**UNIVERSITY OF NAIROBI**

**DEPARTMENT OF SOCIOLOGY AND SOCIAL WORK**

# A COMPARATIVE STUDY ON FACTORS THAT DIFFERENTIATE HIV POSITIVE WOMEN WHO DISCLOSE THEIR STATUS FROM WOMEN WHO DO NOT DISCLOSE

## (A CASE STUDY OF RGC SUPPORT GROUP THERAPIES IN MATHARE SLUMS)

**BY**

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**A research project presented in partial fulfillment of the requirements for the award of the Degree of Master of Arts in Sociology (Rural Sociology and Community Development), University of Nairobi**

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## DECLARATION

I declare that this research project is my original work which has not been presented for a degree in any University.

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Registration number: C50/8621/2003

Signature …….

Date …….

This research project has been submitted for examination with my approval as the University supervisor.

……

Professor E.K. Mburugu

Date ……...

## DEDICATION

I dedicate this project to God Almighty my creator, my source of inspiration, wisdom, knowledge and understanding. He has been the source of my strength throughout this program and it is by His grace I have come this far. I also dedicate this work to my husband; Rev Joel Gitahi who has encouraged me all the way and whose encouragement has made sure that I give it all it takes to finish that which I started. I also dedicate this project to my children Rachel, Brian, Victor, Michael and our granddaughter Madeline who always encouraged me to soldier on. Thanks for your understanding and allowing me to take your time. My love for you all can never be quantified.

God bless you

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I would also like to thank the team that helped me collect the data from the field. I would not have made it alone and thus appreciate them for a good job done.

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## ABSTRACT

The study investigated the factors that differentiate HIV positive women who disclose their status from women who do not disclose. The researcher concentrated on women who live in Mathare slums and attend support group therapies at RGC. The main objective of this study was to establish the factors that differentiate HIV positive women who disclose their status from those who do not disclose. The study adapted a descriptive research design to draw a sample of 93 respondents to whom a questionnaire was administered to provide quantitative data. Qualitative data was collected through use of an interview schedule administered to key informants. Data was analyzed to yield descriptive statistics, namely frequencies and percentages and presented in form of tables and charts. Content analysis was used to yield findings from qualitative data.

The findings indicated that majority of women living in slums are HIV positive with no steady form of income. They are either employed as house helps on daily basis or contracted casually to wash clothes in various households. Opinion was equally divided on those who disclosed and those that did not disclose. Even those who disclosed significantly agreed that disclosing ones' HIV status causes rejection, blame, discrimination, stigmatization, separation, divorce and distorted relationships.

The above factors contribute to fear and hence majority of women do not disclose for fear of the above consequences. In addition, disclosure was identified to negatively affect relationships at the short term though with community education and counseling the perception changed and they were positively embraced in the society. Various factors contributed and encouraged women to disclose. However, fear of rejection, discrimination, stigmatization, separation and divorce held back women who did not disclose their status.

Thus, it was recommended that, community education and participation in HIV programs ought to be intensified and designed to be all inclusive. This would remove the fears associated with non-disclosure. Women who disclosed were observed to live a happier life, optimistic and fearless due to overcoming the hurdles associated with negative effects of disclosure. Their adherence to ART was also high and they received care, support and interactions from peers in various support groups they attend. This was unlike those women who never disclosed their status who were in constant fear and did not adhere to ART procedures.

# CHAPTER ONE: INTRODUCTION

## 1.1 Background

Human Immunodeficiency Virus (HIV) is an epidemic that has continuously put human health into a high risk. In Africa, an estimated 30 million people lived with HIV in 2010 while 2.6 million new infections were recorded the same year (UNAIDS 2010). Sub-Saharan Africa which accounts for over 67% of the world's HIV-infected persons about ninety percent of the two million children below the age of fifteen years have HIV virus (Bocquier et al., 2011: Fotso et al., 2007: Harpham, 2009; Satterthwaite, 1995). These limitations are mainly as a result of environmental challenges and inadequate amenities in slum areas (United Nations Human Settlements Programme, 2003). In Kenya, Nairobi city just like any other developing economy has attained a high rate of growth in the last three decades. However, an approximately sixty percent of the urban populations are believed to live in slums (United Nations Population Division, 2008). Slum structures are temporary; they lack proper planning while they are overcrowded with poor hygiene and uncertainty (African Population and Health Research Centre, 2002). Unemployment rates are escalating and most of the residents are involved in cheap trading or causal labour (Beguy et al., 2010). Residents of these settlements are highly affected by mortality and poor quality health care as compared to urban dwellers (Begy et al., 2010 Kyobutungi et al., 2007; Ziraba et al., 2009a. 2009b).

The spread of the HIV virus in Kenya intensified when it was first declared in 1984. Later, it became a leading cause of mortality hence creating a need for the government and the entire health sector in Kenya to find preventive measures of the deadly virus. The virus has affected different sectors across the economy including adults and children.

In June 2011, Kenya's president participated in reviewing the status of HIV/AIDS in Kenya in company of other heads of state. In meeting a serious concern was raised about the new infections and strategies to curb and manage the infections. The prevalence of HIV in Kenya is estimated in accordance to the demographic and Health Survey (2003 and 2008/9). The population based surveys the last ten years indicates that HIV spread among women between the ages of 15-49 ranged from 6.7% in 2003 `to 5.6% in 2012. According to National AIDS Control Council– article (Maisha!) of 2014 Kenya HIV County profile, Kenya has an aggregate of 6% with an estimated 1.6 million who live with the virus. Kenya is ranked top six among the countries facing the highest burden of HIV/AIDS in Africa. It affects the spread of the virus however, in slum areas the level of prevalence is twice compared to the national rate. Slums face risks of scarcity of resources and this makes its prevention almost impossible (Petterson & Hannah, 2012).

In most parts of Sub-Saharan Africa, HIV prevalence is mostly concentrated in the urban areas while the rural areas are highly neglected. Records shows that majority of the residents in the slums are highly exposed to sexual activities compared to other sub-groups however, research shows that residents living in the slums have the highest risk of being infected by the virus. In accordance to these studies, prevalence is high in slums because of several reasons that include multiple sexual partners, lack of awareness, unemployment, abuse of drugs and alcoholism (Dandoo at al. 2002: Zulu et al: 2002, 2003). It can be argued that there exists a link between age and HIV infection because age is strongly attributed to sexual experience and frequency. The age and the trend of HIV infection in the Africa continent has continued to rise, those under the age of 20 years and over 40 years having the highest rate of prevalence (Montana et al. 2007).

In the case of slum population, there exists no decrease in HIV spread after 49 years of age with an exception of the age between 40-44 years in men. The pattern of HIV among the slum residents has been rising; this can be attributed to a hypothesis that a longer period of slum exposure has a high likelihood to increase the risk of infection among old residents. Majority of the slum migrants are aged below 25 years which is a large proportion of older slum residents that may have lived in the slums for longer (Beguyet el... 2010). Ethnic variation in HIV signifies the cultural variances in practices which are connected to HIV infections. Locally, the 'Luo' ethic community is leading in HIV infection (Akwara et. 2003 & Bailey et al ...2002). Extant literature concerning marriage and infection of HIV in the African context is mixed-up. Some scholars indicate that women are more vulnerable compared to male, others indicate that late marriages have a nexus with HIV spread may be due to long duration of exposure to premature sex and multiple partner exchanges (Bongaarts, 2007).

Reniers (2008) notes that there lacks a difference in HIV rates of infection between unmarried and recently married couples. However, marital termination either through divorce or widowhood is connected with high risks of HIV infection. In part, this can be easily be explained by the virtue of the fact that, HIV spread in countries such as Kenya, scattered cases of dead spouses are HIV infected while their spouses risks to be infected. Bruhns and Ramona (2006) note the existence of two aspects which they thought were critical to make an analysis. In the first place, it was observed that a stable HIV spread caused untimely adult mortality while destroying human capital and minimizing the labour force significantly. Secondly, the future generations are weekend.

Children left orphan and surviving adults are weakened both financially and psychologically. This contributes towards the decline of per capital income while making it difficult for communities to raise and educate their children. Theoretical model assumes that parents raise and educate their children for prepare them to be future leaders and to cultivate good morals in them. This model has been calibrated with the help of data in the period 1920-2000. The long-run influence of the disease that depends mainly on the expectations of the parents concerning the future mortality rate can be estimated for duration of 40 years (2000 to 2040).

Bruhns and Ramona (2006) posit that most of the new infections are exhibited among the youth in particular women of ages between 15-24 and men aged 30 years and below. At least, 70% of most of the Kenyan children are born by mothers, who are less than 30 years of age. A high prevalence rate of HIV and AIDS in this category might strongly affect the manner in which families raise their children. When parents are ill, the family income might be affected because they are less productive or because of the stigma to those infected and have difficulty in getting employment. High treatment costs increases become a burden to household's income. Children from families affected by the deadly virus have less access to parental love and guidance. In many cases, they lack access to quality education while they have to work extra-harder to support their siblings. The reason why most parents die between 8-10 years is because of the cost of treatment and lifestyle which is too expensive.

UNAIDS (2013), report depicts that Kenya is presently in the list (number 4) of the largest HIV epidemic in the world (alongside Mozambique and Uganda), based on the total number of people who live with the deadly virus. In 2013, 1.6 million people live with HIV. An estimated 58, 0000 people died from AIDS related infections in the same year even though this decreased by 32%

(2009-2013). Apparently, 1.1 million children are orphaned by the deadly virus. HIV prevalence escalated in 1996 when it was recorded at 10.5%, on the contrary, it declined with a percentage of six in 2013, and this was attributed to scaling up of Antiretroviral Treatment (ART).

Recent research shows that spread of HIV is common among men who have sexual intercourse with their fellow men (MSM). In 2010, Spread of HIV among men who have sex with their fellow men was projected at 18.2%. Use of condom was found to be low but it increased. In 2013, an approximate 69% of MSM indicated that they used condom in their last encounter from 55%, in 2011. However, same sex relationships are illegal in Kenya while they might carry a prison sentence for up to twenty one years.

Homosexuality is perceived as a taboo and against the cultural values because it is seen as a contributor towards stigma and acumen in MSM including lesbians. This prevents many people from accessing HIV services because of harassment. In 2011, at least 18.3% of people who used hard drugs and injections lived with HIV; many of them are concentrated in Nairobi and Mombasa (National AIDs Control Council of Kenya, 2004). Even though the rate of spread of HIV has declined locally, women are still being affected by this epidemic. In 2012, 6.9% of women had contracted HIV unlike 4.2% male. Women between the ages of (15-24) are 3 times more likely to be living with HIV as compared to men of similar age (3% and 1.1% respectively).

Most parts of Sub-Saharan Africa, girl child face discrimination in access to education, employment and healthcare. As a consequence, men mostly control sexual relationships with women while they rarely practice safe sex even when they are aware about the risks involved.

Young women in Kenya are more than three times exposed to sexual violence than men. In many cases, they are forced into early marriages hence unable to negotiate for safe sex. Young women have less knowledge concerning HIV as compared to young men.

Demographic Health Survey of 2014 indicated that only fifty four percent of the young women understood ways to prevent HIV prevention as compared to 64% of young men (UNAIDs 2013, 2014). Mathare is the oldest slum in Nairobi County. Here majority of its residents live on an income of less than 1 dollar a day. Cases of crime and HIV are popular hence the popular of orphaned children and destitute is high. POZ magazine (2016) indicated the level of stigma that is currently being faced by people living with HIV which led to fear making it difficult for those who contracted HIV and AIDS to disclose their status. Although Kenyans were enlightened about HIV and ways of handling people who were infected with the virus, stigma was still a major problem among communities, family members, relatives and employers.

**1.2 Problem Statement**

From the OHTN literature review (2013), non-disclosure is often used as a mechanism to achieve a person's identity goals, which might be to maintain a positive identity and avoid stigma and discrimination. This study reports that if there are regrets about any disclosure event, they generally fall into six categories which include: lack of preparation, poor timing, and wrong context of setting, unsatisfactory disclosure, second hand disclosure and negative outcome.

The number of PLWHIV is estimated to have increased from about 1.4m in 2009 to 1.6 million in 2013. Women in Kenya with HIV prevalence rate of 7.6% are more vulnerable to HIV infection compared to men with a prevalence rate of 5.6%. About 80% to 90% of the PLHIV are

adults. One characteristic of PLWHIV is disclosure. (Maisha! – National AIDs Control Council 2014).

Taylor & Francis (2015) reported that prevention of pregnancy and related stigma and rejection were prioritized above HIV disclosure particularly within casual relations. They further say that disclosure of HIV is an anxiety-provoking experience. They attribute discouragement to disclosure to fear of rejection, exposure and stigma. Taylor & Francis state that HIV serostatus disclosing among the people living with HIV/AIDS is an important component of preventing HIV transmission to sexual partners. Due to barriers like stigma however, many PLWHIV do not disclose that serostatus. Although lots of awareness and trainings have been conducted by the government, non-Governmental Organizations, CBOs, Faith based organizations and other groups; it seems that the issue of disclosure has not been achieved yet.

Heather Worth, Cindy Patton and Diane Gold Stein (2008), state that many HIV positive individuals find it desirable to share information about their HIV status with their partners. The circumstances and timing often vary. Whilst some people are able to tell their sexual partners immediately, others may hold back because of concerns about negative consequences. For many people HIV disclosure is not an event or a onetime conversation. It is a process that takes time and constant communication. Heather Worth, Cindy Patton and Diane Gold Stein (2008) further reported that lack of disclosure has been described legally as fraud, criminal nuisance, and many other charges in additional jurisdiction. They say that these charges assume that everyone can disclose their status at the time of every sexual act. They say that studies demonstrate that there are many valid cultural reasons why individuals do not disclose their HIV status, including fear of domestic violence, fear of familial or partner abandonment, and the community rejection.

They report that these real impacts make disclosure of one's status nearly impossible for many particularly for new diagnostic individuals who are already trying to absorb the shock of their possible death. For some individuals, they say that it is likely that non-disclosure was tied to denial of HIV status and what the implications of that status might mean in terms of safe sex. As the HIV and AIDs pandemic devastates families and communities, the burden is falling most brutally on mother's living with HIV because of the deep rooted stigma. The impact of stigma threatens the well-being of 16.4 million of women living with HIV worldwide affecting her decision making, parenting, participation in social, economic and environmental activities (UNAIDS, 2008).

Findings of a study conducted by BMC health services (2014) show that many women living with HIV report high level of anticipated stigma, resulting in a desire to hide their status from family and friends for fear of being discriminated against. Many women feared desertion following disclosure of their positive status to partners. Consequently, some women preferred to hide their status and adhere to HIV treatment in secret. The study shows that anticipated stigma leading to low disclosure is widely spread and sometimes reinforced by health providers' actions and facility layout contribution to enacted stigma.

It is upon this background that this study aimed at evaluating how disclosure and non-disclosure among women who are HIV positive in the slums of Mathare impact the spread of HIV. The study looked at the gaps not addressed by studies with the aim of encouraging disclose to reduce HIV prevalence. This was achieved through a comparative study to establish factors that differentiate between women who disclose their HIV status and those who do not disclose.

### 1.3 Research Questions

I. What factors underline fears of disclosure among PLWHIV?

II. Is disclosure associated with the likelihood of spread of HIV infection?

III. Does disclosure affect relationships among women and family members?

IV. What are the social factors that differentiate between HIV disclosure and non-disclosure in women?

### 1.4. Objectives of the Study

#### 1.4.1 Main objective/Purpose of Study

The main objective of this study was to establish the factors that differentiate HIV positive women who disclose their status from those who do not disclose. The purpose is to increase disclosure and improve overall health of the HIV victims. Disclosure is also expected to play a significant role of reducing new HIV infections.

#### 1.4.2 Specific Objectives

The specific objectives of this study were:

I. To identify factors that are the basis of fear of disclosure among women living with HIV in Mathare slums.

II. To establish whether disclosure influence spread of HIV infection in Mathare slums.

III. To examine how disclosure or non-disclosure of HIV positive status affects relationships among women.

IV. To establish factors that differentiates between HIV disclosure and non-disclosure among women in Mathare slums.

### 1.5 Justification of Study

Understanding what promotes disclosure of an HIV diagnosis to partners, friends and family are important for a number of reasons. First, disclosure to at- risk partner permits them to play

greater role in either allowing or not allowing unsafe sexual or drug – sharing behavior to occur. Thus disclosure could be a pivotal factor in reducing the behaviors that continue the spread of HIV (Marks, Richardson, & Maldonado, 1991). Second, because disclosure is necessary prerequisite for acquiring social support, revealing one's serostatus becomes an important mental health factor. It has also been demonstrated that suppressing thoughts or communication about difficult experiences can increase the likelihood of stress – related problems (Grenberg & Stone, 1992: Penne baker., Colder & Sharp, 1990). Finally, individuals disclosing to friends and family who provide helpful links to education, health care and the needed social support also demonstrate improved physical health.

For person living with HIV, consequences of disclosing are substantial. Sharing HIV positive diagnosis can provoke feeling of anxiety and threats to personal wellbeing. As Bolund (1990) stated when discussing cancer, "there is one disease AIDS, that has a similar strong attribution of dread" (p 13). Negative social consequences external to the HIV positive individual, such as fear expressed by others, ostracism and degradation may be experienced (Macklin, 1988). Negative emotional consequences of disclosure that have been documented include rejection, abandonment and isolation (Lovejoy, 1990), Zuckerman & Gordon 1988).

This study was not only important to RGC but also to donors and policy makers who support initiative to raise HIV disclosure particularly in urban slums. This study strived to find out from HIV positive women living in the slums of Mathare the reasons why disclosure is still an issue or a problem. Also, it sought to find out from those disclosing the reason they disclose their status and impacts of their disclosure. This is as a result of the challenges being seen among women living with HIV who are not ready to disclose their status. Hence, the study gave the researcher

facts to be used to address the gap which was identified during the study. This were not only shared with the RGC donors, but also with other stakeholders like the local government and those others interested in making interventions in as far as HIV is concerned. The findings of the study were also of great importance to other scholars. This is because it formed the basis upon which studies on factors that differentiate between disclosure and non-disclosure was carried out hence helping to build on the academic literature.

### 1.6 Scope and Limitations of Study

This study focused on the impact of HIV disclosure in the spread of HIV, established effects of non-disclosure, investigated effects of non-disclosure in relationships and established facts that differentiated between HIV positive women who disclose their status from those who do not disclose their status. It targeted at women living with HIV in Mathare who attend the support group therapies of RGC. Due to the sensitivity of the subject of HIV, there was a challenge of obtaining correct information from those who were sampled for the study. Convenience method of sampling was used to collect data. This means only those who were willing and were available for interviews were considered in the sampling. Variety of age group was targeted putting into consideration the main gender for study were women. Since this is a group where majority are not well educated, language challenges was expected and hence questionnaires were simplified but ensured the information required was captured.

# CHAPTER TWO: LITERATURE REVIEW AND THEORETICAL FRAMEWORK

## 2.1 Introduction

This chapter presented relevant literature review on HIV disclosure and relationships, HIV disclosure and stigma, HIV disclosure and Religion, HIV disclosure and Ethnicity, Gender and HIV disclosure and HIV disclosure and violence.

## 2.2. Literature Review

### 2.2.1 HIV Disclosure and Relationships

Bairan, Rick and Blake (2007), found that disclosing ones HIV positive status depends on the kind of social relationships, fear and stigma with social associations being a major theme. Social relationships were grouped as sexual and non-sexual with erratic degree of HIV disclosure that depended on the social connections with the person to whom one disclosed. Further, it was found that HIV was fearful while stigmatizing disease and disclosure of HIV status was a complex phenomenon which was entrenched in several social relationships.

Kathrynne & Sandra (2009), provided for a framework for understanding disclosure. The findings note that expected responses and disclosure targets influences an adolescent's decision to disclose his or her status. Participants anticipated targets to disclose are based on their experience, negative emotional responses, support, acumen and fear. In the publication the Well Project (2015), disclosing one's status is a personal choice but in sexual associations it is a legal obligation. It is better when one reveals their status before engaging in a sexual affair with anyone. Failure to disclose one's status in any sexual relationship is a criminal offense whether or not a partner is infected with HIV.

In serious relationships, disclosing to your partner about your status is the first things to think about. It has been cited that many turn to their families to seek comfort and moral support. A few are worried that they will lose their partners upon disclosure. It is normal to be worried and be shameful. It is important to communicate to your partner about HIV and the importance of being tested and to practice safe sex always before marriage. This however should be done with guidance from a professional doctor to advise the couple on the best approach and ways to prevent them from exposure to HIV before marriage. This will enable them to change their ways of life and respect each other in marriages and relationships.

### 2.2.2 HIV Disclosure and Stigma

Taylor and Francis (2008) noted that HIV is rising among the African women. Among the women who are infected with HIV, very few are able to disclose their status since they fear being stigmatized. It was found that disclosure of ones status is a moderating factor between stigma and psychological functioning. It was found that 98 African American women were HIV infected and 146 were not in the age between 18-50. Raw data was collated at four points in 6 years. The results showed that HIV infected women were more exposed to acumen. However, the results showed that as the level of stigma increased the psychological functioning and disclosure declined. A significant relationship was also established between stigma and distress. It is can be argued that stigmatization influences the decision to disclose.

Murphy et al. (2001) note that when a person discloses their HIV status to third party there is a possibility of that information spreading. Mothers' should note that disclosure to children increases the risk of vulnerability. Women should be concerned that their children may be unable to keep the diagnosis secret leading to stigmatization and isolation (Money hem et al 2002).

Algelo and Nancy (1995) note that stigma affects people with the virus and their partners including their families and friends. Nonetheless, the nature of stigma differs across illnesses. These experiences are influenced by changes in biophysical dimensions of HIV and AIDS. There are 4 phases of HIV and AIDs stigma trajectory these include at risk pre-stigma, diagnosis: this is the stage where a patient tries to identify their identity, Latent is when a patient accepts to live with the illness, Manifest: is the stage the links social and physical death. In this stage, people personalize their illness hence the need to minimize HIV related acumen.

### 2.2.3 HIV Disclosure and Religion

BMC series (2009) stresses the essence of religion in shaping the cultural beliefs and attitudes of people living with HIV. The findings show that shame-related HIV stigma is connected to the religious beliefs for example HIV is retribution from God or that people who have contracted HIV and AIDS fail to conform to Christian teachings. Most people indicate that they would only share their HIV status with their pastor or God. Religious organisations play an influential role in social networks in support of people who live with HIV and AIDS. They also promote or obstruct HIV education, and reject medical treatment of HIV.

Churches offer moral and spiritual support to people and provide salvation including material and personalized care. Church as an institution is mandated to provide Christian teachings and salvation as well as engaging stakeholders such as the government and the private sector in order to uplift the livelihoods of the less fortunate in the society. It is a source of hope and inspiration to many; this is where most people who live with HIV feel accepted. Prayers mediation is perceived as an effective strategy to deal with HIV and AIDS in most African countries, in particular Tanzania. Most religious beliefs hold that HIV develops a poor attitude which affects

their treatment and this exposes them to high risks of death. The church encourages the believers to disclose their HIV status to their partners to coexist peacefully. Today, churches in the Africa request for proof of HIV test from couples before wedding this indeed are policies set to regulate Christian behaviours to minimize spread of HIV and to give hope and encouragement to those infected.

### 2.2.4 HIV Disclosure and Ethnicity

Bird et al. (2009) note that little is known about ethnic variances in relation to HIV-disclosure to sexual partners. Differences in the rate of disclosure between African American and white men who have sex with their fellow men were scrutinized using data from treatment Advocacy program. The results revealed that African-Americans had a lesser likelihood as compared to whites in disclosing their HIV status to their partners. Further, it was found that African American who disclosed to their partners who were HIV negative had a lesser likelihood to participate in unprotected anal sex with partners whose status were unknown. In the US, there exist racial differences in fresh HIV infections that increased tremendously whereby the African Americans accounted for an exceeding 50% of newly diagnosed HIV and AIDS cases in 2007 (CDC, August, 2009).

In Africa MSM are less risky to contract the disease as compared to their white counterparts. (Millett, Flores, Peterson, & Bakeman, 2007: Millett, Peterson, Wolitsk & Stall, 2006). Jonathan, Fowzia, Cecilia, Jane (2008) posit that disclosing ones HIV status could go two ways. One is that it enhances emotional and social support including increased access to HIV prevention and treatment. On the other-hand, it exposes one to risks such as discrimination and loss of economic support. In London, those infected are encouraged to disclose their status to get immediate

treatment however in the US, it was found that cultural factors highly influence people to disclose their HIV status. Most victims feared rejection and hence were afraid to disclose their status especially among heterosexuals compared to gay. This was considered risk because it denied the victims opportunities to make informed decisions and to accept their status.

### 2.2.5 Gender and HIV Disclosure

Research on disclosure in sociology, communication studies and social psychology has generally reveled that women tend to disclose more intimate or sensitive information than men due to traditional sex-role expectations that encourage women to be expressive about emotional matters and inhibit men from such displays (Hill & Stull, 1987). Seemingly, a person with HIV serostatus would qualify as such sensitive or intimate information that we might expect women to express more freely than men. HIV infection however is highly stigmatizing and contagious condition associated with high fatality, all of which may inhibit disclosure of zero positive status among women. If women are financially dependent upon their male partners, fear and verbal or physical assault or abandonment, are drugs addicted, or lack of coping or other social resources, HIV disclosure may be especially constrained (Gielen et al. 1997: Moneyhem et al., 1996).

In one study of injection drug users (IDUs) for example women had a limited likelihood as compared to men in disclosing their sexual partners (51% vs. 72%) and delayed disclosure for longer periods of time than did men (Warren, 1992). Simoni et al., (1995a) reported that while lovers of women who disclosed appeared to be as frequently emotionally supportive as other targets, they also were more likely to become angry and withdraw, with 20% subsequently leaving the respondent.

### 2.2.6 HIV Disclosure and Violence

Gielen (2008) notes that women are more vulnerable to HIV and AIDs compared to men hence they face various risks. The research shows that 50 HIV positive women between the ages of 16-45 located in urban hospital were interviewed. At least 88% of the women present were aware about their status. Only one had disclosed her status to an individual while 82% had disclosed to many people. Even though, two thirds of women were afraid to disclose about their rejection three quarters of the sample supported this disclosure. A quarter of the sample reported negative results of disclosure which included rejection and verbal abuse. Disclosure linked violence was discussed by 9 women (18%). Fear of mistreatment was unearthed in most decisions concerning disclosure. Further, it was revealed that counseling was resourceful in educating the public and the victims how to live with infected persons.

## 2.3 Theoretical Framework

Theoretical framework gives an explanation of how a theory relates and interacts with the study variables. It can either agree or disagree with a study hypothesis (Swanson, 2010).

### 2.3.1 Symbolic Interactionism Theory

This theory claims that people live in an environment that is symbolic which implies that they are guided by values as strong symbols that define their behaviour and the manner in which they relate with each other (Aksan, Kisac & Aydin, 2009). In other words, human beings will act on what is important to him or her and any decision taken will be based on the value attached to it.

### 2.3.2 Rational Choice Theory

The economic status of an individual is a critical motivator of his or her behaviour, confidence and decisions. In line with this study, an individual who is economically stable might be less affected upon realization of their HIV status as compared to a person who is unstable economically (Ashley, 2016). For example, in this study, the decision to disclose or not disclose was determined by weighing the benefits or the opposite. If I disclose my status, will I be rejected, will the result be violence my spouse and others?

### 2.3.3 Social Exchange Theory

This explains about social change and how it influences how individuals relate with one another. The manner in which HIV infected patients are treated in a society highly depends on their level of confidence and interaction with other people. Subjective judgments are mainly built by the manner in which people perceive certain things in the society including the manner, in which people balance right or wrong (Thibaut and Kelley, 1978). This guides the manner in which decisions are made and the values that define how people relate including their perception about money and whether people with money are more valued compared to those who have little.

## 2.4 Conceptual Framework for the Study

The conceptual framework below (figure 2.1) presented the nexus between research study variables. The dependent variable for the study was Decision to disclose while the Independent variables were Social economic, Relationships and Age while the intervening variables included Gender and marital status.

**Social economic** status influences ones decision to either disclose their HIV status or not. Amuri (2011) noted that an HIV rate of infection is higher in urban areas among women and those educated.

With education, it is expected that one will have a good job and thus whether male or female they will be in a position to be self-reliant hence can make decision of disclosing their HIV status without fear. In this case, disclosure of HIV position status might not be a big problem.

**Stigma** is concentrated in areas where people are less educated and poor. Infected women face a high rate of stigma as compared to those uninfected (Tailor & Francis, 2008).

**Relationships**

Merriam Webster defined relationship as the manner in which people are connected. It can be through blood or adoption.

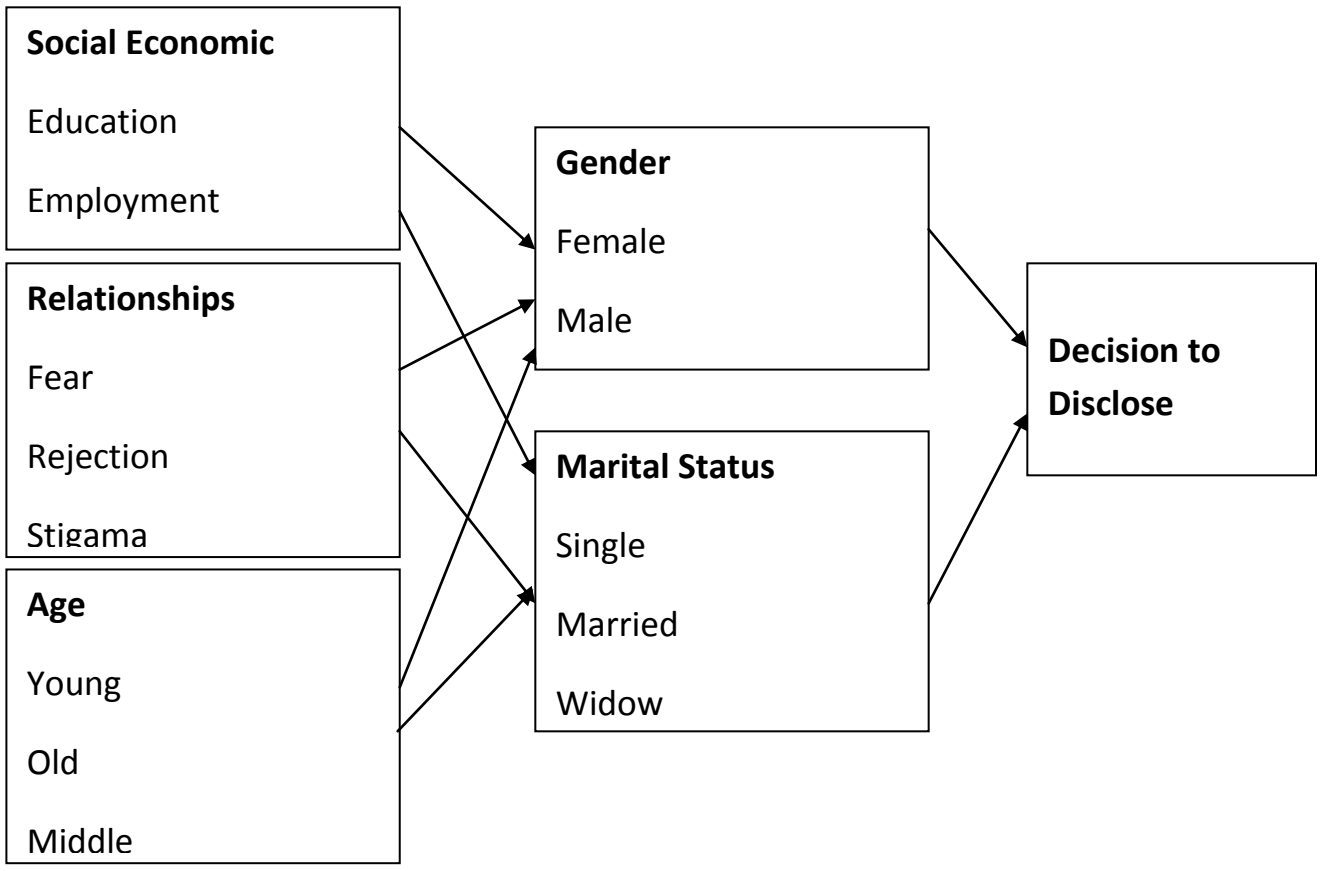
Social relationships can be grouped as sexual and non-sexual, with varying degree of HIV disclosure depending on the social connection with an individual. Spouses fear being rejected, subjected to violence divorced and separated their disclosed their status especial if one party is negative or think they were not responsible. It is likely that single person whether male or female will not fear disclosing their status after all they are not bound by anyone. They do not have anything to lose. A widow is sometimes categorized together with a single person. This is because they also do not have anyone bothering them and thus can make decisions on HIV positive status that are beneficial to them without fear.

**Age**

The decision to either disclose or not ones HIV status for young people is not very distinct. This is because the young person could be having a life partner and may be dating. There could be

fear of being rejected and not loved anymore or as before the disclosure despite whether a male or female. On the other hand, if the young person is not relating with anyone, their decision to disclose may not have challenges. Young adult were significantly more likely to fear to losing their job because of HIV (Charles A. Emlet), May 2006, 20(5)

**Figure 2.1 Conceptual Framework**



# CHAPTER THREE: RESEARCH METHODOLOGY

## 3.1 Introduction

This chapter gives an account of site description, Research design, Unit of Analysis and Units of Observation, population, size of the sample and procedures, approaches of collecting data, Ethical consideration and finally analysis of data.

## 3.2 Site Description

This study was carried out in the Slums of Mathare which is in Starehe Sub County in Nairobi. Mathare is among the oldest and poorest slum in Nairobi County (UN Habitat-Kenya, 2014). People live in 6ft.x8ft. Shanties made of old tin/iron sheets and mud plastered walls. Mathare slum is also characterized by high level of poverty, poor drainage system, high school dropout, malnutrition among the under-five and the elderly and high HIV prevalence among other social ills. There is high level of unemployment and hence high insecurity as people try all means of coping mechanism including mugging and prostitution which have resulted to high level of HIV. This exposes parents to risks of death. Poverty levels have also contributed to high child labor and early pregnancies among teenagers. Most of the homes are headed by women. Even in cases where couples live together, women are seen to take the whole responsibility of raising the children.

## 3.3 Research Design

Burns and Grove (2003: 195), a research is an investigation in which factors get maximum level of control to avoid results interference. Parahoo (1997: 142) terms a research design as a plan of how data will be collated and analyzed. This design is intended to find out how variables associate with each other while attempting to find an appropriate way of answering the research

questions at hand (Ogula, 2005). In this research, the researcher utilized this design to determine the factors that distinguished HIV women who freely disclosed their status from those who failed to disclose their status.

### 3.4 Unit of Analysis and Units of Observation

Yursusev (1993), Unit of Analysis is the entity that is being studied in a given research. This includes what it that is being investigated, in this case is people. In the research, the analysis unit involved **decision to disclose** HIV positive status among women living with HIV (PLWHIV) in the slums of Mathare. Observation units are described using ones data. Units of observation were **women living with HIV at the support group of RGC**. Key informants also formed part of the unit of analysis. They included the Community Health volunteers, Social workers at the support groups and the nutritionist at the RGC HIV support group.

### 3.5 Target population

A Population can be defined as units in a given area which is under scrutiny. The units in such a population are presumed to have similar features (Ogula, 2005). In this research, the target population constituted of HIV infected women in the support groups living in the slums of Mathare and attended RGC support group therapies. It covered two categories of women one of which included those disclosed their HIV positive status and the second one of those who did not disclose their positive status.

### 3.6 Sample Size and Sample Procedure

A sample is a small group or subgroup obtained from the accessible population (Mugenda and Mugenda, 1999).

### 3.6.1 Sample Size

Size of sample constitutes the number of observations present in a sample (Evans & Peacock, 2000). In this study, 96 infected women were sampled, 48 of them being women who disclosed their status and the other 48 being those who did not disclose. The women were systematically sampled from a list provided by RGC. However, the actual sample size was determined by the number of those who were found to be disclosing their status and those who did not disclose. An equivalent number was selected from the two categories as the sample size.

### 3.6.2 Sampling Procedure

According to Scheduler (2001), in systematic stratified sampling, the study population is divided into strata; the research samples are derived from stratum. Stratified sampling techniques were used to group the women in terms of those disclosing their HIV status and those who did not disclose. By sampling from the strata, the researcher ensured that all the categories of women in the area of study were represented in the sample size.

Thus in each of the two strata 48 women who disclosed their positive status and another set of women who had not disclosed were systematically selected to constitute a total sample of 96 women from the support groups of RGC. A list provided by RGC was numbered (for those disclosing and those not disclosing), where the first 48 even numbers for each category were picked for the study. The key informants were the total number of officers in charge of the women hence all the five were interviewed.

## 3.7 Methods of Data Collection

The data collection procedures used was interviews and desk review. Questionnaires and interviews guides were used as the instruments for collecting primary data. Secondary data on

the HIV positive disclosure was collected through desk reviews. The researcher reviewed the 2016 records at the RGC offices.

### 3.7.1 Collection of Quantitative Data

**Questionnaires**

Questionnaire consists of a set of questions that seek specific responses used for research purposes. Ackroyd and Hughes (1991), say that questionnaires have the ability to gather information from many respondents over a short period. Questionnaires can be exploited to collate quantitative and qualitative information. In this research, quantitative data was gathered and analyzed with the aid of statistical software and the outcome was presented in form of Tables.

The instrument was chosen because the target population was considered learned and thus would understand the questions if explained to them. Questions were clustered into several sections whereby a section was intended to realize specific objective. Christian (2005-2016), defines Likert scale as a collection of responses tied to Likert items. Also, Likert item is defined as a statement asked to a respondent during surveys. Likert scale was utilized to test the agreement level of the respondent with regard to specific variables as well as the different areas of support group.

### 3.7.2 Collection of Qualitative Data

**Interview schedule**

Yin (2003), suggests that an interview is an interactive way to collect data that allows feedback between parties. The researcher used interview schedules to collate raw data from sampled women. Kerlinger (1973) observes that most people prefer to communicate through the word of

mouth other than writing. Therefore, the researcher utilized this technique to provide more readily and accurate data. The interview schedule was structured in accordance to the study questions. Interview schedules were administered to key informant who included the community health worker, nutritionists at the support group where the women go for support therapies, social workers and he manager at RGC. Qualitative data was analyzed through descriptive account of the data collected.

### 3.8 Ethical Consideration

Consent was obtained from the research participants before the interviews were conducted. In addition, approval was sought from the qualitative respondents for manual recording of their interviews. Strict confidentiality was observed during data collection, processing and analysis.

### 3.9 Data Analysis

Primary data was cleaned to minimize errors from the respondents. Coding was executed to translate questions and responses to specific categories. Quantitative data collected was analyzed, presented and interpreted using both descriptive statistics while content analysis was applied to analyze qualitative information which was collected using interviews schedules. Statistical Package for Social Sciences (SPSS) was utilized in analyzing qualitative data. Descriptive statistics that includes mean, standard deviation, frequencies and percentages were applied. A presentation of analyzed data was executed inform of tables and pie charts.

# CHAPTER FOUR: DATA ANALYSIS, PRESENTATION AND INTERPRETATION

## 4.1 Introduction

The following chapter presents the analysis of data carried out with relation to the factors that differentiate HIV positive women who disclose their status from women who do not disclose. The data was collected through use of a questionnaire and analysis done by the help of Statistical Package for Social Sciences (SPSS). Since much of the data collected was qualitative as indicated in the chapters above, data presentation would best be presented in form of tables and pie charts in demonstrating the factors that differentiate HIV positive women who disclose their status from women who do not disclose. The chapter starts with analysis of general information collected from respondents (respondents rate and demographic) like gender, level of education, marital status, family size, academic qualification, ethnic composition, duration they have lived with HIV and employment status. Secondly, factors that are basis of fear of disclosure of HIV status was analyzed. Then, effects of disclosure on HIV positive status was considered followed by how disclosure of HIV positive status affects relationships and finally concluded by the difference between those women who disclose their HIV status and those that don't disclose their HIV status. Hence, the four research objectives that were addressed in this chapter are;

I. To identify factors that are the basis of fear of disclosure among women living with HIV in Mathare slums.
II. To establish whether disclosure affects spread of HIV infection in Mathare slums.
III. To examine how disclosure or non-disclosure of HIV positive status affects relationships among women.
IV. To establish factors that differentiates between HIV disclosure and non-disclosure among women in Mathare slums.

## 4.2 Response Rate

This study targeted 96 women living with HIV AIDs virus within Mathare slums and engaged in various employment and self-employment ventures. Data was obtained from 93 of the total sample population for the study which was the support groups living in the slums of Mathare and attend RGC support group therapies which was sampled for this study. The primary data was collected using structured questionnaires which were filled by the data collectors. Only a few preferred to be given the forms to go fill and bring back. This response rate is enough to draw inferences on the factors that differentiate HIV positive women who disclose their status from women who do not disclose representing 97 percent of the response rate which was considered good enough to work with since the number was statistically significant.

## 4.3 Social and Demographic characteristics

### 4.3.1 Marital Status

The total sample population selected composed of females since the study desired to identify the factors of disclosure and non-disclosure among women. With regard to marital status, the following pie chart represents the representation of the women and their status.

The table (**table 4.1)** indicates the marital status of the respondents were married women who formed the largest proportion of the sample population at 50%. This was followed by single women at 32.2% while 19.8% were widows. However, as expected, 7. % of the respondents never indicated their marital status hence represented the missing variable. This demonstrates that the sampled population is family conscious and supports the marriage institution in society.

**Table 4.1: Marital Status of the Respondents**

| Marital status | Frequency (N) | Percentage (%) |
|---|---|---|
| Single | 26 | 30.2 |
| Married | 43 | 50.0 |
| Widow | 17 | 19.8 |
| Total | 86 | **100.0** |

### 4.3.2 Academic Qualification

With regard to the highest level of academic qualification, the women indicated various responses as indicated the **Table 4.2.**

From Table, it is clear that higher education among women especially those living with HIV are relatively low. Only 36 women (38.7%) indicated they possess secondary education with more than 60 percent of them not completing form four hence do not have the required certificates. 45 women (48.4%) possess basic primary education with (12.9%) women having dropped out before completing class eight.

**Table 4.2: Distribution by level of education**

| Level of Education | Frequency (N) | Percentage (%) |
|---|---|---|
| Primary | 45 | 48.4 |
| Secondary | 36 | 38.7 |
| Below primary | 12 | 12.9 |
| Total | 93 | **100.0** |

### 4.3.3. Occupation

When the study sought the occupation status of the respondents, the results presented rather an interesting outcome. Out of the 93 respondents, only a handful of 18 respondents (19.4%) were

employed. However, an interesting feature was noted that, this number was majorly employed as house helps with a handful of income to rely on. Nearly 81% are self-employed. In this line and the types of self-employment which dominated this segment were casual laborers involved in cleaning and laundry industry. They roam in the middle estate on daily basis with the hope of securing laundry to wash and paid a wage after completion of the work. This however is not a reliable source of income for their families as earlier observed many are single and widowed women. Others are involved in small businesses like selling second hand clothes and grocery hawkers.

**Table 4.3: Occupational status of respondents**

| **Occupation status** | **Frequency (N)** | **Percentage (%)** |
|---|---|---|
| Employed | 18 | 19.4 |
| Self employed | 75 | 80.6 |
| **Total** | **93** | **100.0** |

### 4.3.4 Family Size(Number of children)

The data from table 4.4 below shows the family size demonstrated by the number of children. On average, majority of families have three and four children represented by 42 (45.2%) respondents out of 93 with three children being 22 (23.7%) families and four children 20 (21.5%) families respectively. Those who had five children were 15 (16.1%) and those with six children were 13 (13.9%) families respectively. Hence, it is evident from the study that, more than 79.7% represented by 93 families have more than three children without a steady source of income as demonstrated in the occupation discussion above. Hence, the poverty levels are prevalent and high among these women.

**Table 4.4 Family Size**

| Number of children | Frequency (N) | Percentage (%) |
|---|---|---|
| One child | 4 | 4.3 |
| Two children | 8 | 8.6 |
| Three children | 22 | 23.7 |
| Four children | 20 | 21.5 |
| Five children | 15 | 16.1 |
| Six children | 13 | 13.9 |
| More than six children | 9 | 9.7 |
| Two did not have children | 2 | 2.2 |
| **Total** | **93** | **100.0** |

### 4.3.5 Ethnic Composition

Mathare being a cosmopolitan slum, the researcher sort to understand whether this notion is statistically representative. The results are presented (Table 4.5);

Indeed, the ethnic composition is representative and the notion of cosmopolitan aspect is statistically significant at Mathare slum. This is demonstrated by the widespread ethnic composition of Kenyan tribes from Luos, Kikuyus to Somalis at 21(26%), 18(22.5%), and 4(5%) respondents respectively. Other tribes represented in the study were Luyhas. Kamba, Meru, Digos, Kisiis, Tesos and Kalenjins at 9(11.3%), 14(17.5%), 4(5%), 1(1.2%), 4(5%), 1(1.2%) and 4(5%) respectively. Virtually all the major and big tribes in Kenya are represented demonstrating that HIV is not a tribal issue but rather a national one. 13(13.9%) out of 93 did not indicate their ethnicity.

**Table 4.5: Ethnic Composition**

| ***Ethnic Composition*** | ***Frequency (N)*** | ***Percentage (%)*** |
|---|---|---|
| Luo | 21 | 26.3 |
| Luyha | 9 | 11.3 |
| Kamba | 14 | 17.5 |
| Kikuyu | 18 | 22.5 |
| Meru | 4 | 5.0 |
| Digo | 1 | 1.2 |
| Kisii | 4 | 5.0 |
| Teso | 1 | 1.2 |
| Kalenjin | 4 | 5.0 |
| Somali | 4 | 5.0 |
| ***Total*** | **80** | **100.0** |

### 4.3.6 Years since contracting HIV

The duration of living with HIV positive status since contracting the virus is dependent on various factors among them care and medication. Table 4.6 below shows the number of years' respondents indicated they have been living with HIV. Shockingly, 44.05% indicated they have been in that state between 6-10 years. A whopping 63 (67.7%) respondents indicated they have lived for more than 6 years all through to over 15 years. Those who have lived below 6 years are 25 (26.9%) and they have indicated the period since they got knowledge of their status. These statistics indicate that, when well-managed, a person is able to live with HIV virus for decades as witnessed with 8 (8.6%) respondents who have lived for more than 15 years. Hence, being HIV positive is not a death penalty especially when detection is done at early stages. Therefore, constant and frequent checkups are paramount in curbing HIV death related.

**Table 4.6: Number of years lived with HIV**

| No. of years lived with HIV | Frequency (N) | Percentage (%) |
|---|---|---|
| Less than two years | 8 | 8.6 |
| 2-5 years | 17 | 18.3 |
| 6-10 years | 41 | 44.05 |
| 11-15 years | 14 | 15.05 |
| Over 15 years | 8 | 8.6 |
| Missing variables | 5 | 5.4 |
| **Total** | **93** | **100.0** |

### 4.4: Factors Related to Fear of Disclosure of HIV positive status

#### 4.4.1 Fear of Disclosure

Table 4.7 below shows that fear of disclosing HIV positive status was overwhelming evident upon the respondents since more 80.6% of the respondents indicated women feared disclosing their HIV positive status. This is by far a very high figure considering the spirited campaigns and efforts to sensitize the general population concerning the state of HIV/AIDs. These findings from the respondents were supported by the key informants who were interviewed whether they think women do fear disclosing their HIV positive status. These are professionals who work and interact with the women and in their response they indicated that women do fear disclosing their positive HIV status. 3 out of 5 professionals who include nutritionist, village elder, social workers and community health volunteers supported the notion of fear in women through the experience they have hard with them. Various factors were indicated as the cause of this fear from discrimination, fear of carrying the blame, stigmatization and violence. In addition, married women indicated they feared disclosing to their spouses for fear of separation and in the worst case divorce. Even those who had already disclosed their positive HIV status indicated the

stigmatization they had to endure before they managed way round it. Also, they indicated that children are the greatest casualty especially from the myths that being HIV positive is near death penalty. Many women fear disclosing their status to save their children the psychological, emotional and physical pain for knowing the parents are on the death bed. Others indicated that when disclosure is made, friends tend to keep a distance and no longer associate with women living with HIV virus. The supervisor in charge of the support group was quoted saying "If there was understanding of those infected, spreading of HIV would have stopped long ago. One of the key informant reported that "women do not disclose their positive status because of the consequences that follows; some have been brought for counseling in our offices physically abused after they disclosed their status".

**Table 4.7 Response whether women fear disclosing HIV positive status**

| Response | Frequency (N) | Percentage (%) |
|---|---|---|
| Yes | 75 | 80.6 |
| No | 18 | 19.4 |
| Total | 93 | 100.0 |

### 4.4.2 Factors that are basis of fear of Disclosing HIV Positive Status

Since overwhelming respondents indicated they believe there is fear for disclosing HIV positive status including those who have already disclosed, it's worth understanding which factors contribute to this fear despite much publicity and sensitization campaigns. Respondents were requested to indicate their agreement or not to the various factors contributing to this fear and their responses were as shown in **table 4.8.**

From the table, it is clear as to why women fear disclosing their HIV positive status. As earlier discussed, factors like rejection, stigmatization and discrimination ranked the highest at 55 (59.1%), 55 (59.1%) and 67 (72%) respondents as to why women fear disclosing their HIV positive status. Despite various community sensitization and education, such vices are prevalent and they act as deterrent to women who want to come forward and declare their HIV positive status publicly.

### 4.5: Factors that are basis of fear of disclosing HIV positive status

#### 4.5.1 Response on whether Disclosure led to Reduction of HIV Prevalence

From the above discussions, disclosure has been witnessed to be a hard thing especially due to the effects observed after disclosure. However, disclosure of the HIV positive status may generate optimism as well as other benefits. One such kind is reduction of HIV prevalence. The researcher to understand whether this notion holds and the results are presented as below.

Looking at **pie chart 4.1** below, it is clear that opinions were equally divided as to whether disclosure of HIV positive status has led to reduction of HIV prevalence. In this regard, the research sought to understand why there are some women who are comfortable in disclosing their HIV positive status while other are not and its effects on HIV prevalence rates. Even though 1.08% of the respondents did not indicate their opinion, disclosure has equally helped to reduce HIV prevalence rates and not at the same time. Other factors influenced either the reduction or not including the community, family and friends' responses when such a disclosure is done.

The respondents' results were collaborated by the interview conducted with the key informant working with these groups. The research sort to understand from them, whether non-disclosure has increased HIV prevalence and the respond was as follows;

Apart from one respondent out of five, the other four believes that non-disclosure of HIV positive status has greatly contributed to increased HIV prevalence. Non-disclosure especially with indiscipline individuals will spread the HIV virus unprecedented and mitigation measures are hard to institute due to non-disclosure. In addition, the victims may not get the proper medical attention they so require since no one know their condition.

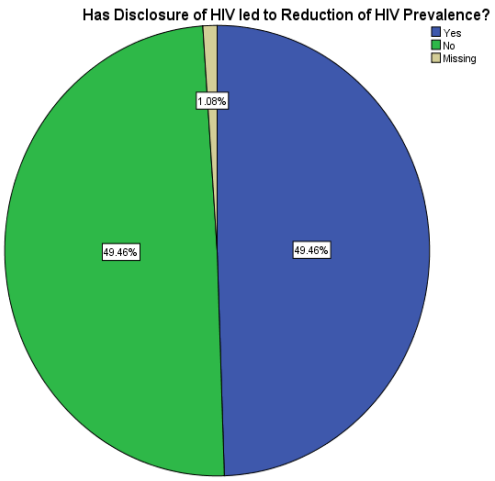
In addition, the analysis above demonstrates that disclosure of HIV positive results will equally have both positive and negative effects to relationships. The pie chart has attested to this fact with equally divided opinion. Half of the respondents indicated that when disclosure is made, relationships will be affected negatively since people will blame the victim, the spouse might even separate and the worst case divorce the victim. In case of disclosure, friends tend to keep a distance and associate only when necessary with the victim hence results to distorted relationships. On the other hand, disclosing would result to more care and proper medical attention being initiated. From the study, spouses have been very supportive to their partners when they know their HIV positive status hence disclosure brought families together. In addition, the victim is free to associate with other family members who have embraced their status hence strengthening the bond as a result of disclosure. Depending on the level of community education and sensitization, the effects of disclosure may go either way; either positive or negative as discussed above.

On the other hand, disclosure of HIV positive status was identified to help in ART adherence. When family members, friends, colleagues, and siblings realize the status of the victim, they play a significant role in ensuring the victim adheres to ART guidelines. This is in contrary when nondisclosure exists and no one knows about the status. In such a scenario, even when the victim skips ART procedures, he/she is not accountable to anyone who further curtails efforts taken

against HIV/AIDs prevalence and spread. There is support groups formed to offer peer education to people living with HIV virus and disclosure would be the best way forward to ensure a victim achieves maximum benefits from such organization. ART procedures are also extremely expensive especially when someone is not formally diagnosed and issued with the necessary documentation. The cost prohibition may result to negative effects in ART procedures especially when not strictly adhered to. However, when there is disclosure, the ART procedures are offered free in government institutions and cost issues may not be an inconvenience hence adherence is enhanced.

The part shaded green with 49.46% represents those respondents who think disclosure of HIV has led to reduction of HIV prevalence. On the other hand the part shaded blue again with 49.46% represents those respondents who think disclosure of HIV has not led to reduction of HIV prevalence. Missing out or not sure were 1.08%.

**Figure 4.1: Response on whether Disclosure has led to Reduction of HIV Prevalence (N=93)**



### 4.5.2 Effects of Disclosure of HIV positive Status

**Table 4.8** below shows the response by respondents on the effects of disclosure on HIV positive status. 60 (65%) respondent strongly agreed that disclosure led to reduction/spread of HIV while 50 (54%) respondents also strongly agreed that non-disclosure increased HIV prevalence. This was further supported by 56(60.2%) respondents who strongly disagreed that non-disclosure has no effect on HIV.

Results from the Key informants indicated that disclosure of HIV positive status has greatly helped in reduction of new cases of HIV infections. They reported that according to their experience in the field, it is nondisclosure that has delayed the reduction of HIV prevalence. Sadly they reported that those who are not ready to disclose continue to have sex with multiple partners thinking they do not have anything to lose after all and in the process they re-infect many others. Hence, non-disclosure has been identified as one of the leading causes of new infections as indicated below with 50(54%) respondents supporting these notion. 42 (45.1%) respondents identified reduced risky behaviors which are likely to increase HIV new infections when disclosure is encouraged among the victims.

**Table 4.8: Response on effects of Disclosure of HIV positive Status**

| Effects of Disclosure of HIV positive status | Strongly Disagree | Disagree | Neutral | Agree | Strongly Agree | Total | |
|---|---|---|---|---|---|---|---|
| | | | | | | % | No. |
| Non-disclosure increased HIV prevalence | 2.2 | 4.3 | 2.1 | 37.6 | 53.8 | 100 | 93 |
| Disclosure led to reduction/spread of HIV | - | 1.1 | 3.2 | 31.2 | 64.5 | 100 | 93 |
| Non-disclosure has no effects on new infections | 60.2 | 28.0 | 1.1 | 3.2 | 7.5 | 100 | 93 |
| Disclosure has negative effects on relationships | 24.1 | 23.0 | 8.0 | 23.0 | 21.9 | 100 | 91 |
| Disclosure results to ART Adherence | 2.2 | 7.5 | 9.7 | 37.6 | 43.0 | 100 | 93 |
| Disclosure reduces risky Behaviors | 4.3 | 12.9 | 5.4 | 45.2 | 32.2 | 100 | 93 |
| Disclosure increases support from family | 24.4 | 23.3 | 7.9 | 22.2 | 22.2 | 100 | 90 |

## 4.6: How disclosure of HIV positive status Affects relationships

### 4.6.1 Parties to which disclosure is made

Disclosure may take various forms and most importantly those that matters to the victim. In this regard, various personnel were listed as possible confidants to the victim and the research sort to know who and in which rank. **(Table 4.9)** demonstrates who victims were comfortable with disclosing their HIV positive status. It is clear that counselors take the lion's share with regard to disclosure. Over 62.6% of the respondents indicated that they had disclosed their HIV status with the counselor. This is mostly driven by the need for counseling services that the victims may require now that they have been taken to another life and adjustments may be challenging without the help of a counselor. From the counselors, disclosure to parents followed next with 12.1% respondents. This was followed closely by disclosure to children who received 11% respondents. Due to consequences of disclosure to spouses, it is evident that this is the reason why only 7.7% had made disclosure to them. Disclosure to pastors followed the spouses with 4.4% and finally friends with 2.2%.

**Table 4.9: People you have Disclosed HIV Status to**

| Parties would disclose to | Frequency (N) | Percentage (%) |
|---|---|---|
| Spouse | 7 | 7.7 |
| Parents | 11 | 12.1 |
| Your children | 10 | 11.0 |
| Pastor | 4 | 4.4 |
| Counselor | 57 | 62.6 |
| Friends | 2 | 2.2 |
| **Total** | **91** | **100.0** |

### 4.6.2. Effects of disclosure to members of the Family

The study dealt with equal number of respondents who have disclosed their HIV positive status and those who have not disclosed.

**Table 4.10** demonstrates the likelihood of how disclosure would affect the relationship between the victim and the family members. From the table the largest portion likely to be affected by the disclosure includes all members of the family (84.5%) both positively and negatively. This cascades down to brothers, sister, siblings, spouses and relatives who may be affected differently depending on the relationship they had with the victim prior to. 13 (15.5%) respondents reported that there is no effects on their disclosure to members of their family while 9.7% did not respond.

**Table 4.10: Effects of disclosure to members of the Family**

| Effects | Frequency (N) | Percentage (%) |
|---|---|---|
| All family members would be affected | 71 | 84.5 |
| No effect | 13 | 15.5 |
| Total | 84 | 100.0 |

### 4.6.3 Response on whether Disclosure affects Relationship between the Victim and Family

Table 4.11 represents potential effects of disclosure of HIV status to family members. From the results, 80.3% indicated that their immediate family members including spouse, siblings, parents and children were the most affected. Only 19.7% of the respondents reported that disclosure do not affect the relationship between the victim and family. 34.4% did not respond to this question either because they were not sure or they did not want to.

In addition, majority respondents indicated that the effects to the parents were mostly negative with blaming, rejection and stigmatization being the common negative effects they received. When it came to siblings, some disowned them and rejected them for their condition and blamed them on their "loose" morals and disgrace they have brought to their families. With regard to children, although they indicated the effect was positive, the initial was a mixture of confused effects considering their future and uncertainty thereof.

This assertion was also supported by the interview conducted to the key informants of whether disclosure has effects on family relationships. All the five respondents concurred that disclosure has a great effect to family relationships. Two of them said that the fact that HIV is still seen as a cause of loose morals, some family members did not want to be associated with such people because of the shame in the society. One key respondent said; "these communities although have

been educated on HIV for a long time, they still do not know the different methods that can cause one to be infected with HIV or even if they know, they still like sticking to one which is prostitution. This is unfortunate".

However as earlier discussed, the effects will be dependent with the relationship between the victim and the family members.

**Table 4.11: Response whether disclosure would affect family member**

| **Response** | **Frequency (N)** | **Percentage (%)** |
|---|---|---|
| Yes | 49 | 80.3 |
| No | 12 | 19.7 |
| **Total** | **61** | **100.0** |

### 4.6.4 HIV Disclosure factors perceived to affect Relationships

Although the study has identified that relationships shall be affected, the nature of relationships that exist and related factors that perceive such relationships determine the type of effects likely to occur. The results are presented in the table below;

From (**Table 4.12**), the seriousness of the relationship and the unsure responses from the family members led in factors which will determine whether the victim will be comfortable in disclosing the HIV status. When the seriousness of the relationships are tight like that of a spouse, the disclosure is done at early stages and easily compared to when victim is in courtship. The personality of those the disclosure is done is also of paramount importance since it determines their response. When disclosure is done, they may reject and blame the victim or embrace the victim and offer all the necessary support available.

**Table 4.12: Disclosure factors perceived to affect relationships**

| Disclosure factors perceived to affect relationships | Strongly Disagree | Disagree | Neutral | Agree | Strongly Agree | Total | |
|---|---|---|---|---|---|---|---|
| | | | | | | % | No. |
| Disclosure is dependent on seriousness of Relationships | 5.4 | 11.8 | 5.4 | 36.5 | 40.9 | 100.0 | 93 |
| Disclosure results to negative emotional reactions | 22.8 | 19.6 | 9.8 | 22.8 | 25.0 | 100.0 | 92 |
| Unsure of responses after disclosure | 10.7 | 9.7 | 3.2 | 32.3 | 44.1 | 100.0 | 93 |
| More single women disclose than married woman | 207 | 9.6 | 2.2 | 22.8 | 34.7 | 100.0 | 92 |
| Disclosure can strain best relationships | 13.1 | 26.1 | 9.8 | 25.0 | 26.0 | 100.0 | 92 |
| Disclosure can cause anger and violence | 11.1 | 23.0 | 27.4 | 13.2 | 25.3 | 100.0 | 91 |

### 4.7 Differences between Women Who Disclose HIV status and those who don't

When the respondents were requested to respond on a scale of strongly disagree all through to strongly agree on the differences of those women who disclose and those who don't, the results were as shown in the table below. From (**Table 4.13,** it is evident that disclosing HIV positive status is the best option according to the respondents. Those women who do not disclose their status have high chances of increasing reinfection rate especially to their spouses. In addition, those who do not disclose are observed not to adhere to procedures of ARTs which are essential in curbing opportunistic infections. It is a myth according to this study that those who disclose their status especially to their spouses loses their love and affection. Though it might be hard for the spouse at first, the research has indicated that those who disclose receive psychological and emotional love and support from their spouses in the long run. Therefore, disclosing the positive HIV status is the best option and should be encouraged.

### 4.7.1: Reasons why some women disclose their HIV Positive Status

From the above reasons provided as to why some women were disclosing their HIV status, majority said that they were seeking care and support both medically and psychologically. The use of support groups was also a major reason as to why they were disclosing since the urge of self-belonging to people who understands you better. Finally, self-acceptance was another reason driven by confidence to come in the open and declare your HIV status.

**Table 4.13 Reasons why some Disclose their HIV Status**

| ***Response on reasons why some women disclose their HIV status*** | ***Frequency (N)*** | ***Percentage (%)*** |
|---|---|---|
| High Confidence | 10 | 22.2 |
| Self-acceptance | 13 | 27 |
| Care and support | 11 | 22.9 |
| Support Groups | 14 | 29.1 |
| **Total** | **48** | **50** |

### 4.7.2 Reasons why some Women do not disclose their HIV positive Status

On the same note, not all women who are HIV positive have disclosed their status. In attempts to understand reasons behind their nondisclosure, the following responses were received.

Looking at **Table 4.14,** discrimination and stigmatization were the greatest concerns as to why some women do not disclose their positive HIV status. Top on the list as well are factors of rejection and blame that they have embarrassed and disgraced the family name hence prevalence of nondisclosure.

**Table 4.14 Reasons why some Women do not Disclose their HIV Status**

| Reasons for not Disclosing | *Frequency (N)* | *Percentage %* |
|---|---|---|
| Fear of Judgment | 7 | 14.5 |
| Rejection | 4 | 8.3 |
| Stigmatization | 10 | 20.8 |
| Blame | 9 | 18.8 |
| Distorted Relationships | 2 | 4.2 |
| Discrimination | 11 | 22.9 |
| Divorce | 5 | 10.4 |
| Total | 48 | 100.0 |

# CHAPTER FIVE: SUMMARY, CONCLUSIONS AND RECOMENDATIONS

## 5.1 Introduction

The analysis carried out in chapter four has demonstrated the factors that differentiate HIV positive women who disclose their status from women who do not disclose. This chapter includes the summary of the findings and analysis, discussions and offered possible solutions to how well disclosures can be handled and more women encouraged to disclose their HIV positive status for its enormous benefits as demonstrated in chapter four. In addition, the conclusions observed when women disclose their HIV positive status and those who do not were also listed in this chapter and possible recommendations were presented to assist in future efforts to curb the spread of HIV/AIDs pandemic.

## 5.2 Summary of the Findings

The analysis conducted in chapter four as highlighted above is derived from data collected with regard to the factors that differentiate HIV positive women who disclose their status from women who do not disclose. The research involved a sample population of 96 respondents all HIV positive victims who were divided into two groups; those who disclose and those who do not disclose their HIV positive status. From this sample population, all the respondents were females who attended therapies of RGC support group. However, only 93 questionnaires were returned fully filled translating to 97 percent success rate. This translated to 97 percent of female respondents castigated by the nature of work, discipline of these women especially those enrolled at RGC support group. In addition, there was 5 interview schedules which were conducted with professionals/key informants some who are in charge of the support group where women with HIV are attended to and some leaders in the village who interact with the women who were interviewed. The interview schedule rates 100 percent successful majorly due to the efforts input

by the researcher and the seriousness of work taken by the professional leading the support groups.

The results indicated a rather unique picture which was demonstrated first by the marital status of the respondents. As earlier observed, only female respondents were chosen in this study to identify the factors that differentiate HIV positive women who disclose their status from women who do not disclose.

The statistics with regard to marital status were rather interesting considering the HIV prevalence rates and trends in Kenya. Other statistics and government reports from the National AIDs Control Council has played the highest levels of new infections with the married couples' age groups. World Health Organization has also placed new infections as well as high levels of those infected with HIV/AIDs as those in stable family relationships and among married couples. When this study was conducted, the results painted a similar picture since more than 46.24% of those with HIV positive status formed the largest portion of the study. Single women with HIV formed 27.96% with only widows forming 18.26 percent. Interestingly, summing up married women with HIV with widow in the assumption that their husbands died due to HIV complications takes the figure to an all-time high rate of 64.5%. This demonstrates the moral decadence in the society especially among those who are expected to offer moral lessons and guidance to the young generation. When those in marriage institutions are the ones leading with HIV infections, the society ought to institute measures to ensure such trends are curtailed failure to which the gains made in fight of HIV/AIDs pandemic would be in vain.

The above statistics and figures may be by large explained by the sample population's level of education. Those women who were sampled indicated very low levels of education with none having a university educational levels. This is understood since the research concentrated on

Mathare which is the second largest informal settlement (slum) in Kenya after Kibra. The level of education in Kenya informal settlements is dismally low hence the exposure to various health issues is absolutely low. In this regard, all the women sampled had either primary of secondary level of education. Despite the numbers favoring primary and secondary education, a close examination of the respondents indicated that more than 70% of them never finished class eight or form four as required by primary and secondary levels respectively. Many of these women were school dropout at primary or secondary levels. The government of Kenya through the Ministry of Education has attributed the high number of girls' drop-outs of both primary as well as secondary in levels due to early pregnancies. Majority of these women never manage back to school especially at Mathare slums and end up been married at early ages another reason why HIV prevalence rates is high among the married women in the slums.

Every country where the levels of education are absolutely low, the employment conditions are as well low due to lack of necessary skills and expertise required in the market. The study indicated that only 19.4% of the total respondents were employed while a majority 74.2% were in self-employment. In close examination of these figures, the self-employment which majority of these women engages in is washing clothes from one household to another. Others are in grocery business while the others are involved in hawking second hand clothes in the slums. Those who are employed are house helps where they perform more the same jobs and responsibilities like those who are in self-employment. This is another fact that makes these category of people vulnerable to HIV infections due to their low income levels. They are further exploited by their employers especially those employed as house helps. To complement on their low income levels, majority of these women may engage themselves in indecent behaviors and vices like prostitution which further increases the reinfection rates of HIV.

These women are also susceptible to fall prey of rapists due to the nature of their work. When roaming from one household to another in search of washing jobs while other hawking second hand clothes, rape cases have been rampant. There are people who take advantage of the poor lighting and congested structures to perform these heinous acts hence further increasing cases of HIV infections. The major reason why majority of these women may not even disclose their positive HIV status is because they are victims of rape which is treated with contempt especially in slums and in Kenyan society. Finally, these women are also vulnerable due to small earnings associated with the type of job they are engaged in. when the earnings are not enough to feed their families yet majority are the bread winners, they are tempted to compromise and offer sexual advances for a small fee. These practices greatly hamper step and gains in curbing HIV reinfections while majority who contract the disease in these means may not be willing to disclose their status especially to their partners hence increasing the reinfection rates.

The research sort as well to identify the economic status of the families in Mathare slums and used the family size to determine their income and consumption proportionate ratio. Family size was measured by the number of children. An interesting trend was identified that majority of the families as discussed in chapter four fell above three children. This measured by the economic parameters in Kenya is a huge family represented by 81% of the total respondents. The high rates of HIV prevalence among these categories may partly be explained from this angle where women are willing to go to any length as long as they feed their large families. Compared to middle class and rich areas where the family size measured by the number of children is on average two kids, the former scenario is likely to increase family strain on resources. Thus, women are forced to engage in all manner of activities as long as they feed their households. In

addition, this may as well be associated factor which has increased HIV prevalence rates in informal settlements like Mathare.

Ethnic composition was equally spread across the Kenya communities. Thus, the disease was widespread across a cosmopolitan population although one ethnic group was found to have higher prevalence rates than others. In this regard, Luos were identified to be leading in the infection rates among the communities sampled. They were also leading to those who disclosed their status compared to those women who did not disclose their HIV positive status. Finally, in the general section, majority of the respondents indicated they had stayed with HIV between 6 to 10 years since contracting the disease. From 6 years and above, more than 75 percent of those with the disease formed the majority. This can be attributed to the fact that they have been attending counseling and RGC support group therapies hence the prolonged life even with HIV. The contracting of the virus ought not to be regarded as a death penalty but rather a process which is capable of being managed as witnessed in the study. With adherence to ART procedures, life with HIV virus may not be different from normal and lifespan may be prolonged in excess of thirty years. However, this is possible when the disclosure is done early in advance to commence ART procedures. There was overwhelming support for prolonged life when there is disclosure compared to those who did not disclose for one reason or another. Consequently, all efforts should be geared towards disclosure of positive HIV status so as to commence with ART early in advance to ensure prolonged and health stay.

### 5.2.1 Factors related to fear of disclosure of HIV positive status

The following section summarized the findings of the research with connection to the research questions and objectives. Therefore, the four research questions that were summarized with regard to the findings are;

I. To identify factors that are the basis of fear of disclosure among women living with HIV in Mathare slums.

II. To establish whether disclosure affects spread of HIV infection in Mathare slums.

III. To examine how disclosure or non-disclosure of HIV positive status affects relationships among women

IV. To establish factors that differentiates between HIV disclosure and non-disclosure among women in Mathare slums.

The research sought to demonstrate the factors that differentiate HIV positive women who disclose their status from women who do not disclose. In this regard, various questions and analysis were explored to test the differences of HIV positive women who disclose their status from women who do not disclose. The study hypothesized that when disclosure is encouraged and strictly adhered to few cases of re- infection would be witnessed besides witnessing a prolonged life as a result of early intervention measures. However, from the respondents' responses, this notion was far from over.

The study identified over 79.6 % of the total respondents fear disclosing their HIV positive status for various reasons. Even those respondents who had indicated they had already disclosed their status thought that, the overwhelmingly number of those who have not disclosed are in such a state because of fear either of discrimination, stigmatization, rejection or even violence from those close family members. Majority pointed out their own personal experiences and recalled how nasty it was especially when they disclosed. The research identified that various

stakeholders ought to continue with campaigns to sensitize the public and the communities on HIV/AIDs and reduce the level of stigmatization, discrimination and other fears that results to disclosure of one's HIV positive status. Fear of the psychological and emotional effects to the children especially among single women and widows was the main reason for non-disclosure. In addition, to the respondents' thoughts and sentiments, fear was also overwhelming supported by the professionals who identified it as one of the major hindrances in their quest to combat the disease. Married women fear disclosing their status majorly due to fear of husband's decision. Some feared that if they disclosed their status, their husbands would be violent and angry and consequences would be dire like rejection, separation and divorce hence the non-disclosure. Despite community education, individual members of the society especially those who are suffering from the disease ought to come out and disclose their status without fear since the professional indicated there are enough measures in place to deal with any consequences of disclosure like stigmatization and discrimination. Finally, the components that victims feared would be the greatest casualty if they disclosed their HIV positive status are rejection, blame, separation, divorce, stigmatization, distorted relationships and discrimination.

### 5.2.2 Effects of Disclosure on women who are HIV positive status

The above section identified that there is prevalent fear for women coming forward and disclosing the HIV positive status. However, due to the spirited campaigns and community education which have been undertaken by various stakeholders, the non-disclosure cases have significantly reduced. In addition, the community had instituted various support measures where the disclosed cases would be handled and this has instilled some level of confidence even to those who had not disclosed their status. Nevertheless, there are effects which were identified with disclosure despite the efforts in place. Stigmatization, separation, divorce and

discrimination were identified as the leading effects of disclosure of HIV positive status. Other effects which were associated with disclosure included rejection, blame, and harsh community treatment of victims. Therefore, much require to be done to ensure these effects and their consequent impacts are minimized to encourage more disclosures.

Although disclosure of positive HIV status has been observed to share a fair proportionate of negative effects and fear has been prevalent, cases where disclosure was made registered significant levels of hope, optimism as well as other benefits. Disclosure, was observed to directly contribute to low levels of new infection of HIV/AIDs since people were conscious of their behaviors and were no longer irresponsible in their sexual behaviors. Disclosure also resulted to early intervention measures like ART procedures which greatly assisted the victims to deal with opportunistic infections hence reduces the effects of HIV virus. This notion was as well held by the professionals who identified disclosure as one of the early therapeutic interventions for HIV victims.

On the other hand, when disclosure was made, relationships were strained to a great extent and couples reported that in the extreme instances, separation and divorce were the evident. Blame was also an adverse effect especially in the family set up when a member disclosed her status with others terming her reckless and irresponsible. Education and continued community sensitization of the transmission modes ought to be prioritized to ensure awareness on various ways one can be infected by the disease. However, other benefits identified with disclosure included high levels of adherence to ART procedures hence reduced reinfection rates. With proper education and trainings, disclosure levels helped victims to be accountable to a family member of a peer in a support group to adherence of ART procedures hence a positive step in curbing the effects of HIV/AIDs.

### 5.2.3 How disclosure of HIV positive status affect relationships

Disclosure is a long and procedural process which does not mean that a victim ought to disclose her status in public. Disclosure is important to start with those people who matters most to the victim before going to the wider circle of relations. From the research, the greatest and most beneficial disclosure was identified involving the victim and the counsellor. This was so because the counsellor may be only person who identifies with the victim's status and devises ways and means of coping with the situation. With constant help and encouragement, victims disclosed to their spouses, children, family members and then the church through the pastors. These disclosures were identified to be beneficial not only to the victim but also those around them and the society in general as a result of adherence to ART and reduced reinfection cases reported.

Notwithstanding the benefits associated with disclosure, it was observed to strain relationships especially among couples. Best relationships were also affected by disclosures like that of siblings, parents as well as children. However, the effects of disclosure were dependent on various parameters which include the seriousness of the relationships, whether the victim is a single woman or married. When disclosure was made, majority of the victims identified initial anger and violent-like character from those who matters to them and such experience discouraged those who had not disclosed. However, there was a proportionate number of victims who were torn on whether to disclose or not. They were unsure of the responses they would receive from those they disclosed.

### 5.2.4 Difference between women who disclose and women who do not disclose HIV positive status

The aspect of disclosure has been widely discussed and inferences bought out as the potential pros and cons. There was a significant difference to those who disclosed their positive HIV status

to those who did not disclose. Over 85 % of the respondents agreed there is a significant difference between those who disclosed and those who did not. Most notably is the fact that those who disclose are no longer worried of people reaction hence do not live in fear. They are also living a healthy life since they can take their ART even in the general public and in the presence of their relatives hence improving their health status. They are also accountable either to their relatives who know their status or peers in support groups hence improving adherence to the ART procedures. They are as well supported with nutritional supplements which boosts their immune systems from public recognized institutions like hospitals and therapeutic centers. This is unlike those who do not disclose. They are unable to access ART procedures, even if they access, they may not strictly adhere to since they fear when they are in general public or in presence of their loved ones and relatives. Their health status therefore is greatly affected adversely especially the notion of living in constant fear all the time.

There are factors which influences some women to disclose their positive HIV status while others don't. When a woman has high levels of self-confidence, the chances are that she will definitely disclose her status and deal with the consequences later. Self-acceptance is also another booster to women who disclose their status. The quest for care and support especially from therapeutic support groups is among the compelling reasons why majority of women would disclose their status while others may not. On the other hand, those who fear disclosing their status are guided by the fact that stigmatization would take a toll on them, there is inherent fear of judgment within them, they fear their spouse and so on. The bottom line is that; they are living in fear of what would befall them if they disclose their positive HIV status. When a comparison was made of those women who disclose and those who don't, a rather optimistic observation was made. Women those who disclose live longer compared to those who don't mostly attributed to

adherence of ART and other therapeutic support services. Those who disclose in the long run gain the confidence and love of their spouses, parents and siblings. However, those women who do not disclose are in constant fear of what would happen if their status would be known. In addition, their health status is highly affected mostly due to lack of essential services and care which are paramount to HIV positive victims.

## 5.3 Conclusions of the Study

### 5.3.1 Main findings on disclosure

The study has identified a consistence pattern of nondisclosure of positive HIV status especially among women living in informal settlement of Mathare. This situation has been attributed to various factors including fear of rejection, discrimination, blame, distorted relationships, separation as well as divorce. Disclosure has also been identified to negatively affecting the relationships among the victims and the people around them. As a result, many women in these settings prefer not to disclose their positive HIV status and conduct therapeutic sessions and ART procedures in secret.

### 5.3.2 Economic and HIV disclosure

Economic status was also identified as one of the greatest hindrances to disclosure of positive HIV status. This was measured by their employment status where they feared disclosing their positive HIV status would significantly reduce their chances of securing the casual employment they have been undertaking.

### 5.3.3 Marital status and HIV disclosure

Married women were found to be more at ease in disclosing their positive HIV status compared to single women. Single women feared disclosure would psychologically and emotionally affect their children especially when the father figure was missing, the effects would be devastating

hence the continued nondisclosure status among single women. The whole aspect of disclosure and nondisclosure was identified not only as a sensitive issue but also one which does not only depend with the woman only. Disclosure and nondisclosure is a far reaching decision which when undertaken influenced the family holistically hence proper thought to be considered before any decision can be taken.

**.3.4 Benefits of disclosure of HIV positive status**

There were enormous benefits which were identified associated with disclosure of one's positive HIV status. When the disclosure is made, people live freely and the aspect of fear was eliminated. Secondly, those who disclosed lived longer since they received the necessary care and support from family members, relatives, general public and support groups. There were also higher levels of confidence to those who disclosed their HIV status compared to those who didn't. Finally, those who disclosed their positive HIV status helped in reducing the re-infection rates as they avoided risk sexual behaviors as compared to those who never disclosed. Therefore, the comparative study that differentiate HIV positive women who disclose their status from women who do not disclose favored those who disclose since the benefits are not only to individual victims but also to the general public.

**5.4 Recommendations**

The study has identified various differences between those women who disclose their positive HIV status and those who do not. In addition, there were various factors which informed their decisions either to disclose or not. With regard to these factors which causes women either to disclose or not, fear was identified as the greatest among other factors. Fear of rejection, stigmatization, distorted relationships, blame, separation and divorce topped the list.

### 5.4.1 Sensitization Campaign

Community ought to **intensify the sensitization campaign** on the disclosure benefits. This would involve counselling close relatives of those infected with HIV as opposed to victims alone. This would increase the awareness and exposure levels hence reduced rejection and discrimination as well as stigmatization.

### 5.4.2 Community awareness

Secondly, **community awareness** ought to focus **on preventative measures as well as control** to ensure the rate of new infections is minimized. To ensure the sensitization campaign is a success, the therapeutic sessions ought to be devolved and taken to household levels as opposed to centralized locations. In the latter case, women may fear to be seen hanging around these centers but when it's taken to local levels, fear of been noticed and seen is eliminated and many more will show up for the sessions.

### 5.4.3 Established rescue center

Thirdly, **all stakeholders should establish rescue center** in various regions where victims of blame, discrimination, stigmatization, divorce and separation due to HIV positive status should be accommodated. This will enhance disclosure since the fears associated with disclosure will be taken care of. When a victim discloses the status and experiences the above fears, they are assured of a fallback position and status where they shall be taken care for.

### 5.4.4 Economic Status

The **economic status** of the affected family ought to be considered positively. Since majority of these women fear disclosing their status for possible termination and subsequent denial of other casual job opportunities, they ought to be economically empowered to ensure they are self-reliant. By so doing, they shall have no fear of disclosing since they don't dependent on others

economically hence low opinion of others while they disclose their status. When the status quo is maintained, they may fear disclosing to their employers and potential employers for fear of rejection and discrimination.

### 5.5 Conclusion of the Study

The study has identified a consistence pattern of nondisclosure of positive HIV status especially among women living in informal settlement of Mathare. This situation has been attributed to various factors including fear of rejection, discrimination, blame, distorted relationships, separation as well as divorce. Disclosure has also been identified to negatively affecting the relationships among the victims and the people around them. As a result, many women in these settings prefers not to disclose their positive HIV status and conduct therapeutic sessions and ART procedures in secret. Sensitization community education and forums ought to be continuous and inclusive to ensure all members of the public are sensitized concerning HIV/AIDs. Economic status was also identified as one of the greatest hindrances to disclosure of positive HIV status. This was measure by their employment status where there feared disclosing their positive HIV status would significantly reduce their chances of securing the casual employment they have been undertaking.

Married women were found to be more at ease in disclosing their positive HIV status compared to single women. Single women feared disclosure would psychologically and emotionally affect their children especially when the father figure was missing, the effects would be devastating hence the continued nondisclosure status among single women. The whole aspect of disclosure and nondisclosure was identified not only as a sensitive issue but also one which does not only depend with the woman only. Disclosure and nondisclosure is a far reaching decision which when undertaken influenced the family holistically hence proper thought to be considered before

any decision can be taken. However, there were enormous benefits which were identified associated with disclosure of one's positive HIV status. When the disclosure is made, people live freely and the aspect of fear was eliminated. Secondly, those who disclosed lived longer since they received the necessary care and support from family members, relatives, general public and support groups. There were also higher levels of confidence to those who disclosed their HIV status compared to those who didn't. Finally, those who disclosed their positive HIV status helped in reducing the reinfection rates as they avoided risk sexual behaviors as compared to those who never disclosed. Therefore, the comparative study that differentiate HIV positive women who disclose their status from women who do not disclose favored those who disclose since the benefits are not only to individual victims but also to the general public.

## REFERENCES


Albright, K. (2003). *HIV/AIDS information seeking and Healthcare communications in sub-Saharan Africa*; Sheffield: University of Sheffield, department of Information studies.

African Population and Health Research Centre, (2002): *Population and Health Dynamics in Nairobi's informal settlements*.

Ackcoyd, S., Hughes, J.A. (1981). *Data collection in context*: Longman publisher.

Amuri, M. (2011). *Social economic status and HIV/AIDS stigma in Tanzania*: 378-382 volume 23 issue 3; published 22/2/2011.

Annette, B, (2007); *A model of HV disclosure and types of social relationships*: John Wiley & Sons.

Ashley, C. (2016). *Sociological Theories*: About Inc.

Bailey, R.C. (2002). *The acceptability of male circumcision to reduce HIV infection*: National center for Biotechnology information.

Beguy, D., Bocquier P., Zulu E. M. (2002). *Circular migration patterns and determinants in Nairobi slum settlements*. Demographic Research; 23:549-586.

Bird, J.D., Fingerhut, D.D., Mikira, D.J. (2009). *Ethnic differences in HIV disclosure and sexual risk*: AIDS Care. 2011 23(4) 444 - 448.

Bongaarts, J. L. (2007). *Marriage and HIV epidemic in sub-Saharan Africa*: Population studies; 61:71-63 [PubMed].

Bruhns, R. (2006). *The long - run effects of HIV/AIDS in Kenya*, Economic Growth centre, Yale University Paper No. 952.

Burns, N., Grove, S.K. (2003). *Understanding nursing research*: Qualitative research, Amazon.com.Inc.

Creswell, J.W (1998). *Qualitative inquiry and Research design*: choosing among the five traditions. Sage publication: London.

Dandoo, F N., Slaon, M, Zulu E. (2002). *Space and hardship, socializing children into sexual activity in Kenya slums:* Fertility and Reproductive Health in Sub Saharan Africa. Greenwood Press: pp 147-158.

Draiman, D. (1993). *HIV affected and vulnerable youth; Prevention issues and approaches*: Rout ledge Amazon.com

Evans, M. (2000). *Probability of distribution functions*; Statistical distribution 3rd edition: John Wiley & Sons.

Faulkner, S.L. (2012). *Knowledge on trust: Analysis of relationship dissolution*, Oxford: Oxford University

Jaeger, R.M. (1988). *Survey Methods in Educational Research*, Washington D.C.: Brooking Institution Press.

Jonathan, E., Fowzia, I., Cecilia, B., Jane, A. (2008). *HIV related discrimination reported by people living with HIV in London*: AIDS AND BEHAVIOUR VOL 2 23-2008, p 255-64.

Kyobutungi, C. (2007). *HIV/AIDS and tuberculosis*, National center for Biotechnology information

Kothori, C.R (2003). *Research Methodology; Methods and techniques*. New Delhi, New Ag. International (p) Limited Publishers

Kerlinger, F.N. (1973). *Foundation of Behavior Research*; New York: Holt, Rinehart and Winston Inc.

Kalichman, S.C. (1995). *Understanding AIDS: A guide for mental health professionals*, American psychological association. Washington DC.

KAIS, (2009). *Center for Disease control and Prevention*: Public Health publication.

Kenya National Bureau of statistics. Wikipedia: the free encyclopedia.

Kelly, H.H., Thibaut, J.W. (1978). *Interpersonal relations: A Theory of interdependence*: New York; Wiley.

Millet, G.A., Peterson J.L., Bakeman,R. (2007*). Explaining disparities in HIV infections among Black and white men who have sex with men- a meta-analysis of HIV risk behaviors*; 2007 Oct 21 (15): 2083-91.

Mayfield, A.E., Rice, E., Flannery, D (2008). *HIV disclosure among adults living with HIV-NCBI*.

Mugenda O.M. & Mugenda. (1999). *Research methods, Quantitative and Qualitative approaches. Nairobi*: Acts Press

National AIDS control of Kenya. (2013). *Kenya AIDS response progress Report 2014*.

Orodho, J.A. (2004). *Essential of Educational and Social Science, research Methods*, Nairobi, Masola publishers

Ogula, P.A. (2005). *Research Methods*, Nairobi: CVEA publications.

Patterson, H. L. (2012). *HIV/AIDS in the Slums of Kenya: Intervening through effective Utilizing Volunteers*. Master's Thesis: University of Pittsburgh.

Parahoo, K. (1997). *Nursing Research principles, process and issues*: Macmillan London.

POZ (March (2013). *HIV/AIDS News*, Wikipedia the free encyclopedia.

Popper, K. (2004). *The logic of scientific discovery*: Routledge. New York

Reiners G. (2008). *Marital strategies for regulating exposure to HIV*, 45: 417-438. [PMM free article] PubMed

Roux, K. A. (2014). *Clinical research conduct in South Africa*: Informed consent (2014). Lambert academic publishing: ISBN 978-3-659-62501-5 (with Britz, R).

Rusbult, L.E. (1983). *The investment model of commitment processes*: Purdue University, agnew @purdue.edu.

Swanson, R.A and Hilton. (2010). *Human Resource Development handbook*, New York: Gilford.

Trochim, William M. (2006). *The Research Methods, knowledge and Base 2nd edition*. Internet webpage, at URL:<http://www: Socialresearchmethods.net/kb/> (version current as of October 20, 2006).

Weiser, S.D. (2009). *Journal of internal medicine*: online publication.

Women and Health volume 538, issue 4, 2004 pages 57-71: published 10/10/2008

Zulu. E. M., Dodoo, F. N. (2002). *Sexual risk- taking in the slums of Nairobi: Kenya*. Population studies: 56:311 -323. [PubMed]

**APENDIX I: QUESTIONAIRE**

**SECTON A: BACKGROUND INFORMATION**

**1**. Name _____ **(optional)**

**2.** Age_____ **(optional)**

**3.** HIV Disclosure status: Disclosed ( ) Not Disclosed ( )

**4.** Marital status: Married ( ) Single ( ) Widow ( )

**5.** Highest academic qualification

_____

**6.** Occupation

_____

**7**. Family size_____ (Number of children)

**8.** Ethnic group

_____

**9.** How long have you been HIV positive status?

- Less than 2 years ( )
- 2-5 years ( )
- 6-10 years ( )
- 11- 15 years ( )
- Over 15 years ( )

**SECTION B: FACTORS THAT ARE BASIS OF FEAR OF DISCLOSURE OFHIV POSITIVE STATUS**

**10.** Do you think that women fear disclosing their HIV positive status? Yes ( ) No ( )

(a) If yes, why do you think they fear?

_____

_____

_____

(b) If no, why do you think they do not fear?

_____

_____

_____

**11**. The following are statements of factors that are basis of fear of disclosing HIV positive status. Please indicate the level of your agreement on each statement. Use a scale shown below where:

1: Strongly Disagree (SD)

2: Disagree (D)

3: Neutral (N)

4: Agree (A)

5: Strongly Agree (SA)

| **STATEMENTS** | SD | D | N | A | SA |
|---|---|---|---|---|---|
| Fear of rejection has contributed to non-disclosure of HIV status | | | | | |
| Fear of blame has contributed to non HIV disclosure | | | | | |
| Fear of divorce/separation affects disclosure of HIV status | | | | | |
| Fear of stigmatization affects disclosure of HIV status | | | | | |
| Fear of distorting relationship affects disclosure of HIV status | | | | | |
| Fear of discrimination affects disclosure of HIV status | | | | | |

**SECTINON C: EFFECTS OF DISCLOSURE ON HIV POSITIVE STATUS**

**12**. Do you think there are effects to disclosing HIV positive status? Yes ( ) No ( )

(a) If yes, please list the effects?

_____

_____

_____

_____

(b) If no, please explain your answer?

_____

_____

_____

**13**. Do you think disclosure of HIV has led to reduction of HIV prevalence? Yes ( ) No ( )

(a) If yes, please give your reasons

_____

_____

_____

(b) If no, please give your reasons

_____

_____

_____

**14**. Do you think disclosure of HIV positive status has effect on relationships? Yes ( ) N0 ( )

(a) If yes, please give our reason

_____

_____

_____

(b) If no, please give your reasons

_____

_____

_____

**15**. Do you think disclosure of HIV positive status results to ART adherence? Yes ( ) No ( )

(a) If yes, explain your answer

_____

_____

_____

(b)If no, please explain your answer

_____

_____

_____

**16.** The following are statements on effects of disclosure of HIV positive status. Please indicate the level of your agreement on each statement. Use the scale shown below where;

1: Strongly Disagree (SD)

2: Disagree (D)

3: Neutral (N)

4: Agree (A)

5: Strongly Agree (SA)

| **STATEMENT** | SD | D | N | A | SA |
|---|---|---|---|---|---|
| Non-disclosure of HIV positive status has increased HIV prevalence | | | | | |
| Disclosure of HIV Positive status has led to reduction/spread of HIV | | | | | |
| Non-disclosure of HIV positive status has no impact on new infections | | | | | |
| Disclosure of HIV positive status has negative effect on relationships | | | | | |
| Disclosure of HIV positive status results to ART adherence | | | | | |
| Disclosure of HIV positive status reduces the behavior that continue to spread HIV | | | | | |
| Disclosure of HIV positive status increases psychosocial support from family members | | | | | |

**SECTON D: HOWDISCLOSURE OF HIV POSITIVE STATUS AFFECTS RELATIONSHIPS**

**17.** The following shows the people you have disclosed your HIV positive status to. Please tick where applicable**.**

(a) Spouse ( )

(b) Parents ( )

(c) Your children ( )

(d) Pastor ( )

(e) Counselor ( )

(f) Friends ( )

**18.** If you have not disclosed your HIV positive status: do you think HIV disclosure can affect relationships between you and any member or members of your family? Yes ( ) No ( )

(a) if yes, with whom would it affect and how?

_____

_____

_____

(b) If no, please explain your answer

_____

_____

_____

**19**. If you have already disclosed your HIV positive status: has disclosure affected the relationship between you and any member of your family? Yes ( ) No ( )

(a) If yes, with whom has disclosure affected and how?

_____

_____

_____

(b) If no, please explain your answer

_____

_____

**20**. Do you think HIV disclosure affects relationships? Yes ( ) No ( )

(a) If yes, how do you think HIV disclosure affects relationships?

_____

_____

_____

(b) If no, why do you think disclosure does not affect relationships?

_____

_____

_____

**21.** The following are some of the HIV disclosure factors perceived to affect relationships. Please indicate level of your agreement. Use the scale shown below where:

1: Strongly Disagree (SD)

2: Disagree (D)

3: Neutral (N)

4: Agree (A)

5: Strongly Agree (SA)

| **STATEMENT** | SD | D | N | A | SA |
|---|---|---|---|---|---|
| Disclosure of HIV positive status is dependent on the seriousness of the social relationship | | | | | |
| Disclosure of HIV positive status results to negative emotional reaction | | | | | |
| Partners are unsure of actual responses to disclosure of HIV positive status | | | | | |
| More Single women disclose their HIV status than married women | | | | | |
| Disclosure of HIV positive status strain the best relationships | | | | | |
| Disclosure of HIV positive status to a partner can cause reaction of anger and violence | | | | | |

**SECTION E: DIFFERENCE BETWEEN THOSE WOMEN DISCLOSING THEIR HIV POSITVE STATUS AND THOSE WHO DO NOT DISCLOSE THEIR STATUS**

**22**. Do you think there are differences between those women who disclose their HIV positive status and those who do not disclose? Yes ( ) No ( )

(a) If yes, please give the differences

_____

_____

_____

(b) If no, please give your reasons

_____

_____

_____

**23**. Give four reasons why some women disclose their HIV positive status.

(a)_____

(b)_____

(c)_____

(d)_____

**24**. Give four reasons why some women do not disclose their HIV positive status

(a)_____

(b)_____

(c)_____

(d)_____

**25.** The following are some of the differences between women disclosing their HIV status and those not disclosing their status. Please indicate level of your agreement. Use a scale shown below where:

1: Strongly Disagree (SD) 2: Disagree (D) 3: Neutral (N)

4: Agree (A) 5: Strongly Agree (SA)

| **STATEMENT** | SD | D | N | A | SA |
|---|---|---|---|---|---|
| Women who disclose their HIV positive status live in fear | | | | | |
| Women who disclose their HIV positive status loose the love of their spouses | | | | | |
| Women who disclose their HIV positive status face stigma and violence | | | | | |
| Women who do not disclose their HIV positive status do not adhere to ARTs | | | | | |
| Women who do not disclose their HIV positive status maintain good relationships with their spouses | | | | | |
| Women who do not disclose their HIV status increase re infection resulting to high prevalence of HIV | | | | | |

**APENDIX II: INTERVIEW SCHEDULE FOR SUPPORT GROUPS**

**1.** What is your occupation?

_____

**2**. For how long have you worked with women living with HIV status?

_____

**3**. Who do you think rank high in disclosing their HIV status than the other? Men ( )

Women ( )

**4.** Do you think women fear disclosing their HIV positive status? Yes ( ) No ( )

Briefly explain your answer

_____

_____

_____

**5**. Do you think stigma on HIV status still exists? Yes ( ) No ( )

Briefly explain your answer

_____

_____

_____

**6**. Do you think non-disclosure has increased HIV prevalence? Yes ( ) No ( )

Briefly explain you answer

_____

_____

_____

**7.** Do you think disclosure has any impact on the spread of HIV? Yes ( ) No ( )

Briefly explain your answer

_____

_____

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**8.** Do you think there are effects to disclosing HIV positive status? Yes ( ) No ( )

Briefly explain your answer

_____

_____

_____

**9**. Is there any difference between those women disclosing their HIV status and those not disclosing?

Yes ( ) No ( )

Briefly explain your answer

_____

_____

_____

**10.** Do you think disclosure affect relationships? Yes ( ) No ( )

Briefly explain your answer

_____

_____

_____

**11.** Is disclosure of HIV positive status dependent on relationship? Yes ( ) No ( )

Briefly explain your answer?

_____

_____

_____

**12.** What would you recommend to improve HIV disclosure?

_____