

THE LIFE CIRCUMSTANCES OF HIV-POSITIVE WOMEN: THE CASE OF MAGUNJE TOWNSHIP, ZIMBABWE

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The increasing levels of human immunodeficiency virus (HIV) and acquired immunodeficiency syndrome (AIDS) in sub-Saharan Africa have seen more women being infected by HIV. This article explores the interplay between culture, HIV transmission and disclosure experiences. The setting for the study was Magunje, a rural village in Zimbabwe. Using a semi-structured interview schedule, the interviews were conducted with women living with HIV/AIDS. It emerged that culture condones male promiscuity, since virility is judged by the number of partners that men have, while women face many challenges with regards to disclosure.

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BACKGROUND

HIV was discovered in the early 1980s (Whiteside, 2008) and has caused much havoc to those affected, resulting in many deaths caused by the human immunodeficiency virus and acquired human immunodeficiency virus syndrome (HIV/AIDS). The study was prompted by the shocking reality of the global HIV-infection level, which was estimated at 31.3 million people at the end of 2008 (www.avert.org). In sub-Saharan Africa alone an estimated 23.5 million people were living with HIV in 2012 (UNAIDS, 2012) and by the end of 2015 WHO estimated that the figure had risen to 25.6 million people (WHO/July 2016). Of this figure, women constitute 58% of the total HIV infections (UNAIDS, 2014). In Zimbabwe, since the discovery of the first AIDS case in 1985, there have been efforts to lower the infection rate. Although the HIV-infection rate stands at 15% in Zimbabwe, which is lower than South Africa's 19% (UNAIDS, 2016), HIV/AIDS is still a cause of concern in Zimbabwe as the rate of new infections is still high. According to UNAIDS (2016), there were 64 000 new HIV infections in 2015 in Zimbabwe.

The shocking reality of HIV in Africa led many African countries to come up with strategies aimed at curbing the rate of new infections whilst treating existing infections. Zimbabwe adopted voluntary counselling and testing (VCT) as one strategy to deal with the HIV epidemic. At the heart of VCT is HIV/AIDS status disclosure to sexual partners, whether past, present or future (Horn, 2010; Seid, Wasie & Admassu, 2012; UNAIDS, 2014). This is because the more people become aware of their HIV status and enforce behavioural change, the more effective prevention and treatment programmes are likely to be. However, previous studies of status disclosure on the African continent have documented that the break-up of marriages, loss of shelter and even murder are the consequences that women face when they disclose their status to sexual partners (Machipisa, 2007; Tsweneagae, Oss & Mgutshini, 2015). There was therefore a need to explore the experiences of Zimbabwean women on HIV status disclosure to sexual partners in the hope of finding a lasting solution to the rise in infection levels amongst women.

There are many studies on HIV/AIDS that have concentrated on the vulnerability of children living in such circumstances. Leatham's (2006) findings, for instance, show that although children from child-headed households (as a result of parents' death from HIV/AIDS) come from surroundings that threaten their wellbeing, their resilience is strengthened by their aspirations for the future. Resilience enables these children to progress well despite difficulties and empowers them to do well in life even though they have been exposed to such challenging situations (Kapesa, 2015; Lee, 2012). Zimbabwe is a patriarchal country, where women have little control over their sexual partners,

resulting in their having to bear the brunt of accusations for allegedly infecting their male partners. This gave rise to the present research, which attempted to find answers to the issue of African women's vulnerability and the resulting resilience that enables them to cope with life after contracting HIV.

RESEARCH SITE

Magunje is the largest rural village and principal growth point in Hurungwe, which is in Mashonaland West province (Manyanhaire, Mhishi, Syotwa & Sithole, 2009). It is situated 245 km to the north-west of Harare (the capital city of Zimbabwe) and is located 25 km off the main Harare-Chirundu highway. Furthermore, the high infection levels which characterise this growth point because of the trucking business provided a context for weighing the effectiveness of HIV status disclosure as a prevention and treatment method. This was deemed essential, since the spread of HIV and AIDS in the Magunje context not only affects Zimbabwe but also Zambia as a consequence of the trucking business between these two countries.

RESEARCH METHODOLOGY

An exploratory research design was employed, leaning heavily on a qualitative research model to enhance the credibility of the study (Nieuwenhuis & Smit, 2012; Rolfe, 2006; Trochim, 2006). Grounded theory as expounded by Corbin and Strauss (2008), with an emphasis on the interpretive approach to data analysis, was applied throughout the study. A purposive sampling method was utilised in order to recruit participants who would be representative of the population of women living with HIV. A potential 15 participants were selected based on the researchers' experience and previous research, as required by the chosen sampling method (Laher & Botha, 2012). Participants were within the 28- to 44-year-old age group, had been living with HIV for a period ranging from one year to five years and had a sexual partner at the time of the study. In the end only 10 women were interviewed as data saturation had been reached by then. According to Laher and Botha (2012), data saturation is achieved by interviewing people in batches of two then analysing those two interviews immediately. This process is repeated, moving back and forth between data collection and analysis until no new information arises and there is total coverage of the issues at hand.

The research utilised a semi-structured, face-to-face interview schedule consisting of open-ended questions accompanied by relevant prompts (Nieuwenhuis & Smit, 2012). The interviews were conducted in Shona, the local language spoken in Magunje, and were audio taped. 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. Data were analysed following the grounded theory approach and during the coding process, as outlined by Charmaz (2006), the researchers moved from single experiences to focus on structures common to all or most cases, thereby producing themes which had not been articulated beforehand. Interviewees' responses for each of these themes were then grouped together and analysed in the light of existing literature and in line with the interpretive approach (Corbin & Strauss, 2008).

In order to enhance the credibility of the study, six of the respondents were re-interviewed. The other 4 could not be interviewed as they had passed away. (There was a gap of eight months between the first interviews and the second follow-up interviews). The re-interview has been cited as the “single most critical technique for establishing credibility” (Rolfe, 2006). In the re-interview respondents confirmed the results of the study, thus narrowing researcher bias.

Throughout the research process ethical principles were adhered to: participation was voluntary; confidentiality was maintained whilst ensuring that participants remained anonymous so as to protect their privacy (Ogletree & Kawulich, 2012). Each interview was followed by a debriefing and counselling exercise to minimise emotional harm to the respondents.

It should also be noted that the interviews were conducted by a registered professional social worker.

RESEARCH FINDINGS

The study centred on unveiling rural women’s experiences of the following: (a) an HIV-positive diagnosis; (b) disclosure to sexual partners; and (c) their coping capacity as well as supportive services available after the diagnosis. Where the respondents’ actual words are used, they are italicised and the names which appear are pseudonyms; respondents’ real names were not asked for. The themes which emerged are outlined below.

Theme 1: Acceptance of HIV

Significantly, all respondents had children, an average of 4 children per respondent. This fact alone made them desire to protect their health at all costs, so that they could live longer and see their children grow, thus helping them accept their diagnosis. One of the respondents, Anna, expressed how her children were a source of strength:

“My children give me the desire to live longer so that I can watch them growing up.”

Non-acceptance of the diagnosis was indicated as having detrimental effects on one’s health as a result of the emotional stress involved, as one respondent stated: *“I just accepted and put everything in God’s hands. I was afraid that dwelling too much on the diagnosis would make me sick.”* Thus having faith in a higher being is one of the factors that makes acceptance of an HIV diagnosis easier (Van der Westhuizen, Roux & Strydom, 2012).

Theme 2: Stigma

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 Centres far from their communities, where it was unlikely that they would meet people they know and where the staff members were unknown to them. In this way they would just be a visiting number that could not be traced back to their village of origin. One respondent (Sipho) declared: *“This disease is highly stigmatising, that is why on that day, we were only two in the room, that is, the doctor and I and so no-one else knows”*.

Another participant (Memory) further revealed how life-changing an HIV-positive diagnosis is: *“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’s emphasis). Memory chose the words *“type of life”* to indicate that an HIV-positive diagnosis means one begins to live a new life focused on sickness because of a compromised immune system. The inevitability of one’s death will be hovering at the back of one’s mind, as the body gradually succumbs to the opportunistic infections as a result of the infection. This finding is in line with previous research, which shows that sometimes people cannot envisage a healthy identity when they are HIV positive, a situation which other researchers have labelled a *“spoiled identity”* (Aransiola, Imoyera, Olowookere & Zarowsky, 2014; Treves-Kagan, Steward, Ntswane, Haller, Gilvydis, Gulati, Barnhart & Lippman, 2016).

Feelings of hopelessness and helplessness were common among respondents as there is no known vaccine or cure for HIV. These feelings were also intensified by the fear that their husbands or partners would divorce them. Chipo described her feelings as follows: *“I felt so hopeless and helpless. The first person I told was my husband, I told him five days later”* [after being diagnosed as HIV positive], *“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”* [Chipo’s emphasis]. The diagnosis, according to Chipo, made her feel like she was now inadequate or less human, that she did not deserve to be loved and accepted by her husband. This became abundantly clear from the gestures she made to mimic her husband’s reaction. This is in line with previous research, which highlights that the worry of what people will think when they discover one’s HIV status leads to self-stigmatisation (Tshuma, 2016; Woollett, 2013): one labels oneself and does not even wait to see how other people are going to react. This stance has a huge impact on one’s self-esteem. Self-stigma has also been said to lead to a *“conspiracy of silence”* by Vranda and Mothi (2013), whereby the fear of stigma leads to keeping the HIV diagnosis a secret.

Theme 3: Disclosure

3.1 Disclosure as a complex process

Respondents revealed that disclosure of one’s HIV status is not an easy task. It was clear that before reaching 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. Seven of the 10 respondents revealed that the decision to disclose their status to significant others was not instant; it was made after much deliberation and thought. Three respondents even had to ask a third party to help them with disclosure.

3.2 Culture and disclosure

The study further revealed that culture plays a role in HIV transmission by making women vulnerable to HIV infection. This is because, on the one hand, culture is permissive with regard to male promiscuity, whilst on the other hand, it insists on the fidelity of females (Barnett & Whiteside, 2006). In this way women end up being the

scapegoats of their partners' infidelity. All the participants in the present study had been married and had contracted HIV within their marriages. They all held their husbands responsible for the infection and some husbands had openly admitted that they were responsible for bringing the infection home. A respondent who elected to be named Rachel elaborated on the negative impact of culture and reasoned: *"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 of being unfaithful."*

3.3 Financial circumstances and disclosure

Some respondents admitted to keeping their HIV status a secret from their sexual partners for fear of desertion, which would translate into loss of social and financial security. It appears as though respondents valued financial security more than the lives of their sexual partners to the extent that they risked infecting their partners by not telling. Takunda, another respondent, admitted: *"I do not disclose and if he happens to get the infection, I will pretend that I did not know about it"*. This she said with great conviction and poise, revealing the extent of her resoluteness and the lengths she would go to in order to avoid being jilted.

Six of the 10 respondents were also of the opinion that food aid offered by non-governmental organisations (NGOs) working in Magunje was not a lasting solution. They felt that if women were helped to start their own projects, this would sustain them financially, thereby eradicating hunger and reducing the incidence of HIV. This would in turn make them less dependent on their spouses, thus giving them the liberty of revealing their status without fear of being ditched. This also means that women will no longer need to get involved in transactional sex or prostitution, as they would have become financially independent. To this, Tendai added: *"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."*

Theme 4: 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. Four of the respondents mentioned that their husbands admitted to having had extramarital affairs prior to the diagnosis. This did not necessarily suggest that they took responsibility for the infection. This revelation 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 had only one partner (Barnett and Whiteside, 2006). Concurring with this line of argument, Barnett and Whiteside (2006) quote Marina Mahathir, head of the Malaysian Council of NGOs, 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"*.

Theme 5: Supportive services

The study further revealed that follow-up support services were non-existent in the area. Following diagnosis, the women had to turn to their husbands or family members for

emotional support. The male partner would be an unlikely alternative to seek support, suggesting that the first port of call would be their children. The respondents also revealed that they would not dream of starting support groups as they preferred concealing their status and did not wish the community members to know that they were living with HIV.

DISCUSSION

What emerged is that the women were confronted with fear, despondency, helplessness and a plethora of other challenges based on their anxiety about disclosing their status. They were afraid of the stigmatisation associated with HIV, which is confirmed in the literature (Vranda & Mothi, 2013; Woolett, 2013). Disclosing their HIV status to anybody was a complicated process that included a lot of soul searching and consideration of its consequences. This was a nerve-wracking exercise which was coupled with other demeaning feelings. These feelings were also intensified by the apprehension that their male partners would reject or divorce them. Their eagerness to survive also led the women refusing to inform their male partners about their status for fear of losing the financial security provided by their husbands. As a consequence, they developed coping mechanisms, drawing on their inherent strengths, which Van Breda (2001) explains as being rooted in the belief that people can continue to grow and change despite apparent hardships.

Notwithstanding the challenges they had to face, they had zeal for life and wanted to live for as long as possible. This love for life, commitment to survive and the need to protect their children spurred them to 'hang in there'. To sustain this need for survival, they resorted to faith in the future and found solace in God. This renewal of faith gave them hope and courage for the future. This coping mechanism suggests that they have inherent strengths that give them courage to deal with with life's issues regardless of the challenges encountered. This shift from concern for life to the resilience of these women mirrors a shift in social work from an interest in problems and deficiencies to an interest in the resilience and strengths of individuals (Saleeby, 2008).

It seems as though none of the women's partners was prepared to take the blame for causing the HIV infection, although some men were bold enough to admit promiscuity and took responsibility for cross-infecting their female spouse. Most men, however, were uncompromising and placed the blame squarely on their spouses. Refusal by men to take the blame for their actions entrenches the cultural stance that tolerates male promiscuity. The role of culture in HIV transmission and its impact on HIV/AIDS status disclosure cannot be ignored. An efficient strategy to deal with this would be to address the socialisation process, since gender inequity has been said to be the major driving force behind the HIV and AIDS epidemic (Afrol News, 2010; UNAIDS 2014). Since gender is socially constructed, this means that it can be socially de-constructed as well by eradicating the imbalance of power in gender relationships.

Rural women prioritise financial security more than anything else, to the extent that they would choose to keep their diagnosis a secret rather than risk losing a partner as a result of disclosure. This has a bearing on future intervention efforts, because if women expect

negative reactions from their current partners, they may choose to keep their status a secret and not disclose to future partners, as is the case in Magunje.

The stigma around HIV/AIDS seems to be a major contributing factor in the failure of HIV counselling and testing to succeed as a prevention method in Zimbabwe. This is because most people seek voluntary counselling and testing (VCT) as a last resort – that is, when they fall sick. If one is healthy, one does not go for VCT; this is only undertaken as a last alternative after presenting symptoms associated with HIV and AIDS.

Women in remote rural areas such as Magunje 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 live positively with the infection. To aggravate matters, 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 people living with HIV/AIDS can address issues affecting them such as disclosure, coping mechanisms and death.

RECOMMENDATIONS

- There is a need for deliberate community involvement such as a church/religion or a health facility such as a clinic – thus giving rise to the possibility of introducing group counselling as a support system which helps members “cope with stressful life events and to revitalize and enhance members’ coping abilities so that they can function effectively for the rest of their lives” (Strydom & Strydom, 2010). Such a platform could be rendered effectively by health and religious facilities in Magunje.
- A socialisation or support group is also a method to help people deal with living with HIV/AIDS. The atmosphere in socialisation groups is light and participants lean upon each other for support, both emotionally and physically (Zastrow, 2009). Organisations currently working with women in the region where the study was undertaken – for instance CADEC (a Catholic organisation), GOAL and the Salvation Army – can help in the formation of such groups. These groups can also be open to people who are HIV negative but who 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 twofold function: provide on-going support for the HIV-positive person, and disseminate knowledge for the HIV-negative participants.
- Furthermore, during pre- and post-test counselling that is offered when one undergoes voluntary counselling and testing (VCT), the focus should also be on disclosure skills. From the participants’ stories it emerged that VCT in Zimbabwe seems to be focused mainly on living positively with HIV and that disclosure appears to have been relegated to the background. 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, since it

is this silence that helps to fuel the spread of the epidemic (Aransiola *et al.*, 2014; Tharao, Massaquoi & Teclom, 2006; Treves-Kagan *et al.*, 2016).

- Men must be encouraged to take an active part in addressing HIV/AIDS issues so that their voices can also be heard. There is a dire need for more research on disclosure involving male participants, the results of which can inform prevention and treatment programmes so as to make them more effective.
- Gender equality should be taught in schools, since the crucial years which mould one's personality are spent there. This means that the department of education is the appropriate site for tackling this socialisation process. The subject Life Orientation can be structured in such a way that it emphasises equality of the sexes, because it is inequality that makes women vulnerable to HIV infection (Afrol News, 2010; Barnett & Whiteside, 2006).
- HIV/AIDS activism in Zimbabwe is gaining momentum and some activists have appeared in the media highlighting their stories on how they contracted the infection and urging people to live positively. This strategy seems to function effectively, but the problem is that these fundamental messages have mostly been broadcast as advertisements, during commercial breaks in popular programmes and this somehow trivialises the whole message. Featuring them as programmes on their own would go a long way in increasing people's knowledge and thereby reducing the incidence of HIV.
- HIV/AIDS awareness campaigns should be expanded for greater coverage and should also be aired on the radio so as to cater for the thousands of people living in rural areas where there is no electricity. There is also a need for these awareness campaigns to tackle stigma, because stigma is one of the factors affecting disclosure (Aransiola *et al.*, 2014; Treves-Kagan *et al.*, 2016; Tshuma, 2016; Woolett, 2013).

CONCLUSION

Magunje Township is plagued by a high incidence of HIV/AIDS. This is perpetuated by women's reluctance to tell their partners of their HIV status once they become aware of it. Their fear of telling stems from men's denial that they are the main carriers of the virus. This has resulted in female partners developing strategies to survive rejection and denial from their spouses. Their strategies range from reliance on their children to confiding in supernatural powers such as God. Since Zimbabwe is a patriarchal society, women are largely dependent on their male partners for financial support and sustenance.

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