UNIVERSITY OF MALAWI

KAMUZU COLLEGE OF NURSING

A STUDY ON PERCEPTIONS OF HIV SERO-POSITIVE MEN TOWARDS HIV PARTNER NOTIFICATION AT QUEEN ELIZABETH CENTRAL HOSPITAL

BY

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DECLARATION

I hereby declare that this dissertation is a result of my own work and effort and that to my knowledge and belief, it has never been presented for any diploma or degree. It does not contain any material previously published or written by another person except where due reference is made in the text.

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DEDICATION

I dedicate this work to my mum and dad, aunt, all my nieces and nephews not forgetting all the men in Malawi.

ACKNOWLEDGEMENT

First and foremost, I thank the almighty God for being with me throughout the research process, what would I have done without Him.

I would also like to acknowledge with thanks the assistance I received from my supervisor, Mrs. W. Chilemba in guiding me through my research study. I sincerely appreciate her input and her patience and forbearance were a Godsend.

My gratitude be extended to my parents, aunt, brothers and sisters for supporting me throughout the academic life, I do not take it for granted.

I give thanks to all my friends for always being there academically and spiritually.

May the almighty God richly bless you all!

ABSTRACT

The purpose of the study was to find out the perception of HIV sero-positive men towards HIV partner notification. The health belief model by Rosenstock (2002) was used to guide the study. A qualitative, descriptive research design was used. Data was collected using a semi-structured interview guide on 12 participants sampled conveniently at Queen Elizabeth Central Hospital-ARV clinic. Content analysis of data was done.

The results of the study have indicated that the participants' age ranged from 26- 45 years of age. Most of them were married and working. Most of the participants new what HIV and AIDS is, how it is transmitted and prevented but some still didn't know the differences between HIV and AIDS.

Most of the participants saw a need for HIV partner notification. Most of them had disclosed their HIV status to their partners as were motivated with such reasons as: preventing HIV infection and re-infection; partners had already disclosed their status to them after getting tested for HIV at the antenatal clinics; the love they have for their partners as well as due to the problems they had gone through together. Other men saw a need for disclosure but did not actually disclose as were afraid of their partners' reactions, that is, were afraid of being divorced and being discriminated against. Some of those who had disclosed were accepted, attained psychological wellbeing and their relationships were maintained and they used condoms to prevent transmission of the HIV virus. Others had quarrels and their relationships turned sour. Those who didn't disclose did not use condoms.

In conclusion, a lot of men know what HIV and AIDS is all about and see the importance in one notifying their partners of their HIV status. However, disclosure decision-making process results from people weighing the pros and cons associated with disclosure.

LIST OF ABBREVIATIONS

AIDS- Acquired Immunodeficiency Syndrome

ARV- Anti-retroviral

DFID- Department for International Development

MDHS- Malawi Demographic Health Survey

HBC- Health Belief Model

HIV- Human Immunodeficiency Syndrome

NAC- National AIDS Commission

NACP- National AIDS Control Programme

PLWHA- People Living With HIV and AIDS

STI- Sexually Transmitted Infections

TB- Tuberculosis

UNAIDS- The Joint United Nations Programme on HIV and AIDS

USAID- United States Agency for International Development

WHO- World Health Organization

DEFINITIONS

Perception- These are ways of regarding, understanding or interpreting something.

Partner- a sharer, an associate

Notify- to make known, to declare, to give notice or information of

Notification- the notice given, the act of notifying

1.0 INTRODUCTION

Acquired Immunodeficiency Syndrome (AIDS) is one of the greatest public health and social problem threatening the human race. The greatest burden of HIV and AIDS pandemic is in sub-Saharan Africa, Malawi inclusive (NAC, 2004). Heterosexual contact is the principle mode of HIV transmission while mother to child transmission accounts for 25% of all new infections (NAC, 2004). The HIV epidemic continues to amplify in southern Africa and there is a growing need for HIV prevention among people who have tested HIV positive. A widely accepted and utilized component of public health programs designed to curtail the spread of the HIV and AIDS epidemic is the voluntary notification of sexual partners of individuals who tested HIV seropositive.

Malawi like its neighbors in the sub-Saharan Africa region has been severely affected by the HIV and AIDS epidemic. Acquired Immunodeficiency Syndrome was first identified in Malawi in May 1985, since then, epidemiological data continues to show an escalating epidemic. Out of a population of nearly 14 million, almost one million people in Malawi were living with HIV at the end of 2007. The AIDS epidemic is responsible for eight deaths every hour in Malawi and it's the leading cause of death amongst adults. Acquired Immunodeficiency Syndrome is a major factor in the country's low life expectancy of just 43 years.

Malawi's first AIDS case was reported in 1985. In response, the Government implemented a short-term AIDS strategy (including blood screening and HIV education programmes), and in 1988, created the National AIDS Control Programme (NACP) to co-ordinate the country's AIDS education and HIV prevention efforts.

Malawi continues to suffer from the connecting problems of poverty, famine and AIDS. However, intensive efforts have been made in recent years to increase awareness about HIV and to prevent its spread, and these efforts appear to have had a positive effect.

Partner notification is an important tool in breaking the chain of infection and allows sexual partners to make an informed choice about engaging in safer sex and prevents potential for transmitting the HIV resistant virus when one is on ARV treatment (Zoanne, 2009). Zoanne (2009) further explains that partner notification is also important to current or past female partner who may be pregnant or contemplating pregnancy. If infected, she will need to make choices about her pregnancy or drug therapies to help prevent HIV transmission to her baby. Partner notification, especially when done by a trained professional, provides partners with crucial health information, counseling and referrals. Disclosure of one's HIV status to a potential sexual partner therefore has important HIV prevention implications.

Because many experts believe that HIV positive status helps to prevent HIV transmission and increases social support to HIV positive individuals, there are efforts to develop overall prevention and wellbeing programmes for HIV positive persons to encourage disclosure and make it a constructive experience. However, there have been few studies on the daily lives of sexual activities of heterosexual men. Hence strategies developed to prevent the spread of HIV are rarely based on detailed knowledge of men whose behavior is intended to change. This is especially evident in developing countries like Malawi. Hence, it is imperative to conduct a research on perception of men towards HIV partner notification to understand them better and improve the sexual health of couples by reducing onward transmission of HIV.

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1.2 BACKGROUND

Human Immunodeficiency Virus and AIDS is a challenge worldwide. Since the discovery of the virus more than 20 years ago, millions of people throughout the world have been infected with HIV. Acquired Immunodeficiency Syndrome remains an epidemic which means that it affects a large number of people and continues to spread rapidly (WHO, 2009). The exact number of people living with HIV and AIDS is unknown despite the fact that it can be diagnosed by a widely used antibody test. From 1996-2000, the estimated number of people with HIV globally was thirty six point one million (WHO, 2000). An estimated 13 million men are living with HIV and 96% of these are in developing countries. An estimated thirty-eight million people worldwide were living with the virus and 25 million were in sub-Saharan Africa which has about10% of the world's population (UNAIDS, 2004. Hung, 2007).About 40 million people in the world are living with HIV infection and AIDS (WHO, 2009).

Malawi has one of the highest national prevalence rates in the world. It is the eighth highest in the Global ranking (DFID, 2008). The total number of people infected with the virus in Malawi is estimated to be one million (WHO/ UNAIDS, 2008). UNAIDS estimated that the national adult prevalence rate was 14.1% in 2005 while the 2004 demographic health survey (MDHS) reported on 11.85 adult prevalence rates. The 2007 HIV sero-survey of the antenatal clinics estimated a national prevalence of 12% for a total of roughly 900,000 Malawians living with HIV. Malawi exhibits significant geographic differences in HIV prevalence. Although prevalence is significantly higher in the urban areas, 80% of the population lives in the rural areas and the epidemic in these areas remain a concern. In the south, where roughly half of the population resides, HIV rates in both urban and rural areas are much higher than in other regions. In (2005), (DFID) found out that Malawi has approximately 86,592 deaths and 84 000 new orphans every year estimated to be due to HIV and AIDS.

The primary mode of transmission in Malawi is heterosexual contact. No information is available about the number of infections transmitted through sex between men, as

homosexuality is illegal, but the number is thought to be relatively low. Malawi's epidemic is feminized as around 60% of adults living with HIV in Malawi are women (UNAIDS, 2006). For instance, AIDS affects more than four times as many women as men amongst the 15-19 age group in Malawi, and about a third more women than men amongst the 20-25 age group. However, amongst those who are over 30 the trend reverses, as more men than women are affected. This pattern reflects the fact that younger women are often married to older men, or coerced into having sex with them. Nearly one in five adolescent females (15-19yrs) reported force or coercion used in their first sexual experience.

The 2004 MDHS demonstrated that women have higher HIV prevalence rates than men, at 13% and 10% respectively. Human Immunodeficiency Virus prevalence among young women (15 to 24 years old) in Malawi is much higher than among men of the similar age: 9% compared to 2% overall.

Human Immunodeficiency Virus is still stigmatized in Malawi, hindering the flow of information to the communities, hampering prevention efforts and reducing the use of HIV and AIDS services. Heterosexual contact being the principle mode of transmission, there is a need to employ the role of those infected to reduce secondary transmission through prevention. There is unmet need for HIV prevention because the majority of the couples are unaware of each other's status, therefore, there is a need to target partner notification especially through assessing men's perception towards partner notification. Public health messages have traditionally urged disclosure to all sexual and drug using partners. In reality, some HIV positive persons may choose not to disclose due to fears of rejection or harm, feelings of shame, desires to maintain secrecy. They may also have feelings that with safer sex there is no need for disclosure and have beliefs that individuals are responsible for protecting themselves (Remien & Bradley, 2007).

Most HIV positive persons disclose their status to some, but not all, of their partners, friends and family. Disclosure generally becomes easier the longer someone has been living with HIV, as he/she becomes more comfortable with an HIV positive status. Disclosure to sex partners is more likely in longer-term, romantic relationships than in

casual relationships (one-night stands, anonymous partners and group scenes). Disclosure also varies depending on perceived HIV status of partners, level of HIV risk of sex activities, sense of responsibility to protect partners (personal vs. shared responsibility) and alcohol or drug use (Remien & Bradley, 2007).

Disclosure is an important public health goal for a number of different reasons. First, disclosure may motivate sexual partners to seek testing and change behavior thereby reducing HIV transmission. Disclosure has many potential benefits for the individual including increased opportunities for the social support, improves access to necessary medical care including ARVs, increased opportunities to discuss and implement HIV risk reduction with partners and increase opportunities to plan for the future.

1.3 PROBLEM STATEMENT

As HIV & AIDS continue threatening the human race severely, there is need to slow it down. The prevention and control of HIV infection depends on the success of strategies to prevent new infections and treat currently infected individuals (Maman, 2004). Emphasis is placed on the importance of HIV status disclosure among HIV infected individuals to their partners. Unfortunately, couples do not inform each other of their HIV status. According to literature review, particular emphasis is placed on women's experiences with disclosure to sexual partners and that they are the ones who disclose their status to the men than the men do. But disclosure is a two way process and if focus is only directed to women, HIV prevention goals cannot be achieved unless men are also involved. A few studies however, have been conducted concerning men and disclosure. This lack of research highlights the need for studies to look at the special needs and concerns of men in terms of disclosure. It would therefore be imperative to conduct a study to find out perceptions of HIV positive men towards partner notification.

1.4 SIGNIFICANCE OF THE STUDY

Disclosure is a multifaceted issue that may be influenced by an individual's perception of the social, psychological and material consequences of informing others.

Human Immunodeficiency Virus and AIDS is a crucial infection that requires everyone's effort. Most of the time you hear stories about a woman realizing her husband taking ARVs without her notice. Taking into consideration polygamy and multiple partners, it therefore poses a risk to all the wives and sexual partners as one man will infect a lot of women thereby increasing the number of infected women.

Therefore, knowing the perception of men towards HIV partner notification is significant as it will help health workers know what men's views are on partner notification, thereby formulate guidelines and strategies to encourage and assist disclosure among those infected with HIV and AIDS especially men, through behavior change which, when not observed raise concerns about the potential for rapid spread of HIV. This also protects their partners (women) through decreasing their exposure to HIV and would change the incidence and prevalence of HIV i.e. reduce the number of HIV infected women thereby reducing the number of infected people in the country at large as HIV prevalence among women is higher than among men. Therefore, dealing with one man means preventing infection to several women, thereby containing the epidemic and reducing burden to the health sector.

1.5 BROAD OBJECTIVE

To explore the perception of HIV positive men towards partner notification.

1.5.1 SPECIFIC OBJECTIVES

- To assess the knowledge of HIV positive men on partner notification.
- To assess men's beliefs on partner notification.
- To describe factors that influence partner notification.
- To find out the effects of partner notification.

CHAPTER TWO

2.0 LITERATURE REVIEW

Holloway (2002) explains that the researcher reviews literature to: Find out what is already known about a subject and identify gaps in knowledge, describe how a study contributes to the existing knowledge of a topic area and to avoid duplicating other people's work. In the clinical practice arena, the knowledge from a critical literature review contributes to the implementation of the research- based practice interventions, protocols and evaluation programmes that improve the quality of the patient care (woods, 1994). The literature that is to be reviewed in this research study comprises of partner notification- related studies that have been done worldwide, in Africa and Malawi.

2.1 DISCLOSURE OF HIV STATUS

Disclosure of Human Immunodeficiency Virus (HIV) positive status is a complex, difficult and very personal matter. Disclosing one's HIV positive status entails communication about a potentially life threatening, stigmatized and transmissible illness. Choices people make about this are not only personal but vary across different age groups, in different situations and contexts, and with different partners, and may change with time, depending on one's experiences (Remien & Bradley, 2007).

Disclosure of HIV infection to sexual partners is a critical component in preventing sexual transmission and in Human Immunodeficiency Virus (HIV) and Acquired Immune-Deficiency Syndrome (AIDS) prevention interventions. Kassaye, Lingerh, and Dejene (2004) suggested that disclosure enables for improved access to prevention and treatment programmes, provides increased opportunities for risk reduction, and helps in planning for the future. Kadowa and Nuwaha (2009) suggested that identifying factors associated with disclosure is a research priority as a high proportion of persons living with HIV and AIDS (PLWHA) never disclose.

In (1998), (Schwenk, as cited in Stein) in his study on factors associated with disclosure of HIV status found that among the 129 HIV-positive patients interviewed at two public hospital clinics in Boston and Providence, 69% of whom were men, forty percent of patients had not disclosed their HIV status to all of their sexual partners. Of those with only one partner, 21 percent had not disclosed their status. The study also showed that patients were more likely to disclose their status if they were white or Latino, women or had only one sexual partner.

Brown, Miller and Kamanga et al. (2009) randomized 30 individuals with newly diagnosed HIV infection presenting to the Kamuzu Central Hospital STI clinic in Malawi to one of three methods of partner notification: passive referral, contract referral, or provider referral. They aimed at finding evidence on the effectiveness of partner notification in sub-Saharan Africa. The passive referral group was responsible for notifying their partners themselves. The contract referral group was given 7 days to notify their partners, after which a health care provider contacted partners who had not reported for counseling and testing. In the provider group, a health care provider notified partners directly.
Results showed that among male partners, partner counseling and testing was 11% for passive, 43% for contract, and 71% for provider referral. Among female partners, partner counseling and testing was 67% for passive, 17% for contract, and 43% for provider referral. This study therefore shows that women are in a position to disclose on their own more than men.

Makoni (2004) in Zimbabwe investigated on whether people disclose, who discloses and their explanations. Interviews and group discussions were conducted on 49 people. Findings revealed that men did not disclose their status to their partners because it is a sign of weakness and as an admission of a need for help and denial about a harsh reality hence try to live as normal a life. Men would only disclose when forced by circumstances, for instance, the need for care. One respondent offering post-test counseling and support said that, although no thorough research had been done into how many men disclose, in her experience, women formed the majority of the people who

disclosed their status to their spouses and was supported by 5 women interviewed who had not known their husbands were infected.

In this study, it was found that women disclose their status to their partners because they want to demand for an explanation as to why they are infected and because they are the usual recipients of HIV and AIDS information hence respond to information by trying to change the behavior. Women also disclose their status to avoid re-infection, hence negotiates for condom use. Findings on the negative consequences included fear of being suspected of being unfaithful and that their husbands would be abusive, violent and dump them.

However, the researcher targeted men and women leaders in HIV related organizations, HIV infected women and the university students but did not interview men living with the virus who would have provided the right information as to how they feel because all those who were interviewed worked under assumptions.

Tadesse, Muula and Misiri (2004), conducted a Cross sectional, questionnaire-administered study at Ante-natal clinics of eleven public health centers and the major referral and university teaching hospital of Queen Elizabeth Central Hospital (QECH) in Blantyre, Malawi to determine 321 pregnant women's perceptions towards selected potential HIV prevention efforts. On HIV disclosure, it was found that about 97% of married women reported desire to tell spouse in case of HIV sero-positive results while only 65.1% had ever discussed about HIV with spouse. Whether woman had ever discussed about HIV and AIDS with spouse or not, however, did not influence desire to disclose HIV status to spouse.

Similarly, Kadowa and Nuwaha (2009) carried out a case control design study to identify factors associated with disclosure among people living with HIV and AIDS in Uganda. The researchers compared 139 (PLWHA) who had disclosed to 139 (PLWHA) who had not disclosed (all of them women) regarding socio demographic characteristics, sexual behavior and individual experiences with disclosure. Findings revealed that factors favoring disclosure include not fearing negative outcomes of disclosure, having

communication skills to disclose, having initiated anti-retroviral therapy and receiving ongoing counseling. Those who did not disclose feared divorce and violence, while others did not even see a need to disclose. Twenty-seven percent of PLWHAs that had not initiated anti-retroviral therapy (ART) and fear negative outcomes need more help in disclosure.

Therefore, measures that empower PLWHA to disclose such as those that lead to improved communication skills should be reinforced during ongoing counseling.

An assessment of the barriers and outcomes for disclosure is necessary to enhance HIV test result and disclosure among couples. Kassaye et al. (2004) carried out a cross-sectional study in Ethiopia to determine the rate, barriers, and outcomes of HIV positive status disclosure among sexual partners. Forty-two HIV-infected women were interviewed using a structured questionnaire. Sixty-nine percent of the women reported having shared their HIV test results with their partners. Among the women who did not disclose their HIV status, 62.5% stated that it was due to fear of partner's reaction (fear of abandonment, rejection and accusation of infidelity). However, 75.9% of the women reported positive partner's reaction after making the disclosure. Eighty one point three percent of the women who had prior discussion about HIV and had HIV testing with their partners had disclosed their results. Condom use was also high among couples that disclosed their HIV status than those who did not. This study indicates that the outcomes of disclosure are encouraging. The anticipated partner reactions and the reality discovered by the study were different.

Human Immunodeficiency Virus (HIV) positive men face multiple challenges when deciding whether to disclose their serostatus to sex partners. Sullivan (2005), reviewed literature on male self-disclosure of HIV-positive serostatus to sex partners to identify influencing factors towards serostatus disclosure. Data analysis suggests that disclosure rates vary based on serostatus, relationship status, and number of sex partners. Rates of disclosure to primary sex partners ranged from 67% to 88%, suggesting that nearly one third of main sex partners were not disclosed to and were at risk of contracting HIV. As the number of sex partners increased, the likelihood of disclosure to all sex partners

decreased, ranging from one quarter (25%) to slightly over half (58%). Perceived efficaciousness and positive outcome expectations play an important role in the process of disclosure to sex partners. Interpersonal factors that positively influenced self-disclosure included spousal support, emotional investment, and communication about safe sex influence disclosure positively. Self-disclosure was not consistently associated with safer sex.

2.2 DISCLOSURE AND SEXUAL RELATIONSHIPS

The relationship between disclosure, sexual risk behaviors and potential transmission of HIV varies. Increased disclosure is associated with reduced sexual risk behavior and disclosure doesn't always alter risk taking behaviors. Even with disclosure, unsafe sex sometimes occurs. Some people engage in safer sex behaviors without any discussion of HIV status (Remien & Bradley, 2007).

This is supported in a cross-sectional study conducted in Los-angels by Marks and Crepaz (2001) to examine the relationship between disclosure of HIV-positive status to sex partners at risk for HIV infection and safer sex practices. Two hundred and six HIV positive men sampled randomly participated in the study. Unsafe sex was defined as unprotected anal or vaginal intercourse with the partner. Results revealed that twenty-five percent of the men engaged in unsafe sex and 48% of the total sample withheld disclosure from the partner. The prevalence of safer sex was not significantly higher among disclosers than among nondisclosures and disclosure was not significantly associated with safer sex. Forty percent of the men disclosed and engaged in safer sex, 35% withheld disclosure and engaged in safer sex, 12% informed their partner and engaged in unsafe sexual behavior and 13% withheld disclosure and engaged in unsafe sex. Risky behavior patterns were associated with using alcohol/drugs before sex, having an HIV-unknown partner, being less emotionally involved with one's partner.

In (2006), (Simbayi, Kalichman and Strebel et al.) sought to investigate the disclosure of HIV status to sex partners and sexual risk behaviors among HIV-positive men and women in Cape Town. Anonymous surveys were completed by 413 HIV-positive men

and 641 HIV-positive women. Results revealed that, among the 903 (85%) participants who were currently sexually active, 378 (42%) had sex with a person to whom they had not disclosed their HIV status. Participants who had not disclosed their HIV status to their sex partners were considerably more likely to have multiple partners, HIV-negative partners, partners of unknown HIV status and unprotected intercourse with non-concordant sex partners. Not disclosing their HIV status to partners was also associated with having lost a job or a place to stay because of being HIV positive and feeling less able to disclose to partners. Hence, HIV-related stigma and discrimination are associated with not disclosing HIV status to sex partners, and non-disclosure is closely associated with HIV transmission risk behaviors.

Thornton (2005) conducted a study in rural Malawi on 2,700 randomly sampled individuals to evaluate the demand for learning HIV counseling and testing results and to estimate subsequent behavior change. Among the HIV positive individuals, those who learnt their status exhibited a higher demand for condoms than those who did not know their status, supporting the view that individuals are willing to bear the costs of safer sex in order to protect sexual partners. However, this study does not indicate the percentages of those demanding for condom use.

Another study was conducted in Malawi by Morah (2007) to investigate whether people aware of their HIV-Positive status are responsible for driving the Epidemic in Malawi. The results provide empirical evidence of differences in knowledge, attitudes and behavior between HIV-positive people and those unaware of their sero-status. It comes to three conclusions: HIV-positive people report better knowledge and attitudes; there is substantially higher safer-sex practice among those aware of their HIV-positive status; and the assertion that the epidemic is spread by those aware of their positive sero-status is unsubstantiated. The overall message is that there is a need to accelerate both HIV testing and positive-prevention work. This study however does not indicate specifically which group of people revealed such results more than the other i.e. men or women.

A challenging issue for many people is the timing of disclosure. If it is not done relatively early, it can become more difficult as time goes on, and can cause significant disruption to an ongoing relationship if the disclosed-to partner feels betrayed due to the lack of an earlier disclosure. Remien and Bradley (2007) suggests that HIV positive persons who have thought through a disclosure plan and have a consistent strategy for managing disclosure are less likely to engage in risky sexual behaviors than those who do not disclose or have inconsistent disclosure strategies.

2.3 DISCLOSURE AND SOCIAL RELATIONSHIPS

Disclosure to significant others may help increase support for HIV positive persons. Zea, Reisen, Poppen, et al. (2003) conducted a study in Washington DC on 301 HIV-positive Latino gay and bisexual men. The aim was to examine disclosure to members of their social networks and the mental health consequences of such disclosure. The sample was recruited from clinics, hospitals, and community agencies in New York City, Washington DC, and Boston. It was found that disclosure was related to greater quality of social support, greater self-esteem, and lower levels of depression. Social support mediated the relationship between disclosure of serostatus and both self-esteem and depression. Thus, disclosure resulted in greater social support, which in turn had positive effects on psychological well-being.

Findings demonstrate that generally Latino gay men are selective in choosing people to whom they disclose their serostatus and that disclosure tends to be associated with positive outcomes.

Remien & Bradley (2007) suggests that disclosing HIV positive status may and sometimes does result in rejection, discrimination or violence. Disclosing to certain persons can also be more of a burden than a benefit. Friends might be disclosed to most often and perceived as more supportive than family members and mothers and sisters can be disclosed to more often than fathers and brothers and perceived as more supportive than other family members.

This is supported in a study done by Zea et al. (2004) which explored disclosure of serostatus in a sample of 155 HIV-positive Latino gay men from New York City and Washington, DC. The researchers examined rates of disclosure to different members of the social network: mothers, fathers, close friends, and primary sexual partners. The researcher examined the role of 3 contextual target-dependent factors (emotional closeness to target, anticipated reactions from target, and target's knowledge of sexual orientation), as well as acculturation and time since diagnosis.
Results revealed that there were high rates of disclosure of HIV-positive serostatus to main partners and closest friends and lower rates to fathers and mothers as a result of long time since diagnosis, acculturation and emotional closeness respectively. These findings highlight the importance of taking into account roles and relationships, and their effect on disclosure.

Similarly, Rohini and Vira (2004) conducted a cross-cultural study on HIV-positive Indian and American men on disclosure, perceived social support and psychological well-being. The purpose of this research was to investigate the relationship between disclosure of HIV-status to partners, parents and siblings, perceived support from family and friends, depression and loneliness. Analysis of the disclosure rates, and reasons for disclosure and non-disclosure of their HIV-status to others was also conducted. Existing datasets on HIV positive Indian (n = 100) and American men (n = 139) were used. Results clearly showed that partners were disclosed to at a greater rate than parents and siblings for both Indian and American men, and disclosure rates to all family members was higher for American in comparison with Indian men. The HIV-positive men's age, employment status, and length of HIV diagnosis together were also found to be significantly associated with disclosure to parents, partners, and siblings. Further, the American men's reasons for disclosure were more relation-focused, whereas for Indians men it was more obligatory or required. Perceived support from family and friends was found to significantly vary by the participants' county-of-origin, and disclosure to family.

Self-disclosure of diagnosis of Tuberculosis to others within the patients' social environment may be problematic because the diagnosis may attract stigma, largely derived from the association of this disease with HIV infection.

In (2008), (Zolowere, Manda, Panulo and Muula) using qualitative in-depth interviews conducted a study in Thyolo on 32 adult Tb patients with ages ranging from 22 to 49 to find out their experiences on self-disclosure as TB is largely as a consequence of the HIV/AIDS pandemic. They explored the relationship of persons to whom Tb patients disclose their diagnoses and identified the motivations for such disclosures. Nineteen participants were male.

Results revealed majority of patients as reporting having disclosed their disease status to close family members, such as spouses, siblings and parents; only a few had disclosed their status to their children. The most common way of disclosure was through personal discussion between the patient and their significant others. Study participants perceived that disclosure brought returns in terms of encouragement and empowerment. Some patients felt stigmatized or feared stigmatization following disclosure of their disease status, and some patients on antiretroviral therapy for HIV felt stigmatized by fellow patients. The findings of this study suggest that Tb patients were interested in disclosing their diagnosis if they felt they would not be stigmatized or stood to gain as a result of self-disclosure. Trust, a feeling of safety, and a sense of obligation to others facilitated disclosure. This research is related to the HIV in such a way that TB has been amongst us for so long and it is transmitted through air. This means that, if people can discriminate such patients, what more will those with HIV be discriminated. At the same time, most of the patients who have been diagnosed of TB also have HIV, therefore, they are related.

2.4 SUMMARY OF LITERATURE REVIEW

It has now been recognized that there are a number of barriers that HIV-infected individuals face when sharing their test results with friends, family and, most importantly, sexual partners. There is considerable interest in finding strategies to encourage disclosure because of the public health benefits that may accrue from the disclosure of HIV status. However, there is no clear-cut explanation for men's non-

disclosure. This point to the fact that the issue of HIV and men has not been explored as fully as the issue of women and HIV.

A lot of studies above have tackled much on women and HIV disclosure, behaviors displayed by HIV infected men, especially those who are gay, who have either disclosed their status to their partners or not and other factors that can affect disclosure among men such as culture. Challenges met by men in disclosing their status as well as benefits seen such as spousal support, emotional investment and communication about safer sex has been revealed in very few studies especially in America.

CHAPTER THREE

3.0 CONCEPTUAL FRAMEWORK

A conceptual model, like theories, deals with abstractions (concepts) that are assembled by virtue of their relevance to a common theme. A conceptual model broadly presents an understanding of the assumptions and philosophic of the model's designer (Polit, 2008).

A framework is the overall conceptual underpinnings of the study. Not every study is based on a formal theory or the conceptual model but every study has a framework- a theoretical rationale (Polit, 2008). In this study, the researcher will use the health belief model which was done by Rossenstock. The Health Belief Model (HBM) is a psychological model that attempts to explain and predict health behaviors. This is done by focusing on the attitudes and beliefs of individuals. The HBM was first developed in the 1950s by social psychologists Hochbaum, Rosenstock and Kegels working in the U.S. Public Health Services. The model was developed in response to the failure of a free tuberculosis (TB) health screening program. Since then, the HBM has been adapted to explore a variety of long- and short-term health behaviors, including sexual risk behaviors and the transmission of HIV/AIDS. The model evolved from the premise that the world of the perceiver determines action. Within this framework, diseases are regions of negative valence which act to repel the individual (Nies & McEwen, 2007). As defined by Clemen-stone (2002), the health belief model is known as a single model with components that interact to explain health behavior. It focuses on the patient compliance and preventive health care practices. The most promising application of this model is for helping develop messages that are likely to persuade individuals to make health decisions (Clemen-stone, 2002). The model postulates that health seeking behavior is influenced by a person's perceptions of a threat posed by a health problem and the value associated with actions aimed at reducing the threat.

Clemen-stone (2002) adds that the premise for the conceptual base of the model is that an individual's perceived susceptibility and perceived severity of the diseases determines

perceived threat that will increase the likelihoods of the preventive action or the participation in a health intervention that will decrease or lessen that perceived threat. Acknowledgement of both perceived susceptibility and severity must exist before a perceived threat becomes sufficient to motivate a readiness for action and behavior.

3.0.0 CONCEPTS IN THE MODEL

1. Perceived Susceptibility: refers to a person's perception that a health problem is personally relevant or that a diagnosis of illness is accurate.
2. Perceived severity: even when one recognizes personal susceptibility, action will not occur unless the individual perceives the severity to be high enough to have serious organic or social complications.
3. Perceived benefits: refers to the patient's belief that a given treatment will cure the illness or help to prevent it.
4. Perceived Costs: refers to the complexity, duration, and accessibility and accessibility of the treatment
5. Motivation: includes the desire to comply with a treatment and the belief that people should do what
6. Modifying factors: include personality variables, patient satisfaction, and socio-demographic factors.

3.0.1 LIMITATIONS OF THE HEALTH BELIEF MODEL

This model places the burden of action exclusively on the client. It assumes that only those clients who have distorted or negative perceptions of the specific disease or recommended health action will fail to act. It may effectively promote the behavior change by altering patient's perspectives but it does not acknowledge the health professional's responsibility to reduce or ameliorate health care barriers (Nies, 2007).

3.1 APPLICATION OF THE MODEL TO THE STUDY

By virtue of being a man, HIV sero-positive, seeing self as being in a position to infect partner and becoming re-infected, one will perceive the issue of partner notification as being serious and important both to self and partner. He will also have the perception that the benefits override the barriers, hence make decisions to notify the partner. The knowledge that the man has on partner notification which might have been acquired through media or books, will also contribute to him leaning towards the positive behavior of notifying the partner of their HIV positive status. Hence, only those men with distorted or negative perceptions on partner notification as a recommended action will fail to act.

3.1.0 CONCEPTS IN RELATION TO PARTNER NOTIFICATION

1. Perceived Susceptibility

Men believe they may have exposed their Partner partners to HIV.

2. Perceived Severity

Men believe the consequences of having HIV without their partners' knowledge or treatment is significant enough to notify their partners.

3. Perceived Benefits

Men believe that the recommended action of notifying their partners of their HIV status would benefit them — possibly by preventing them from secondary infection as well as preventing their partners from contracting it if at all they have not yet been infected.

4. Perceived Barriers

Men identify their personal barriers towards notifying their partners of their HIV status (i.e. fear of being stigmatized) and explore ways to eliminate or reduce these barriers

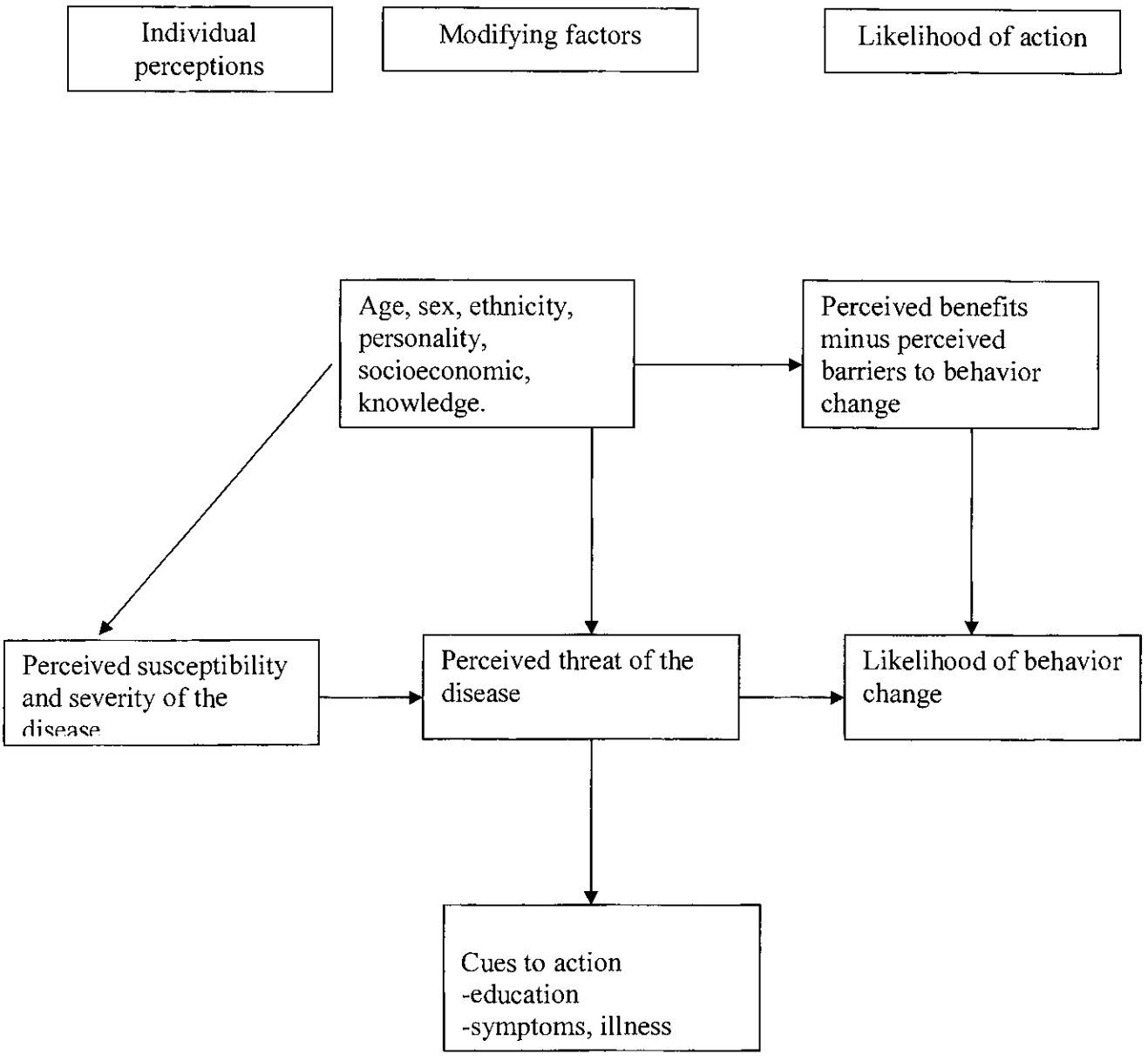
5. Cues to Action

Men receive reminder cues for action in the form of incentives, or reminder messages (such as posters that say, "69% of couples do not know each other's HIV status". Are you one of them? Find out now"). If men have also been provided with how-to information.

6. Self-Efficacy

Men receive guidance (such as information on how well they can communicate to partners so they can know about their HIV status)

DIAGRAMATIC REPRESENTATION OF THE HEALTH BELIEF MODEL



SOURCE: ROSENSTOCK I.M: THE HEALTH BELIEF MODEL, CLEMENSTONE, 2002, P387.

CHAPTER FOUR

4.0 RESEARCH METHODOLOGY

4.1 RESEARCH DESIGN

A research design is a blueprint for conducting a study (Burns & Groves, 2005). The study used qualitative descriptive study design which according to Cormack (2000) examines social life by gaining an understanding of the meaning people attach to their experiences and behavior. It involves collection and analysis of narratives. It is designed to gain more information about the characteristics within a particular field of study and its purpose is to provide a picture of situation as they naturally happen (Burns, 2005). In-depth interviews were conducted. Therefore, the design was selected to explore the perceptions of HIV positive men towards HIV partner notification which after the analysis has given us more information on the study topic.

4.2 STUDY SETTING

This is the physical location and the conditions in which data collection takes place in a study (Polit, 2006). This was conducted at Queen Elizabeth Central Hospital Anti-retroviral therapy (ARV) clinic where I encountered a lot of people who came to collect the Anti-retroviral therapy (ARV), therefore, it was very easy to find the subjects.

4.3 SAMPLING

Sampling is the selection of the study subjects from the target population under study (Seaman & Verhonik, 1982). A convenience sampling technique was used in this study. This method helped the researcher select the most readily available subjects for the study. Burns & Groves (2005) explains that in a convenience sampling, subjects are involved in the study because they happened to be in the right place at the right time. Available subjects were simply entered into the study until the desired sample size was reached. Therefore all HIV seropositive men at the ARV clinic were eligible to participate.

4.4 SAMPLE SIZE

This is the total number of study participants participating in a study (Polit, 2006). A total of 12 subjects were involved. In qualitative research, the focus is on the information obtained from the person, situation or event sampled versus the size of the sample (Burns, 2005). The number of participants was adequate when saturation of information was achieved in the study area; therefore, I got enough information with the 12 participants.

4.5 PRE-TESTING

Pre-testing of the study for two people was conducted at Thyolo District Hospital. As Cormack (2000) explains, this facilitated the testing of the adequacy of the research design of the main study and it helped the researcher identify problems with the study design which was then rectified before embarking on the actual study; it also gave the researcher experience of administering the data collecting instrument, and also helped determine whether the instrument (interview guide) was collecting the type of data required.

4.6 DATA COLLECTION

A semi-structured interview guide, developed in English and translated to Chichewa was used in this study. An interview is a conversation or exchange that has a structure and a purpose between one interviewer and one respondent. Its purpose was to obtain description on the perceptions of the individual respondents on HIV partner notification. The semi-structured interview guide, which was a set of questions and probes, had guidelines an interviewer became familiar with. The questions were open-ended in nature. Its advantages included that the researcher was able to gain immediate response from interviewees which allowed further questioning and probing on a particular aspect of their replies and allowed the interviewer to ask unambiguous questions.

The researcher sought permission first from the nurses working in the ARV clinic to seek permission from the clients if they were interested to participate in the study. If they were willing to participate, they then met the researcher in the separate room where detailed information about the research was explained including the purpose and conditions of the

research. Those who agreed to participate in the study were given consent forms to sign. In-depth interviews were carried out in the same room for privacy's sake. Data was collected for a period of 3 days and each interview lasted for about 30-45 minutes and 5 subjects were interviewed in a day.

4.7 DATA ANALYSIS

Data has been analyzed using content analysis. This technique was used as it provided a systematic means of measuring the frequency, order or intensity of occurrence of word phrases or sentences.

The process of data analysis has involved reading each transcript thoroughly, identifying the information provided, developing the codes, applying the codes developed into the content and comparing the transcripts to identify differences and similarities of what was given. Furthermore, transcribed data has been categorized into themes and then a description according to the themes has been provided.

4.8 ETHICAL CONSIDERATIONS

Any good research is supposed to conform to the moral, ethical and legal standards of the society where the research is being carried out. To observe this therefore, approval and permission of the research study was sought from the Kamuzu College of Nursing research and publications committee, Queen Elizabeth Central Hospital director and participants themselves respectively.

The participants were given detailed information about the research and were informed of their rights which are the rights to: voluntary participation; refuse to participate or to withdraw; maintain self-respect and dignity; confidentiality and anonymity; privacy; self-determination; right not to be harmed and the right to services. Informed consent forms were then provided to all those who were willing to participate to sign after being given the information concerning the study. The participants were interviewed in a private room were there were just the two of us to maintain privacy .Confidentiality and anonymity was observed through restricting accessibility of data to the researcher and

supervisor and in no way has the information been disclosed in a manner traceable to the participants. The use of codes not names on interview guide sheets was used.

No any abusive language was used during the interviews. The participants benefits from participating in this study might not have been direct, but rather, it might help counselors to know how to deal with PLWHA during counseling so they can encourage disclosure. No money or incentives were given. The risks however, involved in this study might have been that the individuals were reminded of the psychological trauma that they might have undergone when they learnt they had HIV.

4.9 DISSEMINATION OF RESULTS

The results of the findings are available in the library and the basic department.

4.9 LIMITATIONS OF THE STUDY

Since HIV and AIDS is a sensitive issue, it might have been difficult for the participants to air out their views.

CHAPTER FIVE

5.0 PRESENTATION OF THE FINDINGS

The main aim of the study was to explore the perception of twelve HIV sero-positive men towards HIV partner notification. This chapter presents the results of the study. It includes demographic data; the knowledge the participants had on HIV and AIDS and HIV partner notification; their beliefs on HIV partner notification; factors that influence HIV partner notification and the effects of partner notification.

5.1 DEMOGRAPHIC DATA

The age of the participants ranged from 28 to 45 years with a mean of 37 years. Most of the respondents were the Chewa, Ngoni and the Lomwe by tribe. Ten of them were Christians and two were Muslims. Seven of the respondents had ever attended secondary education, four attended primary education and one attended tertiary education. Among the respondents, half of them were working: two were minibus drivers; one garden boy; one security guard; one carpenter and one cleaner. Four of them were not working and two were self- employed. Eight participants were married, three of them were single and one was divorced. See this information on table 3 below.

TABLE 3

DISTRIBUTION OF AGE, TRIBE, RELIGION, EDUCATION, OCCUPATION AND MARITAL STATUS.

Variable	Number of participants (n=12)
Age	
20-25	0
26-30	3
31-35	5
36-40	2
41-45	2
46-50	0
Tribe	
Chewa	3
Yao	1
Lomwe	3
Ngoni	3
Tumbuka	1
Mang'anja	1
Religion	
Christianity	10
Islamic	2
Others	0
Education	
Secondary school	7
Primary school	4
Never attended school	0

Occupation	
Working	6
Not working	4
Business (self- employed)	2
Marital status	
Married	8
Single	3
Divorced	1

5.2 KNOWLEDGE ON HIV, AIDS AND HIV PARTNER NOTIFICATION

Upon assessing the participants' knowledge on HIV and AIDS, it came to 5 conclusions. Some (four) participants demonstrated lack of knowledge on HIV as they said it is a sexually transmitted illness. *Human Immunodeficiency Virus is a sexually transmitted illness which has no cure, (P08) said.* Most of the participants demonstrated having known what HIV is as evidenced by one of the participants (P12) who said that *HIV is a virus that causes AIDS.* One participant (P03) said *HIV is the virus that destroys the body's immunity.*

Most of the participants (ten) demonstrated having knowledge on what AIDS is. This is evidenced by what was said by participant (P09) that *AIDS is a disease that is caused by the virus HIV. He further narrated that it is a stage whereby that HIV has started manifesting in one's body.*

Other participants (three) said that AIDS is a disease of various illnesses or diseases. Participant (P06) said, *"AIDS ndi chipwirikiti cha matenda".*

TRANSMISION OF HIV AND AIDS

Most of the participants had knowledge on HIV and AIDS transmission. They all indicated that HIV is transmitted through sexual intercourse. Eight participants mentioned HIV infection being transmitted through the use of infected razor blades while some said was through used needles and the two others indicated that it was through kissing, used teeth brush and blood transfusion. Others demonstrated lack of knowledge in terms of other ways of getting HIV apart from sexual intercourse. This is evidenced by (P2) indicating that *HIV is transmitted through some foods that they eat that other people prepare and through the air that they breathe.*

PREVENTION OF HIV AND AIDS

In terms of ways of preventing HIV transmission, it indicated that the participants had knowledge on how they could prevent it. This is evidenced in the following responses yielded: abstinence; condom use; faithfulness between partners; avoid using already used razor blades and avoiding blood transfusion. On abstinence, most participants (ten) said

that one could totally prevent contracting HIV through abstaining from sex. As indicated by P03, *abstinence is the only sure way of preventing HIV.* Condom use also came out as a preventive measure. Seven participants mentioned this. Participant (P09) said that *it would be better to use condoms because sometimes partners are unfaithful.* One participant (P02) favored faithfulness between partners. He indicated that *HIV could be prevented especially if the partners were being faithful to each other, otherwise other methods such as condom use might not be a long term way of preventing HIV unless you are already infected.*

Few participants mentioned avoiding the use of infected razor blades and blood transfusion as some of the preventative measures for HIV. Blood transfusion might pose one to contract the HIV infection. Participants P07 and P09 indicated that *if one receives blood from an HIV infected individual, he will definitely contract it.*

HOW TO KNOW WHETHER YOU ARE HIV POSITIVE OR NOT

Participants demonstrated knowledge as follows: blood test for HIV and signs and symptoms of diseases. Getting your blood tested might help to find out whether you are HIV positive or not. This was demonstrated by most of the participants. Participant (P04) reported that *unless one gets tested, he wouldn't know he is HIV positive or not.*

Most of the participants reported that one could know his/ her HIV status through the signs and symptoms that one would present with. They indicated that getting sick now and again especially from such diseases as diarrhea, numbness, general body pains and skin conditions might alert one that he should seek medical interventions as might be HIV positive. These signs and symptoms did not stand independent of HIV testing as the individuals still ended up getting tested. Participant (P01) said that *he had persistent loss of appetite; therefore he was suspicious that he had HIV, then he got his blood tested.*

SEVERITY OF HIV AND AIDS IN MALAWI

Most of the participants demonstrated having knowledge on the increasing numbers of people getting infected. Most of them said the numbers had increased so much so that almost three quarters of the population is infected. Some also said that looking at how the

people were at the ARV clinic, it was different with the attendance in the previous years indicating severity of infection. Participant (P11) said *the pandemic had increased up to the extent that he was even able to recognize one who is HIV positive just by looking at his appearance.*

However participant P08 maintained that the HIV pandemic is decreasing because few people are dying of AIDS.

PARTNER NOTIFICATION

The responses yielded in this study indicated that most of the participants viewed partner notification as one method to be instituted to prevent the spread of HIV. Other participants had no comments on this matter. One participant (P11) said *partner notification all depended on how partners relate with each other.*

SHOULD PARTNER NOTIFICATION BE CONDUCTED

Most of the participants demonstrated a need for conducting partner notification as well as the knowledge on the main importance of partner notification. The responses that came out included that, conducting partner notification would help protect their partners from becoming infected and also prevent themselves from re-infection in the form of condom use.

Participant(P02) said that *it would be important for us to protect ourselves.* Participant 9 said that *partner notification must be conducted because, lets say, he is on ARVs and his partner doesn't know, it would be difficult for him to use condoms. At the same time, he would transmit weakened HIV virus to his partner while she transmits virulent virus to him. This means that there is nothing being done by taking the ARVs.*

Others indicated that it was helpful as there partners would know and then get tested. Others also mentioned participation of their partners as one of the importance of conducting partner notification whereas others viewed getting treatment earlier as an important factor.

Participant (P01) said *it must be conducted because his partner would remind him when it was time to take the ARVs and to use condoms during sexual intercourse* while

Participant 8 said that *it was important because you do things together such as eating hence you would need her help.* Participant 11 said *it must be conducted because HIV and AIDS is a very dangerous disease hence she should take part.*

5.3 BELIEFS ON HIV PARTNER NOTIFICATION

Some participants believed that partner notification would ease their minds of the stress that they might carry if they do not tell their partners. Others also said that it would help in the prevention of HIV re-infection as they would be using condoms because their partners would become aware of their HIV status while others indicated that they would get the care they needed such as being reminded on taking ARVs and would plan for the future well.

Participant 7 narrated that that *it could be of help because whatever he needed, she would be there to do it for him, that is, when he needed food, a bath, care when sick, she would provide for him.*

Most of the participants didn't see any risk that might accrue following partner notification. Some perceived marriage breakdowns as some of the risks. Participant (P04) said *there could be marriage breakdown and one could be accused of being unfaithful.* He added that *the risks could be there if you are not faithful to one another, 'mukhoza kusemphana chichewa'.*

Other participants were not sure of the risks following partner notification. Participant (P05) said that *he didn't know how his partner might react so he was not sure of the risks.* Other participants demonstrated a fear of partners letting others know about their status as narrated by P01 that *one's partner could tell others especially her friends about one's status hence discriminate him in times of eating, chatting or going for a walk* while (P12) said *if your partner is not prepared to hear the news, she might do something bad as a frustration, for example, when she is sick she could take an overdose of the medication and commit suicide.*

There were different responses that emanated from the time that might be conducive for partner notification. Some indicated the duration of time that would be ideal to take before one discloses whereas others gave reasons pertaining to the actual environment or condition that might be favorable for disclosure. In terms of the duration to take, five participants favored disclosure soon after getting tested for HIV. In terms of favorable time for disclosure, five participants said when chatting and about to sleep in the evening. Participant (P07) further narrated that *when they are free together especially when they are about to sleep and if she is so understanding, she would take it.*
Others said when partners are about to have sexual intercourse.

5.4 FACTORS THAT INFLUENCE HIV PARTNER NOTIFICATION

These are factors that could contribute as well as hinder one in notifying their partners of their HIV sero-status. Two groups of people emerged, that is, those who did and those who did not disclose their HIV statuses to their partners, hence, each group had its own questions.

DISCLOSURE OF HIV SERO-STATUS

From the study, it has been shown that eight of the participants had disclosed their HIV status to their partners. Among them, some disclosed willingly while others disclosed after their wives informed them of their statuses after testing from antenatal clinics. Participants were motivated by different reasons to disclose. Most participants demonstrated knowledge on the importance of disclosure when they said were motivated by the fact that they wanted to prevent HIV infection and re-infection. Participant (7) said that *he was afraid that if his wife was HIV negative, and when they continued to have sex, she might have been infected and he also wanted her to get tested for HIV.*
Others were motivated to disclose because their partners had already disclosed their status so they got tested to find out whether they too were infected and they disclosed in return because they had no choice but to do so.

Others disclosed because of the love they had for their partners and due to the problems they had gone through together. One respondent said that *he was motivated to do so*

because of the love he had for his partner and because they had suffered together for a long period of time when he had cancer so it was proper that he informed her because they had found a route cause to the suffering.

Few of them disclosed because they wanted their partners to get tested as well; to start treatment as early as possible; to get the required treatment that they needed at a particular time such as good food to eat, water to bath and to be escorted to the hospital whenever there was need to do so.

The study also revealed that most of the participants did not face any challenges following disclosure while a few met different challenges ranging from quarrels, misunderstandings, divorce and discrimination.
Participant (P03) said *they had quarrels because she considered him unfaithful while (*P07) *said he had a lot of challenges as his wife complained the whole night and the following day* whereas (P10) *said his partner couldn't take it politely and there were some misunderstandings as she thought he had been unfaithful to her.* Participant (P12) said *he was being discriminated against as she couldn't chat, eat nor have sex with him.*

NON-DISCLOSURE OF HIV SERO-STATUS

It was found that four of the participants had not disclosed their HIV status to their partners. They gave different reasons pertaining to non-disclosure. All the participants displayed fear of disclosure in relation to their partners' reactions upon receiving the news. Such reactions as explained by the respondents included divorce and discrimination. Participant (P11) said *he was afraid of how his partner would react upon getting the news, that is, she might reject him and could instead discriminate against him.* A few were also afraid that their partners could regard them as being unfaithful and that they could also fail to keep the information confident by telling others about the issue.

The study showed that most of the participants saw the importance for partner notification as evidenced by the following reasons given: partners would know their status and prevent further spread of HIV. Participant (P05) said that *disclosure would*

help them to know their statuses hence take HIV prevention measures by reminding each other to put on condoms before sexual intercourse.

One Participant (P12) demonstrated lack of knowledge on the importance of partner notification as he said, "I don't know how important it is".

The love and care that one has towards his partner emanated as one of the factors that might encourage one to disclose as narrated by all the participants. Factors hindering disclosure emerged as stress and fear for the partner's reaction which encompassed divorce, discrimination and rejection. Participant (P02) said *the stress one has as an individual and the fear of how one's partner would react when she gets the news could impend one from disclosing.*

On the recommendations for partner notification, most of the participants said partner notification needs to be conducted and it must be encouraged, but, the disclosed- to should accept you and keep it a secret. One respondent (P09) didn't had nothing to say.

5.5 EFFECTS OR CONSEQUENCES OF PARTNER NOTIFICATION

DISCLOSURE OF HIV SERO-STATUS

Those participants who had disclosed their HIV status experienced different reactions from their partners. Most of those disclosed-to received the news without any problem because knowing their partners HIV status was a solution to their different problems they had gone through together and because they had already tested for HIV.

Participant (P01) said *his partner accepted because they had found a solution to their problem, that is, persistent loss of appetite.*

Though their partners had received the news well, one respondent's partner still wanted to know how his partner got infected whereas the other participant (P07) said *his partner complained the whole night and the following day but afterwards she accepted the condition'.*

Other partners still failed to accept the situation as reported by (P10) and (P12).

On the effects of partner notification, the study revealed that there were both positive and negative effects. Almost all of the participants had experienced some positive effects. These included: being alive till then; had a peace of mind while others lived happily ever after the disclosure. One participant (P03) reported that *notifying his partner had helped him as she had helped throughout his sickness and through escorting him to the hospital to seek medical treatment, that is ARVs, hence he and the partner are still alive.*
The other one (P04) said *he would have died but he was okay then because she helped him to go to the hospital to get tested and they were still supporting one another because they both knew their statuses.*
Some participants were relieved from the guilty hence had peace of mind; others were respected as their partners didn't tell anybody about their status and prepared them food in accordance with the status'.

Few of the participants experienced negative effects after the disclosure. Participants (P10) and (P12) regretted having told their partners because of how they reacted and how their relationships had turned to be, that is, sour. Participant (P08) still felt bad having infected his partner despite letting her know of his sero-status.

From the study, it has been revealed that there were no changes in most of the relationships following disclosure. In some, the relationships were strengthened whereas for others it turned sour. Participant (P12) said *their relationship became sour and they no longer loved each other as we used to'.*

The study also revealed that all participants demonstrated behavior that promoted prevention of HIV transmission. This is true because they all mentioned the use of condoms whenever having sexual intercourse. Participant (P08) said *they used condoms but had taken longtime without having sex* whereas (P10) said *they never had sex anymore.*

The messages that the participants gave to all those people who had not disclosed their HIV status to their partners was that they should do so to prevent re-infection. Participant

(P12) *urged them to do so because if they didn't, they were inviting a lot of problems ahead such as re-infection. The partner might also want to have a child hence infect the unborn baby as you can also engage in unprotected sex'.*

Some said it would promote effectiveness of both prevention of HIV and ARVs treatment. Participant (P08) said they had to *notify their partners because if they didn't, they would be taking ARVs without letting their partners know which is like there would be nothing being done because they would be getting infected as they would find it difficult to use condoms as their partners might ask why they used condoms.* A few participants said they were to do so to be free from guilty and to receive care. Participant (P06) *advised them to do so because he had a lot of friends who tested positive for HIV. A few notified their partners of their status but many didn't. He urged them to do so, so they could receive care as they were very sick but refused and they all died.*

NON- DISCLOSURE OF HIV STATUS

Upon being asked how they thought their partners would react when they broke the news, the participants came up with different responses. Most of them (three) said their partners couldn't accept the situation as could become angry while one of them (P02) didn't expect any problem following disclosure as he said he didn't think his partner could *have any problem with the news.*

In this study, both negative and positive effects were yielded following the participants' disclosure. On the positive effects, half of the participants expected that they would be freed from the guilty that they might have if they still continued keeping confident such an issue while the two others didn't say anything. On the negative factors, half of the participants said their partners could let others know about their HIV status and also develop hatred while one of them (P11) said his partner could become stressful all the time.

On the consequences that might suffice if the participants left their partners unaware of their HIV status, most of them said, taking for instance that their partners were HIV negative, they would be infected and if they were already infected, their CD4 counts

would be decreasing, hence become sick. Participant (P02) said he couldn't *be a free person and it might indicate that he had no love for his partner because it would have been like killing her. He further added that, 'chitetezo cha mthupi mwa iyeyo ndichochepa, pamene changa ndichokwanira'.*

Half of the participants demonstrated using condoms to prevent transmitting HIV to their partners while the other half did not use condoms because they were afraid that the behavior would become questionable.

Despite that these participants did not disclose their HIV sero-status to their partners, they all demonstrated the need for doing so. One participant (P02) said, *'wokondedwa wako akhoza kumayenda modzisamala osadziwa kuti ndioonongeka kale'.* He also said that *one's partner would get tested for HIV and you would plan for the future together'.*

5.6 CONCLUSION

In this study, it was found that though some had knowledge on HIV, AIDS and partner notification, others still confused HIV and AIDS as being the same. It has also been shown that people had different beliefs on HIV partner notification and that a lot of factors (both negatives and positives) and the perceived consequences played a major role in disclosure.

CHAPTER 6

6.0 DISCUSSION OF FINDINGS

This section discusses the findings emanating from the study on the perception of 12 HIV sero-positive men towards HIV partner notification conducted at Queen Elizabeth Central Hospital –ARV clinic. The findings shall be discussed in relation to the available literature. The study implications, recommendations and conclusion shall also be included.

It has been revealed from the study that most participants' age group ranged from 31-38 followed by 26- 30. This shows that most of the participants were middle aged. Age affects how one understands, grasp the concepts and utilize them. Hence, age is associated with disclosure as Rohini (2004) explains.

Culture plays a role in one's perceptions of the phenomenon. What to believe in as well as how to behave varies from culture to culture. In one culture it will be wise for one to disclose while in the other, it would be a sign of weakness. From the study conducted, it means that participants were able to disclose or not depending on their cultural moral, values and beliefs. Rohini (2004) indicates differences in disclosure and reasons for disclosure between the American and Indian cultures. These differences were that American men's disclosure was more relation –focused whereas for the Indian men it was more obligatory or required. All the 12 participants had some religious affiliations. Religion also plays a role in disclosure as religious beliefs differ. Hence religion significantly affects disclosure.

Education is also important in disclosure. It influences people's perception and reception of information. The ability to acquire and apply knowledge is further enhanced with increasing levels of education. In this study, it was found that most of the participants had attended primary and secondary education. This implies that most of the participants can read and write. This could have also influenced their reception of information during pre- and post-counseling on prevention of HIV transmission in terms of condom use and disclosure. Occupation also plays a role in disclosure as it affects either positively or negatively. Rohini (2004) stated that employment status is significantly associated with disclosure to partners. Employment status would, for instance, encourage those

unemployed disclose easily their HIV status to their partners because they would want to have support (financial and psychological) from their partner.
Marital status is also associated with disclosure in such a way that when the partners are married, they would want to have children and support each other both physically and psychologically, they would be prompted to disclose than those who are single. From the study, it shows that most of the participants were married; hence most of them had disclosed their HIV status to their partners.

The results of the study shows that most of the participants had knowledge on what HIV and AIDS are but others despite undergoing pre- and pos- test counseling, took HIV and AIDS as being the same. This indicated that most participants were able to understand what it is that is going on in their bodies which would also affect their partners, therefore, have means to disclose.
Results also revealed that almost all the participants knew that HIV and AIDS is transmitted through sexual intercourse and the use of already used razor blades and injections. With this knowledge, it suggests that there would be high levels of HIV infection prevention measures such as condom use and proper disposal of infected razor blades and injections.

Abstinence and condom use are considered as being important as far as HIV and AIDS prevention is concerned. Our study showed that most of the participants knew that abstinence and condom use would prevent transmission of the virus. This means a high proportion of the participants took part in preventing the spread of HIV and AIDS not only through condom use but also through partner notification because they wouldn't be using condoms unless their partners know why.
HIV counseling and testing is the only sure way one would know his HIV sero-status. Some other signs and symptoms might also play a part in thinking of the HIV and AIDS infection such as when one has persistent diarrhea and Kaposi's sarcoma as well as falling sick every now and again. Most of the respondents in the study said HIV testing and counseling was the only way of diagnosing the infection. Other respondents said that one is diagnosed of being HIV positive just by the signs and symptoms presented. This

means that despite a lot of people having knowledge on how they can know their status, others still do not put into consideration HIV testing and counseling hence would find it difficult to disclose to their partners unless they present with signs and symptoms they feel would be due to HIV. Some might also mistakenly label others as being HIV sero-positive just by the illnesses they might present with. This might create some misunderstandings among the people as well as discrimination.

From the results, it has also been shown that most of the respondents were aware that HIV and AIDS is on the increase though one of them sees a decrease in the prevalence. This knowledge therefore, might have contributed in prompting the respondents to disclose their status to their partners and use condoms so that they take an active role in the prevention as well as the control of HIV infection.
The study also shows that most of the participants had disclosed their status to their partners and that most of them saw the need in one notifying his partner as it prevents HIV transmission. Seeing a need in disclosure encourages one to actually disclose, use condoms so he cannot transmit the virus.

On the beliefs of HIV partner notification, it has been shown that all the participants saw benefits in them notifying their HIV status to their partners. The benefits included being freed from guilty and the prevention of both infection and re-infection of the virus. Kassaye (2004) further supports that disclosure promotes access to prevention and treatment programmes, provides increased opportunities for risk reduction and helps plan for the future. This means that seeing benefits in disclosure encourages one to actually disclose.

The findings also indicate that some respondents perceived having no risks after disclosing while some perceived such risks as marriage breakdowns and discrimination. This means that one would make a decision either to disclose or not depending on the risks they feel they may encounter, how the couple relates with each other and also whether they talk freely about HIV and AIDS.

A challenging issue for many people is the timing of disclosure. As stated by Remien and Bradley (2007) if disclosure is not done relatively early, it can become difficult as time goes by and can cause significant disruption to an ongoing relationship if the disclosed-to partner feels betrayed due the lack of an earlier disclosure. This means that timing determines the outcome of the disclosure. This study revealed that some of the respondents reported having considered informing their partners as soon as their blood got tested for HIV while others said when chatting and about to sleep in the evening as well as before sexual intercourse.

It was important to find out factors that could encourage or hinder males from disclosing their HIV status to their partners. Kadowa (2009), identified factors associated with disclosure as a research priority as a high proportion of PLWHA never disclose. Knowing these factors might also be of help in carrying out pre- and post-test counseling. Contrary to what Kadowa (2009) proposed that a high proportion of persons living with HIV and AIDS never disclose, most of the participants from this study had disclosed their HIV status to their partners. However, different situations might have played part for such results such as culture, marital status and others.

Motivation plays a major role in disclosure and people are motivated by different factors. The study results showed that half of those who had disclosed **their HIV status to their partners** were motivated to do so as they wanted to protect themselves from re-infection and their partners from getting infected. This meant that these participants were able to engage in risk reduction activities such as abstinence and condom use because they never wanted transmission of infection nor re-infection.

Others disclosed because their partners had already disclosed their statuses to them and they had no options apart from doing the same which meant that if there partners had not disclosed that they had HIV, they too wouldn't have done so, and they wouldn't even have tested for HIV. This means that women play a major role in men's disclosure because when the women disclosed their status, men had no option. This is in line with

what Brown (2009) found that women disclose their HIV status on their own more than men.

The love that one has for somebody would also greatly motivate one to disclose. This should be the key to cement the relationship between the partners. But, it might not necessarily mean that those who do not disclose demonstrate hatred rather love might have been overridden by such factors as fear. This also shows that men would disclose under certain circumstances, for instance, the need for care and support. This agrees with the idea raised by Makoni (2004) which stated that men disclose when forced by circumstances such as the need for care.

Despite some men not meeting challenges after disclosure, some were discriminated against, rejected and had quarrels. As stated by Remien and Bradley (2007), disclosing HIV status may sometimes result in rejection, discrimination or violence. These negative outcomes may demotivate others who have not yet disclosed their status to their partners, that is, if experiences are shared. Disclosing your status to certain persons can also be more of a burden than benefit as one respondent regretted having told his wife of his status who complained the whole night upon hearing the news.

Disclosure of HIV positive status is a complex, difficult and very personal matter. Disclosing one's HIV status entails communication about a potentially life threatening stigmatized and transmissible illness (Remien and Bradley, 2007). The findings from this study indicates that some of the respondents did not disclose their HIV status due to such reasons as being afraid of their partners' reactions and fear of discrimination, rejection and divorce. This agrees with what Sullivan (2005) explains that HIV positive men face multiple challenges when deciding whether to disclose their status to their partners. And as stipulated by Simbayi (2006), HIV related stigma and discrimination are associated with non-disclosure. This is in line with what McKee (2004) stipulated that stigma limits the effectiveness of HIV prevention efforts. McKee (2004) states that stigma is a consequence of the association people make between HIV and AIDS and pre-existing prejudices, shame blame and fear related to sexuality. He continues by saying

that fear of stigmatization prevents PLWHA from disclosing their status, protecting their sexual partners and asking for support.
The study results clearly suggests that perceived efficaciousness and positive outcome expectations play an important role in disclosure as Sullivan (2005) puts it.

The study also reveals that all of the participants who had not disclose mentioned love one has for the partner as contributing towards disclosure. This means that when partners love each other, there relationship is good and hence disclosure rate will be high. It is therefore possible that these participants had love for their partners but perceived outcomes might have played a much stronger role than the love they had for their partners.

From the study, it also shows that people who do not disclose their status see partner notification as being important despite the perceived outcomes. The reasons given were the same with those who had disclosed their status such as the need for the prevention of HIV transmission to partners. The participants also recommended that if partner notification was to be on an increase, partners should accept you and keep it a secret. This also means that secrecy plays a major role in disclosure. As supported by Remien and Bradley (2007), disclosure of HIV positive status is a very personal matter.

The reactions of the participants' partners' following disclosure showed that most of them accepted the results because they had found solutions to their problems (different illnesses) while others reacted through discriminating and rejecting their partners. Others accused their partners of being unfaithful. This is in line with Makoni (2004) in her findings that women disclose their status to their partners because they want to demand for an explanation. This means that among the partners, men are regarded as being unfaithful most of the times.

The positive effects yielded in this study on disclosure included being freed from guilty and they got support from their partners which is also why most of the participants disclosed their HIV status to their partners. Therefore, others would be encouraged to

disclose because in this study, most participants got what they expected to, that is, had a peace of mind because they were free from guilty.

On the part of the negative outcomes, this study suggests that most of those who had disclosed did not experience negative outcomes. This clearly shows that the results of the study are encouraging as more people encountered good outcomes though some still regretted having disclosed to their partners due to their reactions.

The consequences of leaving partners unaware of one's HIV status might lead to HIV infection transmission. Though this might suggest that participants would take HIV prevention behaviors such as condom use as well as disclosure, it still shows that perceived outcomes i.e. stigmatization and marriage breakdown have a much stronger impact on disclosure as McKee (2009) states that stigma limits effectiveness of prevention efforts. And again, effective condom results all depends on consistency and proper use, otherwise one might not prevent the HIV transmission.

Most participants from the study reported having no change in their relationships as well as having them strengthened following disclosure. These results are encouraging as would motivate others who haven't disclosed to do so, that is, in cases were men share experiences amongst themselves though others still experienced sour relationships. The study also indicates that most of the men who had disclosed their status to their partners engaged in safer sex, that is, used condoms while most of those who did not had unsafe sexual practices. This means that the prevalence of safer sex is significantly higher among those who disclose than among those who don't. Contrary, Marks (2001) found out that the prevalence of safer sex was not significantly higher among those who disclose than among those who don't and disclosure was not significantly associated with safer sex.

CONCLUSION

The results of this study have clearly shown that more men had disclosed their HIV status to their partners who had already tested for HIV at the antenatal clinics and because of different illnesses which they had wanted to establish their cause. The results have further revealed that a lot of factors motivate and hinder men to disclose.

It was also revealed that most of the participants who had disclosed their status to their partners used condoms while those who didn't did not use condoms. The participants recommended that partner notification should be conducted but partners should keep it a secret, that is, should only be known by the couple and not anyone else.

CHAPTER 7

7.0 IMPLICATIONS AND RECOMMENDATIONS OF THE STUDY

The findings of the study have uncovered the perceptions of 12 HIV sero-positive men towards partner notification at Queen Elizabeth Central Hospital- ARV clinic. This section therefore, highlights the implications and recommendations of the study in relation to nursing research, education, practice and management. It also highlights the strengths and the limitations of the study.

NURSING RESEARCH

The research results will help come up with further areas for research.

According to my knowledge, I have hardly come across research studies in Malawi regarding men and disclosure. However, more studies have been done concerning HIV and AIDS disclosure and women. Results for the study highlight the need for conducting this study at a larger scale.

Topics for further research could be:

- Cultural factors that affect men's disclosure.
- Factors that affect partners' reactions upon receiving news that their partners are HIV sero-positive.
- Do couples talk freely about HIV and AIDS.

NURSING EDUCATION

It is indicated that before initiating ARVs, counseling is done. However, from the study, it shows that a lot of men couldn't isolate HIV from AIDS. This calls for nurse educators and counselors to review and evaluate the counseling process, their skills and the message contained in counseling so that each and every aspect that might encourage disclosure is incorporated into the system if change is to be anticipated.

It also calls for media to avoid putting scare educating messages if HIV and AIDS is to be controlled. Such messages might include "AIDS kills" as well as stereotypes associated with PLWHA as such messages contribute to the perception that AIDS only affects "others" especially those already marginalized such as commercial sex workers. This hinders men to disclose as they wouldn't want to be associated with such acts.

Health workers through media can educate the general public on how stigma affects those experiencing it. This helps change their partners perceptions, hence reduce stigma among families and encourage disclosure at large.

Despite using condoms as reported by those who had disclosed their status to their partners, there is also need to educate individuals during counseling or publicly on consistent condom use if the best results on HIV transmission prevention are to be achieved.

There is also need to address couples and families so that we encourage them to talk freely about HIV and AIDS if perceptions as well as outcomes following disclosure are to be desirable.

The public should also be educated so that couples get tested together. This might reduce the fear the couples might have on disclosure and they would also know their status together.

The public might also be encouraged to identify and develop support systems for HIV positive men post-disclosure to strengthen and provide on-going counseling.

Therefore, this research study will increase the knowledge that the health workers have on men and disclosure and possibly identify the knowledge gaps both for the clients and the health workers in terms of HIV and AIDS at large and skills for counseling which would encourage disclosure respectively.

NURSING PRACTICE

Much as we appreciate that most of the participants had disclosed their status to their partners, a few didn't because of perceived stigma. Stigma and discrimination have a stronger impact on disclosure and have tremendous costs. Human Immunodeficiency Virus increase as people avoid prevention behaviors and getting tested. Health care costs grow because of the difficulties of treating opportunistic infections at advanced stages. Individuals and families struggle to cope with the illness on their own. Therefore, if we do not address stigmatization of PLWHA, any effort to fight HIV and AIDS will have limited results. This can be achieved through development of community based education programmes and policies in relation to disclosure and stigma.

NURSING MANAGEMENT

There is also need to involve PLWHA in designing communication and training interventions which allows PLWHA to redefine their illness, reconstruct their identities and develop tools to reduce stigma and other threats hence increase the immediacy of the illness to others.

LIMITATIONS OF THE STUDY

- The results obtained from the study cannot be generalized because the study was done at one centre with a small number of the participants.
- There was very little time to conduct this study because it was done with other studies concurrently.

RECOMMENDATIONS

- Conduct provider referral partner notification so that the health care provider can notify partners directly which would provide room for partners to be tested and counseled at the same time thereby reducing negative consequences of disclosure.
- Conduct in-service trainings for counselors and nurses on attitudes, interpersonal communication and counseling skills.
- Educate the general public on stigma and its implications.
- To conduct this research at a large scale.

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APPENDICES

APPENDIX 1

8.0 TIME-LINE STUDY (WORKPLAN)

This is the description of the length of time the whole research project will take. Normally, it's a graphical presentation of how long each part of the study will take.

ACTIVITY	APRIL	MAY	JUNE	JULY	AUG	SEPT	OCT	NOV	DEC
Literature review									
Proposal Writing									
Proposal submission									
Clearance									
Pre-testing									
Data collection									
Data interpretation									
Report writing									
Dissertation Submission									

APPENDICES

APPENDIX 1

8.0 TIME-LINE STUDY (WORKPLAN)

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Literature review									
Proposal Writing									
Proposal submission									
Clearance									
Pre-testing									
Data collection									
Data interpretation									
Report writing									
Dissertation Submission									

APPENDIX 2

9.0 RESEACH BUDGET

ACTIVITY	ITEM	COST (S)
1. STATIONERY	2 reams of papers @ k850 each	1, 700
	10 pens at k25 each	250
	typex	200
	Flash disk	5, 500
	4 large envelopes @ k50 each	200
	Tape recorder	8, 000
	subtotal	**15, 850**
2. SECRETARIAL SERVICES	Printing proposal at k10 per page x 4x 43	1, 700
	Printing interview guide at k10 per page x 4 pages x 2	80
	Printing consent form at k10 per page x 2 pages x 15	300
	Printing letters at k10 x 3	30
	binding of the research proposal k160 each x 4	640
	Subtotal	**2,420**
3. COMMUNICATION	Air-time, 5 dollars zain	700
	Travelling to Lilongwe from Blantyre	9000
	Traveling to Blantyre from Thyolo	1, 000
	subtotal	**17, 000**

3. ALLOWANCES	Food and incidentals	3, 000
	subtotal	**3000**
	Grand total	**38, 270**

9.1 JUSIFICATION OF THE BUDGET

9.1.0 STATIONERY

Reams of papers will be used for photocopying and printing of the question guide, proposal and dissertation. The pens will be used in writing the proposal i.e. draft as well as for data collection. Typex will be used to rub off or eliminate some mistakes made and the flash disk for information storage.

9.1.1 SECRETARIAL SERVICES

The services will play a major role in the research process hence need to allocate such amount of money.

9.1.2 COMMUNICATION

Zain airtime will be needed to communicate to the supervisor, trips to and from Blantyre will be useful to meet with the supervisor as well as to collect data. Therefore the amount of money allocated will be enough.

9.1.3 ALLOWANCES

This is useful in terms of the unforeseen circumstances that may arise anytime through the research process.

APPENDIX 3

10.0 INTERVIEW GUIDE

DATE.....

CODE.....

SECTION A

Demographic Data

Age of the interviewee

(a). 20-25 [ ]

(b). 26-30 [ ]

(c). 31-35 [ ]

(d). 36-40 [ ]

(e). 41-45 [ ]

(f). 46-50 [ ]

2. Tribe

(a). Chewa [ ]

(b). Yao [ ]

(c). Lomwe [ ]

(d). Ngoni [ ]

(e). Tumbuka [ ]

(f). others, specify .....

3. Religion

(a). Roman Catholic [ ]

(b). Muslim [ ]

(c). CCAP [ ]

(d).Anglican

(e). Assemblies of God [ ]

(f). others, specify.....

4. Educational level

(a). None [ ]

(b). Primary [ ]

(c). Secondary [ ]

(d). Tertiary [ ]

5. Occupational.....

6. Marital status

(a). married [ ]

(b). single [ ]

(c). divorced [ ]

(d). others, specify.....

SECTION B

1. KNOWLEDGE ON HIV, AIDS AND HIV PARTNER NOTIFICATION

a) What is Human Immunodeficiency Virus (HIV)?

b) What is Acquired Immunodeficiency Syndrome (AIDS)?

c) How is HIV and AIDS transmitted?

d) How can HIV and AIDS be prevented?

e) How can one know that he or she is HIV positive?

f) How severe do you think the problem of HIV and AIDS is in Malawi? Explain.

g) What do you know about partner notification?

h) Why should partner notification be conducted?

2. BELIEFS ON HIV PARTNER NOTIFICATION

a) Of what benefit can partner notification be to you? Explain.
b) What can be the risks of partner notification?
c) When is the good time for partner notification?

3. INFLUENCING FACTORS ON PARTNER NOTIFICATION.

Disclosure of HIV status to partners.

a) What motivated you to disclose your HIV status to your partner?
b) What challenges did you meet in notifying your partner?

Non-disclosure of HIV status to partners.

a) Why haven't you disclosed your HIV status to your partner?
b) Of what importance do you feel partner notification is? Explain.
c) Can you explain some of the factors that affect partner notification? [probes]
d) What are your recommendations on partner notification?

4. THE EFFECTS (CONSEQUENCEIS) OF HIV PARTNER NOTIFICATION

Disclosure of HIV status to partners

a) What was your partner's reaction or response?
b) What are the consequences of your notifying your partner?
[Probes]
c) Now that your partner is informed, how do you feel about it?
d) What is your relationship like with your partner now that she knows your HIV status?
e) What do you do to prevent yourself from being re-infected with HIV?
f) What message can you give to those men who haven't notified their partners?

Non-disclosure of HIV status to partners

a) How do you think your partner can react or respond to the message?

b) What can be the effects (consequences) of you notifying your partner of your HIV status? [Probes]

c) What do you think can be the effects (consequences) if you leave your partner unaware of your HIV status? [Probes].

d) What do you do to protect your partner from contracting HIV?

e) What message can you give to your fellow men who have not disclosed their status to their partners?

THANK YOU FOR YOUR PARTICIPATION.

INTERVIEW GUIDE IN CHICHEWA

DATE.....

CODE.....

SECTION A

Demographic Data

1 Zaka za kubadwa

(a). 20-25 [ ]

(b). 26-30 [ ]

(c). 31-35 [ ]

(d). 36-40 [ ]

(e). 41-45 [ ]

(f). 46-50 [ ]

2. Mtundu

(a). Chewa [ ]

(b). Yao [ ]

(c).Lomwe [ ]

(d). Ngoni [ ]

(e). Tumbuka [ ]

(f). Zina tchulani.....

3. Chipembedzo

(a).Chikhrisitu [ ]

(b).Chisilamu [ ]

(c) Zina tchulani. .....

4. Maphunziro

(a). Pulaimale [ ]

(b). sekondale [ ]

(c).Sukulu ya ukachenjede [ ]

(d). Zina tchulani.....

5. Mumagwira ntchito yanji, tchulani.....

6. Kodi muli pa banja?

(a). Eya [ ]

(b). Ayi [ ]

(c). Zina tchulani .....

SECTION B

1. ZOMWE MUKUDZIWA PA ZA MATENDA A HIV NDI AIDS KOMANSO KUDZIWITSA BWENZI LANU ZA MMENE MULI.

a) Kodi HIV ndi chiani?
b) Kodi AIDS ndi chiani?
c) Kodi HIV ndi AIDS imafala bwanji?
d) Kodi ka chilombo ka HIV ndi AIDS kangapewedwe bwanji?
e) Nanga munthu angadziwe bwanji kuti ali ndi kachilombo ka HIV ndi AIDS? (Kufufuza).
f) Mukuwona kuti bvuto la HIV ndi AIDS panopa yafika potani?
g) Munganenepo chiani pa nkhani yodziwitsa bwenzi za m'mene mthupi muli pa nkhani yokhudzana ndi kachilombo ka HIV ndi AIDS?
h) Ndichifukwa chiani nkhani yodziwitsa bwenzi lanu za m'mene mthupi mwanu muli ikuyenekela kukhalapo?

2. ZIKHULUPILIRO ZOMWE MULI NAZO PA NKHANI YODZIWITSA BWENZI LANU ZA MMENE MTHUPI MWANU MULI PA NKHANI YAH IV NDI AIDS.

a) Kodi kudziwitsa bwenzi lanu za m'mene mthupi mwanu muli kungakupindulireni bwanji? (Kufufuza).
b) Kodi mukuganiza ngati choopsya chingakhalepo ndi chotani ngati inu mudziwitsa bwenzi lanu za m'mene mthupi mwanu muli?
c) Kodi nthawi yabwino yomwe mungadziwitsire bwenzi lanu za m'mene mthupi mwanu muli ndi yiti?

3.ZOMWE ZINGAKUPANGITSENI KUTI MUDZIWITSE KAPENA MUSADZIWITSE BWENZI LANU ZA MMENE MTHUPI MWANU MULI

Kwa omwe adadziwitsa bwenzi lawo zam'mene ali mthupi mwawo.

a) Chomwe chinakukopani kapena kukulimbikitsani kuti mutero ndi chiani?
b) Nanga munakumana ndi zokhoma kapena zobvuta zotani pa nthawi yomwe mumadziwitsa bwenzi lanu za m'mene muli mthupi

Kwa omwe sadaziwitsa bwenzi lawo zamnene ali mthupi.

a) Nchifufukwa chiani simudatero? (Kufufuza).
b) Kodi mukuganiza ngati kufunika kwake kodziwitsa bwenzi lanu za m'mene muli mthupi ndi kotani?
c) Kodi ndi zifukwa ziti zingampangitse kapena kumulepheletsa munthu kuti adziwitse bwenzi lake za m'mene mthupi mwake muli? (Kufufuza).
d) Kodi chomwe mungakonde chitachitika, kuwonjezekela kapena kuchotseledwa pa nkhani yoti munthu adziwitse bwenzi lake za m'mene mthupi mwake muli ndi chotani?

4. ZOTSATIRA ZOMWE ZINGABWERE NGATI INU MUDZIWITSA BWENZI LANU ZA MMENE MTHUPI MWANU MULI PA NKHANI YOKHIDZANA NDI HIV NDI AIDS

Kwa omwe adadziwitsa bwenzi lawo za m'mene mthupi mwawo muli

a) Bwenzi lanu lidaulandira bwanji uthengawu?
b) Zotsatira zake ndi zotani zomwe mwaziona inuyo? (Kufufuza).
c) Mukumva bwanji mukaganizira kuti bwenzi lanu likudziwa za m'mene muli mthupi mwanu?
d) Kodi mungapereke uthenga wotani kwa abambo onse omwe sanadziwitse bwenzi lawo za m'mene ali mthupi mwawo?

Kwa amene sanalidziwitse bwenzi lawo za m'mene ali mthupi mwawo

a) Mukuganiza kuti bwenzi lanu lingawulandira bwanji uthengawu?
b) Mukuganiza kuti zotsatira zake mutati munene za m'mene muli mthupi mwanu zingakhale zotani? (Kufufuza).
c) Nanga chingachitike ndi chiani ngati bwenzi lanu likhala losadziwa za m'mene muli mthupi mwanu? (Kufufuza).
d) Nanga mumatani kuti muteteze bwenzi kuti asatengere kachilombo ka HIV?
e) Kwa anzanu onse omwe sadanene za m'mene ali mthupi mwawo, mungawauze zotani?

APPENDIX 4

The University of Malawi,
Kamuzu College of nursing,
Private bag 1,
Lilongwe.

The chairman,
Research and Publications Committee,
University of Malawi,
Kamuzu College
Private bag 1,
Lilongwe.

RE: PERMISSION TO CONDUCT A RESEARCH STUDY

Iam a fourth year student at Kamuzu College of Nursing pursuing a Bachelors Degree in nursing. In partial fulfillment of the academic award of a Bachelors Degree, am conducting a study of my own interest on **perception of HIV seropositive men towards partner HIV notification.**

I therefore write to request for your approval to conduct this study. Ethical issues, confidentiality and anonymity shall be observed and each participant shall be required to give consent before participation.

Your consideration will be greatly appreciated.
Yours faithfully,
Feliya Nyirenda.

The University of Malawi,
Kamuzu College of nursing,
Private bag 1,
Lilongwe.

The Hospital Director,
Thyolo District Hospital,
P.O Box
Thyolo
Dear sir / madam

RE: APPLICATION FOR PERMISSION TO CONDUCT A PILOT STUDY AT YOUR HOSPITAL

Iam a fourth year student at Kamuzu College of Nursing pursuing a Bachelors Degree in nursing. In partial fulfillment of the academic award of a Bachelors Degree, am required to conduct a study of my own interest. My study topic is **perception of HIV seropositive men towards HIV partner notification.**

I therefore write to request that your institution (Thyolo District Hospital- ARV clinic) be a pilot study site. An interview guide will be used in data collection and two participants (men) will be required. Ethical issues shall also be observed.

Your consideration will be greatly appreciated.
Yours faithfully,
Feliya Nyirenda.

The University of Malawi,
Kamuzu College of nursing,
Private bag 1,
Lilongwe.

The Hospital Director,
Queen Elizabeth Central Hospital,
P.o box
Blantyre.
Dear sir / madam

RE: APPLICATION FOR PERMISSION TO CONDUCT A STUDY AT YOUR HOSPITAL

Iam a fourth year student at Kamuzu College of Nursing pursuing a Bachelors Degree in nursing. In partial fulfillment of the academic award of a Bachelors Degree, am required to conduct a study of my own interest. My study topic is **perception of HIV seropositive men towards HIV partner notification.**

I therefore write to request that your institution (Queen Elizabeth Central Hospital- ARV clinic) be **a** research site. An interview guide will be used in data collection and each participant will be required to give consent before participation. Ethical issues shall also be observed.

Your consideration will be greatly appreciated.
Yours faithfully,
Feliya Nyirenda.

APPENDIX 5

INFORMED CONSENT AND PARTICIPANT INFORMATION

The University of Malawi ,
Kamuzu College of nursing,
Private bag 1,
Lilongwe.

Dear participants,
Iam a fourth year student at Kamuzu College of Nursing pursuing a Bachelors Degree in nursing. In partial fulfillment of the academic award of a Bachelors Degree, am required to conduct a study of my own interest. My study topic is **perception of HIV seropositive men towards HIV partner notification.**

The findings of the study will be helpful as will give guidelines to health workers who wish to help those infected to disclose their seropositivity and protect partners through behavior change. It will also help to prevent secondary transmission of the virus which can reduce the effectiveness of the ARVs as might develop the resistant strains.

Interviews will be used to collect data. Code numbers will be used instead of names and your information shall be kept safe for confidentiality and anonymity's sake. You should also know that you have your own rights such as participating voluntarily, maintaining self-respect and dignity, confidentiality and anonymity, privacy, self-determination, right not to be harmed and the right to services.

Your participation in this study is completely voluntary. You can choose to take part in the interviews or not. You can stop your participation at any time. You do not have to answer any question that you do not want to. Your decision to take part or not and your responses will not affect your coming to this hospital to attend to any treatment whenever

you feel so. The benefit that you might gain from participating in this study might not be direct, but rather, will help counselors to help PLWHA to find means of disclosing. No money or incentives shall be given.

There are no risks involved in your participating in this study as there are no experimental activities involved. However, you might be reminded of the psychological trauma that you might have undergone when you learnt you had HIV.

If you will participate please sign the consent form attached.
Thanks for your cooperation and support.
Yours truly,
Feliya Nyirenda.

CONSENT FORM

I, the undersigned, have read and understood the information and conditions of participating in the above research study. I agree to participate in the study.

Participants signature..... Date.....

Researchers signature..... Date.....

University of Malawi

KAMUZU COLLEGE OF NURSING

RESEARCH AND PUBLICATIONS COMMITTEE

APPROVAL CERTIFICATE

TITLE: PERCEPTION OF HIV SERO-POSITIVE MEN TOWARDS HIV PARTNER NOTIFICATION

INVESTIGATOR(S): FELIYA NYIRENDA

YEAR OF STUDY: IV

REVIEW DATE:

DECISION OF THE COMMITTEE:

SIGNATURE: ..... **DATE**.....

DEAN OF POSTGRADUATE STUDIES AND RESEARCH

CC: supervisor:

DECLARATION OF INVESTIGATOR(S)

I/WE fully understand the conditions which I am/we 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..... **SIGNATURE(S)**.....

Telephone: (265) 01 874 333 / 677 333
Facsimile: (265) 01 876928
Email: queenshosp@globemw.net

All communications should be addressed to:
The Hospital Director

In reply please quote **No.**

QUEEN ELIZABETH CENTRAL HOSPITAL
P.O. BOX 95
BLANTYRE
MALAWI

Ref No. QE/CNO/10

24th August, 2009

Feliya Nyirenda
Kamuzu College of Nursing
Private Bag 1
Lilongwe

Dear Sir/Madam

PERMISSION TO CONDUCT RESEARCH AT QUEEN ELIZABETH CENTRAL HOSPITAL ON "PERCEPTION OF HIV SEROPOSITIVE MEN TOWARDS HIV PARTNER NOTICATION".

The above refers.

I am pleased to inform you that your request to conduct research at QECH has been accepted.

We will appreciate if a copy of your findings is shared with the hospital.

All the best in your studies.

Yours faithfully,

T.N. Soko
CHIEF NURSING OFFICER
For: HOSPITAL DIRECTOR