# ORGANIZATIONAL FACTORS INFLUENCING NON DISCLOSURE OF HIV STATUS AMONG SEXUAL PARTNERS ATTENDING MUHIMBILI NATIONAL HOSPITAL CARE AND TREATMENT CLINIC IN DAR ES SALAAM, TANZANIA

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**Master of Public Health Dissertation**
**Muhimbili University of Health and Allied Sciences**
**October 2013**

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**By**

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**A Dissertation Submitted in Partial Fulfillment of the Requirements for the Degree of Master of Public Health of the Muhimbili University of Health and Allied Sciences**

**Muhimbili University of Health and Allied Sciences**
**October 2013**

## CERTIFICATION

The undersigned certifies that he has read and hereby recommends for acceptance by the Muhimbili University of Health and Allied Sciences a dissertation entitled, **Organizational factors influencing non disclosure of HIV status among sexual partners attending Muhimbili National Hospital Care and Treatment Clinic in Dar es Salaam, Tanzania**, in (partial) fulfillment of the requirements for the degree of Master of Public Health of the Muhimbili University of Health and Allied Sciences (MUHAS).

…….

Dr. S.R. Kamazima

(Supervisor)

Date……

**DECLARATION**

**AND**

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I, **Mary Meshack Mwandolela,** declare that this dissertation is my own original work and that it has not been presented and will not be presented to any other University for a similar or any other degree award.

Candidate's signature……. Date……..…….

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## DEDICATION

To my Parents**,** Meshack S. **Mwandolela** and Twidike Z. **Duma**

for all the sacrifices you made and your endless prayers for me throughout my studies.

To my son **Emmanuel - Mirisho** and my daughter **Glory – Maangwe**

May the Almighty God guide you always!

Amen.

# ABSTRACT


## Background

Disclosure of HIV positive sero-status to sexual partners, friends or relatives is useful for prevention and care. Identifying factors associated with disclosure is a research priority as a high proportion of persons living with HIV&AIDS never disclose. HIV counseling and testing programmes as well as post test care services such as of antiretroviral therapy and pre-ART care emphasize HIV status disclosure among persons living with HIV&AIDS.

## Objective

The broad objective of this study was to establish organizational factors influencing non disclosure among sexual partners attending Care and Treatment Clinic at Muhimbili National Hospital Dar es salaam Tanzania.

## Methods

A descriptive cross sectional study was conducted at the Muhimbili National Hospital Care and Treatment Clinic. A total of 215 respondents participated in this study (207 clients, 5 Counselors and 3 Administrators). Non probability purposive sampling technique was used to select counselors and the administrators. Exit interviews were conducted to the clients using a structured questionnaire to get information on organizational factors contributing to non disclosure of HIV status among sexual partners attending Care and Treatment Clinic.

A review of various documents/records such as job allocation book, staff attendance book, staff roster and client register book, HIV&AIDS policy and guideline was conducted at the study site to get information on availability of personnel, work schedules, workload per care provider per day, number of clients and attendance and availability of policy and guidelines materials. Observations were conducted throughout the study on the issues like number of clients, client flow, availability of equipments and guidelines, client- provider interaction and emerging issues during the course of data collection. In-depth interviewing was conducted with the MNH administrators and the counselors to generate information on issues like availability of funds,

staff availability, training, user involvement and their evaluation of the working environment they have at MNH.

The questionnaire contained both close and open ended questions to generate data needed. The data was entered into a computer and analysed using Statistical Package for Social Sciences version 16 programmes and output was presented in tables.

**Results**

The results showed that 72.8% of the study population disclosed HIV status to their sexual partners, only 27.2% did not disclose. Counselors were seen as a source of disclosure information to the majority of respondents (79.4%) but only few 10.6% got disclosure information from the doctors and only 1.7% got information from other sources.

Long time was also reported by the majority of respondents (53.3%). Absence of workers' involvement was responded by majority of counselors interviewed. Also counselors stated that there was not enough counseling rooms, clients were congested in one room and there was no confidentiality during counseling. Counselors reported working in poor environment, face staff shortage and lacked necessary equipments.

**Conclusion**

Poor organizational leadership existing at the MNH strongly influences low level of disclosure among sexual partners attending the Care and Treatment Clinic Muhimbili National Hospital that need to be addressed.

**Recommendations**

This study did not cover all organizational factors that would influence disclosing of HIV status among the CTC MNH clients a gap that is recommended for further research. The MNH management should strongly improve the existing CTC conditions making sure that all the organizational factors are well addressed to encourage clients develop HIV status disclosing behaviors.

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## LIST OF ABBREVIATIONS

| | |
|---|---|
| HIV | Human Immunodeficient Virus |
| MNH | Muhimbili National Hospital |
| MPH | Master of Public Health |
| NACP | National AIDS Control Programme |
| UNFPA | United Nations Fund for Population Activities |
| UNAIDS | United Nations programme for AIDS |
| VCT | Voluntary Counselling and Testing |
| CTC | Care and Treatment Clinic |
| WHO | World Health Organization |
| STI | Sexual Transmitted Infection. |
| IEC | Information Education and Communication |
| PLWHA | People Living With HIV and AIDS |
| AIDS | Aquired Immunodefficiency Syndrome |
| CDC | Centre for Disease Control |
| PMTCT | Prevention of Mother To Child Transimission |
| ANC | Ant Natal Care |
| ART | Ant Retroviral Therapy |
| OPD | Out Patient Department |
| SPSS | Statistical Package for Social Sciences |
| MUHAS | Muhimbili University of Health and Allied Sciences. |

## OPERATIONAL TERM

**ORGANIZATIONAL FACTORS:** Are elements and descriptors that define an organization's character, property function and impact. Examples of organizational factors include organization leadership, structure, climate, politics, process and procedures.

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# CHAPTER ONE

## 1.0 INTRODUCTION

According to the National Guidelines for the Management of HIV & AIDS, ( 2012), HIV and AIDS is a major health problem globally.The United Nations Programme for AIDS (UNAIDS), estimated that by end of 2009, a total of 33.3 [31.4-35.3] million people worldwide were living with Human Immunodeficiency Virus & Aquired Immuno Deficiency Syndrome. Sub-Saharan Africa is the world's most severely affected region. Though it is home for only 10% of the world's population, it shelters about two third of the total number of people living with HIV globally. One in 12 adults in this region is reported to be infected with HIV [1].

Although there are now reports of declining trends in HIV incidence in a number of countries, presumably due to behaviour changes, prevention programmes and the scaling up of treatment programmes the number of PLHA has continued to rise due to population growth, and more recently, the life prolonging effects of antiretroviral therapy [1] .

Since the first three AIDS cases were reported in Tanzania in 1983, the HIV epidemic has spread rapidly to all districts and communities in the country, affecting all sectors of the society. In 2007, about 2 million persons were estimated to be living with HIV&AIDS, with approximately 600,000 (30%) in need of Ant Retroviral Therapy( ART) by the criteria used at that time. Recent data based on household surveys estimate the sero prevalence among adults aged between 15-49 years in Tanzania to be 5.7% with a wide variability among regions. Sexual intercourse is the main mode of transmission which, in part, explains why sexually active individuals between the age of 15-49 are most severely affected, where women are at a higher risk of infection than men [1].

Strategies to control transmission have changed since 1980s. It started with Information, Education and Communication (IEC), promotion of condom use, Ant Retroviral drugs (ARVs), male circumcision (MC) and now disclosing of HIV status to sexual partners

(WHO 2008). Disclosure is important because individuals are motivated to seek treatment, change behaviour and decrease transmission. Disclosing has a number of benefits for the individual including opportunities for social support, improved access to medical care, increased opportunities to discuss and implement risk reduction with partners, opportunities to take leadership roles in the community and increased opportunities to plan for the future [2]

People Living With HIV find it difficult to disclose their results for a number of reasons; their status will no longer be a secret, fear of rejection and relationships could be lost. Other reasons are the loss of economic support, blame, abandonment, physical and emotional abuse, discrimination and disruption of family relationships. Stigma, perceived or real could be felt at individual, family, community and societal level [2].

Despite studies conducted on barriers to disclosing and strategies implemented by the government to promote disclosure of HIV status among sexual partners, still non disclosure rate is increasing. Currently, the non disclosure rate is reported to be 3%-10% in the USA and 10%-78% in developing countries (WHO 2004). This observation suggests that we are lacking a comprehensive understanding of factors limiting HIV positive individuals to disclose their status to their partners. To do so, I applied the ecological model of behavior change to explore factors for non disclosure that can be changed.

### 1.1 Ecological model for behavior change

The social-ecological model recognizes the interwoven relationship that exists between the individual and their environment. While individuals are responsible for maintaining the lifestyle changes necessary to reduce risk and improve health, individual behavior is determined to a large extent by social environment, that is, the community norms and values,

regulations and policies. Barriers to healthy behaviors are shared among the community as a whole. As these barriers are lowered or removed, behavior change becomes more achievable and sustainable. The most effective approach leading to healthy behaviors is a combination of the efforts at all levels: individual, interpersonal, organizational, community and the public policy.

A review of literature conducted shows that many studies conducted emphasized on the individual factors, a little bit on interpersonal factors and community factors. Hence, there is scanty information on the influence of factors at other levels (organizational and public policy). Therefore, this study was informed by ecological model for behavior change (Figure 1) to establish organizational factors influencing non disclosure of HIV status among sexual partners at Muhimbili National Hospital Care and Treatment Clinic in Dar es salaam.

**Figure 1: The Ecological model**



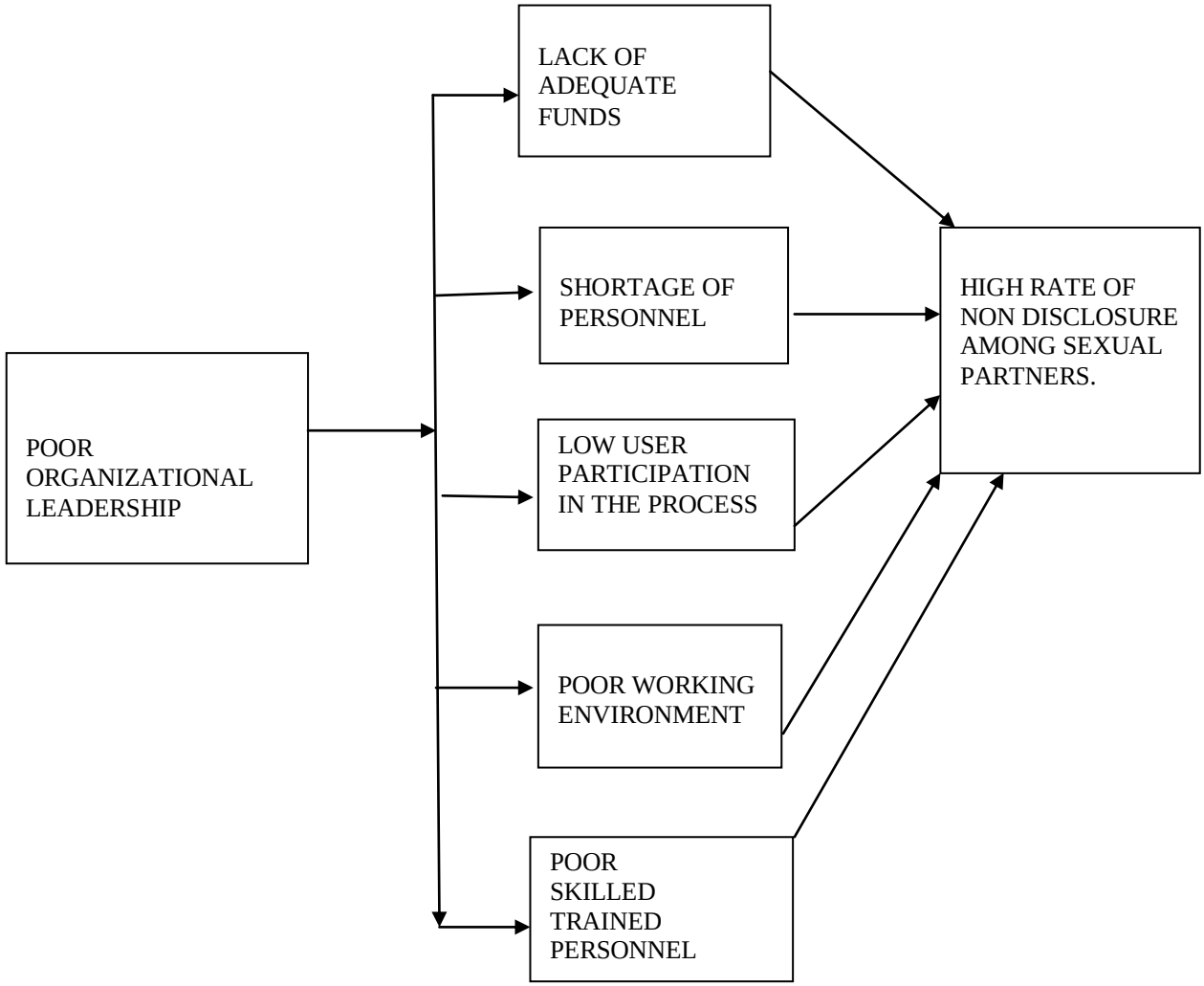

**Source:** http://www.dhs.state.or.us/publichealth/hpcdp/about.cfm#why

## 1.2 Conceptual framework

Conceptual frameworks are structured from a set of broad ideas and theories that help a researcher to properly identify the problem they are looking at, frame their questions and find suitable literature (Smyth, 2004). Organizational factors influencing change include leadership, structure, climate (working environment) politics, process and procedures. Where there is good organizational leadership, for example, the management will ensure availability

of sufficient fund need, availability of enough and skilled personnel, high user involvement in the process, conducive working environment and comprehensive training to the personnel. In this study, it was reported that there is poor leadership at the Muhimbili National Hospital suggesting lack of adequate funds to undertake its roles; has shortage of personnel, which leads to heavy workload and burnout; has poor working environment, which is somehow frustrating to both the health care providers and the clients and that the personnel available are poorly trained, hence lack skills to encourage disclosing behavior change among their clients.This was supported by the newspaper written by the Guardian on Sunday team in July 2012 [42]. Poor leadership,/ organizational coupled with other factors at other levels, contribute to the high rate of non-disclosure to [sexual partners] among HIV positive clients in the country as presented in figure 2.

**Figure 2: Conceptualized organizational factors for not disclosing**




### 1.3 Problem Statement

Factors for not disclosing one's status to anyone, to the sexual partner in particular are somehow known and are considered in the provision of care and treatment services in the country. It is unfortunately that factors established only focus on the individual (fear of losing relationships) interpersonal (friends, family and networks) and the community (stigma), suggesting that there are other factors – the organizational and the public policy levels, for example – that are yet to be explored. Organizational and public policy barriers would limit counselors and other health care providers to focus on pre and post-testing counselling at the

expense of the importance of disclosing of one's status to significant other and more important, to the sexual partner.

The policy and guidelines on testing and disclosing one's status are in place. Among other things, the guideline states that client's HIV status should be kept confidential and that disclosing it to whom and when remains at the client's liberty. This guideline, in part, contradicts with the purpose of the disclosure strategy for controlling the transmission among sexual partners and the community. This study goes beyond the known barriers to disclosing at the individual, interpersonal and community levels, establishing organizational barriers – the leadership factors – influencing non-disclosing among sexual partners receiving care and treatment services at the care and treatment clinic at the MNH.

### 1.4 Rationale of the Study

Findings from this study will contribute to our understanding of other factors limiting disclosing among the Care and Tratment Clinic clients that need to be controlled for the reduction of high rate of non disclosure recorded in the country. Integrating these factors in the planning, implementing, monitoring and evaluation of the care and treatment services at MNH would improve the current situation and set a model for other health facilities providing care and treatment services in Dar-es-Salaam region and the country.

### 1.5 Research Questions

This study aimed at answering the following research questions:

1. What is the proportion of patients attending CTC at MNH disclosed their HIV status to their partners?
2. How does the working environment facilitate or limit comprehensive client counselling at the CTC at MNH?
3. How competent are the health care providers (the counsellors) in motivating clients to disclose their HIV status to their sexual partners?
4. What is the level of involvement of the service users in the process of care and treatment at MNH?

## 1.6 Objectives

### 1.6.1 Broad Objective

The broad objective of this study was to establish organizational factors influencing non disclosure among sexual partners attending CTC at MNH, Dar-es-Salaam, Tanzania.

### 1.6.2 Specific Objectives

The specific objectives of this study were to:

1. Assess the proportion of patients attending CTC at MNH who had disclosed their HIV status to their partners.
2. Determine how the working environment at MNH promotes or limits comprehensive counseling to clients attending the CTC.
3. Assess the health care providers' capability in motivating clients to disclose their HIV status to their sexual partners.
4. Determine the level of involvement of the service users in the process of care and treatment at MNH.

# CHAPTER TWO

## 2.0 LITERATURE REVIEW

The prevention and control of HIV infection depends on the prevention of new infections and treating currently infected individuals. VCT, is an entry point to prevention and treatment services [3,4]. VCT services place emphasis on HIV status disclosure among HIV-infected clients, particularly to their sexual partners. Many international organizations including UNAIDS, WHO and CDC emphasize the importance of HIV status disclosure [5,6].

Self-disclosure of sensitive information is generally thought to have beneficial effects on an individual's health: it lowers stress and lead to better psychological health [7]. In the case of HIV&AIDS, individuals who disclose their status are in a better position in terms of reproductive choices as well as psychosocial support. In addition, disclosure facilitates other behaviours that may improve the management of HIV. For example, women who disclose their status to their partners may be more likely to participate in Prevention of Mother To Child Transmission programs [8,9]. Studies indicate that individuals who disclosed their results have better adherence to ART treatments [10]. A recent mathematical modelling analysis showed that serostatus disclosure reduced the risk of HIV transmission by 17.9% to 40.6% relative to non-disclosure. Increasing the disclosure rate from the base-case value of 51.9–75.7% produced a 26.2–59.2% reduction in risk [11].

Although disclosure has a number of benefits such as opportunities for social support, improved access to medical care, increased opportunities to discuss and implement risk reduction with partners, opportunities to take leadership roles in the community and increased opportunities to plan for the future, it is not without problems. Along with the aforementioned benefits, HIV status disclosure has many potential risks such as fear of rejection, lost of relationships, loss of economic support, blames, abandonment, physical and emotional abuse stigma and discrimination. However, disclosure can also incur negative consequences [14, 15] making the decision to disclose a dilemma for individuals infected with HIV.

Numerous factors have been associated with status disclosure. Research on partnership variables has demonstrated that main/steady/close/regular partners are more likely to disclosure than other/casual/unfamiliar partner [20, 21]. Factors beyond partnership can influence disclosure as well. Specifically, illness severity and length of time since HIV diagnosis have been shown to be positively correlated to disclosure [22]. HIV-infected individuals are more likely to disclose to a partner whom they know is HIV-positive than to an HIV-negative or unknown HIV status partner [17, 18-21]. In a study conducted in Tanzania, a short duration of relationship, polygamous marriage, working out of home, not knowing someone with HIV and lower income were negatively associated with disclosure [21]. In the same study it was found that women who had greater than 6-lifetime sexual partners were less likely to disclose their status.

Another factor associated with disclosure was social support. Individuals with high social support tend to disclose their result more often than those without such support [18]. Self-efficacy has been reported as one of the determinants of HIV status disclosure [16]. Having not disclosed to sex partners was closely associated with lower self-efficacy for disclosing. Women who had not disclosed reported the lowest disclosure self-efficacy. In a study conducted in Tanzania [12] a very strong association was found between prior communication about HIV testing with a partner and HIV-serostatus disclosure.

One study [23] found that women with higher education are more likely to disclose their HIV test result to their sexual partner than women who are illiterate. Gender is also reported to be one of the associated factors of HIV status disclosure. In a study conducted in South Africa, males were found to disclose their result more often to partner than females [24]. In contrast, study in the same country [25] revealed that male sex is associated with non-disclosure of HIV status.

Disclosure of HIV positive status is a complex, difficult and very personal matter that entails communication about a potentially life threatening, stigmatized and transmissible illness to someone [28]. HIV status disclosure serves as an important prevention strategy in PMTCT, it

enables PMTCT attendees to benefit by being able to use ART prophylaxis, practice safe infant feeding and family planning practices [26,27]. Disclosure is also important for psychosocial support, treatment adherence [29-31], stigma reduction and risk reduction behaviour [32] In developed countries HIV status disclosure rate among antenatal care (ANC) women ranges from 42-100% compared to 16.7-32% for developing countries [33]. The Policy in Zimbabwe advocates that all patients and clients, negative and positive, should be empowered to disclose their results to their sexual partners through counselling.

Disclosure of HIV positive sero-status to sexual partners and or close relatives and friends (significant others) is an important public health strategy because it offers a number of benefits to the infected individual and to the general public.[ 34, 34] HIV counselling and testing (HCT) programmes as well as post test care services such as of antiretroviral therapy (ART) and pre-ART care, emphasize HIV status disclosure among persons living with HIV&AIDS. Disclosure to significant others would provide emotional and psychological support to People living with HIV/AIDS whereas disclosure to sexual partners could lead to the partners also undertaking HIV Counselling and Testing [ 36, 37] . Since disclosure creates the awareness of HIV risk to untested sexual partners, it subsequently leads to greater uptake of HCT [38].

Furthermore, disclosure to sexual partners enables couples to make informed reproductive health choices that may ultimately lower the number of unintended pregnancies among HIV positive couples, and even reduce the risk of HIV transmission from the mother to child (MTCT) [39]. Not only does disclosure motivate people to reduce risky sexual behaviours thereby decreasing the transmission of HIV, but it is also associated with improved access to

HIV prevention and treatment programmes and with better treatment outcomes via improving adherence to ART[36,37].

Inspite of all antecedent benefits of disclosure some people may decide to keep their positive HIV status a secret, others may disclose partially to specific people while others may have full/public disclosure (means they disclose their HIV status open or infront of people without

fear).[34,35]. Indeed, the disclosure of HIV positive status has potential risks such as blame, divorce, abandonment, physical and emotional abuse, discrimination and stigma, as well as loss of custody of children and property especially for women. [34,40].

Much of the literature reviewed focused on individual, interpersonal and community factors. Thus, there is a scanty information on how the organizational factors influence CTC clients' ability to disclose – a problem that this study wanted to bridge. The following chapter, chapter three, presents the methodology used to generate data needed for this study.

# CHAPTER THREE

## 3.0 METHODOLOGY

### 3.1 Study area

The study was conducted at the Care and Treatment Clinic which is in the New Out Patient Department building at Muhimbili National Hospital (MNH). MNH is a tertiary referral and teaching hospital, situated in the middle of Dar es Salaam city. It also serves as a referal hospital for Ilala, Temeke and Kinondoni Regional hospitals. Also MNH provides care and treatment to many patients compared to other hospitals in the country, and is expected to be providing quality and comprehensive care for PLHIV, enough personnel and infrastructures.

### 3.2 Study population

The study population was the clients attending at CTC, administrators (head of medical department, head of CTC and incharge CTC) and counselors working at CTC at MNH, Dar es salaam.

### 3.3 Study design

The study design was a descriptive cross-sectional study to establish organizational factors influencing non disclosure of HIV status among clients attending Care and Treatment Clinic (CTC) at Muhimbili National Hospital in Dar es Salaam. The study was conducted between January and March 2013. It included a survey with 207 clients from CTC Clinic at MNH and qualitative in-depth interviews with 8 purposively selected participants, namely 3 Administrators and 5 Health Care Providers (Counselors).

#### 3.3.1 Methods

The study used a combination of qualitative and quantitative methods to collect data needed.

*3.3.1.1 Review of documents*: a review of various documents/records such as job allocation book, staff attendance book, staff roster and client register book, HIV&AIDS policy and guideline were conducted at the study site to get information on availability of personnel, work schedules, workload per care provider per day, number of clients, attendance with availability of policy and guidelines materials.

*3.3.1.2 In-depth interviewing:* was conducted for one and a half hours with the MNH administrators and the health care providers at the pre determined time and place to generate information on issues like availability of funds, staff availability, training, user involvement and their evaluation of the working environment they have at MNH. Similarly, the study participants (counselors) were asked to provide their recommendation on how to improve their service provision skills to promote disclosing behavior among the sexual partners attending the CTC at MNH. This information was collected by tape recording.

*3.3.1.3 Exit interviews:* were conducted with the clients attending CTC at MNH to solicit their evaluation of the disclosing counseling services provided, their involvement in the treatment plan, their perceptions of the health care providers and their recommendations on how to improve the client-provider relationship to encourage disclosing behavior for better treatment outcomes.

*3.3.1.4.Observations:* were conducted throughout the study on issues like number of clients, client flow, availability of equipment and guidelines, client-provider interaction and emerging issues during the course of data collection.

**3.4 Sample size estimation**

Calculating the required sample size enhances the validity of the results.

$$n = \frac{z^2 p\,(100-p)}{e^2}$$

Where;

Z=The standard normal deviation that corresponds to 5% level of statistical significant is1.96 .

P= proportion of expected prevalence for disclosing is estimated to be 16% (WHO 2004).

e=Maximum error of the study, assigned a value of (5%)

$$n = \frac{(1.96)^2 \times 16(100-16)}{25}$$

n = 207

The minimum sample size was 207 participants of the study.

**3.5 Sampling technique.**

Non probability purposive sampling. This technique was used to select health care workers (counselors) and administrators. The method enabled interviewing the participants available at that specific time and day.

A systematic sampling technique was used to obtain clients for exit interview by taking every $6^{.th}$. on the day's client register. The sampling starts by selecting a client from the list at random and then every $k^{th}$ element in the frame was selected, where k, the ampling interval. (k=N/n), where n is the sample size, and N is the population size. This was conducted by selecting the first client randomly from the first six and subsequent respondents were selected after every $6^{th}$ client from the first selected client from the attendance register book of that particular day then I talked with other clients that after finishing adherence counselling with the counselors they have to come after every six client in the next room for exit interview to obtain the required number of the respondents. Also to clients I managed to get a total of 180 clients out of 207 clients needed.

**Key Variables**

The variables measured were:

**Dependent variable**

1. Disclosure of HIV status (categorical variable)

**Independent variables.**

1. Insufficient human resources.
2. Less skilled health care providers.
3. Lack of supplies
4. User participation in the process.
5 .Working hours.
6. Poor working environment

### 3.6 Selection, training of RAs, and pre testing of study tools.

A research assistant was selected basing on the availability and required knowledge on research. One research assistant, a Nursing officer was trained after a brief overview of the purpose of the study. The major focus of the training was on how to conduct interviews after requesting informed consent from the interviewee. Research assistant also was trained about what this study was all about and shown how to establish good rapport before and during interview. Training was provided also for ethical procedures and sensitivity interviewing so as to treat interviewees of both sexes sensitively.

The principle investigator and research assistant conducted the pilot testing. Pre testing of the study tool was conducted with the clients at Mwananyamala Hospital who were not included in the study. Mwananyamala CTC was selected for pre testing because it has a similar set up to that of MNH. This was important to avoid leakage of study related information among targeted participants. During the process, sections of the questionnaire and interview guide which had problems were identified and necessary modifications made.

### 3.7 Data collection

Data were collected by the researcher and one research assistant using structured questionnaire for clients and tape recorder for administrators and counselors. A convenient place was selected for every client where data collection was conducted. Interviews with the counselors took average of one hour and were conducted during the evening at the end of the shift. CTC staffs were informed by their in charge that after lunch time they have to come for interview in a selected room. One participant was interviewed at a time. No other participant was allowed to move around interviewing place. Quality of data collected was regularly checked by the PI. Every other day, the principal investigator and research assistant discussed on problems faced during data collection the previous day and clarifications on such problems were made. The principal investigator also did check up all information collected to ensure that questionnaires were filled correctly.

### 3.8 Data processing, analysis and presentation

Responses obtained from the study participants were coded and computerized.

The data was entered into a computer using SPSS statistical software package version 16.0 programme. Running of frequencies was done in order to check for data entry errors. Data errors that were identified were corrected by reffering to a specific question with errors on the questionnaire. After data cleaning, frequencies were obtained for all variables and were further analyzed using descriptive analysis and cross tabulation and the output was presented using tables.

### 3.9 Ethical consideration and Research clearance

Ethical approval for conducting the research was obtained from MUHAS Ethical Review Board. Permission to carry out the study was obtained from MNH administration. Participants were asked for their willingness to participate in the study. Principal investigator or research assistant provided participants with information related to the aim of the study. Participation was voluntary and every participant was free to withdraw from the study at any time without penalty, but the participants was reminded that participating in this study was beneficial for the understanding of the organizational factors influencing non disclosure of HIV status. Also, they were informed that treatment would not be affected due to participation or withdraw from this study. Written informed consent was obtained from each study participant

### 3.10 Limitation of the study

This study faces three limitations.

1. The study used the clinic set up involving participants who have been exposed to the importance of disclosing during CTC counselling sessions. So, the findings may not be generalized to other populations and settings with different features. However, they were selected because of their experience with the services provided and would recommend on the how to improve the client-provider relationship to encourage disclosing behavior for better treatment outcomes.
2. This study did not covered all organizational factors that would influence disclosing of HIV status among the clients, a gap that is recommended for further research.

3. Problem faced was how to get participants especially administrators. It was very difficult because most of the time they were very busy, such that I managed to interview only one administrator who was incharge of the CTC.

# CHAPTER FOUR

## 4:0 RESULTS

### 4.1 Social demographic characteristics of the participants

A total of 180 clients participated in this study. The majority of the participants 120 (66.7%) were females and 60 (33.3%) were males. The age of the respondents varied from 20-62 years with a median age of 44 years. Majority of the study population 75 (41.7%) were in the age group of 30-39 years and married 63 (35%). Over 60% had completed primary education and 32% completed form four education and about 20% had no formal education. Of all respondents, 47.8% were on ART for 5-9 years.

Five HCPs (the counselors) were interviewed and one administrator who was the incharge of CTC. Among those interviewed, two were assistant nursing officers, two principal nursing officers and one was a senior assistant nursing officer. The counselors interviewed were females. Three nurse counselors and two counselors. Two counselors had diploma in nursing. Table 1 present a summary of the characteristics of the study participants.

**Table 1: Demographic characteristics of the study Participants**

| Characteristics | Male | (%) | Female | (%) | Total | (%) |
|---|---|---|---|---|---|---|
| **Age** | | | | | | |
| 20-29 | 8 | (13.3) | 16 | (13.3) | 24 | (13.3) |
| 30-39 | 23 | (38.3) | 52 | (43.3) | 75 | (41.7) |
| 40-49 | 20 | (33.3) | 38 | (31.7) | 58 | (32.2) |
| 50-59 | 8 | (13.3) | 11 | (9.2) | 19 | (10.6) |
| 60 + | 1 | (1.8) | 3 | (2.5) | 4 | (2.2) |
| **Total** | **60** | **(100)** | **120** | **(100** | **180** | **(100)** |
| **Education level** | | | | | | |
| No formal education | 8 | (13.3) | 29 | (24.2) | 37 | (20.6) |
| Primary education | 34 | (56.7) | 33 | (27.5) | 67 | (37.2) |
| Secondary education | 12 | (20) | 47 | (39.2) | 59 | (32.8) |
| College and above | 6 | (10) | 11 | (9.2) | 17 | (9.4) |
| **Total** | **60** | **(100)** | **120** | **(100)** | **180** | **(100)** |
| **Marital status** | | | | | | |
| Single | 7 | (11.7) | 17 | (14.20 | 24 | (13.3) |
| Married | 21 | (35) | 42 | (35) | 63 | (35) |
| Cohabiting | 20 | (33.3) | 22 | (18.3) | 42 | (23.3) |
| Divorced | 4 | (6.7) | 27 | (22.5) | 31 | (17.2) |
| Widowed | 8 | (13.3) | 12 | (10) | 20 | (11.1) |
| **Total** | **60** | **(100)** | **120** | **(100)** | **180** | **(100)** |
| **Time on ART** | | | | | | |
| 0-4 yea**rs** | 21 | (35) | 45 | (37.5) | 66 | (36.7) |
| 5-9 years | 29 | (48.3) | 57 | (47.5) | 86 | (47.8) |
| 10 years + | 10 | (16.7) | 18 | (15) | 28 | (15.5) |
| **Total** | **60** | **(100)** | **120** | **(100)** | **180** | **(100)** |

**Table 2: Ever disclosed HIV status to the partner**

| **Disclosure** | **Frequency** | **Percentage (%)** |
|---|---|---|
| Yes | 131 | 72.8 |
| No | 49 | 27.2 |
| **Total** | **180** | **100** |
| **Suggestions on how to facilitate partners to disclose** | | |
| Health education and counseling | 139 | 72.2 |
| Partners to be open and free to disclose | 25 | 14 |
| To go together to the clinic with a partner To check for HIV | 16 | 9 |
| **Total** | **180** | **100** |

The respondents were asked whether they have ever disclosed their HIV status. Table 2 above shows a total of 180 respondents who did respond on disclosure of HIV status. About 131 (72.8%) had disclosed their HIV status to their partners and 49 (27.2%) had not.

Also comments/suggestions on how to facilitate partners to disclose HIV status to their partners were given, multiple responses were allowed. About 139 (72.2%) participants suggested that Health Education and Counselling was among the factor which can facilitate the partners to disclose HIV status to their partners, 25 (14%) participants suggested that to be open and free to disclose HIV status to their partners can facilitate their partners to disclose, and 16 (9%) suggested that it is better to go to the clinic together with their partners to check for HIV status.

**Table 3: Ever heard of the importance of disclosing to sexual partners and source of information**

| Ever heard | Frequency | Percentage |
|---|---|---|
| Yes | 167 | 92.8 |
| No | 13 | 7.2 |
| **Total** | **180** | **100** |
| **Source of information** | | |
| Doctor | 19 | 10.6 |
| Counsellor | 143 | 79.4 |
| Nurse in the ward | 3 | 1.7 |
| Nurse NOPD | 3 | 1.7 |
| **Total** | **168** | **93.3** |
| Missing data | 12 | 6.7 |
| **Total** | **180** | **100** |

Respondents were asked whether they have ever disclosed HIV status to their partners. Table 3 shows the total of 180 respondents who did respond on the importance of disclosing HIV status to their partners.

About 167 (92.8%) of the respondents knew the importance of disclosing, 13 (7.2%) of the respondents did not know the importance of disclosing HIV status to their partners. Majority of respondents 143(79.4%) got disclosure information from the counselors, 19 (10.6%) from the doctors and 3 (1.7%) from Nurses In and Out patient Departments.

**Table 4: Waiting time and how it affects the counseling session of the clients.**

| Characteristics | Frequency | Percentage (%) |
|---|---|---|
| One hour-Two hours | 29 | 16.1 |
| Three hours- Four hours | 47 | 26.1 |
| Five hours- Six hours | 60 | 33.3 |
| Seven hours- Eight hours | 34 | 18.9 |
| Eight hours and above | 10 | 5.6 |
| **Total** | **180** | **100** |
| **The rate of waiting time** | | |
| Short time | 10 | 5.6 |
| Normal | 71 | 39.4 |
| Long time | 96 | 53.3 |
| Don't know | 3 | 1.7 |
| **Total** | **180** | **100** |

In order to know the client flow at the CTC MNH, the participants were asked to assess time spent from the time they enter the clinic to get services to the time of exit. Results are presented in Table 4 above. Majority 60 (33.3%) responded that the average of waiting hours is 5-6 hours, 47 (26.1%) responded that the waiting time for the services is 3-4 hours, 34 (18.9%) reported 7-8 hour and 10 (5.6%) reported 8 hours and above.

Similarly, respondents rated the waiting time at the clinic. Majority 96 (53.3%) responded that the waiting hours for services was too long, 71 (39.4%) said the waiting hours was normal, 10 (5.6%) stated that the waiting hours was short and 3 (1.7%) said they didnot know.

**Insuficient funds for overtime payment to counselors affect counseling session**

Health care providers explained that fund availability at this clinic is not well known to them. Every counselor reported a different source of funds to operate the clinic: Muhimbili National Hospital, MDH or other sponsors. Forexample, one counselor reported that *"funds for the CTC activities come from MDH, PEPFAR, EGPAF,MNH and ABBOT. This is from what I know".(An administrator, incharge CTC, Age 39 years, MNH, 2013).*

Another HCP explained *"for sure we don't know the source of funds for operating this clinic, as there is no involvement in anything at this clinic how can we know this" (Counselor, Age - 49 years, MNH, 2013).*

The other counselor observed *"my dear who can involve me in such big thing like Money! My dear it's not possible, we are just doing the job but no involvement in anything, especially which deals with money ... no one will tell you…." (Counselor Age 59 Years, MNH, 2013).*

About allowances counselors said that there is no any allowances paid in case of overtime, this discourages them to have morale on how to encourage disclosing behavior of HIV status to the clients. "Cou*nselor said that in this clinic is different from other CTC, because in other clinics all counselors working there they get risk or overtime allowances but in our clinic we did not get, so this discourage us very much ..." (Counselor Age 47 Years, MNH, 2013).*

**User participation in the CTC Planning process.**

User participation in the process is concerned with the involvement of all stakeholders of the CTC, these includes with counselors, administrators and the clients. Majority of the interviewees reported that there is no involvement in any thing concerning the clinic. This contributes to non disclosure of HIV status to partners as it discourage counselors to loose hope and confidence in their work as they are not involved, so they feel as like they are not part of the clinic.

One counselor said "*as we are stakeholders in this clinic we are not involved in anything especially those issues on strategic planning, even in meetings we are not involved. If we have*

*a problem we are communicating with our clinic incharge, may be she can tell those administrators about our problems*" (Counselor Age 40 years , MNH, 2013).

Another counselor said that "*We are still wondering why we are not involved in meetings, and clinic strategic planning. This is very unfair ... Because we are not involved, even our suggestions and comments are not working .. Bad enough even our clients are not involved"* I recommend that the system should involve all the CTC stakeholders in planning processes so as to know what is going on in their clinic. And this will at least encourage us to have morale of work which can facilitate disclosing behaviot to our clients. (Councelor Age 42 years,CTC MNH 2013).

Another HCP (counselor) stated *"Involvement in planning of this clinic is a challenge to us because there is no involvement especially to HCPs, we are just working but we don't know what is going on in our clinic"* (Counselor Age 47years, CTC MNH 2013). This participant added *"It is very discouraging, we are providing health services to our clients,but we are not involved in anything to make sure that our clinic is operating ... For example, if we are involved at least in strategic plannings of our clinic we can be encouraged and be proud that our bosses value us , at least we can provide quality services to our client"* (Counselor Age 47years, CTC MNH 2013).

An administrator (incharge CTC ) reported *"Nowadays we have weekly meetings on Mondays whenever possible, where we can talk our problems with our workers otherwise no involvement"* (CTC Incharge, Age-39 years CTC MNH 2013).

**Comments/Suggestions on Funds Availability**

Counselors were asked the comments on fund availability for CTC. There were different opinions about this. One of the counselors stated that the Government should give enough funds and supplies for the clinic in order to enable the HCPs to have enough equipments

which can make their work simple. One counselor said that it is better to have fund raising activities which will be under the supervision of clinic staffs. However, another counselor had a different view that *"it is very difficult to depend each and every thing on the Government.*

*These things should be taken care of by the Hospital itself by establishing different activities for raising the funds by itself rather than waiting for the Government and other donors. (Counselor, Age-47 Years, MNH, 2013).*

**Personnel Availability**

Availability of enough HCPs is an indicator of the provision of quality services at any settings. Counselors were interviewed on the availability of personnel at the clinic. Majority said that the number of counselors was inadequate compared to the number of clients attended per day.

One counselor said that *"My dear this isue is very complex to us, we are very busy at this clinic mind you, how can one counselor provide care for more than sixty clients per day, is it possible?. In this situation, we will never come up with a quality care. ( Counselor Age 40 years old, CTC, MNH, 2013).*

Another counselor stated that *"This clinic is very busy. We provide care to 150-200 clients per day and we are only five counselors, sometimes even two or three counselors in case other counselors get emergences. As I know a counselor /client ratio currently is 1:12, so how can one counselor take care of such a number of clients, this is terrible!. (Counselor Age 42 years, CTC, MNH, 2013).*

The other counselor observed that time to sit and talk with one client is not enough. "*We counsel on how to help their partners to disclose and to receive results, but time is not enough. This is because counselors are very few compared to the number of clients attended per day". (Counselor, Age 47years, CTC MNH 2013).*

**Working Environment**

Conducive working environment can make the client comfortable with the care provided or can make the care providers happy with the work or provide quality care. Counselors stated they have difficult working environment: no enough counselling rooms, no trainings/seminars and no incentives (financial incentives like risk and over time allowances).

A counselor said that *"Despite of difficult job which we are doing there is no incentives even appreciation on the job done, it is very discouraging" (Counselor, Age 40 years old, CTC, MNH, 2013).*

One Health Care Provider said that *"working environment is another challenge in our clinic, as I know counselling needs confidentiality, but here we usually sit three counselors and three clients in one room ... There is no confidentiality .... There are no enough rooms at all. (Counselor, Age 52 years old, CTC, MNH, 2013).*

A client supported this observation *"Confidentiality even privacy is not there, I usually feel shy to explain my personal issues because in one room there are so many people and alot of noise"* (Client CTC –Male -37 years old, CTC, MNH, 2013).

**Comments/ Suggestions on the Provision of Quality Care at the clinic.**

Counselors came up with different comments/ suggestions on how to improve the quality of care provided. Several ways were reported: number of staffs and supplies should be increased; the New Out Patient Department building (NOPD) should be used for HIV clients only in order to make a user-friendly clinic; have regular seminars and staffs on job trainings particulary on disclosure; being involved in meetings; plan for staff incentives and motivation and being involved in CTC clinic strategic planning.

# CHAPTER FIVE

## 5:0 DISCUSSION

### Disclosure of HIV status.

The general level of disclosure in this study was high, 72.8% had disclosed HIV status to their partners. This was comparable to other studies in Africa. In a study conducted in Uganda [41] it was found that 97% of subjects had disclosed their serostatus to their partners, two studies from South Africa [40] found that more than 90% had disclosed their HIV serostatus to one or more people. However, this is higher than the one (60.5%) reported from Addis Ababa [23]. Concerning disclosure to one's partner, this study confirms that most participants have disclosed their HIV positive status to their sexual partners, only 27.2% of the people interviewed in this study did not disclose their status to their partners

The rate of disclosure among sexual partners was high. In this study majority of clients 131 (72.8%) disclosed HIV status to their partners and knew the importance of disclosing HIV status to their partners.

This means that clients know all these issues about disclosure but we need a strong leadership which can enable HCP to have enough knowledge and skills on how to facilitate sexual partners to disclose their HIV status. Updated knowledge on disclosure and a conducive working environment for both clients and HCPs would promote disclosure among CTCs clients and increase utilization of services provided.

**Client flow**

Findings from this study show that 60 (33.3%) of the respondents spent 5-6 hours waiting for services, 96 (53.3%) said waiting time for services was too long. Findings show that majority of clients although knew the important of disclosing HIV status to their partners but they are discouraged by factors such as waiting time from time they report to the clinic to the time they finish services (in this study 5-6 hours). Experience from other study conducted in Geneva 1997 shows that clients become more satisfied when they spend less time waiting and spend more time with the service provider (the counselor). That is, the easier clients move through a CTC Clinic, or client flow, can facilitate avoiding delays (or long waits) and increase the quality of services provided. In turn, improved client flow facilitates disclosure of HIV status to the clients. This suggests that need to improve the current CTC services by making the waiting time short and services need to be client friendly that can attract them to come with their partners and get information on disclosure. In turn, this can encourage the clients to disclose HIV status to their partners.

Participants observed that, waiting time for services was too long. Participants spent more that 5-6 hours waiting for the services. They came up with suggestions that, whenever possible, clients should not waste much time before seeing the counselor. In their views, this could reduce their morale to disclose HIV status to their partners. It suggests hiring adequate number of counselors that corresponds with the number of clients (to avoid burn out) and setting and adhering to appointment schedule.

**Working environment**

Working environment is the place where a HCP can provide services comfortably and the client becomes comfortable with the care provided by the HCPs. Such environment includes enough counseling rooms with enough space and well ventilated, enough staffs, enough supplies and incentives (especially financial). The presence of all these features can encourage the HCPs to have working morale, and hence encouraging disclosing behaviors among the clients attending the CTC MNH.

***Confidentiality***

Interviewees suggested that a counseling room should be well ventilated with enough space, also the NOPD building should be specifically for HIV patients only not as a current CTC.

This is a combination of many clinics operating HIV services together with other clinics. This is supported with a study conducted by Mathews C in South Africa 1998 which argued that without promises of confidentiality the clients are less likely to disclose their private and sensitive information required for their care [35]. The interviewees identified confidentiality to be the key feature of the CTC center targeting partners, which they set at the characteristics of the CTC workers and the set up of the CTC.

***Workers/Counselors***

Interviewees suggested that CTC workers need counseling rooms conducive for maintaining confidentiality and privacy and creating partners friendly atmosphere at a partner–centered CTC center. Without conducive working environment, that is, counseling rooms which can accommodate at least one counselor and one client during counseling sessions none will be willing to come to the CTC clinic with the partner to disclose their HIV status. In the view of these interviewees, CTC workers should be doing counseling in a room which is very well ventilated with enough space at least one counselor and one client to maintain confidentiality.

In the view of these interviewees, CTC workers should be polite with the skills on the how to facilitate the partner to disclose HIV status to their partners also the CTC workers should treat clients information private and confidential. Failure to do this, partners will not come to the clinic with their partners so as they will not disclose their status.

On the other view, the interviewees observed that difficult working environment is due to the reason that, HCPs are not well motivated (especially financial incentives), no trainings, and no seminars). Interviewees observed that these reasons may contribute to difficult working environment, at the end of the day will end up with poor working environment, which is somehow frustrating to both the health care providers and the clients. In addition the personnel

available are poorly trained, hence, lack skills to encourage disclosing behavior change among their clients. As a result, some counselors complained of burnout or having more activities to do that cost them more time and energy than expected. Interviewees suggested that it is better to have on the job trainings and seminars which at least make them provide quality care and have an up to date knowledge. These are some of the incentives which will motivate them to work hard so as to encourage disclosing behavior change among their clients.

Other interviewees observed that there is no confidentiality at their CTC. HCPs (Counselors) interviewed suggested that planned CTC center should have both the entry and exit doors so as to reduce the fear of being identified by other clients. So they suggested that New Out Patient Department should be only for HIV clients only, this can encourage clients to come to the clinic without fear and hence encourage their partners to come to the clinic, hence encourage disclosing behaviours.

**Fund Availability**

Interviewees were asked to identify sources of funds to operate their CTC. Every HCP stated different source of funds, the majority stated that fund availability is from MNH, MDH and other sponsors. In their views, MNH is the major source of funds to operate the CTC, though others said the source of funds is from MDH. However, there was one HCP who said that she don't know the source of funds for the CTC MNH. Also, there were contradictions on this point because the CTC administrator stated that the source of funds for the CTC is from PEPFAR, EGPAF, MDH, MNH and ABBOT. This means that there is no involvement at the CTC MNH because the HCPs they do not know much on the source of funds apart from those sources known with the administrator. Also, HCPs are very discouraged not being involved in everything, at their views they are like labors for just doing work but no recognition.

In addition to these sources, interviewees stated that another source of funds for the CTC is from Ministry Of Health and Social Welfare (MOHSW). In the view of this study, it is important to have regular meetings for the HCPs with their administrators so that they can

discuss their issues specifically on the issues of CTC, on how to improve the current CTC and the important of them to be involved in the planning processes so as they can even know the sources of funds for the CTC and time disbursement.

Interviewees were asked the comments/ suggestions on fund availability for the CTC .There were different suggestions as the majority of workers suggested that the Government should give enough funds and supplies for the clinic in order to enable the HCPs to have enough equipment which can make their working environment conducive. In their view, the Government is the one which is supposed to give funds for their CTC.

**User participation in the CTC planning process**

Interviewees were asked on how they were involved in the strategic planning processes of the CTC MNH, the majority stated that there is no any involvement. There are some interviewees who stated that they are not involved in anything concerning their CTC, even the patients are not involved. In their views, involvement of all stakeholders is very important for better outcomes.

**Personnel Availability**

Interviewees were asked on the availability of personnel at the CTC MNH. Majority of the HCPs interviewed stated the number of HCPs is inadequate compared to the number of clients attended per day. In their views the number of workers is not adequate, because they are very busy, there were only five counselors at the CTC, and the numbers of clients attended per day were ranged from 150-200 per day. This meant that one counselor provides care for more than forty clients per day, which is somehow frustrating to both the health care providers and the clients. The personnel available are overworked and hence, lack of working morale which will end up with lack of skills of disclosing behavior change among their clients. In addition to this, interviewees stated that due to shortage of personnel, they are supposed to counsel clients in a very short period especially for those who come for refill of ARVs.

This suggests that there should be adequate personel in order to enable these HCPs to provide quality care to their clients, hence reduce heavy work load and frustrations; which exists at the CTC. Increased work morale among workers can facilitate HCPs to encourge disclosing behavior to their clients.

**Suggestion on how to facilitate partners to disclose**

From this study the respondents were also asked about their suggestions on how they can facilitate their partners to disclose HIV status. They came up with different suggestions such as health education and counseling can help facilitate disclosing ones status. There is evidence that counseling can help increase the frequency of disclosure among sexual partners. A study of 255 men done in Canada found that men who reported being counseled about disclosure at post-test and at their current HIV clinic, were more likely to have disclosed to sexual partners than men counseled only at post-test, only at the HIV clinic, or not counseled at either site.

In this study, results showed that disclosure rate was high this might be due to the fact that during on going counseling issues and doubts about benefits of disclosure is adequately addresed. The findings agrees with the other studies conducted in Burkina Faso, West Africa 2001 that showed that the rate of disclosure increased with number of times that a health professional discussed issues of disclosure at the HIV clinic where clients received care [22].

Another suggestion was that to be free and open to disclose HIV status to the partners can facilitate ones disclosing HIV status. This was supported with one study which showed that people who have witnessed a PHA publicly disclose their sero-status were more likely to disclose. Probably witnessing public openness about HIV may motivate PHAs to disclose their status. [23].

Another suggestion was to go to the clinic together with a partner to check for HIV status, this suggestion was answered by only 16 (8.9 %). This suggestion meant that going together with their partners and get counseling and testing together can facilitate or encourage them to disclose HIV status to their partners.

## CHAPTER SIX: CONCLUSIONS AND RECOMMENDATIONS

In this study, it was reported that there is poor leadership at the Muhimbili National Hospital suggesting lack of adequate funds to undertake its roles; has shortage of personnel, which leads to heavy workload and burnout; has poor working environment, which is somehow frustrating to both the health care providers and the clients and that the personnel available are poorly trained, hence lack skills to encourage disclosing behavior change among their clients.

Though from this study the majority disclosed HIV status to their sexual partners, this study calls for improvement of the existing CTC system by improving the working environment at MNH, so as to promote comprehensive counseling to clients attending the CTC.

### Waiting hours

- Waiting time was reported a problem. Clients were observed congested in the waiting area longing for the services. This suggests that we should improve the current CTC services by making the waiting time short and services need to be client friendly.

I recommend improving client flow by reducing the number of steps required especially for those follow up clients (who come for refill of ARVs), reducing time client have to wait between steps. They should have a different or separate entrance/exit and waiting area and spend less time at the center.

### Working environment

In this study, difficult working environment was reported to be a problem to HCPs. So it can be concluded that working environment should be improved by increasing counseling rooms at least one counselor in one room with one client. It should provide confidentiality as preferred by HCPs and the clients. Similarly, HCPs should be supported through seminars and on the job trainings. Training of workers is an important aspect for the development of better services and demand for the clients. Training should be on the job, or off- the job.

- I recommend continuous training for the CTC workers because they can determine how and when clients receives and even motivated to seek these services. Training should help counselors to provide quality care to the clients. In addition the management should inform staffs about important procedures and their responsibilities on the how to facilitate their clients to disclose HIV status to their partners.
- I recommended counseling rooms that are comfortable and well ventilated with enough space that will allow privacy and free discussions between the counselor and the client. It was observed at the current CTC that the rooms are not enough, as one room accommodate three counselor and three clients at a time.

**User participation in the CTC planning process**

It could be concluded that HCP and the clients as CTC stakeholders are not involved in the management of the clinic; a gap that needs to be addressed for better CTC results.

- I recommend that HCPs should be involved in CTC strategic planning, and also be promoted by attending different seminars, an job trainings, given an incentives (especially financial) so as to provide capability in motivating clients to disclose HIV status to their partners.

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# APPENDICES

## Appendix I - INFORMED CONSENT FORM

Good morning/afternoon

My name is .....

I am a student from Muhimbili University of Health and Allied Sciences. I am conducting a study on the organizational factors contributing to non disclosure of HIV status among partners attending at this clinic.

**Aim of the study**

The aim of this study is to establish organizational factors influencing non disclosure of HIV status among sexual partners.

**Participation**

We would like you to participate in this study by giving us your view and experience on this issue. The participation in this study will take you about twenty minutes to half an hour. If you accept to participate in this study you are requested to answer all questions and you are allowed to skip any question you feel uncomfortable with. Also, your participation in this study is voluntary, you may choose participating or not. However your participation in this study will be highly appreciated.

**Confidentiality**

We would like to assure you that the valued information you are going to give us will remain confidential and will be used for the research purpose only.

**Effects**

There is no unwanted effect which is expected to happen to the participants.

Do you agree to participate in this study? (Put a tick)

Yes..... No.....

I have been informed/read this instructions and understand.

I have agreed/ disagreed to participate in this study.

Participant's Signature.....

Researcher's signature..... Date.....

**Appendix II - IDHINI YA KUSHIRIKI KATIKA UTAFITI**

Habari za asubuhi/mchana

Mimi naitwa .....

Mwanafunzi wa Chuo Kikuu cha Tiba na Sayansi Shirikishi Muhimbili. Nafanya utafiti kuhusu sababu za kimuundo zinazoweza zikasababisha mtu asimwambie mwenza wake majibu kuhusu maambukizi ya virusi vya UKIMWI katika kituo cha tiba Muhimbili.

**Madhumuni ya utafiti**

Madhumuni ya utafiti huu ni kuzitambua sababu za kimuundo zinazoweza zikasababisha mtu asimwambie mwenza wake majibu kuhusu maambukizi ya virusi vya UKIMWI katika kituo cha tiba Muhimbili.

**Ushiriki**

Tungependa ushiriki katika utafiti huu ili tupate mawazo na uzoefu wako kuhusu jambo hili.

Ushiriki katika utafiti huu utakuchukua kama dakika ishirini mpaka therathini hivi. Kama unakubali kushiriki katika utafiti huu utaombwa kujibu maswali, na pia utaruhusiwa kuacha swali lolote ambalo hujisikii kujibu

**Utunzaji wa siri**

Tunapenda kukuhakikishia kwamba taarifa zote utakazotueleza zitabakia kuwa siri na ni kwa matumizi ya utafiti tu.

**Madhara ya utafiti**

Hakuna madhara yoyote yanayotegemewa kutokea kwa mshiriki kutokana na utafiti huu.

Je unakubali kushiriki katika utafiti huu (weka alama).

Ndiyo..... Hapana .....

Nimeelezwa/ nimesoma maelezo haya na kuelewa

Nimekubali/ sijakubali kushiriki katika utafiti huu.

Sahihi ya mshiriki.....

Sahihi ya mtafiti..... Tarehe.....

**Appendix III - INTERVIEW GUIDE FOR THE MNH ADMINISTRATORS**

**Part 1: Identification particulars of the interviewee and social demographic data**

Date of interview.....

Profession.....

Position.....

Age..... Sex: .....

Education.....

How long have you been in this position? Years..... Months.....

**Part II: Fund availability for Care and Treatment Clinic**

1.Can you tell me where do you get money for running Care and Treatment Clinic*?(probe on the sources of funds, current situation )*

2. How do you utilize money allocated at Care and Treatment Clinic? (*probe about adequacy of funds and how it is utilized).*

3.What are your comments on the availability of funds to support for the provision of quality and comprehensive care and treatement to PLHIV*?(probe on adequacy of funds and time disbursment).*

**Part III: User participation in the process.**

1.How do you involve your Health Care Providers(workers) in your planning activities of Care and Treatment Clinic?(*probe on participation of HCPs in the planning process).*

2.What methods/ways do you use to make sure that Health Care Providers and clients give their comments about services provided at care and treatment clinic?

3. What are your comments on the user participation in the planning processs concerning Care and Treatment Clinic?

**Part IV: Personnel**

1.How does the number of health care providers at CTC affect the provision of quality and comprehensive care and treatment particulary how to support the clients to disclose their HIV status *(probe on adequacy of personnel, skills and training and availability of guideline).*

2. Can you explain about the services provided at CTC compared to the number of clients attending at the clinic per day*?(probe on the work load/counsellor/client ratio)*

3.How are you suppose to make sure that you retain your health care workers in their work?(*probe on on job training,incentives,and working environment)*

**Part VI: Conclusion and the way forward**

1.What suggestions would you give to improve the provision of quality and comprehensive care and treatment to people living with HIV at Muhimbili National Hospital? *(probe: specific for disclosing)*

2.Is there anything else you would like to suggest regarding the provision of quality and comprehensive care and treatment to people living with HIV at Muhimbili National Hospital*?(probe: specific for disclosing)*

**Appendix IV - MWONGOZO WA USAILI KWA VIONGOZI CTC MNH.**

**Sehemu; I :Maelezo binafsi ya mshiriki.**

Tarehe ya usaili .....

Cheo .....

Nafasi ya kazi .....

Umri..... Jinsia .....

Kiwango cha elimu .....

Ni kwa muda gani umekuwa katika nafasi hii ya kazi? Miaka ..... Miezi .....

**Sehemu ya II:Upatikanaji wa fedha za kuendeshea klinik ya huduma na matibabu.**

1. Unaweza kunieleza wapi mnapata fedha za uendeshaji wa huduma katika klinik hii ya huduma na matibabu?*(probe on the sources of funds, current situation )*

2.Mnatumia vipi pesa zinazogawanywa katika klinik hii? (*probe about adequacy of funds and how it is utilized).*

3.Je ni nini mawazo yako kuhusiana na upatikanaji wa pesa kwa ajili ya kuwezesha utoaji wa huduma bora kwa wagonjwa walioathirika na VVU katika klinik hii*?(probe on adequacy of funds and time disbursment).*

**Sehemu ya III: Ushirikishwaji/ uhusishwaji wa watoa huduma katika mchakato wa kupanga shughuli za klinik.**

1 Je mnawahusisha vipi watoa huduma (Wafanyakazi) wenu katika kupanga shughuli za kliniki hii ya huduma na matibabu?(*probe on participation of HCPs in the planning process).*

2.Ni njia gani mnazotumia kihakikisha kwamba watoa huduma na wateja wanatoa mawazo yao katika klinik hii ya huduma na matibabu?

3.Je ni maoni gani kuhusu kuhusishwa katika mchakato wa mipango ya klinik hii ya huduma na matibabu.

**Sehemu IV: Watoa huduma /rasiliamali watu.**

1. Je ni kwa jinsi gani idadi ya watoa huduma katika klinik hii ya huduma na matibabu inaathiri utoaji wa huduma bora hususani kuwawezesha wateja kuwaeleza wenza wao

majibu ya VVU? *(probe on adequacy of personnel, skills and training and availability of guideline).*

2.Unaweza kuelezaje kuhusu huduma zinazotolewa katika klinik hii ukilinganisha na idadi ya wateja wanaohudhuria katika klinik hii kwa siku? *(probe on the work load/counsellor/client ratio)*

3.Ni jinsi gani mnafanya ili kuhakikiksha kuwa watoa huduma wanabaki /wanadumu katika sehemu zao za kazi? (*probe on job training,incentives,and working environment)*

**Sehemu ya V: Conclusion and the way forward**

1.Je ni maoni/mapendekezo gani ungependa kutoa ili kuwezesha utoaji wa huduma bora kwa wagonjwa walioathirika na VV katika hospitali ya Taifa Muhumbili?. *(probe: specific for disclosing)*

2.Je kuna jambo jingine lolote ungeweza kupendekeza kuhusiana na utoaji wa huduma bora katika klinik hii ya huduma na matibabu kwa wagonjwa wanaoishi na VVU katika hospitali ya Taifa Muhimbili*?.(probe: specific for disclosing)*

**Appendix V - INTERVIEW GUIDE FOR THE HEALTH CARE PROVIDER.**

**Part 1: Identification particulars of the interviewee and social demographic data**

Date of interview.....

Profession.....

Position.....

Education.....

Age..... Sex: .....

How long have you been in this position? Years..... Months.....

**Part 11: Fund availability for Care and Treatment Clinic**

1.Can you tell me about the availability of funds for running Care and Treatment Clinic?(*probe on the sources of funds, current situation )*

2.Can you explain about the availability and adequacy of equipments and supplies for running care and reatment clinic? *(probe on availability of supplies, equipments and how do they utilize them)*

3.What is your comments on the availability of funds to support for the provision of quality and comprehensive care and treatement to PLHIV*?(probe on adequacy of funds and time disbursment).*

**Part 111: User participation in the process.**

1.Can you tell me about the involvement Health Care Providers (workers) in the planning activities of Care and Treatment Clinic*?(probe on the importance of her/him to be involved in the planning process)*

2. How do you make sure that your comments/views reach to your administrators to solve your problems at your clinic and services provided to the clients.(*probe on the participation in the meetings or any planning process).*

3.What are your comments on the user participation in the processs concerning planning activities of Care and Treatment Clinic?

**Part IV: Personell.**

1.How does the number of health care providers at CTC affect the provision of quality and comprehensive care and treatment particulary how to support the clients to disclose their HIV status (*probe on adequacy of personnel, skills and training).*

2. Can you explain about the services provided at CTC compared to the number of clients attending at the clinic per day*?(probe on the working environment, privacy and confidentiality to clients and incentives ).*

**Part V: Conclusion and the way forward**

1.What suggestions would you give to improve the provision of quality and comprehensive care and treatment to people living with HIV at Muhimbili National Hospital*?(Probe on disclosing*)

2. Is there anything else you would like to add regarding the provision of quality and comprehensive care and treatment to people living with HIV at Muhimbili National Hospital? (*Probe on disclosing)*

**Appendix VI - MWONGOZO WA USAILI KWA WATOA HUDUMA WA AFYA/ WANASIHI.**

**Part 1: Maelezo binafsi ya mshiriki.**

Tarehe ya usaili.....

Cheo.....

Nafasi ya kazi.....

Kiwango cha elimu.....

Umri..... Umri .....

Ni kwa muda gani umekuwa katika nafasi hii ya kazi? Miaka ..... Miezi .....

**Sehemu ya II:Upatikanaji wa fedha za kuendesha klinik ya huduma na matibabu.**

1.Unaweza ukanieleza kuhusu upatikanaji wa fedha za uendeshaji wa klinik hii ya huduma na matibabu? (*probe on the sources of funds, current situation )*

2.Je unaweza ukanieleza kuhusu upatikanaji na uwepo wa vifaa kwa ajili ya uendeshaji wa huduma katika klinik hii? *(probe on availability of supplies, equipments and how do they utilize them)*

3.Nini maoni yako kuhusu upatikanaji wa fedha za uendeshaji ili kuwezesha utoaji wa huduma bora katika klinik hii kwa wateja walioathirika na VVU*?.(probe on adequacy of funds and time disbursment).*

**Sehemu ya III:Ushirikishwaji wa watoa huduma katika mchakato wa mpango kazi katika klinik.**

1.Unaweza kunieleza kuhusu ushirikishwaji wa watoa huduma(wafanyakazi) katika mchakato wa mpango kazi katika klinik hii? *(probe on the importance of her/him to be involved in the planning process)*

2.Ni jinsi gani unahakikisha kuwa maoni/mawazo yako yanafika kwa viongozi wako ili kutatua matatizo katika klinik yako na huduma zitolewazo kwa wateja?(*probe on the participation in the meetings or any planning process)*

3.Ni nini maoni yako kuhusu ushirikishwaji katika mchakato wa mpango kazi wa klinik ya huduma na matibabu?

**Part IV: Watoa huduma /Rasiliamali watu.**

1.Ni jinsi gani idadi/namba ya watoa huduma katika klinik hii inaathiri utoaji wa huduma bora hususani jinsi ya kuwawezesha wateja kuwaeleza wenza wao majibu ya VVU? (*probe on adequacy of personnel, skills and training).*

2.Unaweza kunieleza kuhusu huduma zinazotolewa katika klinik hii ukilinganisha na idadi ya wateja wanaohudhuria katika klinik hii kwa siku *(probe on the working environment, privacy and confidentiality to clients and incentives ).*

**Part V: Conclusion and the way forward**

1.Je una maoni/mapendekezo gani ungependa kutoa kuwezesha utoaji wa huduma bora na matibabu kwa watu wanaoishi na virusi vya ukimwi katika hospitali ya Taifa Muhimbili*?.(Probe on disclosing*)

2.Je kuna jambo jingine lolote ungeweza kuongezea kuhusiana na utoaji wa huduma bora katika klinik hii ya huduma na matibabu kwa wagonjwa wanaoishi na VVU katika hospitali ya Taifa Muhimbili*?.(probe: specific for disclosing)*

**Appendix VII**

**ORGANIZATIONAL FACTORS INFLUENCING NON DISCLOSURE OF HIV STATUS AMONG SEXUAL PARTNERS ATTENDING CARE AND TREATMENT CLINIC AT MUHIMBILI NATIONAL HOSPITAL IN DAR ES SALAAM, TANZANIA.**

**QUESTIONNAIRE FOR CLIENTS**

Date of interview.....

In the following questions, please fill the number of selected item in the space provided.

1. What is your age.....

2. Sex.....

3. For how long have you been attending in the care and treatment clinic?

   1.One month-six months

   2.Seven months- one year

   3.Two years -three years

   4.Four years-five years

   5.Six years and above5.

4. Are you aware of services provided at Care and Treatement Clinic?

   1. Yes

   2. No

5. If yes, mention the services provided at this clinic.

   1.....

   2.....

   3.....

   4.....

   5.....

6. How would you rate the services provided at care and treatment clinic?

   1.Very good

   2.Good

   3.Average

   4.Poor

7. Your choice means.....

8. Have you ever heard about the importance of disclosing HIV status to your partner?

1. Yes
2. No

9. If yes, where have you get this information?

1. Doctor
2 .Counsellor
3. Nurse In Patient Department
4. Nurse Out Patient Department
5. Other specify.....

10.For how long did it take you to get services at this clinic from the time of entering the clinic to the time of exit?

1.One –two hours
2.Three hours –four hours
3.Five hours –six hours
4.Seven hours –eight hours
5.Eight hours and above.

11.How can you rate the waiting time you spend at this clinic?

1. Short time
2.Average
3.Long time
4.I don't know

12. Do you have any opportunity to express your concerns to the Health Care Providers

1. Yes
2. No

13. If Yes, how.....

If no explain.....

14. What would you think to be improved?.....

15. Is the clinic environment enabling you to be free to express your problems?

1.Yes
2.No

16. If Yes how.....

If no explain.....

17.What methods do you use to explain your views/comments about the services provided at this clinic?

1.Suggestion box

2.Letter

3.Media

4.Telephone

5. Nothing i can do

18. If number 5 above, What do you think should be put in place to capture your opinions?.....

19. Do you think giving your comments/ views about the services provided at this clinic will help to improve the services?

1.Yes

2.No

20. (a) If yes, explain.....

(b) If no, why.....

21. Have you ever disclosed your status to your partner?

1. Yes

2. No

22. Do you have any suggestion on what should be in place to facilitate you and other clients to disclosing?.....

**Appendix VIII**

**SABABU ZA KIMUUNDO ZINAZOSABABISHA MTU ASIMWAMBIE MWENZA WAKE HUHUSU MAAMBUKIZI YA VIRUSI VYA UKIMWI KATIKA KITUO CHA TIBA MUHIMBILI.**

**DODOSO KWA WAGONJWA.**

Tarehe ya usaili.....

Weka alama katika kisanduku kwa jibu ulilochagua upande wa kulia.

1.Umri wako.....

2.Jinsia

1. Kike
2. Kiume

3. Ni muda gani umehudhuria katika hii klinik?

1. Mwezi mmoja –Miezi sita.
2 .Miezi saba –Mwaka mmoja
3. Miaka miwili –Miaka mitatu
4. Miaka minne- Miaka mitano
5. Miaka sita na kuendelea.

4. Je, unajua ni huduma gani zinazotolewa katika klinik hii?

1. Ndiyo
2. Hapana

5. Kama ndiyo,ni huduma gani? Taja unazozijua.

1. .....
2. .....
3. .....
4.....
5.....

6. Unazionaje huduma zinazotolewa katika klinik hii?

1. Nzuri sana
2. Nzuri
3. Wastani
4. Mbaya

7. Chaguo lako namba sita (6) maana yake nini?.....

8. Je, umeshawahi kusikia kuhusu umuhimu wa kumshirikisha mwenza wako kuhusu maambukizi ya virusi vya ukimwi?

1. Ndiyo
2. Hapana

9. Kama ndiyo, ni wapi ulielezwa hizi taarifa?

1.Daktari
2. Mshauri
3. Muuguzi Wodini
4. Muuguzi Kliniki ya magonjwa ya nje

10. Je ni kwa muda gani unasubiri huduma kutoka muda uliofika kliniki mpaka muda wa kuondoka katika klinik hii?

1. Saa moja mpaka masaa mawili.
2. Masaa matatu mpaka masaa manne
3. Masaa matano mpaka masaa sita
4. Masaa saba mpaka masaa nane
5. Masaa nane na kuendelea.

11. Je unawezaje kuzungumzia kuhusu muda unaosubiri kupata huduma katika hii klinik?

1.Muda ni mfupi
2.Kawaida
3.Muda ni mrefu
4.Sifahamu

12.Je una nafasi yoyote ya kuweza kutoa maoni yako kwa watoa huduma katika klinik hii ?

1. Ndiyo
2. Hapana

13.(a) Kama ndiyo eleza ni kwa jinsi gani.....

(b) Kama hapana eleza.....

14.Unafikiri kifanyike nini ili kuboresha?.....

15. Je unafikiri mazingira ya kutolea huduma katika klinik hii yanakuwezesha wewe kuwa huru kujieleza matatizo yako?

1. Ndiyo
2. Hapana

16.(a) Kama ndiyo eleza.....

(b) Kama hapana eleza.....

17. Je ni njia gani zinazokuwezesha wewe kutoa maoni yako kuhusu huduma zinazotolewa katika klinik hii?

1.Sanduku la maoni
2.Barua
3.Vyombo vya habari
4.Simu
5.Sina cha kufanya

18.Kama umechagua namba tano (5), unadhani kitu gani kifanyike ili kukuwezesha wewe kutoa maoni yako?.....

19. Je unafikiri kutoa maoni yako kuhusu huduma zinazotolewa katika klinik hii kunaweza kuboresha huduma?

1. Ndiyo
2. Hapana

20. (a) Kama ndiyo eleza.....

(b) Kama hapana eleza.....

21.Je umeshawahi kumueleza mwenza wako kuhusu maambukizi ya virusi vya ukimwi?

1. Ndiyo
2. Hapana

22. Je una maoni gani kuhusu kitu gani kifanyike ili kuwezesha wewe na wagonjwa wengine waweze kuwashirikisha wenza wao kuhusu maambukizi ya virusi vya ukimwi?.....