

**AN INVESTIGATION INTO THE MANIFESTATION OF STIGMA AND  
DISCRIMINATION AND ITS CONSEQUENCES ON HIV/AIDS PREVENTION AND  
TREATMENT EFFORTS AMONGST PEOPLE LIVING WITH HIV/AIDS**

**by**

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## **DECLARATION**

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Date: March 2013

## **ABSTRACT**

The AIDS epidemic has brought out both the best and the worst in people. The disease brings out the best when individuals group together in solidarity to combat the consequences of HIV/AIDS and to support and care for PLWHA. HIV/AIDS also brings out the worst when individuals are stigmatized and ostracized by their loved ones, their family and their communities and discriminated against individually as well as institutionally.

This research has reviewed available scientific literature on HIV/AIDS stigma and discrimination. The research has also established HIV/AIDS stigma and discrimination comes in different forms and occurs in different contexts. Stigma and discrimination play a significant role in HIV/AIDS prevention and treatment efforts. Analysis of this research indicates stigma and discrimination has a negative impact on HIV/AIDS prevention and treatment efforts.

## **OPSOMMING**

Die VIGS-epidemie het beide die beste en die slegste in mense. Die siekte bring die beste wanneer individue groep saam in solidariteit die gevolge van MIV / VIGS te bestry en te ondersteun en sorg vir PLWHA. MIV / VIGS bring ook die ergste wanneer individue gestigmatiseer en verstoot deur hul geliefdes, hul familie en hul gemeenskappe en teen gediskrimineer individueel sowel as institusioneel.

Hierdie navorsing het hersien dat die beskikbare wetenskaplike literatuur oor MIV / VIGS stigma en diskriminasie. Die navorsing het ook vasgestel dat MIV / VIGS stigma en diskriminasie kom in verskillende vorms voor en kom in verskillende kontekste. Stigma en diskriminasie speel 'n belangrike rol in MIV / VIGS voorkoming en behandeling pogings. Ontleding van hierdie navorsing dui daarop dat stigma en diskriminasie het 'n negatiewe impak op MIV / VIGS voorkoming en behandeling pogings.

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“An HIV free generation is possible, it begins with you”

## **ACRONYMS**

ART – Anti Retroviral Therapy

AIDS – Acquired Immune Deficiency Syndrome

HIV – Human Immunodeficiency Virus

PLWHA – People living with HIV/AIDS

STDs – Sexually Transmitted Diseases

STIs – Sexually Transmitted Infections

UNAIDS – United Nations Aids Programme

WHO – World Health Organisation

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## CHAPTER ONE

### INTRODUCTION

#### 1.1 Introduction

Millions of people have been infected with HIV during the past two decades. The absence of effective HIV prevention and treatment efforts means that more and more people will die. Stigma and discrimination are some of the greater enemies in the battle against HIV/AIDS. HIV/AIDS related stigma and discrimination are important factors that need to be addressed to create an effective response to HIV/AIDS prevention and treatment. HIV/AIDS related issues such as stigma and discrimination have of late stood as obstacles in the prevention and treatment of the epidemic. "Finding out that one has HIV presents physical, emotional, social and legal concerns that do not arise when one is tested for other conditions" (Anderson, 2009:3). It is therefore crucial to explore what constitutes HIV/AIDS related stigma and discrimination and the effects they have on HIV/AIDS responses as well as the measures that can be put in place to reduce these effects. HIV/AIDS stigma and discrimination can be experienced in different contexts. Factors such as the lack of knowledge, cultural issues, religious teachings and taboos surrounding the HIV/AIDS epidemic among others are the ones that fuel stigma and discrimination.

A one month study investigating the causes, forms and the effects of stigma and discrimination was carried out in the Masvingo District of Zimbabwe. The research also explored the contexts in which HIV related stigma and discrimination occurs. HIV positive individuals from Batanai, an organisation that support people who are living with HIV/AIDS were interviewed.

#### 1.2 Background of the study

HIV/AIDS has brought about a global epidemic far more extensive than what was predicted even a decade ago. "Still rapidly growing, the epidemic is reversing developmental gains and obliterating millions of lives"(Pelser, Ngwena, & Summerton, 2004:276). The HIV/AIDS pandemic brought about a wide range of reactions from individuals, communities and even nations: from sympathy and caring to silence, denial, fear, anger and even violence. Stigma determines the type and magnitude of the reactions to this epidemic. Stigma and discrimination have fuelled the transmission of HIV/AIDS and have greatly increased the

negative impact associated with the epidemic. HIV/AIDS related stigma and discrimination continue to manifest in communities, creating barriers to preventing further infection, alleviating impact and providing adequate care support and treatment. The stigma and discrimination around HIV/AIDS has hindered open discussions, both of its causes and of appropriate responses. Openness about HIV/AIDS is critical in the successful mobilization of communities and individuals to respond to the epidemic. “Stigma and discrimination cause people living with HIV/AIDS to be seen as a ‘problem’, rather than as a solution to containing and managing the epidemic. Stigma associated with HIV/AIDS is underpinned by many factors including lack of understanding of the illness, misconception about how it is transmitted, lack of access to treatment, irresponsible media reporting on the epidemic, the incurability of HIV/AIDS and prejudice and fears relating to a number of socially sensitive issues including sexuality, disease, death and drug abuse” (UNAIDS 2004:4). Confronting stigma and discrimination is therefore a pre-requisite for effective prevention and treatment of HIV/AIDS. It is because of stigma and discrimination that people become afraid to find out whether or not they are infected, they become afraid to seek out information about how to reduce their risk of exposure to HIV/AIDS and to change their behaviour to more safe behaviour lest this raise suspicion about their HIV status. Stigma and discrimination therefore undermine the ability of individuals and communities to protect themselves and provide support and reassurance to those affected by the disease.

People living with HIV/AIDS are less likely to receive care and support because of stigma and discrimination. “Since the beginning of the epidemic, HIV/AIDS has been linked to certain behaviours and practices which are intravenous drug use, homosexuality and prostitution, which contradict the religious morals, societal values and cultural norms of many societies. The link of HIV/AIDS with such practices has resulted in the rejection of people who are living with HIV/AIDS or suspected to be by their communities. Hence stigma and discrimination faced by people living with HIV/AIDS is multiple and complex” (WHO 2002:1).

HIV/AIDS related stigma and discrimination is also triggered by a lack of understanding of the disease and myths about how it is transmitted. “Stigma and discrimination surrounds HIV/AIDS because it is believed to be a disease that has severe outcomes and whose modes of transmission are perceived to be under a person’s control. Through stigma society always blames infected people for being ill and asserts the innocence and health of those who are

stigmatize”(Devries, 2003:5). Despite intensive educational efforts, different sectors of the general public still are ignorant of how HIV is transmitted and hold misconceptions about the virus. An article on HIV Stigma and Discrimination added “ignorance about HIV and its transmission fuels stigma, in turn, ignorance and stigma lead to discrimination against PLWHA”. Fear of and actual experience with stigma and discrimination reduce an individual’s willingness to practice prevention, seek HIV/AIDS testing, disclose his or her status to others, ask or give care and support and begin and adhere to treatment. There is a great fear of HIV/AIDS due to poor understanding of the disease in the general public. HIV/AIDS related stigma and the resulting discriminatory attitudes create an environment that fuels the epidemic. This also hinders in no small way efforts at stemming the epidemic. It complicates decisions about testing, disclosure of status and ability to negotiate prevention behaviours. Since HIV/AIDS related stigma and discrimination acts at both the societal and at the individual level, there is an urgent need in many contexts to address stigma and discrimination to promote adequate, accessible and acceptable HIV/AIDS programs and services. “HIV related stigma and discrimination have restricted the success of HIV prevention, care and treatment programmes and reduced the willingness of people with HIV to disclose their status to seek out sexual and reproductive health” (Gruskin, 2007:12). Unless concerted corrective actions are taken to improve people’s knowledge to develop a clear understanding of the disease, which is essential to reduce the associated stigma and discrimination all efforts made to contain the epidemic will be futile.

### **1.3 Motivation of the research study**

Despite its negative impact on people living with HIV/AIDS, there has surprisingly been limited number of intervention studies aimed at reducing HIV/AIDS related stigma and discrimination. This particular study has therefore helped in stimulating academic thinking in order to establish how best stigma and discrimination can be managed in order to ensure successful implementation of prevention and treatment interventions. The findings from this study will also add to the body of evidence that already exists on the topic and give direction to policy makers responsible for HIV/AIDS interventions. The experiences that were shared during the research will also contribute to the current debates and responses on stigma and discrimination and inspire others to take action that will create a stigma free environment.

While there is literature written about HIV/AIDS stigma and discrimination, there is still a need to explore and find how it has affected HIV/AIDS prevention and treatment. The study will potentially increase the pool of HIV/AIDS related stigma and discrimination interventions since there are not as many that solely stigma reduction.

#### **1.4 Problem statement**

The objective of research is to solve a problem and it is a guide of the direction that should be taken to produce an answer. The problem statement for this project is thus: How does stigma and discrimination manifests itself among people living with HIV/AIDS and what are the consequences on HIV/AIDS prevention and treatment efforts?

#### **1.5 Objectives of the study**

The following objectives have been formulated:

- To establish the forms of stigma and discrimination that people with HIV/AIDS are subjected to.
- To establish how stigma and discrimination poses obstacles to HIV/AIDS prevention and treatment efforts.
- To determine the strategies and practical actions to challenge and reduce HIV/AIDS related stigma and discrimination.
- To make recommendations on how best HIV/AIDS related stigma and discrimination can be mitigated.

#### **1.6 Research methodology**

Qualitative data collection was used to collect the data. In depth individual interviews on a one-on-one basis was employed. The purpose of the interviews was to probe ideas of the interviewees about the subject of HIV/AIDS related stigma and discrimination. Two focus group discussions were also conducted to extract more data from the participants. The data was audio-recorded as well as written down by the researcher's assistant. The purpose of this qualitative research was to provide rich information about the subject in question. People who are living with HIV/AIDS were the respondents during the research study.

Individuals who are living with HIV/AIDS are the ones who are subjected to stigma and discrimination therefore the ones who can provide adequate information on the subject.

Attention was focussed and looking for certain characteristics from the respondents, purposive sampling was employed. A questionnaire, which is a series of questions that are used to extract data from the respondents during research studies, was used to collect data during the interviews. A focus group discussion guide was used during the focus group dialogue.

### **1.7 Limitations of the study**

Most of the respondents were busy with various income generating activities and found it difficult to set aside some time to participate in the study.

### **1.8 Outline of chapters**

Chapter 2 focuses on the preliminary literature review. This chapter will provide an overview of current and not so current yet still sufficiently relevant literature on the key words in the research question. The objective is to identify the gap between what has been written on the topic and what has not been written.

Chapter 3 indicates how the sample of the study was selected and the reasons why that particular sampling method was chosen. The target population and the research design that is going to be employed will be discussed at length. The data collection technique is highlighted where the data is gathered in order to find answers to the research question. A detailed account is given of the ethical issues and how the researcher conducted herself in the field.

The findings of the research study will be in Chapter 4. In interpreting data the ultimate aim is to come to findings and to draw the conclusions. Each conclusion will be based on substantiated findings from the data the researcher gathered in relation to what is already known so as to reveal possible new insights of existing knowledge.

Chapter 5 is about the conclusions that the researcher drew from the objectives of the study and the recommendations that were also drawn basing on the findings of the research.

### **1.9 Conclusion**

The purpose of this research was to have answers to so many questions that need to be answered. Insights are also drawn from the next chapter which is focussed on the literature survey of the subject under study.

## CHAPTER TWO

### LITERATURE SURVEY

#### 2.1 Introduction

HIV is a virus that can only infect human beings and it weakens the immune system by destroying important cells that fight against diseases and infections. The virus can only reproduce itself by taking over a cell in the body of its hosts. HIV invades the disease fighting cells in the body of its host and destroys them. Overtime HIV destroys so many CD4 cells and the body cannot fight infections and diseases anymore. When this happens the infection can lead to AIDS. "HIV is a virus that is transmitted from person to person through the exchange of body fluids such as blood, semen, breast-milk and vagina secretions. Sexual contact is the most common way to spread HIV but it can also be transmitted by sharing needles when injecting drugs or during childbirth and breast-feeding" (Cichock, 2010:1).

When AIDS infected the first person no one could have thought how the epidemic would spread across the world and how many millions of lives it would change. The epidemic has proved it can devastate families, communities, countries and the world at large. HIV/AIDS has become an international epidemic which can easily cross borders and oceans. An article on HIV/AIDS around the world asserts "already 30million people around the world have died of HIV/AIDS related diseases. In 2010, 2.7million people were newly infected with HIV and 1.8million men, women and children died of AIDS related causes. Around the world 34 million people are now living with HIV/AIDS" (2011:1). As of 2010 approximately 34 million people have HIV worldwide. Approximately 16.8% of those are women less than 15 years of age. Sub-Saharan Africa is the region that is worst affected followed by South and South-East Asia.

The research was conducted in Zimbabwe where the country has witnessed a rise in inflation, a severe cholera epidemic, high rates of unemployment, political violence and a near total collapse of the health system. The country is, however, seeing some progress and improvement regarding HIV/AIDS. Zimbabwe is one of the few countries where the incidence has declined by more than 25% between 2001 and 2009. This is mainly because of the effort made by the nation to prevent the spread of HIV which has been remarkable in the context of such immense challenges. The Avert Journal added "the first reported case of

AIDS in Zimbabwe occurred in 1985. By the end of the 1980s around 10% of the adult population were to be infected with HIV. This figure rose dramatically in the first half of the 1990s, peaking at 26.5% in 1997. But since then the HIV prevalence is thought to have declined making Zimbabwe one of the first African nations to witness such a trend. According to Government figures, the adult prevalence rate was 23.7% in 2001 and fell to 14.3% in 2010. The decreasing number of new infection appears to have played a part in this decline. In Harare the capital, transmission rates peaked when 5.5% of the city became infected in 1991 but slowed down to 1% in 2010.” However, people should be mindful there are many homeless and displaced people in Zimbabwe and these might not have been included in the survey thereby failing to give the real picture of what is on the ground.

The sample chosen for this study comprised of people who are openly living with HIV/AIDS. People with HIV/AIDS were targeted in order to reveal issues that surround the subject of HIV/AIDS related stigma and discrimination.

## **2.2 Stigma**

HIV related stigma refers to unfavourable attitudes, beliefs and policies directed towards people perceived to have HIV/AIDS as well as their loved ones. HIV/AIDS stigma also refers to the severe individual, family or community shame associated with HIV/AIDS. Stigma is a powerful tool of social control where it can be used to marginalise, exclude and exercise power over individuals who show certain characteristics. “Stigma is a social process: a feature of social relations, reflecting the tension, conflict, silence, subterfuge and hypocrisy found in every human society and culture” (Barnett, & Whiteside, 2006: 72). Negative attitudes to people living with the infections are some of the common manifestations of HIV stigma which potentially lead to discrimination.

Stigma had three dimensions which are perceived (felt) stigma, enacted stigma and internalized stigma. “Perceived stigma is real or imagined fear of societal attitudes and potential discrimination arising from a particular undesirable attribute, disease (such as HIV/AIDS) or associated with a particular group” (Brown, Macintyre, & Trujillo, 2003:51). People may think or feel they are stigmatized even when they are treated like others. Enacted stigma is when real experiences of stigmatization are experienced because one is or thought to be HIV positive. When an individual stigmatizes against people living with

HIV/AIDS whether in thought or in action, that is referred to as enacted stigma. Internalized stigma is manifested in self-blame and self-deprecation. The fear of HIV related stigma might cause individuals to isolate themselves to the extent where they do not feel part of the society and cannot receive services and support they need. Internalized stigma can cause anxiety, depression, withdrawal, self-abandonment and feelings of worthlessness re-enforcing shame and social exclusion.

Stigma can lead to prejudiced thoughts, behaviours and or actions on the part of communities, employers, health care providers, co-workers, friends and families. People living with HIV/AIDS are blamed for their conditions and are punished by exclusion, isolation, prejudice and discrimination for contracting the disease. They are often reduced to stereotypes such as drug abusers, gay men, and sex-workers with little regard to their individual experience or situation. Stigma is a stereotyped attitude or view which is unfounded and in most cases a kind of denial and exclusive attitude. "Stigma has been described as a dynamic process of devaluation that 'significantly discredits' an individual in the eyes of others. HIV related stigma is multi-layered tending to build upon and reinforce negative connotations through the association of HIV/AIDS with already marginalized behaviour such as sex work, drug use, homosexual and transgender sexual practices" (UNAIDS 2006:7). Individuals living with HIV/AIDS are often believed to deserve their HIV positive status as a result of having done something 'wrong'. HIV related stigma then is a process by which people living with HIV/AIDS are discredited. This may affect both those infected or suspected of being infected by HIV and those affected by AIDS by association, such as orphans or the children and families of people living with HIV/AIDS. "Stigma begins when dominant groups distinguish human differences whether real or not. It continues if the observed difference is believed to connote unfavourable information about the designated persons. As this occurs, socially labelling of the observed difference is achieved. Labelled persons are set apart in a distinct category that separates 'us' from 'them'. The culmination of the stigma process occurs when designated differences lead to various forms of disapproval, rejection, exclusion and discrimination" (Bruce, 2000:2). Stigma does not only make it difficult for people trying to come to terms with HIV/AIDS and manage their illness on a personal level, but it also interferes with attempts to fight the AIDS epidemic as a whole. On a national level stigma can hinder the Government from taking fast and

effective action against the epidemic, whilst on a personal level it can make individuals reluctant to access HIV testing, prevention, care and treatment. “Stigma is increasingly recognized to have a major impact on public health interventions. Stigma and discrimination lead to delay the presentation to health services, prolonged the risk of transmission and with poor treatment adherence” (Heijinders & van der Meij, 2006:354). HIV/AIDS related stigma must therefore be recognised and addressed as a life altering phenomenon.

### **2.3. Discrimination**

Discrimination is a form of behaviour motivated by stigma. While stigma refers to an attitude or belief, discrimination describes the actual behaviour that violates the rights and interests of the individual or group to which it is directed; HIV/AIDS does not discriminate, people do. “Discrimination refers to the exclusion, differentiation or unjustified denial of equal rights of an individual or group. The discriminated individual is unable to enjoy basic human treatment and is denied the ability to realise their own freedom and happiness” (ILO 2007:11). Discrimination is when an individual is treated with partiality or prejudice, follows stigma and is the unfair and unjust treatment of an individual based on his or her real or perceived HIV status. HIV related discrimination can occur at home, at work and in the communities that people living with HIV/AIDS are living in. The discrimination and devaluation of identity associated with HIV discrimination do not occur naturally. Rather they are created by individuals and communities who, for the most part generate discrimination as a response to their own fears. HIV positive individuals, their loved ones and even their care givers are often subjected to rejection by their social circles and communities when they need support the most. They may be forced out of their homes, lose their jobs or be subjected to violent assault. While access to appropriate treatment and care for individuals with HIV/AIDS is generally recognised as a fundamental right, discrimination prevents individuals from getting tested and seeking or adhering to treatment and care due to the discrimination associated with being HIV positive. “Discrimination remains the single most important barrier to public action. It is a human reason why too many people are afraid to see a doctor to determine whether they have HIV or to seek treatment if so. It helps make AIDS the silent killer because people fear the social disgrace of speaking about it or taking easily available precautions. Stigma and discrimination is the chief reason why the AIDS epidemic continues to devastate societies

around the world” (Tomaszewski, 2011:2). HIV related discrimination is therefore a barrier to infection prevention and treatment efforts.

#### **2.4. HIV/AIDS prevention**

HIV/AIDS can be transmitted in three main ways which are sexual transmission, through blood and through mother to child. “The most common method of transmission (of the disease) is through unprotected sexual intercourse together with an HIV-positive partner” (Peter, & Lamptey, 2006:3). There are actions individuals for each root of transmission can take to reduce or to eliminate risk. “HIV prevention should be comprehensive, making use of all approaches known to be effective rather than just implementing one or two approaches. Successful prevention programmes not only give information, but also build skills and provide access to essential commodities condoms and sterile injecting equipment” (Avert 2011:3). HIV testing and counselling are fundamental for HIV prevention. People with HIV/AIDS are less likely to transmit the virus to others if they know they are infected and if they have received counselling about safer behaviour. For example, a pregnant woman who has HIV /AIDS will not be able to benefit from intervention to protect her child unless her infection is diagnosed. Those who discover they are not infected also benefit by receiving counselling on how to remain uninfected. “Early work on prevention focused on understanding the dynamics of risk behaviour among people living with HIV/AIDS” (Jeffrey, Fisher & Smith, 2006: 1). Individuals can also eliminate or reduce risk of becoming infected with HIV during sex by choosing to abstain from it or delay the action, be faithful to one partner and by making use of condoms, consistently and correctly. Microbicides and male circumcision also reduce the transmission of HIV/AIDS to a certain extend.

#### **2.5. HIV/AIDS treatment**

The antiretroviral drug is the main type of treatment for HIV/AIDS. It is not a cure but it can significantly reduce people’s chances of getting ill. Although anti-HIV medications can not cure HIV, people with it are enjoying healthy lives and living longer. The antiretroviral therapy has been seen to substantially lower the viral load through strict adherence to treatment regimens and increase CD4 count. The incidences and deaths of HIV/AIDS have decreased considerably where antiretroviral drugs are readily available. “Although antiretroviral therapy regimens may not be effective for all infected persons due to drug-resistant strains of HIV and unmanageable adverse effects, it has lowered the viral load of

many” (Marks, 2004:225). The treatment consists of drugs that have to be taken every day for the rest of a person’s life. The main aim of the antiretroviral treatment is to keep the amount of HIV in the body at a low level. This stops any weakening of the immune system and allows it to recover from any damage that HIV might have caused. It prevents HIV from multiplying and destroying infection fighting cells thereby helping the body battle the life threatening infections. The antiretroviral therapy involves a combination (regimen) of three or more anti-HIV medication daily. People need to take more than one drug at a time, if only one drug is taken HIV would quickly become resistant to it and the drug would stop working. Taking two or more antiretroviral drugs at the same time vastly reduces the rate at which the resistance would develop, making the treatment more effective in the long term antiretroviral therapy.

## **2.6. Conclusion**

In a country with a prevalence rate such as Zimbabwe, health system that at one point almost collapsed and the agricultural sector that is shacking, it is crucial that issues of stigma and discrimination are addressed for the country to appropriately make use of the existing prevention package, the care and the treatment of HIV/AIDS.

## CHAPTER 3

### RESEARCH METHODOLOGY

#### 3.1 Introduction

The main aim of research was to gather, analyse and report the ultimate findings leading towards making sound recommendations for the way forward. A scientific research methodology was employed in order to produce quality, reliable and valid results.

#### 3.2 Problem statement

A problem was identified within the framework of the environment where the research will be conducted: How does stigma and discrimination manifest itself among people living with HIV/AIDS and what are the consequences on HIV/AIDS prevention and treatment efforts?

HIV/AIDS is increasingly being recognised as not merely a medical problem but a social problem as well. Social responses to HIV/AIDS are characterized by high levels of stigma and discrimination. Social factors such as stigma and discrimination attached to HIV/AIDS are a major obstacle in the fight against HIV/AIDS. People with HIV are stigmatized leading to severe social consequences with regards to their rights, health care services, freedom, self-identity and social interactions. The research portrayed different ways in which stigma and discrimination manifests itself. Stigma and discrimination has been seen to have negative impact on HIV prevention and treatment efforts.

#### 3.3 Aim of the project

The research is aimed at unveiling HIV/AIDS related stigma and discrimination perpetrated on people living with it and the effects of stigma and discrimination on prevention and treatment efforts in order to minimise infection related stigma and discrimination.

#### 3.4 Objectives

The following objectives were formulated to direct the research with the aim of solving the identified problem:

- To establish the forms of stigma and discrimination that people living with HIV/AIDS are subjected to.

- To establish how stigma and discrimination poses obstacles to HIV/AIDS prevention and treatment efforts.
- To determine the strategies and practical actions to challenge and reduce HIV/AIDS related stigma and discrimination.
- To make recommendations on how best HIV/AIDS related stigma and discrimination can be mitigated.

### **3.5 Research approach**

Research can be conducted either by employing qualitative or quantitative approaches depending on the desired end results that is envisaged to achieve. Due to the sensitive nature of the topic, it was decided a qualitative approach will be appropriate.

Qualitative research seeks to answer certain questions, to explore issues and to understand phenomena from the perspective of the research participant. It answers all the questions beginning with: why, how and in what way? Qualitative research tries to answer given questions by focusing on the local population it affects, gathering perspectives and insights by conducting interview and surveys. It analyses unstructured information. Unlike quantitative research, qualitative research does not rely on statistics or numbers. Qualitative research is used to gain insight into people's attitudes, behaviours, value systems, concerns, motivations, aspirations culture or lifestyles. It emphasises the importance of looking at variables in the natural setting in which they are found. Detailed data is gathered through open ended questions that provide direct quotations. Qualitative research seeks to do all this by using naturalistic methods which are interviews, observations and ethnography and focus group discussions. Qualitative research uses the natural settings which mean "the lived experiences of real people in real setting are the objects of the study. Understanding how individuals make sense of their everyday lives is the stuff of this inquiry" (Amos 2002: 8). These methods allow the researcher to qualify the participants' understanding during the research process through further probing questions. Qualitative research is used to learn about the naturally occurring routines, interactions and practices of a particular group of people in their social environment.

### **3.6 Advantages of qualitative research**

Qualitative research produces more in depth and comprehensive information. It uses subjective information and participant observation to describe the context. Qualitative research also provides a wide range of ways to analyse data. The quality of group experience is also revealed in a way other forms of research do not deliver. It also gives the researcher the freedom to allow the study to unfold naturally. The researcher also gains more detailed and rich data in the form of comprehensive written description. Complex questions are examined which can be impossible with quantitative methods. Qualitative research gives the researcher the room to explore new areas of research and an opportunity to brainstorm possible solutions.

### **3.7 Disadvantages of qualitative research**

It can be difficult to prevent or detect researcher induced bias in qualitative research; the researchers can interpret the research findings according to their biased view. Conducting qualitative research is also time-consuming, “qualitative research takes longer to conduct because of open-ended questions” (Harland, 2001: 31). Its scope is also limited due to the in-depth, comprehensive data gathering approaches required. Open ended question can sometimes create lots of data which can take a longer time to analyse.

### **3.8 Gathering information**

Data collection is a crucial step in every research study. Inaccurate data collection can affect the results of the study and ultimately lead to invalid results. Data gathering plays an important part in impact evaluation by providing information useful to understand the processes behind observed results and assess changes in people’s perceptions of their well-being. Qualitative data collection requires the interpretation of the information gathered most often without the benefit of statistical support. The researcher has to be well versed in interpreting the respondents’ comments in order to get high quality and reliable information. The process of data gathering is all about identifying participants and sites, gain access, determine the type of data to be gathered, develop data collection forms and administer the process in an ethical manner. Data collection approaches for qualitative research “usually involve direct interaction with individuals on a one on one basis or a direct interaction with individuals in a group setting” (Hancock, 2002:9). The main methods for collecting data are individual interviews focus group discussion and observations.

The primary method that will be used to collect data is individual interviews. People will be interviewed who are living openly with HIV/AIDS.

Interviews are useful for getting the participant experience. The researcher can pursue in-depth information around the topic and has the opportunity to probe or ask follow up questions. A questionnaire was used to ensure that same general areas of information are gathered from each interviewee. Two focus discussions will also be conducted as a follow up to what the researcher will have gathered during the individual interviews. A focus group discussion is a data collection method in which a small group of participants gather to discuss a certain topic. A focus group discussion is a rapid assessment in which participants are selected to discuss issues that give an answer to the research question. A focus group discussion guide was developed which listed the main topics or themes to be covered while allowing respondents to talk freely and spontaneously. All questions were open-ended, simple, unbiased and non-threatening. The data collection guide also allowed the flexibility to pursue unanticipated yet relevant issues that may be generated during the discussion. "The process of conducting a Focus Group Discussion involves formulating research questions, developing protocols, soliciting participants, arranging venues, facilitating focus groups, transcribing, analysing data and reporting the findings" (Wong, 2008:256).

### **3.9 Sample selection**

It is usually not possible to include the entire population in a study as this is mainly because of time, costs and sheer number of subjects. Researchers therefore select a sample which is a subset of the total population to represent the entire population. Sampling is used where the population is fairly large and only a portion can be included in the study. "Sampling is simply stated as selecting a portion of the population in your research area which will be a representation of the whole population" (Landreneau, 2004:1). Sampling is the process of data collection when the population is large for the study. It is when units are selected from a population of interest so that by studying the sample the results can be generalised back to the population from which they were chosen. The main types of sampling are non-probability and probability sampling. Probability sampling involves a selection in which each unit has an equal chance of being selected. Types of probability sampling are simple random, stratified random, cluster and systematic. Non-probability sampling is when the units are selected by non-random methods; they are selected according to certain

characteristics that are desired by the researcher. Types of non-probability sampling are convenience, quota and purposive sampling. In any study, the sample that is chosen is critical to the overall research process. The main advantages of sampling are it involves a smaller number of units which saves on time and cost, sampling can produce more accurate results because the researcher has a lot more control over the units and that it is easier to avoid human error when inputting and analysing data in smaller data sets. The limitation of sampling is there is room for potential bias in the selection of suitable subjects for the research; the researcher can select subjects that are more likely to give the desired results or the subjects can select themselves.

The purposive sampling method was used to select the participants. Purposive sampling is when the choice is to access a particular subset of people such as the present study wants to extract information from people who are living with HIV/AIDS. A purposive sampling starts with a purpose in mind. The sample is therefore selected to include the people of interest and leave out those who do not suit the purpose. It targets a particular group of people with certain characteristics. The selected people must be able to give an answer(s) to the research question. Two groups of participants, the first one was made up female participants only while the other one was made up of males. Both groups consisted of people who are openly living with HIV/AIDS. These will be selected from Batanai, an organisation that supports people who are openly living with HIV/AIDS in Masvingo (Zimbabwe). Table 4.1 represent the profile of the participants who participated in the individual interviews.

**Table 4.1**  
**Profile of participants**

<b>RESPONDENT NUMBER</b>	<b>SEX</b>	<b>AGE IN YEARS</b>	<b>MARITAL STATUS</b>	<b>HIGHEST LEVEL OF EDUCATION</b>	<b>EMPLOYMENT STATUS</b>
1	M	29	SINGLE	ORDINARY LEVEL	SELF EMPLOYED
2	F	35	DIVORCED	JUNIOR LEVEL	UNEMPLOYED

3	M	47	MARRIED	PRIMARY LEVEL	UNEMPLOYED
4	M	38	MARRIED	ORDINARY LEVEL	EMPLOYED
5	F	33	SINGLE	ADVANCED LEVEL	EMPLOYED
6	M	27	SINGLE	UNIVERSITY LEVEL	EMPLOYED
7	F	51	WIDOWED	PRIMARY LEVEL	UNEMPLOYED
8	F	35	MARRIED	UNIVERSITY LEVEL	EMPLOYED
9	F	58	WIDOWED	JUNIOR LEVEL	SELF EMPLOYED
10	M	62	MARRIED	PRIMARY LEVEL	UNEMPLOYED
11	F	40	SINGLE	ORDINARY LEVEL	SELF EMPLOYED
12	M	46	MARRIED	ADVANCED LEVEL	EMPLOYED
13	M	37	SINGLE	ORDINARY LEVEL	SELF EMPLOYED
14	F	28	SINGLE	UNIVERSITY LEVEL	EMPLOYED
15	F	49	MARRIED	ORDINARY LEVEL	UNEMPLOYED

### 3.10 Ethical considerations

Research ethics is a set of rules or guidelines governing researchers to move in acceptable directions within limits of freedom. In research ethics are basically concerned about what is acceptable and what is unacceptable. Issues in research ethics usually involve those that

concern moral issues. Researches that involve human subjects or participants raise unique ethical issues. Research ethics is all about the analysis of ethical issues that are raised when people are involved as participants in the research. “The first and the broadest objective in research ethics is to protect human participants. The second objective is to ensure that research is conducted in a way that serves interests of individuals, group and or society as a whole” (Walton, 2008:66). The well-being of the research participants must always be a top priority for all researchers. Researchers must have respect for research participants, researchers must always minimise risk and maximise benefits to the research participants (beneficence), there always should be a fair distribution of the risks and benefits resulting from the research (justice) and the researcher must also respect the community; its values and interests. The ethical principles that various codes in research ethics are: “Honesty, objectivity, carefulness, openness, confidentiality, respect for colleagues, social responsibility, non-discrimination, competence, legality and human subject protection” (Resnik, 2011:3). There must also be an informed consent from the research participants which means that the researcher must ensure that people understand what it means to participate in a particular research study and that they make a conscious decision on whether they want to participate or not. All the information should include confidentially and be protected in a secure environment.

“The consent of the focus group discussion participants is always required. Every participant has the right to refuse to participate in the focus group discussion or to stop his or her participation any time” (Chidi, 2010:3). Before conducting the research consent was obtained from the participants and their permission to have the discussion recorded. The group of participants consisted of both males and females of various age groups and all walks of life. An appropriate venue was chosen where the discussions could take place that is easily accessible to all participants.

The whole discussion was recorded and the common themes were identified. This helped in summarizing the narrative data. The emphasis was on the stated experiences of the participants and on the stated meanings they attach to themselves, to other people and their environment.

### **3.11 Conclusion**

The research methodology has been done appropriately; results will be drawn from what the researcher will have gathered from the participants.

## CHAPTER 4

### RESEARCH FINDINGS

#### 4.1 Introduction

The research findings presented a depressing picture of the situation in the Masvingo District of Zimbabwe. Stigma and discrimination have been found to pervade all spheres of life from home, to the workplace, the health facilities as well as in the community at large. Stigma and discrimination tend to be internalised by people living with HIV/AIDS and can cause serious consequences on their emotional and physical well-being. This chapter dwells on the major findings and interpretations based on the focus group discussions and the individual interviews that were carried out using a structured questionnaire and focus group discussion guide.

The objective of research is to solve a problem and it is a guide of the direction that should be taken to produce an answer. The problem statement for this project is thus: How does stigma and discrimination manifests itself among people living with HIV/AIDS and what are the consequences on HIV/AIDS prevention and treatment efforts?

#### 4.2 Objectives of the study

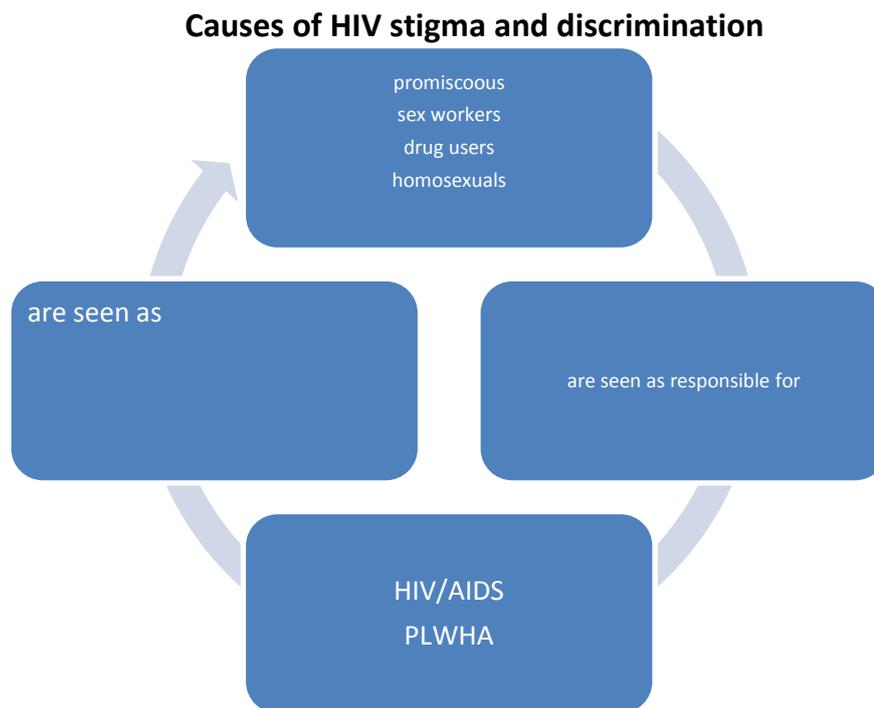
The following objectives have been formulated to guide the study towards finding answers:

- To establish the forms of stigma and discrimination that people with HIV/AIDS are subjected to.
- To establish how stigma and discrimination poses obstacles to HIV/AIDS prevention and treatment efforts.
- To determine the strategies and practical actions to challenge and reduce HIV/AIDS related stigma and discrimination.
- To make recommendations on how best HIV/AIDS related stigma and discrimination can be mitigated.

#### 4.3 Causes of HIV stigma and discrimination

Figure 4.1 show a model depicting the findings of the research study. Reasons were given to support that HIV is a life threatening disease and people therefore react to it in strong ways.

**Figure 4.1**



It is also associated with behaviours such as promiscuity that are already stigmatized in many societies. Most people become infected through sexual intercourse and this often carries a moral baggage. It was also established people are not well informed about how HIV/AIDS is transmitted and this creates irrational behaviour and misperceptions of personal risk. HIV infection is often thought to be the result of personal irresponsibility. Because of religious and moral beliefs, some people believe being infected with HIV is the result of moral fault such as promiscuity and that deserves to be punished.

#### **4.4 Forms of HIV/AIDS stigma and discrimination**

Social responses fears and denial have accompanied the HIV/AIDS epidemic. Stigma is a powerful tool of social control. Stigma and discrimination that is HIV/AIDS related is expressed in different forms. However, this research study focused on those that were observed to be the most prevalent, participants living with HIV/AIDS shared their experiences of what it is like for them to live with the disease.

#### **4.4.1 Isolation**

One of the expressions of stigma and discrimination found in the research is the isolation of people living with HIV/AIDS and sometimes their close family members. According to the participants of the focus group discussions isolation is the pre-dominant reaction to HIV. Stigma is being used to marginalize and exclude people who are living with HIV/AIDS. Cautiousness from fear of infection also leads people to prevent their children from having contact with those known to be living with HIV/AIDS. Also due to fear of infection some family members of those living with HIV/AIDS try to prevent them from doing casual housework such as preparing food for the family. If a person has HIV it is also assumed the person is already dead therefore cannot take part in any decision making process of the family. It was also gathered that for some, specific eating utensils were designated to them when their families discovered that they were HIV positive, this isolates and makes PLWA very vulnerable. These actions and manner in which they are treated results in their loss of power and respect in the community.

#### **4.4.2 Gossip, name calling and insults**

Participants from the focus group discussions and respondents to the individual interviews highlighted gossip, verbal harassment or ridicule and ostracism as frequent community responses to HIV. Participants used words such as “shunned” to describe the community response. It was unveiled when one’s positive HIV status gets to be known by people, they will talk around as HIV is viewed as a near death illness. Consequently, people living with HIV have particular fears about disclosure and knowing whom to trust. There is silence around HIV because of gossip. One participant explained about how gossip creates a situation in which people will not disclose their status to anyone.

#### **4.4.3 Judging, blaming and condemnation**

Sexual intercourse is the main vehicle through which HIV is transmitted; many have been blamed of being promiscuous and their being HIV positive is “punishment” for the immoral behaviour.

#### **4.4.4 Loss of employment**

The research brought to light of some cases where HIV positive people lost their jobs when their status was revealed. Some were denied opportunities such as on the job training

because they were believed to be dying soon. Still in the workplace some PLWHA have been denied promotions because of their status.

#### **4.5 Contexts of stigma and discrimination**

The environment that is fertile for cultivating stigma and discrimination vary from households, workplace, health facilities and religious institutions and at community level.

##### **4.5.1 HIV/AIDS stigma and discrimination at household level**

It is expected of families to be supportive to family members who are ill. The family has an important role in providing care and support to people living with HIV/AIDS. However, the data gathered from this particular research of non-supportive household response to HIV positive people, not all families' response was positive. Respondents who took part in the individual interviews indicated when they shared their HIV status with their families they were subjected to different forms of discrimination which range from being denied to share kitchen utensils to being blamed for being promiscuous. Others were even asked to move out of the family house. The information gathered indicated family responses to infected relatives are heavily influenced by the community perceptions of the disease. Families that include HIV positive people may fear isolation and ostracism within the community. HIV/AIDS is believed to be a disease that brings shame and embarrassment to the family and the family avoids members with HIV. Consequently, they may try to conceal an HIV diagnosis which in turn may cause considerable stress and depression within the family.

##### **4.5.2 HIV/AIDS stigma and discrimination at the workplace**

People who are HIV positive and those suspected to be positively infected are subjected to HIV related stigma at some workplaces. It was gathered from both the focus group discussions and the individual interviews that some people have lost their jobs; some were subjected to emotional and physical isolation while some were denied employment because of their known HIV status. Some participants highlighted they were denied career development opportunities since they were believed to be dying soon. Negative interactions such as unjust hiring and firing, unfair payment, limited employment security and unfair promotion manifest HIV/AIDS stigma and discrimination.

#### **4.5.3 HIV/AIDS stigma and discrimination at health facilities**

It was also established negative attitudes from health care workers generated fear among people living with HIV/AIDS. As a result many keep their HIV status a secret fearing for still worse treatment. The research also discovered related fear and anxiety and at times denial of their status can be traced back to traumatic experiences in health care settings. Discrimination in the health settings include the tendency of neglecting patients, the habit of testing without consent and breaches of confidentiality. The study helped to bring to light several instances of confidentiality breaches affecting people living with HIV/AIDS.

#### **4.5.4 HIV/AIDS stigma and discrimination in religious institutions**

The research also unveiled that some religious leaders are the ones who re-enforce HIV/AIDS related stigma and discrimination. They have used their power to instigate stigma and discrimination rather than to challenge negative attitudes towards people living with HIV/AIDS. Religious leaders believe those who are HIV positive have sinned and they deserve their “punishment”. The moral dimension of HIV stigma and discrimination relates to up until the present time, HIV/AIDS has been strongly linked to sex work which in turn is considered to be evil; increases stigma and discrimination that is associated with HIV/AIDS.

#### **4.5.5 HIV/AIDS stigma and discrimination at community level**

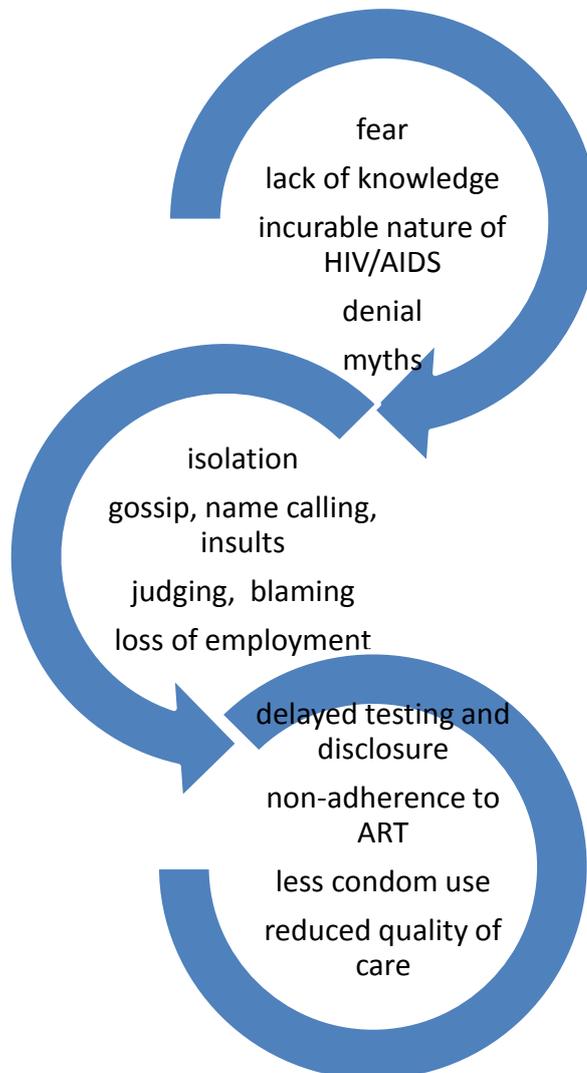
Participants indicated that HIV/AIDS stigma and discrimination in this particular community is commonly manifested in the form of blame, scapegoating and punishment. Those who are perceived to be HIV positive are always shunned by the community. Participants mentioned gossip, verbal harassment or ridicule and ostracism as frequent community responses to HIV. As a result, people living with HIV/AIDS have particular fears about disclosure and knowing whom to trust. The study confirmed HIV/AIDS is perceived as the result of personal irresponsibility and people living with HIV/AIDS are blamed for contracting the infection. It was also discovered the community believes HIV/AIDS brings shame to the community. This has influenced ways in which the community responds to HIV/AIDS and the ways in which stigma and discrimination are manifested. The Masvingo District of Zimbabwe has strong cultural beliefs and explanation about diseases and the causes and this contribute to HIV/AIDS stigma and discrimination.

#### 4.6 Effects of stigma and discrimination on HIV/AIDS prevention and treatment

The research confirmed HIV stigma and discrimination adversely affect every aspect of life for people living with HIV/AIDS and their families. HIV diagnosis was found to be devastating as the illness itself can lead to job loss, social ostracism and denial of emotional support. PLWHA live in fear are less likely to adopt preventative behaviour, go for testing, disclose their HIV status to others, access care and adhere to treatment (figure 4.2).

**Figure 4.2**

**The causes and forms of HIV stigma and how they affect HIV prevention and treatment**



#### **4.6.1 Stigma and discrimination undermines HIV prevention**

Figure 4.2 shows the causes and forms of HIV stigma and how they affect HIV prevention and treatment. This study established that stigma and discrimination has fuelled the transmission of HIV and has increased the negative impact associated with the epidemic. HIV related stigma and discrimination continue to be manifest in Masvingo District creating major barriers to preventing further infection, alleviating impact and providing adequate care, support and treatment. Participants highlighted that stigma and discrimination can reduce the likelihood of people using condoms and accessing services such as educational meetings and counselling. There were responses indicating people who hold stigmatizing attitudes are also less likely to adopt preventive behaviours. Stigma and discrimination discourages people from testing and seeking information on how to protect themselves and others thus deepening the impact of living with HIV/AIDS. PLWHA may choose not to access prevention and education services for fear of being stigmatized. Some participants in the focus groups and individuals involved in the interviews asserted by disclosing their HIV status or using condoms may bring partner rejection, limit sexual opportunities and sexual violence. HIV prevention services are no longer offered in a variety of settings because of stigma and discrimination. While it is widely accepted that HIV prevention should be integrated into broader health and community context, many community venues in Masvingo District have resisted incorporating frank discussions about HIV.

As illustrated in Figure 4.2, the study found stigma and discrimination undermine HIV prevention efforts by making people afraid to find out whether they are infected or not, to seek out information about how to reduce their risk of exposure of the disease and to change their behaviour to more safe behaviour lest this raise suspicion about their status. Stigma and discrimination was therefore seen to undermine the ability of individuals and the community to provide protection.

#### **4.6.2 Stigma and discrimination undermine HIV treatment**

ART requires strict adherence for effectiveness and adherence is the strongest determinant of patient survival. In Masvingo District fear of stigma had led people to grind drugs into powder which can result in inconsistent doses. It was also established stigma and discrimination affects mental health and depression interferes with consistent drug use. The study also showed stigma and discrimination is a barrier to effective HIV treatment

programs because it results in the low uptake of and poor adherence to treatment services. The need for secrecy about HIV status was also seen to affect people's access to the life-saving drug and adherence. Experiences of social rejection, disapproval and discrimination related to HIV was said to be decreasing the motivation of HIV positive people to stay healthy. This study found those who had experienced stigma were also likely to miss HIV clinic appointments and lapse in adherence to their medication.

Participants of the focus group discussions and those with the individual interviews added stigma and discrimination delays treatment and reduce survival thereby leading to a delayed diagnosis. People who begin ART in the earlier stages of HIV have longer life expectancy than those who wait until the disease is more advanced. Stigma therefore increases the risk of death among patients who do not start ART early. There is evidence from the study that stigma and discrimination prevent barriers to good adherence of ART.

#### **4.6.3 Delayed testing and disclosure**

The study also found stigma and discrimination causes delayed testing and prevents disclosure of an HIV positive status to partners, providers and family members. As a result, this deters behaviours that can prevent further spread of HIV such as condom use. It was established the main barriers to disclosure are fear of infidelity accusations, abandonment, discrimination and partner violence. PLWHA in Masvingo are no longer making use of the available voluntary testing and counselling centres because of stigma and discrimination.

#### **4.6.4 Reduced quality of care**

Participants also highlighted stigma and discrimination affects use of health services. Some participants had their status disclosed and they have since decided not to use available health facilities anymore.

#### **4.7 Strategies to reduce HIV/AIDS stigma and discrimination**

Participants of the focus group discussions and respondents of the individual interviews were further asked what they feel should be done to reduce HIV/AIDS stigma and discrimination. It was then suggested strategies to combat HIV stigma and discrimination should include interventions for individuals and that will create awareness of what stigma is, address fears and attitudes for the individual and the benefits if reducing stigma. It was also gathered there should be interventions at community level that meet the need for

information and training as well as structural interventions that address laws and policies. The study also established that interventions must address the drivers of stigma and discrimination by creating awareness, deepening understanding of HIV transmission to address fears of casual contact and address social driven stigma and discrimination. Participants also suggested once these strategies have been put in place, there should be a system to monitor their effectiveness.

#### **4.8 Conclusion**

Please just write a swan song here for the chapter

The study established that HIV/AIDS is not a straight forward phenomenon as attitudes towards the epidemic and those affected vary massively. Reactions to HIV/AIDS vary between individuals and groups of people. AIDS related stigma and discrimination changes over time as infection levels, knowledge of the disease and treatment availability vary.

Stigma and discrimination are major obstacles of effective HIV/AIDS prevention and treatment in the Masvingo District of Zimbabwe. HIV/AIDS related stigma and the resulting discriminatory attitudes create an environment that fuels the epidemic. Stigma of the disease is based on socially shared ignorance, fear and misinformation. This is particularly more intense in this part of Zimbabwe where a combination of arguably poor health systems is entangled with poor legal and ethical framework. The role of stigma and discrimination has been seen to be that of being a barrier to all the essential components that make up a good prevention and treatment programs.

## CHAPTER 5

### CONCLUSIONS AND RECOMMENDATIONS

#### 5.1 Introduction

The findings of the research indicated stigma and discrimination undermines the ability of individuals to protect them which increases everyone's vulnerability. Recommendations are ultimately a culmination of information derived from eliciting responses from participants in a project. The aim of the research was to determine how can the impact of HIV related stigma and discrimination be addressed.

The objective of research is to solve a problem and it is a guide of the direction that should be taken to produce an answer. The problem statement for this project is thus: How does stigma and discrimination manifests itself among people living with HIV/AIDS and what are the consequences on HIV/AIDS prevention and treatment efforts?

#### 5.2 Discussion

The research aimed at unveiling HIV/AIDS related stigma and discrimination perpetrated on people living with HIV/AIDS and the effects of stigma and discrimination on HIV/AIDS prevention and treatment efforts in order to minimize HIV/AIDS related stigma and discrimination.

The study has confirmed there is a strong link according the objective of how stigma and discrimination poses obstacles to HIV/AIDS prevention and treatment.

#### **Objective one:**

**To establish the forms of stigma and discrimination that people with HIV/AIDS are subjected to.**

Stigma and discrimination are a daily reality to people living with HIV/AIDS. Stigma and discrimination has a negative impact on prevention, care and treatment of HIV/AIDS. The study therefore sought to establish the forms of stigma and discrimination that people living with HIV/AIDS are subjected to in their daily lives.

#### **Objective two:**

**To establish how stigma and discrimination poses obstacles to HIV/AIDS prevention and treatment efforts.**

There was a focus on how stigma and discrimination poses obstacles to HIV/AIDS prevention and treatment. HIV/AIDS stigma and discrimination increase people's vulnerability, isolate them, deprive them of their human rights, care and support and worsen the impact of the infection. The study also sought to establish how stigma and discrimination creates an environment that fosters the spread of the epidemic

**Objective three:**

**To determine the strategies and practical actions to challenge and reduce HIV/AIDS related stigma and discrimination.**

There are different forms of HIV related stigma and discrimination and these forms occur in various contexts. Strategies and practical actions can be employed to challenge and reduce the impact of HIV stigma and discrimination. Recommendations on how best HIV/AIDS related stigma and discrimination can be mitigated are the ultimate step to complete a process of research.

**5.3 Recommendations**

**Objective four:**

**To make recommendations on how best HIV/AIDS related stigma and discrimination can be mitigated.**

The ultimate contribution research can make to the body of knowledge is to provide recommendation to pave the way for the future by addressing the multi-dimensional results of stigma and discrimination. The following are the recommendations that are proposed;

- There is need for the Government of Zimbabwe to introduce policies to strengthen and re-enforce national action frameworks that embrace the principle of equal rights for people living with HIV/AIDS. While it is important to protect people living with HIV/AIDS through the law, this must also be backed by other measures.
- There is also a need to identify ways to ensure frequent and regular provision of HIV/AIDS related information and to dispel myths, fears and anxieties on various issues related to HIV/AIDS.
- The role of people living with HIV/AIDS in developing and implementing strategies for reducing HIV/AIDS related stigma and discrimination should be promoted.

Activities which give people living with HIV/AIDS a platform to make their voices heard must therefore be identified.

- The Government of Zimbabwe must also network with people living with HIV/AIDS to help them increase self-confidence and enhance the self-image of people living with HIV/AIDS.
- Mainstreaming HIV/AIDS in the workplace to provide employees with information and education to raise awareness of HIV/AIDS related stigma and discrimination.
- Sanctions for health workers who do not comply with the codes of conduct and policies must be put in place.
- There is also a need for future research assessing the progress and impact of intervention of stigma and discrimination reduction. It is also essential to adopt tools and indicators to measure stigma and discrimination.

#### **5.4 Recommendations to the limitations of the study**

The limitations of the study identified most of the respondents were busy with various income generating activities and found it difficult to set aside time to participate. It is recommended there is community sensitization to be conducted before the research commences so that the respondents are available to participate without interruptions.

#### **5.5 Conclusion**

Stigma and discrimination is often motivated by the need to blame, fear and accept ignorance from others. Negative attitudes about HIV/AIDS have created an environment in which people become more afraid of stigma and discrimination associated with HIV/AIDS than HIV/AIDS itself. Fear and discrimination have been in the fore front in such a way that people have chosen not to look at the possibility that they too can be infected. It is only when and only when we confront stigma and discrimination that the war against HIV/AIDS can be won. The solution to HIV/AIDS stigma and discrimination lies in the hands of individuals; everyone should fight fear, process shame, accept ignorance and appeal to injustice surrounding the HIV/AIDS epidemic. Stigma and discrimination will continue to exist as long as societies as a whole have a poor understanding of HIV/AIDS and the pain and suffering caused by discriminatory practices. A more accommodative and educational environment needs to be created to increase the visibility of people with HIV/AIDS as a 'normal' part of any society.

AIDS related stigma poses a problem in the Masvingo District of Zimbabwe, imposing severe hardships on people who are its targets and this ultimately interferes with treatment and prevention of HIV. The development of effective healing responses to HIV/AIDS has been limited by stigma and discrimination. Stigma and discrimination fosters the growth of the epidemic as prevention efforts are undermined due to people's reluctance to get tested and unsafe and risky behavioural patterns are perpetuated. Shame and secrecy also works against the adherence of ART.

Emphasis on the eradication of AIDS related stigma and discrimination would assist in creating a social climate conducive to a rational, effective and compassionate response to the epidemic.

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## APPENDIX A

### Questionnaire on Stigma and Discrimination on people living with HIV/AIDS

#### Introduction

My name is **Sheila Chipangura**. I am doing an **MPhil in HIV/AIDS Management** at **Stellenbosch University**. I am supposed to do a research study on chosen topic area as part of the requirements for my studies. I have chosen Batanai Support Group so that I can interview people who are openly living with HIV/AIDS. The main objectives of the study are to establish the forms of stigma that are perpetrated on people living with HIV/AIDS and to also establish the possible interventions that can be put in place to reduce or mitigate HIV/AIDS related stigma. Therefore your honest and genuine participation by responding to the prepared questions is highly appreciated.

#### Confidentiality

Some of the questions that I am going to ask you are very personal; all your responses will therefore be confidential. Your name will not be written on this form and will never be used in connection with what you are going to tell me today. You are allowed to stop your participation whenever you feel. It will take 30-45 minutes to complete the questionnaire. Your honest participation is greatly appreciated.

#### PERSONAL INFORMATION

Date:

1. Respondent's sex.    Male      
                                         Female
2. What is your marital status? Single      
                                         Married      
                                         Widowed      
                                         Divorced
3. How old are you? \_\_\_\_\_ years old.
4. What is the highest level of education that you have completed?  
                                         No formal education

- Primary level
- Secondary level
- Post-secondary qualification

5. Are you employed? Yes
- No

6. Who do you live with? With family
- With friends
- Alone
- Other specify \_\_\_\_\_

#### **DISCLOSURE**

1. When did you know about your HIV status?
2. How old were you when you got to know about your HIV status?
3. What was the reason(s) for going for an HIV test?
4. Why did you make a choice of disclosing your status?
5. Do you know of any facility offering HIV testing and counselling to people who live around you?

#### **STIGMA AND DISCRIMINATION**

1. How do you define HIV/AIDS related stigma and discrimination?
2. What are the main causes of HIV/AIDS related stigma and discrimination?
3. What are the forms of stigma and discrimination that you have been subjected to because of your HIV status?
4. In what context do the forms of HIV/AIDS related stigma and discrimination occur? (please share your experiences if any)
5. Do you see any relationship between stigma and discrimination and HIV prevention and treatment efforts?

6. What do you think can be done to reduce or to mitigate HIV/AIDS related stigma and discrimination?

**THANK YOU FOR PARTICIPATING IN THIS INTERVIEW**

**APPENDIX B**

**FOCUS GROUP DISCUSSION GUIDE FOR HIV/AIDS RELATED STIGMA AND DISCRIMINATION  
BATANAI SUPPORT GROUP IN MASVINGO, ZIMBABWE.**

Good morning/afternoon/evening. My name is **Sheila Chipangura**. I am doing my studies at **Stellenbosch University** and part of my study requires me to do a focus group discussion. With me here is **Julius Kamera** my colleague who will be helping in taking notes so that we don't forget some of the important issues that are going to come out of this discussion. The main objectives of the study are to unveil the forms of stigma and discrimination that people who are living with HIV/AIDS are subjected to and the possible interventions that can be put in place to reduce this.

Our discussion is going to take about 45minutes.

I will help to guide the discussion and to make sure that everyone has a chance to speak. My friend will be recording the whole discussion but no names are going recorded so your name will never be used in connection with this discussion so this discussion is confidential. I value everyone's contribution and I will appreciate it if we speak one at a time so that we can all hear what everyone has to say.

**FOCUS GROUP DISCUSSION PARTICIPANTS' PROFILE**

NO	SEX	AGE	MARITAL STATUS	HIGHEST LEVEL OF EDUCATION COMPLETED	EMPLOYMENT STATUS
1					
2					
3					
4					
5					
6					
7					
8					
9					

10					
11					
12					
13					
14					
15					

1. What was the reason(s) for going for an HIV test?
2. Why did you make a choice of disclosing your status
3. Do you know of any facility offering testing and counselling services around you?

*Probe: distance from where they stay, attitude of health workers, efficiency, confidentiality issues*

4. What do you understand by “HIV/AIDS related stigma and discrimination”?

*Probe: the difference between stigma and discrimination*

5. What are the forms of stigma and discrimination that people who are living with HIV/AIDS are subjected to?

*Probe: share personal experiences*

6. In what context do these forms of stigma occur?

*Probe: who stigmatises people living with HIV/AIDS and where does this happen*

7. In your opinion, do you think HIV/AIDS related stigma has posed obstacles in HIV/AIDS prevention and treatment efforts?

*Probe: share personal experiences*

8. What do you think can be done to reduce HIV/AIDS related stigma and discrimination?

*Probe: are there any interventions already in place, what can be done differently to win this war?*

**THANK YOU FOR PARTICIPATING IN THIS DISCUSSION.**