

Full Length Research Paper

Single HIV infected women's experiences with HIV and coping strategies: The case of Chitungwiza and Epworth in Zimbabwe

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The existence of HIV among people in sexual relationships has become one of the major factors leading to dissolution of relationships thereby creating single-parents in large numbers. Despite the growing prevalence of HIV infected single women, relatively few psychosocial support systems are available for them. There is not much information addressing this subject specifically focusing on women single parents in the view of HIV and AIDS. This study analysed HIV infected single women experiences with the infection, single parenting and their coping strategies in Zimbabwe. We found that their experiences with both HIV and single parenting were mainly negative and characterised by prolonged episodes of threatened psychological and social wellbeing. Their experiences also determined their coping strategies some of which, to some extent serve to exacerbate the spread of HIV and also negatively affect their psychosocial wellbeing. Efforts to provide psychosocial support and practical guidelines targeting HIV infected single women need to be strengthened.

Key words: HIV, single parenting, coping strategies, HIV infected women.

INTRODUCTION

High HIV prevalence among the sexually active reproductive age group is a contributing factor to dissolution of relationships thereby creating single stigmatised women (Porter et al., 2004; Grinstead et al., 2001; Carpenter et al., 1999; Bunnell et al., 2005; Philip and Georges, 2010). In Sub-Saharan Africa and in Zimbabwe in particular, the AIDS epidemic has had a dramatic effect on marital relationships (Philip and Georges, 2010). Its existence within families and other intimate relationships has not only contributed to the negative change in the traditional values and patterns that guided marital and other intimate relationships, but also to the increased vulnerability of

women and children to poverty and HIV infection itself (International Community of Women Living with HIV). In the early years of HIV and AIDS in Zimbabwe, like many other countries, women were almost always the first ones to be diagnosed with HIV and were subsequently accused of bringing it into the relationship and/or family (UNAIDS, 2005).

Being a single women living as a single parent is now a common experience among women of childbearing age in Zimbabwe. And for those who are living with HIV, they not only have to cope with challenges of being HIV positive, but also deal with social consequences of it. Despite their increased numbers in Zimbabwe, there are still few services available for the women and neither are there social support systems for them too. To date there is not much published information addressing this subject and focusing specifically on single mothers living with HIV

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and AIDS. HIV positive single mothers' experiences with HIV, single parenting, and their coping strategies towards single parenting, and remarriages are of public health interest. In this study, we explore HIV infected single women's experiences with HIV infection, parenting and their coping strategies in Zimbabwe.

MATERIALS AND METHODS

The study was conducted with HIV infected single women. Purposive sampling was employed to select 36 HIV infected single parent women who were enrolled in the Better Health for the African Mother and Child (BHAMC)¹ cohort study of women on a Prevention of Mother to Child Transmission of HIV (PMTCT) program. They were all diagnosed with HIV while pregnant between 36 to 38 weeks gestation in 2002 to 2003. The BHAMC study was cleared by the Medical Research Council of Zimbabwe (MRCZ) Ethical Committee and written informed consent was obtained from the participants before participating in this study. For this study, HIV positive single women were identified through their participation in HIV support groups. Participants were interviewed on their experiences with HIV and how they were coping with HIV infection and single parenting. Data was collected using focus group discussions (FGDs) lasting for 1 h 30 min. A total of 3 FGDs of deserted, separated/divorced and widowed single parents were conducted. Qualitative data analysis was conducted and two thematic areas were identified: Experiences with HIV infection, single parenting and coping strategies.

RESULTS

Demographic characteristics

Thirty-six women aged between 25 and 38 years participated in this study. All participants reported being Christians, and most of them had primary level education and had spent more than two years as single parents. They were not formally employed and earned a living through vegetable vending, cross-border trading, or a combination of both. Some also participated in micro – credit scheme and received donations from NGOs operating in their communities.

Experiences with HIV infection

The women reported being in reconstituted families and their experiences were observed within and between the three strata of their current marital status. In general, most reported negative life experiences. Some of the women who disclosed their HIV status soon after their

diagnosis were immediately divorced. Others were simply deserted (partner just went away and never came back, such that the participant would hear of his whereabouts from other people. We quote the experiences of the women as they narrated them to us:

“...I seroconverted in 2004, the day I got to know about it I was disturbed. I didn't think twice before I confronted my husband. I was angry that I never slept around so where did I get the disease from?...when we shouted at each other blaming one another of infecting each other, he then said to me, its over between us? I should pack my stuff, go and never come back to his house. He said where in the world had I ever heard of a Pastor who has AIDS and said I would embarrass him. He threw my clothes out, insulted and accused me of everything. Although I tried to reason with him after all that, my efforts failed and I just knew that it was the end of our relationship. Within a short period of time I heard that he married a girl from the church and they relocated to another location...”

This describes the experiences of most participants especially those who seroconverted and disclosed their HIV status between year 2002 and 2004. Such reactions as hostility, denial, blame and disbelief are documented in others studies as common experiences among people and couples testing positive to HIV for the first time (Fieldman et al., 2002). There are some who were not divorced and pushed out of their households directly, but their partners employed tactful and unique ways to get rid of them. Some were sent back to their parents' home in the pretext that they were disrespectful and insubmissive to their husbands. They were ordered to go back to their parents for corrective purposes based on traditional and cultural values of a patriarchal Shona society.

Some participants reported that their ex-husbands engaged in deliberate alcohol abuse, bedwetting and soiling their underwear and blankets, going to bed wearing shoes, domestic violence largely physical and emotional violence to push them away. When these circumstances became unbearable the women were forced to leave. When relationships were dissolved in this way, the husband or partner would not carry the blame that they chased their wives away rather the women will be blamed that they left their husbands, and this culturally, presents problems for the women. Another quote from a separated single parent who left under such circumstances:

“...You know what?!...I was not chased out immediately in a direct way, but I noticed that I was no longer needed...I was shouted and insulted...when I asked why he came home late he would beat me up and insult me saying you want me to come home to be “hit by the soldiers you are carrying” leave me alone and see what you can do with your disease...sometimes he would come home drunk arriving late at night...then he started deliberately bed-

¹The BHAMC Study was an 8 – year follow-up PMTCT collaborative study between the University of Oslo and University of Zimbabwe conducted in Epworth and Chitungwiza local clinics in Zimbabwe. The study's main objectives was to assess the effect of single dose (SD) nevirapine (NVP) given to pregnant women in labor within 72hrs post delivery to the infant on cognitive and somatic growth of children. 1050 (479 were HIV positive, 571 HIV Negative) pregnant women in their third trimester were enrolled into the study and followed up to measure the purported results of the study.

wetting (enuresis)...He would even sleep wearing his clothes and shoes...so I had to do a great deal of washing blankets and clothes...you know how bad a drunk man's urine can smell...until I decided I couldn't take it anymore, besides there was no more sex at home..."

Combinations of hard talk, insulting and passive resistance were also used to silence the women as well as to push them out of the relationships. Passive resistance, commonly referred to as "silent treatment", or "picture no sound" among the participants was also an experience that almost all the study participants reported having experienced following disclosure of their HIV status to their then husbands. We quote from a 27 year old deserted parent:

"...my husband was giving me a picture no sound and he gave me real trouble...and at that time I was pregnant...so I would talk about preparation for the baby and he would just go quiet...sometimes he would eat the food but not talk to me...he would ask our elder son to give him that and that but not ask me to even when I am closer to it than the child...he would just keep quiet, go out without telling me where he is going...If I am lucky on that day he would just respond with one word answers...until one day he went and never returned...he went to Mozambique, he doesn't even know this child up to now...and you know also that if someone is giving you a silent treatment you don't know what to do and what he is thinking of...maybe he will be thinking of killing you or committing suicide..." said a 27 year old deserted participant.

The experience of this woman with the "picture no sound" technique was common in the majority of the deserted participants. Under these circumstances, women would try to endure the difficult to bear situations often summarizing their resilience with such statements as "...I am just staying for my children..."

Despite their differing causes of single parenting, the women reported that following diagnosis with HIV they felt let down by their sexual partners who were then the primary suspects to have infected them. They engaged in prolonged episodes of crying usually at night or in places where they could not be seen by other people. They made deliberate efforts to isolate themselves so they could cry as much as they can. They cursed their partners and some considered aborting their babies and committing suicide. They went through phases of lowered self-esteem and emotional distress. With time some women noticed that crying could only help them feel better but does not take away the problem and so decided to take the first step to accept it. They began to try solutions to solve their problems which were now multiple: Dealing with a positive HIV status, desertion/divorce/separation, social pressures and stigma associated with divorce and single parenting, economic

challenges and preparations for the index infant.

COPING STRATEGIES

When they began to feel overwhelmed with suicidal thoughts and feelings of loneliness and desperation the first action taken by many was to seek refuge from their extended families. They sought accommodation, food, social and psychological support for themselves and their children. These in most cases were provided but short lived for three main reasons. First, some of the extended family members were also undergoing some forms of marital problems if not similar to the ones faced by the participants. Second, the extended family members were faced with economic hardships such that they could not afford to feed extra persons who may actually need a special diet as a result of their HIV status. Third, extended family members tried to assist the women address the challenges they faced in their relationships, but upon realising that the disharmony was due to the HIV status, they began to avoid them too. This increased levels of stigma which was also extended to the participants' children. These were mentioned by the participants, we quote:

"...it took me time to disclose my HIV status to my family and I was determined not to but the pressure got too much for me as they kept encouraging and demanding that I go back to my husband...so I then told them that my separation was as a result of my HIV status...from that moment on I was stigmatised and accused why I told him such a thing. They asked me what I was thinking when I told him and they said that's your fault, your problem and even here there is no more space for you to stay with your children and asked me to go back to him or else find alternative accommodation..."

"...the moment I told them I suffered more than I was tortured by my ex...nobody wanted to even touch my baby or even talk to us...I could see people were seriously troubled and uncomfortable with us around them... until they told me that they were no longer in a position to stay with us. They said, we cannot stay with in-laws children here, it will attract evil spirits, rather go back to your husband or else look for somewhere to stay then we will assist you pay rentals..."

"...I was stigmatised by my own blood relatives, my own sister was even thinking that I am chasing after her husband, she thought I was trying to seduce her husband...she didn't want me to be in the house when her husband was around..."

For most participants who were either separated or divorced, the extended family was not a long lasting support system under the circumstances so they had to

look for alternative ways of coping both on the psychosocial and economic sense. Some participants reported that they looked for alternative accommodation where they would rent at least a one-room which they would use as both kitchen and bedroom. Once the problem of accommodation was solved they had to deal with the problem of finding food and maintaining their health. This was most challenging as they were unemployed and had lost their source of income the moment they left their spouses. In order to provide for themselves, they engaged in money micro-credit (money lending) clubs with their fellow neighbours, others sought piece jobs like collecting waste paper and plastic containers for recycling while others sought domestic work and others registered with non – governmental organisations (NGOs) operating in their communities to receive monthly rations of food supplements for People Living with HIV/AIDS (PLWHA). Few participants actually opted for the last one as it required some levels of vetting which also came along with disclosing one's HIV status. For most women this was not preferred as they were just going through the consequences of disclosing their HIV status and this would also mean that it would become public knowledge once they begin receiving support from the NGOs. They could only predict much more trouble if the whole community got to know their HIV status.

The widowed women reiterated that they suffered more than the other women in this study indicating that they had to cope with poor health due to HIV infection, loss of their husbands to death and further loss of their property and even children in situations where the relatives of the deceased claimed custody of the children. This group of women had to employ some coping strategies to survive being stripped off of their property and even wife inheritance. They had to go upfront and disclose their HIV status, not for the purposes of protecting their own and other people's health but for their material gain. They knew very well that they will be stigmatised and so no one would try to claim wife inheritance and custody of the children.

"...we already knew we were infected and our baby too, my husband and I were getting sick more often one week he is down and the next week it's me down until he died. Our families knew but never talked openly about it...when my husband died, things got ugly. My husband's relatives started contemplating on stripping me of everything, property and children...but it failed because they started fighting on their own over how they would share the property and children...then I heard that they were planning that the elder brother will have to inherit me when we do the memorial service and distribution of my late husband's clothes...when I noticed that he will take away everything from me and I will remain suffering with the children, I decided to go public, I told them straight up that I am HIV positive... I told them on the day of distributing my husband's clothes...but they still tried to

force me to get into the marriage saying that I am lying about my HIV status until I showed them my cards from the hospital...you know even today they don't like me at all, they don't even visit the children..."

Participants had to cope with the socio-economic challenges coupled with coping with declining health. They could not afford health care costs even when drugs were subsidised. Others relocated to the rural areas where they did not have to pay rentals and encounter daily living expenses. They came back to town when they got better.

Living as single parents, the women began to feel overwhelmed with responsibilities. They had to concentrate their efforts on the challenges to their conventional breadwinner responsibilities and challenges of socialization in a bid to provide the stable relationships necessary to care for and support children. They had also to cope with stress, task, responsibility and emotional overload. Some tried to find jobs but could not get any because during that time there was a high economic meltdown in Zimbabwe. Most of the participants engaged in vending business as well as cross-border trading. Some began to consider disclosing their HIV status in order to obtain food from the donations from NGOs operating in their communities. To minimise their chances of being stigmatised some women simply relocated to other residential areas. Below is another quotation from one of the participants:

"...when things began to be more difficult for me, no husband, no job, selling tomatoes not bringing enough income to support myself and family I decided that I rather register with NGOs to obtain the monthly rations for vulnerable group feeding (VGF), and doing so meant that I disclose my status and everyone in the community will know... so I went ahead now we are not starving...we have something to eat and sometimes we sell some of it so that we get money for rentals and school fees..."

Some participants decided to engage in new relationships with the aim of re-marrying as a way of coping with socio-economic challenges, to obtain some emotional support from their partners as well as to gain community respect. In new relationships, some opted not to disclose their HIV status. Those who managed to re-marry had varying experiences in those relationships and reported that they at least obtained some level of social support and reduced their chances of being stigmatised as single-parents. However such luxury came at a price. They found themselves in situations where they had to choose between their new husbands and their children. Those who chose their husbands had to part with their children. The children would have to go and join their paternal relatives or if possible maternal grandparents.

They also had to conceive and bear children to strengthen their new marriages. At this point they had to

choose between disclosing their HIV status and protect the babies or not to disclose their HIV status and risk their lives and those of the babies. Some secretly took contraceptives so as to prevent conceiving. A number of the women resorted to the last option which they reported it failed them too as they had pressure of preserving their marriages through cementing their relationships through conception. In situations where they succumbed to that pressure, they would take ARVs secretly and their husbands remained ignorant for a long time.

Those who chose to remain single had their share of living with stigma associated with being a single parent and also that of being "labelled" to be HIV infected. They reported that their main reason for choosing not to remarry were fear of abandonment which may result once they disclose their HIV status. They also feared falling in the same situation as previously experienced. They had the dilemma of whether to get married to an HIV infected partner or not, finding that particular person and their greatest challenge was how to disclose the HIV status to the new partner. They had many fears regarding the new relationships especially with sexual and conception matters which would negatively affect their marriages.

Although they considered and engaged in sexual relationships, this group of women indicated that they will not remarry. Such an arrangement would fulfill their social and sexual support needs but will not oblige them to disclose their HIV status or to conceive. This also put them at risk of cross infections and reinfections.

Conclusion

This paper has described the HIV infected women's experiences with the infection, single parenting and their coping strategies. Their experiences with HIV were mainly negative. These findings are in agreement with previously widely documented evidence of negative life experiences of HIV infected women in the developing countries (Maman and Medley, 2004; Kako PM, et al 2011; Mdlalose BNN 2006). Their experiences with HIV seem to influence their coping strategies in the new family setups they chose to take up or at least they found themselves in. It is however disturbing that some chose not to disclose their HIV status to their new sexual partners. This has negative impact on the public health efforts of trying to limit the spread of HIV infection as those infected spread the infection through non-disclosure to sexual partners. This study noted that with time and experience the single parents increasingly became resilient and found alternative ways of coping with the challenges their HIV status brought along. They began to find support from those people whom they could identify with in terms of their HIV status and shared experiences and solutions to problems from the support groups. However, they did not rule out their living fears of unpredictable status of their health. They disclosed

uncertainty over how to choose their next partners, risk disclosing their HIV status and the heartbreaks due to abandonment and potential of more stigmas. These findings are not unique to participants in this study; many other studies have reported fear of abandonment, violence, stigma and discrimination as some of the barriers to disclosure of HIV status (Kebede et al., 2005; Maman et al., 2003; Kako, 2011; Mdlalose, 2006; Kadowa and Nuwaha, 2009). This has important implications for public health practitioners concerned with psychological and social well being of people and the prevention of spread of HIV. Efforts to provide sound psychosocial support and guidelines targeting HIV infected women who aspire to lead a normal and satisfying life of marital and sexual relationships need to be addressed. There is strong need to encourage disclosure of HIV status and to encourage eradication of stigma associated with both HIV and single parenting.

Our results suggest that such women may choose to avoid disclosing their positive HIV status to avoid problems that come along with it but exacerbates the spread of infection which again affects psychosocial well-being of the women concerned. We recommend development and implementation of targeted psychosocial support systems to support People Living with HIV (PLWHIV) who become single parents. They should assist families to be able to cope with HIV without dissolving their relationships and unions, encourage the communities not to stigmatise single parenting as it seems to both exert pressure of marriage to deserted/unmarried, separated and divorced and is highly influential in shaping the urgency and security many women feel surrounding marriage. There is also a need to assess disclosure of HIV status in among couples in remarriages, assess psychosocial wellbeing of children of single parents as well as single parenting among males living with HIV.

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