends are they hugged and comforted participants when they were informed about their HIV status. They were rather welcoming and supportive. The reason might also be that most participants in this study disclosed to family members thus the comforting and welcoming as there is an African saying that blood

is thicker than water. Therefore these results contradict with Medley 2004) who states that disclosure places an individual at an increased risk of rejection and blame.

It is evident from the study that the majority of participants lack knowledge on HIV/AIDS. Participants were not aware of the meaning of HIV/AIDS and how the diagnosis could affect their life. The findings contradict with Akinyemi (2013) who suggests that there is a higher level of awareness of HIV in the present. The findings of the study also contradict those of Klopper (2011) which state that majority of participants had some level of understanding on HIV/AIDS.

The study revealed that 46.4% of partners, family members and friends were shocked or stunned and asked whether other people were HIV positive. This indicates that there is stigma and discrimination concerning HIV as people still did not accept HIV as any other illness. The stigma leads to lower rate of disclosure. This corresponds with Klopper (2011) who underscores that the fear of stigmatisation leads to non-disclosure of HIV status.

5.6 CONCLUSION

The study revealed that less than 1/5 of respondents disclosed their status to their partners, which deductively suggests that there is a problem with disclosure. This leads to high chances of transmission of HIV as PLWH would rather disclose to family members than divulge their status to current sexual partners. Family support system makes individuals to disclose to family members as they experience positive reactions which lead to psychosocial support and emotional support resulting in adherence to treatment.

Findings indicate that PLWH for a period ranging between 21 and 30 years have disclosed. The longer the individual lives with HIV, the higher the acceptance and awareness of HIV which leads to disclosure.

Non-disclosure to sexual partners is due to fear of being rejected, lack of psychosocial support and emotional support together with stigma and discrimination. This is clearly indicated in the study as sexual partners tend to reject, abandon or put the blame on the individual disclosing. Friends tend to gossip, misjudge and lose respect for their friends disclosing to them, leading to non-disclosure, as PLWH fear negative outcomes.

5.7 RECOMMENDATIONS

A qualitative study that is exploratory will benefit HIV status disclosure as respondents will be able to share their opinions concerning disclosure issues.

I recommend future researchers to include the private sector when collecting data as high socio economic respondents prefer private sector for routine treatment rather than public sector.

5.8 LIMITATION OF THE STUDY

The study targeted specific population in a referral centre. Findings may not be generalised to other populations and settings.

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APPENDIX A

HIV STATUS DISCLOSURE QUESTIONNAIRE

SOCIO-ECONOMIC IMPLICATIONS OF DISCLOSING HIV STATUS

IN GABORONE, BOTSWANA

Onalenna Thebeyadira

**DEPARTMENT OF NURSING SCIENCE: FACULTY OF AGRICULTURE,
SCIENCE AND TECHNOLOGY**

NORTH-WEST UNIVERSITY, MAFIKENG CAMPUS

Information for participants in the study

Purpose of the study

The purpose of this study is to determine and describe the level of HIV status disclosure and to investigate determinants of disclosure among PLWH receiving care treatment and support in order to make recommendations towards promoting disclosure at a treatment centre, Gaborone, Botswana.

Procedures

You are requested to respond to this questionnaire that will take you 15-20 minutes. The purpose of this consent form is to ask for your permission to participate. If you agree to participate, the researcher will ask you to sign a consent form. Your answers will not be viewed by anyone except the researcher and will be stored in a locked place under control. Your name will not appear on the questionnaire.

The risks to you as a participant in this study are minimal. You will be asked to fill a questionnaire with sections 1 to 4. Section 1 of the instrument shall measure demographic information, section 2, reasons for disclosure, section 3 reasons for non-disclosure and section 4 reactions to disclosure.

Although you will not receive any immediate benefit from this research, the benefit will be in the future as potential findings of this study will inform policy, human rights and guidelines developers on the level and factors influencing disclosure among PLWH. Recommendations to promote disclosure will help in the prevention of HIV transmission, adherence to treatment, informed reproductive health choices and care and socio-economic support from sexual partners, family, friends and the community. Prevention of HIV transmission will result in reaching the target of zero HIV infections by 2016 which will lead to a free HIV generation in Gaborone, Botswana.

I hope you will feel comfortable to open up about your ideas on HIV status disclosure as the information is important to the future generations of Botswana.

Right to refuse or withdraw

Your participation in this research is voluntary. You do not have to participate if you choose not to. If you choose to participate, but prefer not to answer certain questions, you are free to do so. You are also free to terminate and withdraw from the study at any time. You are free to ask questions before signing the consent form. If you have any questions, please contact me: **Onalenna Thebeyadira**

Cell 72132632

thebeyadirao@gmail.com

Informed Consent Form

(North-West University, Mafikeng Campus)

**Title of Project: SOCIO-ECONOMIC IMPLICATIONS OF DISCLOSING HIV
STATUSIN GABORONE, BOTSWANA**

Principal Investigator: Onalenna Thebeyadira

Participant's name: -----

I would like to invite you to take part in this study which aims to determine and describe the level of HIV status disclosure and to investigate determinants of disclosure among PLWH receiving care treatment and support in order to make recommendations that seek to promote disclosure at a treatment centre, Gaborone, Botswana. Taking part in this study is entirely voluntary. If you decide to participate you must sign this form to show that you want to take part.

I understand that:

1. I am free to end my involvement or to recall my consent to participate in this research at any time.
2. Information given up to the point of my termination of participation could however still be used by the researcher.
3. The researcher grants anonymity and that data will under no circumstances be reported in such a way as to reveal identity.
4. The researcher will make no reimbursement for information given on my participation in this study

Signature of participant -----

Signature of researcher -----

SECTION 1:Demographic information

Age	
Gender	1.Male 2.Female
Level of education	1.Below Junior Certificate 2.BGCSE 3.Graduate 4.Postgraduate
Employment status	1.Employed 2.Self-employed 3.Unemployed
Relationship Status(married, cohabitation,single)	1.Single 2.Married 3.Cohabiting 4.Separated 5.Divorced 6.Widow
Physical Address	

Number of years living with HIV	
Have you disclosed your HIV status to anyone	1.Yes 2.No
If yes (who did you disclose to?)	1. Partner 2. Family member 3. Relative 4. Friend

Please turn over to the next page

SECTION 2

Please answer each of the following by circling the appropriate response. Go to section 3 if have not disclosed.

Note: Reasons for disclosure assessed on a 5-point scale(1=not at all a factor; 5=very much a factor)

ITEMS

	1	2	3	4	5
1. I wanted my sexual partner/family/friend to hear the information from me.					
2. This partner/family/friend had a right to know.					
3. I wanted to reassure this sexual partner/family/friend.					
4. I wanted to prepare this sexual partner/family/friend for what might happen.					
5. I wanted this sexual partner/family/friend to know what was wrong with me.					
6. This sexual partner/family/friend needed to know how sick I was or could become.					
7. I wanted to get this sexual partner/family/friend to get the support he/she needed.					
8. I did not want to keep secrets from this sexual partner/family/friend.					
9. This sexual partner/family/friend could handle the truth.					
10. I thought this sexual partner/family/friend was mature enough to know.					
11. I felt I could not hide it anymore.					

12. I rely on this sexual partner/family/friend for practical support (e.g. help around the house).					
13. I rely on this sexual partner/family/friend for emotional support.					
14. I was worried that this sexual partner/family/friend might overhear information about my diagnosis.					
15. This partner/family/friend kept asking me questions about my being sick.					
16. I did not think about telling this partner/family/friend: I just blurted it out.					

Key: 1-Not at all a factor; 2-somewhat a factor; 3-Moderately a factor; 4-A factor; 5-Very Much A Factor

SECTION 3

If you have not disclosed. Please go to Section 4; if you have disclosed, please respond to this segment. (1=not at all a factor; 5=very much a factor).

ITEMS

	1	2	3	4	5
1. This sexual partner/family/friend deserves to have a carefree lifestyle as possible.					
2. I do not want this sexual partner/family/friend to worry about me.					
3. I do not want to scare this sexual partner/family/friend.					

4. I do not want this sexual partner/family/friend to be hurt by the reactions of others.					
5. I want to protect this sexual partner/family/friend so that no one hurts him/her because of my status.					
6. This sexual partner/family/friend does not need to be burdened by my status.					
7. I want to keep this information from the sexual partner/family/friend as long as possible.					
8. This sexual partner/family/friend is not ready to know.					
9. It would be too stressful for me to tell this sexual partner/family/friend.					
10. This sexual partner/family/friend cannot handle the truth right now.					
11. This sexual partner/family/friend is not mature enough to know about my status					
12. I fear this sexual partner/family/friend might tell others of my HIV status.					
13. My diagnosis is personal.					

14. This sexual partner/family/friend does not need to know how sick I could become.					
15. This sexual partner/family/friend does not have any reason to know.					
16. I am afraid this sexual partner/family/friend will ask too many questions					
17. I am afraid this sexual partner/family/friend will ask questions that I am not prepared to answer					
18. I am afraid this sexual partner/family/friend will be annoyed with me.					
19. I am afraid I will have to tell this sexual partner/family/friend how I contracted HIV.					
20. I am afraid this sexual partner/family/friend will lose respect for me.					

Key: 1-Not at all a factor; 2-somewhat a factor; 3-Moderately a factor; 4-A factor; 5-Very much a factor

SECTION 4

Answer the following only if you have disclosed.

ITEMS

After disclosing my status, my sexual partner

	1	2	3	4	5
1. Hugs me.					
2. Is worried about me and the family.					
3. Comforts me.					
4. Asks questions regarding the meaning of HIV/AIDS and the meaning of my being sick.					
5. Cries because of emotional distress.					
6. Tells me it is going to be okay.					
7. Is shocked and stunned.					
8. Asks whether other relatives were or are HIV-positive (e.g. child, father, sibling).					
9. Is fearful about the future.					
10. Asks questions about how the diagnosis will affect his/her life.					
11. Feels sorry for me.					
12. Asks whether she/he is HIV positive.					
13. Does not seem to understand what this means.					

14. Tells me that she/he is scared.					
15. Responds with anger at the infected person: "God; you."					
16. Is physically upset(e. g shaking, complains of stomach ache					
17. Is in denial.					
18. Told someone else about my HIV status.					
19. Appears disinterested and bored.					
20. Tries to change the subject.					
21. Becomes violent.					
22. Does not want to touch me because she/he is scared she/he might get it.					
23. Rejects me and tells me to leave.					

Key: 1-Not at all a factor; 2-somewhat a factor; 3-Moderately a factor; 4-A factor; 5-Very Much A Factor

APPENDIX B

HIV STATUS DISCLOSURE QUESTIONNAIRE (SETSWANA VERSION)

KAMOGANO YA SEEMO SA MOGARE WA HIV Boleng mogo tsa botsogo mo Gaborone

LEPHATA LA TSA BOOKI

UNIBESITHI YA BOKONE BOPHIRIMA, MAFIKENG

TLHALOSO YA BATSAYAKAROLO MO DIPATLISISONG

BOMOSOLA JWA DIPATLISISO

Bomosola jwa dipatlisiso tse ke di dirang kego batlisisa selekanyo sa kamogano ya seemo sa mogare le go tlhalosa mabaka aa rotloetsang kana a tshabisa baba tshelang le mogare wa HIV go bolelela bakapelo le masika ka seemo sa bone sa mogare mo kokelong ya Gaborone. Maikaelelo ke gore ko bokhutlong jwa dithuto tsame ke kgone go rotloetsa lego ntsha dikgakololo go rarabolola mathata a sephiri ka mogare wa HIV mogo bao ba tshelang le bone mo Gaborone, Botswana.

DITSAMAISO

O kopiwa go tsaya karolo mogo arabeng dipotso di kanna lesome le botlhano goya kogo masome a mabedi. Maikaelelo a mokwalo o kego kopa tumalano ya gago ya go tsaya karolo mo dipatlisisong tse. O kopiwa go ikwala ele sesupo sa gore o dumelana gore o tsaya karolo. Dikarabo tsa gago ga dina go bonwa kana go balwa ke ope ko ntleng ga mmatlisisi. Leina la gago ga lena go tlhagelela gope mo dipotsong le dikarabo tsa dipatlisiso.

Dipatlisiso tse ga dina bodiphatla bope mo motseyeng karolo. O kopiwa go araba dipotso tse di nang le karolo tse nne. Karolo ya ntlha e bua ka botshelo jwa motsayakarolo, karolo ya bobedi :mabaka aa rotloetsang kamogano ya seemo sa

mogare wa HIV, karolo ya boraro: mabaka aa kganelang kamogano ya seemo sa mogare wa HIV, karolo ya bone ke maikutlo mabapi lego amogana ga seemo sa mogare wa HIV.

Le fa go le jalo botlhokwa jwa dipatlisiso tse ke isago ya lefatshe la Botswana. Kwa bokhutlong jwa patlisiso e, ke tla kgona go ntsha dikgakololo tse di supang gore sese bakang sephiri le kamogano ya seemo sa mogare ke eng le gore go ka thusanngwa jang kgang e. Go amogana seemo sa mogare mo mokapelong leba masika goka thusa go emisa kamano ya mogare wa HIV ka ngwaga wa 2016.

Ka jalo ke solofela fa ole motsayakarolo o tla phuthologa go amogana le nna maikutlo a gago mabapi le go amogana ga seemo sa mogare wa HIV go bakapelo le ba masika ka se sele botlhokwa mo isagong ya tshaba ya kamoso ya Botswana.

TSHWANELO YAGO BOELA MORAGO KANA GO TLHOKA GO TSAYA KAROLO MO PATLISISONG

Go tsaya karolo gago patelediwe. O na le tshwanelo yago araba dipotso mme o tlogele tse dingwe tse osa ikutlweng go di araba. O na le tshwanelo yago boela morago kana gosa tseyeng karolo mo patlisisong nako nngwe le nngwe. Fa ona le dipotso kana dikakgelo oka ntshwara mo mogaleng oo fa tlase: Onalenna Thebeyadira

72132632

thebeyadirao@gmail.com

TUMALANO YAGO TSAYA KAROLO

UNIBESITHI YA BOKONE BOPHIRIMA (MAFIKENG)

KAMOGANO YA SEEMO SA MOGARE WA HIV Boleng mogo tsa botsogo mo Gaborone

Leina la Mmatlisisi:-----

Leina la Motsayakarolo:-----

Kego laletsa go tsaya karolo mo dipatlisisong mabapi le go batlisisa selekanyo sa kamogano ya seemo sa mogare wa HIV lego tlhalosa mabaka aa rotloetsang kana a tshabisa baba tshelang le mogare wa HIV go bolelela bakapelo le masika a bone ka seemo sa mogare wa HIV. Maikaelelo ele go rotloetsa lego ntsha dikgakololo mabapi le kaha bothata jwa seemo boka rarabololwang ka teng mo Gaborone. Go tsaya karolo gago patelediwe. O kopiwa go tlatsa pampiri kwa tlase go dumalana gore o tsaya seabe mo patlisisong.

Ke tlhaloganya gore :

1. Ke gololesegile go emisa go tsaya seabe mo patlisisong e, ka nako nngwe le nngwe.
2. Dikarabo tse ke di fileng ha ke emang teng dika dirisiwa mo dipatlisisong.
3. Mmatlisisi o tshepisa gore mekwalo ya patlisiso e etla bewa mogo sireletsegileng Leina ga lena go tlhagelela gope mo dipotsong le dikarabo.
4. Jaaka motsayakarolo ga gona tuelo epe eke tla e fiwang ke mmatlisisi.

Monwana wa Motsayakarolo: -----

Monwana wa Mmatlisisi:-----

DIPOTSO

KAMOGANO YA SEEMO SA MOGARE WA HIV

KAROLO YA NTLHA

DINTLHA KGOLO KA MOTSAKAROLO

Dingwaga	
Bong	1.Rre 2.Mme

Selekanyo sa thuto(O badile bokae ko sekolong).	1.Dithuto tse dipotlana 2.Dithuto tse dikgolwane 3.Dithuto tse dikgolwana tsa bodiredi(Graduate) 4.Dithuto tse dikgolo tsa bodiredi(Postgraduate)
Seemo sa gago sa Nyalo	1.Ga kea nyala/nyalwa 2.Ke nyetse/nyetswe 3.Ke nna le molekane wame ntle le nyalo 4.Ke tladile/tladilwe 5.Ke motlholagadi/moswagadi

Aterese ya bonno:	
Tsa Khiro:	1.Ke a bereka 2.Ga ke bereke 3.Ke a ipereka 4.Ke moithaopi 5.Ke moithuti
Fa karabo ele Ee kana Nnya gore o boletse ka seemo sa gago sa mogare wa HIV.	1.Ee 2.Nnya

Fa karabo gore o boleletse mang:	1.Mokapelo 2.Lesika le le gaufi 3.Lesika le le kgakala 4.Tsala
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KAROLO YA BOBEDI

Tswee tswee araba dipotso tse di latelang ka go tshwaya karabo ee maleba.Bongwe ke tumalano ee tseneletseng le karabo, bothano ke tumalano ee kwa tlase le karabo.Fetela kwa karolong ya boraro ha osa bolelela ope ka seemo.

DIPOTSO

	1	2	3	4	5
1. Ne ke batla mokapelo/lesika/tsala gore a utlwe seemo sa mogare ka nna.					
2. Mokapelo/lesika/tsala o na le tshwanelo yago itse ka seemo sa mogare.					
3. Ne ke batla go tihaloetsa mokapelo/lesika/tsala.					
4. Ne ke batla go baakanyetsa mokapelo/lesika/tsala mabapi le sese tla diragalang.					
5. Ne ke batla mokapelo/lesika/tsala go itse gore bothata ke eng ka nna.					

6. Mokapelo/lesika/tsala o tshwanetse go nna le kitso ya bokoa jwame.					
7. Ne ke batla mokapelo/lesika/tsala go nna le kemonokeng ea e tlhokang.					
8. Ne ke sa batle go direla mokapelo/lesika/tsala sephiri mabapi le seemo same.					
9. Mokapelo/lesika/tsala o kgona go amogela boammaruri.					
10. Mokapelo/lesika/tsala o na le boikarabelo jwa go itse nnete ka seemo same.					
11. Ke ne ke ikutlwa gore keka se fitlhe seemo same goya go ileng.					
12. Ke ikantse mokapelo/lesika/tsala mo botshelong jwame.					
13. Ke ikaegile ka mokapelo/lesika/tsala mo kemonokeng ya gagwe ya tshidilomaikutlo.					
14. Ke ne ke tshwenyegile gore mokapelo/lesika/tsala o tla utlwa ka seemo same sa mogare mo bathong.					
15. Mokapelo/lesika/tsala o ne a nna a mpotsa dipotso ka bokoa jwame.					
16. Ga ke a akanya ka bolelela mokapelo/lesika/tsala ka seemo					

same,ke boile fela.

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Elatlhoko: Mabaka ago amogana seemo sa mogare wa HIV a tlhatlhobiwa mo sekaleng sa go ema ka botlhano. 1=Ga se gone 5=Ke gone tota.

KAROLO YA BORARO

HA OSA AMOGANA SEEMO SA MOGARE FETELA GO KAROLO YA BONE

1=Ga se gone 5=Ke gone tota

DIPOTSO

	1	2	3	4	5
1. Mokapelo/lesika/ tsala o na le tshwanelo yago tshela botshelo jo bo gololesegileng.					
2. Ga ke batle mokapelo/lesika/tsala a tshwenyega ka nna.					
3. Ga ke batle go tshosa mokapelo/lesika/tsala.					
4. Ga ke batle mokapelo/lesika/tsala a utlwiwa botlhoko ke kafa batho bamo tsayang ka teng ntateng ya seemo same.					
5. Ke batla go sireletsa mokapelo/lesika/tsala gore a seka a utlwiwa botlhoko ke batho ntateng ya seemo same.					
6. Mokapelo/lesika/tsala ga tlhokane lego tshwenngwa.					

7. Ke batla go lobela mokapelo/lesika/tsala go a go ileng.					
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8. Mokapelo/lesika/tsala ga mo seemong sa go itse seemo same.					
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9. Go ka ntswhenya mo maikutlong go bolelela mokapelo/lesika/tsala.					
10. Mokapelo/lesika/tsala ga a kake a amogela nnete ka seemo same jaanong.					
11. Mokapelo/lesika/tsala ga ana boikarabelo jwa go itse nnete mo nakong eno.					
12. Ke tshoga gore mokapelo/lesika/tsala o ka bolelela ba bangwe ka seemo same.					
13. Bokoa kana bolwetsi jwame ke sephiri same.					
14. Mokapelo/lesika/tsala ga a tshwanela go itse gore kena le mogare kana gore ke kgona go lwala.					
15. Mokapelo/lesika/tsala ga a na lebaka lepe la go itse seemo same.					
16. Ke tshoga gore mokapelo/lesika/tsala otl'a mpotsa dipotso tse dintsi					
17. Ke tshoga gore mokapelo/lesika/tsala otl'a mpotsa dipotso tse keka se kgoneng go di araba.					
18. Ke tshoga gore mokapelo/lesika/tsala otl'a ntenegela.					

19. Ke tshaba gore ketla tshwanelwa ke go bolelela mokapelo/lesika/tsala gore ke tsenwe ke mogare jang.					
20. Ke tshaba gore mokapelo/lesika/tsala otlala emisa go ntlotla jaaka pele.					

Elatlhoko: Mabaka a go tlhoka go amogana seemo sa mogare a tlatlhojwa mo selekanyong sa botlhano.

KAROLO YA BONE

ARABA TSE DI LATELANG HA ELE GORE O AMOGANE KANA O BOLELETSE MONGWE KA SEEMO SA GAGO SA HIV.

DIPOTSO

	1	2	3	4	5
1. O ile a nkatla.					
2. O tshwenyegile ka nna le ba lesika .					
3. O ile a nkgomotsa.					
4. A mpotsa dipotso mabapi le seemo same sa mogare le gore go raya eng ha ke lwala.					
5. A simolola go lela a supa kutlobotlhoko.					
6. O ne a mpolelela gore gotla siama.					

7. O ne a tshogile kana a hakgametse.					
8. O ne a botsa gore a batho ba bangwe ba na le mogare wa HIV(Sekai ngwana,rragwe le ngwanawangwana).					
9. O tshwenyegile ka bokamoso.					
10. O ne a botsa dipotso kaha seemo same setla fetolang botshelo jwa gagwe ka teng.					
11. A nkutlwela botlhoko.					
12. A mpotsa gore a le ene ona le mogare.					
13. Go lebege asa tthaloganye gore go nna le mogare go raya eng.					
14. O ne a mpolelela gore o tshogile.					
15. O ne a tenega. Tenego mogo yo omo tshetseng mogare"Modimo;wena".					
16. O ne a supa tenego (a roroma,a re mala a botlhoko).					
17. O ne asa dumele se ke se buang.					

18.O ne a bolelela mongwe ka seemo same.					
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19. O ne a lebega a sena sepe lenna kana a sena kgatlhego.					
20. O ne a leka go fetola kang.					
21. O ne a ntwantsha.					
22. Ga a batle go ntshwara ka gore o tshaba gore ketla mo tshela.					
23. Ga a mpatle are ke tsamaye kana re kgaogane.					

TELEPHONE: 363 2766
FAX: 391 0647
TELEGRAMS: RABONGAKA
TELEX: 2818 CARE BD



Republic of Botswana

MINISTRY OF HEALTH
PRIVATE BAG 0038
GABORONE

REFERENCE NO: PPME 13/18/1 PS V (325)

15 July 2014

Health Research and Development Division

Notification of IRB Review: New application

Onalenna Thebeyadira
P.O. Box 1968
Molepolole

Protocol Title:	HIV STATUS DISCLOSURE IMPLICATION FOR CARE IN GABORONE
HRU Approval Date:	14 July 2014
HRU Expiration Date:	14 July 2015
HRU Review Type:	HRU reviewed
HRU Review Determination:	Approved
Risk Determination:	Minimal risk

Dear Ms Thebeyadira

Thank you for submitting new application for the above referenced protocol. The permission is granted to conduct the study.

This permit does not however give you authority to collect data from the selected sites without prior approval from the management. Consent from the identified individuals should be obtained at all times.

The research should be conducted as outlined in the approved proposal. Any changes to the approved proposal must be submitted to the Health Research and Development Division in the Ministry of Health for consideration and approval.

Furthermore, you are requested to submit at least one hardcopy and an electronic copy of the report to the Health Research, Ministry of Health within 3 months of completion of the study. Approval is for academic fulfillment only. Copies should also be submitted to all other relevant authorities.

Continuing Review

In order to continue work on this study (including data analysis) beyond the expiry date, submit a Continuing Review Form for Approval at least three (3) months prior to the protocol's expiration date. The Continuing Review Form can be obtained from the Health Research Division Office (HRDD), Office No. 7A.7 or Ministry of Health website: www.moh.gov.bw or can be requested via e-mail from Mr. Kgomotso Motlhanka, e-mail address: kgmmotlhanka@gov.bw. As a courtesy, the HRDD will send you a reminder email about eight (8) weeks before the lapse date, but failure to receive it does not affect your responsibility to submit a timely Continuing Report form.

Amendments

During the approval period, if you propose any change to the protocol such as its funding source, recruiting materials, or consent documents, you must seek HRDC approval before implementing it. Please summarize the proposed change and the rationale for it in the amendment form available from the Health Research Division Office (HRDD), Office No. 7A.7 or Ministry of Health website: www.moh.gov.bw or can be requested via e-mail from Mr. Kgomotso Motlhanka, e-mail address: kgmmotlhanka@gov.bw. In addition submit three copies of an updated version of your original protocol application showing all proposed changes in bold or "track changes".

Reporting

Other events which must be reported promptly in writing to the HRDC include:

- Suspension or termination of the protocol by you or the grantor
- Unexpected problems involving risk to subjects or others
- Adverse events, including unanticipated or anticipated but severe physical harm to subjects.

If you have any questions please do not hesitate to contact Mr. P. Khulumani at pkhulumani@gov.bw, Tel +267-3914467 or Lemphi Moremi at lamoremi@gov.bw or Tel: +267-3632754. Thank you for your cooperation and your commitment to the protection of human subjects in research.

Yours sincerely



P. Khulumani

For Permanent Secretary



