

**THE NEED FOR POSITIVE LIVING AMONG PEOPLE LIVING WITH HIV.  
A CASE STUDY OF HARARE'S HATCLIFFE EXTENSION SUBURB.**

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## ABSTRACT

The purpose of this study is premised on the basis that in the absence of a cure for the Human Immunodeficiency Virus (HIV) the emphasis is on living positively with HIV, a term used to describe leading a normal, non-risky life while following preventive and supportive measures to live longer though infected with HIV. This study aimed at assessing the nature and scope of services available to People Living With HIV (PLWH) in Hatcliffe Extension Suburb, to identify and profile hindrance factors that prevent PLWH to access the above referred services and live positively in general. The study also aimed at proposing solutions to identified challenges faced by PLWH in their quest to living positively. The research methodology was qualitative and purely exploratory involving 54 participants. 50 of them were PLWH while the other 4 were key informants. Four (4) Focus Group Discussions (FGDs) were conducted; in-depth interviews were used with key informants and case studies for participants who were sampled from the FGDs. The study focused on just one suburban setting with a cohesive support group network while the participants were purposively selected. The research findings revealed that there is in existence some infrastructure to cushion PLWH. These include free Voluntary Counseling and Testing (VCT) services, existence of the National AIDS Council (NAC) among others. It also emerged from the results of the study that PLWH were aware of the need for positive living and were consciously and actively pursuing it. However, their efforts were being hampered by an array of social, economic, cultural and structural challenges. Chief among them were stigma, lack of income to access good nutrition, culturally driven women sexual disempowerment and the bottlenecks that were encountered in early access to anti-retroviral therapy and other related medical services. The study concluded that in order to ensure the full realization of positive living by PLWH, there is need to address the barriers to positive living. It was recommended that service providers as well as media practitioners should highlight how some cultural beliefs and behaviors contribute in complicating life for PLWH. The study also recommended that organizations which cater for PLWH together with all the relevant stakeholders should aim to address the challenges to positive living. Dissemination of information should be tailor made to address how different age groups and sexes should live positively considering their unique challenges.

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Last but not least I would want to express my indebtedness to my wife Loi whose nagging persistence urged me on to complete this Dissertation.

### **Dedication:**

This Dissertation is dedicated to our dear daughter, Blessing (Jr.) Roberta Chikomborero a little angel who has prevailed against all odds. She has taught me that life is a gift and that with consistent determination no battle is insurmountable.

## **Acronyms:**

AIDS	Acquired Immuno Deficiency Syndrome
ART	Anti Retroviral Therapy
ARVs	Anti Retroviral Drugs
BCC	Behavior Change Communication
CBO	Community Based Organizations
DAAC	District AIDS Action Committee
FGDs	Focus Group Discussions
HIV	Human Immuno- Deficiency Virus
KIs	Key Informants
MOHCW	Ministry of Health and Child Welfare
MSM	Men who have Sex with Men
NAC	National AIDS Council
NACP	National AIDS Coordination Programme
NGOs	Non-Governmental Organizations
PITC	Provider Initiated Testing and Counseling
PLWH	People Living With HIV
PPTCT	Prevention of Parent to Child Transmission
PSI	Population Services International
STDs	Sexually Transmitted Diseases
SWs	Sex Workers
TB	Tuberculosis
UNAIDS	United Nations AIDS Programme
VCT	Voluntary Counseling and Testing

WAAC

Ward AIDS Action Committee

WHO

World Health Organization

ZNNP+

Zimbabwe National Network of People  
living with HIV

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## **CHAPTER ONE**

### **BACKGROUND TO THE STUDY**

#### **1.0 Introduction:**

This chapter presents a brief overview of the study. A background to the study is provided, the chapter also highlights the aim, objectives, justification of the study and also states the problem that the study seeks to investigate and attempt to provide answers for.

#### **1.1 Background information of the Study**

The HIV and AIDS epidemic continues to surpass efforts to contain it, eroding gains in all sectors of development such as health, education, food security and quality of life for most countries the world over (SADC 2007). The UNAIDS (2008) estimates the world to be experiencing over 2.7 million new infections annually. Sub Saharan Africa is reported to be bearing 68% of the burden of these infections. Over 33.2 million people are believed to be living with HIV globally. 22.5 million of them (67.7%) are reported to be in Sub Saharan Africa (UNAIDS and WHO 2008). UNAIDS (2007) reported the world to be losing 2.1 million people to AIDS-related deaths annually of which 1.6 million (76%) of these are lost to Southern Africa. The socio-economic and human deprivation existent in the African continent is compounded by the negative effects of the epidemic, (Poku 2005).

The following factors have been identified as some of the major drivers of the HIV epidemic in Southern Africa; multiple concurrent partnerships coupled with low use of condoms in these and other forms of long term sexual relationships, low individual self risk perception and lack of male circumcision (SADC 2006 and NAC 2006). The

UNAIDS (2008) argues that concurrent partnerships coupled with high viral load during the acute HIV infection phase may have contributed to the rapid spread and the high prevalence levels of HIV in Southern Africa. Serial casual relationships and sex work, the delayed treatment of Sexually Transmitted Infections (STIs), dry sex vaginal sex practices, early sexual debut among the youths and vertical transmission through mother to child, are among other factors sustaining the epidemic in Zimbabwe and the Southern African region as a whole (SADC 2006).

In Zimbabwe HIV prevalence has been declining due to reasons which include sexual behavior change, greater use of condoms, fear of death following experiences of death of loved or close relatives believed to increase self risk perception among others. According to government figures, the adult prevalence was 23.7% in 2001, and fell to 13, 7% in 2010 (UNGASS 2010). Though encouraging, the current prevalence as well as HIV related mortality is still high.

Some gains made in fighting against HIV and AIDS have been attributed to the introduction of anti retroviral treatment. Mahy (2010) noted the significant progress that has been made in getting millions of people on treatment: between 1995 and 2009, an estimated 14.4 million life years were gained globally, among adults attributable to antiretroviral therapy. In sub-Saharan Africa alone, 2 million life years were gained between 2002 and 2008 (WHO 2008). However, despite these gains, HIV and AIDS related mortality remains unacceptably high. This could be because fewer than half of Africans who need treatment are receiving it; against a background where access to antiretroviral treatment lessens the toll of AIDS (WHO/UNAIDS/UNICEF: 2009). Indeed this raises questions around factors limiting

access to antiretroviral treatment. However, it is important to note that antiretroviral treatment is just one component of the total package of positive living. HIV positive people are expected to adopt positive living in order to effectively fight against the deadly effects of HIV and AIDS. Some of the components of positive living include: eating a healthy and balanced diet; access to psycho-social support; preventing re-infection through exercising safe/protected sex or abstinence; early treatment of opportunistic infections; exercising to keep the body fit among other recommendations.

## **1.2 Setting of the Study**

Hatcliffe Extension high density suburb is one of a number of settlements that was set up under Operation 'Garikai' (loosely translated to mean an exercise to bring about good living)-the government program that was initiated to resettle those left homeless after a clean-up campaign code named Operation 'Murambatsvina' loosely translated to mean a campaign to get rid of filth. The government started allocating un-serviced stands in Hatcliffe in 2005 in the aftermath of the operation that saw around 700,000 people lose their homes and some ultimately their livelihood (Tibaijuka 2005). Amnesty International (2010) observed that the residents of this suburb are among the poorest and most marginalized people in Zimbabwe. The households totaling around 3 000 epitomize all the socio-economic challenges that bedeviled the country during the last decade. The majority of these households five years down the line still live in what were meant to be temporary shelters. The makeshift structures approximately 5 meters long and 2 meters wide comprise of thick plastic sheet walls and a roof of iron sheets. The innovative ones have partitioned the structures into two tiny rooms using old bed sheets to bring some modest level of decency to their squalid living conditions. A significant proportion of the able-bodied population of the said

settlement is not formally employed and depends on small and erratic income generating initiatives. Like many other residential areas of its nature in Zimbabwe and elsewhere in Sub-Saharan Africa the suburb has not been spared from the HIV and AIDS scourge.

### **1.3 Statement of the problem**

Zimbabwe has experienced a high death rate mainly due to people succumbing to the HIV and AIDS scourge. Between 2002 and 2006 the country's population is estimated to have decreased by four million people, infant mortality doubled since 1990 and the average life expectancy for women who are particularly affected by the Zimbabwe AIDS epidemic is 47 (<http://www.avert.org/aids-zimbabwe.htm>).

This gloomy picture is against a background where the condition has no cure yet. The only available option for PLWH is to adopt positive living which is a package of mitigatory measures that are deemed to prolong the life of PLWH. Such measures entail among others: the treatment of opportunistic infections; avoidance of re-infection mainly through practicing safe sex or abstinence; eating a health and balanced diet; exercising to keep the body fit; living a stress free life through counseling and psycho social support; and adherence to anti retroviral treatment. This has not been effectively implemented against a background where Zimbabwe has faced severe socio-economic and political challenges over the past decade. Resulting in unprecedented unemployment rate of over 90% (GoZ; 2010); deepening poverty with over 80% of the population living below the poverty datum line (World Bank [WBI]; 2007); massive flight of health professionals to foreign countries in search of greener pastures; diminished government capacity to finance public service provision; limited donor assistance to Zimbabwe due to sour political relations with donor

countries among others. This scenario and its attendant challenges are deemed to negatively impact on the efforts by PLWH to live positively. This study therefore attempts to establish how the need for positive living among People Living with HIV (PLWH) is being sustained in the face of such challenges.

#### **1.4 Justification and significance of the study**

In the absence of an HIV cure and limited access to available treatment, the general recommendation is for PLWH to adopt positive living. However, it is important to note that positive living is a whole complex package involving making positive choices to care for one's mental and physical health, having a positive outlook on life and avoiding risky behaviors.

It is therefore important to understand how PLWH maneuver in this complex web and how they fare particularly against a background where a high mortality rate emanating from people succumbing to HIV and AIDS is being experienced in the country. This study is therefore expected to generate valuable information on the feasibility and viability of the adoption of positive living by PLWH in Hatcliffe Extension. Such information might be used to enhance the positive living efforts by PLWH in Hatcliffe Extension and elsewhere depending on relevance. Moreover, information generated from this study will expectantly help to better inform policy makers and other stakeholders that offer support services to PLWH to improve and tailor make their policies and services to the needs of PLWH in their bid to live positively. In addition, information generated from this study may add to the existing body of literature on positive living.

## **1.4 Aim of the study**

This study investigated the challenges faced by PLWH in their quest to live positively.

### **1.4.1 Research Objectives**

1. To assess the nature and scope of services available to PLWH in Hatcliffe Extension.
2. To identify and profile hindrance factors that prevent PLWH from accessing the above referred services and live positively in general.
3. To identify the anticipated possible solutions to challenges faced by respondents.

## **1.5 Limitations of the Study**

Residents of poor communities may be desperate for external monetary and material aid hence the execution of a study of this nature may misleadingly heighten their expectations of material benefits. However, the researcher made it clear to the respondents that the study was not a process towards material provision. Though this clarification may not have completely removed elements of bias amongst the respondents it helped in reducing the extent of bias arising from the ‘expectancy and gratitude effects’.

## **1.6 Delimitations of the Study**

The study drew participants who were HIV positive from Hatcliffe Extension suburb. These participants were supposed to belong to one of the twenty five (25) support groups which catered for people with HIV.

## **1.7 Definition of terms**

**Adherence:** The term means taking medication at the right time and exactly as the prescribed directions state.

**Anti Retroviral Drugs (ARVs):** Treatments for HIV that include three or more drugs. The drugs target different stages of the HIV replication cycle, making the HIV less likely to multiply and mutate.

**Drugs' Side effects:** An often undesirable effect that occurs in association with the use of a particular medication .examples of common drug side effects include nausea, vomiting and dizziness.

**Epidemic:** Affecting or tending to affect a disproportionately large number of individuals within a population, community, or region at the same time

**HIV Positive:** Means having the Human immunodeficiency virus (HIV), a member of the retrovirus family that causes acquired immunodeficiency syndrome (AIDS), a condition in humans in which the immune system begins to fail, leading to life-threatening opportunistic infections.

**HIV Prevalence:** Quantifies the proportion of individuals in a population who have HIV at a specific point in time, usually given as a percentage.

**Lipodystrophy:** A disturbance of fat metabolism in which the subcutaneous fat disappears over some regions of the body, but is unaffected in others.

**Positive living/living positively with HIV:** A term used to describe leading normal, non-risky life while following preventive and supportive measures to live longer though infected with HIV.

**Positive Prevention:** Encompasses the empowerment of people living with HIV to take control of their sexual health as a way of preventing the transmission of HIV and other sexually transmitted infections (STIs);

**Safe sex:** Sexual activity and especially sexual intercourse in which measures such as the use of a condom, are taken to avoid acquiring or spreading a sexually transmitted disease.

**Stigma:** Unfavorable attitudes, beliefs, and policies directed towards people perceived to have HIV and/or AIDS as well as towards their significant others and loved ones, close associates, social groups, and communities.

## **Summary**

Chapter 1 focused on introducing the issue under study. The background to the study helped to contextualise the subject under research. The problem statement outlined the prevailing difficult environment as well as some of the anticipated sources of challenges to positive living. An elaboration of why the issue is worth studying was covered under justification of the study followed by the expected value of the study. Possible limitations to the study were also highlighted and lastly the scope of the study population was addressed in the delimitation section. A definition of the study's key terms was also done in this chapter.

## **CHAPTER TWO**

### **LITERATURE REVIEW:**

#### **2.0 Introduction**

The chapter explores the services available to PLWHA in support of positive living. Some theories to help explain the dynamics of positive living are also discussed under this chapter. In addition, the chapter contains a conceptual framework which outlines some of the possible factors that negatively affect efforts to live positively by PLWHA at a more personal level.

#### **2.1.0 Theoretical Framework of Positive Living**

Three theories were used to explain the concept under study. The Maslow's Hierarchy of Needs, Self Preservation Theory as well the Drive Theory. Each of these would be explained in detail and how it can be used in explaining humans' desire to live as well as the challenges faced by people living with HIV and AIDS in their quest to live positively.

#### **2.1.1 Maslow's Hierarchy of Needs**

Maslow's hierarchy of needs is a theory in psychology, proposed by Abraham Maslow in his 1943 paper "A Theory of Human Motivation" as cited in Robbins, Judge and Vampbell (2010).

Maslow's hierarchy of needs is often portrayed in the shape of a pyramid, with the largest and most fundamental levels of needs at the bottom, and the need for self-actualization at the top. Figure 2 below represents the Maslow's Hierarchy of Needs.

Fig 1: Maslow's Hierarchy of Needs (Adapted from Lahey and Cimineno 1981)



The most fundamental and basic four layers of the pyramid contain what Maslow called "deficiency needs" or "d-needs": esteem, friendship and love, security, and physical needs. With the exception of the most fundamental (physiological) needs, if these "deficiency needs" are not met, the body gives no physical indication but the individual feels anxious and tense. Maslow's theory suggests that the most basic level

of needs must be met before the individual will strongly desire (or focus motivation upon) the secondary or higher level needs.

### **Physiological needs**

For the most part, physiological needs are obvious; they are the literal requirements for human survival. If these requirements are not met, the human body simply cannot continue to function.

Air, water, and food are metabolic requirements for survival in all animals, including humans. Clothing and shelter provide necessary protection from the elements. The intensity of the human sexual instinct is shaped more by sexual competition than maintaining a birth rate adequate to survival of the species.

### **Safety needs**

With their physical needs relatively satisfied, the individual's safety needs take precedence and dominate behavior. In the absence of physical safety, due to terrorist attack, war, natural disaster, or, in cases of family violence, childhood abuse, etc, people (re-)experience post-traumatic stress disorder and trans-generational trauma transfer. In the absence of economic safety, due to economic crisis and lack of work opportunities, these safety needs manifest themselves in such things as a preference for job security, grievance procedures for protecting the individual from unilateral authority, savings accounts, insurance policies, reasonable disability accommodations, and the like.

## **Love and belonging**

After physiological and safety needs are fulfilled, the third layers of human needs are social and involve feelings of belongingness. The absence of this aspect of Maslow's hierarchy, due to hospitalization, neglect, shunning, ostracism etc can impact individual's ability to form and maintain emotionally significant relationships in general, such as friendship, intimacy and family.

Humans need to feel a sense of belonging and acceptance, whether it comes from a large social group, such as clubs, office culture, religious groups, professional organizations, sports teams, gangs, or small social connections (family members, intimate partners, mentors, close colleagues, confidants). They need to love and be loved (sexually and non-sexually) by others. In the absence of these elements, many people become susceptible to loneliness, social anxiety, and clinical depression.

## **Esteem Needs**

All humans have a need to be respected and to have self-esteem and self-respect. Esteem presents the normal human desire to be accepted and valued by others. People need to engage themselves to gain recognition and have an activity or activities that give the person a sense of contribution, to feel self-valued, be it in a profession or hobby. Imbalances at this level can result in low self-esteem or an inferiority complex. People with low self-esteem need respect from others. They may seek fame or glory, which again depends on others.

Most people have a need for a stable self-respect and self-esteem. Maslow noted two versions of esteem needs, a lower one and a higher one. The lower one is the need for the respect of others, the need for status, recognition, fame, prestige, and attention.

The higher one is the need for self-respect, the need for strength, competence, mastery, self-confidence, independence and freedom. The latter one ranks higher because it rests more on inner competence won through experience. Deprivation of these needs can lead to an inferiority complex, weakness and helplessness.

### **Self-actualization**

“What a man can be, he must be.” This forms the basis of the perceived need for self-actualization. This level of need pertains to what a person's full potential is and realizing that potential. Maslow describes this desire as the desire to become more and more what one is, to become everything that one is capable of becoming. This is a broad definition of the need for self-actualization, but when applied to individuals the need is specific. For example one individual may have the strong desire to become an ideal parent, in another it may be expressed athletically, and in another it may be expressed in painting, pictures, or inventions. As mentioned before, in order to reach a clear understanding of this level of need one must first not only achieve the previous needs, physiological, safety, love, and esteem, but master these needs.

### **Maslow's Hierarchy of Needs' Study Applicability**

Maslow's Hierarchy of Needs helps in explaining what motivates one's behavior at any one point in time as well as one's requirements at any one point in time. Living positively for PLWH requires a combination of different aspects which must be combined together and these factors have different levels of motivation for different individuals. According to Maslow, for one to pursue a certain dimension for him/her to live positively, it is a prerequisite that some other needs have to be met first. If these needs are not met first, then positive living is not a priority.

### **2.1.2 Self-Preservation Theory**

This theory was propounded by Chesser in 1968 cited in Robbins et al (2010). Self-preservation is behavior that ensures the survival of an organism. Chesser (1968) defines self preservation as the driving force in all living things. It is universal among living organisms. In some vertebrates, pain and fear are parts of this mechanism. Pain causes discomfort so that the organism is inclined to stop the pain. Fear causes the organism to seek safety and may cause a release of adrenaline, which has the effect of increased strength and heightened senses such as hearing, smell, and sight. Self-preservation may also be interpreted figuratively; in regard to the coping mechanisms one needs to prevent emotional trauma from distorting the mind.

Self preservation is the will to live, the unconscious drive which maintains the struggle for existence at all levels. Self-preservation is keeping oneself alive, either physically or psychologically.

#### **Self Preservation's Study Applicability**

Self preservation theory can be used to explain the drive for life that is expected of people living with HIV and AIDS given the threatening condition that they would be living with. Using this theory, it is expected that PLWH will marshal all their psychological and physical resources to preserve life and self

### **2.1.3 Drive Theory**

The Drive Theory was postulated by Sigmund Freud who argued that the desire to stay alive is an instinctive one, built into the psyche of the organism. Sigmund Freud considered instincts to be basic building blocks of human behavior and play a central

role in his drive theory, which postulates that human behavior is motivated by the desire to reduce the tension caused by unfulfilled instinctive urges or drives. For Freud, the life instinct (Eros) and its components motivate people to stay alive (Atkinson 1987).

Humans are subject to the same stimuli and reactions as any other animal. Hunger, thirst, fear, and exhaustion are physical sensations that cause instinctive physical reactions. Most of these reactions are unpleasant, and people avoid the stimuli that cause them, or, if they are unavoidable, take actions to reduce them. Humans have a brain that is capable of perceiving and solving problems. They react to a threatening situation through applying their brains to the problem and finding a solution to it. Even more, humans can alter rather than merely adapt to the environments in which they find themselves to enhance their chances for survival. Taflinger (1996) asserts that irrespective of tribe, religion, race, sex, or geopolitical setup, man seeks to do everything possible to ensure his continued existence.

### **Drive Theory's Study Applicability**

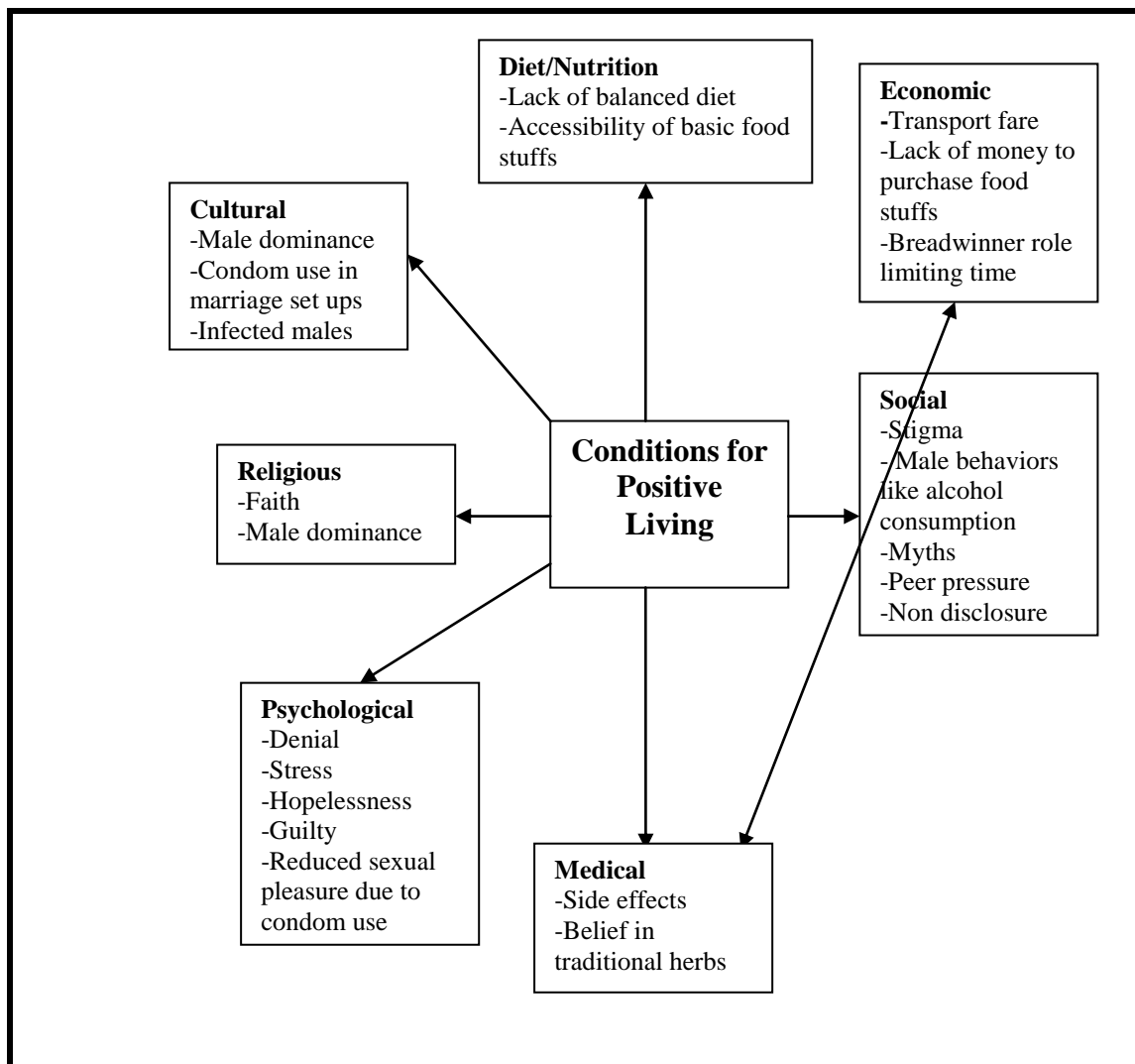
According to the drive theory, humans have an innate and unconscious desire to reduce conflicts between Thanatos (death instinct) and Eros (life instinct), favoring rather Eros in order to prolong life and postpone death as much as possible. In the context of PLWH, it can be argued that unconsciously or consciously, people should engage in behaviors that sustains life and at the same time reducing actions that results in early death.

### **2.2.0 Conceptual Framework**

FHI (2011) defines positive living as a lifestyle adopted by a person infected with HIV in order to live life as fully as possible while slowing progression of the condition.

The study is premised on the understanding that living positively is a complex issue which is composed of a number of interrelated factors that include culture, economic well being, medical issues and religion among others. Successfully achieving to live positively with HIV depends on one's ability to successfully negotiate these factors and the interplay between them. However, it is important to note that one's ability to successfully negotiate these factors also depends on the contribution and commitment by other stakeholders such as the community members, family members as well as the government. Figure 2 below diagrammatically shows the conceptual framework underpinning the current study or some of the factors mentioned above and a brief discussion on some of them. It is important to note that the conceptual framework is not exhaustive, additional factors may emerge from the field.

**Fig 2: Conceptualizing Positive Living:**



### 2.3.0 Services available for mitigating the HIV and AIDS pandemic in

#### Zimbabwe:

#### 2.3.1 HIV prevention education:

Children in Zimbabwe are currently taught about HIV and AIDS in schools. In 2006 the Ministry of Education, Sport and Culture, and UNICEF initiated an in-service training scheme of primary and secondary school teachers in HIV and AIDS life-skills and counseling. By the end of 2007 around 2753 primary and secondary schools had

been reached by the scheme (UNGASS, 2006). Outside of schools, efforts to educate and inform people about HIV and AIDS (which are often organized by NGOs) have used a number of different means to convey prevention messages, including television and radio, drama, and community groups. With around half of the people living with HIV in Zimbabwe having been infected during adolescence or young adulthood, education campaigns have primarily targeted young people. As a result, knowledge about HIV and AIDS in Zimbabwe is higher than the average for sub-Saharan Africa (UNAIDS, 2008). A greater understanding and awareness of HIV and AIDS is thought to lead to changes in sexual behavior, which has been shown to reduce the number of new HIV infections. A study carried out in 2006 suggested that the adoption of safer sexual behaviors was one of the reasons why HIV prevalence in Zimbabwe has declined (Hallett et al, 2006).

### **2.3.2 Voluntary Counseling and Testing (VCT):**

The Zimbabwean government stressed the importance of VCT in its National AIDS Policy in 1999. Between 2005 and 2007 the total number of VCT sites increased from 395 to 649 (UNGASS: January 2006-December2007). A target has now been set to increase the number of people who know their status from 20 percent in 2007 to 85 percent by 2010 (UNGASS: January 2006-December2007).

In 2007, the government shifted focus from voluntary testing to Provider-Initiated Counseling and Testing (PITC), meaning that whenever a person visits a healthcare facility, they will be offered HIV testing as part of the hospital service. This model will help both the service provider and the infected person to plan effectively on either living positively or maintaining a negative status (The Herald Newspaper 2007). However, it has been identified that consultation fees charged in state public health

institutions are deterring people from accessing any health services, including HIV testing and treatment, until their immune systems have become very weak (All Africa, 2010). This is problematic not only for the patient, but for efforts to prevent further HIV transmission. This is compounded by a strong reluctance to access testing amongst much of the population; people living with HIV face a particularly high level of discrimination in Zimbabwe, and many people fear that if they are found to be HIV-positive they will be victimized. In places where there is little access to ARVs, some see testing as pointless.

### **2.3.3 Services for preventing Parent-to-child transmission (PPTCT):**

HIV prevalence among pregnant women (aged 15-49) is 16 percent and mother to child transmission accounts for the highest number of HIV infections, after heterosexual sex (the primary route of transmission) (UNGASS, 2010). In Zimbabwe, more than 17,000 children are infected with HIV every year (IRIN, 2008), the majority through mother-to-child transmission. As with VCT, the provision of services to prevent the transmission of HIV between mothers and their children during pregnancy is gradually being scaled up. The prevention of parent-to-child transmission (PPTCT) pilot programme was launched at four sites in 1999 and today the programme is nationwide. It aims to provide pregnant women with free VCT services and give them access to nevirapine, a drug that significantly reduces the chances of transmission occurring.

The provision of drugs to prevent parent (mother)-to-child transmission of HIV rose from 6.6 percent in 2005 to 56 percent in 2009 (UNGASS 2010). Although this is an encouraging scale-up, the provision of PMTCT services remains severely limited by a lack of funding, and access to nevirapine remains low (UNAIDS, 2008).

Approximately 30 percent of infants born to HIV infected mothers are also infected and an estimated 152,189 children are living with HIV in Zimbabwe, most of who became infected through mother-to-child transmission (UNGASS, 2010). This number has declined since 2008, when 158,770 children were living with HIV (UNGASS, 2010). It is believed this is due to mortality, as a result of a limited access to antiretroviral treatment.

#### **2.3.4 Condom use**

Increased condom use has been recognized as a major factor in the recent decline in Zimbabwe's HIV prevalence (UNGASS, 2010). The number of free condoms distributed by the government, NGOs and social marketing campaigns tripled during the 1990s and further increased in subsequent years. The number of condoms sold through the private sector has also increased dramatically, and most condoms are now purchased rather than acquired for free, suggesting that condom use has become more accepted in Zimbabwean society (UNAIDS, 2005). It has also been reported that female condom sales are high in Zimbabwe (DFID, 2006).

#### **2.3.5 Male Circumcision (MC)**

The overall picture of the high HIV prevalence rates bears testimony to the limited success of the various HIV prevention strategies that have been implemented. Research studies into more efficacious HIV prevention strategies both in the developed and developing world have found male circumcision to be more effective in preventing new heterosexually transmitted HIV infections by men from women. If the evidence for the efficacy of male circumcision in HIV prevention is anything to go by, male circumcision could be the panacea to combat, halt and eventually start

reversing the epidemic in line with Millennium Development Goal (MDG) number 6 (UNAIDS 2008:15).

In the past five years, some evidence from Randomized Controlled Trials (RCTs) in South Africa by Auvert et al (2005), in Uganda by Gray et al (2007) and in Kenya by Bailey et al (2007) concluded that male circumcision offers an average of 60% protection against heterosexual transmission of HIV from women to men among circumcised men.

A technical partnership between Zimbabwe's Ministry of Health and Child Welfare (MoHCW) and Population Services International (PSI) has enabled the country to make significant strides in embracing and rolling out male circumcision as an integral part of the current HIV prevention strategies.

#### **2.4.0 National Aids Council**

The National AIDS Co-ordination Programme (NACP) was set up in 1987 and several short term and medium term AIDS plans were carried out over the following years, it was not until 1999 that the country's first HIV and AIDS policy was announced. This policy was implemented the following year by the newly formed National AIDS Council (NAC), which took over from the NACP. At the same time, the government introduced an AIDS levy on all taxpayers to fund the work of the NAC. While these measures have had a positive impact, the government's response to HIV and AIDS has ultimately been compromised by numerous other political and social crises that have dominated political attention and overshadowed the implementation of the national AIDS policy. The NAC has also been constrained by poor organization and a lack of resources (Auvert et al 2005).

### **2.5.0 Stigmatization of PLWH**

According to Sayles (2009), AIDS-related stigma and discrimination refers to prejudice, negative attitudes, abuse and maltreatment directed at people living with HIV and AIDS. They can result in being shunned by family, peers and the wider community; poor treatment in healthcare and education settings; an erosion of rights; psychological damage; and can negatively affect the success of HIV testing and treatment (Woudenberg 1998).

ATLIS (2010) notes that, AIDS stigma and discrimination exist worldwide, although they manifest themselves differently across countries, communities, religious groups and individuals. They occur alongside other forms of stigma and discrimination, such as racism, homophobia or misogyny and can be directed towards those involved in what are considered socially unacceptable activities such as prostitution or drug use

Nyblade (2009) argues that stigma not only makes it more difficult for people trying to come to terms with HIV 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, the stigma associated with HIV can deter governments from taking fast, effective action against the epidemic, whilst on a personal level it can make individuals reluctant to access HIV testing, treatment and care for fear of victimization and earning themselves some negative labels. Sharp et-al (2001) also note that stigma-related violence or the fear of violence prevents many people from seeking HIV testing, returning for their results, or securing treatment, possibly turning what could be a manageable chronic illness into a death sentence and perpetuating the spread of HIV.

### **2.5.1 Types of HIV and AIDS-related stigma and discrimination**

AIDS-related stigma can lead to discrimination such as negative treatment and denied opportunities on the basis of their HIV status. This discrimination can affect all aspects of a person's daily life, for example, when they wish to travel, use healthcare facilities or seek employment. Stigmatization comes in different packages and is perpetuated by different people or groupings of people as outlined below.

#### **2.5.1.2 Government Related Stigma**

A country's laws, rules and policies regarding HIV can have a significant effect on the lives of people living with the virus. Discriminatory practices can alienate and exclude people living with HIV, reinforcing the stigma surrounding HIV and AIDS.

In 2010, UNAIDS reported that 71 percent of countries now have some form of legislation in place to protect people living with HIV from discrimination. However, Ban Ki-moon, Secretary-General of the United Nations, believes that "almost all permit at least some form of discrimination".

There are many ways that governments can actively discriminate against people or communities with (or suspected of having) HIV and AIDS. Many of these laws have been justified on the grounds that HIV and AIDS pose a public health risk. Below are some examples of government level stigma and discrimination against people living with HIV and AIDS.

Kirby, Laris and Rolleri (2007) highlights that President Museveni of Uganda supports the national policy of dismissing or not promoting members of the armed forces who test HIV positive. The Chinese government advocates compulsory HIV

testing for any Chinese citizen who has been living outside of the country for more than a year (China View 2007). Epstein (2007) has it that the United Kingdom legal system can prosecute individuals who pass the virus to somebody else, even if they did so without intent. Many countries impose compulsory HIV testing without prior consent or protection to confidentiality. Such compulsory tests are conducted, for instance to expecting mothers under the banner of protecting the child from contracting HIV from the parents (Klein 2010). Meaningful as it may seem, it is a clear sign of abuse, violation of rights and stigmatization from the part of legislation to people living with HIV and AIDS.

Programs that fail to address stigma help perpetuate discriminatory laws and practices and, in some cases, result in failure to enforce laws against them. Such programs also miss an opportunity to influence policy direction.

### **2.5.1.3 Healthcare Related Stigma**

In healthcare settings people with HIV can experience stigma and discrimination such as being refused medicines or access to facilities, receiving HIV testing without consent, and a lack of confidentiality. Such responses are often fuelled by ignorance of HIV transmission routes amongst doctors, midwives, nurses and hospital staff (Epstein 2007).

Sharp et al (2001) argue that lack of confidentiality has been repeatedly mentioned as a particular problem in health care settings. Many people living with HIV and AIDS do not get to choose how, when and to whom to disclose their HIV status. Studies by the WHO in India, Indonesia, the Philippines and Thailand found that 34 percent of respondents reported breaches of confidentiality by health workers (UNAIDS 2008).

According to Gallo (2009), doctors in healthcare setting in resource-poor areas with limited or no drugs have reported a frustration with the lack of options for treating people with HIV and AIDS, who were seen as 'doomed' to die. This frustration may mean that AIDS patients are not prioritized or are actively discriminated against. Fear of exposure to HIV as a result of lack of protective equipment is another factor fuelling discrimination among doctors and nurses in under-resourced clinics and hospitals.

Stigma and discrimination in healthcare settings are not confined to developing countries. As noted by Hooper (1999: 37), a woman in UK reported that:

*“I have a dental problem and I go to this clinic, and I go there, two maybe three times. So eventually I told them about my condition. They explained that I would have to be the last appointment of the day. I have been to that room, and sat on that chair, and the same doctor examined me as before, but after I told them I was HIV positive. So I went for the last appointment of the day last week, they covered the chair, the light; the doctors were wearing three pairs of gloves...”*

A review of research into tackling stigma in health care settings advocated a multi-pronged approach, requiring action on the individual, environmental and policy levels. For example, health care workers need to be made aware of the negative effect that stigma can have on the quality of care patients receive, they should have accurate information about the risk of HIV infection (the misperception of which can lead to stigmatizing actions), and they should also be encouraged not to associate HIV with immoral behavior. Facilities should have sufficient equipment and information so

health workers can carry out universal precautions and prevent exposure to HIV (UNAIDS 2010).

Policies within health care settings can also be effective in reducing stigma. Such programs would involve participatory methods like role play and group discussion, as well as training on stigma and universal precautions. The involvement of people living with HIV could lead to a greater understanding of patients' needs and the negative effect of stigma.

#### **2.5.1.4 Restrictions on travel and stay**

Many countries have laws that restrict the entry, stay and residence of people living with HIV. As of December 2010, people living with HIV were subject to restrictions during long-term stays (more than 90 days) in sixty-five countries and of these, 18 also applied restrictions during short-term stays. Restrictions for short-term stays include the need to disclose HIV status or to be subject to a mandatory HIV test (UNAIDS 2010).

It is reported that around thirty countries including Egypt, Russia, and Singapore deported foreigners based on their positive status alone (ATLIS 2010). Sharp et al (opcit) note that some countries have policies that could violate confidentiality of status if, for example, a stamp is required on a waiver or passport in order to gain entry or stay. Students living with HIV are barred from applying to study in certain countries including Malaysia and Syria.

Until the 4th of January 2010 the United States restricted all HIV positive people from entering the country, whether they were on holiday or visiting on a longer-term basis (UNAIDS 2010).

A database maintained by the German AIDS Federation, the European AIDS Treatment Group and the International AIDS Society, presents updated information on such travel restrictions in 196 countries (Gallo 2009).

Deportation of people living with HIV has potentially life threatening consequences if they have been taking HIV treatment. If they are deported to a country that has limited treatment provision, this could lead to drug resistance and death. Alternatively, people living with HIV may face deportation to a country where they would be subject to even further discrimination, a practice which could contravene international law.

### **2.5.1.5 Community Related Stigma**

Community level stigma and discrimination towards people living with HIV is found all over the world. A community's reaction to somebody living with HIV can have a huge effect on that person's life. If the reaction is hostile a person may be discriminated against and may be forced to leave their home, or change their daily activities such as shopping, socializing or schooling.

Community-level stigma and discrimination can manifest as ostracism, rejection and verbal and physical abuse. It has even extended to murder. AIDS related murders have been reported in countries as diverse as Brazil, Colombia, Ethiopia, India, South Africa and Thailand. Sayles (2009) notes that in December 1998, Gugu Dhlamini was stoned and beaten to death by neighbors in her township near Durban, South Africa, after speaking openly on World AIDS Day about her HIV status. It is therefore not surprising that people living with HIV who participated in a global study or those who decide to come out in the open, feared social discrimination following their status disclosure.

### **2.5.1.6 Discrimination within a family setup**

In the majority of developing countries families are the primary caregivers when somebody falls ill. There is clear evidence that families play an important role in providing support and care for people living with HIV and AIDS. However, not all family responses are supportive. HIV positive members of the family can find themselves stigmatized and discriminated against within the home. There is concern that women and non-heterosexual family members are more likely than children and men to be mistreated (Hooper 1999).

As noted by UNAIDS (2009:35) one woman from Zimbabwe had this to say

*“When I was in hospital, my father came once. Then he shouted that I had AIDS. Everyone could hear. He said: this is AIDS, she’s a victim. With my brother and his wife I wasn’t allowed to eat from the same plates, I got a plastic cup and plates and I had to sleep in the kitchen. I was not even allowed to play with the kids.” HIV-positive woman, Zimbabwe.*

A Dutch survey of people living with HIV found that stigma in family settings, in particular avoidance, exaggerated kindness and being told to conceal one's status was a significant predictor of psychological distress. This was believed to be due to the absence of unconditional love and support, which families are expected to provide. Sayles (2009) notes that discrimination is more painful when perpetrated by close relatives whom one considers as the people who should stand by him/her. Furthermore, people living with HIV are often worried about losing family and friends if they disclose their status. As a global study illustrated, 35 percent of those interviewed cited this as a concern surrounding disclosure (Zaidi 2006).

It has been observed, that some family members still find it very difficult to share appliances, utensils, toiletries and clothes with a family member who is living with HIV. This observation was confirmed by an international survey of more than 2000 respondents half of whom said they had encountered someone who was afraid to have casual contact with them because of their infection with HIV or AIDS, and 1 in 4 reported that someone would not kiss them or share food or drink with them. These reactions to people with HIV and AIDS reflect still relatively widespread beliefs in many countries that HIV or AIDS is easily transmitted through everyday activities, and that people with HIV or AIDS should be avoided.

#### **2.6.0 Access to Health Facilities and HIV and AIDS**

Literature on the impact of AIDS on the health service sector indicates that in all economically burdened countries the AIDS epidemic is adding additional pressure on the health sector. As the epidemic matures, the demand for care for those living with HIV rises, as does the toll of AIDS on health workers. In sub-Saharan Africa, the direct medical costs of AIDS (excluding antiretroviral therapy) have been estimated at about US\$30 per year for every person infected, at a time when overall public health spending is less than US\$10 per year for most African countries (DMSAC, 2005 ; Kanye Rural Administration Centre; 2005).

As the HIV prevalence of a country rises, the strain placed on its hospitals is likely to increase. HIV has so much in common with other infectious diseases but it has the distinctive feature of leading to the resurgence of illnesses like Tuberculosis (TB) that were once thought to be under control. In sub-Saharan Africa, people with HIV-related illnesses occupy more than half of all hospital beds (Uys and Cameron 2003).

The chronic underinvestment in health infrastructure is epitomized by the diminished capacity of the health sector to treat other diseases.

Government-funded research in Botswana has suggested that, on average, HIV-positive patients stay in hospital four times longer than other patients (NAB, 2004). Hospitals are struggling to cope, especially in poorer African countries where there are often too few beds available. This shortage results in people being admitted only in the later stages of illness, reducing their chances of recovery.

In most developing countries, the infrastructure is overwhelmed by the number of people who need to be attended to. The number of medical personnel as well as the number of health institutions does not tally with the people who need to benefit from the services.

This anomaly gave rise to an increase in Home Based Care (HBC) patients, whereby bed ridden AIDS patients are moved from hospitals to home where they are looked after by family members (Uys and Cameron 2003). AIDS patients will end up in the hands of less medically experienced members of the family who can easily get overwhelmed by the demands of the challenges of looking after a sick person considering both available resources as well as level of knowledge.

Considering health personnel, excessive workloads, poor pay and migration to richer countries are among the factors contributing to this shortage. Although the recent increase in the provision of antiretroviral drugs (which significantly delays the progression from HIV to AIDS) has brought hope to many in Africa. It has also put increased strain on healthcare workers. Providing antiretroviral treatment to everyone

who needs it requires more time and training than is currently available in most countries. This trend puts a number of PLWH at risk of inadequate health attention.

It has also been noted that counsellors in the field of HIV and AIDS are inadequate to cater for the ever increasing number of people infected with the pandemic (Zaidi 2006). Due to this critical shortage of counsellors, counselling sessions end up being conducted in groups, depriving beneficiaries of individually tailor made help. Zaidi (opcit) also notes that the number of counsellors seem to be inadequate due to lack of demand in the field in Zimbabwe as well as better opportunities counsellors enjoy outside the country. Lack of demand for professional counselling emanates from belief in social networks such as uncles, aunts and friends as providers of advice and guidance.

### **2.6.1 Treatment and HIV Medication Adherence**

The introduction of ARV treatment not only prolongs lives but also improves the quality of life of people living with HIV. Many people are still alive because they have the opportunity to access ARV treatment. However, ARV treatment is only beneficial when people adhere to the treatment regimes on a daily basis for the rest of their lives. The term adherence means taking the drugs exactly as described. This includes taking all of the medication at the right time and exactly as the directions state. It also means ensuring that there will be no interactions with other drugs being taken. Anything below 95 percent adherence has been associated with increases in viral load and drug resistance (BHIVA 2001). Therefore adherence to antiretroviral treatment is extremely important. This means missing no more than one dose a month, if taking antiretroviral drug treatment once a day.

The biggest obstacle to successful treatment is medication adherence. The method by which antiretroviral medications suppress the HIV virus necessitates a very strict regimen of medication. Drugs must be taken exactly as prescribed without missing doses if they are to work to their full potential. Unfortunately, adherence is not always that easy. The array of medication side effects, lack of energy and concerns about confidentiality, medication adherence is very difficult.

In many countries adherence to treatment remains a huge challenge. Many factors affect a person's ability to adhere to their treatment regime, including:

- Not having disclosed to their family members;
- Needing to take their medicines in secrecy;
- Sharing their medicines with other people they think are HIV positive;
- Not being able to afford transport costs to go to the clinic to ensure a regular supply of medicines;
- Feeling unwell;
- Not having access to drug substitution therapy like methadone,
- Not having sufficient food to take with medicines.

### **2.6.2 Antiretroviral Drugs and Side Effects**

Like most medicines, antiretroviral drugs can cause side effects. These unwanted effects are often mild, but sometimes they are more serious and can have a major impact on health or quality of life. On rare occasions, side effects can be life threatening (Zaidi 2006).

Sayles (2009) has it that once started; antiretroviral treatment must be taken every day for life. Every missed dose increases the risk that the drugs will stop working. It is

therefore vital that people receiving antiretroviral treatment get all the help they need to minimise the impact of side effects. Often there are several ways to lessen the harm, either by treating the side effects or by switching to alternative antiretroviral drugs.

Antiretroviral drugs differ in how commonly they cause particular side effects. For example, efavirenz is the drug most associated with psychiatric symptoms, while protease inhibitors are more likely to raise levels of cholesterol and triglycerides. Hooper (1999) argues that this should be considered when deciding which drugs to take.

Salles (2009) notes side effects vary from person to person and it is impossible to predict exactly how each individual will be affected. Some people take antiretroviral treatment for years with few problems, while others find the same drugs intolerable. Nevertheless some characteristics and pre-existing conditions (such as high blood pressure or hepatitis infection) are known to increase the risk from certain side effects. Doctors should assess these factors before advising patients on which drugs to choose. Some side effects appear shortly after starting an antiretroviral drug and disappear within a few weeks as the body gets used to the new chemicals. This is often the case with nausea, diarrhoea and headache, for example. Unfortunately other side effects such as peripheral neuropathy (nerve damage) and lipodystrophy (fat redistribution) tend to worsen over time and may never go away. Also some problems may not emerge until months or even years after treatment are started.

Older PLWH may experience signs of ageing that could resemble certain side effects. For example, when people get older they might be more susceptible to increased fat in

the abdomen, which could look similar to the changes that are caused by lipodystrophy.

Side effects of ARVs put more weight on the already burdened medical infrastructure in as far as medical personnel and resources are concerned. Side effects also put pressure on the patient hospital visits are bound to increase as one tries to deal with the after effects of ARVs. Stress may also increase as one may get worried over the development of such issues as skin rash. Hooper (1999) argues that PLWH have a tendency of being hyperactive, they may notice development of rash with a lot of discomfort which may even become counterproductive.

### **2.7.0 HIV and AIDS and Marriage Dynamics**

According to Zaidi (2006), African and Asian women generally have a low self-perception of HIV yet their risk is inextricably linked to the behavior of their husband. Despite the overwhelming evidence of the marital unit as a significant locale for transmission for women throughout the world, there has been little effort to explore the marital relationship as a focus for intervention in the prevention of HIV and other STDs.

In the traditional African setup, many men migrate from rural areas, leaving wives in the husbands' parental homes, and until they finally settle in towns and cities, seeing them only during periodic visits back to the rural village. A significant number of women report a lifestyle that is highly restricted; women show limited exposure to mass media and report only limited access to friends, relatives or neighbors.

Men's risky sexual behavior may begin prior to marriage with male-to-male sexuality, with female sex workers, or with "love" relationships. If migration separates husbands

and wives, married urban migrants living in urban areas without their wives have higher drug risk scores and higher sex risk scores compared to single men and married men living with wives. Research has shown that there is a significant association between men with sexual health problems, STI-like symptoms, and a risky lifestyle that included current involvement with commercial sex workers and other extramarital sexuality (Gallo 2009).

Gallo (opcit) notes that for a subset of husbands and wives, these dynamics create an interrelationship among extramarital sex, marital violence, and forced sex. Studies have indicated that a majority of women (62.4%) reported that their husbands had forced them to have sex, at times without protection, 20.4% reported forcible sex on the first night of the marriage; 74.9% were forced to perform unwanted sexual acts; and 36.3% reported that their last sex was only as a result of the husband's desire. Over 40% of women reported physical abuse by their husbands, and a strong link was established between unwanted sexuality and marital violence. Women reporting the most severe problems of abuse were more likely to have experienced forced sexual intercourse and to have husbands who had been forceful and did not care about the wife's sexual satisfaction. This brings the dimension of power in a typical African or Asian family where power lies with the husband. Husbands are culturally empowered to determine who to have sex with, when and how to do it, leaving the female part less powerful and more vulnerable even with a full knowledge of what needs to be done for a positive life even when one has HIV and AIDS.

This picture indicates that a subset of marital relationships in typical African marriages carry significant risk for women, as men visit commercial sex workers and conduct extramarital affairs, limit women's mobility, access to services and

acquisition of knowledge, practice forcible sex, and are involved in marital violence. The sexual interaction that characterizes these couples may involve both the greater likelihood of the husband having HIV and/or STD as well as increasing the risk of transmission through tissue tearing as a result of forcible and/or unwanted sex. At the same time, studies demonstrate that there is also a significant subset of marital relationships in which there is equity, communication, a lack of violence and a satisfying sexuality, establishing positive role models in the urban communities (Newman 2001).

The condom is the only contraceptive method proven to reduce the risk of all STIs including HIV. They can be used as a dual-purpose method, both for prevention of pregnancy and protection against STIs (WHO 2011). The condom has enjoyed success in reducing the rate of STIs which may be attributable to the fact that the condom does not call on people to change their sexual habits per se. People could still have sex as often as they are used to, the only change being that they now have to wear condoms. However, it has been observed that the widespread use of condoms remains problematic, especially for men, with myths and notions of cultural barriers prevailing. Fuller (2008) is of the view that the use of condoms is curtailed by a number of factors which include the perception by men that they reduce sexual sensitivity, they elicit religious disapproval, they are too expensive for the poorest households and the fact that they cannot be used for HIV prevention while a couple is trying to conceive. Poor patterns of HIV positive status disclosure between sexual partners hinder the effective negotiation of condom use.

Fuller (2008) asserts that double standards where young women are expected to enter marriage as virgins and remain faithful once there while male infidelity is expected as

a form of entitlement; female sexuality lacks both an identity and recognition of assertiveness. It is estimated that 60-80% of African women living with HIV have had only one partner but were infected because they were not in a position to negotiate safe sex or prevent their partners from having additional sexual contacts (Barnett and Whiteside, 2006). Sexual abuse, rape and coerced sex are all common, and as the economy deteriorates more women are turning to sex work or transactional sex as a means of survival (Mail and Guardian Newspaper, 2010).

UNAIDS (2004) observes that the knowledge that women have about the prevention of contracting HIV is often rendered useless by the discrimination and violence they face, and their relative powerlessness to refuse sex or negotiate safe sex, especially in the context of marriage.

Male (or female) condoms are irrelevant when a woman is being beaten and raped. Moreover, forced vaginal penetration increases the likelihood of HIV transmission. In addition, the fear of violence prevents many women from asking their partners to use condoms, accessing HIV information, and from getting tested and seeking treatment, even when they strongly suspect they have been infected. Many women are in danger of being beaten, abandoned or thrown out of their homes if the HIV-positive status is known. If HIV-prevention activities are to succeed, they need to occur alongside other efforts that address and reduce violence against women and girls (UNAIDS 2004).

Related to this is the notion that there is evidence to suggest that gender also plays a strong role in experiences of stigma. AIDS-related stigma for women is intensified because of their subordinate role in society (Soskolne, 2003; Rohleder and Gibson, 2005). Studies by Soskolne et al (ibid) revealed that AIDS-related stigma is a barrier

for women accessing free VCT and PPTCT services. On the other hand, once diagnosed HIV-positive, men were found avoiding seeking help, treatment, or support, for fear of stigma. Such behavior was seen as related to the male ‘macho’ culture of needing to be seen to be strong, while HIV was still seen as largely a ‘female thing’ and thus it was mainly women who attended support groups.

### **2.8.0 Religion and HIV and AIDS**

Gilbert et-al (2007) argue that the topic of religion and AIDS has become highly controversial in the past twenty years, primarily because many prominent religious leaders have publicly declared their opposition to the use of condoms, which scientists feel is currently the only means of stopping the epidemic. This then means that after one acquires HIV or has AIDS and belongs to a church that preaches anti condom gospel, such individuals will be caught in between attending church for spiritual enhancement and living positively by practicing safe sex.

Some religious leaders would challenge the use of ARVs as signs of “lack of faith in God”, encouraging their followers not to take ARVs and also not to get opportunistic infections treated on time. Such kind of gospel derails efforts by some organizations for people living with HIV and AIDS to live positively through taking care of themselves both physically and spiritually (Gilbert et al 2007).

Marshall and Taylor (2006) further explore the position of churches in relation to HIV in a study in Burkina Faso, Zimbabwe and South Africa in regard to gender relations and sex. The study revealed that some local evangelical churches were largely silent regarding gender and sex issues, or reinforced traditional values which contribute to HIV infection. The church has, at times, misunderstood biblical teaching and, as a

result, appeared to contribute to the problem. In the absence of teaching to the contrary, church adherents assume that the church endorses traditional values and practices relating to gender. Inequalities in gender relations exacerbate the impact HIV and AIDS are having on women and girls in Africa. The study revealed that local evangelical churches have contributed to and reinforced traditional attitudes to gender:

- Churches see talking about sex as inappropriate and believe the Bible requires women to be submissive, preventing women from challenging husbands on sexual issues.
- In South Africa, church teaching about sex is unsupportive and judgmental, failing to respond to young people's need for help dealing with sexual issues.
- In rural Zimbabwe and Burkina Faso, wives are submissive to husbands, who use biblical texts selectively to justify the way they treat them.

#### **2.9.0 HIV and AIDS, Diet and Physical Exercise**

Exercise has been proven to provide many health benefits, ranging from increased aerobic fitness to improved mood for the general population. Although healthcare professionals previously recommended that persons with HIV and AIDS refrain from exercise due to concerns of symptom exacerbation or increased risk of infection, current research implies that persons with HIV and AIDS can reap some of the same benefits of exercise as the general population (Newman 2001). Today, therapeutic exercise is becoming a more commonly prescribed alternative therapy for persons with HIV and AIDS, although many physicians refrain from prescribing exercise (Stringer et-al, 1998). Much more research is needed to categorize all the benefits of exercise for persons with HIV/AIDS. Some existing studies show conflicting results or inconclusive findings, often due to small sample sizes because of dropouts.

However, much of the research does show definitive results of several exercise benefits (Gallo 2009).

The overall immunological safety of exercise for persons with HIV and AIDS has been widely researched. Previous concerns revolved around the belief that exercise could result in decreased effectiveness of the immune system, and possible decrease in CD4 cell count. However, several studies have shown that CD4 cell count does not change significantly with exercise (Stringer et al., 1998; Bopp, Phillips, Fulk, and Hand, 2003), thus concluding that exercise is likely to be safe for persons with HIV and AIDS.

Participating in exercise can also result in psychological benefits. In a study conducted by Stringer et al. (1998), participants completed a Quality of Life (QOL) questionnaire at entry and after completion of the study. The participants who engaged in exercise during the study improved in all questions on the QOL. Some of the benefits of exercise, such as decreased lipodystrophy, could also result in psychological benefits.

Current exercise guidelines for persons with HIV and AIDS vary, depending on the stage of the person's HIV/AIDS, medications, functional capacity, and symptoms. It is recommended to consult with the person's physician before implementing a program. Most exercise prescriptions consist of endurance or resistance exercises, or a combination.

For one to fully benefit from exercises, one should not only consult with their physician, but also with qualified personnel from a gym. A combination of these two professionals will help in determining the individual's nature and extent of training. In

addition, prescribed diet is tailor made to the individual taking into consideration someone's individual physical nature, the extent of progression of HIV and AIDS, their economic standing among other issues.

### **2.9.1 Prescribed Diet for PLWH**

There is need for PLWH to adhere to a special kind of diet whether engaging in exercises or not. Meeting immediate food, nutrition and other basic needs is essential if HIV and AIDS affected households are to live with dignity and security. Providing nutritional care and support for people living with HIV and AIDS is an important part of caring at all stages of the disease (Stringer et al 1998).

The role nutrition plays vary along the disease continuum (disease progression over many years), with consideration given to the patient's age, gender, behaviours, current medication, drug history, socioeconomic status , and associated health concerns.

In all cases, adequate hydration (fluid intake) and increased calorie and protein intake are necessary to fight the infection. Proper nutrition must begin immediately to support nutritional deficiencies (including vitamin A and E, the B vitamins, magnesium, and zinc) that occur early in the disease process. These nutritional deficiencies contribute to decreased immunity and disease progression. Stringer et al (1998) suggest that once the patient has been diagnosed with HIV infection, more protein and complex carbohydrates, along with moderate amounts of fats, should be consumed. The diet should include lean meat, fish, beans, seeds and nuts, whole-grain breads and cereals, and fruits and vegetables. Moderate amounts of fat for energy and calories can be acquired through foods such as nuts, avocado dip, peanut butter, and seeds.

Gallo (2009) notes that diet for PLWH should include each of the five major food groups (dairy, vegetable, meat, fruit, and bread). The sixth group (fats and sugars) should be used sparingly. Patients with a poor appetite should eat six or more small meals throughout the day, rather than three large ones. In prolonged cases of appetite depression, a physician may prescribe an appetite stimulant.

However, good nutrition is usually identified as a potential challenge for many people with HIV, especially in developing countries. When infected with the HIV virus the immune system works harder to fight infection and this increases energy and nutrient requirements. Further infection and fever also increase the body's demand for food. When the body fights any infection, it uses more energy making it necessary to eat more than what one usually does. The difficulty is that, when one feels unwell, one eats less than normal resulting in weight loss. Weight is gained by eating more food, either by eating larger portions and/or eating meals more frequently, using a variety of foods. Medicines San Frontiers (2009) observes that while it is essential that PLWH, more so those on ARVs receive adequate nutrition for the drugs to work effectively, there are obstacles to obtaining the food with reports of HIV positive patients in such desperation that they are actually selling their ARV medication in order to buy food.

It is however important to note that some of the elements of the recommended diet for PLWH is beyond the reach of many people, especially those in poverty. Due to practical reasons, knowledge of the correct diet is not easily translated into behaviour.

The health belief model by Rosenstock (1966) argues that people assess potential gains and losses in when contemplating engaging in any health related behaviour. They take into consideration the challenges they face as well as the perceived benefits

they stand to derive from the behaviour. In this case, the cost of diet, physical exercises among other issues is considered against the possible gains in the form of enhanced health status as well as the potential for a longer life span.

### **2.9.2 Staying healthy by being productive**

Red Sky Healing (2008) postulates that HIV and AIDS researchers have shown that trying to live a productive life can contribute to feelings of normality. It is widely recommended that patients do not let HIV become who they are, but just something they have. This is an issue most HIV patients face. People feel that HIV is a diagnosis that means they will have to change their whole life. However, as with any condition that threatens your health, HIV is just that, a condition. Having HIV does not mean one cannot live a productive life, with the normal joys, sorrows, and accomplishments.

HIV is not a curable condition but it is something one will have to deal with for the rest of their life. The best thing one can do is to accept the condition and try to maintain their physical and mental health.

### **2.9.3 Socioeconomic Issues**

It has been observed that PLWH view prevailing socioeconomic circumstances as a challenge to living positively with the virus. PLWH might have other more pressing problems that they face on a daily basis (like unemployment, poverty, domestic violence). Research findings suggest that in the context of unemployment, poverty, and lower socioeconomic status, HIV status becomes a secondary concern to the infected individuals. In a study conducted in a black township in Cape Town, findings revealed that HIV and AIDS was only one of the major social stressors threatening

people living in everyday poverty (Kalichman and Simbayi, 2009). Poku (2005) concurs with the Cape Town study findings by postulating that the daily struggle to survive overshadows attention and concern about the virus that does not demonstrate any immediate harm and notes that poverty aggravates all the predisposing factors to HIV infection.

#### **2.9.4.0 Psychological Issues**

##### **Hope**

Hope is one of the most useful concepts to individuals who are successfully living with HIV. While most people maintain some hope for a cure, hope often becomes focused on preventing the debilitating infections that so often are a hall mark of HIV infection. Hope is also about being able to maintain a meaningful quality of life. For people with HIV who have taken care of a lover or numerous friends who also had AIDS, their hope is to be adequately and lovingly cared for in the event of serious illness or debilitation. In addition, hope often becomes directed towards achieving a specific goal, that once reached becomes the impetus for setting additional goals (<http://www.thebody.com/content/art2469.html>).

##### **Pressure from the society**

Some PLWH especially adolescents experience lots of pressure that is exerted upon them by the immediate society that is constantly 'watching them'. This scenario is defined by the [http://en.wikipedia.org/wiki/Imaginary\\_audience](http://en.wikipedia.org/wiki/Imaginary_audience) website as the theory of the imaginary audience. It refers to an egocentric state where an individual imagines and believes that multitudes of people are enthusiastically listening to him or her at all times. Though this state is often exhibited in young adolescence, people of any age may harbor a fantasy of an imaginary audience.

#### **2.9.4.1 Coping strategies of HIV and AIDS-affected households in Africa**

UNAIDS (2006) postulates that, there are three main coping strategies that appear to be adopted among affected households. Savings are used up or assets sold; assistance is received from other households; and the composition of households tends to change, with fewer adults of prime working age in the households.

Almost invariably, the burden of coping rests with women; upon a family member becoming ill, the role of women as carers, income-earners and housekeepers is stepped up. They are often forced to step into roles outside their homes as well. In parts of Zimbabwe, for example, women are moving into the traditionally male-dominated carpentry industry. This often results in women having less time to prepare food and for other tasks at home. The resultant scenario where women shoulder most of the household responsibilities is a switch of roles especially the 'breadwinner role'. According to the <http://www.imow.org/economica/stories/viewStory?storyid=3698> website advocates of the male breadwinner model asserted that there was a necessary sexual division of labor; under this model, men became the "producers" and women the dependent "consumers."

One of the more unfortunate responses to a death or sickness in poorer households is removing the children (especially girls) from school. Often the school uniforms and fees become unaffordable for the families and the child's labour and income-generating potential are required in the household (UNAIDS 2006).

#### **Summary**

The literature review focused on the conceptualization and the underpinning theoretical framework of positive living. It also concentrated on aspects of life that

complicate positive living. In addition, the Chapter also highlighted the services that are in place to help people living with HIV to live positively.

## **CHAPTER THREE**

### **METHODOLOGY**

#### **3.0 Introduction**

In this chapter, a detailed report of the research methodology and methods that were employed by this study is given. More specifically, it encompasses the research approach, study populations, sampling, and data collection plan and data analysis. Relevant ethical considerations are also included in the last part of this chapter.

#### **3.1.0 Research Approach**

According to Hancock (1998:2), “qualitative research is concerned with developing explanations of social phenomena” from the perspectives of the local population it involves. It is an approach to scientific research which consists of detailed descriptions of situations, types of interaction, people’s values, opinions and behaviors, and produces subjective data. In the qualitative paradigm, research aims to provide a thorough understanding of phenomena and pays due regard to context, in particular socio-cultural dynamics. Hancock (1998:2) further points out that the qualitative approach seeks to answer questions about how and why certain practices have developed in the way they have. In qualitative research, no attempt is made to manipulate the situation under study as is the case with experimental research. Social phenomenon is described as it occurs. The findings produced in qualitative research are not arrived at by means of statistical procedure or any means of quantification. Hancock (1998:2) provides the following additional features of the qualitative research approach:

- Data are used to develop concepts and theories that help to understand the social world.

- Data are collected through direct encounters with individuals through one to one interviews, group interviews or observation.
- The intensive and time-consuming nature of data collection necessitates the use of small samples.
- Understanding of the situation is gained through a holistic perspective.
- It takes account of constant interaction between points of view, processes and accepts contradictions.
- It distinguishes between what people say they have to do (the rules), what they say they do (the norms) and what they actually do (reality).

Akpaka (2006:7) provides a valuable summary of qualitative research: “the aim of understanding lies at the heart of the qualitative approach to research with a far greater emphasis on processes and the significance of attitudes, points of view and actions than on their frequency”.

The present investigation concurs with all these postulations. In particular, the study seeks an in-depth understanding of the challenges faced by PLWH in adopting positive living in Hatcliffe Extension. The intention of the study is to give meaning to the subject of positive living as it is studied in its context, which may differ in reality as opposed to theory. It seeks to grasp what is actually happening (reality) with positive living in a natural setting. Furthermore, the research used small samples for the purpose of intensive data collection. The samples are two NAC representatives, one ZNNP+ representative, one City Health Department representative and forty-six PLWH from the various support groups in Hatcliffe Extension. Data was collected through direct interaction with respondents.

The advantages of using the qualitative approach in the present study are that: more in-depth and comprehensive information about challenges to positive living were produced; investigations were conducted in the natural settings (i.e. in the communities); and that the study as expected yielded a holistic picture of challenges to positive living as experienced by PLWH in Hatcliffe Extension.

### **3.1.1 Research Design**

A research design is simply a guide for conducting research. Babbie and Mouton (2001:74) define research design as a plan or blueprint of how a researcher conducts the research. The research design focuses on the kind of study being planned and the results aimed at. The type of research design chosen depends on the type of problem, the knowledge already available about the problem and the resources available for the study (Varkevisser et al. s.a:119). Several classifications of study designs are possible. This study was primarily a descriptive case study because the primary purpose was to describe and understand challenges to positive living by Hatcliffe Extension PLWH through systematic collection and presentation of data in order to give a clear picture of the phenomenon. Cresswell (1994:145) states that qualitative research is descriptive in that the researcher is interested in process, meaning and understanding gained through words or picture. The current research emphasized lived experiences of people living with HIV and AIDS. It examines life experiences of living positively in an effort to understand and give these experiences a meaning. Case studies are detailed investigations of individuals, organizations or other social units. The focus of attention was on Hatcliffe Extension community of PLWH.

In the present study the investigator collected a large volume of new data through interviews (primary data) and to a lesser extent used secondary data, through reviewing existing literature.

### **3.2.0 Study Populations**

Rubin and Babbie (1993:224) define a study population as “the theoretically specified aggregation of study elements from which the sample is actually selected”. The population of interest for this study was PLWH who are support group members. Hatcliffe Extension has a total of 25 support groups of PLWH with membership ranging from 9 to 12 members per each support group, giving a total membership of 258 from the 25 groups of which 166 of them were females while the remaining 92 were males. It is also important to note that the support groups were relatively homogenous at least in terms of demographic characteristics, that is, in relation to gender they all contained more women than men; in terms of age they had a bias towards adults as compared to adolescents. Other indices like level of education and occupations were also similar between the support groups as established prior to sampling. All the 25 support groups in Hatcliffe Extension were purposively considered in building the sample for this study. This was meant to elicit a cross-sectional picture of the subject of investigation through selecting a representative sample. Support group members were a valuable category of respondents as they had first-hand experience with positive living including the challenges encountered.

### **3.2.1 Sampling Approach and Methods**

A research problem usually has a bearing on some or other population. As a result of the size of a population, it is usually not practically and economically feasible to involve all members of a study population. Consequently we have to rely on the data

obtained from a sample of the study population. Sampling therefore involves the selection of a number of study units from a defined study population (Dane 1990:37). A multi stage sampling procedure with non-probability purposive sampling was used in the present study.

A defining characteristic of non-probability approaches to sampling is that there is no specification as to equal chance. The primary sampling method used in this study is purposive selection due to the descriptive nature of the study. Purposive sampling is defined by Rubin and Babbie (1993:225) as the selection of the sample on the basis of the researcher's own knowledge of the population, its elements and the nature of the research aims. Purposive sampling was employed in the identification of Hatcliffe Extension community at the time of the investigation. According to Huysamen (1994:44), a primary advantage of non probability sampling is that they are less complicated and more economical in terms of time and financial expenses than probability sampling methods. This advantage applies well to the present research as time and financial considerations were paramount in determining which community to work with. Justifications for the purposive sampling of the studied community are provided under relevant sampling stages described below.

### **Stage 1 – Selection of Hatcliffe Extension local community**

Hatcliffe Extension local community was purposively sampled from all the local communities in the City of Harare due to the following reasons:

- The investigator has worked in this community before, therefore, relied on experience and knowledge in deliberately selecting the community.
- The community was conveniently located for the researcher to frequently travel for logistics and data collection.

- The community offered a high concentration of support groups for PLWH and happens to be one of the communities hardest hit by poverty and HIV and AIDS.

### **Stage 2 – Selection of respondents from support groups members**

Fifty respondents were selected from the 25 support groups available in Hatcliffe Extension suburb. Stratified and convenient sampling techniques were made use of in selecting the respondents. That is, initially the population in all the support groups was categorized into strata first by gender (male and female) then by age (adults versus adolescents). Convenience sampling (availability) was then used to select participants from the different strata in different support groups with a deliberate bias to include more females than males and more adults than adolescents in the sample to reflect the composition of the population. In the end a sample size of 50 respondents was drawn with each of the 25 support group providing 2 members. Fifty respondents represented 19.4% of the total support group membership of 258 people.

#### **3.2.2 Key informants**

Four key informants were drawn from identified organizations that were giving technical support to the support groups in Hatcliffe Extension. These were the National Aids Council, City of Harare Health Department and ZNNP+. The following staff members were selected from the organizations to act as key informants: the National AIDS Council District Coordinator who plays a critical coordination role of all the stakeholders; the Ward AIDS Action Committee (WAAC) Chairman who directs the daily activities; the local health facility community nurse who also on a daily basis works with support group members advising on health matters; and ZNNP+ 's advocacy officer who works with the support groups in championing the

rights of PLWH. These four key informants were purposively selected for their intimate knowledge of the support groups that they have attained through their interaction with them in their various specialized roles.

### **3.2.3.0 Data Collection techniques**

The following sections describe the data collection techniques and instruments used in the research process.

#### **3.2.3.1 Key informant Interviews**

Varkevisser et al (s.a.:143) define an interview as “a data collection technique that involves oral questioning of respondents either individually or as a group”. In the context of the present study, key informant interviews were in-depth conversations aimed at gathering information from people who had first-hand knowledge on positive living as well as personal experiences of working with infected individuals, thereby giving them an in-depth understanding of vulnerability issues in the communities they serve. Specifically, key informants included the NAC District Coordinator for Harare North a key member of the Ward Aids Action Committee, a local health official and a representative of ZNNP+. The advantages and disadvantages of key informant interviews for the current investigation are presented below. They drew from the work of (Patton 2002:341).

- They allow the researcher to obtain information about challenges to positive living from persons with diverse backgrounds and opinions, and allow for in-depth exploration and probing.
- The research subject was not an observable phenomenon, hence the need to

Gain insight into the perspectives of respondents. Interviewing assumes that the perspectives of others are meaningful, knowable and able to be made explicit.

- Richness of data and deeper insight into the subject of positive living.
- Interviews allowed the researcher and respondents to come face to face helping to clarify questions which could have been misunderstood by respondents.

There are also disadvantages associated with interviewing. They include the following:

- The presence of the interviewer could have influenced responses.
- Difficulties related to generalizing results to the larger population because of small sample sizes.

The approach provided the key informants with a largely free- ranging discussion on the issues related to the need for positive living among infected individuals.

### **3.2.3.2 Focus Group Discussions (FGDs):**

Morgan (1988) points out that the defining characteristic of FGDs is the explicit use of the group interaction to produce data and insights that would be less accessible without the interaction found in the group. He further argues that the group situation can stimulate people in making explicit their views and perceptions. Four focus group discussions (FGD) were conducted with PLWH belonging to the support groups. It is hoped that group interaction will produce a wide range of responses allowing participants to build on each other's ideas and comments, thereby providing an in-depth view on the subject of the study. Thus a huge amount of information is

collected within a short space of time and at a low cost, which is convenient to the current researcher. This set up allows the investigator and the respondents to come face to face helping to clarify questions which could have been misunderstood by respondents. In addition, the use of focus group discussion accommodated illiterate participants.

However, Booyesen (2007: 3) notes that the interview technique has the challenge of reactive and investigator effect. Thus, the presence of the interviewer in this study might have influenced responses. That is, participants might have simply said what they felt or believed please the interviewer rather than what they actually believe.

### **3.2.3.3 Case Studies**

The FGDs revealed some pertinent and interesting issues that needed further investigation but this particular data collection technique (FGDs) could not provide a suitable environment for such investigation. It was decided that it would be effective to purposively select 7 case studies from the focus groups to provide more in depth data on the issues under investigation. The case studies comprised of 2 couples, 2 widows and a widower; each couple was jointly interviewed. Specifically the cases were selected on the basis of having raised the issues of concern during FGDs.

Theodorson and Theodorson (1969) define a case study as a method of studying social phenomena through the thorough analysis of an individual case which provides an opportunity for the intensive analysis of many specific details that are often overlooked with other methods. The essential methodological features of a case study are its provision of an in-depth detailed analysis and that it enables detailed probing and also allows the researcher to utilize personal observation (Casley and Lury, 1984).

### **3.3.0 Data Collection Instruments**

In-depth qualitative interviews were conducted with the aid of a semi structured interview schedule. Semi-structured interviews were preferred in this study because they are flexible and provide room for the respondents to freely express their feelings, views and opinions. The schedule was basically a checklist of topics that were to be addressed in the interviews meant to provide a guide to the general line of inquiry not restrict the discussions. This was deliberately designed to allow the researcher to engage in open, broad and flexible discussions with interviewees. The topics included in the schedule were neither strictly followed in chronological order nor were they meant to exhaustively cover the scope of the discussion. This is unlike a more structured or standard questionnaire with a pre determined order and set of questions which tend to be rigid and narrow in scope. There was minimum interruption by the interviewer when the participant was discussing a subject at length. Some items were omitted from the schedule as in discussing a topic participants would cover other topics that were intended for the discussion subsequently. In addition, the questions changed progressively. As I held more interviews, new questions and areas of interest emerged that added value to my research. A sample of the final outlook of the schedule is contained in the appendix.

### **3.4.0 Data Collection Procedure**

The researcher obtained consent from the key gate keepers who are the Director of Health Services for the City of Harare, the NAC District Coordinator for Harare North and the Ward AIDS Action Committee (WAAC) for Hatcliffe Extension to carry out the study. The gate keepers had already liaised with other stakeholders in the area to sensitize them about the study and get their buy in for the pre-test of the tools and the

subsequent actual data collection. Appointments with the support group members and the key respondents were done through the NAC District Coordinator.

It is important to note that, observations from the first focus group discussion revealed that some female participants were dominated by and not very free to air out some of their sentiments in the presence of male respondents. The same applied to some teenage respondents who tended to be dominated by adults. For that reason, the subsequent focus groups were split into exclusive male, exclusive female and then teenagers/adolescents. This appeared to work out as the subsequent disaggregated groups produced more open and detailed discussions.

### **3.4.1 Piloting**

Maxwell (1998:79) highlights that researchers could pre-test instruments to get used to the data collection exercise and to help the researcher to understand better the subject of investigation. The data collection instruments used in this study was pre-tested in Harare. The pre-test subjects involved were people to whom the data collection instruments were at least relevant. The pre-testing helped practicing the interviewing technique. It also provided the researcher with the opportunity to probe relevant responses from the key informants and to identify and address shortcomings in the environmental setting. For example, the researcher's first concern was choosing the appropriate venue for the FGDs. Generally, an environment that helped set the necessary mood for the discussions was preferred. The pilot study also provided the researcher with an opportunity to test the validity and reliability of the research instruments.

### **3.4.2 Data Analysis**

As Tesch (1990) posits, qualitative data analysis, unlike quantitative data analysis, is not concerned with statistical analysis, but with analysis of codes, themes, and patterns in the data. A thematic content analysis was used to analyze the data collected from both In-depth Interviews and Focus Group Discussions.

### **3.4.3 Ethical Considerations**

Considerations of ethics are an inherent part of every phase of a researcher's life for both social and practical reasons (Kazdin, 1980). Even though everyone's behavior is under observation somehow, whether or not a particular program has been designed for this purpose, issues to do with discussing personal experiences within a group raises questions about ethics (Atherton, 2003).

### **3.4.4 Confidentiality and Informed consent:**

Confidentiality is paramount in a study of this nature that deals with sensitive issues like one's HIV status. The researcher was cognizant of the fact that exploitation of participants is unethical. According to Kazdin (1980), members should be given a reasonable choice about own participation and the right to their own privacy should be respected. Informed consent to talk and interview respondents was sought and all participants signed a consent form. All information obtained was treated with privacy and strict confidentiality and kept under lock and key. Each person's performance, opinions, insights and recommendations were treated with strict confidentiality. To ensure anonymity and confidentiality, real names of participants were not required during the whole process. Only pseudonyms were used to allow researcher to easily identify and coordinate participation.

All the data collected was used for purposes of the study only.

### **3.4.5 Neutrality**

Researcher respected the opinions of the respondents without deliberately seeking to influence them. The researcher ensured neutrality by avoiding a judgmental approach during the interviews and the FGD.

### **3.4.6 Official Deception**

The researcher observed the need to debrief respondents on the purpose of the study. The researcher sought to avoid leaving the respondents in doubt as to the use of the findings as well as raising false hope in the respondents by clearly stating the aim and objectives of the FGDs and Key Informants (KI) interviews.

## **CHAPTER FOUR**

### **RESEARCH FINDINGS AND DISCUSSION**

#### **4.0 Introduction**

Chapter four of this dissertation focuses on presenting findings on the challenges faced by people living with HIV and AIDS in their quest for positive living in Hatcliffe Extension Suburb. Presentation of findings will be done concurrently with the discussion. In discussing findings, emphasis is on bringing on board possible reasons and explanations for the emerging trends. The Chapter will begin by describing the biographical characteristics of the sample and will go on to present and discuss the themes that emerged from the focus group discussions, key informants as well as those who participated as case studies where semi structured interviews were conducted. The Chapter will be closed by a conclusion.

##### **4.1.0 Biographical Information for FGDs**

Fifty participants took part in the study. They were drawn from different support groups in Hatcliffe Extension suburb. The sample composed of 36 females and 14 males. Twenty percent (20%) of the participants were teenagers Those who were 50 years and beyond constituted only five percent (5%) of the entire sample clearly indicating that HIV infections start by increasing as age groups increase then up to a certain point, the rate decrease as age groups increases. Table 1 below shows the age groups of participants and the corresponding proportions of participants.

**Table 1: Participants' Age Groups and Corresponding Proportions**

<b>Age Range</b>	<b>Number of Participants</b>	<b>Percentage (%)</b>
12 years -19 years	10	20
20 years - 29 years	17	34
30 years - 39 years	12	24
40 years - 49 years	8	16
50 years and above	3	6

The study also used four key informants who were drawn from different organizations which deal with people living with HIV and AIDS. Two females and two males participated in the study as key informants. All the key informants occupied strategic positions in their respective organization which made them suitable to comment on the issues under discussion.

#### **4.2.0 Services rendered to PLWHA**

##### **4.2.1 National Policy and Strategies**

Findings from this study revealed that there is a supportive national legislative/policy environment that is promoting the well being of PLWHA in Hatcliffe. Indeed, the government of Zimbabwe has over the years come up with some measures to mitigate the plight of people living with HIV and AIDS. Chief among them was the formation of the National Aids Council (NAC)- a body that administer and govern HIV and AIDS related activities; the Zimbabwe National HIV/AIDS policy (1999); and the Zimbabwe National HIV/AIDS Strategic Plan (2005- 2010). The NAC is very visible and active in Hatcliffe Extension with structures from district to ward level and they are coordinating support group meetings for PLWHA among other HIV/AIDS work

being implemented by other partners. NAC in conjunction with Zimbabwe National Network for People Living with HIV and AIDS (ZNNP+) also administer provisions of the Zimbabwe HIV/AIDS policy which include psycho social support inform of counseling; education campaigns to fulfill the right of PLWHA of access to information on protection against HIV and other STIs. NAC also reported that they are administering the AIDS levy with the idea of subsidizing antiretroviral treatment and other needed services. Though commendable, NAC representatives were quick to point out that though their policies are very good on paper, they are facing serious financial constraints hindering effective service delivery.

#### **4.2.2 Antiretroviral Therapy and Opportunistic Infection Treatment**

Another essential service for PLWHA found in Hatcliffe Extension is the administering of anti retroviral drugs and treatment of opportunistic infections. This is primarily being carried out by a local city council health facility with government support. Essentially this is a public health service outlet and queues of patients seeking services at the clinic could be witnessed. The queues were reported by the clinic staff member to be a permanent feature and also a reflection of the overwhelming need for medical services by residents of this area.

#### **4.2.3 VCT and PPTCT Services**

The same healthcare facility, also offered HIV testing as part of the clinic service. This model was reported to assist both the service provider and the infected person to plan effectively on either living positively or maintaining a negative status. However, it was reported that though the number of people coming for testing is continuously increasing, currently the number of people making use of this service as a proportion of the total population was said to be disappointing and it was estimated at less than a

quarter. In addition to VCT, the clinic also offers prevention of mother to child transmission. As with VCT, the provision of services to prevent the transmission of HIV from mothers and their babies aims to provide pregnant women with free VCT services and give them access to nevirapine, a drug that significantly reduces the chances of transmission occurring. A good number proportion of pregnant mothers were said to be enrolling on this program although a few were still said to be delivering from home.

However, it has been noted that consultation fees charged in state public health institutions are deterring people from accessing any health services, including HIV testing and treatment. This is problematic not only for the patient, but for efforts to prevent further HIV transmission. This is compounded by a strong reluctance to access testing amongst much of the population; people living with HIV face a particularly high level of discrimination in Zimbabwe, and many people fear that if they are found to be HIV-positive they will be stigmatized.

#### **4.3.0 Challenges faced by PLWHA in an endeavor to live positively associated with the services they receive.**

Participants in the general (heterogeneous) focus group discussion highlighted some factors which deterred them from living positively with the condition. However, these factors were not fully explored due to the heterogeneous nature of the group which comprised of different age groups and different sexes. Some participants felt culturally and morally restricted to fully participate and meaningfully contribute to the discussion. This led the researcher to consider having 3 more focus groups. One comprising adolescents, the second group comprised of adult women only and the third group was constituted by adult male participants. This was done in order to encourage free participation amongst respondents and divulging of all the important

information without restrictions. Although the presentation will not be done according to these groups, where different groups raised different issues or differed in opinion on the same issue, this will be indicated during the discussion.

#### **4.3.1.0 Factors hindering access to services that impact on positive living**

#### **4.3.11 Socio-psychological problems**

##### **Denial**

Chief among the psychological challenges raised was the aspect of denial. This was very common within the FGDs. It emerged that some people living with HIV and AIDS have difficulty in accepting the fact that they were living with HIV and AIDS. Results reveal that they could not believe that they had acquired the virus due to the earlier on assumptions they held such as “*it won't happen to me proposition*”. Denial was also due to the fact that HIV and AIDS is associated with death. By extension, this behavior can be explained in terms of the drive theory which asserts that, man seeks to do everything possible to ensure his continued existence (Taflinger; 1996). According to the drive theory, humans have an innate and unconscious desire to reduce conflicts between Thanatos (death instinct) and Eros (life instinct), favoring rather Eros in order to prolong life and postpone death as much as possible. However, in this case it is rather a futile attempt as it is denial of reality which will not produce desired results. That is, once PLWH deny their status, it then follows that individuals will live as if they are negative, thereby not paying attention to elements of positive living such as recommended diet, early treatment of opportunistic infections among other precautions.

## **Stress and hopelessness**

Another psychological theme which emerged was the element of stress. Stress was cited as one of the stumbling blocks to positive living. Although not all, but some respondents in the various FGDs argued that they often get stressed over issues such as how near their death could be and who will look after their children after they are gone. They got stressed over the impending death. The researcher inferred the fear of death as one of the probable reasons why some PLWH succumb early to the virus. Stress produces some chemicals such as adrenalin and cortisol which interfere with normal biological functioning, thereby putting one at risk, especially those living with HIV. Linked to stress has been the feeling of hopelessness. Indeed due to too much stress some respondents had lost hope of a bright future. Many of them argued that they had already “written themselves off” and there was little they could do to help their situation. One of the participants had to say “*tangomirira kufa, hapana zvimwe zvatichaita*” meaning “we are now waiting for death and there is nothing more we can do”. Hopelessness as a state of mind strips individuals of power to act to reverse or mitigate their problems. This is consistent with findings in the literature that, lack of hope acts against the will and desire to live and makes individuals passive and tend to be at the mercy of the environment (<http://www.thebody.com/content/art2469.html>). Such hopelessness also led to undesired behaviors like excessive alcohol intake. Hopeless people believe they cannot change the environment, be it internal (body functions and processes) as well as external (social, economic surroundings among others).

Another issue which emerged from the male FGD was the issue of financial inadequacy as a cause of stress. The group indicated that due to the daily demands

they shoulder, they usually end up being stressed as they will be left with less money for some other foods and services or at times, they would feel guilty for failing to provide for the so called “good for our health” products. The guilty usually translates into some form of stress. Similarly, in the case studies of couples financial inadequacy was reported as the main element which made living positively with HIV difficult. Thus lack of adequate financial resources emerged as the root cause of most of the marital disputes that bedevil their marriages. As already alluded to, stress has some devastating effects on PLWH, even though they may want to live positively.

### **Guilt conscience**

Respondents from all the focus groups also reported suffering from guilty conscience which also significantly contributes to their stress levels. Adult married people living with HIV blamed themselves for bringing the virus into their marriages. They felt they deserved to die for behaving in a manner which had put the whole family at risk. One respondent had to say “*dai pasina inini, mhuri yangu ingadai ichifara, pasina zvese zvechirwere izvi*” meaning had it not been for me, my family could have been happy without all these issues of HIV and AIDS. One key informant from ZNNP+ also confirmed that some of the PLWH were failing to forgive themselves thereby remaining stuck in one position instead of moving ahead with their lives. This was also true of the adolescents FGD in which adolescents were blaming themselves for having messed up their lives. While some blamed their parents for infecting them with HIV, some laid the blame upon themselves indicating that they were easily fooled into having sexual intercourse leading to their infection. Once one blames themselves, they feel they deserve punishment and they feel nature is punishing them for what

they have done and there is nothing they can do, setting the already mentioned element of hopelessness in motion.

The adolescents also indicated some social challenges associated with living with HIV. They reported that it was difficult for them to ask for money to buy such items as condoms from their parents yet they needed to have sex with their partners at the same time avoiding re-infections which come as a result of having unprotected sex.

Adolescents also indicated that even when they can afford to buy a condom, buying it was not easy as the whole community knew that they were not married. This went along with the existing literature which indicates that one engages in a cost benefit analysis when making some health choices. When the perceived cost is higher than the perceived benefit, one will not engage in a healthy behavior and the opposite is true, when the perceived benefit outweighs perceived cost, one will engage in a healthy behavior (Rosenstock 1966). They argued that buying a condom sent the wrong message to others in a supermarket queue. It emerged out that the desire to keep their names clean in the community acted against the spirit of positive living. They blamed the society for the expectations that it holds for adolescents. This behavior by adolescents can also be explained by the notion of imagery audience which is a developmental issue which states that adolescents usually think they are the centre of attraction when in most cases no one notices what they would be doing and no one pays attention to their actions ([http://en.wikipedia.org/wiki/Imaginary\\_audience](http://en.wikipedia.org/wiki/Imaginary_audience)).

#### **4.4.0 Stigma from various quotas**

Another important theme which emerged from the study was the issue of stigmatization as a hindrance factor to positive living for people living with HIV.

Failure of the society to embrace and incorporate those living with HIV has been singled out as one of the factors which complicates life for the infected as it alienates them away from the entire society (Cloete et al 2010). The participants cited the following phrases that were being used by the public as variations of synonyms of being HIV positive:

1. *Ane mukondombera* (S/he is infected with the dreaded killer disease)
2. *Vari pachirongwa* (They are on ART)
3. *Kamurwere* (S/he is a weakling)
4. *Ane shuramatongo* (S/he has AIDS)
5. *Ane perm* (he/she has treated hair)

The last phrase, '*ane perm*', gave an implicit insight into how people deduce an individual's status from their general appearance, in this case, the state of their hair (perm refers to some old fashioned hairstyle that made hair appear thin and wasted which is a common symptom in people at an advanced stage of HIV progression).

The extreme images depicted people living with HIV as a well defined category that is only waiting and anticipating death that is not too far away into the future. Phrases like '*ari mubhazi*' translated 'he/she is on a bus' implies that the HIV positive person is on a journey whose abrupt destination is sure death. The same idea was also clearly expressed in the phrase 'she/he is in the departure lodge'. One phrase; '*mubest before*' implies that a person living with HIV is like a perishable commodity whose day of expiry is known and not far away. The image of a perishable commodity was also evoked in such derogatory phrases like '*Mubetter nhasi*' translated 'he/she is better today'.

The FGD participants regarded the above phrases and terms as being very stigmatizing especially after they had noted that acceptance by the significant others in one's life is very important for social support and psychological well being. They argued that they would feel more confident to soldier on when others accept them unconditionally. Particularly, stigmatization by close relatives or family members was lamented more and deemed to be depressing. One respondent had to say "*Pane vanhu vasingafanire kukurasa kana waita chirwere, vanhu ivavo vakakusema, haurarame*", meaning "there are some people who should never let you down, if these are to let you down, you will surely die". Similarly, according to Sayles (2009) segregation by close relatives or associates is more devastating than when it is perpetrated by some distant associates. The over emphasis on family stigmatization could be inter-linked with cultural factors whereby Zimbabweans live a communal life compared to Western life which is more individualistic. Family based stigma also turned to be a major issue due to the popularization of the Home Based Care (HBC) model whereby HIV and AIDS patients are cared for at home with by the family members. Uys and Cameron (2003) state that HBC is a direct response to inadequate medical infrastructure which cannot comprehensively provide for all the people living with HIV. There is therefore bound to be challenges to positive living when those entrusted to take care of a patient stigmatize and keep the individual at arm's length. Key informants also weighed in by arguing that although counseling to deal with one's psychological being is done after one is diagnosed with HIV, the environment in which people operate and live in is not very supportive. It emerged that counselors and other professionals provide information for positive living but the PLWH get stressed as they fail to implement the recommendations due to social constrains such as stigma. This is in line with Sayles (2009) who notes that social ills such as

discrimination and stigmatization negatively affect PLWH as well as their quest to live positively.

Participants also brought on board stigma on the part of medical personnel whom they accused of having some negative attitudes towards them. They argued that they usually get treatment last, with preference being given to those who are HIV negative requiring treatment for ailments unrelated to HIV. However, key informants indicated that at times HIV patients misinterpret efforts by health workers and caregivers to protect themselves from the virus as discrimination. They pointed out that it is highly recommended that when one is looking after an HIV patient, they should put in place some protective measures such as putting on gloves to avoid contamination. Key informants argued that when patients are not careful, they may be tempted to think that they are being looked down upon or being kept at an arm's length by relatives or professional caregivers and may interpret it as stigma. PLWH were therefore encouraged to learn to separate health precautions exercised by significant others and being stigmatized. Such a misinterpretation was cited as one of the unnecessary causes of stress. Similarly, Uys and Cameron (2003) note that medical practitioners in developing countries are usually burdened with a lot of patients who need their services against a background of inadequate or weak medical infrastructures. This was true of the local clinic in Hatcliffe Extension which was understaffed.

However, some forms of stigmatization such as those one experiences when s/he is travelling to other countries did not emerge out of the current study. Most likely due to the socio-economic position of the participants that made them ignorant of possible travel restrictions. In addition, as highlighted by Maslow in his hierarchy of needs, people's needs move after satisfying the previous set of needs. Participants who

participated in the study were struggling to meet basic necessities such as food and clothing and it is highly unlikely that they will consider travelling abroad.

### **Peer pressure**

Key informants also brought up the issue of peer pressure resulting in a lot of sexual activities going on among teens. Peer pressure was linked to adolescents' intense desire to belong which would at times mean doing anything to penetrate a social group, even when it meant going against one's personal or family values.

### **Reduced sexual sensation**

Reduced sexual sensation which results from using a condom was another theme which the male group emerged with. They indicated that although condoms were good for their health, at times they opted to have unprotected sex with a desire to "increase sexual pleasure" thereby acting against the idea of positive living. Key informants also shared similar sentiments with the male group.

## **4.4.1 Religious factors**

### **Discouragement of adherence to drugs**

Religion has also been cited by the participants as one of the factors that compromises PLWHA's quest for positive living. It emerged that some church ministers negatively viewed the element of taking ARVs. Respondents indicated that the intake of ARVs is sometimes viewed as lack of faith in God. They reported that at times they were openly discouraged from taking their daily tablets under the pretext that HIV and AIDS had no cure and that only God will heal them if they truly believed. Gilbert et al (2007) argues that religion can be both a source of inspiration as well as a hindrance to positive living. It was argued that PLWH in churches are caught between the need to belong and the need to adhere to their medical regimen. Due to the high level of

desperation exhibited by some PLWH, they tend to be gullible to the extent that they buy in to some of the sermons by some church leaders to their own peril.

The same issue was also raised by the key informants who indicated that some clergymen thrive on other people's misery, especially those who are disadvantaged in one way or the other by claiming possibilities of miracles. Key informants argued that church leaders should be more realistic. It was recommended that church leaders should work hand in hand with those organizations which work with PLWH instead of working in opposition.

### **Instilling of a sense of guilty**

Key informants went ahead and revealed another aspect which did not come out in the focus group discussion. It was argued that some church leaders instill a sense of guilt as they at times blame PLWH. They are considered as sinners and outcasts when in effect they want help and acceptance. Such treatment is likely to result in segregation and stigmatization of PLWH, a scenario which negatively affects their efforts to live positively.

## **4.4.2 Medical factors**

### **Side effects of ART**

Side effects of some medication especially those associated with ARVs were also mentioned as one of the factors militating against the quest by PLWH to live positively. ARV drugs according to the WHO (2009) are some of the most 'toxic' drugs around and can have intense negative side effects such as skin reactions, nausea among others. Indeed fear of these side effects has been cited as deterrent to positive living as one has to choose either to take the drugs and risk side effects or completely shun the drug and risk dying early.

### **Use of herbal medicines concurrently with ART**

Another issue falling under the broad category of medical challenges which was raised by the case study respondents was the mixing of traditional/herbal medicines with more western type of medicines. Herbal medicines may react with western medicines when taken together (Auvert 2004). It emerged that due to the high levels of desperation, PLWH are vulnerable to any form of suggestions, even those not scientifically tested and proved. One participant said that, "*Hauzivi chakakodza nguruwe*" meaning to say you never know what might help you. Some key informants also highlighted the issue of combining traditional and western medications as a source of complications unnecessarily resulting in the deterioration of the health of PLWHA. They noted that this results from paying attention to rumours which usually circulate in the locality claiming that this herb or that other herb is alleviating or even healing HIV and AIDS. One key informant had to say "*pane vanhu vanotsvaga mari nekunyeba, kuti tumidzi twavo tutengwe. Nekuda kupona, vanhu vedu vanenge vaine chirwere vanomhanyidzana ikoko, ivo zvakare vachitambira maARVs*" meaning "there are some people who spread around rumours in order to sell their herbs, due to desperations, our people will run to those people for assistance, at the same time, receiving ARVs. This state of affairs greatly hinders the aspect of drug adherence which is crucial in one's efforts towards living positively with HIV, as postulated by BHIVA (2001) anything below 95 percent adherence has been associated with increases in viral load and drug resistance. This researcher however, seems to have noted that most PLWH combine these two forms of medications due to a deep seated belief that "the condition may be reversed". This is in line with the already mentioned challenge of denial, in this case, denying that HIV and AIDS cannot be treated.

An inadequate medical personnel was another theme which emerged from the current study. Inadequate health personnel results in inadequate and delayed attention being given to PLWH. Medical personnel assist PLWH to live positively as they offer the medical support which is very critical in the lives of PLWH. DMSAC, 2005; Kanye Rural Administration Centre (2005) argues that a vibrant health infrastructure is required in the quest not only for a positive living, but in the fight against HIV and AIDS as well. Perhaps, the inadequate medical personnel are a result of the brain drain which rocked the nation a few years ago .As revealed by the <http://www.thebody.com/content/art38190.html> website Zimbabwe is the country hardest hit by the brain drain on the continent, resulting in the loss of over 50 percent of key professionals. The country has been hit by an exodus of doctors, nurses, midwives and lab workers, seriously taxing a health care system already burdened by the AIDS epidemic. This serious lack of medical personnel inevitably threatens and undermines the quest by PLWH to live positively.

#### **4.4.3 Economic factors**

##### **Lack of finance**

Adolescents who took part in the study lamented inadequate finances to fund their ‘positive living’ efforts. Indeed as noted to by this researcher most of them were unemployed as they had just completed their ‘O’ levels with some even still in school. One male adolescent had to say “*positive living yacho inoda mari, of which hatina mari yacho, kana condom chairo rinotoda kutengwa*” translated to “positive living requires money that we do not have, even a condom needs to be bought” teenagers lack of money is likely to be partly emanating from the economic conditions that prevailed in the country prior to the introduction of the multicurrency regime. The period had some intense and far reaching effects on the entire populace including the

adolescents who were even younger by then. Unemployment rates increased dramatically. Teenagers argued that their inability to purchase condoms regularly leads them to frequently indulge in unprotected sex. Even though service providers have argued that condoms are offered at a nominal cost, teenagers argued that they could not afford to buy condoms every time they intended to engage in sexual activities. This finding does not concur with the drive theory which postulates that individuals engage in behaviors which promote and lengthens life at the expense of those that seem to act against the spirit of long life. However, results have conformed to Maslow's hierarchy of needs as it emerged that adolescents in this case are pre-occupied with the basic physiological needs at the expense of security needs which in this case are offered by the use of a condom. This is typical of any poor community where residents struggle to meet basic needs. This outcome is in line with Sayles' (2009) observation that poor communities are the worst affected by HIV and AIDS. The behavior by these teens of prioritizing sex at the expense of their safety is in line with Maslow's hierarchy of needs which states that unless basic needs are met will one consider moving up to safety/security needs. Prostitution among adolescent girls was cited as a means to earn some money to care for the younger siblings. Prostitution completely militates against the notion of positive prevention which underpins the notion of positive living by PLWH.

### **Male breadwinner role**

The male breadwinner role also pushes some men living with HIV to the edge, to the extent of even selling ARVs to purchase food stuffs. Male participants who took part in the study revealed that their efforts towards positive living were hindered by the guardian roles they assumed over their families. They argued that they had a

responsibility to make sure that their families had something to eat, to wear and are attending school before they consider their personal welfare. Men also noted that their wives were very demanding in as far as material things were concerned. They argued that their finances were very meager yet their spouses made a lot of demands under the pretext that “it will improve their (the female spouses) health”. One participant said “*zvese zvinongonzi zvakanakira hutano hwedu*” translated to “everything is said to be good for our health. It emerged from the results that males were usually engaged in some economic activities, an element which took most of their time. This issue is also reflected in the composition of the sample whereby most of the participants were females and less were males as they were reported to be engaged in some economic activities to earn some income for their families. Males are culturally regarded as the breadwinners who should ensure that they provide for their spouses and families (<http://www.imow.org/economica/stories/viewStory?storyid=3698>).

### **Unemployment**

Husbands disclosed that they were not formally employed and earned a living from meager activities such as chopping down trees and selling the firewood, carrying groceries for people who would have done their shopping or illegal fishing. Such earnings were reported to be highly inadequate not only to fund special requirements for PLWH but for the general upkeep of their respective families. The wives testified that they were basically housewives who were running some vegetables markets which did not have significant returns.

#### **4.4.4 Cultural factors**

Some cultural factors have been reported to be militating against PLWH and these cultural factors differ from one age group to the other and from one sex to the other.

##### **Male dominance**

Married women in the exclusive female FGD argued that culture empowers men more than women even when the issues are to do with the sexuality of females. Male dominance was identified as one of the issues which hindered married women living with HIV from living positively. In a typical Zimbabwean culture, men are the household heads and they have the last say in all the household activities, even those pertaining to sex. Similar sentiments were also echoed in the male FGD when a theme emerged whereby they argued that they derive power and authority over the woman by virtue of the fact that they parted with some cash when they paid lobola. Generally, it is the man who dictates when and how sexual intercourse should be done. Since males are culturally allowed to be more outgoing than their female counterparts, they are likely to question sexual suggestions (such as putting on a condom during intercourse) emanating from their wives who are socially expected to be indoors.

Due to the cultural biases against women, the researcher noted that many women's knowledge about condom use and re-infections was of no meaningful use because they could not culturally negotiate condom use with their male counterparts, especially those who had a strong traditional inclination. Women risked earning themselves some negative titles the moment they tried to introduce the element of condom use, especially in marriages where it was not used. Zaidi (2006) supports these findings arguing that male dominance restricted females from successfully implementing their newly acquired knowledge in as far as safe sex is concerned. It is

argued that in many developing countries, cultural practices disempower women even in situations where they are the most affected. Married men confirmed the notion which was raised by females. A theme of cultural identity emerged from this group. One participant had to say “*zvakagara zvakadaro, murume ndiye musoro wemba, mukadzi anotoita zvinodiwa nemurume wake*” translated to “it has always been like that, the husband is the head of the household and a wife should do what pleases her husband”. Some males argued that they felt undermined when their wives take a leading role in as far as sexual matters are concerned.

The same argument was also raised by key informants who highlighted that male dominance was entrenched in many people’s minds to an extent that most males do not see female input as valid, instead, they feel threatened. Key informants further indicated that male dominance was mainly associated with poor societies and those who did not manage to acquire meaningful levels of education.

### **Males as macho and adventurous**

Adolescent boys also alluded to the fact that they are culturally empowered to be risk takers. Boys are culturally expected to be very outgoing and having a multiplicity of lovers. A Shona adage which goes “*bhuru rinorwa rinoonekwa nemavanga*” meaning ‘a fighting bull is identified by the wounds’ clearly indicates how culture promotes and tolerates sexual risk behaviors by males. It is argued that the so called wounds are STDs. This trend is in line with the proposition by Gallo (2009) who identified the boy child as being more exposed to HIV and AIDS than his female counterpart. Culturally, those boys who engage in sexual activities are regarded as heroes while their female counterparts are regarded as having loose morals. Such societal attitudes put pressures on boys to measure up, thus increasing their chances of acquiring HIV

and at the same time discouraging girls from engaging in sexual activities which are not sanctioned by the society, thus reducing their chances of acquiring HIV. This point was also highlighted by all the key informants who asserted that cultural values are high in less developed areas such as the one where the study was conducted.

Traditionally, men are allowed to enjoy themselves outdoors while women are restricted indoors. Females in the focus group indicated that this imbalance posed a challenge to them as their HIV positive husbands usually go out and have extra marital affairs and when they are back home, they refuse to use condoms, thereby increasing the chances of re-infections. According to the female participants, men put themselves at risk by trying to prove their manhood.

In addition to the above, key informants also indicated men's need to please friends and to feel the need to conform to what colleagues would be doing, thereby frequently putting themselves at risk due to the need to belong.

Such an argument may also be the reason why male participants in the current study diminished in number as the age range increases. In addition, such a trend could be attributed to the nature of work usually done by males which is strenuous. From the anecdotal evidence that the participants provided the researcher deduced that it seems as if females tend to live longer with HIV compared to their male counterparts. Results have revealed that although PLWH decline with increasing age, males decline at a much faster rate than females. Such a trend is also reflected in the sex composition of the participants who took part in this study. According to the findings, the proportions of PLWH were declining as the ages of participants increased. This is supported by Sayles (2009) who acknowledges that HIV and AIDS are more concentrated in the younger generation more than the elderly.

Case studies also brought to light the need for procreation as a hindrance factor to positive living. The need to have an additional child or children yet pregnancy would pose some risks to both the parents and the unborn baby. Such a desire would usually result in marital conflicts, especially when one wants the child and the other one is showing some reservations. When sex is done for procreation, then it becomes clear that no condoms would be used in the process. Unprotected sex is not recommended for PLWH, especially when considering living positively. Unprotected sex increases chances of re-infection. Sex for procreation is further complicated when a couple is searching for a male child who is culturally regarded as more valuable than a female. According to the [http://www.ipsnews.net/africa/Focus/religion/note\\_11.shtml](http://www.ipsnews.net/africa/Focus/religion/note_11.shtml) website the birth of male children is still the source of pride in many societies and the desire for a male child has resulted in husbands pressuring their wives to have more children, in some cases putting the health of the women in danger. Such a cultural scenario will continuously compel a couple to engage in unprotected sex, hoping to have a baby boy. The role of the extended family members in a marriage also compels a couple to consider prioritizing conceiving a baby boy. These would be putting a lot of pressure on a couple to “keep on trying”, an issue which puts the couple at risk of re-infections and birth complications on the part of the female parent. This researcher also attributed the pressure for an additional child, especially a boy to the fear of death. It seems apparent that when one is positive, they usually accept the nearness of death and they feel the compelling desire to “put their house in order” before they depart from the face of the earth, hence the need to leave behind a baby boy who will perpetuate the family name.

#### **4.4.5 Anticipated possible solutions**

It is against a background of the articulated psycho social problems that the researcher proposes that more psycho-social support in the form of counseling be provided. Although key informants reported that counseling was being done at the local clinic, it clearly emerged that the clinic was severely understaffed in terms of the number of counselors vis-à-vis the clientele base. Thus most of the time PLWH resorted to peer counseling within their support groups and get resource persons once in a while. Notwithstanding the importance of peer support, the researcher felt that some of the critical emerging psycho-social issues like denial, guilt feelings, and hopelessness required professional counselors to deal with them. This would help respondents come to terms with their condition, accept their situation and reduce their stress levels thereby starting to live positively. The researcher's position was also supported by the key informant at the local clinic who cited inadequate professional counselors making the counselor-client ratio very high. This is in sharp contrast with Zaidi (2006) 's postulation in the literature that counseling as a professional discipline is not well appreciated by the general populace due to the cultural fall back which has been there for centuries. These cultural fall backs were said to include social systems such as the roles of aunts and uncles in providing counseling. Findings from this study revealed that respondents were flocking for this service only to access it inadequately. This could be because the referred social systems have crumbled in the modern society, particularly the extended family concept.

Key informants also recommended that where traditional social support systems such as aunts and uncles are in existence, they should be complimented with professional counselors. In addition, there was a call for professional counselors to appeal more to

the cognition of PLWH. The study revealed that most professional counselors focus mainly on more tangible and physical aspects of positive living such as diet, avoiding re-infections among other issues at the expense of cognitive restructuring.

Key informants encouraged PLWH to desist from taking drugs and herbs which would not have been medically tested as these are likely to interfere with the ARV drugs. In addition the researcher feels that more vigorous education campaigns targeted at PLWHA need to be carried out enlightening them of the dangers of concomitant medication as well as teach them to tolerate side effects associated with antiretroviral treatment.

It was suggested that although medical practitioners are inadequate in the health sector in Zimbabwe, each institution, should have staff dedicated to deal with HIV and AIDS related issues. Such a setup will ensure that, PLWH receive adequate and immediate attention. However, some respondents objected to this notion arguing that such an arrangement will be a form of institutionalized stigma. The latter school of thought was also supported by key informants who argued that PLWH should not be treated differently from the rest of the populace as such a stance would be tantamount to stigmatization.

In order to deal with the cultural male dominance, it is believed that males should be fully incorporated in discussions with key informants to help them appreciate their female folks. Since the males are usually preoccupied with activities that contribute to their economic wellbeing a flexible schedule should be put in place in order make them take part in these discussions without compromising their roles as bread winners in their respective families. Males can easily conform when the resource persons are males as well and from reputable organizations such as Padare Men's Forum.

In addition, parents should embrace the element of equality between the girl child and the boy child. Cultural preferences for the boy child should be done away with as this tends to promote risk behaviors on the part of boys at the same time restricting girls' exposure to useful information which they could receive as they venture outdoors. Parents and guardians should ask themselves for whom they are preserving the girl child for since the to-be husband is busy engaging in risk behaviors which will eventually be endured also by the innocent girl child whom they would have thought was safe. It is therefore important that moral values are passed on to both boys and girls unselectively. If values of equality are socialized into today's children, they will grow up seeing themselves as equals, thus moving away from the cultural dimension of male dominance and female inferiority complex in marriages.

As a possible solution to the cultural element which places more value on the boy child thereby forcing couples to continuously engage in unprotected sex, it is suggested that workshops be conducted to demystify this assertion. The gospel of equality between girls and boys should be re-emphasized. Partners in a marriage should also be taught assertive methods which will enable them to stand their ground when pressure from the extended family members mounts. Notwithstanding the role played by the extended family, its impact on marriages should be revisited in as far as preventive interventions are concerned.

## **Conclusion**

The Chapter sought to highlight the outcomes of the study as well as providing possible explanations for the emerging trends. Results were analyzed and discussed in relation to the objectives of the study. Possible explanations were linked to existing literature.

## **CHAPTER FIVE**

### **SUMMARY, CONCLUSION AND RECOMMENDATIONS**

#### **5.0 Introduction**

Chapter 5 is the last Chapter of this study and focuses on the summary, conclusion and recommendations. Summary encompasses an outline of the whole study. The conclusion entails focusing on the aim and objectives of the study and reviewing to what extent these would have been met. The Chapter ends with recommendations both to relevant stakeholders in the field of HIV and AIDS as well as to academics for further studies.

#### **5.1 Summary of the Study**

The study sought to identify challenges which are faced by people with HIV and AIDS in their quest to live positively. This study comes in the background that there is much emphasis on adopting a positive life even when one is positive. However, there are some factors which one needs to negotiate in order to live positively. In other words, living positively is a complex combination of different factors and it is not an issue of one individual or one sector but it needs a multi sectorial approach whereby all stakeholders should play a part in order to deal with the challenges experienced by PLWH to live positively. The study was conducted in Hatcliffe Extension suburb in Harare. The area was chosen because the challenge to live positively with HIV is greater in poverty stricken settings like the one under study where the pandemic's devastating effects are also more evident.

The aim of the study was to bring out the challenges faced by PLWH in their quest to live positively. As its objectives, the study sought to assess the nature and scope of

services available to PLWH in Hatcliffe Extension, to identify and profile hindrance factors that prevent PLWH to access the above referred services and live positively in general and to propose solutions to identified challenges faced by PLWH in living positively.

The study was premised on a conceptual framework which conceptualized that living positively with HIV is a function of a number of factors which include religious, culture, social pressures, and psychological aspects among other factors. Some theories were also used to try to explain the phenomenon under study. These theories were Maslow's Hierarchy of Needs, the Drive Theory and the Self Preservation Theory.

Literature reviewed indicated that people living with HIV were marginalized right from national policies down to the family level. Some acts of stigmatization are done under the "for the interest of the public" banner yet they are detrimental to those PLWH. Literature also indicated that although PLWH have some difficulties, there are some existing facilities in place meant to cushion them from the condition. These include but not limited to provision of ARVs, availability of condoms as well as medical intervention in reducing parent to child transmission.

A qualitative design was adopted for this study due to the sensitivity of the matter. Focus group discussions, key informants and case studies were used in the collection of data. In each of these, the researcher used interview guides which had a checklist of issues which he used in conducting the interviews. All in all the study had 54 participants of which 50 of them were PLWH while the remaining 4 were key

informants drawn from organizations which worked with PLWH. The 50 participants were sampled from 25 support groups which operated in Hatcliffe Extension using the purposive sampling procedure.

Four focus group discussions were conducted. The first one was composed of participants who were of different age groups and different sexes. It was however realized that the study would benefit more by having participants who were more similar in one group to tap as much information as possible. This led to the constitution of a focus group discussion composed of adolescents; the second group was composed of adult women while the last group was composed of adult men. Case studies were considered for 2 sets of couples who had earlier on taken part in the focus group discussions but who had unique marital experiences in as far as challenges of living positively were concerned. In addition, case studies also included 2 widows and a widower as well

Results have indicated there are some challenges which were considered general by all participants regardless of age and sex. These include stigmatization, challenges at health institutions as well as reacting to ARVs. It however emerged that some challenges were unique to some certain groups of PLWH. Married women lamented the male dominance as one of their unique challenges to live positively. Males also highlighted the issue of social expectations and the breadwinner role as one of their challenges. The males highlighted the stress they experience as a result of having to meet the family's economic necessities such as paying rentals, seeing to it that children are going to school. Young people who were not yet married highlighted their inability to meet the expenses associated with positive living as well as the need

to keep their public images clean, especially when it comes to buying condoms in the public outlets.

## **5.2 Conclusions of the Study**

The study aimed to meet specific objectives. It was evidenced from the study that PLWH had some facilities which were meant to cushion them from possible threats of the condition. These included provision of ARV drugs and counseling among other services. Participants also highlighted that they were being helped deal with their medical issues and demands by their respective support groups.

In relation to challenges of positive living experienced by PLWH, it emerged that they were facing a number of challenges. The major challenges were to do with cultural biases against women, cultural expectations on men which end up exposing their families and marriages to the pandemic or re-infections. Another major challenge which was reported in the study was the issue of stigmatization. It was reported that stigmatization runs from institutions such as hospitals down to the family level. The study also revealed that challenges of living positively differ with age group and sex. Women, especially the married bear the bulk of the brunt of some of the challenges.

According to the outcome of the study, these challenges should be tackled from different angles by different stakeholders. Participants argued that the medical infrastructure should be improved in order to meet the demands of PLWH as the numbers of the infected is significantly high. In addition, policy makers were also urged to be careful as they craft policies to avoid segregating the PLWH. Counselors were also urged to address the cognitive processes of PLWH instead of entirely focusing on material issues such as the need for condom use and getting treated for

opportunistic infections. If not addressed well, cognitive processes were argued to be the causes of stress in many PLWH.

### **5.3 Recommendations**

HIV and AIDS is no longer an issue of individuals, but has turned to be a national issue. There is need to adopt a holistic approach which pulls together efforts from different stakeholders.

Organizations which cater for the needs of PLWH together with all the relevant stakeholders should focus on the challenges to positive living. Dissemination of information should be tailor made to address how different age groups and sexes should live positively considering their unique challenges. Information on the requirements of living positively is over emphasized at the expense of the institution of mechanisms to counter the challenges mentioned in this study.

The government should come up with policies that cushion PLWH from stigmatization, especially in government related institutions such as the hospitals where many of the infected access their health and medical services. It is also important for organizations catering for PLWH to intensify their efforts to address not only PLWH but those who are negative as well as they are the main perpetrators of stigmatization.

It is also important to note that future researchers may benefit if a similar study is carried out with some other categories of individuals such as the economically empowered, those who live in mining towns as well as farming towns. Each setting is likely to present its unique challenges to PLWH.

It would also be important for future studies to include service providers of PLWH such as medical practitioners and get to hear what they think and how they treat PLWH. Getting information from their side will also help in solving the problems faced by PLWH in their quest to live positively.

#### **5.4 Conclusion**

Chapter five marked the end of the study and it looked at the summary of the whole study whereby the whole study was summarized. The Chapter went on to present the conclusions of the study. In this section, the outcome of the study was looked into in relation to the set objectives. The Chapter ended with recommendations to relevant stakeholders and future researchers in the area of challenges faced by PLWH in their bid to live positively with HIV.

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## **7.0 Annexure 1: Authorization Letter**

## 7.1 Annexure 2: Interview Checklist

- **Psychological factors**

Denial- (Accepting the condition of being positive vs. denying that one is living with the condition.

Stress- (Managing to handle the psychological challenges associated with HIV and AIDS vs. succumbing to the demands associated with the condition)

Hopelessness – (A feeling that one is in control and his/her effort is directly related to the outcome that follows vs. a feeling that one is no longer in a position to control events in his/her life and that there is no direct relationship between his/her effort and outcomes).

Guilty – (A feeling of no self blame for the condition vs. a feeling of self blame)

Reduced sexual pleasure due to condom use – (Psychological sexual satisfaction when using condom vs. perceived reduction in sexual pleasure resulting from condom use).

- **Medical Factors**

Side effects – (Reacting to ARVs vs. not reacting)

Belief in traditional medicine vs. belief in western medicine or both

- **Social Factors**

Stigma – Being socially accepted in all realms of life regardless of one's condition vs. being alienated due to the HIV and AIDS condition

Alcohol Abuse – (Drinking alcohol for recreational purposes vs. drinking to run away from social alienations and challenges associated with HIV and AIDS

Myths associated with the condition, especially on transmission modes

Peer influence in the positive direction or in the negative direction

Disclosure or lack of it due to fear of victimization

- **Cultural Factors**

Male dominance

Condom use in marriage setups

Infected males

- **Religious Factors**

Faith related behaviors

Male dominance resulting from religious factors

- **Economic**

Transport fare – Adequate or inadequate  
Money to purchase recommended food stuffs  
Breadwinner role limiting time

- **Diet/Nutrition**

Lack of (access to) balanced diet  
Accessibility (lack of accessibility) to basic food stuffs

- **Cultural factors**

Cultural loyalty/ fear of cultural shock in foreign land

- **Political factors**

Patronage beneficiary- (level and extent of connections with the political system)

Activist- (level of interest in political affairs of the country; roles played in the political processes of the country)

- **Economic factors**

Alternative/ supplementary sources of income- (consultancies; membership on boards of companies; returns on physical assets and other assets including equity in companies and intellectual property)

Secure source of income- (e.g. remittances in hard currency)

## **7.2 Annexure 3: Key Informant Interview/FGD Consent Form**

You are invited to participate in a study being conducted by Abel Blessing Matsika a University of Zimbabwe Master of Social Work Student. I hope to learn more about **The need for positive living among people living with HIV in Hatcliffe Extension Suburb**. You have been selected to participate in the study because of your knowledge about the subject under review. Any information that is obtained in connection with this study and that can be identified with you will remain anonymous and confidential and will only be used for academic purposes.

Your decision whether or not to participate will not prejudice your future relations with the researcher or the institution to which he is affiliated.

If you have any questions please feel free to seek for clarification. It is your right to choose not to respond to questions that you may view as being too intrusive.

**YOU ARE MAKING A DECISION WHETHER OR NOT TO PARTICIPATE.YOUR SIGNATURE INDICATES THAT YOU HAVE DECIDED TO PARTICIPATE, HAVING READ THE INFORMATION PROVIDED ABOVE.**

Signature:

Date: