UNIVERSITY OF MALAWI

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FACTORS CONTRIBUTING TO DISCLOSURE AND NON DISCLOSURE OF STATUS OF HIV POSITIVE PREGNANT WOMEN TO THEIR SPOUSES AT LIMBE HEALTH CENTRE.

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DECLARATION

I, ***Cathy Butao***, declare that this dissertation is a product of my own effort. It has never been submitted for any degree at any institution. Where reference to other people's work has been included and acknowledgements have been made.

Candidate: CATHY. P. BUTAO Date: 19-11-2008

Signature: .....

Supervisor: M. L. MGOCHA Date: 19-11-08

Signature: .....

DEDICATION

This work is dedicated to my late Husband, **Patrick. F. Butao**, I wish you were around, you could have a word. You gave me courage and knowledge in many ways and you taught me a lot which has helped me face life in a positive way, and in the same way here I am.

To my lovely and wonderful daughter, **Chisomo Patricia Butao**, you make my life better. Your affection and perseverance has made things simple. You are such a great friend.

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ABSTRACT

HIV/AIDS has had an adverse impact on most institutions and families in Malawi. Both rural and urban households are among the most affected units and women have become prominent members of these household facing the impact of the epidemic, though little is known about what these women are going through.

Despite all these problems, statistics of pregnant women who are HIV infected continues to rise while their support from their partners has shown to continue declining (NAC, 2005). Discovering factors that influence women's disclosure has helped to improve behaviour change among people who know of an HIV infected person hence reducing HIV transmission. Being aware of partners HIV status is believed to decrease the likelihood of unprotected sex and unwanted pregnancies hence reduce Mother to Child Transmission of HIV.

This paper elucidates the implications of the epidemic on the infected pregnant women in their role to disclose their status to their spouses.

The findings of this study indicate that non disclosure has had a negative impact on different families in Malawi. This includes social, physical, financial support from partners of these households. Most women who have never disclosed their status, have suffered emotional stress and there is full support to those who have disclosed their results.

Furthermore, HIV pregnant women are under serious financial, physical and emotional stress due to their new role of providing care to unborn baby. The study has further revealed that more pregnant women have little knowledge of how the medical staff can assist them disclose their results to their spouses they are excluded from making decisions in issues concerning HIV/AIDS, despite their role as sole care provider to those who are infected and affected.

Key words: Pregnant women, HIV, AIDS, Status Disclosure, Spouse.

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CHAPTER 1

1.0 INTRODUCTION AND BACKGROUND

From the moment scientists identified HIV and AIDS, social response of fear, denial, stigma and discrimination have accompanied the epidemic. In many societies people living with HIV and AIDS are seen as shameful. Worldwide the impact of HIV and AIDS on women is literally acute. In many developing countries women are often economically, culturally and socially disadvantaged and lack equal of access to treatment, financial support and education. In other societies, women are mistakenly perceived as the main transmitters of sexually transmitted diseases (www.org.aidsstigma&disclosure].

HIV and AIDS in Malawi is a biggest health problem affecting about 940 000 by the year 2005 (www.avert.subsaharan.aids.statics.org). Malawi whose population is now close to 13 million had an estimated 14% of its adults aged between 15-49 years (child bearing age group) living with the virus (UNAIDS, 2006). The National AIDS Commission is responsible for prevention and management of HIV and AIDS activities in the country with funding from the global fund. Antiretroviral therapy was first introduced in Malawi in 2003 and about 13 000 infected were on treatment by the end of year 2004.

However it was discouraging that 64% of couples utilized the chance as individuals and not as couples because of lack of disclosure or openness (Muula, 2007). There were even instances when other couples never knew that both are on the treatment because of what they termed as confidentiality or not wanting the partner to be aware.
Statistics of pregnant women who are HIV infected continues to rise while their support from their partners declines (NAC, 2005). Discovering

factors that influence women's disclosure may help to improve behaviour change among people who have come to know of an HIV infected person hence reducing HIV transmission, men involvement and support in the health care delivery services. Being aware of partners status may decrease the likelihood of unprotected sex and unwanted pregnancies hence reduce Mother to Child Transmission of HIV, hence the purpose of the study.

As such the study was aimed at exploring factors that influence pregnant women to disclose or non disclosure their HIV status to their spouses, with the hope that it would contribute in the reduction of HIV transmission between sex partners, promotion of male involvement and support to their partners especially those who were pregnant. The study was conducted using quantitative and qualitative designs. It was conducted at Limbe Health Centre in Blantyre district, the commercial city of Malawi.

Despite that knowledge is power that promotes understanding and help in planning for things, disclosure and partner notification still remains an ignorant issue in the world of HIV and AIDS. The truth is that partner notification is a breach of confidentiality but it may protect partners from getting HIV infection. The study has proved to reveal some factors that contribute to disclosure and how pregnant women can be helped to disclose their status to their spouses.

The study expects to discover more of these effects in the rest of the women who had no chance to be interviewed. This will help to facilitate HIV status disclosure amongst pregnant women.

1.1 PROBLEM STATEMENT

The prevalence rate of HIV transmission is increasing daily in Malawi. Little is known about the prevalence of HIV status disclosure and its association with gender, education and socio-economic status. About 940 000 people are already infected with the virus and 500 000 of these are women (www.avert.org/subaadults.htm).

Despite this alarming rate of women who are infected by HIV in Malawi, many women are seen to become pregnant and continue to transmit the infection to the babies. On the other hand, more men are not seen accompanying their wives to the antenatal clinic or delivery suit. Men are not aware about information given to women at the Antenatal Clinic or Delivery or Postnatal Clinic. The counselling is done to women alone because of the absence of their spouses. Since it is important for the spouses to know the status of their sexual partners, the ability and requirement to disclose the results is the woman's decision. As a result other women do disclose while others do not, depending on what they think about disclosure.

However non-disclosure leads to increased transmission of the deadly virus due to unprotected sex. This also leads to lack of support from spouses due to lack of knowledge on the burden these HIV infected women are carrying. The men in turn are at risk of exposure of the virus unless if they have already been tested.

Reports have shown that many divorces occur as a result of HIV positive results especially if it is a woman who has been found to be positive (Malawi Human Rights, 2006). Most of the times, the situation is worse when the man discovers himself that his spouse is HIV positive. This also leads to gender violence.

Non-disclosure also leads to delay to ART because there is little support from the spouses or families. Knowing factors that influences HIV status disclosure among pregnant women will therefore help promote behaviour change among couples hence reducing HIV transmission, and promote male involvement in health care delivery.

1.2 SIGNIFICANCE OF THE STUDY

- The results from this study will help identify ways that may promote behaviour change among couples or sex partners that will reduce HIV transmission.
- The results will also promote male involvement in health care delivery especially those that concerns HIV, pregnancy and delivery because men are responsible for the wellbeing of the mothers and their babies.
- These results will help to empower women on the issues of HIV and be in the fore front in fight against this AIDS pandemic.
- This will help the health personnel on how they can approach disclosure processes in order to decrease the rate of divorces and violence against women.
- The HIV research institutions will benefit from the results on how they can improve their modalities in instilling change in the approach to HIV status disclosure among different people.
- The results will help equip clients with the knowledge regarding rights and benefits of HIV disclosure among patients or clients.
- The results will act as a basis for further investigation on issues regarding HIV disclosure especially among pregnant women.
- The results obtained from this study will assist HIV and AIDS Organizations in developing policies on how best to deal with HIV status disclosure.

CHAPTER 2

2.1 GENERAL OBJECTIVES

To determine factors that influence HIV pregnant women disclose their status to their spouses.

2.2 SPECIFIC OBJECTIVES

1. To determine the proportion of HIV positive pregnant women who disclose their status to their spouses.
2. To explore when do HIV positive women disclose their status to their spouses.
3. To determine problems that women face when they disclose their HIV status to their spouses.
4. To identify ways on how HIV disclosure can be promoted among pregnant women.

2.3 DEFINITIONS OF TERMS

- **AIDS** : a group of signs and Symptoms that characterize HIV infection
- **ANTIRETRIVIRAL** : treatment that increases the life of a person infected with HIV
- **ANTENATAL CARE** : care given to pregnant Mothers by service providers.
- **COUNSELLING** : discussion done with patient

Or client by service provider that will help the patient make up a decision.

- **DISCLOSURE** : to reveal or make known ones HIV results
- **DISCRIMINATION** : unfair treatment of some body on the basis of certain status.
- **HIV** : Human Immunodeficiency Virus. The virus that causes AIDS disease.
- **NOTIFICATION (PARTNER)** : this is informing partner of ones status, or treatment.
- **PMTCT** : Prevention of Mother To Child Transmission of HIV
- **NON-DISCLOSURE** : Client does not reveal status to anyone
- **SPOUSES** : Ones husband's or boyfriend
- **STIGMA** : devaluing or discrediting somebody on the basis of a certain status.

2.4 LITERATURE REVIEW

The unified and global commitment to HIV and AIDS pandemic is very challenging which needs a lot of effort. This effort requires more resources and effective use of resources devoted to research, prevention, care and treatment for those infected and affected by the pandemic. Simultaneous and sustained expansion of both prevention and treatment efforts are needed if the pace of the epidemic is to be slowed, otherwise the irrational fears and negative responses of the families and the public at large will continue to influence the transmission rate.

Previous researchers have comprehensively documented rates of HIV disclosure to family at discrete time periods yet none have taken a dynamic approach to this phenomenon (Mfutso-Bengo, UNIMA-COM, 2005)

Globally, new infections among women, especially young women continued to outpace those among men. This is a stark reminder that gender inequity and violence against women fuel the epidemic. According to UNAIDS and WHO, disclosure, stigma and discrimination, whether actual or feared, remain perhaps the most difficult obstacle to prevention of HIV.

According to Global Health Council (2006), by the end of year 2005, about half a million of all people living with HIV and AIDS world wide, were women. About 60 % of these women were from the Sub-Saharan Africa and 32% of these were within 19 and 49 years of age, which is a child bearing age. 46% of these Sub-Saharan HIV infected population were women.

Some research indicates that married women are at risk for HIV transmission than unmarried because they are more frequently exposed to intercourse within marriage. However, most women are confined to circumstances under which sex takes place. They get pregnancies frequently and they do not disclose to their family members what information they usually get from the health facility (Global Health Council, 2006).

According to UNICEF-Malawi 2005 statistics on HIV, about 36% of men aged 18 to 49 years have comprehensive knowledge on HIV. About 76% of these men do share information about HIV with either families or friends. The statistics show that 41% of women of the same age group have comprehensive knowledge on HIV but only 21% share information concerning HIV with families or friends. However, according to 2006 statistics, about 92% of pregnant women attend antenatal care coverage. This means that they have a lot of information that they gain from the health providers but they do not share with their families or spouses.

Malawi Networks of People Living with HIV and AIDS (July 2007), described non disclosure as the major cause of self stigma among HIV infected people. Most pregnant women would rather disclose their HIV status to their parents or relatives hoping that they will take care of the baby when the mother dies especially during delivery. Most women fail to negotiate condom use to their sex partners despite disclosing their results. This makes other women opt not to disclose their HIV status to their sex partner because there little is chance to protect themselves.

Being sexually transmitted infection, HIV is still a taboo subject in many communities within Malawi, and discrimination is common. As a result, few people living with HIV make their status known. Most people have difficulty discussing the subject with their spouses or families, and most

support groups do not meet openly. Other people, especially women will rather disclose to pastors at church to seek God's Intervention before they disclose to their spouses or families.

Dignitas International Organization for HIV and AIDS (Malawi Missions) explains on the importance of involving men to scale up PMTCT in Malawi. This organization believes that for effective PMTCT, the couple needs HIV testing and counselling so that men should understand why pregnant women ought to have the HIV test. Men need civic education to appreciate the importance of testing their pregnant wives so that the unborn babies are spared from HIV and also to strengthen their love as one body. These men will also support their wives who will be on ARVs.

According to Malawi National AIDS Commission (2006), Malawi and its neighbouring countries in the sub-Saharan African region has been severely affected by HIV and AIDS epidemic. In Blantyre city , pregnant women attending antenatal clinic had a rise of HIV sero-prevelence from 2.6% in 1986 to over 30% in 1998. It fell a little to 28.5% in 2001. HIV infection rates are lower in rural Malawi but are on the increase. These statistics have also affected all sectors of Malawi society including the health sector. For example maternal mortality rate has at least doubled hence increasing the number of orphans in the country.

Malawi Human Rights Commission (MHRC) describes HIV and AIDS as not only a health problem but also a human right issue. This is because it impacts negatively on the psychological, physical and emotional well being of an individual or society. It is also a human right issue because some of the responses to HIV and AIDS pandemic have often tended to promote stigma, discrimination and denial thereby violating human rights and promotes non disclosure by most people. People living with HIV and AIDS have their human rights, such as disclosure or non

disclosure, being violated on the basis of their status. The fight against HIV and AIDS cannot be fully addressed if the rights based approach to the issue is ignored (MHRC , July 2007).

Levy et al (1999) has described that women do not disclose their HIV sero- status results to any one including sex partners, families, friends and health care professionals. This group of women appraised themselves that disclosure process is too difficult or risky to undertake. These women would rather be engaged in avoidant behaviours to hide their illnesses rather than disclosing HIV status especially when a woman is pregnant. To them carrying pregnancy is a problem on its own and disclosure of HIV status is another burden.

Kalichman and Nachimson (1999) found in their study of disclosure that men and women who did not disclose their status to their sex partner, did not practice safer sex. Condom use which also leads to unwanted pregnancies hence reducing mother to child transmission of HIV was not used most of the times by these couples. Results in this study showed that partners of those who did not disclose status were at risk of HIV infection. This risk of infecting partners infecting partners without notification takes on greater significance for women. This is so because putting someone at risk of HIV infection through sexual activity without disclosure is a criminal act, punishable by imprisonment in Georgia, North Carolina and South Carolina (USA). The punishment is worse if the woman is found to be pregnant because chances of infecting both the mother and unborn baby are very high.

Sowell et al (1997) described pregnant women's specific criteria for deciding to whom to disclose their status. This was a study that was done in Bulgaria. The identified criteria were generally based on one of the three factors; their relation to the person (e.g. health care provider,

sexual partner or family member), the quality of their relationship (accepting versus rejecting) and the perceived ability of the other person to keep the information confidential. Other women say that it is easy to disclose to health profession in order to be assisted better when they are sick, but they find it difficult to disclose to their sex partners. The findings underscore the need for counselling to be culturally and personally sensitive in order for disclosure to be as positive and successful experience as possible.

Learning that one is HIV infected creates an internal struggle about whether or not to disclose ones HIV sero-positivity. The decision to disclose is selective and consists of several steps which includes adjusting to the diagnosis, assessing ones disclosure skills, deciding whom to tell, evaluating the recipients circumstances, anticipating the recipients reaction and having a motivation to disclose (Kimberly et al 1995)

The decision to disclose ones status becomes more difficult when it also involves pregnancy. The disclosure must include to whom, when, where and how to reveal ones status (Serovich et al 1998). Disclosure of sensitive information is generally thought to have beneficial effects on an individual's health and the unborn baby in cases of pregnancy. This may lower stress levels and ultimately lead to better preparations for the baby and the sex partner.

In Africa, women tested for HIV during antenatal care are counselled to share with their sex partners their HIV test results. This encourages partners to undertake HIV testing. A study done by Ditrame Plus PMTCT project in Abidjan investigated the key moments for disclosure of HIV status of pregnant women to their spouses and the impact on partner HIV testing. The results showed that most women who were found HIV

negative (97%) disclosed their status to their sex partners and 84.6% of men reported to have been encouraged and went for a test. Only 46.2% of the pregnant women who were tested positive reported the results to their sex partners and 37% of these already knew their results. About 68% tested after their wives disclosed their results to them. Out this 34.4% were found to be sero-discordant couples.

To improve the women's adherence to the advices given to prevent postnatal and sexual HIV transmission, specific psychosocial counselling and support should be provided to women during their key moments of disclosure of HIV status to their partners. These moments includes at the end of pregnancy, weaning and resumption of sexual activity. Counselling pregnant women and their sex partners is very much recommended. These results indicates that partners of HIV positive women who disclosed their HIV status were about three times more likely to take an HIV test than the partners of HIV positive women who did not disclose (Berer, M.1993).

Currently about 23 USA states have laws that make it a crime for persons who have HIV to engage in various sexual behaviours without, in most cases, disclosing their HIV positive status to prospective sex partners. HIV pregnant women are advised to disclose their results to their sex partners in order to prevent the mother to child transmission. This helps them to make a better choice to have or not to have another pregnancy. The law ideally complement the HIV prevention efforts of the Public Health Professionals through the disclosure based HIV transmission prevention strategy. This strategy has really seen numbers of HIV transmission, and stigmatizing attitudes towards persons living with HIV being reduced (Galletly and Pinkerton, 2006).

Living with a secret, such as HIV, can be more emotionally harmful than the rejection that could result from disclosure (Margoles-Shan, 2007). Many women who have kept a secret for a long time, feel a sense of relief after telling. Studies have shown that pregnant women who never disclosed their status, ended up having intrauterine death and many complications due to stress. Since more women are at risk of violence when disclosing their HIV results. If they are worried that their spouses will be violent, they are counselled to involve a neutral third party present such as a therapist, HIV advocate or any health professional or church leaders.

It is well known that disclosing HIV tests results to ones sexual partner allows the partner to engage in preventive behaviours as well as the access of necessary support for coping with sero-status illness. The issue is different with pregnant mothers, there have been always low turn ups when it comes to disclosure. But this may motivate partners to seek testing or change behaviours and ultimately decrease the transmission of HIV (Deribe, et al February, 2008).

This study was done to determine the rate, outcomes and factors associated with HIV positive status disclosure among pregnant mothers and service providers. The results shows that 71.6% women disclosed their results to service providers in order to be on ART. Only 84.4% disclosed to at least one person and about 42.5% told only their sex partners. 14.2% of those delayed the disclosure to their sex partners until they were on ART, stating the reason as fear of negative reaction from their partners. 80.3% of the disclosed couples reported a supportive reaction from their partners. This concludes that lack of disclosure results in limited ability to engage in preventive behaviours and to access support.

UNAIDS and WHO support the concept of "shared confidentiality" which means that a person infected with HIV is encouraged and voluntarily chooses, to disclose his /her status to a variety of people from whom he/she can get support. In certain countries and regions such as Africa, this may be culturally appropriate. The purpose of shared confidentiality is to encourage better support, care and prevention of individuals, families and communities affected by HIV. In areas where shared confidentiality is practiced widely, a decrease in HIV related stigma and discrimination may be noted (Corgan et al, 2003).

A study done by Dlamini (University of Swaziland), in Swaziland, Lesotho, Malawi, South Africa, and Tanzania on effects and manifestations of HIV and AIDS stigma and disclosure, indicates that Health care providers play a greater role when it comes to disclosure or non disclosure. Health care workers who encouraged People Living with HIV and AIDS to disclose their HIV status must consider carefully the implications of encouraging disclosure in an environment of stigma. They must recognize the real possibility that People Living with HIV and AIDS may experience serious verbal and physical abuse as a consequence of disclosure. Partners who choose to disclose their sex partners should be encouraged taking caution on the social, psychological behaviour of other partner.

A study done by Bangkok Collaborative Perinatal HIV Transmission Study Group, December 1999 on Counseling Pregnant Women and New Mothers on HIV, indicates that women do wish to disclose their HIV status to their partners, but the way that they wish to make this disclosure varies from one woman to the other, and intensive counselling may be needed. The woman must decide with the counsellor whether or not to inform her husband, and the best way to inform him of her HIV status. In case she is not sure whether to disclose or not, the counsellor

encourages her to think about the future, give her time to consider and decide how she wants to do it.

Although African women constitute the vast majority of HIV cases in South Africa, little is known about the psychosocial consequences they face at disclosure. A qualitative study done in South Africa aimed to explore HIV-infected women's experience at disclosure of their status to their partners. The revealed that male partners who had a history of abusive behaviour were more likely to abuse their female partners either verbally or physically. There was a tendency for the occurrence of abusive behaviour after disclosure in male couples that were interviewed. It was revealed that social stigma appears to play a role in influencing partner reaction following disclosure. These findings have implications for the development of interventions to enhance women's disclosure to their HIV-positive status to their partners and benefit for PMTCT in case of pregnant mothers. Further research would be useful in examining the socio-cultural factors influencing pregnant mothers involve their sex partners in PMTCT (Deverell A, et al, 2002) .

Little is known about the prevalence of HIV status disclosure and its association with pregnancy, gender, education and socioeconomic status among HIV infected people. A cross-sectional study was conducted at Chris Hani- Baraguanath Hospital in Soweto, South Africa. HIV status disclosure was assessed to come up with results. Of the 120 patients evaluated, 15 were antenatal mothers, 72% were women, the rest were men. 96% of the population were Black African people. 65% unemployed, 65.9% education lower than high school diploma. The mean age was 34 years.

The average length of time a participant had known she/he was HIV positive was 3.5 years. 90.5% reported having disclosed their status to at least one person. However, of the 75 participants who reported having a

sex partner, 38% had not disclosed their status to their partner regardless of being pregnant or not. Disclosure was not significantly associated with length of time known to be HIV positive, pregnancy, antiretroviral use, age, gender, education or socio-economic status. The results indicated that a significant proportion of HIV infected individuals in the study population did not disclose their HIV status to their sexual partner. This raise the ethical dilemma of HIV status disclosure among sexual partners, the potential role of stigmatization as well as the risk of super infection with continuing unprotected sex.

CHAPTER 3

3.0 THE CONCEPTUAL FRAMEWORK

3.1 ROY'S ADAPTATION MODEL

HIV AND AIDS disclosure, stigma and discrimination represents a set of shared concepts, values, attitudes, and beliefs that can be conceptualized at both cultural and individual levels. Many theories describe these concepts.

A concept is a term that abstractly describe and names an object, a phenomena, or an idea, through providing it with a separate identity or meaning (Burns & Grove, 2005).

A theory is a way of explaining some segments of the empirical world and can be used to describe, explain, predict or control that segment (Chinn & Kramer, 1999, in Burns & Grove 2005)

A theory consists of a set of concepts that are defined and interrelated to present a view of phenomenon. A theoretical basis for this study will derive from Roy's Adaptation Model.

Roy's Adaptation Model describes a person as a bio psychosocial being in constant interaction with the changing environment (Roy, 1980). A person continually changing and attempting to adapt. When a person is not corresponding positively to environmental changes, then the nursing concern arises. The person uses both innate and acquired mechanism to make ready himself /herself to adapt to his/her environment.

Roy defines a person as an adaptive system with regulator and cognator acting to maintaining adaptation in the four adaptive modes namely;

physiologic function, self concept, role function and interdependence (Roy, 1984). The constant interaction of persons with their environment whether diseased or not, is recognized by both the internal and external change. This person must maintain his/her own integrity, i.e. each person must adapt, hence the person is viewed as an adaptive system (Butao, C. et al 2007).

The concepts identified under this theory are; human adaptive system, adaptation, environment (focal stimuli, contextual stimuli and residual stimuli), Health, cognator, coping, stressors, goal of nursing and the four adaptive modes.

ADAPTATION: Is the individuals ability to cope with the consistently changing environment .

HUMAN ADAPTIVE SYSTEM: both individuals and groups who are in constant interaction with the environment.

ENVIRONMENT: all conditions, circumstances and influences that surrounds and affect the development and behaviour of humans as adaptive systems with particular consideration of person and earth resources (Roy & Andrews, 1999)

STRESSORS: Stimuli from the environment that require a person to adapt.

COGNATOR: Thoughtful responses to stimuli which are related to high brain functions e.g. emotions, feelings and conception.

FOCAL STIMULI: Those things which immediately affect people

RESIDUAL STIMULI: Surrounding circumstances present at the time which may influence a negative response to the focal stimuli.

ADAPTIVE MODES: Ways that a person e.g. through physiological needs, self concept, role function or interdependence relations.

COPING: Routine process to aid and support the client in an attempt to adapt to stimuli in one or more of the four adaptive modes.

NURSING GOAL OF NURSING: It is to promote adaptation in each of the four modes and contribute to person's health, quality and dying with dignity. Nursing is the scientific discipline with a practice orientation , its science of nursing is interested which promote adaptation and health, how persons cope with health and illness and nursing intervention (Roy & Andrew, 1991).

HEALTH : A state and process of being and becoming an integrated and whole person.

PHYSIOLOGIC MODE: the physical responses and interactions with human's environment.

SELF CONCEPT MODE: This is a component of physical self and personal self which includes body sensations and body image.

ROLE FUNCTION MODE: consists of a set of expectations of how a person in a particular position will behave in relation to a person who holds another position.

INTERDEPENDENCE MODE: its underlying need is relational integrity or security in nurturing relationships. The mode focuses on the giving and receiving of love, respect and values.

In this Roy's Adaptation Model, human adaptive system has inputs of stimuli and adaptation levels such as Mandatory Counseling and Testing on HIV at the antenatal clinic, the output as a result on how this person will react to the results, adapt to it and the response to be taken thereof that serves as the feedback and the control process known as copying mechanism (Figure 1).

The human adaptive system has input coming from external environment as within the system such as how the partner reacts to the index HIV status results or how the index perceives the idea of disclosing the results.

Figure 2 illustrates the Roy's Adaptation Model on how individual's decision to take a health action based on perceptions and adaptability. The nurse assess the clients behaviour hence diagnosing the problem to be solved in relation to behaviour change. A family can also play a big role in helping the infected and affected person come up with better decisions in HIV status disclosure depending on situation adaptation.

FIG 1 :

DIAGRAMMATIC REPRESENTATION OF A SIMPLE HIV ADAPTIVE SYSTEM

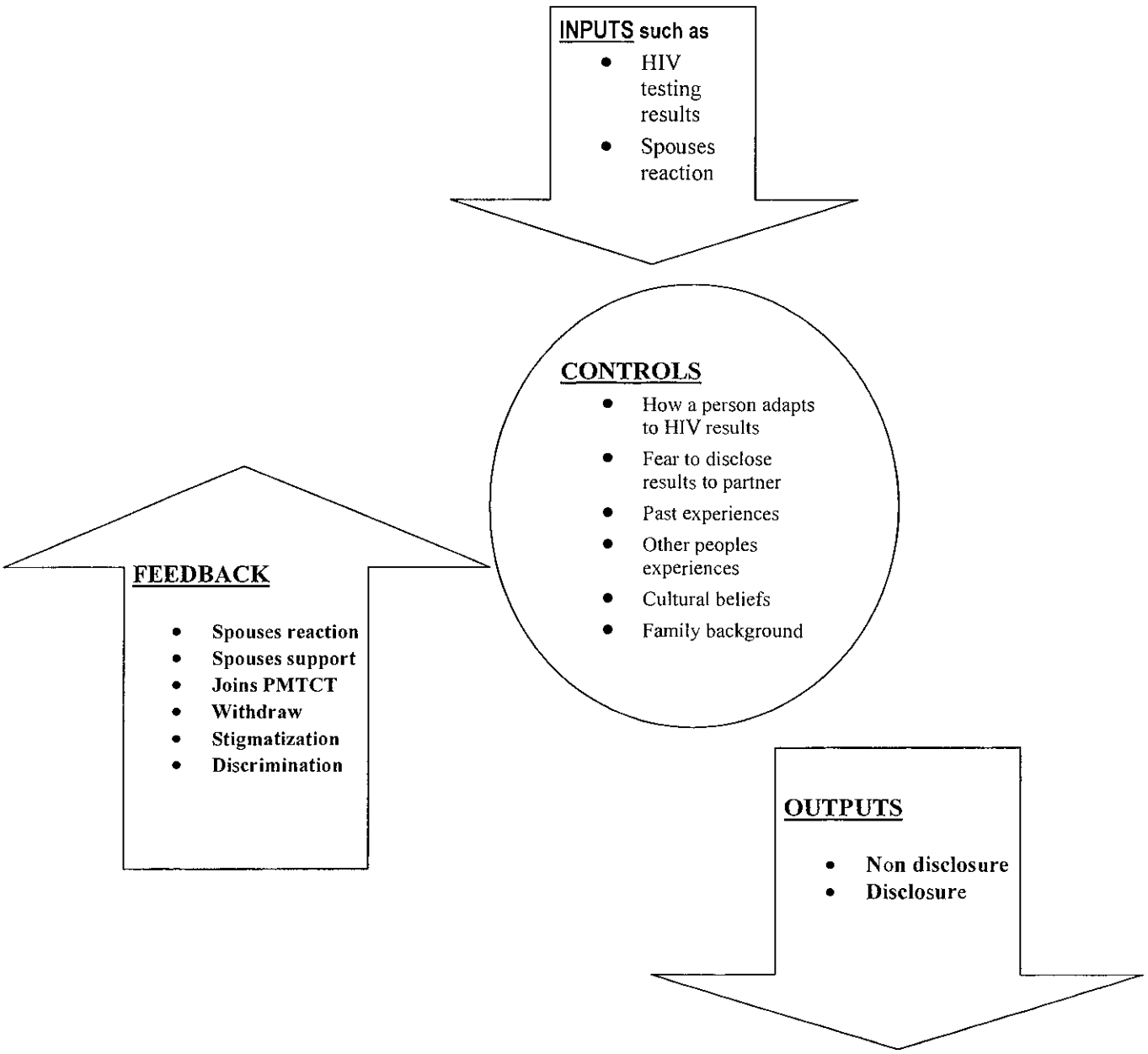
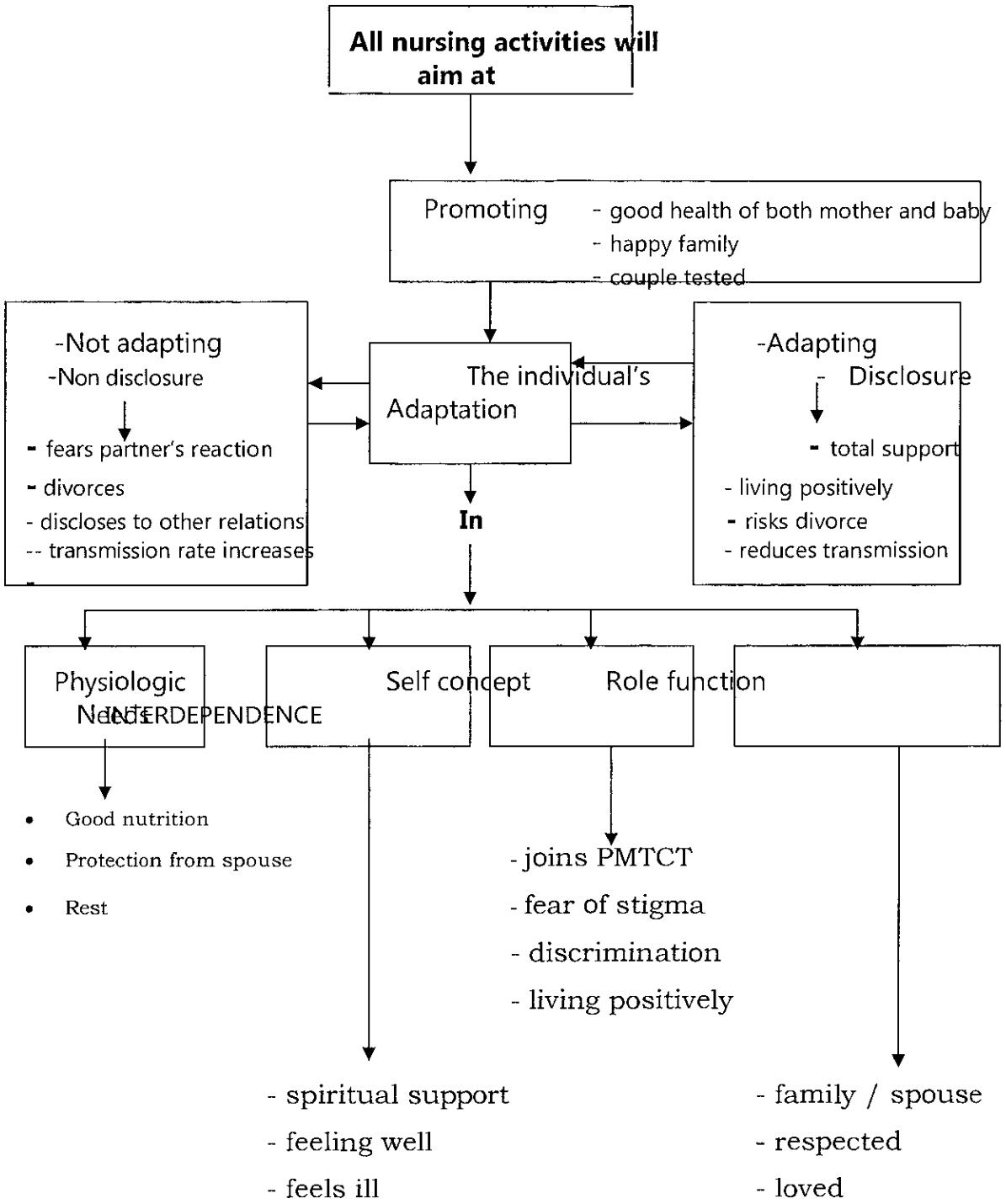


FIG 2

A DIAGRAMMATIC REPRESENTATION OF ROY'S ADAPTATION MODEL



3.2 APPLICATIOIN OF THE MODEL TO THE STUDY

The goal of care providers in health care settings is to provide quality health care services where as clients goal is to receive quality health care services which includes sound decision making. This indicates that both care providers and clients have the same goal especially there is good interaction.

This model is centered on the behaviour of people towards a health problem and a decision made. The health care providers facilitate good decision making but the desire to put the decision-made across depend lies in the hands of the client.

In this study, participants adapted differently to HIV testing results. Those who adapted did not had problems to share their results to either spouses or anyone depending on how they interacted or believed upon that person. Lack of adaptation led to non-disclosure in most of the participants.

However adaptation varies in time frame from one person to the other. Other participants disclosed their HIV test results instantly upon receiving their results where as other people took time before they consider disclosing their results to somebody.

The adaptive modes (physiological needs, self concept, role function and interdependence) also gave clue to the pregnant mothers on the benefit or risk of disclosure. These mothers made decision on who to tell and when. The modes also identified the essential concepts relevant to nursing as the human adaptive system, environment, health and nursing.

The goal of nursing is to promote adaptive responses which are behaviour that positively affect the health of the person in terms of growth, survival, reproduction and mastery. For example, if the nurse takes the position of disclosing clients results to his/her partner, may lead to violence or divorces and confusion in many families unless if the government passes a law mandating counsellors to do so.

However this may help reduce further transmission of the infection among couples since they may be aware of their status. Hence promoting more support for each other and early initiation of ART.

CHAPTER 4

4.0 METHODOLOGY OF THE STUDY

4.1 RESEARCH DESIGN

This study was conducted using both qualitative and quantitative designs. A qualitative study design is a study in which data collected is in a narrative or non numeric form where as a quantitative study design is a study in which data collected is in numeric form (Polit & Hungler, 1991).

Qualitative studies are primarily concerned with in-depth study of human phenomena in order to understand their nature and the meaning they have for individuals involved (Maura Hunt cited in Desmond C, 1991). The participants of this study are pregnant women who are HIV positive and have disclosed or not disclosed their HIV results to their spouses.

4.2 SAMPLE AND SETTING

The sample size for the proposed study was drawn from pregnant women attending antenatal clinic (ANC) at Limbe Health Centre in the catchment's area of Blantyre District Health Office. The sample size consisted of both HIV positive pregnant mothers who had disclosed their status results to their spouses (sex partner) and those who had not disclosed their status results to their spouses.

The sample was 30 subjects for both types of pregnant HIV Positive women. Only HIV positive women who were between 18 and 49 years of age were recruited into the study.

A convenient sampling of these antenatal mothers was used, to select subjects to avoid biases despite having many attending the clinic. This

type of sampling took advantage of subjects that fell within the population of interest and were readily accessible by the researcher. This also helped to reduce stigma since the study was dealing with HIV status which is a sensitive issue in the community.

4.3 DATA COLLECTION

Data was collected using in-depth interviews on the selected subjects an interview guide which was done in Chichewa language. The tool contained open and closed ended questions. Data was collected by interviewing subjects in order to get relevant information concerning women's knowledge on HIV disclosure to their spouses, why did they disclose or not disclose their status, when did they opted to disclose their status to their spouse, support they do got from spouses and any relevant information they could provide.

The researcher conducted the interviews on her own to ensure consistency in asking questions. The data collected was in form of subject's views. The interviews were done in privacy using a private room and one at a time basis, in order to make the subjects free to talk.

Subjects were assured of anonymity and confidentiality by using code numbers and not names. Subjects were also pre-warned that the data would be used by the researcher and other health personnel, who might want to use the information to improve HIV status disclosure among pregnant women.

4.4 DATA ANALYSIS

Qualitative data was analyzed using content analysis. Narration of recurring regularities that could be shown in different categories was included in the thematic analysis of the whole data. On the other hand

Quantitative data where possible was analyzed using Statistical Package for Social Studies (descriptive statistics such as percentages and/or frequencies- SPSS).

A transcribed data working sheet was developed to target the responses applicable to the various categories. Data was compiled on each category analyzed according to the variables of the study. Different concepts which were central to the study were also analyzed using numbers.

ETHICAL CONSIDERATION

Prior to commencement of the study, letters were written by the researcher to Ministry of Health, Kamuzu College of Nursing –Ethics and Research Committee, Blantyre District Health Office soughting permission. Upon getting the permission, the researcher wrote the in-charge of Limbe Health Centre, to inform her about the study which was to take place.

Subjects informed about the nature, purpose, benefits and risks of the study and were asked to give informed consent prior to their participation. Subjects had the right to withdraw from the study at a time without any consequences. Those accepted to participate in the study were given a consent form to sign or stamp (for illiterate subjects but witness) on their name.

Absolute confidentiality on the information obtained was assured to the subjects through the use of code numbers and not names.

CHAPTER 5

5.0 PRESENTATION OF FINDINGS

5.1 INTRODUCTION

This chapter presents the results of the findings on factors that contribute to disclosure of status of HIV positive of pregnant women to their spouses. Information was collected from thirty [30] HIV positive pregnant women who were also counselled for PMTCT. Descriptive statistics have been used to analyse demographic data. Qualitative data has been analysed using content analysis. Direct quotations from participants have also been presented.

5.2 DEMOGRAPHIC DATA

This section presents sample characteristics in relation to the subject's age, mental status, religion, educational and occupation. Some of this demographic data has been presented in tables. Thirty women were recruited from Limbe Health Centre, Antenatal Clinic to participate in the study. These women were from different locations within the Limbe Health Centre catchments area, which is under Blantyre District Health Office.

TABLE 1: Characteristics of Distribution of Subjects By Age

Characteristic		**N=30 [Frequency]**	**% [Percentage]**
AGE	18-25 years	11	36.7%
	26-35 years	9	30.0%
	36-45 years	7	23.3%
	>46 years	3	10.0%
	Total	**30**	**100%**

Majority of the participants 66.7% [n=20], were within the age range of 18-35 years and 33.3%[n=10], participants were above 36 years old.

TABLE 2: MARITAL STATUS OF PARTICIPANTS

Characteristic	**N=30 [Frequency]**	**% [Percentage]**
MARITAL STATUS		
Married	26	86.6%
Not married	2	6.7%
Widow	2	6.7%
Total	**30**	**100%**

Majority of the participants, 86.7% [n=26] were married, and only 13.3% [n=4] were either not married or widowed.

TABLE 3: DISTRIBUTION OF RESULTS BY NUMBER OF CHILDREN

Characteristic	**N=30 [Frequency]**	**% [Percentage]**
NUMBER OF CHILDREN		
0-2	17	56.7%
3-5	8	26.6%
6-8	5	16.7%
Total	**30**	**100%**

More than half, 56.7%[n=17] of the participants had at least two children and about 43.3% [n=13] had 3 or more children

TABLE 4: PARTICIPANTS LEVEL OF EDUCATION

Characteristic	N=30 [Frequency]	% [Percentage]
LEVEL OF EDUCATION		
None	4	13.3%
Primary	14	46.7%
Secondary	10	33.3%
Tertiary	2	6.7%
Total	**30**	**100%**

Only 13.3% [n=4] of the participant did not go to school, 46.7% [n=14] attempted some primary education, 33.3% [n=10] had some secondary education and 6.7% [n=2] had as far as tertiary education.

TABLE 5: PARTICIPANT'S SOURCE OF INCOME

Characteristic	N=30 [Frequency]	% [Percentage]
SOURCE OF INCOME		
Employment	13	43.3%
Husband's support	3	10.0%
Business	14	46.7%
Total	**30**	**100%**

Majority of the participants 46.7% [n=14] earn their living through business, 43.3% [n=13] were employed and 10% [n=3] depended on their husband support.

TABLE 5: PARTICIPANT'S DENOMINATION

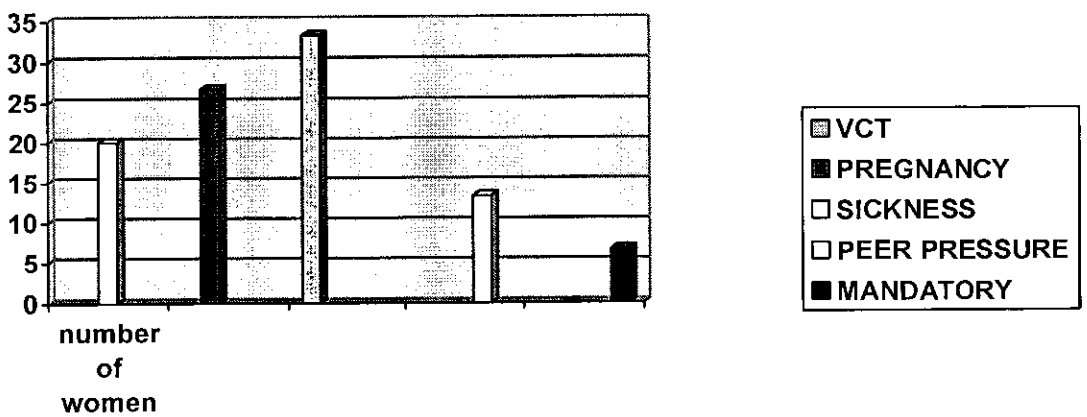
Characteristic	N=30 [Frequency]	% [Percentage]
DENOMINATION		
C.C.A.P	4	13.3%
R/C or Anglican	6	20.0%
SDA	7	23.3%
Pentecost Churches	13	43.4%
Total	**30**	**100%**

All the participants 100% [n=30], were Christians of different denominations, i.e. C.C.A.P, Roman Catholic , Anglican, SDA and other Pentecostal Churches.

5.3 HIV AND AIDS

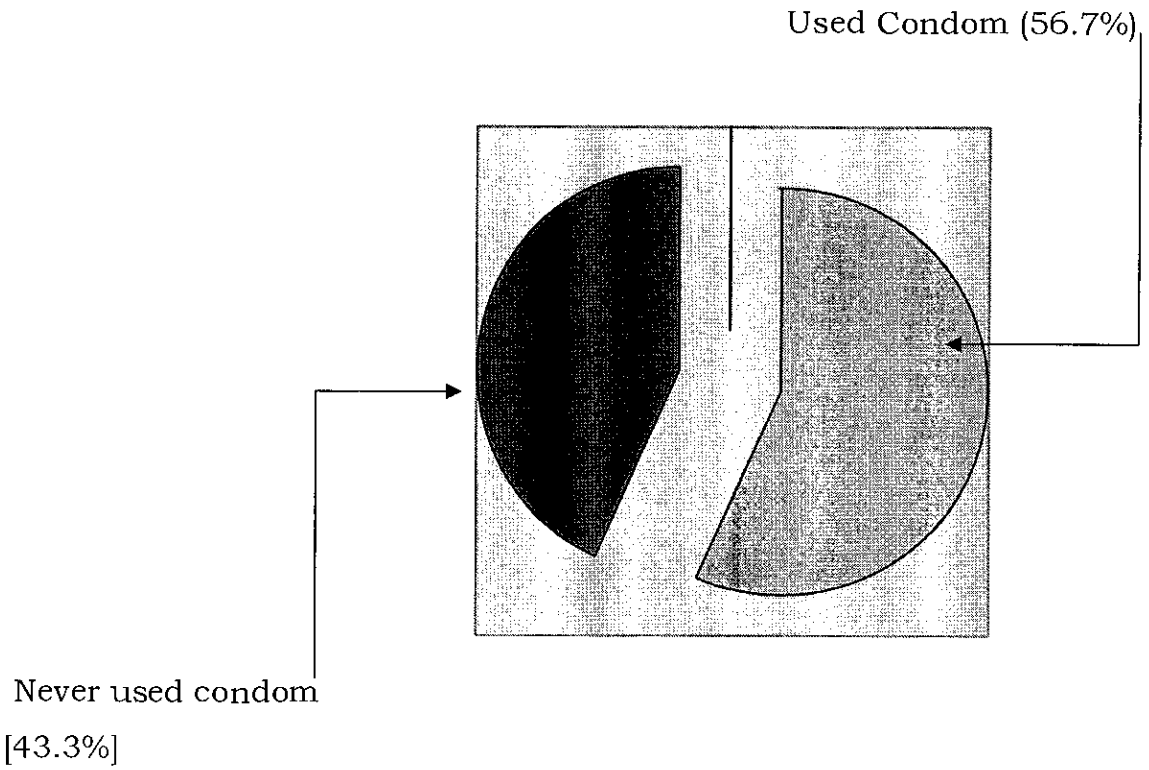
All the participants 100% [n=30] had had their HIV test done and were all HIV positive pregnant women.

5.3.1 HIV TESTING



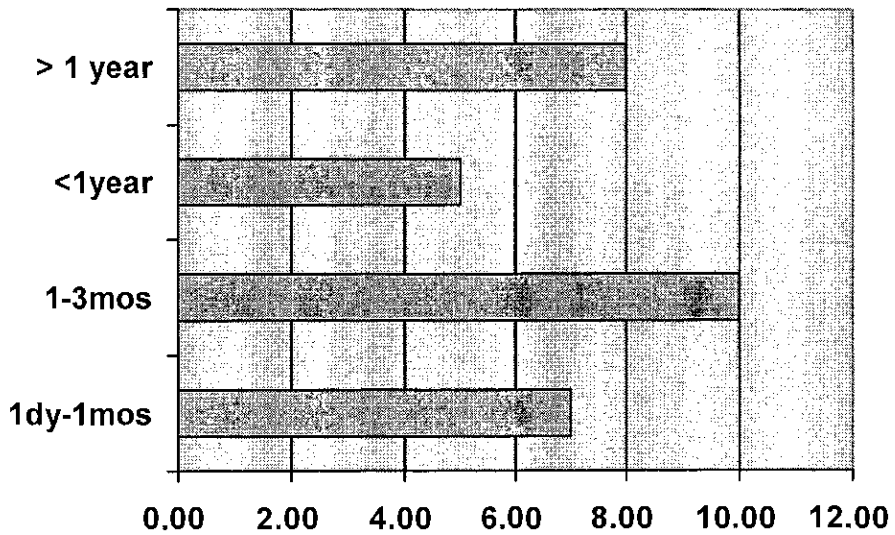
Majority of the participants, 33.3% [n=10] had their HIV test on voluntary basis, 26.7% [n=8] had their test because they were found to be pregnant, 20% [n=6] went for HIV testing because of sicknesses, 13.3% [n=4] went for HIV testing because of peer pressure while 6.7% [n=2] were tested on mandatory basis as part of PMTCT programme.

5.3.2 CONDOM USE



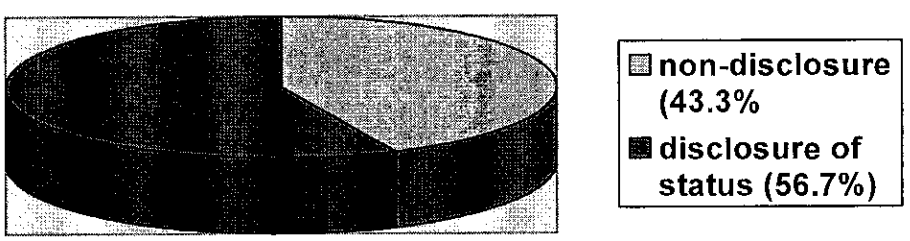
A total of 56.7% [n=17] participants had ever used either male or female condom before and 43.3% [n=13] had never used a condom.

5.3.3 PERIOD BEING HIV POSITIVE



Majority of the participants 33.3% [n=10], have stayed between 1-3 months with HIV, 26.7% [n=8] have stayed with the virus for more than a year, 23.3% [n=7] for less than a month while 16.7% [n=5] for less than a year but more than three months.

5.3.4 STATUS DISCLOSURE



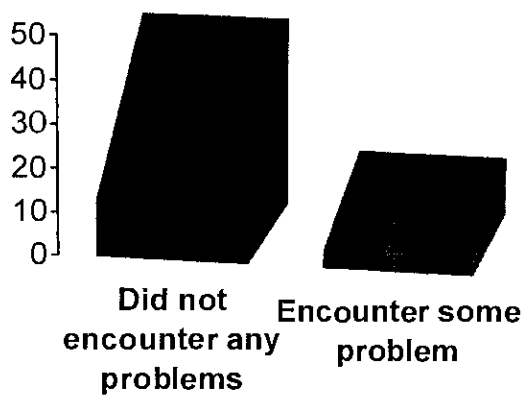
More than half of the participants 56.7% [n=17] disclosed their HIV status to their spouses while 43.3% [n=13] did not disclose.

5.3.5 PERIOD TAKEN TO DISCLOSE ONES STATUS

When was disclosure of status done?	Frequency [N=17]	Percentage %
Same day of getting results	10	43.3
Next day	1	3.3
After a month	3	10
Took some time	3	10

Out of the 56.7% [n=17] participants who disclosed their status to their spouses, 33.3% [n=10] disclosed their results same day of getting results, 10% [n=3] of these disclosed after a month and 10% [n=3] took some months to disclose while one participant [3.3%] said to have disclosed her results the following day upon receiving her results.

5.3.6 PROBLEMS ENCOUNTERED AFTER DISCLOSURE



Majority of the participants 43.3% [n=13] did not encounter any problem from their spouses while 13.3% [n=4] did encounter some problems when they disclosed their status.

5.3.7 INTENTION TO DISCLOSE STATUS- for those not disclosed their results.

When do you intend to disclose your status	Frequency [N=13]	Percentage %
Don't know	8	26.7%
After delivery	3	10%
When I accept the results	2	6.7%

Out of the 43.3 [n=3], who did not disclose their status to their partners, 26.7% [n=8] did not know when they would disclose their results, while 10% [n=3], said they would disclose after delivery and 6.7% [n=2] said would disclose after they have fully accepted the HIV results.

CHAPTER 6

6.0 DISCUSSION OF FINDINGS

6.1 INTRODUCTION

The study aimed at determining factors that contribute to disclosure of status of HIV positive of pregnant women to their spouses. This chapter presents the discussion on the themes that emerged from the study.

6.2 DEMOGRAPHIC DATA

Most of the participants were within the child bearing age. The study aimed at determining factors that contribute to disclosure of status of HIV positive of pregnant women to their spouses, therefore this was the right group to be targeted.

The study showed that 86.7% [n=26] of the participants were married which was the intention of the study as it was looking for pregnant women with spouses in order to assess disclosure of their status to spouses. About 13.3% [n=4] of the participants were either not married [but had a fiancée or boy friend] or widowed. This meant that despite not married one has the right to HIV testing and disclosure of results.

The findings of the study revealed that more than half of the participants had at least 2 children. This may have indicated that women disclosed their results or not, considering how much support they got from their spouses with children or not. This is in agreement with the study done by Chimombo [2003], which discovered that presence of children in the family determined the disclosure of HIV status to spouse. The study revealed that many women disclosed their status to their spouses in order to agree for no more children because they were afraid of increasing the statistics of orphans in the area.

The findings further revealed that most of the participants had attempted some education. This is in correlation with the results on occupational status where the majorities earn their living through business or employment than depending on their husband support. It is expected that occupation and earnings are more likely to empower women if they perceive their earnings as important for meeting the needs of their households [MDHS, 2004].

The education status has the implication on decision making capability, e.g. on whether to disclose or not and probably retention of information is more difficult such as HIV counselling. The situation may be improved by educating the client about effects of HIV in simpler terms and on-going counselling.

The study further revealed that all the participants belonged to a religious group. This is an indication that people from these religions could be encouraged to participate in community networks for community support and action apart from their spouses. Couples may seek couple counselling from church elders or fellow Christians to build the families, which have affected by the virus. Groups of women in the community could share difficulties with HIV disclosure and how they could break the news through sharing of experiences.

6.3 HIV AND AIDS

The findings of the study revealed that the majority of the participants did not know the benefit of what comes with disclosure of their HIV positive status to the spouses. Most of the reasons why women disclosed their status to the spouses were to support from the husband and to motivate the husband have his own test for HIV. One participant

mentioned that she disclosed her results to her husband because she wanted to protect the baby.

6.3.1 HIV TESTING

Findings of the study indicated that majority of the participants went for HIV testing voluntarily. Most of the participant's response on " ***why HIV testing***," indicated that they even had their test done before, they became pregnant. This is concurring with the MDHS [2004], whereby it stated that more women know their HIV status in first trimester or even before they fall pregnant and they are aware about PMTCT.

6.3.2 CONDOM USE

The results indicated that most women used condoms being counselled on safe sex to protect the baby and themselves. However, they did not use condoms frequently. This agrees with the findings of a research done by Morril and Nolland, [2006], that although half of the women who received counselling on HIV, make effort to change their sexual behaviour, they usually meet resistance. Many participants reported that their spouses reacted too condom use, others cooperated during the first days only then refused condom use later.

This is also in agreement with the Global Health Council, [2006], which stated that married women are at risk for HIV reinfections than unmarried because they are more frequently exposed to unsafe sex within marriage. They get pregnancies more often but they don't disclose what happens before, during and after sex to their family members. Malawi Network of People Living with HIV and AIDS [2005], stated in its study that most HIV women failed to negotiate condom use with their partners despite disclosing results as a result other women opted not to tell their HIV spouses because it did not make any difference.

Disclosure of status and condom use was significantly associated with knowing the partners HIV status.

6.3.3. HIV AND LIVING POSITIVELY

The study findings showed that the participants had knowledge that they were HIV positive although some did not accept their results. The majority of the participants had stayed more than three months [but less than a year] with the virus. However the majority took more than a day to disclose their status to their spouses.

One participant said that; " *I had my HIV test during my second pregnancy, that was 2002, but I disclosed my status to my husband during this fourth pregnancy and that last month.*"

The findings are in line with a study by Margolese, [2007], who stated that living with a secret such as HIV, can be due to emotional behaviour, and this is harmful than rejection. Many women are very good at keeping secrets for a long time but later they do reveal. These women feel a sense of relief after telling the secret.

6.3.4. STATUS DISCLOSURE

The study has shown that more than half [56.7%] of the participants had disclosed their status to their spouses. This is in contrast to a study done by Deribe, et al, [2007], whereby only 28.7% of the pregnant women interviewed, had disclosed their HIV status to their spouses. However the majority [84.4%] of the participants had disclosed to at least one person.

Despite not being familiar with the benefits of disclosure, the study revealed that participants with HIV, disclose their status to their spouses due to several reasons associated with culture, social aspect, values or

personal rights. However the right to disclose lays in the hands of the individual.

One participant said; " *It is my right to disclose or not to disclose, whether to my husband or whoever,,,, If I don't want, I can't disclose no matter what am being told,,,*"

This is concurring with what Malawi Human Rights Commission [2006], said, that people living with HIV and AIDS have their Human rights such as disclosure or non disclosure being violated on the basis of their status. HIV and AIDS are the human rights issues because some responses to HIV and AIDS pandemic have often tended to promote stigma, discrimination and denial thereby violating human rights and promote non disclosure.

However majority prefer to disclose status in order to gain social support from the one they have disclosed to. This is concurring with a study done by Ditrame Plus PMTCT Project [2007], in Abidjan, whereby 96.7% of pregnant HIV positive women were discovered to have disclosed their status within 3 months in order to seek support from their spouses.

Research has shown that disclosure helps to change risk behaviours such that couples are able to make informed reproductive health choices [Maman, 2007].

The findings of the study further suggested that the intention to disclose did not correlate well with actual disclosure. Pregnant women at Antenatal Clinic were counselled to share information with their partners at home after counselling and testing, for whatever results they got. Many women promised to do that. A similar study done by Ladner, [2004], revealed that a higher proportion of women said indented to disclose their results than the much smaller proportion of women at follow-up who said to have actually disclosed their status.

As the Roy Adaptation Model states, people tend to react differently towards situations they have faced. The women who did not disclose might be because they did not accept their results, i.e. they did not adapt to the situation they were in, hence took a lot of time to disclose their results.

The study further revealed that disclosure was an issue for significant proportion of participants, since only 43.3% did not inform their partners of their status and another proportion were not aware whether their partners had had an HIV test before. Some clients disclosed because they expected some benefits though the benefits did not occur.

The other challenge that may have occurred was that disclosure was followed by rejection and discrimination which might have been accused of infidelity .

However disclosure was also beneficial because it facilitated couple counselling hence increasing male involvement in the process and assurance of ongoing psychosocial support to meet the mother's needs who chose disclosure as an option. This was similar to a study done by UNICEF, [2007], across sub-Saharan region to identify factors to scale up Voluntary Counselling and Testing, disclosure and follow up. It was revealed that despite culture having influence on disclosure especially on pregnant women, more men [82.7%], promised to support their spouses who were found to be HIV positive. However it was noted that in most cases the women's fear of abandonment was greater than fear of violence and so were the children.

6.3.5 PERIOD TAKEN TO DISCLOSE ONES STATUS

The study findings have shown that majority of the participants who disclosed their HIV status to their spouses, did it on the same day upon receiving their results. They said to have disclosed such earlier in order

to influence the partner to have his test done and compare with their results thereby reducing further infections.
However, some participants said to have delayed to disclose their status due to fear of violence. They preferred to study their men before disclosing the results.

A related study was done by Dr Maman [2004], in Nigeria, where it was discovered that men disclose results earlier than women when tested HIV positive. However pregnant women, attending PMTCT services, often disclosed early in order to access treatment to prevent transmission of HIV to their infants, yet for sexual risk behaviour, they might also be disclosure to sexual partner. Men often disclosed their results early to obtain care and support. In addition men easily disclosed their negative HIV results to their partners as evidence that they were faithful and more easily disclosed positive results too elicit care and support.

Although majority of these participants disclosed their status to their spouses on the same day, an equivalent number of participants, disclosed their results after a month, i.e. after another counselling session at the Antenatal clinic. At the subsequent visit, the pregnant women were reminded what happened at the previous visit and were assessed if they have taken any action following their results. Some women were encouraged to disclose results or not when they heard their friend's experience on disclosure, or when they were reminded by the medical staff on what to do.

This is in line with a study done by Deribe [2008], that out of 67.4% pregnant women who disclosed their status to some one, 48% disclosed their status after being recounselled and motivated by friends, women groups or medical profession.

According to Roy's Adaptation Model, the controls such as other people's experience, past experience to HIV testing results [inputs], an individual will determine the output, i.e. disclosure or non disclosure hence the feedback. Activities done at the Antenatal clinic on initial or subsequent visits such as counselling, sharing of experiences, motivated or demotivated participants to disclose or not disclose their HIV status to their spouses.

6.3.6. PROBLEMS ENCOUNTERED WITH DISCLOSURE

About 43.3% did not encounter any problem after disclosing their status to their spouses because of different views of their male counterparts. This is supported by a study done Sowel [1999], that revealed that acceptance by male counterparts results in greater social support which in turn has positive effects on psychological well being.

However it conclusion disagrees with what the same study revealed that disclosure was generally associated with positive outcomes because some participants got positive outcomes while others got negative outcomes.

The study further revealed that other participants encountered wide range of reactions from their spouses after they disclosed their HIV positive status.

One participant said; " after I told him my positive results, he shouted at me and said I am a prostitute, that I want to kill him." This spouse ended up in divorcing the wife. The reaction would make the spouse isolate himself from the wife and so was the wife. If this reaction was known to other women and was left to continue, then many women might have refrained from disclosing their HIV positive results to their spouses or significant others.

The study also revealed that HIV women experience stigmatization in relationship with their spouses as a reaction towards disclosure. This might be due to perceived emotions towards the deadly disease AIDS. As a self concept reaction, the woman might decide not join PMTCT in fear of discrimination. The findings underscore the need for counselling to be culturally and personally sensitive in order for disclosure to be as possible and successful experience as possible.

6.4. REASONS FOR DISCLOSURE OR NON-DISCLOSURE

Majority of the participants [56.7%], disclosed their status to their spouses. The participants stated that it was good for the partners to know in order to prevent from transmitting the virus to each other. The study findings showed that it was good for the spouses to know the HIV status of their wives [pregnant women] because they can be prevented from retransmission of the virus.

One participant said that, "..... *he is my husband the owner of this pregnancy, he must know my condition to prevent from transmitting the virus..*"

Another one said, "... *its my responsibility to tell my husband my results because he is my sex partner.*"

This is concurring with Margolese Shan [2007] in his study where it was revealed that women took an initiative to disclose each and every result to their spouse in order to prevent from further transmission. Despite not knowing the other benefit of disclosure that the expected baby could also be prevented from the infection, many participants knew that they could prevent themselves from transmission of the virus.

The study also showed that participants disclosed their status to their spouses as a way of reinforce these men had their own HIV test and not

depend on the index results. Some couples only depend on partners results and this misleads people.

One participant said,"*... I brought my husband here at the clinic so we were together in the counselling session, so he was encouraged to have his blood tested as well* ". "*... I told him in order to encourage him have his test done and agree on family planning and use of condom* ." said another participant.

The participants wanted their spouses to have their own HIV test in order to have a comparison and plan accordingly. This was also good because status might differ depending on time of exposure [window period] or sensitivity of the. This is evidenced by a study done by Ditrame Plus PMTCT Project [2006], which revealed that 26.4% of the women who disclosed their results to their spouses, their men tested negative, which was the opposite to the results of the pregnant women as sero-discordant couples.

The study further revealed that participants disclosed their status in order to gain social support from their spouses. ",,, *I told him everything what happened at the Antenatal Clinic including the HIV test and other blood test so that he should support me* ." said one participant. As pregnant women they would need good food, care and psychological support more from the men who had impregnated them than their usual friends.

According to Roy's Adaptation Model, a person adapts to the stimuli when he gets support from relevant people. In this case these pregnant women who have been challenged with the HIV, will adapt to this status after disclosure when their spouses [relevant people] give them total support and live in a happy family hence living positively.

On why other pregnant women did not disclose their status to their spouses, participants generalised fear of divorce as the main problem while some were just afraid of the outcome like lack of support or violence.

One participant said that. "*... I can't tell him my status because I am afraid of divorce and yet I have four children, who is going to take care of these children?*" while another participant commented that, "*...I am afraid he will leave me and look for other women because he may think am a prostitute, since HIV is associated with prostitution.*" Another one said "*,,,am afraid he will tell me to abort this pregnancy because he once refused me at first when I was found to be pregnant.*" These responses critically revealed how difficult and dangerous disclosure of status is. If not done properly, many would be harassed.

According to Roy's Adaptation Model, families can play a bigger role in helping the infected and affected persons come up with better decisions in any diseases like HIV and AIDS in accepting the situation and coming up ways to accommodate themselves in the family like disclosing the results according to how they adapted the situation. If these participants continues to kept the secret they would feel isolated and not been accommodated by their family members. Gender based violence would also be characterised by sentiments.

Some participants did not disclose because they did not accept their results because they were not counselled properly.

A Participant said, "*... I don't believe that I have the virus that causes the deadly disease AIDS, nobody in our family has suffered from this virus.*" This meant that the participant did not accept the results may be because pre-test counselling was not done or not done properly. It might

also mean that she was forced to have the test [in mandatory cases] which lead to denial of results.

Another participant said, *"... Its hard for me to accept these results because my husband was found HIV negative a couple of months ago."*

Another said, *"... I am waiting for another month to go so that I can have another test of HIV because I don't believe that I am HIV positive, my husband is my first man to have sex with and this is my first pregnancy."*

It was very difficult for these participants disclose their results to their participants hence no chance for safer sex. They were not sure of their results such that they would not even thought of asking for PMTCT or ART treatment.

On whom do they feel comfortable or safe to disclose their results, apart from their spouses, most participants preferred to tell their relations like; mother, father, sister, brother, cousin or friends .

One participant said, *" I would rather disclose to my mother, because I am her daughter she will understand me and take care of me especially when I will start suffering from AIDS unlike my husband."* **While another said**, *"... I will tell my friend because we share secrets and she will keep this issue secret for me, unlike my husband, he is going to tell his relatives."* **Another said**, *"... Its good to tell the pastor, because is going to pray for me and he will be the best person to disclose this to my husband."*

Participants felt comfortable to disclose their status the ones they trusted like friends or blood relations than their spouses. This meant that trust and belief also played a great role in disclosure of status in the lives of the participants.

Despite all these responses, other participants still felt that they cannot disclose to someone about their results. This meant that they put their

trust in themselves. They believed no human being would keep their secret.

A participant said, "*...There is nobody I can share my status, because I don't trust people, they may pretend to keep secrets but one day they will disclose.*" **Another said**, " *I don't want my husband or any relative to know my status because they don't love me.*" These responses meant that the participants were isolated.

These challenges might have been even more pronounced for marginalised women who often experienced discrimination, stigma and rejection because their sexual behaviour might have been fallen outside what is traditionally accepted for women. This could be the reason why some participants felt it was important not to actively promote disclosure without simultaneously putting in place mechanisms for identifying and supporting those women who were likely to experience negative outcomes. Communities must be mobilised to normalise the notion of disclosing one's status and to provide ongoing psychosocial support.

6.5. SUPPORT FROM MEDICAL PROFESSION ON DISCLOSURE

On how best medical profession can help pregnant women to involve their spouses in disclosure of HIV results, the study revealed that majority of the participants believed that couple counselling during HIV testing or any Antenatal Visit, will be the only chances to involve men support their spouses who are known to be HIV positive.

Participant said, "*... I think, you nurses should insist that every pregnant woman should always bring her spouse to the clinic for counselling to give chance these men know what happens here.*" Men dominate in decision making in many relationships and while women would accept testing, they can return for the result only after discussion with their partners.

Many participants showed interest to bring their spouses for counselling sessions which will also be one way to motivate men to be involved in PMTCT, family planning issues and many more issues that concerns pregnant women.

The other option was to sensitize men in various work place on activities done at the Antenatal or Labour and delivery, which include HIV testing and counselling. " *You should sensitize men at their work place on activities you do to us here so that they should be aware and even ask us when we go back home, such that they will not be surprised to here whatever we tell them.*" said one participant. Male involvement must be a key element in addressing and eliminating potential negative consequences of sero-status disclosure.

Some suggested that there should be a law passed to allow medical staff disclose results to partners only.
A participant said, "... *I wish the government gave you mandate to disclose results to our husbands, there is need to have a law that will allow you, medical staff disclose results because its not easy to tell your partner these results.*" Some countries like Nigeria, Uganda and Bulgaria [www.hivinsite] a law was passed to give mandate medical practitioners disclose one's status as a measure to reduce HIV transmission.

However women also lack empowerment to challenge their spouses with disclosure. Men would be in a better position to disclose than women.
One participant said, " *Women should be empowered that they should make decisions on their own and not only get what our partners tell us. We need to tell them the truth and not fear them.*" **Another participant said**, "... *We women all what we need is courage to disclose the results because not all husbands are difficult and it is not all the time or situations that*

spouses become difficult, some spouses are good and supportive but they lack knowledge." This meant that there was a certain proportion of women who would want to disclose but they lacked courage. Participants needed to be empowered with information through interactive communication, mass media and education strategies. These would help in making informed choices and decisions towards change of high-risk behaviours which includes disclosure of status and adaptation to the new practices.

6.6 CONCLUSION

The findings of the study revealed that some participants disclosed their HIV positive status to their spouses despite taking time to disclose the results, for instance some participants stayed up to a year or so before they disclosed the results to their spouse.

It has been found that different factors such as presence of children in the family, cultural beliefs that the husband is the decision –maker, disease burden, social support influence pregnant women to disclose their HIV positive status to their spouses. The study highlighted a number of factors that contribute to disclosure of one's status in order to reduce secondary transmission of HIV and the need to strengthen efforts to facilitate disclosure of HIV status.

Disclosure is beneficial for most women. However, there is more to learn about complexities of disclosure, how to identify the small proportion of women who experience negative consequences of disclosure and understanding how women can be supported to disclose without negative consequences. This is a big challenge to the medical profession.

CHAPTER 7

7.0 IMPLICATIONS OF THE STUDY.

The study has helped to highlight the proportion of women who disclose their HIV positive status to their spouses, factors that influence this disclosure of status and some of the problems women encounter when they disclose their HIV positive status to their spouses. This study can also help in the improvement of care and support to women who fear to disclose their status and those who disclose the status but encounter some problems. These findings can help improve nursing in all its fields that is; practice, management, education and research.

7.1 NURSING EDUCATION

Educators in the nursing training institution should be equip the students with updated information on issues pertaining to HIV disclosure because the study has shown that there are many factors that contribute to HIV positive status disclosure. This calls for change in counselling strategies and skills. There is need to empower health workers with counselling skills in order to provide better skills. These counselling skills should be included in the training curriculum.

7.2 NURSING PRACTICE

The study has confirmed several factors that contribute to HIV status disclosure to spouses which in turn affect couples in one way or another. There is need to intensify counselling to pregnant HIV positive mothers on disclosure and be equipped with information on how best they can disclose their status. As UNAIDS and WHO recommends, shared confidentiality should be encouraged among couples. Men should be highly be involved in issues concerning pregnant women by giving them

awareness talks wherever they meet and encourage them to escort their female counterparts to the Antenatal clinic.

7.3 NURSING MANAGEMENT

The government of Malawi through NAC needs to take an action in updating HIV counselling strategies and male involvement on issues of PMTCT. Stanhope and Lancaster, [1988] says that, involvement of all concerned as early as possible ensures that relevant information reaches those who need to know.

7.4 NURSING RESEARCH

There is need to conduct more research on domestic violence that occurs as a result of disclosure. The findings of that may help to find ways of improving HIV disclosure amongst couples. There is also need to conduct a research on support rendered by men whose spouses have disclosed their status and their involvement in treatment. This will help to assess how best men can be involved in issues that concerns pregnant women.

7.5 RECOMMENDATIONS

The following are the recommendations that have been made to promote disclosure of HIV status amongst couples;

- Counselling should be an on-going process not just done for once for pregnant women and even couples.
- Strategies in HIV counselling especially pregnant women should change. Women should be advised to bring their spouses when coming for counselling at the Antenatal Clinic.
- Government should intensify more campaigns on stigma, discrimination and gender violence that come due to disclosure of HIV positive status.

7.6 LIMITATIONS OF THE STUDY

The study had several limitations. The responses rate was low [noly 30 participants] and those who did not respond may have different sexual behaviours from those who responded.

However the respondents differed significantly on HIV related variables and demographic.

7.7 DISSEMINATION OF RESULTS

The results will be disseminated by leaving a copy of the research report at the Blantyre District Health Office, a copy at one of the research institutions, [Johns Hopkins Research Project] and another at the Library of Kamuzu College Nursing.

7.8 AREAS OF FURTHER RESEARCH

The researcher feels there is need to carry out the same research to establish cultural factors that contribute HIV status disclosure in other rural areas to know the differences in experience.

The study has also shown some effects that women encounter when they disclose their status to their spouses, however the magnitude has not been established hence need for another study.

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TIME LINE FOR THE RESEARCH

ACTIVITY	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEPT	OCT	NOV	IMPLEMENTOR /SUPERVISOR
	← FEBRUARY 2008- NOV 2008										
Problem Identification											Cathy Butao /Mr. M. Ngwale
Literature Review											Cathy Butao
Proposal Development											Cathy Butao
Obtaining Clearance (Approval)											Mr. Muotcha / KCN Research Committee
Data Collection											Cathy Butao
Data Analysis											Cathy Butao / Mr. Muotcha
Report Writing											Cathy Butao / Mr. Muotcha
Write –up Binding											Cathy Butao
Dissertation submission											Cathy Butao / Mr. Muotcha
Dissemination											Cathy Butao

BUDGET

ITEM	COST
a) Stationary	
4 Reams of photocopying papers @ K750 each	K 3000.00
10 Ball-pens @ K20. each	K 200.00
4 Pencils @ K25. each	K 100.00
1 Hard cover @ K550.	K 550.00
3 Plastic folder with covers @K250 each	K 750.00
5 A4 envelops @ K80 each	K 400.00
5 small envelops @ K30 each	K 150.00
b) Telephone Bills	
5 calls (5 minutes maximum) @ K140 per call	K 700.00
c) Transport Costs	
Lilongwe to Blantyre 2 trips @ K2800 (coach line) per one way	K11200.00
KCN to Ministry of Health return @ K90.	K 180.00
d) Lunch Meals & Refreshments	
3 Lunch meals @ K700 per meal	K 2100.00
Refreshments for 3 days @ K200 per day	K 600.00
e) Incentives	
30 Participants @ K200 each	K 6000.00
f) Project copies	
3 copies of research proposal @ K3000 each	K 9000.00
3 copies of finished dissertation @ K4000 each	K12000.00
Dissemination of results	K 6000.00
Subtotal	**K 52930.00**
15% contingency	K 7939.50
Grand Total	**K 60 869.50**

JUSTIFICATION OF THE BUDGET

a) Stationary

Adequate stationary was needed to cater for drafts and writing of final documents of both the proposal and the dissertation. The same papers were used for drafting and writing letters seeking permission for the research study.

b) Telephone Bills

The researcher needed to phone her supervisor booking appointments for different meetings regarding the research study.

c) Transport

The researcher was based in Lilongwe (KCN) the time the research was being conducted and the study took place in Blantyre, Limbe. She travelled twice to and from Blantyre, i.e. to deliver letters of permission to Blantyre District Hospital and Limbe Health Centre and to collect data. She also travelled to Ministry of Health (MOH) to deliver letters of permission to conduct the research.

d) Lunch meals and refreshments

During the data collection period, the researcher had meals for her lunch and refreshments, since she spent more hours at the health facility to interviews 30 participants or more.

e) Project copies

The researcher was required to produce 3 copies of finished proposal and also 3 finished dissertation which had to be submitted to the

following equally; the college (KCN), Blantyre District Health Office and one to be kept by the researcher herself.

f) 15% Contingency

This was to cater for the rise in transport and material costs. It also served as an additional money where necessary.

APPENDEX A:

LETTER TO MINISTRY OF HEALTH

Cathy. P. Butao
University of Malawi
Kamuzu College of Nursing
P/Bag 1,
Lilongwe.

Date: 8th August 2008

The Secretary for Health
Ministry of Health
Box 30377
Lilongwe.

Dear Sir/Madam

REQUEST TO CONDUCT A RESEARCH ON FACTORS INFLUENCING DISCLOSURE AND NON-DISCLOSURE OF STATUS OF HIV POSITIVE PREGNANT WOMEN TO THEIR SPOUSES AT LIMBE HEALTH CENTRE

I am a mature year two student pursuing a Bachelors of Science Degree in Health Service Management at Kamuzu College of Nursing. In partial fulfilment of the this award, I am expected to conduct a research study, hence the request.

I, then seek your permission from your office to allow me conduct my research at Limbe Health Centre on a research topic entitled above. Antenatal mothers will be asked questions related to HIV disclosure to spouses. This will help health personnel find better ways of counselling and helping antenatal mothers to disclose their status to their spouses hence reduce further HIV transmission among couples.

I look forward to your favourable consideration.

Yours Faithfully,

Cathy P Butao, Mrs.

APPENDEX B :

LETTER TO THE DISTRICT HEALTH OFFICE

Cathy. P. Butao
University of Malawi
Kamuzu College of Nursing
P/Bag 1,
Lilongwe.

Date: 8th August 2008

The District Health Officer
Blantyre District Office
P/Bag 66,
Blantyre.

Dear Sir/Madam

PERMISSION TO CONDUCT A RESEARCH AT LIMBE HEALTH CENTRE

I am a mature year two student pursuing a Bachelors of Science Degree in Health Service Management at Kamuzu College of Nursing. In partial fulfillment of the this award, I am expected to conduct a research study, hence the request.

The aim of this letter is to seek your permission to interview some antenatal mothers at Limbe Health Centre on a research topic entitled ***"Factors influencing disclosure and non-disclosure of status of HIV positive pregnant women to their spouses."*** Antenatal mothers will be asked questions related to HIV disclosure to spouses.

I look forward to your favourable consideration.

Yours Faithfully,

Cathy P Butao, Mrs.

APPENDEX C:

LETTER TO THE INCHARGE, LIMBE HEALTH CENTRE

Cathy. P. Butao
University of Malawi
Kamuzu College of Nursing
P/Bag 1,
Lilongwe.

Date: 8th August 2008

The In-charge
Limbe Health Centre
P/Bag 66,
Blantyre.

Dear Sir/Madam

PERMISSION TO CONDUCT A RESEARCH AT LIMBE HEALTH CENTRE

I am a mature year two student pursuing a Bachelors of Science Degree in Health Service Management at Kamuzu College of Nursing. In partial fulfilment of the this award, I am expected to conduct a research study, hence the request.

The aim of this letter is to seek your permission to interview some antenatal mothers at your Health Centre, Limbe, on a research topic entitled "***Factors influencing disclosure and non-disclosure of status of HIV positive pregnant women to their spouses.***" Antenatal mothers will be asked questions related to HIV disclosure to spouses.

I look forward to your favourable consideration.

Yours Faithfully,

Cathy P Butao, Mrs.

APPENDIX D:

LETTER SEEKING PERMISSION FROM KCN RESEARCH COMMITTE

TO: THE RESEARCH COORDINATOR
KAMUZU COLLEGE OF NURSING RESEARCH COMMITTEE.

FROM: CATHY BUTAO, MRS
MATURE YEAR 2 STUDENT
KAMUZU COLLEGE OF NURSING

DATE: JULY 2008

RE: PERMISSION TO CONDUCT A RESEARCH STUDY

DEAR SIR/MADAM,

I am a mature year 2 KCN student pursuing a Bachelors of Science Degree in Health Services Management. As a requirement for the award of this degree, am expected to conduct a research study, hence the request.

The aim of this letter is to request the committee to allow me conduct my research study at Limbe Health Centre, entitled "***Factors influencing disclosure and non-disclosure of status of HIV positive pregnant women to their spouses.***"

The study will be conducted between the months of August and September 2008. Enclosed is the research proposal.

I am looking forward to your favourable response.

Yours truly,

CATHY P BUTAO, MRS.

APPENDIX E: APPROVAL LETTER BY KCN RESEARCH COMMITTEE

University of Malawi
KAMUZU COLLEGE OF NURSING

RESEARCH AND PUBLICATIONS COMMITTEE

APPROVAL CERTIFICATE

TITLE: *FACTORS CONTRIBUTING TO DISCLOSURE AND NON DISCLOSURE OF STATUS OF HIV POSITIVE PREGNANT WOMEN TO THEIR SPOUSES AT LIMBE AT LIMBE HEALTH CENTRE*

INVESTIGATORS: CATHY P. BUTAO (MRS.)

DEPARTMENT/YEAR OF STUDY: *BSc.N*

REVIEW DATE : *JULY 2008*

DECISION OF THE COMMITTEE: *APPROVED*

SIGNATURE: pp ..... **DATE:** 19-07-08

DEAN, POSTGRADUATE STUDIES & RESEARCH

cc Supervisor:

UNIVERSITY OF MALAWI
KAMUZU COLLEGE OF NURSING
19 07 2008
BASIC STUDIES DEPARTMENT
PRIVATE BAG 1, LILONGWE

DECLARATION OF INVESTIGATOR(S)

I/we fully understand the conditions under which I am/we are authorized to carry out the above mentioned research and I/we guarantee to ensure compliance with these conditions. In case of any departure from the research procedure as approved, I/we will resubmit the proposal to the committee.

DATE 19-07-08 SIGNATURE(S) .....

APPENDIX F:

CONSENT FORM FOR THE PARTICIPANT

INVESTIGATOR

Cathy Butao. Mrs.
University of Malawi
Kamuzu College of Nursing
P/Bag 1, LL
Tel: 08 863 408
09 863 408

SUPERVISOR

Mr. Mutcha (Basic Studies)
University of Malawi
Kamuzu College of Nursing
P/Bag 1, LL
Tel: 09 442 780
01 751 622

INFORMED CONSENT

Good morning!!

My name is Mrs. Cathy Butao. I am a mature year 2 student from Kamuzu College of Nursing studying a degree in Health Services Management. In partial fulfillment of this degree, I am required to conduct a research study.

I am conducting a research on ***" Factors that Influence HIV Pregnant Women Disclose or Not disclose their status to their Spouses."***

You, being one of the pregnant women who have found to be HIV positive and have either disclosed or not disclosed your status to your spouse, have been selected to participate in this study.

The discussion will take an average of one hour. You will be asked questions related to your experience with HIV and status disclosure to your spouse. All the responses will be written down. To ensure privacy, you will not be asked to give your name but a code number will be used instead. Any information that you give will be kept in strict confidence.

However the information will be used to find ways on how best medical professions can help to promote disclosure among pregnant women hence reducing further HIV transmission. All the information given will only be accessible to the investigators and her supervisor only.

You are free to take part in the study or not. You are also at liberty to withdraw from the study at any point. Your decision, not to take part or withdraw, will not have any effect on you. However, I would be grateful if you can allow me to discuss with you some questions relating to this topic.

For further Information contact the investigator and supervisor's addresses above.

You are requested to sign on the space provided to show that you have understood the information provided and you are willing to participate in the study:

To be completed by participant.

I have understood the information about the study and I am willing to take part.

Participant's signature_____ Date_____

Investigator's Name_____ Date_____

Investigator's signature_____

Many thanks for your acceptance to take part in this study.

APPENDIX G:

KALATA YA MVOMEREZA KUTENGA NAWO GAWO PA KAFUKUFUKU

WOFUFUZA

Cathy Butao. Mrs.
University of Malawi
Kamuzu College of Nursing
P/Bag 1, LL
Tel: 08 863 408
09 863 408

WOYANG'ANIRA

Mr. Mutcha (Basic Studies)
University of Malawi
Kamuzu College of Nursing
P/Bag 1, LL
Tel: 09 442 780
01 751 622

KALATA YA CHILOLEZO

Mulibwanji !!!!

Ine ndine Mai Cathy P Butao. Ndine wophunzira wa ku sukulu ya anamwino ya Kamuzu Koleji amene ndikuchita maphunziro aukachenjede. Kuti ndilandire pepala la maphunzirowa, ndikuyenera kuchita kafukufuku.

Kafukufuku wangayu ndikufuna kuona zomwe zimawachititsa amayi apakati amene apezeka ndi kachirombo ka HIV, komwe kamayambitsa matenda a EDZI, kupanga chisankho chowafotokoza kapena kusafotokoza zotsatira za HIV kwa amuna awo.

Inu, ngati mmodzi mwa amayi a pakati, amene munapezeka ndi kachiromboka ndipo munafotokoza zotsatira zanu kapena ayi, kwa amuna anu, mwasankhidwa kuti mutenge nawo mbali pa kafukufukuyu. Zokambirana zanthu zitenga ola limodzi. Mufunsidwa mafunso okhudzana ndi nkhaniyi ndipo ine ndidzilemba mayankho anu. Pofuna

kunsunga chinsinsi, zokambirana zanthu sitilemba dzina lanu pali ponse koma tigwiritsa ntchito nambala. Mayankho amene ndilembe, adzasungidwa mwachinsinsi. Komabe zotsatira zamayankho anu zidzathandiza kupeza njira zopititsira patsogolo mmene amayi apakati angamafotokozere amuna awo zotsatira zakachirombo ka HIV, ndicholinga chofuna kuchepetsa chiwerengero chofalitsa kachirombo ka HIV.

Mayankho anu adzatha kuonedwa ndikugwiritsidwa nthito ndi ine komanso aphunzitsi oyang'anira kafukufukuyi basi. Muli ufulu kutenga mbali mukafukufukuyi nthawi iri yonse ndipo sipadzakhala chovuta china chirichonse.

Ndithokoza kwambiri ngati mungandilole kuti tikambirane za nkhaniyi. Ngati muli ndi mafunso ena apadera mukhoza kufunsa kudzera pa ma adiresi ali pachikalatachi.

Mukupephedwa kusaina kuti mwamvetsetsa zomwe takambirana zakafukufukuyi, ndipo mwapanga chisankho chotenga nawo mbali mukafukufukuyi.

Posaina wotenga mbali mukafukufu

Ine ndamvetsa zakafukufukuyu ndipo ndamvomera kutenga nawo mbali mosaumirizidwa:

Posaina mayi_____ Tsiku_____

Dzina la wopangitsa kafukufuku_____ Tsiku_____

Posaina wopangitsa kafukufuku_____

Zikomo kwambiri povomera kutenga nawo mbali pakafukufuku

APPENDIX H:

QUESTIONARE FOR THE PARTICIPANT

DISCLOSURE AND NON DISCLOSURE OF STATUS OF HIV POSITIVE PREGNANT WOMEN TO THEIR SPOUSES AT LIMBE HEALTH CENTRE.

INTERVIEW GUIDE

Code Number _____ Interview Date _____

SOCIO- DEMOGRAPHIC DATA:

1. Age _____ years
2. Residence / Address _____
   _____
3. Marital Status _____
4. Number of Children _____
5. Level of Education
   - None _____
   - Primary _____
   - Secondary _____
   - Other (Specify) _____
6. Your present occupation _____
7. Is your spouse working? YES ___ NO ____
8. Ways of getting money _____
9. Denomination _____

SEXUAL BEHAVIOUR AND DISCLOSURE:

We know you have been counseled to use condoms, but we also know that some people find it difficult to use condoms every time they have sex; below are some questions which we want to know about your sexual behaviour.

10. Do you have a main partner / husband ? YES_____
NO _____

11. Have ever used a condom in your life during sex?
- Yes _____*(go to11b)*
- No _____ *(go to question 13)*

(b) which type of condom? Female condom _____
Male condom _____

12. In the last 3 months, how often did you and your partner use a condom during sex? Never _____
- Sometimes _____
- Always _____

13. Since this pregnancy, do you think your sex partner do have sex with other women apart from you? . Yes _____
- No_____
- Don't Know _____

14. In the past 6 months, have you been diagnosed and treated for :

a) Syphilis _____
b) Offensive vaginal discharge _____
c) Vaginal sores _____
d) Any Sexually Transmitting Infection (specify) _____

The following questions are sensitive but I will be grateful if you give enough information:

15. How many sex partner have you had in your life time? _____.*(estimate if unsure).*

16. Since this pregnancy, how many sex partners have you had?_____.

17. What prompt you to go for an HIV test?

- Mandatory _____
- VCT _____
- Peer pressure _____
- Sickness_____
- Pregnancy *(the fact that am pregnant)* _____

18. For how long have you been diagnosed HIV positive?

- 1 day _____
- < a month_____
- 1-3 months _____
- < a year _____
- > a year _____

19. Have you ever disclosed your status to your spouse?

- Yes _____ *(go to question 20)*
- No _____ *(go to question 21)*

20. When did you disclose your status to your spouse?

- Same day of getting results _____
- Next day _____
- After a month _____
- Took some time _____

(b) why _____

(c) did you encounter any problem from your spouse after disclosing your status? Yes _____

No _____

21. When do you intend to disclose your status to your spouse?

_____

22. What could be the reason for your delay to disclose your status to your spouse?

- Fear of divorce _____
- Fear of violence_____
- Nothing _____
- Lack of support _____
- Fear of discrimination _____
- Other (*specify*) _____

23. To whom do you feel safe to disclose your status?

- Pastor _____
- Spouse_____
- Friends_____
- Family _____
- Other (*specify*)____

(b) What could be your reason(s) for your answer above?_____

_____

24. How do you think, you can best involve your spouse in taking care of you as an HIV pregnant woman?_____

_____

25. How do you think we (as medical professions) can help you as an HIV pregnant woman, disclose or continue to disclose your status to your spouse?_____

_____

_____

_____

APPENDIX I:

MAFUNSO KWA ALOWA KAFUKUFUKU

KAFUKUFUKU WOFUNA KUDZIWA ZOMWE ZIMAWACHITITSA AMAYI APAKATI, AMENE APEZEKA NDI KACHIROMBO KA HIV , KUFOTOKOZA KAPENA KUSAFOTOKOZERA AMUNA AWO, ZOTSATIRA ZA ZOYESA ZAWO ZA HIV.

NDONDOMEKO YA MAFUNSO

Nambala _____ Tsiku Lofunsidwa _____

1. Zaka _____
2. Kokhala / Adilesi_____
   _____
3. Banja _____
4. Muli Ndi Ana Angati? _____
5. Maphunziro
   - Sindinaphunzirepo _____
   - Pulaimale_____
   - Sekondale_____
   - Koleji_____
   - Zina (Tchulani) _____
6. Mumagwira Ntchito.
   - Inde _____
   - Ayi _____
7. Amuna / Abwenzi Anu Amagwira Ntchito
   - Inde _____
   - Ayi _____
8. Njira Zopezera Ndalama _____
9. Mpingo Wopemphera _____

MAFUNSO OKHUDZANA NDI MOYO WOGONANA KOMANSO ZINA

Tikudziwa kuti munawuzidwa zogwiritsa ntchito makondomu pamoyo wanu komanso tikudziwa kuti anthu ena amaona kuti ndizowavuta kugwiritsa ntchito makondomu nthawi zones pamene agonana ndi amuna / abwenzi awo.

10. Kodi Muli Ndi Mwamuna / Bwenzi Lokhazikika?
    - Inde _____
    - Ayi _____
11. Munayamba Mwagwiritsapo Makondomu Pamoyo Panu?
    - Inde_____(*Yankhani Fuso 11b*)
    - Ayi _____*(Yankhani Fuso 13*)

    (B) Kondomu Yake Yiti?
    - Ya Abambo_____
    - Ya Amayi _____
12. Pamiyezi itatu yapitayi, mwagwiritsapo ntchito kondomu kangati pogonana ndi abwenzi / amuna anu.
    - Palibe _____
    - Nthawi Zina _____
    - Nthawi Zonse_____
13. Chitengere mimba imeneyi, mukaganiza kuti amuna / abwezi anu, amagona ndi akazi ena?
    - Inde ____
    - Ayi _____
    - Sindikudziwa _____

14. Pamiyezi isanu ndi umodzi yapitayi, mwapezekako ndi kuchizidwako matenda awa:
    - Chindoko _____
    - Chikazi chodabwitsa _____
    - Zironda za kumusi _____
    - Matenda ena opatsirana pogonana (*tchulani*) _____

Mafunso otsatirawa ndi wochititsabe manyazi, koma ndikhala wokondwa mutandipatsa mayankho oyenerera:

15. Mwagonanako ndi amuna angati pamoyo panu? _____
16. Chikhalire ndi mimba imeneyi, mwagonanako ndi amuna angati? _____
17. Chinakupangitsani ndi chani kuti mukayezetse za kachirombo ka HIV komwe kamayambitsa matenda a EDZI?
    - Kukakamizidwa _____
    - Kudzipereka ndekha _____
    - Anzanga _____
    - Matenda _____
    - Chifukwa chopezeka ndi mimba _____
18. Papita nthawi yayitali bwanji chipezekere ndi kachirombo ka HIV komwe kamayambitsa matenda a EDZI.
    - Tsiku limodzi ___
    - Osatha mwenzi ____
    - Pakati pa mwenzi umodzi ndi itatu _____
    - Osatha chaka _____
    - Kuposa chaka

19. Kodi munayamba mwawafotokozerapo amuna / abwenzi anu zotsatira za zoyesa zanu za kachirombo ka HIV?

Inde _____(*yankhani fuso 20)*

Ayi _____(*yankhani fuso 21)*

20. Kodi munawafotokozera liti amuna anu zotsatira zazoyesa zanu za kachirombo ka HIV?

- Tsiku lomwelo _____
- Tsiku lotsatira _____
- Patatha mwenzi _____
- Patapita nthawi yayitali ___

(b) Chifukwa chiyani _____

_____

(c) Kodi munapezeka ndi vuto mutafotokoza zotsatira za Zoyesa zanuzo kwa amuna anu?

- Inde ____
- Ayi _____

21. Kodi mukuganiza kuti muwafotokozera liti amuna anu za zoyesa zanu za ka chirombo ka HIV? _____

22. Ndi chifukwa chiyani mwakhala nthawi chonchi musanawafotokozere amuna anu zotsatira za zoyesa zanu za kachirombo ka HIV?

- Kuaopa kutha kwa banja _____
- Kuopa kumenyedwa kapena kutozedwa ____
- Palibe chifukwa _____
- Kuopa kusowa chithandizo _____
- Kuopa kusalidwa _____
- Zina (*Tchulani*) _____

23. Ndindani mungakondwe kumuuza zotsatira za zoyesa zanu za kachirombo ka HIV:

- Abusa ___
- Amuna / abwenzi anga ____
- Nzanga _____
- Banja langa _____
- Ena (*Tchulani*) _____

24. Kodi mukuganiza kuti mungawagwiritsa ntchito bwanji amuna / abwenzi anu kuti akuthandizeni inu ngati mayi wapakati amene ali ndi kachirombo ka HIV komwe kamayambitsa matenda a EDZI? _____

_____

25. Kodi a chipatala angajuthandizeni bwanji kuti inu muwafotokozere amuna /abwenzi anu kapena kupitiriza kufotokoza zotsatira za zoyeza zanu za nkachirombo ka HIV?

_____

_____

_____

_____