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Knowledge, attitudes and practices of HIV positive patients regarding disclosure of HIV results at Betesda Clinic Namibia

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CHAPTER 1: INTRODUCTION

HIV prevalence is increasing and more people are being infected despite the messages and the advertising.[1] In Namibia, The World Health Organization recorded 452 cases in 1994, 1836 in 1995, 1775 in 1996 and 26 096 in 2002. Namibia has one of the highest HIV/AIDS prevalence rates in the world of 21.3% as at end of 2003. Two hundred and ten thousand (210 000) people were estimated to be living with HIV/AIDS, more than one in five adults. In 2003 an estimated 16000 Namibians died of HIV/AIDS, which was the leading cause of death among adults and children.[2] Is it because HIV is a stigmatized disease or people's knowledge on HIV is inadequate? Are people disclosing and are the people's attitudes towards the disease changing? These are some of the questions which need answers. In Namibia where tradition is highly respected, culture is diverse, HIV is increasing, no studies on disclosure were found and yet disclosure is critical in the treatment and prevention of HIV.

Another question was whether individuals were having peace of mind after disclosure. The researcher had a patient who was on antiretroviral treatment for five years. In 2008 he was involved in a dispute and suffered severe chest injuries. Upon admission he could not ask his wife to bring his antiretroviral medication as he had not disclosed. He defaulted treatment for one month and the viral load increased in somebody who had an unrecordable viral load. His wounds six months later had not healed and he might not be the only one.

Prevention of the spread of HIV depends on the testing and treatment of infected individuals. Without disclosure the success of HIV control is hindered. Disclosure is important because individuals are motivated to seek treatment, change behaviour and decrease transmission. It has a number of benefits for the individual including opportunities for social support, improved access to medical care, increased opportunities to discuss and implement risk reduction with partners, opportunities to take leadership roles in the community and increased opportunities to plan for the future.[3] A considerable

amount of literature documents the experience of stigma and discrimination but fail to document the benefits of disclosure.[4]

Disclosure is a difficult process and a challenge. One of the biggest concerns is confidentiality. Can one trust the person they are telling and can they keep a secret? No literature was found on people's knowledge regarding the importance of disclosure but people are aware that disclosure can have positive and negative effects. People living with HIV find it daunting to disclose their results for a number of reasons; their status will no longer be a secret, fear of rejection which is a possibility when one decides to disclose and relationships can be lost. Other reasons are loss of economic support, blame, abandonment, physical and emotional abuse, discrimination and disruption of family relationships.[5]

Fears are natural as stigmatization may and does happen.[6] Stigma can occur as internalized stigma which is a result of the internalization, acceptance of the lived situations, discrimination that a person endures over time and or externalized where other people stigmatize an individual. Stigma can be felt at individual, family, community and societal level. It prevents individuals from being tested, prevents people from recognizing that they or their family members are HIV positive and inhibits people from seeking care, support and treatment. Stigma can also cause people to mislead others, impede people from using protection, prevent quality care, increase social insecurity, hinder people from getting access to benefits, increase transmission, morbidity and mortality.[7]

People stigmatize because they are insecure, afraid, ignorant and they lack knowledge.[8] Society needs to be educated. The cycle of stigma and discrimination should end. When HIV/AIDS was first detected it was closely associated with certain subgroups; carriers were ostracized and branded. Those who stigmatize think stigmatizing keep HIV away from them and they are better or safe from HIV. The victims should be encouraged to learn to let go of internal stigma, accept themselves, be confident, disclose and believe that they deserve love and support from the community.

This study focuses on HIV positive patients so that the true practices and attitudes of the society as interpreted by the victims are understood. Other studies focused on specific groups of the society for example patients with tuberculosis, pregnant women, men who have sex with men and drug users.[9]

1.1 Aim: To determine knowledge, attitudes, and practices of HIV positive patients regarding disclosure of HIV status at Betesda clinic in Namibia.

1.2 Objectives

1. To determine the participant profile namely age, sex, marital status, level of education and ethnicity.
2. To determine reasons for disclosure and non disclosure.
3. To explore attitudes of HIV positive patients with respect towards disclosure of HIV results.
4. To determine knowledge with regard to disclosure of HIV results.
5. To understand practices of HIV positive patients with regard to disclosure of HIV results.

CHAPTER 2: LITERATURE REVIEW

Disclosure is a necessity in the prevention and control of HIV infection and is an essential component of behaviour modification, access and adherence to treatment. Rates of disclosure among studies done in developed countries ranged from 42% to 100% depending on the type of partner to whom the person disclosed. The lowest rates of disclosure were reported among past partners or casual partners. In developing countries disclosure rates were lowest ranging from 16.7% to 86%. The lowest rates were among pregnant women tested in antenatal care in Sub-Saharan Africa (16.7% to 32%).[10] Even black Africans living in UK were reluctant to disclose to significant partners.[11] The study will focus on disclosure practices and attitudes as viewed by the HIV positive, there is not much literature on this, some studies had looked at subgroups of the community with other cofactors and these individuals are in some way already labelled by the society.[12]

No documented literature was found on knowledge regarding disclosure of HIV positive results. People are aware that disclosure can have positive and negative effects. Knowledge on HIV as a disease is very high but no literature was found on whether people had knowledge on the importance of disclosure.[13]

Disclosure of a positive result is difficult and is an important decision for all infected people. It plays an important role in how individuals cope with their disease. While disclosure can have positive effects on individual's health, compliance, family support, societal support and reducing stress, it also has negative effects. For majority of patients disclosure is stressful; rejection, discrimination and regrets are some of the consequences. People are worried about the external world and are afraid of being judged.[14]

Disclosure is a process and it consists of several steps including adjusting to the diagnosis, assessing one's disclosure skills, deciding whom to tell and when, evaluating the recipient's circumstances, anticipating the recipient's reaction and having a motivation to disclose.[15] The decision to disclose depends on the stability of the

relationship, feelings for the partner, feeling responsible for the partner's health, partner asking or partner disclosing first. Disclosure is also influenced by a sense of responsibility to partners, acceptance of being positive, the perceived transmission risk, context and meaning of sex.[16,17]

Mothers are the most likely family members to be told, because they are known to be compassionate, caring and more understanding as compared to fathers or other siblings. Many choose not to tell certain family members either because they fear their reaction, they want to protect the member from other people's negative reactions or from worrying about them or they are too young to understand.[18]

In a study done in Yunnan China, upon disclosure most reactions were positive and supportive. Several disclosed when they were very ill and most regretted not disclosing early. The primary source of support was the family and help in the form of daily routine activities like bathing, feeding, mobility, financial assistance, support in the disclosure process, medical assistance and psychological support were provided. Friends were not told by most but HIV positive friends were most likely to be told. Few of those who attended church had told their pastor or congregation. Going to church was a source of strength, the fellowship, rituals and the teaching helped deal with the disease. [19]

Disclosure to a sexual partner led to risk reduction behaviour, partner testing, increased care seeking behaviour, anxiety relief, increased sexual communication and motivation to plan for the future. In studies done in South Africa, where there was failure to disclose, patients presented to hospital very late, in the late stages of HIV. The patients were reluctant to acknowledge their status and support systems for example the family, partners and siblings were not aware of their status and could not help.[20] Once HIV status was known family members took precautions when handling secretions and helped patients plan their future. People have been known to use bare hands when handling blood.[21] Those who had more social support had better health and less distress.[22]

Adherence is crucial in the success of highly active antiretroviral treatment. Forgetting,

traveling and being ashamed to take medication at family gatherings are some of the reasons given for poor compliance.[23] With poor compliance there is failure of treatment, development of resistance and deterioration of health. Virological success is significantly higher in adherent patients, 81% versus 56% and limited disclosure was found to be independently associated with non adherence.[24]

In a study done in Chennai South India, patients were afraid to disclose as they feared stigma but actual stigma experienced by those infected with HIV was much less, 26% compared to the fear of being stigmatized or perceived stigma at 97%.[25] Internalized stigma is the worst form of stigma and is a hindrance to disclosure, in order to progress with the prevention of spread of HIV the extent of the problem has to be understood. Patients are afraid of the unknown, rejection by the family, rejection by the community, isolation and psychological burden, protection of family from shame, protection of family from obligation to help and avoidance of communication regarding highly personal information.[26] Other reasons for non disclosure were nobody's business, denial, having a low viral load and just sex. [27]

In communities with high rates of disclosure of HIV infection, disclosure led to greater access to formal institutional support and opportunities to take positive leadership roles in the community. Upon disclosure negative life events were rare.[28] In a study done in South West Nigeria, it was shown that greater disclosure was related to increased social support, social self competence and decreased problem behaviour, the guilt of keeping a secret and fabrications which accompany non disclosure ended.[29] Support from health professionals increased.[30]

A Study done in Mombasa Kenya found that women were more likely to disclose than men. Differences in disclosure rates varied based on sex partner factors such as serostatus, relationship status and number of sex partners. About 67%-88% disclosed to primary sex partners, suggesting that nearly one third of main sex partners were not disclosed to and were at risk of contracting HIV, whereas a pattern of lower disclosure among casual partners was evident. Unsafe sexual behaviour was associated with non

disclosure.[31] As the number of sex partners increased the likelihood of disclosure to all sex partners decreased by 25% to 58%. Increased disclosure was associated with being married, more counseling and knowledge of partner's sero-status. Interpersonal factors positively influencing self-disclosure included spousal support, emotional investment and communication about safe sex.[32]

In African-American men studies have shown that initially men did not disclose and many continued not to disclose. Those who did not disclose were concerned with negative consequences such as rejection and recipients telling others, but it also limited the amount of social and emotional support they received with regard to their HIV disease. If and when they disclosed it was to sexual partners, immediate family members and health care providers.[33] Analysis has shown that stigma drives HIV out of the public sight, so reducing the pressure for behaviour change. It delays the desire to know one's status, accessing treatment, limits the possibility of using safer sexual practices and the use of condoms can be seen as a marker of HIV.[34]

In a study done in South Africa, those who did not disclose were more likely to have not used a condom during their last sexual encounter, to have used alcohol heavily before sex, to have multiple sex partners and to have engaged more frequently in sexual intercourse.[35] Lepraz and Marks showed that men who disclosed their seropositive status and explicitly discussed the topic of safer sex with their at-risk partners had a significantly higher prevalence of protected anal or vaginal intercourse than men who did not and condom use among couples was easily negotiated.[36]

Stigma is documented to have occurred, especially in serodiscodant couples where the woman is the one who is positive. Break up of marriages and sexual relationships, harassment by in-laws and domestic violence have been reported. In studies done in Mabvuku Zimbabwe, within the family and community women were significantly more likely to experience discrimination, ridicule, harassment, physical assault and being forced to change place of residence than men. Most studies focused on stigma and discrimination.[37]

Violence was reported more often by women in Sub-Saharan African (3.5% to 14.6%) than women in USA (0.4%-4%).[38] In 1998 a South African woman was killed by neighbours when she announced that she was living with HIV.[39] One Indian lady was forced out of her home by the in-laws when the husband died from HIV. In India 37% were forced to be tested because they were too ill. For 10%, disclosure was a requirement to get a job, 15% were refused treatment and results were given in front of a third person such as employer, government official, or police. Breaches of confidentiality occurred like third person receiving results without the consent of the recipient, women were coerced into abortion, some lost their insurances and some were denied education.[40]

In Namibia scores of women were sterilized without their consent or under pressure from doctors. A 31-year-old pregnant woman from the Goreangab dam area of Namibia went to deliver her baby, but was told by doctors that because the baby was "too large," she would have to be sterilized. She was informed that if she refused to agree to the sterilization procedure, she would have to give birth without medical care. 20 year old Susan walked into a doctor's office for emergency surgery, unaware that she was pregnant. When she woke up from her surgery, was told by doctors that her womb had to be ripped out because she had HIV. Susan is now infertile and she will never have children.[41]

Understanding different cultures and religions is important when it comes to disclosure. Ethnic groups understand and interpret diseases differently. To avoid conflicts during counselling one has to understand culture and to in-corporate specific elements when counselling. Cultural barriers play an important role and these cultural barriers are persistent even in migrants. Practices and attitudes are influenced by culture. In some cultures it is taboo to discuss sexual issues and women are not empowered to the extent that they are not able to exercise their own interest in sexual encounters.[42] In most African cultures, people believe in witchcraft leading to blame and hatred. Conflicts among close family members may arise and this may hinder disclosure resulting in the spread of the infection.[43]

It was taboo for the Latino women to discuss sex related issues. Latino men made decisions regarding sex and condom use was determined by men who were the principal buyers of the condom.[44] Women underutilized primary health services making it even more difficult to discuss any precounselling with the women yet HIV was common in the Latino women, 11 times higher than the whites. The only way to reach to these women was through their men.[45]

In the Shona culture, mothers are not empowered to discuss sex related issues, it is considered to be the role of grandmothers. However, changing times mean grandmother could be staying very far from the family and would be very difficult for her to discuss sensitive issues as she would not be well acquainted with the kids.[46]

In South Africa asylum seekers are a challenge. Health services and social support may not be available. They may have no families and are alone in a foreign country where they are not welcome and are afraid to trust anyone, HIV testing is delayed and disclosure is very difficult.[47] From my experience in Namibia, foreigners like Angolans and Zimbabweans were not welcome in State hospitals where treatment was cheaper, they were charged exorbitant fees or sent away if their nationality was known.

Teenagers are a vulnerable group and most of them are experimenting and involved in risky behaviours.[48] Condoms are thought to be for prostitutes, are embarrassing to purchase, embarrassing to put on, difficult to dispose and denote unfaithfulness, and intention to use is high versus actual use in the majority of teenagers.[49,50] When it comes to disclosure they are immature, are not sure of the unknown and cannot trust anyone, neither their friends nor their family. The reaction of friends and parents is unpredictable upon disclosure. Some families are supportive and others may blame the recipient. Friends may support or one may become an outcast.[51]

Skinner in South Africa showed that more HIV negative women disclosed their results than the HIV positive ones, in 81.9% of the negative and 48.9% of the HIV positive the partners reacted positively.[52] In Dar es Salaam Tanzania 64% of the HIV positive women

and 79.5% of the HIV negative women (p=0.028) reported that they had shared HIV results with their partners. Among those who did not disclose, 52% were afraid of their partners' reaction. Among those who disclosed 5% reported negative reactions.[53]

Studies done in African countries have shown that HIV positive individuals have their own way of coping with the disease. Restructuring, seeing oneself as alright, letting go, turning to God, hoping, changing behaviour, keeping oneself active, using humour, joining a support or social group, disclosing ones HIV status, speaking to others with the same condition and educating others were some of the coping strategies. Others coped by getting counselling, helping others cope with the disease, learning from others, acquiring knowledge, understanding the disease and getting help.[54,55] The church provided moral, social and spiritual support.[56] Negative coping strategies such as resignation, distraction, self blame, engaging in risky behaviour, drug and alcohol abuse, wishful thinking and blaming others have been reported.[57] Negative coping strategies were associated with depression and anxiety.[58]

As individuals struggle with disclosure, there is need for intervention to assist and help them make decisions. Families, society, and individuals should be counselled so that they understand the disease and live positively with HIV. Disclosure is important in the control, compliance, healthy living and providing the necessary support. The prevention and control of HIV infection depends on the success of strategies to prevent new infections and treatment of currently infected individuals. Within HIV testing and counselling, emphasis should be placed on the importance of HIV status disclosure among HIV infected individuals particularly to their sexual partners. Management of HIV is changing and the way people perceive and understand HIV is also changing. What was found in studies done years ago is different from recent as the knowledge on HIV is increasing and support groups discouraging spreading of HIV are evolving. Most countries now have laws to protect and support HIV positive people.

CHAPTER 3: METHODS

3.1 Study Design: This study was a cross-sectional descriptive study.

3.2 Site of study: Site of study was Betesda clinic in Namibia. Betesda is a private clinic in Katutura, a high density suburb in Windhoek. The clinic provides primary health services to the community mainly those on medical aid. It offers dental, pharmaceutical, X-ray services, consultations and has six screening rooms; some of the rooms are used as observation rooms depending on whether they are needed. It has a procedure room where minor procedures are done under local anaesthesia. It has 2 permanent doctors, 3 locum doctors, 5 permanent nurses and 2 counsellors. Doctors treat the majority of the patients and a few patients are seen by the nurses. Nurses do observations, dressings, immunizations and home visits.

The clinic operates from seven o'clock in the morning to ten o'clock at night from Monday to Sunday including public holidays. It has a television in the reception area which is mainly used for educational programs. The sister in charge organizes group discussions with patients, families are welcome to these meetings and this is done once in four months. She finds an interesting topic and invitations are issued in the clinic. All patients with different illnesses wait in the same queue and there is no separate HIV clinic. HIV services offered at the clinic are pre counselling, post counselling, HIV testing, follow up and treatment of HIV positive patients by the doctors and home visits of defaulting patients by the nurses. A pharmacy is available where patients use their medical insurance to get medication or buy if they are not insured. Patients are free to go to other pharmacies to get medication.

3.3 Study population: Betesda clinic had 1013 known HIV positive patients. The study population was all HIV positive patients attending Betesda clinic.

3.4 Sample size: Calculating the required sample size enhances the validity of the results

of the study and reduces the chances of errors. Given 1013 patients, a sampling error of 5% the ability to detect a difference of 50% and a 95% confidence level, the required sample size was 245. It is recommended that we introduce an inflation fraction to take care of problems of non-response, a 10% inflation fraction was added giving a sample size of 269. This sample was sufficient to represent Betesda clinic HIV positive patients.

3.5 Sampling method: Convenience sampling method was used. All HIV positive patients in the queue were selected as these patients were mixed with patients with other diseases. There is no separate HIV clinic. Selection of patients was done before they were attended to by a doctor, newly diagnosed (those tested at Betesda clinic) patients were missed on the same day the diagnoses was made (as status was unknown or negative at that time) but those tested at another clinic or centre were entered into the study. Once a patient agreed to enter the study a green sticker was put inside the first cover, to prevent repeat selection. It took six weeks to reach sample size.

3.6 Inclusion criteria: All willing HIV positive individuals tested from the first of January 2004. The clinic started to operate in December 2003.

3.7 Exclusion criteria: Those below 18years of age, those unable to give consent and those who refused to give their consent were excluded. Newly diagnosed patients were still unknown at the selection time but if they were to come back later during the day they were entered into the study. Those tested before one January 2004 were excluded to prevent recall bias.

3.8 Measuring tool or instrument: A Questionnaire was used. (See appendix 3). The questionnaire was formulated by the researcher with the assistance of the statistician and research supervisor. Questionnaires from other studies did not address the issues the researcher wanted to address.

3.9 Data collection: All eligible, willing patients were selected and a number allocated to each patient to maintain confidentiality. All patients passed through a room (which was

used to complete the questionnaire) one at a time. Upon entering patients were asked by the researcher whether they required an interpreter. The researcher informed the patients about the study, answered questions and identified eligible patients by asking them if they were tested, what their status was, when they were tested and a questionnaire was used. Those who were HIV positive were asked to enter the study. If they were willing to enter the study, a consent form (see appendix 2) was given to them to sign.

Once the questionnaire was completed, it was not taken out of the room. For those patients who refused to enter the study an uncompleted questionnaire was put by the researcher in the box which was in the room, to have an accurate number of those who refused to enter the study. Data collection was done from eight o'clock to five o'clock daily until the sample size was reached. A counsellor at the clinic had agreed to assist with the counselling.

3.10 Pilot Study: The researcher conducted a pilot study on twenty consenting patients at Katutura clinic. This was to help determine the time it took to complete the questionnaire, sensitive questions, for clarifications and simplification of questions to make it easier for the patients to answer questions. The pilot study questionnaires were not used in the actual study. Pilot questionnaires were analyzed to test data entry.

3.11 Study limitations: Exclusion of patients who could not afford medical aid and those who could not afford treatment in a private clinic.

3.12 Risk of the study: Psychological stress during the interview. A counsellor was available to provide counselling to those affected by the study.

3.13 Sources of Bias: To overcome language problems a professional interpreter was used. Sampling bias was overcome by selecting all eligible patients, those tested before one January 2004 were excluded and this was done to try to overcome recall bias.

3.14 Ethical issues: Confidentiality and privacy were maintained by providing a room

when completing the questionnaire and allocating a number to patients instead of using their names. Informed consent was obtained, date of birth and address were not put on the form (age group appeared). Permission to conduct the study was obtained from Betesda Clinic authorities; ethical clearance was obtained from the Post Graduate Committee and Human Research Ethics Committee of the University of the Witwatersrand. Critically ill patients were excluded as they were in no condition to give consent and it was difficult to even inform them about the study without compromising their privacy. A copy of the consent form was signed by every patient participating in the research study.

3.15 Definitions for the purposes of this study: Psychological stress is characterized by a behavioural pattern that occurs causing a change in mood e.g. crying, sudden sadness, unresponsive in someone who was communicating, inability to talk, inability to concentrate, nail biting, pacing, sudden aches and pains and inability to relax.[59]

CHAPTER 4: RESULTS

Two hundred and sixty three respondents were entered into the study, 4 patients were too sick and 2 were in a hurry, 36% were females, 41% were married, 28% were single, 27% were cohabitating, 2% were widow/widowers and 1% were divorced. Those who entered the study first knew their status in the following years; 2% knew their status in 2004, 9% in 2005, 22% in 2006, 25% in 2007, 24% in 2008, 15% in 2009 and 3% in 2010. Ethnic groups were distributed as follows; 87% were Oshiwambo, 3% were Herero, 3% were Foreigners, 3% were Damara and 5% were other groups which consisted of Shilozi, Caprivian, Kavango, Nama and Mixed race.

Fifty five percent were in the age group 38 to 47yrs, 21% 48 to 57yrs, 16% 28 to 37yrs, 6% 58 to 67yrs, 3% 18 to 27yrs and none were above 67yrs. With educational level 49% were from grade 8 to 12, 38% grade 1 to 7, 7% were higher which consisted of college and university level and 6% never went to school.

Table 4.1 What do you think about disclosure? – Positive thoughts

Positive thoughts	**Percentage**	**Frequency**
Good	41%	107
Important	14%	36
Ok	11%	29
Helps	2%	6
Necessary	0.4%	1
Total	**68.4%**	**179**

The question what do you think about disclosing HIV results was asked and the responses were as follows see Table 4.1, Table 4.2 and Table 4.3. Sixty eight percent responded positively to what they thought about disclosing their status. See table 4.1.

Approximately 2/3 of the respondents had positive thoughts on disclosure. 41% said it was good, 14% said important, 11% said it was ok.

Table 4.2 What do you think about disclosure? – Negative thoughts

Negative thoughts	Percentage	Frequency
Not good	13%	35
Difficult	5%	13
Don't like it	2%	5
Problem	2%	5
Scary	1%	3
Not important	1%	3
Others (not necessary, dirty, stigmatized)	3%	6
Total	**27%**	**70**

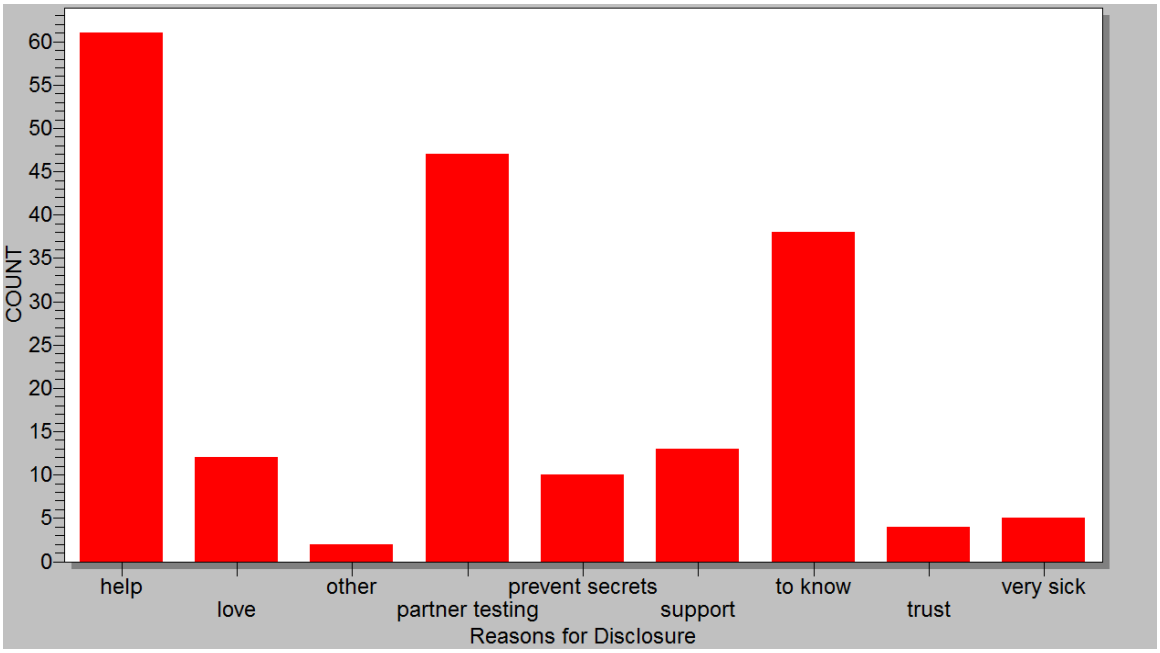
Twenty seven percent of the respondents had negative thoughts on disclosure. 13% said not good, 5% difficult and 3% were others (dirty, stigmatized, and not necessary).

Table 4.3 What do you think about disclosure? – Neutral thoughts

Neutral thoughts	Percentage	Frequency
Depends	3%	8
Not sure	2%	4
Others (don't know, nothing)	1%	2
Total	**6%**	**14**

A minority of the respondents were neutral on what they thought about disclosure. Three percent said it depends and 3% were not sure or did not know.

Figure 4.1 Reasons for disclosure



The question what were your reasons for disclosing was asked and the response was as follows see Figure 4.1. Reasons for disclosing were 32% they needed help, 25% partner to go for testing, 20% to let relatives know why they were sick, 7% for psychological support and 6% because they loved the people they were telling. See figure 4.1

Table 4.4 Reasons for not disclosing

Reasons for not disclosing	**Not disclosed**	**Disclosed**
Fear of the community gossiping	20% (54)	59% (155)
fear divorce	1% (3)	
My secret	3% (9)	
No trust	1% (3)	3% (8)
Relatives will worry	0.4% (1)	
Total	**25.4% (70)**	**62%(163)**

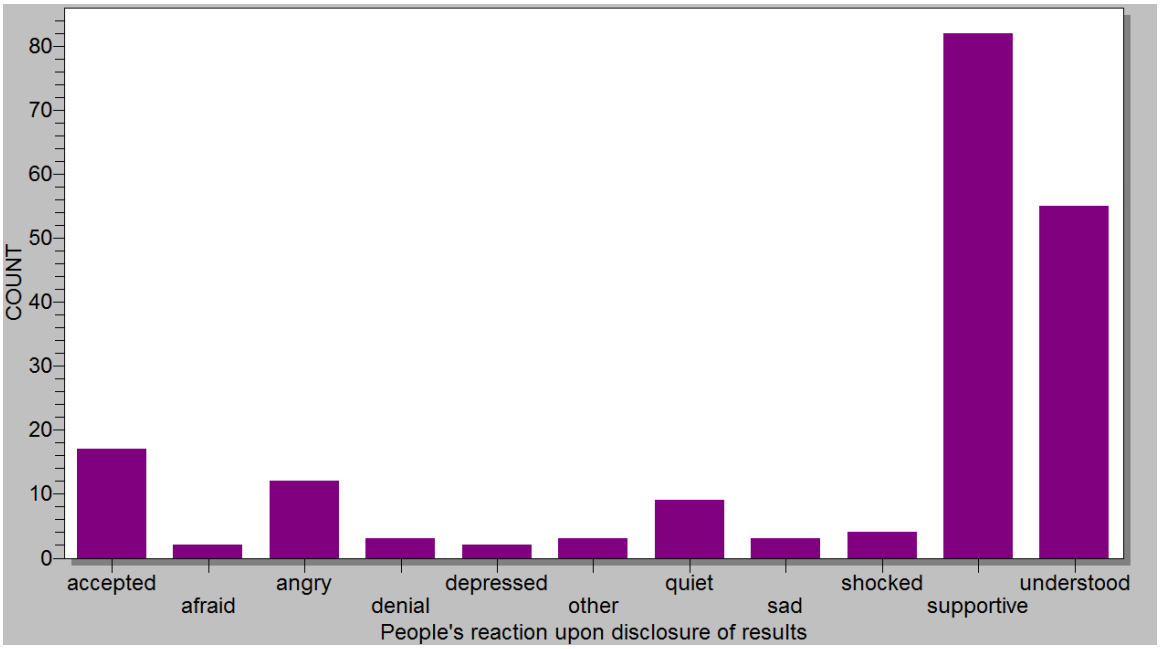
The question what were your reasons for not disclosing was asked and the response was as follows see Table 4.4. Reasons for not disclosing were; 79% said they feared the community gossiping (the talking and the finger pointing), 3% said it was their secret and 62% of the disclosed had a reason why they were not disclosing to everyone.

Table 4.5 To whom have you disclosed?

To whom have you disclosed	**Percent**	**Frequency**
Spouse/Partner	73%	141
Family (brother, mother, sister, child, uncle, niece Grandfather)	40%	76
Friend	4%	8
Employer	0.5%	1
Pastor	0.5%	1
Total	**_**	**227**

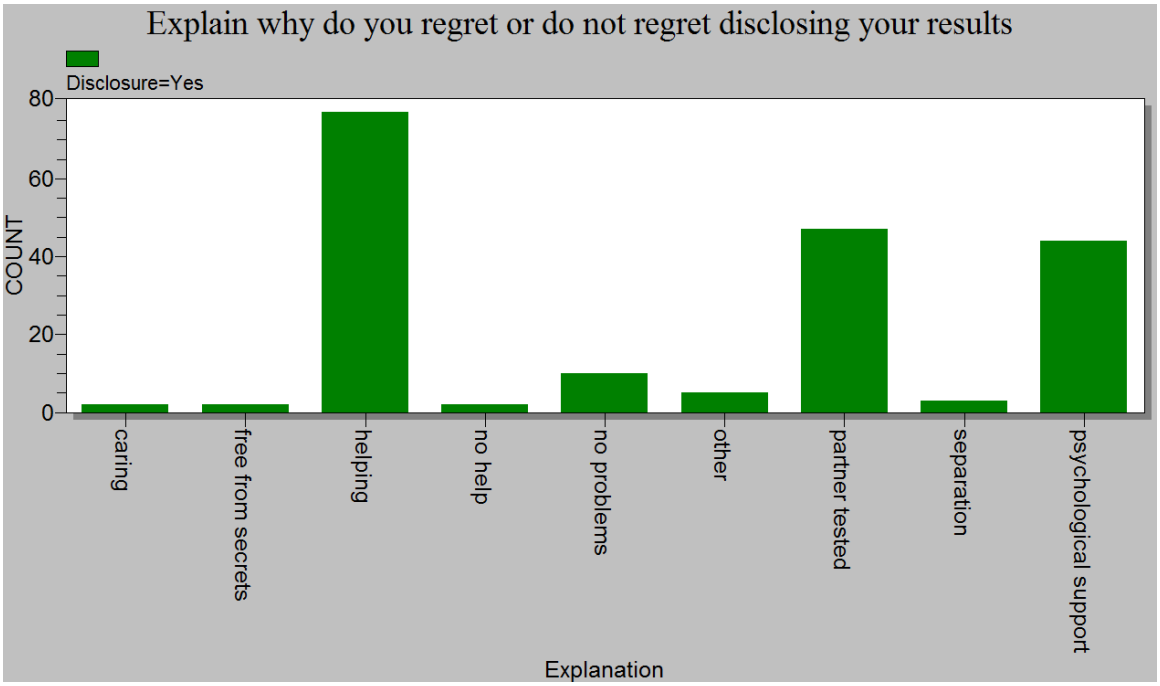
The question if you have disclosed your status to anyone, to whom have you disclosed was asked and the response was as follows see table 4.5. Seventy three percent of the respondents had disclosed their results, 60% had disclosed within one week of knowing their results, 11% within 3 months, 14% from 3-6 months, 12% from 6-12 months and 3% after 12 months. Those who had disclosed, had disclosed to the following people, 73% had disclosed to their partners whilst 23% had disclosed to more than one person, 15% had disclosed to brother, 21% had disclosed to sister, 8% had disclosed to mother, 4% had disclosed to friend, 4% had disclosed to children, 4% had disclosed to others and included uncle, employer, grandfather and pastor. See Table 4.5

Figure 4.2 How did people you disclosed to react to your results?



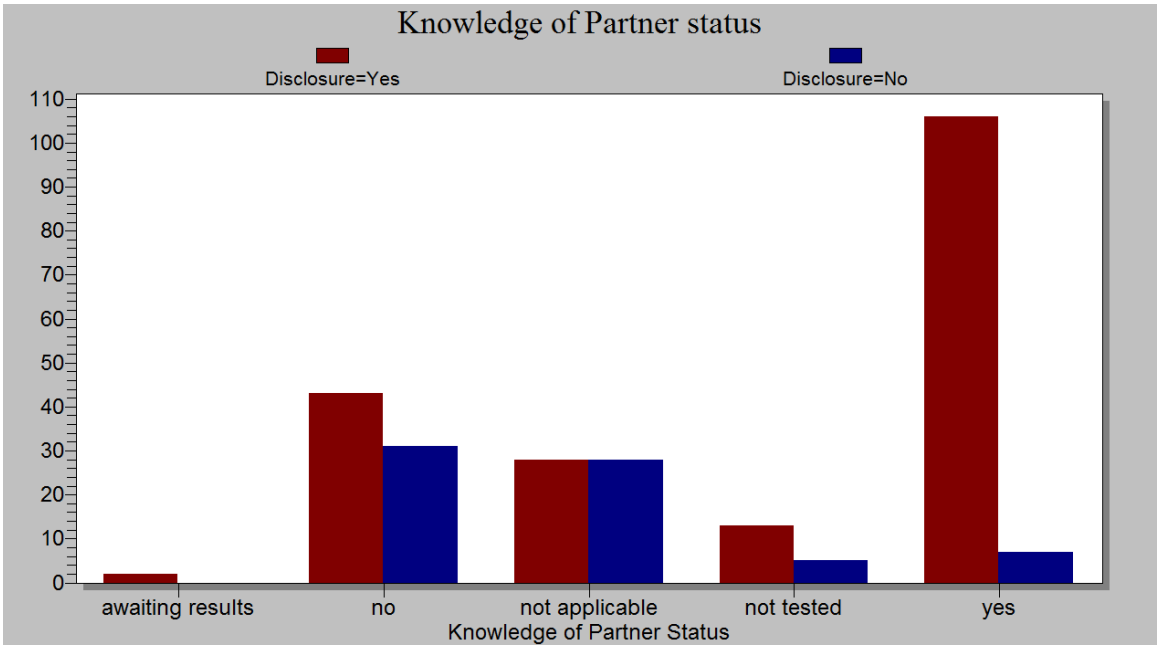
The question how did people you disclosed to react to your results was asked and the response was as follows see Figure 4.2. The reactions of people disclosed to were as follows; 43% were supportive, 29% understood, 9% accepted, 6 % were angry, 5% were quiet.

Figure 4.3 Explain why do you regret or do not regret disclosing your results.



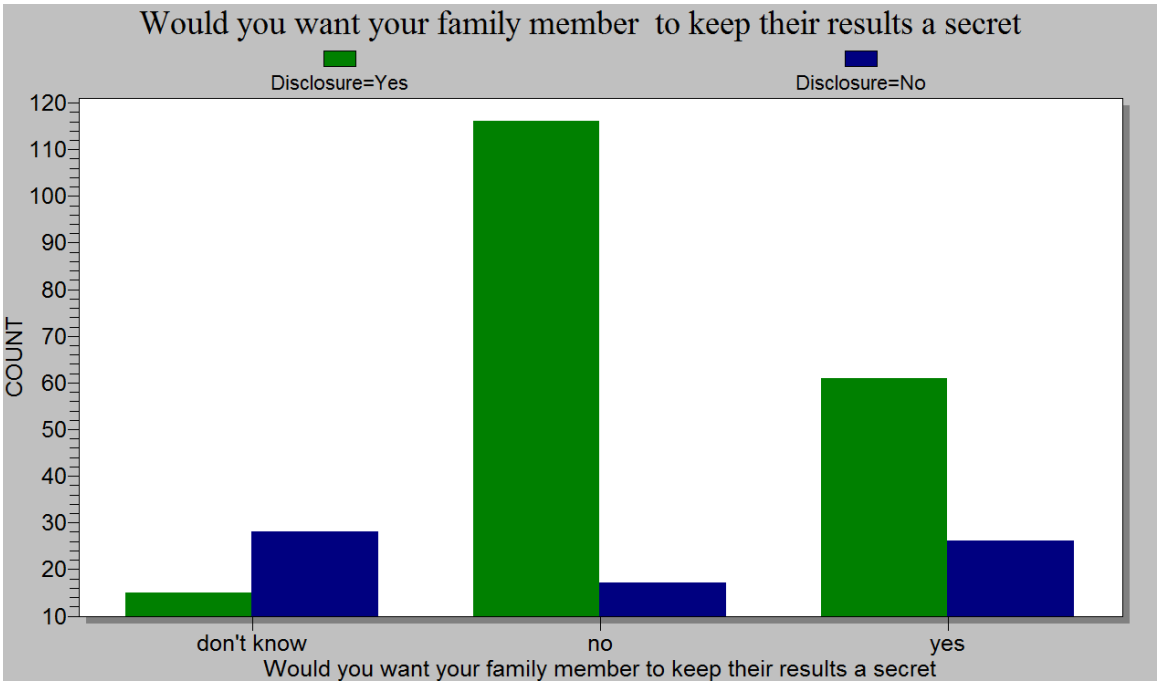
The question explain why do you regret or do not regret disclosing your results was asked and the response was as follows see Figure 4.3. Of those who had disclosed 96% did not regret disclosing their status. Those who were treated positively had the following responses from the people they disclosed to; 40% helping, 24% partner was tested, 23% were given psychological support, 5% no problems were encountered. Those who received negative treatment received it in the form of; 2% separation, 3% were others and included fighting, gossiping, fear mum will talk and no help.

Figure 4.4 Knowledge of Partners' Status and disclosure



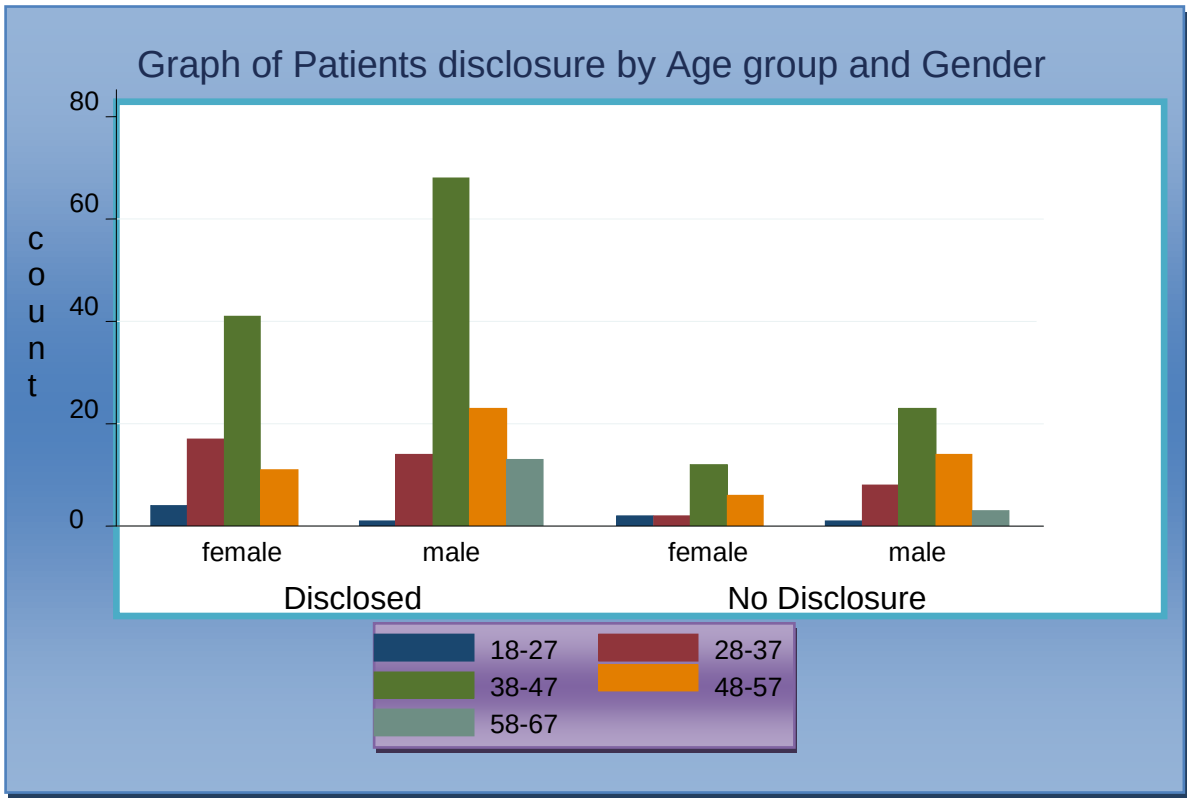
Forty three percent knew their partners status of these 94% had disclosed, 28% did not know their partner's status of these 58% had disclosed, 7% of the partner's were not yet tested of these 72% of the respondents had disclosed. See fig 4.4 for the distribution.

Figure 4.5 Would you want a member of your family to keep their results a secret?



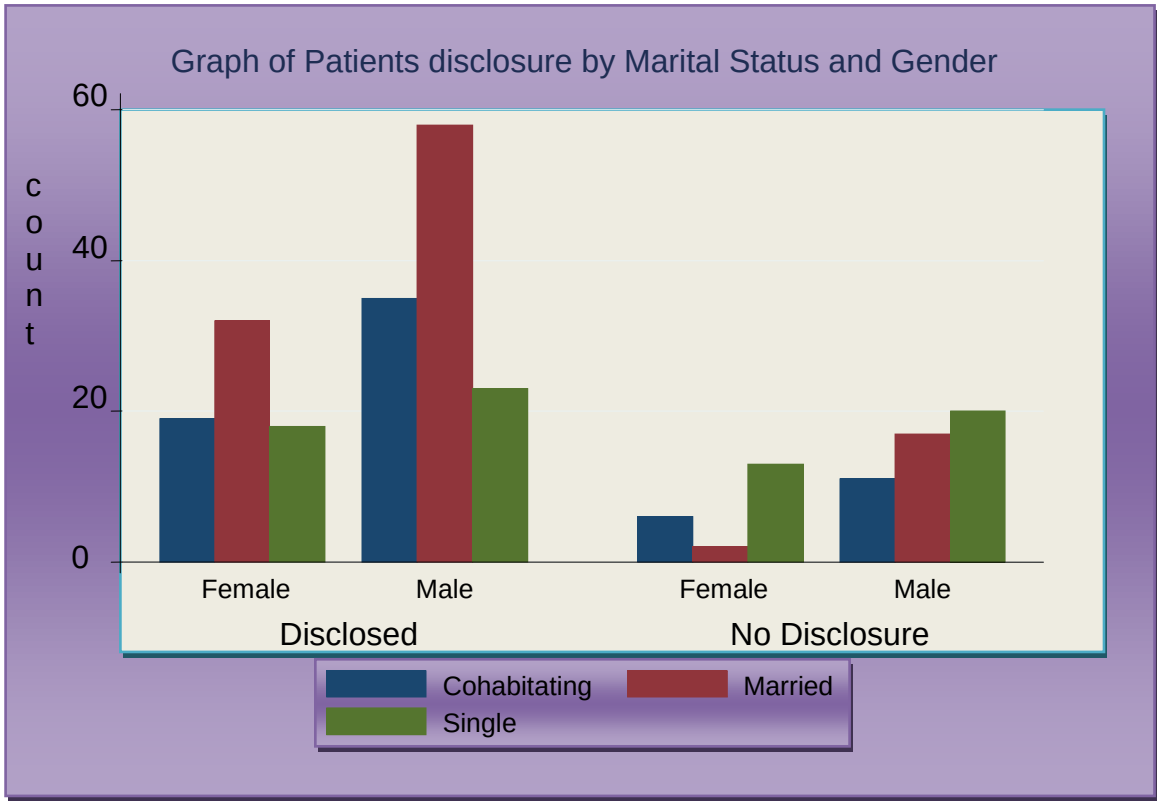
The question Would you want a member of your family to keep their results a secret was asked and the response was as follows see figure 4.5 Thirty three percent of the respondents said yes they would want a member of their family to keep their HIV results a secret of these 70% had disclosed, 51% of the respondents (the majority) said no, they would not want a member of their family to keep their results a secret, of these 87% had disclosed, 16 % said they don't know, of these 35% had disclosed.

Figure 4.6 Patients disclosure by Age group and Gender



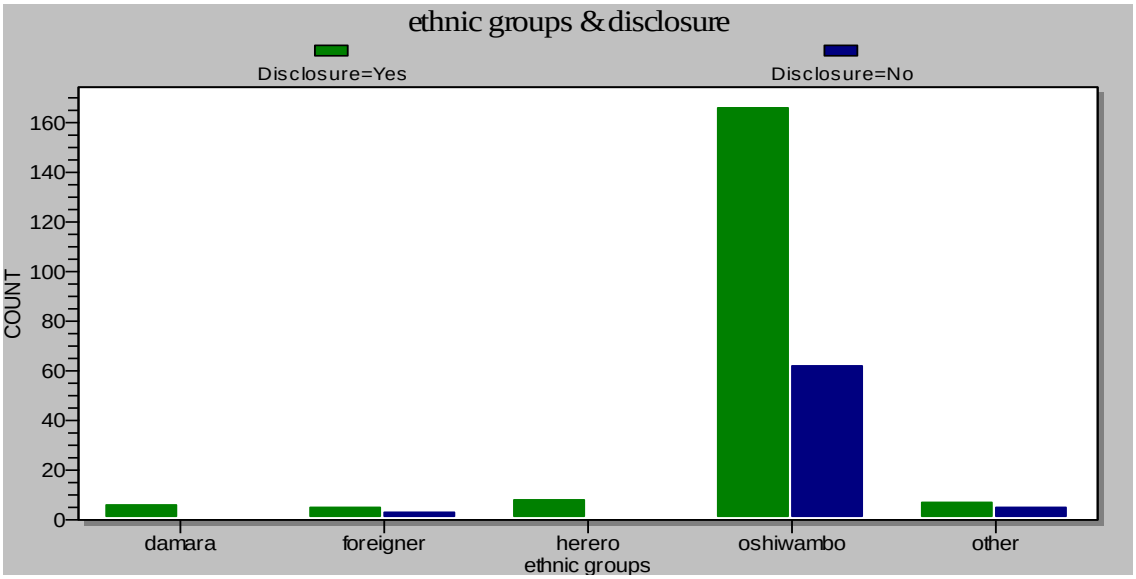
Sixty three percent of 18-27 year olds had disclosed whilst 37% had not, 76% of 28-37 year olds had disclosed whilst 24% had not, 76% of 38-47 year olds had disclosed whilst 24% had not, 63% of 48-57 year olds had disclosed whilst 37% had not, 81% of the 57-68 year olds had disclosed whilst 19% had not. See figure 4.6

Figure 4.7 Patients disclosure by Marital Status and Gender



Eighty three percent of the married had disclosed whilst 17% had not, 76% of those cohabitating had disclosed whilst 24% had not, 55% of singles had disclosed whilst 45% had not. Non disclosure was found to be higher among the singles and divorced than other groups, while disclosure was highest among the married and cohabitating. See figure 4.7

Figure 4.8 Ethnic groups and disclosure



Eighty six percent of the Damara had disclosed whilst 14% had not, 63% of the foreigners had disclosed whilst 37% had not, 100% of the Herero had disclosed whilst none had not, 73% of the Oshiwambo (the major group) had disclosed whilst 27% had not, 58% of the other had disclosed whilst 42% had not. See figure 4.8.

Table 4.6 Patients disclosure by Educational level and Gender

LEVEL OF EDUCATION	**DISCLOSURE =YES**		**DISCLOSURE = NO**		**TOTAL**
	Male	Female	Male	Female	
Grade 1-7	20% (52)	7% (19)	8%(22)	2%(6)	**37% (99)**
Grade 8-12	20% (52)	17% (46)	7%(18)	5%(14)	**49%(130)**
Higher	3% (7)	2.6% (7)	1%(2)	1%(2)	**7.6%(18)**
None	3% (8)	0.4% (1)	3%(7)	0%(0)	**6.4%(16)**
TOTAL	**46% (119)**	**27%(73)**	**19%(49)**	**8%(22)**	**100%(263)**

Seventy two percent of grade 1-7 had disclosed whilst 28% had not, 75% of the grade 8-

12 had disclosed whilst 25% had not, 78% of the higher education had disclosed whilst 22% had not, 56% of the no education had disclosed whilst 44% had not. See Table 4.9 for the distribution.

CHAPTER 5: DISCUSSION

Disclosure is a necessity in the management of HIV. With disclosure compliance increases, social support is high and witch-hunting is reduced as this is high in African nuclear families especially when a close family member is sick. Social support provided by family and friends has both practical and emotional components, helping to build new positive identities, accept their status and to buttress against insults from neighbours. Analysis has shown that positive living is closely associated with better health outcome.[60]

Seventy three percent of the respondents had disclosed. Stigma is probably phasing out and people are slowly opening up. Similar results were found in a study done in Tshwane South Africa where stigma was found to be significantly lower than that perceived to be present in the community.[61] Respondents were aware that without disclosure there was neither help nor support. Individuals will choose to share information if the rewards are greater than the costs of disclosing. More than half (60%) disclosed very early soon after testing, within one week. This was very surprising as in most of these families the husbands stay in town to work whilst the wives and children stay in the rural areas where they grow their own food and they meet during holidays. Agricultural workload is considered the responsibility of the women in Namibia.[62] This means most of these families were trying very hard to get these results to their families as early as possible.

In this study knowledge on disclosure was positive. When respondents were asked what they thought about disclosure the majority 68% had positive thoughts on disclosure. Respondents said it was good, important, helps and necessary. The majority were understanding disclosure. A minority 27% had negative thoughts. These were not good, not important, it causes problems, scary and stigma whilst 5% were not sure. Educating these few individuals about the importance of disclosure so that they understand should be encouraged. This can be done during counselling sessions.

Respondents did not disclose to everyone in the community but to trusted selected

individuals. Seventy three percent disclosed to their partners, 21% disclosed to their sisters and 23% had disclosed to more than one person. Other people they were disclosing to were mother, brother, children, uncle, grandfather, pastor, friends and employer. The majority of the respondents disclosed for a reason, almost 100% had a reason to disclose whilst 0.5% disclosed without a reason. The majority of the respondents disclosed because they wanted help. Other reasons for disclosure were partner to go for testing, they were angry, wanting their relatives to know, very sick, prevent secrets, sharing and love. Reasons for non disclosure were fear of people talking, no trust, did not want relatives to worry about them, fear of divorce and private issue. In a study done in Southwest Ethiopia, perceived positive outcome expectations were most frequently associated with disclosure, 95% had disclosed to at least one person and 91% had disclosed to their current partners and only 5% reported negative reactions.[63]

Similar findings were seen in a study in South Africa, patients' decision to disclose were based on expectations of support from family and friends, personal preparedness and trust whilst fear of being labelled restricted disclosure.[64] This was observed in China from illness narratives, fear of isolation and the urge to protect close family members hindered disclosure, "My psychological pressure is big in this aspect. I first considered what effects this will have on my offspring, my children. . . . " (Married female PLWHA, age 56), "People would try to avoid you as soon as they know. How could I tell them? Nobody would talk to you then, and nobody would visit your home, either . . . . They would probably say, "hmm, this girl is not good, otherwise how could she be infected?" They would not talk to you ". (Married female, age 57; mother of a single female PLWHA, age 30, Page 436).[65]

Those who had disclosed 81% received a positive reaction from the people they disclosed to. Forty three percent (43%) received a supportive reaction, 29% of the people they disclosed to understood, other reactions were acceptance, prayed, helped, sympathetic, worried, denial, afraid, angry and shocked. Asked whether the respondents regretted disclosure 96% had no regrets. All of them were supported by the people they disclosed to; 40% received help, 25% of the partners went for testing, 23% were given

psychological support and 1% received prayers. This is very important in families. The majority of the respondents were having a positive attitude towards disclosure.

Ignorance is fading and people are beginning to understand disclosure. Those who did not disclose said they were afraid of people talking and finger pointing. Those who disclosed, only a few 4% regretted disclosing as they had received negative treatment from the people they disclosed to, this was in the form of domestic violence, separation from relationships and gossiping. Fear of stigma was still high although stigma itself was very negligible. In a review article similar findings were recorded 54-94% feared abandonment, discrimination and violence but 4-15% reported experiencing violence.[66] In a project done in Katutura Namibia, women testing negative were found to have higher levels of disclosure of their results to their partners than those testing positive, the latter fearing reactions. Those who had disclosed did so to close family members and relatively soon after being told. When HIV positive women disclosed contrary to their fear of blame they reported receiving support from their families.[67]

Eighty three percent of the married and 76% of the cohabitating had disclosed to their partners or spouses. If one's partner discloses one is more likely to disclose. This is very important in relationships as it becomes easier to negotiate safer sex, discuss future pregnancies and compliance is good as there is no need to hide medication or fabricate a lie. In a study done in Cape town a close association between having not disclosed HIV status to sex partners and engaging in practices with high risk of HIV transmission was observed, people who had not disclosed reported more sex partners, more unprotected vaginal and anal intercourse.[68] 94% of those who knew their partner's status had disclosed. Knowledge of partner's status is more likely to result in the other partner disclosing. A few of the respondents were still keeping their results a secret although they knew their partners status. Identifying these few in clinics every time they come for follow up is important. Lack of awareness of partner's serostatus may result in transmission of HIV especially within serodiscodant couples as protective behaviours may not be adopted.[69]

Non disclosure was found to be higher among the singles and divorced than other groups,

whilst disclosure was highest among the married and cohabitating. In secure relationships people tend to disclose their deepest secrets as anticipation of a negative reaction is very low. When people are single or divorced the relationships are insecure and disclosing HIV positive results can be risky as the response can be unpredictable. In a study done in South West Ethiopia, Deribe found that individuals who were living in the same house with their partners were 9.2 times more likely to disclose their HIV positive results compared to those who did not live in the same house.[70]

When respondents were asked whether they would want their family members to keep their results a secret 60% of those who had disclosed said they would not want their family members to keep their results a secret. This is understandable, if one discloses one would expect the person one disclosed to, to do the same. Surprisingly, 32% of those who had disclosed said they would want their family members to keep their results a secret. Some people believe in respecting other people's wishes. 24% of those who did not disclose said they would not want their family members to keep their results a secret. If one is not willing to disclose then one should not expect other people to disclose to them. Without disclosure there is no support from the family or community.

There was not much difference in disclosure among all age groups. Non disclosure ranged from 24% to 37% among all age groups. The 18-27 age groups were few 3%, either this young age group was not coming for testing or they were going somewhere else or they were taking precautions so as not to contract the disease. This is a critical age group, relationships are starting, families are starting, babies are being born and it is critical that this age group is tested. Probably they were going where free testing and treatment was given. HIV testing uptake among young age groups was found to be low in a study done in Nairobi, Kenya. 19% of males and 35% of the females had been tested, of these, 7% of males and 32% of females, the test was mandatory. Half of those who had ever had sex but never tested reported that they had not been tested because they were not at risk.[71] Educating young people thereby increasing awareness and importance of HIV status will help prevent the spread of HIV.

The majority of the respondents 87% were from the Oshiwambo ethnic group. This was

probably due to the fact that more Oshiwambos were living in the area surrounding the clinic and the clinic was easily accessible. 70% of the clinic staff were Oshiwambos and the owner of the clinic was also Oshiwambo. These staff members were probably encouraging their relatives to come to the clinic for treatment.

Counselling should be an ongoing process and should be available to everyone whether HIV positive or not. Disclosure should be encouraged as a chronically ill person without physical, financial and emotional support from friends, relatives and community will find it difficult to manage on their own. Internal stigma, shame or fear of discrimination can lead to infected people living an isolated lifestyle, the social circle becoming smaller, avoidance of HIV related topics, feeling uneasy when HIV related issues are being discussed and mothers may be forced to breastfeed exposing their babies to HIV infection as alternative methods of feeding may raise eyebrows in the family or community.

In resource limited settings like Namibia, free drama documentaries for example the South African movie Yesterday can be shown in the waiting rooms in clinics. Advertising the times is important so that those who are free can see it. Dramas with an African set up can have an impact in countries like Namibia. Formation of support groups, for example, HIV positive anonymous groups where HIV positive people meet, share their experiences, support each other and develop friendships, should be initiated in clinics as a form of counselling.

The results should be interpreted with caution as the study was done in a private clinic where patients on either medical insurance or those who could afford were seen, which was a limitation. To properly represent all groups i.e. the rich, the poor, low and high density suburbs, cluster random sampling is a better method where clinics in Windhoek are the clusters and then random selection of respondents from the chosen clinics is done. The study also relied on self reporting. It is known that self reporting is subject to reporting bias. Another problem in retrospective studies is recall bias, respondents may have problems remembering, especially after a long time.

CHAPTER 6: CONCLUSION

Disclosure plays an important role in the management and prevention of the spread of HIV. In this study knowledge of disclosure was encouraging; most thought disclosure was important and good. Patients seen at Betesda clinic in Namibia are disclosing although fear of stigma is still high. They are disclosing to certain specific, trusted people in the community and not to everyone. In a study done in Johannesburg South Africa disclosure levels were high 92% had disclosed but there was a high level of delay, 15% disclosed after one year and 21% had not disclosed to partners.[72] Stigmatization is still present although fading with time.

The community's attitudes towards HIV are changing, when a church in Zimbabwe instructed its HIV positive members to stop their medication, the community did not take it lightly when one member died. Church members could not even attend her burial for fear of being beaten up as the community was accusing the church of causing her death.[73]

People's attitudes and practices toward disclosure are encouraging, upon disclosure the majority are benefitting. They are getting help, psychological support and partners are being tested. A minority who failed to disclose were afraid of the unknown. Making a decision to disclose is not easy, most HIV positive people have to juggle between the advantages of disclosing to a limited circle or disclosing to the whole community which can be risky. In certain situations it is easier to opt for silence but silence can have its disadvantages.

CHAPTER 7: RECOMMENDATIONS

Counselling should be offered by the doctors, nurses or counsellors (whoever is reviewing them) as an ongoing process in clinics every time HIV positive patients come for review or follow up. This should be offered every time patients come for their reviews and at Betesda this is done every six months. All patients are seen by the doctor and during the consultation counselling is offered for at least 10 minutes if major problems are identified an appointment with the counsellor is made and this can take 30 minutes to 2 hours depending on the nature of the problem. Depending on the problem family conferences can be organized by the counsellor. At Betesda there is a permanent HIV counsellor available from eight o'clock to five o'clock weekdays and half day on Saturdays. In terms of costs, the initial consultation can be covered by the consultation fee, the second is covered by medical insurances and cash patients can be charged a minimal fee. This can be discussed with the management. If the staff members are committed this can be done within the normal working hours. A trial can be done for two weeks to see if this is feasible.

Posters and pamphlets should be available in clinics promoting disclosure, discouraging stigma and highlighting the effects of stigmatization. Clinics can make their own, collect from seminars or ministry of health (in Namibia there are always a lot of free posters there). Members of staff can design posters, discuss with management on materials needed approximate cost is R100. The back of old calendars can be used to cut costs. If posters are to be collected from the ministry of health one has to phone to enquire if the required posters are available and a member of staff can be sent to collect. Costs R10 for transport and posters are free.

HIV anonymous groups' formation can be initiated in clinics. Introduction of the topic can be done by anyone interested. Interested members of staff will meet to discuss the aims and objectives. The venue initially can be any clinic, upon discussion with the management and meetings can be held at an agreed time. Invitation letters and handmade

posters can be delivered to other General Practitioners and HIV clinics in Windhoek. Cost of printing will be approximately R50. Depending on the popularity of the anonymous group a committee can be developed to discuss aims, objectives, fund raising projects and any other issues.

Appendix 1 - Participant Information leaflet

Box 7794

Katutura

Namibia

Knowledge, attitudes and practices of HIV positive patients regarding disclosure of HIV results at Betesda clinic in Namibia. *Omaunhongo, omashiivo no maluumbato kombinga yokushiivifa omanyamukulo enaombuto yomukifi woHIV mokaklinika kaBetesda mo Namibia.*

Dear Patient *Ovanaudu ovaholike*

I am a family Medicine student at the University of Witwatersrand. *Ame omunafikola-ndokotola ko University yaWitwatersrand.* I am conducting a survey on knowledge, attitudes and practices regarding disclosure of HIV results. The research is for the degree purposes only. *Ondina oPolojeka yokupulaapula omunhongo, omashiivo, nomaluumbato kombinga yokushiivifa omanyamukulo ena ombuto yoHIV. Hano opolojeka eyi oyinasha ashike nofikola oyo yatumbulwa pombada*. The information gathered will help us to prepare educational programmes on disclosure of sensitive results. *Opolojeka eyi oyinasha nomapendulepo okuvatela ovanhu monakwiiwa mokushiivifa omanyamukulo avo ena ombuto*. I would like you to answer the questions on the questionnaire. *Ohandi ndiinidile nefimaneko munyamukule omapulo nomanyamukulo ngashi taalandula apa*. If you do not want to enter the study your care at this clinic will not be affected in any way, it will remain the same. *Didilika: ngeenge itashi dulika ukufe ombinga komapulo opolojeka eyi epangoloye mokaklinika kaBetesta otalitwikile*.

The questionnaire is completely anonymous and confidential. Your name will not appear on the form. If you are willing to answer the questions, please do so now. No questionnaire will be taken out of the clinic and be returned later. I would like you to answer the questions as carefully and completely as possible. If you do not wish to answer some of the questions feel free not to do so. *Opolojeka eyi oyafimaneka uunhu womunhu, omauyelele aeshe aatokayandja eeli meameno nokapuna omunhu umwe tashiivifilwa eshi wanyamukula. Ompapila yomapulo otayi yadekelwa mokaklinika itayi twaalelwa keumbo. Inashipumbiwa ushange edina loye pofoloma. Ngeenge opena*

omapulo amwe otodulu okwaanyamukula twikila ashike nepulo eli todulu okunyamukula. The results of the study will be sent to the University of the Witwatersrand because I am a student there and this study is for the degree purposes. The results will also be forwarded to Betesda medical clinic for anyone who is interested to read. This study was approved by the Ethics committee University of the Witwatersrand, for contact details see below. If you require any further information be free to contact me on the numbers given below. *Iizemo yepekapeko otayi katumwa koUniversity ya Witwatersrand, oshoka oko ndi li omwiilongi hoka, noya nuninwa okugwanithitha okantu yopo mbanda meilongo lyandje. Iizemopekapeko wo mbika otayi ka tumwa kokapangelo kuunamiti ko Betesda opo yi leshwe kukehe ngoka e na ohokwe. Iizemopekapeko oyo tuu mbika oya ziminwa nokukolekwa kokomitiye yokukaleka po omikalo noimaihumbato gonawa moUnivesity ya Witwatersrand. Tala uuyelele wiihwa po pevi. Uuna wa pumbwa uuyelele wi ihwapo, owa manguluka okukwatafana nangame konomola dhongodhi dha gandjwa pevilela.*

If you are willing to enter the study please do so now. If you feel you don't want to answer some of the questions you are free not to answer. If you want to contact the ethics committee you are free to do so. The contact information is provided below. *Uuna wa hala okukutha ombinga nomapekapeko ngaka, shininga ngashingeyi. Ngele owu uvite kutya ino hala okuyamukula omapulo gamwe, manguluka waa ga yamukule. Ngele owahala okuninga ekwatathano nokomitiyekalekepo yomaihumbatonawa moUniversity yaWitwatersrand, owamanguluka okushininga. Uuyelele womakwatathano owa gandjwa pevi*

Thank you for your time and assistance. *Tangi unene kefimbo nokevatelo.*

*(Oye)*Dr Penelope Tom

Family Medicine Student at the University of the Witwatersrand

Contact details: Telephone +264 812362437

Email penelopetom2000@yahoo.com

Ethics committee University of the Witwatersrand- Wits research office 10th floor Senate House East Campus Telephone +27 117171234

Appendix 2 Consent form

I *[Ame]* _____

Agree / do not agree (circle the appropriate /*tenda okakelenga kengamukulo elili mondjila)* to participate in the disclosure research study being undertaken by Dr P Tom at Betesda clinic. *[ndaitavela/ina ndiitavela (tenda enyamukulo eli lili mondjila) ndikufe ambinga mokukongaouyele pamukalo woku eta pouyelele eyi tayi wilikwa komu ndokotola P Tom woko Betesda clinic.]*

Signature _____ Date_____

Appendix 3 Questionnaire */omapulo*

Knowledge attitudes and practices of HIV positive patients regarding disclosure of HIV results. *Omaunhongo nomali umabato kovanhu vamonika ombuto yoHIV kombinga yokuyelifa omaukwatya avo*

Please note*: Please be aware that anybody who sees this form will know that you are HIV positive. I would appreciate it if you do not take this form outside this room. Thank you.*

Section A: Demographic information/ *ouyelele wopashikandjo*

Question number	Question / *epulo*	Response / *enyamukulo*
1	Sex / *okakwashike ko kanhu*	A. Female /*omukulo* B. Male */ omusamane*
2	Age in years / *owuna eedulangapi?*	1. 18-27 2. 28-37 3. 38-47 4. 58-67 5. 68+
3	Marital status / *Owa hombolwa*	A. Married / *Eeno onda hombola* B. Single / *omwiikaleli* C. Divorced */ onda hengana* D. Widow *Omufiyekadi* /widower *omusamane afilwa* E. Co-habitating /*oho kalapamwenomulumenhu,nomukainhu woye meumbo* F. Other specify /*kumwe kwiili*
4	What is your ethnic group / *Omuhoko woye owumukwashike?*	A. Oshiwambo B. Damara C. Herero D. Foreigner*/ omuzayizayi*

		E. Other specify / *shimwevali*
5	What is your highest level of education / *Owa hulila mongapi kofikola?*	A. No education *Inandi fikola* B. Grade 1(sub A) to grade 7 (std5) *Ondondo yotete fiyo onhivali* C. Grade 8 (std6) to grade 12(std9) *Ondondo itihetatu fiyo omatilika* D. Higher / *elongo lopombanda*

Section B Measures of disclosure

Question Number	question */ epulo*	Response *enyamukulo*
1	When did you know about your HIV status/ *omanyamukulo oye okutya owamonika omukifi owaamona naini?*	
2	What do you think about disclosing HIV results */ Oto shitile ngahelipi komukalo wokuhololа omanyamukulo?*	Ask as an open ended question, record answer given. *pula onge epulalo lya yeuluka*
3	Have you disclosed your status to anyone */ owalombwelele omunhu nale omanyamukulo oye?*	A. Yes/ *eeheno* B. No/ *ahawe*
4	If yes to above to whom have you disclosed */ ngeenge owalomwelele omunhu olye walombwela?* *Note; more than one option can*	A. Partner *mouholike woye* B. Brother *mumwanyoko omumati* C. Sister *mumwanyoko omukadona* D. Mother/*meme woye* E. Father/ *tate woye*

	be selected	F. Child/children / *ounona voye* G. Friend */ kahewa koye* H. Other specify / *umwe elili*
5	When did you disclose after knowing your HIV / *statuskonima eshiwaa mona owaaholola kovanhu naini?*	Answer if applicable/ *inashipumbiwa*
6	What are your reasons for disclosing / *netomelo loye olashike una okuholola oanyamukulo oye?*	Ask as an open ended question, record answer given. *pula onge epulalo lya yeuluka. (answer if applicable)*
7	What are your reasons for not disclosing / *netomelo loye mbela ola shike opo ukale ino holola omanyamukulo oye?*	Ask as an open ended question, record answer given. *pula onge epulalo lya yeuluka. (answer if applicable)*
8	Do you regret disclosing / *Owelipa mbela ombedi eshiwa holola oukwatya woye?*	A. Yes */ eeheno* B. No*/ ahawe* C. Not sure/ *kandishishi nana* D. *Not applicable*
9	Explain your answer to question 8 / *fatulula enyamukulo kepulo etitatu answer if applicable*	Ask as an open ended question, record answer given. *pula onge epulalo lya yeuluka*

10	How did people you disclosed to react to your results? *konima eshi wahola omanyamukulo oye omaluumbato ovanhu ava walombwela okwali eli ngahelipi? (answer if applicable)*	Ask as an open ended question, record answer given. *pula onge pulo lyayeuluka enyamukulo nali shangwe*
11	Do you know your partner's HIV status/ *ouna ouyelele wamukweni kombinga omukiti ou woHIV?*	A. Yes*/ eheno* B. No /*ahawe* C. not tested*/ina kufwa ohonde* D. awaiting results*/okwateelela omanyamukulo aye* E. not applicable*/inashipumbiwa* (circle the appropriate/*tenda okakelenga kengamukulo elili mondjila)*
12	Would you want a member of your family to keep their results a secret. *Owa hala aakwanezimo lyoye yakaleke iizemo yomakonakono go HIV ngoshiholekwa*	1. Yes/*Eeno* *2.* No/*Aawe* 3. don't know*/ Kandishiwo*

Thank you for taking your time to answer these questions

Appendix 4 Authorization letter

Box 7794

Windhoek

Namibia

30 November 2008

Betesda Clinic
Box 98038
Pelican Square
Windhoek
Namibia

Dear Madam

RE: Permission letter to conduct a survey: **Knowledge attitudes and practices of HIV positive patients regarding disclosure of HIV results**

I would like to carry out a study on Knowledge attitudes and practices of HIV positive patients regarding disclosure of HIV results at your clinic. The study is in partial fulfillment of my Degree Programme: - Masters in Family Medicine at the University of Witwatersrand.

I would interview patients . Information gathered will be available to the University of the Witwatersrand Staff, Betesda Staff, patients and any other interested parties. Recommendations will be submitted to the Betesda clinic management.

Thank you in advance

Dr Penelope Tom

(Permission granted)/ not granted (circle the appropriate)

Josephine Kalenga

Betesda clinic Managing Director

BETESDA MEDICAL CENTRE
REG. cc/2002/1389
C/O ABRAHAM MASEGO & INDEPENDENCE AVENUE
P.O. BOX 98038
PELICAN SQUARE
TEL: (061) 278900
FAX: (061) 278903

Appendix 5 Ethics approval letter

UNIVERSITY OF THE WITWATERSRAND, JOHANNESBURG
Division of the Deputy Registrar (Research)

HUMAN RESEARCH ETHICS COMMITTEE (MEDICAL)
R14/49 Dr Penelope Tom

CLEARANCE CERTIFICATE	**M091107**
PROJECT	Knowledge Attitudes and Practices of HIV Positive Patients Regarding Disclosure of HIV results at Betseda Clinic Namibia
INVESTIGATORS	Dr Penelope Tom.
DEPARTMENT	Department of Family Medicine
DATE CONSIDERED	2009/11/27
DECISION OF THE COMMITTEE*	Approved unconditionally

Unless otherwise specified this ethical clearance is valid for 5 years and may be renewed upon application.

DATE 22/01/2010 **CHAIRPERSON** .....
(Professor PE Cleaton-Jones)

*Guidelines for written 'informed consent' attached where applicable
cc: Supervisor : Dr J Musonda

DECLARATION OF INVESTIGATOR(S)

To be completed in duplicate and **ONE COPY** returned to the Secretary at Room 10004, 10th Floor, Senate House, University.
I/We fully understand the conditions under which I am/we are authorized to carry out the abovementioned research and I/we guarantee to ensure compliance with these conditions. Should any departure to be contemplated from the research procedure as approved I/we undertake to resubmit the protocol to the Committee. **I agree to a completion of a yearly progress report.**

PLEASE QUOTE THE PROTOCOL NUMBER IN ALL ENQUIRIES...

REFERENCE

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