KING CEASOR UNIVERSITY

IMPLICATIONS OF SERO-STATUS DISCLOSURE AMONG SEXUAL PARTNERS IN UGANDA.

A SITUATIONAL ANALYSIS OF CLIENTS REPORTING FOR HIV COUNSELING AND TESTING AT MULAGO NATIONAL REFERRAL HOSPITAL

BY

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FEBRUARY 2024

DECLARATION

I, **Naluwooza Esther**, declare to the best of my knowledge that this is my original work and has never been submitted to any other institution for any academic award or grant and is being submitted with the approval of my supervisor;

Signature.....Date.....

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APPROVAL

Name of student: Naluwooza Esther

Title: Implications of sero-status disclosure among sexual partners in Uganda. A situational analysis of clients reporting for HIV counseling and testing at Mulago National Referral Hospital.

I hereby accept this research report for the above research study/ project and approve it for submission to King Ceasor University Bunga (St. Augustine).

Supervisor's approval

Signature: ……. Date: ……

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DEDICATION

All my dedication is to God. I thank Him for His care and provision all my life and during this entire research period. May all the glory and honour return to Him.

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DEFINITION OF TERMS

AIDS: The diagnosis for a group of related symptoms and conditions, caused by HIV infection that destroys the immune system.

Disclosure: This is the act of making new or secret information known to another person. In this case, it is sharing the results of HIV test with the sexual partner.

HIV: A virus that attacks the immune system and can therefore destroy the body's ability to fight off infection. It can lead to life-threatening illnesses called opportunistic infections, and ultimately to death.

HIV Serostatus: The status of a person's blood whether or not he has anti-bodies against HIV.

Persons living with HIV/AIDS (PLWHA): Persons who have tested positive for HIV, are diagnosed with AIDS, and are still alive. They include every living person who has ever received an AIDS diagnosis regardless of their current state of health.

Sexual partner: Consensual sexual relations, is generally a person with whom an individual is engaging in a sexual activity.

LIST OF ABBREVIATION

AIDS	Acquired Immunodeficiency Syndrome
ART	Anti-Retroviral Therapy
HIV	Human Immunodeficiency Virus
HIVDR	HIV Reinfections and HIV Drug Resistance
PLWHA	People Living with HIV/AIDS
SPSS	Statistical Package for Social Sciences
UNAIDS	Joint United Nations Programme on HIV/AIDS
WHO	World Health Organization

ABSTRACT

Voluntary HIV disclosure among sexual partners has both advantages and disadvantages. The advantages include helping people with HIV to ask for and receive social support, have safer sex, and assistance to access HIV treatment among sexual partners while disadvantages are such as being blamed, discriminated against, depressed, divorced, and verbally abused after a voluntary disclosure. This study assessed the implication of serostatus disclosure among sexual partners at the HIV counseling and testing center at Mulago National Referral Hospital in Uganda. This was a cross-sectional and descriptive study, involving 157 adult PLWHA, selected using a non-probability convenience sampling method and questionnaires to collect data, which was analyzed using Statistical Package for Social Scientists (SPSS). Data was presented in frequency tables, pie charts, and graphs with explanatory remarks. The study revealed that 98(62.4%) of the respondents disclosed their HIV-positive serostatus to their sexual partners. Sixty respondents (61.2), 50(51%), 26(26.5), and 18(18.3%) of those who disclosed their HIV status with sexual partners reported having depression, being blamed/beaten, divorced, and being stigmatized respectively. On the other hand, 19(19.3%), 11(11.2%), and 8(8.1%) received social support from their partners, their partners were tested after their disclosure and discussed safer sex with their sexual partner after disclosure respectively. The findings suggest that PLWHA have varying experiences, ranging from depression, being blamed/beaten, desertion or separation, and stigma to support, safer sex, and partner testing, with the majority suffering negative experiences. Therefore, there is a need to develop programs for counseling PLWHA on the management of negative experiences, living positively, self-disclosure, and prevention of re-infection with HIV.

Key Words: Sero-Status; Disclosure; HIV

CHAPTER ONE: INTRODUCTION

1.0 Introduction

This research dissertation is about a study on "Implications of sero-status disclosure among sexual partners in Uganda. A situational analysis of clients reporting for HIV counseling and testing at Mulago National Referral Hospital". It was proposed because along with the benefits, HIV sero-status disclosure to sexual partners has a number of potential risks for the individual including loss of economic support, blame, abandonment, physical and emotional abuse, discrimination, and disruption of family relationships.

This chapter covers the following areas; the background of the study, problem statement, purpose of the study, objectives of the study, research questions, significance and scope of the study.

1.1 Background to the Study

Human Immunodeficiency Virus (HIV)-positive self-sero-status disclosure is the process and autonomous decision by which an HIV-positive person voluntarily informs another person (be it a sexual partner, family member(s), or friend) of his or her HIV status (Gabbidon et al., 2020; Melis et al., 2020). World Health Organization [WHO] (2016) observed notes that a person can choose to disclose his or her HIV status to a family, a group of people, or media (full-disclosure) or to a friend or relative, or health worker (partial disclosure) chooses not to reveal his or her status to anyone (non-disclosure).

HIV serostatus to the sexual partner is considered to be one of the important public health interventions in HIV prevention and care (Gabbidon et al., 2020). Despite the practical and psychological complexities involved (like stigma) in HIV serostatus disclosure to a sexual partner, several benefits of HIV self-disclosure include a reduction in HIV transmission,

decreased feelings of isolation, increased access to social support, and improved outcomes from anti-retroviral therapy (ART) (Steinert et al., 2017; UNAIDS, 2020).

Similarly, HIV- positive serostatus disclosure has been identified as one of the effective measures that have the potential of reducing risky sexual behaviors, especially among those that are sexually active (whether concordant HIV positive or discordant) (The Uganda Ministry of Health, 2019). Melis Berhe et al. (2020) noted that HIV-positive serostatus disclosure provides an opportunity to discuss condom use and other contraceptives that would reduce further HIV transmission and enables them to make informed reproductive health choices with all its benefits. It is against this background that even UNAIDS and WHO supports HIV serostatus disclosure to sexual partner as a key HIV prevention intervention so long as it is free from criminalization (UNAIDS, 2020; Sanga et al., 2021). Along with these benefits, however, HIV status disclosure to sexual partners has a number of potential risks for the individual including loss of economic support, blame, abandonment, physical and emotional abuse, discrimination, and disruption of family relationships (Shifraew et al., 2019).

Health workers are not only required to encourage HIV-positive serostatus disclosure to the sexual partner right from when the sexually active person tests HIV positive, but also, should encourage those being enrolled to disclose their HIV serostatus to their sexual partners (Gabbidon et al., 2020). Even those who failed to disclose after receiving HIV testing services or before being on ART, should be continuously supported by health workers for HIV-positive serostatus disclosure to their partners (Gabbidon et al., 2020; UNAIDS, 2021).

Despite the documented evidence on the benefits of HIV-positive serostatus disclosure among sexually active partners, it is reported that the magnitude of HIV-positive serostatus disclosure in

low-and middle-income countries, is generally lower (about 50%) compared to the developed world with about (79%) (Damian et al., 2019; Gabbidon et al., 2020).

Relatedly, it is reported that Uganda has low rates of HIV-positive serostatus disclosure among sexually active people (Kavuma et al., 2022). This poses a threat to HIV prevention, care, and treatment efforts since it is not only likely to affect the ART treatment outcomes but could also increase HIV reinfections and HIV drug resistance (HIVDR) whose rate is increasing in Uganda and other Sub-Saharan African countries with HIV burden (Asio et al., 2020; Kavuma et al., 2022).

Much as there is a handful of studies done in some Sub-Saharan African countries about the HIV-positive serostatus disclosure among people on ART, those done specifically on the implications of sero-status disclosure among sexual partners are hardly available in Uganda. Probably, this would help to address the paucity of literature on HIV serostatus disclosure to sexual partners among people on ART in Uganda and beyond.

This study aimed at understanding the implications of serostatus disclosure among sexual partners among clients reporting for HIV counseling and testing center at Mulago National Referral Hospital, Uganda.

1.2 Problem Statement

HIV sero-positive disclosure to sexual partners has been remarkably advocated for owing to its significant influence (Dessalegn et al., 2019). Disclosure may motivate sexual partners to seek testing, change behaviour and ultimately decrease transmission of HIV (Yee et al., 2018). In addition, disclosure has a number of potential benefits for the individual including increased opportunities for social support, improved access to necessary medical care including antiretroviral treatment, increased opportunities to discuss and implement HIV risk reduction with partners, and increased opportunities to plan for the future (Yee et al., 2018).

Inspite of the benefits of disclosure, the process always presents with a myriad of consequences among people living with HIV/AIDS (PLWHA). As such, it is a conduit for stigma, identity transformation, social discrimination, psychological distress, loss of relationships and marriages (Yee et al., 2018). In fact low disclosure rates have been reported across studies as a result of the persisting HIV-positive serostatus partner disclosure negative experiences (Kavuma et al., 2022). Consequently, disclosure becomes a stressful process.

Attempts have been made in Uganda to foster disclosure due to its potential benefits but along with these benefits, HIV status disclosure to sexual partners has a number of potential risks for the individual. However, evidence is lacking in the context of the implications of HIV-positive serostatus disclosure among sexual partners with respect to studies conducted in Uganda. This leaves a knowledge gap and it was the researcher's intention to conduct this study to address this identified gap in the literature.

1.3 Purpose of the Study

The purpose of the study was to assess the implication of sero-status disclosure among sexual partners at HIV counseling and testing center at Mulago National Referral Hospital in Uganda.

1.4 Specific Objectives

i. To assess the willingness of HIV positive individuals towards disclosing their serostatus to their sexual partners at HIV counseling and testing center at Mulago National Referral Hospital, Kampala District.
ii. To determine the implication of serostatus disclosure among sexual partners at HIV counseling and testing center at Mulago National Referral Hospital, Kampala District.

1.5 Research Questions

i. What is the willingness of HIV positive individuals towards disclosing their serostatus to their sexual partners at HIV counseling and testing center at Mulago National Referral Hospital, Kampala District?
ii. What are the implications of serostatus disclosure among sexual partners at HIV counseling and testing center at Mulago National Referral Hospital, Kampala District?

1.6 Justification of the Study

Voluntary, self-disclosure among sexual partners is crucial and has various advantageous effects. Voluntary disclosures helps people living with HIV to ask for and receive crucial social support, have safer sex and obtain assistance to access HIV treatment among sexual partners. Despite positive outcomes, HIV disclosure is also associated with several negative outcomes. Recently, studies have shown a slight increase in the magnitude of negative outcomes of HIV disclosure, which can explain why there has been a decline in HIV disclosure in some areas. These negative outcomes have been highly limiting voluntary HIV disclosure among sexual partners. There is a

knowledge gap regarding the trend in the implication of HIV disclosure in hyper-endemic areas with high HIV prevalence including Uganda. A literature review did not identify any studies examining the implication of serostatus disclosure among sexual partners in Uganda. This study was aimed at assessing the implication of sero-status disclosure among sexual partners at HIV counseling and testing center at Mulago National Referral Hospital in Uganda.

1.7 Significance of the Study

Findings would assist with the creation of future health education programs aimed at creating safe environment to disclose HIV status, which may reduce the community risk of contracting the virus.

The findings of this study would help to understand ways in which the community may facilitate safe self-disclosure of HIV infection to sexual partners and how to act as critical enablers to bring about positive social change.

The awareness of the negative outcomes of the disclosure would assist policymakers to develop or adapt intervention-based solutions that can increase the disclosure rate among sexual partners.

The findings of this study would inform the practices of healthcare providers, policy makers and research agendas, in the context of HIV prevention, care and treatment interventions among sexually active people on ART.

The study also provide a valuable point of reference for researchers carrying out similar studies in future and also contribute to the available body of literature on the implication of HIV-serostatus disclosure among sexual partners. Also the study served as a partial fulfillment for the award of Bachelor's Degree in Nursing Science.

1.8 Scope of the Study

1.8.1 Subject Scope

The study aimed at investigating the implication of HIV-positive serostatus disclosure among sexual partners.

1.8.2 Geographical Scope

The study was conducted at Mulago National Referral Hospital located in Hospital Zone Village, in Mulago I Parish, Kawempe Division Sub County, in Kampala District, Uganda.

1.8.3 Time Scope

This research process took 8 months, starting from August 2023 – March 2024 and during this time, a proposal was written and approved, data was collected, analyzed, presented, interpreted and a report was written.

CHAPTER TWO: LITERATURE REVIEW

2.1 Introduction

This chapter describes the literature review cited by other scholars about implication of HIV-positive serostatus disclosure among sexual partners. The literature is presented according to the objectives of the study.

2.2 HIV Positive Sero-status Disclosure Among Sexual Partners

Peng et al. (2022) carried out a systematic review and meta-analysis on the proportion of HIV disclosure to sexual partners among people diagnosed with HIV in China and results showed that the pooled proportion of HIV disclosure to sexual partners was 65%. Sub-group analyses indicated the proportions of HIV disclosure to regular, casual and unclassified sexual partners were 63%, 20%, and 66% respectively. Fifty-seven percent disclosed on the day of diagnosis, 62% disclosed within 1 month, and 39% disclosed 1 month later.

In a systematic review carried out by Adeoyo-Agboola et al. (2018) on HIV disclosure among PLWHA in Nigeria, findings indicated that the included studies reported disclosure rates ranging from 39.5% to 97.5%: 50.9% disclosure rate among sexual partners; 39.5% among adults patients; 88% women attending antenatal clinic; 96.7% pregnant women; 89% nursing mothers; 91.4% nursing mothers; 97.5% adult patients; 75.6% sexual partners; 61.5% among adult patients.

In another study conducted by Pashaei et al. (2021) on HIV serostatus disclosure to sexual partner: a survey among women in Tehran, Iran revealed that most of them had disclosed their HIV status to at least one person (94.1%) and their sexual partners (86.5%). In the univariate analysis, being married, living with a sexual partner, being aware of sexual partners' HIV status,

and gaining the support of sexual partner were associated with higher odds of HIV status disclosure. In the multivariate analysis, being aware of sexual partners' HIV status, and gaining the support of sexual partners remained associated with HIV status disclosure. Among the 23 individuals who did not disclose to their sexual partners, the main reason for non-disclosure was the fear of abandonment (82.6%). It was closely tied to the fear of confidentiality and trust in sexual partners (48%). Moreover, they prefer to keep their status secret because they do not have trust in their partners in keeping it confidential and about two-thirds of them (28%) cited shame and the fear of stigma and discrimination as other important reasons. Three of the non-disclosed women had intended to disclose seropositive status at least once but later changed their minds.

In a related study done by Nordberg et al. (2020) to assess the social concerns related to HIV status disclosure and participation in the prevention of mother-to-child transmission of HIV care among pregnant women in Kenya showed that isolation or lack of support from family or friends, fear of separation, and fear of conflict with a partner were the concerns of women which led to non-disclosure of their status to their sexual partners.

Ambissa et al. (2021) in their study on HIV-positive status disclosure to a sexual partner and associated factors among HIV-positive pregnant women attending antenatal care in Dire Dawa, Ethiopia found out that (86.5%) of HIV-positive pregnant women disclosed their HIV status to their sexual partner. Regarding the time of disclosure, (51.9%) disclosed within the 1st month of diagnosis. Nearly half (48.1%) of the mothers had sex with a partner before disclosure, among those 48 (30%) of them used condoms.

According to Gabagambi (2023) in the study on disclosure of HIV status to sexual partners among people with HIV in Singida Regional Referral Hospital of Tanzania revealed that more

than three-quarters (78%) of the respondents had voluntarily disclosed their HIV status to a sexual partner. Adjusted multivariable logistic revealed that HIV status disclosure to sexual partners was significantly associated with living with a sexual partner, knowledge of HIV disclosure, known serostatus of the sexual partner and HIV disclosure related stigma. About 69% of the study respondents reported having risky sexual practices before disclosure to their sexual partners. One hundred and seventy-eight respondents (60.3%) disclosed their status within one month of diagnosis, (27.8%) between one to six months, and (11.9%) disclosed after six months of knowing their HIV status. Fear of divorce was a leading reason given by (30.1%) of the respondents who had not disclosed their status. Four respondents (16%) who reported fear of divorce as the reason not to voluntary disclose were males.

Ogbozor. (2018) in their study on HIV-positive status disclosure barriers in stable heterosexual partners in Warri, Nigeria revealed that in less than 6 months since HIV diagnosis, (28.2%) respondents had disclosed their status to their partners. Other respondents who had made the disclosure were represented by 13.9% (7-12 months); 20.8% (1-2 years; and 37.1% (> 2 years), respectively.

In a related study conducted by Kavuma et al. (2022) on the factors associated with HIV positive serostatus disclosure to sexual partners among sexually active young people on anti-retroviral therapy in Central Uganda, almost half (48.7%) of the respondents had two-way disclosure where each partner had disclosed their HIV serostatus to their sexual partner while 24.4% of the study respondents had one-way disclosure where the study respondents knew their partners' status and their partners did not know. For the study respondents who had not disclosed to one another were 26.9%. Three themes emerged from the analysis of qualitative data for

respondents' non-disclosure partners, which include: fear of being stigmatized; desire to continue accessing basic needs (poverty); and preventing causing trauma to sexual partners.

Kakumba (2018) in the study done on the factors influencing disclosure of HIV sero-status among women attending ART clinic at Nabweru Health Center III, Wakiso District, the findings showed that out of the 100 respondents who completed the survey, the prevalence of disclosure was 76% while as non-disclosure was estimated at 24%.

According to Batte et al. (2016) in a population-based cross-sectional survey among slum dwellers in Kampala Uganda on disclosure of HIV test results by women to their partners following antenatal HIV testing revealed that overall 83.8% of the women reported that they had disclosed their HIV status to their sexual partners. Disclosure was significantly higher among women whose partners had also tested for HIV. Other factors that were associated with disclosure were secondary education or above, having attended 3 or more antenatal care visits, being married/cohabiting and whether or not they would opt not to disclose a family member's HIV status.

2.3 Implication of HIV-Positive Sero-status Disclosure Among Sexual Partners

Pashaei et al. (2021) in their study conducted on HIV serostatus disclosure to sexual partner: a survey among women in Tehran, Iran in which one hundred and seventy HIV-positive women were enrolled revealed that the majority of women who disclosed to their sexual partner(s) reported positive reflections from their sexual partners (82%), that is, they confirmed that their partners were supportive and understanding and did not show violence or bad behavior. About one in four women (25%) stated that disclosure encouraged sexual partners to take HIV tests though a smaller proportion (9.3%) had experienced divorce or separation after disclosure and 14

of them (8.7%) were abandoned by their sexual partners. In those who disclosed to at least one person (including sexual partner or anyone else), more than half (51.8%) declared that they experienced stigmatization and discrimination after the disclosure. Similarly, some of them experienced negative reflections from the society (29.3%) and ignorance by the community (18.1%). Despite this, more than one-third of them (41.2%) reported that they received support from their families.

In a related study conducted by Nordberg et al. (2019) about social concerns related to HIV status disclosure and participation in the prevention of mother-to-child transmission of HIV care among pregnant women in Kenya, the findings revealed that some women reported negative reactions including divorce/separation, abandonment, stigma, and discrimination from their partners.

According to Delile (2018) in the study conducted on self-disclosure of Human Immunodeficiency Virus status in personal relationships among South Africans living with Human Immunodeficiency Virus, the response of sexual partners to disclosure varied widely; some were motivated to get tested and use condoms, decline and respond only with anger, blame, even abandonment; and (e) after accessing medical care, most PLWHIV reported support and appearing less sick, which reduces social stigma.

A cross-sectional study by Yonah et al. (2018) in Mwanza, Tanzania aimed to provide information on self-disclosure of HIV status in PLWHA to sexual partners and their experiences when they disclosed. Those who disclosed their status reported closeness to that person, emotional support after disclosure, and being discriminated against.

In another study done by Obionu et al. (2021) on human immunodeficiency virus status disclosure among people living with HIV virus receiving care in Enugu, Nigeria showed that some had partners decline further sexual intercourse after disclosure of their HIV status. Some agreed to use condoms during sexual intercourse after disclosing their HIV status. One respondent's disclosure of HIV status caused her sexual partner's disappearance.

Taylor et al. (2020) in their study on patterns and predictors of HIV status disclosure in the 12 months after diagnosis in Mozambique, most respondents felt freed when they disclosed their HIV status. Reduced stress was felt by some respondents choosing to disclose. Respondents felt reassured and relieved that they expressed their feelings and got the feedback from their sexual partners. Even though some outcomes were contrary, they were able to deal with the issue.

Gabagambi (2023) in the study on disclosure of HIV status to sexual partners among people with HIV in Singida Regional Referral Hospital of Tanzania, revealed that 90% of the respondents' sexual partners tested for HIV after disclosure. Majority (70%, 90% and 87%) of those who disclosed their status reported having received social support from their partners, their partners were tested after their disclosure and discussed safer sex with their sexual partner after disclosure respectively.

In a related study conducted by Damian et al. (2019) on the factors associated with HIV status disclosure to partners and its outcomes among HIV-positive women attending care and treatment clinics at Kilimanjaro region, Tanzania found out that 11% of disclosed respondents living with HIV claimed to be beaten or blamed by their sexual partners after the disclosure; while 7.3% and 3.3% reported that their partners either run away or were confused respectively.

Dessalegn et al. (2019) in their study carried out on HIV disclosure: HIV-positive status disclosure to sexual partners among individuals receiving HIV care in Addis Ababa, Ethiopia revealed that the percent of respondents who discussed safer sex with their sexual partners after the disclosure was 67%. Unfortunately, 62%, 20%, 18%, and 12% of disclosed respondents reported having depression, being blamed/beaten, divorced, and being stigmatized respectively.

According to Ambissa et al. (2021) in their study about HIV-positive status disclosure to a sexual partner and associated factors among HIV-positive pregnant women attending antenatal care in Dire Dawa, Ethiopia, following disclosure, 46.2%) of the male sexual partners were supportive of their partners and 85.3% respondents who disclosed their HIV-positive serostatus to others started practicing safer sex.

CHAPTER THREE: METHODOLOGY

3.1 Introduction

The chapter presents the methods used in carrying out the research including the study design and rationale, study setting and rationale, study population, sample size determination, sampling procedure, inclusion criteria, definition of variables, research instrument, validity, reliability of the instrument, data collection procedures, data management, data analysis and presentation, ethical consideration, limitations of the study and dissemination of results.

3.2 Study Design

The study design was cross sectional and descriptive, employing quantitative data collection methods. A cross sectional type of design was chosen because it allows collection of data on prevalence of a certain phenomenon under investigation at a single point in time, from a group of respondents whose characteristics can be described.

3.3 Study Setting

The study was conducted at Mulago National Referral Hospital in Kampala District which is found in central Uganda. The coordinates of the hospital are: latitude 0.3411”N and longitude 32.5769”E. The health center is the biggest health facility in the country and it offers many health care services including immunization, child health services, obstetrics and emergency care, HIV/AIDS management services, general patient management, laboratory services, nutrition services, antenatal and post natal services and many others.

3.4 Justification/ Rationale

The study setting was selected because attempts have been made to foster disclosure due to its potential benefits but along with these benefits, HIV status disclosure to sexual partners has a number of potential risks for the individual. However, evidence is lacking in the context of the

implications of HIV-positive serostatus disclosure among sexual partners with respect to studies conducted in Uganda. This leaves a knowledge gap and it was the researcher's intention to conduct this study in the national referral hospital with a huge number of HIV positive clients to address this identified gap in the literature.

3.5 Study Population

This study targeted people with HIV who were attending HIV counseling and testing center at Mulago National Referral Hospital in Uganda.

3.5.1 Sample Size Determination

The study included a total of 157 respondents. This sample size was presumed representative enough of the entire study population. The sample size was determined by the use of (Cochran, 1963) equation which is expressed as;

$$\mathbf{n}=\frac{z^2 p\, q}{e^2}$$

Where;

n' is the desired minimum sample size, **Z** is value at **α**= 0.05 which is 1.96= 2 **e** =margin of error which is proposed to be 0.5 **P** is the proportion with the desired characteristics (in this case, **P** is taken to be 0.11 – adopted from Damian et al., 2019).

q + p = 1 therefore, 1-p = q (1-0.11=0.89) by substitution,

$$n = \frac{2^2 \times 0.11 \times 0.89}{0.05^2}$$

$$n = \frac{4 \times 0.11 \times 0.89}{0.0025} = 156.64$$

The sample size was 157 respondents

3.5.2 Sampling Procedure

Non-probability convenience sampling was used to recruit PLWHA aged 18 years and older at the HIV counseling and testing center at Mulago National Referral Hospital (for at least 3 months) and who ever had sexual partners since they were HIV diagnosed.

3.5.3 Inclusion Criteria

Adult persons living with HIV/AIDS at the HIV counseling and testing center at Mulago National Referral Hospital (for at least 3 months) and who ever had sexual partners since they were HIV diagnosed, physically able and willing to participate were included in the study upon written consent.

3.5.4 Exclusion Criteria

Persons living with HIV/AIDS who were in physical poor health and those unwilling to participate were excluded from the study.

3.6 Definition of Variables

3.5.1 Dependent Variable

The dependent variable of this study was HIV sero-status disclosure among sexual partners at Mulago National Referral Hospital in Kampala district.

3.5.2 Independent Variables

The independent variables included socio-demographic characteristics and the implication of serostatus disclosure among sexual partners.

3.7 Research Instrument

Data was collected using a structured and pre-tested interviewer-administered questionnaires. This was used to enable the researcher to gather the necessary information required to achieve the objectives of the study.

3.6.1 Validity and Reliability of the Instrument

The interviewer-administered questionnaire was designed under the guidance of the supervisor, pre-tested to counter the ambiguities and take charge of the validity and consistence of its questions before it was used in the actual data collection. The pre-testing exercise was done from Kawempe Regional Referral Hospital and this was among 10 HIV positive adult clients.

3.8 Data Collection Procedure

Data was collected by structured and pre-tested interviewer-administered questionnaire. The training on the purpose of the study, the content of the questionnaire, particularly on issues related to the confidentiality of the responses, and the rights of participants was provided to the 2 research assistants on two consecutive days. The interviewers were proficient in Luganda and English, and they were staff members at the HIV counseling and testing clinic. Female respondents were interviewed by the female interviewer and male respondents by male interviewer. The questionnaire was first prepared in English and then translated into Luganda and back to English to check for consistency of the questions. The final version of the questionnaire was reviewed by an expert panel to establish content validity. Respondents were recruited consecutively at the clinic during their follow-up visits. All consented respondents were interviewed.

Potential study participants were identified in terms of the inclusion and exclusion criteria by using client interviews obtained when individuals came for a scheduled appointment. They were approached before their scheduled appointments and after providing adequate information about the purpose of the study, individuals were invited to participate in the study. Those who consented to participate after a written informed consent was obtained were interviewed on exit soon after they had received their treatment from the health care providers. For those respondents

who could not read and write, a hand-signature method mark on the document was applied to take their consent form.

3.8.1 Data Management

Data management involved cross-checking of the each questionnaire for completeness immediately before letting the respondent to leave. The researcher supervised the two research assistants and cross-checked each questionnaire every day after data collection. The questionnaires were then sorted, reviewed and responses were summarized basing on the study objectives before being entered into the computer.

3.8.2 Data Analysis and Presentation

The responses on the questionnaires were manually entered into the computer spreadsheet ahead of the analysis using Statistical Package for Social Scientists (SPSS) version 20. This gave rise to the generation of pie charts, tables and graphs.

3.9 Ethical Considerations

The study was approved by King Ceasor University Research and Ethics Committee. Ethical approval to conduct this research in Mulaga National Referral Hospital was obtained from the Research and Ethics Committee of Mulago, the permission was granted. The head of the respective clinic was contacted and helped in the identification of eligible participants. Written and verbal consent were obtained from the respondents individually. The right of the respondent to withdrawal from the interview or not to participate at all was assured. In order to maintain respondent confidentiality, the interviews were conducted in a private room with the door closed and all of the documents with respondent's information well protected in a closed locker and only the principal investigator had access to the key.

3.10 Limitations of the Study

There was a couple of limitations in this study. The results only describe the HIV positive serostatus disclosure implications of the respondents in a single facility. Given this limitation, the results of this study still provide valuable insights on the implications of PLWHA and add to the understanding of the self-disclosure and its impact.

3.11 Dissemination of Results

On completion of the study, a report was developed and disseminated to; King Ceasor University Bunga, Mulago National Referral Hospital and the Ministry of Health Department of HIV/AIDS control.

CHAPTER FOUR: RESULTS

4.1 Introduction

This chapter presents results of the study in relation to the specific objectives. It shows socio-demographic data, sero-status disclosure status and implication of HIV sero-status disclosure among sexual partners. A total of 157 respondents studied were all adult persons living with HIV/AIDS at the HIV counseling and testing center at Mulago National Referral Hospital who ever had sexual partners since they were diagnosed. The results were presented as below.

4.2 Socio-Demographic Data

Table 1: Respondents' Demographic Data **n=157**

	Age category	**Frequency (f)**	**Percent (%)**
	18-29 years	10	6.4
	30-41 years	54	34.4
	42-53 years	80	50.9
	54-65 years	13	8.3
	Gender	**Frequency (f)**	**Percent (%)**
	Male	57	36.3
	Female	100	63.7
	Level of education completed	**Frequency (f)**	**Percent (%)**
	Primary	88	56.1
	Secondary	44	28.0
	Tertiary/ University	12	7.6
	Others (did not complete primary)	13	8.3
	Total	**157**	**100.0**

From the Table above, slightly more than half 80(50.9%) of the respondents ranged between 42-53 years and the minority 10(6.4%) were aged between 18-29 years. More than half 100(63.7%) of the respondents were female and the minority 57(36.3%) were male. More than half

88(56.1%) of the respondents were completed primary level and the minority 12(7.6%) attained tertiary/ University.

Table 2: Respondents' Marital Status **n=157**

	Responses	**Frequency (f)**	**Percent (%)**
	Never married	5	3.2
	Married or cohabiting	90	57.3
	Divorced or separated	54	34.4
	Widowed	8	5.1
	Total	**157**	**100.0**

More than half 90(57.3%) of the respondents and the minority 5(3.2%) had never married.

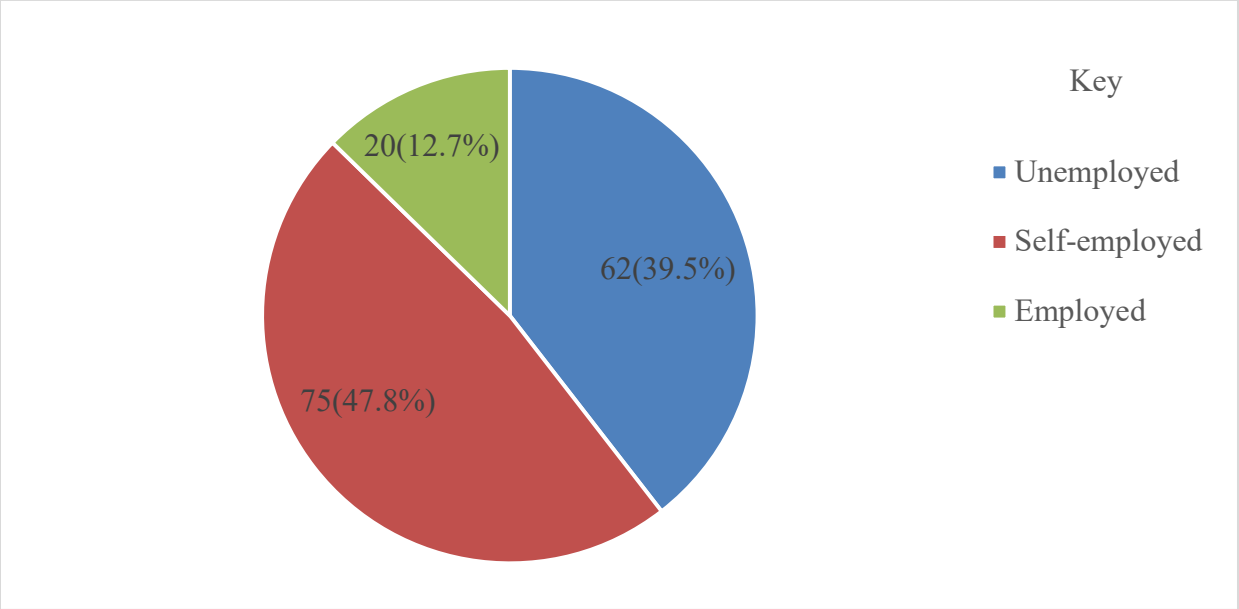


Figure 1: Respondents' Work Status **n=157**

From figure 1 above, nearly half 75(47.8%) of the respondents were self-employed, 62(39.5%) were unemployed and 20(12.7%) were totally unemployed.

4.3 HIV Positive Sero-status Disclosure Among Sexual Partners

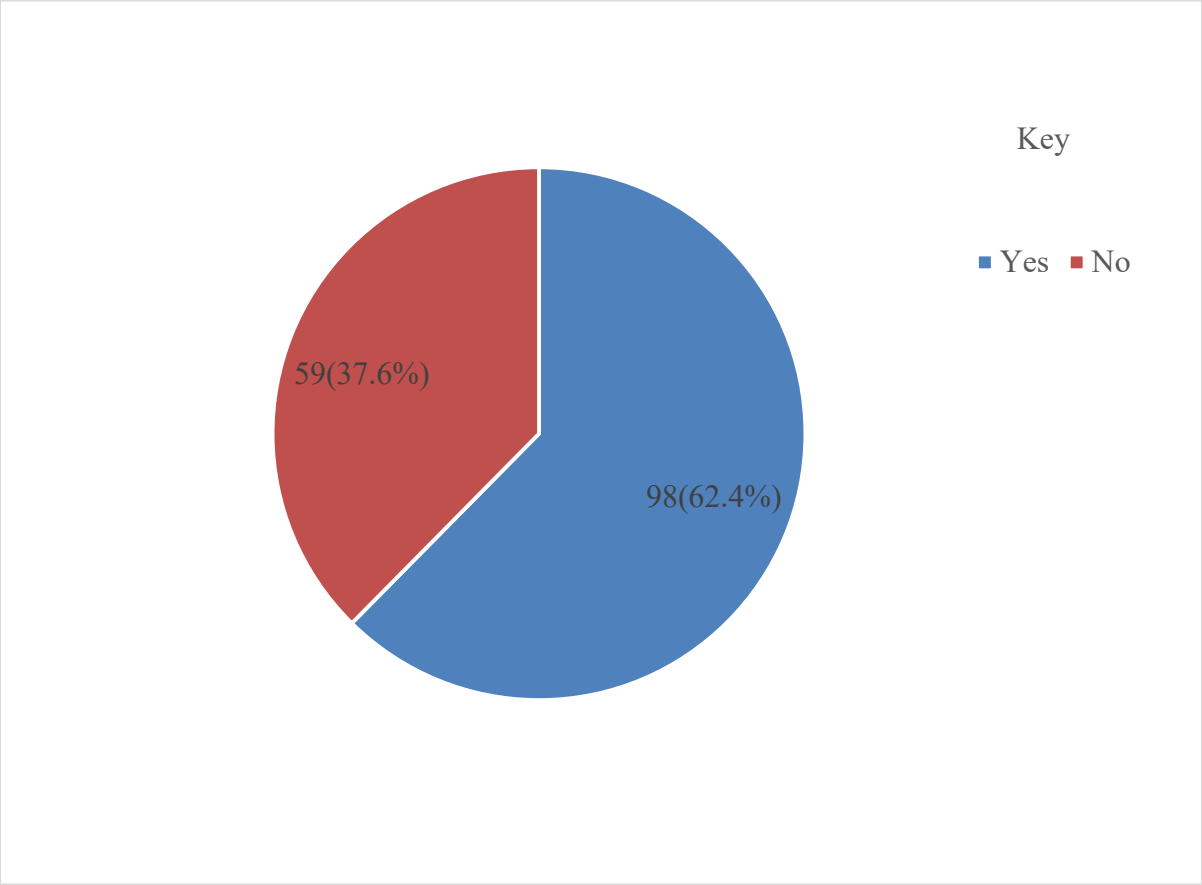


Figure 2: HIV Sero-status Disclosure to Sexual Partner **n=157**

More than half 98(62.4%) of the respondents disclosed their HIV positive sero-status to their sexual partner while 59(37.6%) had not disclosed their HIV sero-status to their sexual partner. This implies that many people with a positive HIV diagnosis are not likely to disclose their status to sexual partners thereby putting them at risk of getting infected.

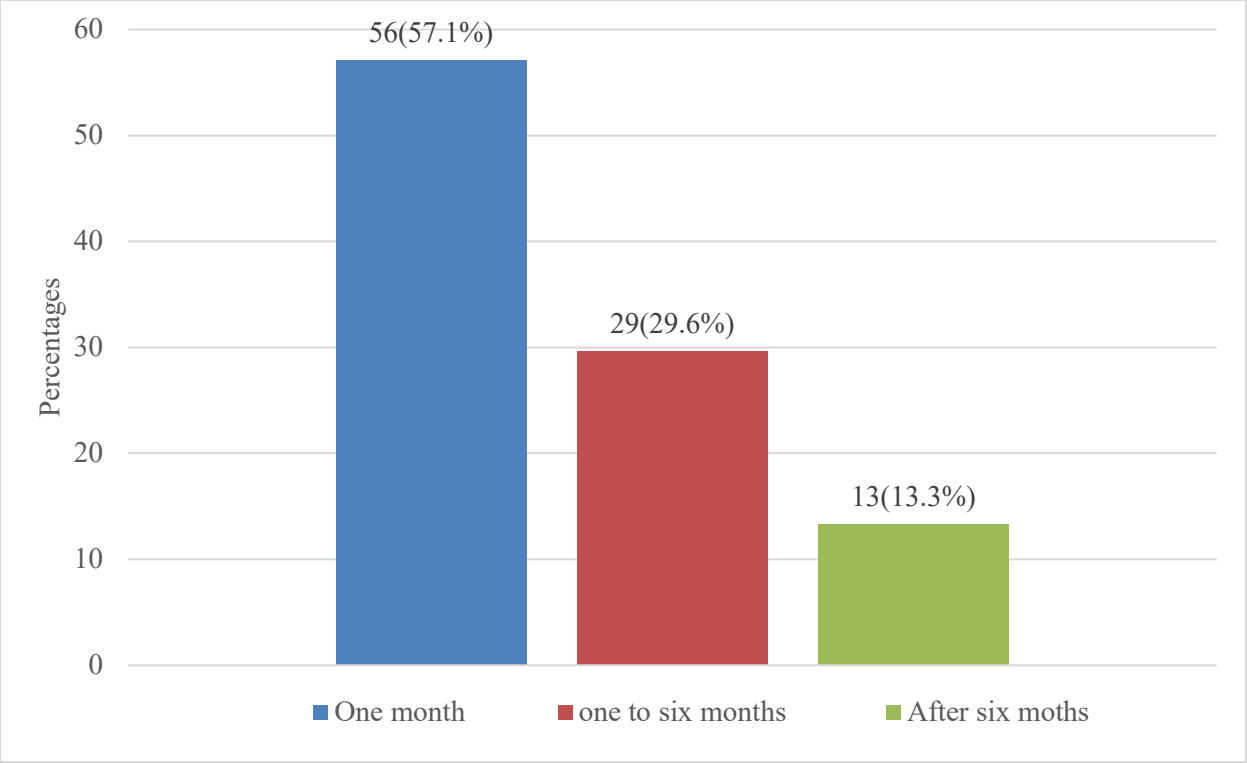


Figure 3: Duration Taken to Disclose HIV Status to Sexual Partner After Diagnosis n=98

Fifty six respondents (57.1%) disclosed their HIV positive sero-status to sexual partner within one month of diagnosis, 29(29.6%) between one to six months, and 13(13.3%) disclosed after six months of knowing their HIV sero-status. Delayed serostatus disclosure amongst PLWHA imply that HIV transmission will continue to persist among sexual partners in this area.

Table 3: Information Regarding Change of Sexual Partners **n=98**

	Changed partners since being diagnosed with HIV	**Frequency (98)**	**Percent (%)**
	Yes	50	51.0
	No	48	49.0
	Disclosed HIV positive status to all sexual partners	**Frequency (50)**	**Percent (%)**
	Yes	10	20.0
	No	40	80.0

From Table 3 above, out of the 98 respondents who had disclosed their HIV positive sero-status to their sexual partner, 50(51%) of them changed partners whereas 48(49%) did not. Of the 50 respondents who changed sexual partners since being diagnosed with HIV, 40(80%) did not disclose their sero-status to all sexual partners while 10(20%) disclosed to all the sexual partners. This disempowers sexual partners to make knowledgeable reproductive health varieties which ultimately increase the number of unplanned pregnancies and even increase the risk of HIV transmission.

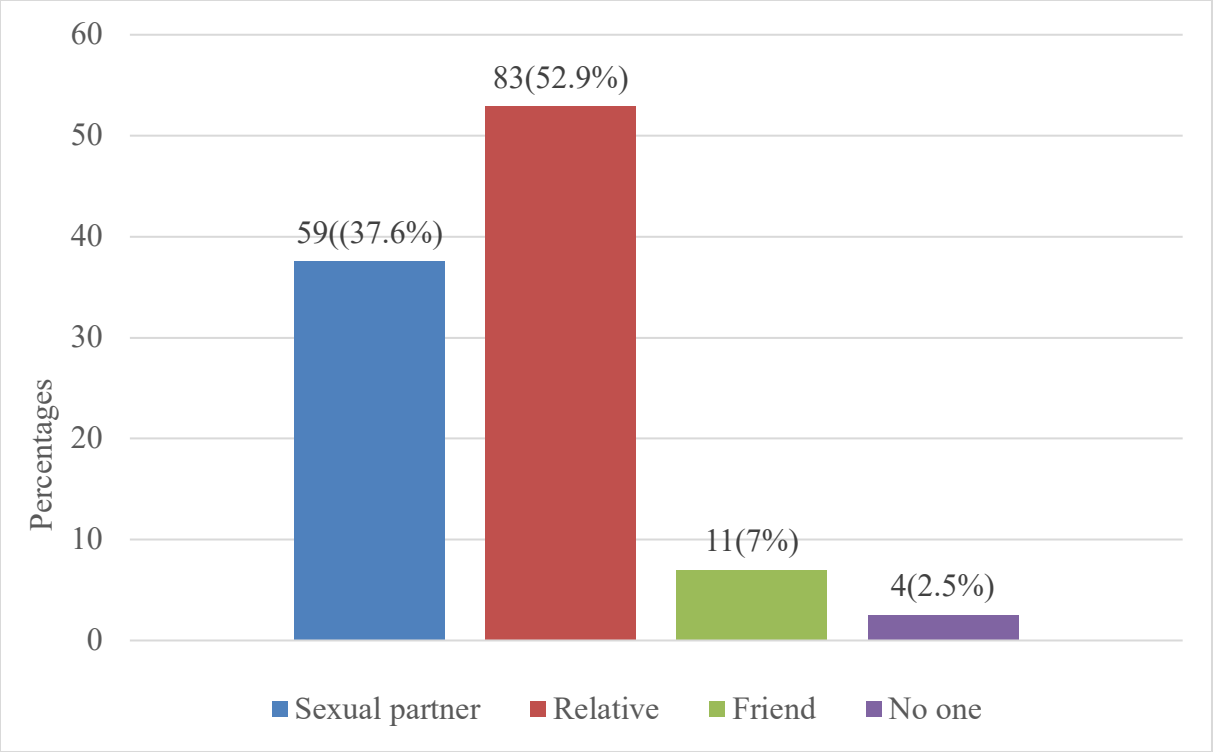


Figure 4: Information about Disclosure of HIV Status **n=157**

Figure 4 shows that, slightly more than half 83(52.9%) of the respondents reported first having disclosed their HIV sero-status to their relatives, 59(37.6%) to their partners, 11(7%) to their friends and 4(2.5%) had disclosed to no one. These findings imply that majority of PLWHA in the study area were more likely to disclose their HIV status to a relative than to other social support networks. This preference to disclose to relatives could be explained by the confidence they have with relatives, the strength of their relationship and the feeling of responsibility that might facilitate open and close communication, which in turn made them easily disclose their HIV status to the relatives.

Table 4: Reasons for Non-disclosure of HIV Sero-status to Sexual Partner n=59

	Responses	Frequency (f)	Percent (%)
	Fear of divorce	20	33.8
	Fear of being stigmatized	18	30.5
	Fear of being blamed/beaten	12	20.3
	Fear of breaking of confidentiality	10	16.9
	Fear of depression	5	8.4

***Multiple Responses Included**

Fear of divorce was a leading reason given by 20(33.8%) respondents who had not disclosed their sero-status, followed by fear of being stigmatized 18(30.5%), fear of being blamed/beaten 12(20.3%), fear of breaking of confidentiality 10(16.9%) and fear of depression 5(8.4%). This implies that the anticipation of negative reactions and internalisation of stigma acts as barriers to HIV status disclosure and these complex phenomena might prevent persons from disclosing their seropositive status and the fear of negative consequences may prevent persons at risk from seeking Voluntary Counselling and Testing services.

4.4 Implication of HIV Positive Sero-status Disclosure Among Sexual Partners

Table 5: Implication of HIV Sero-status Disclosure Among Sexual Partners n=98

	Responses	Frequency (f)	Percent (%)
	Received social support from partner	19	19.3
	Discussed safer sex	8	8.1
	Partner tested for HIV	11	11.2
	Desertion or separation	26	26.5
	Blamed/beaten	50	51.0
	Got depression	60	61.2
	Stigmatized	18	18.3

***Multiple Responses Included**

It was found that 60(61.2), 50(51%), 26(26.5), and 18(18.3%) of those who disclosed their HIV sero-status with sexual partners reported having depression, being blamed/beaten, divorced, and being stigmatized respectively. On the other hand, 19(19.3%), 11(11.2%), and 8(8.1%) of those who disclosed their HIV sero-status reported having received social support from their partners, their partners were tested after their disclosure and discussed safer sex with their sexual partner after disclosure respectively. Therefore, PLWHA may suffer social rejection, financial insecurity, shame, guilt, low self-esteem, depression and other psychological problems, and hence those who perceive a harsh environment may be reluctant to or even afraid of disclosing their HIV serostatus to others, thereby putting their intimate partners and significant others at risk.

CHAPTER FIVE: DISCUSSION, CONCLUSION AND RECOMMENDATIONS

5.1 Introduction

This study focused on voluntary HIV disclosure among sexual partners receiving care and treatment follow-up at Mulago National Referral Hospital in Kampala district. This chapter deals with discussion of the study findings, presents the conclusions originating from the study whereas the third section presents some recommendations.

5.2 Discussion

5.2.1 HIV Sero-status Disclosure Among Sexual Partners

The current study revealed that less than three-quarters (62.4%) of respondents had voluntary disclosed their HIV sero-status to a sexual partner and only (37.6%) of these reported sexual partner as the first person they told their status. This finding is similar to two other studies, one conducted by Peng et al. (2022) in China, with disclosure rates of 65% and that of Adeoyo-Agboola et al. (2018) in Nigeria, with a 51% disclosure rate among sexual partners. On the contrary, the HIV disclosure rate in this study was lower than in Tanzania (Gabagambi, 2023), Iran (Pashaei et al., 2021), and Ethiopia (Ambissa et al., 2021) where prevalence of HIV disclosure to sexual partners were 78%, 86.5%, and 86.5% respectively.

There might be two rationales for the low HIV disclosure rate in Uganda. First, the different HIV disclosure policies in the world would affect HIV partner disclosure. However, at present, Uganda has only a national level policy of “prevention and control regulation”, stating that HIV partner disclosure should be totally voluntary. Second, HIV-related stigma has been confirmed to be the key barrier for HIV disclosure. In Uganda, HIV stigma is higher than in developed countries and some African countries.

Unfortunately, out of the 98 respondents who had disclosed their HIV positive sero-status to their sexual partner, 50(51%) of them changed partners but majority 40(80%) failed to disclose their status to all sexual partners, which increases the likelihood of transmitting the infection to their sexual partners. These findings are similar to findings of two earlier studies conducted in Singida Regional Referral Hospital of Tanzania by Gabagambi (2023) in which 69% of the study respondents reported having risky sexual practices before disclosure to their sexual partners, and also in Dire Dawa, Ethiopia where nearly half (48.1%) of the respondents had sex with a partner before disclosure (Ambissa et al., 2021). One of the main reasons presumed for this could be stigmatization as well as the nature of the sexual partner particular casual and unidentified sexual partners.

Fear of divorce was a leading reason given by 20(33.8%) respondents who had not disclosed their HIV sero-status, followed by fear of being stigmatized 18(30.5%), fear of being blamed/beaten 12(20.3%), fear of breaking of confidentiality 10(16.9%) and fear of depression 5(8.4%). These findings are similar to findings of a study conducted in Kenya to assess social concerns related to HIV status disclosure which claimed that isolation or lack of support from family or friends, fear of separation, and fear of conflict with a partner were the concerns which led to non-disclosure of their status to their sexual partners (Nordberg et al., 219).

5.2.2 Implications of HIV Sero-status Disclosure Among Sexual Partners

It was unfortunately observed that 61.2%, 51%, 26.5% and 18.3% of respondents who had voluntary disclosed their HIV positive sero-status to their partners reported having depression, being blamed/beaten, desertion or separation, being stigmatized respectively. These results were inconsistent with a study done by Gabagambi (2023) in Tanzania which claimed that 70%, 90% and 87% of those who disclosed their status reported having received social support from their

partners, tested for HIV after disclosure, and discussed safer sex with their sexual partner after disclosure respectively. In this study, only 19.3%, 11.2%, and 8.1% of those who disclosed their status reported having received social support from their partners, their partners were tested after their disclosure and discussed safer sex with their sexual partner after disclosure respectively. This magnitude of the negative outcome can explain why there lacks significant improvement in HIV disclosure to sexual partners to date.

5.3 Conclusion

The rate of HIV disclosure noted in this study is a bit encouraging, but more interventions should be done to improve disclosure in Uganda. The findings suggest that PLWHA who disclose their HIV status to their sexual partner have different experiences. In this sample, reactions on the part of their intimate partners varied from depression, being blamed/beaten, desertion or separation and stigma to support, safer sex and partner testing. However, majority respondents suffered the negative experiences following disclosure and only a few had positive experiences from their intimate partners.

This implies that the negative experiences following disclosure scares many PLWHA to share their sero-status with their sexual partners hence promote the non-disclosure of HIV seropositive status instead of fostering disclosure. Therefore, improved rates of disclosure can be attained by considering and intervening in the negative outcomes following disclosure reported in this study.

5.4 Recommendations

The government of Uganda, need to develop programs for counselling of PLWHA on the management of negative experiences, living positively, self-disclosure and prevention of re-infection with HIV. This may help to reduce the self-stigma experienced by PLWHA thereby encouraging self-disclosure of seropositive status to intimate partners and to significant others.

The Ministry of Health education programs should encourage and promote mutual partner HIV testing to increase awareness of the partner`s HIV status.

The Ministry of Health should conduct educational forums with full community engagement and other stakeholders in fighting the HIV epidemic, this will increase advocacy for disclosure, and emphasize the participation of couples instead of the male or female partner alone. This improvement of the disclosure can be done through the adoption and scale-up of partner services within the care and treatment center setup. Moreover, educational campaigns should encourage a reduction in the number of sexual partners as it is one of the factors which slow down the disclosure rate in Uganda.

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APPENDIX I: CONSENT FORM

Study title "Implication of serostatus disclosure among sexual partners at HIV counseling and testing center at Mulago National Referral Hospital in Uganda"

1. The Investigator in Charge of this Study is

Name	**Institution of affiliation**	**Telephone number**	**Email address**
Naluwooza Esther	King Ceasor University Bunga	0701148271	esthernalu@gmail.com

2. Organizational Affiliation or Collaboration and Sponsorship

This study is being conducted by **Naluwooza Esther**, a student nurse in King Ceasor University, Bunga.

3. Background and rationale of the study.

This research project is about "Implication of serostatus disclosure among sexual partners at HIV counseling and testing center at Mulago National Referral Hospital in Uganda"

4. Purpose of the Study

To examine "Implication of serostatus disclosure among sexual partners at HIV counseling and testing center at Mulago National Referral Hospital in Uganda" because we need information regarding this matter. This is a research study and not a provision of clinical care.

5. Length of Data Collection.

The researcher will endeavour to use limited time to avoid any inconveniences in in the routine facility activities.

6. Study Procedure

Before the process is initiated, the study must be explained to you and you should be given chance to ask questions. You must read and sign this consent form and you will be given a copy of it.

7. Possible Risks or Discomforts while Taking Part in this Study.

There are no possible risks anticipated while taking part in this study.

8. Possible Benefits to you in Taking Part in this Study.

There are no direct benefits to specific individuals but this study may help to address the challenges associated with HIV positive serostatus disclosure to sexual partners.

8. Approval of the Research Study

This study has been approved by the King Ceasor University, Bunga Research and Ethics Committee.

9. Confidentiality of Study Records and Medical Records.

Information collected for this study is confidential. However, the Sponsor/Company, King Ceasor University Bunga Research and Ethics Committee, Mulago and Ministry of Health will receive copies of the study records. In the event of any publication regarding this study, patients' identity will not be disclosed.

10. Names of Contacts for Questions about the Study.

If you have any questions about taking part in this study, or if you think you may have been injured because of this study, call the principle investigator "Naluwooza Esther" on 0701148271 or if you have any questions about your right as a research subject, call the chair of King Ceasor University, Bunga Research and Ethics Committee at +256-781457183

12. Feedback on the Study Findings and the Progress of the Study.

You will get feedback on the findings and progress of the study and any new information that affects the study and data that has clinical relevance to you (including incidental findings). All these will be made available to you and your health care providers.

13. Participant's Statement of Consent.

"I have read this consent form or have had it explained to me to my satisfaction the information relating to this study. I understand what my participation will involve and agree to take part in this interview under the terms of this agreement. I have had the opportunity to ask questions about it, and my questions have been answered to my satisfaction. I consent voluntarily to participate in this study, and I understand that I have the right to withdraw at any time, without it in any way affecting my future medical care". I agree to participate voluntarily.

_____ _____

Date signature or thumb mark of participant

_____ _____

Date signature of witness

I certify that the nature and purpose, potential benefits and possible risks associated with participating in the above study have been explained to the above individual.

_____	_____
Date	signature of the person who obtained consent
	_____
	Name of the person who obtained consent (print)

APPENDIX II: QUESTIONNAIRE

Questionnaire number: ……

Instructions: Tick the most appropriate question or respond to questions accordingly

Section A: Socio-demographic characteristics

1. How old are you?
   a) 18-29 years ☐
   b) 30-41 years ☐
   c) 42-53 years ☐
   d) Others (specify)…….
2. What is the sex of the respondent?
   a) Male ☐
   b) Female ☐
3. What was the last level of education you completed?
   a) Primary ☐
   b) Secondary ☐
   c) Tertiary/University ☐
   d) Others (specify)……
4. What is your marital status?
   a) Never married ☐
   b) Married or cohabiting ☐
   c) Divorced or separated ☐
   d) Widowed ☐

5. What is your employment status?

   a) Unemployed ☐

   b) Self-employed ☐

   c) Employed ☐

Section B: HIV positive serostatus disclosure among sexual partners

6. Have you disclosed your HIV status to your sexual partner? (**skip questions 7 to 10 for the No response**)

   a) Yes ☐

   b) No ☐

7. How long did it take for you to disclose your HIV status to your sexual partner since you were diagnosed (months)?.....months.

8. Have you changed sexual partners since you were diagnosed with HIV?

   a) Yes ☐

   b) No ☐

9. Have you disclosed your HIV status to all of them?

   a) Yes ☐

   b) No ☐

10. Who was the first person you disclosed to?

   a) Sexual partner ☐

   b) Relative ☐

   c) Friend ☐

   d) No one ☐

This question is for those who did not disclose their status to their partner(s)

11. What was/were the reason(s) for not disclosing your serostatus to your sexual partner (Tick all that apply to you)

    a) Fear of divorce ☐

    b) Fear of being stigmatized ☐

    c) Fear of being blamed/beaten ☐

    d) Fear of breaking of confidentiality ☐

    e) Others (specify)……

Section C: Implications of HIV positive serostatus disclosure among sexual partners

12. Which of the following have already happened after you disclosed your HIV positive serostatus to your partner(s)? (Tick all that apply)

		Yes	No
1	Received social support from partner		
2	Discussed safer sex		
3	Partner tested for HIV		
4	Separation		
5	Blamed/beaten		
6	Depression		
7	Stigmatized		
8	If any other, please indicate……		

"Thank you very much for your time"

APPENDIX III: INTRODUCTION LETTER

KING CEASOR UNIVERSITY
"Moral Rearmament, Wealth Multiplication"
P.O Box 88, Kampala, Plot 30/33 King Ceasor Road, Bunga Hill Main Campus,
Email: amoskalukusu@kcu.ac.ug

DIRECTORATE OF RESEARCH

MULAGO HOSPITAL RESEARCH AND ETHICS COMMITTEE
RECEIVED
Signature:
Date: 1/12/2023

10th August 2023

The Executive Director,
Mulago National Referral Hospital,
Uganda.

RE: RECOMMENDATION FOR RESEARCH DATA COLLECTION OF :-
NALUWOOZA Esther (Index No. 2021AP/BNS/1189)

I write to recommend the above named student who is pursuing a Bachelor of Nursing from King Ceasor University, in Uganda.

Ms. NALUWOOZA Esther ***esthernalu6@gmail.com)*** is now in her third year of study (3.2) and now expected to write her research dissertation as part of the requirements for the award of her degree. She is working on the topic given as follows:

"***Implications of Sero-status disclosure among sexual partners in Uganda: A situational analysis of clients reporting for HIV Counselling & Testing at Mulago National Referral Hospital, Uganda".***

The purpose of this letter is to request that you allow her undertake data collection from your hospital facility which will assist her to fulfill the requirements of the university.
The results of her research can be shared with you upon the successful completion of her study.

In any correspondence, use the address given herein. Looking forward to hearing from you.
Sincerely,

KING CEASOR UNIVERSITY
P.O. BOX 88, KAMPALA - UGANDA
31 AUG 2023

Amos Ronald Kalukusu (PhD Fellow, Public Health).
Assoc. Director for Research.
Email: amoskalukusu@kcu.ac.ug Tel: 0781457183

CC: DVC Academic Affairs; Cc: Academic Registrar; Cc: Ms. NALUWOOZA Esther

APPENDIX IV: ACCEPTANCE LETTER

TELEPHONE: +256-41554008/1
FAX: +256-414-5325591
E-mail: admin@mulago.or.ug
Website: www.mulago.or.ug

IN ANY CORRESPONDENCE ON THIS SUBJECT PLEASE QUOTES NO.....

MULAGO NATIONAL REFERRAL HOSPITAL
P. O. Box7051
KAMPALA, UGANDA

4 December 2023.

Ms. Esther Naluwooza
Principal Investigator
King Ceasor University.

Dear Naluwooza,

Re: Approval of Protocol MHREC 2661: "Implication of Sero-Status Disclosure among Sexual Partners in Uganda: A Situation Analysis of Clients Reporting for HIV Counseling and Testing at Mulago National Referral Hospital".

The Mulago Hospital Research and Ethics Committee reviewed your proposal referenced above and granted approval of this study on 4 December 2023. The conduct of this study will therefore run for a period of one (1) year from 4 December 2023 to 3 December 2024.

This approval covers the protocol and the accompanying documents listed below;

- Consent form
- Questionnaire

This approval is subjected to the following conditions:

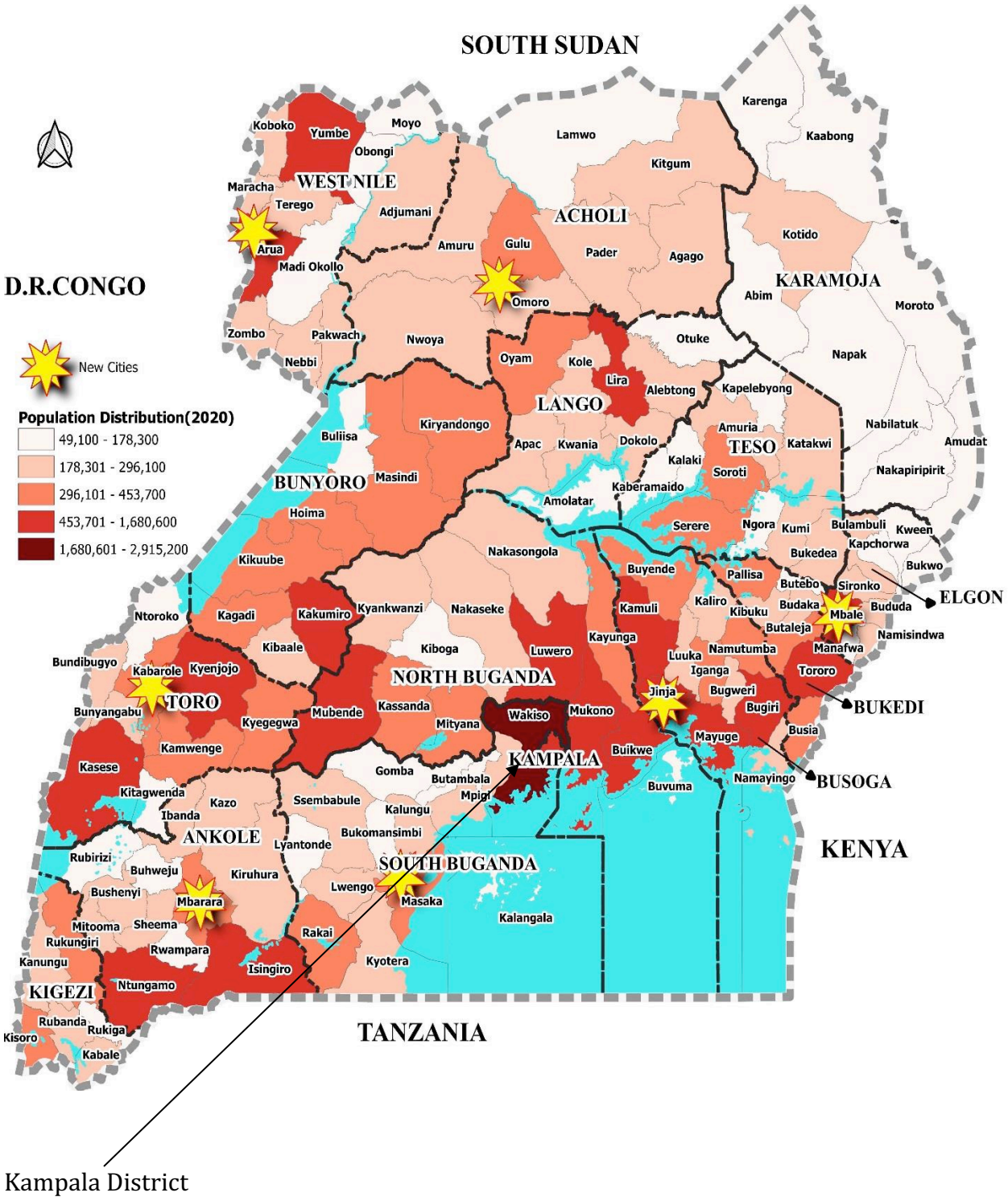
1. That the study site may be monitored by the Mulago Hospital Research and Ethics Committee at any time.
2. That you will be abide by the regulations governing research in the country as set by the Ugandan National Council for Science and Technology including abiding to all reporting requirements for serious adverse events, unanticipated events and protocol violations.
3. That no changes to the protocol and study documents will be implemented until they are reviewed and approved by the Mulago Hospital Research and Ethics Committee.
4. That you provide quarterly progressive reports and request for renewal of approval at least 60 days before expiry of the current approval.
5. That you provide an end of study report upon completion of the study including a summary of the results and any publications.
6. That you will include Mulago Hospital in your acknowledgements in all your publications.

I wish you the best in this Endeavour.

APPROVED
APPROVAL DATE 04 DEC 2023 EXPIRY DATE 03 DEC 2024
MULAGO RESEARCH ETHICS COMMITTEE
IRC

DR. NAKWAGALA FREDERICK NELSON
CHAIRMAN- MULAGO HOSPITAL RESEARCH & ETHICS COMMITTEE.

APPENDIX V: MAP OF UGANDA SHOWING KAMPALA DISTRICT



Kampala District

APPENDIX VI: MAP OF KAMPALA DISTRICT SHOWING MULAGO NATIONAL REFERRAL HOSPITAL



Key

Mulago National Referral Hospital