ADDIS ABABA UNIVERSITY

SCHOOL OF GRADUATE STUDIES

Women's self-disclosure of HIV Infection: Rates, Reasons and Barriers.

Implications for HIV/AIDS prevention

(The Case of HIV outpatient hospital clients and members of PLWHA organizations)

BY

HIWOT GETACHEW DEGU

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 PSYCHOLOGY

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Abbreviations and acronyms

AIDS	Acquired immune deficiency syndrome
ART	antiretroviral therapy
FGD	Focus Group Discussion
GIPA	Greater Involvement of People Living with HIV/AIDS
GNP+	Global Network of People Living with HIV/AIDS
ICW	International Community of Women Living with HIV/AIDS
HAART	Highly active antiretroviral therapy
HBM	Health Belief Model
HIV	Human immunodeficiency virus
MOE	Ministry of Education
MOH	Ministry of Health
NGO	Non-Governmental Organization
PLWHAs	Person living with HIV or AIDS
PMTCT	Prevention of mother-to-child transmission HIV infection)
STI	sexually transmitted infection
TRA	Theory of Reasoned Action
TV	Television
UNAIDS	Joint United Nations Program on HIV/AIDS
UNIFEM	United Nations Development Fund for Women
UNICEF	United Nations Emergency Children's Fund
USAID	United States Agency for International Development
VCT	Voluntary counseling and testing for HIV infection)
WHO	World Health Organization
WLWHAs	Women Living with HIV/AIDS

Definition of Important Terms

HIV-positive status - It is defined as infection with the Human Immunodeficiency Virus (HIV), as determined by a screening Elisa assay and a confirmatory Western Blot assay identifying the presence of antibodies to HIV.

Disclosure - It is defined as the act of informing another person or persons of the positive status of an individual.

Self- disclosure – when the individual herself told to another person about her test result.

Counseling – it is defined as the process of providing information, education, Problem-solving, therapeutic interventions and support through a safe, Confidential, non-sexual, professional relationship aimed at increasing the Capacity of individuals to cope with, understand or overcome difficulties they are experiencing in their lives.

Full / Public- disclosure – when the individual openly reveal / talk about her HIV status to another person or organization in any time and space with out thinking of confidentiality.

Partial disclosure means that you will only tell certain people about your status, for example, a spouse, a relative, a counselor or a friend. Non disclosure- means that you don't reveal your HIV status to anyone.

Salient others – includes people such as parents, friends and health professionals whose opinions are important to the individual.

Asymptomatic – a person who lives with HIV but not yet symptomatic.

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Abstract

Ethiopia is highly affected by HIV/AIDS. Its impact is more severe on women. They are the most vulnerable part of the society due to biological, economical and socio-cultural reasons.

Public disclosure of ones HIV status is important in the fight against HIV/AIDS. It helps to give a human face to the community there by leading to minimize the perceived negative outcomes associated with HIV status disclosure.

The current study aimed to explore aspects related to Self-disclosure of HIV positive status.417 women infected with HIV were the samples of the study. Data were collected using structured interview and focus group discussion. It was subjected to both qualitative and quantitative analysis. The findings were discussed in terms of HBM and TRA theories and other research findings.

Chi-square was used to examine the association between the selected predictor variables and the dependent variable. And binary logistic regression was employed to explore whether the selected predictor variables have an effect on rate of public disclosure. Besides, descriptive analysis was used to analyze some background characteristics of the respondents.

According to the descriptive analysis, rates of HIV status disclosure to extended family members were relatively low where as higher to immediate family members. Husband (68%) and sisters (59%) account relatively the highest rates of disclosure. Rate of public disclosure was 28%.And 23% of the respondents totally didn't disclose to anyone. Beside, those who publicly disclose explained as the positive outcomes of disclosure out weight than the negative outcomes; where as those who haven't yet open about their status stated that the different forms and expressions of stigma and discrimination as a reason for non disclosure. And they further explained that if we have at least the basic necessities, we can confront the various negative outcomes of disclosure .Lastly, FGD participants reported that the motivators of disclosure / non disclosure vary among men and women. And they also said the negative outcomes of disclosure more affect the lives of women than men.

Moreover, based on the bivariate analysis, age, educational status, marital status, , time since diagnosis, work status, follow up counseling ,discussion about disclosure with counselors, behavioral beliefs , and influence of subjective beliefs were found to have an association with rate of public disclosure. However, religion, attitude towards public disclosure, knowledge about HIV/AIDS and exposure to media weren't found to have association with rate of public disclosure.

Furthermore, the regression analysis revealed that except work status of the respondents; their age, educational status, marital status, , time since diagnosis, follow up counseling ,discussion about disclosure with counselors, behavioral beliefs , and influence of subjective norms were found to have an effect on rate of public disclosure.

Based on the findings, mechanisms must be created to help people perceive the benefits of public disclosure than its harms. It is possible through mass media and by promoting follow up counseling. Beside, economic empowerment of women by fostering economic activities through programmes like microfinance will also play a crucial role.

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1. Back ground of the study

1.1 An overview of HIV /AIDS situation

More than twenty years after the first clinical evidence of acquired immunodeficiency syndrome was reported, AIDS has become one of the most devastating diseases humankind has ever faced. With no cure in sight, the virus continues to spread around the world. More than 60 million people have been infected with the virus since the epidemic has begun. And it has become the fourth-largest cause of death worldwide (UNAIDS 2004).In the year 2005, an estimated 40.3 million people globally were living with HIV (UNAIDS& WHO, 2005). In that year alone, there were an estimated 3.1 million AIDS deaths and close to 5 million new HIV infections. In many parts of the developing world, the majority of new infections occur in young adults, with young women being especially vulnerable. About one-third of those currently living with HIV/AIDS are in the age group of 15-24. As a result, the epidemic is believed to be one of the greatest threats to eradicate poverty and achieve the millennium development goals.

Though HIV /AIDS spread all over the world, it has been more severe on sub Saharan Africa (Maman,S.et.al,2001,Norman,A.et.al,2005,de bruyn,T.D,1998 , Banteyerga, H, Kidanu , A ,et al. 2004 and Nyblade,L,et.al,2003) . Out of the 40.3 million PLWHAs, 25.8 million people live in this region. So, over two-thirds reside in Sub Saharan Africa. It is a region with only tenth of the world population (UNAIDS, 2005).Ethiopia isn't an exception. Rather one of the severely affected countries (Antenane Korra, et.al, 2005). The country accounts for approximately nine percent of the infections around the globe. The first evidence of HIV infection in Ethiopia was found in 1984, with the first AIDS case being reported in 1986 (MOH, 2004) .It continues to pose a threat to the

development of Ethiopia. Currently 1.5million people are estimated to live with HIV/AIDS (MOH, 2004) .The number is apart from the unreported and those who have died unnoticed and unaided. This is a staggering number to cope with for resource poor country. HIV prevalence is higher in the age group 15 – 24 years (Antenane Korra, et.al, 2005, P1).And the prevalence is higher among females than males.

1.2 Women and HIV/AIDS

HIV/AIDS has had a devastating effect without discriminating people's socio economic status, religion, sex, ethnicity and others throughout the world. Nevertheless, women's are highly affected by the virus (deBruyn, T.D, 1998, Nyblade, L, et.al, 2003, Aggleton, P. and E. Chase, 2001and Agha, S, 2003). They are the fastest-growing population to become infected with HIV in most regions of the world (Simoni, J. M, et. al and Agha, S, 2003). Globally, HIV infection rates among women of all ages continue to rise disproportionately especially with a dramatic increase in HIV infection among young women(Simoni, J. M, et. al,2000 and Aggleton, P. and E. Chase, 2001). Totally 17.5 million women are living with HIV (UNAIDS, 2005). It is one million more than from 2003.Beside, the young women (15 - 24) years constitutes 60 percent of PLWHAs. These are women in their productive and reproductive years of age.

Nowhere is the epidemic's 'feminization' more apparent than in sub-Saharan Africa (UNAIDS, 2005).Its impact on women living in sub-Saharan Africa remains disproportionate (Maman, S.et.al, 2001).About 13.5 million WLWHAs around the world live in the continent out of the 17.5 million(Norman, A.et.al, 2005).Beside, girls and young women (15-24 years) are three times more vulnerable for HIV infection than young men. As

a result, most women who died of HIV/AIDS were at the prime of their productive life (Banteyerga, H, A Kidanu, et al. 2004. The situation is also similar in Ethiopia. Nearly 60 percent of HIV positive individuals in the country are women (MOH, 2004).

Despite this alarming trend, women know less than men about how HIV/AIDS is transmitted and how to prevent the infection, and what little they do know is often rendered useless by the discrimination and violence they face (MOH, 2004).This is one of the reasons that motivate the researcher to focus on women.

1.3. Causes for women special vulnerability

Early in the epidemic, HIV infection and AIDS were diagnosed for relatively few women but now they are more vulnerable. They experience HIV/AIDS differently than men do in a number of important respects especially in the developing countries like Ethiopia. This is due to biological, social, cultural and economic reasons according to (Ann Eckman et.al, 2004, Urassa, P.et.al, 2005, UNAIDS, 2004 and, Aklilu and Hailom, 2002).

Biologically,

- A woman has larger mucosal surface (the membranes lining the genital tract).As a result, during unprotected sexual intercourse, they are two or four times more exposed to the virus than their partner.
- There is more virus concentration in sperm than in vaginal secretions. The younger are also even more at risk than the mature women. This is due to their immature genital tract. Post menopausal women are also more at risk because of their fragile and reduced genital membranes.

- The fact that STD epidemic is often asymptomatic, women remain untreated for long. Though STDs in either partner increase the risk of HIV infection, women than men are at least four times more vulnerable to infection due to the presence of untreated STDs.

Economically

- Women in many regions do not own property or have access to financial resources and are dependent on men for support. These are husband, father, brothers and sons. Financial or material dependence on men means that women cannot control when, with whom and in what circumstances they have sex.
- Poverty pushes some women into risky behavior or dangerous situations. With no other options in sight, they may resort to sex work to feed their families, for material favors, for daily survival and so on.

Socially and culturally

- Women are not expected to discuss or make decisions about sexuality
- They cannot request, let alone insist on using a condom or any form of protection
- If they refuse sex or request condom use, they often risk abuse, as there is a suspicion of infidelity
- Women are expected to have relations with or marry older men, who are more experienced, and more likely to be infected.

Although, cultural and social influence can be best applicable in case of those women living in rural parts of our country; the interplay of the above factors heightens women special

vulnerability to a disease its most common mode of transmission world wide is a heterosexual contact (Urassa, P.et.al, 2005, UNAIDS, 2004 and Aklilu and Hailom, 2002).

Even when this fact is combined with the workload that women have faced in caring AIDS patients and orphans, the situation becomes very terrible (KL Hackl, et al, 1997). Thus, women and girls are a cause for deep concern. Therefore, those strategies that are going to be implemented in order to prevent the spread of HIV/AIDS must take in to account WLWHAs .This fact is among the reasons that motivates the researcher of this study to focus on women.

A woman's experience of HIV disease, in general, is affected by her roles at home, at work, or in the community. Women in Ethiopia generally earn less than men, are less likely to be in a position of power than men, enjoy fewer career opportunities than men, and receive fewer employment benefits than men .Many of the single-parent families are headed by women. Therefore, this dependence can dramatically increase their chances of becoming infected with HIV. Available at http://womenand AIDS.org.

1.5.The role of PLWHAs

To fight this deadly virus, a lot has been done by many concerned bodies. However, still we need to find out other effective preventive ways as well as properly implement the existing ones. One of the most critical means in the fight against HIV/AIDS is to encourage greater involvement of people leaving with HIV (Muula,A.S and Mfustso–Bengo,J.M,2005). The Greater Involvement of People living with or affected by HIV/AIDS (GIPA) was critical to ethical and effective national responses to the epidemic (Roy,C.M and Cain,R,2001, Muula,A.S and Mfustso–Bengo,J. M, 2005,Cornu,C ,2002 and Paxton,S,2002) .World AIDS

Day 2004 marked the 10th anniversary of a commitment made by governments to promote the greater involvement of people living with HIV/AIDS (GIPA). To mark the occasion, the International Federation of the Red Cross and Red Crescent and the Global Network of People Living with HIV/AIDS (GNP+) conducted a joint project in which PLWHA evaluated GIPA in action. The GIPA principle is the backbone of many interventions worldwide and can be applied to a wide range of groups— from youth to musicians (Ehde DM, Holm JE, Robbins GM., 1995). Different research findings have shown that people with HIV/AIDS can participate at a variety of levels, from engaging in relatively marginal activities, such as appearing on a poster, providing home-based care and participating decision-making stages (UNAIDS, 2004,Paxton, S.2002, Cornu, C, 2002). It also recognizes the important contribution they can make to ensure a holistic response that meets their needs effectively. Furthermore, GIPA is a powerful way of reducing discrimination and fear within society, by giving a human face and voice to the epidemic in the minds of people not directly touched by it (Paxton,S,2002 ,Norman, A, ,2005 and Roy, C. M. and Cain, R.,2001). They help to demystify it and show that having HIV/AIDS is not a death sentence. They also show that anyone can contract HIV, which helps to reduce stigma and discrimination. However, the existence of different perceived negative outcomes of disclosure affect the disclosure decision.

Available at http://www.gnpplus.net/gipa.stories/GIPA_in_action.

1.6 THE IMPORTANCE OF HIV DISCLOSURE

Disclosure can occur in many contexts: disclosure within personal relationships (to lovers, partners, spouses, children, friends and other family); disclosure in the workplace (to an employer, other employees, clients); disclosure to health and other service providers (physicians, emergency services, dentists, social workers, insurers, etc.); disclosure in an institutional setting (prisons, schools, etc.), and disclosure to the general public via the media (Greene, et.al, 2003).

Deciding whether or not to disclose one's HIV-positive status to another person is an important decision. Revealing one's HIV-positive status is not a sign of social responsibility, or of a special trust in someone, but rather a compulsive act to release suppressed tension. Individuals who do not confess need attention; their silence is a sign of their inability to adapt to their illness, as well as of their self-imposed exclusion from society. If they are able to disclose their positive HIV status, it can have the following benefits according to (Green,K,et.al,2003,SimoniJM,1995,Paxton,S,2202,Armistead,Lisa.et.al,1999,Chandra,P.S, et.al, 2003, Holt, R, et.al, 1998 and Serovich, J.M., 2001).

- Disclosure can help a person to accept their status and reduce the stress associated with non-disclosure. "A problem shared can be a problem halved". Keeping secrets may be stressful. So, HIV disclosure to supportive disclosure recipients, other things being equal has the possibility of increasing the life span and improving mental and physical health.

- Disclosure helps a person to have access to medical services, care, and support and so on.

- Disclosure can help people to protect themselves and others .Even, openness about HIV status may especially help women to negotiate protected sex.

- In the case of sexual partners, it helps them to make choices that could lower their risks of HIV transmission. And can prevent if both are positive from infecting each others with modified strains of HIV. For example, they may decide to use condoms, finger cots or not to share needles.

- PLWHAs are at greater risks for contracting STDs due to compromised immune systems. Thus, if disclosure of HIV status results in condom use / or other protective behaviors; their risk of being contracted with STDs could be minimized

- Disclosure of an HIV diagnosis could potentially reduce stigma and discrimination associated with HIV / AIDS. And in return it facilitates opportunities for greater involvement of PLWHAs in the fight against HIV/AIDs.

The above are the major use of disclosure of HIV positive status. Some are important in the context of the individual, others or for interpersonal gain (the individual as well as the community).The main purpose of this study is on aspects related to public disclosure. It is important either for the individual and the community thereby facilitates HIV prevention activities.

1.7 Consequences of HIV positive status disclosure

Disclosure of positive HIV status can have numerous outcomes. The outcomes can be broadly divided in to two (Greene, et.al, 2003, Gielen,1997, Petrak ,et,al,2001, USAID /

Synergy(2004)and Gaillard P, Melis R, Mwanyumba F,et al ,2000).These are the following.

1. Positive outcomes of disclosure

The responses to disclosing an HIV diagnosis may be helpful and supportive. It may help the individuals be able to talk about stresses, get financial support, meet others with HIV , join support groups, remind to take medications, have access to teach others and so on.

2. Negative outcomes of disclosure

On the other hand, disclosure of HIV status may be followed by adverse social consequences. Individuals or their loved ones maybe shunned, discriminated against, or blamed for what happened. Even individuals with HIV may be subjected to verbal and / or physical abuse.

In general, the decision to disclose or conceal positive status is determined based on the perceived outcomes of disclosure. When the people think that the outcomes of disclosure can be positive for self, others or self and others, he/she is going to decide to disclose. And the other way round. This means, perceived negative outcomes of disclosure are serving as reasons / motivators for non-disclosure of HIV positive status (Paxton, S, 2002; Simoni, J.M et.al, 2000).

Consequently, the positive as well as the negative outcomes can have an impact for self, others and both self and others. The impact can be either good or bad. Therefore, the outcomes of disclosure can serve as reasons for disclosure or non disclosure. So, individuals motivator for disclosing or concealing their HIV positive status can be broadly categorized in three ways (Chandra, P.S et.al, 2003; Derlega & Winstead, 2004;).

a. Self-focused reasons – when people decision to disclose / non- disclose their HIV positive status is determined based on fulfilling their personal needs.

b. Others focused reasons - when individuals with HIV consider how their disclosure would affect others prior to decision to disclose or not disclose.

c. Interpersonal focused reasons – when the individual with HIV considers how his/her disclosure decision would affect the relationship. Here the person tries to take in to account self, other and interpersonal in the disclosure/non- disclosure decisions

1.8 Importance of public Disclosure to prevent HIV/AIDS

HIV/AIDS is a major problem all over the world. Negative outcomes of disclosure like Stigmatization and discrimination (both real and perceived) are among the commonest challenges that HIV infected persons and their families face (Paxton, S, 2002 and Muula, A.S and Mfustso - Bengo, J.M, 2005).Public disclosure of HIV positive status has been suggested that among the tools available in the fight against perceived negative outcomes like stigmatization and discrimination. It benefits both the individual and the public. To the individual, benefits include less anxiety, increased social support (Mathews, et al 1999 and Salvator, N, 2003). It also leads to improved access to HIV prevention programs and treatment with HAART and opportunistic infections (Greene, et.al, 2003).To the public, it helps the community to understand better about HIV/AIDS and thereby results in behavioral change among people who know of an HIV infected person (Weiner, 1998).And it has also been found to create awareness of HIV risk to untested partners. Besides, it allows couples to make informed reproductive health choices that

may ultimately lead to reduction in number of unintended pregnancies among HIV positive woman.

The importance of public disclosure in the fight against HIV/AIDS was shared by Dr Peter Piot, the UNAIDS Director, in his speech made on 10 February 2004 when he attended the launch of the Malawi HIV/AIDS Policy in Blantyre, Malawi (Muula, A.S and Mfustso-Bengo, J.M, 2005).Piot's views were shared by other high-level delegates, including the UNICEF representative for Malawi. Their statements followed the public disclosure of Malawi's former Head of State, Dr Bakili Muluzi, when he reported that he had tested negative for HIV but that his younger brother had died from AIDS. Muluzi is not the only notable politician who has disclosed that HIV and AIDS have affected their families; others like the former Zambian President, Kenneth Kaunda, who reported that his son had died of AIDS, and former South African Deputy President, Gatsha Mangosuthu Buthelezi, who made it known that he had lost two children by HIV/AIDS. Earvin 'Magic' Johnson has also disclosed their HIV status with possible public benefit (Ehde DM, Holm JE, Robbins GM, 1995).

Nevertheless, many PLWHA will attest that disclosing one's HIV status publicly takes a lot of courage and consideration (Holt, R, 1998, Paxton, S, 2002). Openness about one's HIV status is more difficult in some countries or cultures than others since disclosing ones status has a number of potential risks including loss of economic support, blame, abandonment, physical and emotional abuse, discrimination and disruption of family relationship (Nyblade, L, et.al, 2003 and Simoni, J., 2002). For instance, individuals who have disclosed that they are HIV infected have been prevented from renting houses and excommunicated from churches because they have been deemed 'sinners'. Others have

suffered marriage breakup. A woman speaking on Television Malawi on 1 December 2003 said that her own parents could not speak to her 'since she was considered already "dead" by virtue of her HIV positive status. Supporting existence of negative outcomes of public disclosure, Member of The Uganda Red Cross Society, David Sekirevu Mukasa said, "In 1992 I lost my teaching job due to the highest degree of stigma and discrimination. I had decided to go public about my HIV positive status. After my first radio programme declared my positive status publicly, I was dismissed. 'We can no longer work with you given the circumstances we have heard from reliable sources,' said the director of the college. I had no alternative but to leave.

Available at http://www.gnpplus.net/gipa.stories/GIPA_in_action.A lot of PLWHA also experience such kind of things in our country too. A much more publicized case was a South African HIV infected woman who had disclosed her status publicly and was murdered in 1998 by her neighbors because of her disclosure (Norman,A,20005).

Public disclosure of HIV positive status may not only lead to individual harm but also to family or societal harm. Disclosure of one's HIV status could subject others, such as family members, to distress (Norman, A, 2005, Petrak, et al, 2001).

In the African socio-cultural context, it is commonly said that an individual belongs to or is part of a community and cannot be perceived individually. The African's thinks that 'I am because we are', which is similar to 'no man is an island'. What happens to one person is of concern to the whole community. Therefore, in a situation where an individual discloses without the consent of his or her community; there is potential conflict between individual autonomy and community interest (Norman Amy, 2005).

In general, the issue of disclosure has long been debated among AIDS activists, health-care workers, and PLWHAs. It has been stated that disclosure is a double-edged sword (Promise Mthembu, 2004 and Norman, A, et.al, 2005). On the one hand, it may be constructive; it may help PLWHAs to get the support and services they need. On the contrary, it can be quite destructive. Some women living with HIV/AIDS are chased out of their homes when they disclose their HIV status; others lose their jobs; many are denied medical care after telling the health-care workers they are HIV-positive. Although it has advantages and disadvantages for the PLWHAs, people have different reasons for promoting public disclosure nowadays. For some people, it is the reduction in transmission of the virus; for others, they believe that it is a way for PLWHAs to get the needed and possible support they can receive (Holt, R, 1998).

http://www.unaids.org/whatsnew/speeches/eng/2002/WAD02PPmessage_en.html.

1.9 .BARRIERS TO DISCLOSURE

Ever since HIV/AIDS has became a known disease in the 1980s, it has been associated with different negative outcomes (Visser, J .M, 2006).These hinder people living with HIV to lead a life free of any psychological disorder. And these attitudes about HIV also create a climate in which people become more afraid of the negative reactions of others than of the disease itself (Parker, R and Aggleton, P, 2002, Petrak, et, al, 2001 and Levy, A, et.al, 1999). The cause of these negative attitudes is because of various factors .There are four major factors that contribute for the existence of negative attitudes related to HIV/AIDS as identified by (UNAIDS, 2003, Visser, J .M, 2006 and De Bruyn ,1999).

_ HIV/AIDS is a life-threatening disease, perceived as contagious and threatening to the community. The disease is not well understood, which results in fear of contracting HIV.

_ People living with HIV are often seen as being responsible for having contracted the disease, which increases the attribution of guilt.

_ HIV/AIDS is related to behavior sanctioned by religious and moral beliefs, which results in the perception that HIV/AIDS is the result of deviant behavior and consequently deserves punishment.

_ HIV/AIDS is associated with pre-existing social prejudices such as sexual promiscuity, homosexuality and drug use—behavior that is already considered 'less worthy' in many societies.

Since HIV/ AIDS has been seen differently by the people, there are different negative outcomes associated with disclosure of an HIV positive status. The PLWHAs are living surrounded by negative outcomes like stigma and discrimination deeply (Visser, J .M, 2006). The existences of these negative outcomes have fuelled the transmission of HIV by undermining the prevention efforts (Parker and Aggleton, P, 2002 and Nyblade, L.et.al, 2003). Negative outcomes of disclosure of an HIV positive status continue to be manifest in every country and regions of the world, creating major barriers for preventing further infection, alleviating impact and providing adequate care, support and treatment (Visser, J .M, 2006, Parker and Aggleton, P, 2002).Moreover, these negative outcomes associated with AIDS have silenced open discussion, both of its causes and of appropriate responses (Serovich, J.M, 2000). Visibility and openness about AIDS are prerequisites

for the successful mobilization of government, communities and individuals to respond to the epidemic. Concealment encourages denial that there is a problem and delays urgent action (Greene et.al, 2003). It causes PLWHAs to be seen as a 'problem', rather than as a solution to containing and managing the epidemic (Nyblade, L, et.al, 2003). Therefore, these negative outcomes are serving as a barrier for disclosure and result Stigma and discrimination which in return creates other violations of human rights which affect the well-being of people living with HIV in fundamental ways (Visser, J .M, 2006).

In short, having negative attitudes towards HIV/AIDS increase the existence of different negative out comes associated with disclosure. They serve as a barrier for disclosure as well as closely tied with greater involvement of PLWHAs. This in turn affects prevention efforts.

There fore, the aim of this paper is to find out the barriers associated with disclosure of HIV positive test result. The focus is on women because the negative outcomes of disclosure are more sever for women's than men's (Aggleton, P. and E. Chase. 2001).

1.10 Expressions and Forms of Stigma

HIV/AIDS-related Stigma and discrimination take different forms and are manifested at different levels—societal, Community and individual—and in different contexts (UNAIDS 2000; Malcolm et al. 1998 and Nyblade, L, et.al, 2003).

1. Physical stigma

The forms of physical stigma can be grouped into isolation and violence, with the former being widespread and the latter less common. Physical isolation of people living with HIV and AIDS occurs in all locations, from the home to community gathering or public spaces

2. Social stigma

The manifestations of social stigma can be grouped into social isolation, loss of identity and role, and voyeurism. Isolation comes in various forms both in relation to important family and community events, as well as in daily life.

3 Verbal stigmas

A third form of stigma is verbal. This can be direct (pointing fingers, insulting, taunting, or blaming), or more indirect (gossip and rumors). Gossip and rumors focus on speculation about whether a person has HIV, usually because of visible signs, illness, behavior, or association with groups seen as "high risk." Once a person is assumed to be HIV-positive, people often speculate about how he or she contracted HIV.

4. Institutional stigma

It refers to the differential treatment within any broadly defined institutional setting that leads to a negative outcome for the person living with HIV.

For detailed explanation, see table 1.1.

Table 1.1 Forms and expressions of stigma and discrimination

Physical	Social	Language/Verbal	Institutional
Isolation -Separating sleeping rooms, eating utensils and clothing and bed linens - not allowed to eat meals with the family and participate in housework (e.g. cooking food). - Confinement to certain rooms of house - Public rejection (refuse to sit next to person on bus, bench, at church, tea shops or in bars). - Separation from children - Abandonment by family **Violence** - Beatings - Being kicked - Throwing stones - Arrests	**Isolation** - Reduction of daily interactions with family and community - Exclusion from and shunning at family and community events -Loss of social networks - Decreased visits from neighbors **Voyeurism** - Increased visits from neighbors, not out of concern but to mock individual or report back to community **Loss of identity/role** - Viewed and treated by community as having no future - No longer considered productive member of society - Automatically associated with "social evils" (e.g., drug use, sex work) - Expected to adopt new role of teaching others about HIV and disclosing status - Loss of power, respect, and standing in community - Loss of right to make decisions about own life - Loss of marriage and Childbearing opportunities	**Gossip** - Speculation on how person acquired virus - Spreading rumors - Whispering behind back **Taunting** - Insults - Mocking - Finger-pointing - Threats **Expressions of blame and shame** - Scolding (e.g., blamed for not listening to elders) - Blamed for bringing "bad luck" to whole family **Labeling and use of derogatory words to describe people living with HIV or AIDS** - In Africa: "moving skeleton," "walking corpse," "keys to the mortuary"	**Loss of livelihood/future** - Loss of employment - Loss of customers/business - Denial of loans, scholarships, visas **Loss of housing** Denied housing Eviction by landlord Differential treatment in schools - Teachers supporting the idea of separating children of HIV+ people to "protect" other students **Differential treatment in health care settings** - Excessive and unnecessary precautions by health care staff - Shuffled between providers to avoid caring for HIV+ patient - Denial of health services - Provision of substandard treatment - Use of separate medical tools for people with HIV or AIDS - Place patients with HIV in separate rooms **Differential treatment in public spaces** - Refusal of services (e.g., will not be served food by vendors, or not served in shared containers) **Media and public health messages and campaigns** - Posters and news stories emphasizing negative images of people with HIV and AIDS and employing fear tactics to warn about HIV and AIDS - Posters and news stories presenting factual information about HIV and AIDS with a moral and judgmental tone - Inflammatory news stories about HIV-positive individuals purposefully infecting others

Adopted from Nyblade, L, et.al, 2003

As we can clearly understand from the above explanation, all the negative outcomes of disclosure are the way in which stigma and discrimination has been expressed. Thus, stigma and discrimination is not something than can occur in an open air rather its existence has been expressed through different ways, levels and contexts.

1.11 The Importance of HIV Counseling

The prevention and control of human immunodeficiency virus (HIV) infection depends on the success of strategies to prevent new infections and to treat currently infected individuals. So, the presence of voluntary counseling and testing (VCT) is one of the key components in the prevention and care program (Antenane Korra, et.al, 2005). It serves both goals (Antenane Korra, et.al, 2005, Krabbendam, A.A, 1998). It provides essential knowledge and support to individuals at risk for contracting HIV, enabling uninfected individuals to remain uninfected and those infected to plan for the future and prevent HIV transmission to others (Krabbendam, A.A, 1998 and Nyblade, L, et.al, 2003). Knowing their HIV status may also enable HIV-infected individuals to access early and appropriate treatment, care and support programmes. Furthermore, HIV-infected women who know their serostatus are in a better position to make informed choices about their reproductive lives and, if pregnant, to access specific interventions, such as antiretroviral prophylaxis and infant feeding counseling and support, which can significantly reduce the risk of mother-to-child transmission of HIV (Urassa, P,2006).

Moreover, counseling services help to motivate PLWHAs to be open about their status. It is possible with having more exposure to counseling services and having discussed issues related to disclosure with counselors and how they can cope up the negative reactions of others (De Rosa C and Marks, G, 1998).Above all, counseling services are very essential

for WLWHAs. Women are financially poor, worry more than their husbands for their children future- who is going to take care of them and face more influence by the social pressure from their families and others. Due to this fact, women are in difficult conditions to learn to live with their HIV infection and accept their HIV status. During this time, counseling can play an important role. It helps them in dealing with the results of HIV test and facilitates other needed things for them (Krabbendam, A.A, 1998).

In short, HIV/AIDS counseling is a confidential process that enables individuals to examine their knowledge and behaviors in relation to their personal risk of acquiring and transmitting HIV infection (Urassa, P.et.al, 2005, Krabbendam, A.A, 1998 and Grinstead, O.A.et.al, 2001). It also helps PLWHAs in general and WLWHAs in particular to feel and better and grow personally (Hoe, D, et. al, and 2003).

1.12 The influence of media in preventing HIV/AIDS

The mass media have a pivotal role to play in the fight against HIV/AIDS. More than 20 years into the epidemic, public understanding of how HIV/AIDS is prevented and treated is mixed and basic awareness about the disease and its impact is solely lacking in many parts of the world, particularly among women and youth (Agha, S, 2003).It doesn't mean that the awareness and knowledge of HIV/AIDS is still low; it is to mean that what they know haven't gone in line with their action.

Media, with its wide-reaching, global infrastructure and communications expertise, the media's ability to change the course of this epidemic is virtually unparalleled. Media, especially via radio and television drama can be used with powerful effect to promote positive attitudes towards PLWHAs. The Soul City initiative in South Africa can be taken

as an example. They have millions of target audiences. In the programme, they consistently present in the drama themes relating to AIDS-related stigma and discrimination, the difficulties of disclosure in a non-supportive environment, and the necessity of treating people living with HIV with compassion and respect (Norman, A, 2005). The indications are that Soul City's work is contributing to greater openness in talking about matters relating to sexuality, increasing awareness that people living with HIV can live healthy, productive lives, and that it is having a 'knock-on' effect in enabling community leaders, teachers and health service providers to use the messages in other areas. In our country also prorammes like 'Yibekal', 'Sinki', 'Fegegita talk show' and one presented by Dagmawi every Sunday are good initiatives.

All over the world, if there had been similar initiatives using media in raising awareness and offering people positive role models in the face of the epidemic; AIDS related stigma and discrimination would have been minimized (Norman Amy, 2005).

Generally, the media can make a difference in the AIDS epidemic. It is possible through the following ways according to (Norman Amy, 2005 and UNAIDS, 2005, Chatterjee, N, 1999) are the following.

- Designate the fight against HIV/AIDS as an overall corporate priority;
- Commit substantial time and/or space to the issue
- Provide current news coverage of the epidemic, both globally and locally;
- Support efforts to train reporters and producers to cover the epidemic;
- Support the development and broadcast of HIV/AIDS-related shows, films, and documentaries;
- Encourage the integration of HIV/AIDS-themes in storylines;

1.13 Theories and models of behavioral change

There are different theories and models of behavioral change. Two of them are the following.

1. 13.1 Health Belief Model (HBM)

It is a psychological model that attempts to explain and predict health. It was developed in the 1950s, holds that health behavior is a function of individual's socio-demographic characteristics, knowledge and attitudes.

Since it was first developed, the HBM has been adapted to explore a variety of long- and short-term health behaviors, including sexual risk behaviors and the transmission of HIV/AIDS. The key variables of the HBM are as follows (Rosenstock, S and Becker, 1994):

1. Perceived Threat: Consists of two parts: perceived susceptibility and perceived severity of a health condition.

    a. Perceived Susceptibility: One's subjective perception of the risk of contracting a health condition,

    b. Perceived Severity: Feelings concerning the seriousness of contracting an illness or of leaving it untreated (including evaluations of both medical and clinical consequences and possible social consequences).

2. Behavioral beliefs – it is the belief that the individual has towards a given behavior after comparing the behaviors benefits against its harm.

a. Perceived Benefits: The believed effectiveness of strategies designed to reduce the threat of illness.

b. Perceived Barriers: The potential negative consequences that may result from taking particular health actions, including physical, psychological, and financial demands.

C. Self-Efficacy – it is the belief in being able to successfully perform the behavior required to produce the desired outcomes.(This concept was introduced by Bandura in 1977.)

3. Cues to Action: Events, either bodily (e.g., physical symptoms of a health condition) or environmental (e.g., media publicity) that motivate people to take action.

4. Other Variables - diverse demographic, socio psychological and structural variables that affect an individual's perceptions and thus indirectly influence health-related behavior.

According to this model, promoting action to change behavior includes changing individual personal beliefs. Individuals weight the benefits against the perceived costs and barriers to change. For change to occur, benefits must outweigh costs.

General limitations of the HBM include:

1) most HBM-based research to date has incorporated only selected components of the HBM, thereby not testing the usefulness of the model as a whole;

2) as a psychological model it does not take into consideration other factors, such as environmental or economic factors, that may influence health behaviors; and

3) the model does not incorporate the influence of social norms and peer influences on people's decisions regarding their health behaviors (a point to consider especially when working with adolescents on HIV/AIDS issues).

Available at http://ww2.fhi.org/en/aids/aidscap/aidspubs/behres/bcr4theo.html

1.13. 2. Theory of reasoned action

The theory of reasoned action was developed in the mid-1960s by Fishbein and Ajzen. As cited by UNAIDS (1999).The theory states that human beings are usually quite rational and make systematic use of the information available to them. The theory variables and their definitions as described by Fishbein et al. (1994) as cited by UNAIDS (1999) are the following.

1. Behavior – it is defined by a combination of four components: action, target, context, and time (e.g., implementing a sexual HIV risk reduction strategy (action) by using condoms with commercial sex workers (target) in brothels (context) every time (time).

2. Intention: The intent to perform a behavior is the best predictor that a desired behavior will actually occur. In order to measure it accurately and effectively, intent should be defined using the same components used to define behavior: action, target, context, and time. Both attitude and norms, described below, influence one's intention to perform a behavior.

   a. Attitude: A person's positive or negative feelings toward performing the defined behavior.

b. Normative Beliefs: Normative beliefs are a combination of a person's beliefs regarding other people's views of a behavior and the person's willingness to conform to those views. As with behavioral beliefs, normative beliefs regarding other people's opinions and the evaluation of those opinions will vary from population to population

3. Behavioral Beliefs: Behavioral beliefs are a combination of a person's beliefs regarding the outcomes of a defined behavior and the person's evaluation of potential outcomes. These beliefs will differ from population to population. For instance, married heterosexuals may consider introducing condoms into their relationship an admission of infidelity, while for homosexual males in high prevalence areas it may be viewed as a sign of trust and caring.

Limitations of the TRA include the inability of the theory, due to its individualistic approach, to consider the role of environmental and structural issues and the linearity of the theory components. Individuals may first change their behavior and then their beliefs/attitudes about it. For example, studies on the impact of seatbelt laws in the United States revealed that people often changed their negative attitudes about the use of seatbelts as they grew accustomed to the new behavior.

Either implicitly or explicitly, nearly all prevention interventions are based on theories (UNAIDS, 1999). As a result, the researcher of this study is interested to analyze barriers for women to disclose HIV positive status to the public in terms of the above two theories.

1.14 Statements of the problem and rational of the study

Everyone - rich or poor, young or old, is affected by the HIV epidemic. However, people in developing countries, particularly young women, are the most vulnerable (UNAIDS, 2005, Aggleton, P. and R. Parker, 2002 and Armistead, L, et, al, 2003).Ethiopia is also affected by the virus. The majority of the victims in the country are adults in the prime of their working and parenting lives (Antenana, k, et, al, 2005).

Whatever devastating impact it has, we don't need to be desperate. Rather we need to confront it in developing various preventive mechanisms. For instance, the involvement of WLWHAs in the prevention programme is among the effective responses to the epidemic (ICW, 2002, Campbell, J., et.al (1998). and Feldman, R., J. et.al, 2002).They can play key roles in the prevention of the virus if opportunities are given for them. There is one saying in Amharic "set a thief to catch a thief" that supports the idea: nobody couldn't be more efficient than the victims in providing solutions. However, the idea hasn't yet come in to reality as a result various reasons. Among these, the absence of supportive environment for disclosing HIV status (Nyblade, L, et.al, 2003 and Maman, S, J, 2001). Low disclosure rate has a direct link with GIPA principle. If many people aren't able to freely disclosing their status, it wouldn't be possible for them to involve in different prevention activities. Rather it will be a dream.

Therefore, the main purpose of this paper is to explore aspects related to self-disclosure of HIV positive status (that is rates, reasons and barriers of disclosure) among HIV positive women.

The researcher focused on women for several reasons. First, women often have limited economic resources with which to deal with their illness (Aggleton, P. and E. Chase. 2001). Second, the impact of HIV/AIDS is more sever on the lives of WLWHAs. For example, they have responsibility for caring infected partners or children (KL Hackle et.al, 1997& Levy, 1999). Beside, since women are more vulnerable, it's believed that they can play a great role to prevent the epidemic. Supporting this, (ICW, 2002 and Feldman, R., J. Manchester, and C. Moaposhere, 2002) also stated that HIV positive women have a unique and valuable role to play in society and in fighting with HIV. Similarly on (ICW, 2002) stated that strategies to reverse the AIDS epidemic cannot succeed unless women and girls are empowered to claim their rights. Lastly, the negative outcomes of disclosure are more severe on women than men (Nblade, L, 2005 and Aggleton, P. and E. Chase. 2001).

Moreover, except one research paper conducted by Kebede Deribe,et.al,2005 that focuses on disclosure to sexual partners; there is no research paper related to public disclosure in case of Ethiopia as to the knowledge of the researcher. Even outside Ethiopia, most past researchers in the area of disclosure focus on barriers, rates, reasons and patterns of disclosure to significant others and sexual partners .Hence, focusing only on barriers for sharing Positive test results to either significant others or sexual partners by itself wont' be enough to fight the virus, this study therefore focuses on finding out barriers, outcomes and rates of public disclosure.

1.15 Research Questions

The main purpose of this study is to explore aspects related to self-disclosure of HIV positive status (that is rates, consequences, reasons and barriers of disclosure) among HIV positive women. More emphasis was given to aspects related to self-disclosure of positive status to the public. To this end, the following are the basic questions of the study.

1. Are there association between the selected predictor variables (the respondents' socio economic and demographic variables, cues to action, behavioral belief, attitude towards public disclosure, normative beliefs) and the dependent variable (rate of public disclosure)?

2. Do the predictor variables (the respondents' socio economic and demographic variables, cues to action, behavioral belief, attitude towards public disclosure, normative beliefs) have an effect on the dependent variable (rate of public disclosure)?

2. What looks like rates of self–disclosure to husband, mother, father, sisters, close friends, lover(s), relatives, children, brothers, and the public?

3. What are the reasons for disclosure or non disclosure to the public?

4. For those who have publicly disclosed, what they have faced / got after disclosure?

5. For those who haven't yet disclosed, do you intend to publicly disclose your HIV status in the future? If yes when?

6. What are the reasons for not confronting the negative outcomes of public disclosure and break up the silence?

Objective of the study

The general objective of the study is to explore aspects related to self – disclosure of HIV positive status (that is rates, consequences, reasons and barriers of disclosure) among HIV positive women. However, more attention was given to find out consequences, reasons and barriers of public disclosure.

Specific objectives

- To identify those predictor variables that have relationship with the dependent variable.
- To identify the effect of the predictor variables on the dependent variable.
- To asses rates of self- disclosure to husband, mother, father, sisters, close friends, lover(s), relatives, children, brothers, and the public
- To asses reasons for disclosure or non disclosure to the public
- To find out what they have got/faced those who have already disclosed to the public.
- To examine whether they have intend to disclose in the future if the haven't yet disclosed. And if yes, when do they think that time will be.
- To identify those reasons which hinder the participants from confronting the negative outcomes of public disclosure and there by break the silence around HIV/AIDS.

1.17 Significance of the study

The barriers of HIV positive status disclosure differ from one cultural setting to the other. So, the study is significant because it identify the barriers of disclosure in the context of urban Ethiopia. And it will be useful to find out entry points to encourage WLWHAs to disclose their status to the public and take part in prevention activities. Beside, the study is helpful to describe programmatic and policy options towards reducing barriers of

disclosure of HIV positive status. Furthermore, it gives information related to self-disclosure of HIV positive status that can be crucial as a stepping stone for other related research.

1.18 Limitation of the study

This study has had the following limitations. First, it failed to include information related to motivators and consequences of disclosure to each target groups. Second, the information collected related to consequences of public disclosure wasn't interims of time periods. Third, their families and sexual partner(s) /husband background characteristics weren't included in the study. Lastly, the way rate of disclosure was measured for each target group didn't provide information concerning to whether she only told to that person or not. Simply it tells us how many of them out of the total respondents disclosed to that target group.

1.19 Delimitation of the study

This study is delimited to WLWHAs in Addis Ababa. It didn't include men in the sample and compare and contrast their responses about issues related self- disclosure of HIV positive status.

2. Research Methodology

2.1 Design of the Study

The central aim of this cross sectional study was to examine aspects related to self – disclosure of HIV positive status (that is rates, consequences, reasons and barriers of disclosure) among HIV positive women. However, more attention was given to find out consequences, reasons and barriers of public disclosure. Data was collected through quantitative and qualitative methods to assess patterns and rates of self-disclosure; barriers, outcomes and motivators of public disclosure.

2.3 The area of the study

Addis Ababa, is the capital city of Ethiopia and amongest others; it is the seat of the economic commission of Africa and the Africa Union. The city is reported to have one of the highest concentrations of HIV/AIDS cases through out the country. According to (MOH, 2004), the HIV prevalence rate in Addis Ababa amounts to 12.4%, with a number of people living with HIV/AIDS that is increasing to 1.5 million. And Women in the age group of 20-29 years show the highest prevalence of HIV. These days 57% of the hospital beds in the city are occupied by AIDS patients (MOH, 2004). If the epidemic continues unchanged, predictions say that there will be 40,000 to 60,000 new HIV/AIDS-cases every year (MOH, 2005).

2.4 Subjects of the study

Women living with HIV/AIDS in Addis Ababa were the target population of the study. Only women's were selected because the focus of this study was about women.

2.5 Sample size determination

In order to determine the minimum sample size for the study, we need to know the rate of public disclosure in the context of Ethiopia. However, as to the knowledge of the researcher, there is no research that clearly explained rates of disclosure to the public. So, for determining the sample size, the researcher calculated by setting p at 0.5 and 1-p at 0.5 that will give the maximum possible sample size. These figures were plugged in the following formula.

$$n = \frac{(Z\alpha/2)^2.p\,(1-p) + 5\ \%\ \text{Contingency}}{d^2}$$

The sample size is determined with the following assumptions.

- A confidence interval of 95%.
- A 5% margin of error is accepted
- 10% contingency, that is, for non-response
- $Z\alpha/2=1.96 \approx 2$ where 2=the standard normal deviate which corresponds to the 95%. Confidence level 0.05
- d^2=margin of error

P = percentage of people who disclosed their HIV positive test result to public.

1-p = percentage of people who did not disclosed their HIV positive test result to public

d = design effect

$$n = \frac{(2)2.\,(0.5).\,(0.5)}{(0.05)2} = \frac{4(0.25)}{0.00025} = \frac{1}{0.00025} = 400$$

400+5 % contingency 400+20=420

2.6 Data collection Instruments

Two types of data collecting techniques were used to collect as much as information as possible in order to avoid bias where possible and to let the information complement each other.

These were structured interview and focus group discussions were the main data gathering instruments in this study.

2.6.1 The Structured Interview

The structured interview was prepared for all eligible samples. It was first developed in English, Translated in Amharic and translated back to English so that accuracy and consistency in wording are ensured.

The interview was used to collect information about the study variables. The specific measures included in the study are described below.

- **Demographic and socioeconomic variables**

Participants were asked their age, level of educational status, religion, whether they have been engaged in income generating activities for pay or not. They were also asked what month and year they tested HIV positive status.

- **HIV disclosure measure**

Respondents were asked to report if they had disclosed their HIV status to anyone (yes/no).Those who answered affirmatively, they were person – by - person asked whether they had disclosed (yes/no) to each of eleven targets / i.e. husband, sexual partner, mother, father, sisters, brothers ,close friends, relatives, other non relatives, children and public disclosure. However, if the respondent mentioned more than one person for each relationship category and if the respondents not disclosed the majority of them, defined as having not disclosed to that target group except parents - mother and father as well as public disclosure were coded dichotomously- disclosed to or not disclosed to. Again respondents were able to indicate "not applicable" if they didn't have such a person to disclose to or not close to that person. Percentages of persons to whom participants had disclosed were calculated using the total number of persons identified within each relation ship category as a denominator.

- **Knowledge of HIV/AIDS**

Respondents knowledge of HIV /AIDS was measured by taking some questions that were relevant to the present study from an objective measure of HIV knowledge questions questionnaire which is developed by M.P.Carey,D,Morrison ,Beedy,and B.T .Johnson,1997). Beside, the researcher made all the necessary changes. It was a true false test item.

The participants were asked the 10 - item test of knowledge about HIV/AIDS. The items covered a wide range of topics including knowledge of and misconceptions about AIDS including transmission routes. Then, their responses were scored by giving 1 point for

each correct answer and the zero for each incorrect answer. Next, the scores were totaled to create a knowledge score. Based on their scores, the respondents were grouped in to three categories by taking the 33 percentile as a cut off point.

- **Attitude towards disclosure**

This measure consists of 3 items assessing the person attitude towards the public disclosure. The items were responded on 3 point scale ranging from 1=never at all to 3= usually. The scores on each differential are summed to provide a total attitudes score. Then it was recoded in to those who have positive and negative attitude towards the behavior by taking the 50 percentile or the mean as a dividing point

- **Discussion issues related to Disclosure with counselors.**

This measure consists of four items that assess whether they have discussed content related to disclosure with their counselors. Out of the four, one was an open ended question.

- **Influence of Subjective norms**

This measure consists of two items that assess the opinion of the patients close parents / friends towards her being open about the HIV diagnosis result and their motivation to comply. The measure of subjective norm is obtained by summing up the response of salient normative beliefs (e.g. My friends/parents/girlfriend/etc. want my result to be secret from others), and the respondents motivation to comply with those expectations (e.g. With regard to being pen about your status, will you do / have you done what your

friends/parents/girlfriend/etc. think you should (yes/no).The sum of the two response were recoded in to two categories – influenced and not influenced.

- **Consequences of public disclosure**

Out comes of disclosure both negative and positive were assessed by asking a series of questions about the occurrence of specific events since she has become open about her status to the community. The items were 20. All the items assessed consequences of public disclosure – negative and positive outcomes. These items were responded on 2 point scales -1 (yes) and 2(no).

The proportion of participants reporting each outcomes (negative and positive) was calculated after eliminating those who said that outcomes of public disclosure were not applicable to them (e.g. some respondents were not married so couldn't experience the break- up of a marriage); there was a not applicable option for each consequences of public disclosure. And after those statements that measure negative outcomes were scored in reverse.

Number of counseling sessions

This measure consists of 3 items. All the items were indicator of the number of sessions one has got counseling services.

Behavioral beliefs

The researcher measured the respondents behavioral beliefs towards public disclosure using 20 statements that assess the respondents perceived barriers and benefits of public disclosure. The items were taken from "Stigma, and Patterns of Disclosure in Rural Women with HIV Infection" By Sowell et al., 1997).Besides, some items were added

based on the literature. Even those items that were taken from "Stigma, and Patterns of Disclosure in Rural Women with HIV Infection" By Sowell et al., 1997) were modified by the researcher according to the context. These items were responded on 4 point scales ranging from 1 / not at all / to 4 / a lot /.The proportion of participants reporting each outcomes (negative and positive) was calculated after eliminating those who said that outcomes of public disclosure were not applicable. During the analysis, since those respondents who said 'not at all' were very small, the response was recoded in to three categories.

Media exposure

This measure consists of three items. The items have had four response sets. During scoring, the response set were recoded in to two. That is those who said daily and at least once within a week were recoded in to one and the other two options were also recoded in to one option. Then their response were recoded in to less and highly exposed to media about HIV/AIDS information.

Each interview took an average of 30 minutes.

The Focus Group Discussion

In order to meet the objectives of the study sufficiently, the qualitative method of inquiry /the focus group discussion (FGDS) was conducted .It offers a different perspective, because the participants interact and discuss the area of disagreement.

A total of 28 HIV positive women were participating. Half of them were selected from organizations of PLWHA and the rest half from 2 hospitals.

The FGD guide has six open ended questions that only focuses on those sensitive issues since the focus group discussions were done after the structured interviews, we were already aware of the sensitive issues that could be brought up in the FGDs.

The participants were required to give their feelings, opinions and suggestions. In all the discussions, Amharic language was spoken. The discussions was taped, typed out, verbatim, translated in to English and analyzed.

2.8 Sampling procedure

To conduct the research, data were collected from different hospitals and organizations of PLWHA because it is the easiest way to get women living with HIV/AIDS through such sites. Beside, the researcher purposely used 2 different target sites having taking two samples from each target sites since she thought and believed that taking samples from various sites can increase diversity /heterogeneity of the study population and that in return increases its representative ness to all HIV positive women living in urban areas.

As a result, two hospitals known in providing different services to HIV positive women out patiently were purposely selected out of five similar hospitals. Namely Tikur Anbessa and Zewuditu hospital .These sites are selected purposely because they are accessible for the patients and are widely used by many clients so that the probability of getting the required number of sample size is very high.

The other samples were selected from two associations of PLWHAs out of eighteen using simple random sampling – Tesfa gohe Ethiopia and Mekidim Ethiopia.

Then the researcher collected information how many women clients within a month go to each site. Based on that information, I proportionally distribute the 440 samples to the four sites.

Determining whom to participate in the structured interview was very difficult using the lists of the clients from the sites and by preparing a sample frame. First, it is not advisable even if possible taking the addresses of the clients from each site and contact them not only because of the issue of confidentiality but also the contacted persons reaction will not be positive Second, they may not give their correct address. Third, they may live by hiding their positive status from their family or some one who live together with them so another problem may be created. Finally, it is unpredictable to know as who can come tomorrow or the next day.

In general because of the presence of different negative outcomes related to disclosure and the above mentioned reasons; most HIV positive people are not willing to acknowledge their status and participate in such kinds of situations. As a result, convenient sampling method was employed in order to select the samples.

All the subjects participated in the study weren't too physically ill and were aware of their HIV status. And had consented to be interviewed for the study after explaining in detail the nature as well as the purposes of the study.

2.9 Field Data Collection

The data were collected starting from February 20 to April 1.Before the main study was conducted a pilot test had been carried out. The structured interview was tried out on 30

women's living with HIV/AIDS to identify and modify the short comings of the instrument. Accordingly some improvements were made.

Then, eight female counselors and eight Para counselors with two female supervisors were recruited and took part in the data collection process. Before the actual data collection, there was a de-briefing session that took the whole day. During that time, each and every relevant issue related to the study and how they can conduct the interview was clearly explained. More over, after the first day of the actual data collection, we all sit together and discussed on issues brought from the field work in order to minimize errors.

The focus Group Discussion was conducted by the principal researcher with the help of one assistant researcher using the FGD guideline.

2.10 Method of Data Analysis

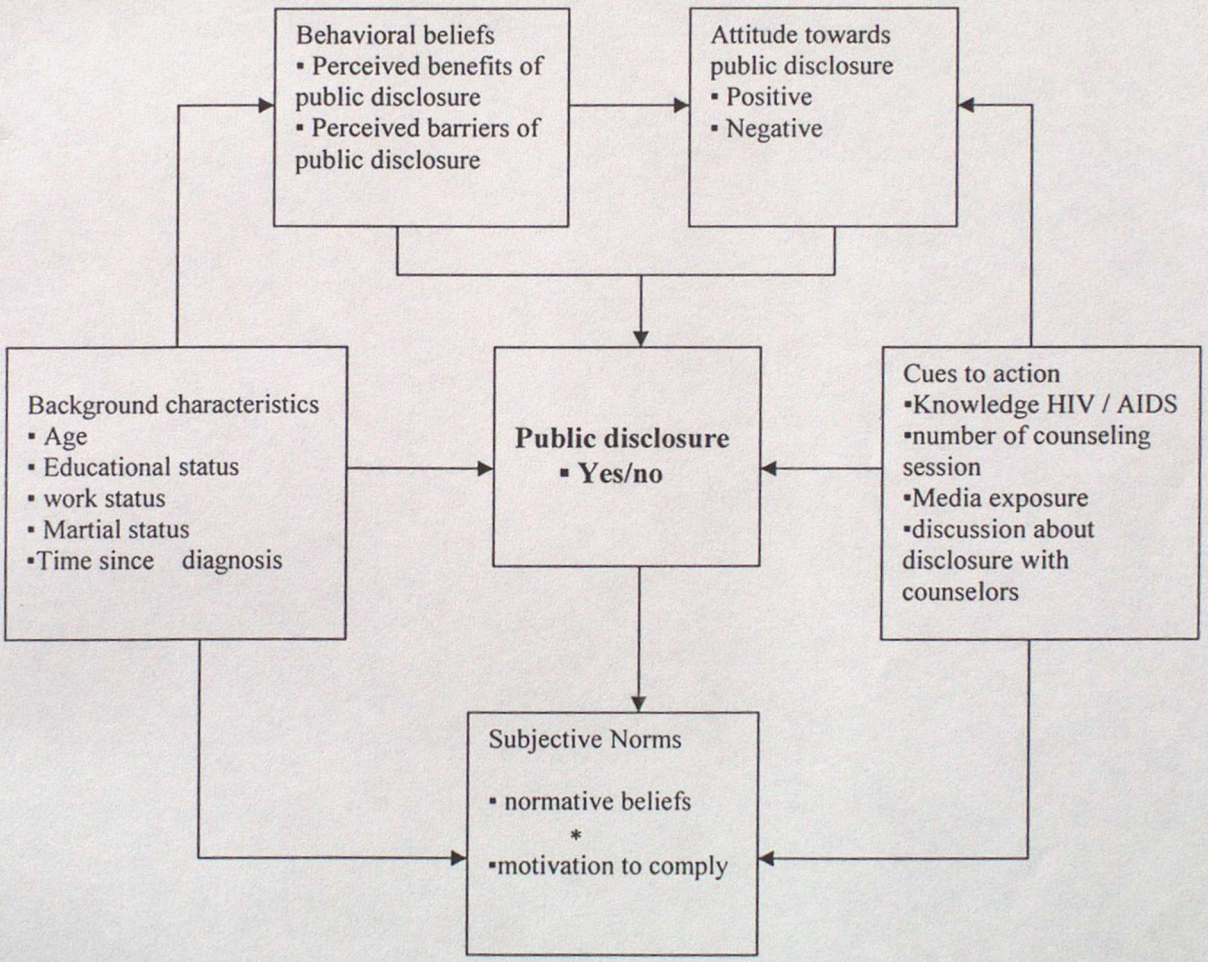
The data were analyzed with quantitative as well as qualitative approaches.

The date collected using the focus group discussion have been presented and analyzed qualitatively. Beside, quantitative analysis was used to calculate frequencies/ percentages and mean(s) wherever applicable where as the information collected using the structured interview after responses of open ended questions were coded ;the data were coded, edited and entered in to computer (SPSS Version 11 Statistical Package) for analysis.

To analyze the data gathered through structured interview, descriptive statistics and cross tabulations were employed. And chi-square test of independence was used to identify those predictor variables that have association with the dependent variable. Moreover, Binary logistic regression was employed to examine the effect of the selected predictor variables on the dependent variable since the dependent variable is dichotomous / that is, 0 and 1/.On the this study, those who disclose their positive status to the public = 1 and the opposite =0 .Multivariate logistic regression was conducted to examine the likelihood of rate of public disclosure of HIV status in relation to the significant predictors in the bi-varite analysis.

2.11 Conceptual framework

For the purpose of this study, public disclosure of HIV positive test result will be treated as outcome variable. Demographic and socio-economic variables, cues to action, behavioral beliefs, subjective norms, and attitude towards public disclosure were treated as independent variable for this study



The researcher developed the above conceptual frame work by taking ideas from Health Belief Model and Theory of Reasoned Action.

Chapter three: Descriptive analysis and the FGDs analysis

3. A. Background characteristics from the survey finding Characteristics

In this chapter, results pertaining to the socio-economic characteristics of respondents are presented. Some of the characteristics analyzed include age, education status, religion, engagement in any economic activities for pay, marital status and so on. Such information is very useful in a number of ways. Some of these are the following. Firstly, to get information as to whom the survey was all about. Secondly to assist readers easily comprehend the findings. Thirdly, they are also important to properly interpret the survey result and to draw applicable recommendations. It was noted in the methodology section that the total number of persons covered in the survey were 417 eligible women.

3.1 Age Distribution of Respondents

To show the age distribution of respondents, five year age groups were formed (Table 3.1). As shown in the Table 3.1, more than four in ten respondents were young people under 30 years of age. The proportions of respondents in the age groups 30-34, 35-39 and 40 and above years were 22.3%, 22.8% and 12.2% respectively. The mean age of respondents in the study was found to be 31.8 years (Table 3.1).

Table 3.1: percentage Distribution of Respondents by Age

Age group	Number	Percent
19 - 24	66	16
25 - 29	112	27
30 - 34	93	22
35 - 39	95	23
40+	51	12
Total	417	100.0
Mean age	31.8 years	

3.2 Level of Education

Table 3.2 presents the distribution of respondents by level of education. As shown in the Table 3.2, 14% of the respondents were less than primary level. The survey also showed that 33 % were primary. Moreover, 41 %, and 12 % of the respondents were secondary and above secondary respectively (Table 3.2).

Table 3.2 Distribution of Respondents by Level of Education

Educational Status	Number	Percent
< primary	60	14
Primary	137	33
Secondary	168	41
> secondary	51	12
Total	417	100.0

3.3 Religions Composition

Information was collected on the religious affiliation of the survey respondents. The composition of the survey population with regard to religious affiliation is shown in Table 3.3. It can be seen from the Table that six in ten respondents were followers of Orthodox Christianity. Muslims accounted for 10.1 percent, Protestant constitute 22.8 percent and followers of other religions constitute 7 percent of the respondents (Table 3.3).

Table 3.3: Distribution of Respondents by Religious Composition

Religious Composition	Number	Percent
Orthodox	251	60
Muslim	42	10
Protestant	95	23
Others	29	7
Total	417	100.0

3.4 Marital Status

Distribution of marital status of the survey population is presented in Table 3.4. According to the data in Table 3.4, 30.9% were married at the time of the survey, 18.2% divorced, 28.3% windowed and 22.5 % never married during the survey (Table 3.4).

Table 3.4: Distribution of Respondents by Marital Status

Marital Status	Frequency	Percent
Currently married	129	31
Divorced	76	18
Widowed	118	28
Never married	94	26
Total	417	100.0

3.5 Time since Initial HIV Diagnosis

In this section time since initial HIV diagnosis is discussed. Such information is believed to be important for a proper understanding of the results that will be presented in subsequent chapters.

Table 3.5 presents number of years elapsed since initial diagnosis of HIV/AIDS. 46.3 percent of the respondents have elapsed 6-10 years since diagnosis of HIV/AIDS. In addition to that, 36.9 percent, 12.2 percent and 4.6 percent of the respondents have elapsed less than one year, one to five years and ten and more years since come to know their HIV positive status (Table 3.5).

Table 3.5: Distribution of Respondents by Time since Diagnosis

Time since diagnosis	Number	Percent
Less than 1 year	154	37
1-5 years	51	12
6-10 years	193	46
10 years and above	19	5
Total	417	100.0

3.6 Work status

A woman who is economically dependent believed to be less vulnerable to the virus. It also determines their social as well as economic standing in the society. Thus, this survey asked the respondents if they were engaged in some kind of income generating activities for pay. Those who have been engaged in some kind of activities were asked further questions. This section will present the resulting data.

According to the data in Table 3.6, 52.0 percent of the respondents were working at the time of the survey. In terms of employment status among the working respondents, three in ten respondents were government employee, 16.1 percent were self employed. Moreover, daily laborer accounted for 11.1 percent and commercial sex work constitute 8.3 percent and homemade amount to 5.1 percent of the respondents (Table 3.6).

Table 3.6: Distribution of Respondents by Work Status and Type of Activity

	Number	Percent
Work Status		
Yes	217	52.0
No	200	48.0
Total	417	100.0
Types of Activities		
Government employee	66	31
Commercial sex worker	18	8
Self employed / "***gulit.***"	35	16
Home maid	11	5
Daily laborer	24	11
Others	63	29
Total	217	100.0

3.7. Cues to Action

3.7.1 Knowledge of HIV/AIDS

Information was collected about their knowledge of HIV/AIDS. Respondents were asked ten questions related to HIV/AIDS. Based on the response given, respondents were categorized in to three as less knowledgeable, moderately knowledgeable and highly knowledgeable. According to the data in Table 3.7.1, 31.7 percent of the respondents were less knowledgeable, 23.7 percent were moderately knowledgeable and the rest 44.8 percent were highly knowledgeable.

Table 3.7.1: Distribution of Respondents by Their Level of Knowledge of HIV/AIDS.

Knowledge of HIV/AIDS	Number	Percent
Less knowledgeable	132	31.7
Moderate knowledgeable	99	23.7
Highly Knowledgeable	186	44.6
Total	417	100.0

3.7.2. Exposure to Media

The survey collected information on how frequently respondents listen to radio, watch TV and read news papers about issues related to HIV/AIDS and disclosure of positive test result. Depending on the response given to the questions, an indexed measure of media exposure was calculated. According to the data in Table 3.7.2, more than two third of the respondents were labeled as highly exposed to media while the remaining 31.2 percent of the respondents were relatively less exposed to media about HIV and disclosure of HIV positive test result related issues (Table 3.7.2).

Table 3.7.2: Distribution of Respondents by Exposure to Information Related to HIV/AIDS through Medias.

Media exposure	Number	Percent
Less exposed	130	31.2
Highly exposed	287	68.8
Total	417	100.0

3.7.2.1 Content of the media messages

In the survey, information was also collected from the respondents regarding the content of the message that they were most frequently exposed from various Medias. As the Table 3.9 shows, 86.3 percent of the respondents identified the fact that they have exposed to information about antiretroviral medicines frequently. Besides, 36.9, 35.3 and 25.2 percent of the respondents identified the fact that they frequently exposed to information about people who live longer years with the virus, people living with the virus teaching others and issues related to disclosure respectively (Table 3.9).

Table 3.7.2.1: Distribution of Respondents by the messages of media exposure

Messages	Number	Percent
About the antiretroviral medicine	360	86.3
Those people who live for longer period with the virus.	154	36.9
People living with the virus teach others	147	35.3
Issues related to disclosure	105	25.2
The place where you can get counseling	76	18.2
Total number of cases	417	100.0

3.7.3 Number of Counseling Sessions

Table 3.7.3, which presents the percentage of respondents who have ever experienced counseling, type of counseling experienced and experience of follow up counseling, shows that 91% of the respondents have experienced counseling at some time in their life. Those who have been experienced counseling were asked further questions about the type of counseling they received and whether they are attending follow up counseling. As can be seen from the Table 3.7.3, the majority (65%) of the respondents have got both pre and post test counseling. Besides, 17.9% and 16.3% of the respondents were attended posttest counseling and pretest counseling alone respectively. Furthermore, respondents

were asked whether they have gone to counseling centers looking for counseling after they knew their test result .As it is indicated in the Table 3.7.3, 57.9% have never visited the centers in search of follow up counseling. However, 42.1% have received counseling. Among them, 36.1% said rarely and 10.6% said usually (Table 3.7.3).

Table 3.7.3 Distribution of Respondents number of counseling sessions

Have you ever received counseling?	**Number**	**Percent**
Yes	380	91.1
No	37	8.9
Total	417	100.0
What type of counseling service you got?		
Pretest counseling only	62	16.3
Posttest counseling only	68	17.9
Pre and posttest counseling only	250	65.8
Total	380	100.0
Are you currently attending follow up counseling?		
No, never	220	57.9
Yes, rarely	124	32.6
Yes , usually	36	9.5
Total	380	100.0

3.7.3.1 Discussion with Counselors' Issues Related to Disclosure

Table 3.7.3.1 present data on whether the respondents have ever discussed issues related to disclosure with their counselors. Around 54.4 percent of respondents who have got counseling in their life recognized as they have discussed issues related to disclosure with their counselors (Table 3.7.3.1).

Table 3.7.3.1 Distribution of Respondents by Discussion about Disclosure with Counselors

Have you ever discussed about disclosure with your counselor?	**Number**	**Percent**
Yes	207	54.4
No	173	45.6
Total	380	100

3.8 Perceived Benefits and Harms of Public Disclosure

The "Health Belief Model" of behavior change suggests that individuals must perceive the benefit/ harm of certain behavior before they will take actions to change that specific behavior. The model further states that individuals will not change their behavior unless they feel confident of their ability to change this behavior, even if they perceived that the behavior is beneficiary. In this survey respondents were asked if they personally feel that public disclosure is beneficiary or harmful. The results are presented in the following sections.

3.8.1 Perceived Benefits

As can be seen from the Table 3..8.1, the most frequently mentioned benefit of public disclosure was it helps to protect PLWHAs from spreading the virus followed by it helps to reduces stigma and discrimination. In addition to that, 68.1% and 64.7% of the respondents believe that public disclosure is beneficiary in terms of encouraging other to disclose and educate the society respectively (Table 3.8.1).

Table 3.8.1 Distribution of Respondents by Perceived Benefits of Public Disclosure

Perceived benefits	Number	Percent
Helps to protect PLWHA from spreading the virus	352	84.4
Reduce stigma and discrimination	308	73.9
Encourages others to disclose their test result	284	68.1
Will educate the society	270	64.7

Note. The total percentage adds to more than 100% due to the subjects giving multiple responses.

3.8.2 Perceived Barriers

Table 3.8.2 shows the percentage of respondents who have identified barriers of public disclosure. The most frequently mentioned reasons were respondents' conviction that public disclosure has fear of rejection followed by protecting others. What is more is the fact that lose of care and support, fear of stigma and fear of others' perception were mentioned by 48.7%, 45.8% and 43.6% respectively (Table 3.8.2).

Table 3.8.2 Distribution of Respondents by Perceived Barriers of Public Disclosure

Perceived barriers	Number	Percent
Fear of rejection	263	63.1
Protecting others	253	60.7
Lose care and support	203	48.7
Being stigmatized	191	45.8
Others look them in different way	182	43.6

Note. The total percentage adds to more than 100% due to the subjects giving multiple responses

3.8.3 Behavioral Beliefs

A composite variable for perceived barriers was derived based on the respondents response. The cutoff points were identified based on the cumulative frequency of the distribution of the total score. Based on the result of the indexed measure of perceived barrier, 33.1 percent perceive relatively less barriers of public disclosure compared to others. However, 34.1 percent perceived moderate barriers and the remaining 32.9 percent perceived higher barriers of public disclosure compared with the previous one (Table 3.8.3).

Table 3.8.3: Distribution of Respondents by Their Perceived Barriers and Benefits

Comparison between perceived barriers and benefits of public disclosure	Number	Percent
Perceived less barriers	138	33.1
Perceived some barriers	142	34.1
Perceived a lot of barriers	137	32.9
Total	417	100.0

Note. The total percentage adds to more than 100% due to the subjects giving multiple responses

3.9 Intention to Disclose

Respondents who were not disclosed their status to the public were asked if they intended to disclose in the future. Those who expressed their intention were further asked how soon they are going to disclose their status. As shown in the Table 3.9, 24 percent of the respondents who were not publicly disclosed their status at the time of the survey expressed their willingness in considering public disclosure of HIV infection in the future. Moreover, nearly 13.9 percent of the respondents were willing to disclose with in a month time since the survey. Furthermore, 37.5 percent and 15.3 percent of the respondents were willing in considering public disclosure with in a year time and after one year respectively (Table 3.9).

Table 3.9: Distribution of Respondents by Intention to Disclose

	Number	Percent
Future intention		
Yes	72	24.0
No	228	76.0
Total	300	100.0
Time for disclosure		
1-30 days	10	13.9
1-12 months	27	37.5
After one year	11	15.3
I don't know	18	25.0
Other	6	8.3
Total	72	100.0

3.10 Attitude towards Disclosure

All respondents were asked whether it is important to disclose ones HIV positive test result to the public. Those who support the idea are recorded as they have positive attitude and the others on the opposite direction. Table shows 3.9.1 that, out of the total respondents, the majority of the respondents' i.e. 83.5% have positive attitude towards public disclosure and the rest 16.5% have negative attitude towards it (Table 3.10).

Table 3.10 Distribution of Respondents by Their Attitude towards Public Disclosure

Positive attitude towards Disclosure	Number	Percent
Have positive attitude	69	84
Have negative attitude	348	16
Total	417	100.0

3.11 Normative influence on decision to disclose

3.11.1 The opinion of the salient others about ones being open

As it is indicated in the previous parts, the "Theory of Reasoned Action" suggests that human beings are rational regarding the decision to change behavior or not. Although the theory further stated that, ones intention is the best predicator that the desired behavior will occur, there are many factors including normative beliefs, i.e. other people's view and opinion of a behavior and the people's willingness to confront those opinions can affect change in behavior towards the desired direction. In this survey respondents were asked what salient others feel about their own decision to publicly disclose their HIV positive status. The results are presented in the following section.

As can be seen from Table 3.11.1, the majority of the respondents (73.4 percent) feel that their salient others don't support their decision to publicly disclose their status, 9.6 percent of the said their salient others support their decision to disclosure HIV test result. The remaining 17 percent of the respondents do not know the opinions of the salient others with regard to public disclosure (Table 3.11.1).

Table 3.11.1: Percentage Distribution of Respondents by the Opinion of the Salient Others.

The opinion of the salient others	Number	Percent
In support	40	9.6
Not support	306	73.4
I don't know	71	17.0
Total	417	100

Moreover, respondents were further asked whether they comply or confront to the opinions of salient others with regard to public disclosure. As the data presented in Table, 3.11.2 more than two-third of the respondents reported that they will comply the opinions of others (Table 3.11.2).

Table 3.11.2 Distribution of Respondents by the Respondents Motivation to comply to the opinion of salient others

Motivation to Comply.	Number	Percent
Comply with norm	282	67.6
Not comply with norm	135	32.4
Total	417	100.0

3.12 Rates of Public Disclosure to Various Target Groups

As a measure of disclosure, respondents indicated whether they had revealed their HIV infection to any one. Those respondents who had revealed their HIV infection to any one were further asked whether they revealed their positive status to the following ten targets: husband, sexual partner, and mother, father, sister, brother, children, other relatives and

close friend. If the target was not applicable for a respondents (e.g. no brother, mother not alive), the respondents was excluded from the analysis of that specific target. Two indexes of disclosure were created by calculating the percentage of targets informed after selecting only applicable targets and public disclosure was independently measured for those respondents who reported the fact that, they had revealed their HIV infection at least to one target.

As can be seen from the Table 3.12, 76.7 percent of the respondents had revealed their HIV infection at least to one person. In other words, only 23.3 percent of the sample had disclosed to no one. As expected, disclosure rates were relatively low for extended family members, somewhat higher for immediate family members, and highest for sisters, husbands and mothers (Table 3.12).

Table 3.12 Distribution of Respondents by Rates of Public Disclosure

Have you told any one about your status?	**Number**	**Percent**
Yes	320	76. 7
No	97	23.3
Total	417	100
For those who say they have disclosed: Who have you told?		
Sisters	155 out of 264	58.7
Husband	88 out of 129	68.0
Mother	89 out of 186	47.8
Close friends	89 out of 226	39.4
Brothers	58 out of 167	34.7
Children	67 out of 198	33.8
Father	31 out of 106	29.2
Relatives	64 out of 320	20.0
Sexual partner	18 out of 96	18.8
Public disclosure	117 out of 320	36.6
Public disclosure	117 out of 417	28.1

Note. The total percentage adds to more than 100% due to the subjects giving multiple responses.

3.13 Reasons for public disclosure

The framework for analyzing reasons for public disclosure and highlighted reasons reflecting a desire to avoid negative consequences to or enhance positive outcomes for self ("self-focused") or others ("other-focused"). As the data in Table 3.11 shows, self-focused reasons emphasizing alleviating stress, severity of illness and need for social support were more commonly cited reasons that motivated them to be open about their HIV infection. Furthermore, senses of ethical responsibility educating others and to encourage others since it mean nothing were among the "other-focused" reasons mentioned by the respondents (Table 3.13).

Table 3.11 Distribution of Respondents by reasons for Public Disclosure

	Motivators of public disclosure	Number	Percent
Self-focused reasons	To alleviate the stress w/t non disclosure	83	71
	Severity of illness	78	67
	Need for social	71	60.7
	Need for financial support	99	85
Other-focused reasons	Sense of ethical responsibility	82	70
	To educate others by sharing my experience	73	62
	To encourage others since it mean nothing	68	58
Number of cases		117	100.0

Note. The total percentage adds to more than 100% due to the subjects giving multiple responses.

3.14 Consequences of Public Disclosure

3.14.1 Positive outcomes of public disclosure

As shown in Table 3.14.1, respondents believe that public disclosure of HIV infection is helpful to get accesses to medication (94.9 percent), increase social support and acceptance (81.2 percent), to keep ones from risky behaviors (74.4 percent), to do things openly (73.5 percent), to freely involved in HIV prevention activities (71.8 percent) and to feel less lonely than before (57.3 percent) (Table 3.14.1).

Table 3.14.1 Distribution of Respondents by Positive outcomes of Public Disclosure

Positive outcomes of public disclosure	Number	Percent
Able to get accesses to medication	111	94.9
Increased social support and acceptance	95	81.2
Able to keep ones from risky behaviors	87	74.4
Able to do things openly	86	73.5
Able to freely involved in HIV prevention activities	84	71.8
Feels less lonely than before	67	57.3
Number of cases	117	100.0

Note. The total percentage adds to more than 100% due to the subjects giving multiple responses

3.14.2 Negative Outcomes of Public Disclosure

Respondents were asked what negative consequences they experienced due to their public disclosure of HIV infection. The most commonly cited consequences includes, being gossiped, lost housing, upset family members, less visited by friends and family members and discriminated from social gathering are just to mention but a few (Table 3.14.2).

Table 3.14.2 Distribution of Respondents by Negative outcomes of Public Disclosure

Negative outcomes of public disclosure	Number	Percent
Gossiped	59	50.4
Lost housing	49	41.9
Upsetting family member	45	38.5
Less visited by families and friends	38	32.5
Discriminated from social gathering	37	31.6
Blamed by others	36	30.8
Fired from job	26	22.2
Separated from my partner	17	14.5
Abandoned by spouse/ partner	4	3.4
Number of cases	117	100.0

Note. The total percentage adds to more than 100% due to the subjects giving multiple responses

3.14.3: Comparison between the consequences of public disclosure

Based on their responses, they have got more positive negative outcomes – 59% than the negative outcomes they have faced- 41%.

Table 3.14.3: Percentage distribution of respondents by comparing between the negative outcomes and positive outcomes of public disclosure

Consequences of public disclosure	Frequency	percent
Positive outcome	48	41
Negative outcome	69	59
total	117	100

3.15 Reasons for not confronting the negative outcomes of public disclosure

In the survey, respondents were asked why they did not disclose their status. Most respondents reported multiple reasons for non-disclosure. These included fear of losing economic support (92.3%), fear of losing job (91.0%), and fear of losing house rent (70.3%) and not to worry others (44.0%). In addition to that, 67% of the respondents reported that it was futile to disclose their HIV status, as they did not imagine any use of the disclosure (Table 3.15).

Table 3.15 distribution of the respondents by reasons for non-disclosure

Reasons for non-disclosure	**Number**	**Percent**
Fear of losing economic support	277	92.3
Fear of losing / not getting jobs	273	91.0
Fear of losing house rent	211	70.3
No use for me	201	67.0
Not to worry others	132	44.0
Other	69	23.0
Total number of cases	300	100.0

Note. The total percentage adds to more than 100% due to the subjects giving multiple responses

3. B. Results of Focus Group Discussions (FGDS)

The second source of information in this survey was focus group discussions, which allowed the researcher to collect more detailed information, conducted with women living with HIV/AIDS in two hospitals and organizations of people living with HIV/AIDS.

The sample consisted of 28 subjects. All were women living with HIV/AIDS. The mean age in years was 34.8 ranges from 25 to 46 .A total of four focus group discussion were held. Each group has had selected from four sites taking age as a criteria for group formation i.e. 25 - 29, 30 - 34, 35 - 39 and 40 and above. The name of the target sites were Tikur Anbessa hospital,Zewuditu hospital,Tesfagohe Ethiopia and Mekidim Ethiopia. Which age group can be taken from which site was determined randomly since the researcher think that differences can't be created.

The first group discussion was with the age group of 25-29 members of Mekidim Ethiopia or PLWHA. As it is illustrated from the table 4 persons / the majority of the focus discussion participants (educational level is primary and junior secondary level (1-8), the rest is secondary and above level (9- above), only one person has been engaged in income generating activities for pay, only one person attend / use follow up counseling and nobody disclose their test result to the public .Beside, time since diagnosis range from 1.5 years – 4 years.

Table3. B.1: Characteristics of those discussants in the age group of 25-29

No	Age	Educational level	Work status	Time since diagnosis	Stages of illness	Follow up counseling	Publicly disclose
1	29	2ndry &above	Yes	4 years	asymptomatic	yes	No
2	28	Primary & junior	No	2.5 years	asymptomatic	No	No
3	26	Primary & junior	No	1.5 years	asymptomatic	No	No
4	29	Primary & junior	No	3 years	asymptomatic	No	No
5	28	Primary & junior	No	2.3 years	asymptomatic	No	No
6	27	2ndry &above	No	3 years	asymptomatic	No	No
7	25	2ndry &above	No	2 years	asymptomatic	No	No

The second group discussion was conducted with Tikur Anbessa clients. In the age group of 30 – 34, 71 percent respondent educational level is secondary and above, the rest 29 percent is primary and junior secondary level (1-8): 71% (5) women haven't been engaged in income generating activities for pay don't have private income, 29% (2) women attend follow up counseling and 29 (2 women) percent disclose to the public. Their educational level was primary (1-8) .Beside, time since diagnosis range from 5 month to 4 years.

Table 3.B.2: Characteristics of those discussants in the age group of 30- 34

No	Age	Educational level	Work status	Time since diagnosis	Stages of illness	Follow up counseling	Publicly disclose
1	30	2ndry & above	No	3.5 years	asymptomatic	No	No
2	30	2ndry &above	No	5 month	asymptomatic	No	No
3	33	Primary & junior	No	3 years	asymptomatic	Yes	Yes
4	33	2ndry &above	No	2 years	asymptomatic	No	No
5	32	Primary & junior	No	1.5 years	asymptomatic	No	No
6	33	2ndry & above	Yes	4 years	asymptomatic	yes	Yes
7	34	2ndry &above	yes	2 years	asymptomatic	no	No

The third focus group discussion was among the age group of 25-29 with members of Tesfa gho Ethiopia / PLWHA/ among 35-39 age group. As it is shown in the table, 3 women educational status is secondary and above, the others 3 persons is illiterate .Almost all except 1 percent didn't attend follow up counseling. Only 3 persons disclose to the public and 2 women have been engaged in income generating activities for pay. Time since diagnosis ranges from 9 months to 4 years except 8 years accounts for 1 person.

3. B.3: Characteristics of those discussants in the age group of 35-39

No	Age	Educational level	Private income	Time since diagnosis	Stages of illness	Follow up counseling	Publicly disclose
1	35	Primary & junior	Yes	4years	asymptomatic	Yes	Yes
2	38	2ndry &above	Yes	2years	asymptomatic	No	No
3	35	2ndry &above	No	1year	asymptomatic	No	No
4	35	illiterate	Yes	3years	asymptomatic	No	Yes
5	37	Primary & junior	No	8years	asymptomatic	No	Yes
6	35	2ndry & above	Yes	9month	asymptomatic	No	No
7	35	Primary & junior	No	3years	asymptomatic	No	No

The fourth focus group discussion was conducted with those women aged 40 and above. They were outpatient clients of Zewuditu hospital.3 persons educational level was primary and / 1-8 /, 2 persons were illiterate, 1 person secondary and above and the remaining 1 person read and write only. Except 2 persons, the majority of the focus group discussion participants haven't yet been engaged in income generating activities for pay. The 6 persons don't attend / use follow up counseling. Only 1 person discloses her test result to the public. Time since diagnosis ranges from 1.5 – 3 years.

The qualitative analysis focused on themes that emerged from the discussions. The major content of the responses were organized and into major themes and identified

representative excerpts. Quantitative analysis was used to calculate frequencies and means wherever applicable.

3. B.4: Characteristics of those discussants in the age group of 40 and above

No	Age	Educational level	Private income	Time since diagnosis	Stages of illness	Follow up counseling	Publicly disclose
1	46	Read and write	No	1.5years	asymptomatic	No	No
2	45	illiterate	No	2years	asymptomatic	No	Yes
3	41	2ndry &above	No	3 month	asymptomatic	No	No
4	43	Primary & junior	No	3 b	asymptomatic	No	No
5	46	illiterate	Yes	2years	asymptomatic	Yes	No
6	44	Primary & junior	No	1	asymptomatic	Yes	No
7	41	Primary & junior	yes	2years	asymptomatic	Yes	No

Details of disclosure

The following details related to disclosure revealed by the analysis.

1. Attitude towards Public Disclosure

Almost all the participants agree that disclosing ones status to others and the general community is useful. However, there are a lot of negative consequences that will come as a result of disclosure so it is better to keep the information secret or only to close persons like your mother. One woman from 25- 29 group aged 28 said

> "I'm keeping in to myself because I might lose a lot of friends. I just don't know how people are going to react "

Another woman from 30-34 group age 32 said

> "I think more positive people should be open about it, because if you cant , you have obviously not come to terms with the fact you are ".

2. Rate of public disclosure

The participants were asked whether they had discussed to the public /community or not. Except 8 out of 28 participants, the rest haven't yet disclosed to the public.

3. Out comes of disclosure

Most respondents (who publicly disclosed their test result) said were asked what they feel and the others reactions to disclosure were generally positive, which is encouraging given the negative outcomes like stigma and discrimination, associated with HIV disease. One participant in the 30 – 34 groups at the age of 33 said,

> "Once I spoke about my situation I was very happy. Speaking out is good for my health I am not taking medicine, only speaking out. When I spoke to society about AIDS,I don't have stress. I feel good. It is really good for your self-esteem. It makes you feel very good about yourself".

Another woman at age of 45 said,

> "I don't want to live being ashamed of myself, denying myself, not telling people who I am .Speaking out makes me feel good. It enhances confidence in myself. It gives me a lot. It empowers me in many areas. I can be myself whenever I want and wherever I want. I feel as I am doing some thing very active and positive for my families And the community. "

4. Reasons /barriers for non disclosure

We know that if those who are living with HIV/AIDS openly talk about their status to others, it will help others to learn a lot and for us, it minimizes at least the psychological problems we have but there are a lot of anticipated negative outcomes.

Most subjects give multiple reasons for non disclosure. These included the following.

4.1. Stigma and discrimination – most of the subjects felt that public disclosure could lead to the labeling by others or attributing this sickness as a pointer towards their bad character. One woman from the 30 – 34 group aged 32 said

> "My friend doesn't have her own house. She lives by renting. Her husband died. People suspect that as he died of AIDS .As a result, all her neighbors treat her in ill-treated way. For example, when her children use the toilet, they will call her and told to her to clean it. You can imagine how being stigmatized is heavier than the virus itself. And how others can decide to disclose having seen/ heard such similar experiences."

4.2. Fear of rejection

Another woman from group 25 - 29 aged 29 said

> "Not only public disclosure but also disclosure to close friends/ relative is rarely easy. For example, I told for one of my best friend since I need some one to share my secret .The next day, she told me as we don't have any relationship now on wards. Imagine I was more confident on her than my families. One thing made me surprise is she didn't decide to stop those behaviors that can expose her to the virus rather she rejected me .The people are afraid of those persons living with HIV not the virus itself."

Another woman from group 30 – 34 aged 31 said,

> "It is not easy to just disclose yourself because you are thinking lots of questions. Am I going to face another rejection like what my partner did or can it be good for me to be freely do anything I want to keep myself healthier and to teach others and contribute something for the prevention of this deadly virus and in doing so wining the virus can I be Happy .You see all these questions come to your mind."

Another woman in group aged 27 said

> "I was working in one pastry before two years. The owner of the house ordered all the workers to take an HIV test and me not to come the next day. You see here. He might heard something .Anyways I lost my job. So why should I disclose to the public. I need to work and get money to survive."

4.3. Protecting others

The majority of the participants expressed concern about bringing disgrace/embracement on their family members by disclosing their status. Some of the respondents' responses were "let's live thinking about me. I can cope up anything but why I am going to create any discomfort for our children's / families for the sake of others .One participant aged 36 from group 35 - 39 said

> "I was so afraid of what might happen to me. I am ready to die any time, but I was not yet ready for my child's future. How they can go and attend to school?"

4.4. No use for me (futility)

Most respondents said that publicly disclosing my status don't have any use for me. Such information must be told only for few persons (for those who are close to you)." They can help me if and only they aren't going to abandoned me; what is the use of telling every one else? They aren't going to help you rather they will gossip about you."

Generally, the majority of the respondent reasons for not disclosing to the public are related to self-focused and other-focused reasons.

5. Reasons for not confronting the negative outcomes of disclosure

The respondents were asked why you always think and worry about stigma and discrimination rather you your self try to change the attitude of the people. The respondents mentioned different reasons for not fighting the negative outcomes. They said you are right but right now it is not possible. We have a lot of problems. For example we don't have our own house and secured means of income. One respondent aged 35 said:

> "Now I am living by renting house .If I am going to be open about my status, the will through out me and my children. However, if I have my own house or legal protection, I don't care what they said, I will teach by knocking every body house".

Another woman aged 27said

> "I need to get money and to treat myself till I am alive. if they know that I am positive, nobody is not going to hire me Nevertheless, if I am sure that my being open about my status wont create such problems, I don't care the other things that will face me by being open. This one is a question of staying alive or not."

6. Difference between men and women

Respondents were asked if there is a difference between men and women in reasons for deciding to disclose or not disclose.

The respondents said of course there is a difference between men and women. The women are the one who is in a sever problem whether she disclose or not disclose .One woman from group 40 and above aged 42 said

> "The men spend most of his time outside the house by doing his work or interacting with others. This fact can create a difference .He doesn't have much time to think about his illness. On the opposite, women spent their time in the house She can't exchange ideas with others. She always thinks again and again about her future. If she disclosed also she is the one in danger or more suffer the negative outcomes of disclosure. You know why? Women are responsible for taking care of the social affairs. At that time, if the community doesn't discriminate and stigmatize her, it will be helpful but if negative outcomes results, she is the one to experience all the psychological problems than men / they don't hear/ see since they spent most of their time outside."

Another woman from group 25-29 said

> "Most men don't want to accept his positive status and stop the sexual relationship and others behavior (like drinking, smoking and chewing chat).Rather they chose to be ignorant about their positive status and continue life as it was before. Nevertheless, most women's vary in this respect from them."

Chapter four: Bivariate and multivariate statistical analysis

4.1 Bivariate analysis

Greater involvement of people living with HIV/AIDS has a number of public health benefits. According to Paxton, S, 2002, their greater involvement is important for several reasons in the formulation and implementation of AIDS policies and programmes. The basic ones are the following.

- publicly acknowledge involvement helps to reduce stigma and discrimination and can be a powerful tool in breaking the silence and helping individuals overcome fear and prejudice.
- PLWHA bring the unique perspective to organizations and can perform valuable functions as AIDS educators.
- involvement builds the morale of PLWHA.

Thought public disclosure has a number of important public health benefits from the self, others and intra-personal perspective (Greene, et.al, 2003) there are a number of barriers that facilitate silence rather than openness about ones being HIV positive. So, in this section comparison was made of people who publicly disclose their HIV positive test result and those who did not disclose their status until the time of the survey against various predictor variables. The bivariate analysis was employed to test for differences in rate of disclosure by different predictor variables. The likelihood ratio test was used to test for any possible differences that might exist between the dependent variable, public disclosure, and other demographic and socio-economic variables.

4.1.1 Age of the respondents

Rate of public disclosure was relatively highest in the age groups 30-34, 35-39 and 40+.It accounts 26.9%, 44.2%, and 33.3% respectively .The proportion was relatively lowest among women <= 29 years old(Table 4.1).

An attempt was made to see whether or not there is any association between age of respondents and public disclosure of HIV positive test result. The chi square test of independency revealed that ($\chi 2$=20.68, p=0.000) there was statistically significant association, between age of respondents and public disclosure. In other words, age of the respondents was found to be related to public disclosure of HIV positive status (Table 4.1).

4.1.2 Marital Status

Marital status was an important variable that explain differences in rate of public disclosure of HIV infection among the study population. It was proportionally highest among widowed -39.8% followed by divorced, 30.3%.And the rate of public disclosure is relatively lower among currently married and never married women with 23.3% and 18 % respectively(Table 4.1).

A Chi square test was administered in order to observe any association between public disclosure and marital status. According to the test result ($\chi 2$= 14.33, p=0.002) there was an association between the two variables (Table 4.1).

4.1.3 Religion

(Table 4.1) presents the cross tabulation between religion and public disclosure. Followers of respondents grouped under the others category relatively accounts the highest rate of public disclosure followed by Protestants. It was 41.4 % and 35% in that order. Next to the two Muslims took the third position with 31%.The lowest rate of public disclosure was 23.1% among followers of orthodox Christians (Table 4.1).

An attempt was made to see whether or not there is any association between religion and rate of public disclosure. The chi square test of association revealed that ($\chi 2=8.38$, $p = 0.035$) there was an association between religion and public disclosure (Table 4.1).

4.1.4 Time since diagnosis

The cross tabulation was made between time since diagnosis and the rate public disclosure. Based on the result public disclosure is relatively high among those respondents who knew as they are living with the virus more than one year that is 1-4 years , 54.9 percent , 6-10 years , 32.6 percent and above 10 years , 52.6 percent and relatively low among those who knew their result less than one year , 10.4 percent (Table 4.1).

The bivariate analysis revealed that Time since diagnosis was strongly associated with disclosure of HIV positive test result. The chi square test ($\chi 2=51.93$, $p=0.000$) showed that there is a strong association between Time since diagnosis and disclosure of HIV positive test result (Table 4.1).

4.1.5 Educational status

Table 4.1 shows the rate of public disclosure and educational status. According to the result. Rate of public disclosure was highest relatively for those who are at primary level (35%) and lowest (6.5 %) are those whose level of education was above secondary level (Table 4.1).

An attempt was made to see whether or not there independency between educational status of the respondents and public disclosure. As shown in the Table 4.1, the chi square test ($\chi 2= 11.41, p=0.009$) of independency prove that, educational status of the respondents was dependent to disclosure of positive HIV result (Table 4.1).

4.1.6 Work status

Having been engaged with some kind of income generating activities for pay was associated with decision to be open about ones HIV positive status. Among the women who have been engaged in income generating activities - 37.4% of them publicly disclose their test result while the rest 16.8 percent among publicly disclose their test result are those women who didn't engaged in any income generating activities for pay(Table 4.1).

In this survey, work status of the respondents was treated as predicator of public disclosure of HIV positive test result. The chi square test ($\chi 2= 22.47, p=0.000$) of independency revealed shows that work status of the respondents was associated with public disclosure of HIV infection (Table 4.1).

4.1.7 Cues to action

4.1.7.1 Number of counseling sessions

The cross tabulation was made between use of follow up counseling and rate of public disclosure. As we have seen rate of public disclosure increases with increase in the time spend in using / attending follow up counseling. 80 percent among those who said "usually" more disclose than who said "rarely" and "never" (Table 4.1).

Follow up counseling was cross tabulated with public disclosure of HIV positive test result and test of independency was administered. The chi square ($\chi 2=62.92$, $p=0.000$) test of independency revealed that there was an association between follow up counseling the disclosure of HIV positive test result (Table 4.1).

4.1.7.1.1 Discussion about Disclosure with Counselors

Discussion about disclosure with counselors was cross tabulated with public disclosure of HIV positive test result and test of independency was administered. Out of those who said "yes", 35.7 disclosed to the public where as only 18.9% out of those who said "No "disclose to the public (Table 4.1).

As shown in Table 4.1, the chi square test of independency ($\chi 2= 14.68$, $p=0.001$) reveled that, rate of public disclosure of HIV positive test result was dependent on discussion of issues related to disclosure with counselors during counseling sessions (Table 4.1).

4.1.7.2 Knowledge about HIV/AIDS

As it is shown in the table 4.1, 23.5 percent were less knowledgeable, 25.3 percent were moderately knowledgeable and 32.8 percent were highly knowledgeable among those who publicly disclose.

Knowledge of respondents about issues related to HIV/AIDS was another variable believed to have an association with public disclosure. Nevertheless, the data presented in Table 4.1 revealed that there is no association between knowledge of respondents about issues related to HIV/AIDS and public disclosure (Table 4.1).

4.1.7.3 Exposure to information related to HIV/AIDS through Medias

As it is shown in the table 4.1, 27.7 percent were less exposed to information related to HIV/AIDS through mass media in the past six months and 28.2 percent were highly exposed among those who disclose to the public.

Exposure to media was cross tabulated with the dependent variable i.e. public disclosure and test of independency was administered. The chi square test revealed that there is no association between exposure to media and public disclosure (Table 4.1).

4.1.8 Comparison of perceived barriers against perceived benefits

Table **4.1** indicated that 63 percent, 14.8 percent and 6.6 percent of the respondents perceived fewer barriers, some barriers and a lot of barriers respectively (table **4.1**).

The chi- square test of independence ($x2 = 127.77$, $P = 0.000$) between respondents behavioral beliefs and rate of public disclosure shows as there is significant association among the two variables.

4.1.9 Attitude to Wards Disclosure

As it is shown in table 4.1, 27.5 percent have positive attitude towards public disclosure and 28.2 percent have negative attitudes towards public disclosure among those who publicly disclose.

Test of independency was administrated between attitudes of the respondents regarding disclosure of HIV positive test result and status of public disclosure at the time of the survey. The test revealed that there is no association between attitude towards disclosure and status of public disclosure (Table 4.1).

4.1.9 Influence of the subjective norms

Respondents were asked whether others opinions and interest have influence in their decision to be open about their status or not. And are they going to comply with the needs of their salient others. As it is clearly shown on the table, out of those whose decision has been influenced by others -18.4 percent and among those whose decision can't be influenced by the normative beliefs - 48.1 percent disclose to the public(Table 4.1).

The chi- square test of independence between respondents' normative beliefs and the rate of public disclosure indicates significant relation ship between the two variables (Table 4.1).

Table 4.1 Chi square test of independency among various predictor variables and the public disclosure

Background Characteristics		Public Disclosure				Total		X^2	
		Yes		No					
		N	%	N	%	N	%	Value	Sig.
Age	<24	12	18.2	54	81.8	66	100	*20.68*	*0.000**
	25-29	21	18.8	91	81.3	112	100		
	30-34	25	26.9	68	73.1	93	100		
	35-39	42	44.2	53	55.8	95	100		
	40+	17	33.3	34	66.7	51	100		
Marital Status	Currently Married	30	23.3	99	76.7	129	100	14.33	0.002*
	Divorced	23	30.3	53	69.7	76	100		
	Widowed	47	39.8	71	60.2	118	100		
	Never Married	17	18.1	77	81.9	94	100		
Religion	Orthodox	43	23.1	193	76.9	256	100	4.87	0.065
	Muslim	13	31.0	29	69.0	42	100		
	Protestant	34	35.8	61	64.2	95	100		
	Others	12	41.4	17	58.6	29	100		
Time Since Diagnosis	< 1 Year	16	10.4	138	89.6	154	100	51.93	0.000*
	1-5 Years	28	54.9	23	45.1	51	100		
	6-10 Years	63	32.6	130	67.4	193	100		
	>10 Years	10	52.6	9	47.4	19	100		
Educational status	<primary	14	23.3	46	76.7	60	100	11.41	0.009*
	primary	48	35.0	89	65.0	137	100		
	secondary	35	20.8	133	79.2	168	100		
	Above secondary	4	6.5	47	93.5	51	100		

Work status	Yes	85	37.4	142	62.6	227	100		
	No	32	16.8	158	83.2	190	100	22.47	0.000*
Follow up Counseling	Never	28	11.9	169	8.1	241	100		
	Rarely	39	28.7	97	71.3	136	100	62.92	0.000*
	Usually	32	80.0	8	20.6	40	100		
Discussion about disclosure with counselors	Yes	81	35.7	146	64.3	227	100		
	No	36	18.9	154	81.1	190	100	14.68	0.001*
Knowledge of HIV/AIDS	Less knowledgeable	31	23.5	101	76.5	132	100		
	Moderately knowledgeable	25	25.3	74	74.7	99	100	3.82	0.147
	Highly knowledgeable	61	32.8	125	67.2	186	100		
Exposure to Media	Less exposed	36	27.7	94	72.3	130	100		
	Highly exposed	81	28.2	206	71.8	287	100	.013	0.911
Behavioral beliefs	Perceived fewer barriers	87	63.0	51	37.0	138	100.0		
	Perceived some barriers	21	14.8	121	85.2	142	100.0	127.77	0.000*
	Perceived a lot of barriers	9	6.6	128	93.4	137	100.0		
Attitude to Disclosure	Positive	19	27.5	50	72.5	69	100		
	Negative	98	28.2	250	71.8	348	100	.011	0.916
Subjective norm influence	Comply with norm	52	18.4	230	81.6	282	100.0		
	Not comply with norm	65	48.1	70	51.9	135	100.0	38.42	0 .000*

* Significant at P< 0.05

4.2 Multivariate Analysis of Selected indicators

In the previous section, the presences of association between various predictor variables against the dependent variable were examined. These types of analysis, however, do not help to identify the relative importance of the variables considered. Therefore, it was sought important to employ multivariate analysis. Specifically, binary logistic regression method of analysis was used in this case as the dependent variable was dichotomous, i.e. variable that assumes only binary responses.

In the logistic regression model, the log of odds ratio of the dependent variable is expressed as a function of various independent variables. In the analysis the backward stepwise method of model building was carried out. In this method, the variables enter the model based on the significance level 0.05 for entering to and 0.1 for removal from the model for the likelihood ratio which is believed to be a better criterion for deciding which variables are to be removed.

4.2.4 Respondents' work status

In the multivariate analysis for determining the correlates of public disclosure of HIV positive test result, work status of the respondents was not found to have significant association (Table 4.2).

4.2.5 Follow up counseling.

As shown in Table 4.2 those women who rarely attend follow up counseling were nearly two times more likely to publicly disclose compared to the reference category i.e. those who never experienced follow up counseling. Moreover, those women who reported usually attend follow up counseling were found to be five times more likely to publicly disclose compared to the reference category. The effect of follow up counseling on the odds of a woman being publicly disclosed her HIV positive test result to the public does show a typical pattern i.e. the probability of public disclosure increases with an increase in the experience and frequency of public disclosure (Table 4.2)

4.2.6Time since initial HIV diagnosis

The result of multivariate analysis revealed that those women who elapsed 6-10 years since diagnosis found to be nearly five times more likely to publicly disclosed compared to those who elapsed less than 5 years. Furthermore, those women who have elapsed more than 10 years after first diagnosed to be HIV carrier found to be 1.4 times more likely to publicly disclose compared to those who elapsed less than five years. Similar to follow up counseling, the effect of time since diagnosis on the odds of a woman being publicly disclosed her HIV positive test result to the public does show a typical pattern i.e

the probability of public disclosure increases with an increase in time since diagnosis (Table 4.2)

4.2.7 Comparison between perceived barriers and perceived benefits (Behavioral beliefs)

The logistic regression revealed significant association between respondents behavioral belief towards public disclosure. The probability of disclosing to the public for those who perceive some barriers 44 percent and those who perceive a lot of barriers 43.1 percent were less likely to disclose compared to those who perceive less barriers – the reference category (table 4.2).

4.2.8 Influence of subjective norms.

The logistic regression result indicated significant relation between the two variables. The regression result showed that the probability of disclosing to the public for those respondents their decision weren't / won' t influenced by salient others was 3.896 times higher than those who said their decision take I to consideration the opinion of others.

In general, the logistic regression result is also in support of the chi- square test of independence except in case of private income, the logistic regression showed as there is no statistically significant relationship between rate of public disclosure and private income.

Table: 4.2 Parameter estimates of the logistic Regression model on determinants of public disclosure of HIV positive test result

Variables	Sig.	Exp(B)
Age Group		
less than 29		
30-39	.036	1.937
40+	.610	.903
Marital Status		
Currently married		
Formerly married	.791	.909
Never married	.022	.472
Education		
Illiterate		
Primary	.419	.727
Secondary and above	.003	.464
Work status		
Yes		
No	.094	.250
Follow up Counseling		
No, never		
Yes, rarely	.000	2.152
Yes , usually	.045	5.303
Discussion about disclosure		
No		
Yes	.000	1.421
Time since Diagnosis		
Less than 5 years		
6-10 years	.000	4.660
>10 years	.029	1.488
Subjective Norms		
Yes		
No	.000	3.896
Behavioral Beliefs		
Perceived Less Barriers		
Perceived many barriers	.000	.044
Perceived a lot of Barriers	.009	.431

*** Significant at P< 0.05**

Chapter five: Discussion of the results descriptive statistics

5. Discussion of the results of the descriptive statistics

5.1.1 Age

Almost all of the respondents age distribution is between 19 - 45 years .Only 3 percent are more than 45 years. The result is similar to those studies that reported as most women livings with HIV/AIDS are in their reproductive age (Maman, S.et.al, 2001 UNAIDS, 2004).

5.1.2 Marital status

The result has shown that women in marriage, single women and formerly married are affected by HIV. The presence of women in marriage having most incidents of HIV can be evidence as marriage cannot be a guarantee for not being infected by the virus. Besides, it has a direct link with the increasing number of AIDS orphans in our country from time to time.

5.1.3 Education

Nearly two-thirds of the respondents attend formal education especially out of this, 40 percent of the respondents level of educational status was secondary and above. It confirms many research results that stated HIV/AIDS is affecting both the illiterate and the literate. Even it seems highly to affect the literate .This in return shows how HIV/AIDS is putting a danger on the countries development by taking the lives of the skilled human power (MOH, 1998:28).

5.1.4 Religion

The majority of the respondents' religious domination was orthodox Christian followed by protestant. This result is comparable with the results of (Krabbendam .A .A et. al ,1998).In that study most of the samples reported as they were members of Christian churches.

5.1.5 Work Status

According to the survey result, more than half of the respondents have been engaged in income generating activities for pay. Nevertheless, among those who said that they are engaged, except around 25 percent of them; they don't have a permanent secured means of income. Therefore, their being economical independent is in question though it is not only the problem of WLWHA. This result is consistent with (Simoni, J.M.2000).

5.1.6 Time since initial HIV diagnosis

About 6 in 10 respondents have lived with the virus for a period ranging from 1- 10 years. On average, they have been living with the virus for 6 years and 7 months. This means they do have enough time to think over it and to be open about their HIV status if they believed in its importance.

5.1.7 Number of counseling sessions

Almost 9 in 10 respondents have got counseling at the time of testing. Around half of them got both pre and post test counseling. The rest have only got either pre or post test counseling. Moreover, compared to the total number of respondents the ones who have had counseling after they have known their HIV positive status is very much low. This result shows as the majorities of them only use counseling service during the pre and post

counseling session. However, Counseling given only for a very short time is not effective in case of HIV. Supporting this, the result study of Krabbendam .A .A . et. al ,1998 reported that counseling given once / twice is found not to be effective for two main reasons. First, if only one / two counseling session is given, the woman may not hear or remember all that is said. Second, in case of depression, access to counseling is important and it appears that periods of depression return frequently.

5.1.8 Discussion about issues related to disclosure

A desired behavior to occur their must be an environment which facilitates its existence. Cues to action are very much important. This is the issue of HBM. Discussion issues related to disclosure with their respective counselors is one of the facilitators that increase the likelihood of the occurrences of high rates of public disclosure. Nevertheless, the majority of the respondents didn't discuss issues related to public disclosure.

5.1.9 Knowledge of HIV/AIDS

All the respondents know something about HIV/AIDS. The majority of them are moderately and highly knowledgeable. Knowledge is power in the struggle to cope with and contain HIV. People who are well-informed about the epidemic are able to assess the threat posed by the virus and to know how best to avoid infection, or, if they are HIV-positive, how to look after themselves and their partners and families (UNAIDS, 2005). But for individuals to be able to act effectively on what they know, they need an enlightened / a conductive environment. This result study is consistent with many studies that reported most people are aware / know something about of HIV/AIDS. Among them, the result is consistent with (Negussie, T, et.al, 2002).

5.1.10 Exposure related to HIV/AIDS information through mass media

The Mass media have a huge contribution in delivering direct information. And they have the potential to influence attitudes, behavior and even policy-making in a myriad of ways through their coverage of the epidemic in news, drama, documentary and discussion (Chatterjee, N, 1999).Moreover the issue is supported by HBM. The theory stated that the presence different environmental stimuli like mass media can play a vital role a given behavior to occur. Based the study result, most respondents were highly exposed to HIV/AIDS information through different medias. It is good since it may increase the probability of the rate of public disclosure.

5.1.11 Patterns of disclosure

Even though the rate of disclosure is low, the study indicates that as women often disclose to multiple categories of people. The rates of disclosure relatively low for extended family members, somewhat highest for husbands and sisters. The result is consistent with Simoni, J .M and et. al 1995 .And the rate of public disclosure was also low. The result was more or less consistent with that of Chandra, P .S et. al, 2003.

5.1.12 Comparison of Perceived benefits and harms of public disclosure

Different uses of public disclosure were mentioned by the respondents. Most were self – focused reasons. Nearly similar reasons were reported in the study result of (Paxton, X, 2002, Horizons (2002), ICRW, 2002A and B and Kalichman, S .C, 2003). On the other hand, they also stated a lot of negative outcomes as harms public disclosure. All were self – focused and others – focused reasons. The existence of such barriers not only causes a problem for further prevention of the virus through participating WLWHAs but also

create a psychological problem more sever than the virus itself (Levy A, et al 1999).This finding is similar with Grinstead, O. A , et. al, 2001, Bantayerga, H, Kindu, A ,2004 and Nyblade, L, et al,2003 .Similarly, Gielen, et.al. , 1998 found that one in five women who disclose their HIV – status experience negative reactions that ultimately result in lose of social support. Therefore, the respondents fear of anticipated negative outcomes result from what from they are observing, seeing and hearing.

Consequently, the majority of the respondents reported more perceived harms than benefits of public disclosure. They compared the benefits against its harm based on their self interest than others focused reasons or any other reasons. Their perception of more negative outcomes of public disclosure than its benefit can affect the likelihood of the existence of higher rates of public disclosure. The idea is supported by health belief model and the theory of reasoned action. The theories explained that perceived self-efficacy to perform a behavior will occur when the perceived benefits are more than its harms. And the result is also consonant with the results of the FGD of the present study.

5.1.13 Motivators and consequences of public disclosure

Although self-focused reasons than others –focused reasons were found to be motivators of disclosure for the majority of the respondents, those who stated other-focused reasons were not that much very few in number. This is useful to assist those strategies planned by the government to fight this virus. This result is similar with Schmidt and Goggin, 2001.

On the contrary, based on the qualitative analysis, most respondents who openly talk about their status thought as they were right and beneficial in many ways when compared

with what they have faced. This finding is consistent with previous research, which found that responses to disclosure from all social networks members tend to be more positive than HIV infected individuals anticipated (Simioni et al, 2000, Wolitski, et al, 1998).Beside; it is consistent with qualitative analysis of the present study.

5.1.14 Attitude towards public disclosure

According to the theory of reasoned action, having positive attitude towards something is an indicator for the action /behavior to exist. However, the majority of the respondents don't have a positive attitude towards disclosing their HIV positive status to the public. It is similar with the finding of the qualitative analysis.

5.1.15 Influence of subjective norms on decision to publicly disclosing positive status.

The majority of the respondent confirmed as their salient others don't want them to be open about their HIV status to the public. This might be due to HIV related stigma and discrimination. If their decision to be open is influenced by others, the probability of having higher rates of public disclosure will be in question. The result is supported by (Nybblade, L, 2005 and Norman, A, 2005).

5.1.16 Intention to disclose

Having intention towards a behavior is an indicator for performing the behavior based on TRA. Nevertheless, only one-fourth of them have had the intention to disclose. According to the theory, intention is influenced by both the individuals' attitudinal and normative considerations about the behavior to be changed. In case of this study, the respondents don't have positive attitude and take in to account the opinion of their salient others in their disclosure or non disclosure decision (most of their salient others don't want them to be open about their status). So, the result is consistent with TRA.

5.1.17 Reasons for not confronting the negative outcomes of disclosure by breaking the silence /barriers of the barriers/.

The respondents mention different reasons that hinder them from disclosing their status leaving aside the negative outcomes of disclosure. All the reasons stated were self-focused reasons. Most reasons stated by them showed as the majority of them are economically dependent on others or as they have financial problems. Krabbendam , A.A, 1998 stated that an HIV infected women is more vulnerable to financial problems than an HIV infected man. He further stated she often cannot work, because she is too ill or she is dismissed when her boss finds out that she is HVI positive. Obtaining adequate and affordable housing is also very difficult for PLWHAs (Smith, et. al, 1990).The result is also consonant with the findings of the FGD. Beside the high rates of subjects reporting " futility" or mentioning that there was " no uses in telling every one " shows that positive outcome expectancy as reported by Semple et. al, (1999) is indeed a very significant predictor of disclosure.

5.1.18 Difference between men and women

All most all the respondents of the focus group discussion explained as there is a big difference between in women and men with regard to disclosure decision and in the severity of the impacts of the negative outcomes of public disclosure. They said the impact of stigma ad discrimination is more sever for women than men. The result is consistent with Nbblade, L, 2005.Beside they said that even if there is a conductive environment for disclosure, men are not willing to tell his status to others.

5.2 Discussion of the results of the Chi- square test and the multivariate analysis

The younger, the less educated and not yet married respondents relatively show low rates of public disclosure. The Respondents' age, education marital status and religion were taken as those factors that can affect disclosure. Only religion was not found to be significant. Similarly, Kalichman, S. C et. al,2003 and Lie, G. T and Biswalo, P .M, 1996 included in their study all the four demographic variables and found to have association with disclosure decision except religion. They confirmed that as religious adherence didn't have any significant association with disclosure decision.

Based on the result of this study, respondents who have engaged in any income generating activities for pay more likely to disclose. It is some what difficult to conclude by saying those who have engaged in income generating activities more disclose than the opposite ones. This is because the respondents means of income except a very few of them is not at least enough to feed themselves three times within a day in a regular base. Beside, controlling the effect of the other variables, having been engaged in income generating activities was not statistically significant.

Those respondents who have discussed issues related to disclosure with their counselors more likely to be open about their status. Supporting this result De Rosa, et al, (1998) found that rates of disclosure (openly talk about ones status) increased monotonically with the number of times that a health official / counselors at the HIV clinic where a person received care discussed issues related to disclosure.

With increase in the number of counseling sessions, there is also an increase in the rate of public disclosure. This study result is consistent with (Krabbendam A.A et.al, 1998;

Armistead, L .et.al, 1992, and Balmer, D.H., Seeley, J. & Bachengana, C. 1996). However the majority of the respondents didn't have the experience of going to VCT centers seeking for counseling services.

There is a wide variation in the length of time before one discloses their status, with much disclosure coming well after the one year mark. Wider disclosure came when the length of the time since initial diagnosis increases – the longer the length of the time, the higher the rate of public disclosure. Based on the result, disclosure rate increases with increase in time since initial diagnosis. This result is consistent with (Kalichman. S. C, 2003, krabbendam, A. A 1998).

Based on the result, those who weren't open about their status were those who highly fear and perceive different negative outcomes of disclosure / being open than those who perceive more benefits. This research result is consistent with health belief model that stated perceived benefits of the behavior should be greater than its perceived harms the person to develop the self-efficacy to perform that behavior. Beside, the finding of Semple et. al (1999) showed that positive outcome expectancy as a predictor for being open about ones status.

The qualitative analysis (the FGD) is also in consonant with the quantitative analysis. Majority of the respondents' reason for not being open is because of fear of the anticipated negative outcomes of public disclosure. Some of the respondents also stated that even from your family members you have to be selective to share your test result in order to minimize harms of public disclosure. One respondent aged 25 explained:

> "you don't have to tell other than those who
> are concerned or responsible for you".

Another women aged 37 stated

> "I am living alone as a result of telling
> my result for my families. So, why should I?
> why am I going to suffer more than this. At least
> now I can work and serve my self".

There is no significant association between those who are less / moderately and highly knowledgeable in being open about their status. This result confirms that lacking / having knowledge related to HIV/AIDS can't determine rates of public disclosure.

Exposure to media didn't have significant association with rate of public disclosure. This might be due to even thought nearly two-thirds of the respondents are highly exposed to HIV/AIDS information through different Mass Medias like news paper, radio and television; the majority of the respondents most of the time have seen /heard information related to the antiretroviral drug. However, mostly they didn't see/heard when others teach, issues related to disclosure, people who lives for longer years with the virus and the place where they can get counseling. These issues are among those issues that are highly linked with disclosure. Based on a health belief model also a behavior to exist there must be cues to action like media. So, as we can understand from their result those things they hear/see didn't have much more link with issues of disclosure. Besides, the finding of (Nbblade, L,et,al 2005 and Maman, S, J 2001.) is in support of the result. They reported that the media transmits fear based public messages about HIV. Fear – based massages in health campaigns focused heavily not only on dearth as the outcome of HIV , but also the depiction of a painful, disfiguring and sometimes shameful death (through linking HIV to socially unacceptable behaviors).These kinds of messages not only heighten the anxiety and magnify the fear of contracting HIV but also fuels stigma in the

form of isolation of people living with HIV and AIDS and in return it also affects disclosure, as explained by a female respondent in Ethiopia:

> "The reason people isolate a person living with HIV/AIDS is because they fear HIV/AIDS. The reason they fear HIV/AIDS is because they hear from different medias i.e. radio and Tv how horrible this disease is and how it is wide spread in the country. And people living with HIV/AIDS as much as tried to hide their positive status not to be isolate".

Similarly another woman in Ethiopia explained:

> "When I watch television and listen to the radio HIV/AIDS program presented in the form of drama, the message of the drama scares me and makes me cry.... In the drama they show how the disease makes people suffered change their physical appearance and look. It disfigures the face of the patient, changes the color from dark to pale. This makes me worry much".

This result study and the findings of Nbblade, L ,(2005) show us the media is expected to do a lot than what exist in order to encourage others to be open about their status since it is believed as media can play a vital role /UNAIDS , 2005/.

Similarly, like knowledge about HIV/AIDS and exposure to media; attitude towards public disclosure is not also significantly associated with public disclosure. Both who have negative and positive attitudes towards the idea of public disclosure; there is no difference in rate of public disclosure. This is due to the fact that they don't have a positive attitude towards their being open about their status. This is because their perceived benefit from the behavior is less than its perceived barriers. This research result is consistent with one of the behavioral change theory that is health belief model.

Those respondents whose decision weren't influenced by salient others more publicly disclose than who said their decision take in to considerations others need and interest. This research result is congruent with theory of reasoned action. The theory stated that as subjective norms have an influence on people's decision to perform or not a given behavior. This is also consistent with the qualitative analysis. The majority of the respondents explained, "Forget about us but what about our families". Supporting this idea, one respondent who already publicly disclose her test result said:

> "Nowadays I am thinking that as my decision was wrong. It is not because of me rather for the sake of my five year old daughter. At school, the other students have been talking about her. Now she may not understand but after 1 or 2 years, am sure it will create some kind of Psychological problem on her".

Chapter six: Summary, Conclusion and Recommendations

6.1 Summary and Conclusion

HIV/AIDS has become the most critical challenge to human beings. It is much more than a medical issue, but also a social problem as well (Mawar, N. and et.al.2005). In Ethiopia, it is also a serious problem. It contributes a lot in staggering the countries development (MOE, 2003). Over 1.5 million people are estimated to be infected; with women accounting 60 percent of the total infection rate (MOH, 2005).

According to various literatures, women are more venerable to HIV infection compared to their men counterparts. It is due to various reasons. First, universally, cultural permission has encouraged men to have multiple partners; while women are expected to abstain or be faithful. There is also a culture of silence around sexual and reproductive health. Simply by adhering to gender roles, men and women are likely to increase their risk of HIV infection. Second, women in many regions do not have access to financial resources and are dependent on men—husbands, fathers, brothers and sons—for support. Without resources, women are not able to refuse sex or to ask their partners to use condoms, even when they know the risk contracting a STDs, including HIV. Besides, poverty pushes some women into risky behavior or dangerous situations. With no other options in sight, they may resort to sex work in order to feed their families (UNAIDS/UNFPA/UNIFEM, 2004).

As it is witnessed in different research findings, the involvement of PLWHA in the fight against AIDS campaign help the prevention programmes to address the root causes of the epidemic – the social and economic factors that make women, men and children vulnerable (De bruyn,T.D,1998,Aggleton,P and E,Chase,2001 and Maman,S,et.al,2005). The one who have experienced the problem could be more efficient either in providing solutions or in being more concerned about it than outsiders. Therefore, the involvement of women suffering from HIV/AIDS will assist the prevention programme. However, involvement of WLWHAs in different activities is limited. This is because public disclosure on the part of women is very limited on account of the perceived negative

outcomes associated with disclosure of positive HIV status. In the absence of public disclosure; expecting women to involve in the prevention activities is impossible. Thus, absence of supportive environment for publicly disclosing their status curtained their involvement thereby undermine prevention efforts.

Therefore, the main aim of this study was to explore aspects related to women self-disclosure of HIV positive status to the public. Beside, the study explored rates and patterns of disclosure.

This study used data from a survey conducted on women living with HIV/AIDS. The date were collected from four sites in the city of Addis Ababa - Tikur Anbessa Hospital, Zewuditu Hospital, Tesfagho Ethiopia and Mekidim Ethiopia. Structured interview and Focus group discussions were used to gather information. The result of this study provides a basis for understanding of aspects related to self – disclosure of HIV positive status among women. Therefore, it is significant to design programs that are effective to prevent the spread of HIV/AIDS.

A descriptive analysis of individual characteristics was made to obtain a general description of the respondents. A chi-square test and cross tabs were used to examine the relationship between the variables Binary logistic regression analysis was also performed to identify the strength of association that each variable has with public disclosure of HIV positive status. Furthermore, the results were discussed in terms of HBM and TRA and previous research findings.

The study's major findings are summarized below.

- A total of 417 WLWHAs were participated in this study. The age of the respondents ranges from 19 – 53. Ninety- seven percent of the respondent age distribution was between 19 and 45 years. The mean age was found to be 31.8 years.
- Most respondents were followers of orthodox. Moreover, the majority of the respondents were attended schooling beyond primary level and were married once in their life.

- Rate of disclosure to family members is higher than to extended family members. Among the family members husbands and sisters were disclosed more than the other family members. Moreover, rate of public disclosure was found to be 28 percent. And 23 percent of the total respondents didn't disclose to anyone.
- Despite the fact that those reported income generating activities that they have engaged in are not enough to provide food at least two times within a day; around half of the respondents reported as they have been engaged in income generating activities for pay.
- Most respondents have no experience of going to VCT centers seeking counseling as an ongoing basis. Moreover, The majority of the respondents didn't discuss issues related to disclosure with their counselors.
- Many respondents stated that they perceive a lot of negative outcomes related to public disclosure of positive HIV status. The mentioned perceived negative outcomes of public disclosure were different expressions and forms of stigma and discrimination. Hence, nearly two- fourth of the respondents' have a negative attitude towards public disclosure.
- More than half of the respondents have lived with the virus for more than one year.
- Nearly one – third of the respondents were moderately and highly knowledgeable about HIV/AIDS.
- The majority of the respondents are highly exposed to information related to HIV/AIDS through different mass Media.
- Even though, the respondents reported to have experience different negative experience, most respondents experienced positive outcomes than negative outcomes after they were open about their status.
- Most women's explained that being economically dependent on others, lack of their own house, the need to protect their families and not understanding the use of being open were the reasons mentioned for not trying to break the silence around the issue and decide to fight the stigma and discrimination. Further they

explained that negative outcomes of disclosure are more sever on women than the men.

- Age was found to have an effect on rate of public disclosure. The multivariate analysis revealed that those in 30-39 years were more likely to disclose than those below age 29 years. Nevertheless, religion has no relationship with public disclosure.
- The rate of disclosure decrease with increase in the level of educational status. And formerly married women are more likely to disclose than currently married women.
- Work status has somewhat an association on rate of public disclosure but when it was compared with others, it didn't have an effect on rate of public disclosure.
- The respondents' behavioral belief has an effect on their decision to be open about their status to the community. When one ones perception of barriers of disclosure is high, the rate of disclosure is low. So, there is an indirect relationship between the two variables.
- A subjective norm was found to have an effect on the decision whether to be open or to be silent about their status. Only a very few participants explained as they have the intention to disclose but they didn't exactly know as to when they are going to disclose their status.
- Half of cues to action were found to have a profound effect on rate of public disclosure. Based on the result, those who usually go to VCT centers seeking counseling and discuss issues related to disclosure were more likely to disclose than the counterparts. On the other hand, knowledge of HIV/AIDS, attitude towards public disclosure and media exposure to issues related to HIV/AIDS have no significant relationship with public disclosure.
- There is a direct association between time since diagnosis and rate of public disclosure. With increase in time since diagnosis, there is also an increase in rate of public disclosure.

In general, ever since HIV/AIDS become a known disease in 1980s it has been associated with fear, stigma and discrimination (Visser,M.J & et.al, 2006). Despite numerous conferences and international efforts to change the negative attitudes and discrimination associated with HIV/AIDS, the disease continues to carry a significant stigma that impacts on many areas of community life (Aggleton, 2000; Gostin & Weber, 1998; Herek, 1999; Herek, Capitanio, & Widaman, 2002). The existence of stigma and discrimination related to HIV/AIDS was a major obstacle to HIV/AIDS prevention and care. Stigma causes people not to be tested and prompt those infected by HIV/AIDS to remain silent and deprive themselves of essential treatment and social care and concern. In return it affects the greater involvement of People living with HI/AIDS. Therefore, we need to combat the existing stigma and discrimination. Even the 2002 and 2003, the focus of the worlds AIDs campaign message "Live and Let Live" has been focused on combating all forms of stigma and discrimination.

6.2 Recommendations

Based on the findings, the following recommendations are forwarded with reference to heath belief model and the theory of reasoned action.

- We need to teach the people how stigma and discrimination affects the lives of PLWHAs especially women. And how it curtained the prevention of HIV/AIDS prevention like the way we are teaching about its transmission and ways of prevention by giving more emphasis about the subject.
- Various services should be given to those who experienced different problems as a result of disclosure. For instance, housing problems should be given due emphasis in order to encourage other to disclose their status and take part in HIV prevention activities. Besides, voluntary disclosure of HIV status backed with relevant support should be encouraged.
- Special attention should be given for ongoing counseling, which will help them to know how they can easily lead their life with the virus, like what is done in case of pre-test and post-test counseling. Furthermore, in the

counseling session, emphasis needs to be given issues related to disclosure and how they can cope up the negative reactions of others. Beside, since the needs and worries of women and men are different; the issues dealt in the counseling sessions for women and men must vary.

- Ensure the economic security of WLWHAs beyond aid with the framework of creating the opportunities that they can work and be productive societies. This is possible through providing loan from microfinance.
- Through media and other possible means, provide accurate information about benefits and harms of public disclosure. And show those women living with the virus who can be a role model.
- Make aware women living with the virus their rights and responsibilities.
- Giving WLWHAs opportunities to involve in the prevention. Their involvement must also include from planning the strategy to its implementation stage. It helps them to have a say in what happens to them and their communities. However, if they aren't skilled, we need to give training for them.
- Organizations working to prevent the spread of HIV/AIDS including community-based organizations need to advocate the involvement of WLWHAs.
- Initiating Religious leaders to teach their followers the impact of stigma and discrimination supporting with God's word.
- Establishing as many as possible organizations of WLWHAs.

In short, if we need to promote the greater involvement of WLWHAs; we need to create conductive environment for disclosure of positive HIV status or empowering women economically and make aware of their rights and duties.

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Annexes

Annex I: ~~Questionnaire~~ Structured Interview

ADDIS ABABA UNIVERSITY

SCHOOL OF POSTGRAGUATE STUDIES

Faculty of Education: Department of psychology

Good morning. My name is----------.The purpose of this questionnaire is to explore aspects related to self disclosure of HIV positive status among HIV positive women. More emphasis was given for those factors that affect public disclosure. The target populations of the study were HIV out patient hospital clients' and members of PLWHA associations. To this end, your cooperation in responding to the questionnaire has had a paramount significant contribution towards the success of the study. Thus, you are kindly requested to give your frank response.

Notice

1. You don't need to tell me your name.
2. The information to be obtained through the questionnaire is going to be used only for the survey.
3. All information you provide will be kept secret.
4. If you don't understand the questions, you can ask further explanations.

Thank you for your cooperation!

RESPONDANTS BACKGROUND INFORMATION

101. Age ____ year and months -----

102. Martial status:

Married	1	Never married	3
Widowed	2	Divorced	4

103. What is the highest level of school you have completed?

< Primary	1	Secondary	3
Primary	2	> Secondary	4

104. What is your religions denomination?

Orthodox 1 Protestant 3

Muslim 2 Catholic 4

Others (specify) 99 ----------

105. Have you been engaged in any income generating activities?

Yes 1 No 2

106. If "yes", in what kind of activity have you been engaged?

Government employee 1 Home maid 3

Commerce / informal sector 2 NGO 4

Other specify 99 _____

201. Did you receive counseling before or after your blood was taken from testing?

Yes 1 No 2

202. If yes, was it

Pre- test counseling 1 post test counseling only 3

Pre and post counseling 2 other 99 --------

203. Have you gone to VCT centers looking for counseling after you knew your test result?

No, I didn't 1 Yes, rarely 2 Yes, usually 3

204. What issues have you discussed with your counselor?

---------- ----------

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205. At the time you were tested for HIV or were told your results, did any counselor discuss with you any thing about disclosure?

Yes 1 No 2

206. Were you referred to any group or place where you could get support to help you deal with negative out comes of disclosure?

Yes 1 No 2

207. Did your counselor tell you that as you don't have to suffer by trying to hide your status?

Yes 1 No 2

208. Did you counselor discuss with you the benefits and harms of disclosure?

Yes 1 No 2

Patterns of HIV Disclosure

301. When did you learn that you are HIV Positive?

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302. Have you told anyone about your HIV status?

Yes 1 No 2

303. If yes, who have you told?

If yes, who have you told?	Yes	No	Not applicable
304. Husband	1	2	77
305.Sexual partner	1	2	77
306. Mother	1	2	77
307. Father	1	2	77
308. Sister(s)	1	2	77
309. Brother (s)	1	2	77
310.Close friend (s)	1	2	77
311. Relatives	1	2	77
313. Children	1	2	77
314. Public disclosure (telling others without thinking of confidentiality)	1	2	77

REASONS FOR PUBLIC DISCLOSURE

What motivates you to disclose?	Yes	No	Not applicable
401. Sense of ethical responsibility	1	2	77
402. Severity of illness	1	2	77
403. Concern for partner/ husband healthy	1	2	77
405. Need for social support to cope with diagnosis	1	2	77
406. To alleviate the stress associated with non disclosure	1	2	77
407.To facilitate HIV preventive behavior	1	2	77
408.To educate others by sharing my experience	1	2	77

Attitude towards public disclosure

	Never at all	occasionally	usually
801. Do you think that being open about ones status is advantageous?	1	2	3
802. Do you think that those who have been open are useful?	1	2	3
803. Do you think that being open is more harmful than its benefit?	1	2	3

CONSEQUENCES OF PUBLIC DISCLOSURE

What have you encountered/ face after you disclose?	Yes	No	Not applicable
501. My families have faced a lot of problems	1	2	77
502. Been abandoned by your spouse /partner	1	2	77
503. Increased social support from your families	1	2	77
504. Less visited by families and friends	1	2	77
505. Lost/ fired from job	1	2	77
506. Lost housing	1	2	77
507. Able to keep my self from risky behaviors	1	2	77
508. Been threatened with violence	1	2	77
509. Been able to do things openly to preserve my health	1	2	77
510.Feel free of burden, more relaxed and relieved	1	2	77
511. Able to get access to medication	1	2	77
512. Been able to involve in HIV/AIDS prevention activities	1	2	77
513. Feel less lonely than before	1	2	77
514. Been blamed by others for my illness	1	2	77
515. Ashamed of my illness	1	2	77
516. Upsetting family members	1	2	77
517. Accusation of infidelity	1	2	77
518. Fear of being gossiped	1	2	77
519. Increased social support from the community	1	2	77
520.Get financial support	1	2	77

Respondents' behavioral belief towards public disclosure

What do you think will happen (good/bad) if one woman is open about her status?	not at all	rarely	usually	Most of the time
601. Her families will be in danger	1	2	3	4
602 She will be abandoned by her spouse /partner	1	2	3	4
603. Her families will support her	1	2	3	4
604.Her families will reject her	1	2	3	4
605. She will be fired from her job	1	2	3	4
606. She couldn't get house for rent	1	2	3	4
607.She will be able to keep herself from risky behaviors	1	2	3	4
608.She will face violence	1	2	3	4
609. She will be able to do openly to preserve her health	1	2	3	4
610.She will be free of burden, more relaxed and relieved	1	2	3	4
611.She will get access to medication	1	2	3	4
612.She will able to involve in HIV/AIDS related activities	1	2	3	4
613.She will be less lonely than before	1	2	3	4
614.She will be blamed by others for her illness	1	2	3	4
615.She will be ashamed of her illness	1	2	3	4
616.Her family members will be Upset	1	2	3	4
617.Accusation of infidelity	1	2	3	4
618.Others will talk about her here and there	1	2	3	4
619.She will get social support from the community	1	2	3	4
620.Others will support her financially	1	2	3	4

Respondents' normative belief

701. What will be the opinion of salient others if decide to be open about your status / already you did it?

Support 1 Not support 2

702. If you decide to be open / already you did it but your families aren't happy in your decision, will you change it?

Comply with norm 1 Not comply with norm 2

Respondents' exposure to HIV/AIDS related information through mass media

	Daily	At least once within a week	At least once within a month	Never at all	other
901. Listen radio	1	2	3	4	99
902. Watch TV	1	2	3	4	99
903. Read a news paper	1	2	3	4	99

In the past four months, about which of the following have you heard /listen?

	Yes	No	I don't know
904. About the free medication	1	2	3
905.People living with the virus teach others	1	2	3
906. issues related to disclosure	1	2	3
907. those people who live for longer period with the virus.	1	2	3
908. the place where you can get counseling	1	2	3
909. about any of the above	1	2	3
Total number of cases	1	2	3

The respondents knowledge of HIV/AIDS.

QUESTIONS	True	False
1001. HIV and AIDS are the same thing.	1	2
1002. A pregnant woman with HIV\AIDS can give the virus to her unborn baby	1	2
1003. A person can get HIV even if she or he has sex with another person only one time	1	2
1004.A woman can get HIV if she has sex during her period	1	2
1005. A person can be infected with HIV for 5 years or more without getting AIDS.	1	2
1006. Taking a test for HIV 1 week after having sex will tell a person if she or he has HIV.	1	2
1007. Having sex with more than one partner can increase a person's chance of being infected with HIV.	1	2
1008. A person can get HIV by giving blood	1	2
1009. Coughing and sneezing don't spread HIV.	1	2
1010. People who have been infected with HIV quickly show serious sighs of being infected.	1	2

2000. Do you intend to be open (publicly disclose) in the future about your status?

Yes 1 no 2

2001. If yes, when?

After few days 1 After few weeks 2

After few months 3 other 99----------

Barriers of the barriers of public disclosure

3000. Why you always worry about the negative outcomes associated with HIV/AIDS? Why don't you fight these negative outcomes and break the silence?

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Annex II: Structured Interview (Amharic version)

አዲስ አበባ ዩኒቨርሲቲ
የድህረ ምረቃ ትምህርት ክፍል
ሳይኮሎጂ ዲፓርትመንት

እንደምን አድረሽ/ዋልሽ:: ሥሜ --------- ይባላል:: ጥናት በማካሄድ ላይ እገኛለሁ:: የጥናቱ ዋና አላማም ከኤች አይ ቪ ቫይረስ ጋር የሚኖሩ ሴቶች ከቫይረሱ ጋር መኖራቸውን ለማህበረሰቡም ሆነ ሊረዳቸው ለሚችል ሰው በግልጽ እንዳይናገሩ የሚያስገድዷቸውን ሁኔታዎች ከግምት ባለፈ መልኩ በትክክል ምን ምን እንደሆኑ ለማወቅና ችግሮቹንም ለመፍታት ምን መደረግ እንዳለበት ለማወቅ ብሎም የመፍትሄ ሃሳቦችን ለመጠቆም ነው:: ስለዚህ ይህ ጥናት ውጤታማ ይሆን ዘንድ የእናንተ ትብብር በጣም አስፈላጊና ወሳኝ መሆኑን እየገለጽኩ ትተባበሩኝ ዘንድ በትህትና እጠይቃለሁ::

ማሳሰቢያ

- ስማችሁን መንገር አይጠበቅባችሁም::
- የሚሰበሰበው መረጃ ለጥናቱ ብቻ የሚያገለግል ነው::
- የምትሰጡኝ መረጃ ሁሉ ሚስጥራዊነቱ የተጠበቀ ነው::
- ጥያቄው ካልገባችሁ ማብራሪያ መጠየቅ ይቻላል::

የመልስ ሰጭ ሁኔታ

101 - እድሜ ___ ዓመት ___ወር

102 - የጋብቻ ሁኔታ

ባለትዳር ነሽ 1 ባለቤትሽ በህይወት የለም 2

ፈተሻል 3 አግብተሽ አታውቂም 4

103 - የትምህርት ደረጃሽ

ከአንደኛ ደረጃ በታች 1 ሁለተኛ ደረጃ 3

አንደኛ ደረጃ 2 ከሁለተኛ ደረጃ በላይ 4

104. ሀይማኖሽ

ኦርቶዶክስ 1 ሙስሊም 2 ፕሮትስታንት 3

ካቶሊክ 4 ሌላ 99 _____

105 - ክፍያ የሚያስገኝ ሥራ ትሠሪያልሽ ወይ?

አዎ 1 አይ 2

106 - አዎ ካልሽ ምን አይነት ሥራ?

የመንግሥት ሠራተኛ 1 የቤት ሠራተኛ 3

ንግድ 2 መንግሥታዊ ያልሆነ ድርጅት 4

ሌላ 99

201 - የምክር አገልግሎት አግኝተሽ ነበር ወይ?

አዎ 1 አይ 2

202 - አዎ ካልሽ

- ቅድመ ምርመራ ብቻ ነው 1 - ከምርመራ በኋላና በፊት ነው 2

- ከምርመራ በኋላ ብቻ ነው 3 - ሌላ 99

203 - የምርመራ ውጤትሽን ካወቅሽ በኋላ የምክር አገልግሎት ለማግኘት የምክር አገልግሎት ወደሚሰጥባቸው ቦታዎች ሄደሽ ታውቂ ነበር ወይ?

አይ አላውቅም 1 አዎ አንዳንዴ 2 አዎ በአብዛኛው 3

204 - ከካውንስለርሽ ጋር ሥለምን ሰለሞን ጉዳዮች ተወያይታችሁ ታውቃላችሁ?

_____ _____

_____ _____

205 - ውጤትሽን ለሌሎች ስለመንገር ተወያይታችሁ ታውቃላችሁ?

አዎ 1 አይ 2

206 - ውጤትሽን ሌሎች ቢያውቁ ሊከተሉ የሚችሉ የተለያዩ ጫናዎችን ለመቋቋም ትችይ ዘንድ የት እና እነማን ጋር መሄድ እንዳለብሽ ተነጋግራችሁ ታወቃላችሁ?

አዎ 1 አይ 2

207 - ካውንስለርሽ ከቫይረሱ ጋር መኖርሽን እደብቃለሁ እያልሽ ራስሽን ማስጨነቅ እንደሌለብሽ ተነጋግራችኋል?

አዎ 1 አይ 2

208. ከካውንስለርሽ ጋር ዉጤትን ለሌሎች መንገር ጥቅምና ጉዳት ተወያይታችሁ ታዉቁ ነበር ወይ? አዎ 1 አይ 2

301 - ከቫይረሱ ጋር መኖርሽን ካወቅሽ ስንት ጊዜ ሆነሽ?

_____

302 - ከቫይረሱ ጋር መኖርሽን ለሌሎች ራስሽ ነግረሽ ታውቂያለሽ?

አዎ 1 አይ 2

303 - አዎ ካልሽ ከዚህ በታች ከተዘረዘሩት ውስጥ ለእነማን ነገርሽ?

	አዎ	አይ	አይመለከተኝም
304. ለባለቤትሽ			
305. ለፍቅር ጓደኛሽ			
306. ለእናትሽ			
307. ለአባትሽ			
308. ለእህትሽ			
309. ለወንድምሽ			
310. ለቅርብ ጓደኞችሽ			
311. ለቅርብ ዘመድ			
312. ለልጅሽ			
313. በተገኘ አጋጣሚ ሁሉ አወራለሁ ለምሳሌ ስለ ኤች አይ ቪ ሲወራ ከሰማሁ ራሴን ሳልደብቅ በውይይቱ እሳተፋለሁ፣ ታምሜ ሲጠይቁኝ ሲመጡም አወራለሁ።			

ውጤትሽን ለሌሎች ለመንገር እንዴት ወሰንሽ?

ለመንገር የወሰንሽው	አዎ	አይ	አይመለከተኝም
401. ሀላፊነት ስለተሰማሽ ነው	1	22	77
402. ለባለቤትሽ (ለጓደኛሽ ጤንነት ስትይ)	1	22	77
403. ህመም ስለጠናብሽ	1	22	77
404. የሌሎች ድጋፍና እርዳታ ስላስፈለገሽ	1	22	77
405. ጭንቀትሽን ለመቀነስ በማሰብ	1	22	77
406. ቫይረሱን ለመከላከል የሚደረገውን ጥረት ለማገዝ	1	22	77
407. ልምድሽን /ተሞክሮሽን በማካፈል ሌሎችን ለማስተማር	1	22	77

ከባይረሱ ጋር መኖርሽን በመናገርሽ ምን ምን ሁኔታዎች ገጠሙሽ/አገኘሽ?

	ቢፈጽም	አንዳንዱ	አይመለከተኝም
501. ቤተሰቦችሽ ችግር ገጠማቸው ወይ?	1	2	77
502. ከባለቤትሽ /ጓደኛሽ ጋር ተለያያችሁ ወይ?	1	2	77
503. ቤተሰቦችሽ በደንብ እንዲንከባከቡሽ ረዳሽ	1	2	77
504. ቤተሰቦችሽና ጓደኞችሽ ከአንቺ ጋር ያላቸውን ግንኙነት ቀነሱ	1	2	77
505. ከስራሽ ተባረሽ /ሥራ አጣሽ	1	2	77
506. የባይረሱን ስርጭት ከማያባብሱ ነገሮች ራስሽን እንድትጠብቂ ረዳሽ	1	2	77
507. ድብደባና ዛቻ የመሳሰሉ ነገሮች ደረሰብሽ	1	2	77
508. ጤንነትሽ ለመጠበቅ የሚረዱ ነገሮችን ያለመሳቀቅ እንድታደርጊ ረዳሽ	1	2	77
509. ጭንቀትሽን ቀነሰልሽ	1	2	77
510. ነፃ መድኃኒቱን እንድታገኝ ረዳሽ	1	2	77
511. ባይረሱን ለመከላከል የሚደረጉ እንቅስቃሴዎች ላይ በነፃነት እንድትሳተፊ ረዳሽ	1	2	77
512. የብቸኝነት ስሜት እንዳያጠቃሽ ረዳሽ	1	2	77
513. በሌሎች እንደጥፋተኛ እንድትቆጠሪ አደረገሽ	1	2	77
514. አፍረሽ ተሸማቀሽ እንድትኖሪ ሆንሽ	1	2	77
515. ቤተሰቦችሽን አበሳጨሻቸው ወይ?	1	2	77
516. ከማህበረሰቡ ድጋፍ እንድታገኝ ረዳሽ	1	2	77
517. የገንዘብ ርዳታ ለማግኘት ጠቀመሽ	1	2	77
518. የሰው ሀሜት በዛብሽ	1	2	77
519. ለትዳር ታማኝ እንዳልሆነች ሴት እንድትቆጠሪ አደገሽ	1	2	77
520. የቤት ኪራይ ችግር ገጠመሽ	1	2	77

መላሾች ውጤትን በግልፅነት መንገር ሊያስከትሉ ይችላሉ ብለው የሚያስቧቸውን ነገሮች

	ፈጽሞ	አንዳንዴ	በአብዛኛው	ሁልጊዜ
601. ቤተሰቦቿ ችግር ላይ ይወድቃሉ	1	2	3	4
602. ከባለቤቷ/ጓደኛዋ ጋር ትለያያለች	1	2	3	4
603. ቤተሰቦቿ እንዲረዷት ይጠቅማታል	1	2	3	4
604. ከሥራዋ ያስባርራታል	1	2	3	4
605. የቤት ኪራይ አታገኝም	1	2	3	4
606. ቫይረሱን ከሚያባብሱ ነገሮች ራሷን እንድትጠብቅ ይረዳታል	1	2	3	4
607. ዛቻ ድብደባ ይደርስባታል	1	2	3	4
608. ያለመሳቀቅ ጤንነቷን ለመንከባከብ የሚረዱ ነገሮች ለማድረግ ይረዳታል	1	2	3	4
609. ጭንቀት እንዳይበዛባት ይረዳታል	1	2	3	4
610. ነፃ መድሀኒቱን ለማግኘት ያስችላታል	1	2	3	4
611. ቫይረሱን ለመከላከል የሚደረጉ እንቅስቃሴዎች ላይ ለመሳተፍ ያስችላታል	1	2	3	4
612. ብቸኝነቷን ይቀንስላታል	1	2	3	4
613. በሌሎች እንድትወቀስ ያደርጋታል	1	2	3	4
614. ተሸማቃና አፍራ እንድትኖር ያደርጋታል	1	2	3	4
615. ቤተሰቦቿ ይበሳጫሉ	1	2	3	4
616. ሀሜት ይበዛባታል	1	2	3	4
617. ህብረተሰቡ ድጋፍ እንዲያደርግላት ይረዳታል	1	2	3	4
618. የገንዘብ ርዳታ ለማግኘት ያስችላታል	1	2	3	4
619. ለትዳሯ ታማኝ እንዳልሆነች ሴት ያስቆጥራታል	1	2	3	4
620. ቤተሰቦቿና ጓደኞቿ ያላቸውን ግንኙነት ይቀንሳሉ	1	2	3	4

701. ላንቺ ቅርብ የሆኑ ሠዎች ማለትም አንቺ ሀሳባቸውን የምትቀበያቸው ሠዎች ውጤትሽን በግልፅ ለመናገር ብትወስኝ ወይም ወስነሽ አድርገሽውም ከሆነ የእነሱ አስተያየት ምን ይሆናል? ወይም ምን ነበር?

ይደግፉታል 1 አይደግፉትም 2

702. አንቺ ፖዘቲቭ ስለመሆንሽ ለሌሎች ለመናገር ብትወስኝ/ ከአሁን በፊት አድርገሽ ከሆነ ሌሎች ሀሳብሽ ባይደግፉት ውሣኔሽን ትለውጫለሽ ወይ?

ውሣኔዬን እቀይራለሁ 1 ውሣኔዬን አልቀይርም 2

መላሾቹ ውጤትን በግልፅ ለሁሉም ስለመንገር ያላቸው አስተያየት

የመላሾቹ አስተያየት	በፍጹም	አንዳንዴ	በአብዛኛው
801. ከቫይረሱ ጋር መኖርን አለመደበቅ ጥቅም አለው ብለሽ ታስቢያለሽ?			
802. ከቫይረሱ ጋር መኖራቸውን በግልፅ የሚናገሩት ተጠቅመዋል ብለሽ ታስቢያለሽ?			
803. ከቫይረሱ ጋር መኖርን በግልፅ መናገር ከጥቅሙ ጉዳቱ ያመዝናል ብለሽ ታስቢያለሽ?			

	በየቀኑ	ቢያንስ በሳምንት አንድ ቀን	ቢያንስ በወር አንድ ጊዜ	አዳምጬ አላውቅም	ሌላ
901. ሬዲዮ የምታዳምጪው	1	2	3	4	98
902. ቴሌቪዥን የምትመለከቺው	1	2	3	4	98
903. ጋዜጣ የምታነቢው	1	2	3	4	98

ስለየትኛው ነበር የሠማሽው	አዎ	አይ	አላውቅም
904. ስለ ነፃ መድሃኒቱ	1	2	88
905. ከቫይረሱ ጋር የሚኖሩ ሰዎች ሲያስተምሩ	1	2	88
906. ውጤትን ለሌሎች ስለመንገር የተመለከቱ ጉዳዮች	1	2	88
907.			
908. የምክር አገልግሎት የት ማግኘት እንደሚቻል	1	2	88

የኤች አይ ቪ ኤድስ እውቀትና ግንዛቤ

	እውነት	ሐሰት	አላውቅም
1001. ኤች አይ ቪና ኤድስ አንድ ናቸው።	1	2	88
1002. ከቫይረሱ ጋር የምትኖር ነፍሰጡር ሴት ቫይረሱን ወደሚወለደው ልጇ ልታስተላልፍ ትችላለች።	1	2	88
1003. በህይወቱ አንድ ጊዜ ብቻ የወሲብ ግንኙነት የፈጸመ ሰው እንኳ የኤች አይ ቪ ቫይረስ በደሙ ውስጥ ሊገኝ ይችላል።	1	2	88
1004. አንድ ሴት የወር አበባዋ በመጣባት ጊዜ ወሲብ ብትፈጽም በቫይረሱ አትያዝም።	1	2	88
1005. አንድ ሰው በቫይረሱ ከተያዘ ከ5 ዓመት ወይም ከዚያ በላይ ኤድስ ሳይዘው ሊቆይ ይችላል።	1	2	88
1006. የግብረ ሥጋ ግንኙነት በተደረገ ከአንድ ሳምንት በኋላ የደም ምርመራ ቢደረግ ቫይረሱ እንዳለበትና ወይም እንደሌለበት ለማወቅ ይቻላል።	1	2	88
1007. ከአንድ ሰው በላይ የግብረ ስጋ ግንኙነት መፈጸም የሰውዬውን/ የሴትዬዋን ለቫይረሱ መጋለጥ እድል ይጨምረዋል።	1	2	88
1008. ደም በመለገስ ኤች አይ ቪ ሊይዝ ይችላል።	1	2	88
1009. በሣል እና በማስነጠስ ኤች አይ ቪ ቫይረስን ከተያዘ ወደ አልተያዘ ሰው ይተላለፋል።	1	2	88
1010. በቫይረሱ የተያዙ ሰዎች ወዲያውኑ ምልክት ያሳያሉ።	1	2	88

2000. መላሿ ወደፊት ውጤትን ስለመንገር ምን እንደምታስብ ከቫይረሱ ጋር መኖርሽን በግልፅ ለመናገርና ለማስተማር ወደፊትስ አስበሻል?

አዎ አስቢያለሁ 1 አይ ፈጽሞ አላሰብኩም 2

2001. አዎ ካልሽ ከስንት ጊዜ በኋላ?

ከቀናት በኋላ 1 ከወራት በኋላ 2ከሳምንት በኋላ 3 ሌላ 99--------

3000. ለምንድን ነው ሁልጊዜ ከቫይረሱ ጋር መኖራችንን ብንናገር ሊከተሉ ስለሚችሉት ችግሮች ብቻ የምናስበው? ለምን እኛ ራሳችን እነዚህን ችግሮች ተጋፍጠን ዝምታውን አንሰብረውም?

_____ _____

_____ _____

Annex 3: Focus Group Discussion Guide

Introduction

Good morning! Welcome to our group discussion. I am -------and I come from ------(note taker/observer introduces herself).

We are here today to discuss about issues related to self-disclosure of HIV status. There are no write or wrong answers. All comments, both positive and negative, are welcome. Please feel free to disagree one with another. We would like to have many points of view. We want this to be a group discussion, so you need not wait for me to call on you. All comments are confidential and used for research purposes only. Your names will not be recorded to protect your confidentiality. We will be happy to answer any questions you have at the end of the discussion.

Age	work status
Time since diagnosis	publicly disclose
Educational status	Follow up counseling

1. What do you think the role of PLWHAs to prevent the virus especially women?
2. Do you think that the women are participating in the prevention program?
3. Why do you think WLWHAs hide their status and what about you? Are openly talk about your status? If not why?
4. Do you think that public disclosure of positive status as it is useful? And if it is useful in what ways and if not how?
5. What do you think to be done to encourage women to disclose their HIV status thereby to help her participate in the prevention programme?
6. Do you think that there is a difference between women and men in disclosure or non disclosure decision?

Declaration

The thesis my original work and has not been presented for a degree in any other university, and that all sources of materials used for the thesis have been duly acknowledged.

Name Hiwot Getachew

Signature HG

Date 06 July 06

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

R. VENKATACHALAM	R. Venkatachalam	06. July 06
Advisor	signature	Date