

**Clients' Experiences of HIV-Positive Post-Disclosure to Sexual Partners  
at St Rita's Hospital, Limpopo Province**

**by**

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the Degree of**

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## **DEDICATION**

This study is dedicated to research participants who are living with HIV/AIDS and attending St Rita's Hospital wellness clinic, to my children, Lethabo Mankurwane and Thabo Sepamo, my niece and nephews, Dinao, Amogelang and Khomotso.

## DECLARATION

I, Pamela Mafenngwe Mamogobo, hereby declare that the mini-dissertation “Client Experiences of HIV-Positive Post-Disclosure to Sexual Partners at St Rita’s Hospital, Limpopo Province” for the Masters of Public Health (MPH) degree at the University of Limpopo hereby submitted by me has not been submitted previously at this or any other university, and that it is my own work in design and in execution and that all reference materials contained herein have been duly acknowledged.

**Pamela Mafenngwe Mamogobo** : .....

**Date** : .....

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## ABSTRACT

**Setting:** The study was undertaken in St Rita's Hospital, a district hospital for health in Makhuduthamaga Municipality, Sekhukhune District, Limpopo Province. The purpose of the study was to describe client experiences of HIV-positive post-disclosure to sexual partners at St Rita's Hospital, Limpopo Province.

**Research design and methodology:** A qualitative, descriptive and phenomenological design was used. Purposive sampling was used to select 15 HIV-positive clients to participate in the study. Semi-structured interviews were conducted for data collection until saturation was reached. Data analysis was done using Techs open-coding method.

**Research findings:** The study found that most of the clients were shocked and worried after testing HIV-positive. Participants whose sexual partners were aware that they were sick, indicated their wish to test and to immediately disclose their HIV-positive status. The study identified that some women found it difficult to disclose their HIV-positive status to sexual partners and continued to have unprotected sex in spite of ongoing counselling and support provided at the clinic. Some women participants who disclosed to sexual partners were accepted and some were rejected by sexual partners. Some women who disclosed their HIV-positive status to sexual partners were unable to motivate sexual partners to be counselled together and have mutual disclosure. These participants therefore continued to have unprotected sex with sexual partners and some became pregnant as sexual partners indicated that they tested HIV-negative elsewhere and were not keen to use condoms. Female participants did not indicate the use of female condoms as part of their responsibility to prevent transmission of HIV.

**Implications, recommendations and conclusions:** The barriers which female participants face to disclose their HIV-positive status to sexual partners and not being able to insist on the use condoms may contribute to a high rate of HIV transmission and disease incidence. There should be establishment of consortiums at community level to provide quality support and follow up to

clients who face challenges or fear to disclose their HIV-positive status to sexual partners.

## **KEYWORDS**

- Clients' experiences
- Disclosure
- Experiences,
- Sexual partner
- HIV-positive

## DEFINITIONS OF CONCEPTS

- Safe Sex** Sex is safe when both partners know their HIV-negative serostatus and neither partner is in the window period between HIV exposure and appearance of HIV antibodies detectable by the HIV test. In this study, safe sex is using condoms to protect each other during each sexual intercourse whether the status is known or unknown (WHO,2011(a) )
- Disclosure** According to UNAIDS (2000) in the context of HIV/AIDS, disclosure refers to the act of informing any individual or organisation the HIV-positive status of the individual person. The information may be communicated personally by the individual person or by a third party with or without consent. In exceptional cases, the HIV-positive person has to give consent for such information on his/her behalf to be shared with other people. In this research disclosure of HIV-positive status is explained as when an HIV-infected person personally tells the sexual partner the HIV-positive status.
- HIV-Positive** According to WHO (2011(a)), being HIV-positive is when the antibodies against HIV show in a blood or oral fluid test. In this study, all clients who tested positive with the ELISA test at St Rita's Hospital Wellness Clinic shall be regarded as HIV-positive.
- Sexual Partner** According to WHO (2011(a)) a sexual partner is the present person that an individual is having consensual sex with. In this study, a sexual partner will include any person who a study participant is having a physical union with penetration of sexual organs.



**Experience** According to Collins South African School Dictionary (2004), experience includes all things that the individual has done or that have happened, usual and new things are included.

## LIST OF ABBREVIATIONS

<b>AIDS</b>	Acquired Immune Deficiency Syndrome
<b>ART</b>	Antiretroviral Therapy/Treatment
<b>ARV</b>	Antiretroviral Drugs
<b>DoH or DHSD</b>	Department of Health and Social Development
<b>ELISA</b>	Enzyme-Linked Immunosorbent Assay
<b>HCT</b>	HIV/AIDS Counselling and Testing
<b>HIV</b>	Human Immunodeficiency Virus
<b>MTCT</b>	Mother-to-Child Transmission of HIV
<b>PLWHA</b>	People Living with HIV/AIDS
<b>PMTCT</b>	Prevention of Mother-to-Child Transmission of HIV
<b>SANAC</b>	South African National AIDS Council
<b>STI</b>	Sexually Transmitted Infections
<b>WHO</b>	World Health Organization
<b>UNAIDS</b>	United Nations Programme on AIDS

## TABLE OF CONTENTS

TITLE PAGE	i
DECLARATION	ii
DEDICATION	iii
ACKNOWLEDGEMENTS	iv
ABSTRACT	vi
KEYWORDS	viii
DEFINITIONS OF CONCEPTS	ix
LIST OF ABBREVIATIONS	xi
TABLE OF CONTENTS	ix
LIST OF TABLES	xv
LIST OF FIGURES	xvi
LIST OF APPENDIXES	xvii
<b>CHAPTER 1: OVERVIEW OF THE STUDY</b>	<b>1</b>
1.1 Introduction and Background	1
1.2 Research Problem	3
1.3 Purpose of the Study	4
1.4 Research Question	4
1.5 Objectives of the Study	4
1.6 Methodology	5

1.7	Significance of the Study Research	6
1.8	Conclusion	6
	<b>CHAPTER 2: LITERATURE REVIEW</b>	<b>7</b>
2.1	Introduction	7
2.2	Policy Guidelines on the Disclosure of HIV-Positive Status to Sexual Partners	7
2.3	Rates of Disclosure in Sub-Sahara Africa and South Africa	9
2.4	Policy that Guide Health Worker Practice on Disclosure of HIV-Positive Status to Sexual Partners	9
2.5	Factors that Facilitate or Hamper the Ability of Individuals to Disclose Their HIV-Positive Status to Sexual Partners	12
2.6	Benefits of Disclosure of HIV-Positive Status to Sexual Partners	15
2.7	Challenges of Disclosure of HIV-Positive Status to Sexual Partners	17
2.8	Conclusion	17
	<b>CHAPTER 3: RESEARCH METHODOLOGY</b>	<b>18</b>
3.1	Introduction	18
3.2	Research Method and Design	18
3.2.1	Qualitative Approach	18
3.2.2	Descriptive Design	19
3.2.3	Exploratory Design	19
3.2.4	Phenomenology	20

3.3	Population	21
3.4	Sampling and Sample Size	21
3.5	Data Collection	21
3.6	Data Analysis	25
3.7	Ethical Considerations	26
3.7.1	Permission to Conduct the Research	26
3.7.2	Anonymity and Confidentiality	26
3.7.3	Protection from Harm and Discomfort	26
3.8	Trustworthiness	27
3.8.1	Credibility	27
3.8.1.	Prolonged Engagement	27
3.8.1.	Persistent Observation	28
3.8.1.	Debriefing	28
3.9	Transferability	29
3.9.1	Thick Description	29
3.9.2	Confirmability	29
3.10	Dependability	30
3.11	Conclusion	30
	<b>CHAPTER 4: DATA ANALYSIS AND INTERPRETATION</b>	<b>32</b>
4.1	Introduction	32
4.2	Demography of the Participants	32

4.3	Themes that Emerged from the Data Analysis	32
4.3.1	Theme 1: Rejection Versus Acceptance of Sexual Partner Related to Disclosure of HIV-Positive Status	34
4.3.1.1	Sub-Theme 1.1: Disclosure of HIV-Positive Status - A Difficult Process Versus a Good Idea to Obtain Support	35
4.3.1.2	Sub-Theme 1.2: Lack of Disclosure of HIV-Positive Status to Sexual Partners and Relatives	38
4.3.1.3	Sub-Theme 1.3: Testing HIV-Positive and Disclosure of HIV-Positive Test Not a Deciding Factor to Maintain An Excellent Relationship	40
4.3.1.4	Sub-Theme 1.4: HIV/AIDS Signs and Symptoms are Not Associated with the Diseases of Sexual Partners	42
4.3.2	Theme 2: Factors that Precipitate HIV Infection and Transmission	42
4.3.2.1	Sub-Theme 2.1: Extramarital Sexual Engagement with an HIV-Positive Partner	43
4.3.2.2	Sub-Theme 2.2: Lack of Honesty About Disclosing an HIV-Positive Status	45
4.3.2.3	Sub-Theme 2.3: Male Partners Refusing to Use Condoms Despite Knowledge of HIV-Positive Status	47
4.3.3	Theme 3: Consequences of An HIV-Positive Result	49
4.3.3.1	Sub-Theme 3.1: Male Partners Get More Agitated After An HIV-Positive Test Result than Their Female Partners	49
4.3.3.2	Sub-Theme 3.2: Different HIV Test Results for Partners Lead to a Strenuous Relationship or a Termination of Intimacy	52

4.3.3. Sub-Theme 3.3: Lack of Disclosure of an HIV-Positive Status Leads to Feelings of Discomfort Around One's Partner	53
4.3.3. Sub-Theme 3.4: Disclosure of HIV-Positive Results Leads to a Positive and Healthy Lifestyle of Infected People	54
4.4 Guidelines for the Process of Disclosure of an HIV-Positive Status to Sexual Partners	56
4.5 Conclusion	60
<b>CHAPTER 5: SUMMARY, RECOMMENDATIONS, LIMITATIONS AND CONCLUSION</b>	<b>62</b>
5.1 Introduction	62
5.2 Summary Related to Objective 1: To Describe the Experiences of HIV-Positive Clients as They Disclosed Their Status to Sexual Partners in St Rita's Hospital Wellness Clinic	62
5.3 Recommendations on Theme 1: Rejection Versus Acceptance of Sexual Partner Related to Disclosure of HIV-Positive Status	63
5.3.1 Recommendations for Education	63
5.3.2 Recommendations for Practice of Counselling	63
5.3.3 Recommendations for Administration and Policy	63
5.3.4 Recommendations for Research	64
5.4 Summary Related to Objective 2: To Identify Challenges Facing HIV-Positive Clients	64
5.5 Recommendations on Theme 2: Factors that Precipitate HIV Infection and Transmission	66
5.5.1 Recommendations for Education	66

5.5.2	Recommendations for Practice of Counselling	66
5.5.3	Recommendations for Administration and Policy	66
5.5.4	Recommendations for Research	66
5.6	Summary Related to Objective 3: To the Determine Psychosocial System that Guides the Process of Disclosure to Sexual Partners	67
5.6.1	Recommendations for Education	68
5.6.2	Recommendations for Practice of Counselling	68
5.6.3	Recommendations for Administration and Policy	68
5.6.2	Recommendations for Research	68
5.7	Summary Related to Objective 4: To Develop Guidelines that Could Assist People Who Live with HIV/AIDS and Who Wish to Disclose Their HIV-Positive Status to Their Sexual Partners	70
5.8	Limitations of the Study	70
5.9	Conclusion	70
	<b>REFERENCES</b>	<b>71</b>
	APPENDIX 1: MEDUNSA RESEARCH AND ETHICS COMMITTEE CLEARANCE LETTER	84
	APPENDIX 2: PERMISSION TO CONDUCT THE STUDY (LETTER FROM THE LIMPOPO DEPARTMENT OF HEALTH AND SOCIAL DEVELOPMENT)	85
	APPENDIX3: INTERVIEW GUIDE	86
	APPENDIX 4: INFORMED CONSENT	89



APPENDIX 5: TRANSCRIPT OF VERBATIM DISCUSSION WITH ONE OF THE CLIENTS	95
APPENDIX 6: INDEPENDENT CODER REPORT	95
APPENDIX 7: LETTER FROM LANGUAGE EDITOR	99

## LIST OF TABLES

<b>Table 4.1</b>	Themes and sub-themes	38
<b>Table 4.2</b>	Guidelines for disclosure of an HIV-positive status to sexual partners	66

## LIST OF FIGURES

<b>Figure 4.1</b>	Gender and age of participants	37
<b>Figure 4.2</b>	Gender, employment status and educational level of participants	37
<b>Figure 4.3</b>	Guidelines for health care workers to enhance and support HIV-positive clients to disclose their status to sexual partners	64

## LIST OF APPENDICES

<b>APPENDIX 1</b>	MEDUNSA RESEARCH AND ETHICS COMMITTEE CLEARANCE LETTER	83
<b>APPENDIX 2</b>	PERMISSION TO CONDUCT THE STUDY (LETTER FROM THE LIMPOPO DEPARTMENT OF HEALTH AND SOCIAL DEVELOPMENT)	84
<b>APPENDIX 3</b>	INTERVIEW GUIDE	86
<b>APPENDIX 4</b>	INFORMED CONSENT	87
<b>APPENDIX 5</b>	TRANSCRIPT OF VERBATIM DISCUSSION WITH ONE OF THE CLIENTS	89
<b>APPENDIX 6</b>	INDEPENDENT CODER REPORT	91
<b>APPENDIX 7</b>	LETTER FROM LANGUAGE EDITOR	94

## CHAPTER 1

### OVERVIEW OF THE STUDY

#### 1.1 Introduction and Background

Disclosure of a positive human immune-deficiency virus (HIV) status is an important public health goal component of management and care of HIV and acquired immune deficiency syndrome (AIDS). The goal of disclosure of an HIV-positive status to a sexual partner seeks to ensure that HIV-positive clients are freely able to negotiate and use condoms consistently with sexual partners. Disclosure of an HIV-positive status to sexual partners could contribute to consistent use of condoms during sexual intercourse by HIV-positive clients to reduce HIV transmission (Medley, Garcia-Moreno, McGill, & Maman, 2004).

One of the health challenges of being HIV-positive is preventing further infection and re-infection. People living with HIV/AIDS continue to engage in unprotected sex with steady sexual partners than with casual sexual partners. The perception of the HIV status of sexual partners is not based on explicit direct disclosure, but rather on observable characteristic (Hong, Goldstein, Rotheram-Borus, Wong, Gore-Felton, & the NIMH healthy living trial group, 2006). Observable characteristics include the level of education or nature and importance of occupation. Occupation as a health related person would denote you are not HIV-positive because of the nature of your profession.

HIV-positive gay men would regard sexual partners to be HIV-positive if they do not engage in anal sex, but frequently visit gay venues and sex clubs. Disclosure of HIV-positive status is inconsistent (Hong et al., 2006). Understanding disclosure of an HIV-positive status to a sexual partner could limit the spread of HIV infection (Julianne, Serovich & Mosack, 2003).

The World Health Organisation (WHO) recognises that disclosure of HIV-positive status is a behaviour modification strategy that ensures that HIV-positive clients take responsibility not to transmit the infection to sexual partners. Sexual partners of HIV-positive individuals are at high risk of contracting the disease. Disclosure of an HIV-positive status to a sexual partner provides insight into reducing the incidence of HIV transmission (WHO, 2003). Disclosure of an HIV-positive status to a sexual partner is fundamental in managing HIV, especially in adhering to complex treatment regimens (Norman, Chopra, & Kadiyala, 2005). Disclosure is an entry criterion for many treatment programmes in resource-strained settings. It is, however, difficult for sexual partners to disclose their HIV-positive status when the other partner's HIV status is unknown. The way each person experiences and copes with the illness is reflected in the manner the individual takes a decision to disclose or not and to whom she/he should disclose. The decision is based on individual perception and local context of HIV/AIDS (Norman et al., 2005). The decision to disclose and the communication by HIV-positive men may lead to safer sex practice. However, studies have shown that HIV-positive people continue to practice unsafe sexual behaviours which include unprotected anal and vaginal intercourse, multiple sex partners, and use of substances before sex. The use of substances is often associated with unprotected sex (Olley, Seedat, Gxamza, Reuter & Stein, 2005).

According to WHO (2003), rates of disclosure to sexual partners both in past or current casual partners range from 42% to 100% in developing countries, and 86% in developed countries. The lowest rates of disclosure of HIV-positive status have been found in antenatal women in Sub-Saharan Africa (16.7% to 32%), including South Africa (WHO, 2003). In South Africa, efforts to prevent HIV through partner notification by introduction of legislation had failed. Advocacy projects raised the problem of stigma attached to such notification that would hamper access of HIV-positive clients to public service (The Women's Legal Center & The Socio-Economic Rights Project, Community Law Centre – University of Western Cape, 1999).

## 1.2 Research Problem

Disclosure of an HIV-positive status to sexual partners poses major social and health problems because the incidence rate of HIV-infected persons is growing at an alarming rate in South Africa. The HIV/AIDS strategic plan acknowledges HIV/AIDS as an epidemic in the country (DoH (Department of Health) South Africa, 2006). Estimates of infected people in South Africa range from 18.8% in the adult population (15-49 years), of which 55% are women. The prevalence of HIV/AIDS is estimated to be 40% for 25-29 years of age and 16% for the age group less than 20 years (DoH South Africa, 2006). Therefore, if these infected clients do not disclose to their sexual partners and do not use condoms each time they have sex, it could lead to an increase in the incidence of HIV-positive clients. The clinical guidelines for the management of HIV/AIDS in adults and adolescents (DoH, South Africa and South African National AIDS Council South Africa (SANAC), 2010) indicate that while ART appears to significantly decrease sexual transmission, unsafe sex on failing ART can still transmit HIV, especially drug-resistant HIV, which can lead to subsequent treatment failure in the partner. The clinical guidelines for the management of HIV/AIDS in adults and adolescents seek to lead to increased uptake and mobilisation of public awareness of HIV/AIDS. The policy further aims to assist individual clients to assess HIV-infection risk to initiate prevention and care intervention and disclosure to sexual partner as one of the strategies (DoH, South Africa, 2010).

The researcher is of opinion that the experience of disclosure of HIV positive status to sexual partners is an untapped area of research in a rural setting like St Rita's Hospital and disclosure of HIV-positive status is an important component of comprehensive HIV/AIDS care. The experiences of clients who have attempted or failed to disclose their HIV-positive status to sexual partners challenge efforts to control the incidence of HIV/AIDS in South Africa. Research endeavours that seek innovative strategies to reduce the incidence of HIV/AIDS transmission, such as disclosure to sexual partners, should be vigorously pursued.

Clients who have tested HIV-positive may want to disclose their status to sexual partners and engage in safe sex in each sexual encounter. It is, however, difficult for them to disclose their HIV-positive status to sexual partners and to engage in safe sex when the status of the sexual partner is unknown or not discussed. Motivation of clients attending St Rita's Hospital wellness Clinic is that they might have disclosed to sexual partners, but there is lack of empirical information which confirm disclosure and stories that could be shared with others who have or have not disclosed.

### **1.3 Purpose of the Study**

The purpose of the study was to explore and describe the experiences of HIV-positive clients, regarding disclosure of HIV-positive status to sexual partners at St Rita's Hospital.

### **1.4 Research Question**

The following research question was used to guide the study: "What are the experiences of HIV-positive clients regarding HIV-positive status disclosure to sexual partners in St Rita's Hospital Wellness Clinic?"

### **1.5 Objectives of the Study**

The objectives of the study were to:

- ❖ Describe the experiences of HIV-positive clients as they disclose their status to sexual partners in St Rita's Hospital Wellness Clinic.
- ❖ Identify challenges facing HIV-positive sexual partners, that is, those factors which facilitate or hinder disclosure of HIV-positive status to sexual partners.
- ❖ Determine the psychosocial systems in place that guide HIV-positive clients through the process of disclosure to sexual partners.



- ❖ Develop guidelines that could assist people who live with HIV/AIDS (PLWHA) who wish to disclose their HIV-positive status to their sexual partners.

## **1.6 Methodology**

A qualitative, explorative, descriptive and phenomenological design was used to describe the lived experiences of PLWHA (de Vos, Strydom, Fouché, & Delport, 2002) as they disclosed their HIV-positive status to their sexual partners. The target population was PLWHA attending the Wellness Clinic at St Rita's Hospital in Limpopo Province, and had a confirmed HIV-positive status through enzyme-linked immunosorbent assay (ELISA). A purposive sampling technique was used to select study participants..

A semi-structured interview was used to collect data from the participants. The instrument had a demographic section and open-ended section. A tape recorder was used with the permission of the participants. Data were analyzed using Techs open-coding method. The researcher organised and prepared data for analysis by transcribing the interview. Data were arranged into different types of sources of information. The researcher repeatedly read the transcripts to obtain a general meaning of the data collected, and then repeatedly read all transcripts one by one and wrote their thoughts in margins. The mixture of data available was organised in paragraphs and themes which were assigned labels (Creswell, 2003).

To ensure trustworthiness, credibility, conformability and dependability were used by prolonged engagement, use of a tape-recorder and audit trail. The proposal was submitted to Medunsa Research and Ethics Committee (MREC) for ethical clearance. Permission to conduct the study was obtained from the Limpopo Province DoH, and informed consent from the research participants. The detailed of methodology will be discussed in Chapter 3 of the study.

## **1.7 Significance of the study**

The study will inform the management and staff of the clinic on challenges and benefits related to HIV disclosure of HIV-positive clients to sexual partners which is an important component of public health promotion and reduction of HIV transmission. Lessons learned from the experiences of these clients will be shared with the policy makers, clinic multidisciplinary team members, peers providing similar care in other areas within and outside Limpopo Province and researchers for policy and protocol review on care of HIV-positive clients.

## **1.8 Conclusion**

In Chapter 1 the overview of the study was discussed. The discussion included the problem statement, research question, aim and objectives, research methodology and the significance of the study. Chapter 2 will outline research studies, policy and literature related to HIV/AIDS disclosure of HIV-positive status to sexual partners.

## **CHAPTER 2**

### **LITERATURE REVIEW**

#### **2.1 Introduction**

This chapter reviews literature relevant to policy guidelines from WHO and other countries and experiences of disclosure of HIV-positive status to sexual partners. Policy guidelines were obtained from published electronic journals and books from the library. The rationale for the literature search was to collect substantiation associated with the research topic that assisted the researcher to make sense of how to undertake the desired study. Published articles from journals and online sources guided the researcher to develop an understanding of the findings of other researchers (Couchman & Dawson, 1996).

#### **2.2 Policy Guidelines on the Disclosure of HIV-Positive Status to Sexual Partners**

Disclosure of an HIV-positive status is an important public health component of management and care of HIV/AIDS (Medley et al., 2004). WHO recognises that disclosure of HIV-positive status is a behaviour modification strategy that ensures that HIV-positive clients take responsibility not to transmit the infection to sexual partners (WHO, 2004). Sexual partners of HIV-positive individuals are at high risk of contracting the disease. Therefore, disclosure of an HIV-positive status to sexual partners provides insight into reducing the incidence of HIV transmission. Disclosure as a public health goal seeks to ensure that HIV-positive clients are freely able to negotiate and use condoms consistently with sexual partners. Disclosure of HIV-positive status to sexual partners could contribute to consistent use of condoms during sexual intercourse by HIV-positive clients to reduce HIV transmission (Medley et al., 2004).

WHO recommends to member states to include disclosure of HIV-positive status in policy and ways to identify and deal with barriers to disclosure in HIV programmes (WHO, 2003). Mediated and supportive referral should be considered where clients fear negative consequences from disclosing HIV-positive status to sexual partners. Supportive referral could include a counsellor, health worker or trusted family member in the disclosure process at home (WHO, 2011(a)). Mediation during disclosure to sexual partners is recommended as it might offer an effective culturally sensitive approach for women (WHO, 2003). According to WHO (2003), there is a dire need to develop gender-specific and culturally-appropriate strategies to optimise disclosure of HIV-positive diagnosis to sexual partners.

The International Planned Parenthood Federation's (2002) programme guidelines advocate that counsellors and facilitators introduce discussion on prevention of sexually transmitted infections (STI), including HIV, safer sex, and challenges related to initiating safer sex practices during pre-counseling. Clients who tested HIV-positive, should ideally be referred for initial pre-counseling discussion with counsellors. The guidelines indicate that at the initial presentation of HIV-positive results, the client might not have interest in discussing transmission of HIV to his/her sexual partner, but it is the responsibility of the counsellor to communicate the importance of prevention of HIV-positive status to the sexual partner.

Uganda is one country in Africa that has been able to promulgate the Uganda: Human Immunodeficiency Virus Control Bill, 2007. The bill states that a person who directly or indirectly omit to disclose or do or does an act knowingly or has reason to or believe it will result in the infection of another person with HIV, commits an offence and is liable to conviction or a fine not exceeding twenty four currency points or to imprisonment not exceeding one year. Intentional transmission or attempts to transmit HIV is liable to two years imprisonment or to a fine not exceeding fifty currency points, or to both. An HIV-positive person must use a condom or any reliable protective measures to protect a sexual partner during sexual intercourse. According to the bill, the medical practitioner or other qualified person giving the result of the HIV test

to any person who tested HIV-positive should always advise the individual on disclosure of an HIV-positive status to his/her sexual partner and on the use of safe sex (Uganda AIDS Commission, 2007). Angola also has Angola: Law 8/04 on HIV/AIDS (2004) which prescribes that HIV-positive client should use condoms during sex and should inform persons with whom they have or intend to have sex of their HIV-positive status. Intentional transmission is punishable under section 353 of the penal code (Angola National Assembly, 2004).

### **2.3 Rates of Disclosure in Sub-Sahara Africa and South Africa**

According to WHO (2003), rates of disclosure to past or current sexual partners range from 42% to 100% in developing countries and 86% in developed countries. The lowest rates of disclosure (16.7% to 32%) of HIV-positive status have been found in Sub-Sahara Africa, including South Africa, for antenatal women (WHO, 2003). It was also found that 10% to 78% of women in underdeveloped countries have a tendency not to share HIV-positive results with anyone compared to 3% to 10% in developed countries. WHO (2003) also found discrepancies between intentions to disclose and actual disclosure - the rates of the latter being lower than those of the former. In spite of this, disclosure rates for both developing and developed countries tended to increase over time (WHO, 2003).

### **2.4 Policy that Guides Health Worker Practice on Disclosure of HIV-Positive Status to Sexual Partners**

WHO recommends that routine pre- and post-test counseling for HIV in clients requesting HIV testing should emphasise the value of disclosing HIV-positive status to sexual partners as a guiding principle to control the HIV epidemic (WHO, 2003). The implications of lack of disclosure of an HIV-positive status should also be accentuated. The discussion between the counsellor and the HIV-positive client during counseling should include disclosure and people who should be notified by HIV-positive clients.

Currently, South Africa does not have an explicit HIV/AIDS policy that directly addresses the issue of HIV disclosure to sexual partners. According to Open Society Foundation for South Africa (2009), disclosure of an individual's HIV-positive status to a sexual partner is protected under the constitution. People living with HIV/AIDS are entitled to rights, equality - including right to privacy and dignity - like any other person in South Africa as enshrined in the Bill of Rights in the Constitution. Any PLWHA, irrespective of age, gender or nationality, is not obliged by law to disclose in any way an HIV-positive status (Open Society Foundation for South Africa, 2009). In 1995, South Africa made some attempts to include HIV/AIDS as a notifiable disease. Draft regulation number R485 dated 23 April 1999 was seeking notification of partner, mandatory disclosure of client's HIV status to the family (The Women's Legal Centre and the Socio-Economic Rights Project, Community Law Centre – University of Western Cape, 1999). Activists in South Africa rejected the draft bill and cited the level of gender violence, rape and status of women as one of the factors that would hinder enactment of such policy in South Africa.

WHO (2003) suggests that health workers should identify multiple opportunities to encourage HIV-positive clients to disclose their status to sexual partners as a paradigm for ongoing support. Counsellors should not use intention to disclose as a predictor of future disclosure behaviour in caring for HIV-positive clients. WHO (2003) further indicates the importance of including communities to support and enhance disclosure of HIV-positive status amongst sexual partners. WHO, therefore, suggests research into the impact of support groups to gain insight on how to strengthen and expand the initiative to enhance disclosure of HIV/AIDS within community practices.

Women who experience or foresee domestic violence as a barrier to disclosure should be addressed through referral to community-based programmes that address domestic violence (WHO, 2003). Member countries should promote strategies that remove harmful gender norms and promote gender equality. WHO(2003) further recommends cross-training of health workers in HIV counselling that includes dynamics of gender violence. The guidelines acknowledge that lack of disclosure to sexual partners has an

impact on the incidence of HIV/AIDS in South Africa, but clients should not be pressured to disclose their HIV-positive status to sexual partners (WHO, 2007, Department of Health (DoH) South Africa, 2010).

Health care providers are not allowed to disclose HIV-positive results to sexual partners without the written consent of the client. However, there are exceptional instances in which the health worker is allowed to communicate a client's HIV-positive status to his/her sexual partner, including the following:

- ❖ Where the sexual partner is clearly known and is identifiable.
- ❖ The sexual partner is at risk of being infected with HIV and the client has refused to inform his/her partner to have safer sex.
- ❖ The client has been informed of the intended action (WHO, 2007 and DoH, South Africa, 2010).

According to WHO (2007) and DoH, South Africa (2010), even though the health worker is allowed to disclose under these exceptional situations, it is, however, recommended that the health worker consider the following:

- ❖ The client should be counselled and the importance of telling a sexual partner about the HIV-positive status should be re-enforced.
- ❖ It should be explained to the client that it is part of the right and responsibility of the health worker to warn the sexual partner of the risk of HIV infection she/he might be facing.
- ❖ The client should be made aware that the patient's right to confidentiality might have to be compromised in circumstances that she/he is knowingly infecting the uninformed sexual partner.
- ❖ The client should, however, be offered an opportunity to inform his/her partner and be made aware that there is support from health workers in situations where she/he needs assistance.

- ❖ To provide more appropriate non-threatening ways of encouraging disclosure of HIV-positive status to sexual partners.

## **2.5 Factors that Facilitate or Hamper the Ability of Individuals to Disclose Their HIV-Positive Status to Sexual Partners**

Ateka (2006) indicates that efforts to prevent transmission of the HIV should involve disclosure of the HIV status to sexual partners, which would have better results than disclosure to the public. Disclosure from an original person to his/her sexual partner(s) has potential public health benefits, including making an informed choice about initiating or continuing sexual intercourse or get tested for the virus. It is acceptable that disclosure does not always lead to safer sex, but it is the right of the partner to be informed (Mohammed and Kissinger, 2006).

Olley et al. (2005) found that the duration of an HIV-positive status had an impact on enabling the individual who is HIV-positive to disclose to the sexual partner. Disclosure of an HIV-positive status to a sexual partner is fundamental in managing HIV, especially in adhering to complex treatment regimens (Norman et al., 2005). Disclosure is an entry criterion for many treatment programmes in resource-challenged settings. It is, however, difficult for one sexual partner to disclose his/her HIV-positive status when the other partner's HIV status is unknown. The way each person experiences and copes with the illness is reflected in taking a decision to disclose or not and to whom he/she should disclose. The decision is based on the individual's perception and local context of HIV/AIDS. The decision to disclose by HIV-positive men may lead to safer sex practice. However, studies have shown that HIV-positive people continue unsafe sexual behaviours, including unprotected anal and vaginal intercourse, multiple sex partners and the use of substances before sex. Use of substances is associated with unprotected sex (Olley et al., 2005).

Kadowa and Nuwaha (2009), in a study conducted in Mityana, Uganda, indicate that ongoing counselling and support enable individuals to disclose



easily to sexual partners. Research participants who have had ongoing counselling support in the wellness clinic were found to have had the ability to disclose to sexual partners based on the impact of counselling services. Kadowa and Nuwaha (2009) further suggest that signs and symptoms that indicate an ARV need in clients who are already attending wellness clinics in poorly-resourced country like Uganda often compel clients to disclose their HIV-positive status to sexual partners.

King et al. (2008) indicate that clients who initially found it difficult to disclose their HIV-positive status to sexual partners used multiple strategies that enabled them to safely disclose afterwards. In a study by King et al. (2008), participants indicated that they requested support from counsellors, friends, priests and other PLWHA with explicit signs of HIV/AIDS to tell or support them as they disclosed to sexual partners. Other participants requested health workers to invite sexual partners for HIV testing so that they could test together and then share HIV test results. Some participants indicated that they placed medicines explicitly for the sexual partner to see and ask and that assisted some study participants to discuss issues around HIV/AIDS with subsequent disclosure of HIV-positive status. Clients who used support predominantly to disclose were able to motivate sexual partners to test for HIV/AIDS and this improved uptake of HIV testing at testing sites and improved access to comprehensive HIV/AIDS care for clients in need thereof (King et al., 2008).

Lack of status or subservient status of women in sexual relationships has been found as one of the contributing factors to the high incidence of HIV infections (Moore & Williamson, 2003). The lack of money to procure needed resources predisposes women to engage in unsafe sexual behaviours. Cultural beliefs and practices often allow men to have multiple sexual partners while women are submissive to men with little power to communicate and negotiate sexual practices. This lack of power of women makes it difficult for them to negotiate safe sex even when they know that their husbands have multiple sexual partners. Some women may not feel safe to initiate safe sex as they tend to be blamed for the spread of STI. A woman can be perceived

as disrespectful when initiating and negotiating safe sex with her sexual partner. In several sexual relations, men are usually older than women (Moore and Williamson, 2003).

Wilson et al. (2007) found that among 1,090 HIV-positive women attending clinics and hospital sites, one third of participants had newer sexual partners within a six month period. In such new relationships, women were more likely to consistently use condoms, unlike in their established relationships. There was no report on mutual disclosure of HIV-positive status and 21% of women reported having two or more sexual partners and 21% reported inconsistent use of condoms. Wilson et al. (2007), therefore, recommended that ongoing support for individual clients on disclosure of HIV-positive status to sexual partners should be emphasized in HIV testing and counselling. Mohammed & Kissinger (2006) acknowledged that disclosure of HIV-positive status is complex as it is linked to other behavioural problems that include use of drugs and same sex activities. Olley et al. (2005) found that some PLWHA continue to practice unprotected sex despite counselling provided during testing on sexual partner notification and the use of protection.

Olley et al (2005) reported that 101 participants have engaged in vaginal sex about six months prior to the study. Out of the 101 participants, 33 were males and 68 females. About 55 (54.4 %, 19 males and 36 females) did not use condoms and 33% knew their sexual partners for less than 6 months with 3.4% having known their sexual partners for less than one day. Of the participants, 6% had more than one sexual partner, 4% had more than one partner and unprotected sex after the use of alcohol. In addition to clients who did not know their HIV status of the sexual partners and did not use condoms, these participants indicated the use of alcohol as a means of coping compared to those who used condoms (Olley et al., 2005). However, in another study, two thirds of HIV-positive participants had confidence in discussing their HIV status before sex in the most recent relationship. In the aforementioned study, partner protection was regarded as a shared responsibility (Hong et al., 2006).

Ateka (2006), in a study of 80 pregnant HIV-positive women attending three perinatal clinics in United States of America (USA) where there is universal access to ARV, irrespective of a CD4 count, found that out of 80 women 77 had responded to the question of disclosure of HIV-positive status to sexual partners. Out of 77 who responded, 66 had disclosed to sexual partners. Roughly 40% of the 80 female participants reported HIV-positive sexual partners, 24% HIV-negative partners and 36% sexual partners of unknown HIV status.

Out of the 19 HIV-positive pregnant women who did not know the HIV status of their sexual partners and have disclosed continued to have support from their sexual partners despite the difference in status. Of the 18 HIV-positive pregnant women who were HIV-positive and sexual partners who were HIV-positive, 15 ended the relationship in spite of the social support conferred by sexual partners.

The study indicates that sharing of HIV-positive status does not necessarily mean that sexual partners may decide to stay together and support each other over the continuum of the HIV/AIDS disease process. Given the research findings, Ateka (2006) underscored the dilemmas related to benefits of HIV-positive status disclosure in relation to social support offered. Ateka (2006) argue that disclosure of an HIV-positive should be motivated by virtue of its ability to reduce incidence of HIV transmission, and not social support. Ateka (2006) also suggests that disclosure of an HIV-positive status should be encouraged with sexual partners, but not necessarily with others as it has direct benefits for reducing the incidence of HIV/AIDS.

## **2.6 Benefits of Disclosure of HIV-Positive Status to Sexual Partners**

According to (WHO, 2003; 2007) there are several potential benefits related to disclosure of an HIV-positive status to sexual partners, including:

- ❖ Increased opportunities for instrumental and expressive social support

- ❖ Improved access to necessary medical treatment and care
- ❖ Better prospects to discuss and implement HIV risk reduction with partners
- ❖ Improved opportunities to plan for the future carefully and thoughtfully

Kadowa and Nuwaha (2009) indicate that disclosure of an HIV-positive status to sexual partners is an important public health strategy as it could motivate sexual partners to go for HIV testing which would thus increase HIV test uptake in the community. Disclosure of a HIV-positive status to a sexual partner creates awareness around HIV/AIDS and risks to the untested sexual partner. Disclosure of HIV-positive status further improves access to comprehensive HIV/AIDS programmes for couples (Kadowa & Nuwaha, 2009; Deribe et al., 2008; WHO, 2003; King et al., 2008).

Couples who are HIV-positive following post-test counseling and receive ongoing support at every visit tend to have improved discussion on subsequent reproductive choices such as decisions around the next pregnancy which may promote prevention of mother-to-child transmission of HIV/AIDS. Disclosure of HIV-positive status tends to add to improved adherence to ART among PLWHA.

Vu et al (2011), in a study undertaken in Cape Town, South Africa, found HIV-positive clients were more likely to disclose an HIV-positive status to steady sexual partners. Clients who fear stigma are unlikely to disclose an HIV-positive status to sexual partners as stigma and discrimination were predominant in newer relationships. Vu et al. (2011) suggests that provision of ART is important in reducing the incidence of HIV infections. Individual and couple counseling is also recommended with emphasis on behavioural intervention that discourages sex with casual partners and encourages disclosure of HIV-positive status to steady sexual partners (Vu et al., 2011). Norman et al. (2005), in a study conducted in South Africa where access to comprehensive management of HIV/AIDS care and ARV is low, found that out

of 18 women in the study 6 reported abandonment, rejection or stigmatisation from their sexual partners after they disclosed their HIV-positive status.

Some women who were abandoned by sexual partners received alternative support from family members, neighbours or obtained professional support materially and emotionally. Family members remained a consistent material and emotional supportive group, thus contributing positively to their livelihood. Ateka (2006) reported that sexual partners broke from relationships where the partner knows the HIV-positive status of the other - 70% of participants continued to support their partners and 83% of HIV-positive client had to break their relationship.

## **2.7 Challenges of Disclosure of HIV-Positive Status to Sexual Partners**

Challenges associated with disclosure include abandonment, loss of support, divorce, physical abuse, loss of custody of children and property (Kadowa & Nuwaha, 2009; WHO, 2003; Seid et al., 2012). A study in Kemissie district Northeast Ethiopia showed that 93.1% of the 360 HIV-positive participants interviewed were able to disclose their HIV-positive status to sexual partners, 74% were accepted by sexual partners and 10.8% had some challenges, and 7.8% faced physical abuse and blame. Those who did not disclose indicated that they feared divorce, stigma and physical abuse. Prior discussion with the sexual partner on intentions to test, including knowledge of the partner's HIV status facilitated the ability of the sexual partner to disclose HIV-positive status (Seid et al., 2012).

## **2.8 Conclusion**

Chapter 2 reviewed the literature regarding the experiences of clients who disclosed their HIV-positive status to sexual partners, HIV-positive disclosure policy guidelines from WHO, South Africa and other countries. Chapter 3 will discuss the methodology that the researcher used to collect data from study participants on their experiences as they tested HIV-positive and disclosed to sexual partners

## **CHAPTER 3**

### **RESEARCH METHODOLOGY**

#### **3.1 Introduction**

Chapter 2 described findings from other studies as well as international and national policies and perspectives that guide practices in relation to disclosure of HIV-positive status to sexual partners. Chapter 3 describes the methodology and research design used in this study.

#### **3.2 Research Method and Design**

A qualitative, descriptive, explorative and phenomenological design was used.

##### **3.2.1 Qualitative Approach**

In this study, qualitative research was considered an appropriate approach to understand the importance that HIV-positive clients attached to their experiences of disclosing an HIV-positive status to their sexual partners. The experiences of HIV positive clients as they disclose to sexual partners in St Rita's hospital wellness clinic are unknown and not clear. The aim of the researcher was to describe as shared by research participants based on their reported experiences. According to Streubert & Carpenter (1999), qualitative research focuses on multiple realities and extensive investigation to provide interpretations of reality and is committed to participants' views and recognises knowledge generated by individual participants in research.

Qualitative researchers believe in conducting an inquiry in a way that does not disturb the natural context of the phenomenon under study, acknowledge individuals participation in social actions by reporting individual verbatim comments. The qualitative approach is able to study human action from the

perspective of social factors. The researcher chose a qualitative approach as the most appropriate to gather data about participants subjective reality.

### **3.2.2 Descriptive Design**

A descriptive research design is a narrative as it describes the situation and events in terms of what the researcher observes and then describes in a more lucid way (Babbie & Mouton, 2009). Descriptive research further describes the dialogue with control over what the participants said and shared with the researcher based on their lived experiences (Champion, 1993). By applying the descriptive method, the researcher investigates the phenomenon intensively in an attempt to come up with a deeper meaning of the phenomenon. This includes attempts to present a picture of the specific details of a situation or social setting. Descriptive research focuses on the 'how' and 'why' and explains the phenomenon understudy in a deeper, intensive and thicker description (de Vos et al., 2002). The researchers' interest is to learn about the participants experience as shared directly by the study participants on individual experiences so as understand the meaning and possible impact of these experiences to public health control of HIV transmission amongst HIV positive clients.

### **3.2.3 Exploratory Design**

Since the inception of the Wellness Clinic at St Rita's Hospital (which initially started as a pilot programme for the DoH), the experiences of HIV-positive clients with respect to post-disclosure of HIV-positive status to sexual partners were never studied. Routinely, in research, an exploratory design is used where there is limited information about the event under study. The researcher tried to identify factors that seem to be more relevant than others to explain the event in terms of the available literature (Munhall and Boyd, 2000). An exploratory design was, therefore, more appropriate as little is known about the experiences of HIV-positive clients on disclosure of their status to sexual partners in this clinic. The researcher noted what the

individual clients were reporting without influencing the information with what she knows about the phenomenon under study.

### **3.2.4 Phenomenology**

Phenomenology is a research design that describes the phenomenon under study as seen and experienced by the research participants (de Vos et al., 2002). Phenomenology further attempts to describe people's perspective and understanding of a particular situation emphasising the richness, breadth and depth of the experiences of the participants (Streubert & Carpenter, 1999). Phenomenology assisted the researcher to describe the experiences of HIV-positive clients' post-disclosure of their HIV-positive status to sexual partners. According to Streubert and Carpenter (1999), phenomenology provides a direct description of people's experiences. Phenomenology is concerned with the consciousness of the individual as she/he engages with the environment or the society she/he lives in. The individuals interpret, give meaning, justify and rationalise the ways that represent their responses to their social environment.

The life world of the individual in phenomenology, according to Babbie & Mouton (2009), accounts to people's life experiences and the meaning that individuals attach to such experiences (Polit & Beck, 2012). Babbie and Mouton (2009) indicate that phenomenology does not account to psychological origin and does not explain the scientific or historical origin. However, phenomenology accounts to direct space, time and life world as experienced by study participants (Streubert & Carpenter 1999). Lived experiences of everyday life are central in phenomenology as it represents what the individual experience, what is true and real in his/her own life. Phenomenology recognises that individuals continuously construct, interact and interpret their ever changing everyday life (Babbie & Mouton, 2009). According to Polit and Beck (2012), individual feelings in relation to what research participants see, hear, feel as they interact with life around them are important to the phenomenological researcher. Phenomenology is influenced



by what the individual feels and what he sees as true experiences around his life world (Streubert & Carpenter 1999).

### **3.3 Population**

According to de Vos et al. (2002) population refers to potential individuals who possess distinctive characteristics of the researcher's interests. In this study, the target population was PLWHA attending the wellness clinic at St Rita's Hospital in the Limpopo Province, and had a confirmed HIV-positive status through ELISA test. The total number of clients was established, which was an average of twenty to thirty clients per day. All clients attending the clinic, irrespective of treatment regimen, were included in the study

### **3.4 Sampling and Sample Size**

According to de Vos et al. (2005), sampling is done when the researcher takes a certain portion of the population as representative to the population under study. The staff in the clinic assisted the researcher to access the desired participants. Purposive sampling was used to select participants who had an experience of disclosing their HIV-positive status to their sexual partners. The name of every third client appearing on the booking list was noted by the researcher. Each third client's name was written down and placed in a container. Client's name picked from the container was picked and client confirmed to be legible for the research based on criteria of the research.

### **3.5 Data Collection**

On the first day of arriving at the clinic, the researcher was introduced to the research participants by the Chief Executive Officer of the hospital and the Operational Manager of the clinic. The general purpose and process of the research was briefly outlined to clients attending the clinic. The researcher was then given access to all clients who booked for the day in the diary kept for booking of patients for follow-up in the clinic. The client was called to a

room assigned to the researcher for interviewing clients. The researcher explained the study to individual clients. As soon as the client agreed to be part of the research, a formal written invitation was given to the clients. Most of the clients agreed on the spot to be interviewed, but some who were selected were not available to be interviewed as they cited issues such as transport and other engagements that they had to attend to. In cases where a name was picked and the client was not available, another name was picked.

A semi-structured interview was used to collect data from the participants. The instrument had two portions. The first portion contained demographic questions and the second had qualitative guiding question with possible probing questions. Demographic information gathered included gender, age, religious affiliation, level of education, type of employment and marital status. The research instrument is attached as an appendix to the report. The demographic data assisted the researcher to better understand the clients' social background. Semi-structured interviews gave the researcher and the participant flexibility to be able to follow a particular interesting avenue that emerged during data collection. It also provided an opportunity for the researcher to attain a detailed picture of the participants' beliefs about the topic under discussion. A tape recorder was used with the permission of the participants.

Each client was made aware that she/he was not forced to answer all questions and could stop participating in the study without compromising care and necessary support in the clinic. As soon as the participant has agreed to participate in the study and assigned time for an interview, a consent form that included permission to use a tape recorder was signed. A unique code number was allocated to each of the participants. The code that appeared on the tape recorder was also noted. The name, phone number and address, unique code given on the interview guide and that of field notes and tape recorded were logged. Participants were made aware that names and phone numbers were obtained for sole use by the researcher for follow up contact and would not be shared with anyone and the pocket book is the researcher's

personal possession merely for the purpose of the research. Participants were also made aware that they were not compelled to answer all questions.

Participants were also assured that in case they did not wish some of the information to be recorded that would be respected. On all probing questions permission was continuously asked from the participants. All study participants were free to answer all questions. Confidentiality of all information obtained from individual participants was assured at all times. Data were collected on a tape recorder and its use was agreed upon with the client prior to the interview so as not to disturb the communication. The purpose of the tape recorder was thus to capture information for later use in order to assist the researcher to concentrate on communicating with the client. The tape recorder was placed in such way that it did not interrupt the communication. Each participant was interviewed at least thrice, that is, when invited to the interview and signing of consent form during interview and when follow up was done to confirm what was shared with the researcher.

Data collected on the tape recorder were marked with the date, time and a unique client code. Notes on short phrases, ideas and key concepts that transpired during the interview were jotted on index cards on which clients' codes and names were omitted. The researcher had a small book with clients' coded and names which only belonged to her to allow her to follow up the client if needed. In this study, the researcher used "bracketing" where the researcher identified and set aside any preconceived beliefs and opinions about the phenomenon under investigation. The researcher identified what she expected to discover, but she deliberately set aside such ideas. Comprehension of the information was completed when saturation was reached, that is, when new data did not enrich the available information. The information obtained was read at each occasion and agreed with the participants (Babbie & Mouton, 2009).

Field notes were taken at each interview with codes attached to the field notes. Field notes assisted the researcher to remember and explore the process of the interview. Field notes assisted the researcher to register what

was heard, seen and experienced throughout the course of the interview. Initially, the researcher asked clients demographic information and filled in the first portion of the interview tool: "How would you describe your experiences of telling your sexual partner that you are HIV-positive?" The researcher initiated the discussion that was focused on the experiences of the HIV-positive clients as they described their lived experiences after they disclosed to their sexual partners that they had tested HIV-positive. Probing questions were asked based on participant's responses.

The researcher had minimal verbal response, but showed attentive listening by using non verbal cues such as 'hmm' and nodding of the head. The researcher included paraphrasing which repeated what the participant was saying as a way of verbal response. The question on the opinion of the client about disclosure of the HIV-positive status was the last question asked. The researcher repeated questions throughout. Each client was allowed to talk freely without interruption and clarification of unclear statement was asked during the interview. The participant was encouraged to pursue an interesting story line and the researcher was able to return to incomplete points where it was felt that the answer was incomplete. A summary of what the participant said, was read to agree to what was really said. At the end of the interview, each participant was asked if there was anything that she/he wanted to say or ask.

The semi-structured interview lasted about 45 minutes with each participant. Time allocated allowed the researcher to clarify questions when there was a need. Northern Sotho as a local language was used when the participants did not understand. Northern Sotho and English were used as one of the clients was from the Western Cape and only fluent in Afrikaans and English. The researcher was able to obtain a large amount of in-depth information quickly. Incidences in which the sharing of experiences were identified to pose emotional and psychological challenges, were set aside by the researcher for referral to other team members which included social workers and psychologists for further intervention.

### 3.6 Data Analysis

Data analysis is when the researcher brings order to a large body of information collected so that it can be synthesised, interpreted and communicated in a report (Polit & Hungler, 1997). Continual reflection of data was done through writing of memos throughout data analysis. Tech's open-coding method was used as discussed in Creswell (2003).

- ❖ The researcher organized and prepared data for analysis by transcribing the interview, and scanning and typing the field notes. Data were arranged into different types of sources of information
- ❖ The researcher read all transcripts one by one analyzed each transcript writing thoughts in the margin. The researcher repeated the exercise for all transcripts.
- ❖ The researcher repeatedly read the notes to obtain general meaning of the information collected to find answers of the research question and objectives.
- ❖ The mixture of information available was categorized into themes. The themes were labeled into the language of the participants. The researcher then coded the paragraphs or categories with terms that best described the information based on the language of the participants(Creswell, 2003).
- ❖ The researcher then consulted with the independent coder who is a specialist researcher to code the data.
- ❖ The researcher did not share the preliminary analysed data with the independent coder, but shared the raw information.
- ❖ The independent coder coded the raw data collected from the study participants.

- ❖ The researcher then compared the coded data with that of the independent coder.
- ❖ The researcher then had a meeting with the supervisor and the independent code to agree on codes

### **3.7 Ethical Considerations**

#### **3.7.1 Permission to Conduct the Research**

The researcher obtained ethical clearance from MEDUNSA Research and Ethics Committee (Letter of clearance is attached as an appendix of the report). Permission to access health service was obtained from the DoH Limpopo Province (Letter of permission is attached as an appendix of the report). The Chief Executive Officer of St Rita's hospital granted permission to interview clients. Informed consent was obtained from research participants after the researcher described the purpose of the study, procedures and processes of the study, discomfort, stress and loss of dignity with participants, the information required from them to continue the study. Clients were also advised that participation was voluntary and if they chose not to do so, it will not bring about any harm or penalty on them. .

#### **3.7.2 Anonymity and Confidentiality**

Participants were assigned unique codes and assured that any personal information they provided would not be published or reported using their individual names.

#### **3.7.3 Protection from Harm and Discomfort**

The researcher did not probe information that would harm the participants. The researcher was not judgmental towards the participants, and accepted what was said as the truth. Participants were told that they could withdraw from the study at any time should they so wish without any penalty or

withdrawal of current care provided at the clinic. Personal individual information obtained from clients would not be shared directly with the management or individuals providing care. Individual clients who needed specific follow-up in relation to health team members were duly referred to such, for example, the use of a social worker and likely support by a psychologist who formed part of the health care team of the clinic.

### **3.8 Trustworthiness**

Trustworthiness is the extent to which the researcher engaged in the methods of research and participants' experiences, and the ability of the researcher to replicate the findings of research and information reflecting on subjects and research (Streubert & Carpenter, 1999). In this study, the researcher used the following measurements of trustworthiness.

#### **3.8.1 Credibility**

Credibility is the ability of the method of inquiry to demonstrate that participants were accurately identified and described (de Vos et al., 2005). Credibility was ensured by using the following measures:

##### **3.8.1.1 Prolonged Engagement**

- ❖ The researcher interviewed and remained with each participant for about 45 minutes until data saturation was reached (Babbie & Mouton, 2009).
- ❖ The researcher was able to read notes taken during the interview for each participant at the end of each day on which interviews were conducted.

- ❖ Follow-up visits were scheduled, where necessary and information collected and read to individual participants to check data and agree on the interpretation of data collected.

### **3.8.1.2 Persistent Observation**

The researcher consistently pursued interpreting data collected by using different methods of participant checks:

- ❖ Follow-up visits of individual clients were done where shared information was read to the research participant's and agreement reached.
- ❖ The researcher asked different questions using a variety of methods to obtain information.
- ❖ The researcher used an interview schedule, field notes and a tape recorder to collect information from individual participants. There was a guiding question that steered the conversation with patient into a free exchange of views on beliefs and experiences related to the research question.

### **3.8.1.3 Debriefing**

The researcher consulted with an external specialist who had a general understanding and practiced proficiency of the study. The external specialist was able to guide the researcher on which steps to take to ensure credibility and trustworthiness.



### **3.9 Transferability**

Transferability is the extent and ability of the findings of the research to be applied in a similar context with other respondents (Polit & Beck, 2008; Babbie & Mouton, 2009). In this study, the researcher maintained the obligation and strategies of transferability as discussed by Lincoln & Guba (1985) namely:

#### **3.9.1 Thick Description**

A thick description is a rich and thorough account of the research context in a qualitative study (Polit & Beck, 2008). In this study, data were collected using one-to-one interviews. The researcher used one interview guide with sections on demographic and guiding questions to initiate the conversation with participants. The following approaches were used to achieve a thick description:

- ❖ Probing was used to collect further information.
- ❖ Each interaction with individual participants was noted and recorded.
- ❖ Field notes were recorded to serve as follow up for participants .

#### **3.9.2 Confirmability**

Confirmability is achieved when the research study's conclusions, interpretations and recommendations can be traced to their sources or supported by documentation (Polit & Beck, 2008; Babbie & Mouton, 2009). In this study, confirmability was assured by using the following classes of data as recommended by Lincoln & Guba (1985):

- ❖ Raw data were recorded on a tape recorder and field notes documented.

- ❖ Data reduction and analysis of field notes and summaries were performed
- ❖ Data reconstruction and synthesised themes were developed. The findings of the research, conclusion and final report were submitted to the supervisor and independent coder (Refer to Appendice 6).
- ❖ Process notes that describe the methodology used in conducting the research, trustworthiness notes and audit notes were secured for future reference and retrieval, as were materials related to the research proposal, instrument development forms, preliminary notes and intentions and expectations of the study.

### **3.10 Dependability**

Two of the 15 participants were unable to attend the interviews as they had to see to pressing personal issues. Therefore, the next available participants were interviewed. Some participants cited social problems not related to the research and the researcher had to consult and discuss the issue with the operational manager and doctors on possible follow-up dates for them to attend to such problems. The researcher submitted raw data to the external reviewer for scrutiny and coding. The report of coded report was discussed with the reviewer to reach agreement on coded data. The findings of the research, interpretation of findings and recommendations and other documents related to the research were stored.

### **3.11 Conclusion**

Chapter 3 described the research methodology used to collect and analyse the data for this study. A qualitative research approach was chosen to evaluate the experiences of HIV-positive clients who attended the Wellness Clinic at St Rita's Hospital in the Limpopo Province, and disclosed their status to sexual partners. Semi-structured interviews were conducted to collect data

from the participants. Ethical considerations were observed, and anonymity and confidentiality of the participants assured. Chapter 4 will discuss the research findings.

## **CHAPTER 4**

### **DATA ANALYSIS AND INTERPRETATION**

#### **4.1 Introduction**

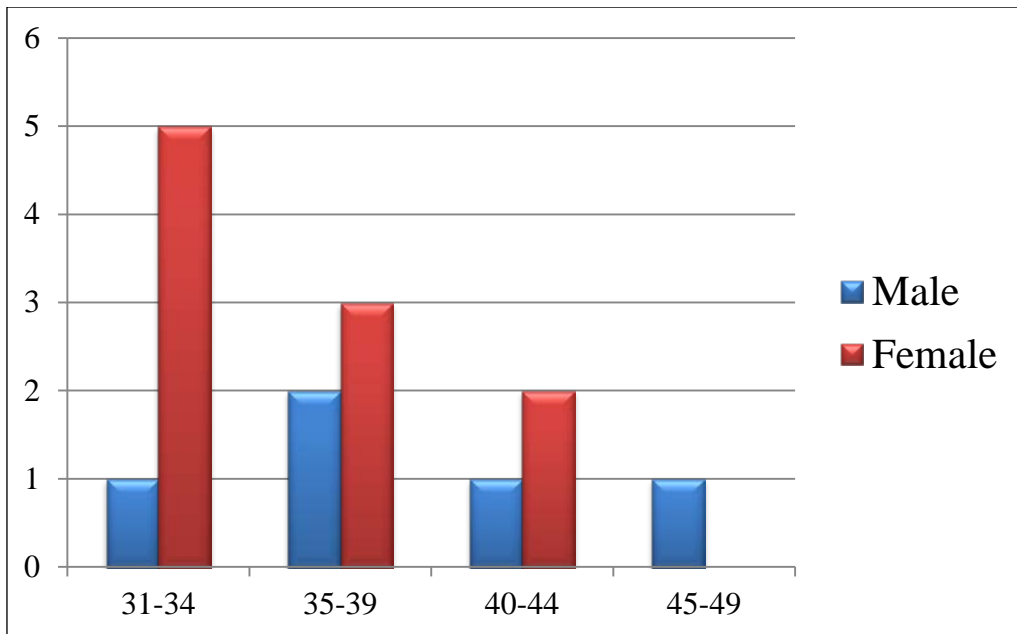
Chapter 4 discusses findings of the research undertaken at the Wellness Clinic of St Rita's Hospital in the Limpopo Province. A literature control is used in order to contextualise the findings.

#### **4.2 Demography of the Participants**

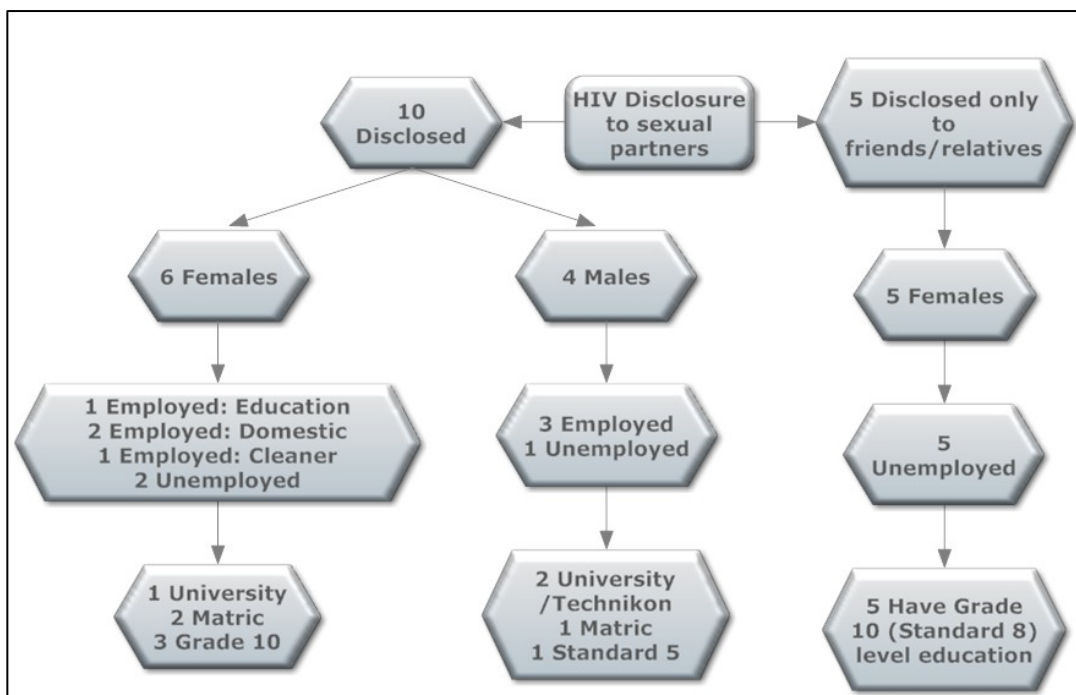
Demographic data of the participants (Figure 4.1 and Figure 4.2) such as age, gender, level of education, employment and marital status assisted the researcher to find out who amongst HIV-positive clients were able to disclose or not able to disclose their status to sexual partners. All male participants were able to disclose to sexual partners. All males were either working or self-employed and 40% have studied up to tertiary level. Five out of ten female participants were employed. Out of the ten (10) participants five (5) which is fifty percent (50%) of female participants were unemployed. Out of the 50 percent of employed participants only 10% percent had a tertiary level of education. Female participants who did not disclose were all unemployed. The ages of the participants ranged from 31 to 49 years. The mean age of the participants was 36.6 years. The participants comprised 10 females and 5 males.

#### **4.3 Themes that Emerged from the Data Analysis**

Three themes emerged from the data analysis and these are summarised in Table 4.1.



**Figure 4.1:** Gender and age of participants (n=15)



**Figure 4.2:** Gender, employment status and educational level of participants

**Table 4.1:** Themes and sub-themes

<b>Themes</b>	<b>Sub-Themes</b>
<b>1. Rejection versus acceptance of sexual partner related to disclosure of HIV-positive status</b>	1.1 Disclosure of HIV-positive status - a difficult process versus a good idea to obtain support
	1.2 Lack of disclosure of HIV-positive status to sexual partners and relatives
	1.3 Testing HIV-positive and disclosure of status not a deciding factor to maintain an excellent relationship
	1.4 HIV/AIDS signs and symptoms are not associated with the diseases of sexual partners
<b>2. Factors that precipitate HIV infection and transmission</b>	2.1 Extramarital sexual engagement with an HIV-positive partner
	2.2 Lack of honesty about disclosing an HIV-positive status
	2.3 Male partners refusing to use condoms despite knowledge of HIV-positive status
<b>3. Consequences of an HIV-positive result</b>	3.1 Male partners get more agitated after an HIV-positive test result than their female partners
	3.2 Different HIV test results for partners lead to a strenuous

relationship or a termination of intimacy

3.3 Lack of disclosure of an HIV-positive status leads to feelings of discomfort around one's partner

3.4 Disclosure of HIV-positive results leads to a positive and healthy lifestyle of infected people

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#### **4.3.1 Theme 1: Rejection Versus Acceptance of Sexual Partner Related to Disclosure of HIV-Positive Status**

Some participants indicated that they were shocked when they learned that they were diagnosed HIV-positive, whilst others, although shocked, accepted their HIV-positive status as, currently in their community, the disease was equated to flu. Some participants reported that they were somehow rejected by sexual partners after disclosing their HIV-positive status. Other participants reported acceptance by sexual partners in the form of material and psychological support as they were sick and subsequently tested HIV-positive.

##### **4.3.1.1 Sub-Theme 1.1: Disclosure of HIV-Positive Status - A Difficult Process Versus a Good Idea to Obtain Support**

There was a problem with females disclosing HIV-positive status to sexual partners. All males reported to have disclosed immediately to their sexual partners. Female participants below the age of 35 years were able to disclose more readily to sexual partners. Some participants experienced violence post-disclosure of their HIV-positive status to sexual partners. The sexual partners refused to use condoms and had unprotected sex and the participants did not indicate whether they have tried to use female condoms.

One participant said: *“It was difficult for me to disclose because he previously refused to present himself for treatment of sexually transmitted infections. I kept on motivating him for HIV test without disclosing. He was refusing. I left to stay with my brother, we both tested and he tested negative and I tested positive. I told him about my initial HIV-positive test then. After the test he blamed me for having not informed him about my intentions to test and not disclosing immediately. He, however, continued to refuse the use of condoms. We had sex without condoms.”*

The response implied that disclosure of an HIV-positive status could be a difficult process and not a good idea to obtain support from a sexual partner and may even result in further spread of HIV if condoms are not used.

According to WHO (2003, rates of disclosure to previous and current casual sexual partners ranged from 42-100% in developing countries and 86% in developed countries. Lowest rates of disclosure of HIV-positive status were found in Sub-Saharan Africa in antenatal women as 16.7% to 32%. King et al. (2008) suggests that the ability of the individual to effectively prevent HIV transmission and adopt protective behaviours is when she/he knows the HIV status of the sexual partner. Disclosures of the sexual partners' serostatus enable them to make informed sexual behavioural choices, appropriate care, treatment and preventive measures to curb the infection.

Mkhize (2011) indicated that participants experienced shock and disbelief after testing HIV-positive which is similar to the research findings of study. Some study participants indicated that they experienced various forms of discrimination from sexual partners following disclosure of their HIV-positive status. Women participants reported breakups in marriages and sexual relationships with sexual partners after disclosure of their HIV-positive status. The study also indicated positive events in participants who tested HIV-positive and disclosed to sexual partners (Grinstead et al., 2001).

Cloete et al. (2010) reported that some participants cited fear and discrimination, including loss of support and accommodation after disclosure



of their HIV-positive status. Some study participants in the USA were found to be affected by psychological challenges that led to psychiatric problems due to stigma as they showed signs of HIV/AIDS illnesses. The impact compromised their ability to adhere to treatment and to disclose to sexual partners (Vanable et al., 2006). Gielen ,et al. (2000) noted that women who experienced violence in their relationships usually delayed disclosure of their HIV-positive status because of fear and discrimination that may result from the sexual partner's response to an HIV-positive status.

Some women in studies conducted by Gielen et al. (2000) and Mkhize (2011) endured non-disclosure and continued to have unprotected sex with sexual partners because of fear of violence. Gielen et al. (2000) further indicated that abuse was common in women who disclosed to sexual partners where the sexual partners HIV status is negative or unknown. Some study participants who did not disclose to sexual partners lacked basic knowledge on HIV/AIDS (Saggurti et al., 2012). Results of a study by Saggurti et al. (2012) indicated that health workers might not have warned the study participants on risks associated with disclosure of HIV-positive status which included violence and dissociation of the relationships. These findings seem to be congruent to the findings in the present study where one of the participants indicated to have continued not to disclose and had unprotected sex with a violent sexual partner whose HIV status was unknown to the study participant.

Parsons et al. (2004) drew attention to negative experiences associated with the disclosure of an HIV-positive status to sexual partners, including stigma, rejection, loss of intimacy and threats. Positive experiences of disclosing an HIV-positive status include increased social support and intimacy with sexual partners. Some participants indicated that they therefore chose to have sexual relationship with partners with similar HIV status.

Paiva et al. (2011) highlighted that some HIV-negative partners continued to have unprotected sex with HIV-positive sexual partners in marriage. Some participants indicated that lack of disclosure was related to a desire to protect

the relationship against challenges. Sullivan (2005) found that research participants indicated that for a successful disclosure of an HIV-positive status to sexual partners they need improved self-esteem, trust and emotional support in the relationship. Some participants indicated that they were unable to disclose to sexual partners and others could not disclose and use condoms in a sexual relationship of only one day.

Nebie et al. (2001) found that some women continue to become pregnant after knowledge of their HIV status, as they seemed to value giving birth as a social responsibility of women versus their individual life, health and that of their unborn children as some tend to transmit the HIV infection to their unborn children. Kadowa and Nuwaha (2009) indicated that disclosure of an HIV-positive status can create awareness on HIV risks amongst sexual partners and partners are able to discuss subsequent reproductive choices that could reduce MTCT of HIV/AIDS. Findings in this research could not indicate that disclosure with mutual HIV testing conferred improved risk reduction and support amongst HIV-positive clients.

#### **4.3.1.2 Sub-Theme 1.2: Lack of Disclosure of HIV-Positive Status to Sexual Partners and Relatives**

Only six out of ten women who participated in this study were able to disclose their HIV-positive status to their sexual partners. Some of these women were not aware of the HIV status of their sexual partners or were told by sexual partners that they were HIV negative as they did not test together. Some research participants indicated that issues of disclosure were not discussed in the Wellness Clinic whilst others stated that they did discuss issues of disclosure of HIV-positive status to sexual partners. One of the participants indicated that she had been on treatment for 8 years and stayed with the same sexual partners with unknown HIV status and to whom she has not disclosed her HIV-positive status and had not used condoms:

*"I started to be ill in 2006 and I've been taking treatment for the past 8 years. My sexual partner is the father of my youngest child. We have been staying*

*together for more than 8 years. I did try to discuss HIV issues with my partner. He went to town and told me that his doctor says he is negative. I did not reveal mine, but I however think that the wife is also positive. I found an empty container of alluvia. I know the types of treatment because I am also on treatment. I asked my partner what is this? and he replied 'I've noticed that my wife is hiding some treatments'.*"

Another participant said: *"I started to be ill. I left Gauteng for home. I came in the clinic and requested an HIV test. I tested HIV-positive, I have not disclosed to him."*

The study undertaken by Finger et al. (2012) revealed that HIV-positive women who acquired HIV due to sexual behavioural challenges continued to have a desire to fall pregnant despite their HIV-positive status. Deribe et al. (2008) pointed out that HIV-positive clients commonly want to disclose to sexual partners, irrespective of being male or female, as both sexes perceive disclosure as a healthy way of life for individuals who live together. Deribe et al. (2008) suggested that individuals who are infected with HIV tend to be more likely to disclose to sexual partners whom they know is HIV-positive rather than an HIV-negative sexual partner or a sexual partner with an unknown status.

DoH South Africa and SANAC (2012) alluded to the fact that more women than men are infected with HIV, possibly due to their low socio-economic status and poor literacy levels compared to their male counterparts. Lower education and employment levels tend to make women dependent on their male sexual partners for a livelihood which may further contribute to women not being able to negotiate for safer sex. According to Mucheto et al. (2009), women's fear of divorce and relationship dissolution presents an impediment to disclosure of HIV-positive status to sexual partners. Mucheto et al. (2009), therefore, suggested that capacity building on strategies that may assist disclosure of HIV-positive status in clients who have challenges on how to do that should be developed. This could assist women to challenge

normative values that hamper disclosure of an HIV-positive status to sexual partners as expressed by most HIV-positive women.

In a one-year study, Wilson et al. (2007) discovered that one third of HIV-positive women were involved in new relationships, some in less than 6 months. These women were found to be using condoms, but have not disclosed their HIV-positive status to sexual partners as compared to women in steady relationships. Wilson et al. (2007) accordingly suggested that discussion on disclosure to sexual partners should be ongoing during wellness clinic attendance to accommodate clients who had initiated newer relationships and might experience challenges in disclosing their HIV-positive status to new sexual partners.

Cooper et al. (2007), in their study in South Africa, cited that cultural and social expectations for men and women also have an impact for men and women who do not have children. Perceived reproductive prospects from the social circle of HIV-positive study participants created a painful dilemma for reproductive choices. Some HIV-positive clients indicated social pressure from societal expectations to have children and this could be one of the contributory factors that inhibit HIV-positive clients not to disclose to sexual partners and relatives for fear of disapproval and stigma attached to such decisions.

#### **4.3.1.3 Sub-Theme 1.3: Testing HIV-Positive and Disclosure of HIV-Positive Test Not a Deciding Factor to Maintain An Excellent Relationship**

Some clients were separated from their sexual partners after they disclosed their HIV-positive status. One participant experienced abuse after both were counselled and tested for HIV. She tested HIV-positive and the sexual partner tested HIV-negative. The sexual partner refused to use a condom. The sexual relationship between the two deteriorated. One participant reported to be uncomfortable with the use of condoms after they were both counselled as a couple and tested for HIV. He tested HIV-positive and the

wife tested HIV-negative. The following story lines surfaced in interviews with the research participants:

*“He refused to use condoms, sexual relations deteriorated. He has stopped visiting me. He took the medical aid card that he provided and removed my name. He is staying with another woman.”*

*“We used the condoms and my wife insisted. I was not happy because as I was sitting alone I would re-think about it. What is the meaning of this marriage? We are young and we don’t have children. We later separated due to other reasons.”*

According to Mlambo and Peltzer (2011) and Dlamini et al. (2007), in some African countries, including South Africa, the way in which individuals respond to disclosure of HIV-positive status to sexual partners is quite complex. The contextual environment of the individual to some extent also determines whether to disclose or not disclose, to accept disclosure or not. Disclosure of HIV-positive status to sexual partners is determined by various factors such as personal factors, the nature of the relationship and challenges related to the relationship. Some study participants’ experienced verbal and physical abuse and neglect as they disclosed to some social networks in their living environment (Dlamini et al., 2007). Mucheto et al. (2009) and WHO (2004) recommended that HIV-positive clients should be encouraged to disclose their status to sexual partners. Disclosure of HIV-positive status to sexual partners could reduce the number of new infections of HIV/AIDS in member countries.

Ateka (2006) is of the opinion that public health should not be compromised by social support in the disclosure of an HIV-positive status as the benefits of public health in disclosure outweigh that of social support. further argues that disclosure by clients of an HIV-positive status to sexual partners does not always mean the sexual partner will accept the status and offer support to clients. It depends on how the other perceives the social environment in which she/he happens to find himself/herself in (Ateka, 2006).

#### **4.3.1. Sub-Theme 1.4: HIV/AIDS Signs and Symptoms are Not Associated with the Diseases of Sexual Partners**

Some participants were motivated by ill health to be tested for HIV/AIDS and only one male participant was motivated by the ill health of his sexual partner. Some of the participant's sexual partners were aware or suspected the presence of opportunistic infections in their sexual partners, but continued to have unprotected sex.

One participant indicated: *"I started to be ill in 2006. I've been taking treatment for the past 8 years. I found an empty container of Aluvia in my partners' bedroom where he stays with the wife."*

Wamoyi et al. (2011) indicated that some men did not disclose their HIV-positive status to sexual partners in a new relationship as they assumed that these partners knew about their HIV-positive status because they reside in the same village. New sexual partners might have heard or observed signs and symptoms of HIV/AIDS. Hong et al. (2006) found that HIV-positive individuals continued to perceive the HIV status of sexual partners on their physical appearance. HIV-positive individuals continued to have unprotected sex with sexual partners who did not show observable physical characteristics of HIV/AIDS.

Marks et al. (2005) found that some HIV-positive clients had a challenge in maintaining behavioural change of using condom consistently. Some study participants were found to be having STI after they were diagnosed HIV-positive and were on ARV. Gilbert & Walker (2010), in a study in South Africa, indicated that participants shared experiences of stigma and discrimination of people known to be HIV-positive within communities they lived in. The intensity of the perceived stigma and discrimination shaped their daily lives as they tried to cope with the disease - which contributed to some participants not adhering to treatment or disclosing their HIV-positive status to significant others, including sexual partners.

### **4.3.2 Theme 2: Factors that Precipitate HIV Infection and Transmission**

Eleven out of 15 participants disclosed to sexual partners. Six female participants disclosed immediately and 3 later after the test result. It took up to 3 months for some female participants to disclose their HIV-positive status to sexual partners. Two out of the three females who delayed disclosure continued to have unprotected sex with sexual partners in spite of the pre- and post-counseling of HIV-positive clients on the use of condoms.

#### **4.3.2.1 Sub-Theme 2.1: Extramarital Sexual Engagement with an HIV-Positive Partner**

Some of the participants continued to have unprotected sex in extramarital sexual relationships. Other participants indicated using condoms and being on ARV, but continued to have sexual relations with a partner whose serostatus was unknown. One participant continued to have children outside wedlock with women of unknown HIV status and he also did not disclose the HIV-positive status to any of those women.

A male participant shared his experience: *“I disclosed immediately to my wife. She tested HIV-negative. Our last child was born in 2007 and she died in 2009 due to query cocaine overdose. I have total of 18 children, including three in my marriage. I don’t know the HIV status of my sexual partner neither of my children. I have not disclosed to my sexual partners.”*

A female participant shared her story line: *“I tested HIV-positive in 2009 and I did not believe it. I did not disclose to my husband as my husband discusses our marital issues with the mother in law who is not supportive. I have other sexual partners, but they don’t know my HIV-positive status. My other sexual partners help me to support my family as my husband was not working. They helped me build the house and buy furniture. My husband has just started working and he is not providing well financially for the family. I also have the responsibility to take my children to school.”*

Multiple sexual partners were found to be one of the sexual behavioural challenges that increased spread of HIV/AIDS amongst sexual partners (DoH South Africa and the South African National AIDS Council (SANAC), 2012). Marks et al,(2005)also found that study participants did not disclose any STI six months after diagnosis, but reported STI after 5 years on ARV. Some participants reported not to have used condoms with recent partners. Bunnell et al. (2006), also found that risky sexual behaviours occurred in married and cohabiting couples wherein the sexual partner seeking medical support did not know the HIV status of the other sexual partner. Consequently, Bunnell et al. (2006) suggested couple counselling and testing of sexual partners to prevent HIV transmission and possible resistance to ARV that may arise due to reinfection of clients on ARV.

Marks et al. (2005) also indicated that some men and women who tested HIV-positive on wellness programmes tend to have other STI indicating that they might be having unprotected sex. Large proportions of women were found to be infected by sexual partners who had extramarital sexual relations. Dunkle et al. (2008) asserted that married women are at higher risk of contracting HIV due to their husbands' extramarital sexual relations that is predominant in most African countries. Dunkle et al. (2008) cited gender inequality created by culture and economic status as one of the factors that could be contributing to increased male-to-female HIV transmissions in developing countries.

Shisana & Simbayi (2002) also suggested that the low social status of women and their economic dependence on male sexual partners allow male sexual partners to determine the type of sexual life in the sexual relationship, which may be coercive and violent. Ainsworth & Teokul (2000) recommended that developing countries which have resource constraints should develop effective economic strategies that integrate poverty alleviation programmes with HIV mitigation strategy. Ainsworth & Teokul (2000) intimated that such an economic strategy could have better impacts more than looking at the general community that include people who are not directly affected by HIV/AIDS.



Corno & de Walque (2012) suggested that extramarital relations due to migration into mines by men from Lesotho and Swaziland could be one of the contributors to the increased incidence of HIV/AIDS in Lesotho and Swaziland. Distant relations tend to contribute to sexual partners engaging in extramarital sexual relations in which condoms are not used and hence contributing to the spread of HIV/AIDS amongst sexual partners. Dunkle et al. (2008) suggested that comprehensive HIV/AIDS intervention strategies should include communities to challenge sexual behaviour rooted in culture that seem to allow men to have extramarital sexual relations that predispose women to risky unprotected sex that increase the incidence of HIV/AIDS within marriages.

The DoH South Africa and SANAC (2012) indicated that the use of alcohol and drugs could be one of the factors that contribute to HIV transmission when used by HIV-positive sexual partners. Mlambo & Peltzer (2012) stated that the use of alcohol and drugs are predisposing factors in transmission of HIV among individuals 21-35 years of age and 63.5 % of the unemployed, of which 53 % constitute females.

#### **4.3.2.2 Sub-Theme 2.2: Lack of Honesty About Disclosing an HIV-Positive Status**

Participants reported their intention to disclose, but the fear of rejection and possible dissolution of the relationship prevented them from doing so. Some of the males and females were not honest about disclosing their HIV-positive status.

One of the participants said: *“We used the condoms and the wife insisted. I was not happy and would re-think about it. What is the meaning of this marriage? We are young and we don’t have children. I was unhappy about the situation. We separated and I married another woman. I was afraid to disclose. I thought she will leave me. I loved her. She looked normal. I would sometime give her the pill out of mercy feeling pity for her, but afraid to tell her. I only told her after the birth of our child.”*

Wamoyi et al. (2011) and Loubiere et al. (2009), indicated lack of honesty in sustaining healthy sexual behaviour, including consistent condom use among HIV-positive clients on ARV. Some research participants continued to have unprotected sex despite HIV-positive status (Loubiere et al., 2009; Benotsch et al. 2012). Some clients were able to abstain from sex due to poor health at 3-6 months after initiating ARV. Clients, however, reported to have resumed sexual desire after 30 months and some would not adhere to consistent use of condoms (Wamoyi et al., 2011). Participants indicated that they used sex to cement their relationship once their health improved (Allen et al., 2011).

Mucheto et al. (2009) found that participants who fear dissolution of the relationship if they were to disclose their HIV-positive status were unlikely to disclose. Olley et al. (2005) corroborated that dissolution of a relationship is a predominant psychological impediment to clients who tested HIV-positive, and such clients were unlikely to disclose their status to sexual partners.

The importance of disclosure to sexual partners is discussed in both pre- and post-counselling for HIV testing in training manuals for health workers in South Africa. Couple counselling with mutual disclosure is recommended for sexual partners (WHO, 2007; DoH, 2010). More than 50% of clients who are HIV-positive in Sub-Saharan Africa have HIV-negative partners. Some HIV-positive clients have not tested or have tested and the HIV status of the sexual partner is unknown and they continued not using a condom, thus compromising the health of the partner (WHO, 2011; DoH, 2010). Therefore, sexual partners should be motivated to test for HIV together and disclose test results to each other. Mutual disclosure of HIV-positive status will increase access of sexual partners to testing and comprehensive HIV/AIDS care (DoH, 2010; WHO, 2007).

Added benefits to sexual partners who have disclosed to each other would encourage sexual partners to take informed decisions about HIV/AIDS prevention and family planning. Disclosure of HIV-positive status could make sexual partners to adopt safer sexual behaviours that include consistent use of both male and female condoms (WHO, 2007). The findings of this study

indicate that although one study participant was counselled and tested with the sexual partner, he was not comfortable using a condom, hence he delayed disclosure of his HIV-positive status to the second wife as she suspected that she might not be HIV-positive and could leave him should she know his HIV-positive status. These findings are in agreement with those of Mucheto et al. (2009) that HIV-positive clients who fear dissolution of the relationship may not readily disclose HIV-positive status. Paiva et al. (2011) concurred that some HIV-positive clients readily disclose in steady regular relationships.

#### **4.3.2.3 Sub-Theme 2.3: Male Partners Refusing to Use Condoms Despite Knowledge of HIV-Positive Status**

Some female participants reported that they have disclosed to sexual partners, but sexual partners refused to use condoms. The use of female condoms was not indicated by these female participants as part of their responsibility to reduce the transmission of HIV/AIDS. Female participants also continued to allow unprotected sex and some had children even after being counselled by health workers and knowing their HIV-positive status.

One participant said: *“After 3 months of taking ARV I started to regain my weight with big buttocks. I went back to Pretoria. My partner is refusing to use condoms. We have a baby who is negative, my viral load is undetectable and he is negative. My partner went for testing alone and he says is negative.”*

One couple shared the following storyline: *“Sister we did not believe the test, we thought it was unreliable and just said it gave wrong readings. We continued with unprotected sex until my husband started to feel unwell. He was tested and the results for both are positive.”*

The woman further shared and said: *“I have a problem as doctors are always changing my treatment. As I checked the clinical notes I found that the viral load that was initially going down is now going up. Increase in viral load could*

*be indicating some treatment adherence problem which unprotected sex is part of the contributors of a rise in viral load.”*

Shisana and Simbayi (2002) indicated that the socio-economic low status of women contribute to HIV transmission as they are forced to be submissive allowing sexual partners to determine their sexual life hence leaving them with limited decision making. Some women experienced violent sex by coercion within the sexual relationship. Marie et al. (2011), however, in a study conducted in Cameroon, indicated that women in steady relationships, but not those below the poverty line and not heads of household, were able to negotiate the use of condoms and disclose HIV-positive status to their sexual partners.

WHO (2004) indicated that disclosure of HIV-positive status was common in steady relationships and amongst sexual partners who are both HIV-positive. Similar findings by Paiva et al. (2011) indicate that study participants were more readily able to disclose HIV-positive status better in steady and regular sexual relationships than in casual relationship. Kiene et al. (2010), in a study in Uganda, found that , provider-initiated HIV/AIDS counselling and testing HIV-positive revealed increased sexual risk behaviour, and disclosure of an HIV-positive status among clients who tested within the researched clinics. Participants who indicated risky behaviour initially improved and indicated abstinence and consistent use of condoms in follow up visits. However, Eisele et al. (2009) and Paiva et al. (2011) indicated that some study participants who have disclosed their HIV-positive status to sexual partners and were on ARV continued to have unprotected sex. These findings are similar to those reported in this research study.

Fan et al (2012) emphasized that men continued not to use condoms in recent sexual debuts and were found to have other STI as well, despite knowledge of their HIV-positive status. Disclosure of HIV-positive status was reportedly low and they indicated unprotected sex with sexual partners of unknown HIV status. Disclosure of an HIV-positive status to a sexual partner is key to prevention and control of HIV/AIDS as such communication may

motivate sexual partners to seek testing, reduce risky sexual behaviours and receive support that include ARV (Gari et al., 2010). In this study, the findings indicate that sexual partners, in spite of the other partners disclosing HIV-positive status, were not very amenable to be tested for HIV and have mutual disclosure of their individual HIV status.

### **4.3.3 Theme 3: Consequences of An HIV-Positive Result**

#### **4.3.3.1 Sub-Theme 3.1: Male Partners Get More Agitated After An HIV-Positive Test Result than Their Female Partners**

Participants in this study expressed feelings of distress in relation to their HIV-positive ELISA test results, as well as to childbearing and the consistent use of condoms. Although they disclosed their HIV-positive status and could understand the implications for childbearing and transmission of HIV infection to children, it caused some form of detriment. One participant expressed the desire to have children as she and her partner were young and did not have children.

All five male participants were married and were able to disclose to their sexual partners after they tested HIV-positive. One male tested HIV-positive and the wife was negative. The couple did not have children. The sexual partners divorced, but the male partner narrated that it was not related to his HIV-positive status. One of the male participants only believed the test results after he became ill and lost weight, he was then motivated to have an HIV test with his wife and accepted the use of condoms in the sexual relationship. Another male client said that even though he disclosed his HIV-positive status to his wife who tested HIV-negative, he continued to have extramarital sexual relationships and impregnated other women whose HIV status he did not know. He has never disclosed his HIV-positive status to any of these sexual partners. His wife had 3 children after he tested HIV-positive and later died from what the husband suspected was an overdose of cocaine.

*“I tested HIV-positive in 1986 and was on chronic medication which was arranged by my company. I was married to an Indian lady and we had 3 children. I told her immediately that day after a positive test. We used condoms, but had children as she tested HIV-negative and all of our children are healthy. I have about 18 children in total, including those from other relations. I am using condoms. I am not sure about the health of other sexual partners and children. My wife died from a query overdose of cocaine.”*

Another participant shared his experience thus: *“My wife insisted that we use condoms. I was not happy because as I was sitting alone I would re-think about it. What is the meaning of this marriage? We are young and we don’t have children. Sister at the clinic said I will never have children maybe after 5 years if God grant that. I was unhappy about the situation. We separated for other reasons. I married another woman and I was afraid to disclose as I thought she will leave me. I loved her and she looked normal. I would sometime give her the pill out of mercy feeling pity for her but afraid to tell her.”*

Kalichman et al. (2002) in the USA found that HIV-positive males continued to have unprotected sex with regular steady partners and casual partners in spite of indicating they have disclosed their HIV-positive status to sexual partners. By contrast, Relf et al. (2009) , reported that some men indicated that they disclosed their HIV-positive status in new relationships to show honesty and not to infect the new partner. Some male participants indicated that it was their responsibility to be truthful and not to lie and this was more important than the negative outcome that they might get from the new sexual partner.

Visser et al. (2008) observed that some pregnant HIV-positive women indicated that their sexual partners responded with disbelief to their HIV-positive status. The study by Visser et al. (2008), therefore, suggests that HIV-positive women should receive ongoing counseling and support to enable them to disclose their HIV-positive status to their sexual partners. Bruce ,et al. (2012) further noted that male participants on ARV who believed that an

undetectable viral load reduces infectiousness continued to have unprotected sex with sexual partners who were either HIV-positive, HIV-negative or of unknown HIV status.

Nattabi et al. (2009), in reviewing published literature on fertility intentions of HIV-positive men and women predominantly in Sub-Saharan Africa and Asia, found that both men and women tended to be influenced by cultural and societal expectations, despite having obtained information on the health risks for pregnancy and childbearing at the wellness clinic they attended. The study found that women got pregnant after their HIV-positive status was diagnosed. Societal expectations included the preservation of lineage and kinship amongst men and women.

Nattabi et al. (2009) suggested that health workers and policy makers should be sensitive to the impact of culture and fertility in providing health services and systems to HIV-positive men and women. It has been suggested that health workers should not be hostile and should correct attitudes and support HIV-positive clients who wish to have children as this may deny PLWHA access to comprehensive HIV/AIDS programmes.

Kaida et al. (2011), in a study conducted in Soweto, South Africa, indicated that part of the challenges for HIV-positive men and women is ability to have children. The study found that a third of the total female participants had a desire to have children. These authors also suggested that although this was not a significant number comparatively, it could enhance access to comprehensive HIV/AIDS care. In addition, HIV-positive clients tended to have children despite their intentions based on cultural and societal pressures, that is, their desire to assume parenthood is grounded in role expectations of men and women.

Taulo et al. (2009), in a Malawi study, indicated that women were inclined to change their decision from not intending to have children to wanting to have children based on cultural expectations. The number of children in the family was found to influence the desire in women to have children, even amongst

HIV-positive women, in spite of the knowledge of the risks to pregnancy and MTCT of HIV associated with an HIV-positive status.

Kaida et al. (2011) suggested that health workers should be non-judgmental and should improve the attitude of undermining client's reproductive desires of HIV-positive clients when providing health care. Kaida et al. (2011) further suggest that comprehensive HIV/AIDS care should also include termination of pregnancy in the comprehensive HIV/AIDS care to ensure optimal services to men and women who are HIV-positive.

#### **4.3.3.2 Sub-Theme 3.2: Different HIV Test Results for Partners Lead to a Strenuous Relationship or a Termination of Intimacy**

Some of the reasons for delaying disclosure of an HIV-positive status include infidelity, gender violence, poor communication and insufficiency of social support. One male participant was uncomfortable because his partner tested HIV-negative and insisted on condom use while his desire was to have children within the relationship. They subsequently separated and he did not disclose immediately to the new sexual partner. The following is an example of some of the negative responses that HIV-positive clients experienced after disclosing their status to sexual partners:

*“After the test he blamed me for having not informed him about my intentions to test and not disclosing immediately. He continued to refuse the use of condoms and we had sex without condoms.”*

Gilbert and Walker (2010), in a study completed in South Africa, indicated that participants shared experiences of stigma and discrimination from people within their communities. The intensity of the perceived stigma and discrimination shaped their daily lives as they lived with the disease which contributed to some participants having to compromise taking the HIV test and having to disclose their HIV-positive status to significant others. Another study in the Kemissie district of northeast Ethiopia concluded that prior discussion with the sexual partners on intentions to test for HIV, including



knowledge of a partner's HIV status facilitated the ability of the sexual partner to disclose an HIV-positive status (Seid et al., 2012). However, those who did not disclose indicated that they feared divorce, stigma and physical abuse. Challenges associated with disclosure included abandonment, loss of support, divorce, possible physical abuse, loss of custody of children and property (Kadowa & Nuwaha, 2009; WHO, 2004; Seid et al., 2012). These studies corroborate the results obtained with HIV-positive clients in St Rita's Hospital, Limpopo Province.

#### **4.3.3.3 Sub-Theme 3.3: Lack of Disclosure of an HIV-Positive Status Leads to Feelings of Discomfort Around One's Partner**

Lack of disclosure of their HIV-positive status filled some clients with feelings of guilt and pity for their partners. Some participants wanted to disclose, but were afraid to do so due to environmental barriers, that is, all the circumstances, people, things, and events around them that affect their life.

One participant shared her experience and said: *"I wanted to disclose to my husband. It was difficult and I was afraid. I was not sure of what I feared. It hurts me each day as we were sitting together chatting or doing things together that I have this secret that I cannot tell. I knew that HIV is transmitted through unprotected sex and we continued to do that with him not knowing."*

Another participant said: *"I wanted to tell her and I was afraid that she would leave me. I loved her. I felt pity for her that I sometimes gave her the pill thinking that it would prevent transmission of the disease to her."*

These observations are similar to those reported by Wong et al (2009) and Paiva et al. (2011) who also found that HIV-positive participants were eager to release their guilt of not disclosing their HIV-positive status to their sexual partners. The desire to disclose an HIV-positive status was motivated by intrinsic feelings that somehow denoted responsibility and preparedness to stop transmitting the HIV-positive virus to sexual partners.

Blem's (2008) study showed that participants who were fathers indicated that they disclosed their HIV-positive status and ended extramarital relations as part of their preparedness to assume a positive responsibility in the family. Disclosure of an HIV-positive status brought cohesion and better planning for the future within their individual families. However, some fathers indicated that they encountered challenges in disclosing their HIV-positive status as they felt vulnerable to the situation. Such vulnerability was also reflected in this study as one male client was afraid to disclose his HIV-positive status. It is likely that he also infected his naive sexual partner. Zea et al. (2005), indicated that study participants felt relief of psychological depression associated with lack of disclosure to sexual partners. Some participants further indicated that they received social support from their sexual partners subsequent to disclosure of their HIV-positive status.

#### **4.3.3.4 Sub-Theme 3.4: Disclosure of HIV-Positive Results Leads to a Positive and Healthy Lifestyle of Infected People**

One of the participants tested because he discovered that his wife has been using ARV for 2 years. His HIV-positive results were disclosed immediately to his wife. Since then, the couple had been using condoms consistently and supporting each other to improve adherence to ARV. The participant continued to be an ambassador of HIV at work and with friends. He was able to share his HIV-positive status with friends as he encouraged those who looked ill to do the HIV test as they sought solutions to their individual health challenges.

One participant said: *"I am married and I don't stay with my wife as I have not completed some of the rituals. We regularly visit each other and have 4 children. She has been taking treatment for 2 years, but hiding it from me. I noticed her movements. I then confronted her. I went for a test and tested positive. I accepted the test and I immediately disclosed to my wife. Our relationship is healthy and we use condoms."*

Another participant said: *“It seems as though this HIV comes from her side, but I have accepted as we have 4 children and the disease is like flu. What helped me to accept is that I am a treatment supporter to several of my friends.”*

Vira's (2003) research conducted in India established that research participants seem to prefer to disclose to sexual partners rather than to extended families. Disclosure to sexual partners as compared with American practice somehow differed as Indian culture makes it obligatory for males to do so. Shriver, Everette and Morin (2000) recommends that public health communities should include PLWHA in deriving solutions that could mitigate primary prevention of HIV transmission. Inclusion of HIV-positive individuals in campaigns that raise awareness could reduce stigmatisation of HIV in communities.

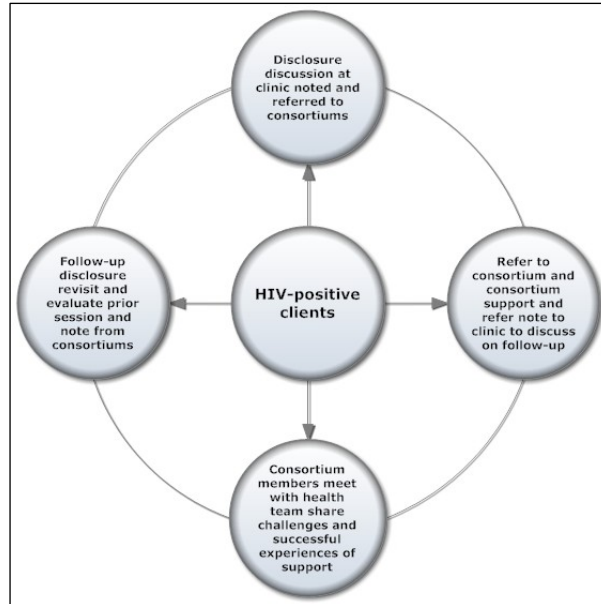
The level of stigma in South Africa hinders HIV-positive people to safely use condoms and disclose their status in order to access a range of services. There is a critical need to devise intervention strategies that would improve the capacity of HIV-positive people to live optimistically with their HIV-positive status (Skinner & Mfecane,2004). Management of stigma would impact on maintenance and control of the HIV/AIDS epidemic in South Africa.

UNAIDS (2010) advised member states to include PLWHA in government initiatives that discuss, plan, implement, monitor and evaluate HIV in the country. Subsequently, South Africa has endorsed the plan and implemented inclusion of PLWHA in all HIV initiatives of the country (DoH, 2010). Bravo et al. (2010) indicate that HIV-positive people are faced with several psychosocial challenges which include disclosure of HIV-positive status, adherence to ARV and parenthood decisions. The authors recommended that HIV-positive clients should be carefully supported by understanding their views on such challenges to reduce the psychosocial impact of HIV-positive status and use of ARV and related behavioural protocols they have to adhere to enable them to accept and live with the HIV-positive status

UNAIDS (2000) indicated that public figures like politicians, musicians and other influential people should be involved to provide human faces to the HIV epidemic in the country which would affirm acceptance of PLWHA and eradicate stigma-related attitudes in communities. UNAIDS (2000) further suggested that direct support of community-based projects that take care of PLWHA will enhance and encourage individuals to test for HIV and disclose an HIV-positive status to protect their sexual partners.

#### **4.4 Guidelines for the Process of Disclosure of an HIV-Positive Status to Sexual Partners**

Clients who encounter challenges in disclosing HIV-positive status and are sexually active should be encouraged to consistently use condoms and disclose to sexual partners. The service providers for comprehensive HIV/AIDS care should develop an institutional arrangement within the services that will enhance disclosure of HIV-positive status to sexual partners as directed in HIV/AIDS policies and enshrined in the country's constitution. St Rita's Hospital should consider initiating a community consortium that will inspire elimination of the stigma attached to HIV/AIDS and, at the same time, improve access to services that seek to reduce the incidence of HIV/AIDS as well as to enhance the life of PLWHA. Further research should be done in an attempt to heighten disclosure of an HIV-positive status and motivate subsequent HIV testing to reduce challenges related to disclosure of clients' HIV-positive status to sexual partners (Figure 4.3 and Table 4.2).



**Figure 4.3:** Guidelines for health care workers to enhance and support HIV-positive clients to disclose their status to sexual partners

**Table 4.2:** Guidelines for disclosure of an HIV-positive status to sexual partners

<b>Theme 1: Rejection versus acceptance of sexual partner related to disclosure of HIV-positive status</b>	
<b>Sub-Theme</b>	<b>Guidelines</b>
1.1 Disclosure of HIV-positive status - a difficult process versus a good idea to obtain support	Disclosure of HIV-positive status to sexual partners should be encouraged. In pre-counseling, counselors should note all responses to client counselling and anticipated responses of sexual partner to a disclosed HIV-positive status in the client's notes.
1.2 Lack of disclosure of HIV-positive status to sexual	Partner notification benefits should be ongoing for all clients' on

partners and relatives

wellness, especially for the current partner, if sexually active. Couple counselling with testing and mutual disclosure should be encouraged.

- 1.3 Testing HIV-positive and disclosure of status not a deciding factor to maintain an excellent relationship

Community consortiums with chiefs and indunas as chairperson should be formed to encourage and plan support for disclosure of an HIV-positive status in clients who are faced with cultural and socially embedded challenges.

The community consortium should comprise a range of professionals and key persons in the community such as lawyers, gender activists, police, a range of health workers, social workers, psychologists, and district and local health teams.

Training and ongoing support should be offered to the consortium members to espouse their roles and to ensure trust and confidentiality.

Clients who anticipate abuse, divorce, dissolution of the relationship or any other challenge should be supported to enable them to disclose their HIV-positive status to sexual partners.

- 1.4 HIV/AIDS signs and symptoms are not associated with the diseases of sexual partners

Where possible, sexual partners should be encouraged to test together and disclose an HIV-positive status to each other.

## Theme 2: Factors that Precipitate HIV Infection and Transmission

Sub-Theme	Guidelines
2.1 Extramarital sexual engagement with an HIV-positive partner	Extramarital sexual relationships should be discouraged during ongoing support in wellness sessions.
2.2 Lack of honesty about disclosing an HIV-positive status	Clients on ARV should be encouraged not to have casual partners. HIV-positive clients should be urged to use condoms consistently.
2.3 Male partners refusing to use condoms despite knowledge of HIV-positive status	Partner counselling and mutual sharing of HIV test results amongst clients attending the wellness clinic should be encouraged.

## Theme 3: Consequences of an HIV-positive result

Sub-Theme	Guidelines
3.1 Male partners get more agitated after an HIV-positive test result than their female partners	<p>Partner notification, couple counselling and testing with support in comprehensive HIV care should be encouraged in HIV-positive clients who are sexually active.</p> <p>Support for disclosure should be discussed and made readily available at clinic and community level.</p> <p>Where possible, HIV/AIDS, gender violence consortiums should be encouraged with financial support. Chiefs should be assisted to chair such consortiums.</p>

**Table 4.2:** Guidelines for disclosure of HIV-positive status to sexual partners  
(continued)

3.1	Consortium support for clients could be strengthened through training of consortium members to demystify stigma and gender mainstreaming related issues which might contribute to disclosure by others and curtailing of transmission of HIV/AIDS.
3.2 Different HIV test results for partners lead to a strenuous relationship or a termination of intimacy	Couple counselling and mutual sharing of HIV results should be encouraged.
3.3 Lack of disclosure of an HIV-positive status leads to feelings of discomfort around one's partner	Consortium groups with both partners being included should include support training and information sharing on safer sex for HIV-positive couples and, where possible, tailor-made support for individual couples attending wellness clinics.  A comprehensive HIV/AIDS programme should include social workers, psychologists, legal support of individuals in need of such services, especially those who anticipate violence on disclosure of an HIV-positive status.
3.4 Disclosure of HIV-positive results leads to a positive and healthy lifestyle of infected people	Where possible, HIV-positive clients who are willing to support and form support groups must be part of the consortium.

#### 4.5 Conclusion

Chapter 4 discussed the findings of the study in relation to what the participants shared with the researcher. Verbatim experiences of the participants were grouped into themes and sub-themes which, in turn, were aligned with literature support. Guidelines were conceptualized that could be



used by health teams to promote disclosure of HIV-positive status by clients attending the HIV clinic. The summary, recommendations, limitations and conclusions are provided in Chapter 5.

## CHAPTER 5

### SUMMARY, RECOMMENDATIONS, LIMITATIONS AND CONCLUSION

#### 5.1 Introduction

This chapter summarises the research findings from the perspective of the study objectives and themes that emerged from the data analysis.

#### 5.2 Summary Related to Objective 1: To Describe the Experiences of HIV-Positive Clients as They Disclosed Their Status to Sexual Partners in St Rita's Hospital Wellness Clinic

Study participants described their experiences of disclosure of an HIV-positive status to sexual partners as follows:

- ❖ Most of the research participants were shocked and in a state of total disbelief after testing HIV-positive. Some participants reported that they felt a profound sense of shame after they were notified of their HIV-positive results.
- ❖ Some of the research participants accepted their HIV-positive status while others rejected it as they thought that it might not be reliable.
- ❖ Some research participants, especially females, expressed that they faced severe challenges after disclosing their HIV-positive status. Some feared discrimination while others were unsure of what they were afraid of.
- ❖ Those female participants who did not disclose their HIV-positive status continued to have unprotected sex with sexual partners and some engaged in extramarital relationships.

- ❖ Some research participants were accepted by their male sexual partners who offered social and economic support.
- ❖ Some male sexual partners' HIV status was unknown to female study participants as they tested elsewhere and reported HIV-negative results and refused to use condoms.

### **5.3 Recommendations on Theme 1: Rejection Versus Acceptance of Sexual Partner Related to Disclosure of HIV-Positive Status**

#### **5.3.1 Recommendations for Education**

- ❖ If possible, clients should be offered an opportunity to have follow-up consultations with the same health worker to ensure continuity in terms of counselling on disclosure, use of condoms and adherence to ARV to decrease the spread of HIV/AIDS.

#### **5.3.2 Recommendations for Practice of Counselling**

- ❖ All clients who tested HIV-positive should be given information and skills that would enable them to disclose their HIV-positive status to sexual partners.
- ❖ Lay counsellors and health workers should ensure that individual clients who tested HIV-positive are cognisant of disclosure and its associated challenges which they may encounter. Such challenges should be documented for planning and refinement of counselling policies and practices.

#### **5.3.3 Recommendations for Administration and Policy**

- ❖ There should be improved documentation on the level of disclosure to sexual partners that each client has reached.

- ❖ Programmes and projects offering HIV/AIDS counselling should prioritise disclosure of clients' HIV-positive status to sex partners.
- ❖ Documentation on disclosure of HIV-positive status of individual clients should be documented in the files of clients attending wellness clinics, especially those who are still sexually active
- ❖ Ongoing skills training, upgrading and updating of HIV/AIDS services should be provided to health workers at all levels, including lay counsellors.

#### **5.3.4 Recommendations for Research**

- ❖ Further research should be undertaken to develop a model of care support on disclosure of HIV/AIDS in rural settings such as St Rita's Hospital that provide comprehensive HIV/AIDS services.

#### **5.4 Summary Related to Objective 2: To Identify Challenges Facing HIV-Positive Clients**

- ❖ Some research participants reported that they have not disclosed their HIV-positive status to sexual partners for fear of violence, separation and divorce.
- ❖ Some female clients who tested with sexual partners and disclosed an HIV-positive status were abused, discriminated against and rejected by sexual partners.
- ❖ Some study participants indicated sexual relationships with multiple partners – HIV-positive, HIV-negative and of unknown HIV status.
- ❖ Clients who did not disclose an HIV-positive status continued to have unprotected sex with sexual partners and continued treatment with ARV.

- ❖ HIV-positive male clients continued to have relationships with sexual partners of unknown HIV status and children outside their stable marriages. Male participants did not always use condoms in extramarital relationships.
- ❖ Some study participants were found to be on ARV, were sexually active yet did not use condoms with sexual partners who stated that they were HIV-negative or the HIV status was unknown.
- ❖ Mutual testing and disclosure were rare amongst research participants and their sexual partners. Discussion on HIV testing with sexual partners seemed to be minimal or absent amongst clients attending St Rita's Hospital Wellness Clinic as some female clients indicated that they continued to have unprotected sex with their regular and marriage partners.
- ❖ Female participants who did not disclose an HIV-positive status to sexual partners indicated fear, were afraid to lose their relationships and face discrimination from in-laws and the community. Even though some of these women did not disclose to their HIV-positive status to sexual partners, they disclosed to some relatives.
- ❖ All males reported to have disclosed to sexual partners and some had mutual testing and disclosure with sexual partners, but then continued to have desire to have more children. Some male participants did not disclose an HIV-positive status to subsequent sexual partners and continued to have children without disclosing their HIV-positive status to sexual partners.

## **5.5 Recommendations on Theme 2: Factors that Precipitate HIV Infection and Transmission**

### **5.5.1 Recommendations for Education**

- ❖ Lay counselors and health workers should be offered ongoing skills advancement on innovative practices that could enhance disclosure of HIV-positive status to sexual partners.
- ❖ Reading materials such as pamphlets, flyers, fact sheets and other educational handouts must be made available clients, lay counsellors and health workers at HIV/AIDS care facilities to share challenges and success stories on disclosure achieved in national and international projects.

### **5.5.2 Recommendations for Practice of Counselling**

- ❖ Real social and psychological challenges for each client should be identified documented and appropriate plans derived and tailor-made to each client needs and set of personal circumstances.
- ❖ Extramarital relationships should be discouraged amongst HIV-positive clients during wellness sessions.

### **5.5.3 Recommendations for Administration and Policy**

- ❖ Formation of HIV/AIDS consortiums should be encouraged to challenge religion, social and cultural practices that contribute to HIV transmission.

#### **5.5.4 Recommendations for Research**

- ❖ There is critical need to translate research into practice of HIV/AIDS care within rural settings. This would continually inform practices that work better and enhance disclosure of an HIV-positive status to sexual partners as it is an important public health goal to control incidence of HIV infection.

#### **5.6 Summary Related to Objective 3: To the Determine Psychosocial System that Guides the Process of Disclosure to Sexual Partners**

- ❖ Clients attending St Rita's Hospital Wellness Clinic were not fully aware that HIV disclosure discussions are provided during pre- and post-counselling as part of a comprehensive HIV/AIDS care programme.
- ❖ Health workers did not follow up HIV-positive clients who indicated that they experienced challenges in disclosing their HIV-positive status to their sexual partners.
- ❖ Follow-up and ongoing discussion on the importance of disclosure of an HIV-positive status amongst health workers, lay counsellors and HIV-positive clients was reportedly minimal.
- ❖ There was no discernible institutional arrangement in place at St Rita's Hospital Wellness Clinic that supported and assisted clients who experienced challenges or fear to disclose their HIV-positive status to sexual partners.
- ❖ Disclosure of an HIV-positive status to sexual partners was discussed during initial counselling and testing and was not ongoing on subsequent visit. Some study participants indicate that disclosure of HIV-positive status was discussed with health workers whilst some indicate its absence.

- ❖ Most of the study participants do not belong to any support group and hence are not able to discuss challenges openly with other clients living with the HIV/AIDS. Some participants report to be supporting other friends living with HIV with treatment support including life partners.

#### **5.6.1 Recommendations for Education**

- ❖ Skills of health workers providing counseling, testing and comprehensive HIV/AIDS care (including health workers in vertical programs like St Rita's Hospital wellness clinic) should be upgraded to enable these health workers to be enhanced in skills and ways that will support clients to manage disclosure to sexual partner's process

#### **5.6.2 Recommendations for Practice of Counselling**

- ❖ Couple counselling with reproductive choice support should be included without stigma to couples who wish to have children. Informed choices should be discussed with individual sexual partners.
- ❖ Health workers should not prejudice couples who are HIV-positive and wish to have children. Couples who wish to have children should be supported with available services within comprehensive HIV/AIDS care that will reduce MTCT and ensure a quality health and life amongst sexual partners

#### **5.6.3 Recommendations for Administration and Policy**

- ❖ Plans of action of disclosure of an HIV-positive status to sexual partner should be discussed and documented on each visit. The disclosure status to sexual partner preparedness and progress since last visit should be discussed and assessed with the view to facilitating the process.



#### **5.6.4 Recommendations for Research**

- ❖ Multidisciplinary health teams should develop innovative ways that would enhance partner testing with mutual disclosure amongst HIV clients attending the clinic.
- ❖ Where possible, time should be assigned for nurses and lay counsellors to present success stories and challenges to administration teams at local and district level for support and identification of gaps in the system.
- ❖ Development of health consortiums that would support community intervention should be initiated and steered towards improved HIV/AIDS care.

#### **5.7 Summary Related to Objective 4: To Develop Guidelines that Could Assist People Who Live with HIV/AIDS and Who Wish to Disclose Their HIV-Positive Status to Their Sexual Partners**

- ❖ It is recommended that a model for HIV/AIDS disclosure guidelines to sexual partner should be initiated at St Rita's Hospital Wellness Clinic to enhance disclosure of clients' HIV-positive status to their sexual partners, and hence to prevent further transmission.
- ❖ The service providers for comprehensive HIV/AIDS care should develop institutional arrangements within the facilities to enhance disclosure of clients' HIV-positive status to sexual partners as directed by HIV/AIDS care policies and enshrined in the country's constitution.
- ❖ St Rita's Hospital should consider initiating a community consortium that will support reduction of stigma attached to HIV/AIDS and improve access to services that seek to reduce the incidence of HIV transmission and enhance the quality of life of PLWHA.

- ❖ Further research on disclosure should be done in order to heighten disclosure of an HIV-positive status to sexual partners and to encourage subsequent partner testing.

## **5.8 Limitations of the Study**

- ❖ The study was undertaken in one district in the Limpopo Province which cannot be generalised to other parts of the province.
- ❖ The researcher used a recall method which could have presented some information limitations, but further checks did not produce any difference in information shared during the first interviews with research participants.
- ❖ Although a limited number of participants was interviewed, the research shed some light on how to enhance gaps and strengths of disclosure practices of clients' HIV-positive status to sexual partners at St Rita's Hospital Wellness Clinic and elsewhere.

## **5.9 Conclusion**

Chapter 5 discussed the achievement of research objectives in relation to the findings of research study. Recommendations and guidelines (see also Chapter 4) that could assist health workers and lay counselors to support client disclosure of an HIV-positive status to sexual partners.

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## APPENDIX 1

### MEDUNSA RESEARCH AND ETHICS COMMITTEE CLEARANCE LETTER

**UNIVERSITY OF LIMPOPO**  
Medunsa Campus



**MEDUNSA RESEARCH & ETHICS COMMITTEE**  
**CLEARANCE CERTIFICATE**

P O Medunsa  
Medunsa  
0204  
SOUTH AFRICA

MEETING: 08/2011

PROJECT NUMBER: MREC/HS/163/2011: PG

Tel: 012 - 521 4000

Fax: 012 - 560 0086

**PROJECT :**

**Title:** Client experiences of HIV positive post disclosure to sexual partners at St Rita's Hospital, Limpopo Province.

**Researcher:** Ms PM Mamogobo  
**Supervisor:** Dr ME Lekhuleni  
**Co-supervisor:** Mr. SF Mattala  
**Department:** Public Health  
**School:** Health Sciences  
**Degree:** MPH

**DECISION OF THE COMMITTEE:**

MREC approved the project.

**DATE:** 13 October 2011

PROF G. Q. GUNBANJO  
CHAIRPERSON MREC



**Note:**

- i) Should any departure be contemplated from the research procedure as approved, the researcher(s) must re-submit the protocol to the committee.
- ii) The budget for the research will be considered separately from the protocol. PLEASE QUOTE THE PROTOCOL NUMBER IN ALL ENQUIRIES.

*African Excellence - Global Leadership*



## APPENDIX 2

### PERMISSION TO CONDUCT THE STUDY (LETTER FROM THE LIMPOPO DEPARTMENT OF HEALTH AND SOCIAL DEVELOPMENT)



LIMPOPO  
PROVINCIAL GOVERNMENT  
REPUBLIC OF SOUTH AFRICA

#### DEPARTMENT OF HEALTH

Enquiries: Selamolela Donald

Ref:4/2/2

01 November 2011

Mamogobo PM

University of Limpopo

Sovenga

0727

Greetings,

**Re: Permission to conduct the study titled: The experiences of HIV positive clients post disclosure to sexual partners at ST Ritas' Hospital, Limpopo Province.**

1. The above matter refers.
2. Permission to conduct the above mentioned study is hereby granted.
3. Kindly be informed that:-
  - Further arrangement should be made with the targeted institutions.
  - In the course of your study there should be no action that disrupts the services.
  - After completion of the study, a copy should be submitted to the Department to serve as a resource.
  - The researcher should be prepared to assist in the interpretation and implementation of the study recommendation where possible.

Your cooperation will be highly appreciated.

Head of Department

Department of Health

18 College Street, Polokwane, 0700, Private Bag x9302, POLOLKWANE, 0700  
Tel: (015) 293 6000, Fax: (015) 293 6211/20 Website: <http://www.limpopo.gov.za>

The heartland of Southern Africa – *development is about people*

## APPENDIX 3

### INTERVIEW GUIDE

#### INTERVIEW QUESTIONS

<p><b>PART 1</b> <b>Demographic Information</b></p> <table border="1" style="width: 100%; border-collapse: collapse; margin-bottom: 20px;"> <tr> <td rowspan="4" style="width: 30%; background-color: #e0e0e0; vertical-align: top;"><b>Age</b></td> <td style="width: 40%;">12 – 25 years</td> <td style="width: 30%;"></td> </tr> <tr> <td>26 - 40 years</td> <td></td> </tr> <tr> <td>41 – 60 years</td> <td></td> </tr> <tr> <td>60 years and above</td> <td></td> </tr> </table> <table border="1" style="width: 100%; border-collapse: collapse; margin-bottom: 20px;"> <tr> <td rowspan="3" style="width: 30%; background-color: #e0e0e0; vertical-align: top;"><b>Gender</b></td> <td style="width: 40%;">Male</td> <td style="width: 30%;"></td> </tr> <tr> <td>Female</td> <td></td> </tr> <tr> <td>Other</td> <td></td> </tr> </table> <table border="1" style="width: 100%; border-collapse: collapse; margin-bottom: 20px;"> <tr> <td rowspan="5" style="width: 30%; background-color: #e0e0e0; vertical-align: top;"><b>Highest Standard Passed</b></td> <td style="width: 40%;">Never went to school</td> <td style="width: 30%;"></td> </tr> <tr> <td>Up to standard 5</td> <td></td> </tr> <tr> <td>Up to standard 10</td> <td></td> </tr> <tr> <td>Up to post matric</td> <td></td> </tr> <tr> <td>University or Technikon</td> <td></td> </tr> </table> <table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td rowspan="4" style="width: 30%; background-color: #e0e0e0; vertical-align: top;"><b>Type of Employment</b></td> <td style="width: 40%;">Unemployed</td> <td style="width: 30%;"></td> </tr> <tr> <td>Self-Employed</td> <td></td> </tr> <tr> <td>Health Sector</td> <td></td> </tr> <tr> <td>Education Sector</td> <td></td> </tr> </table>	<b>Age</b>	12 – 25 years		26 - 40 years		41 – 60 years		60 years and above		<b>Gender</b>	Male		Female		Other		<b>Highest Standard Passed</b>	Never went to school		Up to standard 5		Up to standard 10		Up to post matric		University or Technikon		<b>Type of Employment</b>	Unemployed		Self-Employed		Health Sector		Education Sector		<p><b>Official Use</b></p>
<b>Age</b>		12 – 25 years																																			
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<b>Type of Employment</b>	Unemployed																																				
	Self-Employed																																				
	Health Sector																																				
	Education Sector																																				

	Domestic Worker/Farming		
	Taxi/Driving		
	Migrant Worker		
	Other		

Continued

<b>PART 1 (CONTINUED)</b>		<b>Official Use</b>
<b>Demographic Information</b>		
<b>Religious Affiliation</b>	Catholic	
	Lutheran	
	Anglican	
	ZCC	
	Charismatic	
	Other	
<b>Nationality</b>	South African	
	Other	
<b>PART 2</b>		
<b>Central Question</b>		
How would you describe the experiences of telling somebody that you are HIV-positive?		
<b>Probing Question</b>		
Probing questions were asked after the central question. Probing was used to stimulate further discussion based on the response of the participant. Examples of probing question used include “Who was the easiest person to tell.” Was it easy for you tell this person.” Your sexual partner, Were you able to tell her/him ?What prevented or made it easy for you to tell him or her?		

## APPENDIX 4

### INFORMED CONSENT

Dear participant You are requested to participate in a research study. The study is conducted by Ms PM Mamogobo, a Master of Public Health (MPH) student at the University of Limpopo - Turfloop Campus. The topic of the study is: To describe the experiences of HIV-positive clients regarding disclosure of positive HIV status to sexual partners at St. Rita's Hospital. You are selected because you are attending HIV clinic here in St Ritas Hospital. Kindly note that you won't be remunerated for participating in this study.

In signing this document, I ....., give consent to be interview by Ms PM Mamogobo as a student from University of Limpopo. I understand that I will be part of this research aimed at describing the experiences of HIV-positive clients regarding disclosure of positive HIV status to sexual partners at St Rita's Hospital. Information collected from this study will assist this clinic and other clinics in understating the experiences of disclosure better and improving this service aimed at controlling the incidence of HIV and ADS around St Rita's and elsewhere. I understand that I will be interviewed and asked questions related to my experiences in HIV and AIDS.

I understand that this interview is done freely and I have been informed that it is voluntary and that I can terminate at any stage without penalties being imposed on me. I have been informed that my answers will be handled confidentially and only supervisors will have access to information which will not be having names but codes which are kept by the researcher only. I have been told the results of this study will not indicate my name.

Date: .....

Participant's signature: .....

Interviewer's signature:

.....

## APPENDIX 5

### TRANSCRIPT OF VERBATIM DISCUSSION WITH ONE OF THE CLIENTS

**RESEARCHER=R**

**PARTICIPANT=P**

#### **Introduction: The Researcher**

**R:** Good Morning, Sesi and how are you?

**P:** I am fine and yourself?

**R:** I am fine. I am Ms Pamela Mamogobo an MPH student form University of Limpopo. The reason I am here today is because I am conduction research related to HIV. The title of the research is: The experiences of HIV-positive clients post disclosure to sexual partners at St Rita's Hospital Limpopo Province. I will ask you questions in relation to HIV and some questions are personal because of the nature of the topic. Do you allow me to continue?

**P:** Yes.

**R:** Before we continue with the communication, I need to explain the following. I will be asking your name where you come from and telephone number. I will, however, write such information in this pocket book. This pocket book is for me to write your name so as to contact you for follow-up questions and confirmation of what I wrote in relation to what you shared with me. I will not write your name to use it when reporting what you shared with me. I will be assigning you a code and you are respondent 01. I will be requesting you to sign a consent form that indicates that you allowed me to ask questions. I will be using a tape recorder as well and will be writing down some parts of the conversation with you for the purpose of remembering what we discussed. I will not be sharing the information with anyone,

except with my supervisor and I will not be using your name, but a code.

**P:** Hmm.

**R:** We have two languages, English and Sepedi. Do you understand Sepedi and English? Which one do you prefer?

**P:** The two are okay, we can mix.

**R:** OK fine. We now have to sign the consent form.

**P:** Ok I will sign.

**R:** This is the tape recorder which we will be using. Do you allow me to use it?

**P:** Yes it's fine.

**R:** By the way, do still remember the year that you tested for HIV and tested positive?

**P:** Yes, Sister, I tested HIV-positive in 2006.

**R:** Hmm

**P:** I was not feeling well, I was actually sick and I went to the clinic.

**R:** Hmm

**P:** The sister in the clinic suggested that I should test.

**R:** Hmm

**P:** I immediately tested and I tested positive.

**R:** Hmm. What was your response to the test?

**P:** I was shocked and so afraid.



**R:** Hmm.

**P:** The sister told me that they will give me some treatment and take blood and depending on the results of my blood test I might be sent to St Rita's Hospital where there is treatment for control of the disease. I then went home.

**R:** Hmm. Who was the easiest person to share your HIV-positive results with?

**P:** I am an orphan and all my sisters and brothers are married. I stay in my parent's home with my two children. I have a friend who is also HIV-positive so I was able to share my challenges with her.

**R:** And your sexual partner do you have a sexual partner you are busy with now?

**P:** Yes sister, the father of my young child who is 8 years old.

**R:** Did you share the results with him? Was it easy?

**P:** No sister. It was tough to initiate the discussion. I just suggested that he must be tested for HIV as we see people being ill and dying and we are not sure of ourselves. Actually, sister he is my steady boyfriend and we even have a child. He has his own wife.

**R:** Hmm.

**P:** He went to town and told me that he went to the doctor and he tested negative.

**R:** Hmm. Do you still continue to sleep together?

**P:** Yes sister, but we don't use condoms because he is refusing. He only uses them by force.

**R:** Hmm. Does he know that you are on treatment?

**P:** No I hide it from him and it is a challenge when I have to take an 8 pm treatment and I am with him. I will have to go out in a corner and take the treatment.

**R:** About the wife what is the health of the wife?

**P:** One day as I was visiting and cleaning the bedroom, I found an empty container of Alluvia. I know the types of treatment as it is long that I am on treatment. I asked the husband what is this? He looked at the box and said" I don't know. This means that this woman is on treatment and she is hiding. What is this treatment for (He was talking to himself). This woman maybe she is ill. I don't trust her. At some stage she abscess like.

## APPENDIX 6

### INDEPENDENT CODER REPORT

**CODING REPORT FOR:** MS PAMELA MAMOGOBO

**DATE:** 2012-02-27

**STUDY:** -----

**BY:** Mrs Tebogo Mothiba

**Method:** **Tesch's inductive, descriptive coding technique** (in Creswell, 1994:155-156) was used by following the steps below:

1. The co-coder who is a qualitative research expert obtains a sense of the whole by reading through the transcriptions carefully. Ideas that come to mind were jotted down.
2. The co-coder selected one interview, for example, the shortest was selected, top of the pile and the most interesting and goes through it by asking: "What is this all about?" thinking about the underlying meaning in the information. Again any thoughts coming to mind were jotted down in the margin."
3. When the co-coder has completed this task for several respondents, a list was made of all the topics. Similar topics were clustered together and formed into columns that were arranged into major topics, unique topics and leftovers.
4. The co-coder took the list and returned to the data. The topics were abbreviated as codes and the codes written next to the appropriate segments of the text.
5. The co-coder decided on the most descriptive wording for the topics and grouped them into themes thus reducing the total list of themes by grouping together topics that related to each other. Lines were drawn

between themes to show interrelationships. The co-coder tried out to see whether new themes and sub-themes codes emerged.

6. The co-coder made a final decision on the abbreviations for each theme and sub-themes and placed themes according to importance in the table.
7. The data belonging to each theme were assembled in one column and preliminary analysis was performed which was followed by a meeting between the researcher and co-coder to reach consensus on themes and sub-themes that each one has come up with.

**Table 1 Themes and sub-themes reflecting**

**Central storyline:** Participants who are HIV-positive shared comparable experiences with regard to disclosure of HIV-positive status to sexual partners and family members as difficult which lead to suffering on multiple levels. The experiences of lack of disclosure result from anticipated fear of rejection if family members or sexual partners may know about the positive HIV results *“His family does know that she is positive and I cannot tell them as they will take her somehow”*. On the one hand, experiences emerged that reflect stories related to the upcoming results of the relationship status after disclosure of the HIV-positive results *“My worry is where we stand as a couple after the HIV-positive result”*. On the other hand, participants shared the equal positive sentiment with regard to adherence to anti-retroviral treatment as a way of maintenance of good health and so that as a parent you can live long to take care of your children *“I take treatment and it makes me feel better. Those who die from HIV&AIDS they do so deliberately because there is treatment. It is better to adhere to treatment rather than my children losing me”*.

Main themes	Sub-themes
1. Participants shared comparable stories related to disclosing HIV-positive status to sexual partners and family members which	1.1. Disclosure of an HIV-positive status a difficult process versus a good idea to obtain support. 1.2. Lack of disclosure of HIV-

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resulted from “ <i>fear of rejection</i> ”.	positive status to sexual partners and relatives
	1.3. Testing HIV-positive and disclosure of status not a deciding factor to maintain an excellent relationship
	1.4. HIV & AIDS signs and symptoms are not associated to the diseases by sexual partners
	1.5. Health seeking behaviours and perception prior taking an HIV test.
2. Precipitating factors towards HIV infection transmission	2.1 Extramarital sexual engagement with a positive partner
	2.2 Lack of honesty about disclosing an HIV-positive status
	2.3 Male partners refusing to utilize condom despite knowledge of HIV-positive status
3. Consequences of an HIV-positive results	3.1 Male partners get more agitated after an HIV-positive test result than their female partners
	3.2 Different HIV test results for partners lead to strenuous or termination of the intimate relationship
	3.3 Lack of disclosure of an HIV-positive status lead to feelings of discomfort around one’s partner
	3.4 Granting versus lack of support by partners after testing HIV-positive
	3.5 Acceptance versus lack of acceptance of the partner’s HIV-positive results
	3.6 Disclosure of HIV-positive results lead to positive and healthy lifestyle by the infected

people

- 4. Consequences of taking anti-retroviral treatment as perceived by HIV-positive people
    - 4.1 Adherence to ART lead to healthier life
    - 4.2 Adherence to ART related to living longer for loved ones and children
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**Saturation of data** was achieved related to the major themes 1 and 3 and their sub-themes. The researcher is advised to conduct member checking and or the transcription regarding **Consequences of taking Anti-Retroviral Treatment as perceived by HIV-positive people** and **Precipitating factors towards HIV infection transmission**. The researcher did not submit the complete verbatim transcripts because in some transcripts is her interpretation of what the participants said *“Wife was tested HIV-positive in 2009. She was pregnant. She did not disclose to the partner. Both thought that the results were wrong”* thus it was difficult to conclude that the two mentioned themes’ sub-themes has reached saturation or not (and again in cases where three to five verbatim quotes are not available to substantiate themes).

#### **Limitations to verbatim transcription process**

- **Submission of interpretations of the transcription to the co-coder not the verbatim statements**

The co-coder could not evaluate if the interviewing process met all the principles of qualitative data collection because of the way transcriptions were written as mentioned above.



Mrs Tebogo M Mothiba

## APPENDIX 7

### LETTER FROM LANGUAGE EDITOR

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To Whom it May Concern

This serves to confirm that I have edited the language, spelling, grammar and style of the **Masters in Public Health (MPH)** dissertation by **Pamela Mafengwe Mamogobo: Client Experiences of HIV-Positive Post-Disclosure to Sexual Partners at St Rita's Hospital, Limpopo Province.**

Sincerely Yours