

HIV DISCLOSURE IN GHANA

The Underlying Gender Dimension to Trust and Care Giving

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ABSTRACT: Missing in the debate of HIV/AIDS-positive disclosures is its gender dimension in terms of those likely to disclose their status, as well as the people in whom they are likely to confide this personal and socially perilous news. This article explores the gender dimension of HIV-positive disclosures through in-depth interviews of 25 AIDS patients receiving treatment at a hospital in Ghana. It argues that the people likely to be informed by AIDS patients of their status are those perceived by the patient to be potential care-givers and more often than not these are females. In other words, unlike in most “Western” countries, gender role expectations do shape HIV-positive disclosures in Ghana.

KEYWORDS: HIV/AIDS, disclosure, women, gender, trust, care, Ghana

The HIV/AIDS pandemic continues to be a major health problem around the world three decades after its emergence. Globally, nearly 65 million people have been infected with HIV, and more than 20 million have lost their lives to AIDS. In 2009 alone, HIV/AIDS claimed more than 2.1 million lives (UNAIDS 2010). In 2010, the global estimate regarding the number of people living with the disease was about 33.3 million, of which about 22.5 million (70 percent) lived in sub-Saharan Africa alone (UNAIDS 2010). In Ghana, the first HIV/AIDS cases were reported in 1986; by the end of 1996,

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about 21,000 cases had been reported (Oppong 1998), a number that increased to about 76,139 cases by 2003 (NACP 2004). Between 2000 and 2003, the percentage of the population diagnosed with HIV/AIDS steadily increased from 2.3 percent to 3.6 percent. In 2006, HIV prevalence had decreased to 3.2 percent and further declined to 2.6 percent by 2007. A marginal increase to 2.9 percent in 2009 put the number of people living with HIV/AIDS at 267,069, of which 3,354 were children (NACP 2010). The HIV prevalence for 2011 was estimated at 1.5 percent with approximately 225,478 cases consisting of 100,336 men and 125,141 women living with HIV/AIDS (NACP 2011). It is estimated that new infections of HIV will further decrease in accordance with global trends.

Since a cure has yet to be found for HIV/AIDS, prevention has been a major concern for governments. To this end, disclosure of HIV-positive status is recognised as essential for reducing the incidence of HIV/AIDS and increasing the well-being of those infected (Shehan et al. 2005; Bairan et al. 2007). Christine De Rosa and Gary Marks (1998) have shown that the disclosure of one's HIV-positive status in sexual relationships positively correlates with safer sexual practices, while non-disclosure may lead to unsafe sexual practices.

Furthermore, HIV/AIDS disclosure to family and friends is found to be essential in garnering social support and providing strategies critical to coping with the disease (Greeff et al. 2008). The benefits of HIV disclosures cannot be overemphasised; however, many people living with HIV/AIDS (PLWHAs) do not disclose their status for fear of stigmatisation (Greeff et al. 2008). Ervin Goffman (1963:3) defines "stigma" as a deeply discrediting attribute which reduces a whole person to a tainted and discounted one. According to Goffman, the stigma felt by individuals could reduce their life chances and spoil their identity. Stigmatised individuals could face

discrimination, isolation, status loss, and loss of employment. Although HIV was not yet present when Goffman was writing, the disease fits Goffman's three types of stigma in that it is associated with bodily imperfections, character flaws, and negatively regarded groups.

Studies on disclosure patterns in Africa in general (Shehan et al. 2005; Bairan et al. 2007; Greeff et al. 2008; De Rosa and Marks 1998), and Ghana in particular (Mill, 2003; Dapaah 2012; Kwansa 2013) have looked at the various aspects of HIV/AIDS disclosures. However, the bulk of these studies have largely explored reasons for disclosure, non-disclosure, and possible consequences (Shehan et al. 2005; Bairan et al. 2007; Greeff et al. 2008; De Rosa and Marks 1998) and overlooked the gender dimension of disclosures.

In most cultures, the burden of care falls directly on women, who are perceived as natural carers (MacNeil 1996). Statistics available in the United States indicate that three out of four caregivers are women (Wootton 1998). Likewise in Ghana, the burden of AIDS patients' emotional and physical falls to women, especially to mothers, sisters, and daughters (Radstake 1997; Anarfi 1995). Men on the other hand offer care by providing financial resources and, occasionally, visiting (Sackey 2009). There is the need, therefore, to explore the possible relationship between gendered expectations of care and disclosure by AIDS patients. Consequently, this article explores the role of gender in HIV-positive disclosures through in-depth interviews of 25 AIDS patients receiving treatment at the Koforidua Regional Hospital in Ghana. It argues that those likely to be informed by an HIV seropositive patient of their status are usually women, largely perceived by the patient to be potential care-givers. The article therefore explores the role gender plays in patterns of HIV-positive

disclosures in Ghana, as well as to whom and why HIV-positive disclosures are made.

HIV-Positive Status: To Disclose Status or Not?

The decision to disclose an HIV-seropositive status is a daunting one in a culture that stigmatizes disease and a healthcare delivery system that often blames victims. This socio-cultural milieu is further complicated by the question of to whom, why and how one discloses a positive HIV status. Ann Miller and Donald Rubin (2007) argue that HIV-positive disclosures may differ per culture. Several studies (Marks et al. 1992; Green and Seronovich 1996; Miller and Rubin 2007; Greeff et al. 2008) show that the people to whom AIDS patients in Africa disclose their status differ from other parts of the world. The most remarkable difference is that sexual partners in African societies are much less likely to be informed about an HIV infection than in the United States of America and Europe.

Evidence from African countries shows that the majority of people living with HIV/AIDS (PLWHAs) disclosed their HIV-positive status to family members, but only a few disclosed the information to sexual partners and friends (Lie and Biswalo 1996; Antelman et al. 2001; MacNeil et al. 1999; Miller and Rubin 2007; Moemeka 1996). For instance, Gro Lie and Peles Biswalo (1996), in a study in Tanzania, asked HIV-positive people to indicate their choice of significant others to whom their HIV-positive status would be disclosed. They noted that about 90 percent of their respondents chose close family members of the same sex and generation as their confidants. Similarly, Gretchen Antelman and colleagues (2001) studied pregnant HIV-positive women attending an antenatal clinic in Dar es Salaam, Tanzania, and found that while the majority of the respondents

had disclosed their HIV-positive status to a female family member, only a few had disclosed it to their sexual partners.

Similarly, Joan MacNeil and colleagues (1999) examined the differences in sexual risk behaviours among newly-diagnosed people with HIV in rural Tanzania. They reported that the majority of HIV-positive disclosures were made to parents, followed by spouses and sexual partners. In yet another study on the factors leading to HIV-positive disclosures in Kenya, Miller and Rubin (2007) found that men who are HIV-positive are more likely to disclose their status to their wives, while HIV-positive women disclosed their status to their relatives and not their spouses. In their study, many of the participants did not disclose status to their friends because of fears of rejection and gossip.² Likewise, women living with AIDS did not disclose their illness to their husbands for the same reason, and many wives claimed there was no open discussion on sexual issues with their partners (Miller and Rubin 2007). Similar studies in India also point to a higher rate of disclosure to members of the family than to friends. That HIV-positive status disclosure in Africa and India seems to be most frequently made to the family probably indicates the family's primary support role (Moemeka 1996; Gyekye 1997). In Africa, unlike in most European countries, a support system is provided almost solely by the family. In much of Europe, the state provides welfare for its citizens; in such a case, individuals are also likely to turn to the state's welfare system.

2. Friendship can be defined as a relationship with another person that is intimate, close and private, but not sexual (Turner 2006). This can be contrasted with acquaintanceship—a relationship that is not intimate. The authors did not indicate whether those referred to above are close friends or acquaintances.

Method

This article draws on a wider study of the perception of death of AIDS in the New Juaben Traditional Area of Ghana. The setting for this study is the largest hospital in the Koforidua Municipality, the Koforidua Regional Hospital. Most people of New Juaben belong to the largest ethnic group in Ghana, the Akan, who share a similar culture in terms of language, descent, and inheritance practices. Among the Akan, descent, inheritance and succession are traced through the female line.

The HIV clinic at the Koforidua Regional Hospital (est. 2005) was the first of its kind in the municipality and serves the adjoining conurbations. The clinic has four units: the Data Centre, where data on HIV/AIDS in the Koforidua area are collated and processed; the voluntary counselling and testing unit; the prevention of mother-to-child transmission unit; and the sexually transmitted diseases unit.

The benefits of a qualitative approach to healthcare research are becoming increasingly recognized. After gaining approval from the National AIDS Control Programme (NACP) and the hospital administration, we utilized in-depth interviews as a method to conduct our study of 25 PLWHAs. Participants were obtained with the help of the staff at the HIV clinic. Though the clinic days at the hospital are Tuesdays and Wednesdays, most PLWHAs come to the clinic once a month. The “convenience sampling” method was used; thus, participants who met the study criteria and were willing to participate were screened and introduced to the researcher. All interviews took place in one of the rooms at the centre.

The purpose of the study was explained to the participants and their consent sought before the interviews began. The interviews took place on different days and were conducted, recorded and transcribed in the Akan language, Twi, before being translated into English. The transcribed data

were subjected to content analysis with close attention paid to emerging themes from the narratives, such as care, trust and fear of stigmatization. For anonymity and confidentiality purposes, pseudonyms were used to protect the identity of participants. In all, 19 females and six male participants ranging from 26 to 58 years of age were involved in the study.³ Participants had very low levels of education: two had a secondary school level education, fourteen had a primary/middle school education, and nine had no education at all. Of the 25 participants, five were married, seven were divorced, six were single, one was separated, and six were widowed. Twenty-one interviewees had between one and seven children, while four interviewees had none. The participants were engaged in petty trading, farming, volunteer work, barbering, hairdressing, dressmaking, and some were unemployed.

The Role and Impact of the “Monitor”

In this study, all participants had disclosed their HIV-positive status to at least one person who was also their monitor. A “monitor” is a person who AIDS patients are required to bring with them before they are put on anti-retroviral therapy (ART). The main purpose of a monitor is to supervise the patient and ensure that the ART regimen is adhered to; this regimen must be strictly followed for it to be effective. The health care providers at the HIV clinic explained that invariably, some of the patients are suicidal after their diagnosis and may need someone around them. They also explained that patients need a caregiver, especially at the start of the ART regimen, because of the potentially severe side effects. In cases where patients are

3. This gender breakdown seems to reflect the higher number of women reported with HIV in Ghana. In 2009 the estimated persons living with HIV and AIDS were 267,069, made up of 154,612 females and 112,457 males (NACP 2010).

very weak and require help, a monitor who knows the illness and the drugs being taken can assist the patient when the need arises. Obviously, finding a monitor requires disclosure. Healthcare providers do not see this as a violation of patients' rights; rather they believe it is in the interest of the patients that somebody knows their status.

Patients undergo counselling before and after testing and are encouraged to self-inform their monitors. In some cases, hospital workers inform both the monitor and the patient at the same time. This was the case for most of the participants, because the majority of them reported to the hospital when they were already in the advanced stages of the disease—that is, with full-blown AIDS. Most of them remembered being very sick, and some said they were in a coma for several weeks.⁴ Additionally, many of the monitors were already providing care for the patients; indeed, in several cases it was the monitors who suggested that the participants take an HIV test. As indicated above, the implication of the monitor system is that PLWIAs are forced to disclose their HIV-positive status to someone.⁵

To Whom is HIV-Positive Status Disclosed?

Analysis of the narratives revealed that the majority of the participants disclosed their status to family members. In this study, 19 out of 25 participants had disclosed their status to close relatives; five did so to spouses

4. As already indicated above, some of the participants said that they had been gravely ill before their AIDS diagnosis. Some reported being paralysed and others reported being blind. Two of the participants reported being in a coma for several weeks.

5. Inspired by the proverb *Se wotɔn wo yadɛe a na wonya ano aduro* (It is only when you sell your sickness that you get medicine), Kwansa (2013: 75–102) describes in detail the strategies that PLWHAs in two Ashanti communities employ to disclose or withhold disclosure of their disease. He extensively discusses trust and mistrust but does not take into account the gender factor.

and one made no disclosure to anyone. She was asymptomatic and was not on an ART at the time of the interview. This finding is consistent with studies in other parts of Africa (Lie and Biswalo 1996; Miller and Rubin 2007) where the majority of status disclosures are made to relatives. The rationale for disclosing information to close relatives was the enduring function of the family as the basic support system in Ghana (Gyekye 1997); indeed, the majority of AIDS patients in Africa are cared for by their families as the health care system is inadequate (Crentsil 2007; Kikule 2003).

Gender is a significant factor in deciding to whom to disclose a diagnosis. Of the nineteen participants who had disclosed this information to relatives, only seven did so to male relatives—two discussed it with their sons and five with their brothers. Twelve respondents reported disclosing HIV status to their mothers, making this group the largest in which informants confided. Six of the participants disclosed their illness only to their mothers, and another six to their mothers plus additional relatives. For instance, some married women divulged their status to both their mothers and their husbands. Other informants similarly confided in their sisters in addition to their mothers. The reason for their choice, they said, was the care they hoped to receive from these relatives. It is noteworthy that some of the mothers were already involved in seeking treatment for their children before they were ultimately diagnosed with HIV. For instance, on the care she received from her mother both before and after her diagnosis, a respondent we named Harriet explained:

Had it not been for my mother, I would have been dead by now. No one understands me as much as my mother. She has been with me and has comforted me since I had this virus. She has been my pillar of strength. She took all my children upon herself and catered for them. She said I didn't have enough strength to do so.

Other participants also indicated that they were grateful for the care they had received from their mothers thus far. For example, Gina intimated that her mother ate with her from the same bowl (a common and significant practice in Ghana symbolising belonging and acceptance) as they did before she was diagnosed. Liza, an informant who said she had left her husband for infecting her, is currently living with her mother. She indicated that her mother pays her medical bills and other expenses. Mavis, a participant who has informed her mother but not her father, said of her mother:

She encourages me to take the medicine. Sometimes at dawn she will come and wake me up to take my medicine. She comes to check whether I am taking the medicine.

Nevertheless, some participants reported being isolated and discriminated against after they disclosed their HIV status to their mothers. Stella, who sells vegetables at the local market, explained that her mother would rather buy from others and would not even accept Stella's vegetables as a gift. Likewise her siblings would not eat from the same bowl with her and refused to enter her room. Another woman, Ophelia, indicated that she experienced stigmatisation and discrimination after informing her mother of her HIV status. She explained that her mother would tell the children in the family not to eat her food because she was HIV positive and would insult her at the least provocation. Unlike Stella, Ophelia has moved out of her mother's home and rents her own place. Similar findings were made by Phyllis Antwi and Deborah Atobrah (2009) in a study that compared stigma in the care of cancer and AIDS patients in Ghana. In their study, some participants reported that they were stigmatised and discriminated against by their mothers and other family members.

Other female relatives to whom the participants had disclosed their status were sisters, daughters, and wives. While six of the participants had disclosed their status to their daughters, another four had confided in their sisters as well as other relatives. Three of the participants disclosed their illness to their daughters alone and another three to both their daughters and their mothers.

Significantly, most participants did not disclose their HIV positive status to male relatives; only two of the participants, neither of which had daughters, disclosed their status to their sons, although both described the tremendous care they have thus far received from their children. One participant also disclosed her status to a brother, who became her primary caregiver and has been instrumental in providing financial care. The other four who disclosed their status to their brothers had also disclosed it to their mothers.

More significantly, several of the participants chose to disclose their status to close female relatives but not to close male relatives. Some participants had confided in their mothers but not their fathers. Only Harriet reported that she had disclosed her status to both parents; neither Akuanor Mavis had done the same. Similarly, three participants had only disclosed their status to their daughters while withholding the information from their sons. Auntie Bea, for example, had disclosed her status to her three daughters, but her four sons were only aware that she was sick. She said:

I have seven children—four boys and three girls. Two of them (daughters) were initially by my bedside. In our house [family], only three people apart from me know about my condition. No other person knows.

In addition to the prospect of care as the main motivating factor in disclosing HIV status to female relatives, our study also revealed that trust and

confidentiality played a significant role in the decision. It is noteworthy that some of the participants chose not to disclose their status to male relatives but did so to female relatives. These participants were sure that their relatives would not reveal their status to others. For instance, Akua, who trusted her mother and sister to keep her diagnosis secret, explained:

My sister and mother are the only people who know about my condition [HIV status]; it is very dangerous to inform my father because I suspect he has cursed me with this disease; he will easily spread the news. He will never hear about my condition till the day I die.

Similarly, Mark was of the view that if he disclosed his HIV-positive status to his brothers, they might spread the news. Mark, who is 37 years old, had only disclosed the information to his mother and one of his five brothers. He said:

Hmm. Maybe they have wives. And you telling them about such things [HIV status], maybe they will tell their wives, and they [the wives] may tell others about it. And before you know it, everybody knows that you have this disease. So when you're passing by, people will be saying that this person, he even has some of the disease.

Another reason given by participants for revealing their status to female relatives was the desire to keep the men in their lives from worrying. Some of the parents who had disclosed their status to their daughters but not their sons seemingly believed their daughters could better handle such news and intimated that they did not want their sons to worry or be disturbed. Ama, a 40-year-old woman, explained her reasoning for disclosing her status to her daughter as follows: "It is only my daughter who is aware but the boy is not, because I don't want him to be worried." Mary and Adwoa made similar comments. Indeed, Mary indicated that although she initially told her son about her status, he cried so much that on the advice

of Mary's mother, she lied and said she was only testing him to find out whether he loved her. Her son was 19 years old.

The few respondents who disclosed their status to extended family members did so in accordance with cultural prescription because their own parents were deceased. In Ghanaian culture, the family decides who will take care of the children in the event of the death of their biological parents. A mother's sister, for example, is considered to be one's own mother among the matrilineal Akan and has therefore the same responsibilities as one's biological mother. Two respondents whose parents were deceased disclosed their status to their mother's sisters. One reported that in addition to her maternal aunt (who was incidentally already a caregiver pre-diagnosis), she had also informed her brother, who provides her with her financial needs.

In some cases, participants withheld their HIV status from their relatives out of fear that it would impact their funerals. For instance, 32-year-old Abena only disclosed her status to her husband because she felt that informing her relatives might preclude her from a befitting burial. Because funerals are great social events among the Akan people (Gilbert 1988), their performance is the responsibility of the deceased's family (Arhin 1994; De Witte 2000; Van der Geest 2000). Some of the participants, like Abena, were concerned about how their funerals would be performed when they died.

The study also revealed that disclosure of HIV status to people outside the family, especially to friends, was minimal. One woman informed her pastor, another woman a nurse at the hospital who later became her monitor. Only one participant, Kwaku, reported disclosing his status to a female friend whom he—interestingly—chose to call “sister.” This friend was

also Kwaku's monitor, and he related that he would have died without her care. When asked why he disclosed his illness to a friend instead of to his brothers, Kwaku replied: "I share my secrets only with those who can help me." He went on to describe the tremendous help he had received from this friend since testing positive. In this, however, Kwaku was the exception, not the rule: many of the participants indicated that they had either left their friends or their friends had left them. Some cited confidentiality issues, and others were afraid of stigmatization and discrimination. Kwaku explained that even though he had not informed most of his friends of his illness, those friends who suspected had shunned him. He said:

All my friends who used to hang out with me no longer associate with me. Before then, they used to visit and we would eat *fufu* each morning. . . . After sometime, some of them said I was infected, others said I was not. Others also said it was my sister who was bringing me medicine. I heard about it, but did not confront them. Nobody also personally asked me about it.

Incidentally, some of the participants opined that they did not have friends because it is not good to have many of them. Mark, when asked about his friends, remarked: "I don't like friends anyway. My friends are only two." Mary expressed similar sentiments:

I don't like friends. So it has become part of me. It has always been my sisters and me. I am afraid of friends. They are not good. They can even spread false information about you.

In effect, HIV/AIDS disclosure is dynamic, where notions of care intersect with gender, friends, and even funerals.

Discussion and Conclusion

In this study, the underlying gender dimension of HIV disclosures is remarkable. Most disclosures of status were made to women in their capacity as mothers, wives, daughters, sisters, or female friends. Only two

disclosures were made to men only. The high number of HIV disclosures to females is linked to the expected culturally-dictated caregiving roles of these female relatives. Ghanaian cultural norms regulate who cares for whom during periods of sickness; among the Akan, for instance, wives are expected to care for their sick husbands but not vice versa (Sackey 2009; Van der Geest 2002).

The normative cultural expectation is that children, especially daughters, take care of their aged parents (Van der Geest 2002). While men provide money for care and occasionally visit, women are responsible for the physical care of the sick (Sackey 2009). It is not uncommon for married women to leave their husbands to take care of their ailing parents. In a study of care of the aged in Kwahu, Sjaak van der Geest (2002) relayed the story of a woman who asked permission from her husband to go and tend to her aging parents. Brigid Sackey (2009) recounted the dilemma of a woman torn between caring for her ailing husband and her aged parents. In this particular case, the husband allowed the woman to spend more time with her parents while a nurse was hired to care for the husband (Sackey 2009). Thus, when people living with HIV choose female relatives as “monitors” and confidants, they conform in a way to cultural norms. Invariably, older participants informed their daughters about their HIV status, knowing that they could count on being cared for by their daughters. Even in the case where the participants’ mothers were not alive, other female relatives (and one female friend) were informed. Likewise, when married men informed their wives about their disease and chose them as “monitors,” they did so as a result of the gendered division and ethics of labour that delegates care to females.

Furthermore, the choice of women as the people to whom status can be disclosed indicates the participants’ view that women can be better trusted

to keep their secret from others. Ironically, women are popularly perceived to be gossipers in many cultures (Chrisler and McCreary 2010), and Ghana is no exception. A proverb confirms this stereotype: *ɔbaa tenten so abɛ a, on-wam di* (If a tall woman carries palm nuts, the hornbill [a bird] eats them), which according to Akrofi (n.d.: 5) means, “A talkative woman divulges domestic secrets.” In spite of this, participants perceived that women, more than men, would keep their HIV-positive status hidden. Though trust is not explicitly mentioned as a predictor of HIV disclosures in other studies (Shehan et al. 2005; Miller and Rubin 2007), its importance cannot be underestimated. It has been amply proven that the fear of stigmatization and discrimination act as a barrier to HIV-positive status disclosures (Shehan et al. 2005; Mill 2003). The participants thus needed somebody in whom they could trust to keep their HIV status undisclosed. We have seen, however, that not all the women to whom status disclosures were made kept the secret or refrained from stigmatizing the participants. Women as a potential source of stigmatization in Ghana have also been reported by Antwi and Atobrah (2009).

Additionally, the study suggests that participants are more comfortable disclosing their status to their mothers. In traditional Ghanaian societies, “the relationship between the child and the mother . . . is very warm and intimate. The mother is in fact the child’s most important and first social contact, and this is regardless of the sex of the child” (Assimeng 1999: 106). According to Max Assimeng, this applies to all ethnic groups in Ghana. The bonds that are created between mothers and their children seem to make it easier for children to confide in their mothers as opposed to fathers. Individuals are also closer to their female relatives in matrilineal societies, which may account for the high disclosure rates to sisters and daughters.

Concerns about confidentiality may also explain why disclosures made to friends were infrequent. Though friends may be trusted when sending remittances from abroad (Smith 2007), the same cannot be said of the disclosure of an HIV status. Since HIV/AIDS is a “metaphor” for moral breakdown (Dilger 2008), its disclosure to friends may be tantamount to washing one’s dirty linen in public. In fact, as noted by Van der Geest (2002), it is possible to keep an illness in the family secret until the death of the patient. An Akan proverb *Ayɔnko goro nti na ɔkɔɔ anya ti* (The crab does not have a head because of friends) indicates friends are dangerous, as do slogans on public transport vehicles: *Suro wo yɔnko* (Fear your friend) or “Some friends . . .” It should be noted, however, that similar slogans and proverbs are directed at relatives (Van der Geest 2009b). The underlying thought is that the people closest to you are also the most dangerous because they know your secrets and your vulnerabilities. Witchcraft (*bayie*) therefore thrives among close relatives. This paradox of trust and distrust, closeness and danger, characterises the dilemma of the HIV patient. For instance, in Kwaku’s case we see someone who has both disclosed his HIV status to, and received immense help from, a friend he called “sister.” On the other hand, he later indicates that his other friends have left him because they suspected his illness. How can one person describe how good a friend has been and in the same breath complain that all his friends have left him because they suspected that he was HIV-positive? The problem may be the multiple meanings of “friend” in the Twi language. *Adamfo* or *yɔnko* mean both “friend” and “acquaintance.” Friends are defined as people that can be trusted (Van der Geest 2009a), but at the same time, as the proverbs above show, people that one should also be wary of. As previously stated, closeness—among relatives as well as among friends—engenders

both trust and fear. Apparently, when HIV/AIDS is involved, that trust is strongest in the case of relatives.

This study is exploratory and intends to open up the phenomenon of gender-related HIV disclosures for further research. One limitation we encountered was that the participants were AIDS patients receiving treatment at an AIDS clinic. They had reported to the hospital with advanced stages of AIDS and, as discussed above, were required to bring a monitor before they were given the drugs. The disclosure pattern of those not on an ART is therefore not included in this analysis. Further investigation could include participants who are not undergoing treatment and have consequently not been requested to produce a monitor. Further investigations need to be done on the issue of trust in caregiving. A larger sample size could be useful in eliciting more information on how PLWHAs and patients in general choose people to disclose their sickness to.

In conclusion, identifying people trusted by HIV/AIDS patients and who are willing to provide care is crucial in helping newly-diagnosed PLWHAs cope with the disease. The challenge in identifying people who can be trusted and are willing to provide care could possibly be addressed with an as-yet undeveloped model on how to identify trustworthy people. More importantly, families should be equipped to care for relatives infected with HIV as the burden of care falls on them in the Ghanaian context. Additionally, more needs to be done to reduce HIV-related stigma and discrimination, since this is a disease whose impact goes far beyond the infected. Awareness and education of HIV should be intensified to reduce HIV-related stigmatisation.

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