



## **HIV Disclosure in South Africa: Enabling the Gateway to Effective Response**

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## **Abstract**

The sheer scale of the HIV/AIDS epidemic in sub-Saharan Africa has finally led to an expanded global response. South Africa, a nation where more than 5 million people are estimated to be HIV infected, has established large scale prevention and treatment programmes. Disclosure of one's HIV status is an essential part of behaviour modification, access to HIV treatment and management programmes and for decreasing levels of community stigma. We examined the possible causes for widely differing rates of disclosure in two South African communities of similar ethnic and cultural mix. Qualitative interviews were carried out in 18 households with 25 individuals, and thematic analyses was undertaken. Findings included the negotiation of HIV disclosure, the 'unburdening' of a positive status, and the ability to become involved in community activism and leadership. In both communities, disclosure was the catalyst for access to a variety of important, and often essential resources required to respond effectively to the impact of HIV/AIDS-related shocks. HIV positive people in the community with higher rates of disclosure had greater access formal institutional support through local NGOs and government social services and greater opportunities to take a positive leadership role as HIV positive individuals in the community. The creation of an enabling, resource-rich environment for HIV disclosure holds the potential to form a virtuous cycle whereby individuals are more likely to disclose, thus offering personal and community benefits, and further perpetuating disclosure at all levels within society.

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## **HIV Disclosure in South Africa: Enabling the Gateway to Effective Response**

### **Introduction: HIV Disclosure and Prevention & Treatment Interventions**

The sheer scale of the HIV/AIDS epidemic in sub-Saharan Africa has finally led to an expanded global response. South Africa, where more than 5 million people are estimated to be infected (Department of Health: 2005), has established large scale prevention and treatment programmes. However the uptake and effectiveness of many of these interventions remain sub-optimal and are presently only having a marginal impact on the trajectory of the epidemic (Department of Health: 2005).

There is increasing recognition that disclosing one's HIV status is an essential part of behaviour modification required to reduce the incidence of HIV. Voluntary counseling and testing for HIV is widely promoted as an important first step in behaviour modification. However, without disclosure, few of the benefits can be realized. For example, a study by Ijumba *et al* (2004) in South Africa showed that knowing someone with HIV was associated with condom use at last sexual contact and negatively associated with multiple and casual sex partners. Takai *et al* (1998) also found in Thailand that those with histories of contact with people living with HIV/AIDS have more tolerant attitudes toward the disease as well as to those infected. This supports recent suggestions that the greater personal exposure to the fear-evoking consequences of the epidemic was key in Uganda's success in halting the spread of the virus (Stoneburner and Low-Bear:2004).

Disclosure is also fundamental in managing HIV, especially in terms of adhering to complex treatment regimens. For example, HIV-positive people have reported that they sometimes skipped doses because they could not take a prescribed medication without being observed doing so (Chesney and Smith:1999). Disclosure of HIV status has become an entry criteria for many treatment programmes in resource constrained settings. Finally, access to other forms of care such as home based care and specific social grants are also dependent upon the disclosure of HIV status. From a health policy perspective, effective response across all levels centers on the creation of an enabling environment for disclosure of HIV status.

### **The Price of HIV Disclosure**

Disclosure can be an extremely stressful process, because it makes one vulnerable to perceived stigma of friends, family or the community (Paxton:2002). Stigma has been identified as a barrier to health care, social support, and disclosure (Letteney & Heft Laporte: 2004 Campbell: 2005). However the strategies individuals use to negotiate and counter the fear of rejection and isolation have been relatively under-reported. The way each person experiences and copes with the illness is reflected in the choice of whether, how and to whom to disclose. This decision is embedded within individual perceptions and the local context of HIV/AIDS. Describing and analyzing the internal dialogue pre-

disclosure, and the event itself is an essential step in designing effective interventions that will facilitate disclosure.

Most studies examining disclosure have been conducted in developed country settings (Chesney and Smith:1999, Clark et al:2003, Letteney and LaPorte:2004). Considering the prevalence rates in sub-Saharan African nations, there is a dearth of research on the complex process of HIV disclosure in the region. In this study we describe the realities of disclosure in two South African communities that have very different overall levels of HIV disclosure. We try and tease out key factors that would encourage greater disclosure.

## **Setting**

The research took place at two South African communities – Paarl in the Western Cape and Umzimkhulu in the Eastern Cape - with diverging patterns of disclosure. The communities are geographically diverse in that one is peri-urban and one is rural and they lie in different provinces. However, culturally they are similar in that both communities are rooted in the Xhosa population. While cultural and behavioural norms are similar in both communities, the disclosure rate in Paarl was recently found to be as high as 70%, while in Umzimkhulu the rate was only 30%.

Paarl, a peri-urban/rural commercial farming area in the Western Cape which, despite its relative wealth, has high levels of the socio-economic inequality (Drakenstein:2004). The study was conducted in an area where the majority of people are unemployed or seasonally employed on nearby grape farms. HIV prevalence rate is fast escalating in Paarl. The District Antenatal Survey of the Provincial Department of Health shows that the HIV prevalence increased from 4.5 percent in 2000 to 15 percent in 2004 (Drakenstein Municipality: 2004).

Umzimkhulu lies in one of the poorest rural areas of South Africa, the former Transkei homeland in the Eastern Cape. Employment levels are very low, with only about 12% of residents in the municipality employed. There is a marked dependency on government services, pensions and migrant workers, with 38% of households reporting no income at all (Department of Provincial and Local Government South Africa and South African Local Government Association: 2005). The IMR is 99/1000 live births and the antenatal HIV prevalence rate is 28%.

There is also a broad contextual difference between the two communities in the availability of formal support. While individuals in both communities depend heavily on government grants, those in Paarl can approach a wide variety of NGOs in times of crisis. These include World Vision, Community Health Projects, and Community Centres. There is no similar institutional support in Umzimkhulu.

## **Methods**

This study was part of a larger study which examined the dynamics of responding to the unique impact of HIV/AIDS-related shocks. The identified ‘shocks’ included things like caring for ill family members, coping with the loss of a productive household member, taking in orphaned children, and the experience of being abandoned and/or rejected by family members and loved ones. In Paarl we utilized two local NGOs that support households who are caring for AIDS-orphans and employed community health workers and a fieldworker from a national Preventing Mother To Child Transmission (PMTCT) study that is based in both sites. In Umzimkhulu, we worked with local field workers employed by the PMTCT study to locate those in the community who were not only HIV positive, but who had experienced HIV/AIDS-related shocks.

Respondents were approached by phone or in person and asked if they were interested in participating in the study. If they agreed, they were subsequently introduced to the researchers and were informed of their consent. Ethics were approved by the University of Western Cape, South Africa as well as the University of Calgary, Canada.

A total of 25 HIV/AIDS-affected individuals from 18 households were interviewed, 16 of whom stated they were HIV positive. 14 respondents came from Paarl, and 11 came from Umzimkhulu. Ten key informants were also interviewed who included health care professionals, counsellors, educators, and local NGO workers. The interviews were semi-structured and lasted between one and two hours. The interviews were conducted by experienced researchers, one of which was fluent in the two dominant local languages. Thematic content analyses were used to identify key themes within the interviews. All names utilized in this paper have been changed in order to protect the confidentiality of respondents.

## **FINDINGS**

### **Negotiating/Managing Disclosure**

For all respondents disclosure was not a one-time event, but was experienced as a process. In the space between full, open or public disclosure, and non disclosure, a temporal stage is occupied whereby a positive person manages their HIV disclosure. For some this entails disclosure to some family members, while not for others:

The knowledge of his HIV status is mixed within the members of the household. The first person he disclosed to was his eldest sister. He called her right away and told her because he wanted advice on how to tell his mother. He also disclosed to his mother right away, and although she was devastated, she accepted the news. Siphos brothers do not know of his status because he does not want to worry them. He thinks they need to concentrate on their own lives and he admits that he also does not have the courage to tell them. Although Siphos has disclosed to his eldest sister and his mother, he has refrained from doing so with his father. He said that

he would never disclose to his father because he thinks that his father would talk about his problems to other people and even ridicule him about it. He thinks that if he were to tell his father, his mother and siblings would not be happy and they would be in constant pain (Respondent 6, Umzimkhulu).

For others, HIV management may necessitate disclosure only to those who work in the health care system or those they feel will offer some support. Other studies have shown that HIV positive people expend considerable energy trying to manage information and manipulate their environments appropriately so as to maintain the appearance of uninfected (Clark et al:2003). Our respondents went beyond this form of manipulation, they also applied other tactics in order to maintain relationships, while simultaneously 'feeling out' the impact an HIV positive status would have on their relationships (Box 1). In terms of intimate relationships, this reflects the uncertainty about how a partner will react to news about diagnosis. There may be concern about whether the intimate partners will remain in the relationship, which makes HIV disclosure a way to test a verify each other's commitment (Derlega *et al*:2004).

### **Box 1: Negotiating HIV Disclosure to Children**

Bongi is a 40 year old woman living in Rietvlei, Eastern Cape. In 2003, she gave birth to a baby and found out she was HIV positive. Her daughter was also born HIV positive and only lived for three months. She has never been formally employed and currently lives in a government house. Her livelihood consists of support from her brother who lives in Johannesburg and the informal selling of goods in the community.

Her living daughter, 17, is not aware of her mother's HIV positive status. Her daughter has bad asthma and Bonggi is afraid that if she discloses to her that she might get sick. Bonggi also does not want her to worry about her or to be devastated by her mother's status. However, she hopes that one day she will be able to disclose to her daughter and does grapple with decision frequently. For example, there was a time recently that she told her daughter she was HIV positive. Almost immediately though, she took back the comment and told her that she was joking. To her surprise, her daughter told her that even if she was positive, it would be okay because there are many other people who are positive and it is just like any other disease.

Interestingly, while Bonggi does not talk to her daughter about her own status, she *does* talk to her about HIV/AIDS. She tells her that "you can love someone but that you don't have to have sex with them." She also tells her that if she has unprotected sex all that will come out of it is that she will get pregnant or will get AIDS.

Bonggi's story highlights the complexity of HIV disclosure and the process of negotiation that women undergo. While she would like to disclose to her daughter she does not feel that she is ready to, and even though she thinks that her daughter would be supportive, she had refrained from doing so. However, Bonggi also knows how important it is to speak with children who are young adults about the risks of HIV/AIDS (Respondent 2, Umzimkhulu).

Tactics were also utilized in order to find alternative ways for partners to find out, rather than having to directly disclose themselves:

Indeed, she told her husband she was going to the clinic because she thought she was pregnant. She was trying to find a way to draw him to the clinic (she was not actually pregnant). She wanted someone else to tell him that she was positive, not her (Respondent 8, Paarl)

In another case (Respondent 9, Paarl), the respondent was in a relationship with a man but did not feel ready to disclose her status to him. She had asked him to be tested but he told her that he had been to the clinic and that his results were subsequently lost. She believed that he was “*probably in the same boat*” as her and was also afraid to disclose. At the time of the interview she was planning on taking him to the clinic so that they could both be tested and that she could then act surprised. For many of the respondents the negotiation of disclosure allowed for a certain level of management over one’s status and the ability to make decisions upon the experience of disclosure to family, friends, loved ones and health professionals.

### **The Unburdening of HIV and ‘Freedom’**

Nearly all respondents, experienced a period of struggle before disclosure and had taken a period of time (taking up to a few years) to disclose to those closest to them. During this time, some individuals described the guilt of this burden because they had not disclosed to their loved ones. One respondent (Paarl 6) stated that “*when you haven’t disclosed you are always worried.*” The daily reality of keeping their status a secret was a very difficult and onerous process. However, for each of the respondents, all eventually disclosed to at least one member of their family, a partner or a friend.

Because the knowledge of a positive status is encumbering to an individual, the experience of disclosure often represents a release of this ‘weight.’ Two of the women utilized the word ‘freedom’ when describing how they felt once they had disclosed: One (Paarl 5) stated that “*If you are open, you are free.*”. Another described the following:

She told her sister about her status after a month. Before she told her she was very stressed out, depressed, and lost weight even though she was pregnant at the time. After she told her sister she felt ‘*free*’ (Respondent 14, Paarl).

For others, not only did the events of disclosure to family members unburden them, but by disclosing to other HIV positive people they were able to join a community where this process is shared with people who are going through similarly difficult experiences:

She is a member of the Catholic Church support group. When she began attending she says that she was very depressed but that when she went and spoke with the other women she felt *lighter* (Respondent 6, Paarl).

If you keep it in, people are going to talk about it anyway.” If you tell them, people can help, they won’t talk about it. Otherwise you keep it in and the burden is all on you (Respondent 10, Umzimkhulu).

This correlates to Paxton’s (2002) description of the paradox of coming out openly as an HIV-positive person is that by facing AIDS-related stigma, one finds psychological release- liberation from the burden of secrecy and shame. “The very thing that seems the most dangerous to do, openly confronting stigma and facing possible discrimination and rejection, ultimately can be the most liberating” (Paxton:2002). It is widely accepted that holding back one’s feelings results in stress, which negatively impacts on physical health (Paxton:2002), and that negative emotional reactions, including depression and HIV-related worries are inversely related to disclosure (Derlega *et al.*: 2004). For our respondents, the process of unburdening this weight allowed for both the release of psychological stress and the potential for positive life changes and social support.

### **The Socio-Economic Consequences of Disclosure**

All respondents cited a degree of fear of rejection or abandonment by loved ones as a consequence of disclosure. However, in this sample there were no reports of violence due to disclosure of HIV serostatus. Of the 18 respondents who disclosed their HIV positive status to their families, 6 reported that they had been rejected, abandoned or stigmatized by partners:

She disclosed her status to her boyfriend at the time but he immediately abandoned her. She has seen him since and he is very sick. She encourages him to get tested but he is in denial and won’t. He tells her that people who get HIV/AIDS are ‘whores’ (Respondent 9, Paarl)

While some women experienced rejection and abandonment from partners, most loved ones had expressed concern over the HIV diagnosis and found it difficult at first to come to terms with. In almost all cases where rejection or abandonment occurred, there were alternative sources of support through family members or neighbours who were accessed. The majority stated that by disclosing their status to either loved ones or professionals, they were able to access support both materially as well as emotionally. As Tumi, a single woman living in Paarl (9) stated, “*when you yourself are open you can access the relevant people in order to help you access resources.*” Ziyekele, a respondent in Umzimkhulu (2) claimed that her overall support had actually improved. She “*gets more support now from her mother and her sister-in-law (then she did before).*”

Consistently, family members were the most supportive group in terms of accessing both material services and emotional support. This has important implications as satisfaction with social support has been found to buffer the effect of HIV-related physical symptoms on depressive symptomatology (Simoni *et al.*:1995). Furthermore, people with HIV who are integrated into social networks have higher levels of psychological well-being than those who are not (Simoni *et al.*:1995). Perceptions of social support are also positively associated with the percentage of friends, family and sexual partners to whom the

diagnosis has been disclosed (Derlega *et al*: 2004) This source of support was essential to the well-being of all of all our respondents in that the one respondent who was not receiving family support was the worst off psychologically and materially, and that the vast majority who were accessing support were relatively well-off. Of the 17 respondents in Paarl and Umzimkhulu who disclosed as HIV positive, 16 stated they were receiving either material or emotional support from family members. Of family members, female members were consistently identified most often in terms of providing support:

Her family has been her greatest support. For example, when her child passed away she didn't even have enough money to bury her. Her two nieces and her brother helped pay for the funeral (Respondent 3, Paarl).

She attributes her financial survival to the fact that she can live with her mother and not pay rent. Her family is very supportive both financially and emotionally (Respondent 5, Paarl).

She has a sister-in-law here in Mbewkeni who is very helpful. If she needs paraffin oil or anything, she will help her. She is also very supportive emotionally (Respondent 6, Paarl)

Disclosing to family members consistently allowed HIV-positive people and their families to maintain their livelihoods. Respondents reported being taken in by family members, receiving cash and other goods, and receiving payment for services they otherwise could not afford. In other cases, neighbours had bolstered family resources or had filled in the chasm left by household and extended family members:

She has a neighbor who used to live nearby but who has now moved to Worcester and is very supportive. She comes to visit her and she says that she knows if she ever needed help, this woman would be there for her (Respondent 3, Paarl)

It was her neighbour who also took care of her when she was sick. She helped her a lot, especially during the day when her children were at school. She would help with cooking and cleaning and would even spend the night at times. Even now she still helps her a lot (Respondent 8, Umzimkhulu).

More specifically, for those respondents who had HIV-positive children or were ill themselves, disclosure was the catalyst for accessing necessary support.

She also told her sister who is now looking after her child, but she only did this when she became very ill. Her sister was very supportive and accepted it right away. Immediately after she disclosed her sister said she would take her baby to make life easier for her (Respondent 8, Umzimkhulu)

## **Difference between the Sites**

When comparing the individual responses to HIV/AIDS-related shocks in the two communities, one of the major differences encountered was that of the sources identified as support. In Umzimkhulu, support centred on family, friends and neighbours. While these sources were equally important in Paarl, women in at this site also identified key sources of institutional support in the form of NGOs, hospitals and government grants. The women in this community accessed a wider variety of safety nets and were more aware of different sources of support within their communities. The importance of these institutions was consistently identified:

At the hospital, even right away she was very open about her status. She learned early that in order to get support for her child she had to be open and willing to talk about her problems (Respondent 8, Paarl)

After they were born, she literally had no means of taking care of them {her twins}. She told the doctors that she didn't even have enough money to take them home from the hospital. The doctors then helped her to access the grants, start the ball rolling. It was a quick process, only taking two months. If she had not gotten this support she would have left them at the hospital (Respondent 6, Paarl)

A key example of the diversity of institutional support came in the form of local support groups for those affected by HIV/AIDS. In Paarl, of the 10 respondents who disclosed as HIV positive, 9 were attending support groups. Support groups were easily accessible and were successful in mitigating some of the psychosocial effects of an HIV positive diagnosis:

She does think it was helpful in that provided her with emotional support and an opportunity to speak with others about her problems (Respondent 10, Paarl)

She felt even better when she went to the Roman Catholic Church support group. It was helpful to see that others were going through the same things as she was. This made it a lot better (Respondent 14, Paarl)

Support groups are an essential component of positive living with HIV/AIDS. However, this was a resource which either did not exist or was not accessed by those who had disclosed at the Umzimkhulu site. Not one woman was attending a support group in the region, and we did not come across any key informants who identified the existence of one, despite the fact that the prevalence is significantly higher in this community.

She feels that this could be solved if groups could be formed. These groups would be a place where people would be able to talk about the disease. This would help those who have problems and have nobody to talk to

Thus, while respondents in both sites were able to access family, friend and neighbour support, those in Paarl were able to utilize formal institutional support through local NGOs and government social services.

### **Empowerment and Community Involvement**

Another important difference between the sites was the greater opportunities available for HIV positive people in Paarl to take a positive leadership role and to act as a role model for others. Further, by publicly acknowledging their HIV status they are able to become actively involved in their communities and to lend support to other HIV positive individuals and their affected families. At the most basic level, community involvement entailed lending informal support to those that approached them:

She does support others when she is approached. Someone will come to her and tell them about her status and she will tell them that “they can live with HIV and be healthy.” (Respondent 2, Umzimkhulu)

She also supports others. She knows about another woman who is HIV positive and has offered her support, advice and guidance. When this woman says that she is burdened, the respondent tells her that “she is not alone, that God is with both of them, God knows how they suffer.” (Respondent 4, Paarl)

When there are people in the community who are sick she can tell and she will go and refer them to places where they can receive help. For those who are open she will tell them about her experiences. She tells them that “there is help, your life is not over.” (Respondent 14, Paarl)

Beyond informal support, disclosure also brings about the opportunity to educate others within one’s social network as well as community. Research has shown that the reason people decide to carry out AIDS education is either to prevent further infections or to challenge AIDS-related stigma (Paxton:2002) (See box 3). Our research also found this to be true. Even those who did not publicly disclose to the community, did so to family members and often took the opportunity to educate. In some cases this was to parents and siblings in an effort to alleviate stigma and increase the understanding of their own HIV/AIDS condition. In other cases this was to their children who were taught about HIV/AIDS prevention and education. In this case it was seen as a way to bolster their children’s future resistance to infection. Open discussions about sex and HIV/AIDS were identified as a key factor often missing in their own lives, and was seen as central to their children’s safety. As one respondent stated, “*had my own mother spoken to me about the risks, I think that I probably would not be positive today.*” Disclosure as a means to eradicate stigma as well as to increase resistance is thus a powerful tool in protecting the next generation from similar experiences of discrimination and vulnerability.

However there existed formal avenues for community involvement in Paarl such as NGOs like the Mothers-to-Mothers program, Church support groups and TAC, while this not exist in Umzimkhulu. Three respondents in Paarl were active members of the

Treatment Action Campaign (TAC), an organization of AIDS activists fighting for equal and improved access to antiretroviral therapies. One of the respondents was in fact the Chair of the TAC office in Mbekweni township. Although this respondent had been abandoned by her husband once she had disclosed and had experienced discrimination from her own sisters, she was now publicly acknowledging her HIV positive status on a number of community occasions and fighting to change the face of HIV/AIDS within the community.

Researchers (Paxton:2002) have found that public disclosure can help to reduce stigma and discrimination, can be a powerful tool in breaking the silence surrounding the disease and can help individuals overcome fear and prejudice. In the case of a respondent in Paarl (6), being open about her status allowed her to directly challenge discrimination in the community. She stated that *“When she became open about her status, people did treat her differently but she tells them that, “if you are not tested you don’t know your HIV status.”* Furthermore, respondents themselves benefited from being in contact with others who were HIV positive, and this mitigated their own psychological impact at the time of their diagnosis. As one respondent (Umzimkhulu 10) explained, *“other people who were also positive came to visit me and would tell me that I would be okay. At this time it helped a lot because I really had no hope.”*

### **Box 2: The Story of an ‘Expert Patient’**

One of our most memorable key informant interviews occurred at Rietvlei hospital in Umzimkhulu district when we interviewed Sisanda, a young woman who was working as a counsellor at the local ARV clinic. After only a few minutes of speaking with us about her role, she disclosed her HIV serostatus to us.

When Sisanda first found out she was positive she “just knew that it was something she had to accept.” She also knew right away that it was something she wanted to learn more about. Once she learned more she knew that there was life after being diagnosed HIV-positive. There were things that she could do

She has disclosed to many people herself because she would like to tell them “that there is hope.” One “can live with HIV, that there is life after HIV.” This was her main motivation; to help others who were in a similar situation

In her case, knowing her own status has made her very sensitive to others. She has found that some other health workers can speak harshly to people, but she knows that those who are HIV-positive have to support each other. She has received special training for counsellors who are positive. They work together to monitor other health workers so that if a person is ill-treating another, they can approach them and even report them. They call this program and those involved ‘Expert Patients.’

Ultimately, HIV disclosure opens the door to a dynamic response encompassing community involvement, the support of other HIV positive individuals and their families, as well as enabling a platform for public disclosure and the eradication of stigma. HIV-positive individuals have remained a largely unrecognized and under-utilized resource on the HIV/AIDS prevention and mitigation landscape. This human capital holds great potential, as in the case of Umzimkhulu- a resource-poor community- in desperate need of HIV services directed and managed by other positive individuals. Beyond the impact on the greater community, involvement can also build the morale of people living with HIV/AIDS and can provide a sense of purpose. “Speaking out enables many to take back control over their lives and re-establish personal dignity and pride” (Paxton:2002). This is a benefit which has been channeled in Paarl, but has yet to be in Umzimkhulu.

## **Conclusion**

This article is an engagement with the experiences of HIV disclosure at all levels; from the individual psycho-emotional level, through to the community and national levels. The first goal of this paper was to elucidate the importance of the process of disclosure in the context of sub-Saharan Africa. For our respondents in both peri-urban and rural communities in South Africa, the process by which an individual was able to disclose to family, loved ones, and professionals had a large bearing on how they were able to respond to the impact HIV/AIDS had on their lives and livelihoods. Successful disclosure was often seen as a way to regain the ‘freedom’ that their positive status had taken away from them. Those who had family support were better able to manage their status, both financially and emotionally. Disclosure also held the opportunity to become involved in the local HIV community, and the fostering of important social and material resources. Disclosure was the catalyst for access to a variety of important, and often essential resources required to respond effectively to the impact of HIV/AIDS-related shocks.

Our second goal was to compare the consequences of disclosure in two communities with differing rates of disclosure. We found that many of the experiences surrounding the process of HIV disclosure in the two communities were not entirely dissimilar. Individuals in Paarl and in Umzimkhulu both found it difficult to disclose, went through periods of negotiation and management, and did not encounter dissimilar rates of stigma or rejection from loved ones. However, the major difference when comparing the process disclosure in the two South African settings was in the outcomes enabled and the types of support accessed. The present study design makes it difficult to assign this difference between the communities as a causal factor for the much higher rates of disclosure. However this and other studies have shown that HIV positive people rationally carry out an internal cost-benefit analysis of their potential disclosure. Decisions about disclosure are ultimately influenced by considerations that reflect the impact of stigma (Chesney and Smith:1999) but also the perceived positive outcome. In cases where individuals are able to gain or protect their current livelihoods, they are more likely to disclose. In Chandra *et al*'s (2003) study of HIV disclosure in India, 38% of the subjects reported that they had chosen to disclose to elicit forms of support, which included both emotional and financial support.

Inherently, the creation of an enabling, resource-rich environment for HIV disclosure holds the potential to form a virtuous cycle whereby individuals are more likely to disclose, thus offering personal and community benefits, and further perpetuating disclosure at all levels within society.

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