Chapter 1

Introduction and Background to the Study

1.1 Background to the study
Since the discovery of the Human Immune Deficiency Virus (HIV) about three decades ago, the virus has continued to spread worldwide (Bennett and Erin, 1999). This is due to the fact that “each year, thousands of people become newly infected with HIV, each exposed by another infected person” (Klitzman, 1997:11). On the same note, Dejong (2003) states that on a global scale there are approximately 14,000 new HIV infections daily, while in Sub-Saharan Africa more women are infected than men.

In Zimbabwe, since the discovery of the first AIDS case in 1985, the disease has continued to spread and the rate of HIV infection currently stands at 20.1% (Afrol News, April 2006). Women in Zimbabwe have been hardest hit by HIV and currently have a life span of 34 years, the lowest in the world. Despite the fact that they make up 52% of the population, women represent 58% of HIV positive adults in the country (Ncube, 2005).

In order to curb the rate of HIV infection in Zimbabwe, HIV prevention and control programmes have been put in place. Greene, Derlega, Yep, and Petronio (2003) maintain that the prevention and control of HIV infection can only be successful if there is implementation of strategies that prevent new infections and treat currently infected individuals. One such strategy in use in Zimbabwe is HIV counselling and testing. Within HIV counselling and testing programmes, emphasis is placed on the importance of HIV status disclosure among those who are HIV positive. They are encouraged to disclose their status particularly to sexual partners, whether past, present or potential partners. This is due to the fact that, the more people who are aware of their HIV status and practise safe
sex the more effective prevention and treatment programmes are likely to be (Doka, 1997).

Disclosure to sexual partners can motivate the partners to seek testing themselves. Once these partners get to know their status, this may lead to behavioural changes like embarking on protected sex so as to prevent re-infection with another strain of HIV (Manuel, 1999). For women, HIV status disclosure has proved to be a daunting task. Some studies have revealed that the break up of marriages, loss of shelter, food and relationships and even murder are the consequences that women face when they disclose to sexual partners (Campbell, Marum, Alwano-Edyegu, Dillon, Moore and Gumisiriza, 1997). For African women, the situation is even worse because they are expected culturally to be subservient, thus hindering prevention efforts which emphasise HIV status disclosure to sexual partners. The study therefore explores the experiences of HIV positive Zimbabwean women on HIV status disclosure to sexual partners since infected women represent more than half of HIV infected adults in the country.

1.2 Research Problem

Gender inequity and inequality have been identified as the most critical factors in the spread of HIV and AIDS in Africa (Foreman, 1999). These two variables are mostly visible in the rural areas where cultural attitudes still prevail. Furthermore, most rural women are dependent on their husbands or partners for upkeep due to the low literacy levels that are characteristic of rural areas (Human Rights Monitor, 2001). Such dependence affects their experiences of HIV status disclosure as this makes them choose not to disclose their status for fear of desertion. In addition, the issue of culture hinders the disclosure process since the African culture is patriarchal and women are treated as subordinates. As a result, patriarchal attitudes combined with women’s economical dependence on men, make HIV status disclosure to sexual partners a nightmare for many women. There is need therefore for an understanding of the experiences that
these women undergo in order to come up with appropriate interventions, which are culture sensitive.

In Zimbabwe, women are heavily affected by HIV, for instance in 2004, 58% of all HIV positive people were women (UNAIDS, 2004). However, when it comes to available literature, women’s experiences on HIV status disclosure are missing and yet such experiences are essential since women are the most affected group. As a result, the study was an opportunity to highlight such experiences so that appropriate interventions can be implemented and women can be empowered. In addition, this empowerment will hopefully lower the levels of HIV among women in the Zimbabwean context.

1.3 Rationale of the Study

Women and HIV is an emerging area of research that still needs further exploration in order for HIV status disclosure to thrive as a prevention and treatment method (Greene, Delega, Yep and Petronio, 2003). Following the same line of thought, the study explores the experiences of women on HIV status disclosure to sexual partners. The new information generated from the research hopefully will help in HIV treatment and prevention efforts within the African context.

Most studies examining disclosure have been conducted in developed countries (Chesney and Smith, 1999; Clark et al., 2003; Letteney and Laparte, 2004). These studies cannot be easily generalised to the African setting due to differences in the socio-cultural context. The exploratory study based on African women is an opportunity to compare findings with previous researches that were done in developed countries so as to come up with appropriate ways of dealing with HIV status disclosure within the African context.

The impact of culture on HIV status disclosure of women to sexual partners has not been addressed by past researches (UNAIDS, 2004). As a result, the
researcher is of the opinion that, in order to effectively address the problem of HIV in Africa there is need for solutions that suit the socio-cultural climate. The study fills that gap by focusing on Magunje growth point, a rural area where cultural attitudes are still intact.

Previous researches that have addressed the issue of HIV status disclosure among women did not focus on disclosure to sexual partners per se, but focused on various issues around disclosure, the intended study differs in that it is an in depth study of disclosure to sexual partners. To exemplify, a study by Sowell, Seals, Philips and Julius (2003) explored the phenomenon of disclosure of HIV infection by African American women to various groups of people ranging from sexual partners to relatives and friends. The research was a longitudinal study of reproductive decision-making with a sample size of 322. Another study by Van Dyk and Van Dyk (2003) focused on the attitudes of people towards HIV and AIDS voluntary counseling and testing in South Africa. The study also included a section on HIV status disclosure to partners, family, friends, health care workers and other groups of people. The sample size was 1422 participants.

However, the current research seeks to improve on these past researches by narrowing the focus to sexual partners only and by using a smaller sample size of 10 which is suitable for an in depth qualitative study. The reason for such an option being the desire to come up with new, rich and appropriate information which can be generalized to the population of the study. The aim of such thinking is the desire to help women disclose their HIV status to sexual partners so that HIV status disclosure may thrive as an HIV prevention and treatment programme.

1.4 Research Questions
The research questions that are pertinent to the study are as follows:
1. What experiences do women undergo when they disclose their status to sexual partners?
2. What are the empowerment needs of HIV positive women who intend to disclose their status to sexual partners?

3. How can social workers intervene in order to make HIV status disclosure thrive as a prevention and treatment method?

In order to answer these research questions, goals are formulated that guide the research and these are discussed briefly in the following paragraphs.

1.5 Objectives of the study
The aim of the study is to explore the experiences of African women on HIV status disclosure to sexual partners. In order to achieve this goal the following objectives are set:

- To examine the nature, meaning and impact of HIV status disclosure in sexual relationships as experienced by the sample
- To investigate the impact of culture on HIV status disclosure by focusing on whether culture hinders disclosure to sexual partners
- To investigate the impact of disclosure on the spread of HIV infection as experienced by the sample
- To formulate strategies that can aid women in disclosing their HIV status to sexual partners in the region where the study is undertaken

1.6 Field work site
In this section, a background of the status of women in Zimbabwe is given, particularly rural women since this study was done with rural women. Observations and interpretations of rural women’s disclosure experiences before the study are also highlighted. All this information is then synthesized to give a more accurate understanding of the lived experiences of rural women living with HIV and AIDS.

This research was done at a time when various women groups were lobbying for the recognition of women rights and pushing for the adoption of the domestic
violence bill, so that it could be turned into a law. The Domestic Violence Act was implemented in January 2008 after it was discovered that Zimbabwean women suffered oppression on the domestic as well as public front.

Zimbabwe is a patriarchal country where men dominate on the social, political and economic spheres, whilst women are forced into subordinate positions. This sad state of affairs is imbedded in the socialization process and is tied to culture. As one grows up, one grows up with the ingrained belief that men are superior to women. As a result, although Zimbabwean women make up more than 50% of the country’s population, they are poorly represented in all societal spheres. Comrade Oppah Muchinguri, the Minister of Women’s Affairs, Gender and Community Development, supports this notion when she states that only 19% are women in parliament, 17% in the house of assembly, 36% in senate, 12% for urban councilors and 28% for rural councilors (The Herald, 22 August 2007). She further asserts that although women are the majority of voters, they vote for men because their life experiences have conditioned them to be subordinates.

Growing in such a climate and being exposed to the rural setting where cultural attitudes are still intact and women are viewed as subordinates, and willing subordinates for that matter; the present researcher has always been interested in the impact of culture on both disclosure and disclosure experiences to sexual partners. During vacations, the present researcher studied the social life of these villages, taking note of all events and conversations regarding HIV and AIDS as well as HIV status disclosure to sexual partners which has formed the researcher’s preunderstanding. This was all done in a bid to understand the plight of rural women in the wake of HIV and AIDS. However, this was not enough, it had to be substantiated by first hand experiences of the women themselves, hence the purpose of the qualitative approach to the study. Qualitative approach is the best method to use when one wants to understand how people live and give meaning to their existence.
1.7 Theoretical Framework

The study is rooted in the empowerment of women as a tool for curbing HIV infection so that HIV/AIDS status disclosure will thrive as a prevention and treatment method. In this way, new HIV infections will be prevented whilst current cases will be managed better through the application of measures that prevent re-infection. The present study is therefore informed by various conventions (of which Zimbabwe is a signatory), policies and laws which highlight the desired outcome with regards to the position of women in society. These pieces of legislation are critically analysed in a bid to shed light on the gap between the desired outcome and the reality on the ground to which many women are exposed to. Lastly the theories which attempt to explain women’s experiences of HIV/AIDS are then discussed.

1.7.1 International and Regional Conventions that inform present study

The following international and regional conventions paved the way for the realisation of the rights of women in Zimbabwe, the country where the present study was undertaken.

1.7.1.1 International Consultation on AIDS and Human Rights (1989)

In July 1989, the Centre for Human Rights conducted an International Consultation on AIDS and Human Rights. The consultation revealed that special attention had to be given to the human rights of women since there are certain factors relating to the reproductive role of women and their subordinate position in society which render them particularly vulnerable to HIV infection. A recommendation was then made calling for participating states to ensure that national programmes aimed at combating HIV/AIDS address those factors relating to the reproductive role of women and their subordinate position in some societies which makes them vulnerable to HIV infection.
1.7.1.2 Beijing Platform of Action (1995)
The Beijing Platform of Action is a reform that made a significant point of departure as far as women’s rights are concerned. It was born out of the realisation that despite the launch of the Convention on the Elimination of All Forms of Discrimination against Women in 1979, there had been no significant change in the way women were treated. It was also realised that in most countries women were still treated as inferior citizens thus increasing their vulnerability to HIV infection.

The present day has seen most governments adopting programmes aimed at women empowerment, for instance the Zimbabwean Gender Policy, but there is still a long way to go before women become totally empowered. Kaler (2003) supports this notion and states that women are still a subordinate sector which is dominated by men. In African societies, this treatment of women is attributed to cultural practices, which entrench this subordination. This sad state of affairs has hampered the success of empowerment policies that have been enacted by African governments due to the fact that these policies do not take into account cultural factors which lead to the subordination of women. In the Zimbabwean context, for example, Gender Consultants have criticised the National HIV Policy for failing to bring forth expected fruits due to the prohibitive environment of cultural norms (Ncube, 2005).

1.7.1.3 Women and HIV and AIDS Bill of Rights (2002)
The Women and HIV and AIDS Bill of Rights states that women have the right to disclose their HIV status without fear of violence, discrimination or stigma. The Bill recognises the vulnerability of women as portrayed in the Beijing Platform of Action and also goes a step further by endorsing women’s rights as human rights. Such an ideal situation would see women disclosing their HIV status without encountering violence from their sexual partners, however, the reality is that many women and girls who disclose their HIV status to partners, family
members and communities are physically and emotionally abused.

The charter is aimed at asserting the rights of African women and was endorsed by 53 African states who pledged their commitment to the realisation of the rights of African women. One of the Charter’s strong points on HIV and women’s rights is found in Article 14 which states that women have the right to be informed of their HIV status as well as the HIV status of a partner.

However, since the enactment of this charter, Zimbabwean women are still lobbying for a law that will compel spouses to disclose their HIV status (AIDS Policy and Law, 2005; Chirawu, 2006).

1.7.1.5 Summary
The above mentioned conventions portray that there is need for the empowerment of women so that they become masters of their own destiny. This means being in control of their sexuality and being able to protect themselves from HIV infection.

1.7.2 Zimbabwean Policies which inform present study
1.7.2.1 Zimbabwe’s HIV and AIDS Policy (1999)
The Zimbabwean Government adopted the principles of the Beijing Platform of Action and enacted the National HIV and AIDS Policy in 1999. This policy acknowledges the power imbalances between men and women, which are outlined in the Beijing Platform of Action. The policy acknowledges that women’s vulnerability to HIV and AIDS is as a result of cultural practices, which endorse that vulnerability.
Despite such a critical observation, the National HIV and AIDS policy has however been criticised for failing to bring about the expected changes in society. Gender Consultants blame this failure on the prohibitive environment of cultural norms and the harsh economic climate (Ncube, 2005). The researcher of the present study is of the opinion that the HIV and AIDS epidemic is worse in regions where poverty, gender and economic inequality prevail. Magunje Township, where the research was conducted, falls in this category.

### 1.7.2.2 Zimbabwean Gender Policy

The National Gender Policy of 1999 states that the rate of HIV infection is growing faster among women than men thus demonstrating unequal power relations between men and women with regard to the control of one’s sexuality. Strategic Objective C.3 of the policy thus calls for the development of gender sensitive multi-sectoral programmes for the empowerment of women and girls. The same observation as made at the Beijing Platform of Action is further emphasised in this policy.

### 1.7.2.3 Summary

The two policies cited above highlight the vulnerability of women to HIV infection as a result of cultural practices which perpetuate gender imbalances. Various laws have been enacted in an attempt to bring about a power balance between men and women and they will be discussed below.

### 1.7.3 Laws which inform present study

The following laws will be discussed, namely the Legal Age of Majority Act (1982); Medical Practitioners Regulations 122/87; Sexual Offences Act (2001); Domestic Violence Act (2007).
1.7.3.1 Legal Age of Majority Act

This act established the principle of equality between men and women thus paving the way for other reforms aimed at bringing about this equality. The law confers adult status on all Zimbabweans over the age of 18. It was a huge milestone for women who could not vote, own or register property without male mediation and were considered perpetual minors. Despite this law, women still cannot make major decisions in social relations where they have to seek the consent of their husbands or partners in all major decisions but men can make all decisions independently (Human Rights Monitor, 2001).

1.7.3.2 Medical Practitioners Regulations 122/87

According to this statutory instrument, confidentiality must be kept about health matters of patients so that patients can feel confident to disclose all their ailments so that they get proper treatment (Chirawu, 2006; Kachare, 2008). Under these regulations, disclosure can only be made under the following conditions:

a) Where the medical practitioner is required to make disclosure by the law
b) If Courts subpoena medical records or medical information
c) Where a patient has consented to disclosure to a spouse or partner
d) Where patient is a minor and the guardian has consented to the disclosure
e) Where patient is deceased and consent has been obtained from the estate executor

This clause affects women in the sense that, it prohibits disclosure to the spouse or partner of the patient and up to the present day, women are lobbying for a law that compels such disclosure.
1.7.3.3 Sexual Offences Act (2001)

Section 15 of this act, criminalises deliberate transmission of HIV which carries a maximum sentence of up to 20 years. According to the act one must prove that he or she knew about his or her HIV status and did not take any precautionary measures to protect his or her partner. This law has gained ground in the criminal courts in cases of rape crimes where the offender passes on HIV to the victim.

Zimbabwe does not have an HIV law as in the other states like New Zealand where it is easier to sue someone for wilful transmission of HIV (Bennie, 2009). In Zimbabwe women are the majority but are also the most disempowered group that suing a spouse or partner is unthinkable. In the present study, despite that all the women had got HIV from their partners; no-one had taken any legal action. Moreover, they were not even aware that such a law exists. This shows how much work still needs to be done in order to educate Zimbabwean women especially rural women.

1.7.3.4 Domestic Violence Act

The highlight of this act is the fact that it covers the harm resulting from old age traditional practices which prevail in the country due to patriarchy. These practices include forced marriage, child marriage, wife inheritance, and female genital mutilation. For a long time girls and women who were subjected to such practices did not have the law on their side and had to be meek as a lamb and accept the status quo. However with the advent of this new law, women have the law on their side and can afford to question these cultural practices. Nonetheless, cultural practices do not die easily; they still persist in spite of the new law (Chirawu, 2008). It is however hoped that with the right education women will be able to challenge these cultural practices.
1.7.3.5 Summary

The laws cited above depict the progress the plight of Zimbabwean women and highlights the need for empowerment so that the equality between men and women does not remain on paper alone, but that it translates into reality.

1.7.4 Theories that attempt to explain women’s experiences of HIV/AIDS

1.7.4.1 Human Rights Theories

Human rights theorists base their argument on the fact that in order for HIV and AIDS prevention strategies to be effective, they should promote the human rights of women. They further assert that women experience negative consequences when they disclose to sexual partners due to their unequal social and economic position in Society.

1.7.4.2 Feminist Theories

Feminist theories are based on the premise that the patriarchal nature of society results in the subordination of women because men control every sphere of society. Women have no control even over their own sexuality since the sexual encounter is controlled by men who decide when and how to have sex (Foreman, 1999).

The two feminist theories which inform the study are radical feminism and African feminism. The two theories further explain the negative effects of HIV status disclosure that some studies have revealed to befall women as a result of the social construction of masculinity, which often condones male dominance over women. Jackson (2002) supports this notion by saying that women who inform their husbands of own infection face a greater risk of violence and rejection than men.
Violence also reduces women’s control over their exposure to HIV in the sense that, in settings where violence is regarded as a man’s right, women are in a poor position to question their husbands about their extramarital encounters, negotiate condom use or refuse to have sex (Akerkar, 2001). In addition, Foreman (1999:88) suggests that men drive the global AIDS epidemic since they usually determine the circumstances of intercourse and often refuse to protect themselves and their partners.

The present study, therefore provides a rare opportunity for the most affected group (women) to voice their concerns over their experiences of HIV status disclosure to sexual partners

1.7.5 Summary
The above mentioned theoretical approaches all share one common view with regards to women namely that women are vulnerable beings in society. They portray that society is shaped in such a way that women are subordinate to men and cannot protect themselves against HIV infection because men control the sexual encounter. These approaches are therefore significant because they do highlight the sad plight of women and do call for corrective measures to be employed so as to uphold women’s rights thus elucidating the present researcher’s aims.

1.8 Anticipated Value of the Study
The study will make valuable contributions to the Zimbabwean (1999) HIV and AIDS policy, as it provides a yardstick for measuring the effectiveness of the policy. In addition, the research will also make a contribution to the Zimbabwean social delivery system since the needs of HIV positive women will be weighed against current services available. The research will also influence current legal procedures that deal with HIV status disclosure, for instance, the Sexual
Offences Act (2001). According to the Act, a married person’s HIV status is regarded as private and confidential, thus blocking the effectiveness of HIV prevention and treatment programmes (Irin News, 20 May 2005). The study seeks to rectify this by highlighting the importance of HIV status disclosure in the prevention of HIV infection among those who are HIV negative and the treatment of HIV infections among those who are HIV positive.

Another important contribution that the research will address is the impact of culture on the disclosure process. Culture has been said to contribute to the spread of HIV infection since it glorifies male promiscuity whilst enforcing female fidelity (Foreman, 1999). The present study will therefore shed light on whether culture also has a direct impact on the disclosure process.

1.9 Limitations of the study
The study is aimed at capturing the experiences that HIV positive women undergo when they disclose their status to sexual partners, so as to come up with ways in which women can be helped to disclose freely so that HIV status disclosure can thrive as a prevention and treatment method.

The researcher expected culture to be a limiting factor since the Shona culture is conservative and sexual matters are not discussed openly. However, participants shared their stories openly once the aims of the study had been revealed to them, contrary to the researcher’s apprehension. Most of them felt relieved to share their painful stories with someone making the interviews seem to have had a therapeutic effect on the sample.

1.10 Research Methodology
The methodology of the study is influenced by radical feminist theory which is an emancipatory theory. This type of research requires people to give their personal
experiences of the phenomenon under investigation, and this greatly influences the research design. The study’s methodology is thus divided into the following sections:

1.10.1 Research Approach
The research utilised a qualitative approach since it was an in-depth study of the experiences of HIV positive women who disclose their status to sexual partners.

1.10.2 Research Design
The study utilised an exploratory research design. According to Trochim (2006) an exploratory design is used under the following conditions:

a) When the researcher wants to document the object under study as extensive as possible without restricting the description to topics documented by earlier studies.

b) When the object under study differs from all earlier studied objects and the researcher wants to portray the exceptional character that earlier theories do not portray.

c) When there is little or no information on the subject matter and the researcher has discovered a gap which earlier studies do not cover.

Based on the above criteria, an exploratory research design was the best design to use due to the fact that little is known about the experiences of African women on disclosure of HIV status to sexual partners (Greene et al. 2003). The same authors further state that the impact of culture on HIV status disclosure of women to sexual partners has yet to be researched upon.

The present study does not have a formal hypothesis because it is an exploratory study. According to Trochim (2006) an exploratory study has no formal hypothesis because the purpose of such a study is to explore some area thoroughly in order to develop some hypothesis which can be tested in future
research. Based on the same line of argument, the present study does not have a hypothesis but is informed by research questions (outlined in 1.4, page 4) to which answers are sought. Trochim (2006) supports this notion and asserts that in qualitative research the enquirer uses research questions instead of a hypothesis. He further states that the research questions are made up of a central question and several sub questions related to it which help narrow the focus of the study.

1.10.3 Research Site
Magunje is the largest rural village and principal growth point in Hurungwe Communal land which is in Mashonaland West province (Manyanhaire, Mhishi, Svetwa and Sithole (2009:507). A ‘growth point’ refers to “centres of economic activity which are artificially created or stimulated in disadvantaged regions with the intention that they will eventually become natural centres of economic growth (Conyers, 2001, Carr, 1997, Helmsing, 1986, Penoux, 1958 cit: Manyanhaire, Mhishi, Svetwa & Sithole, 2009:507).

Situated 245 km to the north west of Harare, the capital city of Zimbabwe, Magunje is located on the main trucking route between Harare and Zambia. The nearest town is Karoi which is 35 kilometres away. Truck drivers on their way to and from Zambia stop over at the growth point in search of food as well as entertainment, in the form of women. Local Buses and commuter omnibus drivers also sleep over at the growth point. Military barracks are also located close to the growth point. Combined with the prevailing economic hardships, these factors have contributed to the rise in HIV infection levels.

The above-mentioned factors affected the research in two ways. Firstly, research participants were readily available due to the rise in infection levels. Secondly, they created a context for weighing the effectiveness of HIV status disclosure as a prevention and treatment method. This is essential since the spread of HIV and
AIDS in the Magunje context not only affects Zimbabwe but also affects Zambia as well due to the trucking business.

1.10.4 Research Population
The population of the study consisted of HIV positive women residing in Chidzomba, Kuipa and Kahonde villages, in Magunje Township.

1.10.4.1 Sampling
Purposive sampling method was utilised as the available participants were found through the Catholic HIV and AIDS Herbal Centre. This sampling method was chosen because it maximises the researcher’s ability to “identify emerging themes that take adequate account of contextual conditions and cultural norms” (Erlandson, Harris, Skipper and Allen, 1993:82).

The sample size was 10 women, within the 28-44 years age range. The age range was chosen by the researcher because of its high HIV prevalence rate (UNAIDS, 2004). These women were chosen from Kahonde, Kuipa and Chidzomba villages and in order to be included in the study, participants had to have been diagnosed HIV positive for a maximum of five years and a minimum of one year. In addition, they had to be sexually active since the study focuses on HIV status disclosure to sexual partners.

1.10.5 Data Collection Instrument
The researcher conducted semi structured interviews lasting from forty-five minutes up to one hour. Semi structured interviews were chosen due to the fact that they give room for flexibility and are guided by respondents’ answers. The researcher conducted these interviews from the homestead of the village health worker in order to allow participants some privacy since most of them did not
want their status known by other community members. Such flexibility also made them feel in control of the environment.

The interviews were conducted in Shona and consisted of open-ended questions on which probes were made so as to elicit introspective responses. The reason for choosing this method of data collection was the need to fully explore the experiences, feelings and thoughts of respondents on HIV status disclosure so as to come up with valid and reliable data. The interviews were conducted by the researcher and audio-taped so that no information would be lost. The researcher was further responsible for transcribing and translating the information into English.

Participants were re-interviewed in December 2008 in order to establish the credibility of the present study (see Chapter 3 on credibility and validity. During this interview participants confirmed the study’s results and also made valuable contributions thereby enhancing the credibility of the study.

1.10.6 Analysis of Data
Keeping in line with qualitative requirements, during data analysis the researcher listened to the audio taped stories of the participants several times and analysed these experiences by searching for similarities, differences and emerging themes against the background of existing theory. This was in line with the exploratory research design and grounded theory which emphasises the interpretive approach to data analysis (Glaser, 1998; Charmaz, 2006).

1.11 Ethical Considerations
When undertaking research that involves human participants, a researcher must ensure that the research falls within the ethical requirements that govern such research. This entails maintaining confidentiality, seeking for consent from participants, equitable selection of subjects as well as minimising emotional
harm. In the study, participants were informed about the nature of the study, the benefits and the risks so that they could participate voluntarily. Furthermore, after each session, the researcher debriefed each participant so as to minimise emotional harm. Throughout the research process, the researcher ensured participants did not come to any harm physically or emotionally. This was done through debriefing and counselling each participant after the interview.

1.12 Definition of Key Concepts

The major concepts that were used in this study are as follows:

1.12.1 HIV

The South African Concise Oxford Dictionary (2002:549) defines HIV as the human immune deficiency virus, a retrovirus which causes AIDS. In simple terms this means that HIV is a virus which attacks the immune system making it vulnerable to all types of infections.

1.12.2 AIDS

Grodeck (2003:15) defines AIDS as the Acquired Immune Deficiency Syndrome, a disease caused by HIV, which weakens the immune system making a person suffer from opportunistic infections.

1.12.3 HIV Positive

According to the South African Concise Oxford Dictionary (2002:549) being HIV positive means “...having had a positive result in a blood test for HIV”. This means that one is infected with HIV.

1.12.4 HIV status disclosure

According to Beckerman (2005:1) HIV status refers to the state of either being “HIV positive or negative”. HIV status disclosure, thus, refers to making known to others one’s HIV status.
1.12.5 Sexual partner
For the purposes of this study a sexual partner is defined as a male person with whom one has sexual relations. Sexual relations will be taken to refer to physical intimacy.

1.12.6 Culture
The South African Concise Oxford Dictionary (2002:282) defines culture as the “customs, institutions and achievements of a particular nation, people or group.”

1.13 Outline of Chapters
The study comprises of the following chapters:

- Chapter 1: Introduction and Background to the study;
- Chapter 2: Literature Review. The literature reviewed in the chapter centers on the disclosure experiences of HIV positive women as well as their empowerment so that HIV status disclosure can thrive as an HIV prevention and treatment method;
- Chapter 3: Research Methodology;
- Chapter 4: Presentation of Findings;
- Chapter 5: Conclusions and Recommendations
Chapter 2

Literature review

2.1 Introduction

In this chapter, a review of the available literature on women’s experiences of HIV and AIDS will be made, drawing from the international as well as the African arena. This will be followed by a review of the empowerment model as a tool that women may use in curbing HIV infection.

A review of available literature is essential in the sense that, it contributes towards a clearer understanding of the nature as well as the meaning of the research problem. In addition, literature review helps uncover various studies that have been undertaken as well as the deficiencies of such studies. The deficiencies can be in the form of invalid, incomplete, methodologically flawed, one sided, or biased researches (Obenzinger 2005). As a result, when deficiencies have been realised this paves way for the current study to fill the established gap. Filling the established gap will then add new knowledge to already existing knowledge (Alston and Bowles 2003). Therefore, literature review provides an insight into the dimensions and complexity of the research problem, thus placing the research in a historical context and providing a source for building knowledge about previous thinking.

This chapter will highlight all the above mentioned points by firstly examining the epidemiology of HIV infection in women as well as the various studies that were carried out globally concerning HIV status disclosure to sexual partners. Secondly, an analysis of various international and local institutional as well as legislative instruments and measures aimed at addressing HIV status disclosure will also be made. Thirdly, an analysis of the theories that have been put forward in order to explain how people make disclosure decisions will then follow.
2.2 The Epidemiology of HIV Infection in Women

HIV and AIDS have been with us for approximately 30 years and still continue to challenge us globally. Since the onset of the HIV epidemic, more than 60 million people have been infected with HIV and according to UNAIDS (2002) AIDS is now the leading cause of death in Sub-Saharan Africa. Furthermore, on a global scale, 54% of all HIV positive people are women and in Africa, 2/3 of all HIV positive people are women as well (Hunter, 2003).

Women in Africa are disproportionately affected by HIV and AIDS due to the fact that HIV is transmitted largely through heterosexual sex in the context of gender inequality. As a result, HIV and AIDS are not only driven by gender inequality but entrenches gender inequality, putting women, men and children further at risk. Baylies (2000:1) further states that the factors driving the HIV epidemic are:

….deep-seated and intransigent, embedded in the very power
relations which define male and female roles and positions,
both in intimate relations or the wider society

This scenario is due to the fact that, when it comes to decision making in relationships, men are expected to control the sexual encounter whilst women assume a passive stance. Unequal parties are therefore not in a position to negotiate when and how to have sex, thereby making women vulnerable to HIV infection. Furthermore, the double standard of condoning multiple sexual partners for men, and the expectation that, men should know more about sex, further place women at risk.

According to the HIV and AIDS Epidemic in Zimbabwe (2004) document, Zimbabwean men are expected to exercise complete control in their relationships with women including decisions about how and when a woman will engage in sexual relations. Women on the other hand, are taught from an early age to be
obedient and submissive to males. As a result, these power imbalances make it difficult for women to disclose their HIV status to sexual partners. Since women are usually the first to know about their HIV status via the antenatal clinic or when a child falls sick, the patriarchal nature of the African society makes HIV status disclosure for the HIV positive woman a daunting task.

In an article in the New York Times, Comrade Pascoal Mocumbi, Mozambique’s Prime Minister and former Minister of Health, a physician and a Board member of the International Women’s Health Coalition, made the point that AIDS is spreading rapidly among heterosexuals because of gender inequality and:

*In Mozambique the overall rate of HIV infection among girls and young women, 15 percent, is twice that of boys their age, not because the girls are promiscuous, but because nearly three out of five are married by age 18, 40 percent of them to much older, sexually experienced men who may expose their wives to HIV and sexually transmitted diseases […] To change fundamentally how girls and boys learn to relate to each other and how men treat girls and women is slow, painstaking work. But surely our children’s lives are worth the effort* (Mocumbi, 2001).

The above article portrays how gender inequality is rife in the African context and how this same inequality is fuelling the spread of HIV infection. As a result, in order to combat the spread of HIV infection, the various strategies that have been put in place in order to curb HIV infection should address this inequality. Furthermore, gender inequality is perpetuated by cultural factors which in turn fuel HIV infection as will be shown in the following paragraphs.
2.3 Factors Contributing to Women’s Vulnerability to HIV and AIDS in Africa

As more women are tested than men especially through antenatal settings, HIV is increasingly being seen worldwide as a woman’s disease, such that women are being held responsible for it. This scenario is true about Zimbabwe, just because women are usually the first to know about their HIV status through antenatal settings they are then blamed for being transmitters of HIV. In Nigeria, the same scenario has been confirmed by Falobi (2004). This is not to suggest, however, that women are not vulnerable to HIV infection, they are indeed vulnerable as will be portrayed in the following paragraphs.

Early marriages on the basis of either religious or economic grounds place women in a vulnerable position. In Zimbabwe, some religions encourage early marriages, for instance the Apostolic Faith Sect marries off adolescent girls to elderly members of the church who in most cases will be having other wives. Due to the fact that biologically they would not have matured, early sexual activity increases the risk of HIV infection on the part of these adolescent girls. In some cases these older men (husbands) would have had other partners and are likely to be HIV positive.

Early marriages also foster financial dependence on the husband due to limited schooling and this places women at risk of HIV infection, as they cannot negotiate for safe sex in a sexually unsafe marital relationship. Once married, women are usually expected to remain faithful to their husbands but are unable to compel fidelity in return (Foreman, 1999). A married woman has little or no power to negotiate the basis upon which her sexual relationship with her husband will take place; she has no alternative but to accept the risk that sexual intercourse with her husband entails.

The economic dependence of women increases their risk of exposure to HIV infection in other ways. Lack of access to affordable health care, particularly
treatment of sexually transmitted diseases and other conditions that increase susceptibility to HIV, means women are more likely to become infected as a result of sexual intercourse with an infected partner. Furthermore, low levels of literacy among women means that they are less likely to have access to information about HIV prevention strategies (Campbell, 2003; Hunter, 2003).

Poverty and inequality places women at further risk of HIV infection. Economically independent women are likely to be able to reduce their risk of HIV infection whilst poor women may resort to bartering sex for food and maintenance for themselves and their families. According to Campbell (2003) many young women are involved with older men offering sex in exchange for gifts or lifts. A study by Leclerc-Madlala (2000) revealed that young single women residing in Durban townships eagerly exchanged sex for gifts.

In Zimbabwe, the researcher has noted that in the rural areas some married women got involved in extra-marital affairs in exchange for money for children’s school fees or food. In some cases, sex is also exchanged for favours like ploughing the fields or thatching roofs. Such a scenario is also the norm at Growth points in Zimbabwe, where truck, bus and commuter omnibus drivers are an irresistible attraction for poor women as they have the much needed cash.

Cultural factors also contribute to women’s vulnerability to HIV infection. Women are expected to be sexually innocent whilst men are expected to be sexually experienced (Foreman, 1999). In addition, male infidelity is accepted to the extent that if a man engages in extramarital relations the wife is blamed for failing to satisfy her husband (Ulin, Cayemittes and Gringle, 1996).

Apart from being vulnerable to HIV infection, women are also vulnerable to negative experiences when they disclose their HIV status to sexual partners as well (Gielen et al., 1997; Moneyham et al., 1996; Sherr, 1996). As a result, various conventions and policies have been set up in a bid to protect women’s
rights so that women may enjoy the freedom that their male counterparts enjoy by being able to protect themselves from HIV infection and disclosing their HIV status without fear of violence or stigma. HIV status disclosure is hereby emphasised because it is one of the powerful tools aimed at preventing as well as treating HIV and AIDS.

2.4 The International HIV Policy Framework
On the international level, the following conventions were set up in a bid to protect the rights of women and thus limit their vulnerability to HIV infection.

2.4.1 International Consultation on AIDS and Human Rights (1989)
In July 1989, the Centre for Human Rights conducted an International Consultation on AIDS and Human Rights. The Report that resulted from this consultation emphasizes that special attention should be given to the human rights of women since there are certain factors relating to the reproductive role of women and their subordinate position in society which render them particularly vulnerable to infection.

This theme was taken up by the Committee for the Elimination of Discrimination against Women in its 9th session (1990). A recommendation was made which states among other things, that national programmes aimed at combating AIDS should give special attention to those factors relating to the reproductive role of women and their subordinate position in some societies which make them vulnerable to HIV infection.

The United Nations Development Programme prepared a set of policy principles to assist and guide policy formulation relating to programming and personnel policies. One of these principles states that power imbalances in interpersonal relationships and in society which create women’s subordination must change so that women can protect themselves from HIV infection and its consequences.
2.4.2 The Beijing Platform of Action (1995)
The Beijing Platform of Action is a reform that made a significant point of departure as far as women’s rights are concerned. Held on 15 September 1995, it was realised that despite the call by the Convention on the Elimination of All Forms of Discrimination against Women in 1979, there was no significant change in the way women were treated since in some states, women were still treated as inferior citizens. In addition, women were also singled out as the most affected group since they represent half of all adults newly infected with HIV and AIDS and other sexually transmitted diseases. It was then emphasised that such a scenario was due to the social vulnerability and unequal power relationships between men and women which were obstacles to safe sex practices as a measure for controlling the spread of HIV. A call was then made for all Governments, International Organisations and Non Governmental Organisations to review and amend laws as well as combat socio-cultural practices that contribute to women's susceptibility to HIV infection.

At the close of the conference, it was agreed unanimously that the way forward entailed viewing social, developmental and health issues from a gender perspective. In addition, governments were urged to take specific actions to ensure the empowerment of women so that women could empower themselves against HIV and AIDS. This was to be achieved through the enactment of policies and practices aimed at addressing gender issues. It is encouraging to notice that most governments have adopted programmes aimed at women empowerment but there is still a long way to go before women become totally empowered.

2.4.3 Women and HIV and AIDS Bill of Rights (2002)
This bill addresses the issue of HIV status disclosure by women and acknowledges the fact that women are vulnerable when it comes to disclosing their HIV status. As a result, the bill states that women have the right to disclose their HIV status without fear of violence, discrimination or stigma.
2.5 African HIV and AIDS Policy Framework
In the African context, African leaders adopted the international HIV and AIDS policy framework, and went a step further by conducting the African Charter on the Rights of African women in 2003.

The charter is aimed at asserting the rights of African women and was endorsed by 53 African states who pledged their commitment to the realisation of the rights of African women. One of the Charter’s strong points on HIV and women’s rights is found in Article 14 which states that women have the right to be informed of their HIV status as well as the HIV status of a partner.

However, since the enactment of this charter three years ago, in some African states women are still lobbying for the right to be informed of a partner’s HIV status.

2.5.2 Zimbabwe’s response to the international and regional conventions
The Zimbabwean government took a serious stance to the African and international conventions. The following policies and laws were put in place aimed at narrowing gender inequity and inequality which fuels the spread of HIV infection.

2.5.2.1 Zimbabwean National Gender Policy
The National Gender Policy of 1999 states that the rate of HIV infection is growing faster among women than men thus demonstrating unequal power relations between men and women with regard to the control of one’s sexuality. Strategic Objective C.3 of the policy thus calls for the development of gender sensitive multi-sectoral programmes for the empowerment of women and girls.
The same observation as made at the Beijing Platform of Action is further emphasised in this policy.

2.5.2.2 Zimbabwean HIV and AIDS Policy

Zimbabwe’s National HIV and AIDS Policy of 1999 acknowledges the power imbalances between men and women as well as cultural practices which place women in a vulnerable position where HIV and AIDS issues are concerned. The policy further encompasses all the statutes of the international HIV and AIDS policy framework which recognises the vulnerability of women to HIV as well as the power imbalances that exist between men and women. Furthermore, health officials are allowed by the policy to disclose a patient’s or client’s HIV status to a spouse or partner even where consent is denied. In addition, wilful transmission of HIV or failure to disclose one’s HIV status to a partner carries a maximum sentence of 20 years imprisonment.

Gender Consultants have however criticised the National HIV Policy for failing to bring forth expected fruits due to the fact that, cultural norms combined with the harsh economic climate hamper the policy’s effectiveness (Ncube, 2005). This is due to the fact that even though policies are put in place, their implementation in the wider population takes a long time to be realised. In addition, some people may not even know that such policies exist, especially people living in remote rural areas who are either illiterate or semi illiterate. However, in some cases, policies fail to be implemented effectively because of a clash with some laws or Acts. Zimbabwean women are still lobbying for the right to be informed of their spouses HIV status, even though the policy allows Health Officials to notify partners of HIV positive individuals. This partner notification programme has failed to bear fruits due to the fact that the Current Sexual Offences Act (2001) declares a married person’s HIV status as private and confidential (Irin News, 20 May 2005).
2.5.2.3 Legal Age of Majority Act

This act established the principle of equality between men and women thus paving the way for other reforms aimed at bringing about this equality. The law confers adult status on all Zimbabweans over the age of 18. It was a huge milestone for women who could not vote, own or register property without male mediation and were considered perpetual minors. Despite this law, women still cannot make major decisions in social relations where they have to seek the consent of their husbands or partners in all major decisions but men can make all decisions independently (Human Rights Monitor, 2001).

2.5.2.4 Medical Practitioners Regulations 122/87

According to this statutory instrument, confidentiality must be kept about health matters of patients so that patients can feel confident to disclose all their ailments so that they get proper treatment (Chirawu, 2006; Kachare, 2008). Under these regulations, disclosure can only be made under the following conditions:

a) Where the medical practitioner is required to make disclosure by the law
b) If Courts subpoena medical records or medical information
c) Where a patient has consented to disclosure to a spouse or partner
d) Where patient is a minor and the guardian has consented to the disclosure
e) Where patient is deceased and consent has been obtained from the estate executor

This clause affects women in the sense that, it prohibits disclosure to the spouse or partner of the patient and up to the present day, women are lobbying for a law that compels such disclosure.
2.5.2.5 Sexual Offences Act (2001)

Section 15 of this act, criminalises deliberate transmission of HIV which carries a maximum sentence of up to 20 years. According to the act one must prove that he or she knew about his or her HIV status and did not take any precautionary measures to protect his or her partner. This law has gained ground in the criminal courts in cases of rape crimes where the offender passes on HIV to the victim.

Zimbabwe does not have an HIV law as in the other states like New Zealand where it is easier to sue someone for wilful transmission of HIV (Bennie, 2009). In Zimbabwe women are the majority but are also the most disempowered group that suing a spouse or partner is unthinkable. In the present study, despite that all the women had got HIV from their partners; no-one had taken any legal action. Moreover, they were not even aware that such a law exists. This shows how much work still needs to be done in order to educate Zimbabwean women especially rural women.

2.5.2.6 Domestic Violence Act

The highlight of this act is the fact that it covers the harm resulting from old age traditional practices which prevail in the country due to patriarchy. These practices include forced marriage, child marriage, wife inheritance, and female genital mutilation. For a long time girls and women who were subjected to such practices did not have the law on their side and had to be meek as a lamb and accept the status quo. However with the advent of this new law, women have the law on their side and can afford to question these cultural practices. Nonetheless, cultural practices do not die easily; they still persist in spite of the new law (Chirawu, 2008). It is however hoped that with the right education women will be able to challenge these cultural practices.
2.6 Summary

The Zimbabwean policies and laws cited above depict the desired outcome as far as gender equality and equity are concerned. There is need for these two desirable concepts to translate into reality so that they do not exist on paper only. There is still a lot of work to be done in order for women to be totally empowered. This is highlighted in the following paragraphs on HIV/AIDS status disclosure experiences.

2.7 HIV/AIDS Status Disclosure

Research on disclosure in Sociology, Communication studies and Social Psychology has generally revealed that women tend to disclose more intimate or sensitive information than men. This is attributed to traditional sex role expectations that encourage women to be expressive about emotional matters whilst inhibiting men from such displays. Following this line of thought, one would expect the rate of HIV status disclosure to be higher for men than for women. HIV infection, however, is highly stigmatising, contagious and fatal thus inhibiting disclosure for women.

Research has shown that HIV status disclosure is also affected by relational quality. This is to say that most people disclose their status to steady partners rather than casual partners or one-night stand partners (Ciccarone, Kanouse, Collins, Miu, Chen, Morton and Stall, 2003). Greene, Derlega, Yep and Petronio (2003:69) support this notion and cite the case of one man who had this to say about disclosure to casual partners:

*I always use condoms, but why would I tell someone I picked up at the truck stop. I don’t want to see him again or date. It’s too much to deal with if you talk about HIV. It gets too intense.*

In addition, some people prefer disclosing their status to current sexual partners as opposed to past sexual partners (Greene, Derlega, Yep and Petronio, 2003).
However, in steady relationships, the same authors state that the degree of closeness affects disclosure in the sense that absence of closeness lowers or hinders disclosure.

In order for one to disclose an HIV positive diagnosis one has to weigh the costs for disclosing against the associated rewards. Various consequences of HIV status disclosure abound and these in turn inhibit or promote disclosure. Those who have been living with HIV for a longer period of time and those with increased symptomology are more likely to disclose their HIV status. Those who feel more ashamed about their status are less likely to disclose to casual sexual partners. All the same, stigma has a negative effect on serostatus disclosure for HIV positive women leading to non disclosure.

2.7.1 Positive Consequences of HIV Status Disclosure
As HIV infection progresses, the immune system is compromised further and one becomes ill. It is at this time that one needs all the support, be it financial or social, in order to cope with the illnesses. Hence, disclosing an HIV diagnosis to significant others at this point has positive effects for the individual (Ciambrone, 2003).

After disclosure one can also access available health resources like antiretroviral treatment. In addition, one will also be able to join support groups available for HIV positive individuals. Support groups are beneficial to the individual as they help one to cope with an HIV diagnosis. This is due to the fact that, an HIV diagnosis is stressful to the individual as it uncovers hidden habits or lifestyle of either the individual or his partners. Greene, Derlega, Yep and Petronio (2003:146) illustrate this point by quoting a woman whose husband had disclosed that he got HIV from a male lover, who had this to say: “That’s when I got mad, and that’s when our marriage just went out of the window”. The lady in question could not come to terms with her husband's homosexuality and only managed to do so through membership in a local support group.
On a personal level, disclosing an HIV positive diagnosis to a sexual partner protects that partner from getting infected or from re-infection with another strain of HIV. In addition, disclosure leads to a reaffirmation of one’s sense of self (Parsons et al., 2004; Paxton, 2002). One can also plan for the future more fruitfully, for instance planning for the custody of one’s children, in the event of death. Furthermore, disclosure also provides increased opportunities for risk reduction, for instance, the implementation of preventative measures like the use of condoms (Greene, Derlega, Yep, Petronio, 2003).

Skogmar et al. (2006) are also of the opinion that, disclosure may help break the stigmas surrounding HIV and AIDS so that HIV and AIDS may begin to be accepted the way cancer and other terminal illnesses are accepted. To illustrate the intensity of the stigma surrounding HIV and AIDS, the same authors cite the case of one man who has had to keep his ARV’s in bottles that once held diabetes tablets in order to be accepted by his peers. This is due to the fact that people can readily accept all serious illnesses beyond one’s control like diabetes and cancer but cannot readily accept HIV and AIDS because of the stigma associated with it. Collins and Rau (2000) even suggest that there are three successive epidemics roaming the world. The first one is the HIV epidemic, which is silent and rapidly spreading; the second is the AIDS epidemic, which represents the visible consequences of HIV whilst the third epidemic represents the stigmatization, prejudice and discrimination present in every country dealing with AIDS.

2.7.2 Negative Consequences of HIV Status Disclosure

In the community, disclosure of one’s HIV status is a double edged sword, especially for women. This is due to the fact that, once a woman is known to be HIV positive, the community automatically assumes that her children are HIV positive as well, leading to discrimination of the whole family (Greene et al., 2003). This stigma may also extend to family and friends who may fear that they will also be stigmatised through association with the person with HIV.
al. (2003) cite the case of one woman with HIV who was instructed by her father not to disclose her HIV status for fear that community members would have a bad opinion of her self, her father, and the whole family.

Fear of infection is at the top of the list once one discloses his or her HIV status. Family members become on guard as they try to protect themselves from getting the HIV infection. Despite assurances from previous researches that one cannot get the infection from sharing utensils or from saliva, Greene et al. (2003:139) cite the case of one woman who had this to say about her mother:

*When I got out of a drug rehabilitation program I went to visit my family. Everybody was hugging me. And my mother was just standing back and watching me. She told me, “You shouldn’t kiss the kids. You shouldn’t let them drink out of your cup. You sit over there [pointing away from others].”*

Even those professionally in contact with HIV positive people can also display the same fear of contagion due to misinformation as displayed by the following story of one woman at a drug rehabilitation programme who had this to say;

*I had gone to the bathroom. When I came out, I passed one counselor’s office and he called me in. I asked him what he did want. He said, “What you should do is go and get some bleach and clean the toilet seat. You should clean up behind yourself. It’s bad enough that you are here, but you are going to infect everybody else.” That hurt my feelings* (Greene et al., 2003:138).

The health care system is not without its own prejudices against those who are HIV positive as has been revealed by previous studies. A study by Pool, Nyanzi and Whitworth (2001) revealed that among pregnant women in rural south west Uganda, there was the widespread fear of being discriminated against by medical staff if one was to test HIV positive. Arthur et al. (2000) also state that
this fear of discrimination by health care personnel makes many people to shun voluntary counseling and testing (VCT) services. This fear is also compounded by the fact that health care personnel often adopt a ‘moral policing role’ in which they disclose clients’ HIV positive status to significant others, so as “to protect them” (UNISA centre for Applied Psychology, 2002; Van Dyk, 2001).

2.8 The Experiences of African Women on HIV Status Disclosure
Various studies have shown that more women with HIV than men, support their husbands (UNAIDS, 2002). Jackson (2002) further states that women who inform husbands of own infection face a greater risk of violence and rejection than men do.

A study carried out in Tanzania by Horizons International in 2001, revealed that many women lack autonomy to make decisions about HIV testing since they have to seek for permission first from their husbands. Sixty four percent (64%) of the respondents of the study reported negative reactions of either being blamed for the test or the result, being physically assaulted or being told to leave the house. Furthermore, Falobi (2004) states that Nigerian culture has a long history of labelling, for example in Igbo land, south-east of the country; there is the Osu Caste system in which people of a particular lineage were sacrificed to the gods because they were not fit to marry normal citizens. This labelling system still continues to the present day since Nigerian women are perceived as direct and indirect vectors of STI's. As a result, Nigerian men who are HIV positive can have more than one wife on the basis of religious and traditional norms.

On the same note, a Cape Town study by Matthews et al. (1999) in which 88 HIV positive mothers disclosed their status to husbands or partners revealed the following: 13% experienced violence from partners, 9% were left by partners and 3% were forced to move from home. The study however revealed that disclosure can also yield a positive outcome, since 19% of the respondents revealed that disclosure had resulted in kindness from partners.
Sherr (1996) cites a study by Van der Straten et al. (1995) in which more HIV negative husbands divorced HIV positive wives than the other way round. According to the same study, pregnancies were also more common where the male partner was HIV positive than when the female partner was HIV positive. All the same, when the husband was HIV negative he was more likely to abstain from sex than when the wife was HIV negative. In addition, Campbell, Marum, Alwano-Edyegu, Dillon, Moore and Gumisiriza (1997) contend that violence, the break up of marriages, loss of shelter, food and relationships or even murder are the consequences of disclosure that women encounter. Various studies have also suggested that disclosure of HIV status is a problem for women due to the fact that women are often socially and sexually disempowered and thus, fear the outcome of disclosure (Moneyham et al., 1996; Gielen et al., 1997; Weiss and Gupta, 1998; Gailard et al., 2000; Gielen et al., 2000; Zieler et al., 2000). To illustrate this disempowerment, Van Dyk and Van Dyk (2003) cite the reasons for non disclosure provided by women participants as follows:

My husband will kill me; He will blame me; I know he has many girlfriends, but he will still blame me; His family will say I have bewitched him; He will kick me out and take another woman.

The reasons for non disclosure given by male participants were as follows: Women won’t have sex with me; my wife won’t look after me when I am sick, if she knows that I have AIDS. A comparison of these two sets of responses reveals that women are socially and sexually disempowered.

In a study carried out by Parsons et al. in 2004, 61% of the 52 HIV positive participants expressed the fear that if they disclosed their HIV status they would be rejected both on a personal and sexual level by their casual sexual partners. On the same note, Skogmar et al. (2006) found that fear of rejection led to non-disclosure for the women who participated in their study.
According to Chama and Kayawe (2001), one issue that discourages married individuals from disclosing their HIV-positive status to their spouses is the fact that the person who tested first, will be considered guilty of having brought the infection into the household. The same authors further state that revealing a negative HIV test result creates suspicion also since it’s believed that only people who are not sure of themselves go for testing. A study by Kassaye, Lingerh and Dejene (2005) supports this notion by revealing that 62.5% of their sample had not disclosed their sero-status to sexual partners for fear of partner’s reaction. These women cited the fear of abandonment, rejection and accusations of infidelity as the reasons for non-disclosure.

Furthermore, if women test HIV positive first, they are often perceived guilty of infidelity and the marriage usually breaks (Van Dyk and Van Dyk, 2003; Falobi, 2004). As a result, women tend to keep their diagnosis a secret, exposing themselves and their partners to further risk of infection.

The above studies give a general overview that African women face negative consequences when they disclose to sexual partners. However, in order to ascertain the position of African women’s disclosure experiences one needs to analyse the studies that have been carried out so as to come to a most appropriate conclusion.

2.9 An analysis of studies on women’s disclosure experiences

In this section, four studies of African women’s disclosure experiences will be analyzed. Two of these studies were carried out in America, whilst the other two are South African studies.

2.9.1 HIV status disclosure of African American Women

A descriptive study by Sowell, Seals, Philips and Julius (2003) explored the phenomenon of disclosure of HIV infection by women to various groups of people ranging from sexual partners to relatives and friends. The study specifically
examined women’s level of disclosure to these groups and how the disclosure decisions are made. The sample consisted of 322 African American HIV infected women residing in the southern US. Participants were single women of reproductive age with yearly incomes of less than $10,000. Data was then collected at the first interview of a longitudinal study of reproductive decision making.

The authors chose to focus on African American women due to the fact that although African American and Hispanic women comprise only one-fourth of all United States women, they account for 77% of AIDS cases among women (CDC, 2000). Furthermore, HIV and AIDS remains the third leading cause of death in African-American women of reproductive age (CDC, 1999). In addition, the south of the US is characterized by high levels of HIV infection according to 2000 statistics of the Centers for Diseases control (CDC). In the South there is also limited access to Health Care which is a characteristic of rural areas, furthermore HIV and AIDS is highly stigmatized such that the fear of community members learning of the HIV infection is second greatest after the fear of the disease itself (Sowell, Lowenstein, Moneyham, Demi, Mizuno and Seals, 1997).

The study used Lazarus and Folkman’s theory of stress and coping as the basis for exploring how women disclose their status to significant others. The theory proposes that a person’s cognitive appraisal of a situation or event determines whether that situation or event is viewed as a threat and will determine the person’s response. In addition, Stress theory indicates that a person’s view of the world and their assessment of whether they are able to respond to difficult situations is critical for successful coping (Lazarus and Folkman, 1984). As a result of the stress associated with disclosure of HIV infection, women’s ability to effectively cope may be strained, especially in the context of disclosure to sexual partners. All the same, while it may be necessary for women to disclose their HIV infection to obtain needed resources and support, negative consequences may be associated with such disclosure. Therefore, women’s decisions related to
disclosure of their HIV status are likely to be influenced by their appraisal of the positive or negative consequences of disclosure.

To examine issues surrounding disclosure of HIV status, participants in Sowell, Seals, Philips and Julius (2003) study were asked to indicate who was the first person they had told they were HIV-infected. Choices included husband/partner, parents, siblings, children, other relatives, friends or other. In addition, the women were also asked to indicate the time lapse between diagnosis and disclosure to the first individual. Furthermore, the women were also asked if they had told their current partner that they had HIV.

**Findings of the study**

The study revealed that most women had initially disclosed their HIV status to at least one parent, followed by their husband, siblings, friends, other relations and children. Only 12 (3.8%) women stated that they had disclosed to no one. The vast majority of these initial disclosures (78.3%) were done within the first week after being diagnosed with HIV infection. Of the women who had a current partner, only 25 (8%) had not disclosed their status to that partner. However, in the question about disclosure to specific groups, only 65.4% of the women reported that they disclosed their status to all of their sexual partners.

Many of the participants had specific criteria for choosing whom to disclose to. These criteria were generally based on one of three factors: their relation to the person (health care provider, sexual partner or family member), the quality of their relationship (accepting versus rejecting) and the perceived ability of the other person to keep the information confidential. In addition, sexual partners were often told because of the risk of infection in sexual relations. However, other participants delayed or did not tell sexual partners. One participant said, ‘This is my first relationship since my marriage- I intend to wait six months to tell him because eventually he is going to insist on not using condoms...’ Another participant said, ‘I feel like if I told the males, I wouldn’t have sex anymore’. For
these women, anticipation of negative consequences of disclosure prevented them from disclosing to their sexual partners.

**Critical Analysis of the Study**

The primary purpose of the above study was to explore how HIV-infected women make disclosure decisions focusing on their cognitive assessment of the disclosure event. Secondly, the study sought to identify the characteristics of women who disclosed and at what point this disclosure took place following their HIV diagnosis. In addition, the study also sought to highlight differences between types of disclosure and to whom the women disclosed.

The study made remarkable recommendations or findings where HIV status disclosure of women is concerned but it has some shortcomings. Firstly, the study does not take into account the impact of culture on HIV status disclosure where African women are concerned. It has been documented in literature that African women experience negative consequences when they disclose to sexual partners because they lack the economic and social power to protect themselves (Shaw, 1991). In addition, Baylies (2000) asserts that African women have low status and are powerless when it comes to protecting themselves from contracting HIV or protecting themselves from the negative consequences of HIV disclosure.

Secondly, the study was done in America, a developed country and the present researcher is of the opinion that there are bound to be differences in the way that African women experience HIV disclosure. Despite the double standard of morality in all societies, whether developed or developing which prescribes more circumspect behaviour of women than of men there are bound to be differences in the way African women experience HIV status disclosure. In Zimbabwe, the country where the research took place, there was need for the study to fit into the cultural and economic climate. This was essential in order to come up with accurate information which will guide intervention efforts.
2.9.2 Disclosure experiences of African women working in the United Kingdom

Anderson and Doyal (2004) carried out a descriptive study of women from Africa, living with HIV in London to ascertain their needs and experiences in a foreign country. The sample size was 62 women, recruited from five hospitals between January 2000 and June 2001. Among these participants, 11 were from Zimbabwe. As in most available studies, the study did not focus exclusively on HIV status disclosure but devoted one question to disclosure patterns of these women.

Findings of the study

The results were as follows: Ten of the women had disclosed to health officials only, whilst twenty-two had informed current or previous sexual partners. In addition, six of the participants (10%) stated that they had not disclosed to sexual partners deliberately as a way of protecting themselves from either losing that partner or from abuse. This was an increase of 2% following Sowell et al.’s (2003) study which pegged the percentage of non disclosure to sexual partners at 8%. Although the percentages of non disclosure to sexual partners are closely linked in these two studies, the percentages do suggest that the rate of non disclosure might actually be higher in reality than portrayed in the studies. If one looks at the rate of the spread of HIV infection then the conclusion is such that the rate of non disclosure is actually higher than portrayed in the above studies.

Conclusion

Previous researches support the notion that African women do not disclose their HIV status to sexual partners, due to their economic dependence on men (Campbell et al., 1997; Gailard et al., 2000). However the study by Anderson and Doyal brings in a new twist to the argument, since they concluded that even African women living in the United Kingdom, who are financially viable than their sisters back home are afraid of losing partners through HIV status disclosure. As
a result, fear of losing a partner following disclosure is not tied to financial dependence only. However, the researcher is of the opinion that, where a woman is financially dependent on a husband or partner, then the fear of disclosure is heightened or worsened. To support this point, Kirmani and Munyakho (1996) cite two cases of traditional birth attendants in Kenya who were abandoned by husbands after disclosing their HIV status and turned destitute. These two women regretted having disclosed their status to their husbands since they ended up losing their sources of financial support.

2.9.3 Disclosure experiences of South African women

Two studies from South Africa are analysed and these are studies by Van Dyk and Van Dyk (2003) and Skogmar et al. (2006).

a) A study by Van Dyk and Van Dyk (2003)

This study was aimed at ascertaining the reasons why South Africans resisted participation in voluntary and counseling and testing programmes (VCT) so as to come up with appropriate recommendations. The study utilized UNISA students as voluntary fieldworkers who had the task of randomly choosing two participants from their own communities, to fill in the questionnaires. As a result, the sample size amounted to 1422, and included both urban and rural participants. Even though the study did not focus exclusively on HIV status disclosure to sexual partners, it comprised of one question that required participants to state whether they would disclose the status to husbands or partners.

Findings of the study

Of the 528 married participants, 13.4% stated that they would keep their results a secret. This was a rise of 3.4% compared to the 2004 study of Anderson and Doyal. This rise in percentage supports the present researcher’s argument that the rate of non disclosure is actually higher in reality than is portrayed in these studies. One of the reasons for such a discrepancy might be the fact that during
any given study there will always be people who give ideal answers which are totally the opposite of what they actually do in real life situations.

In the above study, the highest percentage for non-disclosure belonged to men. This was due to the fact that, men were afraid that women would refuse to have sex with them once they disclosed their status. These findings contrast sharply with previous studies which concluded that women tend to keep their HIV diagnoses a secret more than men, for instance studies by Campbell et al. (1997) and Gailard et al. (2002). However, the reasons that participants gave for non-disclosure tally with findings from previous research, for instance, women were afraid of being accused of infidelity, violence or being sent away from home if they disclosed an HIV positive diagnosis to sexual partners or husbands. As for men, the main reason for non-disclosure was the fear of not getting women to have sex with them.

**Critical analysis of the study**

The study makes a major contribution of highlighting how HIV status disclosure affects women and men differently. For men, reasons for non-disclosure are centered on the fear of not getting sexual partners, whilst for women, reasons for non-disclosure spell out the power differences or imbalances. Since the study is in line with findings from other studies that have confirmed power imbalances, one can safely conclude that HIV status disclosure for women is a daunting task.

**b) A study by Skogmar et al. (2006)**

The recent study by Skogmar, Shakeley, Lans, Danell, Andersson, Tshandu, Oden, Roberts and Venter (2006) investigated the effect of antiretroviral treatment and counseling on HIV status disclosure among South Africans. Carried out in Johannesburg, the research was a prospective study of 118 women and 26 men of these, 115 had had one or more partners since diagnosis, 84 had a partner at the time of interview and a further 19 were married.
Findings on Disclosure

The study revealed that 21% had not disclosed their HIV status to their partners. The percentage depicts a rise of nearly 8% as compared to Anderson and Doyal’s 2004 non disclosure rate. This finding is worrying taking into consideration the fact that 80 of these participants had known about their diagnosis for more than 2 years whilst 44 participants had known for more than five years. However, the percentage of non disclosure depicted in this study is in line with findings from previous researches, for instance Olley et al. (2004) found out that 22% had not disclosed to a partner whilst Nachega et al.’s 2005 Sowetan study revealed that 38% had not disclosed to a partner as well. The first study analysed in this chapter that of Sowell et al. (2003) pegged the rate of non disclosure at 8% thus giving the impression that the majority of people do disclose. However, the most recent studies, for instance the study by Nachega et al. (2005) revealed that the rate of non disclosure is actually high; about 38%.

The study further reveals that for those participants (women) who had disclosed their status to sexual partners, 35 had received negative reactions. The negative reactions were as follows: 4 experienced physical violence, 12 were rejected, 9 women were blamed, and 16 partners reacted with denial, whilst 3 partners reacted with silence. Only one male participant reported that he had been blamed by his partner after disclosing, further strengthening the notion that women tend to experience negative reactions more than their male counterparts. Women in this study revealed that disclosure was a risk they preferred not to take since it could make their partners leave the relationship and their children would grow up without a father. Thus, fear of rejection was ranked as the top most reason for non-disclosure.

2.10 Theories of HIV status disclosure

The above studies highlight the plight of women when it comes to HIV status disclosure to sexual partners. Various theories have thus been put forward in order to explain how individuals reach the decision to disclose their status, in
order to explain the reasons for the consequences that accompany such disclosure. Among these theories are medical, psychological, feminist and human rights theories. These theories will be analysed in order to ascertain whether they can be used to explain the disclosure process as experienced by African women.

2.10.1 Psychological Theories
Psychological theories discuss the disclosure process from a cognitive point of view. The consequence theory and the theory of stress and coping will be used as examples.

2.10.1.1 Consequence Theory
The Consequence theory is based on the notion that persons with HIV are likely to disclose their HIV status to significant others and sexual partners once the rewards for disclosing outweigh associated costs. The theory further suggests that as the disease progresses, one undergoes a lot of stress which will make him or her evaluate the consequences for disclosing versus the associated benefits. Disclosure has potential benefits for the discloser. Firstly, disclosure may motivate sexual partners to seek testing, practise safe sex and ultimately decrease the spread of the virus. In addition, the individual benefits from increased opportunities for social support, access to antiretroviral treatment as well as increased opportunities for future planning.

Alongside these benefits, HIV disclosure has a number of potential risks for the individual. Associated risks include blame, physical or emotional abuse, loss of economic support, and the break up of marriages. However, according to the Consequence theory, once an individual decides that the benefits of disclosing outweigh associated risks this eventually leads to disclosure.

The theory tries to explain how the decision to disclose an HIV positive diagnosis is reached for both men and women. However, it does not take into consideration
the cultural impact of disclosing an HIV diagnosis for African women. This is due to the fact that the theory was not generated in the African setting. In the African context, disclosing and HIV diagnosis is not simply a matter of weighing consequences against benefits due to gender imbalances and inequality. Furthermore, the theory does not explain why men react negatively to HIV disclosure by women.

2.10.1.2 Theory of Stress and Coping

This theory proposes that a person’s cognitive appraisal of a situation or event will determine if that situation or event is viewed as a threat and will also determine the person’s response. In addition, a person’s view of the world and their assessment of how they are able to respond to difficult situations is critical for successful coping. Due to the stress associated with disclosure of HIV infection, women’s ability to effectively cope may be strained, especially in the context of sexual relationships where women may be at risk of physical violence, rejection or the break up of marriages following disclosure to sexual partners.

One of the benefits of the theory of Stress and Coping lies in the fact that in order to provide quality health care and support services to HIV-infected women, greater understanding needs to be gained as to how women make decisions related to disclosure. Once this understanding has been gained, health providers and educators can then come up with appropriate interventions that will help women in making the decision to disclose, especially to sexual partners. Disclosure to sexual partners is an important tool in curbing HIV infection.

The shortfall of this theory is that it does not explain why women experience HIV status disclosure the way they do. In other words it does not take into account the power imbalances between men and women, which make women afraid to disclose their status for fear of losing emotional and social security. This notion is confirmed by Kalichman and Nachimson (1999) who assert that HIV positive
women have greater difficulty disclosing their HIV status to sexual partners than do men.

2.10.1.3 Summary of psychological theories
Both psychological theories of disclosure mentioned above focus on the cognitive aspect of disclosure. However, the consequence theory focuses on the impact of disclosure per se and states that disclosure only occurs if it is viewed as beneficial to the one disclosing. This is to say, if one feels that disclosure will bring about negative consequences like rejection or blame, that person will keep the HIV diagnosis a secret no matter how stressful that can be. The theory of stress and coping on the other hand views an HIV positive diagnosis as stressful and suggests that people choose to disclose because they cannot cope on their own. As a result, people do disclose so as to get the support that they need in order to cope with the diagnosis. The theory of stress and coping does not focus on the consequences of disclosure. Both theories are fundamental and complement each other. An HIV positive diagnosis is stressful and one needs to disclose in order to get supportive help and also before one can actually disclose, one needs to weigh the consequences of disclosure.

2.10.2 Medical theories
These theories are built on the notion that physical symptoms of HIV and AIDS act as motivators in the disclosure process, compelling one to disclose the HIV diagnosis to significant others. Disease progression theory will be used as an example of medical theories.

2.10.2.1 Disease Progression Theory
Disease Progression theory is based on the premise that, once an HIV positive person becomes symptomatic, the HIV status cannot be held secret any longer. Furthermore, disease progression results in hospitalisations and physical deterioration, which may make one to disclose his or her status to significant others so as to gain the much-needed social support.
The above theory has been criticised by Serovich (2001) for being outdated. The author further states that the theory found support only during the pre-antiretroviral era when the progression of the disease was unambiguous such that once an individual contracted HIV, the virus rapidly developed into AIDS. The physical manifestations accompanying such progression included lesions and extreme weight loss such that concealing the diagnosis was difficult. However, nowadays, with advances in medicine, HIV positive people live longer and stay healthy for years and do not feel pressured to disclose their status. Even when the disease progresses to such an extent that one is hospitalised, some people even die without disclosing their HIV status to anyone. This point is supported by (Long and Ankrah, 1996:38) who cite the case of a man who kept on insisting to his wife that he had an infection of the liver, until his death although he knew fully well that he was HIV positive. The wife is stated to have remarked:

I was angry that he had refused to tell me. Every day I waited for him to open up but he never did, right up to the day he died. It still pains me even today.

Disease progression theory, as a result fails to explain such variations in the disclosure process where some people may choose not to disclose even though the symptoms of HIV and AIDS can be clearly seen. Some women also do not disclose their status despite being sick, or their children dying; and this is a loophole of the theory. Furthermore, in most African countries anti-retroviral drugs are still not available to many people, that there is no way that the physical manifestations of HIV can be hidden.

2.10.3 Human Rights Theories

Human rights theorists base their argument on the fact that in order for HIV and AIDS prevention strategies to be effective, they should promote the human rights
of women. In addition, the prevention strategies should be planned on the basis of human rights and should be further used as a tool aimed at enabling women to protect themselves against HIV. Women, thus, experience negative consequences when they disclose to sexual partners due to their unequal social and economic position in Society.

2.10.4 Feminist Theories

Feminists view society in terms of gender inequality with women occupying a subordinate position in society whilst men lord it over them. In addition, women are viewed as powerless to protect themselves from HIV infection as well as protecting themselves from the negative consequences of disclosing their status to male sexual partners. Radical feminism and African feminism will be used to highlight the plight of women with regards to HIV and AIDS issues.

2.10.4.1 Radical Feminism

Radical feminist discourse regards patriarchy as the root cause of women’s oppression. Patriarchal attitudes are bred through socialization and the resulting power that is vested in men deprives women of fundamental human rights. In addition, patriarchal attitudes are sustained by a sexual class system in which men assume positions of power and domination while women adhere to positions of subordination. As a result, men benefit from their power over women in every way; from ego-satisfaction to economic and domestic exploitation, sexual domination and political power (James and Busia, 1993; McKay, 1994). Under such circumstances women are powerless to protect themselves from HIV infection since men control the sexual encounter. Furthermore, once women disclose their status to sexual partners or husbands they face violence, desertion, loss of financial support as well as accusations of infidelity (Campbell, Marum, Alwano-Edyegu, Dillon, Moore and Gumisiriza, 1997; Kilewo et al., 2001; Maman, Mbwanbo, Hogan, Kilonzo and Sweat, 2001; Grinstead, Gregorich, Choi and Coates, 2001).
Radical feminism further suggests that women’s HIV status disclosure is accompanied by such negative consequences due to the fact that maleness and male paradigms of rationality are identified with superiority whilst feminity is associated with subjugation and oppression. Culturally accepted male lifestyles like polygamy and having many sexual partners place women and children at high risk of becoming infected through the same male lifestyles. As a result of this social, sexual and economic subjugation women are denied one of the few effective preventive measures for them; that is the negotiation of safer sexual intercourse.

All the same, women do not only lack the power to act or the means to influence male behavior because of the inherent structural gender differences but women have been stripped of voice and self-esteem as well. They feel powerless to the extent that they cannot even talk about safer sexual behavior and practices with their husbands or regular sexual partners. Ulin, Caymites and Gringle (1996) state that if a married woman or long-term partner raises the issue of condoms, men regard this as an admission of infidelity. All the same, even if a woman suspects her spouse or partner of infidelity, she cannot refuse to have sex with him because:

*The man is the master of the house. He is in command. When he asks the woman to have sex, she cannot refuse…* (Ulin, Cayemites, and Gringle, 1996:104).

### 2.10.4.2 African feminism/womanism

This theory developed as a result of the desire of African feminists to come up with a theory that addresses the African situation, from the point of view of the African women themselves. The theory encompasses the African obsession to have children, which is connected to HIV and AIDS and further illustrates that the gender question should be dealt with only in the context of other issues which are relevant for African women. Western feminism, for instance, radical feminism was rejected for being western and for overlooking African peculiarities like
‘interethnic skirmishes and cleansing….religious fundamentalism…in-lawism’ (Ogunyemi, 1997:4).

This theory is favored over radical feminism by the present researcher due to the fact that unlike radical feminism, it views women empowerment as possible within the present society. Radical feminism on the other hand is based on the premise that change is only possible in a new social order which will be based on values centred on women. As a result, African feminism is preferred because of the need to empower women within the present society. The theory is also family oriented and centers on African values. However, the theory is applied with caution due to the fact that it is urban centric. This is to say that, it is only those urban women who are enlightened who realise how oppressive society is; as for rural women, they view patriarchy as the status quo and hence do not see anything wrong with the present social order.

All women, both urban and rural, need to be empowered in order to reduce their susceptibility to HIV and AIDS, and by so doing, this will curb the rate of HIV infection in Africa. When women have been empowered this will also help them cope positively with disclosure experiences. Empowerment of women in Africa is necessary as will be portrayed in the following paragraphs, since women are so disempowered and the continent is characterized by high HIV infection rates, with women being the most affected group.

2.10.4.3 Summary of feminist theories
The above mentioned feminist theories pinpoint patriarchy as the root cause of women’s oppression. African feminism is a development of radical feminism and is most suited to the African climate of women’s subordination since it addresses the African situation from the point of view of the African women themselves. Whereas radical feminism states that change is impossible within the present social order due to patriarchy, African feminism presents a more optimistic stance and suggests that women can be emancipated within the present social
order. This emancipation can be achieved by bringing about equality between the sexes so that women will no longer be viewed as subordinates.

2.11 A Developmental Approach to reducing the risk of HIV infection among African Women

2.11.1 Background to the Developmental Approach

A developmental approach is the best route to follow in the quest for the emancipation of women in Africa in order to significantly reduce their susceptibility to HIV. The developmental approach portrays that women’s experiences of HIV and AIDS are inter-related and have similar origins (www.safaids.net). Hence the focus is on common antecedents rather than the problems themselves and in this way the desired solutions have a lasting impact and help address multiple problems at the same time. Following the same trail of thought, available literature shows that the entire southern African region is made up of patriarchal societies and as a result, cultural practices are the major contributory factor to the increased risk of HIV for women and girls. (www.safaids.net; Chirawu, 2006; Kachare, 2008)

HIV is mostly affecting a particular age group that is the 15-50 age group (UNAIDS, 2004). It is worthwhile to note that women and girls are mostly at risk of HIV because they do not determine the sexual encounter and cannot insist on safe sex (Foreman, 1999; Akekar, 2001). As a result, applying the developmental approach to the present study translates into a holistic approach to the empowerment of women using the empowerment model. The model is not only centred on economic empowerment but also covers the provision of a democratic environment which gives access for all to resources and opportunities.
2.11.2 Background to the Empowerment Model

African women are disempowered and are vulnerable to HIV infection due to the fact that, their lack of resources and understanding constrains them to high-risk sexual behavior, either through prostitution or inability to negotiate for safer sex. Also, women’s vulnerability to infection and risk-taking is increased by cultural attitudes that make it inappropriate for women to be knowledgeable about sex or to suggest condom use (UNAIDS 2001). For instance, most women cannot negotiate for safer sex because of the fear that their partners will desert them. One participant in Eaton et al.’s 1997 study cited by Kauffman and Lindouer (2004) had this to say about her partner:

My partner said to me if I ever mentioned pregnancy or contraceptives to him, he will throw me out of the house. So I never talk about these things with him.

In Zimbabwe, due to the economic hardships which the country is facing at present "Women are getting poorer and poorer, and women continue to be socially and economically dependent on men. What all this means is that women have less control over when and whether they have sex.”(Priscilla Misihairambwi, Director of the Women and AIDS Support Network (WASN) of Zimbabwe)

This scenario is also a result of the patriarchal practices rife in the country, which give men an upper hand over women. This male dominance pervades every aspect of women’s lives and influences their inability to be assertive so as to protect themselves from HIV and AIDS (Abdool, 1998). Poverty and the ingrained belief that women should be subordinate to men very often lead to sexual relations dominated and controlled by men. These factors, worrying in themselves, then translate into violence and coerciveness in sexual relationships (Kauffman and Lindouer, 2004). To illustrate just how deep cultural attitudes go, an elderly woman in Ntseane and Preece’s 2005 study stated that:
In our culture, in marriage two people become one in sickness and in health, this means that if the other person is sick you are also sick. How can I listen to people [western medicine] who do not understand my culture and ask my husband, cousin or any potential marriage partner to use a condom? I must be sick in the head to do that (Ntseane and Preece, 2005)

The above statement explains why HIV prevention programs have even failed to curtail the advent of new infections, because the majority of the people feel that:

Knowing about HIV and AIDS is not a problem. We all know and are actually tired of the radio messages about HIV prevention but…. women have no power when it comes to sexual decision matters. Not only that, most men.... do not believe in using condoms. They say they develop rash around the male organs when they use condoms. Government should try condoms with boys not their fathers, who knows maybe the young ones are different? (Ntseane and Preece, 2005).

As a result, what is really needed in order to deal positively with the HIV and AIDS epidemic is a gender-based response which focuses on how different social expectations, roles, status and economic power of men and women affect and are affected by the epidemic (UNAIDS, 2001). This gender based response will analyze gender stereotypes and explore ways in which inequalities between women and men can be reduced so that a supportive environment can be created. This supportive environment will in turn enable both men and women to undertake prevention and to cope better with the epidemic.

A gender based response is the best way forward because:
• Inequality between the sexes limits women’s access to care and services thereby reducing both men and women’s opportunities to acquire knowledge about safer sexual practices, as well as the development of skills to protect themselves from HIV.

• The large difference in attitudes towards men and women's sexuality, both within and outside of marriage which makes promiscuity in men much more acceptable, exposes men to an increased risk of infection. This risk of infection then increases the chances of transmitting HIV to their partners.

• Although HIV and AIDS affect all people, women are more vulnerable because of biological, social, cultural and economic factors. As a result, the rapid spread of HIV and AIDS among women can be slowed only if a gender based response is applied.

Most people now agree that the lack of cultural and economic power is a key factor in the transmission of the HIV virus among women, since women are helpless to defend themselves against the advances of HIV-infected men. Given that previous HIV and AIDS prevention strategies have focused on providing HIV and AIDS information without recognition of African women’s limited economic empowerment, these strategies have proved to be less effective. There are also many conferences on HIV and AIDS prevention that have been conducted but it is sad to note that most of these participants were either educated elites or in-school youth. Hence, a shift of focus towards village women in their localities, the out of school youth and the younger youth would go a long way in providing the much needed solutions. This is due to the fact that the above mentioned groups are the most vulnerable groups in society because they are the ones most immersed in local discourses.

A focus on the younger youth is worthy because of the fact that it is very difficult to change the older generation whose values have become ingrained to such an extent that it becomes a ‘second self’. Thus, in order to establish enduring
patterns of behavior on the part of boys and men, values such as tolerance, respect for the opposite sex as well as equality must be instilled at a tender age for boys so that by the time they mature they would have mastered this. Young people are now the hope and key to defeating the HIV and AIDS pandemic which is ravaging our continent (Leclerc-Madlala, 2002).

The researcher therefore recommends that future HIV and AIDS empowerment programs should be target-specific and context-based as will be highlighted in the following discussion of existing as well as suggested empowerment programs. At this point, it is essential to define the context in which empowerment of women will be used in this chapter as well as the whole study. Empowerment refers to the 'intent to hand over power to interpret, analyze and come up with solutions' to the affected people themselves (Akerkar 2001: 2). In order for such a scenario to happen, genuine participation is required. Empowerment therefore, occurs when people realize that some important aspect of their lives can be different, and that change is possible. Once a person reaches that state of being able to genuinely make free and informed decisions, then that person is empowered.

### 2.11 Ways in which women can be empowered

There are various ways in which women can be empowered and the following is a discussion of some of these methods. The emphasis in all the highlighted methods is participatory development, whereby both men and women are actively involved in all empowerment programmes. Women as the disempowered group should be encouraged to shape their destiny and should be given the platform to do so. A human rights approach must be emphasized which entrenches the principle that governments are accountable to the people who voted them into power. This will therefore mean that each time a woman fails to negotiate safer sex; this is seen as a violation of her civil rights.
2.11.1 Women to be part of research agendas

Any empowerment program for women that does not involve them fully is a sham and a waste of resources. Women should come up with research agendas and topics that pertain fully to their everyday experiences, so that they can get solutions to their immediate concerns. One such empowerment program was the International community of women living with HIV and AIDS (ICW) Positive women: Voices and choices program. The program was a project led by HIV positive women aimed at exploring the impact HIV on their sexual behavior, wellbeing and reproductive rights in a bid to promote improvements in policy and practice. ICW was partnered by Women and AIDS Support Network (WASN) in Zimbabwe and drew participants from four provinces, namely, Manicaland, Midlands, Matabeleland South and Harare. The result of the project was the empowerment of many Zimbabwean women who participated in that program. Participants had this to say about the program:

From the beginning of this project positive women were involved in issues which will be researched on and that was very encouraging. During the process I realized that I was being empowered. I have really changed gained confidence and I have also gained status in the community. I am now invited to workshops and meetings whenever there are women’s issues being discussed (Otilia Tasikani, team leader: Feldman, Manchester and Maposhere 2002:17).

Other participants also got to know about their rights as women, for instance two peer leaders said:

Before the project, we did not know that if you were forced to have sex by your husband it will be rape. We did not know that you have the right to report it to the police (Feldman, Manchester and Maposhere, 2002:18).
Involving women in this way is a powerful empowerment tool which enables women to have a say in their emancipation. When women feel that they have such influence in research this will give them power to shape their destinies in ways that reduce their risk to HIV and AIDS. This is due to the fact that when the people who are most affected by any development issue become part of the process of defining the problem and finding solutions, this leads to empowerment as an end in itself.

As a result, more studies of this kind are needed since they encourage active participation of HIV affected communities while at the same time linking research to the promotion of change in women’s lives. Similar participatory research for men is needed also because men’s vulnerability to HIV infection and risk-taking is heightened by cultural attitudes that allow sexual promiscuity for men and by the number of predominantly male occupations that entail migration, thus, disrupting family life.

Whiteside and Sunter (2000:140) state that a solution to the HIV and AIDS epidemic is:

*To look upstream at what can be done to change the environment in which people live and make decisions about their sexual behavior. Essentially, the goal is to empower people so that they can make decisions which will reduce risk of infection. This means examining the socio-economic causes of the epidemic and countering them.*

From the above statement, it is clear that one sided empowerment programs will not be successful; hence it makes sense to include men as well. Some programs have tried to involve men and an analysis of these programs will follow.

### 2.11.2 Men to participate in HIV and AIDS prevention programmes

In patriarchal societies like Zimbabwe, men have a dual role. They are not just leaders, policy makers and decision makers in matters of sex; they are also sex
clients in an environment conducive to the spread of the HIV virus. As a result, HIV and AIDS empowerment programmes should promote men's understanding of their role and responsibility with regard to protecting women's health and reducing the transmission of sexually transmitted diseases, including HIV and AIDS. This responsibility is in line with their cultural role of provider and protector of women.

The push for women’s rights by gender based organisations has not provided the much needed results because, before anyone can change their behaviour they need to know and realise the need to change that particular behaviour (Barnett and Whiteside, 2006). Behaviour change is always done in relation to one’s cultural values and beliefs; therefore it is important to empower men to dictate safe sex practices by providing them with discourses that appropriate, rather than resist, existing ones.

In some countries programs of this kind have been implemented on a trial basis, for instance, a Vietnam project by Care International named 'Men In The Know' developed sexuality training for men with the aim of promoting safer sex within relationships. The programme started with 2000 men. The participatory workshop focused on two broad areas namely imparting knowledge on the physiology of sex and challenging socio-cultural factors that shape sexual encounters. In addition, a pilot component was also directed at men who visit sex workers. This component tested the effectiveness of a new approach, 'social marketing', in bringing about behavioural change through the communication techniques commonly used in commercial marketing.

The results were such that men responded positively and commented on how they could now make responsible decisions. However, the researchers came to the conclusion that the deep-rooted gender inequalities that shape sexual encounters are more difficult to transform since men still decide when and where sex would happen as well as how it should happen. However, such programs are needed to conscientise men, even if it means that only a few can change their
behavior at a time. If such programs are implemented in Zimbabwe, this will lead to some change, irrespective of how minor that change can be, better still it is better to save a few than to let everyone die of HIV and AIDS. This is due to the fact that, men and boys are partners, fathers, friends, community members and also leaders. As a result, they can be role models for their families and society by advocating respect for women and intentionally protecting their partners. They can also practice open communication so as to build equal and safe partnerships (UNAIDS, 2001). It is hoped that when men are equipped with the right kind of knowledge and skills they may improve their behavior.

2.11.3 Economic empowerment: Trust Banks

An original idea from Opportunity International, a non governmental organization based in America, but with various partners in Africa; trust banks refer to micro lending enterprises aimed at empowering women economically by offering micro-loans. The reason behind such an initiative is to prevent the use of sex as a means for survival, for economically disadvantaged women, thus reducing women’s vulnerability to HIV infection, gender based violence as well as violence pertaining to HIV status disclosure.

Since most women lack traditional collateral, the loan is given solely on the basis of personal integrity, a move which builds the dignity of the women involved. Furthermore, the loan enhances the self worth of these women, because of the fact that it is a loan and not a hand out. The end result is that these women are no longer forced by economic forces to participate in either commercial sex work or transactional sex. Sexual encounters are then undertaken out of choice instead of obligation or necessity. At this level, the empowerment process becomes complete since women can now make choices. Apart from issuing out loans, Trust banks offer HIV and AIDS education and services at weekly loan repayment business meetings. Such meetings provide a forum for the deliverance of information on prevention as well as coping skills to people living with HIV.
It is the researcher’s opinion that Trust banks meetings can also be used as a forum for helping those women who would not have disclosed their HIV status to sexual partners for fear of being cut off economically by their partners. Discussions with peers can give them the skills they need. Furthermore, once a woman has a stable source of income she would not depend solely on her sexual partner for survival, thus increasing disclosure levels. It also means that women will be in a position to negotiate for safer sex without fear of desertion.

In Zimbabwe, Trust Banks were introduced by Women Vision International, through the Zambuko Trust in 1996. The trust is involved in issuing out loans to groups of 15 to 30 women who want to lift themselves out of poverty. However it seems there has been a shift in HIV and AIDS focus favoring economic empowerment solely (Women Vision International, 2001) since the trust is not offering HIV and AIDS prevention programs or education.

One of the setbacks of trust banks is the fact that they only strive where there is a viable market and where the clients have some sort of expertise in the businesses they venture into. Epstein (2006) gives an account of a failed micro lending program called Shaping the Health of Adolescents in Zimbabwe (SHAZ) led by Megan Dunbar, an American graduate student. The year was 2004, and the program recruited fifty young women aged 16 to 20 from Chitungwiza and Epworth, two slum neighborhoods near Harare. The women were given training in entrepreneurial skills such as making a business plan, identifying markets, and managing finances. The training went as further as addressing the subject of AIDS and AIDS prevention and in September, each woman went into a business venture of her own choice holding a loan of about $150. This loan was to be repaid in monthly installments out of the profits made. However, six months later, only 5% of the girls had met their loan repayment targets. To make matters worse, Zambuko Trust, the microfinance agency that administered the loans for
SHAZ had actually lost track of the majority of girls in the program. What worried the directors of SHAZ most was the fact that, the programme had the opposite effect on these girls since it placed them at risk of HIV infection because most of them resorted to transactional sex after the business ventures failed.

Despite the failure of SHAZ, trust banks, can and are a sure way of empowering women. The good part of these banks is that they can be utilized by all women, whether single or married. For the married woman, participation in a Trust Bank helps her by improving her income generating capacity so that she will not be tempted to seek occasional sexual partners to make ends meet. As the Trust Bank uplifts her economically, she will be able to negotiate for safer sex and can even dare to leave a high-risk sexual relationship. Since many single women become sex workers or rely on transactional sex to make ends meet, Trust Banks will provide these women with financial alternatives to selling their bodies. Girls from low-income families who are vulnerable to enticements by older men (sugar daddies) can also benefit from trust banks in the sense that, once their mothers’ income is increased, there won’t be any reason to get involved with sugar daddies.

AIDS impoverished widows can also be beneficiaries of trust banks because most often, widows are plunged into poverty after the deaths of their husbands as relatives customarily inherit all the assets. As a result, Trust banks can be a source of hope in their misery; since the income generated will secure their economic status, whilst the meetings will provide a supportive structure to begin a new life.

2.11.4 Working with traditional doctors

There is also a need to work with the most influential and effective health educators, namely, traditional doctors, because they are part of the solution and many people have faith in them. Many people shun away from hospitals and visit traditional doctors. One female traditional doctor interviewed in Ntseane and Preece’s (2005) study said:
We have not been fully involved in the fight against AIDS, we refer patients to the modern medical doctors but they never refer patients to us. Is it because they look down upon our practice? They better remember that they [white doctors] and their pills found us here and our patients know better. That is why they still come to us.

The above statement spells out the dissatisfaction of traditional doctors. In Zimbabwe, it is only late last year that traditional doctors were allowed to offer sick leave to their patients, a privilege which had been enjoyed by modern medical doctors since time immemorial. As a result, involving traditional doctors as part of the empowerment solution will help, since in Zimbabwe, the traditional doctors even have their own organization, named Zimbabwe traditional healers association (ZINATHA).

2.11.5 Working with traditional leaders

Traditional leaders like chiefs and village headmen can also be utilized in the empowerment processes. Too often, these structures address meetings where pressing issues in the village are discussed. For instance, in Zimbabwe, at these meetings the norms are reinforced for instance, punishing people who do fieldwork (ploughing on the days that are set aside as sacred by the chiefs). In Magunje, Mondays and Thursdays are days that people are not allowed to go to their fields because they are considered sacred days. If the traditional leaders take it upon themselves to empower men and women to prevent HIV and AIDS by using the same determination they use for sacred rituals, things will work out because they are influential people.

Another introduction in the rural areas of Zimbabwe is the use of neighborhood police who are actually chosen by community members themselves, to ensure peace and order. Most of these neighborhood police focus their attention on criminal activities like robbery and if only they could channel their efforts on
empowerment and ensuring that women do not suffer violence at the hands of males, this would help. It is a pity that domestic violence is still seen as a domestic issue, and yet it is this violence that predisposes or increases the risk of women’s vulnerability to HIV infection. This is due to the fact that, violence reduces women’s control over their exposure to HIV in the sense that, in settings where violence is regarded as a man’s right, women are in a poor position to question their husbands about their extramarital encounters, negotiate condom use or refuse to have sex. (Akerkar, 2001).

2.11.6 Women and Health programs
The good health of any nation is absolutely critical to its longevity and future survival; hence, strategies to improve the health of women must be central to any poverty reduction effort. There exists a strong link between poverty, high birth rates, maternal and child mortality. This link speaks volumes about the abuse of women’s rights as outlined in the Beijing platform for action. To support this notion, an HIV positive woman in Feld et al’s study stated that:

\[
\text{At the moment I am six months pregnant. I had to have a child to please my husband. It is not my choice, my husband paid lobola and he must have a child} \ (\text{Feld et al 2002:27})
\]

The above mentioned woman portrays the plight of many HIV positive women who risk their health in order to please their husbands on the basis of the lobola that was paid for them. As a result, programs aimed at improving the health of women, especially the dissemination of health information to both men and women about the risks involved when women are both HIV positive and pregnant will empower the traditionally bound women.

2.11.7 Working with sex workers
Projects aimed at sex workers would also be one way of empowering women (sex workers) to successfully negotiate safer sex with clients. For instance, the
Sonagachi project, which works with sex workers in India, is an illustration of how essential it is for those who are directly involved to bring change themselves rather than relying on outside help. In the project sex workers distribute condoms, are peer educators, clinic assistants as well as attendants for the Sexually Transmitted Diseases (STD) clinic. Such projects are empowering to the sex workers and would be beneficial to Zimbabwe, especially at Magunje growth point where sex workers have been said to be powerless to negotiate condom use with clients. Instead they have been noted to demand, what they call ‘a risk fee’ which is an extra charge for unprotected sex. Some sex workers even favor unprotected sex since it means more income due to the risk fee, but the sad thing to note is that they forget that an HIV diagnosis is irreversible.

A project almost similar to the Sonagachi project which has proved to be successful in Zimbabwe is the Gweru Women’s AIDS Prevention Association (GWAPA) located in Gweru, Zimbabwe. Members are, single, widowed, divorced or engaged in prostitution. They get training in small business skills and get to support each other at branch level, through peer counseling, financial support and socialization. Members in need of loans to augment their personal business projects are also helped, whilst other women act as peer educators, distributing condoms, performing dramas and educating the community about STD’s and HIV and AIDS. If many similar programs could be launched in the country this would go a long way in empowering women and in turn reducing the rate of HIV.

2.11.8 The use of support groups

Support groups are not a new phenomenon for people living with HIV and AIDS; they have been existence for some time now. However, the problem is that, in some areas they have not been implemented especially in remote areas (rural areas). In some communities, the stigma associated with HIV and AIDS is so great to the extent that one cannot even disclose an HIV status let alone implement or become a member of an HIV and AIDS support group (Greene et
al, 2002). As a result, some rural people who are HIV positive do not know about support groups and thus lose out on the benefits associated with support groups.

Support groups offer collective strength for people living with HIV and AIDS as well as a sense of identity. Members are enabled to become more open about their HIV status, especially disclosing to sexual partners. In addition, support group members get to realize that life continues even after an HIV positive diagnosis. This sentiment was echoed by one woman in Feld et al’s 2002 study, who said:

_The people I met at Mashambanzou (a support center where members form their own support groups) gave me the strength to go on. They were always cheerful and they were always laughing. During my first days, I could not believe they were HIV positive. How can one be so happy when she knows that she is going to die?_ (Feld et al, 2002:29).

The above mentioned woman had tried to commit suicide twice before she joined the Mashambanzou centre.

In the villages around Magunje, support groups do not exist and worse still an HIV diagnosis has a lot of stigma attached to it. The Catholic Church initiated a program for HIV positive people around Magunje where trained volunteers dispense drugs, protective clothing, maize seed, fertilizers as well as herbs(seedlings) to those living with HIV and AIDS in their communities. These volunteers have to date made little success with formation of support groups because people do not want their HIV diagnosis to be known, rather they prefer going to these volunteers secretly and get the drugs they need. In some areas, the program was a total failure since people who are HIV positive were not coming out in the open.
Despite this failure, support groups are essential, and the researcher is of the opinion that NGO’s, religious organizations and even the government should work together to conscientise rural people on the necessity of support groups. Information should be dispensed to rural folk, in the same way that the necessity of antiretroviral drugs has been made to the extent that people now see the need for taking these drugs. People should be educated in such a way that the emphasis is on participation and self-reflection, using participants’ own abundant experiences, as well as promoting active social involvement as a resource for empowerment and change (Trevithick, 2005).

2.11.9 Activism and Volunteerism

These two empowerment strategies are direly needed especially in areas where an HIV diagnosis is highly stigmatized. Activists pay heavy consequences for disclosing an HIV diagnosis, for instance, Gugu Dlamini; a South African woman was stoned to death by members of her community for disclosing publicly her HIV status on 12 September 1998. In Zimbabwe, Tendai Westerhorf, is one strong HIV and AIDS activist who is currently involved in many programs aimed at empowering women to fight the HIV and AIDS epidemic. She has won national and international fame, and some have even remarked that she has aptly replaced Cecilia Chimusoro. The later was also a strong Zimbabwean activist, one of the first to disclose publicly her HIV status. She worked tirelessly till her death advocating for the rights of HIV positive people, especially the stigmatization they face. Many people living with HIV volunteer at counseling centres, support centres, as well as drop in centres for HIV positive people. Volunteerism has positive benefits both for the individual and the community at large.

2.11.10 Upholding Human Rights

Prevention strategies aimed at empowering women will only be effective in protecting women from the effects of HIV if they embrace a recognition and
active promotion of the human rights of women. International forums like the Beijing Platform for Action are a powerful tool that can be actively used to enable women to protect themselves against HIV. The urgent and critical need to improve the social and economic status of women so as to overcome their vulnerability to HIV means that human rights considerations should look beyond immediate concerns such as discrimination against people with HIV and access to health care to address the fundamentally unequal social and economic position of women.

The HIV epidemic on its own has launched a savage assault on the human rights of women. First and foremost women are denied the right to life since they are forced, by reason of their subordination, to be exposed to HIV infection. Furthermore, women are powerless to adopt any measures to avert death from AIDS (Human rights monitor, 2001).

Women also have a right to knowledge, but most women live in ignorance of laws and policies that directly affect their lives, especially women who stay in rural areas which are in most cases remote areas where they are cut off from the rest of the world. For instance, the researcher noted that, despite the fact that there is the Domestic violence law in Zimbabwe, most women in Magunje do not know about the law, and yet that law was enacted with the intention of protecting them. Varaidzo Munyika, A counselor at Musasa Project (a program that deals with abused women) asserted that, even in cases where women have the knowledge of the laws; cultural dynamics are a barrier to the use of laws, because “women never want to use the law - they will exhaust all other social avenues to resolve their differences.” (Plus News, Jan 2007). However, the law was made and needs to be used even if it means, being used as a last resort.

Women also face unequal access to domestic, social, economic, political and public structures (Human Rights Watch, 2001). As a consequence of the inequality embedded in these structures, it is women mostly who suffer
disproportionately from HIV and AIDS (UNAIDS, 2004). Thus, moving women’s issues up the political agenda and increasing their representation in positions of power and decision-making will go a long way in empowering them. Laws aimed at eliminating harmful cultural and traditional practices should also be put in place since these cultural practices and traditions violate the human rights of women and girls.

In rural areas, where farming is the predominant mode of production and women do not own land, there should be a redress of the situation. Government should also go a step further and legalize as well as enforce measures to ensure that women are granted the property and ownership rights that they deserve.

2.12 Conclusion
Women in Africa are vulnerable to HIV infection and an analysis of disclosure experiences portrays that they face negative consequences when they disclose their status to sexual partners. As a result, in order for HIV prevention programs to be successful, there is need for a gender based response which takes into consideration the gender inequalities that is fueling the spread of HIV and AIDS. However, for total empowerment to be realized, men need to be involved also, since they are mainly the ones who control the sexual encounter.
Chapter 3

Research Methodology

3.1 Introduction

The study explores the experiences that HIV positive women undergo when they disclose their status to sexual partners. In order to achieve this goal, a qualitative research approach was utilised. This chapter therefore highlights the steps that were followed in the collection, analysis and interpretation of data. The ethical considerations that the researcher observed also receive attention in this chapter followed by a discussion of the limitations of the study.

3.2 Research Approach

A qualitative approach was utilised for the purpose of this study. Qualitative research "claims to describe life worlds from the ‘inside out’ from the point of view of the people who participate, so as to create a better understanding of their experiences (Flick, Van Kardoff and Steinke, 2004:3). The research, therefore, utilised in depth interviews in order to gain insight as well as an understanding of the disclosure experiences of HIV positive women. This research approach was suitable because the researcher’s need is to understand the experiences of HIV positive women. Furthermore, qualitative studies aim for depth of understanding in order to generate rich observations (Henning, Van Rensburg and Smit, 2004; Rubin and Babbie, 1997). The approach enabled the researcher to obtain a deeper understanding into how these women describe, make sense, interpret and give meaning to their experiences (Schurink, 1998).

3.3 Research Design

An exploratory research design was utilised because of the paucity of information on the experiences of women when it comes to HIV status disclosure to sexual partners. Also, an exploratory design was chosen because previous research
studies on women and HIV do not address the impact of culture on HIV status disclosure (Feldman et al., 2002; Hunter, 2003; Machipisa, 2007). The current study seeks to address this shortfall.

The present study did not make use of a formal hypothesis because it is an exploratory study. This was in line with Trochim (2006) who asserts that an exploratory study has no formal hypothesis because the purpose of such a study is to explore some area thoroughly in order to develop some hypothesis which can be then tested in future research. Based on the same line of argument, the present study however was informed by research questions (outlined in chapter 1) to which answers were sought. Trochim (2006) supports this argument when he states that in qualitative research, the enquirer makes use of research questions instead of a hypothesis.

3.5 The Population
The population of a study refers to all potential subjects in the universe who possess specific characteristics the researcher is interested in (Strydom, 2005). In addition, Gray (2005:82) further defines a population as ‘the total number of possible units or elements that are included in the study’. The population of the study therefore consisted of HIV positive women residing in Chidzomba, Kuipa and Kahonde villages, in Magunje Township. Since the researcher could not interview all HIV positive women residing in the above mentioned villages she had to draw up a sample.

3.5.1 Sampling strategy
In order to participate in the study, respondents had to meet the following criteria:

- They had to be within the 28-44 years age group at the time of the study (see 1.10.4.1, page 12 for an explanation on the choice of the age range)
- They had to have been diagnosed HIV positive for five years or less.
• They had to be sexually active meaning they had to be involved in a relationship with a male partner at the time of the study. This was asked during the preliminary interview.
• Respondents had to be willing to avail themselves for the interviews at the Village Health Worker’s homestead.

Non-probability purposive sampling method was employed in order to get ten HIV positive women as respondents for the study. The reason behind the choice of such a small sample was the desire to come up with in-depth information which is only possible when working with a small number of respondents. In addition, the notion of choosing a smaller sample is supported by Shearfor and Horejsi (2006:614) who maintain that 5 to 10 respondents are sufficient when carrying out a qualitative study.

Purposive sampling is based on the judgement of the researcher on what constitutes the typical elements that embrace the most typical attributes of the population (Strydom and De Vos 1998:198, Alston and Bowles 2003). The researcher thus chooses a particular case because it displays some feature or process that is of interest for a particular study (Silverman, 2000:104). The researcher approached the village health worker, Mr Mavhiri, who was working with HIV positive people under the Ministry of Health’s initiative to provide quality health care for people living in the rural areas, in order to access HIV positive women.

3.6 Data collection
The researcher utilised in-depth one-on-one interviews to collect data from the respondents. Interviews were used as the data collection method in the study since the researcher aimed at understanding disclosure experiences from the point of view of the women concerned (Greeff, 2005). Interviews are further essential as a data collection method in the sense that the human use of
language is not only a behaviour in its own right but is also a window that gives insight into what lies behind human actions (Robson, 2002).

The instrument used in collection of data was the interview schedule which is attached as Appendix A. In addition, the interviews were semi-structured and each main question was accompanied by relevant prompts utilised in order to gain a deeper understanding of the experiences of the respondents. The interview schedule however was not tested in a pilot study due to the sensitive nature of the topic.

3.6.1 Participants and Setting
Arrangements for the interviews were made through Mr Mavhiri who offered his homestead as a venue for the interviews, so as to give the respondents the privacy that they deserved. Such an arrangement further enhanced the creation of a relationship based on trust enabling the respondents to confide in the researcher. The building of trust is essential in any research project in order to come up with accurate results which lead to accurate conclusions.

Preliminary interviews were conducted in which participants’ suitability to participate in the study was assessed. The preliminary interview was a means of screening the participants and focussed on potential participants’ age and HIV status. Five potential participants were turned down because either they had not been tested at any VCT centre or denied that they were HIV positive. A sound explanation for turning them down was explained to them in a humane way.

The interviews were conducted in Shona, the local language spoken in Magunje so that respondents could express themselves freely in their own language. Each interview took 30 to 45 minutes depending on the respondent’s state of health, and the extent to which they wanted to disclose their experiences. In other words, the researcher took care not to strain the respondents who were physically weak but for those respondents who wanted to share their experiences
in detail, the researcher made room for that and provided counselling at the end. However, with each interview, the researcher ensured that all respondents were asked the same questions for standardisation purposes.

3.6.2 Observations
During the interviews, the researcher took note of respondents' behaviour (verbal and body language) and recorded the comments on the field recording form using the guidelines shown in Table 3.1 over leaf. This was done so as to minimise the loss of data and to make accurate conclusions during data collection, reflection and analysis.
Table 3.1 field recording form

<table>
<thead>
<tr>
<th>Observer</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Notes: observations</td>
<td></td>
</tr>
<tr>
<td>- state of health (physical appearance e.g. emaciated body)</td>
<td></td>
</tr>
<tr>
<td>- facial expression at different points in the interview</td>
<td></td>
</tr>
<tr>
<td>- pauses in the conversation and significance, e.g. a pause could denote hesitancy, fear to disclose, or recalling</td>
<td></td>
</tr>
<tr>
<td>- emphasis of certain points or statements, especially on the question on the source of infection</td>
<td></td>
</tr>
<tr>
<td>- confidence level, as a determinant of the truth and knowledge of the subject at hand</td>
<td></td>
</tr>
<tr>
<td>- breaking of voice as a significance of painful memories or strain</td>
<td></td>
</tr>
<tr>
<td>- shortness of breath as a significance of physical strain or painful memories</td>
<td></td>
</tr>
</tbody>
</table>

Event: Qualitative research study

Field researcher’s comments

- On this section, the researcher wrote down the impressions of the interview based on the observations carried out. This was done for each participant. The impressions were then matched with the transcriptions so as to come up with accurate conclusions.

The interviews were audio taped by the researcher and later transcribed. The use of audio tapes is encouraged by Robson (2002:289) who asserts that “The tape provides a permanent record that allows you to concentrate on the interview”. The 10 audio taped interviews were transcribed by the researcher herself, ensuring that the answers obtained from the prompts were merged with answers given for the main questions.
Transcriptions were proof read by Ms S. Zambezi, Shona and English lecturer at Crescent College in Harare. To enhance confidentiality, pseudonyms were assigned to each respondent. The transcriptions are attached as Appendix B.

**Table 3.2: Key to transcriptions**

<table>
<thead>
<tr>
<th>Description of behaviour</th>
<th>Shown in parentheses, for example (laughs), (coughs), (sighs), (picking up invisible objects from her skirt), (straightening her dress), (folding and unfolding her hands).</th>
</tr>
</thead>
<tbody>
<tr>
<td>Paraphrasing others</td>
<td>Quotation marks show when interviewees speak in someone else’s voice.</td>
</tr>
<tr>
<td>Emphasis</td>
<td>Capital letters denote strong emphasis on a particular point, for example, “MEN ARE PROMISCOUS”.</td>
</tr>
<tr>
<td>Held sounds</td>
<td>Held sounds are repeated and separated by hyphens, for example, “N-o-o-o”</td>
</tr>
<tr>
<td>Pauses</td>
<td>Shown by a series of dots (….).</td>
</tr>
</tbody>
</table>

**3.7 Data analysis**

Data was analysed following the grounded theory approach. Grounded theory is a scientific method that is concerned with the generation, elaboration and validation of social science theory (Glaser and Barney, 1998). Data analysis commenced with data reduction, data organisation and then data interpretation with the back up of existing theory (Alston and Bowles, 2003). Literature on disclosure experiences of women was used to link the responses of the participants to findings from previous research studies. This linkage helped in the identification of similarities as well as differences between findings from the study and findings from other studies.
In data reduction, data was coded, summarised, and categorised in order to identify important aspects of the disclosure experiences of women. This means that data was coded with the aim of generating themes, a process known as open coding (Robson, 2002). Coding is a system whereby data is organised according to selected themes. The codes were either descriptive, ‘in vivo’ (direct quotation from the data) or inferential.

The second stage was axial coding where data was organised according to the themes that emerged in the transcripts. In axial coding the researcher linked together the categories that had been developed through open coding in order to come up with a substantive theory (Robson, 2002). Following the same line of thought, Trochim (2006) identifies two stages during data analysis in exploratory research coding which he terms ‘abstraction’ and ‘generalisation’. Abstraction is whereby empirical observations are translated into concepts while in generalisation; the findings are arranged in such a way that they move from single experiences to focus on structures common to all or most cases.

Lastly, the researcher did selective coding in which one aspect was selected as the core category and the researcher focused on that core category. The basis for this selection arises from axial coding which provides the researcher with a picture of the relationships between categories (Robson, 2002). Charmaz (2006) supports this notion and adds that these codes may help the researcher tell an analytic story that has coherence or may move the analytic story in a different direction.

An analysis of the data produced 12 themes which had not been planned beforehand but which emerged from the data. Interviewees’ responses for each of these themes were then grouped together and analysed for similarities and differences. After this, the researcher then utilised an interpretive approach based on grounded theory. This meant linking the findings with literature on
women’s disclosure experiences. The ensuing dialogue with literature either supported the findings or contrasted with the findings. This interpretive approach is essential in the sense that if findings from any given study get support from existing literature it means such findings are reliable, and in cases where findings from a particular study contradict findings from existing literature this then calls for more investigation into the issue(s) at hand thereby setting the trend for future research (Alston and Bowles, 2003).

At the end of data analysis, all the study’s critical questions, as stated in Chapter 1 were answered, thus showing that the study is successful as a scientific query into the disclosure experiences of HIV positive women. Lastly, the researcher used the findings from the present study to come up with a theory of disclosure as experienced by rural women in an African setting. This is a requirement of the grounded theory approach.

3.8 Validity and Reliability
The debate on the applicability of the terms ‘validity and reliability’ in qualitative studies is ongoing, however, despite this debate there is need for qualitative researchers to demonstrate that their studies are credible. Unlike quantitative studies, the credibility of a qualitative study depends on the ability and effort of the researcher (Golafshani, 2003). The present study makes use of Guba and Lincoln’s 1985 model as adapted by Trochim (2006) as a yardstick for measuring the trustworthiness of the study’s outcome. This model was chosen because it better reflects the underlying assumptions of naturalistic inquiry.

Guba and Lincoln’s (1985) model is based on 4 criteria namely credibility, transferability, dependability and confirmability. Their proposed criterion is listed in table 3.3 together with the analogous quantitative criteria.
Table 3.3 Criteria for judging qualitative research

<table>
<thead>
<tr>
<th>Traditional criteria for judging quantitative research</th>
<th>Alternative criteria for judging qualitative research</th>
</tr>
</thead>
<tbody>
<tr>
<td>Internal validity</td>
<td>credibility</td>
</tr>
<tr>
<td>External validity</td>
<td>transferability</td>
</tr>
<tr>
<td>reliability</td>
<td>dependability</td>
</tr>
<tr>
<td>objectivity</td>
<td>confirmability</td>
</tr>
</tbody>
</table>

(Source: Trochim, 2006)

3.8.1 Credibility

This strategy is centred on establishing that the results of the qualitative study are considered to be a true reflection of the participants’ views on the phenomenon under study (Trochim, 2006). Since the aim of qualitative research is to describe the phenomena under study from the participants’ viewpoint then they only are the ones who can rightfully judge the credibility of the study’s outcome (Rolfe, 2006). Following the same line of thought, 6 of the 10 participants in the present study were given the chance to comment on the results of the study at a support group meeting in December 2008. The other 4 participants have since passed away. The 6 participants however confirmed the results of the present study and in some instances added some points they felt had been left out thus increasing the credibility of the study. This strategy of going back to the participants with the results of the study is highly commended by Guba and Lincoln (1989:239) as cited by Rolfe (2006:305) who state that member checking is the ‘single most critical technique for establishing credibility’.

The credibility of a qualitative study also centres on the ability and effort of the researcher, according to Golafshani (2003). The present researcher is a qualified social worker with experience in conducting social work interviews. This quality ensured that the in depth interviews conducted with participants revealed answers to questions at the heart of the study. The whole research process was
also done under strict supervision thereby ensuring that the aims of the study are realised and that the whole research process is done in an ethical manner. All this makes the study’s outcome credible.

A point worthy to take note of is the fact that the present researcher has had vast experience with the phenomenon under study in her former capacity as a volunteer with an NGO dealing with women living with HIV and as an auxiliary nurse. This experience made the researcher familiar with the area under study. This familiarity also spreads to the site of the study which has been the present researcher’s home village for 2 decades. All this familiarity and experience thereby make the present researcher a trustworthy human instrument.

3.8.2 Transferability
This technique refers to the degree to which the findings of a qualitative study can be generalised to other contexts. This therefore suggests that transferability is primarily the responsibility of the person who intends to transfer the findings to other contexts, other than the original study (Trochim, 2006). The qualitative researcher can however enhance transferability by describing fully the research context and assumptions central to the research. In the present study this was done in paragraphs 1.2 (page 2), 1.6 (page 5) and 5.2.6.1 (page 99). The type of sampling method used in the present study also enhances transferability as it ensures that the chosen sample reflects the community under study; see paragraph 3.5.1 (page 64).

Another way to evaluate transferability is by focusing on the data collection methods according to Rolfe (2006). In the present study, the description of the study’s methodology in Chapter 3 (page 63-69) was done in detail to enhance transferability. Transcriptions from the interviews including the researcher’s observations are also attached in order to aid generalization to other contexts. See Appendix C, page 133. Having done all this, it is the responsibility of the one
who intends to transfer the study’s results to judge on the soundness of that transfer.

3.8.3 Dependability

This strategy, according to Trochim (2006) stresses the need for the researcher to account for the changes in the context in which the research takes place. This is due to the fact that qualitative research takes place in real world setting. The real world is not static but is subject to change hence the researcher needs to be present when change occurs so as to record an event before and after change has occurred (Golafshani, 2003). In the present study this was achieved by first gaining experience on the subject under study before actually venturing into conducting the qualitative study.

Dependability as a strategy also calls for a description of the methods used during data collection, analysis and interpretation. This description must be detailed in order to make the methodological practices ‘auditable’ (Sandelowski, 1993:2) as cited by Rolfe (2006:305). Lincoln and Guba (1985:290) as cited by Golafshani (2003:601) term this process an ‘inquiry audit’. Sandelowski (1986:2) as cited by Rolfe (2006:305) explain the audit process as ‘leaving a decision trail’ to enable the reader of the research study to verify the credibility of the whole research process. The study therefore will only be trustworthy or dependable if the reader of the research report deems it so.

In the present study dependability was achieved by member checking as has been highlighted in 3.8.1 above. The intense description of the research methodology in Chapter 3 also adds to the dependability of the research. The present researcher’s qualifications and experience increase dependability as well as the fact that the study was done under strict control and supervision.
3.8.4 Confirmability
Trochim (2006) is of the opinion that qualitative research tends to assume that each researcher brings about a unique perspective to each study. Based on this assumption, confirmability thus refers to the degree to which the results can be confirmed by other researchers. In the present study this was done through the inquiry audit mentioned in 3.8.3 above. This audit is aimed at limiting researcher bias (Trochim, 2006). Studies that confirm the results of the present study have also been highlighted in chapters 4 and 5 in a bid to enhance confirmability of the study’s outcome. The results of the study however, are still open to further confirmation through further research.

3.9 Ethical considerations
During the research process, the researcher adhered to the ethical guidelines which govern all research involving human beings. The following ethics were observed during the interviews.

3.9.1 Gaining access
Gaining access was not a problem for the researcher who grew up in the area surrounding the research site and can speak the local language fluently. Knowledge of the culture of the people concerned also helped the researcher as she had to display how she values the culture making respondents feel free and comfortable to disclose their personal experiences amid a highly conservative culture and a highly stigmatising society.

3.9.2 Informed consent
Following the principle of informed consent, the nature, goals, benefits as well as potential risks of the study were clearly explained to respondents at the onset. Participation was entirely voluntary and respondents were asked to sign a consent form. A copy of the form is attached as Appendix A.
Permission was also sought for the use of a tape recorder, and the researcher ensured that the tape recorder was placed inconspicuously so as not to cause unnecessary anxiety to the respondents as stated by Greef (2005).

3.9.3 Privacy and confidentiality
Strydom (2005) asserts that privacy refers to personal privacy whilst confidentiality is concerned with the handling of information in a confidential manner. It is however clear that these two ethics are there to protect respondents from harm that might arise if their identity is disclosed to the public. To safeguard respondents from such harm, pseudo-names were used so that personal identities of respondents would be secure even in cases where information could be shared by third parties.

3.9.4 Deception of respondents
The researcher ensured that respondents were told the whole truth about the nature of the study, and its benefits. She also went further as telling respondents the risk posed by the study mainly that the study was emotionally draining and could invoke painful memories. No deception or coercion was done in order to make respondents participate in the study.

3.9.5 Restoration of respondents
Debriefing sessions were conducted after the interviews in order to aid respondents to work through the interview experience and its aftermath, in turn minimising emotional harm. During debriefing participants were given a chance to talk about the feelings invoked by the interview and the researcher helped them to step out of the interviewee role. Counselling was then done to enable respondents to continue with their daily lives without disruption due to the painful emotions that the interviews could have evoked.
3.10 Limitations of the study

The study was not without its fair share of limitations, but the researcher tried to work around these limitations in order for the research to be successful. Fouche (2005:119) states that “Although problems are never completely eliminated from any study; the researcher must spell out the various means by which he tries to limit the problems”. The problems encountered will be discussed shortly.

The researcher faced translation problems since some English words cannot be directly translated into Shona, and some of the English words do not exist in the Shona dictum. However, Ms. Zambezi was available for proofreading of the interview schedule as well as the transcripts.

Carrying out the research from the home of the Village Health Worker brought about a limitation of distractions like crying of children, noise from the domestic animals as well as distraction from people arriving at the homestead. Sometimes the distractions would make respondents lose track of what they had been saying, and the researcher had to employ prompts and paraphrase what was said earlier in order to help respondents continue from where they had left off.

Making respondents disclose their sexual experiences was not an easy task for the researcher especially when taking into consideration the conservative nature of the Shona culture and the age gap between the researcher and the respondents. However, the researcher employed all the necessary skills in order to make participants disclose. She also had to repeatedly assure respondents of the confidential nature of the research.

The research topic was a sensitive one that as the interviews progressed respondents could not help getting emotional. Counselling was provided to all respondents and also interview was followed by a debriefing session.
3.11 Summary
This chapter has outlined the process of data gathering and analysis in detail. The study was an eye opener to the researcher who had never carried out a qualitative study before. The answers sought were found without bringing about emotional harm to the respondents. A good point of the study, which had however not been planned beforehand is the fact that it made respondents realise the need of a support group and helped them form one.
Chapter 4

PRESENTATION OF THE FINDINGS

4.1 Introduction
Presentation of the research findings has been done using the words of the respondents as much as possible. This has been done to highlight the fact that these women are experts of their experiences. Excerpts from the transcripts have however been edited to allow the smooth flow of information, after removing pauses and minimal prompts. These excerpts are shown by the use of italics, followed by the respondent's pseudonym in brackets. The full transcripts of interviews are attached as Appendix C.

In this chapter the findings are presented in line with the aims of the study and the researcher’s preunderstanding of the study. Firstly, a profile of the respondents is presented in order to create a brief biographical picture of all the women who took part in the study. Secondly, the discussion focuses on respondents' reports on how HIV status disclosure to sexual partners is experienced. This is followed by an analysis of the interventional networks which help them cope with disclosure experiences. Lastly, their empowerment needs are examined in a bid to educate all stake holders who work with HIV positive women in the rural areas.

4.2 Profile of Respondents
Identifying details of the respondents have been summarized and are illustrated in Table 4.1 overleaf. The table shows that respondents’ ages ranged from 28 to 44 years and according to Barnett and Whiteside (2006), the most people who are at risk of contracting HIV are those between the ages of 15 and 50. The majority of respondents survived on farming whilst only 3 respondents were vendors.
Table 4.1: Profile of Respondents

<table>
<thead>
<tr>
<th>NAME</th>
<th>AGE</th>
<th>MARITAL STATUS</th>
<th>EDUC. LEVEL</th>
<th>SOURCE OF INCOME</th>
<th>NO. OF CHN</th>
<th>VILLAGE</th>
</tr>
</thead>
<tbody>
<tr>
<td>TENDAI</td>
<td>28</td>
<td>WIDOWED</td>
<td>GR 6</td>
<td>VENDING</td>
<td>4</td>
<td>KUIPA</td>
</tr>
<tr>
<td>JULIET</td>
<td>44</td>
<td>MARRIED</td>
<td>NIL</td>
<td>FARMING</td>
<td>10</td>
<td>KUIPA</td>
</tr>
<tr>
<td>RACHEL</td>
<td>32</td>
<td>DIVORCED</td>
<td>GR 7</td>
<td>FARMING</td>
<td>2</td>
<td>CHIDZOMBA</td>
</tr>
<tr>
<td>SOFIYA</td>
<td>33</td>
<td>DIVORCED</td>
<td>FORM 4</td>
<td>VENDING</td>
<td>3</td>
<td>KAHONDE</td>
</tr>
<tr>
<td>MEMORY</td>
<td>35</td>
<td>MARRIED</td>
<td>GR 7</td>
<td>FARMING</td>
<td>3</td>
<td>KAHONDE</td>
</tr>
<tr>
<td>CHIPPO</td>
<td>36</td>
<td>MARRIED</td>
<td>FORM 4</td>
<td>FARMING</td>
<td>2</td>
<td>CHIDZOMBA</td>
</tr>
<tr>
<td>TAKUNDA</td>
<td>36</td>
<td>WIDOWED</td>
<td>NIL</td>
<td>FARMING</td>
<td>8</td>
<td>CHIDZOMBA</td>
</tr>
<tr>
<td>PAIDAMOYO</td>
<td>36</td>
<td>MARRIED</td>
<td>NIL</td>
<td>HUSBAND</td>
<td>3</td>
<td>CHIDZOMBA</td>
</tr>
<tr>
<td>SIPHO</td>
<td>41</td>
<td>MARRIED</td>
<td>NIL</td>
<td>VENDING</td>
<td>6</td>
<td>CHIDZOMBA</td>
</tr>
<tr>
<td>ANNA</td>
<td>44</td>
<td>WIDOWED</td>
<td>GR 6</td>
<td>FARMING</td>
<td>2</td>
<td>CHIDZOMBA</td>
</tr>
</tbody>
</table>

Five of the respondents were married; three were widows whilst two were divorcees. All respondents had therefore gone through the marital institution thereby suggesting that they had contracted HIV within marriage, most probably from their husbands. The divorced participants remarked that they had initiated the divorce after the realization that they were HIV positive. They blamed their husbands for the infection.

When it came to their educational status, the majority of the respondents received basic primary education only. Only two respondents received secondary school education, and the other four respondents never got educated. This finding is supported by Okechukwu (2005) who states that, the female child's educational needs are not attended to, since she is viewed as a temporary member of the family. This is due to the fact that, she eventually leaves the family when she gets married.
4.3 Disclosure experiences of the women

An analysis of the women's experiences of HIV status disclosure revealed a wealth of information which helped shed light on what they encounter in their everyday lives. Respondents had been diagnosed HIV positive for a maximum of 5 years and a minimum of 1 year. The themes which arose from an analysis of their experiences will be discussed in the following paragraphs.

4.3.1 Stigma surrounding an HIV/AIDS diagnosis

An HIV diagnosis was identified as carrying a lot of stigma, blame and shame to the extent that respondents had to go to New Start Centers far from their communities where it was unlikely that they would meet people they knew, and where the staff members were unknown to them. New Start Centers are voluntary counseling and testing sites. All these precautions were made in order to make the diagnosis a total secret, for fear that if any community member got wind of the diagnosis then all community members would end up shunning the HIV positive individual. One respondent (Sipho) said, this disease is highly stigmatizing, that is why on that day, we were only two in the room, that is, the doctor and I, so no-one else knows. This statement highlights the importance of privacy and confidentiality when dealing with HIV/AIDS status disclosure because of the stigma attached to the disease.

The stigma surrounding an HIV/AIDS diagnosis also makes people seek voluntary counseling and testing (VCT) as a last resort, that is, when they fall sick. If one is healthy, she does not go for VCT; she only goes for testing after referral by a doctor when she presents symptoms associated with HIV and AIDS. All respondents in the study decided to take the HIV test due to factors beyond their control, namely, opportunistic infections like T.B. and Herpes. Barnett and Whiteside (2006) state that most people with HIV have a high chance of contracting active T.B. As a result, once someone develops T.B. they suspect that they might be HIV positive and as a result, they decide to get tested for HIV. This notion was supported by Tendai who said, the sicknesses [T.B. and edema]
forced me to get tested, otherwise I would never have thought of that. Chesney and Smith (1999) as cited by Greene et al. (2002) express the same opinion and conclude that stigma delays both HIV testing and disclosure of diagnosis.

4.3.2 Secrecy and an HIV positive diagnosis
From the study it became apparent that an HIV positive diagnosis is viewed by some people as a major secret which cannot be shared with anyone at all. Some potential respondents, 5 of them, had the courage to come to the venue of the interviews but upon being questioned about their status by the researcher during the preliminary interviews they denied that they were HIV positive. They instead preferred to tell the researcher that they suffered from either hypertension or diabetes and that their husbands had died of the same ailments. It was sad to note that these women were afraid that if they participated in the study, community members will then know that they were HIV positive.

4.3.3 Feelings of despondency following an HIV/AIDS diagnosis
Results from the present study revealed that being informed that one is HIV positive was experienced as a pronouncement of a death sentence. Feelings of hopelessness and helplessness were common among respondents due to the fact that there is no vaccine for HIV. These feelings were also intensified by the fear that their husbands or partners would divorce them not wanting to be ostracized by the community. One respondent, Chipo, described her feelings as follows:

I felt so hopeless and helpless. I meditated upon the diagnosis. The first person I told was my husband, I told him five days later after debating on whether to tell him or not because I was afraid he would say I can't stay with such a person and divorce me.

According to this respondent, the diagnosis made her feel like she was now inadequate or less human that she did not deserve to be loved and accepted by
her husband. It was as if being HIV positive had turned her into someone undesirable.

4.3.4 The role of faith in accepting HIV infection
Respondents revealed that faith was essential in the acceptance of HIV infection. They were aware that failure to accept the diagnosis would have detrimental effects on their health due to the emotional stress involved. Having faith in a higher being (God) thus helped them to have hope that they could live longer with the infection and could continue leading normal lives. One of the respondents stated that:

*I just accepted and put everything in God's hands. I was afraid that dwelling too much on the diagnosis would make me sick* (Tendai)

Another respondent, Sipho, stated that *I put everything in God's hands and just accepted my fate* (Sipho). This view is supported by Ciambrone (2003) who states that faith helps HIV positive women to cope with their diagnoses and to accept the inevitable in their lives. Having faith in God thus helps HIV positive women not only to accept the diagnosis but to have the will to live positively.

However, for some respondents, acceptance of the diagnosis was not based on faith but was based on the fact that they had suspected all along that they might be HIV positive, so the diagnosis confirmed their suspicions. Just watching their partners falling sick, then dying of AIDS related symptoms was enough to make them suspect that they also had the deadly virus.

4.3.5 Children and Longevity
This is a theme which emerged from the analysis of the respondents’ profile. Significantly, all respondents had children, an average of 4 children per respondent. This fact alone, made them desire to protect their health at all cost
so that they could live longer and see their children grow. Two of the respondents stated that:

   It is better to survive for 10 or 20 years because by then your children will have grown (Sofiya). My children give me the desire to live longer so that I can watch them growing (Anna).

Ciambrone (2003:83) also came to the same conclusion that children are a source of strength to HIV positive women. She quotes, a respondent (Sheila) who stated that:

   I want to live long enough to see my kids. I want to live long enough to see my kids grow up, after that I don’t care what happens to me because I lived my life.

Having children thus motivates women with HIV/AIDS to live positively so that they can be there for their children.

4.3.6 Gender and HIV transmission
All respondents were involved in heterosexual relationships and they all cited the source of infection as their husbands or sexual partners. Some of the respondents had this to say about their husbands:

   My husband said please, please, forgive me I wronged you, and he told me the woman he had been involved with (Paidamoyo); My husband confessed that he had been promiscuous all along (Sofiya); Men are known to be promiscuous but my husband was VERY promiscuous (Tendai); My husband said I am a man and I cannot deny that I have had other affairs (Juliet).

The above finding is in line with findings from previous research on HIV transmission in heterosexual relationships, which state that 60-80% of African women with HIV had only one partner (Colvin, 2000, as cited by Barnett and Whiteside, 2006). Still in the same line of argument, Barnett and Whiteside
(2006:199) quote Marina Mahathir; head of Malaysian Council of NGO’s who stated that:

It is a fact not repeated enough that 90% of women who have been infected with HIV have only ever slept with one man in their lives, their husbands.

Thus it was confirmed that women are exposed to the HIV and AIDS pandemic through the actions of their husbands or sexual partners.

In the present study, the reason for the vulnerability of women to HIV transmission was confirmed to be the result of the patriarchal nature of the African culture which allows men the freedom to have more than one partner, whilst women are expected to be faithful, to only one person that is the husband.

Respondents who took part in the study had this to say about culture:

Culture makes women vulnerable to HIV since it allows men the freedom to have extramarital affairs. My husband even said that, "I cannot deny the infection, because I am a man" (Juliet). Culture facilitates the spread of the virus in the sense that you cannot caution your husband if he is being unfaithful, because he will divorce you. As a result, men bring the virus home and then accuse women for being unfaithful (Rachel).

4.3.7 Gender and HIV/AIDS status disclosure

In the present study a high disclosure rate was noted which is consistent with literature on disclosure patterns of HIV positive women (Greene et al., 2002). Reasons for disclosure varied: mothers and aunts were told because they were the caregivers, whilst children who were staying with respondents were told so that they could be prepared for the changes that the diagnosis would bring to the household. Schrimshaw and Siegel (2002) as cited by Greene et al. (2003) support this notion and state that where children stay at home; there are high
chances that they will be told about the diagnosis because it is difficult to hide the sickness from them.

The majority (7) of the participants disclosed to their husbands; of these seven, one is now a widow and the other one a divorcee. Of the three respondents who did not disclose, two were afraid of desertion (Takunda and Tendai), whilst the other respondent (Rachel) had separated from her husband and did not know where to find him. The high rate of disclosure to sexual partners in this study supports the finding by Greene and Faulkner (2002) as cited by Greene et al. (2003) who argue that disclosure to sexual partners is on the increase and is higher for women. However, in every study of HIV status disclosure there will always be people who do not disclose to sexual partners for varied reasons. Gaillard et al. (2000) support this view and state that disclosing an HIV positive status to sexual partners is one of the most difficult things that HIV positive people have to deal with.

4.3.8 Culture and disclosure
Culture was also found to have a bearing on HIV/AIDS status disclosure. Within culture, is the power and powerlessness issue whereby gender relations are shaped in such a way that women are powerless to defend themselves from the effects of disclosing an HIV positive status to sexual partners. More often than not, women are afraid to disclose their status, for fear of either being blamed for the infection or for fear of desertion (Sixgashe, Baggaley and Matthews, 2000; Dube, 2003; Machipisa, 2007). Respondents expressed their feelings by voicing that:

\[ \text{Men oppress women and accuse them of infidelity. Men should not accuse women of infidelity because in most cases, they (men) are the ones who bring the virus home (Tendai).} \]
4.3.9 Contradictions between one’s beliefs and actions
Respondents were asked the question "How do you view HIV status disclosure to sexual partners?" so as to assess the congruence between their beliefs and actions. Those respondents who disclosed to their husbands all gave responses that supported disclosure. However, for the three respondents who kept their diagnosis a secret, they gave answers supporting disclosure when in reality they were keeping their diagnosis a secret. This finding revealed the contradiction between one's beliefs and one's actions. It is an important revelation and lies at the heart of HIV and AIDS transmission because knowledge about HIV seems not to directly translate into behaviour change. Hoosen and Collins (2001) and Foreman (1999) state that more often than not, ideals and behaviour are at conflict within the same individual. All the same, human behaviour is not only rooted within culture but is also conceptualized within social relationships (Richter and Griesel, 1998) hence even if disclosure is viewed as desirable some women do not disclose because they are afraid of losing the much needed sources of income (sexual partners).

4.3.10 Financial dependence and non disclosure
In the present study, three women did not disclose their status to sexual partners, for fear of desertion, which would have meant loss of financial security. It appears as if respondents valued financial security more than the lives of their sexual partners to the extent that they risked infecting their partners. Two participants had this to say:

*Men oppress women because they are the providers, as a result women are afraid to disclose their status for fear of losing that financial security. Women can only be emancipated through financial security (Takunda). I do not disclose and if he happens to get the infection I'll pretend that I did not know about it (Rachel)*
4.3.11 The vicious cycle of non disclosure

Non disclosure by women due to the fear of rejection by a male partner has seen the spread of HIV from HIV positive widows to unsuspecting men, who are in most cases, married men. This is due to the fact that widows normally get involved with married men and not single men. They then fail to inform these married men that their deceased husbands could have died of HIV thus passing on the infection to the married men who in turn pass on the infection to their wives. At the end it becomes a chain of people all infected by one person who did not disclose because she was afraid of desertion. The present researcher is of the opinion that this vicious cycle of non disclosure is largely responsible for the high rate of HIV infection in Zimbabwe.

The question on how respondents would handle disclosure to sexual partners if they had been men highlighted the power differences between men and women. Some participants felt that they would disclose freely without fear knowing that they rule and are in control whilst other participants felt that they would choose not to disclose since men are also guilty of failing to disclose. There were even some women who felt that if they were men, they would do exactly the same thing that was being done to them, namely infidelity. Only one participant stated that if she had the chance of becoming a man she was going to protect herself from HIV, since men are in control of the sexual encounter.

The above statements seem to portray that participants felt a need to revenge that non disclosure to sexual partners can be viewed as some form of revenge. They all cited their male partners as the source of the HIV infection which means that they got the infection because their partners failed to inform them of their status. After contracting the infection these women then pass on the virus to unsuspecting men through non disclosure as well and the vicious cycle of non disclosure continues.
4.3.12 Disclosure as a complex process

Respondents revealed that disclosure of one’s HIV status is not an easy task. They further revealed that in order for one to reach the decision to disclose one’s status to either a spouse or a relative one goes through a series of stages in which the benefits of disclosing are weighed against the consequences of disclosure. 70% of the women who were interviewed revealed that the decision to disclose their status to significant others was not instant, it was made after much deliberation and thought. Some respondents had to ask a third party to help them disclose their status to spouses.

The above finding reveals that an HIV diagnosis is not easy to accept. It is like a death sentence which disrupts one’s life. Ciambrone (2003:24) cite one respondent in her study who vividly described the effects of an HIV positive diagnosis as:

......total shock, you just go numb. Of course immediately you've got a death sentence: that's just what you stand there thinking.

One participant in the present study revealed how life changing an HIV positive diagnosis is when she remarked that:

I told my first born who is 15 years old, so that she could know the type of life we were going to live following the HIV diagnosis (Memory)

The participant chose the words type of life to indicate that being diagnosed HIV positive means one begins to live a new life focused on sickness due to a compromised immune system. At the back of one’s mind the inevitability of one’s death will be hovering as the body gradually succumbs to the opportunistic infections as a result of HIV. The complexities of HIV then make it difficult to disclose one’s status because of the fear that negative consequences will result from the disclosure.
4.4 Interventional networks which help HIV positive women cope with disclosure experiences

This section revealed the bleak life of rural women living with HIV and AIDS. Soon after diagnosis, these women live without any follow up care or support. In addition, they do not have any support groups where they can socialize and share their stories with other people living with HIV and AIDS.

However, respondents did not display any symptoms of depression or fatalism that have been cited by other studies to be a result of living without follow up support, according to Gaillard et al., (2000) and Macintyre, Brown and Sosler (2001) as cited by Van Dyk and Van Dyk (2003). Instead the majority of respondents had decided to change their behavior and live positively despite the silence and stigma surrounding an HIV diagnosis in these rural communities. This is a coping mechanism for these women and it portrays that people do have the inner strength to cope with difficult situations in the absence of supportive services. The same strengths need to be recognized, acknowledged and tapped into by the helping professions.

4.4.1 Familial support

Married respondents reported that they get the support they need from their husbands, especially in cases where disclosure has not been made to children; the husband is counted on to keep the secret. Greene et al. (2002) support this notion and stress that where disclosure has not been made to other family members, the spouse is counted on to keep the secret.

Some respondents did not have grown up children and the husband had to take care of his wife when she was sick, even in the case of Chipo, whose marriage was strained after disclosure, her husband looks after her when sick. Takunda disclosed to all her six children whom she lives with and she stated that her children were very supportive of her.
Some respondents stated that they had no familial support because they were afraid to disclose even to family members, for fear of stigmatization. This fear of stigmatization was so great to the extent that one respondent stated that when she needs any support she prefers going to the hospital, especially for informational support.

4.4.2 Support from Non governmental organizations
Two non governmental organizations were cited which used to deliver foodstuffs to people living with HIV and AIDS. However, the services of these organizations have since been terminated because of irregularities that had been occurring. Church groups try to help HIV positive women but there is little that they can do, for instance respondents stated that they can only get pain killers and not Antiretroviral drugs (ARV's) which they need so much. An article from the Standard newspaper on 8 July 2007, stated that only 60 000 people are currently receiving free ARV's out of the 600 000 who are in dire need of them. ARV's are therefore available to only 6% of the target group. The Minister of Health and Child Welfare, Dr David Parirenyatwa, however pegged the figure at 86 000 out of 350 000 people who need the life prolonging drugs (Padera, 2007). The Government of Zimbabwe does not deny the evidence of HIV in the population but inflate the figure of ARV recipients to 25% as opposed to the 10% cited in the Standard newspaper. However, what is worth noting is the fact that the majority of people who need ARV's in Zimbabwe do not have access to them due to lack of resources.

4.4.3 Future support needed in order to cope with disclosure experiences
Respondents expressed the wish for education on how to disclose their status and how to cope with the outcomes of such disclosure. However, they emphasized the fact that such education had to come from outside, for instance, from women based non governmental organisations. They cited that it was easier for an outsider to address such a sensitive issue to them since HIV and AIDS is highly stigmatized in their communities. As a result, even though they knew that
the silence surrounding HIV and AIDS is the one that is fuelling the spread of the epidemic they felt that there was nothing they could do (Dube, 2003; Tharao, Massaquoi and Teclom, 2006). The fear of stigma was so great to the extent that some of the respondents did not access foodstuffs donated by some non governmental organisations for fear that if they registered their names then everyone would end up knowing their status.

The medium for spreading that education was cited as the support group for women living with HIV; respondents cited that they saw the need for a support group but they needed outside help as well because they were afraid of being stigmatized by community members. The reason for the need for a support group was the desire to socialize with other women living with HIV and AIDS, because keeping to oneself increased emotional strain and was likely to lead to an early death. This revelation of desiring the support of like people is essential when dealing with the issue of HIV status disclosure.

Group work intervention would go a long way in the fight for HIV status disclosure to thrive as a prevention and treatment method. This is due to the fact that in a group setting one can practice disclosing their status to group members in a safe, non threatening environment knowing that no-one will be judgmental. This will then provide an outlet for disclosure to other people outside the group for instance, spouses and children. Various authors have stated that support groups are beneficial to people living with HIV since they offer emotional, informational and practical support (Feld et al., 2002; Haley and Stern, 2003; UNAIDS, 2002; Greene et al., 2003).

Six out of ten respondents felt that they needed financial support or food aid. This finding was consistent with the finding by Human Rights Monitor (2001) which concluded that the majority of rural women are poor and need financial assistance more than any other form of support. Women living with HIV need financial assistance more than other healthy women since they need money for
medication and hospital visits. Due to the frequent bouts of illnesses that HIV positive people experience as the immune system weakens makes financial need a top priority for HIV positive rural women.

In Zimbabwe, due to the political situation prevailing, HIV positive people do not have free access to anti-retroviral treatment. They are required to pay half the price for ARV’s and most people, especially those in the rural areas cannot afford them. The government however assists those who cannot afford to pay half the price of anti-retroviral drugs through the social welfare system whereby people approach social workers at government hospitals and request for exemption from paying. The social workers at these hospitals then refer them to the department of Social Services where they get the exemption letters. However, due to the fact that, at rural hospitals there are no social workers due to the massive brain drain that has hit the country; most rural people cannot access free antiretroviral treatment. Participants in the present study further stated that they are sometimes asked to pay for certain injections when they go for treatment at hospitals and if one does not have the money then that injection is not given.

Taking into consideration the fact that the women in the study were either vendors or farmers, (jobs which need physical strength) it is not surprising that as their bodies grew weaker, they failed to support themselves and their children financially. However, being HIV positive and vulnerable physically did not take away their zeal for independence and self support. They stated that they were prepared to work for themselves and not just depend on donations, provided they could get money to start projects which do not require heavy manual labour, for instance, poultry projects.

4.5 Empowerment needs of women living with HIV and AIDS
Trevithick (2005) highlights the fact that one of the techniques of empowerment is to accept client’s definition of the problem and then to engage in a power analysis of the client’s situation. With this noble thought in mind, respondents
were asked how they thought women living with HIV and AIDS could be empowered and they offered suggestions which work from their own point of view. These suggestions are important because they as the people affected, know best about what will work for them.

4.5.1 Educational needs
First and foremost, respondents cited that education was essential for women living with HIV and AIDS and they really wished for women based organizations to take on that educational role. Respondents also felt that this education should cover topics like; nutritional needs for the HIV positive, the need for HIV/AIDS status disclosure to sexual partners and the importance of abstinence following an HIV or T.B. diagnosis.

4.5.1.1 Disclosing an HIV diagnosis
Regarding the disclosure of an HIV diagnosis, one respondent stated that:

There is need for women based organizations to come and educate us especially to encourage us to disclose our HIV status. Disclosure is still a problem, no wonder why the virus is spreading rapidly. This is only possible through outside help because in most cases when well wishers come with donations, most of us miss this supportive help because we are afraid that the whole community will end up knowing that we are living with the virus. We feel ashamed of ourselves (Takunda).

The above statement is a powerful statement which clearly depicts the feelings of women living with HIV and AIDS, they are afraid of being stigmatized by the community to the extent that they protect their diagnosis at all costs. Worse still, they feel inadequate and are ashamed of themselves thus the need of privacy. This silence is detrimental and is a breeding ground for the virus, as a result,
educational programs for the HIV positive should address these issues in order to be of benefit to the people concerned.

**4.5.1.2 Living positively with HIV/AIDS**

Participants also felt that they needed to be educated on the benefits of living positively with HIV. This topic is a fundamental one and has been the theme of many campaigns. Respondents felt that women living with HIV should be taught to have a positive mind, to eat healthily and to focus on raising their children, so as to live longer with the virus. Esther Guzha, a Zimbabwean woman who had lived with HIV for more than 13 years, stated that:

*Most women live longer because they are attached to their children, they are determined to live positively, rather than wait to die.* (Machipi sa, 2007).

This was an important contribution made by the respondents and rural women need this education because soon after diagnosis they do not have any support system, for instance support groups, or post test counseling. Once they receive their diagnosis they are virtually on their own; a move which has seen some women relapsing and having unprotected sex thereby spreading the virus.

Respondents also felt that women living with HIV and AIDS needed to be educated on the benefits of abstaining from sex following an HIV positive diagnosis. They commented that medical practitioners were encouraging abstinence so as to prevent re-infection. Other respondents were also very ill to the extent that sex was no longer thought of since they could no longer enjoy it. This strategy however, is bound to work among the widows and divorcees since they have a choice of taking on new partners or not. As for those who are married, abstinence can only work if the husband is willing to co-operate. All the same, if couples who are HIV positive, engage in protected sex consistently then the chances of re-infection are lowered (Greene et al., 2003). In the study, the respondents who advocated for the above strategy were either widowed or divorced.
4.5.2 Financial needs

In order for any empowerment programme to be successful it should be viable within the given environment, which means, the socio-economic environment should be favorable. Education will not work on its own if the financial needs of HIV positive women are not addressed as well. Women will still avoid disclosure because they are afraid of losing the income they get from partners, so education on its own will not suffice. This therefore means that a solution to the women’s financial problems should also be found in order to make education on the importance of disclosure successful. This statement was supported by the respondents themselves, when they said:

*Women should learn self reliance, they should be financially independent. This can be done through embarking on projects so that they do not get tempted to seek for sexual relations in order to get financial security* (Tendai); *We need financial help so that we can start our own projects* (Memory).

Programmes aimed at financial empowerment of women, for instance Trust Banks (mentioned in chapter 2) where women receive loans which they repay at a later stage are one of the solutions that can help increase the disclosure rate for women. Since these programmes ensure self reliance for women living with HIV and AIDS, women will not get into the snare of seeking sexual relations for financial security and keeping their HIV/AIDS status a secret for fear of losing that security. The present study revealed that women living with HIV have the zeal to be independent financially as they stated that they did not want to depend on donations but needed financial support in order to run their own projects. This is an important finding because being HIV positive does not mean that one cannot function independently. One can still function independently until one reaches the terminal stage.
4.6 Conclusion
The chapter discussed the findings of the study, namely how rural women living with HIV and AIDS experience HIV/AIDS status disclosure to sexual partners. The study revealed that rural women are vulnerable to HIV infection and in some cases, experience negative reactions when they disclose to spouses and intimate others. As a result, they need to be empowered so as to cope positively with disclosure to sexual partners. A number of themes that were not planned by the researcher emerged. This is in line with grounded theory and these themes will receive some attention in the next chapter.
Chapter 5

Major findings and recommendations

5.1 Introduction
The study which was an exploration of the disclosure experiences of HIV positive women, revealed a great wealth of information on the day to day lives of the study sample. The qualitative approach of the study made it possible for them to reveal such information which is part of the private lives of these women, thus making the study to seem to reach its goal. Utilizing ten (10) participants from Magunje, the study revealed that HIV positive women face many challenges when it comes to disclosing their HIV/AIDS status. The chapter therefore highlights some of the findings and conclusions drawn from the study in line with the objectives of the study. Recommendations will also be made in the form of strategies that can aid women in disclosing their HIV status to sexual partners.

5.2 Discussion of major findings
The following are the major findings that were drawn from the study:

5.2.1 HIV counselling and testing thriving as a secondary prevention method
The qualitative data revealed that HIV counselling and testing is thriving more as a secondary prevention method rather than as a primary mode of prevention. Primary prevention refers to the prevention of HIV transmission and secondary prevention is the prevention of re-infection for those already infected with HIV. According to the present study, people only go for testing when they become sick and have contracted the infection (HIV) already. Despite all the efforts that are being made to educate people on the necessity of periodic testing of HIV, all participants in the study had gone for HIV voluntary counselling and testing upon referrals by doctors following presentation of symptoms associated with HIV and AIDS. This finding suggests that voluntary counselling and testing (VCT) in
Zimbabwe is mainly being used for diagnostic purposes since people wait to go for HIV testing when they become sick and not before.

5.2.1.1 Intervention
HIV counselling and testing is thus working as a secondary prevention method of HIV and not as a primary prevention method as desired (Weinhard et al, 1999 cited by Van Dyk and Van Dyk, 2003). This therefore means that the strategy is only preventing re-infection with another strain of HIV for those already infected. There is therefore dire need to change this sad state of affairs by encouraging people to get tested periodically; if a partner cannot be trusted then they should practise safe sex.

5.2.2 Culture as a catalyst in HIV transmission and non disclosure among women
The study further revealed that culture plays a role in HIV transmission by making women vulnerable to HIV infection. This is due to the fact that, on the one hand, culture is permissive to male promiscuity whilst on the other hand it ensures the fidelity of females (Foreman, 1999; Leclerc-Madlala, 2001). All the participants in the present study had gone through the marital institution and had contracted HIV within the same institution. They all held their husbands responsible for the infection and some husbands had openly admitted that they were responsible for bringing the infection home.

Promiscuity and the uncaring nature of men regarding safe sex in the present study have been noted elsewhere as well. McGearay (2001) cites a 39 year old truck driver who had this to say about men and HIV “Yes HIV is terrible Madam…but unless you castrate men, you can’t stop sex and then we all die anyway”. This statement reveals that men are aware of their role in HIV infection but view themselves as helpless to change the situation. The same man cited above further remarks that “Madam, sex is natural. Sex is not like beer or smoking. You can stop them”. This notion is detrimental to HIV prevention efforts
because the problem is not sex. The problem is having sex irresponsibly by either having too many sexual partners or failing to protect oneself from infection when with those partners.

What is sad to note is the fact that not only are women vulnerable to HIV infection due to the promiscuity of their male counterparts, they are also powerless to protect themselves against HIV infection. This is due to the fact that men control the sexual encounter, and more often than not refuse to practise safer sex (Mcgeary, 2001; Dube, 2003; Hunter, 2003; Barnett and Whiteside, 2006). Some of the participants in the present study stated that in some cases they have to force their partners to put on a condom. Men have been said to resist condoms on the basis that they reduce feeling and intimacy during sex but it is always better to experience a reduction in sensation rather than contracting HIV through unprotected sex.

The irony of this refusal of men to practise safe sex is that once a woman contracts the virus from her male partner, she may actually get all the blame, resulting in desertion by her partner. (Sigxashe, Baggaley and Matthews, 2000; Machipisa, 2007). Now, since most women, especially rural women, depend on their partners for economic support, disclosure of an HIV positive diagnosis becomes unthinkable (Booth, Martin and Lankester, 2001; Dube, 2003). Such a move is detrimental to HIV prevention and treatment efforts as some women end up keeping their diagnosis a secret.

In the study, three women kept their status a secret, because they were afraid that their partners would leave them. This would mean losing the financial security which the partners provided. A further three women, were either blamed for the infection or deserted by their partners. This has a bearing on future intervention efforts, because if women experience negative reactions from present partners they may choose to keep their status a secret and not disclose to future sexual partners.
5.2.2.1 Intervention
Various studies have come to the same conclusion that men are responsible for the spread of HIV since they are the ones who have many sexual partners (Foreman, 1999; Dube, 2003; Hunter, 2003). One would therefore conclude that there is dire need for aggressive measures aimed at educating men on the spread of HIV and AIDS.

5.2.3 Rural women are ignorant of HIV status disclosure laws
Rural women, most often live in a world of their own, without knowledge of laws that affect social relations. The study revealed that participants had no knowledge of HIV/AIDS status disclosure laws and some of the participants were continuing to have unprotected sex with partners without disclosing their status. When participants were asked about the HIV/AIDS status disclosure law they remarked that they were not aware that such a law existed.

5.2.3.1 Intervention
From the present study, the researcher deducted that even the knowledge that disclosure laws exist was not enough to make participants choose to disclose their status because for them what was more important was the financial security that they got from partners. As a result, disclosure was viewed as undesirable because it meant loss of a current sexual partner and loss of future sexual partners as well because of the possibility that once one’s status was known then all men in the village would shun the woman concerned. This state of affairs suggests that there is further need for broad educational intervention strategies to empower rural women.

5.2.4 Rural women’s access to health care
Access to health care is a problem for people living in rural areas. There is a shortage of medical staff and the study revealed that most women living with HIV/AIDS had a much shorter life span due to the gross shortage of doctors as well as equipment to carry out the necessary tests before commencement on
antiretroviral drugs. As a result, receiving an HIV diagnosis was perceived as a death sentence and most people with HIV/AIDS died within a short space of time if they did not have relatives living in urban areas who could cater for their health care needs. A sad observation made after the study had been conducted is that of the ten participants who took part in the study, four have since died within a space of a few months.

An observation made by the researcher was that social workers are scarce in rural areas thereby disadvantaging rural people with HIV/AIDS who would be in need of counselling services especially in the form of follow up support. Participants from the present study remarked that there were no social workers at the major rural hospitals and clinics near them; hence they did not receive any help on coping with disclosure experiences. As for those who received negative experiences after disclosure, they either kept to themselves or confided to close family members. This finding reveals the bleak life that rural folks are subjected to and might also have an impact on the high rate of deaths among the HIV positive population in the region where the study was undertaken.

5.2.4.1 Intervention
The problem of shortage of skilled manpower in the rural areas, especially medical staff and social workers, can be solved by improving their salaries and their living conditions. This will act as an incentive and will ensure that there is adequate staff to cater for the rural population: doctors to carry out the necessary tests for ARV commencement, nurses to offer VCT and social workers to offer supportive and other welfare services.

5.2.5 Follow up support after an HIV diagnosis
Women in remote rural areas, live without any follow up support after receiving an HIV positive diagnosis. Follow up support is essential in order to help women living with HIV and AIDS to live positively with the infection (Gaillard et al., 2000; Macintyre, Brown and Sosler, 2001 cited in Van Dyk and van Dyk, 2003). To
make matters worse, there are no support groups in these areas thus making life more difficult for these women. Support groups offer a non judgemental environment in which women living with HIV/AIDS can address issues affecting them like disclosure, vulnerability to HIV infection and coping mechanisms (UNAIDS, 2002; Greene et al., 2003).

5.2.5.1 Intervention
Participants in the study revealed that they lived without any follow up support and did not have any support groups in place. However, what was significant was the fact that nearly all participants admitted that faith in a higher power (God) kept them going. It was that faith that enabled them to face each new day and accept the fact that they had a terminal illness. This finding suggests that faith is indeed a pillar of support for those living with HIV and church groups should take advantage of such a revelation and instil hope in those living with HIV/AIDS because that hope will keep them going. An HIV positive diagnosis should not be seen as a death sentence because death is not imminent. With the correct medication, proper diet and a positive attitude one can live longer with the virus. Unfortunately not all of these factors are available in Zimbabwe. This would suggest that there is a lot of work that still needs to be done in this regard.

During the interviews all ten respondents from the present study expressed the desire to be involved in a project aimed at empowering them as women living with HIV/AIDS. The researcher was moved by this honourable desire and pledged $500 000 Zimbabwean dollars (approximately R1000 at the time) towards a project of their choice. To date the researcher is proud to state that a support group exists as an outcome of the study.

5.2.6 Non governmental organisations and their response to HIV and AIDS
The study also revealed that due to economic hardships and successive droughts, non governmental organisations working in Magunje were now solely focusing on relief aid and had stopped focusing on HIV and AIDS educational
campaigns as well as supportive help for the HIV positive, as was the case in the past. However, the present study revealed that even though people are grateful for the relief aid, they are also in need of educational programs which might help them cope with HIV and AIDS issues. The people in the front line of offering these services are scarce in Magunje that is social workers and nurses. Corrective measures are urgently needed in order to ensure an adequate supply of helping professionals in rural areas.

5.2.6.1 Intervention
People have now come to accept that HIV/AIDS has come to stay and need help in order to cope, for instance, through support groups, projects and other supportive services. Giving needy people food is noble but unfortunately it creates a dependency on the donor. However, if needy people are helped to start their own projects which will sustain them financially this will eradicate hunger and will also reduce HIV incidence. This is due to the fact that women will no longer get involved in transactional sex or prostitution as they would have become financially independent.

In townships like Magunje where the rate of HIV infection is high due to the high rate of prostitution brought about by the presence of international truck drivers and local bus drivers, efforts should be intensified in order to address this problem. Non Governmental Organisations should target the girl child because in most cases these drivers target young school girls who are easily lured by promises of quick cash. The military soldiers who stay at the nearby Magunje barracks also visit the shopping centre and prey on these girls.

If one takes a walk at Magunje Shopping Centre during the late afternoon, one sees young girls some still in school uniform entertaining men old enough to be their fathers. These girls will be competing for clients with their older sisters and mothers who have been in the prostituting business for a long time. Fights between these two groups are very common and it is really a pathetic site to see
people disregarding their health by prostituting. In such encounters if a man refuses to have protected sex it is most likely that that these women would not mind because they are after money. Such behaviour surely increases the rate of HIV and AIDS related deaths and also brings about new strains of HIV from nearby Zambia where international truck drivers will be coming from. The high rate of poverty as experienced in Magunje leads directly to prostitution which is rife in the area. It might not be easy to stamp out poverty which suggests that prostitution will continue for a long time to come.

5.2.7 Disclosure as a complex process
The study revealed that disclosure is not an easy process but is actually a complex process which is experienced not as a single event but as a series of stages. Each woman’s story was unique but some commonalities emerged and these were woven into a model which the present researcher has termed the ‘disclosure model’. This model can be used to either gain insight into the disclosure process or to help women reach the point of disclosure. The 5 stages outlined in the model, however were not experienced uniformly by all women, due to the fact that each woman’s story was unique. Some women skipped some stages whilst others re-experienced the same stages over and over again. With appropriate help, for instance supportive services, all women living with HIV and AIDS should reach the last stage in the model, that is, the disclosure stage.

Disclosure is not depicted as an easy process but as a complex process because that is how it is in reality. The model is similar to the problem solving process as outlined by Compton and Galloway (1989) in the sense that each stage is aimed at a particular goal and the way the work in each stage is carried out determines the effectiveness with which work on the next stage can go forward. Compton and Galloway further state that all human living is effective problem solving, hence the disclosure model is viewed by the researcher as essential for the empowerment of women living with HIV/AIDS. This is due to the fact that, when
one is empowered one is able to direct one’s life and is more likely to succeed (Sathi-Passad, 2000).

**The disclosure model**

According to the findings from the study, the decision to disclose one’s status is experienced in 5 stages which are as follows:

**Stage 1: Adjusting to the diagnosis**

Since HIV is incurable, an HIV diagnosis brings about feelings of fear, shock, pain, anger, helplessness and hopelessness. Ciambrone (2003:24) cite one respondent in her study who stated that, "…..total shock, you just go numb. Of course immediately you've got a death sentence: that's just what you stand there thinking". In order to come to an acceptance of the diagnosis, one has to get over the initial shock.

Some people do not experience any shock after receiving their diagnosis because they would have suspected that they have the virus following the death of a spouse or child. Women in the study who accepted the diagnosis without any shock had suspected that they were HIV positive for a long time, for instance Memory said, *I just accepted the diagnosis and was not surprised because I had become suspicious when my husband got sick.* Other women managed to accept the diagnosis because of their faith; *I accepted and said it is the will of God* (Tendai). There are also those women who quickly accepted the diagnosis, because they were afraid to make themselves more ill by pondering on the diagnosis.

In this stage, women need counseling in order for them to reach the level of acceptance that will motivate them to disclose their status to the people mostly affected by the diagnosis for instance, spouses, and children and intimate others.
**Stage 2: Identifying potential recipients of disclosure**

Once someone has accepted that they are now living with the virus, the next move is to identify people who must be told about the diagnosis. Only people who are directly affected by the diagnosis are most likely to be told (Greene et al., 2003). Also, in order for someone to be chosen as a potential recipient, there has to be some justification of why they should be told. Respondents in the study gave various reasons for choosing the recipients of disclosure, for instance, Anna said, *I told my sister because she was the one looking after me in hospital whilst Memory said, I told my first born who is 15 years old, so that she could know the type of life we were going to live following the HIV diagnosis.*

In this stage, in order to help women who have just been told about their HIV status, education on laws governing disclosure should be given. In the study, some women were not aware of the HIV status disclosure law which compels the disclosure of an HIV positive diagnosis to a sexual partner. As a result, these women did not disclose their status and continued to risk infecting their partners as well as exposing themselves to re-infection. Women who express fear of disclosing their status to partners can be encouraged to bring their husbands along so that they can get tested together and receive the result jointly. Couple testing has been supported by Van Dyk and van Dyk (2003) as another method of lessening the burden of disclosure that many people face, especially women.

The fear entertained by these women is real and cannot be wished away. What would help most is information or knowledge which may be brought in the form of individual counseling or mass education.

**Stage 3: Evaluating personal disclosure skills**

Once the choice of who to tell has been made there follows an evaluation of one’s disclosure skills. The disclosure skills needed are determined by the relationship between the discloser and the disclosure recipient. To exemplify, when disclosing to a child one has to make sure that she discloses in a neutral
manner without blaming anyone, so as not to affect the parent-child relationship. When disclosing to a spouse, one has to do so in a non judgmental attitude so that no negative reaction may result, this point is exemplified by Juliet, she disclosed to her husband angrily and in an accusatory manner. The end result was that they spent three months apart; however in the end her husband admitted his infidelity.

Some women may realize that they lack the skills needed in order to disclose to a particular person, and may ask for a third person to intervene. Paidamoyo asked her grandmother to break the news of her HIV status to her husband and the husband accepted the news positively.

In this stage, women need support as they prepare to disclose to a potential recipient. Support groups can be used as a forum in which women can evaluate the skills they need in order to disclose to a potential recipient. Women can assist each other through role play, so that the one who wants to disclose can identify the skills needed while others give moral support, encouragement and ideas.

**Stage 4: Anticipating reactions of potential disclosure recipients**

Once disclosure skills are in place, that is not the end, one dwells on how the potential recipient is going to react. This stage is vital and most people sail smoothly from stage 1 up to 3 only to get stuck on this stage. This is due to the fact that, if one anticipates a negative reaction, no disclosure is likely to take place and anticipation of a positive reaction is likely to increase the chances of disclosure.

In the study, those single women who anticipated a negative reaction from partners did not disclose their status and continued to jeopardize their health. These women also stated that currently, they keep their HIV/AIDS status a secret and do not disclose to sexual partners. However, for those respondents who were married, although they anticipated a negative reaction from partners, they
disclosed their status and some got a negative reaction while others got a positive reaction.

Women in this stage need help on the clarification as well as the justification of anticipated reactions so that they can make an informed decision. However, the principle of self determination should be applied because at the end of the day, they are the ones who have to live with the consequences of the disclosure.

**Stage 5: Disclosure stage**

In this stage, one is finally motivated to disclose and the decision to disclose is made. The motivation to disclose was highlighted by one participant as follows… *because non disclosure is a sin* (Memory); hence she was motivated to disclose to her husband. Some participants were motivated by the need to prevent re-infection thus leading to disclosure.

In this stage, women need all the support in order to make the intention to disclose a reality. They also need support in order to cope with experiences resulting from the disclosure because such experiences affect future disclosure (Greene et al., 2003).

**5.4.2 Summary of the disclosure model**

The above model can be adapted for use by professionals working with women living with HIV and AIDS and can also be used by family members who want to help a loved one to disclose her status. This is due to the fact that, the model gives an insight into the whole process of disclosure. It is the present researcher’s hope that with further research the model may be adapted to suit the empowerment needs of both men and women thus making HIV status disclosure thrive as a prevention and treatment method. Men need to be part of prevention efforts also because “HIV is not a disease of ignorance. HIV is a disease of denial. People think they are immune…” (Sunday Times, 30 September, 2007).
5.3 Conclusion
The study concluded that in Zimbabwe, rural women are vulnerable to HIV infection because of their inability to negotiate for safer sex. Men control the sexual encounter and women end up risking getting infected because of the need to get financial support from male partners. This trend of affairs has a negative bearing on prevention and treatment efforts since it promotes non disclosure because of the same fear of losing financial security. There is therefore urgent need to empower women to negotiate for safe sex and to disclose their status to sexual partners. The study further revealed that disclosure is a complex process experienced as a series of events and women need to be empowered in order to reach the decision to disclose. The findings from the study also highlighted that the involvement of men in these programmes is essential so that cultural attitudes which lead to the spread of HIV infection can be corrected.

5.4 Recommendations
Khathide (2003:8) asserts that, research should produce “home grown intellectuals who can think with their communities, in the midst of them and for them as well”. With the same thought in mind, the following recommendations will be made. These recommendations have been made in the light of findings from the study and are aimed at empowerment of men and women in the context of HIV and AIDS. Whiteside and Sunter (2000) support this notion and state that, in order to empower people to make decisions that reduce the risk of HIV infection, there is need not only to examine the socio-economic causes of the epidemic but to counter them as well.

The recommendations will be made following the methods of social work practise, namely casework, group work, community work. Lastly, the present researcher will focus on further research.
5.4.1 Recommendations for casework

For casework practice, focus should be on encouraging those who turn up for VCT to be tested periodically for HIV, encouraging couples to be tested together and also reframing VCT to focus on disclosure skills.

5.4.1.1 Encouraging periodic testing of HIV

Casework practise refers to social work intervention with individuals, couples or families on a one-on-one basis. When people go for voluntary counselling and testing at VCT centres, they are engaged either as individuals, couples or families. During such sessions the focus should be on encouraging periodic testing of HIV, for instance encouraging people to get tested once a year. If people get tested often, the infection can be discovered early and further infection to unsuspecting partners prevented. Periodic HIV testing should be encouraged for men and women in both casual and stable relationships, however great emphasis should be placed on those in stable relationships. This is due to the fact that the false trust brought about by the length of the relationship makes people to relax and forget to practise safer sex. HIV testing should also be encouraged for those re-marrying after the death of a spouse so as to prevent the spread of the infection in cases where the widow or widower is HIV positive. If periodic HIV testing could be encouraged in the same way that breast cancer or prostate cancer routine check ups are encouraged then the message will get home.

5.4.1.2 Encouraging couples to get tested together

Those who are in stable relationships can be encouraged to undergo voluntary counselling together. The advantage of such a measure is that they both get to know about their diagnosis unlike if only one partner is tested, that partner may keep the diagnosis a secret thus endangering the other partner’s life. To encourage couples to come for testing together, VCT centres can have one day per week set aside for couples to come in for testing together. Various incentives can also be used to encourage more and more couples to get tested together, for
instance there can be a reward for the couple who manage to encourage 5 other couples from their communities to get tested well.

Another measure to encourage couples to come for testing together, though radical, would be to insist that one will only get tested for HIV when they bring their partner along. This strategy has worked very well with people suffering from sexually transmitted diseases where one is not treated alone but is asked to bring the partner along so that they both receive treatment at the same time. In the same way, couples can be encouraged to come for the test together. If one partner however refuses to come for the test then the willing partner should be tested alone and should receive education on practising safe sex so as to prevent either re-infection or future infection if the HIV test is negative.

5.4.1.3 Focusing on disclosure skills

During pre and post test counselling that is offered when one undergoes voluntary counselling and testing, the focus should be also on disclosure skills. It has been the researcher’s experience with VCT in Zimbabwe that the main focus seems to be on living positively living with HIV, that is, eating healthily, exercising, and avoiding stress to name a few. In the present study, the researcher picked the same trend from participants’ stories as well. It is true that a positive mind is essential in order to live longer with HIV but HIV/AIDS status disclosure is also needed in order to curb the rate of HIV infections in Africa where the rate is alarmingly high. In South Africa, for instance, it has been said that for every person receiving treatment, 4 others are newly infected (The Times, December 3, 2007).

An HIV diagnosis is confidential but people need to be encouraged to disclose their status to sexual partners in order to curb the rate of new infections. During post test counselling people should be encouraged to disclose their status to sexual partners. If one mentions that he or she is afraid to disclose, especially women who fear negative consequences the counsellor can then explore various
ways of disclosure with the client. The counsellor can help the client role play how she is going to break the news to her boyfriend with the counsellor offering supportive feedback. The counsellor can also partake to inform client’s partner on behalf of the client (partner notification) if the client consents to that.

5.4.1.4 Conclusion
In casework, social workers and nursing staff working at VCT centres can make a difference in the fight against HIV and AIDS by working towards encouraging HIV status disclosure and periodic testing of HIV. Due to the shortage of social workers and nursing staff in rural areas, there is need for the department of Social Services to lure social workers to work at governmental VCT sites by offering them competitive salaries and better working conditions. The Zimbabwean government can learn a lot from the South African government where Social Auxiliary workers are concerned. Social auxiliary work is professionalized in South Africa and due to this recognition; many people are becoming social auxiliary workers. These social auxiliary workers help greatly in social service delivery and the advantage is that they (social auxiliary workers) get basic social work training. If the same strategy can be adopted in Zimbabwe, basic service delivery will be enhanced in rural areas where social workers are scarce and social auxiliary workers can offer supportive services for those living with HIV.

5.4.2 Recommendations for group work
In group work, the focus should still be on disclosure skills but with an emphasis on behavioural change to protect oneself and others from infection. Group work is whereby individuals form a team and work towards the realisation of a common goal. The present researcher is looking at educational groups, therapeutic groups and support groups (socialisation). The group setting is a safe environment for those still trying to come to terms with their diagnosis and one gets strength from the realisation that one is not alone in the struggle of accepting HIV.
5.4.2.1 Exploring group counselling

In the absence of a vaccine for HIV, prevention of HIV infection is still the best method to address the epidemic. Since in most cases people fail to stick to behaviour that does not put them at risk of HIV infection, voluntary counselling and testing (VCT) has been adopted as the second best method of dealing with the epidemic. At the heart of VCT programmes is the emphasis on behavioural change.

The counsellors working at New Start Centres where people go for voluntary counselling and testing should be actively involved in this fight for disclosure to thrive as a prevention and treatment method. As part of post test counselling, group counselling can be explored focusing on disclosure and behavioural change. Group counselling is more effective and consumes less time for the already overburdened counsellors due to shortage of staff. These group sessions should target both men and women because focusing on women exclusively will not bring the desired effect, since in most cases, men are the ones who control the sexual encounter. A group can have 10 members and can be made up of 5 men and 5 women; however participants can be asked whether they prefer a mixed group or same sex group. The reason being that, if for instance a woman feels betrayed by her husband for giving her the infection then she will not feel comfortable being in the same group with men.

From the educational groups counsellors can identify participants who need therapeutic help who can be part of therapeutic groups. These groups need to be run by qualified social workers or qualified counsellors who have undergone training in HIV and AIDS counselling. During the group sessions, participants can deal with their emotions following the diagnosis, for instance one might feel the desire to revenge on all women or men by having unprotected sex with them. Such feelings can be discussed in the sessions until one comes to accept the diagnosis. Behaviour change can also be tackled in the therapeutic group as well. A therapeutic group can be made up of 5 to 8 members and might have to
be a same sex group in order for member to feel free to participate in the group. If a counsellor feels that there are some participants who need intensive therapy then a referral to a psychologist can be done.

Socialisation groups are also one method to help people deal with living with HIV and AIDS. The atmosphere in socialisation groups is light and participants lean upon each other and offer each other support, both emotionally and physically. If one has encountered rejection at home then one finds acceptance in the support group. One also gets the chance to discuss one’s fears like losing one’s good looks through sickness, dying and custody of one’s children in the event of death. Support groups offer ongoing support and should be available in all communities, especially in rural communities where they are virtually non existent. Organisations currently working with women in the region where the study was undertaken, for instance CADEC (a catholic organisation), GOAL (a non governmental organisation), and Salvation Army can help in the formation of socialisation groups. These groups will ensure that people living with HIV and AIDS have ongoing support which they desperately need in order to cope with the disease. These groups can also be open to people who are HIV negative but really want to understand how they can cope with caring for loved ones who are HIV positive. In this way the socialisation groups will perform a two fold function, namely, ongoing support for the HIV positive as well as knowledge dissemination for the HIV negative.

5.4.2.2 Conclusion
Working with individuals in a group setting is one method that can be employed in addressing HIV/AIDS status disclosure as well as advocating for behavioural change for the HIV infected and affected. The advantage of the group setting is that many people can be reached at a time and also the fact that group members offer emotional and physical support to one another.
5.4.3 Recommendations for community work
In community work, the recommendations are directed towards the departments of health, education and the department of information and publicity (media). The departments of health and education offer professional community work services so incorporating the recommendations should be an easy task. The department of information and publicity can be encouraged to offer professional community work services especially focusing on activism. The present researcher is of the opinion that change is possible but what is lacking is a critical awareness of HIV and AIDS. Once people have been conscientised through education then everyone will act towards a common goal (the fight against HIV and AIDS).

5.4.3.1 The department of Health and HIV Awareness Campaigns
The department of Health can be encouraged to become actively involved in HIV and AIDS awareness campaigns. These campaigns should shift focus and address attitudes as well as misconceptions surrounding the epidemic. Enough has been said about HIV transmission and nearly everyone is aware of the transmission modes, but why is the rate of HIV infection not going down as fast as is expected? The real problem is the attitudes of people and these should be addressed, in order to make a difference. Knowledge alone is insufficient, attitudes must change.

Partner reduction and avoidance of partner concurrency are some strategies that can be used during these HIV and AIDS awareness campaigns to address the attitudes of people, especially men who view having multiple partners as a sign of virility. The tendency to equate manhood with having multiple partners increases the rates of HIV infection and places women at risk of infection (Foreman, 1999; McGearly, 2001; Leclerc- Madlala, 2001). On the same note, awareness campaigns that challenge such attitudes would go a long way in reducing HIV incidence.
The department of health should also allow village health workers and traditional leaders to be the key players in these campaigns in rural areas. This is due to the fact that they are the ones who work directly in the villages and have an influence on community members by virtue of the position they occupy. If in every village, the village headman would organise an awareness campaign with the help of village health workers, the campaign is bound to be successful since the headman has strong influence over community members. The headman is respected in the village and by virtue of his authority can unite community members to work towards a common goal.

5.4.3.4 The Department of Education and the deconstruction of gender

The role of culture in HIV transmission and its impact on HIV/AIDS status disclosure cannot be ignored. An efficient strategy to use will be to address the socialisation process since gender has been said to be the major driving force behind the HIV and AIDS epidemic (Dube, 2003). As a result, since gender is socially constructed then this means that it can be socially deconstructed as well, by eradicating the power and powerlessness concept.

Women have been socially constructed to think that they cannot insist on safer sex whilst men think their virility can only be expressed through having multiple partners (Eaton et al., 1999 cited by Kauffman and Lindouer 2004; Dube, 2003; Barnett and Whiteside, 2006). It is further estimated that 60-80% of African women had only one partner and were infected because they were either not in a position to negotiate for safe sex or they could not prevent their partners from having additional partners (Barnett and Whiteside, 2006). As a result, the only way forward is to challenge this social construction through socialisation, that way the power and powerlessness concept will be eradicated and the rate of HIV incidence will be reduced. Whiteside and Sunter (2000) support this notion and assert that when the socio-economic causes of the epidemic are addressed, that is true empowerment, since people will now be able to make decisions that reduce their risk of infection.
This deconstruction process or re-socialisation should start at a tender age in order to achieve a high success rate. Since a person’s early and crucial years which mould one’s personality are spent in school then the department of education is the correct choice for to tackle the re-socialisation process. The subject ‘Life Orientation’ can be structured in such a way that it emphasises equality of the sexes because it is inequality which makes women vulnerable to HIV infection (Dube, 2003; Barnett and Whiteside, 2006). Cultural attitudes which lead to the spread of HIV infection, for instance associating male virility with having many partners should also be addressed. It would be a good idea if this re-socialisation process can start from grade 1 right up to grade 12; however ensuring that the subject matter is appropriate for each grade level. The subject should also be structured in such a way that information is built from one grade level to another becoming more broad or intensive as one goes up to the higher grades. Lastly, the subject should be made compulsory so that each and every scholar can benefit.

Schools can also be encouraged to arrange inter-school competitions or debates based on the subject matter, especially from grade 5 onwards since by then scholars will be capable of good judgement and reasoning. The department of education can also arrange its own competitions; firstly on the district level, then the winners for the district level can proceed to the national levels and from there proceed to the national level. Such publicity will ensure that the message gets across and change in the negative attitudes which make people vulnerable to HIV infection will be made possible.

The department of education can also urge non governmental organisations to work towards lobbying for the rights of the girl child, especially the right to education. This can be done through forming partnerships with such organisations or through subsidising projects aimed at addressing gender inequality. The present status of affairs is such that girls in rural communities get married early because they are forced to drop out of school at a young age as
some parents view educating girls as a waste of money. This is due to the fact that the girl child is viewed as a liability by her family because in the end she gets married and joins another family (Human Rights Monitor, 2001; Okechukwu, 2005). What these parents don’t realise is the fact that education means financial independence. Educated women can negotiate for safer sex and can even challenge a partner if that partner is being promiscuous unlike their uneducated counterparts who value financial security more than anything else. Educating the girl child therefore will help curb the rate of HIV infection.

In Zimbabwe, the Girl Child Network headed by Tendai Westerhof is an organisation which is doing tremendous work, lobbying for the rights of the girl child. Many girls have been educated and those who were on the streets prostituting were taken off the streets. There is dire need for many organisations to join in the fight for the rights of the girl child as this will go a long way in ensuring that the vulnerability of women to HIV and AIDS is reduced. These organisations should not only be urban based but should permeate the rural areas where women are tied by culture to a life of subordination. Rural women are willing subordinates who have accepted the status quo because that is the way it has always been. The present researcher is not suggesting that culture should be done away with but is merely suggesting that some cultural attitudes need to be changed so that men and women will not be vulnerable to HIV. Culture is of no use if it leads to the extinction of the population through HIV and AIDS related deaths. The department of education can therefore go a long way in the fight against HIV infection through the re-socialisation process.

5.4.3.3 The department of Information and publicity versus activism
The above department can also make its own fair share of contribution by screening HIV awareness programmes which feature activists. Activism is whereby people go public about their HIV/AIDS status in a bid to educate others about the disease. This strategy helps lower the stigma associated with HIV and AIDS and helps people accept the disease. When people have learnt to accept
this disease, then disclosure for women is going to be easy since their partners will have gained an understanding of the universality of the disease. If HIV and AIDS get accepted in society, the way serious illnesses like cancer or diabetes are accepted then disclosure will thrive as a prevention and treatment strategy.

Activism is also a coping mechanism for the person living with HIV as it is a means of regaining control of one’s life. This is due to the fact that one gets satisfaction from all the efforts aimed at preventing other people from falling prey to the virus. Activism also helps help other people involved in the same high risk behaviours to understand the consequences of their actions. This is due to the fact that there is a positive impact got from hearing the information from someone who understands, someone who has been through the same experiences before.

In Zimbabwe, activism is gaining ground and some activists have been screened live highlighting how they contracted the infection and urging people to live positively. This strategy is efficient but the problem is that, the messages have been screened as advertisements, which are featured during commercial breaks of main programmes. This somehow trivialises the whole message, if these messages could be featured as programmes on their own, people will take them seriously and hence the message will get across. In order for the department of Information and publicity to feature these programmes there is need to have a section which deals with community outreach which will target rural populations. The present researcher feels that rural populations should be targeted because in the rural areas HIV is still highly stigmatised to such an extent that disclosure almost seems like a taboo.

The high rate of stigma associated with HIV in the rural areas might be linked to the fact that there are no supportive services available for the people living with HIV for instance support groups. To solve this problem, the current few activists need to expand their horizon and target rural populations with the assistance of the department of Information and publicity. The urban population has the
advantage of having easy access to televisions and radios which some of the rural population do not have either due to poverty or due to staying in remote areas where there is no television or radio network.

These programmes featuring activists awareness messages should also be aired on radio so as to benefit the people who do not have televisions especially those staying in rural areas. Despite the government’s initiative to electrify most rural areas, there are still thousands of people in the rural areas who cannot afford to electrify their homes because of financial constraints. In the region where the study was undertaken most villagers do not have electricity. As a result, airing awareness messages on radio will reach these masses since most households have radios powered by batteries. These programmes should also be aired at a convenient time, for instance early evening between 6 and 8 pm when all people have come back from work or from school.

5.4.3.4 Conclusion
In community work, the departments of health, education and information and publicity can be involved in the fight against HIV and AIDS by getting involved in awareness campaigns and programmes aimed at rural communities. These departments can actually make a difference in advocating for VCT to thrive as a prevention and treatment method whilst changing attitudes which increase vulnerability to HIV infection.

5.5 Recommendations for further research
Due to the nature of the sample and focus, generalisations to the broader population cannot be made. The information gathered does however reveal something about a particular group of HIV positive women who were studied and gives an in depth glimpse into the total picture thus forming the basis for future research. It is the researcher’s hope that future research will focus on:
• Further researching the intervention strategies suggested above. The strategies need to be tested in order to verify their applicability.

• The impact of culture on the spread of HIV infection as well as on the disclosure experiences of African women.

• Strategies that can be employed in order to make HIV/AIDS status disclosure work effectively to prevent new HIV infections in Zimbabwe where the levels of HIV infection are still alarmingly high.

• Strategies that can be implemented in order to curb the rate of HIV infection in the African continent: strategies which suit the African climate.

The rate of HIV infection is alarmingly high and there is dire need to come up with ways of curbing the infection. Zimbabwe’s infection level stands at 20.1% (Afrol News, 2006) whilst in South Africa, for every person receiving treatment, 4 others are newly infected (The Times, December 3, 2007). It is the present researcher’s hope that future research will bring about the much needed answers to Africa’s HIV and AIDS problem.
REFERENCES


Conference. Durban: South Africa.


HIV affects normal people having normal sex (Sunday Times, 30 September 2007).


Legal Age of Majority Act (1982) Retrieved 17 August 2009, from: http://info@media.uio.no


Sexual Offences Act (2001) Retrieved 17 August 2009, from: http://info@media.uio.no


Shoko, B. *Zimbabwe misses out on key HIV/AIDS talks* (The Standard, 8 July 2007).


The Herald (22 August 2007) *Women poorly represented in political decision making.*

The Times, Monday 3 December 2007. Commentary on the 46 664th AIDS concert held at Ellis Park Stadium, Johannesburg.


Appendix A: Interview Schedule

Cover letter to the Participants

My name is Maureen Kambarami. I am doing my Master of Social Work degree at the University of Fort Hare in South Africa. As part of the requirements of that degree, I am carrying out a study on the experiences that HIV positive women undergo when they disclose their status to sexual partners. The study was approved by the University’s research committee and it is my hope that the research will be successful with your help.

Thank you for agreeing to be part of the study. Please note that your participation is entirely voluntary and you are free to withdraw at any point if you so wish. I also intend to tape record the interview with your permission, however, if you do not wish that the interview be recorded your wish will be respected. Please note that your participation is entirely voluntary and if you wish not to answer any question or wish to withdraw from participating in the study, you are free to do so at any point.

The study is about the disclosure experiences of HIV positive women and you will be asked questions pertaining to your own experiences of disclosing to sexual partners. Another section of the study will deal with the support systems that are available in your community which help you to cope with disclosure experiences, and lastly you will be asked your own opinion on how women living with HIV and AIDS can be empowered.

The information you give will be kept private and confidential and will only be used for research purposes. The interview itself will take 30 to 45 minutes of your time. You will be further asked to choose a pseudonym which will be used in the interview to protect your privacy. Any queries containing the research, your participation and rights can be addressed to Mr Sumbulu, who is my supervisor. His details are attached to this letter.
If you agree to all the conditions mentioned overleaf and have no further questions I will then ask you to sign below to show that you have given your consent.

__________________________ (pseudonym)
__________________________ (signature)

___________________________ (date)

If you need more information, the contact details are as follows:

Researcher: Maureen C. Kambarami  
Cell No’s: 023 510 162 / (27)790303722  
Email: monaleey1@webmail.co.za

Supervisor: Mr A. Sumbulu  
Cell: (27)82 202 2266  
Email: asumbulu@ufh.ac.za
Appendix B.

Interview Schedule

<table>
<thead>
<tr>
<th>THEME</th>
<th>QUESTIONS</th>
<th>PROMPTS</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>A. PERSONAL DETAILS</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1. Can you please tell me about yourself?</td>
<td></td>
<td>- age</td>
</tr>
<tr>
<td>2. Did you manage to attend school?</td>
<td></td>
<td>- where she comes from</td>
</tr>
<tr>
<td>3. What is your source of income?</td>
<td></td>
<td>- marital status</td>
</tr>
<tr>
<td><strong>B. DISCLOSURE EXPERIENCES</strong></td>
<td></td>
<td>- number of children</td>
</tr>
<tr>
<td>4. When were you diagnosed HIV positive?</td>
<td></td>
<td>- if yes, level of education;</td>
</tr>
<tr>
<td>5. What was your reaction to the diagnosis?</td>
<td></td>
<td>- if no, the reasons for not attending school.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- farming</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- husband’s salary</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- any other means(specify)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>the year when diagnosed</td>
</tr>
<tr>
<td></td>
<td></td>
<td>place where the test was taken</td>
</tr>
<tr>
<td></td>
<td></td>
<td>reasons for taking the test</td>
</tr>
<tr>
<td></td>
<td></td>
<td>source of infection; if known</td>
</tr>
<tr>
<td></td>
<td></td>
<td>feelings experienced</td>
</tr>
<tr>
<td></td>
<td></td>
<td>first person to tell of diagnosis</td>
</tr>
<tr>
<td></td>
<td></td>
<td>time lapse between</td>
</tr>
<tr>
<td>Question</td>
<td>Details</td>
<td></td>
</tr>
<tr>
<td>-------------------------------------------------------------------------</td>
<td>------------------------------------------------------------------------</td>
<td></td>
</tr>
<tr>
<td>6. How do you view HIV/AIDS status disclosure to sexual partners?</td>
<td>Diagnosis and disclosure -whether disclosure was made to past and present partners -whether disclosure is viewed as relevant or not and the reasons for such thinking</td>
<td></td>
</tr>
<tr>
<td>7. May you please tell me about your disclosure experiences with sexual partners</td>
<td>-what makes her disclose in a sexual relationship -factors she considers before disclosing to a sexual partner -positive and negative experiences arising from disclosure and their effect on the relationship and future disclosure</td>
<td></td>
</tr>
<tr>
<td>8. In your opinion, what is the impact of culture on how women disclose to sexual partners?</td>
<td>-whether culture promotes or hinders disclosure</td>
<td></td>
</tr>
<tr>
<td>9. If you were a man, how would you handle disclosure to sexual partners?</td>
<td>-whether there are perceived gender differences in disclosure experiences</td>
<td></td>
</tr>
<tr>
<td>C. INTERVENTIONAL NETWORKS</td>
<td>10. What is your source of support when it comes to coping with disclosure experiences?</td>
<td></td>
</tr>
<tr>
<td>D. EMPOWERMENT NEEDS OF HIV POSITIVE WOMEN</td>
<td>11. May you please describe the role played by these sources in helping you cope positively with disclosure.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>12. What further support do you think you need in order to cope well with disclosure experiences?</td>
<td></td>
</tr>
<tr>
<td></td>
<td>13. How do you think women can be empowered so as to deal positively with HIV/AIDS status disclosure to sexual partners?</td>
<td></td>
</tr>
<tr>
<td></td>
<td>14. Having come this far with our interview, how do you feel right now?</td>
<td></td>
</tr>
<tr>
<td></td>
<td>-formal and informal networks</td>
<td></td>
</tr>
<tr>
<td></td>
<td>-on a personal level</td>
<td></td>
</tr>
<tr>
<td></td>
<td>-community level</td>
<td></td>
</tr>
<tr>
<td></td>
<td>-national level</td>
<td></td>
</tr>
<tr>
<td></td>
<td>-debriefing</td>
<td></td>
</tr>
</tbody>
</table>

We have come to the end of our interview. Thank you very much for your participation and co-operation.
Appendix C: Transcriptions

Respondent 1
Pseudonym: Sipho

A. Personal details
Researcher: Can you please tell me about yourself?
Sipho: I am 41 years old and reside in Chidzomba village. I am a married woman and a mother of five.

Researcher: Did you manage to attend school?
Sipho: I never attended school, my parents divorced and I grew up in the care of my aunt. She never sent me to school.

Researcher: What is your source of income?
Sipho: I am a vegetable vendor; I sell tomatoes, vegetables and bananas.

B. Disclosure experiences

Researcher: When were you diagnosed HIV positive?
Sipho: I was diagnosed in..... (tries to recall date and fails, at the end consults her card). It was in 2005 and I got tested in Magunje; following endless bouts of illnesses which made me suspect that something was wrong with my immune system (fidgets nervously).

[When asked whether she knew the source of the infection, she says confidently...] YES, MY HUSBAND. He is the one I suspect.

Researcher: What was your reaction to the diagnosis?
Sipho: I put everything in God’s hands and just accepted my fate (begins playing with her fingers). During pre-test counseling when they asked what I would do if I found myself HIV positive I just told them that there is nothing I could do. Soon
after the test, the first person I told was my child. However, when I told my husband, he did not get angry or question me. He just kept quiet and expressed no desire to get tested as well stating that it made no difference.

**Researcher:** How do you view HIV status disclosure to sexual partners?
Sipho: Disclosure is important so that you can use condoms so as to prevent re-infection.

**Researcher:** May you please tell me about your disclosure experiences with sexual partners?
Sipho: When I told my husband... (coughs) He was surprised and he said, A-a-a, I won’t go for testing even if that’s the case, it won’t make any difference. However, there are no negative feelings between the two of us and nothing has changed in our relationship.

**Researcher:** In your opinion, what is the impact of culture on how women disclose to sexual partners?
Sipho: Culture is okay, the problem is MEN. Men impose laws on their wives and it is these laws which hinder disclosure. Its not about culture, it’s these laws which make women afraid to disclose their HIV status.

**Researcher:** If you were a man, how would you handle disclosure to sexual partners?
Sipho: If I were a man I would not face any problems, because men are the rulers, they rule over women and are not afraid of anything.
C. Interventional networks

Researcher: What is your source of support when it comes to coping with disclosure experiences?
Sipho: There is no source of support, each person copes alone, since I came back from the New Start Centre in 2005, I just read the booklets that they gave me.

Researcher: What support do you think you need in order to cope well with disclosure experiences? [Interruption, as someone approaches the homestead]
Sipho: What is the question that you had asked?
Researcher: [repeats the question]
Sipho: We need support groups where you go and socialize and forget for a while about the virus. If you just stay in isolation, you end up thinking about a lot of things and that will make you ill again. However, a support group is not easy to start because people do not want to be known that they have the deadly virus because people talk, the whole community will end up knowing that you are HIV positive. You cannot confide even to a friend, because that friend has her own friend who has her own friend, the result is a chain of people who end up knowing your story (looks at the researcher as if to seek approval). As a result, we need external help, especially education on how to disclose and to cope with disclosure experiences, just like what you have done by approaching us it makes it easy for us to share our stories.
D. Empowerment needs of HIV positive women

**Researcher:** How do you think women can be empowered so as to deal positively with HIV status disclosure to sexual partners?
Sipho: Women need external help on how to disclose, they are afraid to come out in the open for fear that everyone will end up knowing that they are HIV positive. Education is also needed and it is lacking in the rural areas.

**Researcher:** Having come this far with our interview, how do you feel right now?
Sipho: The interview has not disturbed me in any way; it was a relief to share my story.

[After the interview, the researcher debriefs her and offers some counseling after which the respondent leaves.]
Respondent 2
Pseudonym: Chipo

A. Personal details

Researcher: Can you please tell me about yourself?
Chipo: I am a 36 year old, married woman who resides in Chidzomba village. I have two children with my husband [her voice is shaking and she is physically weak]

Researcher: Did you manage to attend school?
Chipo: I got educated up to Form four

Researcher: What is your source of income?
Chipo: We survive on farming

B. Disclosure experiences

Researcher: When were you diagnosed HIV positive?
Chipo: In 2003, I got tested for HIV at the New Start Centre in Magunje. I had been sick for a long time to the extent that I was always in bed. Even now, I spend most of my time sleeping in the kitchen, next to the fire. I suspect that my husband is the one who gave me the virus because I know that I was faithful to him.

Researcher: What was your reaction to the diagnosis?
Chipo: I felt hopeless and meditated upon the diagnosis [stares ahead and avoids eye contact with the researcher]. I just meditated. The first person I told was my husband, I told him five days later after debating on whether to tell him or not.
**Researcher: How do you view HIV status disclosure to sexual partners?**

Chipo: Disclosure is important so that you do not kill an innocent person, however the problem is that men will scold or beat you if you disclose accusing you of infidelity.

**Researcher: May you please tell me about your disclosure experiences with sexual partners?**

Chipo: After being told my diagnosis, I spent five days without telling my husband meditating on what would happen once I told him. I was afraid that soon after telling him, he would divorce me and say I cannot stay with such a person. Eventually when I told him he said a lot of things...... (At this point she did not want to disclose what those things were, and the researcher had to re-assure her of confidentiality, she finally disclosed but was nervous all the way). He said, “It's you! You are responsible, why did you go alone?” He scolded me and accused me of being promiscuous. Now he does not say anything he just looks at me. (After this disclosure, respondent becomes restless and her face registered pain).

**Researcher: In your opinion, what is the impact of culture on how women disclose to sexual partners?**

Chipo: Culture hinders disclosure since it ensures the subordination of women making them afraid of their husbands’ or partners’ reactions. Some men do not allow their wives to go for testing; now it’s difficult when you are sick to just stay at home not doing anything about your situation. That is why I went for testing alone and then got all the blame.

**Researcher: If you were a man, how would you handle disclosure to sexual partners?**

Chipo: Umm, men don’t disclose (laughs nervously) they don’t disclose. (From this point, her voice was shaky and she showed signs of strain, as a result she started giving very short answers).
C. Interventional networks

Researcher: What is your source of support when it comes to coping with disclosure experiences?
Chipo: I do not have any source of support (tears glistening in her eyes).

Researcher: What support do you think you need in order to cope well with disclosure experiences?
Chipo: We need education, if someone could come and address us, just like what you have done. It would help us face life more positively.

D. Empowerment needs of HIV positive women

Researcher: How do you think women can be empowered so as to deal positively with HIV status disclosure to sexual partners?
Chipo: Women need education so that they can disclose to sexual partners.

Researcher: Having come this far with our interview, how do you feel right now?
Chipo: I am feeling so sick, my whole body is painful.
[The researcher offers her some counseling in order to strengthen her emotionally and to give her hope.]
Respondent 3
Pseudonym: Sofiya

A. Personal Details

Researcher: Can you please tell me about yourself?
Sofiya: I am 33 years old and reside in Kahonde village. I have 3 children and am a divorcee (her breathing is a little bit labored and she is shivering).

Researcher: Did you manage to attend school?
Sofiya: Yes, up to form four.

Researcher: What is your source of income?
Sofiya: I am a vendor; I buy fish directly from the fisherman at the Fishing Camps and later resale the fish in my community.

B. Disclosure experiences

Researcher: When were you diagnosed HIV positive?
Sofiya: I got tested this year, 2007 at the Fishing camps (a place near Kariba where people go to trade goods like mealie-meal, vegetables and maize in exchange of fish). The reason why I took the test was that I had developed Herpes and so suspected that I could be HIV positive. My former husband is the source of the infection and when I told him he even confessed that he was promiscuous (as a result, she left him).

Researcher: What was your reaction to the diagnosis?
Sofiya: I accepted the diagnosis and told myself that I would get the much needed help, be it, foodstuffs or education, which would make me survive for more years. The first person I told was my mother, I told her soon after the diagnosis.
Researcher: How do you view HIV status disclosure to sexual partners?
Sofiya: Disclosure is relevant so as to stop the spread of HIV and to protect those who are HIV negative.

Researcher: May you please tell me about your disclosure experiences with sexual partners?
Sofiya: I do not have any partner at the moment because from the time I got tested I was told by the doctors to abstain from sex, so as to prevent re-infection. Besides, my body is so painful that sex is out of the question. However, when I told my husband, he showed no surprise, he even said “I was promiscuous, I enjoyed during my time”. He also went for testing and his results came back positive.

Researcher: In your opinion, what is the impact of culture on how women disclose to sexual partners?
Sofiya: Culture does not hinder disclosure if adhered to, this is because, if we were to adhere to culture men would be faithful and there would be no HIV just like what used to happen in the old days. Not for someone to boast and say “I was promiscuous” like what my husband did. (When she quotes her husband, her chest is drawn outwards and she beats her breast to emphasize the boasting). Women would also get married as virgins and the rate of HIV would be low.

Researcher: If you were a man, how would you handle disclosure to sexual partners?
Sofiya: I would be at an advantage, because men have an advantage. If women go for testing, men accuse them of infidelity stating that the one, who goes for testing first, is the promiscuous one. Furthermore, men do not disclose.
C. Interventional networks

Researcher: What is your source of support, when it comes to coping with disclosure experiences?
Sofiya: There is no source of support, in the village. You cannot even disclose to family members, because if you do so, everyone in the village will end up knowing your status. If you need support for instance education, you have to go the hospital (looks down guiltily).

Researcher: What support do you think you need in order to cope well with disclosure experiences?
Sofiya: Education on the nutritional needs of HIV positive people as well as the guidelines for healthy living. We also need help with medication which is difficult to obtain when you do not have enough money because you are too ill to work for yourself. Projects which are easy and light to maintain like poultry projects will also go a long way in assisting us financially.

D. Empowerment needs of HIV positive women

Researcher: How do you think women can be empowered so as to deal positively with HIV status disclosure to sexual partners?
Sofiya: Women should be educated to understand that HIV is real and is a disease that survives in people. They should open up and get help before it is too late. Women should also learn to abstain from sex when they get the virus, it is better to survive for 10 or 20 years because by then your children will have grown. When you have children, what more do you want, we begin sexual relations at a young age, so why can’t we abstain and give rest to our compromised bodies. Furthermore, women should learn to abstain so as to prevent re-infection.
Researcher: Having come this far with our interview, how do you feel right now?
Sofiya: I do not have any complaint. [After the interview debriefing occurs]
Respondent 4
Pseudonym: Anna

A. Personal details

Researcher: Can you please tell me about yourself?
Anna: I am 44 years old, reside in Chidzomba village and am a widow. I have two children.

Researcher: Did you manage to attend school?
Anna: I only managed to go as far as grade 6.

Researcher: What is your source of income?
Anna: I survive on farming just like everyone else in this area.

B. Disclosure experiences

Researcher: When were you diagnosed HIV positive?
Anna: My first husband died in 1999 and I remarried. However, in 2002, I gave birth to a sickly child who later died. After the death of my child I developed TB and that is when I began to suspect that I had the virus. When I went to Karoi for treatment the doctors encouraged me to get tested for HIV and I agreed. The results came back positive.

Researcher: What was your reaction to the diagnosis?
Anna: I accepted the diagnosis since I already suspected that I had the virus.

Researcher: How do you view HIV status disclosure to sexual partners?
Anna: Disclosure is important so as to protect the already compromised body by abstaining from sex. Doctors encourage those who have suffered from TB to
abstain from sex, saying abstinence lessens the impact of the virus. If a man proposes to me, I tell him that there is nothing I can offer him in return, since my health is much more important to me than a sexual relationship. People in my community know that I was sick to the point of dying, but now due to abstinence I have recovered so I will not jeopardize my health.

**Researcher:** May you please tell me about your disclosure experiences with sexual partners?

Anna: My husband died in 1999 before I knew that I was HIV positive. However with the second man that I got involved with, when I gave birth to a sickly child I became suspicious that something was wrong. I disclosed to him but he expressed no wish to get tested himself. However from that time I made up my mind to abstain from sex so as to protect my already compromised body. My health and my children are now important to me than any man. I do not have all the necessities of life that I need, but I have life, and do not need any man. If a man proposes, I tell him openly that I am HIV positive and am abstaining so there is nothing more that I can offer him.

**Researcher:** In your opinion, what is the impact of culture on how women disclose to sexual partners?

Anna: Culture should be adhered to. Women should inform their husbands of the desire to go for HIV testing so that there won’t be any conflict when they test HIV positive.

**Researcher:** If you were a man how would you handle HIV status disclosure to sexual partners?

Anna: You know men rule over women because they say they are the heads of households, if I were a man I’d do the same (smiles at the irony of the statement). Women are oppressed by men.
C. Interventional networks

Researcher: What is your source of support when it comes to coping with disclosure experiences?
Anna: My children…. They give me the desire to live longer so that I can watch them growing.

Researcher: What further support do you think you need in order to cope well with disclosure experiences?
Anna: We need educational support on how to live positively, for instance the right foods to eat and so on. Socializing is also important, so that we do not continuously think about having the virus, however, we do not have any support group around and each person just keeps to herself.

D. Empowerment needs

Researcher: How do you think women can be empowered so as to deal positively with HIV status disclosure to sexual partners?
Anna: Women should be educated on the importance of abstaining so that they live longer. We need people who come and educate us.

Researcher: Having come this far with our interview, how do you feel right now?
Anna: I am glad to have shared my story rather than keeping all this to myself.

[After the interview debriefing occurs]
Respondent 5
Pseudonym: Tendai

A. Personal Details

Researcher: Can you please tell me about yourself?
Tendai: I am 28 years old, reside in Kuipa village and am married. I also have four children.

Researcher: Did you manage to attend school?
Tendai: Yes, up to grade 6.

Researcher: What is your source of income?
Tendai: I am a vendor.

B. Disclosure experiences

Researcher: When were you diagnosed HIV positive?
Tendai: In 2005 at Chidamoyo Hospital. I thought of getting an HIV test because I had developed TB as well as edema of the stomach and legs. The sicknesses forced me to get tested otherwise I would never have thought of getting tested. As for the source of infection, it’s MY HUSBAND, HE WAS PROMISCOUS INDEED.

Researcher: What was your reaction to the diagnosis?
Tendai: I just accepted and put everything in God’s hands (looks down). I was afraid of dwelling too much on the diagnosis because that would make me sick. The first person I told was my sister. She was the one who was looking after me in hospital, so when the results came I told her. From that time I started abstaining following doctor’s advice.
Researcher: How do you view HIV status disclosure to sexual partners?
Tendai: Disclosure is important so that you do not kill an innocent person; however in real life situations disclosure is not easy. As a result, it is better to abstain.

Researcher: May you please tell me about your disclosure experiences with sexual partners?
Tendai: I tested HIV positive when my husband was dead already. I do not disclose to sexual partners. We live in the rural areas, who will approach me again if I disclose that I am HIV positive? (looks at the researcher challengingly). If it was in town, it would be better because one can just move on to another location, where she is not known then find a partner again. Even if I were to disclose men would not believe me. Since the death of my husband all the men I have been involved with refuse to use condoms, I have practically to hold the … (pauses for some seconds) with force and put on the condom.

Researcher: In your opinion what is the impact of culture on how women disclose to sexual partners?
Tendai: Culture does not hinder disclosure but it is men who oppress women and accuse them of infidelity. Men should not accuse women of infidelity because in most cases, they (men) are the ones who bring the virus home.

Researcher: If you were a man, how would you handle disclosure to sexual partners?
Tendai: I would not accuse my partner of infidelity, I would just keep quiet.
C. Interventional networks

Researcher: What is your source of support when it comes to coping with disclosure experiences?
Tendai: I have no source of support; family members are not even supportive (looks down guiltily, researcher encourages her to go on). At one point, when I disclosed to my aunt, she gave me my own plate, cup, and washing bowl so that I would not pass on the infection to others.

Researcher: What support do you think you need in order to cope well with disclosure experiences?
Tendai: A support for the HIV positive will be a good thing, however it is difficult to form a support group because people do not want to be known for fear that the whole community will end up knowing. We also need help in forming our own projects which do not require heavy labour, because of our frail bodies (looks at her body which shows signs of illness).

D. Empowerment needs of HIV positive women

Researcher: How do you think women can be empowered so as to deal positively with HIV status disclosure to sexual partners?
Tendai: Women should learn self reliance, they should be financially independent. This can be done through embarking on projects so that they do not get tempted to seek for sexual relations in order to get financial security.

Researcher: Having come this far with our interview, how do you feel right now?
Tendai: I have no emotional strain.

[After the interview debriefing occurs]
Respondent 6
Pseudonym: Memory

A. Personal details

Researcher: Can you please tell me about yourself?
Memory: I am 35 years old, reside in Kahonde village and I am married. My first husband died and the one I have now is my second husband.

Researcher: Did you manage to attend school?
Memory: Yes, I went as far as grade 7.

Researcher: What is your source of income?
Memory: I survive on farming and gardening. I exchange the vegetables I get from my garden with fish at Nyaodza co-operative and then resale the fish at a profit to community members.

B. Disclosure experiences

Researcher: When were you diagnosed HIV positive?
Memory: This year, 2007. My second husband suffered firstly from TB and then herpes. This made me suspect that it might be HIV, so when I heard that in Gachekache (a village approximately 20 km away) they were carrying out an HIV counseling and testing programme, I went there. The results came back positive. I do not know the source of infection I just know that I do not have any other sexual partners besides these two husbands of mine. I could have got the infection from my first husband who was a civil servant and used to travel a lot, or I could have got it from the present husband since he divorced three wives before he married me.
Researcher: What was your reaction to the diagnosis?
Memory: I just accepted the diagnosis and was not surprised because I had become suspicious when my husband got sick (face registering resignation). The first person I told about my status was my husband and I told him as soon as I came back from the Testing Centre. I then told my first born, a daughter who is 15 years old and said, (straightens out her dress and looks ahead intently as if the daughter is before her) “I your mother am now living with the virus, so I wanted you to know that our life is going to change now’.

Researcher: How do you view HIV status disclosure to sexual partners?
Memory: Disclosure is very important because non disclosure is a sin, it is, killing intentionally.

Researcher: May you please tell me about your disclosure experiences with sexual partners?
Memory: I did not hesitate to tell my husband because when he married me he knew that I was a widow and he accepted me like that, so when he accepted me, he accepted the HIV as well (said challengingly). He had been married three times as well, so he could have had the virus in him when we married. I did not experience any negative feelings when I told him; he accepted our fate because when we got married we did not go for HIV testing. He also went for testing and his results came back positive as well.

Researcher: In your opinion, what is the impact of culture on how women disclose to sexual partners?
Memory: Culture helps the virus to spread because men are promiscuous, they do not stick to one sexual partner. Women are expected to be faithful to their husbands but cannot compel fidelity in return. Some women do not disclose their status to sexual partners for fear of negative reactions and others do not disclose as a form of revenge to the male race after getting the virus from their husbands. It is better for people to get tested before marriage and if one partner refuses
THEN THE RELATIONSHIP SHOULD END because that shows that he or she is HIV positive and is thus afraid to be known.

**Researcher:** If you were a man, how would you handle disclosure to sexual partners?
**Memory:** If I were a man I would not have any problems disclosing because I would not be afraid of anything.

**C. Intervventional networks**

**Researcher:** What is your source of support when it comes to coping with disclosure experiences?
**Memory:** I have no source of support. There is no support group for the HIV positive in this community, people are afraid to disclose their status because the whole community will end up knowing (looks down). However there used to be an organization which used to issue out foodstuffs to the HIV positive, some time ago. The representatives concerned used to steal the foodstuffs until people living with HIV realized that they were being used to feed other people who did not qualify for the foodstuffs. The programme has since been phased out.

**Researcher:** What support do you think you need in order to cope well with disclosure experiences?
**Memory:** If there can be a support group for people living with HIV and AIDS, it would make life easier for us.

**D. Empowerment needs**

**Researcher:** How do you think women can be empowered so as to deal positively with HIV status disclosure to sexual partners?
**Memory:** We need financial help so that we can start our own projects; personally I love farming but do not have the money to buy the required inputs like fertilizer
(looks at the researcher, who nods in encouragement). A project for a grinding mill or a shop will also be viable in our village. The present shops charge high prices for basic commodities.

Researcher: Having come this far with our interview, how do you feel right now?
Memory: I feel okay.
[After the interview debriefing occurs]
Respondent 7
Pseudonym: Takunda

A. Personal details

Researcher: Can you please tell me about yourself?
Takunda: I am 36 years old and I am a widow. I reside in Chidzomba village and have 8 children. My husband died 7 years ago, but I have since been involved with another man.

Researcher: Did you manage to attend school?
Takunda: My parents never sent me to school.

Researcher: What is your source of income?
Takunda: I survive on farming.

B. Disclosure experiences

Researcher: When were you diagnosed HIV positive?
Takunda: I tested HIV positive in 2006. I was tested at Chidamoyo Hospital. I had been sick continuously for a long period so I thought it was better to get tested for the virus. I suspect that I got the infection from my husband (when asked by the researcher how she could say for certain when she had been involved with someone else following the death of her husband, she said that she was not sure).

Researcher: What was your reaction to the diagnosis?
Takunda: I was upset and emotionally troubled. When I came back from the hospital, I told my children and grandchild about the diagnosis. However, I did not disclose to the man I was involved with because I was afraid that he would leave me. The man has since died (said without registering any emotion).
Researcher: How do you view HIV status disclosure to sexual partners?
Takunda: It is difficult to disclose to sexual partners because they will leave you and you will lose the source of financial support.

Researcher: May you please tell me about your disclosure experiences with sexual partners?
Takunda: I did not disclose to my sexual partner who has since died. To me, financial security is important more than anything else. As a result, I am afraid to disclose. Presently, I prefer to just use condoms without disclosing but the problem is that men do not want to use condoms; you have to force them to do so. [When asked what she would do if a partner refuses to use a condom, she laughed and said ‘that is the difficult part’]

Researcher: In your opinion what is the impact of culture on how women disclose to sexual partners?
Takunda: Men oppress women because they are the providers, as a result women are afraid to disclose their status for fear of losing that financial security. Women can only be emancipated through financial security (this statement is said with conviction).

Researcher: If you were a man, how would you handle disclosure to sexual partners?
Takunda: If I were a man I would protect myself from HIV, now I cannot, because of this oppression (this is said resignedly).
C. Interventional networks

Researcher: What is your source of support when it comes to coping with disclosure experiences?

Takunda: I do not have any source of support; moreover it is very difficult to disclose one’s status because everyone will end up knowing. In the urban areas, it is better because you can just move on to another place where people do not know you and you can then find someone else who loves you. Here, in the rural areas, it is difficult because once men know your status they will leave you alone, it’s as if you cease to exist (at this point she begins to play with her hands, folding and unfolding them).

Researcher: What support do you think you need in order to cope well with disclosure experiences?
Takunda: I need help with foodstuffs, there was an organization which had pledged to help us (people living with HIV and AIDS) with food parcels but they only did that for three months and have since stopped their operations.

D. Empowerment needs of HIV positive women

Researcher: How do you think women can be empowered so as to deal positively with HIV/AIDS status disclosure to sexual partners?
Takunda: There is need for women based organizations to come and educate us especially to encourage us to disclose our HIV status. Disclosure is still a problem, no wonder why the virus is spreading rapidly. This is only possible through outside help because in most cases when well wishers come with donations, most of us miss this supportive help because we are afraid that the whole community will end up knowing that we are living with the virus. We feel ashamed of ourselves.
Researcher: Having come this far with our interview, how do you feel right now?

Takunda: I am alright (her face contradicting her statement, since it displayed emotional disturbance).

[After the interview the researcher counseled her on the need to disclose especially to sexual partners]
Respondent 8
Pseudonym: Rachel

A. Personal details

Researcher: Can you please tell me about yourself?
Rachel: I am 32 years old and reside in Chidzomba village. In addition, I am a mother of two, although I separated from my husband a few years ago.

Researcher: Did you manage to attend school?
Rachel: Yes I did, in 1988 I was in grade 7 and I did not go any further with my education.

Researcher: What is your source of income?
Rachel: I sustain myself through farming.

B. Disclosure experiences

Researcher: When were you diagnosed HIV positive?
Rachel: In 2006, at Chidamoyo hospital. At that time my legs were swollen and painful and my whole body was painful, so I decided to go for testing. My husband is the one who gave me the virus, you know men! It is very difficult for them to be faithful.

Researcher: What was your reaction to the diagnosis?
Rachel: The diagnosis pained me very much (shakes her head). However, the first person I told was my mother. I told her as soon as I returned from Chidamoyo. As for my husband, I did not tell him of the diagnosis because we had already separated and I did not know where to find him.
Researcher: How do you view HIV/AIDS status disclosure to sexual partners?
Rachel: Disclosure is important but you know men, they will say you are lying. I am also afraid of desertion if I disclose to a sexual partner.

Researcher: May you please tell me about your disclosure experiences with sexual partners
Rachel: I do not disclose (laughs nervously) N-o-o, I don't disclose (continues laughing). I find it very difficult for me to do so. If a partner contracts the virus from me, I do not mind I will pretend to be ignorant and say it has just happened or I will just tell him the truth. He won’t beat me, he won’t (laughs). The problem is that if I disclose my status he will leave me and I will lose him. However, these days I am very sick and am abstaining because no one can propose to me in this state but if I were to find a potential partner I will first look at the financial support he will be giving me before thinking of disclosing. If he is giving me everything that I need then I will not disclose because disclosure will mean losing all that.

Researcher: In your opinion what is the impact of culture on how women disclose to sexual partners?
Rachel: Culture facilitates the spread of the virus in the sense that you cannot caution your husband if he is being unfaithful, because he will divorce you. As a result, men bring the virus home and then accuse women for being unfaithful.

Researcher: If you were a man, how would you handle disclosure to sexual partners?
Rachel: If I were a man, I’d do the same thing; I’d also accuse my partner (displays a challenging face).
C. Interventional networks

Researcher: What is your source of support when it comes to coping with disclosure experiences?
Rachel: (shakes her head nervously) I do not have any support system.

Researcher: What support do you need in order to cope well with disclosure experiences?
Rachel: I would be glad to get help with school fees for my oldest child who is aged seven. The child is at home and is not going to school because I do not have any money, (pauses and says while looking down) the school fees is not much, but I cannot afford it. I am always in bed. I also feel strongly that if there was a support group, it would make life easier for us but it is difficult to start this group, because people do not want to be known that they have the virus. We need outside help in order to get started.

D. Empowerment needs of HIV positive women

Researcher: How do you think women can be empowered so as to deal positively with HIV status disclosure to sexual partners?
Rachel: (Laughs nervously) I do not have any suggestion.

Researcher: Having come this far with our interview, how do you feel right now?
Rachel: I am okay (laughs)

[After the interview, the researcher offers her counseling on the need to disclose to sexual partners and also educates her on the HIV status disclosure law]
Respondent 9
Pseudonym: Juliet

A. Personal details

Researcher: Can you please tell me about yourself?
Juliet: I live in Kuipa village and I am a 44 year old married woman. I have 10 children with my husband.

Researcher: Did you manage to attend school?
Juliet: I never attended school because my parents believed that if you send a girl child to school she would become a prostitute.

Researcher: What is your source of income?
Juliet: I survive on farming.

B. Disclosure experiences

Researcher: When were you diagnosed HIV positive?
Juliet: In 2006, I went to Karoi for the test because I had non-stop diarrhea, so when my child who had visited me left me money for food, I decided to use it for bus fare. When they told me that my results were positive I immediately knew that my husband was responsible because the woman he had been involved with was also sick at that time. This woman’s husband had also died from HIV related illnesses [her voice became hoarse at this point up to the end of the interview]

Researcher: What was your reaction to the diagnosis?
Juliet: I was ANGRY, VERY ANGRY INDEED. When I came back I just confronted my husband there and there, because I was very angry. He was the first person I told about the diagnosis, and at first, he refused, saying “you are lying, do you think I have HIV? It’s a lie, I do not have HIV.” However, when I
pointed out to him that the woman he had been involved with was also sick, he then panicked and said he also felt that something was also wrong with his health, he was not his usual self. The diagnosis left me bitter, even up to now. I really wish God had let me die of another illness not HIV, because I have always been faithful to my husband.

**Researcher:** How do you view HIV/AIDS status disclosure to sexual partners?
**Juliet:** Disclosure is important, if the woman my husband got involved with had disclosed her status, my husband and I would be HIV negative right now.

**Researcher:** May you please tell me about your disclosure experiences with sexual partners
**Juliet:** When I confronted my husband in my anger, he refused at first, saying it was all lies. We spent many days arguing over this, and that was in September. As from September up to November I refused to have sex with him until my mother said to me ‘even if you refuse to have sex with him, what difference will it make since you are both HIV positive now?’ I then reversed my decision. Later on, my husband admitted his infidelity and even confessed that he was feeling that his health was not okay. He also said that when he got involved with that woman, he had not known that her husband had been suffering from HIV. He had been given the hospital cards to read but because he is not educated he had not managed to uncover the illness so he bought the story which that woman was selling namely that her husband had died of constant head aches.

**Researcher:** In your opinion, what is the impact of culture on how women disclose to sexual partners?
**Juliet:** Culture does not hinder disclosure but makes women vulnerable to HIV since it allows men the freedom to have extramarital affairs. My husband even said that, “I cannot deny about the infection, because I am a man”.
Researcher: If you were a man, how would you handle disclosure to sexual partners?
Juliet: I would disclose freely knowing that no negative experience will arise because men rule.

C. Interventional networks

Researcher: What is your source of support when it comes to coping with disclosure experiences?
Juliet: I do not have any source of support, no one knows about the HIV diagnosis except the two of us. There used to be a non governmental organization which used to give out foodstuffs to people living with HIV and AIDS but the representative used to confiscate the goods for own use. At one time when I wanted to register my name so that I could receive the foodstuffs, she (representative) refused to write my name saying that I was not HIV positive but I just wanted to use my husband’s political position to gain access to free foodstuffs. As a result, I never managed to receive the beans, kapenta and cooking oil that some people got.

Researcher: What support do you think you need in order to cope well with disclosure experiences?
Juliet: There is no support system, no support group, and no education that we receive and yet these things are important for our well being as people living with HIV and AIDS. It is also very difficult to get the nutritional food which we are supposed to eat in order to boost our immune system. All our cattle died because of that disease (Foot and mouth) and now we have to till the land using hoes and that way it is difficult to cultivate a portion large enough to ensure that there is enough to eat.
D. Empowerment needs of HIV positive women

Researcher: How do you think women can be empowered so as to deal positively with HIV/AIDS status disclosure to sexual partners?
Juliet: HIV positive women should be educated on the need to disclose their status to sexual partners. They should not continue to spread the virus, because that is cruelty. Spreading the virus means killing the whole nation. Those with children should focus on raising their children and not seek for sexual relationships which might jeopardize their health further. However empowerment programmes are difficult to implement because these HIV positive widows do not want to stay alone, they want men and sex but do not want to disclose their HIV status. Even if they are given money to start their own projects, they will still need men and will not disclose, so it is difficult to empower them.

Researcher: Having come this far with our interview, how do you feel right now?
Juliet: I feel relieved to have found someone to share my painful story with.
[The researcher then offers her counseling on how to accept the diagnosis and live positively with HIV]
Respondent 10
Pseudonym: Paidamoyo

A. Personal details

Researcher: Can you please tell me about yourself?
Paidamoyo: I am a 36 year old married woman who resides in Chidzomba village. I have 3 children with my husband.

Researcher: Did you manage to attend school?
Paidamoyo: I was never educated because my elder sister died at school and my parents vowed never to send any other child to school again. That is how I came to be uneducated (shrugs and shakes her head).

Researcher: What is your source of income?
Paidamoyo: My husband supports me through the temporary jobs that he carries out in the community.

B. Disclosure experiences

Researcher: When were you diagnosed HIV positive?
Paidamoyo: I was tested in Karoi in 2004. I got very sick soon after the birth of my child, so when the doctors suggested that I get tested I agreed. I got the virus from my husband.

Researcher: What was your reaction to the diagnosis?
Paidamoyo: I got VERY ANGRY (her face becomes a mask of anger). The first person I told was my grandmother. I was afraid to face my husband because I thought that he would say that I was lying. My grandmother then accompanied me to inform my husband, this was three days after my results came back positive.
Researcher: How do you view HIV/AIDS status disclosure to sexual partners?
Paidamoyo: Disclosure is important so that people do not go around spreading the virus.

Researcher: May you please tell me about your disclosure experiences with sexual partners?
Paidamoyo: When I told my husband about my diagnosis we spent many days arguing over the matter. I was so angry at him and he continuously asked for forgiveness, saying “please, please my wife forgive me” (says this with head leaning to one side and a pitiful expression on her face). He even told me the woman he had been involved with, I do not know maybe he just lied to me because we had moved to another town and so there was no way that I could verify the information. He did not inform the woman concerned about the diagnosis because we had moved.

Researcher: In your opinion what is the impact of culture on how women disclose to sexual partners?
Paidamoyo: Women are being infected by men and there is nothing that can be done especially if you have a husband who drinks, you never know what takes place at the beer halls. He can say that he is going to Magunje and when he comes back he brings you a parcel. You will thank him profusely using his totem not knowing that he got involved with another woman there.

Researcher: If you were a man, how would you handle disclosure to sexual partners?
Paidamoyo: If I were a man, I would do the same. I would bring the virus home, men say they are hunters; they were given spears; now those spears are killing us. As a result, they cannot control themselves. If I were a man, I would disclose without fear.
C. Interventional networks

Researcher: What is your source of support when it comes to coping with disclosure experiences?
Paidamoyo: I do not have any support.

Researcher: What support do you think you need in order to cope well with disclosure experiences?
Paidamoyo: (Playing with her fingers, she says: ) I need support with food stuffs, nutritional foods like beans, groundnuts, peanut butter; I heard that in some areas they receive such foodstuffs from NGO's. If we receive such help (continues playing with her fingers) this will help us disclose our status because you have to disclose in order to get registered. We also face problems with obtaining medication, when you go to hospital you are referred to the pharmacy to go and buy the medicine required and if you do not have the money you will die.

D. Empowerment needs of HIV positive women

Researcher: How do you think women can be empowered so as to deal positively with HIV/AIDS status disclosure to sexual partners?
Paidamoyo: Women should be educated on the importance of disclosing their status to sexual partners. As for those women who still go around spreading the virus, there is something wrong with the way they think. They do not think at all and they cannot be helped because they love men too much. HIV positive women should learn to stay healthy, live positively and look after their children.

Researcher: Having come this far with our interview, how do you feel right now?
Paidamoyo: I have no complaint.
[After the interview, debriefing and counseling occurs]