Disclosure of HIV status to family: A qualitative exploration with adult patients admitted at Jane Furse Memorial Hospital, Limpopo Province

By
Moyahavho Evelyn Ralebona

Submitted to
Sefako Makgatho Health Sciences University
Department of Public Health

In Partial Fulfilment of the Requirements for the Degree of Master of Public Health

Supervisor: Professor Sphiwe Madiba

February 2018
Declaration

I, Moyahavho Evelyn Ralebona, declare that “Disclosure of HIV status to family: A qualitative exploration with adult patients admitted at Jane Furse Memorial Hospital, Limpopo Province” is my own work and that all the sources that I have used or quoted have been indicated and acknowledged by means of complete references. It is submitted for the degree of Master of Public Health at the Sefako Makgatho Health Sciences University. It has never been submitted before for any degree or any examination at this or any other institution.

_________________________________________  ________________________________________
Document signed and date.

Signature                                      Date

Moyahavho Evelyn Ralebona
Dedication

This research is dedicated to my late father Mr Edward Matome Ralebona
Acknowledgements

First and foremost, I should like to express my sincere gratitude to my supervisor Prof Sphiwe Madiba for her continuous support of my master’s research, for her patience, motivation, enthusiasm, and immense knowledge. I have been extremely lucky to have a supervisor who cared so much about my work and consistently allowed this paper to be my work, and who responded to my questions and queries so promptly. Her guidance helped me at all stages of conducting the research and writing this thesis. I could not have imagined having a better advisor and mentor for my master's study.

I thank my colleagues at Jane Furse Hospital for being supportive every time I needed help. I also appreciate the work done by the managers and nurses in the Jane Furse Hospital medical wards for giving me support throughout the study.

The heroes and heroines of this study were the interviewees, because without them this study would not have materialised. No words can fully express my feelings of indebtedness to them for the critical role they voluntarily played in this research project.

My sincere appreciation also goes to my husband, Mr Vhonani Makhari, for spending sleepless nights proof-reading my work without fail throughout the period of the study.

Last but not least, I should like to thank other members of my family, notably my parents, Mrs Annah Ralebona and my late father Mr Edward Matome Ralebona, for bringing me into this world in the first place and supporting me spiritually throughout my life; and my kids Mvelelo, Tshanduko and Ndugelo Makhari for just being there during the difficult time of my conducting this research, and giving me space in which to focus.
Abstract

Introduction
Disclosure becomes crucial when AIDS-related illnesses set in, as the risk of infecting family members who often play the role of caregivers is high. Family members have been identified as important caregivers to provide social support for members infected with HIV. However, this is possible only if disclosure occurs. There is evidence that the rate of disclosure to family members remains low, particularly in poorly resourced settings, including South Africa.

Aim of the study
To explore the disclosure experiences of adults with AIDS-defining illness and examine ways used to disclose to significant family members.

Methodology
The study used an explorative qualitative descriptive design using in-depth interview with 28 adult patients admitted with AIDS-related illnesses. The patients were recruited from the medical wards of a rural district hospital in Limpopo Province. The NVivo statistical package was used to analyse the data, using a thematic approach.

Findings
Most patients disclosed to significant family members, even though the disclosure was delayed. Disclosure for most occurred when the health condition had deteriorated and the patient was admitted to hospital. The need for family support was the main reason for disclosure, which occurred especially when the PLWHA needed support on many levels. Most preferred face-to-face conversations with family members, but they avoided using the word “HIV” when they disclosed. The fear of stigma, rejection and gossip was the main barrier that led to delayed disclosure or non-disclosure to family members, even when the individual was sick with AIDS-related illnesses. Nevertheless, most had a positive outlook towards living with HIV and benefitted from disclosing, since they no longer had to keep their diagnosis secret.

Conclusion
The positive reactions from the family, the support provided, and the acceptance of an HIV diagnosis played a great role in how they perceived themselves. However, the fear of stigma, rejection, isolation, and discrimination from sexual partners and family members was real for PLWHA.

**Recommendations**

It is therefore important that the fear of stigma, isolation, rejection, and discrimination be taken into considerations when health care providers develop disclosure-counselling strategies.

There is a need for the development of strategies to support PLWHA after diagnosis, and disclosure should be emphasised to encourage PLWHA to disclose to significant persons in their lives.

**Key words:** opportunistic infections, disclosure, non-disclosure, family members
## Abbreviations

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>AIDS</td>
<td>Acquired Immune Deficiency Syndrome</td>
</tr>
<tr>
<td>ART</td>
<td>Antiretroviral treatment</td>
</tr>
<tr>
<td>ARV</td>
<td>Antiretroviral</td>
</tr>
<tr>
<td>HIV</td>
<td>Human Immune Virus</td>
</tr>
<tr>
<td>PLWHA</td>
<td>People living with HIV/AIDS</td>
</tr>
<tr>
<td>WHO</td>
<td>World Health Organization</td>
</tr>
</tbody>
</table>
## Table of contents

*Declaration*                                                                                     i  
*Dedication*                                                                                   ii  
*Acknowledgements*                                                                            iii  
*Abstract*                                                                                      iv  
*Abbreviations*                                                                               vi  

### Chapter 1: Introduction and background  
1.1 Introduction                                                                                     1  
1.2 Problem statement                                                                               2  
1.3 Study aim                                                                                       3  
1.4 Research questions                                                                              3  
1.5 Study objectives                                                                                4  
1.6 Study significance                                                                              4  

### Chapter 2: Literature review  
2.1 Introduction                                                                                     5  
2.2 Hospitalisation for PLWHA                                                                     5  
2.3 Reasons for testing                                                                             5  
2.4 Perceptions of disclosure                                                                       6  
2.5 Factors contributing to disclosure                                                               6  
  2.5.1 Time since diagnosis with HIV                                                                6  
  2.5.2 Socio-demographic factors                                                                  7  
  2.5.3 Knowledge of the partner’s status                                                           7  
  2.5.4 Level of education                                                                         7  
2.6 Benefits of disclosure                                                                         7  
2.7 Reactions to diagnosis                                                                         8  
2.8 Patterns of disclosure                                                                         8  
2.9 Reasons for disclosure                                                                         9  
2.10 Carrying out disclosure                                                                        10  
2.11 Family reaction to disclosure                                                                 10  
2.12 Barriers to disclosure                                                                        11  
  2.12.1 Lack of trust                                                                              11  

vii
<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>2.12.2 Protecting others</td>
<td>11</td>
</tr>
<tr>
<td>2.12.3 Fear of stigma</td>
<td>12</td>
</tr>
<tr>
<td>2.13 Experience of disclosure</td>
<td>12</td>
</tr>
<tr>
<td>2.13 Conclusion</td>
<td>13</td>
</tr>
<tr>
<td><strong>Chapter 3: Methodology</strong></td>
<td>14</td>
</tr>
<tr>
<td>3.1 Introduction</td>
<td>14</td>
</tr>
<tr>
<td>3.2 Study design</td>
<td>14</td>
</tr>
<tr>
<td>3.3 Study setting</td>
<td>14</td>
</tr>
<tr>
<td>3.4 Study population</td>
<td>14</td>
</tr>
<tr>
<td>3.5 Sample size</td>
<td>15</td>
</tr>
<tr>
<td>3.6 Recruitment</td>
<td>15</td>
</tr>
<tr>
<td>3.7 Data collection</td>
<td>15</td>
</tr>
<tr>
<td>3.8 Data analysis</td>
<td>16</td>
</tr>
<tr>
<td>3.9 Trustworthiness</td>
<td>16</td>
</tr>
<tr>
<td>3.10 Ethical considerations</td>
<td>17</td>
</tr>
<tr>
<td>3.11 Conclusion</td>
<td>17</td>
</tr>
<tr>
<td><strong>Chapter 4: Presentation of findings</strong></td>
<td>18</td>
</tr>
<tr>
<td>4.1 Introduction</td>
<td>18</td>
</tr>
<tr>
<td>4.2 Description of the demographic profile</td>
<td>18</td>
</tr>
<tr>
<td>4.3 Themes</td>
<td>23</td>
</tr>
<tr>
<td>4.3.1 The context of hospitalisation</td>
<td>24</td>
</tr>
<tr>
<td>4.3.2 Reasons for testing for HIV</td>
<td>25</td>
</tr>
<tr>
<td>4.3.3 Reaction to HIV-positive results</td>
<td>26</td>
</tr>
<tr>
<td>4.3.4 Perceptions of disclosure</td>
<td>28</td>
</tr>
<tr>
<td>4.3.5 Carrying out disclosure</td>
<td>29</td>
</tr>
<tr>
<td>4.3.6 Self-reaction to disclosure</td>
<td>34</td>
</tr>
<tr>
<td>4.3.7 Family reactions to disclosure</td>
<td>35</td>
</tr>
<tr>
<td>4.3.8 Reasons for not disclosing</td>
<td>37</td>
</tr>
<tr>
<td>4.3.9 Family support</td>
<td>38</td>
</tr>
<tr>
<td>4.3.10 Experience of living with HIV</td>
<td>39</td>
</tr>
<tr>
<td>4.4 Conclusion</td>
<td>41</td>
</tr>
<tr>
<td><strong>Chapter 5: Discussion, conclusions, and recommendations</strong></td>
<td>42</td>
</tr>
<tr>
<td>5.1 Introduction</td>
<td>42</td>
</tr>
<tr>
<td>5.2 Description of the study sample</td>
<td>42</td>
</tr>
</tbody>
</table>
5.3 Disclosure of HIV status to family .......................................................... 43
5.4 Disclosure barriers ............................................................................. 45
5.5 Mode of conversation for disclosure .................................................... 46
5.6 Family reaction to disclosure ............................................................... 46
5.7 Experiences of disclosing to family ...................................................... 47
5.8 Conclusion ............................................................................................ 47
5.9 Limitations of the study ...................................................................... 49
5.10 Recommendations .............................................................................. 49
References ................................................................................................. 50

Appendices ............................................................................................... 56

Appendix 1: Interview guide-English ......................................................... 56
Appendix 2: Demographics questionnaire .................................................. 59
Appendix 3: Interview guide-Sepedi ............................................................ 61
Appendix 4: Informed consent English ....................................................... 65
Appendix 5: Informed consent-Sepedi ......................................................... 66
Appendix 6: Ethical clearance certificate .................................................... 67
Appendix 7: Approval from Jan Furse hospital .......................................... 68
List of tables and figures

Table 4.1: Demographics of people living with AIDS ................................. 18
Table 4.2: Patients’ clinical history ............................................................. 19
Figure 4.1: Age distribution of the study participants .................................. 20
Figure 4.2: Gender distribution of study participants .................................. 21
Figure 4.3: Length of time knowing HIV status ........................................ 21
Figure 4.4: Period during which participants reported taking ART ................ 22
Figure 4.5: Distribution of the participants who had disclosed their HIV status .... 22
Figure 4.6: Category of persons disclosed to ............................................. 23
Table 4.3: Themes and subthemes .............................................................. 23
Chapter 1: Introduction and background

1.1 Introduction

The disclosure of one’s HIV-positive status is an important prevention strategy and yet a difficult decision for most people living with HIV (PLWHA). Disclosure is one of the most complex psychosocial challenges that PLWHA can face (Chaudoir et al., 2011). The literature indicates that many people diagnosed with HIV do not reveal their HIV-positive status to those around them (Obermeyer et al., 2011). Social relations and family dynamics play a key role in determining the patterns of disclosure to significant people in the life of PLWHA (Hardon et al., 2013). This means that people live in a social context that influences whether to disclose their HIV status to others or not to disclose. Selecting people to disclose to includes weighing people’s potential reactions to the disclosure and anticipating the effects of the disclosure on others (Pride, 2013). Other studies also report that PLWHA tend to evaluate their relationships when deciding whether or not to disclose or not disclose to those that they perceive as offering support, while avoiding disclosure to those whom they perceive could harm them (Lugalla et al., 2012; Maman et al., 2014). Safety and support are essential ingredients for positive disclosure outcomes, therefore PLWHA need to feel safe when disclosing (Ssali et al., 2010).

Although research regarding disclosure to family and friends in sub-Saharan Africa is limited, the existing data reveal both the benefits and the risks of disclosure (Ayitumbe, 2015). Studies conducted in South Africa have found that disclosure could have both positive and negative outcomes for PLWHA (Greeff et al., 2008; Maman et al., 2014). However, for the majority of PLHA, disclosure is withheld because of the fear of rejection, discrimination and abandonment by family, friends and sexual partners (Dos Santos et al., 2014). This view is supported by Ayitumbe (2015), who finds that disclosure to family involves risks such as negative emotional reactions, the fear of stigmatising children, the fear of abandonment and the fear of being disowned. The fear of negative outcomes following HIV serostatus disclosure may result in individuals opting to withhold knowledge of their status from family, sexual partners, friends and community members (Yonah et al., 2014). The literature suggests that stigmas are an important barrier to disclosure and that fears about negative reactions
from partners, family members and communities are a major barrier to both testing and disclosure (Gilbert and Walker, 2010; Maman et al., 2014).

Disclosure is an important component of secondary HIV prevention and has been reported to benefit PLWHA in several ways. Disclosure can result in social support for PWHA, when family and friends react positively to the disclosure. It has also been shown to improve adherence to antiretroviral treatment (ART), to reduce HIV transmission and risky behaviours, and to make it easier for PLWHA to ask for and receive support from relatives and adult children (Atuyambe et al., 2014; Norman et al., 2007; Yonah et al., 2014). Even though HIV status disclosure is important for reducing HIV transmission and the prevention of new infections, the social support function of HIV status disclosure has been emphasised to a far greater extent than the potential preventive role of disclosure to sexual partners (Maman et al., 2014). The prominence of social and material support highlights the need for material provision for PLHA, implying that treatment and care alone are not enough to facilitate disclosure (Ssali et al., 2010). As a result, most PLWHA disclose their HIV status to family members because of their close and mutual relationship, as well as the social support they expect to gain (Lugalla et al., 2012). Good relationships and anticipated social and psychological support are among the prime factors that shape the dynamics of the disclosure process, particularly in terms of how and when to disclose and to whom (Lugalla et al., 2012).

Most PLWHA prefer to disclose their HIV status to family and then partners and then friends, before any other groups or individuals (Greeff et al., 2008; Pride 2013). PLHA often feel obliged to disclose their HIV-positive status to women, because they anticipate support and care from them once they fall ill (Hardon et al., 2013). Family members can help PLWHA to adhere to ART and their clinic schedules. They can also PLWHA to cope with their condition, increase social support, decrease the stress they experience, and help them to share knowledge of their HIV status with other people (Greeff et al., 2008). However, current findings show that HIV disclosure is more common between sexual partners than disclosure to relatives, family members and friends (Adeoye-Agboola et al., 2016).

1.2 Problem statement

Although family members have been identified as important caregivers providing social support for members infected with HIV (WHO, 2005), this is only possible if disclosure
occurs. There is evidence that disclosure to family members remains low, particularly in poorly resourced settings, including South Africa (Obermeyer et al., 2011). Research findings suggest that HIV disclosure is more common between sexual partners than disclosure to relatives, family members, and friends (Adeoye-Agboola et al., 2016). However, these findings are among young adults who by nature would prefer to disclose to sexual partners because of the link between sexual behaviour and HIV infection.

Available data in South Africa show that higher disclosure rates to family members were found in urban sites than in rural areas because of the availability of HIV treatment and care services (Norman et al., 2007). Although Pride (2013) argues that PLWHA disclose when their health deteriorates and their physical symptoms become obvious, this is not the case among HIV-infected patients in wellness clinics. Based on anecdotal data from healthcare providers in rural settings, patients who consult in health facilities when they are critically ill with AIDS-related illness are often accompanied by family members who are not aware of their HIV status. PLWHA are often reluctant to disclose their status because they fear being rejected and abandoned by the people that they stay with (Dos Santos et al., 2014). However, these data are from urban settings. There is a dearth of data on disclosure to family members in rural settings in South Africa, and few studies explore the experiences and outcomes of HIV status disclosure to family members.

Disclosure becomes crucial when AIDS-related illnesses set in, as the risk of infecting family members who often play the role of caregivers is high. Yet the focus of disclosure studies is on healthy adults, particularly women. The findings of this study will bridge the gap in the data in this topic and inform strategies to improve disclosure counselling for PLWHA.

1.3 Study aim

To explore the disclosure experiences of adults with AIDS-related illness and examine the ways used to disclose to significant family members.

1.4 Research questions

1. What are the experiences of adults with AIDS-related illness about the disclosure of their HIV status to their family members?
2. What are the ways used by adults with AIDS-related illness to disclose to their family members?

1.5 Study objectives

1. To explore the experience of adults with AIDS-related illnesses about disclosure to significant family members.
2. To examine the ways used by adults with AIDS-related illness to disclose to significant members of their families

1.6 Study significance

The study will inform the development of disclosure counselling strategies that intend to encourage PLWHA to disclose their status, to the benefit of both the patients and the caregivers. It will also provide an in-depth understanding of when and how disclosure occurs when AIDS-related opportunistic illnesses have set in, to inform health care providers about how to when to provide disclosure counselling. Currently there is dearth of data on disclosure to significant family members, yet they are the people expected to be caregivers when the individual is sick with AIDS-defining illnesses. This is particularly important in rural settings, where the denial of HIV diagnoses is still frequent. The findings of this study will further contribute to the existing body of knowledge in understanding disclosure in the rural context. The study will also develop hypotheses for further quantitative studies investigating disclosure.
Chapter 2: Literature review

2.1 Introduction
This chapter presents a review of previous research done on the disclosure of one’s HIV status to significant others. The focus of the review is on the disclosure of their HIV status by adults in sub-Saharan Africa. The review excludes disclosure to children and adolescents with perinatally-acquired HIV.

2.2 Hospitalisation for PLWHA
AIDS-related illnesses and bacterial infections are regarded as the leading causes for hospitalisation for PLWHA globally. A systematic review of the causes of hospitalisation for PLWHA has shown that globally a delayed diagnosis of HIV and a weak immune system results in PLWHA suffering from TB, which leads to hospitalisation (Ford et al., 2016). A study of opportunistic infections has shown TB taking the lead (Namutebi et al., 2013). The review further showed that a third of patients were newly diagnosed with HIV on admission in the hospital, suggesting delayed HIV testing and diagnosis. Furthermore, over a quarter of the patients admitted in a hospital with AIDS-related illnesses were taking ART on admission to the hospital, suggesting their poor adherence to their medication (Ford et al., 2015). The infections that were found after the initiation of ART were likely to be there before the initiation of ART, and stigma was a factor that led patients to present late for care (Namutebi et al., 2013).

2.3 Reasons for testing
Partners of PLWHA are tested because their physical health is deteriorating, even though they view themselves as being infected already since their partners are HIV-positive (Musheke et al., 2016). The literature also show that some people are tested after they have lost their families and friends due to HIV/AIDS, while others consent to be tested if they believe that they are at risk of contracting HIV. This is particularly important if they believe that their partners were unfaithful and having multiple sexual partners or have practised unsafe sex (Meehan et al., 2015). Similarly, people are tested because they have health
problems or because they are very ill and they want to confirm their suspicion of being HIV-positive (Jürgensen et al., 2012).

2.4 Perceptions of disclosure

The responses to the disclosure of HIV status are complex, as is the question of whether males and females should themselves disclose their HIV status or whether the health care worker has to assist with regard to disclosure depending on the situation (Arrey et al., 2015; Le Roux-Kemp, 2013). Males and females view their disclosure of their HIV status in different ways. Men view the disclosure either negatively or positively, while women, view disclosure positively, provided it is done by the health care worker. Males who viewed HIV disclosure negatively mention fear of stigma as the reason and those who have positive reactions are happy about the preventative effect it has regarding the transmission of HIV (Lekalakala-Mokgele, 2016). Madiba and Mokgatle (2016) explored how adolescents with perinatally-acquired HIV experience living with HIV and found that those who view disclosure negatively are afraid of stigma while others perceived disclosure as good since it will assist them to take care of their health. A study conducted in Namibia reported that most of its participants viewed disclosure positively. They said that it is important and helped the to gain support from their family and loved ones, once they were aware of their illness. They also said that they received psychological support from knowing their sexual partner’s HIV status (Tom, 2013). In a study conducted in the USA, young women perceived disclosure negatively, especially when they thought that the partner would not stay in the relationship very long. Those who perceived disclosure positively and thought that disclosing their HIV status was the right thing to do were unable to confide in their partners (Clum et al., 2013).

2.5 Factors contributing to disclosure

Various factors influence people to disclose or not to disclose. For example, for women, the relationships that women have, their dynamics, and their social and cultural contexts motivate women to disclose or not to disclose (MacQueen et al., 2016).

2.5.1 Time since diagnosis with HIV

People who have known their HIV status for a longer period are more likely to disclose their status than those who have known their status for a short period (Przybyla et al., 2013). When
PLWHA stay longer in health care facilities, they are told about the advantage of health care treatment, including disclosure, sharing their experiences with other people, and having a continuous counselling. Those services encourage PLWHA to disclose their HIV status (Alemayehu et al., 2014). Several studies have also noted that receiving ART for a long time is associated with more frequent disclosure of one’s HIV status (Klopper et al., 2014; Yaya et al., 2015).

2.5.2 Socio-demographic factors
Several studies report that various sociodemographic factors are associated with disclosure. The studies show that people who are not married are less likely to disclose their HIV status to their partners and other family members, while individuals with secondary education fear disclosure the most (Dankoli et al., 2014; Karim et al., 2015; Klopper et al., 2014; Tom, 2013).

2.5.3 Knowledge of the partner’s status
The literature shows that individuals who know their partners’ HIV status and have discussed HIV with them before they are tested for HIV are more likely to disclose their HIV status than those who do not know the HIV status of the their partner (Klopper et al., 2014; Yaya et al., 2015).

2.5.4 Level of education
There is evidence that the level of education of individuals influences the decision to disclose or not to disclose. The level of education has an impact on the fear of stigmatisation. PLWHA with secondary education are more frightened of stigmatisation, which affects their disclosure (Klopper et al., 2014).

2.6 Benefits of disclosure
The disclosure of HIV occurs for different reasons and in different contexts. Disclosure to sexual partners helps with the choice of safer sex practices, disclosure to health care workers assists with gaining access to treatment and care services, and disclosure to one’s family helps in that one may then receive various kind of support. It also depends on the needs, circumstances and relationships that one has (Pride, 2013).
Knowing your status is better than not knowing it, because if you know it you will be able to take your ARVs. Furthermore, testing will ensure that people conduct themselves in a proper manner and take treatment. It will also help you to live a healthy life with people around you (Ntsepe et al., 2014).

2.7 Reactions to diagnosis

The literature shows that people respond differently to being told that they are HIV-positive. Even though different people will demonstrate different reactions, there are commonly cited reactions to testing positive. Most people demonstrate shock, anger, and depression after being told that they are HIV-positive. They also react with fear, as they relate HIV to a death sentence. Many express their fear because of the interpretation that the community places upon HIV/AIDS. Furthermore, people fear dying from AIDS to such an extent that they may attempt to commit suicide due to the shame of receiving a HIV diagnosis. Some go into denial and refuse to believe the HIV test results (Meda 2013; Wolpaw et al., 2014). People who are in denial of their HIV status may take many years to accept their HIV diagnosis (Kutnick et al., 2017). Furthermore, a diagnosis of HIV/AIDS makes people to feel guilty, because they think that they could have infected other people. If people have unresolved pain and sadness, this can recur and exacerbate their feelings of guilt (Fabianova, 2011). A study done by Madiba and Mokgatle (2016) on the experience of adolescents living with HIV/AIDS shows that adolescents demonstrate anxiety after learning that they are HIV-positive.

2.8 Patterns of disclosure

Most PLWHA disclose their status to their sexual partners (Dankoli et al., 2014; Tshweneagae, 2015). Seid, Wasie, and Admassu (2012) state that most of the participants in their study had disclosed their status to at least one family member. Similarly, people living with HIV preferred to disclose to their family members first, and then to their partners. Females disclosed to their family members first and then their spouses, while males preferred to tell their spouses first (Klopper et al., 2014).
2.9 Reasons for disclosure

PLWHA have a problem that leads them to be sceptical about who, when and how to disclose their HIV status to various people, including their family, friends and sexual partners. They preferred to disclose their status to people who can keep a secret. Gender does not contribute to their disclosure choices (Maman et al., 2014; Przybyla et al., 2013). According to Pride (2013), PLWHA disclose their HIV status for different reasons. For example, partners disclose to make sure that as a couple they make safer sexual choices. Disclosure to health care workers occurs in order to be able to access treatment and care services, and in order to be able to receive advice when they need care and treatment and for HIV prevention, such as continuous condom use. People also disclose to health care workers because they want to talk confidentially about their lives with HIV/AIDS, since they never get a chance to talk about their illness with anyone other than the health care workers. Finally, disclosure to family members occurs so that PLWHA can have support for their various needs, including their adherence to ART. They also disclose in the hope of receiving positive reactions from their family, friends and workmates. They disclose to sexual partners in order to induce behaviour change and HIV prevention, as well as to prevent the transmission of the disease to their sexual partners (Atuyambe et al., 2014). It is also argued that women living with HIV also disclose because they want to continue having babies (Arrey et al., 2015).

Shikwane et al (2013) also find that PLWHA perceive disclosure as important, especially when the health condition deteriorates. They believe that at that time they will need assistance from other people, particularly family and partners. They are of the view that people will be able to help them or know what to do when they know their condition. Some also believe that disclosure helps PLWHA to live a healthy life without worries and without stress. Most PLWHA disclosed their HIV status when their health was deteriorating, to get support from their family, children, and partners (Oseni et al., 2017).

According to Madiba and Letsoalo (2013), women living with HIV in a prevention of mother to child transmission of HIV (PMTCT) programme disclosed to their family members because they were in need of support to adhere to PMTCT procedures. They disclosed so that they could receive support when taking their treatment, engage in exclusive breastfeeding, and give their babies Nevirapine. In addition, people who are not on ART believe that
disclosing their status will help them to receive medication that will finally improve their health (Conserve et al., 2014).

2.10 Carrying out disclosure

The literature shows that PLWHA have a problem with who to tell, when to tell them, and why they have to tell people, after they are diagnosed with HIV (Przybyla et al., 2013). In most cases PLWHA prefer to sit down with their family members and announce that they are HIV-positive. The actual disclosure occurs for some people on the day that they are diagnosed. However, for others disclosure occurs after days, weeks, months, and years after the diagnosis (Denis, 2014). Most PLHIV disclose their HIV status on the same day as the diagnosis (Karim et al., 2015). Other PLWHA disclose their status within six months of disclosure, while a few PLWHA disclose their HIV status within one week of knowing it. Most women delay disclosure to their partners. They reveal their HIV status only when they think they can confide it as if they had just found out about it (Tom, 2013).

The disclosure of HIV status is an emotional incident in the life of PLWHA. Denis (2014) reports that most of the participants in his study had cried when they explained their diagnosis to their family members. This explains why PLWHA prefer to use metaphors when they disclose their HIV status. They use words like “lying on the mattress”, “let’s allow it to happen”, and “lighting the candle”. All these phrases are references to death, and are indirect ways in which someone might say “I am HIV positive” (Bhatia et al., 2017; Tshweneagae et al., 2015).

2.11 Family reaction to disclosure

The literature shows that PLWHA who disclose their HIV status experience a variety of responses from people they disclose to. This includes both support and rejection (Hunter-Adams et al., 2017). Some PLWHA experience kindness, acceptance and support (Natae and Negawo, 2016; Wessman et al., 2017). However, other PLWHA (very few) encounter blame, stigma, violence, abandonment and anger. In some cases, family members reacted by not speaking to the PLWHA after disclosure had taken place (Denis, 2014). Women who disclosed to their sexual partners experienced negative reactions such as violence from their partners (Maman et al., 2014). Some PLWHA experienced separation from relationships after
disclosing their HIV status (Tom, 2013). Partner reactions to disclosure of HIV status moves from positive, negative and neutral. However, most women reported that their partners were shocked and upset when they were told about the HIV diagnosis. A lack of education contributed to the partners’ reactions, since some could not believe the results due to the poor knowledge they had regarding HIV (Clum et al., 2013; Madiba and Letsoalo, 2013).

2.12 Barriers to disclosure

There is evidence that PLWHA have difficulty in disclosing their HIV status to significant others. The literature has documented the various barriers to disclosure experienced by different population groups. According to Walcott et al (2013), barriers to HIV status disclosure among sexual partners include the fear of violence, of disharmony in the relationship, of rejection, and of stigma among. Most PLWHA worry about being blamed for bringing the infection home. Similar reasons for non-disclosure were reported by Arrey et al. (2015), who found that the fear of destroying the relationship, shame, and stigma, discrimination, rejection, abandonment and violence were reasons why PLWHA opt not to disclose to sexual partners. Most women fear being mocked after their HIV-positive status is disclosed. Some reasons for the delay in the disclosure of the HIV status were having difficulty with accepting the HIV diagnosis and a fear of losing the partner. Those who eventually disclosed mentioned having feelings of guilty for delaying the disclosure to their partners (Clum et al., 2013; Madiba and Letsoalo, 2013).

2.12.1 Lack of trust

A lack of trust in people was another reason for the non-disclosure. If there is mistrust and suspicion in a relationship and people do not trust each other, it is difficult for disclosure to occur. PLWHA worry about their partners leaving them or about being told that they are the ones who brought the disease home or into the relationship, so they may opt to keep silent about their diagnosis (Bhatia et al., 2017).

2.12.2 Protecting others

Although the main barriers against disclosure involve social rejection and discrimination, PLWHA may also fear disclosure because they are trying to protect their elderly parents from the burden of the HIV diagnosis. They have difficulty with disclosure particularly to elderly family members because they worry about how the disclosure will affect their health as well
as their family members’ emotional and physical well-being (Madiba and Letsoalo, 2013; Maman et al., 2014). Similarly, parents living with HIV report not feeling free to disclose their HIV status to their children, since they believe that children think that HIV kills and their children will worry that their parents will die.

Some PLWHA do not think it necessary to disclose their HIV status to their partners if the partner shows no interest in discussing the results of the HIV test. After testing positive, most do not see the need to tell their partners about their HIV status, but keep their status a secret. Some of the women felt that disclosure could put their relationships in danger of breaking up, while others indicated that they would disclose to their partners only if they are very ill (Groves, Maman, and Moodley 2012). Some of the women had been accused by their men for being responsible for bringing the infection home, and that led them not to disclose (Madiba, 2017).

2.12.3 Fear of stigma
The main factor that contributes to non-disclosure to other people is the fear of stigmatisation (Dankoli et al., 2014; Karim et al., 2015; Klopper et al., 2014; Tom, 2013). According to Ntsepe et al. (2014) stigma and rejection are common in communities. Thus, PLWHA report incidents of discrimination from community members, irrespective of how knowledgeable they are about HIV/AIDS. For example, people continue to prevent them from touching or playing with their children, even though they know that HIV cannot be transmitted through touching (Madiba, 2017).

2.13 Experience of disclosure
PLWHA have positive and negative experiences regarding the disclosure of HIV (Arrey et al., 2015). Those who had experienced the negative consequences reported abandonment, violence, discrimination, and rejection (Madiba, 2017). Some PLWHA experienced stigmatisation by their partners, and some reported that they were afraid to stay single. If their partners left them, no one would accept them because of their HIV positive status. Moreover, they believed that their partners had told other people about their HIV status (Madiba and Letsoalo, 2015). Some PLWHA had also experienced stigma from nurses and doctors who were not directly involved with their HIV treatment and care. In some of the facilities,
PLWHA were told that they would be seen last for every visit because they were infected with HIV and the equipment used to treat them had to be sterilised (Greeff et al., 2008).

Those with positive experiences reported that they received support and empathy from their families, friends and partners. They were helped to adhere to their HIV treatment, and that had an impact on their general well-being (Madiba and Letsoalo 2013). Those who received negative reactions described the denial of the HIV diagnosis and rejection from their partner.

2.13 Conclusion

Various previous studies show that disclosure is a complex process that includes dynamic relationships. Stigma and rejection were highlighted by majority of the researchers as the main causes of the non-disclosure by PLWHA of their HIV status to the next person,
Chapter 3: Methodology

3.1 Introduction

This chapter will discuss in detail the method used in the study, including the study design, the site, the population, the sample size, recruitment, data collection, ethical considerations, and the budget.

3.2 Study design

The study used an explorative qualitative descriptive design involving in-depth interview with adult patients with AIDS-related conditions. The researcher wanted to acquire individual views from each participant. According to Patton (2002), in-depth interviews are used to explore people’s individual perceptions in detail.

3.3 Study setting

In Makhuduthamaga, Greater Tubatse and Fetakgomo Municipality in Limpopo Province, HIV services are provided in primary health care facilities, of which there are 19, PHC and ART are initiated in all the PHC through the nurses. The study was conducted in medical wards at Jane Furse Memorial Hospital, one of the rural hospitals in Makhuduthamaga municipality. The hospital is about 130 km from Polokwane, the capital of Limpopo Province. The municipality has a high rate of poverty and unemployment, and 42% of the population has no income. The hospital serves a population of about 283 307. There are two medical wards, one female and one male, where patients with medical conditions are admitted. These include patients with AIDS-related conditions.

3.4 Study population

Adult patients living with AIDS who had been admitted to the medical wards at Jane Furse Memorial Hospital for AIDS-related illnesses were included in the study. Patients with AIDS-related conditions were referred for admission from the wellness clinic, the outpatient department, and casualty. The hospital records show that approximately 30 patients are admitted to the adult medical wards monthly.

Inclusion and exclusion
Only patients who were well enough were included in the study.

3.5 Sample size

A purposive sampling method was used, where patients living with HIV/AIDS admitted to the medical wards at Jane Furse Memorial Hospital were selected. The researcher selected only those patients who had formed an understanding of one’s need to disclose one’s HIV status to one’s family. In this study, all the patients who depended on other people for care and support were recruited to participate in the study (Creswell, 2007). The sample size was determined by data saturation (Creswell, 2007), but the researcher interviewed 28 people living with HIV, and stopped only because data saturation had been reached. There were in-depth interviews.

3.6 Recruitment

Recruitment started after obtaining ethical clearance from the University Research and Ethics Committee and after permission had been granted by the hospital management. The researcher explained the purpose of the study to the nursing manager in the medical wards and requested permission to conduct the study. Patients living with HIV/AIDS were identified using files with the help of a nurse in charge, and the researcher approached patients, explained the purpose of the study, and asked them to volunteer to participate. Written informed consent was obtained before the patient is interviewed.

3.7 Data collection

Face-to-face in-depth interviews were conducted by the researcher using an interview schedule with open-ended questions. The researcher had an assistant researcher who had been trained at Sefako Health Science University to collect data. The tool was developed in English and translated into Sepedi, the local language spoken by patients in the study setting. The interviews were conducted in one of the consultation rooms in the medical wards to ensure privacy and confidentiality. All the interviews were conducted on the day after the patients had been seen by the doctor, and all procedures were completed in order not to disrupt the ward routine. The interviews were recorded using a voice recorder after permission had been obtained from the patients. Each interview lasted for about 30 to 45
minutes. One or two patients were interviewed on the day that the researcher was available for the interviews. The data collection lasted for seven months.

3.8 Data analysis

The audio-recorded data from the in-depth interviews were transcribed verbatim and translated into English by the researcher. The data were analysed using content analysis. The researcher read and re-read the transcripts several times to identify themes to include in a code book. The researcher managed to come up with 39 codes, which were reduced to nine themes with seventeen subthemes. The transcripts were then imported into Nvivo11, the qualitative analysis software package that was used for the data analysis. The findings were presented thematically. The demographic data was used to describe the participants and was analysed using Stata, because it allows the analysis of quantitative data.

3.9 Trustworthiness

Credibility, dependability, transferability and confirmability were criteria used to establish the trustworthiness of the study findings.

Credibility was ensured by using a good digital recorder to facilitate verbatim transcription. The researcher read and re-read the transcripts several times to immerse herself in the participant’s views so that she could understand the context of the study. The field work, including the data collection, took seven months. There were frequent debriefing sessions between the supervisor and the researcher. The data were triangulated by writing interview notes, conducting in depth interviews, and collecting demographic data. Transferability was ensured by selecting participants purposively, to whom the research processes were elucidated by the researcher, from the data collection to the final report. Dependability was established by using an audit trail to document all the entire research process to allow other researchers to trace the course of the research step by step via the decisions made and procedures described. Confirmability was achieved through making an audit trail and triangulating the data. Lastly, NVivo 11 computer software was used for the data analysis (Guba and Lincoln, 1994).
3.10 Ethical considerations

The research proposal was submitted to the School of Health Care Sciences Research Ethics Committee (SREC) and the Sefako Makgatho Health Sciences University Research Ethics Committee (SMUREC) for approval.

The researcher requested permission from the hospital management to conduct the study in the institution.

Written informed consent was obtained from the patients who were willing to participate in the study before beginning the data collection. The purpose of the study was explained to the participants and they were told that they could withdraw from the study at any time without compromising their treatment and care in the hospital.

The in-depth interviews were confidential.

The researcher arranged with the hospital psychologist to be on stand-by for participants who might need counselling during or after the interview.

3.11 Conclusion

The study used an explorative qualitative descriptive research design based on in-depth interviews. Adult patients living with AIDS-related conditions and admitted to medical wards at Jane Furse Hospital were interviewed. NVivo 11 was used to analyse the data. Strategies for trustworthiness were used. Written informed consent was obtained from the patients who were willing to participate in the study.
Chapter 4: Presentation of findings

4.1 Introduction
This chapter presents the findings derived from the in-depth interviews with the participants. The purpose of this chapter is to describe the experiences of PLWHA in relation to disclosing their HIV status to their family members, and the relationship that they have with their family members. The chapter also describes the demographics of the participants and sets out the themes that emerged from the data, illustrating them with excerpts from the recordings of the interviews.

4.2 Description of the demographic profile
In-depth interview were conducted with 28 patients admitted to hospital with AIDS-related illnesses. 10 of them were male and 18 were female.

<table>
<thead>
<tr>
<th>Table 0.1: Demographics of people living with AIDS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Variable</td>
</tr>
<tr>
<td>--------------------------------</td>
</tr>
<tr>
<td><strong>Marital status</strong></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td><strong>Living arrangement</strong></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td><strong>Employment</strong></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td><strong>Income</strong></td>
</tr>
<tr>
<td></td>
</tr>
</tbody>
</table>
Table 4.1 presents selected demographics of the study participants. Over half (15) were single, 11 were married, and two were widowed. Most of the participants (21) were unemployed and were receiving pension, child, and disability grants. Most (20) had secondary education and two had no formal education.

<table>
<thead>
<tr>
<th>Level of education</th>
<th>Sub-category</th>
<th>Freq.</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>No formal education</td>
<td></td>
<td>2</td>
<td>(7.1)</td>
</tr>
<tr>
<td>Tertiary education</td>
<td></td>
<td>3</td>
<td>(10.7)</td>
</tr>
<tr>
<td>Primary school</td>
<td></td>
<td>4</td>
<td>(14.3)</td>
</tr>
<tr>
<td>Secondary school</td>
<td></td>
<td>19</td>
<td>(67.9)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Variable</th>
<th>Sub-category</th>
<th>Freq.</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reason for testing</td>
<td>Wanted to know status</td>
<td>1</td>
<td>(3.6)</td>
</tr>
<tr>
<td></td>
<td>Partner died</td>
<td>1</td>
<td>(3.6)</td>
</tr>
<tr>
<td></td>
<td>Child was sick</td>
<td>1</td>
<td>(3.6)</td>
</tr>
<tr>
<td></td>
<td>Other</td>
<td>3</td>
<td>(10.7)</td>
</tr>
<tr>
<td></td>
<td>Advised by the nurse to</td>
<td>3</td>
<td>(10.7)</td>
</tr>
<tr>
<td></td>
<td>test</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Pregnancy</td>
<td>3</td>
<td>(10.7)</td>
</tr>
<tr>
<td></td>
<td>Partner was sick</td>
<td>3</td>
<td>(10.7)</td>
</tr>
<tr>
<td></td>
<td>I was sick</td>
<td>13</td>
<td>(46.4)</td>
</tr>
<tr>
<td>Taking ART</td>
<td>No</td>
<td>5</td>
<td>(17.9)</td>
</tr>
<tr>
<td></td>
<td>Yes</td>
<td>23</td>
<td>(82.1)</td>
</tr>
<tr>
<td>Adherence to ART</td>
<td>Not adhering</td>
<td>10</td>
<td>(35.7)</td>
</tr>
<tr>
<td></td>
<td>Adhering</td>
<td>18</td>
<td>(64.3)</td>
</tr>
<tr>
<td>Admission</td>
<td>First time</td>
<td>13</td>
<td>(46.4)</td>
</tr>
<tr>
<td></td>
<td>Repeated admission</td>
<td>15</td>
<td>(53.6)</td>
</tr>
</tbody>
</table>
Table 4.2 presents the clinical history of the patients. Most tested for health-related reasons. Either they were sick or their partners were sick when they decided to test - though some were advised by health professionals to test. More than half (15) had repeated admissions. Almost all (23) were taking ART and were adhering to ART (18), while ten were not adhering to ART.

Figure 4.1: Age distribution of the study participants

![Age distribution chart]

Figure 4.2 shows the age categories of the participants. The largest group was aged between 30 and 39 years, and over half were older than 40 years. This shows that the HIV epidemic affects older people, on whom there is less focus in HIV prevention programmes.
Figure 4.2: Gender distribution of study participants

Figure 0.1 shows the gender distribution of the participants. There were more females (18) than males (10). This is in line with the general health-seeking behaviour of males and females.

Figure 4.3: Length of time knowing HIV status

Figure 4.3 presents how long it was since the patients tested for HIV. The findings show that over two-thirds (20) had been living with HIV for two years and more, with 10 having lived
with HIV for more than 5 years. This shows that most of the patients had been living with HIV for a long time.

**Figure 4.4: Period during which participants reported taking ART**

Figure 4.4 presents the length of time for which the patients had been taking ART. More than half (15) had been receiving ART for more than 2 years, but 13 patients had been on ART for less than a year.

**Figure 4.5: Distribution of the participants who had disclosed their HIV status**

![Pie chart showing disclosure status](image-url)
Figure 4.5 presents the number of patients who reported that they had disclosed their HIV status. Most (23) had disclosed their HIV status to one person and five had not disclosed their HIV status to anyone.

**Figure 4.6: Category of persons disclosed to**

Figure 4.6 presents the distribution of persons the patients reported to have disclosed their status to. Most (10) reported that they had disclosed to a close relative such as a sibling or an aunt. The persons to whom they reported to have disclosed their HIV were in most cases the ones the patients lived with in the same household.

### 4.3 Themes

Ten themes emerged from the analysis of the 28 in-depth interviews. Disclosure emerged as a super-theme containing three sub-themes. The themes are presented in table 4.3.

**Table 4.3: Themes and subthemes**

<table>
<thead>
<tr>
<th>Theme</th>
<th>Sub theme</th>
</tr>
</thead>
<tbody>
<tr>
<td>The context of hospitalisation</td>
<td></td>
</tr>
<tr>
<td>Reasons for testing for HIV</td>
<td></td>
</tr>
<tr>
<td>Reaction to HIV-positive results</td>
<td></td>
</tr>
</tbody>
</table>
### Perceptions of disclosure

<table>
<thead>
<tr>
<th>Carrying out disclosure</th>
<th>Delayed disclosure</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>Reason for disclosure to family</td>
<td></td>
</tr>
<tr>
<td>Time of disclosure</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Self-reaction to disclosure</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Family reactions to disclosure</td>
<td></td>
</tr>
<tr>
<td>Reasons for not disclosing</td>
<td></td>
</tr>
<tr>
<td>Family support</td>
<td></td>
</tr>
<tr>
<td>Experience of living with HIV</td>
<td></td>
</tr>
</tbody>
</table>

### 4.3.1 The context of hospitalisation

Opportunistic infections related to AIDS are the leading causes for the hospitalisation of PLWH, particularly in settings where HIV testing is delayed for various reasons, such as fear of stigma and discrimination. All the participants were hospitalised after having AIDS-related illnesses, and have been in the hospital for approximately two to three days when they were interviewed. Most stated that they had been hospitalised several times. They recounted their clinical symptoms when they were admitted to the hospital:

*My joints were painful, and I had a headache, a running stomach (31-year-old female)*

*I was unconscious, and I could not see the difference (51-year-old male)*

*I started vomiting, I started having diarrhoea I even refused not knowing what is it, I was never sick, I was fat, I even lost weight, and right now, I am shivering (36-year-old female)*

*For me to be admitted..., I had a cough..., I coughed a lot..., I lost strength while I was coughing. When I went to the clinic they gave me medication [ARV], it became worse. I had pain in my heart in such a way that I couldn’t do anything (34-year-old female)*

*It was the problem of diarrhoea and being scared (33-year-old female)*
It is TB, I know that it is TB (21-year-old female).

4.3.2 Reasons for testing for HIV

The participants were asked about the circumstances that led to their undergoing an HIV test. The participants gave various answers. The most common reasons reported included being sick, pregnancy, and the death of their sexual partners.

The reason is that my boyfriend with whom I am cohabiting died and he was sick, and I did not know what his problem was, then my family told me to go to the clinic and test (31-year-old female).

I didn’t just go and test I was going to the clinic for pregnancy, I was going there for regular check-up and when I got there they took my blood and then they found that I was positive (45-year-old female).

After my husband passed away, I suspected that my husband had a problem [AIDS] (57-year-old female). I was worried that people are dying from this thing [AIDS] I decided to go for blood test to check my situation [status], so that if I am in the list, I have to start taking treatment, prevention is better than cure (49-year-old female).

In fact, I used to take my wife to the doctor because she was always sick. The doctor said that he was worried because we come repeatedly for consultation and he suggested testing my wife who tested positive. He then insisted that I also test at the same time and I tested HIV-positive (48-year-old male).

My husband was coughing all the time, I asked him what was wrong with him and he said he does not know anything. When I was pregnant, they told me that I am HIV-positive (33-year-old female).

I started losing weight and I said there is a problem.... I said actually there is a problem, let me go to the clinic to see what the problem is (45-year-old female).
I was staying with a Xhosa woman in Gauteng, she found that she has this thing [HIV] when she went to the clinic, so she forced me to go for testing with her (60-year-old male).

It is because my boyfriend was not faithful, and I did not trust him, then I decided to test, because I was staying somewhere and he was staying at work and when I visited him he used to show me many girlfriends and said that they are his (33-year-old female).

My husband came to the hospital having grown some strange things over the body, So..., since I was working in the hospital at the house keeping department, I kept quiet but told myself that this is HIV. I then said let’s go to the hospital and they tested him they said indeed its HIV, so even myself I ended up saying let me also test and see (54-year-old female).

I had sex with a guy, when I finished having sex with him; he told me that he has AIDS. This person did not tell me before having sex even though I asked him about his status and he said no, he then told me after having sex, he said I have AIDS, I said no and he said yes, I didn’t do anything I just went to the clinic (20-year-old female).

4.3.3 Reaction to HIV-positive results

The participants responded to a question about their reaction to finding out that they were HIV-positive. Acceptance and worry emerged in the data with regard to the reaction of participants to their diagnosis. The following comments were made:

It is just that, it is now that I am starting to be worried but that time I was not worried, now I am worried because I am starting to lose weight (31-year-old female).

I understand that it is a disease that cannot just get out of your body even if it is treated, you just feel better, and I realised that besides accepting nothing would help me (37-year-old female).

I just accepted even now I just accepted I don’t have any stress (34-year-old female).
I didn’t have a problem when they told me but that time my head was spinning I did not know to whom and where will I start disclosing, whom will I start telling, I said let me start telling this man that I am sleeping with (45-year-old female).

Because it was still that time when the disease was still new and killing people, I was scared and shivering I didn’t accept easily (37-year-old female).

I was angry (45-year-old female).

I just accepted, there is nothing that they can do; I cannot kill myself and leave these kids (45-year-old female).

Actually, I didn’t feel good, I didn’t understand that something like this can happen to me [Being HIV] when I am no longer doing anything [having sex] I have been alone since 2010 (53-year-old male).

I realised that there was nothing I could do because we are used to this thing [people being HIV], it is all over the world, it is a disease, it doesn’t start with me, some die from it, some are more sick than me and I am looking at them. So, I realised that there was nothing I could do (60-year-old male).

I felt the pain, it pained me, it pained me because I am I am faithful while my husband has women in Gauteng, and it ended up really paining me (54-year-old female).

I just accepted because I already knew that my wife has the disease [HIV] (45-year-old male).

Ah I don’t even believe [my HIV status], I just accept and say no I am alive, but let me believe what I am being told by the doctors (60-year-old male).

I was shocked, I was confused but when I was still confused I asked myself about the unborn baby that I was carrying, I said for me to protect this unborn baby that I am carrying let me not be confused and continue with this treatment to save this unborn baby that I am carrying (47-year-old female).
4.3.4 Perceptions of disclosure

The perceptions of disclosure often reflect the personal views of PLWHA and are a measure of the community views of disclosure. The participants were asked about their views about the disclosure of HIV status in general. The researcher made it clear that this was not about their personal disclosure practice. In response, both positive and negative views were mentioned by the participants concerning disclosure in general. Most commented on the reason people do not disclose said that they felt that disclosure was not good because of the stigma around HIV:

Some people do not treat us well when we are sick, they spit on us, those who don’t treat us in a good way should not be told (45-year-old male).

HIV is not something that has to be disclosed, when I arrive in the village, it is a secret, the disease is only known by my family, it will be wrong if many people can know about this disease (60-year-old male).

I don’t think it is good to tell people about your HIV status while it is already known that many people don’t like the disease (45-year-old Male).

Nevertheless, some of the participants reported that the disclosure of one’s HIV status to significant people was good, and shared their reasons as outlined below:

I think that it is good because we are able to show people that they must just accept, someone will tell you that when you see me like this, I am living with the disease (45-year-old female).

If you do not tell anyone you will end up losing weight more and end up dying because you don’t tell people that you are sick, you kept quiet; being quiet will lead you to being sick (53-year-old male).

I think it is OK, you become relieved and you don’t think too much but if you do not tell other people and you make it your secret, you will find yourself having too much stress but if you start telling your friends, telling people, you will take it as if it is nothing (33-year-old female).
While some of the participants believed that it is good to disclose, there were those who felt that disclosure to other people is good only under certain conditions, as given below:

*People at home should not disclose to strangers, we only have to know as a family, we must know as a family only (36-year-old female).*

*They must disclose but they shouldn’t mention my name (21-year-old female).*

### 4.3.5 Carrying out disclosure

Although a few participants reported that they had not disclosed their HIV status to their family members, those who had disclosed reported that they had done so to various family member including parents, siblings, children, aunts and other significant people such as neighbours and friends and church leaders. When the PLWHIV were asked about how they had carried out the disclosure to their family members, most reported that they had sat down with their family members and disclosed. However, some participants had avoided words like “I am HIV-positive”, as reflected in the following excerpts that show how they carried out disclosure:

*I told my younger sister, I told her that I am sick and I am like this and this, I am suffering from this disease [HIV]. So, my younger sister said I must tell them at home and I said I will tell them when I feel free. But I then told my brother and my brother told my mother and she said there is no problem if it is like this and she said you are not the first one to have the disease (37-year-old female).*

*I told her [my sister-in-law] that I am HIV-positive, I told her I have the disease that is killing people, and I will die very soon, I frightened her...., you see...., I tried to frighten her when I saw her changing...., I told her that I was sorry, I was just joking. I am not going to die I am just telling you that I am HIV-positive (37-year-old female).*

*Actually in 2014 when I started having pain in my body, when they came to visit me [her family] I told them one by one, they were so worried so I told them that I am*
HIV-positive and explained that when I have any disease it become stronger due to the HIV disease that I have (48-year-old male).

She called yesterday late [my aunt], she wanted to know how I was. I told her that my situation is like this, when I checked they told me that I have this disease [HIV] (45-year-old female).

I was sitting with them and I told them..., I said eh..., at the clinic, they are saying I have this disease [HIV]. My mother said do not be scared all this people have it (21-year-old female).

I told them that, since I am sick like this and they sometimes bath me, they must not bath me without wearing anything on their hands; they must wear gloves (54-year-old female).

Some PLWHA used their medication to explain their HIV status to their family members:

I sat down with my children, I was shameful, I said my children don’t be surprised, this load that you see [ARVs] it is the one that is carrying my life (57-year-old female).

I told my children that you see the bottles I am carrying; they are for diseases like this [HIV]. You must know that your mother has this disease [HIV] but don’t tell anyone, but when I am sick, you must tell the home-based caregivers that I am taking medication for HIV (33-year-old female).

I just told them [my family members].... I told them that I now drink the night tablet (Maria, a 34-year-old female)

I just put them [ARVs] in an open space when I am at home (31-year-old male).

One of the participants showed his wife the HIV test results, as reflected below:
I said have a look, here are the results, she said let me also test [the wife], and she tested negative (51-year-old male).

4.3.5.1 Delayed disclosure
Most of the participants stated that they had disclosed their HIV status some while after being diagnosed. They reported various reasons for delaying the disclosure, such as wanting to protect their dignity, the fear of stigma, and the hope to be able to tell them in future.

You heard me saying the issue of dignity; they will say it means you were having sex with men, this and that (45-year-old female).

Normally I cannot say that come here let me tell you that I am suffering from this [HIV], if it is the issue of them being here and surprised that this man always gets sick then I have to tell them that I have this disease [HIV] (48-year-old male).

It is because I wanted to see what kind of people they were, I didn’t tell my older daughter in law, she doesn’t know..., she doesn’t know this issue [HIV] (54-year-old female).

You don’t have to go around telling people about your status as if you don’t think, and it will be like you are mad (60-year-old male).

It was this disease [HIV] that made me to be ashamed of myself... (45-year-old male).

4.3.5.2 Reason for disclosure to family
Most of the participants reported that they had disclosed to various family members for various reasons. Most had disclosed to their family members for support. The following excepts explain their reasons:

I found out that you have to tell people so that you are able to get support (51-year-old male).

I wanted my sister in law to be comforted and be satisfied that we are all taking [ARV’s] and not feel like she is the only one (49-year-old female).
It is because I find that she is the person who sometimes prepare food for me to eat, you see, so I can’t make it a secret in her home (45-year-old female).

I feel that I will find help from them [my family] (54-year-old female).

I told my family members so that one day when I am sick, they will be able to help me because I am this kind of a patient (47-year-old female).

All of my relatives know especially because sometimes when there is a problem you have to call them and tell them that you are not well so that you get support, then every time they will say but what type of a disease is this one then you must explain to them and say no be careful my disease goes like this and like this (48-year-old male).

4.3.5.3 Time of disclosure

When the participants were asked about the time they took to disclose their HIV status to their family members, they reported different period of delay. Some participants disclosed on the same day on which they were told their HIV status, while others took their time to disclose, as reflected in the following quotations:

I just disclosed to her [my aunt] the same day I went to the clinic after they told me that I am positive. I came back home, and I disclosed at that time in that day (31-year-old female).

I told her [my wife] because I got admitted, I told her to come to the hospital, I said have a look, here are the results (51-year-old male).

I am sure I told them after three months (33-year-old female).

It took me four years to tell them, I make it a secret for me not to tell anyone (33-year-old female).

I think it took me almost a year man (45-year-old male).

From the day that they had tested my blood (53-year-old male).
I wanted my sister in law to be comforted and be satisfied that we are all taking ARVs and not feel like she is the only one (49-year-old female).

It is because she is the one who sometimes prepare food for me to eat you see, so I can’t make it a secret in her home (45-year-old female).

All of my relatives know especially because sometimes when there is a problem you have to call them and tell them that you are not well so that you get support (48-years-old male).

Some of the participants reported that they had delayed disclosure up until they had to disclose because they were sick;

I disclosed when I became sick and they wanted to know what my problem was. It is then that I started explaining that I have something like this [HIV] (37-year-old female)

When I am sick like this all of them want to know what is it that I am suffering from (45-year-old female).

I was sick all the time..., usually I am not a person who always gets sick, and they wanted to know what was the disease that I was suffering from, I told them (34-year-old female).

Some said that they had disclosed because they trusted the people they disclosed to

I understand that my mother will not go around telling people about my illness (36-year-old female).

I trust them [my friends] because they grew up with me, we live together, we attended school together, we comfort each other and we don’t bother each other (33-year-old female).

I trust her [my aunt] (45-year-old female).
Some of the participants reported that they had disclosed because the people they disclosed to were family members with whom they spent most of their time or lived with them;

*I spend much time with them sometimes (45-year-old male).*

*They are my family that I live with full time (33-year-old female).*

### 4.3.6 Self-reaction to disclosure

Most of the participants reported good feelings when they were asked how they had felt after disclosing their HIV status to their family members.

*I felt free, yes..., because I took off the heavy load on me (37-year-old female).*

*I was scared at first but after I tell them, I felt free in my spirit (57-year-old female).*

*I feel good now because I now know that they know what I am suffering from so that they are not surprised when they see me losing weight not knowing what makes me to lose weight (37-year-old female).*

*I feel good when I talk to other people about it [HIV] because it makes them to be protected (33-year-old female).*

*It was well with me (33-year-old female).*

A few of the participants experienced bad feelings after their family members knew about their HIV status:

*Yes, that time I was still fine but after my wife knew, eish..., things changed (51-year-old male).*

*I didn’t feel good (21-year-old female).*
4.3.7 Family reactions to disclosure
The participants reported positive and negative reactions from their families when they disclosed their HIV status. The data reveal that after the initial reactions of the family members to the disclosure, some participants experienced positive reaction and had good relationships with their family members:

My boyfriend just said that we have to be faithful now, take care of ourselves, we just have to take the medication together so that even if we want to have a child we must know that the child is protected (34-year-old female).

They only said that I must not stop taking the treatment (31-year-old male)

They did not have a problem with it [the HIV status], they told me that it is life..., we are living. Even this friend of mine that brought me here, she is negative but she told me that this is life there is no problem..., she said no do not be afraid, you are going to be healthy it is life (47-year-old female).

I was never treated in a different way, they treated me well..., all of them (49-year-old female).

No there was no one who have changed (51-year-old male).

Others narrated incidents of being discriminated against and treated badly by their family members:

It is like my sister-in-law couldn’t share a couch with me or talk with me the way I am sitting with you now, she thought I will infect her while talking to her (37-year-old female).

After I told him he left her [her sexual partner], he said he is not positive and he left, he said it means I came with my disease, he left then I remained (45-year-old female).
She is the one staying with me at home when I tell her that “I am feeling weak I want to go to the hospital please call the ambulance for me”, she doesn’t care (33-years-old female).

I cannot even tell you what we are fighting for, he just have some issues [her husband]. As I said since this issue [HIV] he often insult me about it [her HIV status], eish (crying) (47-year-old female).

My aunt she goes around telling people all over and says I have AIDS, I don’t care when she talks (34-year-old female).

They don’t care; my mother said she doesn’t want to see a corpse in her home, she doesn’t want to see a corpse in her home (34-year-old female).

This man [her boyfriend] left me and got another girlfriend and they stayed together (45-year-old female).

People have issues…, at home they tell everyone…, after I told them they just talk anyhow. At that time I was working in the mine, I stayed in the mine for men that is I am positive (45-year-old female).

There was no one taking care of me, my brother took care of me when they said everyone must cook her own pot (34-year-old female).

Some of the participants reported that their family members found it hard to accept their HIV status, as reflected below:

They were scared [her children], the girl was too much scared; she thought that I was going to die like their father and they will be left as orphaned. I told her not to be scared…, that I am going nowhere…, she has already accepted (57-year-old female).

She cried, she cried bitterly [her daughter], she went to school and I thought that she won’t cope, I thought she won’t pass (54-year-old female).
They did not believe me [her family members], they went to the clinic and asked the doctor if it is true that I have HIV, they said they did not believe me because they knew me, they said they knew what kind of person I was because I live with epilepsy and mental illness (33-year-old female).

We fought a lot with my wife; she was angry that I was hiding something so big [HIV], but now we don’t have a problem (60-year-old male).

4.3.8 Reasons for not disclosing

Non-disclosure was a key focus of the study and the few participants who did not disclose their HIV status to anyone were asked to provide reasons for not disclosing to their family. The participants provided reasons for delaying, as reflected in the excerpts below:

I know that they are the kind of people, who sometimes talk about me, have you seen it when you don’t expect a person to say anything, but they just talk (31-year-old female).

It makes no difference, they can’t make me healthy…, and I tell them to do what? I take the treatment (52-year-old male).

I did not tell my wife, I forgot (60-year-old male).
I just thought they [the family] will take me somehow [treat me differently] (45-year-old male).

I am a person who pray for people and I baptise people [a pastor], and I ordain evangelists, so you cannot just go around telling people [disclosing] as if you are not a leader… Hah! (60-year-old male).

My family is far, I cannot tell my in-laws because they are the first ones who will tell people that I had killed their brother…, they won’t say I contracted it from their brother, but will say “It means that our brother was killed by her”, so I just leave it like that (57-year-old female).
I did not tell my husband’s family, I am scared to tell them because they hate me, and they said I had killed their brother (33-year-old female).

They do not know anything we do not talk to each other, when I left home we were not in good terms. They will just go around gossiping (34-year-old female).

4.3.9 Family support
When the participants were asked about the kind of support they received from their family members, they highlighted emotional support and some financial support. The following excerpts outline their views:

My family always support me because they prepare food for me; they do everything for me during bath time they pour water for me (37-year-old female).

My sister is the one supporting me (51-year-old male).

My mother gives me support; so even when I sleep I no longer sleep on my bed; I sleep in her bedroom on a mattress next to her. She gives me support and say my child you are not the first one (34-year-old female).

I have no one to give me support, I told the father of my children, I told him that they say I am HIV-positive, he said where are the results, I don’t know how did I reply then, but he didn’t care (36-year-old female).

The pastor’s wife knew that I take medication and I am sick. She told me not to be scared and asked me to come to her place. She said she has a sibling who has the same disease as mine [HIV]. When I feel weak every day, I think that the person who can help me when I feel weak is the pastor’s wife, I don’t have her number but I know where she lives I just limp until I reach her place (37-year-old female).

In fact, we supported each other, my wife and myself because I was with her when she tested and then I tested and they found that I also have the disease [HIV]. Then we supported each other, we realised that this thing is with us but we don’t have to have a problem even if death can come but we would have tried (48-year-old male).
But now he always says let's go to the clinic, it is my brother, they will help you, he accompanied me here for admission (34-year-old female).

My brother helps me with cash sometimes when I don't have enough (45-year-old male).

The participants also indicated the kind of support they want from their families.

I want my aunty to help me with... with many things like cooking when I feel weak (34-year-old female).

In fact, I want my aunt to take care of my children (31-year-old female).

I am OK with support; I am OK with everything (51-year-old male).

I wish that my siblings could tolerate me the way that they have accepted me, they must not reject me, and they must just tolerate and support me (57-years-old female).

4.3.10 Experience of living with HIV
The data reveal that participants who disclosed their HIV status to their family members and sexual partners had positive and negative experiences of living with HIV. They recounted how they had managed to navigate their lives as people who are living with HIV, particularly after disclosure. Most experienced living with HIV positively, which influenced how they perceived themselves and the significant others in their lives, as outlined in the following excerpts:

I can free my soul, and know that I do have the disease and that there is no way it can be reversed but it is something that cannot be treated, the person just get better (37-year-old female).

I experienced that I no longer have a secret..., a secret for life because AIDS is not the same as TB that you can say you take treatment for six months and be cured. I just understand that it is for life (34-year-old female).
I learned that when you have problems and you tell other people they will give you different guidance, someone will come with this and the other one with that (33-year-old female).

I have learned that you do not have to have a secret, when you test and they tell you that you are HIV-positive, you have to tell other people especially your family so that they can know your status (47-year-old female).

Living positively with HIV made them realise that they have a responsibility towards their children and other family members, as reflected in the quotes below:

Is that I don’t want them to be like me, I don’t want them to be in the situation that I am in right now do you hear me? Even my children I don’t want anything, I don’t want to infect other people because they didn’t send me to be infected by this disease [HIV], this disease kills (37-year-old female).

I have learned something, those who come after me should know that this disease should not be kept secret, it’s important to just tell people straight (53-year-old male).

Since I started with medication I don’t care about people and what they say (31-year-old male).

Although there were only a few of them, some of the participants recounted their negative experiences of living with HIV;

I am just surprised after taking the treatment[ARVs] I became ill, actually this treatment confuses me because before I started taking treatment I was not sick, I even told my mother that if I didn’t take the treatment I would be fine and not sick (36-year-old female).

While most of the participants had disclosed, it is important to note that disclosure was delayed for a long time. Some of the participants explained how they managed to hide the fact that they are HIV-positive by deceiving their family members;
They don’t know that I am taking medication for HIV; they know that I am taking medication for high blood (52-year-old male).

They don’t know that I have this disease [HIV] (45-year-old female).

For the participants who had not disclosed to their families, living positively as people with HIV was a challenge. They described how they protected their family members from contracting HIV without formally disclosing their status, as reflected in the following excerpts:

I told them that they don’t have to touch where the blood is coming out (45-year-old male).

I said they must not touch me (34-year-old female).

I tell her to wear the gloves (21-year-old female).

4.4 Conclusion

The findings are that 82.86% of the participants had disclosed their HIV status. This amounts to 23 of the participants. Most were between the ages of 30-39. 75% of the participants were unemployed, 64.29% were females, and 67.86% had secondary education. Almost all participants confirmed that they had been admitted because of AIDS-related illness. They said that they had delayed disclosure due to their fear of stigma and they had disclosed since they wanted to receive support from their family members. They reported that they had received both positive and negative reactions from their family members.
Chapter 5: Discussion, conclusions, and recommendations

5.1 Introduction

This study aimed to explore the disclosure experiences of people living with HIV/AIDS. This chapter will discuss and interpret the data supplied by the participants in Chapter Four, confirming and contrasting them with the data discovered in the previous research projects. The chapter will conclude with a description of the limitation of this project and a set of recommendations.

5.2 Description of the study sample

The sample consisted of 28 patients admitted to an adult hospital ward with AIDS-related illnesses. Opportunistic infections related to AIDS are the leading cause of hospitalisation for PLWH (Ford et al., 2015). This is particularly true in settings where HIV testing is delayed for various reasons such as the fear of stigma and hurtful discrimination. In the current study, almost half of the participants (13 out of the 28) had been hospitalised several times with AIDS-related opportunistic diseases like TB, excessive diarrhoea etc. Namutebi et al (2013), in a study conducted in Ghana among adult patients on ART, found that most of the subjects in that study were severely immunocompromised. Although the current study did not explore the clinical profiles of the participants, their clinical symptoms suggested severe immunosuppression.

The literature shows that patients present late for HIV testing because of a poor uptake of HIV counselling and testing services and a fear of stigma (Namutebi et al. 2013). The findings were that most of the participants were newly diagnosed and tested for HIV when they were sick (13 out 28), or because the partner was sick or had died and they were advised to test by the nurses (8 out of 28). In a systematic review, Ford et al (2015) also found that a third of the participants in that study were newly diagnosed on admission in the hospital, which suggested delayed HIV diagnosis. In many settings HIV testing is delayed for various reasons, such as fear of stigma and discrimination.
Almost all of the participants (23) were receiving ART. 13 of the 28 participants had been receiving ART for about a year, but others had been on ART for more than three years (9 out of 28). It is of concern that 10 out of the 28 participants were not adhering to ART.

There were more females (18) than males (10) and their ages ranged between 18 and 69 years, but more than half (15 out of 23) were 40 years old and above. Only 4 of the participants were in employment. The rest were unemployed and were receiving old age, disability, and child grants. Most (20 out of 28) had secondary education. Concerning their living arrangements and marital status, over half (15 out of 28) were single and were living with their children or parents.

### 5.3 Disclosure of HIV status to family

The disclosure of their HIV status remains a complex process for PLWHA, even when they have debilitating opportunistic infections. The disclosure pattern observed in the study is in line with the views held by the participants about disclosure in general. Most of them felt that disclosure was not good because of the threat of HIV-related stigma. While the findings revealed that most of them (23 out of 28) had disclosed their HIV status to at least one family member, the time it took them to disclose their HIV status even to their own family members is of concern. The time span between HIV testing and disclosure of the HIV status varied from days to months and even to years. Other studies have reported similar findings, where disclosure occurred days, weeks, months, and even years after diagnosis with HIV (Denis, 2014). Another research project indicates that most women delay the disclosure of their HIV status to their sexual partners until they feel that it is safe to disclose (Tom, 2013).

In the current study, some of the participants had disclosed to significant family members while they were in hospital. This finding is in line with those of other studies that note that most PLWHA disclose when their health condition has deteriorated. It is not clear what motivates people to disclose when they are critically ill, but the literature suggests that PLWHA disclose to get support from family, children, and partners. They believe that it is important to disclose at this time because the people they tell will be able to help them or will know what to do only when they know the subject’s condition (Oseni et al., 2017; Shikwane et al., 2013).
Furthermore, the study revealed that the timing of disclosure to significant people varied depending on gender, age, the nature of the sexual relationship and the health status of the participants, as well as the context of the environment and the integrity of the people surrounding the participants. The findings indicate that most of the single participants disclosed their HIV status to their family members rather than to their sexual partners. This could be explained by the fact that most of the participants who were single lived with their parents or children. It is of note is that other studies have reported similar observations, that PLWHA prefer to disclose to family members first, followed by their sexual partners (Klopper et al., 2014; Natae and Negawo, 2016). In the current study most of the participants emphasised that it was much safer to disclose to family members because of the stigma attached to a HIV diagnosis. They felt that family members would keep their HIV status secret to avoid stigma and discrimination. On the other hand, the literature has shown that women who disclose to their sexual partners have experienced violence, rejection, abandonment, being blamed for bringing the infection home, and stigmatisation from their partners (Arrey et al., 2015; Clum et al., 2013; Madiba, 2017).

Similar to what has been documented in the literature, the study revealed that married participants disclosed to their spouses. Since disclosure was motivated by wanting to receive support, the spouses became the most appropriate people to fulfil that need. Several other studies also found that married people are inclined to disclose to their spouses (Dankoli et al., 2014; Karim et al., 2015; Klopper et al., 2014; Tom, 2013).

For most of the participants, disclosure was motivated by how the person disclosed to would react to the HIV diagnosis, if the person would be able to give relevant support, and if the person would be able to keep the participant’s status secret. This partly explains the choice of the person disclosed to by some of the participants in the study. Trusting the persons they intended to disclose to be the key to motivating the participants to disclose. It is noteworthy that most of the people disclosed to were significant family members, particularly the persons the participants lived with. As already said, the spouse was the most appropriate person to give support to the partner and keep the subject’s HIV status secret. It should be noted that the spouse has as much to lose if the status of the subject is known to other people. Family members are likely to be discriminated against if the HIV status of a member of the family is known to people outside the family. According to Madiba (2017), the context in which disclosure occurs has an impact on whether or not PLWHA disclose their HIV status to other
people. If PLWHA believe that the environment in which disclosure should occur is not safe, disclosure is delayed.

The study revealed that another factor influencing the selection of whom to disclose to was whether or not that person deserved to know the subject’s HIV status. However, in-depth exploration of the data revealed that getting support was the main reason for disclosing to family members. As already stated, most of the disclosure occurred very late, after the participants had tested HIV-positive and their condition had deteriorated. They reported that they now needed someone to do certain things for them; hence the disclosure.

5.4 Disclosure barriers

The findings revealed that even though most of the participants disclosed to significant family members, they delayed disclosure, with some waiting until their health had deteriorated. In the current study, 13 out of 23 participants disclosed after their admission to hospital. This practice is of great concern, as it militates against the early initiation of ART and the prevention of the transmission of HIV to the subject’s sexual partners and family members during care. The participants gave more or less the same reasons for delaying disclosure to family members and not disclosing to people outside their extended families. In the current study, 5 out of the 28 participants did not disclose their status to anyone. It should be noted that these participants were already sick from AIDS-related opportunistic infections and probably needed some support of some sort from significant family members. Three of the participants who had not disclosed were married, which suggests that their spouses would now be infected. One of the male participants felt that disclosure would not make a difference, since telling others would not make him healthy. The findings suggest that the participant was in denial, and because he denied his HIV-positive results, disclosure could not happen.

The participants cited fear of stigma, lack of trust, and shame as their main reasons for delaying disclosure or not disclosing to family members. This suggests that they felt that stigma and discrimination could come from family members and sexual partners as well as from the community as a whole. When the participants who had disclosed recounted their post-disclosure experiences, they narrated incidents of being discriminated against and rejected by their family members. One young woman reported that her family did not want to
share their cooking utensils with her but expected her to have her own pots, while some of the women were abandoned by their sexual partners following disclosure. Similarly, Clum et al. (2013) found that delay in disclosure resulted from the fear of losing the partner, particularly among women. The fear of stigma was identified in several studies as a major factor that contribute to delayed disclosure to other people or motivated non-disclosure (Dankoli et al., 2014; Karim et al., 2015; Klopper et al., 2014; Tom, 2013).

5.5 Mode of conversation for disclosure

The study revealed that most participants preferred a face-to-face conversation with their family members when disclosing their status. This finding is in line with what has been observed in other studies. Thus, Denis (2014) previously reported that PLWHA preferred to sit down with their family members when disclosing their HIV status. The findings further revealed that most of the participants used metaphors when they explained their condition to their families. Most avoided saying “I am HIV positive”. Instead they referred to HIV as “this disease” or “this thing”. Some of the patients made use of their ART medication to communicate their HIV status to their family. They reported that they took their ART in front of their family members without telling them that they were for HIV. They believed that if the family members recognised the ART medication, they would interpret that as signifying that the subject was HIV-positive. The findings are similar to those of other studies which also found that PLWHA opted to utilise euphemisms when they disclosed their HIV status (Bhatia et al., 2017; Tshweneagae et al., 2015).

5.6 Family reaction to disclosure

According to Hunter-Adams et al. (2017), PLWHA who disclosed their HIV status experienced support and rejection and from significant others. As already stated, some of the participants in the current study were discriminated against and rejected by their family members while some women patients were abandoned by their sexual partners. Other studies reported that PLWHA go through blame, stigma, violence, abandonment, and anger, discrimination and rejection (Arrey et al., 2015; Denis, 2014). However, most of the participants in the current study reported that their families reacted positively to the disclosure and they received emotional support and encouragement with adherence to ART. The findings are in line with some studies that found that PLWHA experienced kindness,
acceptance and support from family members following disclosure (Natae and Negawo, 2016; Wessman et al., 2017). Most participants were supported by their families, who reacted positively to the disclosure. In line with other studies, they experienced acceptance and support following disclosure (Natae and Negawo, 2016; Wessman et al., 2017). The forms of support most commonly described included emotional support, financial support, physical care, support for adherence to ART, and accompaniment on clinic visits and follow up. The study also found that the support they received led to the subjects’ positive attitude and desire to live positively with HIV.

5.7 Experiences of disclosing to family

The data revealed that the participants had both positive and negative experiences of living with HIV. Disclosure was beneficial for most, as they reported that they felt good after disclosing their HIV status to their family members. They recounted how they had managed to take control of their lives as people who are living with HIV, but were bothered by their deteriorating health conditions. The findings revealed that after disclosure PLWHA feel relieved at no longer having to keep a secret which they felt was a heavy burden, because they understood that living with HIV is a lifelong task.

The data further revealed that living positively with HIV made them realise that they have a responsibility towards their children and other family members. They felt that they had to protect their children from being infected with HIV by educating them about HIV, and for some this meant living openly with HIV. The findings revealed that some of the participants deceived their family members by substituting other diseases for HIV, when they talked about being ill. On the other hand, participants who had not disclosed to their families found living positively a challenge. While they wished to protect their families from contracting HIV, this was difficult without formally disclosing.

5.8 Conclusion

Disclosure to family member and significant others is crucial, particularly when the individual is sick with AIDS-related illnesses. The study found that most of the patients disclosed their HIV status to significant family members even though disclosure for most was delayed. The selection of the family member to disclose to was based on whether the person
would be able to give them support, how the person would react to the HIV diagnosis, and whether the person would keep the HIV status secret. Nevertheless, the need for family support was the main reason for disclosure, especially since disclosure often occurred when the condition of the PLWHA had deteriorated and they needed support on many levels.

Disclosure of their HIV status remains a complex process for PLWHA. This is evident in the manner in which the disclosure occurs. While most of the participants preferred having a face-to-face conversation with their family members, they avoided using the word HIV, and instead referred to “this disease” when they disclosed. Throughout the interviews they hardly ever used the term “HIV”. Other ways of disclosing were to show the family member the test results or to openly take the ART medication in front of family member to whom they had not formally disclosed.

The study established that it was safe to disclose to family members because of the stigma around HIV, since the whole family was likely to be discriminated against if people came to know about the HIV status of a family member or a spouse. The fear of stigma, rejection, and gossip was the main barrier against disclosure and led to delayed disclosure and non-disclosure to family members, even when the individual was sick with AIDS-related illnesses. The findings of the current study and the literature are that the fear of stigma and rejection is real for PLWHA. Furthermore, the findings are that the fear of stigma extends to primary caregivers, family members, and sexual partners. However, stigma and rejection were more frequently experienced by participants who disclosed to their sexual partners rather than to their family members. Nevertheless, some family members rejected and isolated some of the participants. It is therefore important that these fears be taken into consideration when health care providers develop disclosure-counselling strategies.

The study established that most of the patients had a positive outlook to living with HIV and benefitted from disclosing, since they no longer had to keep their diagnosis secret. The positive reactions to the disclosure from most of the families and the support they provided contributed to the positive attitude of the participants. However, it is important to note that disclosure for most of the participants was delayed for a long time, even though most eventually disclosed. The effort to live positively should not be attributed to disclosure alone as most of the patients had already adopted positive strategies to protect their families from HIV infections and to educate their children about the prevention of HIV transmission. The
acceptance of an HIV diagnosis played a great role in how the patients perceived themselves. Most indicated that they had accepted their HIV diagnosis after testing and regarded HIV as a disease like all others.

5.9 Limitations of the study

The study was done in a rural area. Therefore it might not represent people living with AIDS in an urban area. The family members of the participants were not interviewed to confirm the narratives given by the participants.

5.10 Recommendations

It is important that the fear of stigma, isolation, rejection, and prejudicial discrimination be taken into consideration when health care providers develop disclosure-counselling strategies. There is a need for the development of strategies to support PLWHA after diagnosis, and disclosure should be emphasised to encourage PLWHA to disclose to significant persons in their lives.

Further research should be conducted with a larger sample size to determine the prevalence of disclosure to significant family members in rural settings and assess the impact of stigma on disclosure and access to testing and ART services.
References


Gilbert, L. and L. Walker. 2010. “‘My biggest fear was that people would reject me once they knew my status…’: stigma as experienced by patients in an HIV/AIDS clinic in Johannesburg, South Africa.” *Health & social care in the community* 18(2): 139-46.


Le Roux-Kemp, A. 2013. “HIV/AIDS, To Disclose or not to Disclose: That is the Question.” PER: Potchefstroomse Elektroniese Regsblad 16(1): 00-00.


## Appendices

### Appendix 1: Interview guide-English

1. **Tell me about the reasons for your admission in the hospital**

   **Probes**
   - How long have you been in the ward?
   - When you first came in the ward how was your first health status?
   - What did the doctors say was wrong with you?
   - What are some of the symptoms that you were having?
   - Is this the first time you were admitted? If not, how many times were you admitted?
   - What were reasons for your previous admissions?
   - How long did you stay at home before this admission?

2. **Before you were admitted in hospital, what were the circumstances or reasons that led to your decision to test for HIV?**

   **Probes**
   - Did you ever consider testing before these circumstances?
   - If no what were the reasons?

3. **When you first tested HIV positive, how did you feel about being positive?**

   **Probes**
   - Was there a time when you felt pain?
   - What made you to feel that way?
   - How long did those feelings last?
   - How did you deal with the way you felt about being HIV positive?
   - How do you feel now about living with HIV?

4. **What are your views about HIV positive people disclosing their HIV status to other people in general?**

   **Probes**
   - In your views, should they disclose or not disclose?
   - Why do you think so?

5. **What do you think are some of the reasons people do not disclose their status to other people?**
6. You just shared with me your views whether people should disclose, I want us to talk about personal experience about disclosing your status. Have you disclosed or not disclosed your status to close family members?

7. If you have disclosed to family members, what were the circumstances that made you to disclose

**Probes**
- Whom did you tell and why did you choose this person?
- How long did it take you to disclose after testing positive? Why so?
- How did the person you disclosed to react?
- Why did you not disclose to other family members?
- Probe for each person disclosed

8. You just told me that you disclosed to some of your family members, please tell me how you carried out the disclosure.

**Probes**
- Was disclosure planned or unplanned?
- Was disclosure direct or indirect?
- What were the words used in disclosing?
- Probe for each family member disclosed to

9. How did you feel when you first disclosed your status to family members?

**Probes**
- Good , relieved, scared, unsure, sad, regret
- Was there a time when you felt you are treated differently because of disclosing your HIV status? If so explain.
- Who treated you differently?
- How long did this treatment last?
- Was there a change in the relationships that you had with your family members after disclosing your status? If so what were those changes?
- Which relationships changed?
- How do you feel now?

The following questions are for participants who have not disclosed
10. If you have not disclosed your status to your family members, what makes it difficult to disclose

**Probes**
- Fear of stigma and discrimination
- Fear of abandonment
- I wanted to protect my parents or children

11. Do you plan to disclose your status to family members in future?

**Probes**
- What should happen for you to disclose?
- Do you need help to disclose to family members?
- Whom do you think could help you to disclose?
- Whom will you disclose to?

12. You told me that you have been sick for some time, what do you tell your family about your illness?

**Probes**
- How do your family members help you when you are ill in the absence of disclosure?
- What do you tell your family about the reasons for admission?
- How do you adhere to ART without disclosure to family members?

13. The following questions are for all participants (disclosed and not disclosed)
Since you have been ill, who in your family is caring (assisting you with your needs) for you?

**Probes**
- Why this person?
- What kind of assistance is provided by this person?
- What kind of assistance do you need from this person and your family?
- How do you protect them from HIV transmission during care?
- If you have not disclosed to your caregiver, what are your reasons?
### Appendix 2: Demographics questionnaire

<table>
<thead>
<tr>
<th>1. Age</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Single</td>
</tr>
<tr>
<td></td>
<td>Married</td>
</tr>
<tr>
<td></td>
<td>Living with partner</td>
</tr>
<tr>
<td></td>
<td>Divorced</td>
</tr>
<tr>
<td></td>
<td>Widowed</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>2. Marital status</th>
<th>My partner and children</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>My children only</td>
</tr>
<tr>
<td></td>
<td>My children and my siblings</td>
</tr>
<tr>
<td></td>
<td>My parents</td>
</tr>
<tr>
<td></td>
<td>My parents and my children</td>
</tr>
<tr>
<td></td>
<td>My parents and my siblings</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>3. Who do you live with?</th>
<th>Employed</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Unemployed</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>4. Employment</th>
<th>Salary</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Child Grant</td>
</tr>
<tr>
<td></td>
<td>Old age pension</td>
</tr>
<tr>
<td></td>
<td>Disability</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>5. What is your source of income</th>
<th>Primary school</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Secondary</td>
</tr>
<tr>
<td></td>
<td>High school</td>
</tr>
<tr>
<td></td>
<td>Tertiary education</td>
</tr>
<tr>
<td></td>
<td>No formal education</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>6. Level of education</th>
<th>Christian</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Other</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>7. Religion</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>8. When did you first learn that you are HIV positive? (provide time in years)</th>
<th>I wanted to know my status</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>I was sick</td>
</tr>
<tr>
<td></td>
<td>Partner passed away after being sick</td>
</tr>
<tr>
<td></td>
<td>My child was sick</td>
</tr>
<tr>
<td></td>
<td>I was pregnant</td>
</tr>
<tr>
<td></td>
<td>I was advised by the nurse to test</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>---</td>
<td>---</td>
</tr>
</tbody>
</table>
| **10.** Are you on ART treatment? | Yes  
|   | No  |
| **11.** How long are you on ART? (*provide time in years*) |   |
| **12.** Are you adhering to your ART? | Yes  
|   | No  |
| **13.** If no why? |   |
| **14.** Did you disclose your status to anyone? | Yes  
|   | No  |
| **15.** If yes, to whom did you disclose your HIV status first? | Spouse  
|   | Parent  
|   | Close relative  
|   | Close friend  
|   | Children  
|   | Other  |
| **16.** What are the reasons for admission? |   |
| **17.** Is this first time you were admitted | Yes  
|   | No  |
| **18.** If no, when was the other time you were admitted |   |
Appendix 3: Interview guide-Sepedi

1. Ke kgopela o hlalose lebaka la go amogelwa ga gago ka mo sepetlela

_Potseso_
- O na le nako e kakang o le ka mo sepetlela?
- Ge o thoma go tla ka mo sepetlela seemo sa gago be se le jwang?
- Dingaka di re bothata bja gago ke eng?
- O be o ikwa bjanga ge o etla sepetelele?
- Ke la mathomo o amogelwa? Ge e ba e sale la mathomo, o amogetswi ga kae peleng?
- Lebaka la go dira gore o amogelwe pele ke eng?
- O dutse nako ye kakang ka gae pele ga gore ba o amogele?

2. Pele gago amogelwa mo sepetlela, ke maemo afe ao a direlego gore o tjeye sephetho sa go hlahlobjwa bolwetsi bja HIV?

_Potseso_
- A o ile wa nagana ka go hlahlobjwa pele ga seemo se?
- Ge go se bjalo o nagana gore mabaka ke a mafeng?

3. Ge o thoma go hlahlobjwa bolwetsi bja HIV, o ikwile bjang ka goba le bolwetsi?

_Potseso_
- Sa le wa ba le nako ye o ileng wa kwa bohloko?
- Ke eng se se dirileng gore o ikwe ka mokgwa wo?
- Maikutlo ao ao tjeere nako e kakang
- O phetse bjang le ka mokgwa wo bego o ikwa ka gona ka moraga gago ba le bolwetsi bja HIV?
- O ikwa bjang bjale ka go phela le bolwetsi bja HIV?

4. Taba ya gore batho ba banang le bolwetsi bja HIV ba botje batho ba bangwe ka bolwetji o e bona jwang?

_Potseso_
- Ka mmono wa gago ba swanetje go botja batho ba bangwe goba aowa?
- Ke ka lebaka la eng o gopola ka mokgwa wo
• nagana gore ke mabaka a mafe ao a dirang gore batho ba se ka nyaka go botsa batho babangwe ka seemo sa bona?
• Botsesa mabaka a go kgetholla go hlatholla

5. O mpoditse mmono wag ago wa gore batho ba swanetje go bolela batho babangwe ka bolwetsi bja bona, ke be ke rata gore re bolele ka ga maitemogelo a gago mabapi le go hlathollela batho ka seemo sa gago. O kgonne goba ga wa kgona go botsa ba leloko la geno ka ga seemo sa gago?

6. Ge e ba o boditse ba leloko la geno , ke eng se se dirilego gore o ba botse

**Potseso**

• O boditse mang le gona ke lebaka lefe la go dira gore o mmotje
• Go o tjeere nako e kakang go hlatholla ka morago gago hlahlobja bolwetsi bja HIV? Lebaka?
• Motho yo o moditseng o e tsjeere bjang?
• Lebaka la go se botje ba bangwe ba leloko ke eng?
• Botsesa motho e mong le e mong yo a hlatholotseng

7. O mpoditse gore o boditse ba bangwe ba leloko la geno, ke kgopela gore o mpotse go o ba boditse bjang

**Potseso**

• Go ba botja ga gago ,o be o itukisheditje gona goba aowa?
• ba boditse mahlong goba ka tsela e nngwe?
• shomishitje mantswe afe ge o ba hlathollela?
• Botsesa go motho e mong le e mong yo a hlatholetseng leloko la gabo

8. O ikwile bjang ge o thoma go botja ba leloko la geno

**Potseso**

• Gabotse, go lokologa, go boifa, go se be le bonnete, go nama, go itshola?
• Esa le gwa ba le nako ye o bego o ekwa gore o a kgethollwa ka lebaka la go hlathollela ba geno seemo sa bolwetsi bja gago
• Ke mang yo a ilego a go kgetholla?
• Kgethollo yeo e tjeere nako e kaakang?
- Tswalano ya gago le ba leloko e fetogile bjang ge o seno ba hlalosetsa ka ga seemo sag ago? Ga e ba go bjalo naa ke di phetogo dife the o di lemogilego?
- Ke tswalano e feng ye e fetogileng?
- O ikwa bjang gona bjale?

**Di potseso tse di latelago ke tsa batho b aba hlatholotseng**

9. Ge e ba ga wa hlalosetsa ba leloko la geno, ke eng se se dirang gore go be boima go ba hlalosetsa

**Potseso**
- Go tshaba go kgethollwa
- Go tshaba go lahlwa
- Ke be ke nyaka go tshireletsatsa batswadi goba bana

10. O nagana go hlaloetsa ba leloko la geno seemo sagago nako ye etlago

**Potseso**
- Go swanetsi go direge eng gore o hlaloetse ba leloko
- O nyaka thuso go hlaloetsa ba leloko la geno?
- Ke mang yo o naganang gore a ka go thusa go hlalosa seemo sa gago?
- O tlo hlaloetsa mang?

11. O mpoditse gore o na le nako e telele o lwala, o botsa ba leloko la gago gore bolwetsi bja gago ke eng?

**Potseso**
- Ba leloko la geno ba go thusa bjang ge o lwala o sa ba botsa?
- botsa ba leloko la gago gore lebaka ke lefe la go amogelwa ga gago ka mo sepetlela?
- O nwa bjang dihlare ka tswanaelo ge o sa botsa ba leloko?

**Di potseso tse di latelago ke tsa batsea karolo ka moka (bahlatholotseng le bas a hlatholang)**
12. Sa le o thoma go lwala, ke mang wa leloko yo a go hlokomelang (go o thusa ka dinyakwa)?

**Potseso**
- Go baneng motho yo?
- O go fa thekgo ya mohuta mang?
- O hloka thekgo ya mohuta mang go tswa go motho yo le ba leloko la geno?
- O ba tshireletsa bjang go bolwetsi bja HIV ge ba o hlokomela?
- Ge e le gore ga wa botsa ba bago hlokomeemlang, mabaka a gago ke a afe?
Appendix 4: Informed consent English

Informed consent form: English

Name of Study: Disclosure of HIV status to family: A qualitative exploration with adult patients admitted at Jane Furse Memorial Hospital, Limpopo province

I have heard the aims and objectives of the proposed study and was provided the opportunity to ask questions and given adequate time to rethink the issue. The aim and objectives of the study are sufficiently clear to me. I have not been pressurized to participate in any way.

I understand that participation in this study is voluntary and that I may withdraw from it at any time and without supplying reasons. This will have no influence on the regular treatment that holds for my condition neither will it influence the care that I receive from the hospital.

I know that this study has been approved by the Sefako Makgatho Health Science University Research and Ethics (SMUREC). I am fully aware that the results of this study will be used for scientific purposes and may be published. I agree to this, provided my privacy is guaranteed.

I hereby give consent to participate in this study and will attend phase two if requested to attend.

____________________  ______________
Name of participant       Date

Statement by the Researcher
I provided verbal information regarding this study
I agree to answer any future questions concerning the study as best as I am able.
I will adhere to the approved protocol.

____________________  ____________________  ______________
Name of Researcher       Signature       Date
Appendix 5: Informed consent-Sepedi

**Informed consent: Sepedi**

**Name of Study:**

Ke kwele ka maikemišetšo a bakgopedi ba thuto ebile ka fiwa le monyetla wa go botšiša dipotšišo le nako ya go naganišiša ka seo. Maikemišetšo a ba thuto a kgwagetše bokaone mo go nna. Ga se ka gapeletšwa go tšea karolo. Ke kwešiša gore go tšea karolo mo thutong e ke go ithaopa le gore ke kgona go tšwa mo go yona neng le neng ntle le go fana ka mabaka. Se se ka se be le khuetšo efe goba efe go kalafo yaka ya ka mehla ya maemo a ka gape e ka se huetše le ge e kaba tlhokomelo yeo ke e humanago mo sepetlela.

Ke a tseba gore thuto e e dumeletšwe ke ba Sefako Makgatho Health Sciences University Research and Ethics Committee (SMUREC). Ke kwešiša ga botse gore ditlamorago tša thuto e ke go thuša batho le gore di ka phatlalatšwa. Ke dumelelana le se, ge e le gore maina a ka a ka se tšweletšwe.

Ke ithaopa go tšea karolo mo thutong e.

|_______________________|____________________|_______________|
|Leina la motšea karolo| Mosaeno wa mohlokomedi| Letšatši kgwedi|

Molaetša wa monyakišiše
Ke file polelomolomo go ya le ka thuto ee .
Ke dumela go araba dipotšišo tšeo di ka botšišwago go elana le thuto e.
Ke tla latela melao ya dinyakišišo yeo e filwego

|_______________________|____________________|_______________|
|Leina la monyakišiše| Mosaeno wa monyakišiše| Letšatši kgwedi|
Appendix 6: Ethical clearance certificate

Sefako Makgatho Health Sciences University
Research & Postgraduate Studies Directorate
Sefako Makgatho University Research Ethics Committee
(SMUREC)

Molotlegi Street, Ga-Rankuwa 0208
Tel: (012) 521 5617/6398 | fax: (012) 521 3749
Email: lorato.phiri@smu.ac.za
P.O. Box 183 Medunsa 0204

APPROVAL NOTICE - NEW APPLICATION

04 August 2016

Ms E Ralebona
Department of Public Health
P.O Box 215
Medunsa, 0204

MEETING: 06/2016
SMUREC Ethics Reference Number: SMUREC/H/158/2016: PG

The New Application received on 20 July 2016, was reviewed by members of Sefako Makgatho University Research Ethics Committee on 04 August 2016 and was approved on 04 August 2016.

Title: Disclosure of HIV status to family and primary care givers: A qualitative exploration with adult patients admitted at Jane Furse Memorial Hospital, Limpopo province

Researcher: Ms E Ralebona
Supervisor: Prof S Mafika
Department: Public Health
School: Health Care Sciences
Degree: MPH

Please note the following information about your approved research protocol:

Protocol Approval Period: 04 August 2016 – 04 August 2017

Please remember to use your protocol number (SMUREC/H/158/2016: PG) on any documents or correspondence with the REC concerning your research protocol.

Please note that the REC has the prerogative and authority to ask further questions, seek additional information, require further modification, or monitor the conduct of your research and the consent process.

After Ethical Review: Please note a template of the progress report is obtainable in the Research Office and should be submitted to the Committee before the year has expired. The Committee will then consider the continuation of the project for a further year (if necessary). Annually a number of projects may be selected randomly for an external audit. Translation of the consent document in the language applicable to the study participants should be submitted.

International Organisation (ICRG000028591), Institutional Review Board (IRB0000010389) Expiry date: 09 December 2018,
Federal Wide Assurance (FWA000023943) Expiry date: 31 August 2017 and NHREC No: REC 210408-003

Sincerely

[Signature]
DR C BAKER
DEPUTY CHAIRPERSON SMUREC

[Stamp]
Appendix 7: Approval from Jan Furse hospital

LIMPOPO
PROVINCIAL GOVERNMENT
REPUBLIC OF SOUTH AFRICA

DEPARTMENT OF HEALTH
SEKHUKHUNE DISTRICT

REF : 4/2/2
ENQ : Mashiane P.N
Tel : 015 633 2352

DATE : 06 December 2016

TO : JANE FURSE HOSPITAL

FROM: HUMAN RESOURCE UTILIZATION AND CAPACITY DEVELOPMENT

SUBJECT: APPROVAL FOR PERMISSION TO CONDUCT RESEARCH AT JANE FURSE HOSPITAL

1. The above matter bears reference.

2. The Head of Department has granted approval for Ralebona M.E to conduct research in your institution. Ralebona M.E has registered for a Master’s degree in Public Health at Sefako Makgatho Health Sciences University. The title of her research is “Disclosure of HIV status to family and primary care givers: A qualitative exploration with adult patients admitted at Jane Furse Memorial Hospital, Limpopo Province”.

3. The student will present herself, scope and schedule of her work in your institution during the assumption of research conduct.

4. Hope the matter is clear and understandable.

[Signature]
District Executive Manager
Mrs. Maepa M.L

[Signature]
Date 08/12/2016

Private Bag X04
Chuenespoort 0745. Tel: 015 633 2300. Fax 015 633 7927. Website: http://www.limpopo.gov.za

The heartland of southern Africa – development is about people