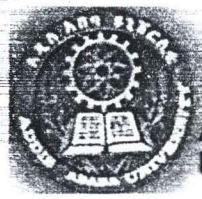
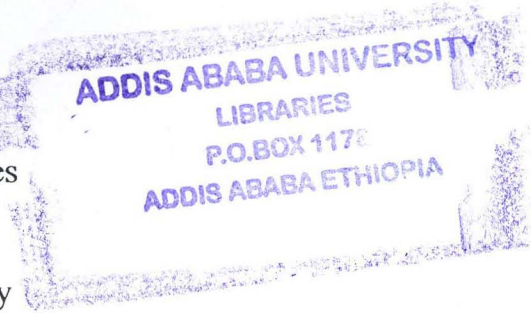


SELF-DISCLOSURE PROBLEMS AMONG SEXUAL PARTNERS LIVING WITH HIV/AIDS: THE CASE OF HOSPITAL CLIENTS IN ADDIS ABABA

by

Abdu Ebrahim Mohammed

A Thesis Submitted to the school of Graduate Studies
of Addis Ababa University in Partial Fulfillment
of the Requirements for the Degree of
Master of Arts in
Counseling Psychology



Addis Ababa University
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(Guidance and Counseling Stream)

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Approval of the Board of Examiners

Chairperson, Department of Graduate Committee	Signature
Advisor	Signature
Examiner	Signature

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List of Acronyms

AIDS	Acquired Immune-Deficiency Syndrome
APA	American Psychologists Association
ARC	AIDS Resource Center
ART	Anti-Retroviral Treatment
BOLSA	Bureau of Labor and Social Affairs
CSA	Central Statistic Authority
FDRE	Federal Democratic Republic of Ethiopia
FHAPCO	Federal HIV/AIDS Prevention and Control Office
FMOH	Federal Ministry of Health
GBV	Gender Based Violence
HCT	HIV Counseling and Testing
HIV	Human Immunodeficiency Virus
HIV/AIDS	Human Immunodeficiency Virus/ Acquired Immune-Deficiency Syndrome
ILO	International Labor Organization
MDGs	Millennium Development Goals
MOE	Ministry of Education
MOFED	Ministry of Finance and Economic Development
MOJ	Ministry of Justice
MOLSA	Ministry of Labor and Social Affairs
MTCT	Mother to Child Transmission
OVC	Orphan and Vulnerable Children
PITC	Providers Initiated Testing and Counseling
PLWHA	Persons Living With HIV/AIDS
SAT	Southern African AIDS Trust
SDD	Stigma, Discrimination and Denial
UN	United Nations
UNAIDS	United Nations Program on HIV/AIDS
UNICEF	United Nations Children's Fund
VCT	Voluntary Counseling and Testing
WHO	World Health Organization

Abstract

This study examines self-disclosure problems among sexual partners living with HIV/AIDS who are hospital clients in City Government of Addis Ababa. In this study the experiences of HIV positive status, the nature of self disclosure, the reasons for self disclosure and non self disclosure, the benefits and probable risks of self-disclosure, types and levels of sero-positive status self-disclosure related discussions and their association with the clients' socio-demographic variables were studied.

The study applied quantitative research designs. Little qualitative methods were also injected to supplement the data. A Self-Report Questionnaire was prepared and administered for 300 participants who were clients of Black Lion and Zewditu Memorial Hospitals, proportionally, for the quantitative interpretation of the data. The qualitative data was also collected through Interview guides, natural observations, visits and document analyses. The data were analyzed through the application of both descriptive (percentage, mean, and standard deviation) and inferential (Chi-square ($\chi 2$)) statistics.

The researcher found that from all the participants more than half of them had known their sero-positive status between 1 to 5 years period, 64.3 percent were started using ART while 27.3 percent did not start ART for different reasons (56.1 percent did not recommended by doctors and the rest 43.9 percent of them need some more counseling, time for decision and access to enough and nutritious foods), 72.7 percent knew their HIV positive status through medical related testing, 64 percent of the total participants (N=192) were self-disclosed their sero-positive status to their sexual partner(s) (43.75 percent of them disclosed the same day since diagnosed, for example) while 36 percent of them (N=108) did not yet to do so. Among the participants who disclosed their sero positive status the opportunity to utilize the benefits and refrains from the risks of self disclosure were found to be plentiful. Moreover, only a quarter of participants revealed higher level of sero-positive status self disclosure related discussions with their sexual partners, while about half of them have lesser level of discussion and the rest 24.7 percent of them have no discussion on the issue. In general, all the participants were found to be less frequently discussant of their sero-positive status to their sexual partner(s). In line with these, marital status has significant group difference in the levels of self disclosure related discussions, while ethnicity has significant group difference in the types of self disclosure related discussions. Whereas, average monthly family income, self disclosure and time period for self disclosure have shown significant group differences both in the types and levels of self disclosure related discussions. On average, about 70 percent and 60 percent of the participants agreed on reasons for self-disclosure and self-non disclosure, respectively. Thus, the reasons for self-disclosure and self-non disclosure used in this specific study could serve as reasons both in items or group levels that can be used in studying similar researches.

Thus, facilitating self disclosure related discussions among sexual partners living with HIV/AIDS shall have resonance effect and was the prior recommendation. It should be promoted and scaled up through professional post test counseling services, proper information dissemination programs and awareness and advocacy programs through media. This will ease self disclosure for the better prevention of the spread of HIV infection among sexual partners living with HIV/AIDS.

1. INTRODUCTION

1.1 Background of the Study

HIV/AIDS is a young disease that comes to our attention only in the early 1980's but found to be among the highly shredded ones. This epidemic is rapidly spread to the extent that everybody in most parts of the world could sense it easily. Thus, it became highly possible to observe the scourge of HIV/AIDS in every small district as it has had a devastating effect on individuals, families and communities everywhere the disease has spread.

HIV/AIDS has passed through three different epidemics: the epidemics of HIV, AIDS, and Stigma, Discrimination, and Denial (SDD). The epidemic of SDD is a continuing challenge in the current world (Piot, 2000) and is central for global AIDS challenge as the disease itself (Mann, 1987).

HIV kills so many adults in the prime of their working and parenting lives. It destroys to workforce; breaks and impoverishes families; orphans millions of children, and shreds the framework of communities. However, it is common for people who subject themselves to high-risk situations or behaviors to deny that they are at risk of HIV infection. They often avoid testing, and if they are tested, they avoid following up on results, as if avoiding a clinical diagnosis might prevent the disease (FHAPCO & FMOH, 2004).

According to WHO (2004) report when people know their HIV positive status they often avoid disclosing their sero-positive status and discussing the issue with professionals and family members, including their sexual partner(s). Non- disclosure of one's sero-positive status because of the associated SDD and probable risks of self-disclosure by itself restrict people from the tremendous benefits of sero-positive status self disclosure to one's sexual partner(s).

HIV/AIDS seemed to be sex selective. The increase in the proportion of women being affected by the epidemic is still continues. It was estimated that about 6 out of 10 new infections are in women. 5000 women are infected with HIV daily and 90% of them were found to be in developing countries. For example, in Sub-Saharan Africa, there are 13 women for every 10

infected men (UNAIDS, 2006). Similarly, the problem of HIV/AIDS seemed to be higher among females than males in Ethiopia. Consequently, younger females who are living with HIV/AIDS outnumber males, while more males are observed in older age groups that are above 30 years (UNAIDS, 2006; FMOH, 2006; ARC, 2006).

HIV/AIDS became more than a health problem and turn out to be a psychological, social and economic problem of every country although the situation is most worrying in developing countries like Ethiopia. The psychosocial, medical/health and economic impact would be greatest in these countries where they already have severe problems. Moreover, the problem of SDD became central in global and national AIDS challenges. It affects the prevention of the epidemic and the current issues of care and support as the disease has no cure to date.

In the fight against the scourge of this deadly disease lots of efforts have been made both in national and international scenarios. It has got much more emphasis to the extent that it became part of the eight Global Millennium Development Goals (MDGs) and the national millennium agenda of Ethiopia. But, the results could not stop the prevalence of HIV infections and are not as such satisfactory. Thus, such efforts should include and facilitate self-disclosure of ones' sero-positive status through informed and voluntary consent, especially for counter sexual partner(s). Such positive acceptance of one's HIV positive status increases the utilization of Voluntary Counseling and Testing (VCT) services among the counter sexual partner(s) that can save millions of lives from HIV infections.

According to literatures self-disclosure is one of the eligibility criteria for receiving antiretroviral drugs (ART) and any other further treatments. In this sense, a person who is living with HIV/AIDS (PLWHA) must inform at least to his/her sexual partner(s) or anyone in his/her family that he/she is HIV positive. This is so because people who disclose their sero-positive status are more likely to be successful in terms of adherence and having a reliable support system (FHAPCO & FMOH, 2007; FHAPCO, 2007).

To this end partner-notification programs might help PLWHA who want to tell their partners but do not feel comfortable doing so. Some of them might decide to not tell people with whom they live (including their sexual-partner/s) because they fear losing their home and family support. In

most cases the reaction of a partner or other family members could be violent. At times, it may also be possible to give alternative explanations for changed behavior (FHAPCO & FMOH, 2007; WHO, 2004; Olley & Stein, 2004; Hubley, 2002; UNAIDS, 2001; Hertz, 1992; and Ross et al., undated).

However, it should be noted that self-disclosure of ones' sero-positive status, especially to ones' sexual partner is not a one shot agenda. It is a process that needs professional support, the acceptance and willingness of the person in problem, and preparation to properly manage the risks and utilize opportunities of this life threatening issue. In doing so, research activities in the area of self-disclosure will have tremendous benefits in understanding the nature, the extent and prevalence rates of the problem at hand; the gender-wise differentiation of the problem; the risks and negative effects faced by different clients in previous time that discourages current and future clients to do so; and the benefits of opening up on the issue of ones' sero-positive status disclosure to sexual partners that facilitates the process of self-disclosure among clients. This could save millions of lives, stop or reduce the prevalence of the deadly disease, encourage taking voluntary counseling and testing in part of the other sexual partner, and taking antiretroviral drugs and other proper measures to live positively with the virus.

Accordingly, this study tried to investigate and discuss Self-Disclosure problems among Sexual Partners living with HIV/AIDS who are clients of two different hospitals (namely Black Lion and Zewuditu Memorial Hospitals) in the City Government of Addis Ababa.

1.2 Objectives of the Study

The general objective of this study is to investigate and discuss Self-Disclosure Problems among Sexual Partners Living with HIV/AIDS who are clients of two different hospitals (namely Black Lion Hospital and Zewditu Memorial Hospital) in the City Administration of Addis Ababa. The specific objectives of this study are:

1. To describe the nature of sero-positive status self-disclosure problem among Sexual Partners living with HIV/AIDS;
2. To investigate the benefits of sero-positive status self-disclosure as experienced by Sexual Partners living with HIV/AIDS;
3. To explore the risks of sero-positive status self-disclosure as experienced by Sexual Partners living with HIV/AIDS;
4. To analyze the characteristics of sero-positive status self-disclosure related discussions among Sexual Partners living with HIV/AIDS;
5. To evaluate the different variables that affect sero-positive status self-disclosure related discussions among Sexual Partners living with HIV/AIDS; and
6. To appraise the reasons for Sero-positive status Self-disclosure and Self-Non Disclosure among Sexual Partners living with HIV/AIDS.
7. To illustrate the possible recommendations that logically be made to improve self-disclosure problems among Sexual Partners living with HIV/AIDS.

1.3 Statements of the Problem

In the fight against HIV/AIDS much more efforts have been made. The traditional efforts that exerted to reduce the spread of HIV have focused on people who are at risk for becoming infected owing to their drug use or sexual behavior (gay men and commercial sex workers, for example). Through this basic understanding people can be labeled as people who are at risk situation vs. people who are not at risk situation; only by observing their social environment, analyzing their economic conditions and/or studying their behavior. Though, through community outreach messages about prevention and access to health care services, the goal has been to empower people to protect themselves from contracting the virus. Unfortunately, in the fight against HIV/AIDS through the traditional approach, HIV/AIDS was considered as a punishment, crime, war, horror and/or otherness. This, in turn, breads the epidemic of SDD that exhibits clear impact on individuals' sero-positive status self-disclosure.

The contemporary approach to the prevention of the spread of HIV focuses directly on the potential sources of infection. Because, HIV is spread by people who are infected, so it makes sense to consider how the epidemic can be understood and fought from that angle. Indeed, changing the behavior of one infected person may help prevent many of that person's sexual partners from becoming infected. However, it should be noted that this is a sensitive question that could be perceived as blaming the victims or discriminating against or stigmatizing a group of people. Fortunately, a body of empirical studies has emerged in recent years that address this topic in an unbiased and straightforward manner. Thus, the HIV epidemic can and should be addressed with a concerted effort at prevention directed toward those who are infected.

In line with this, our country's five years strategic plan that aimed at intensifying multi-sectoral HIV/AIDS response in 2004 – 2008 (HAPCO & FMOH, 2004) has focused on the active involvement of PLWHA from which much more positive outcomes would expect. The strategic document articulated that PLWHA have to be given a central place in the prevention of the scourge of HIV/AIDS.

It is also encouraging that after becoming aware that they are infected, many people substantially reduce their risky sexual behavior and drug use. This outcome underscores the importance of HIV testing so that people can learn their status. Equally important, those in whom HIV has been diagnosed must be successfully linked to medical care and supportive services. In addition, since living with HIV is challenging and some people continue to engage in risky behavior or relapse periodically the need for ongoing prevention programs is clear.

However, there are people who subject themselves to high-risk situations or behaviors but deny that they are at risk of HIV infection. They often avoid testing, and if they are tested, they avoid following up on results, as if avoiding a clinical diagnosis might prevent the disease (FHAPCO & FMOH, 2004). Moreover, those people who know their HIV positive status also avoid disclosing their sero positive status and discussing the issue with professionals and family members, including their sexual partner(s) (Hiwot, 2006; Harvard School of Public Health, 2006; The Foundation for AIDS Research, 2005; Kebede et al., 2005; WHO, 2004; UNAIDS, 2001; and UNAIDS, 1999). Thus, it is essential to understand the rates, benefits, risks, reasons and processes of HIV infection self-disclosure/self-non disclosure among sexual partners living with HIV/AIDS for the better prevention of HIV infections in the City Government of Addis Ababa.

To this end, this specific study tried to find answers to the following questions.

1. What looks like the rates of sero-positive status self-disclosure to sexual partners living with HIV/AIDS?
2. What are the benefits of sero-positive status self-disclosure as experienced by Sexual Partners living with HIV/AIDS?
3. What are the risks of sero-positive status self-disclosure as experienced by Sexual Partners living with HIV/AIDS?
4. What look like the types and levels of sero-positive status self-disclosure related discussions among Sexual Partners living with HIV/AIDS?
5. Do the socio-demographic factors independent of the types and levels of the participants' sero-positive status self-disclosure related discussions to their sexual partner(s)?
6. What are the reasons for sero-positive status self-disclosure and Self-Non Disclosure among Sexual Partners living with HIV/AIDS?

1.4. Significance of the Study

Sexual partners who are living with HIV/AIDS have developed different attitude towards their sero-positive status, based on the different experiences and teachings they have learned in the course of their life with in the community they live. The awareness and understanding of sexual partners living with HIV/AIDS, in turn, plays greater role on their attitude that determines the necessity and effectiveness of sero-positive status self-disclosure. Thus, the attitude developed by these group of people at different time periods for different reasons have had greater effects in understanding the roles and effectiveness of sero-positive self-disclosure that will, in turn, affect their choices in taking appropriate measures on the problem they faced (proper treatments; medication; experience sharing; and open discussion with family members, for example) as it is both the cause and effect of their attitudinal formation.

If the perception that HIV/AIDS is a punishment, crime, war, horror, and/or otherness gives rise to negative attitudes, it will have greater effects on the self-disclosure of one's sero-positive status to his/her sexual partner(s). If it occurs, the problem will never be restricted to those who are infected and affected by HIV/AIDS; but it will go beyond individuals to public or nationwide scenarios. Thus, timely and clear understanding on the roles of individuals' sero-positive status disclosure to their sexual partners might be helpful in understanding the roles and effectiveness of pre- and post-testing counseling services, enchanting appropriate measures on the problem the clients faced and taking correct and early measures for the future positive development of the services rendered for the non-tested counter sexual partners and many others. Thus, the following are among the most important intended social, medical and psychological values of this study:

a. The finding will hopefully assist those infected and affected by HIV/AIDS and other stakeholders working in the fight against HIV/AIDS to understand self-disclosure problems and the related harms among sexual partners living with HIV/AIDS,
b. It will provide basic information to counselors, psychologists, health professionals, researchers and other professionals who work directly and/or indirectly with sero-positive status self-disclosure problems among individuals living with HIV/AIDS in general and sexual partners living with HIV/AIDS in particular, and
c. Finally, it will initiate and serve as a basis for extensive studies on these less touched but highly important issues in the future.

1.5. Delimitations and Limitations of the Study

This study tried to investigate self-disclosure problems among sexual partners living with HIV/AIDS who are clients of ART Clinics in the Black Lion and Zewditu Memorial Hospitals in the City Administration of Addis Ababa. The study was first designed to have more samples through inclusion of one hundred fifty (150) additional participants who are clients of ART Clinic in Alert Hospital. But, because of the time taking nature of the institutional ethical clearances' and its very long procedures, even after getting the regional health bureau's approval and written ethical clearances for the study, the research was limited to use only three hundred (300) participants from the above mentioned two hospitals. In addition, the complexity and time-taking nature of the analysis part of the study; the paucity of the time for the study coupled with financial problems were also among other reasons for limiting the sample size of this specific study.

Moreover, the arranged Focus Group Discussions and Selected Case Studies were cancelled due to busy and overburdened nature of VCT clinic staffs, financial and time constraints, the huge and complex nature of the study and other unmanageable reasons that relates to the case under study.

1.6 Organization of the Thesis Research

This thesis research has been designed to have five consecutive chapters. The first chapter discussed the *'what all about'* of the research work. It introduces the research topic, the research questions, the general and specific objectives, the delimitations and limitations, and the significance of the study. As a final point, this chapter concluded by discussing the organization of the thesis research and presenting operational definitions for selected terms and terminologies used in this specific study.

Chapter two is focused on the literature review part of the study. This chapter tried to sift out previous works and findings that emphasized on the nature of sero-positive status self-disclosure/non-disclosure; historical developments and policy issues; and the roles of sero-positive status self-disclosure to sexual partner(s) (especially the rates, reasons, benefits, and risks of sero-positive status disclosure to one's sexual partner(s)).

The methodology part of the study is presented in the third chapter. The chapter discussed about the research design, participants, instruments, procedures, methods of data analysis, and the ethical issues of the research under study. The analysis of the data collected through the research tools is also broadly discussed in the fourth chapter. Finally, the summary, conclusions and recommendations part of the study was presented in the concluding chapter at last in chapter five.

1.7 Operational Definitions

In this specific study the following terms are used operationally and defined as follows:

- **Disclosure**: means telling others that you are HIV positive that could be voluntary or involuntary; especially when this information is revealed by some else without your approval or knowledge.
- **Self-Disclosure:** means voluntarily telling others that you are HIV positive.
- **Sexual Partners:** either member of a married couple or of an established unmarried couple.
- **Clients:** a person using the services (a person who is being counseled, for example) of VCT and ART centers/clinics of the two selected hospitals under study.

2. REVIEW OF RELATED LITERATURE

2.1 The Nature of the Problem: The Scourge of HIV/AIDS in Brief

The timely killer disease of HIV/AIDS has had a devastating effect on individuals, families and communities; everywhere the disease has spread. Although it has many physical effects perhaps some of its most profound effects are on the psychological, social, economic, and health of the HIV positive person, his/her loved ones, and the community at large. It decimates or destroys to workforce; breaks and impoverishes families; orphans millions of children, and shreds the framework of communities. Thus, Annan has predicted and summarized this fact, in the first UN Security Council Meeting by saying that "... *Impact of AIDS is no less destructive than that of warfare itself, and by some measures, far worse*" (Jan. 2000).

HIV/AIDS was first identified in the early 1980s. Since then, it has spread around the world. Millions of people have been infected and millions have died. The problem of HIV/AIDS has been described as having three 'waves'. In the first wave, people are infected with the virus. In the second wave, people become ill. The third wave is made up of the effects of people dying of HIV/AIDS, such as on surviving children and young people. In other words, the three phases of HIV/AIDS epidemic are the epidemic of HIV, the epidemic of AIDS, and the epidemic of stigma, discrimination, and denial (SDD). Many countries, particularly in Africa, are already affected by the third wave. The third phase is "as central to the global AIDS challenge as the disease itself" (Mawar et al., 2005; Mann cited in Parker and Aggleton, 2002; Hubley, 2002).

Despite international efforts to tackle HIV/AIDS since then, stigma, discrimination and denial (SDD) remain among the most poorly understood aspects of the epidemic. Whereas, stigma is understood as a "continuing challenge" that prevents concerted action at community, national, and international levels. It is so because people living with HIV are stigmatized leading to severe social consequences related to their rights, health care services, freedom, self-identity and social interactions. It is also severely hampers the treatment and diagnosis of HIV contributing to further spread of the disease (Mawar et al., 2005; Piot cited in Parker and Aggleton, 2002).

Moreover, on its severe problem a vicious circle is emerging: poverty and social disruption are underlying factors in the spread of HIV; the resulting AIDS epidemic is causing further social and economic distress at all levels of society. Another vicious circle is also exists between food shortages, malnutrition and AIDS. As it is known that nutritional treatment is essential for persons living with the AIDS virus, they need enough and more balanced diet every day. If they could not get that, the problem will be shortly changed and they became AIDS patient (UNAIDS, 2004; Hubley, 2002; Parker and Aggleton, 2002; Ross et al., undated).

There is no treatment that cures HIV/AIDS infections permanently to date. This by itself evokes anxiety because of its association with death. Hence, the fact that HIV/AIDS is an incurable that leads to death often requires enormous psychosocial adjustments. According to Mawar et al. (2005), Hubley (2002), Ross et al. (undated) and Regamonti (undated), the responses follow series of stages, but some may skip several stages. According to them the stages of reactions to HIV positive status can be summarized as follows:

Stage I. **Shock, Denial and Anger**: in most cases this is the initial stage because people who are living with HIV/AIDS feel guilty for their infections and the anger directed to those who they believed infected them. They do not acknowledge having the disease or deny its likely consequences. It is so because individuals have goals, expectations, and significant relationships that could be highly threatened by the HIV infection so that they are reluctant to admit their diagnosis or their risk of infection.

Stage II. **Withdrawals**: people living with HIV/AIDS do not know how others will react to them after infection but they are surely recognized the stigma associated with HIV/AIDS. Thus, they will discontinue from their social interaction.

Stage III. **Bargaining**: When the time passes people living with HIV/AIDS will start talking their HIV infection to some and selected significant others carefully.

Stage IV. **Look for others**: Then after, in this stage, people who are living with HIV/AIDS may look for others in the same situation to obtain peer support and discuss problems.

Stage V. **Acceptance**: in some cases seeing themselves as special or different may occur, followed by altruistic behavior or acceptance of their infected status. It is an essential stage because in order to battle HIV successfully, people must have some level of acceptance of the disease so that they can seek counseling, social support, and medical care.

Professional counselors, social workers, health care workers, ministers of religion, trained volunteers, friends and family play crucial roles in providing psychosocial support for people living with HIV/AIDS (PLWHA). It is so because one of the first steps in providing adequate assistance for people with HIV is to make sure the helper is thoroughly aware of and comfortable with the facts about HIV transmission. Hence, according to Hubley (2002) and Rigamonti (undated) it can be said that counseling and support can help people with HIV share their feelings about secrecy and stigma and consider how these influence their emotional and physical health. It can also help people consider how their own behaviors can promote health and well being, such as seeking resources for adequate nutrition, shelter, proper medical follow-up, adequate sleep and management of stress and anxiety.

2.2 Historical Development and Policy Issues—an Overview

The history of AIDS backs to early 1980's and the time in the pre 1980s is known as the silent period. It is also believed that AIDS was being transmitted before it was recognized as a new disease (ARC, 2006; Hubley, 2002; UNAIDS, 2001).

During the silent period and after wards, it may have several terminologies and known characteristics in different parts of the world. For instance, in Uganda it was known as 'slim disease'. It was in 1982 that Center for Disease Control produced a case definition for AIDS in Atlanta, United States (Backin, 2004; Hubley, 2002; and UNAIDS, 2001).

HIV/AIDS was first prevalent among patients with Sexually Transmitted Infections. It was in 1983 that the AIDS virus (HIV virus) was isolated from the blood of AIDS patients in France. It was the first initiative that makes the development of tests, which could detect antibodies to the virus in blood, possible. In this endeavor ELISA blood test was the premier. In 1986, an international committee agreed to rename the virus as Human Immunodeficiency Virus or HIV (Backin, 2004; and UNAIDS, 2001).

According to the Joint United Nations Program on HIV/AIDS (UNAIDS) and World Health Organization (WHO) (2007) the number of people living with HIV in the year 2007 showed a little reduction when compared to the year 2006. In 2007 it was estimated to be 33.2 million

(30.6 – 36.1 million). In most cases the change is due to advances in the methodology of estimations of HIV epidemics (Angola, India, Mozambique, Zimbabwe, Kenya, and Nigeria, for example) that contributes for the lion share of the changes (i.e., above 70% of the changes). In some cases, in both Kenya and Zimbabwe for example, there is increasing evidence that a proportion of the declines is due to a reduction of the number of new infections which is in part due to a reduction in risky behaviors. Hence, of all HIV infections. Adults account for 30.8 million (28.2 – 33.6 million), Women account for 15.4 million (13.9 – 16.6 million) and Children under 15 years account for 2.5 million (2.2 – 2.6 million). Sub-Saharan Africa remains the most seriously affected region, with AIDS remaining the leading cause of death.

According to the document (UNAIDS and WHO, 2007) the major elements of methodological improvements in 2007 included greater understanding of HIV epidemiology through population-based surveys, extension of sentinel surveillance to more sites in relevant countries, and adjustments to mathematical models because of better understanding of the natural history of untreated HIV infection in low- and middle- income countries.

The vital findings of the Epidemic Update (2007) include:

- Every day, over 6,800 persons becomes infected with HIV and over 5,700 persons die from AIDS, mostly because of inadequate access to HIV prevention and treatment services.
- The HIV pandemic remains the most serious of infectious disease challenges to public health.

In Ethiopia, it was in 1984 that the HIV virus was detected. In 1986, the first two AIDS cases were reported to the Federal Ministry of Health (FMOH). But, the HIV/AIDS policy that created an enabling environment for HIV/AIDS prevention and control was formulated by MOH and adopted by the Council of Ministers only in 1998. Since the beginning of HIV/AIDS surveillance activities in 1989 the HIV epidemic appears to have steadily increased in Ethiopia. The HIV/AIDS Prevention & Control Office (HAPCO) was established in 2002, under the Prime Minister's Office. The aim of HAPCO includes resource mobilization, advocacy, and the coordination of the sectoral responses (MOH, 2006).

The 2005 Demographic and Health Survey of Ethiopia estimated national adult HIV prevalence to be 1.4%, with infection levels highest in the Gambela (6%) and Addis Ababa (4.7%) regions

(Central Statistical Agency and ORC Macro, 2006). Ethiopia's epidemic stabilized in urban areas in 1996-2000, after which HIV infection levels declined slowly, notably in Addis Ababa. In rural Ethiopia, where the majority of the population resides, the epidemic has remained relatively stable since HIV prevalence peaked in 1999-2001 (Federal Ministry of Health, 2006).

2.2.1 Legislative and Policy Framework in Ethiopia

In Ethiopia, HIV/AIDS is increasing rapidly since the first HIV infections were identified and the first AIDS cases were reported. For this reason the Government of Ethiopia has responded by establishing institutions in charge of coordinating the efforts to combat the epidemic. In addition, adoption and implementation of policies, strategies and legislation that regulate the efforts has also been made part of the response. On this, Mizanie (2007) has analyzed the legal and policy frameworks of three African countries including Ethiopia. The analysis focused on HIV testing from an African human rights system perspective. A little summery put under in this sub title summarizes the policies, strategies and legislation relevant to HIV testing in our country.

2.2.1.1 The 1998 Policy on HIV/AIDS

Paragraph 3 (2) of the policy document lays down the principle by saying 'testing and counseling shall be voluntary and shall be encouraged along with counseling devices'. In addition, the Policy incorporates two exceptions to voluntary nature of testing: HIV screening for job recruitment purpose (pilots - civil aviation and air force, for example) and testing of blood donors. It also affirms confidentiality of testing results. Moreover, PLWHA shall, nevertheless, be encouraged through repeated counseling to accept the need for notifying his/her sero-status to others (spouse, friends, and family). When a person refuses to notify after adequate counseling and his/her partner is at risk of infection, based on circumstances, the endangered partner has the right to directly access the information regarding the sero-status of the partner (Mizanie, 2007; and MOH, 2002).

2.2.1.2 The 2007 Guidelines for HIV Counseling and Testing in Ethiopia

One of the main aims of adopting the 2007 Guideline for HIV Counseling and Testing (HCT) in our country is to scale up HIV testing. Scaling up of HIV testing is justified by the development of affordable and effective medical care for people living with HIV. The Guidelines encompass detailed provisions on the requirements or the 3C principles of consent, counseling and

confidentiality both in Voluntary Counseling and Testing (VCT) and Providers Initiated Testing and Counseling (PITC) (Mizanie, 2007).

The need for informed consent in all cases, except in mandatory testing, is capitalized in Paragraph 1(1) of the Guidelines. Moreover, to ensure genuine consent, counselors should make sure that clients adequately understand benefits, implications and consequences of testing; and recognize the right of clients to withdraw consent at any time, even after blood has been taken for HIV testing (FHAPCO, 2007; and Mizanie, 2007).

The Guidelines state that *'adequate pre- and post-test counseling shall be offered to all clients'*. In provider-initiated testing and counseling (PITC), the pre-test session consists of education or information to individuals, couples or groups, and should be brief and focus on the benefits of testing and services available. Unlike pre-test counseling, post-test counseling should be provided in person. However, the form of the post-test counseling session depends on the test result; this is often brief in provider-initiated testing (FHAPCO, 2007).

Clients' confidentiality will be maintained at all times. Results can be shared with other persons only at clients' request or agreement. It is the client's decision to learn the test results, which should never be issued in a public area but in private, in a session alone or as a couple. HCT sites should not provide written HIV test results to clients to ensure confidentiality and avoid misuse of result (Mizanie, 2007).

There are also circumstances under which confidentiality may be breached such as danger to self and others, child abuse, etc... In situation that a PLWHA is engaging in behavior that places others at risk of infection, the psychiatrist should seek the patient's agreement either to cease that behavior or to inform the individual(s). But, any breach of confidentiality should be undertaken only after all other efforts to work with the patient have failed. The potential profound impact of such notification and the problems it may generate should also be considered (APA, 2003). Accordingly, the 2007 Guidelines clearly put two forms to breach confidentiality of testing results. Firstly, in cases where testing is ordered by a court of law, results should be communicated directly to the appropriate authority. Secondly, partner notification shall be encouraged in cases where one partner receives the results alone. When a client fails to disclose

employment mandatory testing in civil service institutions (see article 13 (1)). While the Proclamation provides for production of medical certificate as a pre-condition for candidates who qualify for a job, it unequivocally states that the medical certificate does not have to include HIV test result. The Proclamation also prohibits HIV testing of civil service employees. Likewise, the Labor Proclamation prohibits HIV testing of employees that fall under its scope of application, notably workers in private business companies and profit motivated government enterprises. Moreover, article 34 of the 1961 Criminal Procedure Code of Ethiopia is interpreted as allowing compulsory testing of accused sexual offenders (Mizanie, 2007).

In general, having good policies and legislations does not by itself guarantee protection of human rights in HIV testing. However, HIV testing shall be undertaken in compliance with the 3C principles (consent, counseling and confidentiality) that have clear foundation in Global, African regional and National human rights documents. Accordingly, it can be said that mandatory and compulsory models of HIV testing are contrary to human rights norms that cannot be justified. except tissue and blood donors mandatory testing. Moreover, authorizing courts to order mandatory testing in the 2007 HCT guidelines opens a '*Pandora's box*' for human rights abuses. It should also be noted that HIV screening of insurance applicants in Ethiopia is done despite clear laws and policies prohibiting them. Thus, such prohibitions should be totally removed and considerable efforts have to be exerted to ensure that the policies and laws are implemented practically both in private and public spheres (ibid, 2007).

In conclusion, some of the policy and strategy documents that relates to HIV/AIDS in Ethiopia include the following:

- ✓ Ethiopian Strategy Plan for Intensifying Multi-Sectoral HIV/AIDS Response 2004-2008 (2004).
- ✓ Guidelines for HIV Counseling and Testing in Ethiopia (2007).
- ✓ Guidelines for Prevention of Mother-to-Child Transmission of HIV in Ethiopia (2007).
- ✓ Policy on HIV/AIDS of the Federal Democratic Republic of Ethiopia (1998).
- ✓ Strategic Framework for the National Response to HIV/AIDS in Ethiopia 2000-2004 (2000).

2.3 Counseling and Voluntary HIV Testing: A Prerequisite for Action

Voluntary HIV counseling and testing is a prerequisite or a gateway for any action related to HIV infections. It is widely promoted as an important first step in behavior modification required for reducing the incidence of HIV. Thus, at the very least, individuals can be provided with information about reducing their and their partner's exposure to HIV infection. In addition, knowing ones HIV sero-status before and during delivery minimizes the child's exposure to the infection (UNAIDS, 2001).

HIV Testing and Counseling serves as a critical prevention and treatment tool in the control of HIV epidemic. It can effectively reduce risk behavior among individuals at risk for HIV. It is also a critical component of prevention strategy to reduce MTCT. In addition, it offers the opportunity to identify HIV infected individuals and channel them into treatment programs. This means that knowing that they are HIV positive has motivated many people to plan their lives more carefully and deliberately. Thus, they are achieving much more because they have developed a positive attitude to life (WHO, 2004; and SAT, 2000).

However, according to USAIDS (2001) there is a great deal that people need to know before deciding whether or not to be tested for HIV. Much of it is straightforward information that can be imparted in groups. But, reaching a decision is not an easy task. After basic information has been given, most people will need counseling at an individual level to help them assess their level of risk and consider the implications of a positive or negative result in their own situation, before deciding whether or not to be tested. The document also articulated that pre-test information and counseling emphasized on the following issues:

- Information about the sexual transmission of HIV and how to prevent it;
- Information about transmission of HIV from mother to child, and possible interventions;
- Information about the HIV-testing process;
- Assurance of confidentiality and discussion of shared confidentiality and couple counseling;
- The implications of a negative test result, including information on how to remain HIV-negative, promotion of breastfeeding and family planning;
- The implications of a positive test result, including costs and benefits of potential interventions, promotion of safe infant feeding practices and family planning, a discussion of their own, their families and their child's survival and the possible exposure to stigma; and
- Counseling for risk assessment.

Furthermore, it should be noted that a negative result should never be presumed to indicate a lack of anxiety or of a need for further counseling. Information and counseling for HIV-negative people should concentrate on preventing future infection. Where couples have been tested together and both are negative, information given in pre-test counseling about prevention of sexual transmission of HIV should be reinforced and the particular importance of avoiding infection during pregnancy and breastfeeding should be stressed (UNAIDS, 2001).

In general, when a partner is infected, or when his/her serological status is not known, the importance of prevention information and counseling is greater (UNAIDS, 2001). In addition, HIV counseling is essential for persons living with HIV/AIDS (PLWHA) for survival. Talking about survival skills is a vital part of HIV counseling because it helps people understand that their life is not over for the reason that a laboratory test has found that they are infected with HIV. It helps them to accept a positive HIV test result by reinforcing the message that this result does not mean the end of their life as it is not an immediate death sentence. Thus, survival skills should be discussed in all counseling sessions as early as possible, preferably during pre-test counseling. It is also a very important subject of post-test counseling (SAT, 2000).

2.4 The Role of HIV Status Disclosure to Sexual Partner(s)

According to WHO (2004) disclosure became an important public health goal for a number of different reasons. Firstly, it may motivate sexual partners to seek testing, change of behavior and ultimately decrease transmission of HIV. Secondly, it facilitates other health behaviors that may improve the management of HIV that includes: participate in Mother to Child Transmission (MTCT) program, receive support from families or others in the individual's social networks, be able to access available support services, willingness to adopt and maintain health behavior (cessation of breastfeeding and adherence to treatment regiments, for example). Therefore, it is important to be able to share HIV status with one's sexual partner.

The results of different researches revealed that women may be at high risk of HIV infection even soon after child birth. A research in Malawi, for example, revealed the same and found that this may be because their husbands or partners have sex with other partners during a woman's pregnancy or the abstinence that often follows it, becoming infected at that time and passing on the new infection as soon as sexual relations with the new mother resume. This represents a

double danger if the mother is still breastfeeding, since there is a very high likelihood of transmitting infection to the infant when the mother carries the high viral load associated with new HIV infections (WHO, 2004).

In the fight against HIV/AIDS much more efforts has been made that can be interpreted from the different angles of intervention mechanisms. It should be addressed with a concerted effort at prevention directed toward those who are infected. Because HIV is spread by people who are infected, so it makes sense to consider how the epidemic can be understood and fought from that angle. It is encouraging that after becoming aware that they are infected, many people substantially reduce their risky sexual behavior and drug use. Indeed, changing the behavior of one infected person may help prevent many of that person's sexual partners from becoming infected. But it should be understood in unbiased and straightforward manner that by no means perceived as blaming the victim or discriminating against or stigmatizing a group of people (Marks, 2005).

In Ethiopia, the five years strategic plan that aimed at the intensifying multi-sectoral HIV/AIDS response in 2004 to 2008 (HAPCO & FMOH, 2004) has focused on the active involvement of people living with HIV/AIDS (PLWHA) from which much more positive outcomes would expect. It articulated that PLWHA has to be given a central place in the fight against the scourge of the deadly disease of HIV/AIDS.

Accordingly, it would seem ethical for PLWHA to notify their sexual partner of their sero-status. It is so because it helps in promoting safe sex, reducing the transmission of or re-infection with HIV. If not, failure to disclose their HIV sero-status can place their sexual partners at risk. However, the results of series of researches both in developing and developed countries are found to be in contrary with this fact. Olley et al. (2004) revealed that 78% had not disclosed their HIV sero-status to their sexual partners and 46% had no knowledge of their sexual partner's sero-status. It also showed that being in a married relationship, being male, having more than two multiple partners and non-use of condom at last sex were significantly associated with non-disclosure of HIV sero-status.

Simbayi et al. (2006) also showed that the HIV epidemic continues to amplify in southern Africa and there is a growing need for HIV prevention interventions among people who have tested HIV positive. It is concluded that 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. So, interventions are needed in South Africa to reduce the AIDS stigma and discrimination and to assist people with HIV to make effective decisions on disclosure.

In general, it is essential to understand the rates, benefits, risks, and processes of HIV infection self-disclosure to sexual partners living with HIV/AIDS. Hence, the United Nations (2004) document that was the result of series of researches in the area, both in the developing and developed nations and other series of researches (Hiwot, 2006; Harvard School of Public Health. 2006; The Foundation for AIDS Research, 2005; Kebede et al., 2005; UNAIDS. 2001; and UNAIDS, 1999; for example) disclosed these issues as summarized below:

2.4.1. Rates of HIV Status Self-Disclosure or Nondisclosure among Sexual Partner/s

It is difficult to make long-term changes in sexual behavior without being able to share HIV test results with a sexual partner or partners. Disclosure to a sexual partner or partners can be viewed as an important indicator of understanding and acceptance of HIV status. There are, however, societal factors that have a strong influence on rates of disclosure, particularly for women. Here it is believed that the views of counselors may influence disclosure rates. Moreover, it is also noted that often counseling clients about disclosure is just an instruction or suggestion to disclose and clients are not engaged in practical strategies of how to do this (i.e. problem-solving or role-playing, for example) that may be a mitigating factor in the lower effectiveness of counseling interventions (WHO, 2004; and UNAIDS, 2001).

It is found that disclosure of one's HIV status increases both practical and emotional support for those who test sero-positive. It is also believed that sharing HIV status is not only important in enabling people to receive emotional support from family and friends and help in future decision-making, it also reflects people's ability to understand and accept their HIV status. However, rates of disclosure to partners and family/friends vary considerably, but in many

studies (particularly from developing countries) people have found it easier to discuss their HIV status with a close friend or family member than with their partner (UNAIDS, 2001).

It should be remembered that the rates of disclosure among studies from the developing world were notably lower than rates reported from the developed world. In the eleven researches conducted in sub Saharan Africa the rates ranged from 16.7% to 86%. Among the studies that reported disclosure rates to current and/or steady partners the average rate of disclosure was 49%, considerably less than the average rate reported from studies conducted in the developed world (79%) (WHO, 2004). The different researchers analyzed by WHO (2001) also revealed the same. In the United Republic of Tanzania HIV positive people shared their HIV test results with a "significant other" of the same sex. Those who were married or cohabiting did not choose their partner (Lie and Biswalo cited in WHO, 2004). In Uganda the majority of people (90.4%) were able to reveal their HIV sero status to close relatives. 85.3% of them reported revealing their HIV status to relatives other than household members and 67% revealed their status to household members. Only 36% revealed their status to spouses or regular sexual partners. This suggests that emotional support is sought over a broader family and community network.

Similar findings were apparent from Zambia. In early times people found it difficult to share results, especially immediately following testing (Kelly et al. cited in UNAIDS, 2001) while a later evaluation from the same site showed that most people were able to share their HIV status with someone (Baggaley et al. cited in UNAIDS, 2001). However, women in particular said it was shameful to have HIV and, if they were known to be sero-positive, they worried they would be discriminated against, and were particularly reluctant to tell their partner. In Uganda also, 22 families with 1 or more adult members with HIV were interviewed about their responses to HIV and stigma (McGrath et al. cited in WHO, 2004). Approximately half of the PLWHA interviewed said that they had not informed any of their family. They said that they feared their family would worry or would not understand. Some said that they feared rejection if their families knew of their positive status. Family members who were informed said that they were shocked or feared the loss of their relative with HIV.

In Ethiopia, however, there are no practical research findings in the area of HIV status disclosure to sexual partner/s. As far as the researcher's effort to collect such research works, there are only

two research activities in the area. The one is a published article that focuses on disclosure to sexual partners in South Western part of Ethiopia (Kebede et al., 2005). The other is unpublished thesis research that focused on public disclosure in Addis Ababa (Hiwot, 2006). Both researches were sex oriented and focused only on women. The later research revealed that rate of disclosure to family members is higher than to extended family members. Among the family members more sero positive status disclosure was seen for husbands (68%) and sisters (59%). However, about a quarter (23%) of all the participants did not disclose their sero-positive status to anyone, both in the family and/or extended family members.

On the other hand, the disclosure rates to sexual partner in developed countries were quite high, ranging from 42% to 100%, depending in large part on the type of sexual partner to whom the person disclosed. Among the fifteen studies that reports disclosure rates to current and/or steadily sexual partners the average rate of disclosure was 79%. The lowest rates of disclosure were reported among past partners or current casual partners. In general, women disclosed the multiple categories of people (WHO, 2004). Similarly a study from London also revealed that people were more likely to share their test result when they had symptomatic HIV disease or needed treatment and that disclosure enabled people to obtain additional support (Miller et al. cited in UNAIDS, 2001).

As a whole, a document that synthesizes the current information available on HIV status disclosure (WHO, 2004) revealed that rates of disclosure to sexual partners are higher among women in the developed world (Average 71%, Range: 42% - 100%) compared to women in the developing world (Average 52%, Range: 16% - 86%). In addition, the document summarizes the following points:

- Disclosure rates to sexual partners increase over time;
- There are cultural factors that influence the patterns of self disclosure to sexual partners and other social network members;
- Women often disclose to multiple categories of people;
- There is a core group of people who choose not to disclose HIV test results to anyone (3-10% in USA and 10-78% in developing countries); and
- There is a disparity between intention to disclose and actual disclosure.

In conclusion, it is likely that the barriers that individuals face when deciding to share their results with their partner will vary depending on the circumstances under which they were tested (WHO, 2004). For this reason it should be noted that the rate of disclosure differs in different VCT settings (disclosure following VCT, Antenatal settings, Couple Counseling, and Premarital VCT, for example) both in developing and developed nations. The discussion follows:

2.4.1.1 Disclosure following VCT

Most studies show that the majority of people share their HIV results with someone and disclosure rates increase over time as people adjust to their test result. Levels of disclosure to spouse/sexual partner/s are, however, usually lower. In studies done in developing countries disclosure rates range from 24-79%. Partner testing is lower (<1-75%). Studies from industrialized countries also show that not all women are able to tell their partners that they have been tested (UNAIDS, 2001).

Different studies conducted in developing countries revealed similar results. In Lusaka less than 50% of people with positive results were able to tell their sexual partners (Baggaley et al. cited in USAIDS, 2001). A very small percentage (<5%) of partners subsequently came for counseling and testing. Inability to discuss HIV test results with a sexual partner makes adopting safer sex practices more difficult. In Rwanda, after testing 75% of sero-positive women said that they did not expect a supportive response from their partners when they told them about their status. However, when they were re-interviewed three years later, acceptance, understanding and sympathy were the most common reactions of their partner after disclosure. Nevertheless, 21% had still not been able to tell their partner. Of the men, 48% had tested for HIV following their partner's disclosure of her sero-positive status (Keogh et al. cited in UNAIDS, 2001).

In Zimbabwe, informing marital partners was found to be a major problem for most people with HIV (Meursing et al. cited in USAIDS, 2001). However, with "enhanced counseling" 75% were able to disclose to their partner/spouse. In another study, out of 3,381 men who were enrolled in a factory, worker cohort 56% returned for their HIV test result (Dube et al. cited in USAIDS, 2001). Although all men were encouraged to bring their sexual partners for VCT, only 7% did so. In Burkina-Faso, only 24% of people who were sero-positive and living in a stable

relationship were able to tell their partner about their result. The authors acknowledge that it is a major obstacle to HIV prevention (Badini et al. cited in USAIDS, 2001).

The same is true in developed countries. A study from London revealed differing patterns of disclosure. Although most people were able to share their HIV status with someone it was often difficult for sero-positive people to share their HIV status with their sexual partner, especially if the partner was a casual or non-primary sexual partner (Miller et al. cited in USAIDS, 2001).

2.4.1.2 Disclosure following VCT in Antenatal Settings

There is increasing emphasis on offering VCT to women attending antenatal clinics to enable them to take interventions to prevent mother to child transmission (MTCT). Thus, many studies are looking at disclosure to male partners in this context. Disclosure rates – and subsequent testing rates of sexual partners – vary considerably. It is often difficult for women in developing countries to share their HIV status with their partners/spouses and testing women alone (rather than as a couple) does not facilitate disclosure. Innovative ways of involving men in antenatal testing should be sought so that women are not blamed or isolated if they are found to be sero-positive. If men can be offered VCT they can take an informed and active role in decisions around the future, family planning and coping with MTCT interventions (UNAIDS, 2001).

In antenatal settings women are usually tested alone, yet important decisions relating to their status should ideally be shared with their partner. In South Africa less than 50% of sero-positive women were able to disclose their HIV status to anyone and only a minority of these discussed it with their partner (Sigxaxhe cited in USAIDS, 2001). In Botswana disclosure to partners is also reported as being low and very few men are either tested together with their partners/ wives or agree to test at a later date (Mazhani et al. cited in UNAIDS, 2001). Information from 13 study sites offering VCT and MTCT interventions – from west (Abidjan, Bobo-Dioulasso), east (Addis Ababa, Nairobi, Mombassa, Dar Es Salaam) and southern Africa (Blantyre, Lusaka, Harare, Soweto, Durban) and 1 from Thailand – showed low numbers of men agreeing to testing in most settings (Cartoux et al. cited in USAIDS, 2001). In numerical terms, the percentage of men, whose partner/s are sero-positive, who agreed for testing are in all West African sites (<1%), South Africa (5%), Dar Es Salaam (10%), Blantyre (10%), Lusaka (10%), and Bangkok (75%) (UNAIDS, 2001).

In Kenya, Women were advised to tell their sexual partner their HIV status and to bring their partner for further counseling and testing, if desired (Temmerman M, et al. cited in UNAIDS, 2001). However, of the 324 women who were found to be sero-positive only 66 (27.2%) communicated their test result to their partner and only 21 partners subsequently tested (5, or 23.8%, were sero-negative). Because of the adverse outcomes of partner disclosure that occurred during the study, the policy of partner notification was changed and women were counseled to make their own choices about whether or not to involve their partner. Subsequently, only 109 out of 311 (35%) of women with a sero-positive result ever returned for their test result and only 9 (3%) partners came for VCT. In Rwanda, of the 1,223 women screened for HIV at an antenatal clinic 70% of the women who had post-test counseling said that they wished their partners to be tested for HIV. However, despite the encouragement of the counseling staff and the available infrastructure only 8% of the partners were tested (Ladner et al. cited in USAIDS, 2001). Similarly, , although all women had disclosed their HIV status to their partners following antenatal VCT in the United States, only 56% of sero-positive and 44% of sero-negative women knew their partner's HIV status (Lester P et al. cited in USAIDS, 2001).

2.4.1.3 Couple counseling

Couple counseling and testing is aimed at enabling the couple to negotiate appropriate changes in sexual behavior together. It helps them plan together for their future and that of their dependants, with the support from their counselor at both pre- and post-test. Couple counseling overcomes the problems of disclosure to partners and has been a successful intervention where it has been promoted, although in some countries there are barriers to attending. However, high rates of sero-discordancy among married couples have been noted in many studies (USAIDS, 2001).

According to USAIDS (2001), in developing countries many studies have shown that a significant proportion of couples in steady relationships have *sero-discordant* HIV test results. In Zambia there were 52 discordantly infected couples from the sample of 245 (21%) (Hira et al., 1990), in the multi-centre study (N=589) 17% were sero-discordant (Coates et al., 2000), at AIC in Kampala, Uganda, of 1,853 couples that attended together 7% were sero-discordant (Baryarama et al., 1998), in rural Uganda 7% of couples were sero-discordant (Carpenter et al., 1999). The risk of sero-conversion, in the later study, was found to be 105.5 per 1,000 person-

years for sero-negative women married to sero-positive men and 51.7 for sero-negative men married to sero-positive women. It can be said that the results of the mentioned studies highlights that married adults, particularly women with sero-positive partners, are at very high risk of HIV infection.

The majority of studies of couple counseling among sero-discordant couples also report successful outcomes in terms of changing behavior to prevent HIV transmission to negative partners (USAIDS, 2001). In Rwanda a far higher proportion of couples wanted to receive HIV counseling and testing together (Allen, 1993). Furthermore, in another study, the use of VCT services by cohabiting couples is effective in reducing HIV transmission within HIV discordant couples and diminishing the acquisition of new HIV infections in sero-negative couples (Allen et al., 1992; Allen et al., 1993). In Kinshasa also couple counseling was shown to be effective in changing sexual behavior in sero-discordant couples (Kamenga et al., 1991). Thus, intensive counseling followed testing and this led to a low rate of HIV sero-conversion – 3.1% per 100 person y ears of observation in Congolese married couples with discordant HIV status who attended VCT.

It is very shocking to hear about the high probability of sero-positive individuals having sex with others. At AIC in Uganda, the probability of a sero-positive man having sex with a new partner who was sero-negative was 0.81, and among sero-positive women 0.84. Thus, there is a high probability that people who are sero-positive will develop sexual relationships with sero-negative partners and, unknowingly, transmit HIV if VCT is not available (UNAIDS, 2001). However, the use of couple counseling that can facilitate sero-status disclosure showed popularity. In Uganda, for example, although couple counseling was not popular when the services was set up – in 1992 less than 9% of attendees were couples – this services has become more popular, with 26% of couple attendees in 1996 (UNAIDS, 1999).

Better results have been seen in industrialized countries. In a study from the United States, for example, couple counseling was shown to be highly effective in preventing HIV transmission. No sero-conversions were observed after 193 couple-years of follow-up among discordant couples following VCT (Padian et al. cited in USAIDS, 2001).

2.4.1.4 Premarital VCT

Pre-marital testing is being promoted in some countries, especially by religious organizations and parents of young people. There are no data on the long-term outcomes of this strategy. In Nigeria, Catholic community organizations are promoting pre-marital VCT (Ubane et al. cited in USAIDS, 2001). At AIC in Uganda, increasing numbers of people coming for VCT indicated that marriage plans was the reason they wish to be tested. In 1992, 6% of those attending VCT did so because of pre-marital testing and this figure rose to 35% in 1998 (Turyagyen Da cited in UNAIDS, 2001).

2.4.2. Reasons for HIV Status Self-Disclosure or Nondisclosure

According to the UNAIDS (2001) document the reasons for HIV status disclosure or non-disclosure in many developing countries do not show significant differences. In Lusaka many people who had not told their partner said that this was because they were ashamed of being sero-positive or having gone for a test. Those who were sero-negative said that even going for a test would make their partner suspicious. Some said that they feared blame, abandonment or abuse if their partner found out they were sero-positive. Although both women and men expressed these worries, women more commonly expressed them.

In Zimbabwe also the main reasons for non-disclosure were relatively good health and emotional status, denial of diagnosis, fear of rejection, limited knowledge of and belief in strategies to "live positively with HIV", unacceptability of condoms and safer sex, and women's economic dependency and lack of power in sexual situations. Moreover, twelve focus-group discussions (FGDs) were conducted and several reasons were given for this (UNAIDS, 2001).

- They experienced difficulties with introducing the subject of VCT because of the uncommunicative nature of their relationships.
- They feared that sero-discordant results would lead to divorce.
- They feared that results would reveal their partners' or their own past, present or future infidelities.
- They thought that VCT was not a high priority compared with other issues in their lives.
- Their wives were unable to attend the urban VCT site because they lived in rural areas.
- The men reported that the wives would assume they were negative if their husband was negative.
- The men reported a lack of interactive communication between their counselors and themselves during pre-test counseling and they did not feel able to confide in them.

WHO (2004) document also revealed that the most common barriers to sero positive status disclosure include fear of abandonment, fear of rejection/discrimination, fear of violence, and fear of upsetting family members. It also further discussed that length of time since diagnosis and severity of illness were positively association with disclosure. Furthermore, factors that motivated people to disclose to partners, family and friends include a sense of ethical responsibility, failing health, social support, minimizing stress associated with non-disclosure, and disclosure as a way to facilitation HIV preventive behavior. However, among the motivators for disclosure ethical responsibility and concern for partner's health was the major reason cited for disclosing to sexual partners. A couple of research results also reported on the role that counseling may play in facilitating disclosure (WHO, 2004).

2.4.3. Benefits of HIV Status Disclosure to Sexual Partner(s)

Unless women and their partners fully understand the benefits of a HIV test, they are unlikely to choose to have one. Women should be told that, in the absence of any intervention, less than half the babies born to HIV-positive women will contract the virus from their mother. Intervention can reduce that amount to less than 10%. However, it should be clear to a woman that the most effective interventions cannot be made available to women whose HIV status is not known (WHO, 2004).

It is believed that disclosure of one's sero-positive status can have many benefits. Some of such benefits include: acceptance of ones status and reduce the stress of coping on their own; access to medical services, care and support that they need; protect themselves and others; better equipped to influence other to avoid infection; reduce stigma, discrimination, and denial; stop rumors and suspicion and reduce the stress caused by "keeping a secret"; and promotes responsibility and can plan for the future (SAT, 2000).

In terms of intimate relationships, disclosure reflects the uncertainty about how a partner will react to news about diagnosis. There may be concern about whether the intimate partners will remain in the relationship, which makes HIV disclosure a way to test or verify each other's commitment (Derlega et al. cited in Norman et al., 2005). Similarly, disclosure has public health benefits that include expanded awareness of risk that may lead to decreased sexual risk-taking and ultimately decreased transmission of HIV. Moreover, there are also potential benefits to the

individual who chooses to share results with his/her sexual partners (WHO, 2004). Thus, disclosure of HIV status to sexual partners may lead to:

- Increased opportunities for instrumental and expressive social support,
- Improved access to necessary medical treatment and care,
- Increased opportunities to discuss and implement HIV risk reduction with partners, and
- Increased opportunities to plan for the future carefully and thoughtfully.

Moreover, sero positive status disclosure enhances behavioral change in different people. A study by Ijumba et al. (2004) in South Africa showed that knowing someone with HIV was associated with condom use at last sexual contact and negatively associated with multiple and casual sex partners. Takai et al. (1998) also found in Thailand that those with histories of contact with people living with HIV/AIDS have more tolerant attitudes toward the disease as well as to those infected. This supports recent suggestions that the greater personal exposure to the fear-evoking consequences of the epidemic was a key in Uganda's success in halting the spread of the virus (Stoneburner and Low-Beer cited in Norman et al., 2005).

Finally, it is widely accepted that holding back one's feelings results in stress, which negatively impacts on physical health (Paxton, 2002), and that negative emotional reactions, including depression and HIV related worries are inversely related to disclosure (Derlega et al. cited in Norman et al., 2005). This is to mean that because the knowledge of a positive status is encumbering to an individual, the experience of disclosure often represents a release of this 'weight.' Many people utilized the word 'freedom' when describing how they felt once they had disclosed. It is psychological release- liberation from the burden of secrecy and shame. For others, not only did the events of disclosure to family members unburden them, but by disclosing to other HIV positive people they were able to join a community where this process is shared with people who are going through similarly difficult experiences (Norman et al., 2005; SAT, 2003).

2.4.4. Risks of HIV Status Disclosure to Sexual Partners

Clients must be given clear information about the potential downside of HIV testing. Where breastfeeding is universal, privacy is limited and breast-milk substitutes are expensive, it may be impossible for a HIV positive woman to choose alternatives to breastfeeding without advertising

her HIV status to her family or community. However, the risks of disclosure of HIV status to the broader welfare of both mother and infant far outweigh the likely benefits of HIV testing. Thus, the individual benefits that women may receive from sharing HIV test results with their partners need to be balanced against the potential risks that an individual woman may face if she discloses. For this reason, counselors should discuss with a woman the likelihood that she will be ostracized, divorced or otherwise discriminated against if her HIV status is revealed (WHO, 2004).

According to WHO (2004) the potential risks of HIV status disclosure to sexual partners include Loss of economic support; Blame; Abandonment; Physical and emotional abuse; Discrimination; and Disruption of family relationships. Another potential risk of disclosure is the possibility that children may face violence or abandonment as a result of their parent's disclosure of their positive status whether or not the children are also HIV-positive.

Similarly, HIV infection as relevant to gender based violence (GBV) is primarily acquired through sexual relations. GBV, in turn, interfere with the ability to negotiate safer sex or refuse unwanted sex. It also interfere with women abiiity to access treatment and care, maintain adherence to ARV treatment, or carry out her infant feeding choices. Thus, a vicious cycle of increasing vulnerabilities to both GBV and HIV can be established. Moreover, the linkages between violence against women and HIV/AIDS can be explained in the form of direct and indirect mechanisms. The direct one is coercive sex while the indirect risks include unable to negotiate condom use; childhood sexual abuse; partnership with older/riskier men; and deter from seeking HIV testing, prevent disclosure of their status, and delay their access to AIDS treatment and other services (Harvard School of Public Health, 2006; The Foundation for AIDS Research, 2005; WHO, 2004; and Maman et al., 2001).

2.4.5. The process of HIV status disclosure

There is increasing recognition that disclosing one's HIV status is an essential part of behavior modification required to reduce the incidence of HIV. Voluntary counseling and testing for HIV is widely promoted as an important first step in behavior modification. However, without disclosure, few of the benefits can be realized (Norman et al., 2005; WHO, 2004).

Disclosure is to be encouraged, but it is important that people take time to think through the issues carefully (SAT, 2000). It is so because disclosure can be an extremely stressful process that can make one vulnerable to perceived stigma of friends, family or the community. Stigma has been identified as a barrier to health care, social support, and disclosure. However the strategies individuals use to negotiate and counter the fear of rejection and isolation has been relatively under-reported. The way each person experiences and copes with the illness is reflected in the choice of whether, how and to whom to disclose. This decision is embedded within individual perceptions and the local context of HIV/AIDS. Describing and analyzing the internal dialogue pre disclosure, and the event itself is an essential step in designing effective interventions that will facilitate disclosure (Norman et al., 2005).

Disclosure is also fundamental in managing HIV, especially in terms of adhering to complex treatment regimens. For example, HIV-positive people have reported that they sometimes skipped doses because they could not take a prescribed medication without being observed doing so (Chesney and Smith cited in Norman et al., 2005). Moreover, access to other forms of care such as home based care and specific social grants are also dependent upon the disclosure of HIV status. From a health policy perspective, effective response across all levels centers on the creation of an enabling environment for disclosure of HIV status. Hence, disclosure of HIV status has become an entry criterion for many treatment programs in resource constrained settings.

For all people, however, disclosure was not a one-time event, but was experienced as a process. In the space between full, open or public disclosure, and non disclosure, a temporal stage is occupied whereby a positive person manages their HIV disclosure. For some this entails disclosure to some family members, while not for others; i.e., the knowledge of his/her HIV status is mixed within the members of the household. For others, HIV management may necessitate disclosure only to those who work in the health care system or those they feel will offer some support (SAT, 2000).

Other studies have shown that HIV positive people expend considerable energy trying to manage information and manipulate their environments appropriately so as to maintain the appearance of un-infection (Clark et al., 2003). Similarly, in a research nearly all respondents, experienced a

period of struggle before disclosure and had taken a period of time (taking up to a few years) to disclose to those closest to them. During this time, some individuals described the guilt of this burden because they had not disclosed to their loved ones. The daily reality of keeping their status a secret was a very difficult and onerous process. However, for each of the respondents, all eventually disclosed to at least one member of their family, a partner or a friend (Norman et al., 2005).

According to WHO (2004) most studies that have examined HIV status disclosure describe the outcome rather than the process of disclosure. Kimberly has developed a useful framework to describe the decision-making process for disclosure. The framework outlines a six-step process that includes dilemmas, barriers and decisions at each step.

- **Step I**. Adjustment to the diagnosis. At this stage in the disclosure process, individuals may need help adjusting to their diagnosis and reaching a level of personal acceptance.
- **Step II.** Evaluation of personal disclosure skills. Individuals need to evaluate whether they possess the skills necessary for telling others.
- **Step III**. Evaluating the appropriateness of disclosing to a potential recipient. This process involves taking inventory of one's social network and deciding on an individual basis who should be told, taking into account certain criteria such as role and physical distance from that recipient.
- **Step IV**. Evaluating the circumstances for disclosure. There may be certain circumstances that prohibit disclosure to certain individuals.
- **Step V**. Anticipating the reactions of the potential recipients. Individuals need to weigh these anticipated reactions against the anticipated benefits of disclosure to each individual.
- **Step VI**. Identify their motivation for disclosure to each recipient.

The document further explained that by expanding our definition of disclosure from the outcome to the process, we can acknowledge and appreciate the numerous factors that influence the decision to disclose, including individual psychological state, personal communication skills and communication patterns, anticipated reactions and individual motivations for disclosure. We can also think of multiple levels of interventions to help support individuals through the process (WHO, 2004).

3. METHOD OF THE STUDY

In this study, the researcher focused and examined Self-Disclosure Problems among Sexual Partners Living with HIV/AIDS who are clients of two hospitals (namely Black Lion Hospital and Zewuditu Memorial Hospital) in the City Government of Addis Ababa.

The nature of sero-positive status self- disclosure and self-non disclosure, experiences of HIV positive status, the reasons for self disclosure/non-disclosure, and the benefits and risks of HIV positive status self disclosure among sexual partners living with HIV/AIDS have got proper emphasis in this specific research. The effects of the independent variables that include Sex, Age, Educational Background, Religion, Marital Status, Ethnic Group, Employment Status, Working organization's type, and Monthly family income were also examined based on the research questions depicted in this specific study.

3.1 Design

The present survey was designed based on quantitative methods of research. To supplement the quantitative data and triangulation purposes the researcher tried to inject little qualitative data. A detailed structured interview guide in the form of questionnaire was used for the quantitative part of the study, while the qualitative description part of the data was gathered through natural observations, visit reports, interviews, document analysis, and focus group discussions made as relevant to this specific study.

3.2 Participants

Sexual partners living with HIV/AIDS in Addis Ababa City Government were the target population of the study. According to the MOH – HAPCO Monthly HIV Care and ART Update report updated during the data collection period, i.e. as of end of Miyazya 2000 (May 10, 2008) clients ever enrolled on ART only in the public sector were 60,911 and both in the public and private sectors were 68,665 while clients currently on ART only in the public sector were 26,643 and both in the public and private sectors were 30,313 (ARC, 2008). The emphasis was given for sexual partners living with HIV/AIDS because they are the potential sources of HIV infections, especially on their counter partners, that need self-disclosure of ones sero positive-status.

The study was encompassing sexual partners living with HIV/AIDS who were clients of ART Clinics in Black Lion and Zewuditu Memorial Hospitals, from 12 to 30 of May 2008, as major sources of data. Moreover, selected counselors and significant others (officers, experts and researchers) were active participants and significant data sources in the study.

The sampling technique used in this specific study was random sampling technique, taking place in the two different ART Clinics (in the Black Lion and Zewditu Memorial hospitals). Samples of one hundred fifty (150) participants were randomly selected from each hospital that made the total participants of the study 300 individuals who are clients of the two hospitals mentioned above. It was also tried to make sure that the gender wise (male and female) distribution be comparatively proportional in the two hospitals, eventually of the whole study.

To be specific, the participants that were included in the study include:

- Three Hundred (300) randomly selected sexual partners living with HIV/AIDS who were clients of the two purposively selected Hospitals from 12 to 30 May 2008. The participants have participated in the in-depth interview conducted by data collectors, assistant researchers and the researcher himself;
- Purposively selected Four (4) HIV counselors, two from each of the hospitals under study have participated in the information dissemination and interview sessions of the study;
- Ten (10) antiretroviral drug adherents who are members of PLWHA associations have filled out the open ended questionnaire prepared at the initial stage of the study for item collection; and
- Forty Five (45) antiretroviral drug adherents who are members of PLWHA associations and some clients of Addis Ababa Social and Civil Affairs Bureau's Social Problems Prevention, Rehabilitation and Institutionalized Services Coordination Department have participated in the pilot study and filled out the first draft of the deep-interview guide prepared in the form of questionnaire.

3.3 Instruments

The main instrument used in gathering data for this specific study was a structured interview guide prepared in the form of questionnaire. Guiding questions for further interview and focus group discussion were also prepared. The techniques of natural observation, visit reports, interviews, and

document analysis were also applied to understand the problem in depth and supplement the data collected through the structured interview guide/questionnaire.

3.3.1 Structured In-depth Interview Guide in the Form of Questionnaire

The questionnaire was designed and pilot tested by the researcher himself. Some parts of the questionnaire were also adapted and revised by the researcher. After reviewing previous works and collecting possible items through the open-ended questionnaire, the researcher designed the instrument that was used in this specific study.

For these reasons the final draft of the structured interview guide/ questionnaire that was used in the field study includes the following sections:

I. **Demographic and Socio-Economic Information** that include different variables such as Sex, Age, Educational Background, Religion, Marital Status, Ethnic Group, Employment Status, Working organization's type, and Monthly family income. The relevant demographic and socioeconomic related questions were also supplemented the different scales in all the sections of the in-depth structured interview guides/questionnaire. However, all the demographic and socio-economic variables might have an effect in the nature, rates, reasons, benefits and risks of sero-positive status self-disclosure among sexual partners living with HIV/AIDS.

II. **Experiences of HIV Positive Status among Sexual Partners living with HIV/AIDS** that include the time of diagnosis, current CD-4 status, the use of Antiretroviral drugs, the condition of HIV positive status self-disclosure and self-non disclosure, the HIV status of the other partner and the occurrence of unsafe sexual experience after knowing ones' sero-positive status but before disclosing the issue to the other sexual partner(s).

III. **The Benefits and Risks of Sero-Positive Status Self-Disclosure Scale** was a five point Likert scale with eleven items on which four items reflects the positive statements or the benefits of sero-positive status self-disclosure while the rest seven items shows the risks of self-disclosure in the form of negative statements. The items were collected from the compilation of series of research works by WHO (2004). The scale measures the extent of feelings on each item based on one's own evaluation.

IV. **A Scale/ Items on the Types and Levels of HIV Status Disclosure Related Discussions to Sexual Partner(s)** that includes four relevant items with quantifiable options. According to the scores, participants were classified as persons with high-, less-, or non-discussant of issues related to one's sero-positive status self disclosure to their sexual partner(s). This means that all the participants were categorized as individuals who are highly, less or non-discussant of his/her sero-positive status to his/her sexual partner(s).

V. **Reasons for HIV-Positive Status Disclosure/ Non-Disclosure to Sexual Partner(s)**: this five point Likert scale was adopted from a research work entitled "*Reasons for HIV Disclosure or Nondisclosure to Casual Sexual Partners*" (Serovich and Mosack, 2003). It has thirty-one (31) possible items with appropriate options. The total items were divided in to two broad dimensions: Reasons for Sero-Positive Status Self-Disclosure vs. Reasons for Sero-Positive Status Self Non-Disclosure. The former further divided in to four different sub-scales. The sub-scales include: Responsibility, Instruction, Relationship Consequences, and Emotional Release. Whereas, the reasons for sero-positive status non-disclosure was a scale that had no sub-scale.

3.3.2 Interview and Focus Group Discussion Guides

In addition to the deep structured interview conducted by the researcher there were interview sessions and focus group discussions with some selected HIV counselors and other participants in the main study. To this effect, Semi-Structured Interview and Focus Group Discussion guides were prepared for gathering supplementary information from the different groups of participants in this specific study. The information gathered through these instruments was helpful to understand the problem in depth.

3.4 Procedures

An open-ended questionnaire was distributed at the beginning of the study for ART adherents who were members of PLWHA associations. This group of participants was selected from the officials of Tesfa Goh Ethiopia (Down of Hope) PLWHA Association. This was done to collect the possible items concerning self-disclosure problems among sexual partners living with HIV/AIDS. This group of ART adherents who are members of PLWHA associations was purposively selected

for their better experience in self-disclosure; psychological adjustment; and understanding, awareness, and knowledge concerning HIV/AIDS.

The instrument was pilot tested before the field study. In doing so the validity and reliability of the instrument was checked and rechecked by the researcher based on the data collected for the pilot survey. Because, the final research tool or the questionnaire was expected to measure self-disclosure problems among sexual partners living with HIV/AIDS: the rates and possible responses of sero-positive status self-disclosure/non-disclosure; the nature of sero-positive status self-disclosure related discussions and the reasons for sero-positive status self-disclosure and self-non disclosure among sexual partners living with HIV/AIDS.

In the pilot study, the draft of the initially organized Structured Interview Guide/Questionnaire was administered for forty five individuals who are living with HIV/AIDS (n=45) from Tesfa Goh Ethiopia (Down of Hope) PLWHA Association and some clients of Addis Ababa Social and Civil Affairs Bureau's Social Problems Prevention, Rehabilitation and Institutionalized Services Coordination Department.

Moreover, in checking the face validity of the instrument, during the construction of all the scales the comments of two professionals in the area as well as the appraisal of two language experts, both Amharic and English languages, were accepted. The major comments and suggestions got major emphasis and incorporated in the prepared instrument.

Based on the collected data the Alpha method of reliability of the instruments were tested and depicted below.

The Benefits and Risks of Sero-Positive Status Self-Disclosure Scale:

The scoring procedure followed five point Likert scale technique. In the pilot survey the instrument was tested and found to be valid and reliable enough to measure the benefits and risks of self-disclosure among sexual partners living with HIV/AIDS. The scale was reliable in Alpha methods of reliability both in the pilot study (Alpha = 0.9890) and in the main research (Alpha= 0. 9777).

Reasons for HIV Positive Status Self-Disclosure/Non-Disclosure Scale:

Five point Likert scale technique was used in the scoring processes of the scale. The scale was found to be reliable in Alpha methods of reliability both in the pilot study (Alpha = 0.9562) and in the main research (Alpha= 0. 9328).

Scale/Items on the Types and Levels of HIV Positive Status Self-Disclosure Related Discussions:

According to the weight for each option given the minimum and the maximum scores any participant could get are 4 and 20, respectively. The sum of the omitted score values for all the items (if it occurs) was 12. Therefore, participants who have scored 4 to 12 can be categorized as Non-discussant or persons who did not have discussion about their sero-positive status with their sexual partner(s). Those who scored 13 to 15 and 16 to 20 could also be considered as individuals who have discussion about their sero-positive status to their sexual partner(s) in Less-discussant and Highly-discussant manner, in that order.

However, it should be noted that having higher score on the scale is not the only and sufficient condition to have open discussions/self-disclosure, positive growth and mutual developments among sexual partners living with HIV/AIDS. In addition, most of the individuals who scored higher and considered as highly discussant participants did not respond on the fourth item and most others wrote, "*I'll never stop our discussion*".

The Types and Level of HIV positive status Self-Disclosure Related Discussions Scale was reliable in Alpha methods of reliability both in the pilot study (Alpha= 0.7421) and in the main research (Alpha= 0.7604). Moreover, the instrument could discriminate the participants as it is clearly depicted the results of the pilot study in table 3.1.

Types of Sero-positive Status Disclosure	Scale Value	Number of participants	Percentage
Non-Discussant	4-12	23	51.1
Less/Minimal Discussant	13-15	10	22.2
Highly Discussant	16-20	12	26.7
Total		**45**	**100**

Table 3.1 Levels of HIV Positive Status Self-Disclosure Related Discussions

Although most of the participants have indispensable experience in self-disclosure of their sero-positive status to their sexual partners, it was supposed to get lower rate of highly discussant group of participants for the attached SDD or probable risks of self-disclosure. The results of the pilot study were also revealed the same. Therefore, this instrument was found to be valid and reliable to be used in this specific study.

Before conducting this specific study approval and permission was sought from the department's thesis research committee. After getting the approval and permission of the designed research by the department and the assigned thesis research advisor, Regional Ethics Review Committee (i.e., Ethical Review Committee of the Addis Ababa City Government Health Bureau) was requested to review and evaluate the thesis research proposal and the related research tools (the consent letter and the Structured Interview Guide/Questionnaire in both Amharic and English Versions). The committee approved the thesis research in written only after the comments given by the committee were incorporated in the research documents (see Appendix C).

Moreover, due care was taken to ensure that all those who accept to participate in the study do so voluntarily and give their informed consent. After research participants who are above 18 years of age were selected, the principal investigator and data collectors of this specific study explained to them the aims and objectives of the study. In addition, those who agree to participate in the study were given a chance to ask for any clarification about points on which they are not clear. They were informed that any information collected during the course of the study would be kept confidential and that no personal name would appear on research documents, instead code was used. Furthermore, written consent was sought for participating on the structured interview.

3.5 Method of Data Analysis

The data was tabulated, analyzed and interpreted in line with the research questions raised by this specific study by using quantitative with little qualitative analyses. Moreover, both descriptive (percentage, mean and standard deviation) and inferential statistics (Chi-Square) were employed in the analysis of the study. The association of types and level of self-disclosure related discussions to the background variables was also tested by Chi-square (X^2) statistical tests.

4. FINDINGS OF THE STUDY

In this study self-disclosure problem among sexual partners living with HIV/AIDS was studied. The data collected for the study encompasses biographic information and socioeconomic status of the participants, their experiences in living with HIV/AIDS, the reasons for self-disclosure/non-disclosure, the benefits and risks of self-disclosure, and their types and levels of self-disclosure related discussions to their sexual partner(s), The results of all the information gathered for this specific study was discussed as follows:

4.1. Biographic and Socioeconomic Information of the Participants

A total of three hundred (300) individuals who are living with HIV/AIDS were randomly selected from the two hospitals namely, Black Lion and Zewditu Memorial Hospitals, proportionally. The biographic and socioeconomic information of all the participants that includes the sub cities covered, sex, age, educational background, religion, marital status, ethnic group, employment status, organizational type and monthly family average income were gathered and discussed as described below.

Table 1 presents the respondents' distribution by sub city and sex in the study.

Table 1: **Sub city and Sex wise Distribution**

Sub City and Sex		Respondents	
		N	%
Sub City:	Addis Ketema	5	1.7
	Akaki-Kaliti	35	11.7
	Arada	41	13.7
	Bole	15	5.0
	Gullele	20	6.7
	Kirkos	75	25.0
	Kolfe-Keranyo	24	8.0
	Lideta	44	14.7
	Nifassilk-Lafto	14	4.7
	Yeka	27	9.0
	Total	**300**	**100.0**
Sex:	Male	136	45.3
	Female	164	54.7
	Total	**300**	**100.0**

As seen from Table 1, all the ten sub cities were included in the study. A quarter of the participants (N=75) were from Kirkos sub city and 1.7 percent (N=5) of them were from Addis Ketema Sub city. Almost 53.3 percent of the participants were from Kirkos, Lideta and Arada sub cities. The participants from the remaining seven sub cities were 46.8 percent.

It is also seen from Table 1 that 54.7 percent (N=164) of the participants were female while the rest 45.3 percent (N=136) were male.

Table 2 Portrays the age and education wise distributions of the participants' in this study.

Table 2: **Age and Education**

Age and Education		Respondents	
		N	%
Age in Years:	18-24	31	10.3
	25-34	150	50.0
	35-44	85	28.3
	45-54	28	9.3
	Above 55	6	2.0
	Total	**300**	**100.0**
Education:	Illiterate	23	7.7
	Elementary	75	25.0
	Secondary	122	40.7
	Certificate	34	11.3
	Diploma	36	12.0
	First Degree	8	2.7
	Post graduate degree	2	0.7
	Total	**300**	**100.0**

As observed from Table 2, half of the participants (N=150) were at the age range of 25 to 34 years olds. Participants who were above 55 years old during the study period were only two percent (N=6) of the participants.

Table 2 further showed that 40.7 percent (N=122) of the participants were in their secondary education while only 3.4 percent (N=10) of them were degree holders. In general, 84.7 percent (N=220) of the participants were under secondary education and the rest 15.3 percent (N=80) were certificate, diploma and degree holders.

Table 3 reveals the religious affiliation, marital status and ethnicity of the participants' in this study.

Table 3: **Religion, Marital Status and Ethnicity**

Religion, Marital Status and Ethnicity		Respondents	
		N	%
Religion:	Orthodox	198	66.0
	Protestant	60	20.0
	Catholic	6	2.0
	Muslim	34	11.3
	Others	2	0.7
	Total	**300**	**100.0**
Marital Status:	Married	127	42.3
	Divorced	29	9.7
	Widowed	39	13.0
	Dating/ Cohabiting	105	35.0
	Total	**300**	**100.0**
Ethnicity:	Amhara	114	38.0
	Gurage	16	5.3
	Oromo	58	19.3
	Silte	3	1.0
	Tigre	22	7.3
	Others	9	3.0
	Missing Items	78	26.0
	Total	**300**	**100.0**

As seen in Table 3, 66 percent (N=198) of the participants were followers of Orthodox Christianity while 11.3 percent (N=34) of them were Muslims. The table further showed that 42.3 percent (N=127) of the participants were married couples. 22.7 percent (N=68) of the participants were also divorced and widowed. Moreover, 57.3 percent (N=172) of the participants were from the Amhara and Oromo ethnic groups while participants form the other ethnic groups were 42.7 percent (N=128).

Table 4 discloses the employment status, organizational types and average monthly family income of the participants' in this study.

Table 4: **Employment Status, Organizational Types and Average Monthly Family Income**

Employment Status, Organizational Types and Average Monthly Family Income	Respondents		
	N	%	% out of the Employed Group
Employment Status: Employed	171	57.0	
Unemployed	117	39.0	
Retired	12	4.0	
Total	**300**	**100.0**	
Organizational Types: Governmental Org.	59	19.7	34.5
Non-Governmental Org.	31	10.3	18.1
Private Organizations	30	10.0	17.5
Self-Employed	51	17,0	29.8
Skipped Items	129	43.0	
Total	**300**	**100.0**	**100.0**
Av. Monthly Family Income: Below 200 birr	98	32.7	
201-500 birr	103	34.3	
501-1000 birr	38	12.7	
1001-1500 birr	28	9.3	
1501-2000 birr	14	4.7	
Above 2000 birr	19	6.3	
Total	**300**	**100.0**	

It can be seen from Table 4 that 57 percent (N=171) of the participants were employed while the rest 43 percent (N=129) of them were under employed (unemployed and retired). From the employed group of participants 70.2 percent (N=120) were employees in GOs, NGOs and private organizations while the rest 29.8 percent (N=51) of them were self-employed. The table further discloses that 79.7 percent (N=239) of the participants got an average monthly family income of less than Eth. Birr 1,000.00. 20.3 percent (N=61) of the remaining participants also got an average monthly family income of more than Eth. Birr 1,000.00.

4.2 Experiences of HIV Positive Status among Sexual Partners Living with HIV/AIDS

Table 5 reveals the participants' personal experiences, especially time since diagnosed and ways to know their sero positive status.

Table 5: **Time Since Diagnosed and Ways to Know Sero Positive Status**

Time Since Diagnosed and Ways to Know Sero Positive Status	Respondents	
	N	%
Time Since Diagnosed: Only before three months	27	9.0
3-12 months	42	14.0
1-3 years	80	26.7
3-5 years	76	25.3
5-10 years	56	18.7
Above 10 years	19	6.3
Total	**300**	**100.0**
Ways to Know Sero Positive Status Through medical related testing	193	64.3
Through non-medical related testing	107	35.7
Total	**300**	**100.0**

As it is clearly shown in Table 5, most of the respondents reported that they knew their HIV positive status with in 1 to 5 years period (52%, N=156). About a quarter of them (N=69) were also reported that they knew their sero-positive status with in a year period. The table further revealed that 64.3 percent (N=193) of the participants knew their sero positive status through medical related testing while the rest 35.7 percent (N=107) of them knew through non-medical related testing, especially for passport and marriage processes.

Table 6 discusses the participants' CD-4 status, use of ART and the reasons for non use of ART drugs (if any).

Table 6: **CD-4 Status, Use of ART and Reason for non use of ART**

CD -4 Status, Use of ART and Reason for non use of ART drugs		Respondents		
		N	%	% out of All ART Users
CD -4 Status:	Only less than 100	20	6.7	
	101-150	36	12.0	
	151-200	48	16.0	
	201-250	49	16.3	
	251-300	59	19.7	
	Above 300	88	29.3	
	Total	**300**	**100.0**	
Use of ART:	Yes	218	72.7	
	No	82	27.3	
	Total	**300**	**100.0**	
Reason for non use of ART:	My doctor did not recommend it since my CD-4 status is ok.	46	15.3	56.1
	Although my doctor recommended it, I still need some more counseling.	10	3.3	12.2
	Although my doctor recommended it, I still need some more time for decision.	11	3.7	13.4
	Although my doctor recommended it, I do not have enough access to enough and nutritious foods.	15	5.0	18.3
	Skipped Items (ART users)	218	72.7	
	Total	**300**	**100.0**	**100.0**

It is clearly depicted in Table 6 that about 34.7 percent (N=104) of the participants had a CD-4 count of less than 200 while the rest 65.3 percent (N=196) of them had a CD-4 count of greater than 200. Table 6 further described that from all the participants the majority (27.3 percent, N=82) had started using the antiretroviral drugs while 27.3 percent (N=82) of them did not yet started using antiretroviral drugs, irrespective of the reasons for non-use of the drugs.

Moreover, 56.1 percent (N=46) of those who had not yet started ART have reported that they did not yet started ART because they had better CD-4 count and their doctor did not yet recommend their use of antiretroviral drugs. The rest 43.9 percent (N=36) of those who did not yet started ART also reported that they did not yet started ART because they 'did not have enough access for adequate and nutritious food', 'needs some more time to decide', and 'needs some more counseling on sero-positivity'.

4.3 HIV Positive Status Disclosure/Non-Disclosure of the Participants

Table 7 discusses the rate of self-disclosure among sexual partners living with HIV/AIDS and the time period for their self-disclosure processes.

Table 7: **Rate of Self-Disclosure and Time for Self-Disclosure**

Rate of Self-Disclosure and Time for Self-Disclosure	Respondents		
	N	%	% out of All ART Users
Rate of Self-Disclosure: Yes (Self-Disclosed)	192	64.0	
No (Self- Non Disclosed)	108	36.0	
Total	**300**	**100.0**	
Time for Self-Disclosure: The same day.	84	28.0	43.75
Within a week.	22	7.3	11.5
Within a month.	28	9.3	14.6
Within three months.	41	13.7	21.4
Others	17	5.7	8.8
Skipped Items (Non-disclosed)	108	36.0	--
Total	**300**	**100.0**	**100.0**

Table 7 shows that about 64.0 percent (N=192) of the participants responded the question 'did you disclose your HIV status to your sexual partner(s)?' positively while 36.0 percent (N=108) of them responded the question negatively. This means that 64.0 percent of the participants have disclosed their sero-positive status to their sexual partner(s) while 36.0 percent of them did not yet disclosed their sero-positive status to their sexual partner(s).

Moreover, those who have disclosed their sero-positive status at the same day when they have diagnosed were 43.75 percent (N=84) of the self-disclosed participants while the rest 56.25 percent (N=108) of them took a week or more time period for their sero-positive status disclosure since their HIV diagnosis.

4.4 Benefits and Risks of Self-disclosure among Sexual Partners living with HIV/AIDS

Sero-positive status self-disclosure to one's sexual partner(s) might have different kinds of benefits and probably risks. These benefits and risks can be easily seen from the following discussions.

4.4.1. General Findings

Table 8 describes the general findings concerning the benefits and risks of self disclosure experienced by sexual partners living with HIV/AIDS.

Table 8: **Results of the General Findings**

S/N	Benefits and Risks of Self-Disclosure	Always		Many times		Missed Items		Some-times		*Not at all (Never)*	
		N	%	N	%	N	%	N	%	N	%
1.	Blame.	18	9.38	28	14.58	1	0.52	51	26.56	94	*48.96*
2.	Increased opportunities for instrumental and expressive social support.	88	45.83	31	16.15	2	1.04	38	19.79	33	*17.19*
3.	Disruption of family relationship.	22	11.46	24	12.50	1	0.52	36	18.75	109	*56.77*
4.	Discrimination.	17	8.85	24	12.50	2	1.04	50	26.04	99	*51.56*
5.	Improved access to necessary medical treatment and care.	107	55.73	45	23.44	1	0.52	16	8.33	23	*11.98*
6.	Violence or abandonment on children.	12	6.25	23	11.98	8	41.67	31	16.15	118	*61.46*
7.	Increased opportunities to discuss and implement HIV risk reduction with partners.	97	50.52	42	21.86	2	1.04	38	19.79	13	*6.77*
8.	Physical and emotional abuse.	14	7.29	27	14.06	5	2.60	38	19.79	108	*56.25*
9.	Increased opportunities to plan for the future carefully and thoughtfully.	97	50.52	44	22.92	3	1.56	32	16.67	16	*8.33*
10	Loss of economic support.	13	6.77	16	8.33	2	1.04	41	21.35	120	*62.50*
11	*Abandonment.*	*16*	*8.33*	*13*	*6.77*	*4*	*2.08*	*41*	*21.35*	*118*	*61.46*

The general findings of the study showed that most of the participants were strongly agree with the positive statements that reflect the benefits of self disclosure while most of them showed strong disagreement with the negative statements that illustrate the risks of self disclosure. As it is shown in Table 8, about 48.96 percent (N=94), 56.77 percent (N=109), 51.56 percent (N=99), 61.46 percent (N=118), 56.25 percent (N=108), 62.50 percent (N=120), and 61.46 percent (N=118) reflects their strong disagreement on the risks of self disclosure that includes Blame, Disruption of family relationship, Discrimination, Violence or abandonment on children, Physical and emotional abuse, Loss of economic support, and Abandonment, in that respective order.

On the other hand, Increased opportunities for instrumental and expressive social support, Improved access to necessary medical treatment and care, Increased opportunities to discuss and implement HIV risk reduction with partners, and Increased opportunities to plan for the future carefully and thoughtfully have got strong agreement by 45.83 percent (N=88), 55.73 percent (N=107), 50.52 percent (N=97), and 50.52 percent (N=97), respectively.

Table 9 clarifies the mean and standard deviation of both the benefits and risks of self-disclosure among sexual partners living with HIV/AIDS.

Table 9: **Benefits and Risks of Sero-positive Status Disclosure**

Benefits and Risks	N	Mean	Std. Deviation
RISKS	192	28.51	6.747
BENEFITS	192	15.36	4.105
Valid N (list wise)	192		

In addition, the mean scores, see Table 9, of both benefits of sero-positive status disclosure (mean of 15.36 with s.d. = 4.105) and risks of sero-positive status disclosure (mean of 28.51 with s.d.= 6.747) found to be highest that reflects the opportunity to utilize the benefits and refrains from the risks of sero-positive status disclosure among sexual partners living with HIV/AIDS is abundant among the participants in this specific study.

4.4.2 The Positive Outcomes/Benefits of Self-disclosure among Sexual Partners living with HIV/AIDS

The positive outcomes of sero-positive status disclosure to one's sexual partner(s) might be many and diversified. But, it can be categorized in four broad areas as follows.

Table 10 reveals the mean and standard deviation of the four items on the benefits of self-disclosure.

Table 10: **Positive Outcomes (Benefits) of Self-disclosure**

Positive Outcomes	N	Mean	Std. Dev.
Increased opportunities for instrumental and expressive social support.	192	3.54	1.614
Improved access to necessary medical treatment and care.	192	4.03	1.408
Increased opportunities to discuss and implement HIV risk reduction with partners.	192	3.90	1.384
Increased opportunities to plan for the future carefully and thoughtfully.	192	3.91	1.392
Valid N (list wise)	192	15.36	4.105

The mean values that represent the four general benefits of HIV sero-positive status to one's sexual partner(s) have been calculated and found to be highest in this specific study. According to the calculated mean values improved access to the necessary medical treatment and care got the priority with a mean score of 4.03 (with s.d.=1.408). Other kinds of benefits that include improved opportunities to plan for the future carefully and thoughtfully; increased opportunities to discuss and implement HIV risk reduction with partners; and increased opportunities for instrumental and expressive social support showed a mean statistic values of 3.91 (with s.d.=1.392), 3.90 (with s.d.1.384), and 3.54 (with s.d.=1.614) in that respective order.

4.4.3 The Negative Effects (Risks) of Self-disclosure experienced by Sexual Partners living with HIV/AIDS

There might be different risks associated with one's sero-positive status disclosure to his/her sexual partner(s). Seven well searched items on the risks of sero-positive status disclosure were given for all participants in the deep-interview questionnaire. All the participants have responded for each item based on their knowledge and experience related to sero-positive status. The mean and standard deviation statistics of each item as well as the total items is depicted below in Table 11.

Table 11 reflects the mean and standard deviation statistics of the seven items on the risks of self-disclosure among sexual partners living with HIV/AIDS.

Table 11: **The Negative Effects (Risks) of Self-disclosure**

The Negative Effects	N	Mean	Std. Deviation
Blame.	192	3.91	1.387
Disruption of family relationship.	192	3.97	1.454
Discrimination.	192	3.99	1.354
Violence or abandonment on children.	192	4.15	1.298
Physical and emotional abuse.	192	4.04	1.347
Loss of economic support.	192	4.24	1.235
Abandonment.	192	4.21	1.273
Valid N (list wise)	192	28.51	6.747

The calculated mean values for the risks of sero-positive status self-disclosure to one's sexual partner(s) showed that Loss of economic support, Abandonment, Violence or abandonment on children, Physical and emotional abuse, Discrimination, Disruption of family relationship, and Blame have got a mean value of 4.24 (with s.d.=1.235), 4.21 (with s.d.=1.273), 4.15 (with s.d.=1.298), 4.04 (with s.d.=1.347), 3.99 (with s.d.=1.354), 3.97 (with s.d.=1.454), and 3.91 (with s.d.=1.387), respectively.

4.5 Types and Levels of Self- disclosure Related Discussions

The participant of this specific study can be categorized in to two broad areas (Discussant vs. Non-discussant) based on their type of sero-positive status self disclosure related discussion to their sexual partners. Moreover, based on their level of self-disclosure related discussions the discussant group of participants can be categorized in to two groups; i.e., highly discussant vs. less discussant group of participants. The discussion for both the types and levels of self-disclosure related discussions discussed as follows.

4.5.1 Types of Self- disclosure Related Discussions

Table 12 shows the mean and standard deviation statistics based on types of self-disclosure related discussions with sexual partner(s) living with HIV/AIDS.

Table 12: **Types of Self- disclosure**

Types of Self-Disclosure Related Discussions	Frequency	Percent	Mean	*Standard Deviation*
Non-Discussant	74	24.7	6.41	*1.364*
Discussant	226	75.4	13.76	*3.353*
Total	*300*	*100.0*	*11.94*	*4.358*

From all the participants, about 75 percent (N=226) responded that they have self-disclosure related discussions with their sexual partners while the rest 25 percent (N=74) showed that they did not have self-disclosure related discussion with their sexual partners.

Moreover, the calculated mean and standard deviation statistics also revealed a clear difference in the types of self disclosure related discussions among sexual partners living with HIV/AIDS. Based on the results, those who did not have self-disclosure related discussions got a mean value of 6.41 (with s.d.=1.364) while those who have self-disclosure related discussion with their sexual partners living with HIV/AIDS showed a mean score of 13.76 (with s.d.=3.353). In general, the total participants found to have self-disclosure related discussion that could be understood from the mean score values, i.e., a mean score values of 11.94 (with s.d.=4.358).

4.5.2 Levels of Self- disclosure Related Discussions

Table 13 describes the levels of self-disclosure related discussions among sexual partners living with HIV/AIDS.

Table 13: **Levels of Self- disclosure Related Discussions**

Levels of Self-Disclosure Related Discussions	Freq-uency	Percent	Sum	Mean	*Standard Deviation*
Non-Discussant	74	24.7	474	6.41	*1.364*
Less-Discussant	146	48.7	1698	11.63	*1.990*
Highly-Discussant	80	26.7	1411	17.64	*1.070*
Total	*300*	*100.0*	*3583*	*11.94*	*4.358*

In discussing the levels or frequency of self-disclosure related discussions among sexual partners living with HIV/AIDS a clear difference in the results was seen. Those who did not discuss their sero-positive status to their sexual partner(s) accounts for 24.7 percent (N=74) while those who discussed their sero-positive status to their sexual partner(s) in less and high levels accounts for 48.7 percent (N=146) and 26.7 percent (N=80), respectively. The calculated mean scores (see Table 13) revealed the same. Those who did not have disclosure related discussions and those who have both less and higher levels of self-disclosure related discussions revealed a mean scores of 6.41 (with s.d.=1.364), a mean scores of 11.63 (with s.d.=1.990) and a mean scores of 17.64 (with s.d.=1.070) in that respective order. But, average mean for all the participants of this specific study showed that all the participants were found to be less frequently discussant of their sero-positive status to their sexual partner(s). They scored a mean value of 11.94 (with s.d. = 4.358).

4.5.3 Associations of Types and Levels of Self- disclosure Related Discussions with the Participants' Background Information

Table 14 discusses the association of types and levels of self-disclosure related discussion with the hospitals used by the participants.

Table 14. Hospitals Used

Hospitals Used	Highly Discussant				Less Discussant				Discussant				Non-Discussant			
	N	%	Mean	S.d.	N	%	Mean	S.d.	N	%	Mean	S.d.	N	%	Mean	S.d.
Black Lion Hospital	40	50	17.65	1.051	74	50.7	11.15	1.78	114	50.4	13.43	3.484	36	48.6	6.19	1.348
Zewditu Memorial Hospital	40	50	17.63	1.102	72	49.3	12.13	2.082	112	49.6	14.09	3.195	38	51.4	6.61	1.366
Total	80	100	17.64	1.07	146	100	11.63	1.99	226	100	13.76	3.353	74	100	6.41	1.364
Chi-Square (χ^2) Value	χ^2= 0.010, df=1 χ^2 (1,0.05) = 3.841								χ^2== 0.072, df=1 χ^2 (1,0.05) = 3.841							

The participation rate of clients in the two studied hospitals were distributed equally early at the beginning of the data collection process purposively. The participants were expected to differ both in the types and levels of self-disclosure related discussions based on the hospitals they used. However, the participants' type and level of self-disclosure related discussions found to be proportional. Most of the participants who were clients in both hospitals (50.7 percent of Black Lion and 49.3 percent of Zewditu Memorial Hospital clients) found to be less discussant of their

sero-positive status to their sexual partner(s). Those who were found to be non-discussant participants both from Black Lion and Zewditu Memorial Hospitals accounts for 48.6 percent and 51.4 percent, respectively. Moreover, the results of the calculated mean and the related standard deviation statistic values showed the same.

In addition, the non-parametric chi-square calculation was computed to clearly observe the relationship between the types and levels of self-disclosure related discussions based on the hospitals they prefer to use. The null hypothesis of *'is hospitals used independent of the participants' types and levels of self-disclosure related discussions, both in extent and frequency'* was statistically tested.

Examination of the obtained Chi-square statistic also revealed insignificant difference both in the type (Discussant vs. Non-Discussant: χ^2 (1, 0.05) = 0.072) and levels (Highly Discussant vs. Less Discussant: χ^2 (1, 0.05) = 0.010) of self-disclosure related discussions. This means that the hospitals used was found to be independent and showed no significant group differences in the clients' types and levels of self- disclosure related discussion to one's sexual partner(s).

Table 15 discusses the association of types and levels of self-disclosure related discussion with the sub city covered by the study.

Table 15. Sub Cities Covered

Sub City	Highly Discussant				Less Discussant				Discussant				Non-Discussant			
	N	%	Mean	S.d.	N	%	Mean	S.d.	N	%	Mean	S.d.	N	%	Mean	S.d.
Addis Ketema	1	1.3	18.00	-	4	2.7	11.75	1.708	5	2.2	13.00	3.162	-		-	-
Akaki-Kaliti	9	11.3	17.33	0.707	16	11.0	11.19	1.601	25	11.1	13.40	3.291	10	13.5	9.90	0.994
Arada	11	13.8	17.45	0.934	22	15.1	11.77	2.159	33	14.6	13.67	3.276	8	10.8	5.25	1.488
Bole	5	6.3	18.20	1.789	7	4.8	12.14	2.41	12	5.3	14.67	3.750	3	4.1	7.33	1.155
Gullele	5	6.3	17.00	1.000	12	8.2	12.00	1.859	17	7.5	13.47	2.853	3	4.1	7.67	0.577
Kirkos	24	30.0	17.87	1.116	33	22.6	11.33	2.146	57	25.2	14.09	3.709	18	24.3	6.78	1.166
Kolfe-Keranyo	5	6.3	18.40	1.140	10	6.8	11.70	2.497	15	6.6	13.93	3.882	9	12.2	6.78	0.972
Lidata	15	18.8	17.47	0.990	17	11.6	11.47	1.586	32	14.2	14.28	3.314	12	16.2	5.67	1.497
Nifassilk-Lafto	1	1.3	18.00	-	7	4.8	11.00	2.236	8	3.5	11.88	3.227	6	8.1	7.00	1.095
Yeka	4	5.0	17.00	0.816	18	12.3	12.28	1.904	22	9.7	13.14	2.550	5	6.8	5.00	1.000
Total	80	100	17.64	1.070	146	100	11.63	1.990	226	100	13.76	3.353	74	100	6.41	1.364
Chi-Square (χ^2) Value	χ^2 = 8.735, df=9 χ^2 (9,0.05) = 16.919								χ^2 = 9.040,df=9 χ^2 (9,0.05) = 16.919							

The sub city wise distribution of participants showed a clear difference in the rate of participation. The rate of participation ranges from lowest 1.7 percent (N=5) in Addis Ketema Sub city to the highest of 25 percent (N=75) in Kirkos Sub city. Like wise, the rates of both the

types and levels of self-disclosure related discussions follow similar patterns although the distribution varies a lot.

From the total participants only 26.7 percent (N=80) were found to be highly discussant concerning their sero-positive status with their sexual partner(s). In this respect, Kirkos, Lideta, Arada and Akaki-Kaliti sub cities found to be better than others, with a participation rate of 30 percent (N=24), 16.6 percent (N=15), 13.6 percent (N=11) and 11.3 percent (N=9) in that respective order. About a quarter (N=74) of all the participants were found to be none or very less discussant of their HIV positive status with their sexual partner(s). In line with this, highest percentages were found in Kirkos (N=16 or 24.3%), Lideta (N=12 or 16.2%), Akaki-Kaliti (N=10 or 13.5%), Kole-Keranyo (N=9 or 12.2%), and Arada (N=8 or 10.6%) sub cities than others. However, the majority of all the participants (N=146 or 48.7%) were found to be less discussant of their sero-positive status to their sexual partner(s). Moreover, the calculated mean and standard deviation statistics also showed similar results.

In testing the null hypothesis of *'Is participants' Sub city independent of the types and levels of self-disclosure related discussions of ones sero-positive status'* the calculated Chi-square statistic showed a significant group difference. Thus, there is no significant group differences both in the types (Discussant vs. Non-Discussant: χ^2 (1, 0.05) = 9.040) and levels (Highly Discussant vs. Less Discussant: χ^2 (1, 0.05) = 8.735) of self-disclosure related discussions among participants based on their sub city.

Table 16 discusses the association of types and levels of self-disclosure related discussion with the participants' Sex.

Table 16. Sex

Sex	Highly Discussant				Less Discussant				Discussant				Non Discussant			
	N	%	Mean	S.d.	N	%	Mean	S.d.	N	%	Mean	S.d.	N	%	Mean	S.d.
Male	40	50	17.55	1.061	63	43.2	11.79	2.009	103	45.6	14.03	3.291	33	44.6	6.39	1.321
Female	40	50	17.73	1.086	83	56.8	11.51	1.978	123	54.4	13.53	3.400	41	55.4	6.41	1.414
Total	80	100	17.64	1.070	146	100.0	11.63	1.990	226	100	13.76	3.353	74	100	6.41	1.364
Chi-Square (χ^2) Value	χ^2 = 0.977, df=1 χ^2 (1,0.05) = 3.841								χ^2 = 0.022,df=1 χ^2 (1,0.05) = 3.841							

From the total highly disclosed participants the sex wise disparity is null; the participation rate of both sexes found to be 50 percent (N=40). But, both in the less discussant and non-discussant groups of participants females showed highest level of participation, with 56.8 percent (N=83) and 55.4 percent (N=41) respectively. The calculated mean and standard deviation statistics showed the same result.

A null hypothesis that could be written as *'Is the participants' sex-wise difference independent of their types and levels of sero-positive status disclosure to one's sexual partner(s) related discussions'*. The calculated Chi-square statistic revealed that there was no significant group difference in the participants sero-positive status disclosure related discussions to their sexual partner(s) based on their sex wise differences, both in the types (Discussant vs. Non-Discussant: χ^2 (9, 0.05) = 0.022) and levels (Highly Discussant vs. Less Discussant: χ^2 (9, 0.05) = 0.977).

Table 17 discusses the association of types and levels of self-disclosure related discussion with the participants' age.

Table 17. Age

Age	Highly Discussant				Less Discussant				Discussant				Non Discussant			
	N	%	Mean	S.d.	N	%	Mean	S.d.	N	%	Mean	S.d.	N	%	Mean	S.d.
8-24 Years Olds	5	6.25	18	1.581	18	12.3	11.17	2.383	23	10.2	12.65	3.626	8	10.8	6.38	1.685
25-34 Years Olds	47	58.75	17.85	1.142	63	43.2	11.30	1.820	110	48.7	14.10	3.609	40	54.1	6.53	1.261
35-44 Years Olds	23	28.75	17.30	0.635	42	28.8	12.12	1.978	65	28.8	13.95	2.981	20	27.0	6.15	1.565
45-54 Years Olds	5	6.25	16.80	0.837	19	13.0	11.79	1.960	24	10.6	12.83	2.729	4	5.4	6.75	1.258
Above 55 Years Olds	-		-	-	4	2.7	13.00	2.160	4	1.8	13.00	2.160	2	2.7	6.00	0.00
Total	80	100	17.64	1.070	146	100	11.63	1.990	226	100	13.76	3.353	74	100	6.41	1.364
Chi-Square (χ^2) Value	**χ^2 = 8.735, df=4 χ^2 (4,0.05) = 9.488**								**χ^2 = 9.040, df=4 χ^2 (4,0.05) = 9.488**							

From the total participants those who were found to be highly, less and non-discussant groups of participants accounts for 26.67 percent (N=80), 48.67 percent (N=146), and 24.67 percent (N=74), respectively. 58.75 percent (N=47) and 28.75 percent (N=23) of all the highly discussant group of participants were found to be at the age range of (25-34 years olds) and (35-44 years olds), respectively. Whereas, no one who was at the age range of (above 55 years olds) found to be highly discussant about his/her HIV-infections to his/her sexual partner(s).

Those participants who are in the middle ages of (25-34 years olds) (N=63 or 43.2%), and (45-54 years olds) (N=42 or 28.8%) have shown less level of sero-positive status disclosure related discussion with their sexual partner(s). Similarly, those who were in the middle ages of (25-34 years olds) (N=40 or 54.1%) and (35-44 years olds) (N=20 or 27.0%) were found to be non-discussant of their sero-positive status with their sexual partner(s). Moreover, the calculated mean and standard deviation statistics revealed the same.

To test the null hypotheses *'is the participants' age independent of their types and levels of sero-positive status disclosure related discussions to one's sexual partner(s)'* was computed. The calculated chi-square statistic value revealed that age has no significant relation both in the types (Discussant vs. Non-Discussant: χ^2 (4, 0.05) = 2.270) and levels (Highly Discussant vs. Less Discussant: χ^2 (4, 0.05) = 8.780) of self-disclosure related discussion to ones sexual partner(s).

Table 18 discusses the association of types and levels of self-disclosure related discussion with the participants' educational background.

Table 18. Educational Background

Educational Background	Highly Discussant				Less Discussant				Discussant				Non Discussant			
	N	%	Mean	S.d.	N	%	Mean	S.d.	N	%	Mean	S.d.	N	%	Mean	S.d.
Illiterate	3	3.8	18.0	1.732	12	8.2	12.00	2.374	15	6.6	13.2	3.321	8	10.8	6.25	1.669
Elementary	15	18.8	17.87	1.302	39	26.7	11.10	1.744	54	23.9	12.98	3.461	21	28.4	6.57	1.363
Secondary	33	41.3	17.67	1.109	57	39.0	11.98	1.95	90	39.8	14.07	3.228	32	43.2	6.41	1.411
Certificate	12	15	17.92	0.793	16	11.0	11.88	2.094	28	12.4	14.46	3.459	6	8.1	6.50	1.049
Diploma	14	17.5	17.07	0.73	16	11.0	11.56	2.22	30	13.3	14.13	3.256	6	8.1	6.00	1.414
First Degree	2	2.5	17.5	0.707	5	3.4	10.40	1.949	7	3.1	12.43	3.823	1	1.4	6.00	0
Post graduate degree	1	1.25	17.0	0	1	0.7	11.00	0	2	0.7	14.00	4.243	-		-	-
Total	80	100	17.64	1.07	146	100	11.63	1.99	226	100	13.76	3.353	74	100	6.41	1.364
Chi-Square (χ^2) Value	**χ^2 = 5.666, df=6 χ^2 (6,0.05) =12.592**								**χ^2 = 5.309, df=6 χ^2 (6,0.05) = 12.592**							

Among those who were non-discussant group of their sero-positive status to their sexual partner(s) secondary and primary education accounts for 43.2 percent (N=32) and 28.4 percent (N=21), respectively. No participants were found to be non-discussant in the postgraduate level. From all less-discussant groups of participants about 65 percent or more were found to be at their secondary (N=57 or 39.0%) and primary (N=39 or 26.7%) education. Certificate and diploma holders were also accounts for 11.0 percent (N=16) each from less-discussant groups of participants. Similarly, 41.3 percent (N=33), 18.8 percent (N=15), 17.5 percent (N=14), and 15 percent (N=12) of all those who were found to be highly discussant group of participants were

found to be at their secondary education, elementary education, diploma holders and certificate holders, respectively. Moreover, the calculated mean and standard deviation statistics also showed similar results as discussed so far.

Moreover, the results of the calculated chi-square statistic on the null hypotheses of *'is the participants' educational background is independent of their types and levels of sero-positive status disclosure related discussions to one's sexual partner'* revealed that the participants' educational background has no significant relation both in the types (Discussant vs. Non-Discussant: χ^2 (6, 0.05) = 5.309) and levels (Highly Discussant vs. Less Discussant: χ^2 (6, 0.05) = 5.666) of self-disclosure related discussion to ones sexual partner(s).

Table 19 discusses the association of types and levels of self-disclosure related discussion with the participants' religious affiliation.

Table 19. Religious Affiliation

Religious Affiliation	Highly Discussant				Less Discussant				Discussant				*Non-Discussant*			
	N	%	Mean	S.d.	N	%	Mean	S.d.	N	%	Mean	S.d.	N	%	Mean	*S.d.*
Orthodox	54	67.5	17.69	1.130	96	65.8	11.81	2.048	150	66.4	3.34	3.336	48	64.9	6.27	*1.284*
Protestant	13	16.25	17.31	1.032	29	19.9	10.97	1.762	42	18.6	12.93	3.352	18	24.3	6.72	*1.447*
Catholic	3	3.75	18.00	0.000	3	2.1	14.00	1.000	6	2.7	16.00	2.280	-	-		
Muslim	10	12.5	17.70	0.949	17	11.6	11.47	1.700	27	12.0	13.78	3.389	7	9.5	6.29	*1.701*
Others	-	-	-	-	1	0.7	9.00	0.000	1	0.4	9.00	0.000	1	1.4	8.00	*0.000*
Total	80	100	17.64	1.070	146	100	11.63	1.990	226	100	13.76	3.353	74	100	6.41	*3.353*
Chi-Square (χ^2) Value	*χ^2 = 1.526, df=4 χ^2 (4,0.05) =9.488*								*χ^2 = 2.897, df=4 χ^2 (4,0.05) = 9.488*							

From all the participants 66 percent (N=198) were found to be followers of Orthodox Christianity while Protestants, Catholics and Muslims accounts for 20 percent (N=60), 2 percent (N=6) and 11.3 percent (N=34), respectively. From the 74 non-discussant group of participants those who were followers of Orthodox Christianity and Protestant Christianity accounts for 64.9 percent (N=48) and 24.3 percent (N=18), respectively.

More than 85 percent of those participants who were less discussant group of participants include Orthodox Christianity (N=96 or 65.75%) and Protestant Christianity (N=29 or 19.86%) while Muslims accounts for 11.64 percent (N=17). Similar proportion was also seen on the distribution

of those participants who were highly discussant of their sero-positive status to their sexual partner(s). From all highly discussant group of participants followers of Orthodox Christianity, Protestants and Muslims were also accounts for 67.5 percent (N=54), 16.25 percent (N=13) and 12.5 percent (N=10), in that respective order. This could be understood from the calculated Mean and Standard deviation statistics also.

Moreover, the results of the tests of a null hypotheses that could be written as *'is the participants' religious affiliation independent of their types and levels of sero-positive status disclosure related discussions to one's sexual partner'* revealed that *the* participants' religious affiliation has no significant relation both in the types (Discussant vs. Non-Discussant: χ^2 (4, 0.05) = 2.897) and levels (Highly Discussant vs. Less Discussant: χ^2 (4, 0.05) = 1.526) of self-disclosure related discussion to ones sexual partner(s).

Table 20 discusses the association of types and levels of self-disclosure related discussion with the participants' marital status.

Table 20. Marital Status

Marital Status	Highly Discussant				Less Discussant				Discussant				*Non-Discussant*			
	N	%	Mean	S.d.	N	%	Mean	S.d.	N	%	Mean	S.d.	N	%	Mean	*S.d.*
Married	52	65.0	17.83	1.061	53	36.	12.08	2.055	105	46.5	14.92	3.319	22	29.8	6.59	*0.959*
Divorced	4	5.0	17.75	1.708	14	9.59	11.29	2.091	18	7.96	12.72	3.392	11	14.9	6.09	*1.64*
Widowed	3	3.8	17.00	1.000	26	17.81	11.35	1.979	29	12.8	11.93	2.576	10	13.5	6.30	*1.70*
Dating/ Cohabiting	21	26.3	17.24	0.889	53	36.30	11.42	1.875	74	32.8	13.07	3.116	31	41.9	6.42	*1.43*
Total	80	100	17.64	1.070	146	100	11.63	1.990	226	100	13.76	3.353	74	100	6.41	*1.50*
Chi-Square (χ^2) Value	*χ^2 = 20.083, df=3 χ^2 (3,0.05) =7.815*								*χ^2 = 7.785, df=3 χ^2 (3,0.05) = 7.815*							

From the highly discussant group of participants those who were married and cohabiting/dating participants' accounts for the highest proportion with 65 percent (N=52) and 26.25 percent (N=21), respectively. While divorced and widowed participants accounts only for 5 percent (N=4) and 3.75 percent (N=3) in that respective order.

41.9 percent (N=31) of dating/cohabiting and 29.7 percent (N=22) of married couples have found to be non-discussant of their sero-positive status to their sexual partner(s) while 36.3

percent (N=53 of each) were found to be less-discussant group on the issue. It is simple to understand the same from the calculated mean and standard deviation statistics computed and depicted above.

Furthermore, the results of the tests of a null hypotheses that could be written as 'is *the participants' marital status independent of their types and levels of sero-positive status disclosure related discussions to one's sexual partner(s)'* revealed that the participants' marital status has significant relation in the levels (Highly Discussant vs. Less Discussant: χ^2 (3, 0.05) = 20.083) of self-disclosure related discussion to ones sexual partner(s) while it has no significant relation in the types (Discussant vs. Non-Discussant: χ^2 (1, 0.05) = 7.785) of sero-positive status disclosure related discussions. .

Table 21 discusses the association of types and levels of self-disclosure related discussion with the participants' ethnicity.

Table 21. Ethnicity

Ethnic Group	Highly Discussant				Less Discussant				Discussant				*Non-Discussant*			
	N	%	Mean	S.d.	N	%	Mean	S.d.	N	%	Mean	S.d.	N	%	Mean	*S.d.*
Amhara	31	38.8	17.81	1.046	61	41.8	12.11	2.034	92	40.7	13.03	3.226	22	29.7	6.54	*1.283*
Gurage	4	5.0	17.50	0.577	10	6.9	11.60	1.776	14	6.2	13.29	3.148	2	2.7	6.00	*2.828*
Oromo	19	23.8	17.42	1.017	18	12.3	11.28	1.994	37	16.4	14.43	3.476	21	28.4	6.52	*1.401*
Others	3	3.8	17.00	0.000	3	2.1	10.67	1.155	6	2.7	13.83	3.545	3	4.1	6.33	*1.528*
Silte	2	2.5	19.00	1.414	-	-	-	-	2	0.9	19.00	1.414	1	1.4	4.00	-
Tigre	5	6.3	17.40	0.894	7	4.8	11.14	2.116	12	5.3	13.75	3.621	10	13.5	6.20	*1.229*
Missing Items	16	20.0	17.63	1.310	47	77.2	11.28	1.942	63	27.9	12.89	3.312	15	20.3	7.00	*1.254*
Total	80	100	17.64	1.070	146	100	11.63	1.990	226	100	13.76	3.353	74	100	6.41	*1.364*
Chi-Square (χ^2) Value	*χ^2 = 11.691, df=6 χ^2 (6,0.05) =12.592*								*χ^2 = 14.041, df=6 χ^2 (6,0.05) = 12.592*							

From the total highly discussant group of participants' the Amharas and the Oromos accounts for 38.75 percent (N=31) and 23.75 percent (N=19) in that respective order. While those who missed the item by saying 'we are mixed-up, Ethiopians, etc' accounts for 20 percent (N=16). Among the less discussant group of participants, while those who missed the item accounts for 32.19 percent (N=47), the Amharas and the Oromos also accounts for 41.78 percent (N=61) and 12.33 percent (N=18) in that respective order. On the other hand, 29.73 percent (N=22), 28.38 percent (N=21) and 20.27 percent (N=15) of the non-discussant group of participants were found to be

Amharas, Oromos and those who missed the item, respectively. The calculated mean and standard deviation statistics also revealed the same result.

Moreover, to test the null hypotheses *'is the participants' Ethnic group independent of their types and levels of sero-positive status disclosure related discussions to one's sexual partner'* is computed. The calculated chi-square statistic value revealed that ethnic group has significant relation in the types (Discussant vs. Non-Discussant: χ^2 (6, 0.05) = 14.041) while it has no significant relation in the levels (Highly Discussant vs. Less Discussant: χ^2 (6, 0.05) = 11.691) of self-disclosure related discussion to ones sexual partner(s).

Table 22 discusses the association of types and levels of self-disclosure related discussion with the participants' employment status and organizational types.

Table 22. Marital Status

Employment Status	Highly Discussant			Less Discussant			Discussant			*Non-Discussant*		
	N	Mean	S.d.	N	Mean	S.d.	N	Mean	S.d.	N	Mean	*S.d.*
Employed	53	17.55	0.911	83	11.63	1.967	136	13.93	3.327	35	6.49	*1.292*
Unemployed	27	17.81	1.331	56	11.55	2.026	83	13.59	3.468	34	6.35	*1.475*
Retired	-	-	-	7	12.29	2.138	7	12.29	2.138	5	6.20	*1.304*
Total	80	17.64	1.070	146	11.63	1.990	226	13.76	3.353	74	6.41	*1.364*
Chi-Square (χ^2) Value	χ^2 = 4.893, df=2 χ^2 (2,0.05) =5.991						χ^2 = *4.704, df=2* *χ^2 (2,0.05) = 5.991*					
Organizational Types	**Highly Discussant**			**Less Discussant**			**Discussant**			***Non-Discussant***		
	N	Mean	S.d.	N	Mean	S.d.	N	Mean	S.d.	N	Mean	*S.d.*
Skipped Items	27	17.81	1.331	63	11.63	2.034	90	13.49	3.393	39	6.33	*1.439*
Governmental Organizations	21	17.43	0.346	29	11.69	2.089	50	13.10	3.303	9	6.67	*1.581*
Non-Governmental Organizations	12	17.42	0.900	12	11.75	2.340	24	14.58	3.374	7	6.43	*1.397*
Private Organizations	6	17.83	0.983	14	11.86	2.107	20	13.68	3.345	10	6.30	*1.494*
Self-Employed	14	17.71	1.139	28	11.39	1.663	42	13.50	3.366	9	6.56	*0.726*
Total	80	17.64	1.070	146	11.63	1.990	226	13.76	3.353	74	6.41	*1.364*
Chi-Square (χ^2) Value	*χ^2 = 4.671, df=4* *χ^2 (4,0.05) =9.488*						*χ^2 = 7.601, df=4* *χ^2 (4,0.05) = 9.488*					

From the employed group of participants 66.25 percent (N=53), 56.85 percent (N=83), and 47.3 percent (N=35) were of them found to be highly, less and non-discussant group of their sero-positive status to their sexual partner(s) while 33.75 percent (N=27), 38.36 percent (N=56) and

45.95 percent (N=34) of the unemployed group were found to be highly, less and non-discussant group of their sero-positive status to their sexual partner(s).

The organizational type of those employed participants also differs. Among those who were government employees 26.25 percent (N=21), 19.86 percent (N=29) and 52.70 percent (N=39) were found to be highly, less and non-discussant groups of participants. 12 percent (N=15) NGO employees, 7.5 percent (N=6) of employees in private organizations and 17.5 percent (N=14) of self employed participants were found to be highly discussant groups while 10.62 percent (N=24) NGO employees, 8.85 percent (N=20) of employees in private organizations and 18.58 percent (N=42) of self employed participants were found to be less discussant groups. On the other hand, from those who were found to be non-discussant groups of participants government employees, NGO employees, those who are working in the private sector and self employed participants accounts for 12.16 percent (N=9), 9.46 percent (N=7), 13.51 percent (N=10) and 12.16 percent (N= 9), in that respective order.

In addition, the non-parametric chi-square calculation was computed to clearly observe the relationship between the types and levels of self-disclosure related discussions based on the participants' employment status and organizational type they were working in. The null hypothesis of *'is the participants' employment status and organizational type independent of the participants' types and levels of self-disclosure related discussions, both in extent and frequency'*. The calculated chi-square statistic value revealed that the participants' employment status has no significant relation both in the types (Discussant vs. Non-Discussant: χ^2 (2, 0.05) = 4.704) and levels (Highly Discussant vs. Less Discussant: χ^2 (2, 0.05) = 4.893) of self-disclosure related discussion to ones sexual partner(s). Moreover, the participants' organizational type has also no significant relation both in the types (Discussant vs. Non-Discussant: χ^2 (4, 0.05) = 7.601) and levels (Highly Discussant vs. Less Discussant: χ^2 (4, 0.05) = 4.671) of self-disclosure related discussions to ones sexual partner(s).

Table 23 discusses the association of types and levels of self-disclosure related discussion with the participants' average monthly family income.

Table 23. Average Monthly Family Income

Average Monthly Family Income	Highly Discussant				Less Discussant				Discussant				*Non-Discussant*			
	N	%	Mean	S.d.	N	%	Mean	S.d.	N	%	Mean	S.d.	N	%	Mean	*S.d.*
Below 200 birr	12	15	17.92	1.240	62	42.5	11.42	1.904	74	32.7	12.47	3.012	24	32.4	6.50	*1.383*
201-500 birr	32	40	17.56	1.014	37	25.3	11.70	1.884	69	30.5	14.42	3.318	34	46.0	6.32	*1.387*
501-1000 birr	15	18.8	17.33	1.234	17	11.6	11.76	2.137	32	14.2	14.38	3.319	6	8.1	6.33	*1.633*
1001-1500 birr	8	10.0	17.50	0.535	15	10.3	11.73	2.434	23	10.2	13.74	3.427	5	6.8	6.80	*1.095*
1501-2000 birr	4	5.0	17.75	0.500	5	3.4	12.80	2.388	9	4.0	15.00	3.202	5	6.8	6.20	*1.483*
Above 2000 birr	9	11.3	18.11	1.269	10	6.9	11.70	1.889	19	8.4	14.74	3.649	-	-	-	-
Total	80	100	17.64	1.070	146	100	11.63	1.990	226	100	13.76	3.353	74	100	6.41	*1.364*
Chi-Square (χ^2) Value	*χ^2 = 18.903, df=5 χ^2 (5,0.05) =11.070*								*χ^2 = 13.311, df=5 χ^2 (5,0.05) =11.070*							

From all the participants those participants with a monthly average family income of below 200 birr, 201-500 birr, 501-1000 birr, 1001-1500 birr, 1501-2000 birr and above 2000 birr accounts for 15 percent (N=12), 40 percent (N=32), 18.75 percent (N=15), 10 percent (N= 8), 5 percent (N=4) and 11.25 percent (N=9) from the highly discussant groups; 42.47 percent (N=12), 25.34 percent (N=37), 11.64 percent (N=17), 10.27 percent (N=15), 3.42 percent (N=5) and 6.85 percent (N=10) from the less discussant groups; and 32.43 percent (N=24), 46.0 percent (N= 34), 8.11 percent (N=6), 6.76 percent (N= 5), 6.76 percent (N=5) and 0.00 percent (N=0) from the non-discussant groups in that respective order. The mean and standard deviation statistics also showed the same.

In testing the null hypothesis of *'Is participants' monthly average family income independent of the types and levels of self-disclosure related discussions of ones sero-positive status'* the calculated Chi-square statistic showed a significant group difference. Thus, there is a significant group differences both in the types (Discussant vs. Non-Discussant: χ^2 (5, 0.05) = 13.311) and levels (Highly Discussant vs. Less Discussant: χ^2 (5, 0.05) = 18.903) of self-disclosure related discussions among participants based on their average family monthly income.

Table 24 discusses the association of types and levels of self-disclosure related discussion with time since diagnosed

Table 24.Time since Diagnosed

Time Since Diagnosed	Highly Discussant				Less Discussant				Discussant				*Non-Discussant*			
	N	%	Mean	S.d.	N	%	Mean	S.d.	N	%	Mean	S.d.	N	%	Mean	*S.d.*
Only before three months	6	7.5	16.67	0.816	13	8.90	11.62	2.364	19	8.41	13.21	3.119	8	10.8	7.13	*0.991*
3-12 months	14	17.5	17.57	1.016	20	13.7	11.15	1.899	34	15.0	13.79	3.574	8	10.8	6.50	*1.690*
1-3 years	18	22.5	17.61	1.195	37	25.3	11.27	2.143	55	24.3	13.35	3.539	25	33.9	6.40	*1.384*
3-5 years	24	30.0	17.88	0.947	36	24.7	11.83	1.964	60	26.6	14.25	3.398	16	21.6	6.38	*1.204*
5-10 years	11	13.8	17.27	0.647	31	21.2	12.00	1.770	42	18.6	13.38	2.811	14	18.9	6.00	*1.519*
Above 10 years	7	8.8	18.43	1.397	9	6.2	12.11	1.833	16	7.1	14.88	3.612	3	4.1	6.33	*1.528*
Total	80	100	17.64	1.070	146	100	11.63	1.990	226	100	13.76	3.353	74	100	6.41	*1.364*
Chi-Square (χ^2) Value	*χ^2 = 3.390, df=5 χ^2 (5,0.05) =11.070*								*χ^2 =4.281, df=5 χ^2 (5,0.05) =11.070*							

From the highly discussant group of participants those know their sero positive status 3-5 years, 1-3 years and 3-12 months back accounts for 30 percent (N=24), 22.5 percent (N=18) and 17.5 percent (N=14) while each accounts for 24.65 percent (N=36), 25.34 percent (N=37) and 13.4 percent (N=20) from the less discussant group of participants in that respective order. From the non-discussant group of participants those who know their sero-positive status before 1-3 years, 3-5 years and 5-10 years accounts for 33.78 percent (N=25), 21.62 percent (N=16) and 18.92 percent (N=14), respectively. The results of the mean and standard deviation calculations also revealed similar results.

Moreover, the results of the tests of a null hypotheses that could be written as *'is the time since diagnosed is independent of the participants' types and levels of sero-positive status disclosure related discussions to one's sexual partner(s)'* revealed that *the* time since diagnosed has no significant relation both in the types (Discussant vs. Non-Discussant: χ^2 (5, 0.05) = 4.281) and levels (Highly Discussant vs. Less Discussant: χ^2 (5, 0.05) = 3.390) of self-disclosure related discussion to ones sexual partner(s).

Table 25 discusses the association of types and levels of self-disclosure related discussion with ways to know sero-positive status

Table 25. Ways to Know Sero-positive Status

Ways to Know Sero-Positive Status	Highly Discussant				Less Discussant				Discussant				*Non-Discussant*			
	N	%	Mean	S.d.	N	%	Mean	S.d.	N	%	Mean	S.d.	N	%	Mean	*S.d.*
Through medical related testing	49	61.25	17.7	1.004	92	63.0	11.5	1.980	141	62.4	13.7	3.401	52	70.3	6.4	*1.399*
Through non-medical related testing	31	38.75	17.6	1.179	54	37.0	11.8	2.013	85	37.6	13.9	3.288	22	29.8	6.6	*1.299*
Total	80	100	17.6	1.070	146	100	11.63	1.990	226	100	13.8	3.353	74	100	6.4	*1.364*
Chi-Square (χ^2) Value	*χ^2 = 0.069, df=1 χ^2 (1,0.05) =3.841*								*χ^2 = 1.509, df=1 χ^2 (1,0.05) =3.841*							

Those participants who knew their sero-positive status through medical related testing has better participation rate both in the types and levels of self-disclosure related discussions. They accounts for 61.25 percent (N=49) of the highly discussant, 63.01 percent (N=92) of the less discussant and 70.27 percent (N=52) of the non-discussant group of participants. The mean and standard deviation statistics also revealed similar results.

Whereas, the calculated chi-square on the null-hypothesis of '*is ways to know sero-positive status independent of the participants' types and levels of sero-positive status disclosure related discussions to one's sexual partner(s)*' showed that the ways to know sero-positive status has no significant relation both in the types (Discussant vs. Non-Discussant: χ^2 (1, 0.05) = 1.509) and levels (Highly Discussant vs. Less Discussant: χ^2 (1, 0.05) = 0.069) of self-disclosure related discussion to ones sexual partner(s).

Table 26 discusses the association of types and levels of self-disclosure related discussion with current CD-4 status

Table 26. Current CD-4 Status

Current CD-4 Status	Highly Discussant				Less Discussant				Discussant				*Non-Discussant*			
	N	%	Mean	S.d.	N	%	Mean	S.d.	N	%	Mean	S.d.	N	%	Mean	*S.d.*
Only less than 100	5	6.3	18.0	0.707	7	4.8	10.6	2.149	12	5.3	13.67	4.163	8	10.8	6.5	*1.309*
101-150	9	11.3	17.4	0.726	19	13.0	11.1	1.779	28	12.4	13.11	3.392	8	10.8	6.9	*0.991*
151-200	12	15.0	18.0	1.651	25	17.1	11.6	1.981	37	16.3	13.65	3.576	11	14.9	7.0	*1.414*
201-250	12	15.0	17.8	0.937	26	17.8	12.2	1.877	38	16.8	13.97	3.115	11	14.9	5.8	*1.328*
251-300	16	20.0	17.3	0.931	28	19.2	11.9	2.054	44	19.5	13.86	3.107	15	20.3	6.3	*1.163*
Above 300	26	34.5	17.6	1.023	41	28.1	11.6	2.050	67	29.6	13.91	3.432	21	28.4	6.3	*1.586*
Total	80	100	17.6	1.070	146	100	11.6	1.990	226	100	13.76	3.353	74	100	6.4	*1.364*
Chi-Square (χ^2) Value	*χ^2 = 1.079, df=5 χ^2 (5,0.05) =11.070*								*χ^2 = 2.904, df=5 χ^2 (5,0.05) =11.070*							

Those participants who had a current CD-4 count of above 300 (32.5 percent or N=26) and 251-300 (20 percent or N=16) showed better proportion from highly discussant groups of participants. The same is true both in the less and non-discussant groups of participants. Although the calculated mean and standard deviation showed clear differences both in types and levels of sero-positive status disclosure, it has no disparity with in the different groups based on the CD-4 count.

To clearly observe the relationship between the extent and frequency of self-disclosure related discussions with ones' sexual partner(s) and the participants' current CD-4 status Chi-square calculation was in order. The results of the null-hypothesis *'is current CD-4 status independent of the participants' types and levels of self-disclosure related discussions with ones sexual partner(s)'* revealed that the participants' current CD-4 status has no significant relation both in the types (Discussant vs. Non-Discussant: χ^2 (5, 0.05) = 2.904) and levels (Highly Discussant vs. Less Discussant: χ^2 (5, 0.05) = 1.079) of self-disclosure related discussion to ones sexual partner(s).

Table 27 discusses the association of types and levels of self-disclosure related discussion with use of antiretroviral drugs.

Table 27. Use of Antiretroviral Drugs

Use of ART Drugs	Highly Discussant				Less Discussant				Discussant				*Non-Discussant*			
	N	%	Mean	S.d.	N	%	Mean	S.d.	N	%	Mean	S.d.	N	%	Mean	*S.d.*
Yes	63	78.8	17.7	1.060	106	72.6	11.6	1.944	169	74.8	13.9	3.374	49	66.2	6.5	*1.386*
No	17	21.3	17.5	1.125	40	27.4	11.6	2.133	57	25.2	13.4	3.288	25	33.8	6.2	*1.332*
Total	80	100	17.6	1.070	146	100	11.6	1.990	226	100	13.8	3.353	74	100	6.4	*1.364*
Chi-Square (χ^2) Value	*χ^2 = 1.030, df=1 χ^2 (1,0.05) =3.841*								*χ^2 = 2.058, df=1 χ^2 (1,0.05) =3.841*							

Except those participants who were found to be non-discussant group 66.22 percent (N=49), those who use ART drugs have accounted for over 70 percent from the highly (78.75 percent or N=63) and less (72.60 percent or N= 49) discussant groups. The mean and standard deviation statistics also revealed clear difference both in the types and levels of self-disclosure related discussions.

However, a null-hypothesis that could be phrased as *'is use of antiretroviral drugs independent of the participants' types and levels of self-disclosure related discussion with ones sexual partner(s)'* revealed that use of ART drugs has no significant relation both in the types (Discussant vs. Non-Discussant: χ^2 (1, 0.05) = 2.058) and levels (Highly Discussant vs. Less Discussant: χ^2 (1, 0.05) = 1.036) of self-disclosure related discussion to ones sexual partner(s).

Table 28 discusses the association of types and levels of self-disclosure related discussion with self disclosure.

Table 28. Self Disclosure

Self-Disclosure	Highly Discussed				Less Discussed				Discussed				*Non-Discussed*			
	N	%	Mean	S.d.	N	%	Mean	S.d.	N	%	Mean	S.d.	N	%	Mean	*S.d.*
Yes	79	98.8	17.6	1.076	78	53.4	12.3	1.957	157	69.5	15.0	3.121	35	47.3	6.6	*1.140*
No	1	1.3	18.0	-	68	46.6	10.9	1.785	69	30.5	11.0	1.967	39	52.7	6.2	*1.525*
Total	80	100	17.6	1.070	146	100	11.6	1.990	226	100	13.8	3.353	74	100	6.4	*1.364*
Chi-Square (χ^2) Value	*χ^2 =50.059, df=1 χ^2 (1,0.05) =3.841*								*χ^2 = 11.894, df=1 χ^2 (1,0.05) =3.841*							

Participants were asked whether or not they have disclosed their HIV positive status to their sexual partner(s). From the highly discussant groups of participants those who answered the question positively accounts for 98.75 percent (N=79) while they accounts for 53.42 percent (N=78 participants) and 47.30 percent (N= 35) in the less and non-discussant groups. The mean and standard deviation statistics also clearly revealed differences both in types and levels of self-disclosure related discussions with ones' sexual partner(s).

To check whether self-disclosure is independent of the types and levels of self-disclosure related discussions chi-square calculation was in order. The calculated chi-square statistics revealed that self-disclosure has significant relation both in the types (Discussant vs. Non-Discussant: χ^2 (1, 0.05) = 11.894) and levels (Highly Discussant vs. Less Discussant: χ^2 (1, 0.05) = 50.059) of self-disclosure related discussion to ones sexual partner(s).

Table 29 discusses the association of types and levels of self-disclosure related discussion with time period for self disclosure.

Table 29.Time Period for Self-Disclosure

Time Period of Disclosure	Highly Discussant				Less Discussant				Discussant				*Non Discussant*			
	N	%	Mean	S.d.	N	%	Mean	S.d.	N	%	Mean	S.d.	N	%	Mean	*S.d.*
The same day.	40	50.0	17.5	0.906	26	17.8	12.8	1.883	66	29.2	15.6	2.698	18	24.3	6.7	*1.018*
Within a week.	13	16.3	17.5	0.967	8	5.5	12.3	2.252	21	9.3	15.5	3.043	1	1.4	8.0	*0.000*
Within a month.	8	10.0	18.8	1.165	14	9.6	11.7	1.899	22	9.7	14.3	3.832	6	8.1	6.5	*1.517*
Within three months.	17	21.3	17.5	1.281	18	12.3	12.2	2.065	35	15.5	14.8	3.209	6	8.1	6.8	*0.983*
Others	1	1.3	17.0	0.000	12	8.2	11.9	1.881	13	5.6	12.3	2.287	4	5.4	5.8	*1.258*
Skipped Items	1	1.3	0.0	18.00	68	46.6	10.9	1.785	69	30.5	11.0	1.967	39	52.7	6.2	*1.525*
Total	80	100	17.6	1.070	146	100	11.6	1.990	226	100	13.8	3.353	74	100	6.4	*1.364*
Chi-Square (χ^2) Value	*χ^2=66.596, df=5 χ^2 (5,0.05) =11.070*								*χ^2= 15.270, df=5 χ^2 (5,0.05) =11.070*							

From those who have found to be highly discussant group of participants about 50 percent (N=40) were disclosed their sero-positive status to their sexual partner(s) while they accounts only for 17.81 percent (N=26) and 24.32 percent (N=18) in the less and non discussant groups of participants, respectively. From the calculated percentage, mean and standard deviation it is

understood that most of the participants who disclosed their sero-positive status to their sexual partner(s) took up to three months time period for self-disclosure, since their diagnosis.

In addition, the non-parametric chi-square calculation was computed to clearly observe the relationship between the types and levels of self-disclosure related discussions based on the participants' time period for self-disclosure. The null hypothesis of *'is the participants' time period for self-disclosure independent of the participants' types and levels of self-disclosure related discussions, both in extent and frequency'*. The calculated chi-square statistic value revealed that the participants' time period for self-disclosure has significant relation both in the types (Discussant vs. Non-Discussant: χ^2 (5, 0.05) = 15.270) and levels (Highly Discussant vs. Less Discussant: χ^2 (5, 0.05) = 66.596) of self-disclosure related discussions to ones sexual partner(s).

4.6 The Reasons for Self-disclosure/Non-disclosure among Sexual Partners living with HIV/AIDS

The reasons both for self-disclosure and self Non-disclosure are many and diversified. A total of thirty one (31) items were prepared and given for all participants of this specific study.

The results of the study showed that most of the participants strongly agree with items related to self-disclosure and on items reflected the possible reason for self Non-disclosure. The calculated mean for the total items were also found to be 116.94 with a standard deviation of 23.097 that reflected similar results as discussed above. On average, 60 percent of all the participants found to agree on statements related to reasons for self Non-disclosure, while above 70 percent of all the participants agree on statements that reflects reasons for self-disclosure.

4.6.1 The Reasons for Self Non-Disclosure

As it is mentioned above the reasons for self Non-Disclosure are many and diversified. But, in this specific study fifteen (15) items that related to reasons for self Non-disclosure were given for each participant to express their degree of agreement or disagreement on each item. The results of each item were computed and depicted below in Table 30.

Table 30 discusses the reasons for self-non disclosure among sexual partners living with HIV/ AIDS.

Table 30. Reasons for Self Non-Disclosure

S/N	Reasons for Self-Non Disclosure	Strongly Disagree		Disagree		Missing Items		Agree		Strongly Agree		Mean	Std. Dev.
		N	%	N	%	N	%	N	%	N	%		
1	We weren't very close to one another.	38	12.7	56	18.7	-	-	120	40.0	86	28.7	3.53	1.401
2	Our relationship was pretty casual.	45	15.0	44	14.7	1	0.3	125	41.7	85	28.3	3.54	1.420
3	I couldn't figure out how to talk about the diagnosis.	50	16.7	49	16.3	-	-	121	40.3	80	26.7	3.44	1.454
4	People have big mouths and may tell others.	58	19.3	64	21.3	-	-	107	35.7	71	23.7	3.23	1.498
5	We didn't know one another very well.	46	15.3	55	18.3	1	0.3	127	42.3	71	23.7	3.41	1.417
6	Concerned my sexual partner/s wouldn't understand.	32	10.7	60	20.0	-	-	130	43.3	78	26.0	3.54	1.347
7	I worried person would no longer like me after knowing.	43	14.3	68	22.7	-	-	110	36.7	79	26.3	3.38	1.443
8	My diagnosis is my own private information.	45	15.0	72	24.0	1	0.3	111	37.0	71	23.7	3.30	1.439
9	Concerned how my sexual partner/s would feel about me after knowing.	30	10.0	52	17.3	-	-	136	45.3	82	27.3	3.63	1.316
10	I don't have to tell anyone if I don't want to.	45	15.0	75	25.0	1	0.3	110	36.7	69	23.0	3.28	1.438
11	I have a right to privacy.	40	13.3	68	22.7	1	0.3	115	38.3	76	25.3	3.40	1.416
12	I felt ashamed about being HIV-positive.	33	11.0	63	21.0	4	1.3	120	40.0	80	26.7	3.50	1.367
13	Our relationship wasn't very serious.	18	6.0	46	15.3	-	-	135	45.0	101	33.7	3.85	1.213
14	I had difficulty accepting my HIV status.	25	8.3	45	15.0	-	-	150	50.0	80	26.7	3.72	1.242
15	I didn't know how to tell my sexual partner/s about my diagnosis.	26	8.7	41	13.7	-	-	151	50.3	82	27.3	3.74	1.240

Most of the reasons for self Non-disclosure among sexual partners living with HIV/AIDS were found to be relationship matters. For all the participants being none very close in relationship (68.7 percent), casual nature of relationship (70 percent), not known each other very well (66 percent) and loss relationship (78.7 percent) were found to be a reason for self Non-disclosure.

Other reasons for self Non-disclosure also related to information transmission. 66.7 percent of the participants did not figure out how to talk the diagnosis, 59.4 percent of the participants have fear to tell others in the part of their sexual partner(s), 69.3 percent of the participants have fear of not understand in part of the other sexual partner and 77.6 percent of the participants did not know how to talk the diagnosis to their sexual partner(s).

Privacy related issues were also found to be reasons for self Non-disclosure. Among such reasons, 66 percent of the participants have fear of dislike, 72.6 percent of the participants have fear of future relationship, 59.7 percent of the participants have lack of interest, 60.7 percent of

the participants believed that they have the right to private information, 63.6 percent of the participants justified privacy as a reason, 66.7 percent developed shame, and 76.7 percent of the participants still not accepted the diagnosis (denial) were found to be reasons for self Non-disclosure. The calculated mean and standard deviation showed similar results for each items.

In general, the calculated mean of 52.48 with a standard deviation of 14.311 revealed that all the fifteen items were found to be reasons for self Non-disclosure among sexual partners living with HIV/AIDS.

4.6.2 The Reasons for Self-Disclosure

There may be several reasons for self-disclosure among sexual partners living with HIV/AIDS. Among the different reasons sixteen (16) items were given for all participants to show their degree of agreement or disagreement. The discussion follows.

Table 31 discusses the reasons for self-disclosure among sexual partners living with HIV/AIDS.

Table 31. Reasons for Self-Disclosure-General Findings

S/N	Reasons for Self-Disclosure	Strongly Disagree		Disagree		Missing Items		Agree		Strongly Agree		Mean	Std. Dev.
		N	%	N	%	N	%	N	%	N	%		
1	Wanted to see how my sexual partner/s would feel about me after disclosing	19	6.3	20	6.7	1	0.3	89	29.7	171	57.0	4.24	1.164
2	My sexual partner/s had a right to know what was happening to me.	20	6.7	21	7.0	-	-	96	32.0	163	54.3	4.20	1.178
3	I wanted to educate my sexual partner/s about the disease.	18	6.0	33	11.0	-	-	95	31.7	154	51.3	4.11	1.219
4	Didn't want to carry this around by myself	12	4.0	33	11.0	2	0.6	112	37.3	141	47.0	4.12	1.125
5	I felt a sense of duty to tell my sexual partner/s.	12	4.0	36	12.0	1	0.3	97	32.3	154	51.3	4.15	1.157
6	Wanted to make sure that people know the seriousness of the disease.	20	6.7	59	19.7	-	-	106	35.3	115	38.3	3.79	1.316
7	It would be cathartic.	18	6.0	50	16.7	1	0.3	112	37.3	119	39.7	3.88	1.264
8	I wanted my sexual partner/s to know what he or she was getting into by being in a relationship with me.	17	5.7	37	12.3	1	0.3	106	35.3	139	46.3	4.04	1.214
9	My goal was to teach others about the disease.	29	9.7	53	17.7	3	1.0	92	30.7	123	41.0	3.76	1.394
10	Wanted to find out if my sexual partner/s would be with me after disclosing	20	6.7	47	15.7	-	-	109	36.3	124	41.3	3.90	1.279
11	Didn't want to risk any more health problems for me or my sexual partner/s.	12	4.0	42	14.0	-	-	111	37.0	135	45.0	4.05	1.171
12	Wanted to see how my sexual partner/s would react when I told him/her	14	4.7	42	14.0	-	-	122	40.7	122	40.7	3.99	1.179
13	Would be able to get information off my chest	15	5.0	39	13.0	-	-	125	41.7	121	40.3	3.99	1.174
14	Wanted to make sure that people know the seriousness of the disease.	20	6.7	59	19.7	-	-	106	35.3	115	38.3	3.79	1.316
15	I felt obligated to tell my sexual partner/s.	10	3.3	36	12.0	1	0.3	115	38.3	138	46.0	4.12	1.111
16	My sexual partner/s had a right to know what was happening to me.	15	5.0	43	14.3	1	0.3	104	34.7	137	45.7	4.02	1.220

On average, above seventy percent of all the participants show their agreement on each item. The calculated mean statistic also found to be a minimum of 3.76 with a standard deviation of 1.394 that clearly shown their agreement on each items.

To understand the reasons for self-disclosure among sexual partners living with HIV/AIDS, the sixteen (16) items were categorized into four specific issues, namely Responsibility, Instruction, Relationship Consequences and Emotional Release. The discussion for each issue follows.

Table 32 discusses the reasons for self-disclosure that relates to responsibility issues.

Table 32. Reasons for Self-Disclosure-- Responsibility

S/N	Reasons for Self-Disclosure	Strongly Disagree		Disagree		Missing Items		Agree		Strongly Agree		Mean	Std. Dev.
		N	%	N	%	N	%	N	%	N	%		
1	My sexual partner/s had a right to know what was happening to me.	20	6.7	21	7.0	-	-	96	32.0	163	54.3	4.20	1.178
2	I felt a sense of duty to tell my sexual partner/s.	12	4.0	36	12.0	1	0.3	97	32.3	154	51.3	4.15	1.157
3	I wanted my sexual partner/s to know what he or she was getting into by being in a relationship with me.	17	5.7	37	12.3	1	0.3	106	35.3	139	46.3	4.04	1.214
4	Didn't want to risk any more health problems for me or my sexual partner/s.	12	4.0	42	14.0	-	-	111	37.0	135	45.0	4.05	1.171
5	I felt obligated to tell my sexual partner/s.	10	3.3	36	12.0	1	0.3	115	38.3	138	46.0	4.12	1.111

From the sixteen (16) items five (5) items were responsibility related reasons for self-disclosure among sexual partners living with HIV/AIDS. As it is shown in Table 32 among all the participants eighty percent or more of them agree on the reasons for self-disclosure that related to responsibility. The minimum mean statistics of the five items also found to be 4.05 that strengthen the results discussed above.

Table 33 discusses the reasons for self-disclosure that relates to instruction or educating others.

Table 33. Reasons for Self-Disclosure-- Instruction

S/N	Reasons for Self-Disclosure	Strongly Disagree		Disagree		Missing Items		Agree		Strongly Agree		Mean	Std. Dev.
		N	%	N	%	N	%	N	%	N	%		
1	Wanted to make sure that people know the seriousness of the disease.	20	6.7	59	19.7	-	-	106	35.3	115	38.3	3.79	1.316
2	My goal was to teach others about the disease.	29	9.7	53	17.7	3	1.0	92	30.7	123	41.0	3.76	1.394
3	I wanted to educate my sexual partner/s about the disease.	18	6.0	33	11.0	-	-	95	31.7	154	51.3	4.11	1.219

Three (3) items that clearly reflected instruction related reasons for self-disclosure were incorporated in the in-depth interview questionnaire. 73.6 percent, 71.7 percent and 83.0 percent of all the participants found to agree with the reasons to know the knowledge of the people about the seriousness of the disease, the goal to teach others and to educate sexual partner(s) in that respective order. The calculated mean and standard deviation statistics also revealed similar results.

Table 34 discusses the reasons for self disclosure that relates to relationship consequences.

Table 34. Reasons for Self-Disclosure-- Relationship Consequences

S/N	Reasons for Self-Disclosure	Strongly Disagree		Disagree		Missing Items		Agree		Strongly Agree		Mean	Std. Dev.
		N	%	N	%	N	%	N	%	N	%		
1	Wanted to see how my sexual partner/s would feel about me after disclosing	19	6.3	20	6.7	1	0.3	89	29.7	171	57.0	4.24	1.164
2	I wanted my sexual partner/s to know what he or she was getting into by being in a relationship with me.	17	5.7	37	12.3	1	0.3	106	35.3	139	46.3	4.04	1.214
3	Wanted to find out if my sexual partner/s would be with me after disclosing	20	6.7	47	15.7	-	-	109	36.3	124	41.3	3.90	1.279
4	Wanted to see how my sexual partner/s would react when I told him/her	14	4.7	42	14.0	-	-	122	40.7	122	40.7	3.99	1.179

Self-disclosure of one's HIV status to his/her sexual partner(s) might have relationship consequences. Such relationship consequences might be reasons for self-disclosure. From the relationship consequences four items were included among the reasons for self-disclosure among sexual partners living with HIV/AIDS. The percentage of participants in their degree of agreement or disagreement, the mean and standard deviations statistics were computed and depicted in Table 34.

Most of the participants responded positively on all the four items. In this regard, sexual partners wanted to see how their counter sexual partners would feel about them after disclosing, wanted to know their sexual partners' were getting into by being in relationship with them, wanted to make sure that whether their sexual partners would be with them after disclosing, and wanted to see the reactions of their sexual partners after they told them the issue were found to account 86.7 percent, 84.0 percent, 77.6 percent and 81.4 percent, respectively. The minimum mean statistic was found to be 3.90 (with s.d.=1.279) that would reflect similar results as described above.

Table 35 discusses the reasons for H-positive status self-disclosure that relates to emotional release.

Table 35. Reasons for Self-Disclosure-- Emotional Release

S/N	Reasons for Self-Disclosure	Strongly Disagree		Disagree		Missing Items		Agree		Strongly Agree		Mean	Std. Dev.
		N	%	N	%	N	%	N	%	N	%		
1	Didn't want to carry this around by myself	12	4.0	33	11.0	2	0.6	112	37.3	141	47.0	4.12	1.125
2	It would be cathartic.	18	6.0	50	16.7	1	0.3	112	37.3	119	39.7	3.88	1.264
3	Would be able to get information off my chest	15	5.0	39	13.0	-	-	125	41.7	121	40.3	3.99	1.174
4	My sexual partner/s had a right to know what was happening to me.	15	5.0	43	14.3	1	0.3	104	34.7	137	45.7	4.02	1.220

Emotional release might be a case for self-disclosure of one's sero-positive status to his/her sexual partner(s). Four (4) items, in this regard, were included among the reasons for self-disclosure in the questionnaire used in this specific study.

People did not want to carry their being sero-positive status by themselves (84.3 percent), it would be cathartic (77.0 percent), would be able to get the issue off their chest (82.0 percent), and believe that their sexual partners had a right to know what was happening to them (80.4 percent) so that they have disclosed their sero-positive status to their sexual partner(s) living with HIV/AIDS. The minimum mean statistic for the four items was found to be 3.88 with a standard deviation of 1.264 that revealed similar results as mentioned above.

Table 36 discusses the general findings of the reasons for sero-positive status self-disclosure and self-non disclosure among sexual partners living with HIV/AIDS.

Table 36: General Findings

Reasons for Self-Disclosure/ Non-Disclosure	*Calculated Statistic*	
	Mean	Std. Deviation
Responsibility	20.61	4.398
Instructions	11.66	3.141
Relationship Consequences	16.22	3.666
Emotional Release	12.00	2.888
Reasons for Self-Disclosure (Total)	64.46	13.551
Reasons for Self Non-Disclosure (Total)	52.48	14.311
Reasons for Self-Disclosure & Self-Non- Disclosure (Total)	116.94	23.097

In general, the calculated mean and standard deviation statistics (see Table 37) clearly revealed that all the thirty one (31) reasons for sero-positive status self-disclosure and self non-disclosure among sexual partners living with HIV/AIDS could serve as a reason both in item or group levels.

4.7 Discussion

In this part of the study a critical observations were made based on the general and specific objectives of the study. A critical observation on the general results of the findings has shown relevant similarities with the hypothesis. The details for all the findings discussed below.

4.7.1 Experiences of HIV Positive Status

According to UNAIDS (2001) report there was a great deal that people need to know before deciding whether or not to be tested for HIV reaching a decision, however, not easy. For this reason, all the participants had known their sero- positive status at different time period. Some of them (N=27 or 9 %) diagnosed only before three months of this study while others (N=19 or 6.3%) were also tested before 10 or more years. About half of the participants were tested between 1 to 5 years period. Thus, the finding resulted in the expected conclusion. In addition, about 65 percent (N=193) knew their sero-positive status through medical related testing while the rest 35 percent (N=107) knew their status through non-medical related testing.

Moreover, from all the participants 34.7 percent (N=104) had a CD-4 count of less than or equal to 200 counts while 65.3 percent (N=196) of them had a CD-4 count of more than or equal to 200 counts.

About 72.7 percent (N=218) of all the participants have stated using antiretroviral drugs while 27.3 percent (N=82) of them did not yet started the same. The reasons for non-use of ART drugs were found to be many and different. In this specific study, 56.1 percent (N=46) of non-users of ART drugs did not recommended by their medical doctors as their CD-4 status is ok. The rest 43.9 percent (N=36) of them did not start ART drug use because they need some more counseling (12.2 % or N=10) and time (13.4% or N=11) for decision making and lack of access to enough and nutritious foods (18.3% or N=15).

4.7.2 HIV Positive Status Self-Disclosure and Self- non disclosure

Self-Disclosure is not a one-time event, but was experienced as a process. It is not only an outcome, it is also a process. Kimberly (2004) has developed a Six-Step Disclosure Process Framework. In this study, in general, 64.0 percent (N=192) of all the participants revealed that

they have disclosed their sero-positive status to their sexual partner(s) while the rest 36.0 percent (N=108) did not yet disclosed their sero-positive status to their sexual partner(s). Since self-disclosure is a process the time for self-disclosure were also found to be different for different individuals. Only about 44 percent of all those self-disclosed individuals made known their sero-positive status to their sexual partner(s) the same day of their diagnosis. The rest 11.5 percent, 14.6 percent and 21.4 percent of the participants have disclosed within a week, a month and three months period in that respective order. There are also people (N=17 or 8.8%) who disclosed their sero positive status to their sexual partners after three months period since diagnosed.

In this regard eleven researches were conducted in sub-saharan Africa. In these research works the average rate of disclosure among current and/or steady partners was 49 percent which is less than the result of this specific study. The difference may be because of the difference in study time and area, the experiences of the participants and being an average result of eleven research works. In the developed world the rate was found to be 79 percent while in Uganda only 36 percent were revealed their status to spouses or regular sexual partners that may differ because of the standard of living of participants (WHO, 2004). In Addis Ababa, sero-positive women's disclosure to their husband accounts for 68 percent on a study done by Hiwot (2006) for the partial fulfillment of her masters program on public disclosure. Here the difference is minimal but it may be occurred due to the sex oriented or women focused nature of the study done by Hiwot (2006). It should be also noted that women often disclose to multiple categories of people. A research done on gay men also revealed that only 52 percent of the casual sexual partners had been informed of the participants' HIV status (Serovich and Mosack, 2003). The result may be different because of the sexual orientation of the participants.

4.7.3 Benefits and Risks of Self-Disclosure

HIV positive status disclosure to one's sexual partner(s) has many benefits and probably risks. From the results of different researches conducted in different countries of the world, WHO (2004) have summarized the potential benefits in four items and risks in seven items, that were used in this specific research work.

In this specific research, only those who already have disclosed their sero-positive status to their sexual partner(s) were asked to show the levels of their agreement or disagreement both in the

benefits and risks of self-disclosure based on their experiences. The results showed as it was expected that the majority of participants have showed strong agreement with the benefits and strong disagreement with the risks of self-disclosure, though 17 to 38 percent minimum and maximum variation was seen and recoded on the other way.

4.7.4 Types and Levels of Self-Disclosure Related Discussions

According to literatures summarized by WHO (2004), there was a disparity between intention to disclose and actual disclosure. The same is true in the current research work also. In this specific research work only 192 (or 64 percent) of all participants were found to disclose their sero-positive status to their sexual partner(s). But, 226 (or 75.3 percent) of all the participants were responded as they had self disclosure related discussions with their sexual partners. Similarly, 108 of the participants were found to be non self disclosed with their sexual partners while only 74 of them responded as they had self-disclosure related discussions with their sexual partners. Thus, there was a participants' increase of 34 in the discussant group and a decrease of the same number in the non-discussant groups.

From the studied demographic and socioeconomic variables hospitals used, the sub cities covered, sex, age, educational background, religious affiliation, employment status, organizational type, time since diagnosed, ways to know sero-positive status, current CD-4 status and use of antiretroviral drugs were found to be independent and showed no significant group difference in the clients' types and levels of self-disclosure related discussions to one's sexual partner(s).

On the other hand, marital status has shown significant group difference in the levels of self-disclosure related discussions while it has no significant group difference in the types of self disclosure related discussions. Ethnic group has also shown significant group difference in the types of self-disclosure related discussions while it has no significant group difference in the levels of self disclosure related discussions.

Whereas, average monthly family income, self-disclosure and time period for self-disclosure have shown significant group differences both in the types and levels of self-disclosure related discussions.

In this regard, a study done by Serovich and Mosack (2003) revealed that age, race or income did not adequately explain disclosure to casual sexual partners. This difference may be due to the sexual orientation of the participants (homosexuality vs. heterosexuality) and standard of living (developed vs. developing countries).

4.7.5 Reasons for Sero-positive Status Self Disclosure and Self-non disclosure

The reasons for HIV positive status self-disclosure and self-non disclosure in many developing countries do not show significant differences (UNAIDS, 2001). In this specific study thirty-one possible items with appropriate options that could be divided in to two broad dimensions (reasons for self disclosure vs. reasons for self non-disclosure) were adopted from the works of Serovich and Mosack (2003).

In general, most of the participants showed strong agreement with items related to self-disclosure and on items reflected the possible reasons for self non-disclosure. On average, 60 percent of all the participants found to agree on statements related to reasons for self non-disclosure, while above 70 percent of them agree on statements that reflect reasons for self-disclosure.

Most of the reasons for self non-disclosure among sexual partners living with HIV/AIDS were found to be relationship matters that includes not being very close in relationship (68.7 percent), casual nature of relationship (70 percent), not known each other very well (66 percent) and loose relationship (78.7 percent). Information transmission is also another common reason that includes could not figure out how to talk the diagnosis (66.7 percent), fear to tell others in the part of their sexual partner(s) (59.4 percent), fear of not understand in part of the other sexual partner(s) (69.3 percent) and did not know how to talk the diagnosis to their sexual partner(s) (77.6 percent). The other reason for self non-disclosure were related to privacy that includes fear of dislike (66.0 percent), fear of future relationship (72.6 percent), lack of interest (59.7 percent), exercising the right to private information (60.7 percent), keeping privacy (63.6 percent), developed feeling of shame (66.7 percent) and denial and non-acceptance of the diagnosis (76.7 percent).

In this specific study, the reasons for self-disclosure were categorized in four broad dimensions. The major reasons for self-disclosure were found to be responsibility issues that includes exercising partners right to know (86.3 percent), sense of duty (83.6 percent), want to know partners reactions (81.6 percent), don't want to risk any more health problem (82.0 percent) and feeling of obligation (84.3 percent). The second major reasons for self disclosure were found to be relationship consequences that includes wanted to see the reaction of the other sexual partner(s) after disclosure (86.7 percent), wanted to brief the consequences of their relationship (81.6 percent), to check continuation of the relationship after disclosure (77.6 percent) and wanted to see the reaction of the other sexual partner during disclosure (81.4 percent). The next reason for self disclosure were found to be emotional release issues that related to do not want to carry the burden (84.3 percent), would be cathartic (77.0 percent), get of information from one's chest (82.0 percent) and conviction to the other partner's right to know (80.4 percent). Instruction related issues were found to be the last reason for self disclosure that includes to know public understanding (73.6 percent), to teach others (71.7 percent) and to educate one's sexual partner (83.0 percent).

Moreover, the data collected through the qualitative research design that include natural observations, visits, document analysis, interviews and focus group discussions supplements and strengthen what was discussed above based on the quantitative method of data collection, especially through the in-depth interview guide/questionnaire. This is, therefore, the current research work revealed similar results as it was designed earlier in the beginning of this specific study.

5. SUMMARY, CONCLUSIONS AND RECOMMENDATIONS

In studying self-disclosure problem among sexual partners living with HIV/AIDS the experiences of HIV positive status, rate of self disclosure, reasons for sero-positive status self disclosure and self-non disclosure, benefits and risks of self disclosure, types and levels of sero-positive status related discussions and their association with the clients' background were touched in depth. Three hundred (N=300) sexual partners living with HIV/AIDS who were clients of two hospitals (namely Black Lion and Zewditu Memorial Hospitals) in the month of May 2008 were the major sources of data. Selected HIV counselors and significant others (officers, experts and researchers) were also contacted and discussed to supplement the data. The arranged Focus Group Discussions and Selected Case Studies were cancelled due to the burdens of staff members, financial and time constraints, the huge and complex nature of the study and other unmanageable reasons that relates to the case under study.

The data collected for the study encompasses biographic information and socioeconomic status of the participants, their experiences in living with HIV/AIDS, the benefits and risks of self-disclosure and their types and levels of self-disclosure related discussions to their sexual partner(s), and the reasons for sero-positive status self-disclosure and self- non disclosure, The summary, conclusions and sound recommendations of the study discussed as follows:

5.1 Summary

The results of this specific study can be summarized as follows:

Experiences of HIV Positive Status among Sexual Partners Living with HIV/AIDS

1. Participants had known their sero-positive status at different time periods. About 52 percent of the participants reported that they have known their HIV positive status between 1 to 5 years ago. Moreover, 6.3 percent (or 19 participants) of all the participants have known their sero-positive status before 10 years or more time period and can live more than a decade positively with the virus.

2. Most of the participants knew their sero-positive status through medical related testing. Only 35.7 percent of the participants reported that they have known their sero-positive status through non-medical related testing while 64.3 percent of them knew their HIV positive status through medical related testing.
3. The majority of participants could maintain their current CD-4 status more than 200 counts. 65.3 percent of all the participants reported that their CD-4 count was more than 200 counts while 34.7 percent of them reported that it was less than 200 counts.
4. Since the study was undertaken in clients of ART clinics majority of the participants had using antiretroviral drugs but also some other did not yet started for different reasons. About 72.7 percent of all the participants were found to be users of ART drugs while 27.3 percent of them did not start the use of ART drugs for different reasons. 56.1 percent of all those participants who did not yet started ART drug use reported that their doctor did not recommended it since their CD-4 status is ok. 12.2 percent of them reported that they were in need of some more counseling, 13.4 percent of them were also in need of some more time for decision and 18.3 percent of them complain that they had not enough access to enough and nutritious foods.

HIV Positive Status Self-Disclosure an d Self-non disclosure of the Participants

1. Majority of the participants have disclosed their sero-positive status to their sexual partner(s) by themselves. 64 percent of all the participants have reported that they have self-disclosed their HIV positive status to their sexual partner(s) while 36.0 percent of them reported on the other way.
2. Self-disclosure is not a onetime event, but was experienced as a process. Thus, the disclosure process took different time periods among the different participants, irrespective of the reasons. 43.75 percent of all those who have reported that they have disclosed their HIV positive status to their sexual partner(s) made known their status the same day after their diagnosis while 8.8 percent of them took more than three months period.

Benefits and Risks of HIV Positive Status Disclosure

1. Sero-positive status self-disclosure to one's sexual partner(s) might have different kinds of benefits and probably risks.
2. Results of the General Findings of self-disclosure:
   - Most of the participants were strongly agree (ranged from 45.83 to 55.73 percent of all disclosed participants) with the positive statements that reflect the benefits of self disclosure while most of them were showed strong disagreement (ranged from 48.96 to 62.50 percent of all disclosed participants) with the negative statements that illustrate the risks of self disclosure.
   - The opportunity to utilize the benefits (mean=15.36 with s.d. =4.105) and refrains from the risks of sero-positive status disclosure (mean=28.51 with s.d. =6.747) among sexual partners living with HIV/AIDS is profuse among the self disclosed participants in this specific study.
3. Positive Outcomes (Benefits) of self-disclosure
   - The positive outcomes of sero-positive status disclosure to one's sexual partner(s) are many and diversified. Through categorizing it in to four broad areas, the study revealed that *improved access to the necessary medical treatment and care* got the priority with a mean score of 4.03 (with s.d. =1.408). Other kinds of benefits that include *improved opportunities to plan for the future carefully and thoughtfully*; *increased opportunities to discuss and implement HIV risk reduction with partners*; and *increased opportunities for instrumental and expressive social support* showed a mean statistic values of 3.91 (with s.d.=1.392), 3.90 (with s.d.=1.384), and 3.54 (with s.d.=1.614) in that respective order.
4. Negative Effects (Risks) of self-disclosure
   - There are different risks that associated with one's sero-positive status disclosure to his/her sexual partner(s). In the seven well searched items given for disclosed participants in this specific study *Loss of economic support* (mean=4.24, s.d. = 1.235), *Abandonment* (mean=4.21, s.d.= 1.273), *Violence or abandonment on children* (mean=4.15, s.d.= 1.298), *Physical and emotional abuse* (mean=4.04, s.d.= 1.347), *Discrimination*(mean=3.99, s.d.= 1.354), *Disruption of family relationship* (mean=3.97, s.d.= 1.454), and *Blame* (mean=3.91, s.d.= 1.387) have got the priority in that respective order.

Types and Levels of Self-Disclosure Related Discussions

1. Types of Self-Disclosure Related Discussions
   - About 75 percent (N=226 participants) of all the participants responded that they have self-disclosure related discussions with their sexual partners while the rest 25 percent (N=74 participants) showed that they did not have self-disclosure related discussion with their sexual partners.
   - The total participants found to have self-disclosure related discussion (mean= 11.94 with s.d. =4.358). More specifically, those who did not have self-disclosure related discussions got a mean value of 6.41 (with s.d.= 1.364 while those who have self-disclosure related discussion with their sexual partners living with HIV/AIDS showed a mean score of 13.76 (with s.d.= (with s.d.= 3.353).
2. Levels of Self-Disclosure Related Discussions
   - A clear difference in the levels/frequency of self-disclosure related discussions among sexual partners living with HIV/AIDS was seen. Those who did not discuss their sero-positive status to their sexual partner(s) accounts for 24.7 percent (N=74) while those who discussed their sero-positive status to their sexual partner(s) in less and high levels accounts for 48.7 percent (N=146) and 26.7 percent (N=80), respectively.
   - About half of the participants showed less level of self-disclosure related discussions while more than a quarter showed higher levels of disclosure related discussions. Only about a quarter of all the participants revealed their non-discussant level of self-disclosure related discussions. Those who did not have disclosure related discussions and those who have both less and higher levels of self-disclosure related discussions revealed a mean scores of 6.41 (with s.d.= 1.364), a mean scores of 11.63 (with s.d.= 1.990) and a mean scores of 17.64 (with s.d.= 1.070) in that respective order.
   - All the participants were found to be less frequently discussant of their sero-positive status to their sexual partner(s). They scored a mean value of 11.94 (with s.d.= 4.358).

3. Associations of Types and Levels of Self-Disclosure Related Discussions to the Background Information

- The demographic and socioeconomic variables that includes hospitals used, the sub cities covered, sex, age, educational background, religious affiliation, employment status, organizational type, time since diagnosed, ways to know sero-positive status, current CD-4 status and use of antiretroviral drugs were found to be independent and showed no significant group difference in the clients' types and levels of self-disclosure related discussions to one's sexual partner(s).
- Marital status has shown significant group difference in the levels of self-disclosure related discussions while it has no significant group difference in the types of self disclosure related discussions.
- Ethnic group has shown significant group difference in the types of self-disclosure related discussions while it has no significant group difference in the levels of self disclosure related discussions.
- Average monthly family income, self-disclosure and time period for self-disclosure have shown significant group differences both in the types and levels of self-disclosure related discussions.

Reasons for Sero-positive status Self-Disclosure and Self-non disclosure

1. General Findings
   - Most of the participants strongly agree with items related to self-disclosure and on items reflected the possible reason for self Non-disclosure. The calculated mean for the total items were also found to be 116.94 (with s.d.= 23.097) that reflected similar results as discussed above.
   - On average, 60 percent of all the participants found to agree on statements related to reasons for self Non-disclosure, while above 70 percent of all the participants agree on statements that reflects reasons for self-disclosure.

2. The Reasons for Sero-positive Status Self Non-Disclosure

- On average, above 70 percent of all the participants agree on statements that reflects reasons for self-disclosure.
- Most of the reasons for self Non-disclosure among sexual partners living with HIV/AIDS were found to be relationship matters. For all the participants being none very close in relationship (68.7 percent), casual nature of relationship (70 percent), not known each other very well (66 percent) and loose relationship (78.7 percent) were found to be a reason for self Non-disclosure.
- Information transmission is also other reason for self Non-disclosure. 66.7 percent of the participants did not figure out how to talk the diagnosis, 59.4 percent of the participants have fear to tell others in the part of their sexual partner(s), 69.3 percent of the participants have fear of not understand in part of the other sexual partner and 77.6 percent of the participants did not know how to talk the diagnosis to their sexual partner(s).
- Privacy related issues were also other reasons for self Non-disclosure. Among such reasons, 66 percent of the participants have fear of dislike, 72.6 percent of the participants have fear of future relationship, 59.7 percent of the participants lack of interest, 60.7 percent of the participants believed that they have the right to private information, 63.6 percent of the participants justified privacy as a reason, 66.7 percent developed shame, and 76.7 percent of the participants still not accepted the diagnosis (denial) were found to be reasons for self Non-disclosure.
- The calculated mean of 52.48 (with s.d.= 14.311) revealed that all the fifteen items were found to be reasons for self Non-disclosure among sexual partners living with HIV/AIDS.

3. The Reasons for Sero-positive Status Self Disclosure

- On average, above seventy percent of all the participants show their agreement on each item. The calculated mean statistic also found to be a minimum of 3.76 (with s.d.= 1.394) that clearly shown their agreement on each items.
- Specifically, among all the participants eighty percent or more of them agree on the reasons for self-disclosure that related to responsibility. The minimum mean

statistics of the five items also found to be 4.05 (with s.d.= 1.214) that strengthen the results discussed above.

- To know the knowledge of the people about the seriousness of the disease (73.6%), the goal to teach others (71.7%) and to educate sexual partner(s) (83.0%) were the instruction related reasons for self-disclosure among sexual partners living with HIV/AIDS. The calculated mean and standard deviation statistics also revealed similar results.
- From the relationship consequences four items were included among the reasons for self-disclosure among sexual partners living with HIV/AIDS. The reasons include sexual partners wanted to see how their counter sexual partners would feel about them after disclosing (86.7%), wanted to know their sexual partners' were getting into by being in relationship with them (84.0%), wanted to make sure that whether their sexual partners would be with them after disclosing (77.6%) and wanted to see the reactions of their sexual partners after they told them the issue (81.4%). The minimum mean statistic was found to be 3.90 (with s.d.= 1.279) that would reflect similar results as described above.
- People did not want to carry their being sero-positive status by themselves (84.3 percent), it would be cathartic (77.0 percent), would be able to get the issue off their chest (82.0 percent), and believe that their sexual partners had a right to know what was happening to them (80.4 percent) so that they have disclosed their sero-positive status to their sexual partner(s) living with HIV/AIDS. The minimum mean statistic for the four items was found to be 3.88 (with s.d.= 1.264) that revealed similar results as mentioned above.
- In general, the calculated mean, standard deviation and other statistics clearly revealed that all the thirty one (31) reasons for self-disclosure and Self-non disclosure among sexual partners living with HIV/AIDS could serve as a reason both in item or group levels.

5.2 Conclusions

In studying self-disclosure problems among sexual partners living with HIV/AIDS the experiences of HIV positive status, rate of self disclosure, benefits and risks of self disclosure, types and levels of sero-positive status related discussions and their association with the clients' socioeconomic background and reasons for self disclosure and Self-non disclosure, were touched in depth. Therefore, based on the results of this specific study the following conclusions were made.

People living with HIV/AIDS had known their sero-positive status at different time periods for different reasons. Most of them knew their HIV positive status through medical related testing while about one third of them have known through non-medical related testing such as passport and employment processes. Majority of ART clinics clients have started using antiretroviral drugs and maintain their CD-4 counts that help them to live with the virus positively. But, some others (at least a quarter) did not yet start the same for different reasons. The reasons include that their doctor did not yet recommend it since their CD-4 status is in better condition. In addition, they were in need of some more counseling, some more time for decision making and had not got enough access for adequate and nutritious foods.

HIV positive status self-disclosure is not a onetime event, but was experienced as a process. The disclosure process took different time periods among the different participants, irrespective of the reasons. About half of disclosed participants have made known their sero-positive status the same day after their diagnosis while about ten percent of them took more than three months period.

There is sero-positive status self-disclosure problem among sexual partners living with HIV/AIDS though the rate seemed to be low. Majority of clients in the ART clinics have disclosed their sero-positive status to their sexual partner(s) by themselves. But, at least a third did not yet disclosed their HIV positive status to their sexual partner(s) and 56.25% of those self-disclosed participants did not disclosed the same day of their diagnosis. Thus, the rate is not low in practical terms, because:

- the participants of this study were ART clinic clients who expected to have better access to information for proper decision making;

- A single individual who did not accept the result & disclose his/her sero-positive status could infect plenty number of his/her sexual partner(s).
- Moreover, the result revealed that there is a clear disparity between the knowledge of the participants and their change in behavior.

Thus, the efficacy of the existing information dissemination mechanisms and the post-testing counseling services should be studied.

Sero-positive status self-disclosure to one's sexual partner(s) has different kinds of benefits and probably risks. The opportunity to utilize the benefits and refrains from the risks of sero-positive status disclosure among sexual partners living with HIV/AIDS is profuse among ART clinic clients.

The positive outcomes of sero-positive status self-disclosure to one's sexual partner(s) are many and diversified that can be categorizing in to four broad areas. *Improved access to the necessary medical treatment and care* got the priority followed by *improved opportunities to plan for the future carefully and thoughtfully*; *increased opportunities to discuss and implement HIV risk reduction with partners* and *increased opportunities for instrumental and expressive social support*, in that respective order.

There are different risks associated with one's sero-positive status disclosure to his/her sexual partner(s) that can be tested in seven well searched items. *Loss of economic support* got the priority followed by, *Abandonment*, *Violence or abandonment on children*, *Physical and emotional abuse*, *Discrimination*, *Disruption of family relationship*, and *Blame*, respectively.

There are many reasons both for HIV positive status self-disclosure and self-non disclosure among clients of ART clinics who have sexual partner(s) living with HIV/AIDS. But, most of the participants were found to strongly agree with items related to self-disclosure and on items reflected the possible reason for self Non-disclosure.

Most of the reasons for self Non-disclosure among sexual partners living with HIV/AIDS were found to be relationship matters that include being not very close in relationship, casual nature of the relationship, not known each other very well and lose relationship.

Problems in information transmission is also the other reason for self Non-disclosure that include did not figure out how to talk the diagnosis, fear to tell others in the part of their sexual

partner(s), fear of not understand in part of the other sexual partner and did not know how to talk the diagnosis to their sexual partner(s).

Privacy related issues were also other reasons for self Non-disclosure that include fear of dislike, fear of future relationship, lack of interest, right to private information, privacy as a reason, shame and not accepted the diagnosis (denial). In general, all the fifteen items were found to be reasons for self Non-disclosure among sexual partners living with HIV/AIDS.

In studying the reasons for HIV self-disclosure among sexual partners living with HIV/AIDS above seventy percent of all the participants show their agreement on the given sixteen items. Thus, all the items could be used in studying HIV/AIDS self disclosure among sexual partners living with HIV/AIDS. It could also serve as a tool in similar studies.

The reasons for HIV self-disclosure could be categorized in to four major areas that could help us for clear understanding of the issue at hand. In such categorization eighty or more percent of all the participants agree on the reasons for self-disclosure that related to responsibility. Such reasons include knowing the knowledge of the people about the seriousness of the disease, the goal to teach others and to educate sexual partner(s).

Relationship consequence and emotional release as reasons for HIV self-disclosure for sexual partners living with HIV/AIDS were practical for seventy seven or more percent of all the participants. Relationship consequences related reasons include wanted to see how their counter sexual partners would feel about them after disclosing, wanted to know their sexual partners' were getting into by being in relationship with them, want to make sure that whether their sexual partners would be with them after disclosing, and wanted to see the reactions of their sexual partners after they told them the issue. Similarly, did not want to carry being sero-positive status by themselves, it would be cathartic, would be able to get the issue off their chest, and believe that their sexual partners had a right to know what was happening to them were emotional release related reasons for self-disclosure of one's HIV status.

Instruction related reasons that include the reasons to know the knowledge of the people about the seriousness of the disease, the goal to teach others and to educate sexual partner(s) also chosen by seventy or more percent of all the participants. In general, the reasons for HIV

positive status self-disclosure and self-non disclosure can be used in studying similar researches that could serve as a tool.

Self-disclosure related discussions are the first steps and are very important tools in disclosing one's sero-positive status to one's sexual partner(s). People living with HIV/AIDS, even those who are clients of ART clinics differ both in their types and levels of self-disclosure related discussions with their sexual partner(s). In further studying the levels of self-disclosure related discussions those individuals who did not have self disclosure related discussions with their sexual partner(s) were accounts for a quarter while fifty percent of them showed lesser level of self-disclosure related discussions. Clients' of the ART clinics who have higher level of self-disclosure related discussions with their sexual partner (s) were also accounts for a quarter. In general, all the participants were found to be less frequently discussant of their sero-positive status to their sexual partner(s).

There is a clear difference between the types and levels of self-disclosure related discussions and the participants' demographic and socioeconomic backgrounds. Most of such variables have shown significant group difference with the rates of self disclosure related discussions to one's sexual partner(s).

The demographic and socioeconomic variables that includes self-disclosure, average monthly family income, and time period for self-disclosure have significant association both with the types and levels of self-disclosure related discussions. Moreover, marital status has shown significant group difference in the levels of self-disclosure related discussions while it has no significant group difference in the types of self disclosure related discussions. Ethnic group has also shown significant group difference in the types of self-disclosure related discussions while it has no significant group difference in the levels of self disclosure related discussions.

On the other hand, other variables that relates to hospitals used, the sub cities covered, participants' sex and age, educational background, religious affiliation, employment status, organizational type, time since diagnosed, ways to know sero-positive status, current CD-4 status and use of antiretroviral drugs were found to be independent and showed no significant group difference both in the types and levels of self-disclosure related discussions to one's sexual partner(s).

5.3 Recommendations

Based on the evidences that have been mentioned in the previous chapters and their many dimensional threats and coercion the following general and specific recommendations both in short and long term basis are in order.

5.3.1 Short Term Recommendations

1. Persons living with HIV/AIDS shall be the first priority for the prevention of the spread of HIV and for the proper care and support of persons living with HIV/AIDS. As it was observed that self-disclosure related discussions among sexual partners living with HIV/AIDS is low. The problem of sero-positive status self non-disclosure, in turn, is also viable though the rate seemed to be lower among sexual partners. But, an individual who is living with HIV/AIDS can be potential sources of infections for several numbers of people who are his/her sexual partners. For these and many other reasons the involvement of people living with HIV/AIDS in the prevention of new HIV infections through behavioral change should be imperative. Thus, focusing on the potential sources of infections (i.e., PLWHA) than on people who are at risk should get the priority in the prevention of the spread of HIV virus.

2. It is observed that people living with HIV/AIDS, even those who are clients of ART clinics have low level of discussions on issues related to sero-positive status self-disclosure for sexual partner(s). Thus, offer appropriate information with greater emphasis on survival skills, the benefits and probable risks of HIV-positive status self-disclosure and communication skills for proper transmission of self-disclosure related information for sexual partner(s) living with HIV/AIDS in simple and understandable language should be in order. It should be further supported by awareness raising and advocacy programs through mass media in artistic and thoughtful manner.

3. Offer professional post testing counseling services by trained professional counselors that can facilitate behavioral change in the part of persons living with HIV/AIDS (PLWHA) should get proper emphasis. The current post testing counseling services

should be encouraged, supported and sustained by trained professional counselors, professional ethics and community services, than health related paraprofessionals support in and around health institutions. Because, the involvement of trained professional counselors will facilitate behavioral change among PLWHA that, in turn, may prevent many of those persons' sexual partners from becoming infected with HIV virus.

5.3.2 Long Term Recommendations

1. Redefining Training Programs for Counselors with special emphasis on HIV/AIDS counseling. Although most of the programs are implemented by Ministry of Health with trained medical personnel (nurses and/or medical doctors), the involvement of professionally trained counselors should be a must. Ministry of Education and Addis Ababa University, Department of Psychology should give training opportunities for counselors with continued and sustainable trainings (pre-service trainings, in-service trainings, workshops, seminars, etc ...). The counselors should be equipped with the necessary counseling theories and current practices.
2. Revisiting the Pre- and Post-testing counseling Programs. The existing pre- and post-testing counseling program should be revisited and empowered through the direct involvement of trained professional counselors to get good results as expected and planned.
3. Practical Implementation on the Policy, Strategic Frameworks, Strategic Plans and Guidelines. It should be understood that HIV/AIDS is not only a medical agenda. It should be fought through the involvement of multi-disciplinary professionals from different disciplines, especially trained professional counselors. Without the involvement of such professionals the implementation of the existing policy, strategic frameworks, strategic plans and guidelines could not be fully addressed and ripe what is expected in the documents.
4. More intensive researches on the area, especially on the role of self-disclosure and professional counselors' involvement in the post-test counseling programs for the better prevention of the spread of HIV virus should be undertaken.

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Appendices

Appendix A: Letter of Informed Consent and Self-Report Questionnaire

Appendix B: Guiding Questions of the Interviews and Focus Group Discussions

Appendix C: Regional Ethical Clearance from Addis Ababa City Government Health Bureau

Appendix A. Letter of Informed Consent and Self-Report Questionnaire

Letter of Informed Consent

1. ***Title of the Study:*** Self-Disclosure Problems among Sexual Partners Living with HIV/AIDS (the Case of Hospital Clients in Addis Ababa).
2. ***Purpose of the Study:*** The purpose of this study is to investigate and discuss Self-Disclosure problems among Sexual Partners living with HIV/AIDS who are clients of three different hospitals (namely Alert Hospital, Black Lion Hospital, and Zewuditu Memorial Hospital) in the City Administration of Addis Ababa.
3. ***Procedures:*** I will be asked to complete a brief questionnaire related to HIV status self disclosure among sexual partner/s. In addition, in the questionnaire I will be completing a rating scale of the reasons for HIV status disclosure or non-disclosure to sexual partner/s.
4. ***Risks and Discomforts:*** There are no known medical or psychological risks or discomforts associated with this study. Although I may experience stress when answering these questions, I will be given enough time to answer the questions.
5. ***Benefits:*** I understand there are no known medical benefits to me for participation in this study. However, the results of the study may help researchers gain a better understanding of the need, benefits and risks of HIV status disclosure among sexual partners.
6. ***Participant's Right:*** I may withdraw from participating in the study at any time.
7. ***Financial Compensation:*** Participating in this study will not put me into any expenses.
8. ***Confidentiality:*** I will only complete the questionnaire. The questionnaire will only be read by the data collector/researcher (if necessary). I understand that the results of this study will be kept confidential unless I ask that they be released. The results of this study may be published in professional journals or presented at professional conferences, but my questionnaire or identity will not be revealed unless required by law.
9. ***Address for Further Questions:*** If I have a question of concerns, I can call [redacted] (the principal investigator) at [redacted] at any time during the day or night.

I understand my rights as a respondent/subject in the mentioned research, and voluntarily consent to participation in this study. I understand what the study is about and how and why it is being done. Thus, I do hereby state that I have read and understood the above mentioned declaration and hereby state that I agree to the conditions attaching thereto.

_____	_____	_____
Subject's Signature	*Date*	*Place (Name of the Hospital)*
_____	_____	_____
Investigator's Signature	*Date*	*Place (Name of the Hospital)*

Appendix A. Continued...

አዲስ አበባ
ዩኒቨርሲቲ
Addis Ababa
University

ADDIS ABABA UNIVERSITY
SCHOOL OF GRADUATE STUDIES
DEPARTMENT OF EDUCATIONAL PSYCHOLOGY
(COUNSELLING PSYCHOLOGY STREAM)

Your information will be kept confidentially!

A QUESTIONNAIRE REGARDING

HIV Status Disclosure to Sexual Partners Living with HIV/AIDS

The aim of this questionnaire is to obtain information regarding HIV Status Disclosure to sexual partners who are clients of Alert, Black-Lion, and Zewditu Memorial Hospitals in Addis Ababa. Each data collected through this instrument will be absolutely used only for research purposes. The information provided will be kept confidential and no one will be affected by it.

The researcher assures you that no one will ever know the specific responses given. Your name and specific addresses should not be written in any place in the questionnaire. Therefore, be kind enough to spare some time to answer all the questions and items frankly and honestly. Your frank and honest response will have major contribution in this study that will be thankful and highly appreciated.

Thank you very much for your cooperation in advance!

The Researcher!

Your information will be absolutely used only for research purposes!

Appendix A. Continued...

Questionnaire on HIV Status Disclosure to Sexual Partner/s

PART ONE: *DEMOGRAPHIC AND SOCIO-ECONOMIC INFORMATION.*

DIRECTION: Please fill in the following blank spaces and/or mark (√) in the spaces provided that correspond the right information.

1. Are you willing to participate in this research work? a. Yes, ☐ b. No. ☐

   Address: **Addis Ababa**. Sub City _____ Kebele _____

2. Name of the Hospital Used: (a) Alert Hospital ☐ (b) Black-Lion Hospital ☐

   (c) Zewditu Memorial Hospital ☐

3. Sex: (a) Male ☐ (b) Female ☐

4. Age: (a) 18 to 24 years old ☐ (b) 25 to 34 years old ☐ (c) 35 to 44 years old ☐

   (d) 45 to 55 years old ☐ (d) above 55 years old ☐

5. Educational Background: a. Illiterate ☐ b. Elementary ☐ c. Secondary

   d. Certificate ☐ e. Diploma ☐ f. First Degree ☐ g. post graduate degree ☐

   h. Others (specify) ____. Please specify your specialization area also? _____

6. Religion: a. Orthodox ☐ b. Protestant ☐ c. Catholic ☐

   d. Muslim ☐ e. Others (specify) _____

7. Marital Status: a. Single ☐ b. Married ☐ c. Divorced ☐

   d. Widowed ☐ e. Dating/ Cohabiting ☐ f. Others (specify)

8. Ethnic Group: _____

9. Employment Status: a. Employed ☐ b. Unemployed ☐ c. Retired ☐

   d. Others (specify) _____

Appendix A. Continued...

10. If you are employed, please specify your organization's type? a. Governmental ☐

b. Non-Governmental ☐ c. Private ☐ d. Self-Employed ☐ e. Others, Specify _____

11. Average Monthly income of your family? a. below 200 birr ☐ b. 201-500 birr ☐

c. 501-1000 birr ☐ d. 1001-1500 birr ☐ e. 1501-2000 birr ☐ f. above 2000 birr ☐

PART TWO: **Experiences of HIV Positive Status Disclosure among Sexual Partners.**

DIRECTION: Please fill in the following blank spaces and/or mark (√) in the spaces provided that correspond the right information.

1. When did you know your HIV status? a. Only before three months ☐ b. 3-12 months ☐

c. 1-3 years ☐ d. 3-5 years ☐ e. 5-10 years ☐ f. above 10 years ☐

2. How did you know your HIV status? a. through medical related testing ☐

b. through non-medical related testing ☐ Please specify, _____

3. How looks like your current CD-4 status? a. Only less than 100 ☐ b. 101-150 ☐

C.151-200 ☐ d. 201-250 ☐ e. 251-300 ☐ f. above 300

4. Did you start/use Antiretroviral Drugs? a. Yes, ☐ b. No, ☐

5. If you do not use/start Antiretroviral Drugs, why it is so? (You can choose more than one that applies). a. My doctor did not recommend it since my CD-4 status is ok. ☐

b. Although my doctor recommended it, I still need some more counseling. ☐

c. Although my doctor recommended it, I still need some more time to decide. ☐

d. Although my doctor recommended it, I do not have enough access to nutritious food. ☐

e. Others (specify) _____

6. Did you disclose your HIV status to your sexual partner/s? a. Yes, ☐ b. No, ☐ c. Others

Appendix A. Continued...

7. If your answer is 'yes' for question number 6 above, when did you disclose since you know your HIV sero positive status?

(a) The same day. ☐ (b) Within a week. ☐ (d) Within a month. ☐

(e) Within three months. ☐ (e) Other, (specify) _____

8. If your answer is 'yes' for question number 6 above, please rate the extent of your feelings on the items that follows; (Please use the following scale based on your own evaluation).

S/N	STATEMENTS	ALTERNATIVES			
		Always	Many times	Some-times	Not at all (Never)
1.	Blame.				
2.	Increased opportunities for instrumental and expressive social support.				
3.	Disruption of family relationship.				
4.	Discrimination.				
5.	Improved access to necessary medical treatment and care.				
6.	Violence or abandonment on children.				
7.	Increased opportunities to discuss and implement HIV risk reduction with partners.				
8.	Physical and emotional abuse.				
9.	Increased opportunities to plan for the future carefully and thoughtfully.				
10.	Loss of economic support.				
11.	Abandonment.				

9. What were the major reasons for disclosing /Non-disclosing your HIV positive status to your sexual partner/s? _____

_____

10. Have you known your sexual partner/s' HIV status? a. Yes, ☐ b. No, ☐

Appendix A. Continued...

11. If your answer for que. # 10 above is 'yes' what looks like your sexual partner/s' HIV status?

a. HIV—Positive ☐ b. HIV—Negative ☐ c. other (specify) _____

12. If your answer for que. # 10 above is 'yes' when did you know that?

a. You both know at a time.☐ b. before knowing your HIV status ☐

c. After knowing your HIV status ☐ d. other (specify) _____

13. If your answer for que. # 10 above is 'yes' how you know your sexual partner/s 'HIV status?

a. S/he told you ☐ b. somebody told you (specify) _____

c. Your counselor told that. ☐ d. other (specify) _____

14. Have you had any unsafe sexual experience with your sexual partner/s before disclosing your HIV sero positive status? a. Yes, ☐ b. No, ☐

PART THREE: <u>A Scale/ Items on Level of HIV Status Disclosure to Sexual Partner/s</u>

DIRECTION: Please read carefully each of the following items and circle the letter of your choice on the bases of your level of HIV Infection Self-Disclosure related Discussions with Sexual Partner(s). Please, be open and honest.

1. Do you have open discussion on your HIV Status with your sexual partner/s?
   (a) Yes, I have open discussion on my HIV status and still do.
   (b) I had open discussion on my HIV Status, but no longer want to do.
   (c) I do not have open discussion on my HIV Status with my Sexual Partner/s, but sometimes I encountered with these issues.
   (d) No, Never!

2. Do you consider yourself as a regular discussant of your HIV Status with your sexual partner/s?
   (a) Yes, I am totally a regular discussant. (b) Yes, I am mostly a regular discussant.
   (c) No, I am not mostly a regular discussant. (d) No, I am not totally a regular discussant.

Appendix A. Continued...

3. If you have open discussion on your HIV Status with your sexual partner/s, how often do you discuss with him/her?

(a) Daily. (b) Several time a week. (c) Once or twice a month.

(d) Less often or less than once a month.

4. If you had open discussion on your HIV Status with your sexual partner/s. but no longer you want to do, how long has it been since you stopped open discussion with your sexual partner/s?

(a) More than a day but less than a week. (b) More than a week but less than a month.

(c) More than a month, but less than six months. (d) More than six months.

PART FOUR: *Reasons for HIV Status Disclosure/* **Non-Disclosure.**

DIRECTION: The following items are some of the reasons for HIV infection Self-Disclosure or Non-Disclosure with your sexual partner/s. Please, properly evaluate the reasons for HIV status Disclosure or Non-Disclosure based on the options given below. Feel free in expressing your degree of agreement or disagreement in each of the statements. Please, put a tick or check mark (√) on your degree of agreement or disagreement to each item on the basis of your experience with HIV status disclosure or non-disclosure and on what you feel, think, act and see the actual reason for the disclosure or non-disclosure of your HIV status. Use the following scale for your responses:

(1) = It is not at all a factor (***Strongly Disagree***).
(2) = It is slightly a factor (***Disagree***).
(3) = It is moderately a factor.
(4) = It is mostly a factor (A***gree***).
(5) = It is very likely a factor (***Strongly Agree***).

S/N	*STATEMENTS*	*ALTERNATIVES*			
		Strongly Agree	***Agree***	***Dis-agree***	***Strongly Disagree***
1.	Wanted to see how my sexual partner/s would feel about me after disclosing				
2.	My sexual partner/s had a right to know what was happening to me.				
3.	We weren't very close to one another.				
4.	Our relationship was pretty casual.				
5.	I couldn't figure out how to talk about the diagnosis				

Appendix A. Continued...

S/N	STATEMENTS	ALTERNATIVES			
		Strongly Agree	*Agree*	*Dis-agree*	*Strongly Disagree*
6.	I wanted to educate my sexual partner/s about the disease.				
7.	Didn't want to carry this around by myself				
8.	I felt a sense of duty to tell my sexual partner/s.				
9.	Wanted to make sure that people know the seriousness of the disease.				
10.	People have big mouths and may tell others.				
11.	We didn't know one another very well.				
12.	Concerned my sexual partner/s wouldn't understand.				
13.	It would be cathartic.				
14.	I wanted my sexual partner/s to know what he or she was getting into by being in a relationship with me.				
15.	My goal was to teach others about the disease.				
16.	Wanted to find out if my sexual partner/s would be with me after disclosing				
17.	I worried person would no longer like me after knowing.				
18.	My diagnosis is my own private information.				
19.	Concerned how my sexual partner/s would feel about me after knowing.				
20.	Didn't want to risk any more health problems for me or my sexual partner/s.				
21.	Wanted to see how my sexual partner/s would react when I told him/her				
22.	Would be able to get information off my chest				
23.	I don't have to tell anyone if I don't want to.				
24.	I have a right to privacy.				
25.	I felt ashamed about being HIV—positive.				
26.	I wanted my sexual partner/s to know what he or she was getting into by being in a relationship with me.				
27.	I felt obligated to tell my sexual partner/s.				
28.	My sexual partner/s had a right to know what was happening to me.				
29.	Our relationship wasn't very serious.				
30.	I had difficulty accepting my HIV status.				
31.	I didn't know how to tell my sexual partner/s about my diagnosis.				

Appendix A. Continued...

የፍቃደኝነት ማረጋገጫ ቅጽ

1. *የጥናቱ ርዕስ፡-* ከኤች. አይ. ቪ.. ቫይረስ ጋር መኖርን ከማሳወቅ/አለማሳወቅ ጋር በተያያዘ በትዳር ጓደኞሞች (በፍቅረኛሞች) መካከል የሚከሰቱ ችግሮች (በአዲስ አበባ ከተማ ውሥጥ በሚገኙ ሆስፒታሎች ውሥጥ አገልግሎት በሚያገኙ ተጠቃሚዎች ላይ የተደረገ ጥናት)፡፡ (Self-Disclosure problems among Sexual Partners living with HIV/AIDS /the case of Hospital Clients in Addis Ababa/)
2. *የጥናቱ ዓላማ፡-* የዚህ ጥናት ዓላማ በአዲስ አበባ ከተማ በሚገኙ ሶስት ሆስፒታሎች (ማለትም በአለርት፣ በጥቁር አንበሳና በዘውዲቱ መታሰቢያ ሆስፒታሎች) ውሥጥ ተገልጋይ በሆኑ የትዳር ጓደኞሞች (ፍቅረኛሞች) መካከል ኤች. አይ. ቪ.. ቫይረስ ጋር መኖርን ከማሳወቅ/አለማሳወቅ ጋር በተያያዘ በመካከላቸው የሚከሰቱ በጎ ነገሮችን ወይም ችግሮችን ማጥናት ነው፡፡
3. *የጥናቱ አካሄድ፡-* በትዳር ጓደኞሞች (ፍቅረኛሞች) መካከል ኤች. አይ. ቪ.. ቫይረስ ጋር መኖርን ከማሳወቅ/አለማሳወቅ ጋር በተያያዘ የሚከሰቱ በጎ ነገሮችን ወይም ችግሮችን መሠረት አድረጎ የተዘጋጀውን መጠይቅ እንድሞላ እጠየቃለሁ፡፡ በተጨማሪም የትዳር ጓደኞሞች (ፍቅረኛሞች) ከኤች. አይ. ቪ.. ቫይረስ ጋር መኖራቸውን ለማሳወቅ/አለማሳወቅ ምክንያት ሊሆኑ የሚችሉ ጉዳዮችን አስመልክቶ በመጠይቁ ላይ የተካተተውን ሠንጠረዥ (ሬቲንግ እስኬል) ካለኝ ተሞክሮና ከማውቀው አንጻር እንድሞላ እንደምጠየቅ ተገንዝቤያለሁ፡፡
4. *አስቸጋሪ ሁኔታዎችና አለመመቸት፡-* ከህክምናም ሆነ ከስነ ልቦና ጋር ተያያዥነት ያላቸው የታወቁ ችግሮች በዚህ ጥናት ላይ እንደሌሉ አረጋግጫለሁ፡፡ ሆኖም ግን መጠይቁን በመመላት ሂደት ውስጥ መጠነኛ ድካም ወይም ውጥረት ሊገጥመኝ ስለሚችል መጠይቁን ለመመላት በቂ ጊዜ እንደሚሰጠኝ አውቃለሁ፡፡
5. *ጥቅማጥቅሞች፡-* በዚህ ጥናት ላይ በመሳተፌ ከህክምና ጋር ተያያዥነት ያላቸው የሚታወቁ ጥቅማ ጥቅሞች እንደማላገኝ አውቃለሁ፡፡ ሆኖም ግን የጥናት ውጤቱ በዘርፉ ለተሰማሩ ተመራማሪዎች በትዳር ጓደኞሞች (ፍቅረኛሞች) መካከል ኤች. አይ. ቪ.. ቫይረስ ጋር መኖርን ከማሳወቅ/አለማሳወቅ ጋር በተያያዘ በመካከላቸው የሚከሰቱ በጎ ነገሮችን ወይም ችግሮችን ለማወቅ፤ የችግሩን ደረጃ፣ ጥቅምና ጉዳቱን አስመልክቶ ሰፋ ያለ ግንዛቤ ሊያገኙበት እንደሚችሉ አምናለሁ፡፡
6. *የተሳታፊነት መብት፡-* በማንኛውም ጊዜ ቢሆን በዚህ ጥናት ላይ መሳተፌን ማቆም እንደምችል አውቃለሁ፡፡
7. *የማካካሻ ክፍያ፡-* በዚህ ጥናት ላይ መሳተፌ ምንም ዓይነት የተለየ ወጭ እንዳወጣ እንደማያደርገኝ አውቃለሁ፡፡
8. *ምሥጢራዊነት፡-* ለዚህ ጥናት የተዘጋጀውን መጠይቅ እንድሞላ እጠየቃለሁ፡፡ እንደ አስፈላጊነቱ መጠይቁን መረጃ ሰብሳቢ/ተመራማሪ እንዲያነብልኝ ሊደረግ ይችላል፡፡ ሆኖም ግን የሰጠሁት መረጃ እኔ ግልጽ እንዲደረግ እስካልፈቀድኩ ጊዜ ድረስ ምሥጢራዊነቱ እንደሚጠበቅ ተረድቻለሁ፡፡ የዚህ ጥናት ውጤት ለህትመት ሊበቃ ወይም በተለያዩ መድረኮች ላይ ሊቀርብ እንደሚችል አውቃለሁ፡፡ ሆኖም ግን እኔ የሞላሁት መጠይቅ ህግ እስካላስገደደ ድረስ ምሥጢራዊነቱ እንደሚጠበቅ ተረድቻለሁ፡፡
9. *ተጨማሪ ጥያቄዎች፡-* ከጥናቱ ጋር በተያያዘ ማንኛውም ዓይነት ጥያቄ ቢኖረኝ ወይም ተጨማሪ መረጃ ቢያስፈልገኝ የጥናቱን አስተባባሪ [redacted] በሞባይል ቁጥር [redacted] በማንኛውም ጊዜ ደውዬ ላናግራቸው እንደምችል ተገንዝቤያለሁ፡፡

ከላይ በተጠቀሰው ጥናት ላይ በምሳተፍበት ወቅት በጥናቱ ላይ የሚኖረኝን መብት ተረድቼ በጥናቱ ላይ ለመሳተፍ ተስማምቻለሁ፡፡ በተጨማሪም የሚካሄደው ጥናት ምን እንደሆነ፣ እንዴትና ለምን እንደሚሰራ ለመረዳት ችያለሁ፡፡ ስለሆነም ከላይ የቀረቡትን መግለጫዎች ሁሉ አንብቤ (ወይም ተነቦልኝ) እና ተረድቼው ከላይ በቀረቡት ጉዳዮች ላይ ሁሉ ተስማምቼ በጥናቱ ላይ ለመሳተፍ ሙሉ በሙሉ ፍቃደኛ መሆኔን በተለመደ ፊርማዬ አረጋግጣለሁ፡፡

የጥናት ተሳታፊው ፊርማ	*ቀን*	*ቦታ (የሆስፒታሉ ስም)*
የጥናት አስተባባሪው ፊርማ	*ቀን*	*ቦታ (የሆስፒታሉ ስም)*

አዲስ አበባ
ዩኒቨርሲቲ
Addis Ababa
University

አዲስ አበባ ዩኒቨርሲቲ
የድህረ ምረቃ ትምህርት ክፍል
የትምህርት ሳይኮሎጂ ዲፓርትመንት
(የካውንስሊንግ ሳይኮሎጅ ክፍል)

የምትሠጡት መረጃ በጥንቃቄና በአስተማማኝ ሁኔታ ይያዛል!

<u>ከኤች. አይ. ቪ.. ቫይረስ ጋር መኖርን ከማሳወቅ/አለማሳወቅ ጋር በተያያዘ በትዳር ጓደኞሞች (ወይም ፍቅረኛሞች) መካከል የሚከሰቱ ችግሮችን ለማጥናት *የተዘጋጀ* መጠይቅ</u>

የዚህ መጠይቅ ዓላማ ከኤች. አይ. ቪ.. ቫይረስ ጋር መኖርን ከማሳወቅ/አለማሳወቅ ጋር በተያያዘ በትዳር ጓደኞሞች (ወይም ፍቅረኛሞች) መካከል የሚከሰቱ ችግሮችን ለማጥናት በአዲስ አበባ ከተማ በሚገኙ ሆስፒታሎች (ማለትም በአለርት፣በጥቁር አንበሳና በዘውዲቱ መታሰቢያ ሆስፒታሎች) ውሥጥ አገልግሎት ከሚያገኙ ተጠቃሚዎች ላይ መጠነኛ መረጃ ማሠባሠብ ነው። በዚህ መጠይቅ አማካኝነት የሚሠበሠብ እያንዳንዱ መረጃ ሙሉ ለሙሉ ለምርምር ስራ <u>ብቻ</u> የሚውል ይሆናል። የምትሠጡት መረጃ በጥንቃቄ የሚያዝ ሲሆን ማንም ግለሠብ በሠጠው መረጃ ሠበብ ምንም ዓይነት አደጋ (ወይም ችግር) አይገጥመውም።

ከእርስዎም ውጭ ማንም ግለሠብ እርስዎ የሠጡትን መልሥ ማወቅ እንደማይችል የጥናቱ አስተባባሪ ያማውቃታል። የእርስዎ ስምና የተለዬ አድራሻ በመጠይቁ ማንኛውም ገፅ ላይ መጻፍ አይኖርበትም። ስለዚህ እባክዎ መጠነኛ ጊዜ ይመድቡና ለእያንዳንዱ ጥያቄ እውነተኛ መልስ በመሥጠት ይተባበሩን። የእዕርስዎ ዕውነተኛ ምላሽ ለምርምሩ ከፍተኛ አስተዋጽኦ ስለሚኖረው ምሥጋና የሚያስገኝና የሚደነቅ ነዉ።

ለሚያደርጉልን ትብብር ሁሉ ከወዲሁ ከፍ ያለ ምሥጋናችንን እናቀርባለን!

የጥናቱ አስተባባሪ

የምትሠጡት መረጃ ለምርምር ሥራ ብቻ ይዉላል!

ከኤች. አይ. ቪ. ቫይረስ ጋር መኖርን ከማሳወቅ/አለማሳወቅ ጋር በተያያዘ በትዳር ጓደኛሞች (ወይም ፍቅረኛሞች) መካከል የሚከሰቱ ችግሮችን ለማጥናት የተዘጋጀ መጠይቅ

ክፍል አንድ፡- *ግለሠባዊ፣ ማኅበራዊና ኢኮኖሚያዊ መረጃዎች*

መመሪያ፡- እባክዎን በተሠጡት ክፍት ቦታዎች ላይ ትክክለኛውን መልስ ይሥጡ፤ አማራጭ መልስ ለተሠጣቸውም ጥያቄዎች ትክክለኛውን መልስ በመምረጥ ምልክት (☑) ያድርጉ።

1. በዚህ ጥናት ላይ ለመሳተፍ ፍቃደኛ ነዎትን? ሀ. አዎን ☐ ለ. የለም ☐

አድራሻ፡- አዲስ አበባ ክፍለ ከተማ፡- _____ ቀበሌ፡- _____

2. አገልግሎት የሚያገኙበትን ሆስፒታል ስም ቢገልጹልን? ሀ. አለርት ☐

ለ. ጥቁር አንበሳ ☐ ሐ. ዘውዲቱ መታሰቢያ ☐

3. ጸታ፡- ሀ. ወንድ ☐ ለ. ሴት ☐

4. ዕድሜ፡- ሀ. ከ18 እስከ 24 ☐ ለ. ከ25 እስከ 34 ☐ ሐ. ከ35 እስከ 45 ☐

መ. ከ45 እስከ 55 ☐ ሠ. ከ55ዓመት በላይ ☐

5. የትምህርት ሁኔታ፡- ሀ. ያልተማረ/ች☐ ለ. አንደኛ ደረጃ ☐ ሐ. ሁለተኛ ደረጃ ☐

መ. ሠርተፊኬት ☐ ሠ. ዲ□ሎማ ☐ ረ. የመጀመሪያ ዲግሪ ☐

ሰ. ድኅረ-ምረቃ ዲግሪ ☐ ሸ. ሌላ (ይጠቀስ) _____

እባክዎን የስልጠናውን/ሙያውን ዓይነት ይግለጹልን? _____

6. ሃይማኖት፡- ሀ. ኦርቶዶክስ ☐ ለ. □ሮቴስታንት ☐ ሐ. ካቶሊክ ☐

መ. መስሊም ☐ ሠ. ሌላ (ይጠቀሥ) _____

7. የጋብቻ ሁኔታ፡- ሀ. ያላገባ/ች ☐ ለ. ያገባ/ች ☐ ሐ. የፈታ/ች ☐

መ. የሞተችበት/የሞተባት ☐ ሠ. ጓደኛሞች/ፍቅረኛሞች ☐ ረ. ሌላ (ይጠቀሥ)

8. ብሔር፡- _____

9. የስራ ሁኔታ፡- ሀ. በሥራ ላይ ያሉ ☐ ለ. ሥራ የሌለው/ላት ☐ ሐ. ጡረተኛ ☐

መ. ሌላ (ካለ ይጠቀስ) _____

10. ሠራተኛ ከሆኑ እባክዎን የሚሰሩበትን ድርጅት ዓይነት ይግለጹልን?

ሀ. የመንግስት ድርጅት ☐ ለ. መንግስታዊ ያልሆነ ድርጅት ☐ ሐ. የግለሰብ ተቀጣሪ ☐

መ. የግል ሥራ ☐ ሠ. ሌላ (ካለ ይጠቀስ) _____

11. እባክዎን የቤተሰብዎን አማካይ የወር ገቢ ይግለጹልን?

ሀ. ከ200 ብር በታች ☐ ለ. ከ201-500 ብር ☐ ሐ. ከ501-1000 ብር ☐

መ. ከ1001-1500 ብር ☐ ሠ. ከ1501-2000 ብር ☐ ረ. ከ2000 ብር በላይ ☐

ክፍል ሁለት፡- <u>ከኤች. አይ. ቪ ቫይረስ ጋር መኖርን ለትዳር ጓደኛ/ ፍቅረኛ ከማሳወቅ/አለማሳወቅ ጋር የተያያዙ ተሞክሮዎች</u>

መመሪያ፡- እባክዎን በተሠጡት ክፍት ቦታዎች ላይ ትክክለኛውን መልስ ይሥጡ፤ አማራጭ መልስ ለተሠጣቸውም ጥያቄዎች ትክክለኛውን መልስ በመምረጥ ምልክት (☑) ያድርጉ።

1. ከኤች. አይ. ቪ ቫይረስ ጋር እንደሚኖሩ መቼ አወቁ?

ሀ. ከሶስት ወራት በፊት ☐ ለ. ከ3 እስከ 12 ወራት ☐ ሐ. ከ1 እስከ 3 ዓመታት ☐

መ. ከ3 እስከ 5 ዓመታት ☐ ሠ. ከ5 እስከ 10 ዓመታት ☐ ረ. ከ10 ዓመታት በላይ ☐

2. ከኤች. አይ. ቪ ቫይረስ ጋር እንደሚኖሩ እንዴት አወቁ?

ሀ. ከህክምና ጋር በተያያዘ ምርመራ ☐

ለ. ከህክምና ጋር ባልተያያዘ ምርመራ ☐ እባክዎን ያብራሩልን _____

3. በአሁኑ ወቅት የሲ.ዲ-4 ይዞታዎ/ቁጥርዎ ምን ይመስላል?

ሀ. ከ100 በታች ☐ ለ. ከ101 እስከ 50 ☐ ሐ. ከ151 እስከ 200 ☐

መ. ከ201 እስከ 250 ☐ ሠ. ከ251 እስከ 300 ☐ ረ. ከ300 በላይ ☐

4. የእድሜ ማራዘሚያ መድኃኒት መውሰድ ጀምረዋልን? ሀ. አዎን ☐ ለ. የለም ☐

5. የእድሜ ማራዘሚያ መድኃኒት መውሰድ ያልጀመሩ ከሆነ እባክዎን ለምን እንዳልጀመሩ ይግለጹልን? (ከቀረቡት አማራጮች ከአንድ በላይ መምረጥ ይችላሉ።)

ሀ. የእኔ ሲ.ዲ-4 ጥሩ ሁኔታ ላይ የሚገኝ ስለሆነና ሐኪሜ እንድጀምር ስላልመከረኝ ☐

ለ. ሐኪሜ እንድጀምር ቢያዘኝም ተጨማሪ ካውንስሊንግ ስለሚያስፈልገኝ ☐

ሐ. ሐኪሜ እንድጀምር ቢያዘኝም ለመወሰን ተጨማሪ ጊዜ ስለሚያስፈልገኝ ☐

መ. ሐኪሜ እንድጀምር ቢያዘኝም በቂ ምግብ ማግኜት ስለማልችል አልጀመርኩም ☐

ሠ. ሌላ (ካለ ይገለጽ) _____

6. ከኤች. አይ. ቪ ቫይረስ ጋር እንደሚኖሩ ለትዳር ጓደኛዎ (ወይም ጓደኞችዎ ወይም ፍቅረኛዎ/ችዎ) አሳውቀዋልን? ሀ. አዎን ☐ ለ. የለም ☐ ሐ. ሌላ (ካለ ይገለጽ) __

7. ለጥያቄ ቁጥር 6 መልስዎ አዎን ከሆነ ከቫይረሱ ጋር እንደሚኖሩ ካወቁ ጀምሮ በምን ያህል ጊዜ ውሥጥ ነው ያሳወቁት? ሀ. የዕለቱ ዕለት ☐ ለ. በአንድ ሳምንት ጊዜ ውስጥ ☐

ሐ. በአንድ ወር ጊዜ ውስጥ ☐ መ. በሶስት ወራት ጊዜ ውስጥ ☐

ሠ. ሌላ (ይገለጽ) _____

8. ለጥያቄ ቁጥር 6 መልስዎ አዎን ከሆነ ከማሳወቅዎ ጋር በተያያዘ ምን ዓይነት በጎ ነገር ወይም ችግር ገጠመዎት? (የገጠመዎትን በጎ ነገር ወይም ችግር ከታች በቀረቡት ጥያቄዎች መሰረት ከተሞክሮዎትና ከሚያውቁት በመነሳት በራስዎ ምዘና አንጻር ይግለጹልን።)

ተ.ቁ.	ከኤች. አይ.ቪ.. ቫይረስ ጋር መኖርን ለትዳር ጓደኛ/ፍቅረ ከማሳወቅ ጋር በተያያዘ የገጠሙ በጎ ነገሮች/ችግሮች	አማራጮች			
		በጣም በከፍተኛ ደረጃ	በከፍተኛ ደረጃ	በመጠኑ	በጭራሽ አልገጠመኝም
1.	በማሳወቁ ወቀሳ፣ ነቀፋ ... ደርሶብኛል።				
2.	ማሳወቁ አጋዥ/አበረታችና ትርጉም ያለው ማኅበራዊ ዕገዛ እንዳገኝ ረድቶኛል።				
3.	በማሳወቁ የቤተሰባዊ ግንኙነት መፍረስ ችግር ገጥሞኛል።				
4.	በማሳወቁ አድሎ ደርሶብኛል።				
5.	ማሳወቁ አስፈላጊ ለሆኑ የህክምና ምርመራና ድጋፍ አቅርቦቶች አግዞኛል።				
6.	በማሳወቁ በልጆቼ ላይ የኃይል ጥቃትና መተው/መጣል ደርሶባቸዋል።				
7.	ማሳወቁ ከትዳር ጓደኛዬ ወይም ጓደኞቼ ወይም ፍቅረኛዬ ጋር ቫይረሱ ከሚያደርሳቸው ጉዳቶች ለመጠበቅ በስፋት እንድወያይ ረድቶኛል።				
8.	በማሳወቁ አካላዊና ስሜታዊ ጉዳት/ ጥቃት ደርሶብኛል።				
9.	ማሳወቁ ስለወደፊቱ በጥሞናና በማስተዋል ለማቀድ ረድቶኛል።				
10	በማሳወቁ የሚደረግልኝ የኢኮኖሚ ዕገዛ ቆሞብኛል።				
11	በማሳወቁ ተጥያለሁ ወይም ትቶኝ ሄዷል/ሄዳለች።				

9. ከቫይረሱ ጋር እንደሚኖሩ ለትዳር ጓደኛዎ (ወይም ጓደኞችዎ ወይም ፍቅረኛዎ/ችዎ) ለማሳወቅዎ/ አለማሳወቅዎ ዋና ዋና ምክንያትዎ ምን ምን ነበሩ? _____

_____

10. የትዳር ጓደኞችዎን/የፍቅረኛዎን የኤች አይ. ቪ.. ሁኔታ ያውቃሉን?

ሀ. አዎን ☐ ለ.የለም ☐

11. ለጥያቄ ቁጥር 10 መልስዎ አዎን ከሆነ የትዳር ጓደኞችዎ/የፍቅረኛዎ የኤች. አይ. ቪ.. ሁኔታ ምን ይመስላል? ሀ. ኤች. አይ. ቪ.-- ፖዘቲቭ ☐ ለ. ኤች. አይ. ቪ.-- ኔጌቲቭ ☐

ሐ. ሌላ (ይገለጽ) _____

12. ለጥያቄ ቁጥር 10 መልስዎ አዎን ከሆነ መቼ አወቁ? ሀ. በአንድ ላይ ነው ያወቃችሁት☐

ለ. የእርስዎን የኤች. አይ. ቪ. ሁኔታ ከማወቅዎ በፊት ☐

ሐ. የእርስዎን የኤች. አይ. ቪ. ሁኔታ ካወቁ በኋላ☐ መ. ሌላ (ይገለጽ) _____

13. ለጥያቄ ቁጥር 10 መልስዎ አዎን ከሆነ የትዳር ጓደኞችዎን/የፍቅረኛዎን የኤች አይ. ቪ.. ሁኔታ እንዴት አወቁ?

ሀ. የትዳር ጓደኛዎ/ፍቅረኛዎ ነግሮዎት/ ነግራዎት ☐

ለ. ሌላ ሰው ነግሮዎት (ዝምድናዎን/ቅርበትዎን ይግለጹ) _____

ሐ. የጤና ባለሙያ ወይም ካውንስለር ነግሮዎት ☐ መ. ሌላ (ይገለጽ) _____

14. ከኤች. አይ. ቪ. ቫይረስ ጋር መኖርዎን ካወቁ በኋላ ለትዳር ጓደኛዎ/ፍቅረኛዎ ከማሳወቅዎ በፊት ጥንቃቄ የጎደለው የግብረ ሥጋ ግንኙነት ፈጽመዋልን? ሀ. አዎን ☐ ለ. የለም ☐

ክፍል ሶስት፡- <u>ከኤች. አይ. ቪ. ቫይረስ ጋር መኖርን አስመልክቶ ከትዳር ጓደኛ/ፍቅረኛ ጋር ያለን ግልጽ ውይይት ደረጃ መለኪያ ጥያቄዎች፡፡</u>

መመሪያ ሶስት፡- እባክዎን ከታች የቀረቡትን ጥያቄዎች እያንዳንዳቸውን በጥሞና ያንብቡና ለትዳር ጓደኛዎ/ፍቅረኛዎ ከኤች. አይ. ቪ. ቫይረስ ጋር መኖርዎን ማሳወቅን/አለማሳወቅን አስመልክቶ ያለዎትን ግንኙነት መሠረት በማድረግ የመረጡትን ፊደል ያክብቡ፡፡ ለምርምር ስራ ብቻ የሚውል ስለሆነ እባክዎን ዕውነተኛና ግልጽ ይሁኑ፡፡

1. ከትዳር ጓደኛዎ/ፍቅረኛዎ ጋር ከቫይረሱ ጋር መኖርዎን አስመልክቶ ግልጽ ውይይት ያደርጋሉን?

(ሀ) አዎን አሁንም ውይይታችን እንደቀጠለ ነው፡፡

(ለ) ብንወያይም ለመቀጠል ግን ፍላጎት የለኝም፡፡

(ሐ) የማንወያይ ቢሆንም አንዳንዴ በአጋጣሚ ጉዳዩን እናነሳለን፡፡

(መ) በጭራሽ! ልወያይ አልችልም፡፡

2. ከኤች. አይ. ቪ. ቫይረስ ጋር አብረው መኖርዎን አስመልክቶ ራስዎን ከትዳር ጓደኛዎ/ፍቅረኛዎ ጋር መደበኛ ተወያይ አድርገው ይቆጥራሉን? ሀ) አዎን እኔ ሙሉ በሙሉ መደበኛ ተወያይ ነኝ።

(ለ) አዎን እኔ ባብዛኛው መደበኛ ተወያይ ነኝ።

(ሐ) የለም እኔ ባብዛኛው መደበኛ ተወያይ አይደለሁም።

(መ) የለም እኔ ሙሉ በሙሉ መደበኛ ተወያይ አይደለሁም።

3. እርስዎ ከኤች. አይ. ቪ.. ቫይረስ ጋር መኖርዎን አስመልክቶ ከትዳር ጓደኛዎ/ፍቅረኛዎ ጋር በግልጽ የሚወያዩ ከሆነ በምን ያህል ጊዜ ይወያያሉ?

(ሀ) በዬዕለቱ (ለ) በሳምንት ብዙ ጊዜ

(ሐ) በወር አንዴ ወይም ሁለቴ (መ) አልፎ አልፎ ወይም በወር ከአንዴ በታች

4. ከኤች. አይ. ቪ.. ቫይረስ ጋር መኖርዎን አስመልክቶ ከትዳር ጓደኛዎ/ፍቅረኛዎ ጋር በግልጽ የሚወያዩ ከነበረና ለመቀጠል ፍላጎት ከሌሎት ውይይቱን ካቋረጡ ምን ያህል ጊዜ ይሆንዎታል?

(ሀ) ከአንድ ቀን በላይ ነገር ግን ከአንድ ሳምንት በታች

(ለ) ከአንድ ሳምንት በላይ ነገር ግን ከአንድ ወር በታች

(ሐ) ከአንድ ወር በላይ ነገር ግን ከስድስት ወራት በታች

(መ) ከስድስት ወራት በላይ

ክፍል አራት፡- ከኤች. አይ. ቪ.. ቫይረስ ጋር መኖርን አስመልክቶ ለትዳር ጓደኛ/ፍቅረኛ ለማሳወቅ/አለማሳወቅ ምክንያት ሊሆኑ የሚችሉ አመላካቾችን መለኪያ ጥያቄዎች።

መመሪያ አራት፡- ከታች የቀረቡት ዓረፍተ ነገሮች እያንዳንዳቸዉ ትክክል ወይም ስህተት የሚባል/የሆነ ምላሽ የላቸውም። ለእያንዳንዱ ዓረፍተ ነገር እንደ ሌሎች ግለሰቦች ሁሉ እርስዎም የተለዬ ምርጫ አለዎት። ስለዚህ ለእያንዳንዱ ዓረፍተ ነገር የስምምነትዎን ወይም የተቃዉሞዎን መጠን በሚገልጹበት ጊዜ ነጻ ይሁኑ። እባክዎን ከኤች. አይ. ቪ.. ቫይረስ ጋር በሚኖሩ የትዳር ጓደኞሞች/ፍቅረኛሞች መካከል አንዱ ለሌላው ከቫይረሱ ጋር እንደሚኖር ለማሳወቁ/ላለማሳወቁ ከሚያቀርባቸው ምክንያቶች አንጻርና እርስዎም ካለዎት የተግባር ተሞክሮ አንጻር ለእያንዳንዱ ዓረፍተ ነገር የስምምነትዎን ወይም የተቃውሞዎን መጠን ሰረዝ (☑) በማድረግ ያሳዉቁ/ይግለጹ።

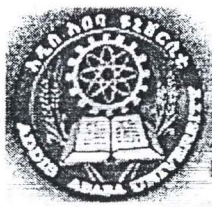
Appendix A. Continued...

ተ.ቁ.	ከኤች. አይ.ቪ. ቫይረስ ጋር መኖርን ለትዳር ጓደኛ/ፍቅረኛ ለማሳወቅ/ላለማሳወቅ የሚቀርቡ ምክንያቶች	አማራጭ መልሶች			
		በጣም እስማማለሁ	እስማማለሁ	አልስማማም	በጣም አልስማማም
1	የትዳር ጓደኛዬ/ፍቅረኛዬ ስለ ሁኔታው ካወቀ በኋላ ምን እንደሚሰማው ማወቅ ስለምፈልግ አሳውቂያለሁ።				
2	የትዳር ጓደኛዬ/ፍቅረኛዬ በእኔ ላይ ምን እንደተከሰተ የማወቅ መብት ስላለው አሳውቂያለሁ።				
3	ወትሮም በጣም ቅርብ ስላልነበርን አላሳወኩም።				
4	ግንኙነታችን በጣም ድንገተኛና የቅርብ ጊዜ ስለነበር አላሳወቅኩም።				
5	ስለ ምርመራ ውጤቴ እንዴት ማውራት/ማሳወቅ እንዳለብኝ ስላላሰብኩበት አላሳወቅኩም።				
6	የትዳር ጓደኛዬ/ፍቅረኛዬን ስለበሽታው ማስተማር ስለምፈልግ አሳውቂያለሁ።				
7	ጉዳዩን በውስጤ ይገፍ መቆየት ስላልፈለግኩ አሳውቂያለሁ።				
8	ለትዳር ጓደኛዬ/ፍቅረኛዬ ማሳወቅ ግዴታዬ እንደሆነ ስለተሰማኝ አሳውቂያለሁ።				
9	ማኅበረሰባችን ስለበሽታው በደንብ መገንዘቡን ለማረጋገጥ ስለፈለግሁ አሳውቂያለሁ።				
10	ሰዎች ሚስጥር ስለማይጠብቁ ለሌላ ሰው እንዳይነግሩብኝ ስል አላሳወቅኩም።				
11	እርስ በእርሳችን በደንብ ስለማንተዋወቅ አላሳወቅኩም።				
12	የትዳር ጓደኛዬ/ፍቅረኛዬ ስለ ሁኔታው እንደማትረዳ/እንደማይረዳ ስላመንኩ አላሳወቅኩም።				
13	የታመቀ ስሜቴን ለማውጣት ያስችለኛል ብዬ ስለማምን አሳውቂያለሁ።				
14	የትዳር ጓደኛዬ/ፍቅረኛዬ እኔ ጋር በመሆኑ/ኗ ምን ሊገጥመው/ሊገጥማት እንደሚችል እንዲረዳ/እንድትረዳ ስለምፈልግ አሳውቂያለሁ።				
15	የእኔ ዓላማ ሌሎችን ስለበሽታው ማስተማር በመሆኑ አሳውቂያለሁ።				
16	ከቫይረሱ ጋር እንደምኖር የትዳር ጓደኛዬ/ፍቅረኛዬ ካወቀ/ች በኋላ አብሮኝ/ራኝ መቀጠሉን/ሏን ለማወቅ ስለምፈልግ አሳውቂያለሁ።				
17	ሰዎች ሁሉ ከቫይረሱ ጋር መኖሬን ካወቁ አይፈልጉኝም/ አይቀርቡኝም ብዬ ስለምጨነቅ አላሳወቅኩም።				
18	የእኔ የምርመራ ውጤት የግል መረጃዬ/መብቴ ስለሆነ አላሳወኩም።				
19	የትዳር ጓደኛዬ/ፍቅረኛዬ ከቫይረሱ ጋር መኖሬን ካወቀ/ቀች በኋላ ስለ እኔ ምን እንደሚሰማው/ት ስላላሰበኝ አላሳወቅኩም።				
20	ለእኔም ሆነ ለትዳር ጓደኛዬ/ፍቅረኛዬ ተጨማሪ የጤና መታወክ እንዳይደርስብን ስለምፈልግ አሳውቂያለሁ።				

Appendix A. Continued...

ተ.ቁ.	ከኤች. አይ.ቪ.. ቫይረስ ጋር መኖርን ለትዳር ጓደኛ/ፍቅረኛ ለማሳወቅ/ላለማሳወቅ የሚቀርቡ ምክንያቶች	አማራጭ መልሶች			
		በጣም እስማማለሁ	እስማማለሁ	አልስማማም	በጣም አልስማማም
21	የትዳር ጓደኛዬ/ፍቅረኛዬ ከቫይረሱ ጋር እንደምኖር ስነግረው ምን እንደሚሰማው ማዬት ስለምፈልግ አሳውቂያለሁ፡፡				
22	በውሥጤ ያለውን መረጃ ለማውጣት/ለማካፈል ስል አሳውቂያለሁ፡፡				
23	እኔ ሳልፈልግ ለማንም ማሳወቅ ስለማይጠበቅብኝ አላሳወኩም፡፡				
24	ያለመናገር/ ያለማሳወቅ መብት ስላለኝ አላሳወቅኩም፡፡				
25	ከቫይረሱ ጋር በመኖሬ ኃፍረት ስለሚሰማኝ አላሳወቅኩም፡፡				
26	የትዳር ጓደኛዬ/ፍቅረኛዬ ከእኔ ጋር በመሆኑ/ኗ ምን ሊገጥመው/ማት እንደሚችል ሊያውቅ/ልታውቅ ስለሚገባ አሳውቂያለሁ፡፡				
27	ለትዳር ጓደኛዬ/ፍቅረኛዬ የማሳወቅ ግዴታ ስላለብኝ አሳውቂዋለሁ፡፡				
28	የትዳር ጓደኛዬ/ፍቅረኛዬ በእኔ ላይ ምን እየተከሰተ እንደሆነ የማወቅ መብት ስላለው/ላት አሳውቂያለሁ፡፡				
29	ቀድሞውንም ግንኙነታችን የጠበቀ ስላልነበር አላሳወቅኩም፡፡				
30	ከቫይረሱ ጋር መኖሬን ለመቀበል ስለተቸገርኩ አላሳወቅኩም፡፡				
31	ለትዳር ጓደኛዬ/ፍቅረኛዬ እንዴት መንገር እንዳለብኝ ስላላወቅኩኝ አላሳወቅኩም፡፡				

Appendix B. Interview and Focus Group Discussion Guide



ADDIS ABABA UNIVERSITY

SCHOOL OF GRADUATE STUDIES

DEPARTMENT OF EDUCATIONAL PSYCHOLOGY

(COUNSELLING PSYCHOLOGY STREAM)

Guiding Questions for Interview with Clients of ART Clinics

Thank you for your interest in this interview session in advance. In this interview session we will have some time to discussion issues that related to your experiences in your sero-positive disclosure to your sexual partner.

Name of the Hospital: _____

1. Would you please tell me about the time and reason for your first diagnosis of HIV/AIDS and a brief history of your sero-positive status?
2. Have you disclosure your sero-positive status to your sexual partner/s? When did you disclose since you diagnosed?, for what reason?, and in what condition?
3. What do you say about the processes of your Sero-positive status self-disclosure to your sexual partner/s?
4. What are the major benefits you have achieved so far in disclosing your sero-positive status to your sexual partner/s?
5. What are the major risks you have taken so far in disclosing your sero-positive status to your sexual partner/s?
6. What are the major reasons for your self-disclosure/non-disclosure of Sero-positive status to your sexual partner/s?

Appendix B. Continued...

አዲስ አበባ ዩኒቨርሲቲ
Addis Ababa University

አዲስ አበባ ዩኒቨርሲቲ
የድህረ ምረቃ ትምህርት ክፍል
የትምህርት ሳይኮሎጂ ዲፓርትመንት
(የካውንስሊንግ ሳይኮሎጅ ክፍል)

ከፀረ-ኤች. አይ.ቪ. መድኃኒት ክሊኒክ ተጠቃሚዎች/ደንበኞች ጋር
የሚደረጉ ቃለ-መጠይቆች የመነሻ ጥያቄዎች

የሆስፒታሉ ስም፡- _____

ለቃለ-መጠይቁ ፍላጎት/ፍቃደኝነት ስላላዩን በቅድሚያ እናመሰግናለን፡፡ በዚህ የቃለ-መጠይቅ ጊዜያችን ከኤች. አይ.ቪ ቫይረስ ጋር መኖራችሁን ለትዳር ጓደኛችሁ/ፍቅረኛችሁ ከማሳወቅ/አለማሳወቅ ጋር በተያያዘ ያገኛችኋቸውን በጎ ጎኖችና ችግሮች እንዲሁም የወደፊት ተስፋዎች አስመልተን እንወያያለን፡፡

1. እባክዎን ለመጀመሪያ ጊዜ የኤች. አይ.ቪ. ምርመራ ያደረጉበትን ጊዜና ለምን እንደተመረመሩ እንዲሁም ከቫይረሱ ጋር ከመኖር ጋር ያላለፋቸውን ነገሮች አጠር አድርገው ቢያብራሩልኝ?
2. ከኤች. አይ. ቪ. ቫይረስ ጋር እንደሚኖሩ ለትዳር ጓደኛዎ/ፍቅረኛዎ አሳውቀዋልን? መቼ? በምን ዓይነት ሁኔታ?
3. ከኤች. አይ. ቪ. ቫይረስ ጋር እንደሚኖሩ ለትዳር ጓደኛዎ/ፍቅረኛዎ ለማሳወቅ/አለማሳወቅ ምን ዓይነት ሂደቶችን አሳለፉ ቢያብራሩልኝ?
4. ከኤች. አይ. ቪ. ቫይረስ ጋር እንደሚኖሩ ለትዳር ጓደኛዎ/ፍቅረኛዎ በማሳወቅዎ/አለማሳወቅዎ ያገኟቸው ዋና ዋና ጥቅሞች ምን ምን ናቸው ቢያብራሩልኝ?
5. ከኤች. አይ. ቪ. ቫይረስ ጋር እንደሚኖሩ ለትዳር ጓደኛዎ/ፍቅረኛዎ በማሳወቅዎ/አለማሳወቅዎ ምን ምን ችግሮች ገጠመዎት ዋና ዋናዎቹን ቢያብራሩልኝ?
6. ከኤች. አይ. ቪ. ቫይረስ ጋር እንደሚኖሩ ለትዳር ጓደኛዎ/ፍቅረኛዎ ለማሳወቅዎ/አለማሳወቅዎ ዋና ዋና ምክንያቶች ምን ምን ነበሩ ቢያብራሩልኝ?

Appendix B. Continued ---

አዲስ አበባ
ዩኒቨርሲቲ
Addis Ababa
University

ADDIS ABABA UNIVERSITY

SCHOOL OF GRADUATE STUDIES

DEPARTMENT OF EDUCATIONAL PSYCHOLOGY

(COUNSELLING PSYCHOLOGY STREAM)

Guiding Questions for Interview with ART Clinic Staffs

Name of the Hospital: _____

Thank you for your interest in this interview session in advance. In this interview session we will have some time to discussion issues related to the ART Clinic and the problems and prospects of self-disclosure among sexual partners living with HIV/AIDS.

1. Would you please tell me the brief history of the ART Clinic?
2. Would you tell me the general and specific objectives, the basic activities and the achievements so far of the ART clinic, please?
3. What do you say about the rate of self-disclosure/non-disclosure of Sero-positive status among sexual partners living with HIV/AIDS who are clients of your ART clinic?
4. What do you say about the benefits of self-disclosure/non-disclosure of Sero-positive status among sexual partners living with HIV/AIDS who are clients of your ART clinic?
5. What do you say about the benefits of self-disclosure/non-disclosure of Sero-positive status among sexual partners living with HIV/AIDS who are clients of your ART clinic?
6. Do you have any experience in relation to the benefits and risks of self-disclosure among sexual partners living with HIV/AIDS?
7. What do you say about the reasons for self-disclosure/non-disclosure of Sero-positive status among sexual partners living with HIV/AIDS who are clients of your ART clinic?

Appendix B continued---

አዲስ አበባ ዩኒቨርሲቲ
Addis Ababa University

አዲስ አበባ ዩኒቨርሲቲ
የድህረ ምረቃ ትምህርት ክፍል
የትምህርት ሳይኮሎጂ ዲፓርትመንት
(የካውንስሊንግ ሳይኮሎጅ ክፍል)

ከፀረ-ኤች. አይ.ቪ. መድኃኒት ክሊኒክ ሰራተኞች ጋር የሚደረጉ ቃለ-መጠይቆች
የመነሻ ጥያቄዎች

የሆስፒታሉ ስም፡- _____

ለቃለ-መጠይቁ ፍላጎት/ፍቃደኝነት ስላላዩን በቅድሚያ እናመሰግናለን፡፡ በዚህ የቃለ-መጠይቅ ጊዜያችን ከፀረ-ኤች. አይ.ቪ. መድኃኒት ክሊኒክ ጋር የተያያዙና የክሊኒኩ ተገልጋዮች ከኤች. አይ.ቪ ቫይረስ ጋር መኖራቸውን ለትዳር ጓደኛቸው ከማሳወቅ/አለማሳወቅ ጋር በተያያዘ ያገኟቸው በጎ ጎኖችና ችግሮች እንዲሁም የወደፊት ተስፋዎች ላይ እንወያያለን፡፡

1. እባክዎን ስለፀረ-ኤች. አይ.ቪ. መድኃኒት ክሊኒካችሁ አጠር ያለ ገለጻ ቢያደርጉልኝ?
2. የፀረ-ኤች. አይ.ቪ. መድኃኒት ክሊኒካችሁን ጥቅልና ዝርዝር ዓላማዎች፣ ዋና ዋና ሥራዎችና ከአሁን በፊት የተገኙ ውጤቶችና በጎ ተሞክሮዎችን ሊያብራሩልኝ ይችላሉን?
3. የፀረ-ኤች. አይ.ቪ. መድኃኒት ክሊኒካችሁ ተጠቃሚዎች ከሆኑ ከቫይረሱ ጋር የሚኖሩ የትዳር ጓደኞሞች/ፍቅረኞሞች መካከል ከቫይረሱ ጋር እንደሚኖሩ ለትዳር ጓደኞቹው/ፍቅረኞቹው የማሳወቅ/አለማሳወቅን አስመልክቶ ምን የሚነግሩኝ ነገር አለ?
4. የፀረ-ኤች. አይ.ቪ. መድኃኒት ክሊኒካችሁ ተጠቃሚዎች የሆኑ ከቫይረሱ ጋር የሚኖሩ የትዳር ጓደኞሞች/ፍቅረኞሞች ከቫይረሱ ጋር እንደሚኖሩ ለትዳር ጓደኞቹው/ፍቅረኞቹው በማሳወቃቸው/አለማሳወቃቸው ምክንያት ስላገኙት በጎ ነገር ምን የሚነግሩኝ ነገር አለ?
5. የፀረ-ኤች. አይ.ቪ. መድኃኒት ክሊኒካችሁ ተጠቃሚዎች የሆኑ ከቫይረሱ ጋር የሚኖሩ የትዳር ጓደኞሞች/ፍቅረኞሞች ከቫይረሱ ጋር እንደሚኖሩ ለትዳር ጓደኞቹው/ፍቅረኞቹው በማሳወቃቸው/አለማሳወቃቸው ምክንያት ስለደረሰባቸው ችግሮች ነገር ምን የሚነግሩኝ ነገር አለ?
6. የፀረ-ኤች. አይ.ቪ. መድኃኒት ክሊኒካችሁ ተጠቃሚዎች የሆኑ ከቫይረሱ ጋር የሚኖሩ የትዳር ጓደኞሞች/ፍቅረኞሞች ከቫይረሱ ጋር እንደሚኖሩ ለትዳር ጓደኞቹው/ፍቅረኞቹው በማሳወቃቸው/አለማሳወቃቸው ምክንያት ስላገኙት በጎ ነገር ወይም ችግሮች ምን ዓይነት ትምህርት ሠጪ ተሞክሮ ያስታውሳሉ? እባክዎን ይንገሩኝ፡፡
7. የፀረ-ኤች. አይ.ቪ. መድኃኒት ክሊኒካችሁ ተጠቃሚዎች የሆኑ ከቫይረሱ ጋር የሚኖሩ የትዳር ጓደኞሞች/ፍቅረኞሞች ከቫይረሱ ጋር እንደሚኖሩ ለትዳር ጓደኞቹው/ፍቅረኞቹው ለማሳወቃቸው/አለማሳወቃቸው ምክንያት ናቸው ብለው ከሚያቀርቧቸው መካካል ዋና ዋናዎቹን ቢነግሩኝ?

Appendix C: Regional Ethical clearance from Addis Ababa City Government Health Bureau.

Date: A.A.H.B/36/0/451

Ref. No: Mar 9/2008

የኢትዮጵያ ፌዴራላዊ ዲሞክራሲያዊ ሪፐብሊክ
የአዲስ አበባ ከተማ አስተዳደር ጤና ቢሮ
The Addis Ababa City Administration
Health Bureau

To: Whom it may concern
Addis Ababa

The ethical review committee of the Addis Ababa health bureau has reviewed the research proposal entitled " Self- Disclosure Problems among Sexual Partners Living with HIV/AIDS the case of Hospital clients in Addis Ababa".

Please find attached here with the two pages reviewed result of approval of the proposal.

With Regards

Alemnesh Wolde (Dr.)
Head
Health Bureau

Appendix C: Continued---

ADDIS ABABA CITY ADMINISTRATION HEALTH BUREAU
ETHICAL REVIEW COMMITTEE

ETHICAL REVIEW FORM

Tel: 251 1 513911 P.O.Box 30738 Addis Ababa

CRITERIA/ITEM	RATING
1.consent form • Does the consent contain all the necessary information that the subject should be aware of?	✓ Yes ------Requires revision ------No -----Not applicable -----Not attached
2. Are the objectives of the study clearly stated?	✓ Yes ------No
3. Are the methods ethically sound? • Justice • Beneficence • Respect for a person	✓ Yes ------Not well described -----No
4.Are provisions to overcome risks well described and accepted? • DSMC	------Yes ------No ✓ Not applicable
5.Are there provisions to provide standard/ best proven care?	------Yes ------No ✓ Not applicable
6. Are the safety procedures in the use of vaccines, drugs and other biological products acceptable?	------Yes ------No ✓ Not applicable
7. Are the procedures to keep confidentiality well described?	✓ Yes ------No -----Not applicable
8. Are the proposed researchers competent to carry out the study in a scientifically sound way?	✓ Yes ------No -----Not applicable -----Unable to assess
9. Does it have material transfer agreement?	------Yes ------No ✓ Not applicable
Recommendation	✓ Approved -----Approved on condition ------Not approved
Remarks	Aprved after corrections are incorporated

Appendix C: continued---

ETHICAL COMMITTEE MEMBERS

Name	Signature
1- Dr Achamyeleh Alebachew	
2- Dr Girma Wolde mickael	
3- W/r Fantu Tsegaye	
4- Dr Zelalem Demeke	
5- Dr Wengele Teketel	

Declaration

This thesis is my original work and has not been presented for a degree in any other university.

Abdu Ebrahim Mohammed

Date: June 15, 2009.

This thesis has been submitted for examination with my approval as the university advisor.

Dr. Dessalegn Chalchissa

Date: June 15, 2009.