The Calculus of Disclosure of HIV Seropositive Status: Experiences of HIV Positive Pregnant Women at a Rural Hospital, Manicaland, Zimbabwe.

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Abstract

The aim of this study is to explore the factors affecting disclosure of pregnant women's seropositive status results. Several studies have shown that most break-ups of marriages, loss of shelter, relationships or even death, suicides are some of the calamities that most women encounter when they disclose. A phenomenological research design was used in order to understand the factors that influence disclosure of seropositive status results among pregnant women. The study focused on HIV positive pregnant women aged 18-30 years from a rural Hospital. Ten participants were purposively selected for in-depth semi-structured interviews and thematic analysis was used. The study revealed that status disclosure is a daunting task for pregnant women, fear of reaction by husbands, family and children, loss of financial support, stigma, accusation of infidelity and abandonment are the major challenges for HIV positive pregnant women when considering the calculus of disclosure. Family rejection and stigma were the major challenges affecting the disclosure of HIV seropositive status. HIV/AIDS is still a misunderstood phenomenon and considered as a shame and embarrassment, hence the stigma. There is need for vigorous and deliberate education for the individuals both HIV positive and negative, families and the society at large on HIV/AIDS issues.

Key words: Disclosure, Seropositive status, pregnant women and HIV.

Introduction

Ever since the discovery of Human Immunodeficiency Virus (HIV) about three decades ago, the spread is steadily increasing. This can be as a result that each year, many thousands of people are being infected with HIV, as a result of being exposed to the virus by another infected person. In the same line De Jong (2013) argues that on a global scale there are more or less than 14000 new HIV infections on a daily basis. In Zimbabwe, the HIV pandemic has continued to spread and according to the UNAIDS (2013) statistics of PLWHA are estimated between 1 300 000 to 1 400 000, and women of child bearing age that is between of ages

between 15-45 are at an estimated 690 00- 750 000 which is about 53.57% of the total number of adults living with HIV. Women in and around Zimbabwe have been the hard hit by HIV and currently have a life span of 34 years, the lowest in the world. In spite of the fact that women make up 52% of the populace, they also signify 53.57% of the HIV positive adults in Zimbabwe (UNAIDS, 2013).

Several measures and strategies have been put in place in order to curb the rates of HIV infection in Zimbabwe. One of these strategies that are being implemented in Zimbabwe is HIV counselling and testing which encompasses PMTCT services, prominence is placed on the significance of HIV serostatus disclosure among those who test positive. They are encouraged to disclose their status predominantly to sexual partners, whether they are current or previous as well as potential sex partners. Disclosure can be capable of motivating the other partner to seek testing, as a result this may start a chain of reaction that can lead to behavioural change like embarking on safe sex to prevent re-infection with another strain of HIV. The study therefore explores the factors that make disclosure a daunting task for pregnant women since infected women represent more than half of the infected adult population within Zimbabwe.

The issue of non-disclosure has negatively impacted in the PMTCT services. Some of the outcomes being increased numbers of exposed children testing positive, increased mothers' deteriorating psychologically and health wise during and after delivery.

The purpose of this study was to explore the factors affecting disclosure of pregnant women's seropositive status results so that HIV status disclosure may thrive as an HIV prevention and treatment programme. The study would also look into pregnant women's views, anticipations and patterns of disclosure they would follow.

Visser, et al. (2008: 6) define HIV disclosure as "an act of informing another person or persons of the HIV status of an individual". They further explained that disclosure can take place in various contexts such as within personal relationships (to sexual partners, children, friends and other family members), in the workplace (to the employer, co-workers and clients), to health care providers, in an institutional setting as well as to the public via media. This study focused on the self-disclosure of HIV positive pregnant women to sexual partners.

HIV disclosure is a decision making process and not an outcome (UNAIDS, 2004). Kimberly (1995) in UNAIDS (2004) adopted a framework which describes the process of HIV disclosure. The framework consists of steps that involve dilemmas, barriers and decisions at each step.

Individuals may require help in adjusting to the diagnosis and achieving a personal acceptance of such diagnosis. It takes a lot of thinking to understand a new self. A self who is now positive, a move from "US" concept to "THEM" concept. "THEM" who are positive and "US" who are negative. There is a psychological strain of leaving the comfort of your perceived group to the new group of them who are positive. This adjustment takes a lot of calculation. To disclose or not to, then becomes a daunting task under adjustment to the diagnosis.

HIV positive individuals assess whether they have necessary skills to enable them to disclose to others. Life is lived as a group but understood as an individual. The question here is how do you tell others? Do you tell relatives, only those who are positive, and those who are negative, siblings? Where do you start? What is your social standing in the community? All this will impact heavily on your personal disclosure skills.

An individual takes an inventory of all social networks and decides who to disclose to, taking into consideration aspects such as role of the person to be disclosed to as well as the physical distance from the recipient. Having gathered strength to disclose, the question of who to disclose to, becomes a daunting task. Who should know first and why? Do you understand issues of HIV? Have you accepted your status? All these will affect the appropriateness of disclosure.

Individuals evaluate various circumstances or factors that may prevent them from disclosing. Are you going to lose or benefit by disclosing? Are you going to get blame or support by disclosing? How close are you to the people to be disclosed to, in terms of relationship and distance? What is the general talk and understanding of HIV in your family and among your significant others? How do they view HIV positive people? All these calculations have a bearing on the disclosure of HIV seropositive status.

Individuals weigh the expected benefits and expected reactions from individuals to be disclosed to. What is the culturally view of HIV in your community? What is your relationship with your partner? Trying to calculate what other people are going to say or how they are going to react is highly stressful. Fear of offending or letting down our significant others, or being judged by them for what has happened to us can be a huge barrier to disclosure.

Individuals explore motivators of disclosing to each recipient. If individuals have nothing to gain from disclosure, they would prefer not to, and if they perceive that they will lose by disclosure, they will not disclose at all. If they perceive that the recipients are going to judge them for what has happened to them, they will not disclose.

Disclosure is advocated using time-honoured adages such as, 'honesty is the best policy' and 'do unto others'. This seems to reflect enduring influence of basic moral socialisation agents such as family, schools and church (Rier & Indyk, 2007).We are taught that honesty is extremely valuable to a relationship and as such couples should be up front with their status. Pregnant mothers often frame disclosure as vital for a healthy relationship and as a test of commitment. As a result of PMTCT programs, women are often the first member of a relationship to get to find out their HIV statuses as it is a mandatory policy of the MOHCC that every pregnant mother attending antenatal care services should be tested first. PMTCT programs advise women to disclose their HIV test result to their partner and to encourage him to have an HIV test too. But for many women, particularly those who are HIV-positive, talking to their partner about HIV/ AIDS is hard because of fears of rejection (which could mean loss of housing and food) accusations of infidelity amongst other things. Health care providers too face an ethical challenge: how to address the issue of negative consequences following disclosure, while, at the same time, promoting disclosure, given that most women report positive outcomes (Rier & Indyk, 2007).

Hypothetically, rewards of disclosing are multiple and can result in the acquisition of numerous resources. These resources may be emotional, physical or social in nature. For example, emotional benefits might include the acquisition of social support, relief from sharing a burdensome secret, and the intrinsic reward of educating others about HIV or the risks of having sex (Visser et al. 2008). Disclosure of one's HIV positive status to sex partners has been found to lower infection rates as persons may be motivated to engage in or adopt safer sex practices (Van Dyk & Van Dyk, 2003). As for the complexity of a pregnant mother disclosing her HIV positive status, there are many reasons given for and against HIV positive persons disclosing to sexual partners, friends, family, employers, strangers, and healthcare providers. Reasons for disclosure include the following: it is the right thing to do to protect others, reaffirmation of self, increased social support, catharsis, desire to educate others, seeking help, desire to test someone's reaction, being in a close or supportive relationship, and a mechanism for dealing with the disease (Derlega et al. 2000; Medley et al., 2004; Serovich and Mosack, 2003; Wolitski et al., 2003).

However, the reasons for not disclosing include the following: stigma, need for privacy, fear of rejection by sexual partners, threats to personal well-being, potential loss of income, substance use, difficulty in communicating, denial, low viral load, type of sex, location of sexual encounter, legal reprisal (fear of arrest), and condom use (no need to disclose) (Carr & Gramling, 2004; Derlega et al.; 2000). Personal characteristics may also influence disclosure decisions. Persons who disclose their HIV status are typically younger, are females, have high ethical

and moral standards, are more spiritual, and are in a sero-discordant relationship, have participated in interventions that teach techniques for disclosing, or have advanced HIV disease (Wolitski et al., 2003; Greene & Faulkner., 2002).

Learning that one is HIV-infected creates an internal struggle about whether or not to disclose one's HIV-seropositive status (Marks et al., 1992). The decision to disclose is selective and consists of several steps, including adjusting to the diagnosis, assessing one's disclosure skills, deciding whom to tell, evaluating the recipient's circumstances, anticipating the recipient's reaction and having a motivation to disclose (Kimberly et al., 1995). The decision to disclose one's status is a difficult one, and must include to whom, when, where and how to reveal one's status to others. The decision to tell one's family members may be especially difficult (Kimberly et al., 1995; Serovich et al., 1998; Kadowa & Nuwaha, 2009). Thus, this calculus involved a careful, reasoned evaluation of the risks and benefits for oneself and significant others when disclosing one's diagnosis of HIV. The goal of the calculus is to disclose the diagnosis in situations where the risk is minimized and the benefits were maximized.

Black and Miles (2002) developed a typology of disclosures among pregnant women. In their study, they found that a small group was categorized as secretive disclosers and an even smaller group as full disclosers.

One's perceptions of the world and how one responds to challenging situations are very significant for successful coping (Kirmani & Munyakho, 1996). Therefore because of the stress that comes along with disclosing a positive serostatus, a woman's aptitude to cope effectively will be strained, particularly with reference to relationships where the woman is at risk due to pregnancy. Despite the fact that the woman must disclose in order to access the vital resources and support, negative consequences are more likely to be associated with such disclosure. A woman's decision correlated to disclosure is more likely to be influenced by evaluation of both the negative and positive results associated with disclosure, hence the calculus of disclosure.

Methodology.

In this study, the research methodology was qualitative phenomenological research design and data was gathered by in-depth semi-structured interviews. Qualitative methods are helpful not only in giving rich explanations of complex phenomena (serostatus disclosure), but in creating or evolving theories or conceptual bases, and in proposing hypotheses to clarify the phenomena. Smith (2008) asserts that individuals are very active in their perceiving, they search, they pay attention selectively, they make choices, and their perception always has a meaning which relate to their life world. This means that qualitative researchers study things in

their natural settings, attempting to make sense of, or interpret phenomena in terms of meanings that people bring to them. Interviews were held in the offices provided for by the Hospital and participants were interviewed one by one so as to maintain confidentiality.

Purposive sampling was used to select participants. Purposive sampling relies on the judgment of the researcher, when it comes to selecting the units that are to be studied and the sample being investigated is quite small (10 participants). The sample size is determined by data saturation that is when the researcher is no longer getting any new information from the respondents. The main goal of purposive sampling is to focus on particular characteristics of a population (pregnant women) that are of interest, which will best enable you to answer your research questions. The target population was HIV positive pregnant women at a rural Hospital in Manicaland, Zimbabwe. It is mandatory that pregnant women who are attending Hospital under antenatal care be test for HIV. There are lectures that are given to pregnant women by medical practitioners on a regular interval concerning pregnancy issues.

After going through all the ethical considerations through the Ministry of Health and Child Welfare, the researchers were cleared to carry out their research. The researchers were given the opportunity to address pregnant women who were attending their routine lectures. The details of the research were given to the pregnant women and the researchers asked those who met the criterion to volunteer. The researchers had pre-interviews one-on-one discussions with all the potential participants. Only ten pregnant women aged (18-30) years, who met the criterion set by the research were then purposively selected. In order to maintain the anonymity of the research participants, all participants were coded with letters as their pseudo names.

Schostak (2006) views the in-depth semi-structured interview as a moment of listening for both the interviewer and the interviewee. Analysis was directed at determining the core factors that kept pregnant women calculating their disclosure. Their reflections on the meanings of experiences and anticipated results of disclosure were turned into themes. Hence, thematic analysis was used. The purpose of the in-depth semi-structured interview study is to understand the experience, not predict or control that experience. However, richly described data or sufficient contextual information can provide researchers with enough information to judge the fittingness of applying the findings to other settings. Validity, in qualitative research involves demonstrating that the interpretation (of data) is based on sound reasoning, systematically applied. Credibility infers that the research results are reasonable, possible and believable, not only to the researcher but to those researched.

Results and discussion.

Demographic Information

Ten participants were interviewed as indicated below.

Table 1: Respondents to Demographic Information Questions.

Participant	Age	Sex	Marital status	Education level	Relationship duration	Number of years since tested positive
A	18	Female	Single	Primary	1year	5months
B	23	Female	Married	Secondary	6 years	1 year
C	21	Female	Single	Secondary	2 years	1 year
D	19	Female	Single	Secondary	2 years	3months
E	28	Female	Married	Tertiary	7 years	7 years
F	25	Female	Married	Tertiary	6 years	1 year
G	23	Female	Single	Secondary	2 years	6months
H	29	Female	Single	Tertiary	8 years	6 years
I	30	Female	Married	Secondary	9 years	8 years
J	27	Female	Married	Secondary	6 years	1 year

The findings indicated that three out of ten participants' highest level of educational qualification is tertiary level. The findings also show that six out of ten participants only had made it to secondary level of education and also one out of the ten participants only attained primary level education. The table above also shows that six out of ten participants had more than five years in their relationship.

The main objective of the research was to identify, describe and evaluate the challenges faced by the pregnant women in HIV status disclosure.

Disclosure experiences of pregnant women.

An analysis of the pregnant women's experiences of HIV status disclosure revealed a wealth of information which helped to shed more light on what these pregnant women encounter in their everyday lives.

Status Disclosure experiences

Status disclosure is a challenging procedure especially when the results are positive. The research findings showed their experiences differ across HIV positive pregnant mothers upon status disclosure.

> *"It is very difficult to me to disclose my status to my husband because I'm afraid of being rejected,"* (Participant B) *"I do not disclose my status because I know this will lead to a breakup with my boyfriend the father of my kid"* (Participant C)

"It's not easy to trust anyone when it comes to HIV status. You tell someone and you become the talk of the day. Status disclosure leads to breakups and rejection." (Participant F)

The HIV positive pregnant women as according to the respondents do not disclose their status because they think that it will lead to rejection and breakups especially when dating an HIV negative partner or the one whose status is not known.

Stigma and Discrimination

An HIV positive diagnosis was identified as carrying a lot of stigma, blame and shame to the extent that some respondents had to go to New Start Centres 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 Centres are voluntary counselling and testing sites. All these precautions were made in order to keep the diagnosis a secret, for fear that if the members of the community find out about the diagnosis then all community members would end up shunning the HIV positive individual.

> *"… people will label me a prostitute, I am afraid I'll be shunned by the society, I can't tell anyone." (Respondent A).*

> *"I am already ashamed of myself, with the education I have, I can't let it be known. I would rather keep it to myself (pause), as a respectable member of the society they will strip me of my dignity"* (Respondent E)

The HIV positive pregnant women did not disclose their status because they thought they will be stigmatized and discriminated by family, friends and society

at large. Other participants did not disclose their statuses due to myths and beliefs surrounding living with HIV.

Anticipated risks when considering status disclosure

Fear of rejection

HIV positive pregnant women feared being rejected by their intimate partners, family, children, friends and society at large upon disclosing their statuses.

> *"My husband has been everything to me. All that came into my mind was being rejected by him after telling him the results.*
> *To be honest I was scared, I knew my husband wouldn't accept me after this. I have no family, it's just me, my husband and my son, where would I go?"*
> (Respondents B)
> *"...I couldn't thinking of how I would disclose it to my 6 year old girl... I remembered her words sometime when we visited our aunt who was suffering from HIV in the hospital.*
> *She said that only prostitutes suffered from this disease. I thought my only child was going to reject me so would rather keep the result to myself."*
> (Respondent G)

The findings also showed that HIV pregnant women needed the love they were receiving from their families, children, friends, and their husbands therefore could not stand being rejected by them after disclosing their statuses. This led to them being unwilling to disclose their HIV status.

Infidelity and lack of Trust.

HIV positive pregnant women because of the fact that in most cases they are the first to know their HIV positive statuses, they fear that upon disclosing to their husbands, they are the ones who are blamed for it. 2 respondents reviewed their experiences under this theme and had this to say:

> *"... just because I got tested first and was diagnosed positive doesn't mean I was sleeping around (long pause), but I thought he would never trust me on this..."*
> (Respondent A)

> *"... I knew if I told him he would never go for testing himself. He would just say I'm the one who brought the disease into the marriage..."* (Respondent D)
> *"With the pride my husband has, he would never admit to it even when I know he is the one who gave me HIV, he will just say it to the whole family that I was cheating on him"*
> (Respondent E)

This fear of being blamed of infidelity and lack of trust is causing HIV positive pregnant women not to disclose because they fear their image will be tarnished.

Financial dependence and non-disclosure

Financial dependency amongst pregnant women is a common theme that leads to nondisclosure.

In the present study, respondents did not disclose their status to their husbands, for fear of desertion which meant loss of financial security. They 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 financial security. Women can only be emancipated through financial security. (Pause)..., I do not disclose and if he happens to get the infection I'll pretend that I did not know about it..."* (Respondent B)

> *"... at my age, I haven't found a job yet... He is the breadwinner for the family. I don't have any source of income if I lose him, though I went to school, I can't find a job; he supports me in everything... I can't afford to lose him... I won't disclose to him"* (Respondent E)

It appeared that these respondents valued financial security more than the lives of their husbands to the extent that they risked infecting their husbands. They were more concerned with their immediate needs rather than considering the implications non-disclosure has upon their health.

Fear of violence

The issue of HIV positive status disclosure has been often associated with gender based violence that follows disclosure of the positive result.

> *"We fight a lot at home, mainly because he does not know what's good for his health? He drinks, clubs and have fights with his friends when he gets drunk. I can't imagine the*
> *thought of telling him that I'm positive. He might beat me and with my condition I can't risk telling him at all."* (Respondent A)

The research findings showed that usually the violence received by HIV positive pregnant women is in form of physical, verbal and emotional abuse.

Patterns of disclosure

HIV positive pregnant mothers use several patterns when disclosing. Some did not disclose at all, some used selective disclosure pattern while others used the full disclosure pattern.

Secretive Disclosure

> *"...at 23 I'm still considered young and I don't think I'll be able to live with myself if people knew that I am positive, I won't be able to cope, so it's better I keep this to myself..."* (Respondent B) *"... I'm a very shy person, I don't even know where to start if people knew about my status, so I prefer my status stay between three people, myself, God and the counsellor".*
> (Respondent E)

The respondents did not disclose because they feared the stigma associated with a positive result

Selective Disclosure

Research findings also found out that 4 out of the 10 respondents used selective disclosure pattern. Most HIV positive pregnant women tend to describe a calculus of disclosure that includes elements of selectivity in determining whom to tell and not to tell. Typically, positive pregnant mothers tell close family members, such as their partners, mothers, and sisters, and occasionally, all older members of the immediate household, but were highly selective as to whom to tell outside of the household.

> *"… I was scared and shy. I cried most of my times until the wife of my church pastor discovered that I was not ok. She counselled me trying to find out what was troubling me. Willingly and filled with love, trust and security she was the first person I disclosed to"*
> (Respondent F)

The respondents showed that it's never easy to disclose a HIV positive status, but however as difficult as it is there is need to tell somebody.

Full disclosers

> *"...I can't live knowing and hiding something like this inside. The benefits include gaining future support, I haven't had problems with anybody, and thus I have to let it be known so that other women out there become aware of HIV... The first person I told was my husband because of the nature of my work, I told him because he is always supportive and he was also open enough to get tested too. He has always been there for me in sickness and in health as he vowed at our wedding, he is my pillar of strength. I also did this for my children, they give me the power to fight, and I feel much better that everyone knows about my status..."*
> (Respondent I)

Respondents showed that they had weighed the benefits and risks of disclosure but accepted their statuses and were able to tell everyone about them. The respondents also disclosed because they knew their husbands would support them.

Discussion

The research was aimed at investigating the perceived factors associated with HIV positive pregnant women's disclosure of serostatus.

Views of pregnant women pertaining to disclosure.

In this study respondents were afraid of disclosing their HIV status due to fear of negative consequences, such as divorce, discrimination and stigma, violence, rejection amongst other fears. This finding is comparable to studies conducted elsewhere; Thompson (2000) also noted that women felt stigmatised and were afraid of disclosing. The belief that disclosure causes negative outcome may lead to non-disclosure. However from some of the respondent's views, they mentioned both the benefits and anticipated risks associated with disclosure.

Therefore, interventions should focus on changing these behavioural beliefs hence change negative attitudes towards disclosure. Also from the findings in the research respondents were asked the question "How do you view HIV status disclosure to your partner?" 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, some respondents who kept their diagnosis a secret gave answers supporting disclosure when in reality they were keeping their diagnosis a secret.

The findings of this research showed that the risk or losses arising from openness and confrontation of stigma may serve as a resource for pregnant mothers not to disclose. Stigma has a negative impact in making HIV status disclosure a striving primary prevention strategy.

Research findings also showed that these pregnant mothers were most likely not to disclose if there was probability of their statuses being disclosed somewhere else as they feared to lose their dignity. However in a study Kadowa and Nuwaha (2009) reported that women who felt more stigmatized, had a low self-esteem and those who had more symptoms of depression were less likely to disclose their diagnosis. After the diagnosis, levels of anxiety and depression are often high and the extent of emotional reaction can be affected both by the degree to which the individuals feels stigmatized and social support available from others, hence high level of anticipated stigma condenses non-disclosure.

Risks that pregnant women anticipate when considering disclosure of their HIV seropositive status.

From the responses given by the pregnant women in this research, fear of rejection indeed is an anticipated response. HIV positive pregnant mothers feared being

rejected by their intimate partners, family, children, friends and society at large upon disclosing their statuses.

Majority of the participants were scared to be rejected by their intimate partners more than everyone else. In support of this Kadowa and Nuwaha (2009) concluded that rejection is a common feeling amongst the pregnant mothers. However despite this fact, it's not in all cases that they are rejected. For instance there are other pregnant mothers who disclosed but they were not rejected and surprisingly the husbands were supportive.

The study showed that majority of the pregnant women depended on their partners for financial support and disclosing an HIV positive result to a partner was putting oneself at risk of being divorced, abandoned and blamed for infidelity. Fear of accusation of infidelity and lack of trust is one of the risks associated with HIV status disclosure.

From the research findings the researcher noted that most pregnant women anticipated violent outcomes upon status disclosure. Two different people will always have different interests, likes, dislikes and also the view of the world in generally. The issue of HIV positive status disclosure has been often associated with gender based violence that follows disclosure of the positive result. Rice et al. (2009) also noted that a pregnant women's disclosure of her HIV infection to husband may trigger violent episodes despite him being responsible for transmitting the virus or not. However in this case the mother is the first to know her status thus most man deny knowledge about them being positive. Also Gielen et al. (1997) found that one-fourth of women in their study had experienced negative consequences of disclosure that included verbal and physical abuse. This as well has been seen in the respondents who anticipated violence from their husbands as they had experiences of such violence before.

Patterns of disclosure.

The findings of this research showed that HIV positive pregnant women chose different patterns of disclosure due to various reasons. The patterns of disclosure which were used in this research include secretive, selective and full disclosure. The findings of the research showed that majority of the HIV positive pregnant women chose secretive disclosure as their pattern of disclosure. The major reason for choosing secretive disclosure was to avoid stigma and discrimination. The other reason for choosing secretive disclosure pattern was because they were afraid of being rejected by their husbands, families and children, this was also evident from the conclusions drawn by Bennet and Erin (1999) who propounded that fear of burdening or disappointing others was a major barrier among the Asian/Pacific

women they studied. HIV positive people face stigma and discrimination in their day to day lives; hence these HIV positive pregnant women didn't want to be part of the victims of being stigmatized and discriminated, therefore they chose to keep their statuses to themselves. Anderson and Doyal (2004) stated that non-disclosure plays a central role in HIV transmission, and is associated with greater risk per sexual encounter. Baron and Greenburg (2002) observed that negative consequences of non-disclosure include risk of reinfection since safer sex methods cannot be negotiated for. Moreover from the findings of the research, we got to know that another majority of pregnant women used selective disclosure pattern. Most HIV positive pregnant women tend to describe a calculus of disclosure that includes elements of selectivity in determining whom to tell and not to tell.

Findings showed that the decision was often made to tell others, particularly family members, who were in positions to provide assistance and support. In a study Bartos and McDonald (2000) found that HIV status disclosure to one's family, friends, and lovers was positively related to social support and the use of more adaptive coping strategies. Trust is one of the considerations, one discloses to a person they trust, a person whom they know is supportive. Moreover, findings also showed that only a few people go all the way to full disclosure. This entails being completely open about the HIV diagnosis within the confines of adult relationships. They chose full disclosure because it was in their best interest as they got some people to take care of them when they got sick.

Conclusions and recommendations

Pregnant women viewed disclosure with mixed feelings, while almost all of them agreed that disclosure was a good and necessary act but they had reservations about their acceptance by the society. They felt that there being no law that enforces their partners to be there on their first HIV test so as to know their statuses at the same time, they would always be blamed for knowing first. Pregnant women listed their anticipated risks for disclosure as rejection, loss of trust, infidelity, financial loss, violence and the blame of knowing first. While all pregnant women would love to disclose the majority preferred secretive or selective disclosure over full disclosure.

Pregnant women who are HIV positive are always involved in dialogical self in the form of calculus of disclosure. Permutations and computations of whether to or whether not to disclose. The study concludes that the family rejection, stigma and discrimination are the major challenges affecting the disclosure of HIV seropositive status among the pregnant women and that HIV/AIDS is still a misunderstood phenomenon which is considered as a shame and embarrassment, hence the stigma and discrimination.

There are several strategies to consider when modifying current voluntary HIV testing and counselling protocols in order to increase the rates of safe HIV status disclosure among HIV positive women who are tested during antenatal care. The standard protocols for HIV testing and counselling offered by Hospitals do not dedicate sufficient time to considering the challenges of HIV status disclosure that are faced by women. Standard counselling protocols need to be enhanced for HIV infected women, concentrating on barrier to partner notification, and additional counselling needs to focus on helping women identify the pros and cons of disclosure. If women mention fear of violence as a barrier to disclosure during counselling, counsellor should be prepared to refer women to domestic violence services.

Counselling support should identify the women most at risk for negative outcomes following disclosure through the use of screening tools. Such screening tools should ask women about prior communication with their partners regarding HIV and HIV testing, prior experience with violence, and anticipated reactions of partners to HIV status disclosure. Based on results of the screening counsellors may present women with alternative options: these would include opting not to disclose, or deferring disclosure until a time when the woman feels it is safe to do it.

Government and civic organisations should encourage broader community-based initiatives to deal with underlying gender norms and social attitudes about HIV/AIDS. Fear of stigma was one of the barrier to disclosing HIV test results most often mentioned by women. It is therefore important to initiate community-based programmes that would normalize HIV testing in the community and reduce the amount of stigma women perceive towards people infected with HIV. This, in turn, would allow women to feel more comfortable disclosing their own HIV status to others.

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