

Gender and disclosure of HIV positive status to sexual partners – The struggle of rural women in Sekhukhune district, Limpopo Province, South Africa

P.M. MAMOGOBO, M.E. LEKHULENI AND T.M. MOTHIBA

Department of Nursing Science, University of Limpopo, South Africa.
E-mail: Pamela.mamogobo@ul.ac.za

Abstract

Disclosure of HIV-positive status is a challenge to rural women for fear of stigma and rejection by the male partner. The purpose of this study was to describe the disclosure of HIV positive status to sexual partners by rural men and women. A qualitative phenomenological research design was used. Purposive sampling was used to select fifteen participants for the study. Semi-structured one to one interviews were used to collect data. The study revealed that rural women were fearful to disclose their HIV positive status as this may lead to losing their sexual partners. Two major themes emerged from the study: rejection versus acceptance of the sexual partner related to disclosure of HIV status and precipitating factors towards HIV infection transmission. The study recommends the formation of support groups to minimize the devastating impact of HIV disclosure and the implementation of necessary coping strategies.

Keywords: Disclosure, rural women, sexual partners.

How to cite this article:

Mamogobo, P.M., Lekhuleni, M.E. & Mothiba, T.M. (2014). Gender and disclosure of HIV positive status to sexual partners –The struggle of rural women in Sekhukhune district, Limpopo Province, South Africa. *African Journal for Physical, Health Education, Recreation and Dance*, June (Supplement 1:1), 100-112.

Introduction

Disclosure of positive Human Immune Deficiency Virus (HIV) status is an important component of public health goal (Medley, Garcia-Moreno, McGill & Maman, 2004). Disclosure of HIV positive status to the sexual partner, friends and relatives is a useful prevention and care strategy for people living with HIV (Kadawa & Nuwaba, 2009). The World Health Organization (WHO) recognises that disclosure of HIV-positive status is a behaviour modification strategy which ensures that HIV-positive clients take responsibility not to transmit the infection to sexual partners. Sexual partners of HIV-positive individuals are at high risk of contracting the disease. Disclosure of HIV-positive status to a sexual partner therefore provides insight into reducing the incidence of HIV transmission (Medley et al, 2004).

According to Maman and Medley (2004), rates of disclosure to past or current sexual partners range from 42% to 100% in developing countries and 86% in developed countries. The lowest rates of disclosure (16.7% to 32%) of HIV-positive status have been found in Sub-Saharan Africa, including South Africa, for antenatal women (Maman and Medley, 2004). It was also found that 10% to 78% of women in underdeveloped countries have a tendency not to share HIV-positive results with anyone compared to 3% to 10% in developed countries. Maman and Medley (2004) also found discrepancies between intentions to disclose and actual disclosure - the rates of the latter being lower than those of the former. In spite of this, disclosure rates for both developing and developed countries tend to increase over time (Maman & Medley, 2004).

Disclosure of HIV-positive status to sexual partners poses major social and health problems because the incidence of HIV-infected persons is growing at an alarming rate in South Africa. The HIV/AIDS strategic plan acknowledges HIV/AIDS as an epidemic in the country (DoH South Africa, 2006). Estimates of infected people in South Africa range from 18.8% in the adult population (15-49 years), of which 55% are women. Specifically, the prevalence of HIV/AIDS is estimated to be 40% for 25-29 years of age and 16% for the age group less than 20 years (DoH South Africa, 2006).

Benefits of disclosure of HIV positive status to a sexual partner include motivation of the sexual partner to test hence improving uptake of HIV counselling and testing. Such disclosure also creates awareness and risks associated with unprotected sex and reduce transmission of HIV and risky sexual behaviour amongst sexual partners (Kadawa & Nuwaba, 2009; Ateka, 2006). Added benefits amongst sexual partners subsequent to the disclosure of HIV positive status may include the tendency to improve access to necessary medical treatment thus providing the needed care for the couple. Consequently, sexual partners may start initiating discussion and plan for the future carefully and thoughtfully (Maman and Medley, 2004; Kadawa & Nuwaba, 2009).

Ateka (2006) study suggests that disclosure is beneficial if encouraged amongst sexual partners as it has better public health importance as compared to disclosure to the public. Ateka's (2006) study further indicates that disclosure of HIV positive status to the sexual partner does not always guarantee support and security that sexual partners will support and stay together along the HIV continuum. Some women, after disclosure of HIV positive status to their sexual partners, were subjected to abuse, rejection and abandonment. Some lost their children, permanent residence and economic support from sexual partners emanating from disclosure of the HIV positive.

Wilson et al. (2007) found that among 1,090 HIV-positive women attending clinics and hospital sites, one third of participants had newer sexual partners

within a six month period. In such new relationships, women were more likely to consistently use condoms, unlike in relationships that are established. There was no report on mutual disclosure of HIV-positive status as 21% of the women reported having two or more sexual partners and 21% of the women indicated inconsistent use of condoms.

Lack of status or subservient status of women in sexual relationships has been found as one of the contributing factors to the high incidence of HIV infections (Moore & Williamson, 2003). Financial constraints to meet personal needs predispose women to engage in unsafe sexual behaviours. Cultural beliefs and practices often allow men to have multiple sexual partners while women are submissive to men with little power to communicate and negotiate sexual practices. This lack of power of women makes it difficult for them to negotiate safe sex even when they know that their husbands have multiple sexual partners. Some women may not feel safe to initiate safe sex as they tend to be blamed for the spread of STI. A woman can be perceived as disrespectful when initiating and negotiating safe sex with her sexual partner. In several sexual relations, men are usually older than women (Moore & Williamson, 2003).

Seid, Wasie and Adamassu's (2012) study in Kemissie district of northeast Ethiopia showed that 93.1% of the 360 HIV-positive participants interviewed were able to disclose their HIV-positive status to sexual partners, 74% were accepted by sexual partners 10.8% had some challenges, and 7.8% faced physical abuse and blame. Those who did not disclose their status indicated that they feared divorce, stigma and physical abuse. Prior discussion with the sexual partner on intentions to test, including knowledge of the partner's HIV status facilitated the courage of the sexual partner to disclose HIV-positive status (Seid et al., 2012).

Vu et al. (2011), in a study undertaken in Cape Town, South Africa, found that HIV-positive clients were more likely to disclose their HIV-positive status to steady sexual partners. Clients who fear stigma are unlikely to disclose their HIV-positive status to sexual partners as stigma and discrimination were predominant in newer relationships. Norman et al. (2005) also conducted a study in South Africa where access to comprehensive management of HIV/AIDS care and ARV is low; and found that out of 18 women in the study 6 reported abandonment, rejection or stigmatisation from their sexual partners after they disclosed their HIV-positive status. Some women who were abandoned by sexual partners received alternative support from family members, neighbours or obtained professional support materially and emotionally. Family members remained a consistent material and emotional support group, thus contributing positively to their livelihood. Ateka (2006) reported that sexual partners broke from relationships where the partner knows the HIV-positive status of the other - 70% of participants continued to support their partners and 83% of HIV-positive

client broke their relationship. Therefore, the present study was carried out to investigate the experiences of a group of rural women in Sekhukhune district of Limpopo Province, South Africa concerning disclosure of their HIV positive status to sexual partners.

Methodology

Design

Qualitative phenomenological research design was used to find out the experiences of rural men and women concerning disclosure of HIV positive to their sexual partners. The target population was all people living with HIV/AIDS attending wellness clinic at a district hospital in Sekhukhune district of Limpopo Province. Purposive sampling was used to select fifteen participants for the study

Data Collection

The clinic manager and nursing staff assisted in the preparation for the interviews and granted access to patients' records. The process used in the clinic for return dates was established. Names of patients appearing in the diary due for follow up on the day of the research were noted down and every third client was selected. Eventually 15 participants (5 men and 10 women were selected).

The clinic manager provided a room where the researcher was able to interview individual clients in privacy. Verbal and written consents were obtained from each client before the interview. Data collection was done using semi-structured in-depth interviews with an open-ended question to guide the conversation with individual clients (Creswell, 2003). Probing was used for follow up questions and to elaborate more on the topic under discussion.

Field notes were taken during data collection which included non-verbal communication cues observed in individual interviews and their interpretations as noted by the researcher. These field notes were used also to validate the taped comments. Audiotape was used to capture the communication accurately and provided the opportunity for participants to directly share their reality of the phenomenon under study (Creswell, 2003).

Data analysis

Tesch's open coding data analysis outlined in Creswell (2003) was used to analyse the interview transcripts and field notes which addressed the research questions. The results are presented analytically in order to create a clear understanding of the phenomenon studied. Themes and sub-themes which

emerged from data analysis reflected struggles of rural women about disclosure of HIV positive status to sexual partners.

Results and Discussion

Two themes emerged during data analysis as presented in Table 1.

Table 1: Themes and Sub-themes

Themes	Sub-themes
1. Rejection versus acceptance of sexual partner related to disclosure of HIV-positive status	1.1 Disclosure of HIV-positive status - a difficult process for female participants versus a good idea to obtain support 1.2 Testing HIV positive and disclosure of HIV – positive status determined by the type of relationship in which women find themselves
2. Precipitating factors towards HIV infection transmission in females	2.1. Male partners get more agitated after the HIV- positive test 2.2. Male participants refuse to get tested and use condoms

Demographic data of the participants (Figures 1 and 2) such as age, gender, level of education, employment and marital status assisted the researchers to find out who amongst HIV-positive clients were able to disclose or not to disclose their status to sexual partners.

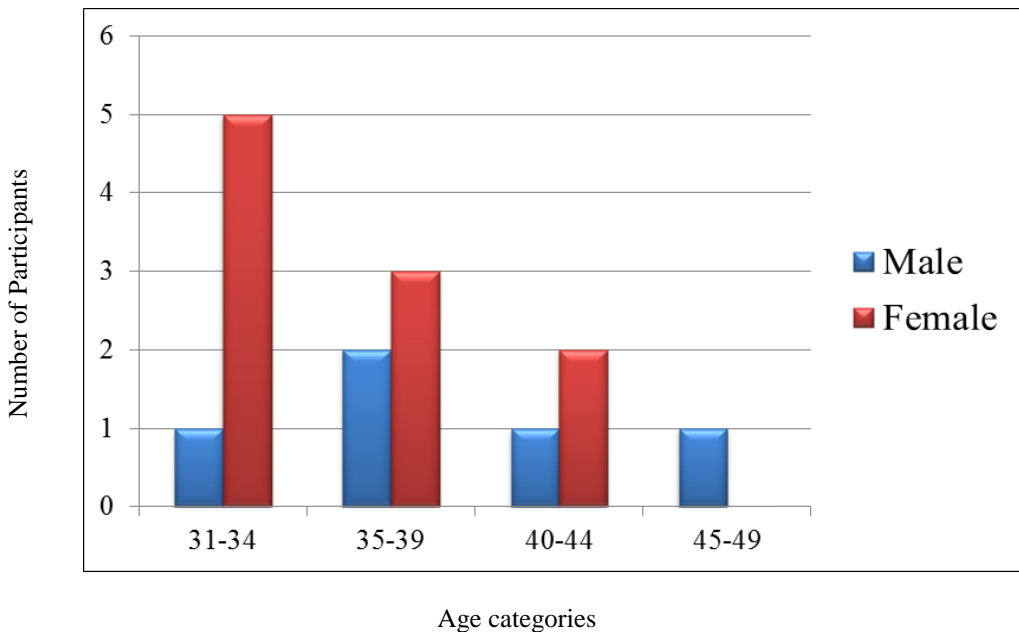


Figure 1: Gender and age of participants (n=15)

All male participants were able to disclose their HIV positive status to sexual partners. All males were either working or self-employed and 40% have studied up to tertiary level. Fifty per cent of female participants were unemployed and only 10% per cent attended tertiary education. Female participants who did not disclose were all unemployed. The ages of the participants ranged from 31 to 49 years (Mean age: 36.6 years). Figures 1 and 2 illustrate ages, level of education and employment status of the participants, respectively. The demographic data assisted the researchers to draw meaningful conclusions and information shared by the study participants.

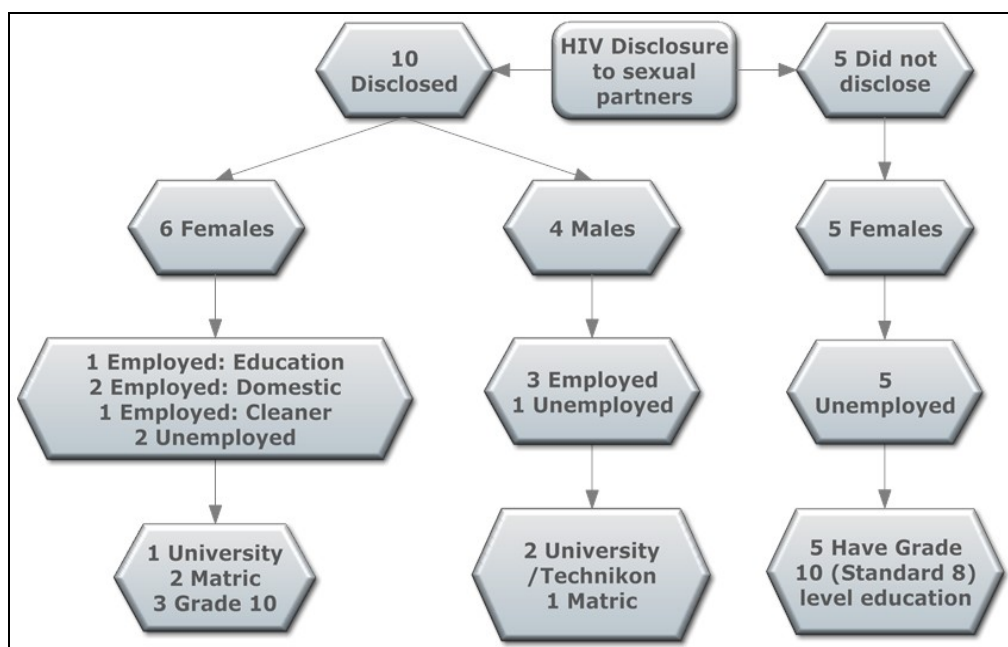


Figure 2: Gender, employment status and educational level of participants

Theme 1: Rejection versus acceptance of sexual partner related to disclosure of HIV- positive status.

The findings revealed that the participants experienced both rejection and acceptance by their sexual partners after disclosure of their HIV status.

Sub-Theme 1.1: Disclosure of HIV-positive status - a difficult process for female participants versus a good idea to obtain support

Women had a problem in disclosing HIV-positive status to sexual partners, in contrast to men who made immediate disclosures. Female participants below the age of 35 years were able to disclose more readily to sexual partners than older ones. Some participants experienced violence after disclosure of their HIV-positive status to sexual partners. The sexual partners refused to use condoms

and had unprotected sex. The participants also did not indicate whether they have tried to use female condoms. One participant said: *“It was difficult for me to disclose because he previously refused to present himself for treatment of sexually transmitted infections. I kept on motivating him for HIV test without disclosing. He was refusing. I left to stay with my brother, we both tested and he tested negative and I tested positive. I told him about my initial HIV-positive test then. After the test he blamed me for having not informed him about my intentions to test and not disclosing immediately. He, however, continued to refuse the use of condoms. We had sex without condoms.”*

The research findings are congruent with those of Gielen, McDonald, Burke, and O’Campo (2000) and Mkhize (2011) studies that indicated that some female participants endured non - disclosure of HIV positive status to sexual partners and continued to have unprotected sex for fear of dissolution of the relationship. Gielen et al (2000) further found that abuse was common among women who disclosed their HIV positive status to sexual partners and were not sure of the partners HIV status as there was never mutual testing and mutual disclosure of the HIV status. Parsons et al. (2004) also reported negative experiences of women who disclosed to male sexual partners with unknown HIV status which included stigma, rejection, loss of intimacy and threats.

In this study participants responses implied that disclosure of an HIV-positive status is a difficult process for female participants and some female participants could choose not to disclose their status for fear of comprising the financial and material support provided by the spouse especially where the female partner is not employed and depends on her spouse. Mkhize’s (2011) study indicates that participants reported breakups in marriages and sexual relationships with sexual partners after disclosure of their HIV-positive status.

Sub-Theme 1.2: Testing HIV positive and disclosure of HIV- positive status is determined by the type of relationship in which women find themselves

Only six out of 10 women who participated in this study were able to disclose their HIV-positive status to their sexual partners. Out of the six that disclosed the HIV positive status one was rejected by the spouse who tested HIV negative. Only one woman had mutual test with the husband after both did not believe the initial HIV positive test during pregnancy. The couple could only use condoms consistently when the health of the husband deteriorated and he agreed to be tested with the wife as he was confirmed HIV- positive. The four other female participants have disclosed to male sexual partners but were not sure of the male sexual partners HIV status. They have continued to have unprotected sex and some even had children despite their positive HIV status.

The following are the storylines of the couple who volunteered to participate in the study as one partner was sampled for the interview

Story line from the woman: *“I tested HIV positive in 2009 and I was pregnant. I disclosed the results to my husband. We both thought that the results were wrong; the machines were not giving the correct readings. I was given nevirapine and baby also given treatment after birth. My baby is well not positive with HIV test. We continued to have unprotected sex because we did not trust the results during pregnancy and after the birth of the child.”*

Storyline from the man: *“I started to have loss of appetite and feeling nauseas. I felt tired. My wife even stopped using her favourite spice because of my nauseas at the smell of food. I thought I was feeling nauseas and unable to eat because of the smell of the spice. I was however able to continue taking my beer without any problem. I then asked my wife to accompany me to a doctor as I started vomiting food. The following day we went to the HIV clinic where we tested together and both found to be having the virus. Nurses congratulated my wife for bringing me for testing. Treatment was then prescribed. Sister I must tell you that “I am married to a good woman. We care and love each other. We are actually a good family. I am the one who brought the disease “. I would cheat when I am at work”.*

Storyline from one of the female participants: *“I tested positive in 2009. I was sick and I wanted to go to the clinic to have HIV test. I was open to my parents and my sexual partner. My parents took me to traditional healers and my partner said “I don’t think you are HIV- positive” don’t think about that. I never had a problem in telling my partner that I have tested HIV- positive. I trusted him because I’ve been staying with him for some time and I know the type of person he is. I was not afraid to tell him about my HIV- positive status. I was sick. I needed help. I asked and discussed with him before going for a test. When I came back with the results I was able to communicate with him. He accepted me and said it is part of life. He was able to support me emotionally and with money for food throughout 2009. He paid me a visit whilst I was in my parent’s home as I left for treatment here at home. He was able to provide me with R500 every week so as to buy food as I was told preferred food that I could eat as I was sick and thin.My partner is a good person “I think I am the one who brought the disease as I had other relationships after my divorce. I might have contracted it then. Not from him. He is a good caring man. I don’t want to tell lies”*

Storyline from one female participant who was subsequently rejected by her husband: *“He gave me the medical aid to use in case I needed any consultation. I then started attending the clinic where I received treatment and became better. Now he no longer pays me a visit. He somehow doesn’t allow me to visit him in*

..... *He has even cancelled the medical aid. He however supports his son with money for school and he allows him to pay him a visit during holidays*

Wilson et al. (2007) found that one - third of female study participants in steady relationship, were able to share HIV- positive status to sexual partners as compared to women in newer relationship. Predominantly, women who had newer relationships were able to use condoms consistently in new relationship even though verbal sharing of the HIV positive status was challenging. Mucheto et al. (2009) and (WHO, 2004) therefore recommended that HIV positive clients should be encouraged to disclose their status to sexual partner as this could reduce the incidence of HIV. Ateka (2006) indicated that sharing of HIV positive status is beneficial to public health and clients should be encourage to disclose their status as social and psychological acceptance and support depends on how the other partner perceives the social environment in which the two live in.

Theme 2 Precipitating factors towards HIV infection transmission in females

The findings indicate that there are a number of factors which precipitate HIV infection transmission in women. The discussion of the precipitating factors is reflected in the sub-themes below.

Sub-Theme 2.1 Male partners get more agitated after HIV- positive test

Out of the five male participants, only one male ensured consistent use of condoms. All of the 4 male participants did not consistently use condoms and some continued to have children with women of unknown HIV status did not disclose their own positive HIV status.

The following are excerpts from two of the male participants: *“I was then told that I am HIV positive.I then did the second test which tested positive and my wife was negative. I was told to use condom with every sexual intercourse. I was started on treatment.At home we continued to use the condom as we were told. My wife would always remind me. As time went on I felt bored with the condoms because both of us were young and we did not have children. I discussed the use of condoms and having children with nurses in the clinic. I was told that treatment is life long and I cannot have children maybe I could try that after 5 years. This would also depend on God’s mercy”*.

The other male participant shared his own experiences by stating that: *“I have a child with another woman as we subsequently separated after some undisclosed disagreements at home. This is another woman. I never told her that I am HIV-positive. It took up to six months to do so. It would bother me. Each time I*

wished to tell her that I am HIV- positive and the treatment that I am taking is for HIV. I was afraid my conscience couldn't allow me. I looked at her and she looked to be well without a disease what if she leaves me? I love her. This feeling prevented me from telling her. I love her and I wanted to stay with her. I felt pity for her. We were not using condoms. I would sometime give her my treatment thinking that it would help her even though she didn't look sick. I love her and I wanted her to be with me. I thought if she is negative and if she would know my HIV- positive status she would leave me and I love her and wanted to stay with her”.

The other male participant shared his experience as well:

“I tested HIV- positive in 1986 and on treatment since then my wife tested negative and we did not use condoms as she is negative. We had three children and she died due to cocaine overdose I have about 18 children including children from my marriage, with different women. I am not sure of other women's HIV status and I did disclose mine.”

Relf et al. (2009) reported that some male study participants indicated that they disclosed to sexual partners, used condoms consistently as it is their responsibility to be truthful and honest to their sexual partners. However Kalichman, Rompa, Luke and Austin's (2002) study found that some of HIV - positive male participants continued to have unprotected sex with steady sexual partners and casual sexual partners in spite of indicating that they have disclosed that HIV-positive status to sexual partners. Bruce, Harper and Suleta, (2012) study indicated that some male participants on ARV with undetectable viral load continued not use condoms with female sexual partners with unknown status, as they believed that HIV was no longer infectious.

Sub-Theme 2.2: Male participants refused to get tested and use condoms

One of the female participants was able to disclose HIV positive status with the sexual partners but the male sexual partner indicated negative HIV test from elsewhere. Some male sexual partners continued to refuse consistent use of condoms in spite of the HIV positive results of the female sexual partners. One female participant tried to persuade the sexual partner to test and to use condoms. All female participants did not indicate the use of female condoms as one method of preventing re-infection.

A female participant, who failed to disclose her status directly but only did so in a form of parables shared her disclosure story as follows *“I tested HIV positive in 2004 and on antiretroviral for eight years. My partner has tested and says is negative. I did not disclose my HIV- positive status to him directly but requested that we should test for HIV. He is refusing to test with me. Our child who was*

born in 2005 is HIV- negative. Our relationship still continues. His wife had TB and was given treatment for 6 months. Seemingly his wife, to whom he is formally married to, is sick as I found a bottle of empty “Alluvia”. He did admit that the wife seem to be ill as she once developed abscesses. Since that time I recommended the use of condoms during sex as he suspect that the wife is ill and is not telling him. This gives me strength not to tell my boyfriend as he trusts that I am fine. Each time I enforce the use of condom; it is not easy. To my horror he wants another baby”.

Cooper, Harries, Myer, Orner and Bracken (2007) indicate that cultural and social expectations for men and women who do not have children and are HIV-positive impact on the response regarding consistent use of condoms and reproductive choices. Perceived reproductive prospects from social circle of HIV-positive participants create a painful dilemma for reproductive choices. Mucheto (2009) therefore suggested that HIV positive clients should be capacitated during wellness clinic so that they could be able to challenge normative values within the communities that question reproductive choices related to their HIV positive status

Recommendations

Based on the findings the following recommendations are made:

Programmes and projects offering HIV/AIDS counselling should prioritize disclosure of clients' HIV-positive status to sex partners. Couple counselling *with mutual disclosure amongst sexual partners should be strengthened and individual couples have difficulties to test and disclose their status should be supported and encouraged to do so.* Skills of health workers providing counseling, testing and comprehensive HIV and AIDS care should be upgraded to enable the health workers to be enhanced in skills and ways that will support clients to manage the process of their HIV - positive disclosure to sexual partners. Documentation on disclosure of HIV-positive status of individual clients should be kept in the files of clients attending wellness clinics, especially those who are still sexually active. Multidisciplinary health teams should develop innovative ways that would enhance partner testing with mutual disclosure amongst HIV clients attending the clinic.

Community groups should be formed in rural areas that include chiefs and other important people in the community who will support HIV positive women in abusive relationships. Such community groups should challenge cultural and social norms that oppress women and sustain women abuse thus predisposing them to HIV infections.

Further research should be undertaken to develop a model of care support on disclosure of HIV/AIDS in rural settings such as St Rita's Hospital Wellness Clinic that provides comprehensive HIV and AIDS services.

Conclusion

Disclosure of HIV- positive status amongst sexual partners with consistent use of condoms is an essential component of comprehensive HIV/AIDS care. Women in rural areas continue to face challenges with sexual partners to ensure control of transmission of HIV through disclosure and consistent use of condoms. Status of women in sexual relationships based on unemployment, cultural pressure that continues to challenge women in efforts to control incidence of HIV within rural communities must be challenged in communities. Health centres and health workers that offer HIV testing and counselling should priorities disclosure of HIV- positive status amongst couples based on policy and endeavour to safely provide support for women with such challenges to do so. Community structures that will demystify HIV disclosure should be formulated to contribute meaningfully to reduction of HIV infection.

References

- Ateka, G.K. (2006). HIV status disclosure and partner discordance: A public health dilemma. *The Royal Institute of Public Health*, 120, 493-496.
- Bruce, D., Harper, G.W. & Suleta, K. (2012). Sexual risk behavior and risk reduction beliefs among HIV-positive young men who have sex with men. *AIDS Behavior*. Published online 15/2/2012.
- Cooper, D., Harries, J., Myer, L., Orner, P & Bracken, H. (2007). "Life is going on": Reproductive intentions among HIV-positive women and men in South Africa. *Social Science and Medicine*, 65(2), 274-283.
- Creswell, J.W. (2003). *Research Design. Qualitative, Quantitative and Mixed Methods Approaches*. London. SAGE Publications.
- Department of Health South Africa (2006). HIV and AIDS and STI strategic plan for South Africa 2007 – 2011. Government printers: Pretoria
- Gielen, A.C., Mcdonald, K.A., Burke, J.G. & O'Campo, P. (2000). Women's lives after an HIV-positive diagnosis, disclosure and violence. *Maternal and Child Journal* 4(2), 111-120.
- Kadowa, I. & Nuwaha, F. (2009). Factors influencing disclosure of HIV-positive status in Mityana district. *African Health Sciences*, 9(1), 26-33.
- Kalichman, S.C., Rompa, D., Luke, W. & Austin, J. (2002). HIV transmission risk behaviours among HIV-positive persons in serodiscordant relationships. *International Journal of STD & AIDS*, 13, 677-682.

Maman, S. & Medley, A. (2004). Gender dimensions of HIV status disclosure to sexual partners: Rates, barriers and Outcomes. A review paper. Geneva, Switzerland: World Health Organization.

Medley, A., Garcia-Moreno, C., McGill, S. & Maman, S. (2004). Rates, barriers and outcome of HIV serostatus disclosure among women in developing countries: implications for prevention of mother-to-child transmission programmes. *Bulletin of the World Health Organization*, 82(4). Geneva, Switzerland: WHO.

Mkhize, L. (2011). The psychological effects of disclosing HIV diagnosis: A preliminary investigation. A master of clinical psychology thesis. Accessed on 14/8/2012 from <http://hdl.handle.net/10386/286>.

Moore, A.R. & Williamson, D.A. (2003). Problems with HIV/AIDS prevention, care and treatment in Togo, West Africa: Professional caregivers' perspective. *AIDS Care: Psychological and Socio-Medical Aspects of AIDS/HIV*, 15(5), 615-627.

Mucheto, P., Chadambuka, A., Shambira, G., Tshimanga, M., Notion, G. & Nyamayaro, W. (2009). Determinants of nondisclosure of HIV status among women attending the prevention of mother to child transmission programme, Makonde district, Zimbabwe. *The Pan African Medical Journal*, 8, 51.

Norman, A., Chopra, M. & Kadiyala, S. (2005). HIV disclosure in South Africa: Enabling the gateway to effective response. <http://www.ifri.org/renewal> www.google accessed 28 November 2009.

Parsons, J.T., Van Ora, J., Missildine, W., Purcell, D.W. & Gomez, C.A. (2004). Positive and negative consequences of HIV disclosure among seropositive injection drug users. *AIDS Education and Prevention*, 16(5), 459-475.

Relf, M.V., Bishop, T.L., Lachat, M.F., Schiavone, D.B., Pawlowski, L., Bialko, M.F., Boozer, D.L. & Dekker, D. (2009). A qualitative analysis of partners selection, HIV serostatus disclosure, and sexual behavior among HIV-Positive urban men. *AIDS Education and Prevention*, 21(3), 80-297.

Seid, M., Wasie, B. & Adamassu, M. (2012). Disclosure of HIV-positive Results to a sexual partner among adults clinical service users in Kemissie District, Northeast Ethiopia. *African Journal of Reproductive Health*, 16(1), 97 – 104.

Vu, L., Andrinopulos, K., Matthwes, C., Chopra, M., Kendall, C. & Eisele, T.P. (2011). Disclosure of HIV status to sex partner among HIV-infected men and women in Cape Town, South Africa. *AIDS Behaviour*, Published online January 2011 accessed from www.google on 15/6/2012.

Wilson, T.E., Feldman, J., Vega, M.Y., Gandhi, M., Richardson, J., Cohen, M.H., McKaig, R., Ostrow, D., Robison, E. & Gange, S.J. (2007). Acquisition of new sexual partners among women with HIV infection: Patterns of Disclosure and sexual behavior within new partnerships. *AIDS Education and Prevention*, 19(2), 151-159.

World Health Organization (2007). Guidance of provider initiated HIV testing and counseling in health facilities. Accessed from www.google scholar on 15/6/2012.