MENTAL HEALTH AND EXPERIENCE OF PARTNER VIOLENCE AMONG WOMEN WHO DISCLOSE HIV SEROSTATUS AT MUHIMBILI HEALTH INFORMATION CENTRE, DAR ES SALAAM

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By

Dorothy Mushi, (MD)

A Dissertation Submitted in Partial fulfillment of the Requirement for the Master Degree in Psychiatry of Muhimbili University of health and Allied Sciences

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CERTIFICATION

The undersigned certify that they have read and hereby recommend for acceptance by Muhimbili University of Health and Allied Sciences a dissertation entitled "***Mental Health And Experience Of Partner Violence Among Women Who Disclose HIV Serostatus At Muhimbili Health Information Centre In Dar Es Salaam,Tanzania,*** in (partial) fulfillment of the requirements for the degree of Master of Medicine (Psychiatry and mental health) of Muhimbili University of Health and Allied Sciences.

_____

Dr. Jessie Mbwambo

(Supervisor)

Date_____

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ABSTRACT

HIV and violence are two of the major health problems affecting the lives of millions of women worldwide an important component of HIV voluntary counseling and testing (VCT) programs is encouraging clients to inform partners of their serostatus. Yet many clients do not disclose results to partners due to negative consequences such as stigma, anxiety and depressive symptoms, intimate partner violence, loss of intimacy, and threats to personal well-being.

Building on a previous study this study explored the links between violence, mental health and HIV serostatus disclosure among women attending VCT at MHIC.

METHODOLOGY: From September 2011 to March 2012 stand-alone VCT facility-based cohort follow up study was conducted and quantitative method for data collection was used to identify the magnitude and factors associated with mental health and experience of partner violence among women who disclose HIV serostatus at Muhimbili Health Information Centre, Dar es Salaam (n= 607) women who met inclusion criteria for study were interview at baseline and after three month. Every client was screened for the anxiety- depressive symptoms and assessed for intimate partner violence using Hopkins Symptoms Checklist 25 (HSCL-25) for anxiety and depression and Conflict Tactic Scale (CTS) respectively. Both tools have been validated for use in the Tanzania context. Simple descriptive analysis was done to determine the magnitude of HIV serostatus disclosure, violence and mental health. Bivariate, student T-test and logistic regression mode were applied to determine the significant associations and factors independently associated with HIV serostatus disclosure.

RESULTS: A total of 607 participants were enrolled at baseline while 523 were re-interviewed at three month post HIV test. 84 were lost to follow up; the characteristic which was found to differ from those who were followed up was significant baseline history of sexual violence. 440 (84%) disclosed their HIV serostatus to their primary partners within three month post HIV test. Among those who disclosed 216 (49.1%) experienced physical violence (p=0.000), 170/440 (38.6%) reported to have low level of anxiety symptoms, while 109/440 (24.8%) reported to experienced high level of depressive symptoms (p=0.00). Among non disclosure 35(43.2%) did not share results due to fear of partner reaction.

CONCLUSION; Eight out of ten women who received VCT service shared their HIV serostatus with their primary partners. Prior communication with partner about VCT service predicts the tendency for HIV serostatus disclosure. During HIV serostatus disclosure nearly five out of ten of women experience physical violence from their partner while two to three experience high level of depressive symptoms. Despite high encouragement for HIV serostatus disclosure during VCT services two out of ten women did not share their HIV serostatus result due to fear of partner reaction, most mentioned they feared physical abuse and abandonment.

RECOMMENDATIONS; Need for increased innovative interventions that support HIV serostatus disclosure among clients attending VCT. Also there is a need to screen for violence and mental health of clients attending VCT.

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ACRONYMS/ABBREVIATIONS

AIDS	Acquired Immuno Deficiency Syndrome
CTC	Care and Treatment Clinic
CTS	Conflict Tactic Scale
HIV	Human Immuno Deficiency Virus
IPV	Intimate Partner Violence
MHIC	Muhimbili Health Information Centre
MHO	Mental Health Outcome
MNH	Muhimbili National Hospital
MUHAS	Muhimbili University of Health and Allied Science
PAHO	Pan America Health Organization
PEPFAR	President's Emergency Plan for AIDS Relief
SSA	Sub Saharan Africa
STD	Sexual Transmitted Disease
UNAIDS	United Nations Programmed on HIV/AIDS
VCT	Voluntary Counseling and Testing
VVU	Virusi vya Ukimwi
W H O	World Health Organization

DEFINITION OF TERMS

1. Violence in this study refers to or applied to intimate partner violence

2. Intimate Partner Violence (IPV) - describes physical, sexual, or psychological harm by a current or former partner or spouse, can occur among heterosexual or same-sex couples and does not require sexual intimacy.

3. IPV can vary in frequency and severity. It occurs on a continuum, ranging from one hit that may or may not impact the victim to chronic, severe battering.

4. Primary partner is defined as a sexual partner a participant has been with for three months or longer.

5. Mental health in this study applies to current (at time of data collection) anxiety and depressive symptoms.

CHAPTER ONE

1.0: INTRODUCTION AND LITERATURE REVIEW

1.1. INTRODUCTION

The prevention and control of HIV infection depends on the success of strategies to prevent new infections and treat currently infected individuals. HIV testing and counseling services are a critical prevention and treatment tool in the control of the HIV epidemic. Among other services it emphasizes the importance of HIV status disclosure among HIV-infected clients, particularly to their sexual partners. HIV status disclosure is an important public health goal for a number of different reasons; including motivating sexual partners to seek HIV testing, change sex risk behavior and ultimately decrease transmission of HIV. In addition to this, disclosure may facilitate health behaviors related to antiretroviral drugs (ARV) use that may improve the management of HIV. Disclosure may also facilitate support from family or others in patient's social networks and increase abilities to access available support services.[1, 2, 3]

However it has now been recognized that there are a number of barriers that particularly HIV-infected women face when sharing their test results with friends, family and most importantly sexual partners. Therefore, there is considerable interest in finding strategies to encourage disclosure because of the public health benefits that may accrue from the disclosure of HIV serostatus.

1.2: LITERATURE REVIEW

1.2.1: Magnitude of HIV

Globally 33.3 million people were reported living with HIV/AIDS by the end of the year 2009 compared to 33.4 million at the end of the year 2008. However this was an increase of 27% compared to the 26.2 million people reported in 1999[4]. UNAIDS's report on the global AIDS epidemic indicated that slightly more than half of all people

living with HIV were women and adolescent girls. Sub Saharan Africa still leads in the burden of HIV/AIDS globally, though the rate of new HIV infections is on the decline, In 2009 there were 22.5 million people living with HIV/AIDS which accounted for 68% global burden of HIV/AIDS.[5] More women than men in sub-Saharan Africa, live with HIV; young women aged 15-24 years were as much as eight times more likely than men to be HIV positive.[5.] In the year 2009, there were an average of 2.1 million deaths due to AIDS globally, sub-Saharan Africa contributing two thirds of all deaths (66.7%). This makes HIV a leading cause of death and the cause of a 15-year drop in life expectancy in Sub Saharan Africa.[6.] The high magnitude of HIV amongst women warrants attention to HIV prevention efforts in this population subgroup.

An estimated 6.5% of the Tanzania mainland population is infected with HIV; with rates of 7.7% in adult women and 6.3% adult men in a total population of 41 million. Overall 1.4 million are living with HIV infection[7].

1.2.2: Prevalence of HIV serostatus disclosure

The rate of HIV serostatus disclosure varies among populations both globally and within regions. In the USA, HIV serostatus disclosure to sexual partners varies from 58.0% to 76.0%.[1] However, in lower income contexts such as the West Indies only 28.8% of HIV seropositive women had disclosed their status to sexual partners.[20] In sub-Saharan Africa (SSA) the rate of serostatus disclosure to partners in women is shown to range from 19.6% in Tanzania to 90.7% in Nigeria.[17, 26]

Settings providing services for prevention of mother to child transmission of HIV (PMTCT), is one context within which provider initiated screening for HIV provides opportunity to explore HIV status disclosure to partners and possible barriers. Most women in such settings, do not primarily attend facilities for HIV testing, and it is observed that rates of partner disclosure of HIV status are much lower among antenatal

attendees than in women that voluntarily test for HIV the rate of disclosure reported in these facilities ranged from 16.7% to 86%.[36]

More recent studies in antenatal care in SSA, show rates of partner disclosure may be as high as 88.0% in antenatal care. For example, a Nigerian study among recently diagnosed HIV positive pregnant women attending a PMTCT clinic showed 88.0% of 280 recruited had disclosed their HIV status to their husbands. Other HIV status disclosee's in this population included religious leaders and close family members. The only reason for non-disclosure to husbands in this study was the fear of divorce. However, in partner disclosure situations, the partner's reaction was reported to be supportive and understanding [26]. There is some indication that in antenatal settings of SSA, the assistance of health care providers to women for partner disclosure of HIV status may be invaluable. For example, a Nigerian study found that 89% (500/560) of women had disclosed their HIV serostatus to their partners; of these, 39.6% (199/502) required the assistance of health workers while 59.4% (298/502) disclosed to partners on their own.[25]. On the other hand, rates of partner HIV disclosure may be lower amongst women in some parts of SSA. In urban Tanzania, for example, a study among 1,050 HIV positive women in antenatal care found only 16.7% had disclosed to partners 18 months after diagnosis.[17] It is likely rates of disclosure may have been even lower soon after HIV diagnosis in this study, as longitudinal studies show changes in rates of HIV serostatus disclosure over time suggesting a process involved in decisions related to such disclosure to partners. In a South African study, at enrollment, 59% of HIV positive pregnant women (N=293) had disclosed to their partners and 42% to others. This rate rose to 67% and 59% respectively, by three months follow-up. [27]. Increase in HIV serostatus disclosure over time has also been observed in Tanzania. Among 1,078 HIV positive women in antenatal care in Dar es Salaam, 22% disclosed HIV status to their partner within two months of diagnosis; however this figure rose to only 40% disclosure to partners after 46 months of follow-up.[16] Factors influencing the relatively lower rates of HIV serostatus disclosure in antenatal populations in Tanzania are as yet not clear.

1.2.3: Factors associated with HIV serostatus disclosure

A relatively recently review of SSA studies where women were directly asked about barriers to HIV serostatus disclosure to their partners, or where factors associated with lack of such disclosure was reported shows a number of barriers to HIV status disclosure. The most commonly reported barriers included; fear of abandonment, rejection and discrimination, violence, and accusations of infidelity as well as not wanting to upset family members.[37] A Nigerian study of disclosure in an antenatal population (N=280), for example, showed factors associated with HIV non-disclosure to a partner included; being single, low educational status, religious affiliation, and non-membership to a support group. [26] Several other SSA show very similar observations. A study conducted in Kinshasa, among 364 antenatal attendees, 187 of whom were HIV positive, showed, regardless of HIV status, 63% mentioned fear of divorce as a barrier to HIV status disclose, while 86% feared accusations of infidelity. In Mombasa, among 331 HIV positive pregnant women in antenatal care 94.1% reported fear of partner reaction, should they disclose their HIV status. [33] Similarly in Nairobi, a study among 520 women accessing services for sexually transmitted diseases (STD) who did not test for HIV, showed perceived barriers for HIV disclosure included fear of accusation of infidelity (63%); fear of abandonment by partner (55%); and fear of violence by partner (51%).[34] Non-disclosers amongst HIV positive women in two antenatal studies in Tanzania reported fears of wider spread knowledge of their HIV status to others (32%), social isolation or being stigmatized (14%-46%), worrying others (17%), conflict with partner, violence or divorce (15%-46.4%) and just being afraid were (11%).[16,17]

More recent studies have explored psychosocial factors predictive of disclosure of HIV status to partners by women, that is study designs that offer some insights into the strength and direction of associations between such factors and disclosure. For example

in South Africa a total of 293 (62%) HIV positive pregnant women were enrolled in a longitudinal (three month's follow-up) study that aimed to understand social and psychological factors that affect disclosure of HIV status. Identified independent predictors of HIV serostatus disclosure to partners including; being married (Adjusted odds ratio (AOR) 2.32; 95% confidence interval (CI) 1.20–4.47), prior discussion about testing (AOR 4.19; CI 2.34), having a partner with tertiary education (AOR 2.76; CI 1.29–5.88) and lower reported experiences of partner violence (AOR 0.48; CI 0.24–0.97). Better housing (AOR 1.26; CI 1.06–1.49), less financial dependence on partners (AOR 0.46; CI 0.25–0.85), and knowing someone with HIV (AOR 2.13; CI 1.20–3.76) were associated with prior disclosure to others. Increased levels of stigma at baseline decreased the likelihood of disclosure to partners post enrollment (AOR 0.91; CI 0.84–0.98) and increased levels of avoidant coping decreased subsequent disclosure to others (AOR 0.84; CI 0.72–0.97).[27]

The risk of violence has also been reported to be an outcome of women's HIV status disclosure in some studies, and may explain some of the fears associated with non-disclosure reported earlier. In Nigeria for example, among women who disclosed their HIV status, between 3% and 15% report negative reactions including blame, abandonment, anger, and violence.[29] However while fear of violence is reported to be a barrier to disclosure by significant proportions of non-disclosing women, amongst those that do disclose many report supportive responses. In the Nigerian study, following HIV status disclosure, 86.9% (430/495) of the partners were reported to be supportive, 5.7% were indifferent and 6.7% were quarrelsome and abusive while 1.0% was violent.[25] Other studies also show women disclosing report supportive responses from partners, with proportions ranging from 62% to 14.6 % in Rwanda and Tanzania.[17, 24, 30.] In these studies, proportion reporting negative reactions ranged from 21% to 61%; these included fear, disbelief, shock, blame and anger. In the Rwandan study slightly over a quarter of women reported their marriage deteriorated.[30]. In a qualitative study that interviewed 26

HIV positive women who were in sero-discordant relationships in Uganda, who had experienced IPV, findings showed that the frequency of IPV increased after diagnosis of HIV serostatus, and women who tested HIV-positive and with sero-negative husbands were told to leave their homes.[31] In South Africa domestic violence was significantly positively associated with violence in childhood, having no further education, liberal ideas on women's roles, drinking alcohol, having another partner in the year, having a confidant(e), his boy child preference, conflict over his drinking, either partner financially supporting the home, frequent conflict generally, and living outside the Northern Province. No significant associations were found with partners' ages, employment, migrant status, financial disparity, cohabitation, household possessions, urbanization, marital status, crowding, communication, his having other partners, his education, her attitudes towards violence or her perceptions of cultural norms on women's role.[13]

Women's HIV serostatus disclosure has been associated with both positive and negative outcome in both developed and developing countries. [28] However, it is important to note that the majority of HIV status disclosing women mentioned at least one positive outcome from disclosure; ranging from increased support and acceptance and kindness. At an individual level, disclosure has been associated with reported lower anxiety, fewer symptoms of depression, and increased perceived social support. Among the important finding from both developed and developing countries, was the observation that disclosure was not associated with the break-up of long-term relationships.[28]

1.2.4: HIV, IPV and HIV serostatus disclosure

Magnitude of IPV: Intimate partner violence is the most common form of violence against women, worldwide the prevalence of lifetime intimate partner violence has been reported to range from 10% to 71% of women in marriage or current partnerships [8,9,10,11,12,18]. In sub-Saharan Africa, the reported prevalence of intimate partner violence

ranges from 20% to 71%[12, 13, 14, 15]. However the prevalence of intimate partner violence is believed to be under-estimated globally because of under-reporting and lack of standardization of measurement methods.[8]

Violence and HIV status in women: Study done in USA showed that HIV-positive women in sero-discordant couples where the man was HIV-negative were the most likely to experience violence. The rate of reported violence in these relationships was 13% as compared to no violence reported in sero-discordant relationships where the man was HIV-positive and the women HIV-negative. Of concern is the small but still significant number of women reporting that they were forced to leave their homes after disclosing their status. [19]

The main barriers to HIV status disclosure among people living with HIV/AIDS include fear of stigmatization, abandonment, divorce, physical and emotional abuse, and several forms of deprivations.[16,20]

HIV-infected people often fear rejection and abandonment following disclosure of their status[1] These concerns keep some women from disclosing to others even when they would like to, and for some, disclosure has in fact led to negative consequences including violence.[1,2]

In USA one survey of medical and mental health professionals treating HIV infected women, health professionals reported treating female patients who expressed a fear of physical violence(45%), emotional abuse (56%), and abandonment (66%) related to disclosing their HIV status. [2] In a USA study assessing violence in women with or at risk for HIV infection, high levels of adult physical and sexual abuse was shown for both HIV seropositive (66.4% and 45.7% respectively) and HIV-seronegative women (69.2% and 48.4% respectively). [21]

In study among 305 HIV-positive women receiving antenatal care in Nigeria the prevalence of intimate partner violence was 32.5%, with psychological violence being

the most common form of violence reported (27.5%) and physical violence the least reported (5.9%). Identified risk factors for experiencing violence were multi parity (OR 9.4; CI 1.23–71.33), respondent with an HIV-positive child (OR 9.2; CI 4.53–18.84), experience of violence before they were diagnosed HIV-positive (OR 44.4; CI 10.33–190.42) and women with partners without post-secondary education (OR 2.3; CI 1.40–3.91). [22]

HIV status, violence and serostatus disclosure by women: Few studies in SSA have explored the association between HIV serostatus disclosure and experience of IPV in non-pregant populations of women. Other than a study conducted in 1999, when HIV prevalence rates were high in the general population, there has been no recent study in Tanzania, after stabilization of the HIV epidemic, that explores relationships between women's disclosure of HIV status to partners and experiences of IPV in voluntary counseling and testing (VCT) settings. The study enrolled 245 women from a VCT clinic, 52%, regardless of their HIV serostatus, feared their partner's reaction to their decision to test for HIV; principally fear of abuse or abandonment. Partner violence was a serious problem among many female VCT clients, with more than 25% of women agreeing with the statement "violence is a major problem in my life". Of the 245 women, those HIV-positive (about 1/3), were 2.68 times more likely than HIV-negative women to report having experienced a violent episode with a current partner. The proportion of physically abusive partners of HIV-positive women was also significantly higher than that for HIV negative women (61% vs 37%). Younger HIV-positive women aged 18-29 years, were ten times more likely to report partner violence than younger HIV-negative women.[24]

1.2.5: Depression, anxiety, HIV and HIV disclosure

HIV serostatus disclosure in women population was associated with both positive and negative outcome in almost both developing and developed countries. Majority of women mentioned at least one positive outcome from HIV serostatus disclosure such as

less anxiety, fewer symptoms of depression, and increased social support (meta analysis study reported in 10 of 27studies). Three studies also mentioned that disclosure caused the respondents to feel closer to their friends and family members or others in their social network. [28]

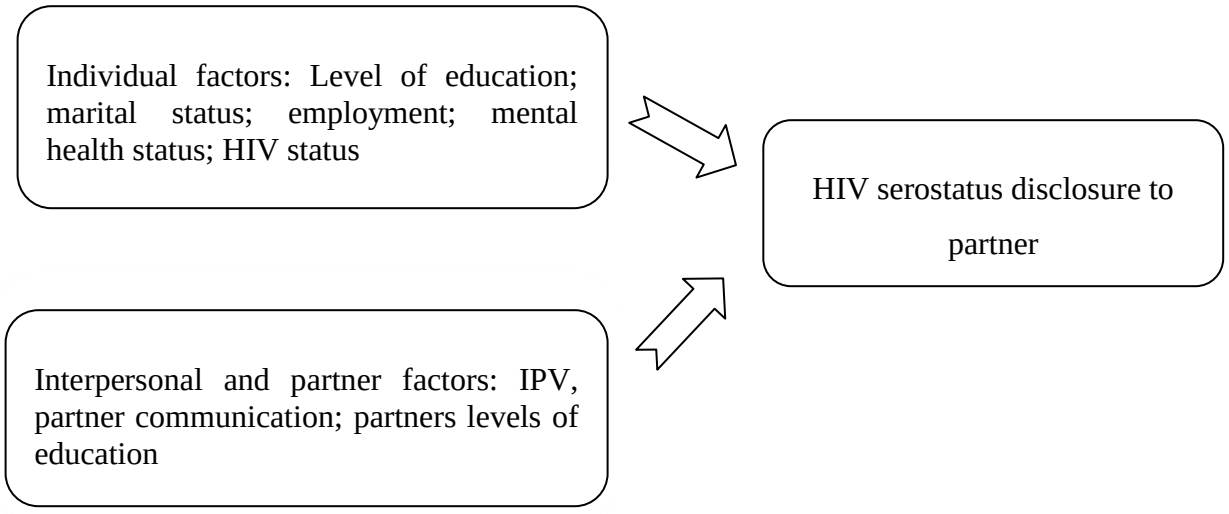
1.3: PROBLEM STATEMENT

Worldwide 10% to 70% of women have experienced intimate partner violence. However the prevalence of intimate partner violence is believed to be under-estimated because of under-reporting and lack of standardization of methods, [8] HIV serostatus disclosure by women is reported to contribute to intimate partner violence. In addition, a significant numbers of negative and positive mental health consequences of disclosing HIV serostatus to sexual partners such are stigma, symptoms for anxiety, depression, loss of intimacy, and threats to person are abound.[28]

1.4: RATIONALE

HIV serostatus disclosure is one of the major public health components of the prevention efforts for HIV transmission reduction. However, such disclosure has negative impacts for women, in terms of intimate partner conflict, and mental health consequences such as anxiety, depression and stigma, in particularly the East African settings. This may hinder implementation of disclosure practices. Despite the significance of HIV serostatus disclosure for transmission prevention, very few quantitative studies have explored psychosocial factors associated with disclosure of HIV serostatus amongst Tanzanian women. This study will provide additional information on such associations during a time when the HIV epidemic is stable in Tanzania. The outcome of this study is expected to contribute to a body of knowledge that can inform comprehensive strategies for improving HIV serostatus disclosure amongst women.

1.5: THEORETICAL FRAME WORK



i) ***Individual factor measures:*** age, marital status, employment, and level of education. Older and those with less anxiety and depression symptoms were hypothesized to be more likely to disclose their HIV status to partners.

   HIV negative women were hypothesized to be more likely to disclose their HIV status to partners.

ii) ***Interpersonal measures:*** Women with no prior exposure to IPV were hypothesized to be more likely to disclose HIV test results to their partners. Women that communicate with partners on intention to test for HIV were hypothesized to be more likely to disclose HIV test results to their partners.

1.6: OBJECTIVES

1.6.1: Broad objective

To determine magnitude and factors associated with mental health and experience of partner violence among women who disclose HIV serostatus at Muhimbili Health Information Centre, Dar es Salaam

1.6.2: Specific objectives

1. To determine the prevalence of HIV serostatus among women who disclose HIV serostatus at MHIC.
2. To determine factors associated with HIV serostatus disclosure among women who disclose HIV status at MHIC.
3. To determine the prevalence of IPV among women who disclose HIV serostatus at MHIC.
4. To determine the prevalence of anxiety and depressive symptoms among women who disclose HIV serostatus at MHIC.
5. To determine the barriers experienced among women who disclose HIV serostatus at MHIC.

CHAPTER TWO

2.0. METHODOLOGY

2.1. Study area

The study was conducted at Muhimbili Health Information Centre located at Muhimbili National Hospital grounds in Ilala Municipality at Dar es Salaam city. The service offered at MHIC included voluntary Counseling and Testing (VCT), it is one of the programs that have been established to meet the growing need for counselling and testing services hence contribute significantly towards prevention of the HIV epidemic. About 1000 clients were attending per month, of which 50% were women therefore offering the opportunity for study convenient population that were easily accessible for the two phases of data capture points with consideration of the limited time and resources.

2.2. Study design

A stand-alone VCT facility based cohort follow up study where quantitative research methods were used to collect information from September 2011 to March 2012.

2.3. Study participants

The sample population comprised all women aged 18 years and above attending VCT at Muhimbili Health Information Centre who met eligibility criteria during the study period.

Selection criteria

Inclusion criteria for the recruitment of study participants included;

- Female clients who received pre-test counseling, HIV testing, and post-testing counseling at MHIC aged 18 years and above who provided consent to participate in the study.
- Being in a relationship with a primary sexual partner (in relationship for at least 3 months).
- Resident of Dar es Salaam and able to attend three month follow-up visit (coincides with three months HIV re-test visit at facility)

Exclusion criteria for the recruitment of study participants included;

- Participant who were sick and not able to remain for the interview.

2.4. Sample size estimates

The estimated sample size N is computed using the formula below,

$$N = \frac{Z^2 p (1-p)}{e^2}$$

OR

$$N = \frac{Z^2 p (100-p)}{e^2}$$

Where;

N = estimated Sample Size

Z = is the standard deviation in normal population, which turns out to be 1.96 when using 95% confidence interval.

P= prevalence of HIV serostatus disclosure to their primary partner among women attend VCT

e= margin of error

The prevalence of HIV serostatus disclosure to their partners among women attend VCT was 70%.Therefore the sample size will be based on the prevalence of 70% ,based on this prevalence ,I can accept the lower boundary of 67% and the upper boundary of 73%, thus the margin of error is 3%

Hence from the formula above the sample size will be

$$N = \frac{1.96 \times 1.96 \times 70(100-70)}{3 \times 3}$$

N = 896

2.5. Sampling technique

Convenience sampling was used; we enrolled every woman who met the eligibility criteria and who consented to participate in the research study.

All women clients aged above 18 years and met eligibility criteria for study were recruited by counselors after the post HIV-test counseling session, those clients who were ready to participate were referred to the interviewers for details explanation and were signed the consent form before being interviewed.

2.6. Research instruments

Standardized structured questionnaire that was researcher administered was used for data collection. The questionnaire had been translated into Swahili as shown in appendix IV.

2.6.1. Socio-demographic factors for participant's and her primary partner included; age, marital status, religious affiliation, level of education and employment status. Other information such are participant and partner's HIV serostatus, HIV serostatus disclosure to partner and the perceived/experienced barriers during HIV status disclosure were also enquired.

2.6.2. Intimate Partner violence was measured using the Conflict Tactic Scale (CTS). CTS is a screening tool with 27 items that measure different strategies that couples use to resolve conflicts, including physical, sexual and emotion violence it has been validated for use in Tanzania, The score 0= never,1= once, 2= for; 2-3times,3=for; 4-10 times, and 4=for more than 10 times. The CTS was administered to participant at the time of enrollment to assess intimate partner violence at baseline. Three-month post HIV test were re-interviewed to assess intimate partner violence post disclosure. The CTS subscales of physical violence and verbal abuse demonstrated good internal consistency; reliability coefficients for these scales were 0.9496 and 0.8013.[24]

2.6.3: Mental health symptoms for anxiety and depression were assessed using Hopkins Symptom Checklist-25 where by 10 items asses for anxiety and 15 items assed for depressive symptoms. The tool has been validated for use in Tanzania with internal consistency of the HSCL-25 (alpha 0.93).[32] the tool was administered during enrollment to assess the anxiety-depressive symptoms at baseline and three months post HIV testing. The tool assessed for the presence and frequency of symptoms. The scores are categorized as: 0 to 4 where by 0 = this never happened 1 = happened Once, 2 = 2-3 times, 3 = 4 - 10 times and 4 = >10 times in the past year.

2.7. Data collection and management

Two diploma holders in nursing were hired as research assistants and underwent a brief protocol training session of three days that included understanding the study objectives, research ethics, data collection methods and familiarization with the study data

collection tools. The study instrument was pretested at Magomeni Health Centre (VCT clinic) prior to the start of study activities. Twenty five pilot phase participants were interviewed twice within two days by different members of the research team. First day fifteen interviews were conducted by the principal investigator and were repeated by a research assistant. Second day ten interviews were conducted as repeated interviews by the research assistants. This was done to check for inter rater reliability. The data generated were used to test utility of and refine the study interview guide and data capture tool. Two phases of data collection were done first phase semi-structured questionnaire and tools for screening of violence, anxiety and depression were administered to women who have provided informed consent for participation. The purpose was to gather some demographic and baseline information as regards to violence and the state of mental health. Then re-interview after three months aimed to inquire about disclosure, mental health and violence post disclosure. For clients who are in need of further assistance they were referred accordingly. About thirty consenting participants were subjected to structured interviews on each day of the main data collection phase. At the end of each day of data collection the principal investigator assessed the completed interview forms to check for omissions and inappropriate responses which helped to improve the quality of data collected.

All the completed interviews were stored in the cabinet that only the PI had access to so as to maintain participants' confidentiality. Because of technical audit purposes and for reference during in future data analyses, the completed interview forms will be stored for three years before destroying them.

2.8. Data analysis

Socio-demographic independent variables were age, marital status, level of education of participant and religion. Risk factors of interest treated as independent variables were IPV, anxiety and depressive symptoms. Data were edited, cleaned, coded, entered and analyzed using SPSS version-17 for Windows. Descriptive statistics were calculated to

determine rate of disclosure the main outcome in these analyses. Bivariate analyses were done to determine the presence of a statistically significant association between explanatory variables and the outcome variable. To identify independent associated factors multiple logistic regression were employed.

A logistic regression model was produced with disclosure as outcome variable. All explanatory variables that were associated with the outcome variable in bivariate analyses, variables with a P-value of ≤0.02 and variables consistently found to be associated with disclosure in other studies were included in the forward logistic models. P-value 0.02 was used to enter a variable in the model.

Objectives 1and 2: To determine the prevalence of HIV serostatus disclosure and barriers experienced during disclosure, simple descriptive statistics were used to summarize findings.

Objective 3: To determine the magnitude of IPV. The modified version of the Conflict-Tactic Scale was used to ask for the frequency of specific behavioral experience during two different periods in the one year before and three month after HIV testing. The CTS provided the summary score of ever experienced or not experienced for three different forms of violence that is physical, emotion and sexual violence.

Objective 4: To determine the prevalence of anxiety and depressive symptoms among participants by HIV serostatus disclosure. For anxiety it involved the computation of mean sum scores of responses to the 10 items of the Hopkins Symptom Check List for anxiety. As the distribution was not normal, tertiles (low, moderate and high) of anxiety symptoms were computed. Scores below 1.2 were reported as low; between 1.2 and 1.69 as moderate and above1.7 reported as high. Bivariate analysis was done to determine the association between disclosure and anxiety symptoms. For depressive symptoms it involved the computation of mean sum scores of responses to the 15 items of the Hopkins Symptom Check List for depression. The lower tertile for depression symptoms

was constructed for scores below 1.5, between 1.5 and 2.0 as moderate and above 2.0 were reported as high. Simple descriptive statistics were used to assess the extent of the three levels of depressive symptoms, and then bivariate analysis was done to determine the association between disclosure and depressive symptoms.

2.9. Ethical considerations

Ethical clearance to conduct the study was sought from Muhimbili University of Health and Allied Sciences Ethical Review Board. Permission to do the study was obtained from Muhimbili National Hospital and MHIC management to allow provision of information necessary for the study from data base system regarding clients who attending voluntary counseling and testing at MHIC. Informed consent to participate in the study was sought from study participants of whom confidentiality was assured; also the benefits and risks of participation were stated in the consent form. Clients were informed that, there was no financial gain obtained by participating in this study and that the analysis to be done will in no way expose their data as it would be a group analysis.

CHAPTER THREE

3.0. RESULTS

3.1: Sample Characteristics

Socio-demographic characteristics of the participants interviewed at baseline are shown in Table 1. Of the 607 women who participated, 6.8% self-reported an HIV positive status, 64.9% were aged less than 30 years, 59.8% were dating, 56% had primary education, and 45.6% were self-employed. The lower age range was 18 and upper age range was 67 with mean age of 28 years old. 84 of the participants were lost follow up and table 2; described their socio-demographic characteristics by their self reported HIV status, where by 13% were self reported to be HIV infected, 62% were aged less than 30 years, 60.7% were cohabiting, 56% had primary education. Of them 70% reported history of sexual violence with their partners in the past one year, and it was statically significant (p=0.000). The major reason for lost to follow-up was unable to access them through phone and they did not turn up during second phase of data collection as we appointed them during the baseline interview.

Table 1: Socio-demographic measures at baseline by their self-reported HIV serostatus (N=607)

Characteristics	**Self-reported HIV Status**				
	Positive n (%)	Negative n (%)	Not ready n (%)	Total N (%)	p-value
Age(years)					0.588
18-29	21 (51.22)	361 (65.88)	12 (66.67)	394 (64.91)	
>30	20 (48.78)	187 (34.12)	6 (33.33)	190 (35.09)	
Marital status					0.957
Married Monogamy	14 (34.15)	152 (27.74)	6 (33.33)	172 (28.34)	
Married Polygamy	0 (0.0)	16 (2.92)	0 (0.0)	16 (2.64)	
Dating	23 (56.10)	329 (60.04)	11(61.11)	363 (59.80)	
Cohabiting	4 (9.76)	51(9.31)	1 (5.56)	56 (9.23)	
					0.170
Education level					
Not formal	5 (12.20)	21 (3.83)	0 (0.0)	26 (4.28)	
Primary	26 (63.41)	301 (54.93)	13 (72.22)	340 (56.01)	
Secondary	9 (21.95)	184 (33.58)	4 (22.22)	197 (32.45)	
College	1 (2.44)	42 (7.66)	1 (5.56)	44 (7.25)	
Employment status					0.051
Student	0 (0.0)	13 (2.37)	0 (0.0)	13 (2.14)	
Employed	17 (41.46)	146 (26.64)	2 (11.11)	165 (27.18)	
None	2 (4.88)	144 (26.28)	6 (33.33)	152 (25.04)	
Self employed	22 (53.66)	245 (44.71)	10 (55.56)	277 (45.63)	

† P- value from χ^2 test for difference between proportions

Table 2: Socio-demographic factors of participants lost to follow up at three months by self-reported HIV status (N=84)

Characteristics	**Self report HIV status**				
	Seropositive n (%)	Sero-negative n (%)	Not ready n (%)	Total N (%)	p-value
Age(years)					
18-29	4 (36.36)	44 (67.69)	4 (50)	52 (61.9)	0.108
>30	7 (63.64)	21 (32.31)	4(50)	32(38.1)	
Marital status					0.873
Monogamy	3 (27.27)	15 (23.08)	3 (37.5)	21 (25)	
Polygamy	0 (0)	2 (3.08)	0 (0)	2 (2.38)	
Dating	1 (9.09)	9 (13.85)	0 (0)	10 (11.9)	
Cohabiting	7 (63.64)	39 (60)	5 (62.5)	51 (60.71)	
Education					0.645
No formal	1 (9.09)	5 (7.6)	0 (0)	6 (7.14)	
Primary	7 (63.64)	34 (52.31)	6 (75)	47 (55.95)	
Secondary	3 (27.27)	23 (35.38)	1 (12.50)	27 (32.14)	
College	0 (0)	3 (4.62)	1 (12.50)	4 (4.76)	
Employment status					0.1
Student	0 (0)	1 (1.54)	0 (0)	1 (1.19)	
Employed	5 (45.45)	12 (18.46)	0 (0)	17 (20.24)	
Self employed	6 (54.55)	34 (52.31)	7 (87.50)	47 (55.95)	
None	0 (0)	18 (27.69)	1 (12.50)	19 (22.62)	

† P- value from χ^2 test for difference between proportions

3.2. Sociodemographic factors associated with HIV serostatus disclosure to their primary partner

It was found that 440(84%) of the participants disclosed their HIV serostatus to their primary partners with in three month post HIV test. Among them 20 (4.5%) were self-reported HIV infected while 7 (1.6%) they were not ready to report their HIV status, 293(66.6%) were aged less than 30 years (p=0.41), 199(45.7%) were self-employed (p=0.342), 256 (58.2 %) were dating and 238(54.2%) of them had prior communication with partner about VCT as shown on table 3. Variation on prior communication with partner about VCT was statically significant (p=0.000). 246(56 %) had primary education, and variation of education level was marginally significant (p=0.05).

Table 3: Magnitude and Factors associated with serostatus disclosure among women attend VCT at MHIC(N=440)

Characteristics	**Disclosure to primary partner**			
	Disclosure n (%)	Non disclosure n (%)	Total N (%)	p-value
Age(years)				
18-29	293(66.59	49 (59)	342 (39.39)	0.41
>30	147 (33.40)	34 (44.58)	181(81.21)	
Marital status				0.421
Monogamy	133 (30.23)	18 (21.69)	151 (28.87)	
Polygamy	12 (2.73)	2 (2.41)	14 (2.68)	
Dating	256 (58.18)	56 (67.47)	312 (59.66)	
Cohabiting	39 (8.86)	7 (8.43)	46 (8.80)	
Education				0.054
No formal	13 (2.95)	7 (8.43)	20 (3.82)	
Primary	246 (55.91)	47 (56.63)	293 (56.02)	
Secondary	144 (32.73)	26 (31.33)	170 (32.50)	
College	37 (8.41)	3 (3.61)	40 (7.65)	
Employment status				0.342
Student	9 (2.05)	3 (3.61)	12 (2.29)	
Employed	119 (27.05)	29 (34.94)	148 (28.30)	
Self employed	199 (45.68)	31 (37.35)	230 (43.98)	

Characteristics	Disclosure to primary partner			
	Disclosure n (%)	Non disclosure n (%)	Total N (%)	p-value
None	113 (25.68)	20 (24.10)	133 (25.43)	
Women self reported HIV serostatus				0.0612
HIV positive	20 (4.5)	10 (12)	30 (5.7)	
HIV negative	413 (93.9)	70 84.3	483 (92.4)	
Not ready	7 (1.6)	3 (3.6)	10 (1.9)	
Women informed partner to go for VCT				0.000
Yes	238 (54.21)	14 (16.87)	252 (48.28)	
No	202 (45.79)	69 (83.13)	271 (51.72)	

† P- value from χ^2 test for difference between proportions

3.3. Magnitude of intimate partner violence, anxiety and depressive symptoms among women who disclose their HIV status to primary partner

It was found that among women who disclosed their HIV status to their partner; 216(49.1%) experienced physical violence from their partners while 157 (35.7%) did not experience any form of intimate partner violence. The variation among women who experienced IPV and those who did not experienced IPV were statically significant (p=0.000)as it is shown on table 4.The t-test for the mean difference between baseline history of violence and that of three month post HIV test was statically significant.(T > t = 0.0016) and physical violence was independently associated with HIV serostatus disclosure. (OR 2.5, 95% CI 1.35, 2.86, p=0.000).

Among women who disclose their HIV status to their primary partner; 170 (38.6%) experience low level of anxiety symptoms while 127 (28.9%) experienced high level of anxiety symptoms post HIV test as shown on table 4. Variation in level of anxiety was statistically significant (p=0.042) however the mean T-test for the difference of the baseline anxiety symptoms and three month post HIV test was not significant (T > t = 0.9420) and high anxiety level was not independently associated with HIV serostatus disclosure.(OR 0.83, 95% CI 0.594, 1.168, p=0.29).

HIV serostatus disclosure among women receiving VCT services was also associated with depression.It was revealed that women who disclose their HIV status to their primary partner, 174 (39.6%) experience low level of depressive symptoms while 109 (24.8%) experienced high level of depressive symptoms post HIV test as it is shown on table 4. The difference in level of depressive symptoms were statistically significant (p=0.000) .The mean T- test for the difference of the baseline depressive symptoms and three month post HIV test was also statically significant (T > t = 0.02) and high depressive symptoms remained independent associated with disclose.(OR 2.89, 95% CI 1.99, 4.19, p=0.00).

Table 4: Factors associated with HIV serostatus among women who disclose their HIV serostatus to their primary partner (N=440)

Factors associated with disclose	**Serostatus disclosure to partner**			
	Disclosure n (%)	Non disclosure n (%)	Total N (%)	P-value
Intimate partner Violence				
Emotion	13 (2.95)	6 (7.23)	19 (3.63)	0.000
Physical	216 (49.09)	5 (6.02)	221 (42.26)	
Sexual	54 (12.27)	47 (56.63)	101 (19.31)	
Not experience	157 (35.68)	25 (30.12)	182 (34.80)	
Anxiety symptoms				
Low	170 (38.64)	29 (34.94)	198(38.05)	0.042
Moderate	143 (32.50)	19 (22.89)	162 (30.98)	
High	127 (28.86)	35 (42.17)	162 (30.98)	
Depressive Symptoms				
Low	174 (39.55)	21 (25.30)	195 (37.28)	0.000
Moderate	157 (35.68)	0(0.0)	157 (30.02)	
High	109 (24.77)	62 (74.70)	171 (32.70)	

† P- value from χ^2 test for difference between proportions

3.4. Experienced/Perceived barriers during HIV serostatus disclosure

The experience and perceived barriers during HIV serostatus disclosure by women to their primary partners is best described in Table 7, figure 1 and 2 below. Table 7 shows the distribution of perceived barriers among women who did not disclose their serostatus to their primary partner and it shows that 35(43.2%) reported fear of partner reaction as the perceived barrier for not disclosing while 20 (23.5%) mention specifically fear of physical violence.

Figure 1 shows distribution of primary partner reaction after sharing of HIV results. 283(64.6%) reported their partners were supportive, 12 (2.5%) reported their partner were physical abuse while 2 (0.5%) reported their partner chased them away from home.

Figure 2 shows the distribution of the experience barriers among women who disclose their serostatus to their partner. 207(34.4%) reported their relationship was strengthen following disclosure, few of them reported negative reactions such as partner denied the result were 5(0.9%) and who forced to left home were 4(0.9%).

Table 5: Distribution of the perceived barriers among women who do not disclose their HIV serostatus to their partner (N=84)

Perceived barriers	**Frequency** n (%)
Partners reaction	35(43.21)
Not plan	19(23.46)
Fear of divorce	1(1.23)
Fear of abandonment	4 (3.70)
Physical abuse	20 (23.46)
Blamed unfaithful	3(2.47)
Stigmatized	1(1.23)

Figure 1: Primary partner reaction following disclose of HIV test result

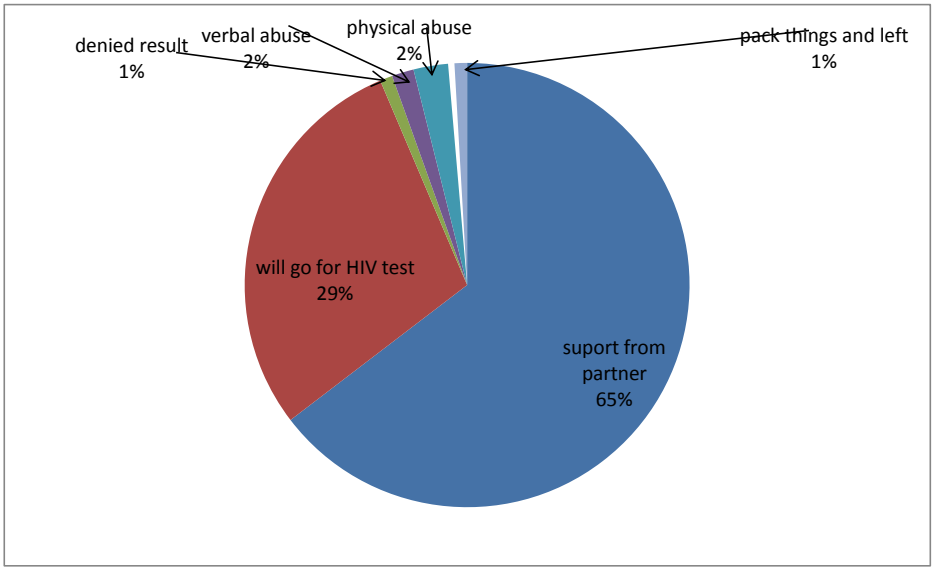
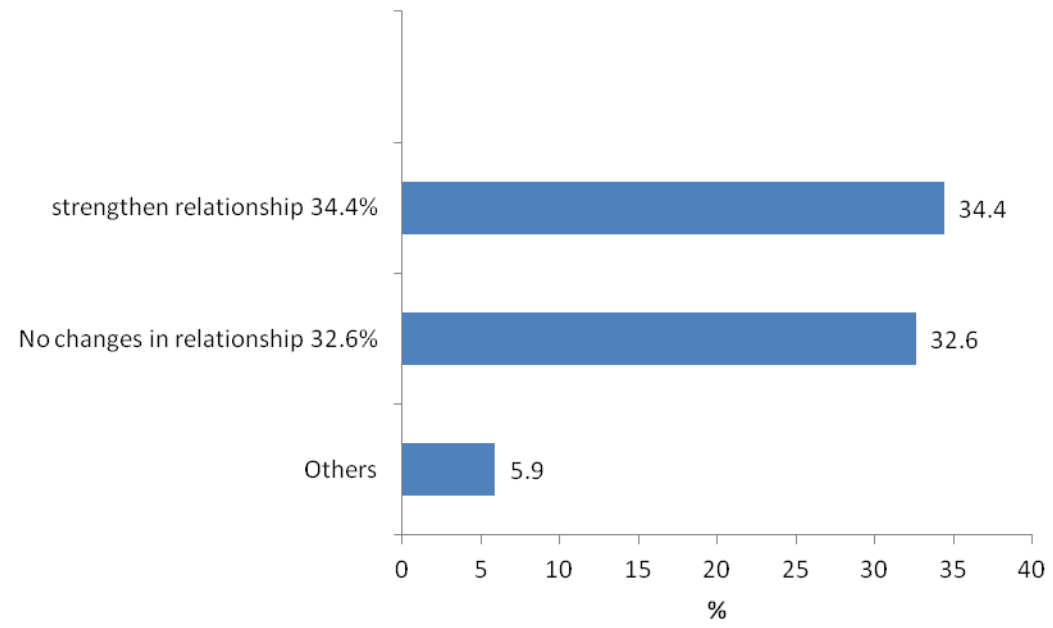


Figure 2: Distribution of the experienced barriers among women who disclose their HIV serostatus to their partner



Others stand for

- Divorced,
- Stigmatized by family members,
- Increased support from relatives
- Break sexual relationship

Table 6 shows regression analysis of self reported HIV serostatus disclosure to primary partner by predictors of interest. In bivariate analysis three variables were found to be significantly associated with HIV serostatus disclosure, therefore multiple logistic regression model was done to identify factors that were independently associated with HIV serostatus disclosure to their primary partner. These factors include depressive symptoms, violence, and prior communication with partner about VCT. Others that have

been included were those found in literature review to be independent associated with HIV serostatus disclosure such as age, HIV serostatus and anxiety symptoms.

The analysis revealed that women who were older than 30 years tended to disclose to their primary partner by nearly two times more compared to women who were less than 30 years (OR 1.56, 95% CI 1.03-2.36 p=0.04).

Respondents who disclose to their primary partners were nearly five times more to experienced high depressive symptoms compared to experiencing low level of depressive symptoms. (OR 4.7, 95% CI 2.72-8.17 p=0.000).

Participants who disclose their HIV serostatus to their primary partner were two and half times more likely to experience physical violence compared to experiencing emotion violence. (OR 2.5, 95% CI 1.35, 2.86, p=0.00).

Among women who disclose their HIV status to their primary partner the odds of experiencing high level of anxiety symptoms compared to low level is 0.8. (OR 0.8, 95% CI 0.93, 2.74, p=0.09).

Women who had prior communication with their partner about VCT were six times more likely to disclose their HIV status to their primary partners as compared to those who did not have prior communication with their primary partners (OR 5.97, 95% CI 3.18-10.68, p=0.00).

Among women who disclose their HIV status to their partner the odds of reporting being HIV seronegative was (OR 0.83, 95% CI 0.43-1.59, p=0.57).

Table 6: Regression analysis of self reported HIV serostatus disclosure to partner by predictors of interest

Variable	N (%)	Unadjusted OR (95% C.I); p-value	Adjusted OR (95% C.I); p-value
Age(years)			
Less than 30	293	0.88 (0.86, 2.23); 0.47	0.93(0.76, 1.65); 0.33
More than30	147	1.38 (1.89, 2.57); 0.01	1.56 (1.03, 2.36); 0.04
Moderate depressive symptoms	157	1.36(0.49, 0.96); 1.00	1.31(0 .85, 1.37); 1.00
High depressive symptoms	171	2.76(2.34, 4.53); 0.01	4.71(2.72, 8.17); 0.00
Moderate anxiety symptoms	162	0.77(0.61, 1.11); 1.00	0.65(0.42, 1.44); 0.42
High anxiety symptom	162	0.86(0.58, 1.56); 0.84	0.78(0.93, 2.74); 0.09
Sexual violence	101	1.89(3.08, 9.71); 0.61	1.48(0.66, 5.35); 0.23
Physical violence	221	1.92(1.35, 2.86); 0.00	2.50(1.35, 2.86); 0.00
Self-reported HIV seronegative	413	0.40 (0.09, 1.57); 0.17	0.83(0.43, 1.59); 0.57
Self-reported HIV seropositive	20	1.17 (0.24, 5.50); 0.85	0.31(3.41, 5.38); 0.40
Prior communication			
Yes	238	0.62(2.81, 2.94);0.51	5.97(3.18, 10.68); 0.00
No	202	0.17(0.09, 1.34); 0.46	0.95(0.74,1.86);0.51

CHAPTER FOUR

4.1. DISCUSSION

4.1.1 Prevalence of HIV serostatus disclosure

The main objective of this study was to determine the magnitude, factors and mental health outcomes associated with partner violence among women who disclose their HIV serostatus to primary partners at Muhimbili health information centre at Dar es Salaam.

The findings revealed eighty four percent of the women who received VCT services shared their serostatus with their primary partners within three months post HIV test. These results are consistent with findings from several studies. In USA it ranged from 58.0% to 76.0% Gielen et al[1]while in Africa the rate ranged from 22.0% to 77.0% Antelman et al.[16] King et al.,2008; Maman et al.[24]In Nigeria Sagay[25] found that 89% of the women have disclosed their HIV status to their partners. The cross section study conducted in South West Ethiopia by Kassaye[23] found 69% of the women reported that they had shared their HIV test results with their primary partners.

Prior communication with partners about HIV testing was significant associated with disclosure to partner and it was consistent with observation done at same study area about ten years ago Maman et al, [24] however it was inconsistency with finding from study done in South Africa Jewkes et al,[13] The study revealed that, women who are older than 30 years of age tend to disclose more compared to young women. Maman et al, [24] Literatures reveal that, being HIV negative was among the independent factor associated with disclosure but this study did not reveal that association.

The rate of disclosure had increase by about five percent from the previous observed rate from study conducted in the same area about one decade ago. Probably it could be due to increase in the rate of prior communication with primary partners about VCT, greater

emphasis done at VCT about disclosure, increase awareness about HIV/AIDS, campaign toward HIV/AIDS prevention and long history of positive support received from the partners following disclosure.

4. 1.2. Intimate partner violence among women who disclose their serostatus to their primary partner

Nearly half of the women who disclose their HIV status to their primary partners experienced physical violence this was consistent with finding from several studies WHO /WHD,[8] Ellsberg et al,[9] Fikree et al,[10] Heise et al,[11] Koenig et al,[12] also from sub-Saharan Africa by Koenig et al,[12] Jewkes et al,[13] Watts et al, [14].

4. 1.3. Anxiety and depressive symptoms of the women who disclose their HIV serostatus to their primary partner

It was observed that HIV serostatus disclosure was associated with high level of depressive symptoms; it was inconsistent with observations found in a meta-analysis done which comprised of eighteen studies from both developed and developing countries. With regard to anxiety symptoms it was found that disclosure was not associated with high levels of anxiety symptoms similar to the findings from the meta-analysis study by WHO about HIV status disclosure[28].

4 .1.4. Barriers experience/perceive during HIV serostatus disclosure to their primary partner

The major reason for not disclosing HIV serostatus to their primary partners was fear of their partner's reaction, most mentioned fear of divorce and abandonment, while those who disclosed mostly reported positive partner reactions with similar findings observed from both western countries and Africa WHO/ HIV status disclosure[28]. Also in keeping with findings from studies done by Sagay et al,[25]Keogh et al,[30]Kassaye et al,[23]Kumar et al,[20] Gielen et al,[1] Antelman et al[16]. Therefore HIV serostatus disclosure was associated with both positive and negative outcomes in almost both developed and developing countries.

4.2. STUDY LIMITATIONS

4.2.1. Time limit

The time given for the study was limited, therefore it allowed only for a cross sectional study, a limited sample size, and further more some studt participants were lost to follow up as they were no map cues to follow up patients who were unable to come for re-interview.

- Cross sectional study- hence it is unclear if the violence and mental health consequences are the outcomes of disclosure or otherwise.
- Limited sample size- since there was second phase of interview at three month post HIV test, therefore I had to limit the sample size to a number that I would manage to reinter view three month post test HIV test.
- Lost to follow up - due to limited follow up time of only three months I did not manage to follow up all the participants interviewed at base line therefore we analyzed and treated them as lost to follow up and they were 13.8% with significant baseline history of sexual violence as compared to those who were follow up.

4.2.2. Shortage of funds

The dissertation was to be done with very limited resources. I was unable to reimburse transport to all re-interview, and it could be a contributing factor to the lost to follow up.

4.2.3. Recall bias/ culture and norms about IPV

There may have been under-reporting or over-reporting of the responses depending on the participants perceptions on what would be acceptable responses to the questions. Also could be due to culture and norms, some women may have had difficulties talking about intimate partner violence.

CHAPTER FIVE

5.0. CONCLUSION AND RECOMMENDATIONS

5.1. CONCLUSION

It was observed that eight out of ten women who received VCT service shared their HIV serostatus with their primary partners. Prior communication with partner about VCT services predicted the tendency for HIV serostatus disclosure, however following disclosure nearly five out of ten of women experience physical violence from their partner while two to three experience high level of depressive symptoms. The high disclosure rate may be the result of encouragement for people to disclose their HIV serostatus during VCT services; only two out of ten women did not share their serostatus result due to fear of partner reaction, most mentioned were physical abuse and abandonment on the other hand six out ten of those who disclosed to their primary partners were supported.

5.2. RECOMMENDATIONS

- Need for increased innovative interventions that support HIV serostatus disclosure among clients attending VCT.
- Also there is a need to screen for violence and mental health of clients attending VCT.

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7.0. APPENDICES

Informed consent explanations

To be read and questions answered in a language which the study subject is conversant (English or Kiswahili)

7.1. APPENDIX I: INFORMED CONSENT FORM – ENGLISH VERSION

To be read and questions answered in a language in which the study subject is conversant (English or Kiswahili)

My name is Dr Dorothy Mushi, I am a pursuing master's degree in Psychiatry at the University of Health and Allied Sciences. I am doing a study entitled mental health and experience of partner violence among women who disclose HIV serostatus at Muhimbili Health Information Centre, Dar es Salaam as part of my degree award fulfillment. Being one among the clients attending this center; I would like to ask you to participate in this study. First I will explain to you about the study and I will be ready to answer any question that you have.

The aim of this study is to determine the magnitude, and factors associated with mental health and experience of partner violence among women who disclose HIV serostatus at Muhimbili Health Information Centre, Dar es Salaam

This study will be conducted by me under my supervisor.

This is a medical research and you are required to understand the following which apply to all in medical research.

Your participation is completely voluntary and you may withdraw consent at any time in the course of the interview.

Refusal to participate will not in any way affect your health services/benefits which you are entitled.

After reading the explanation, don't hesitate to ask any questions in case you need clarifications.

I will assess you using an instrument which will take about 30-45 minutes.

No invasive procedures such as drawing blood will be involved.

All information obtained from this study will remain confidential.Serial numbers instead of your name.

RISKS:

Some of the topics in the interview are personal. For example we will be asking questions about your partner and how you resolve conflicts. They may make you feel uncomfortable. You do not have to answer any question you do not want to. If you feel uncomfortable you can end the interview at any time. If you would like to talk with counselors after this interview it can be arranged for you.

There will be no direct benefits to you. However the overall study will be of benefit for provide information that can be used to develop interventions and comprehensive care to women who are have HIV and subjected to intimate partner violence.

If you have any questions related to this study, or your health you can call me on my telephone numbers 0713-405896, or you may contact Prof M. Abood, a chairman of the Research Senate and Publication committee, P.O. Box 65001 Dar es Salaam.

I the undersigned do hereby volunteer to participate in this study. The nature and purpose have been fully explained to me.

I understand that all information obtained will be used for this study only.

SIGNED _____ DATE _____

WITNESSED _____ SIGNATURE _____

DATE _____

7.2. APPENDIX II: INFORMED CONSENT FORM – SWAHILI VERSION

FOMU YA RIDHAA KUSHIRIKI KWENYE UTAFITI KUHUSU MATOKEO YA UNYANYASAJI WA KIJINSIA NA AFYA YA AKILI KWA WANAWAKE WANAOHUDHURIA HUDUMA YA USHAURI NASAHA NA UPIMAJI WA VVU WANAPOWASHIRIKISHA WENZI WAO MATOKEO YA UPIMAJI KATIKA KITUO CHA MAELEZO YA AFYAMUHIMBILI

Jina langu ni …….

Ninatokea chuo kikuu cha tiba na afya Muhimbili katika idara ya afya na magonjwa ya akili ninafanya, utafiti kuhusu utafiti kuhusu matokeo ya unyanyasaji wa kijinsia na afya ya akili kwa wanawake wanaohudhuria huduma ya ushauri nasaha na upimaji wa vvu wanapowashirikisha wenzi wao matokeo ya upimaji katika kituo cha maelezo ya afya Muhimbili.

Ikiwa huu ni utafiti wa sayansi ya tiba unapaswa hufaamu yafuatayo kabla ya kushiriki;

Dhumuni la Utafiti huu

Kama nilivyo sema hapo awali dhumuni ni.kufanya utafiti kuhusu matokeo ya unyanyasaji wa kijinsia na afya ya akili kwa wanawake wanaohudhuria huduma ya ushauri nasaha na upimaji wa vvu wanapowashirikisha wenzi wao matokeo ya upimaji katika kituo cha maelezo ya afya Muhimbili.

Namna ya kushiriki

Ushiriki wako kwenye utafiti huu ni wa hiyari kabisa na unaweza kukataa kushiriki au kusitishamahojiano au majadiliano wakati wowote. Kukataa kushiriki hakutahingilia uduma zako za tiba wala faida unazotakiwa kuzipata.

Usisite kuhuliza swali lolote pale unapoona kuna sababu. Kama ukikubali kushiriki mahojiano yataendeshwa kwa kutumia dodoso maalum.

Madhara

Ikiwa wakati unajieleza ukipata kikwazo na kuona unahitaji mshauri nasaha kwa mazungumzo zaidi tutakuwa tayari na pale inapobidi kukurufaa kwa mtaalamu tutakusaidia

Usiri

Taarifa zako utakazozitoa hazitawekwa hadharani kwa namna yeyote ile kwa hiyo ushiriki wakohautafahamika. Jina lako au taarifa zozote zinazokutambulisha hazitaambatanishwa na na taarifa zakoutakazozitoa.

Mwisho wa ufafiti taarifa hizi zitafungiwa na baadaye kuharibiwa baada ya kuwekwa na kutunzwa kwenye mfumo wa electroniki

Kumbuka
Hakutakuwa na faida ya moja kwa moja kwako kutokana na utafiti huu ila matokeo ya utafiti yatasaidia katika mpango wakupunguza unyanyasaji wa kijinsia dhidi yawanawake na pia yatasaidia kuboresha uduma za afya ya akili.

Nani wa kumuuliza

Kama una maswali zaidi ambayo ungependa kuuliza kuhusiana na utafiti huu, tafadhali wasiliana na

Mtafiti Mkuu

Dr Dorothy Mushi,

Idara ya magonjwa ya akili

Chuo Kikuu cha afya Muhimbili

Prof M. Abood

Mwenyekiti wa kamati ya utafiti na machapisho ya chuo

S.L.P. 65001 Dar es salaam, Tanzania

Sahihi…….

Unakubali Kushiriki?

Mshiriki amekubali…….

Nimesoma au nimeambiwa kuhusu yaliyomo humu ndani. Maswali yangu yamejibiwa. Nakubali kushiriki katika utafiti huu.

7.3. APPENDIX III QUESTIONNAIRE- ENGLISH VERSION

MENTAL HEALTH AND EXPERIENCE OF PARTNER VIOLENCE AMONG WOMEN WHO DISCLOSE HIV SEROSTATUS AT MUHIMBILI HEALTH INFORMATION CENTRE, DAR ES SALAAM

Please fill the answer that is correct for you

1. GENERAL INFORMATION

Date of interview: {...../...../2011}

Name of interviwer: .....

II. DEMOGRAPHIC CHARACTERISTICS OF RESPONDENT

1. Number of interviewee:.....

2. What is your date of birth? ___/___/___

3. What is your religion?

a) Moslem

b) Christian

c) Traditional religion

d) None

e) Others(mention)

4. What is you currently marital status?

a) Married monogamous

b) Married polygamous

c) cohabiting

d) Not married and not living with a sexual partner under the same roof

e) Separated

f) Divorced

g) Widowed

5 For how long have you been together with your partner?

a) less than year
b) more than Years
c) Don't know

6. How many children have you given birth to your partner? _____

7. What is education level

a)No formal education

b) Primary education

c)Secondary Education

d)College/ University

8. What is your employment status?

a) Employed

b) Unemployed

c) Self employed

Now I would like to ask you a little more about your main partner/husband.

9 How old is he?

_____ years

10. Primary partner/Husband education level

a) No formal education

b) Primary education

c) Secondary education

d) University/ college

e) I don't know

11. Husband/ primary partner employment status

a) Employee

b) Self employee

c) Don't know

12. Does he have other sex partners?

a) Yes

b) No

c) Don't know

13 Has he ever been tested for HIV? If yes go to number 14

a) Yes

b) No

c) Don't know

14. His HIV serostatus?

a) HIV Sero-positive
b) HIV Sero-negative
c) Don't know

15.(i)Does your husband/primary partner know that you have come for HIV test?

a) Yes

b) No

15.(ii) If Yes, how does he responded?

(a) Allowed

(b) Not allowed

(c) Nothing

(d) Others (explain)

16. Would you mind telling me what your HIV test results were?

a) HIV positive

b) HIV negative

c) Don't know

d) not ready to disclose

HOPKINS SYMPTOM CHECKLIST

The following are symptoms which might be bothering in the past days, highlight symptoms according to their extremes.

No		1=Not at all	2=A little	3=Quite a bit	4=Extremely
1	Being suddenly scared for no apparent reason				
2	Feeling fearful				
3	Feeling fearful, faintness, dizziness, or weakness				
4	Nervousness or shakiness inside				
5	Heart pounding or racing				
6	Trembling				
7	Feeling tense or keyed up				
8	Headaches				
9	Spells of terror or panic				
10	Feeling restless, not being able to sit still				
11	Feeling low in energy, slowed down				
12	Blaming oneself for things				
13	Crying easily				
14	Loss of sexual interest or staying asleep				
15	Poor appetite				
16	Difficulty falling asleep or staying asleep				
17	Feeling hopeless about the future				
18	Feeling blue				
19	Feeling lonely				
20	Thoughts of ending one's life				
21	Feeling trapped or caught				

22	Worrying too much about things				
23	Feeling no interest on things				
24	Feeling everything is an effort				
25	Feelings of worthlessness				

Violence assessment

Asses for history of violence conflict tactic scale No matter how well a couple gets along, there are times when they disagree, get annoyed with the other person, want different things from each other or just have fights or arguments because they are in a bad mood, are tired or for some other reason. Couples also have many different ways of trying to settle their differences. I am going to read you a list of things that might happen when you and your partner have differences. Please tell me how often the following things have been done to you in the past one year. Also let me know if your partner has not done one of the things in the last year, but it has happened before.

0= this never happened 1= happened Once

2=2-3 times in the past year 3= 4-10 times in the past year

4= >10 times in the past year

1. My partner showed he cared even though we disagreed.
2. I explained my side of the disagreement to my partner.
3. My partner insulted or swore at me
4. My partner shouted or yelled at me
5. My partner stomped out of the house during a disagreement.
6. My partner did something to spite me.
7. My partner showed respect for my feelings about an issue.

8. My partner destroyed something belonging to me.
9. My partner threatened to hit or throw something at me.
10. My partner threw something at me that could hurt.
11. My partner twisted my arm or my hair. .
12. My partner shoved or pushed me. .
13. My partner beat me up. .
14. My partner grabbed me. .
15. My partner threatened me with a knife or a gun. .
16. My partner used a knife or a gun on me. .
17. My partner punched or hit me with something that could hurt.
18. My partner choked me.
19. My partner burned or scalded me on purpose.
20. My partner suggested a compromise to a disagreement.
21. My partner kicked me.
22. My partner made me have sex without a condom.
23. My partner used force to make me have sex.
24. My partner used force to make me have oral sex.
25. My partner insisted on sex when I did not want to (but did not use physical force)
26. My partner used threats to make me have oral sex.
27. My partner used threats to make me have sex.

Question number 17 to 20 to be ask after three month

17. Did you disclosed your HIV test results to your husband/sexual partner

(a)Yes (go to number 19)

(b) No (go to number 18)

18. If you have not disclosed your HIV test results to your husband/sexual partner what are your reasons for not telling your husband or sexual partner about your HIV test results.

a) I still plan to tell him

b) I will not tell him

c) Fear of divorced

d) Fear of rejected/abandoned

e) I am HIV negative so there is no reason to tell him

f) He will verbally abuse me

g) He will beat me (physically abuse me)

h) He will not care

i) Consider unfaithful/ Infidelity

j) He will stigmatized

k) Others

19. Can you tell me how your partner reacted to you when you told him about your HIV status? (Check all that apply)

a) He showed support and understanding

b) He told me he was going to come in for HIV testing

c) He did not react at all (denial)

d) He blamed me for the results (verbally abused)

e) He physically assaulted me

f) He told me to pack my things and leave the house

g) He packed his things and left me in the house

h) Other, specify:_____

20. Did any of the following things happen to you as a result of disclosing your HIV serostatus to your partner?(Tick all that apply)

a) Break up of marriage

b) Strengthening of relationship with a spouse/sexual partner

c) Neglected by family member

d) Increased emotional support from family/relatives

e) Break up of sexual relationships

f) Others explain

7.4. APPENDIX IV QUESTIONNAIRE- SWAHILI VERSION

Dodoso la utafiti kuhusu matokeo ya unyanyasaji wa kijinsia na afya ya akili kwa wanawake wanaohudhuria huduma ya ushauri nasaha na upimaji wa VVU wanapowashirikisha wenzi wao matokeo ya upimaji katika kituo cha maelezo ya afya Muhimbili.

Tafadhali jaza/tiki jibu ambalo unaona ni sahihi kwako.

I. MAELEZO YA AWALI

Tarehe ya mahojiano: {...../...../2011}

Jina la msahili: .....

II. MAELEZO BINAFSI

1. Namba ya mshiriki anayehojiwa:.....

2. Umezaliwa mwaka gani (.....)
3. Je! Wewe ni muumini wa dini gani?

   a. Muislamu
   b. Mkristo
   c. Dini za kimila
   d. Mpagani
   e. Nyingine(Taja)

4. je unaweza kunieleza hali yako ya ndoa?
   a) Nimeolewa ndoa ya mke mmoja
   b) Nimeolewa ndoa ya wake wengi
   c) Ninaishi kinyumba
   d) Nina mwenza ila hatuishi pamoja
   e) Tumetengana
   f) Nimepewa talaka
   g) Mjane

5.je wewe na mwenza wako mmekuwa mkiishi pamoja kwa muda gani?
   a) Chini ya mwaka
   b) Zaidi ya mwaka
   c) Sijui

6. Mmezaa watoto wangapi na huyu mwenza wako…….....….

7. Elimu yako ni
   a) Sijasoma
   b) Msingi
   c) Sekondari
   d) Chuo/ chuo kikuu

8.Ningependa unieleze hali ya ajira yako
   a) Nimeajiriwa
   b) Sina ajira
   c) Nimejiajiri mwenyewe

Sasa nitapenda kukuuliza zaidi kuhusu mwenza wako

9. Je mwenza wako ana umri gani?.....

10. Je! mwenza wako ana kiwango gani cha elimu?
   a) Hajasoma
   b) Elimu ya msingi
   c) Elimu ya sekondari
   d) Elimu ya chuo
   e) Sijui

11. Je mwenza wako anafanya kazi gani?
   a) Ameajiriwa b)Ajira binafsi c)Sijui

12. Je mwenza wako ana mahusiano na wanawake wengine?
   a)Ndio b)Hapana c)Sijui

13. Je mwenza wako amewahi kupima VVU?Kama jibu ni ndiyo nenda namba 14

   a)Ndio b)Hapana c)Sijui

14. Je majibu yake yalikuwaje?.....

   a) Ana maambukizi ya VVU
   b) Hana maambukizi ya VVU
   c) Sijui

15(i). Je! Umemweleza mwenza wako kwamba unakwenda kwenye huduma ya ushauri nasaha na upimaji wa VVU?

a) Ndio b) Hapana

15(ii).Kama jibu ni ndio, Je! Alilichukuliaje

(a) Alikuruhusu (b) Alikukataza (c) Hakusema lolote

(d) Mengineyo, Eleza ……

16. Kama hutojali, je unaweza kunieleza majibu yako ya vipimo vya VVU?

a) Nina maambukizi ya VVU
b) Sina maambukizi ya VVU
c) Sijui
d) siko tayari kukueleza majibu yangu

Swali namba namba 17 mpaka namba 20 yaulizwe atakapokuja mara ya pili

17 Je! ulimwambia mwenza wako majibu ya vipimo vyako vya VVU?

a) ndiyo (nenda swali la 19)
b) hapana (nenda swali la 18)

18. Kama hujamwambia mwenza wako majibu yako ya VVU, ni sababu zipi zimekufanya usimwambie?(Tiki ambayo ni sahihi)

a) Napanga kumwambia
b) Sina mpango wa kumwambia
c) Hofu ya kupewa talaka
d) Hofu ya kutelekezwa
e) Hakuna sababu ya kumwambia kwani sina maambukizi ya VVU
f) Atanisema vibaya
g) Atanipiga
h) Hatanijali
i) Atanilaumu kwa kutokuwa mwaminifu
j) Atanyinyanyapaa
k) Sababu nyinginezo, eleza…….

19.Unaweza ukaniambia Mwenza wako alichukuliaje majibu yako ya VVU? (Tiki ambayo ni sahihi)

a)Alielewa na kunipa ushirikiano
b)Aliniambia na yeye ataenda kupima VVU
c)Alikataa majibu
d)Alinilaumu kwa maneno makali/masimango

e)Alinipiga/alinijeruhi
f)Alinifukuza nyumbani
g)Alichukua vitu vyake na kuondoka nyumbani
h)Sababu nyingine, eleza:_____

20. Je! Kuna lolote kati ya haya yalikutokea baada ya kumshirikisha mwenza wako majibu yako ya VVU? (Tiki ambayo ni sahihi)

a) Ndoa ilivunjika
b) Uhusiano wako na mwenza uliimarika
c) Ulitengwa na wanafamilia
d) Ulipata ushirikiano wa karibu kutoka kwa wanafamilia na ndugu
e) Ulivunja mahusiano ya kimapenzi
f) Sababu nyingine, eleza

(Dalili hizi za magonjwa ya akili na unyanyasi wa kijinsia ziulizwe anapokuja mara ya kwanza na baada ya miezi mitatu.)

Kwa mara ya kwanza; je katika kipindi cha mwaka mmoja uliopita ulishawahi kuwa na dalili zifuatazo?

HOPKINS SYMPTOM CHECKLIST-25: *(Swahili version for Anxiety and Depression Scale)*

MAELEKEZO: Orodha iliyo hapa chini, ina dalili ambazo watu wanaweza kuwa nazo wakati mwingine. Tafadhali sikiliza kwa umakini dalili zilizopo, na uamue ni zipi kati ya dalili zilizotajwa zimekusumbua, au kukufadhaisha, katika wiki iliyopita hadi leo.

Ja. Anxiety Sub-Scale

1) Kushituka ghafla bila sababu maalum	1=HAMNA HATA KIDOGO	2=KID-OGO	3=IPO KIASI	4=IPO SANA	MAT-ANX1	
2) Kuwa na uwoga	1=HAMNA HATA KIDOGO	2=KID-OGO	3=IPO KIASI	4=IPO SANA	MAT-ANX2	
3) Kujisikia kutaka kuzirai, kizunguzungu au kukosa nguvu.	1=HAMNA HATA KIDOGO	2=KID-OGO	3=IPO KIASI	4=IPO SANA	MAT-ANX3	
4) Kujisikia kuwa na wasiwasi.	1=HAMNA HATA KIDOGO	2=KID-OGO	3=IPO KIASI	4=IPO SANA	MAT-ANX4	
5) Moyo kwenda kasi au kudunda sana kuliko kawaida.	1=HAMNA HATA KIDOGO	2=KID-OGO	3=IPO KIASI	4=IPO SANA	MAT-ANX5	
6) Kutetemeka.	1=HAMNA HATA KIDOGO	2=KID-OGO	3=IPO KIASI	4=IPO SANA	MAT-ANX6	
7) Kujihisi kuwa na msongo wa mawazo	1=HAMNA HATA KIDOGO	2=KID-OGO	3=IPO KIASI	4=IPO SANA	MAT-ANX7	
8) Kuumwa kichwa.	1=HAMNA HATA KIDOGO	2=KID-OGO	3=IPO KIASI	4=IPO SANA	MAT-ANX8	
9) Kuwa na vipindi vya hofu au mshituko mkubwa.	1=HAMNA HATA KIDOGO	2=KID-OGO	3=IPO KIASI	4=IPO SANA	MAT-ANX9	
10) Kujisikia hali ya kuhangaika hadi huwezi kukaa mahali umetulia.	1=HAMNA HATA KIDOGO	2=KID-OGO	3=IPO KIASI	4=IPO SANA	MAT-ANX10	

Jb. Depression Sub-Scale

1) Kujisikia kukosa nguvu, na kujiona unafanya shughuli polepole.	1=HAMNA HATA KIDOGO	2=KID-OGO	3=IPO KIASI	4=IPO SANA	MAT-DE11D	
2) Kujilaumu kwa matukio yanayotokea yanayokuhusu wewe na wengine wanaokuhusu.	1=HAMNA HATA KIDOGO	2=KID-OGO	3=IPO KIASI	4=IPO SANA	MAT-DE12D	
3) Kulia kirahisi.	1=HAMNA HATA KIDOGO	2=KID-OGO	3=IPO KIASI	4=IPO SANA	MAT-DE13D	
4) Kutokua na hamu ya kimwili(Kujamiana) au kupendezwa na shughuli zinazohusiana na kujamiana.	1=HAMNA HATA KIDOGO	2=KID-OGO	3=IPO KIASI	4=IPO SANA	MAT-DE14D	
5) Kukosa hamu ya kula chakula.	1=HAMNA HATA KIDOGO	2=KID-OGO	3=IPO KIASI	4=IPO SANA	MAT-DE15D	
6) Wakati unapolala, unashindwa kupata usingizi, au kulala moja kwa moja hadi asubuhi.	1=HAMNA HATA KIDOGO	2=KIDOGO	3=IPO KIASI	4=IPO SANA	MAT-DE16D	
7) Kujisikia kuwa umekata tamaa katika siku za usoni	1=HAMNA HATA KIDOGO	2=KIDOGO	3=IPO KIASI	4=IPO SANA	MAT-DE17D	
8) Kujisikia kukosa raha.	1=HAMNA HATA KIDOGO	2=KIDOGO	3=IPO KIASI	4=IPO SANA	MAT-DE18D	
9) Kujisikia mpweke.	1=HAMNA HATA KIDOGO	2=KIDOGO	3=IPO KIASI	4=IPO SANA	MAT-DE19D	
10) Kuwa na mawazo ya kutaka kujiua.	1=HAMNA HATA KIDOGO	2=KIDOGO	3=IPO KIASI	4=IPO SANA	MAT-DE20D	
11) Kujisikia huna uwezakano wa kujitoa katika matatizo ulionayo.	1=HAMNA HATA KIDOGO	2=KIDOGO	3=IPO KIASI	4=IPO SANA	MAT-DE21D	
12) Kuwa na hali ya wasiwasi kupita kiasi kuhusu mambo mbali mbali.	1=HAMNA HATA KIDOGO	2=KIDOGO	3=IPO KIASI	4=IPO SANA	MAT-DE22D	
13) Kujisikia kutokuwa na hamu na kitu chochote (vitu ambavyo ni muhimu kwako).	1=HAMNA HATA KIDOGO	2=KIDOGO	3=IPO KIASI	4=IPO SANA	MAT-DE23D	
14) Kujisikia hali ya kujilazimisha ili kuweza kufanya kitu chochote.	1=HAMNA HATA KIDOGO	2=KIDOGO	3=IPO KIASI	4=IPO SANA	MAT-DE24D	
15) Kujisikia huna umuhimu/maana	1=HAMNA HATA KIDOGO	2=KIDOGO	3=IPO KIASI	4=IPO SANA	MAT-DE25D	

Kupima kiwango cha unyanyasaji

Japokuwa watu wenza wanakuwa pamoja mara nyingi hutokea wakati wakatofautiana, wakalumbana, kukasirikiana au kupigana kwasababu hawapo kwenye hali ya kawaida, wamechokana au kwasababu nyingine. Lakini wenza huwa wana njia za kutatua matatizo yao wenyewe. Tafadhali niambie ni mara ngapi mambo haya yamekutokea katika kipindi cha mwaka mmoja uliopita, na vilevile kama kuna mambo ambayo mwenzi wako hajakutendea kwa kipindi cha mwaka uliopita lakini aliwahi kukutendea kipindi cha nyuma;

0= Haijawahi tokea 1= Ilitokea mara moja

2= ilitokea mara 2-3 3= ilitokea mara 4-10 4=Zaidi ya mara 10

		MARA YA KWANZA	**BAADA YA MIEZI MITATU**
1.	Mwenza wangu aliniijali japokuwa tulitofautiana .		
2.	Nilimweleza mwenza wangu kuwa sikubali.		
3.	Mwenza wangu alinitukana.		
4.	Mwenza wangu alinigombeza sana.		
5.	Mwenza wangu aliondoka nyumbani baada ya kutoelewana		
6.	Mwenza wangu alisababisha nikaumwa		
7.	Mwenza wangu aliheshimu hisia zangu kuhusu tatizo		
8.	Mwenza wangu aliharibu vitu vyangu		
9.	Mwenza wangu alitishia kunidhuru au kunirushia kitu		
10.	Mwenza wangu alinirushia kitu ambacho kingeniumiza		
11.	Mwenza wangu alizivuta nywele zangu na kuumiza mkono wangu		
12.	Mwenza wangu alinisukuma		
13.	Mwenza wangu alinipiga		
14.	Mwenza wangu aliniteka		
15.	Mwenza wangu alinitishia kisu au bunduki		

16.	Mwenza wangu alitumia kisu au bunduki kuniumiza		
17.	Mwenza wangu alinipiga na kitu ambacho kingeniumiza		
18.	Mwenza wangu alinikaba		
19.	Mwenza wangu alinichoma makusudi		
20.	Mwenza wangu alipendekeza suluisho la tofauti zetu		
21.	Mwenza wangu alinipiga teke		
22.	Mwenza wangu alinilazimisha kufanya mapenzi bila kondomu.		
23.	Mwenza wangu alinifanyisha mapenzi kwa kutumia nguvu		
24.	Mwenza wangu alinifanyisha mapenzi ya mdomo kwa nguvu		
25.	Mwenza wangu alilazimisha mapenzi nami sikutaka(lakini hakutumia nguvu)		
26.	Mwenza wangu alitumia vitisho kunifanyisha mapenzi ya mdomo		
27.	Mwenza wangu alitumia vitisho nifanye nae mapenzi		

Baada ya miezi mitatu; Je baada ya kumshirikisha mwenza wako majibu yako ya VVU je ulipata dalili zifuatazo?

HOPKINS SYMPTOM CHECKLIST-25: (Swahili version for Anxiety and Depression Scale)

MAELEKEZO: Orodha iliyo hapa chini, ina dalili ambazo watu wanaweza kuwa nazo wakati mwingine. Tafadhali sikiliza kwa umakini dalili zilizopo, na uamue ni zipi kati ya dalili zilizotajwa zimekusumbua, au kukufadhaisha, katika wiki iliyopita hadi leo.

Ja. Anxiety Sub-Scale

1) Kushituka ghafla bila sababu maalum	1=HAMNA HATA KIDOGO	2=KID-OGO	3=IPO KIASI	4=IPO SANA	MAT-ANX1
2) Kuwa na uwoga	1=HAMNA HATA KIDOGO	2=KID-OGO	3=IPO KIASI	4=IPO SANA	MAT-ANX2
3) Kujisikia kutaka kuzirai, kizunguzungu au kukosa nguvu.	1=HAMNA HATA KIDOGO	2=KID-OGO	3=IPO KIASI	4=IPO SANA	MAT-ANX3
4) Kujisikia kuwa na wasiwasi.	1=HAMNA HATA KIDOGO	2=KID-OGO	3=IPO KIASI	4=IPO SANA	MAT-ANX4
5) Moyo kwenda kasi au kudunda sana kuliko kawaida.	1=HAMNA HATA KIDOGO	2=KID-OGO	3=IPO KIASI	4=IPO SANA	MAT-ANX5
6) Kutetemeka.	1=HAMNA HATA KIDOGO	2=KID-OGO	3=IPO KIASI	4=IPO SANA	MAT-ANX6
7) Kujihisi kuwa na msongo wa mawazo	1=HAMNA HATA KIDOGO	2=KID-OGO	3=IPO KIASI	4=IPO SANA	MAT-ANX7
8) Kuumwa kichwa.	1=HAMNA HATA	2=KID-OGO	3=IPO KIASI	4=IPO SANA	MAT-ANX8

9) Kuwa na vipindi vya hofu au mshituko mkubwa.	1=HAMNA HATA KIDOGO	2=KID-OGO	3=IPO KIASI	4=IPO SANA	MAT-ANX9
10) Kujisikia hali ya kuhangaika hadi huwezi kukaa mahali umetulia.	1=HAMNA HATA KIDOGO	2=KID-OGO	3=IPO KIASI	4=IPO SANA	MAT-ANX10

Jb. Depression Sub-Scale

1) Kujisikia kukosa nguvu, na kujiona unafanya shughuli polepole.	1=HAMNA HATA KIDOGO	2=KID-OGO	3=IPO KIASI	4=IPO SANA	MAT-DE11D	
2) Kujilaumu kwa matukio yanayotokea yanayokuhusu wewe na wengine wanaokuhusu.	1=HAMNA HATA KIDOGO	2=KID-OGO	3=IPO KIASI	4=IPO SANA	MAT-DE12D	
3) Kulia kirahisi.	1=HAMNA HATA KIDOGO	2=KID-OGO	3=IPO KIASI	4=IPO SANA	MAT-DE13D	
4) Kutokua na hamu ya kimwili(Kujamiana) au kupendezwa na shughuli zinazohusiana na kujamiana.	1=HAMNA HATA KIDOGO	2=KID-OGO	3=IPO KIASI	4=IPO SANA	MAT-DE14D	
5) Kukosa hamu ya kula chakula.	1=HAMNA HATA KIDOGO	2=KID-OGO	3=IPO KIASI	4=IPO SANA	MAT-DE15D	
6) Wakati unapolala, unashindwa kupata usingizi, au kulala moja kwa moja hadi asubuhi.	1=HAMNA HATA KIDOGO	2=KIDOGO	3=IPO KIASI	4=IPO SANA	MAT-DE16D	
7) Kujisikia kuwa umekata tamaa katika siku za usoni	1=HAMNA HATA KIDOGO	2=KIDOGO	3=IPO KIASI	4=IPO SANA	MAT-DE17D	
8) Kujisikia kukosa raha.	1=HAMNA HATA KIDOGO	2=KIDOGO	3=IPO KIASI	4=IPO SANA	MAT-DE18D	
9) Kujisikia mpweke.	1=HAMNA HATA KIDOGO	2=KIDOGO	3=IPO KIASI	4=IPO SANA	MAT-DE19D	
10) Kuwa na mawazo ya kutaka kujiua.	1=HAMNA HATA KIDOGO	2=KIDOGO	3=IPO KIASI	4=IPO SANA	MAT-DE20D	
11) Kujisikia huna uwezakano wa kujitoa katika matatizo ulionayo.	1=HAMNA HATA KIDOGO	2=KIDOGO	3=IPO KIASI	4=IPO SANA	MAT-DE21D	
12) Kuwa na hali ya wasiwasi kupita kiasi kuhusu mambo mbali mbali.	1=HAMNA HATA KIDOGO	2=KIDOGO	3=IPO KIASI	4=IPO SANA	MAT-DE22D	
13) Kujisikia kutokuwa na hamu na kitu chochote (vitu ambavyo ni muhimu kwako).	1=HAMNA HATA KIDOGO	2=KIDOGO	3=IPO KIASI	4=IPO SANA	MAT-DE23D	
14) Kujisikia hali ya kujilazimisha ili kuweza kufanya kitu chochote.	1=HAMNA HATA KIDOGO	2=KIDOGO	3=IPO KIASI	4=IPO SANA	MAT-DE24D	
15) Kujisikia huna umuhimu/maana	1=HAMNA HATA KIDOGO	2=KIDOGO	3=IPO KIASI	4=IPO SANA	MAT-DE25D	