To tell or not to tell: disclosure to children and family amongst Thai women living with HIV/AIDS

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SUMMARY
HIV disclosure is a complex phenomenon. The choice of disclosure or non-disclosure is a reflection of how each HIV-positive person experiences and deals with HIV/AIDS in their everyday life. In this study, we qualitatively explore the experiences of disclosing HIV status to family members and children among HIV-positive women living in Thailand. Due to fear of stigma and discrimination, the women decided to tell only a few people, usually their significant others including parents and children. Although most women received good support from their family members, some were rejected and discriminated against by their family members. This stems from lack of knowledge about HIV/AIDS among family members. Women found disclosure to their children a difficult decision to make. Only some women told their children about their HIV status. They wished to protect their children from emotional burden. This protection also appeared in their attempts to prepare their children for dealing with HIV/AIDS. Support from family members played a major role in the lives of HIV-positive women. Although disclosure has been promoted as a means of ending stigma and discrimination, our data suggested that disclosure may not be positive for some women. This has implications for health promotion in HIV health care. Healthcare providers need to appreciate the ramifications of promoting disclosure to HIV-positive women who are mothers.

Key words: disclosure; Thai women; HIV/AIDS; social support

INTRODUCTION
Disclosure has received much attention in the literature concerning HIV/AIDS. HIV disclosure or non-disclosure is a complex phenomenon. There are various issues influencing the decision-making and process of disclosure. The experiences of the person living with HIV/AIDS (PLWHA) who decides to disclose or not to disclose are also diverse. The choice of disclosure or non-disclosure is a reflection of how each HIV-positive person experiences and deals with HIV/AIDS in their everyday life (Bailey and Darak, 2013; Greeff, 2013; Saucedo et al., 2013). Although HIV-positive people should have their rights to choose to disclose or not, they may have no control over the reactions and behaviours of others to whom they have revealed their HIV status (Greeff, 2013).

Disclosure can have both positive and negative consequences (Landau and York, 2004; Greeff, 2013). It can lead to more social support from family members and others (Ross et al., 2007a,b). However, according to Petrak et al. (2001), whether individuals will receive more social support once they disclose their HIV status is still unclear. Disclosure is intrinsically linked with stigma and discrimination (Scambler, 2009). A disclosure of HIV status can also be problematic for many HIV-positive people. It creates anxiety because these individuals cannot foretell the feelings and reactions of others by their disclosure.

HIV-positive women who are also mothers encounter a number of challenges when making
their decision to disclose their HIV status to their family members and particularly their children. Not only have these women to deal with their own stigma and discrimination, but also they are concerned about the potential emotional burden as well as the possibility of stigma that may attach to their children (Davies et al., 2009; Palin et al., 2009; McDonald, 2013; Rochat et al., 2013). For example, if their HIV status becomes known in the community, their children may be stigmatised and their family members may see them as ‘unfit’ mothers (Davies et al., 2009, p. 553). Hence, these mothers may decide not to disclose their HIV status to their significant others for fear of experiencing negative consequences such as social ostracism or expulsion from home (Sandelowski and Barroso, 2003; Hejoaka, 2009; Greeff, 2013; Qiao et al., 2013). Not surprisingly, we witness many mothers living with HIV/AIDS who live in social isolation and endure anxiety and depression because of their HIV status (Li et al., 2011; Davies et al., 2013).

Thailand is one of the Asian countries that has been hit hard by the epidemic of HIV/AIDS. Currently, over half a million (530,000) of Thai people are living with HIV/AIDS (UNAIDS, 2012). In 2012, there were 210,000 HIV-positive women, aged 15 and over, living in Thailand (UNAIDS, 2012). Similar to many women in other parts of Asia, the majority of Thai women contracted HIV from having sex within monogamous relationships with partners who engaged in high-risk behaviour (Ainsworth et al., 2003; Liamputtong et al., 2012). Despite living with HIV/AIDS, many women have become mothers (Liamputtong et al., 2012; Ross, 2013).

Within the Thai context, there is a lack of in-depth knowledge regarding disclosure among women who are mothers and living with HIV/AIDS, particularly how they disclose their illnesses to their significant others. In this study, we explore the experiences of revealing HIV status to family members and children among HIV-positive women living in Central Thailand. In particular, we examine women’s accounts of disclosure, the ways they manage their disclosure and the ramifications of disclosure. Our findings can be useful for sensitive health promotion programmes for HIV-positive women in Thailand and elsewhere.

**DISCLOSURE AND SOCIAL SUPPORT: THEORETICAL FRAMEWORK**

Based on the models of disclosure behaviour, it is suggested that an evaluative judgement for the anticipated responses of others is used in the disclosure decision-making process (Serovich et al., 2005; Bogart et al., 2008). Disclosure will only occur if there is anticipation that support will be received from others. However, disclosure will be delayed if a non-supportive result is expected (Sauceda et al., 2013). Greeff (2013, p. 76) similarly proposes the consequences theory of HIV disclosure, which suggests that individuals living with HIV/AIDS may disclose their HIV status to family members ‘once the reward for disclosing outweighs the associate costs’. For HIV-positive individuals, disclosure has considerable repercussions, and the effects can be both positive and negative. These consequences will thus be assessed before decisions about the disclosure can be made.

Due to the stigma associated with HIV/AIDS, social support from social networks is extremely important in disclosure or non-disclosure (Burgoyne, 2004; Gregson, 2004; Davies et al., 2013). It has been suggested that people who have strong social support will disclose their illness status in addition to actively seeking ways of dealing with the illness instead of avoiding it (Lindau et al., 2006; Davies et al., 2013). Generally, social support acts as a ‘buffer’ to diminish distress and strengthen resilience for individuals who experience stressful life events (Richmond et al., 2007; Zhao et al., 2011). Social support includes emotional, tangible and informational support (Mbekenga et al., 2011). It also includes the informal support that an individual receives from her social networks such as family and other significant members.

Social support is linked with better health and quality of life in people living with HIV (Burgoyne, 2004; Gregson, 2004). For people living with HIV/AIDS, ‘a supportive group environment’ can have a marked positive impact on their mental and physical health ([Davies et al., 2009], p. 553). HIV-positive individuals with extensive social support have less depression, feelings of hopelessness and physical symptoms than those who lack or have lower levels of support (Mizuno et al., 2003; Lindau et al., 2006; Ross et al., 2009). In this study, we base our discussions on the link between disclosure and social support.

**METHODOLOGY**

This study is based on our larger project on the experiences of women living with HIV/AIDS in
Thailand. A qualitative approach is adopted because qualitative researchers accept that, to understand people’s behaviour, we must attempt to understand the meanings and interpretations that people give to their behaviour. This approach is particularly useful when we have little knowledge of the participants and their world views (Liamputtong, 2013).

Because we aimed to understand the lived experiences of women living with HIV/AIDS, descriptive phenomenology was adopted as our methodological framework. Descriptive phenomenology allows us to understand the issues under study from the experiences of those who have lived through them (Carpenter, 2013). Hence, this permitted us to examine the experiences of HIV-positive women and how they dealt with HIV/AIDS in our study. Within the phenomenological framework, the in-depth interviewing method is usually adopted by qualitative researchers. In this study, in-depth interviews were conducted with 26 Thai women.

Purposive sampling technique (Liamputtong, 2013) was adopted; only Thai women living with HIV/AIDS who were mothers were approached to participate in the study. The participants were recruited through advertising on bulletin boards at hospitals where drug trials have been undertaken and personal contacts made by the Thai co-researchers, who have carried out a number of HIV/AIDS research projects with Thai women. In conducting research related to HIV/AIDS, the recruitment process needs to be highly sensitive to the needs of the participants. The sensitivity of this research guided our decisions about how we would approach the women and invite them to take part in this research. We directly contacted potential participants ourselves only after being introduced by our network or gatekeepers. Because of the sensitive nature of this study, we also relied on snowball sampling techniques; that is, our previous participants suggested others who were interested in participating. We enlisted the assistance of leaders of two HIV/AIDS support groups to access the women in this study. We also took part in the activities of the groups as part of the methodology of our study.

The number of participants was determined by a theoretical sampling technique, which is to stop recruiting when little new data emerge; this signifies data saturation (Liamputtong, 2013). The socio-demographic characteristics of the women are presented in Table 1.

Interviews were conducted by both authors in the Thai language to maintain as much as possible the subtlety, and any hidden meanings, of the participants’ statements (Liamputtong, 2010). Interviews were conducted at a place where the women felt most comfortable: often at a coffee shop or food centre. The women did not wish to be interviewed at their own homes as most had not disclosed their HIV status to their family members. For this study, we used the following questions to prompt the women to talk with us:

1. Did you tell anyone about your HIV/AIDS?
2. Please tell us about your reasons for disclosure/non-disclosure.

Table 1: Socio-demography of Thai women, \( n = 26 \)

<table>
<thead>
<tr>
<th>Characteristics</th>
<th>No.</th>
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<tbody>
<tr>
<td>Age</td>
<td></td>
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<tr>
<td>20–30</td>
<td>4</td>
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<tr>
<td>31–40</td>
<td>17</td>
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<tr>
<td>&gt;40</td>
<td>5</td>
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<tr>
<td>Religion</td>
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<tr>
<td>Islam</td>
<td>1</td>
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<tr>
<td>Marital status</td>
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<tr>
<td>Married</td>
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<tr>
<td>Divorced</td>
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<tr>
<td>Widowed</td>
<td>2</td>
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<tr>
<td>Living together</td>
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<tr>
<td>Single mother</td>
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<tr>
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<td>11</td>
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<tr>
<td>Vocational college</td>
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<tr>
<td>Occupation</td>
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<tr>
<td>Home duties</td>
<td>3</td>
</tr>
<tr>
<td>Self-employed</td>
<td>6</td>
</tr>
<tr>
<td>Outreach/health workers</td>
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<tr>
<td>Casual/part-time job</td>
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<tr>
<td>Government officials and office workers</td>
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</tr>
<tr>
<td>Unemployed</td>
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<tr>
<td>Number of children</td>
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<td>1</td>
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<tr>
<td>1</td>
<td>12</td>
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<tr>
<td>2–3</td>
<td>13</td>
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<tr>
<td>Number of HIV-positive children</td>
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<tr>
<td>Not yet known</td>
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<tr>
<td>Family income (in baht)</td>
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<td>&lt;5000</td>
<td>12</td>
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<tr>
<td>5001–10 000</td>
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<td>&gt;10 000</td>
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<td>Health insurance scheme</td>
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<td>30 Baht scheme</td>
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<tr>
<td>Social security scheme</td>
<td>7</td>
</tr>
<tr>
<td>None</td>
<td>1</td>
</tr>
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</table>
(3) Who did you tell as a first person?
(4) In your own experience, what were the consequences of your disclosure?

These questions were followed by other prompted questions to allow the women to articulate more on the issues.

Prior to the commencement of the study, ethical approval was obtained from the Faculty of Health Sciences Human Ethics Committee, La Trobe University, Australia and Ethics Committee at Chulalongkorn University, Thailand. Before making an appointment for interviews, the participant’s consent to participate in the study was sought. After a full explanation of the study, the length of interviewing time and the scope of questions, the participants were asked to sign a consent form, which was kept in a locked filing cabinet to protect the confidentiality of the participants. Each interview took between 1 and 2 h. Individual participant was paid 200 Thai baht as a compensation for their time in taking part in this study. This incentive is necessary for sensitive research because it is a way to show that research participants are respected for their time and knowledge.

With permission from the participants, interviews were tape recorded. The tapes were then transcribed verbatim in Thai for data analysis. The transcripts did not contain the real name of our participants; we invented a fictitious name for each woman (see also below). The in-depth data were analysed using a thematic analysis (Braun and Clarke, 2006; Liamputtong, 2013). This method of data analysis aims to identify, analyse and report patterns or themes within the data. Initially, we performed open coding where codes were first developed and named. Then, axial coding was applied which was used to develop the final themes within the data. This was done by reorganizing the codes which we had developed from the data during open coding in new ways by making connections between categories and sub-categories. This resulted in themes, and they were used to explain the lived experiences of the participants. The emerging themes are presented in the findings section. In presenting women’s verbatim responses, we used fictitious names to preserve confidentiality.

FINDINGS

There are several themes that emerged from the interviewed data. They are presented below.

### Disclosure: to tell or not to tell

Once they have been diagnosed with HIV, women had different views about disclosure of their HIV status and this depended largely on their relationships with their family members and others. Some kept it secret, but others would inform their family about their illnesses.

### Disclosure and family members

All women in this study were infected by their partners/husbands and most of them kept their HIV status and of their partners/husbands secret. They did not even tell their family members. Due to stigma and discrimination towards people living with HIV/AIDS that is still prevalent in Thai society, the women had fear of being blamed or rejected by family members (see also the section below). Importantly, however, the women were concerned about the emotional well-being of their significant others. They were afraid that their family members might not be able to cope with the bad news. Arunee, for example, did not tell her mother that she had HIV because her mother had a heart disease. She was afraid that the news about her HIV would shock her mother. Similarly, Kesaree was concerned that the bad news might create emotional burden to her mother.

I want to tell my mum about it, but I am afraid that she might rab mai dai [not being able to deal with it]. She has diabetes, high blood pressure and heart disease. I am afraid that if I told her and she could not deal with it, some bad thing might happen to her.

Nevertheless, there were women who dealt with the illnesses by informing their extended family members about their HIV status. They made decisions based on their evaluation of the likely outcomes; that is whether they would receive support or not. More often, the women would first confide in their mothers. This was a reflection of a strong tie between mothers and daughters in Thai society. However, some women would inform other significant others. Puangthip only informed her older sister with whom she had a close relationship. She could discuss her difficulties with her sister whenever she needed. When she first learned about her HIV, she felt too stressed and needed to talk to someone. Hence, she chose to inform her sister about the illness, but not anyone else.

It is interesting to note that due to fear of being rejected and discriminated against, women...
were also selective about the person to whom they would disclose. Niramol did not wish to tell her father about her HIV status, although her mother and siblings knew about it. She suggested that her father was an old-fashioned man and could not accept an illness like HIV/AIDS.

My sister-in-law, my brother and mother know about my illness, but not my father. My father is an extreme khon hua boran [old-fashioned person] and he cannot accept bad things easily... I used to ask him about HIV/AIDS when I was pregnant as I was not very confident about his attitudes. I asked him what sort of person gets AIDS and he said it is only people who like having sex with lots of people who will get AIDS and they are not good people. I nearly shed tears when he said so, but I just walked away from him. So, I decided not to tell him. My mother also told me not to tell him as he would rab mai dai [not being able to receive the bad news].

**Discloser and children**

Most women in our study had very young children but a few had teenage children. Women made a very serious decision about disclosure to their children. Some women revealed their HIV status to their children so that they might prepare themselves for the future. Pacharee told her two young daughters soon after she learnt about her HIV status. She believed that her daughters would be strong enough to deal with her illness. In Pacharee’s case, the disclosure led to more caring from her children. The girls would remind her to take her medications and help with housework so that their mother did not have to work too hard.

However, many women did not wish to disclose their HIV status to their young children. They believed that their children were too young to understand the meanings of having HIV/AIDS. Kanokwan had not disclosed her HIV status directly to her young son.

He has not been told directly as I think he would not understand what it means. Sometimes I would just say in passing that your mother is sick and she pen AIDS [HIV-positive]. My son did not say anything. Even when I said that I am not well and have to go to hospital, he did not even question me. So, I think he is still too young to be told about it.

Women were worried that knowing about their HIV status would cause anxiety, which might also lead to further suffering among their children.

I have not thought of telling them yet because children have not developed enough comprehensive thinking skills. If I told them now, they might be thinking too much. Nowadays, things are different; a lot of people commit suicide when they cannot deal with difficulties. I am afraid that if I told the children, they might think too much. I don’t want to cause more suffering for them. I am going through a tough time now but I don’t want my children to go through like what I have to go through. (Pailin)

Nevertheless, for women who had teenage children, it was inevitable that the children would know about their HIV status. Daranee did not disclose her HIV status to her daughter but her daughter questioned her about her health status.

At the beginning my daughter did not know that I pen AIDS [has AIDS], but one day when she was about 13, she asked me ‘Mae, do you pen AIDS?’ I think she learnt about AIDS from school. Because she asked me, I had to tell her. She became very quiet and kept to herself for a long time. However, a week later she was okay and asked me how I got it. She actually suspected that I got it from her father. He died when she was five, so she must have known something for a while!

We asked the women whether, as mothers, should HIV-positive women disclose their HIV status to their children. Most women remarked that this depended on the quality of relationships between mothers and children as well as the ages of the children. More often, the women suggested that children should not be told until they were ready to accept the negative news. However, some suggested that mothers should do so as soon as possible as they personally would feel frustrated about not being able to reveal their health condition to their children.

Interestingly, women attempted to prepare their children for the disclosure by whatever means they believed would work for them. Isara had two daughters and never disclosed her illness to them directly. However, she wrote a letter about the lives of mothers living with HIV/AIDS to Her Royal Highness Princess Soamsawali, who is the patroness of mother-to-child transmission prevention at the Thai Red Cross AIDS Research Centre in Bangkok. Her older daughter read it and asked if she was also pen AIDS. Isara did not admit it but said she had another health condition. She took her daughters to educational sessions about HIV/AIDS so that they would have knowledge about its transmission and how to protect themselves. Although the children were not told, they were suspicious about her
illness. The younger child would always remind her to take her medications on time.

At the time of the interview, Yardthip had not yet told her daughter about her health condition. She wished to wait until the child was old enough to understand the issue. However, the child noticed that she had to take several medications daily and several times asked her about her health. Yardthip too used other health conditions to conceal her HIV status.

"I think I will tell her when she is in year 9 in high school. Nowadays, I have to take several medications and I keep them in a drawer. My daughter often asks me why I take a lot of medications. I told her that I have gained a lot of weight and the doctor prescribed the drugs to get rid of cholesterol in my blood. So, it seems to be a common thing in the family now. She always asks if I have taken my medications. I will tell her when I think she can accept and deal with the truth."

Yardthip, who was a volunteer health worker, took her daughter to AIDS support groups and other activities. Most of her colleagues who were also HIV positive looked physically well. She thought this would make her daughter feel that her mother was always among ‘normal’ people. She also bought books about HIV/AIDS for her child to read. She said that this was the way to prepare her child when she would be told that her mother had AIDS, so that she could accept and deal with it properly.

Disclosure and its consequences

There are several repercussions of disclosure.

Better support

Most women received good support from their immediate family members. When she first learned about it, Naree, for example, told her mother and sister about her HIV status. Both the mother and sister could not believe that Naree would contract such a disease, but accepted that it had happened to her. They also told her not to worry too much about the disease and do whatever she could in order to prolong her life. Most women suggested that revealing the status of their illnesses to their significant others helped them to deal with their health and other issues better than trying to keep it secret. It also made them feel relief about their ill health and living situations.

After a period of secrecy, Tasana told all immediate family members including her parents and younger sister. Tasana’s father gave her emotional support and some comfort in life using Buddhist philosophy by saying that all human beings will suffer because they have made some mistakes in their lives. She also received good emotional support from the whole family.

"My parents know about my HIV. My father tells me not to think too much [worry] about it. He says, we all make a mistake in our lives. He gives me kam lang jai [emotional support]. My younger sisters also give me a lot of emotional support. They tell me not to think too much but to look after myself."

Due to a kinship tie, disclosure about HIV status also brought some women closer to their family members. By telling family members about her illness, Yardthip became closer to her sister and received more support from her family. This helped her to deal with her illness better.

"When I was kread [emotional stress], my symptoms became worse. I could not eat and I lost a lot of weight; I was down to 38 kgs. Viruses started to creep in and every evening I would have bad headache. It was so terrible and I was so thin. I decided to tell my sister. After I told her, she was much better. From trying to ignore each other before, we are now much closer. Since she knew about my HIV, she has looked after me. She would ring me often. When I was having side effects from ARV, she came to stay and look after me. I think telling your family is good. Before, I would keep everything inside my chest. Now, I can just ring her and talk about my health problems."

Rejection and discrimination

Although most women received good support from their significant others, there were also women who experienced rejection and discrimination from their family members. More often, this stemmed from lack of understanding about HIV/AIDS. Some women experienced discrimination from their own mothers. Pensri’s mother, when told about her illness, started to separate everything from Pensri. She would not use the same utensils that Pensri had used, although they had been washed. She was overwhelmed with the idea that HIV could pass on to others including herself through sharing utensils in the household. However, through the media campaigns and having heard more stories about HIV/AIDS as well as Pensri’s own attempt to educate her mother, she began to understand the disease and accept that it could not be passed on by sharing.
utensils. Sharing a household with her mother became easier for Pensri.

With my mum, now it is not so much a problem. We can live together. But before this, she would separate everything from me. Like a plate or spoon, she would not use the same set that I have used. She would have her own ong [a water container used for bathing, washing or even drinking] or khan [a utensil used to scoop water from ong]. She thought that HIV/AIDS could be passed on from sharing these things. However, now she understands the disease and she even said to people that the disease cannot jump from me to others. It will not transmit to others like tuberculosis.

Some women experienced rejection from other family members. Isara’s brother and sister-in-law, for example, did not wish to be associated with her and her children for fear of being contaminated by HIV despite the fact that her children were HIV negative.

Talking about my family, I cannot touch my niece. My sister invited my brother and the family for dinner at a restaurant and my children went with my sister. My brother would not eat anything that day and after that he rang my sister and reprimanded her for taking my children to the dinner. My brother has a good education and works as a manager but he is very afraid of this disease. He is afraid that my children would pass it onto his child.

The cases of Pensri and Isara suggest that some women living with HIV/AIDS were still isolated in society, even within their own family environment.

**DISCUSSIONS AND CONCLUSION**

Disclosure of HIV status often entails risk, especially when the revelation is likely to be ‘emotionally intense’ for all concerned individuals (Bailey and Darak, 2013, p. 230). Within a sociocultural context where HIV/AIDS sufferers are still stigmatised, individuals who reveal their HIV status open themselves to adversities (Smith et al., 2008). Although these individuals no longer have to struggle with concealing a secret, they may be exposed to stigmatised responses from others (Greeff, 2013). People living with HIV/AIDS tend to conceal their health status for fear of being rejected and discriminated against (Medley et al., 2009; Greeff, 2013).

Nevertheless, many HIV-positive individuals disclose their health status. These individuals make decisions about disclosure or non-disclosure based on the benefit or the cost of their actions. They also take into consideration the person or people to whom they reveal their health status as well as the timing of disclosure (Greeff, 2013; Sauceda et al., 2013). Often, they predict that stigma might follow. Thus, it is not too surprising to see that many HIV-positive individuals, including the women in our study, decide to tell only a few people, usually their significant others including parents, close relatives and children (Baumgartner, 2007; Dageid and Duckett, 2008; Greeff, 2013).

Home can be a space where women receive support from their significant others. In our study, most women received good support from their family members. However, as Bailey and Darak (2013, p. 238) suggest, the home space contains ‘different meanings and connotations’ to people living with HIV/AIDS. For some, home space can be ‘a source of stigma and discrimination’ (Bailey and Darak 2013, p. 238). The participants in their study were reluctant to disclose their HIV status as they feared that their ‘safe space’ might be altered into a space ‘fraught with uncertainty’ (p. 234). They found that some participants were discriminated against by their own extended family members. We have also found this pattern in our study; some women were rejected and discriminated against by their family members. We contend that this stems from lack of knowledge about HIV/AIDS among family members. Despite decades of the epidemic within the country and the extensive media campaigns throughout the 1990s, some Thai people do not have sufficient knowledge and understanding of HIV/AIDS, its transmission and prevention (Apinundecha et al., 2007; Liamputtong et al., 2009). Many misconceptions about modes of transmission still abound (Boer and Emons, 2004; Liamputtong et al., 2009). As physical and moral appearances are important in Thai society, shame is therefore experienced by Thai people living with HIV/AIDS (Liamputtong et al., 2009). The continuing high rates of HIV/AIDS and shame and stigmatisation attached to the epidemic contributes to inappropriate knowledge and understanding of the infection and its transmission among the Thai people.

Previous studies have shown that disclosure to their children is a difficult and complex decision to make (Sandelowski et al., 2004; Tompkins, 2007; Murphy, 2008; McDonald, 2013; Rochat et al., 2013). This also occurred among the women in our study. Only a few women told...
their children about their HIV status. Others chose not to, but attempted to prepare their children for the future. Women took into account the ages of their children; most believed that their children were too young to be able to deal with their HIV (Tompkins, 2007; Delaney et al., 2008; McDonald, 2013). But more importantly, they wished to protect their children from emotional burdens. McDonald (2013) has also documented this in her study with Australian women that the participants did not disclose their HIV status to their children because they wanted to prevent ‘unnecessary worry’ to their children.

Importantly, for many mothers in our study, this desire for protection also appeared in their attempts to prepare their children for their health condition and dealing with HIV/AIDS. We contend that the women performed their ‘maternal responsibility’ (Liamputtong, 2009). Motherhood, according to Murphy (2000, p. 298), is a ‘moral enterprise’. Mothers who fail to ensure the health and well-being of children run the risk of being seen as persons who ‘failed to act responsibly’. Consequently, mothers’ identities as ‘moral, responsible and prudent persons’ can be threatened. The women in our study constructed themselves as ‘active, responsible, [and] rational’ mothers whose duties are to enhance the health and well-being of their children. They have, in Osborne’s word (1997, p. 185), been ‘responsibilised’. The women did things which would give them the right to place themselves within the discourse of good and responsible mothers: ‘The ‘good mother’ is one who maximizes physical and psychological outcomes for her child, regardless of personal cost’ (Murphy, 2000, p. 292).

It is worth noting that our findings also suggested that attempts to protect their loved ones from psychological harm was extended to other significant others, particularly their parents. Previous researches (Ross et al., 2007a; Ho and Mak, 2013; McDonald, 2013; Sauceda et al., 2013) have also similarly suggested. In Thai culture, parents are treated with high respect. Children are also culturally obliged to consider the well-being of parents, physically and emotionally (Phillips, 1965; Liamputtong, 2007; Ross et al., 2007a). Those who disregard the well-being of parents are seen as khon nerakham (Mulder, 1985). This has a significant repercussion, usually the person will be ‘punished by the principle of moral justice’, that is karma (Mulder, 1985, p. 35), known as bab or kan in Thai (Liamputtong, 2007).

We contend that support from family members plays a major role in the lives of the HIV-positive women. Most women in our study received support from their significant others after their disclosure. This is a reflection of a norm within Thai culture. The family tie is strong in most Thai families (Liamputtong, 2007). Often, family members help each other, particularly in times of difficulties such as living with stigmatized illnesses. In their study, Ross et al. (2007b, 2012) also suggested that the disclosure of their HIV status to family members or partners has led to the participants gaining support from them. The support they received has a significant ramification. As discussed earlier, social support is intrinsically linked with better health and quality of life in people living with HIV/AIDS (Burgoyne, 2004; Gregson, 2004; Liamputtong et al., in press). Existing studies have demonstrated that self-disclosure of an HIV-positive status leads to better physical and mental health outcomes among people living with HIV/AIDS (Ross et al., 2012). In particular, research has shown an association between disclosure and the reduction in depression levels (Zea et al., 2005), the increase in quantity and quality of social support and personal self-esteem (Simoni et al., 2005; Sowell and Phillips, 2010).

Our findings have implications for health promotion programmes. According to Sowell and Phillips (2010), disclosure helps to reduce HIV-related stigma commonly experienced by HIV-positive individuals and should be promoted in HIV health care. While we agree to this, our data suggested that disclosure may not be positive for some women. Healthcare providers need to appreciate the ramifications for promoting disclosure to HIV-positive women who are mothers. For women who decide to disclose, guidance provided by healthcare providers for disclosure should be done in a sensitive way (Greeff, 2013; Rochat et al., 2013). Following Muula and Mfutso-Bengo (2005), we recommend that the promotion of disclosure needs to be synchronized with suitable counselling for HIV-positive women and their families so that they can deal with the situation appropriately. The counselling should be done with cultural sensitivity so that the benefit and harm to each individual and family can be seriously considered (Rochat et al., 2013). Additionally, Strachan et al. (2007) propose that disclosure promotion can be adopted as part of standard HIV primary care. We recommend that to do so, healthcare
providers need to have sufficient knowledge of the disclosure, and other salient issues, such as levels of stigma in the locality and socio-cultural practices, such as social support, of individual women and families. The women should be well supported so that they can deal with their disclosure appropriately.

ACKNOWLEDGEMENTS

We are grateful to all the women who participated in this study. We thank Frances Happ who edited this paper for us. This study is based on a collaboration research grant provided by the Faculty of Health Sciences, La Trobe University.

FUNDING

The research on which this paper is based was funded by the Faculty of Health Sciences’ Collaborative Grant.

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