

**DETERMINANTS OF HIV RELATED STIGMA AND DISCRIMINATION AMONG
HEALTHCARE PROFESSIONALS AT A HEALTH FACILITY IN MALAWI**

by

STEPHEN EMILIO NJOLOMOLE

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DECLARATION

I declare that the study entitled '**DETERMINANTS OF HIV-RELATED STIGMA AND DISCRIMINATION AMONG HEALTHCARE PROFESSIONALS AT A HEALTH FACILITY IN MALAWI**' is my own work and that all the sources that I have used or quoted have been indicated and acknowledged by means of complete references.



SIGNATURE:

DATE: 11/07/2016

DR NJOLOMOLE Stephen Emilio

DEDICATION

I dedicate this dissertation to my wife, Rahabe; my two sons, Noel and Joel who endured my absence during the implementation of this research project.

ACKNOWLEDGEMENT

I wish to thank Prof Makombo Ganga-Limando, my research supervisor for tirelessly guidance during the preparation and writing of this dissertation. His inputs and guidance are greatly appreciated.

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I give Glory to God Almighty for keeping me well throughout the project and for giving me the necessary wisdom.

**DETERMINANTS OF HIV-RELATED STIGMA AND DISCRIMINATION AMONG
HEALTHCARE PROFESSIONALS AT A HEALTH FACILITY IN MALAWI**

STUDENT NUMBER: 46447458

STUDENT NAME: DR NJOLOMOLE Stephen Emilio

DEGREE: MASTER OF PUBLIC HEALTH

DEPARTMENT: HEALTH STUDIES, UNISA

SUPERVISOR: Prof M GANGA-LIMANDO

ABSTRACT

Background: Certain individual and institutional factors such as knowledge about stigma and discrimination, fear of infection, social judgement, legal and policy environment act as actionable drivers and facilitators of HIV-related stigma and discrimination. These factors may hinder the utilisation and quality of care provided to people living with HIV.

Purpose: The purpose of the study was to establish the actionable drivers and facilitators that determine the different forms of HIV-related stigma and discrimination among healthcare professionals at a district hospital in Malawi.

Methods: The study used a descriptive correlational study. Data was collected through self-administered questionnaire. Data were analysed using SPSS and STATA 12. Fisher's Exact Test was used to conclude the association and binary logistic regression was used to model the degree of the statistical relationships.

Results: The results showed statistically significant relationship between knowledge of stigma and discrimination, social judgement and awareness of workplace policy and HIV-related stigma and discrimination.

Recommendations: Interventions aimed at increasing knowledge about HIV-related stigma, reducing social judgement, reinforcing HIV-related workplace policies are needed to reduce HIV-related stigma and discrimination in healthcare settings.

KEY WORDS: *Actionable drivers and facilitators, determinant, health facility, HIV related stigma and discrimination, types of HIV related stigma and discrimination.*

LIST OF ABBREVIATIONS

AIDS	Acquired Immunodeficiency Syndrome
ANC	Antenatal Clinic
CI	Confidence Interval
GNP+	Global Network of People Living with HIV
HIV	Human Immunodeficiency Virus
HTC	HIV Testing Counselling
MANET +	Malawi Network of People Living with HIV
MDHS	Malawi Demographic and Health Survey
NAC	National AIDS Commission
NAF	National Action Framework
NHSRC	National Health Sciences Research Committee
NSF	National HIV and AIDS Strategic Framework.
NSP	National Strategic Plan
STIs	Sexually Transmitted Infections
SD	Standard Deviation
UNAIDS	Joint United Nations Programme on HIV and AIDS
UNISA	University of South Africa
PEP	Post Exposure Prophylaxis
PMTCT	Prevention of Mother- To- Child Transmission
PLHIV	People living with HIV and AIDS
OR	Odds Ratio

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CHAPTER ONE

ORIENTATION TO THE STUDY

1.1 INTRODUCTION

In this chapter the researcher provides an orientation to the study in terms of the background of the research problem, the statement of the research problem, the aim and objectives of the study, the significance of the study, the theoretical framework of the study, the definition of key concepts, an overview of the research method, and an overview of the structure of the dissertation.

1.2 BACKGROUND OF THE RESEARCH PROBLEM

Malawi is one of the countries most affected by HIV and AIDS pandemic in Africa. The country has approximately 930,000 people infected with HIV and 86,502 people die of HIV and AIDS related diseases annually (MDHS 2010). Stigma and discrimination is one of the key barriers to HIV and AIDS prevention, treatment, care and management (Vyas, Patel & Shukla 2010; UNAIDS 2012).

Malawi integrated strategies aimed at reducing HIV related stigma and discrimination into the National HIV and AIDS Policy. This policy is based on the principles of the promotion and protection of human rights, the right to equality before the law and freedom from discrimination as entrenched in the constitution. The National HIV and AIDS policy views the fight against HIV and AIDS related stigma and discrimination as an essential element of an effective health sector response to HIV and AIDS (National AIDS Commission 2003). No studies have been done to evaluate the impact of the policy on HIV and AIDS related stigma, in terms of monitoring the trend on HIV and AIDS related stigma.

Several quantitative and qualitative studies have looked at HIV related stigma and discrimination at healthcare facilities in terms of the perpetrators of such behaviour, the forms of stigma and discrimination, and the impacts of stigma and discrimination among others (Mazengera 2008; Vyas et al. 2010). Authors argue that HIV related stigma and discrimination at healthcare facilities are often perpetrated by healthcare professionals (Feyissa, Abebe, Girma & Woldie 2012). This behaviour is often expressed through practices such as the refusal of admission, the provision of substandard care, the testing without informed consent, and breaches of confidentiality (Feyissa et al 2012). High level of irrational fear, type of clinical facility, level of education, and gender have been associated with HIV related stigma and discrimination among healthcare professionals (Hossain & Kippax 2010). Stigma and discrimination perpetrated by healthcare professionals have far reaching detrimental impacts on efforts to mitigate HIV (Dos Santos, Mellors, Wolvaardt & Van der Rys 2014; Mavhandu-Mudzusi & Ganga-Limando 2014).

According to Strive (2012), HIV-related stigma and discrimination at healthcare facilities are determined by certain individual and institutional factors that act as actionable drivers or facilitators. He argued that successful intervention aimed at reducing HIV related stigma and discrimination at healthcare settings should focus on modifying those drivers or facilitators (Strive 2012). It is within this context that this study looked at the determinants of HIV related stigma and discrimination from individual and institutional environment perspectives.

1.3 STATEMENT OF THE RESEARCH PROBLEM

It is known that HIV-related stigma and discrimination do exist in healthcare facilities across the world and their impacts on HIV prevention, treatment, care and support are well-documented in the literature (UNAIDS 2012). It is argued that certain individual and institutional factors such as knowledge about stigma and discrimination, fear of infection, social judgement, legal and policy environment act as actionable drivers or facilitators of HIV-related stigma and discrimination (Strive 2012). However, the extent to which these actionable drivers and facilitators determine the different forms of HIV-related stigma and discrimination at healthcare facilities in Malawi is under documented. The researcher intended to answer the following main question: “What are the actionable drivers and facilitators that determine the different forms of HIV related stigma and discrimination at a health facility in Malawi?”

1.4 PURPOSE OF THE STUDY

The purpose of this study was to establish the actionable drivers and facilitators strongly associated with the different types of HIV-related stigma and discrimination among healthcare professionals at a district hospital in Malawi.

1.5 OBJECTIVES OF THE STUDY

The objectives of the study were to:

- 1.5.1 Explore and describe the actionable drivers or facilitators of HIV-related stigma and discrimination among healthcare professionals at a district hospital in Malawi in terms of (i) knowledge regarding HIV-related stigma and discrimination, (ii) fear of contracting HIV, (iii) social judgement toward

people with HIV, (iv) awareness of the legal and policy environment, and (v) resilience.

1.5.2 Explore and describe the different types of HIV-related stigma and discrimination among healthcare professionals at a district hospital in Malawi.

1.5.3 Determine the strength of association between the actionable drivers or facilitators of HIV-related stigma and discrimination and the different types of HIV-related stigma and discrimination among healthcare professionals at a district hospital in Malawi.

1.6 RESEARCH HYPOTHESES

The following null hypotheses were used in this study:

1.6.1 There is no significant association between the participants' level of knowledge regarding HIV-related stigma and discrimination and the different forms of HIV-related stigma and discrimination

1.6.2 There is no significant association between the participants' level of fear of contracting HIV and the different forms of HIV-related stigma and discrimination

1.6.3 There is no significant association between the participants' level of social judgement towards people with HIV and the different forms of HIV related stigma and discrimination

1.6.4 There is no significant association between the participants' level of awareness of the legal and policy environment and the different forms of HIV-related stigma and discrimination

1.6.5 There is no significant association between the participants' resilience and the different forms of HIV- related stigma and discrimination.

1.7 SIGNIFICANCE OF THE STUDY

Identifying the determinants of HIV-related stigma and discrimination at healthcare facilities is significant for public health practitioners and policy-makers. The researcher believed that the results of this study can be used as baseline information to formulate interventions aimed at reducing HIV –related stigma and discrimination. In addition, the results will add on the existing body of knowledge regarding the determinants of HIV-related stigma and discrimination at healthcare settings, more specifically; the forms of HIV-related stigma and discrimination and their actionable drivers or facilitators.

1.8 DEFINITIONS OF KEY TERMS

Actionable drivers or facilitators are factors that shift as a result of interventions. Drivers are factors that are seen as inherently negative, while facilitators have either positive or negative influences on HIV stigma and discrimination (Strangl, Brady & Fritz 2012). For this study actionable drivers and facilitators referred to knowledge regarding HIV-related stigma and discrimination, fear of contracting HIV, social judgement, and legal and policy environment.

Determinants are factors or things are influence the presence or absence of an event or a phenomenon. Actionable drivers or facilitators as dependent variables in this study referred to the participants' levels of (i) knowledge regarding HIV stigma and discrimination, (ii) fear of contracting HIV, (iii) social judgement, (iv) awareness of the legal and policy environment protecting patient against HIV-related stigma and discrimination, and resilience.

Health facility for this study will refer to the selected district hospital in Malawi.

HIV stigma is a social construct characterised by a deviation from an ideal or expectation, contributing to a powerful discrediting social label that reduces the way individuals see themselves and are viewed as persons (Visser, Makin, Vandormael, Sikkema & Forsyth 2009).

HIV discrimination refers to discriminatory actions directed at people perceived to have AIDS or HIV, and at the individuals, groups and communities with which they are associated (Lekas et al, 2011).

Types of HIV-related stigma and discrimination as dependent variables in this study was measured in terms of the proportion of the respondents who admitted to anticipated stigma, perceived stigma, experienced stigma, and belief about the rights of people with HIV.

1.9 CONCEPTUAL FRAMEWORK

The researcher used the framework for reducing and measuring HIV stigma and discrimination to structure the study and design the questionnaire (Strangl, Llyod, Brady & Fritz 2012). The framework is based on the assumption that any individual can anticipate, experience and/or perpetuate HIV related stigma and discrimination, regardless of his or her own HIV status (Strangl, et al 2012). It divides stigma into five key concepts structured in a hierarchical manner starting with actionable drivers and facilitators. Within this framework drivers and facilitators lead to a number of manifestations of HIV-related stigma (Strangl, et al 2012). The researcher selected this framework because it illustrates how stigma functions, how it can be measured and where to intervene.

1.10 OVERVIEW OF THE RESEARCH METHOD

The study was carried out within the quantitative research approach, using a descriptive correlational design. Census sampling technique was used to select the participants. Self-administered questionnaires were used to collect data. The researcher adhered to all the ethical principles outlined in the University of South Africa Research Policy as well as the universal ethics principles. Details on ethical considerations are included in Chapter Three.

1.11 STRUCTURE OF THE REPORT

The report consists of five chapters. **Chapter One** provides the context of the study. **Chapter Two** presents the literature related to the determinants of HIV-related stigma and discrimination with particular focus on stigma and discrimination perpetuated by healthcare professionals. **Chapter Three** describes details regarding the methodology. **Chapter Four** presents and discusses the results of the study according to the various objectives of the study. **Chapter Five** concludes with a summary, recommendations and limitations of the study.

A list of references and relevant supporting documents are included as appendixes at the end of the report.

CHAPTER TWO

LITERATURE REVIEW

2.1 INTRODUCTION

The second chapter provides a brief epidemiological overview of HIV in Malawi, prevalence and impacts of HIV-related stigma and discrimination with focus on health settings, factors associated with HIV-related stigma and discrimination, policy response and interventions strategies aimed at preventing and mitigating HIV-related stigma and discrimination.

2.2 UNDERSTANDING HIV-RELATED STIGMA AND DISCRIMINATION

2.2.1 Brief epidemiological overview of HIV in Malawi

According to the UNAIDS report of 2012, Sub-Saharan Africa remains the most HIV and AIDS affected region. The region accounts for 69% of the people living with HIV worldwide with nearly 1 in every 20 adults living with HIV (UNAIDS 2012). In 2010, Malawi was among the highest 8 countries on the global ranking in HIV and AIDS prevalence. The life expectancy in country during the same period was at 39.7 years with approximately 86,502 deaths annually due to the disease (MDHS 2010).

According to Malawi Demographic Health Survey (2010), the HIV prevalence among pregnant women increased from about 2 % in 1986 to 15% in 1998 with continued declined from 12% in 2007 to 10.5% in 2010 (MDHS 2010). While the HIV prevalence among adults decreased slightly between 2004 and 2010 from 12% to 11% respectively. In terms of gender, the HIV prevalence over the same period remained at 13% among women but decreased among males from 10% to 8 % (MDHS 2010).

2.2.2 Prevalence and impacts of HIV-related stigma and discrimination

HIV-related stigma and discrimination have been reported within the family structures, the communities, the workplace and healthcare settings around the world (MacQuarie, Eckhaus & Nyblade 2009). However, stigma and discrimination perpetrated by healthcare professionals have far reaching detrimental impacts on efforts to mitigate HIV (Dos Santos, Mellors, Wolvaaradt & Van der Rys 2014; Mavhandu-Mudzusi & Ganga-Limando 2014).

This behaviour is often manifested by the denial of care, refusal of family planning and reproductive health services, disclosure of patients HIV sero-status without consent, insensitivity to the concerns of PLHAs, and labeling on the cover page of the record books of patients (Global Network of People Living with HIV and Malawi Network of People Living with HIV 2012; Mazengera 2008). Other authors (Ekstrand, Ramakrishna, Bharat & Heylen 2013) indicated that HIV-related stigma and discrimination in healthcare settings are manifested by the denial of the right to have children and mandatory testing for female sex workers and surgery patients

Studies conducted in Malawi showed that HIV-related stigma and discrimination are ongoing phenomena that continue to act as a barrier to treatment and utilisation of healthcare services among people living with HIV (Global Network of People Living with HIV and Malawi Network of People Living with HIV 2012). According to the 2010 report of the UNAIDS, stigma and discrimination alongside with poverty, low literacy levels and high rates of casual and transactional unprotected sex in general population play a key role in the high prevalence of HIV in Malawi (UNIADS 2010). Similar studies showed that HIV-related stigma and discrimination constitute a barrier to: HIV testing (Tsai, Bangberg, Kegeles, Katz, Haberer, Muzoora et al 2013), serostatus disclosure (Logie & Gadalla 2009), retention in care (Bwirire et al

2008), uptake and adherence to anti-retroviral therapy (Global Network of People Living with HIV and Malawi Network of People Living with HIV 2012).

2.2.3 Factors associated with HIV-related stigma and discrimination

Several factors have been associated with HIV-related stigma and discrimination perpetrated by healthcare professionals. In Vietnam, authors (Li, Lin, Guan & Wu 2013) associated HIV-related stigma and discrimination perpetrated by healthcare professionals to individual socioeconomic status. Other studies (Hossain & Kippax 2010; Reach Trust 2008) associated stigma and discrimination among healthcare professionals with high level of irrational fear, type of clinical facility, level of education, and gender (Hossain & Kippax 2010; Reach Trust 2008).

Avoidance of involuntary disclosure of serostatus by healthcare professionals and negative reactions were identified as the main reasons for non-utilisation of postnatal services among HIV-positive mothers in selected facilities in Malawi (Bwirire, Fitzgerald, Zachariah, Chikafa, Massaquoi, Moens, Kamoto & Schouten 2008; Chinkonde, Sundby & Martinson 2009). However, the National AIDS Commission identified the lack of comprehensive knowledge about HIV and AIDS as the major contributor to stigma and discrimination against PLHIV in Malawi (NAC 2014).

2.3 PREVENTION AND MITIGATION OF HIV-RELATED STIGMA AND DISCRIMINATION

2.3.1 Policy response

Several strategies have been employed to prevent and mitigate HIV related stigma worldwide. Efforts to fight HIV and AIDS in Malawi began in 1986. These early efforts concentrated on the prevention and spread of the virus (NAC 2014). In 2001, these efforts were aligned with regional guidelines on the fight against HIV and AIDS (Abuja Declaration and Framework for Action for the Fight against HIV and AIDS, Tuberculosis and other related Infectious Diseases). In the same year, the government signed the United Nations Declaration on HIV and AIDS and established the National AIDS Commission (NAC 2014). In 2003, the government launched the National HIV and AIDS Policy which contained the guiding principles for all HIV prevention programmes. This National HIV and AIDS Policy was supported by a legislative aimed at reinforcing its implementation at various sectors (NAC 2003).

The National HIV and AIDS Policy was followed by the development of several strategic frameworks such as the HIV Prevention Strategy, National Behaviour Change Intervention Strategy, Prevention of Mother to child Scale up Plan, Abstinence Strategy, Mutual Faithfulness Strategy, National Plan of Action for Scaling up Sexual Reproductive Health and HIV Prevention Interventions among youths, Condom Use Strategy, HIV Testing and Counselling (HTC) Scale-up Plan, Male Circumcision Policy, etc. (NAC 2014). The reduction of HIV-related stigma and discrimination in all settings was included in the objectives of the National HIV and AIDS Prevention strategy (NAC 2014).

The current efforts to fight HIV and AIDS are guided by the 2011 National HIV and AIDS Policy. This policy is based on the principles of the promotion and protection of human rights, the right to equality before the law and freedom from discrimination as entrenched in the constitution (NAC 2014). The fight against HIV and AIDS related stigma and discrimination is considered as an essential element of an effective health sector response to HIV and AIDS (NAC 2014).

2.3.2 HIV-related stigma and discrimination reduction interventions

Stangl, Lloyd, Brady, Holland, and Baral (2013) indicated that they have seen considerable progress in the stigma-reduction field between 2002 and 2013. However, they point out the lack of effective HIV-related stigma-reduction interventions that can be implemented at a large scale by national governments.

In Thailand, monthly campaign and funfair as community-based interventions were found to reduce HIV related stigma and discrimination (Jain, Nuankaew, Mongkholwiboolphol, Banpabuth, Tuvinnun, Ayuthaya & Richter, 2013). In Uganda, community-based support groups led by PLHIV showed great potential in reducing HIV-related stigma and discrimination at community level (Mburu, Ram, Skovdal, Bitira, Hodgson, Mwai et al. 2013). Sengupta, Banks, Jonas, Milles & Smith (2011) identified information sharing, skills building; counselling and testimonies by PLHIV as strong interventions in reducing HIV-related stigma and discrimination.

In Malawi, there hasn't been any study to evaluate the strategies aimed at reducing stigma and discrimination. However, some practical steps have been taken to reduce HIV-related stigma and discrimination (NAC 2014). Some examples of these measures include (i) the development and implementation of HIV Workplace Policy which promotes equal treatment of PLHIV at the workplace, (ii) promotion of

associations and organisations of PLHIV, (iii) appointment of PLHIV as boards' members in several HIV-related organisations including NAC, (iv) awareness and advocacy campaigns, and promotion of HTC and PMTCT services involving PLHIV (NAC 2014).

2.4 CONCLUSION

The effect of stigma and discrimination on PLHIV or those perceived to be positive has posed a challenge in HIV prevention efforts. Due to stigma and discrimination in the country, some people have failed to access condoms, HTC, PMTCT, STI and PEP services. There is evidence that some interventions reduce stigma.

CHAPTER THREE

RESEARCH METHODOLOGY

3.1. INTRODUCTION

This chapter describes the research methodology in terms of the approach, the design, the setting, the population, the sample and sampling techniques, data collection procedures, data analysis, and the ethical considerations. A conclusion is provided at the end of the chapter.

3.2 RESEARCH APPROACH

The researcher used the quantitative approach to address the objectives of this study. Quantitative approach involves collecting and analysing measurable data in terms of quantity (Polit & Beck 2012). The quantitative approach was congruent with the purpose and objectives of this study which generated numerical data in order to establish the determinants of HIV-related stigma and discrimination without manipulating the variables.

3.3 RESEARCH DESIGN

The study used a descriptive correlational design. A descriptive correlational research aimed at describing the relationships among variables as opposed to making inferences of causality (Polit & Beck 2012). In descriptive correlational design, the researcher analyses the data from the respondents as a single group rather than creating subcategories of participants and he/she explores the extent of association between dependent and independent variables (McMillan & Schumacher 2014). The descriptive part of this study described the actionable drivers and facilitators of HIV-related stigma and discrimination and the different

types of HIV-related stigma and discrimination as they existed among the respondents (objectives 1.5.1 and 1.5.2). While the correlational part of the design explored the relationships between the actionable drivers and facilitators of HIV stigma and discrimination and the different types of HIV stigma and discrimination (objective 1.5.3).

3.4 SETTING AND POPULATION OF THE STUDY

The study took place at a public district hospital in Malawi. The hospital is located at the Southern region of Malawi. The hospital had a total of 94 healthcare professionals and 94 administrative and support staff.

The population of this study included all healthcare professionals who were working in the research setting.

3.5 SAMPLE

The sample for this study consisted of all 94 healthcare professionals working at the hospital. The decision was due the size of the accessible population as well as its heterogeneity.

3.6 DATA COLLECTION

3.6.1 Data collection instrument

The researcher used a self-administered questionnaire as an instrument for this study. As stated in Chapter One, the researcher used the framework for reducing and measuring HIV stigma and discrimination (Strangl, Llyod, Brady & Fritz 2012) to design the questionnaire. The questionnaire consisted of three sections.

The first section contained 8 items describing the characteristics of the respondents. It included biographical data and exposure to in-service training related to specific aspects of HIV and AIDS (see Appendix 1).

The second section contained five subscales with 32 items measuring the actionable drivers and facilitators of HIV-related stigma (see Appendix 1). The first subscale contained 6 measurement items (Q 1.1-1.6) related to knowledge about stigma and discrimination; subscale two with 10 measurement items (Q 2.1-2.10) dealt with fear of contracting HIV; subscale three with 10 measurement items (Q 3.1-3.10) related to social judgement against people living with HIV; subscale four with 5 measurement items (Q 4.1-4.5) looking at the legal and policy environment; and subscale five with one measurement item (Q 5) looking at resilience.

The third section of the questionnaire contained four subscales with 22 items measuring the types of stigma and discrimination (see section III). The first subscale consisted of 2 measurement items (Q 6.1-6.2) looking at the anticipated stigma; subscale two with 12 measurement items (Q7.1-7.12) related to the perceived stigma; subscale three contained 6 measurement items (Q 8.1-8.6) related to experienced stigma; and subscale four contained 2 measurement items (Q 9.1-9.2) related to discrimination (see Appendix 1).

3.6.2 Validity and reliability of the instrument

Validity is a quality criterion referring to the degree to which inferences made in the study are accurate and well founded (Polit & Beck 2012). The internal validity was enhanced by means of ensuring adequate sample size to obtain a representative sample of the target population. In this study, the sample size consisted of the total population. In addition, the researcher used simple English to avoid any ambiguity.

The validity of the questionnaire was further enhanced by the use of the conceptual framework in the design of the questions.

Reliability of a data collection instrument refers to the degree of similarity of the results obtained when the measurement is repeated on the same subject or group (Polit and Beck 2012). The questionnaire was reviewed by the supervisor and pilot tested with 10 respondents from a different health facility. Furthermore, the questionnaire had a Cronbach's alpha of 0.754.

3.6.3 Data collection process

Data were collected from 19th October to 30th December 2015 after the ethical clearance and permission from the hospital management. The questionnaires were hand delivered by the researcher. A general communication was sent to the hospital staff to inform them through the normal channel of communication about the study. Thereafter, the researcher hand delivered the questionnaire with a return envelope to the different units of the hospital.

The respondents were requested to drop the completed questionnaires in a box which was made available at the unit. Respondents were given one month to return the completed questionnaire. To enhance the response rate, the researcher posted a reminder at the notice boards of the different units two days before the closing date and the District Health Officer urged the participants to return the questionnaires during the morning Handover meetings. This period was further extended to a further one month due to low response rate. The low response rate during the initial period was mainly due to a large number of the respondents who were on holiday.

3.7 DATA MANAGEMENT AND ANALYSIS

The researcher scrutinized each returned questionnaire to ascertain whether all questions were answered as expected. For easy of analysis, each questionnaire was given a unique number to facilitate error tracking where necessary. The Statistical Package for the Social Sciences (SPSS Version 20) was used for data capturing, editing and analysis.

Summary descriptive statistics were conducted to describe and summarize data. The frequency tables and percentage distribution were used to describe the dependent and independent variables. Cross tabulations and measures of associations were used to establish the strengths of association between dependent and independent variables (chi-square, fishers exact). All Pearson chi-square analysis tables contained cells with expected count of less than 5. Thus, Fisher's Exact Test was used to conclude the association. The relationship was deemed significant if $p < 0.05$. Stata version 12 was later used to model the degree of the statistical relationships using binary logistic regression.

3.8 ETHICAL CONSIDERATIONS

The study was conducted within the universal ethical principles (respect for person, beneficence, non-maleficence, and justice) and the ethics policy for postgraduate research prescribed by the University of South Africa. The questionnaire and study proposal were reviewed and approved by the UNISA's Health Studies Higher Degrees Committee and Malawi National Health Science Research Committee (Refer to Appendix 3).

Participation to the study was voluntary. The researcher ensured that the respondents were fully informed about the study. The initial information was posted on the notice board and an Information Sheet with the contact details of the researcher was attached to the questionnaire. The information on the Information Sheet included details about the purpose and the scope of the study, the benefits for participating in the study and the right to withdraw if they wish to.

The respondents were informed that should they refuse to return the questionnaire there will be no consequences (see Appendix E). Each respondent was requested to sign a written consent form which was attached to the questionnaire (see Appendix F). This study did not have any potential for physical, mental and social harm to the respondents.

The questionnaires did not contain any information that could be traced back to the respondents. The returned envelopes were destroyed and the questionnaires were locked away by the researcher. No individual names or identifier were used in the report. This study did not pose any potential harm for the respondents. The respondents were instructed to sign the consent form and return it with the completed questionnaire.

3.9 CONCLUSION

The third chapter described the methodology followed by the researcher to address the research objectives. It provided the rational and motivation for the selected approach. It also examined how data were processed in the study and how the ethical principles were observed. In the next chapter the results of the main findings are presented.

CHAPTER FOUR

PRESENTATION OF THE MAIN RESULTS

4.1 INTRODUCTION

This chapter presents and discusses the main results of the study. The chapter is structured according to the three main objectives of the study. The first sub-section describes the characteristics of the participants. Of the 63 questionnaires which were distributed, 51 (85.0%) were returned and analysed.

4.2 DESCRIPTION OF THE RESPONDENTS

The respondents are described in terms of their biographical characteristics and the exposure to in-house HIV related training. Seven variables were used to assess the biographical characteristics of the respondents. They included age, gender, religious affiliation, ethnic group, highest level of education, professional occupation, and length of work in the hospital. Table 1 provides the frequency distribution of the results.

The respondents' age varied from 21 years to 62 years with a mean age of 35 years (SD 9.70). Of the 51 (100%) respondents, 32 (63.0%) were less than 45; 32 (63.0%) were males; 49 (96.0%) were Christians; 33 (64.6%) hold a diploma as the highest qualification; 28 (55.0%) were equally distributed between nurse/midwives and clinical officers; 26(51.0%) were working in the hospital for more than 2 years. In general, the length of work at the hospital ranged from 1 year to 19 years. The respondents belonged to seven different ethnic groups with the Lomwe and Ngoni being the highest with 17 (33.3%) and 16(31.3%) respectively.

Table 1: Respondents' biographical data (N=51)

Characteristics	Frequency	Percentage (%)
Age in years:		
▪ 20-24	03	6.0
▪ 25-34	21	41.0
▪ 35-44	08	16.0
▪ 45 and above	19	37.0
Gender:		
▪ Male	32	63.0
▪ Female	19	37.0
Religious affiliation:		
▪ Christians	49	96.0
▪ Muslims	02	4.0
Ethnic Group:		
▪ Lomwe	17	33.3
▪ Ngoni	16	31.3
▪ Chewa	05	10.0
▪ Others(four different groups)	13	25.4
Highest level of education:		
▪ Professional certificate	13	25.4
▪ Diploma	33	64.6
▪ Degree	05	10.0
Professional Occupation:		
▪ Nurse/Midwives	14	27.5
▪ Clinical Officers	14	27.5
▪ Laboratory Technicians	11	21.0
▪ Medical Assistants	06	12.0
▪ Medical Officers	04	8.0
▪ Pharmacists	01	2.0
▪ Radiographers	01	2.0
Length of work in the hospital:		
▪ 1 -2 years	25	49.0
▪ More than 2 years	26	51.0

Table 2 presents the frequency distribution of the respondents' exposure to HIV related in-house training. It was a multiple answer question with five items or five different training topics (mode of transmission of HIV, prevention of the spread of HIV, treatment, care and management of HIV and AIDS, HIV-related stigma and discrimination, and universal precaution). They were expected to indicate if they participated to each of these training at their hospital.

Of the 51 respondents, 19 (37.0%) were exposed to HIV related stigma and discrimination training and more than 90.0% were exposed to each of the remaining four HIV related training.

Table 2: Respondents' exposure to HIV-related in-house training (N=51)

Type of training	Frequency	Percentage (%)
Mode of Transmission of HIV:		
▪ Yes	48	94.0
▪ No	03	6.0
Prevention of the spread of HIV:		
▪ Yes	48	94.0
▪ No	03	6.0
Treatment, care and management of HIV and AIDS:		
▪ Yes	48	94.0
▪ No	03	6.0
HIV related stigma and discrimination:		
▪ Yes	19	37.0
▪ No	32	63.0
Universal precaution of infections:		
▪ Yes	47	92.0
▪ No	04	8.0

4.3 FACILITATORS OF HIV-RELATED STIGMA & DISCRIMINATION

This section refers to the first objective of the study which looked at the actionable drivers and facilitators of HIV-related stigma and discrimination among healthcare professionals in terms of:

- (i) knowledge regarding HIV-related stigma and discrimination,
- (ii) fear of contracting HIV,
- (iii) social judgement towards PLHIV,
- (iv) awareness of the legal and policy environment, and
- (v) resilience.

A total of 32 items were used to generate data for the above sub-components. The results of the summary descriptive analysis of these items are presented under the related sub-components.

4.3.1 Knowledge regarding HIV-related stigma and discrimination

The researcher used a multiple answer question with six items to explore and describe the respondents' knowledge regarding HIV-related stigma and discrimination. Each statement described the common behaviour related to HIV stigma or discrimination among the healthcare professionals. Table 3 provides the frequency distribution of the results.

As shown in Table 3, the respondents had good knowledge about HIV-related stigma and discrimination. About 88.9% of the 51 respondents were able to identify the behaviours that reflect stigma and discrimination against HIV patients.

Table 3: Knowledge regarding HIV-related stigma and discrimination (N=51)

Variables	Frequency and percentage (%)	
	Yes	No
<i>Do you think that the statements below indicate the presence of HIV-related stigma and discrimination?</i>		
1. Name calling and /or labelling	47 (92.0%)	4 (8.0%)
2. Delaying the provision of care to a patient because of his/her HIV status	45 (88.0%)	6 (12.0%)
3. Refusing treatment and care to a patient because of his/her HIV status	46 (90.0%)	5 (10.0%)
4. Disclosing the HIV status of a patient to others without his/her consent	46 (90.0%)	5 (10.0%)
5. Providing poor quality care to a patient because of her HIV status	47 (92.0%)	4 (8.0%)
6. Taking extra precautions that you would not take if dealing with a patient with similar problem	41 (80.0%)	10 (20.0%)

4.3.2 Fear of contracting HIV

The researcher used a multiple answer question with ten items to explore and describe the respondents' fear to contract HIV. Five of the ten items were related to general myths about HIV transmission (items 1-5) while the other five (6-10) were related to procedures involving possible contact with the blood products. Table 4 provides the frequency distribution of the results.

As indicated in Table 4, 46 (90.0%) to 49 (96.0%) of the respondents (N=51) did not have irrational fear about the general myths attached to HIV transmission. This proportion of the respondents who did not have irrational fear of contracting HIV for the blood related statements varied from 21 (41.0%) to 33 (65.0%). With 30 (59.0%) respondents' out of 51 admitting having fear of contracting HIV through recapping needles after injecting a patient with HIV. Of the 51 respondents, 22 (43.0%) were afraid of contracting HIV by drawing blood from a patient with HIV.

Table 4: Fear of contracting HIV (N=51)

Variables	Frequency and percentage (%)	
	Yes	No
<i>HIV can be contracted by:</i>		
7. Shaking hands with a patient with HIV	2 (4.0%)	49 (96.0%)
8. Cleaning the linen used by a patient with HIV	3 (6.0%)	48 (94.0%)
9. Cleaning the room used by a patient with HIV	2 (4.0%)	49 (96.0%)
10. Taking vital signs of a patient with HIV	2 (4.0%)	49 (96.0%)
11. Conducting clinical examination (physical or gynaecological) of a patient with HIV	5 (10.0%)	46 (90.0%)
12. Dressing wounds of a patient with HIV	20 (39.0%)	31 (61.0%)
13. Drawing blood from a patient with HIV	22 (43.0%)	29 (57.0%)
14. Recapping needles after injecting a patient with HIV	30 (59.0%)	21 (41.0%)
15. Assisting a woman with HIV positive status in labour and delivery	19 (37.0%)	32 (63.0%)
16. Assisting a woman with unknown HIV status in labour and delivery	18 (35.0%)	33 (65.0%)

4.3.3 Social judgement towards PLHIV

The researcher used a multiple answer question with ten items to explore and describe the respondents' social judgement towards people living with HIV. These ten statements reflected the common beliefs and cultural attitudes towards people living with HIV. Table 5 provides the frequency distribution of the results.

Of the 51 respondents, 45 (88.0%) to 49 (96.0%) of the 51 respondents have none judgemental attitudes towards people living with HIV. The proportion of the

respondents who have judgemental attitudes towards people living with HIV varied from 2 (4.0%) to 6 (12.0%) out of 51 respondents.

Table 5: Social judgement towards PLHIV (N=51)

Variables	Frequency and percentage (%)	
	Yes	No
<i>Statements related to social judgement towards PLHIV</i>		
1. PLHIV could have avoided it if they wanted to	6 (12.0%)	45 (88.0%)
2. PLHIV should feel ashamed of themselves	2 (4.0%)	49 (96.0%)
3. PLHIV do not care if they infect others	4 (8.0%)	47 (92.0)
4. PLHIV have had many sexual partners	2 (4.0%)	49 (96.0%)
5. PLHIV are sinners	3 (6.0%)	48 (94.0%)
6. PLHIV should not be allowed to have children	3 (6.0%)	48 (94.0%)
7. PLHIV must not be mixed with other in-patients	2 (4.0%)	49 (96.0%)
8. PLHIV should not have the same rights like other patients	4 (8.0%)	47 (92.0%)
9. PLHIV should not have the right to take their own decision	4 (8.0%)	47 (92.0%)
10. I would not maintain a relationship with a colleague of a friend living with HIV	2 (4.0%)	49 (96.0%)

4.3.4 Awareness of legal and policy environment and resilience

The researcher used a multiple answer question with five items to explore and describe the respondents' awareness of legal and policy environment and one item to explore and describe the respondents' resilience. One of the five statements (item 1 on Table 6) of the awareness of legal and policy environment was related to the awareness of the existence of the hospital policies against stigma and discrimination and the other four were related to the reinforcement of these policies by the management (items 2-6 on Table 6). Resilience was explored and described

with one item related to the respondents' stand against stigma and discrimination.

Table 6 provides the frequency distribution of the results.

Of the 51 respondents, 42 (82.0%) were aware of the hospital policies against discrimination of patients with HIV; 45 (88.0%) to 47 (92.0%) will not engage to any stigmatising and discriminatory acts because of the reinforcement of the policies by the hospital management. With regard to resilience, 48 (94.0%) of the 51 respondents did not engage in any corrective act towards a colleague in the past 12 months from the date of data collection.

Table 6: Awareness of legal & policy environment and resilience (N=51)

Variables	Frequency and percentage (%)	
	Yes	No
<i>Statements related to awareness of legal & policy environment</i>		
1. My hospital has policies in place to protect patients with HIV against discrimination	42 (82.0%)	9 (18.0%)
2. I will get in trouble with the hospital management if I talk badly to a patient because of his/her HIV status	45 (88.0%)	6 (12.0%)
3. I will get in trouble with the hospital management if I refuse to attend to a patient because of his/her HIV status	47 (92.0%)	4 (8.0%)
4. I will get in trouble with the hospital management if I provide poor services to a patient because of his/her HIV status	47 (92.0%)	4 (8.0%)
5. I will get in trouble with the hospital management if I do not protect the rights of a patient because of his/her HIV positive status	46 (90.0%)	5 (10.0%)
<i>Statement related to resilience</i>		
1. In the past 12 month, have you confronted and/or educated a staff who was talking badly or mistreating a patient because of her/his HIV status	3 (6.0%)	48 (94.0%)

4.3.5 Discussion

As indicated in chapter one, facilitators of HIV-related stigma and discrimination referred to factors that have either positive or negative influences on HIV stigma and discrimination (Strangl, Brady & Fritz 2012). Five variables (knowledge regarding HIV-related stigma and discrimination, fear of contracting HIV, social judgement, legal and policy environment and resilience) were used to explore and describe these factors among the respondents. The objective was to establish the proportion of healthcare professionals with these Characteristics.

The results of this study indicate that most of the respondents (i) were knowledgeable about what constitute stigma and discrimination towards people living with HIV; (ii) did not have irrational fear of contracting HIV; (iii) were non-judgemental towards people living with HIV; (v) and aware of the legal and policy protecting people with HIV. A large proportion of the respondents were not resilient toward HIV-related stigma and discrimination issues. These results are related to the profile of the respondents. As indicated in Table 2, more than 90.0% of the respondents (92% to 94.0%) completed training related to prevention, treatment, care and management of HIV.

However, there were a high proportion of respondents (59.0%, n=30) who expressed fear of contracting HIV through by recapping needles after injecting a patient with HIV. This proportion was followed by 43.0% (n=22) and 39.0% (n=20) who expressed fear of contracting HIV by drawing blood and dressing wounds respectively. These fears are of particular concerns in view of the training and the level of education of the respondents. PLHIV go through these medical procedures and are likely to be discriminated. This argument is supported by authors (Hossain

& Kippax 2010) who associated fear of contracting HIV through medical practices with HIV related stigma and discrimination among healthcare professionals.

4.4 FORMS OF HIV-RELATED STIGMA AND DISCRIMINATION

This section refers to the second objective of the study which explored and described the different forms of HIV-related stigma and discrimination among healthcare professionals. It focused on the presence or not of the following types of stigma and discrimination:

- (i) anticipated stigma,
- (ii) perceived stigma,
- (iii) experienced stigma, and
- (iv) discrimination.

A total of 22 items were used to generate data for the above five sub-components of HIV-related stigma and discrimination. The results are presented according to the above sub-components.

4.4.1 Anticipated and perceived HIV-related stigma

Anticipated and perceived HIV-related stigma were explored and described with multiple answer questions. For HIV-related anticipated stigma, the question consisted of two items. One refers to reluctance to work with a colleague living with HIV and the other to reluctance of colleagues to test for HIV due to fear of others. With regard to the HIV-related perceived stigma, the multiple answer questions consisted of twelve items. These items looked at the perceived stigma in the past 12 months. Ten of these items referred to the interactions between the healthcare professionals and the clients with HIV in general and two were specific to pregnant women. Table 7 provides the frequency distribution of the results.

Table 7: Anticipated and perceived HIV-related stigma (N=51)

Variables	Frequency and percentage (%)	
	Yes	No
<i>Statements related to anticipated stigma:</i>		
1. Workers in my hospital are reluctant to work together with a colleague living with HIV	1 (2.0%)	50 (98.0%)
2. Workers in my hospital are reluctant to test for HIV due to fear of colleagues' reaction if the result is positive	8 (16.0%)	43 (84.0%)
<i>Statements related to perceived stigma in the past 12 months</i>		
1. Client being called names and/or labelled because of his/her HIV status	9 (18.0%)	42 (82.0%)
2. Client being asked to wait until last because of his/her HIV status	6 (12.0%)	45 (88.0%)
3. Client being refused admission because of his/her HIV status	2 (4.0%)	49 (96.0%)
4. Client being denied treatment and/or left unattended because of his/her HIV status	7 (14.0%)	44 (86.0%)
5. Client being refused surgery because of his/her HIV status.	3 (6.0%)	48 (94.0%)
6. Client with HIV being discharged from the hospital while still needing treatment and care	5 (10.0%)	46 (90.0%)
7. Pregnant women being neglected during labour and delivery because of her HIV status	1 (2.0%)	50 (98.0%)
8. Pregnant women being tested for HIV without her informed consent	4 (8.0%)	47 (82.0%)
9. Disclosure of the HIV status of patient without his/her consent	15 (30.0%)	36 (70.0%)
10. Physical contact with a patient living with HIV being avoided without gloves	5 (10.0%)	46 (90.0%)
11. Workers wearing double gloves to perform simple medical procedures on patients with HIV but they don't do the same when performing the same procedures with other patients	5 (10.0%)	46 (90.0%)
12. Staff disposing or burning linen used by patients with HIV on discharge	1 (2.0%)	50 (98.0%)

The proportion of the respondents who noted perceived stigma ranged from 1 (2.0%) to 15 (30.0%). Of the 51 respondents, 8 (16.0%) and 1 (2.0%) have noticed

anticipatory stigma among their colleagues; 4 (8.0%) and 1(2.0%) noted perceived stigma towards pregnant women.

4.4.2 Experienced HIV-related stigma and discrimination

Experienced HIV-related stigma and discrimination were explored and described with multiple answer questions. For HIV-related experienced stigma, the question consisted of six items. These items looked at the experienced stigma in the past 12 months. All the six items referred to the behaviour of the colleagues and family members' towards professionals working with HIV clients. One of the statements related to discrimination referred testing of patients without informed consent and respect for confidentiality of the HIV status of the patients. Table 8 provides the frequency distribution of the results.

The researcher used multiple answer questions with six items to explore and describe the presence of experienced stigma and two items to explore and describe the presence of discrimination among the respondents. Table 8 provides the frequency distribution of the results.

With regard to perceived stigma, the proportion of the respondents of noted the stigmatising behaviour was 2 (4.0%) for each of the six items. Of the 51 respondents, 48(90.0%) indicated that they will never breach the confidentiality of the HIV status of the clients, and 44(86.0%) indicated that they will never conduct a HIV testing without the client informed consent.

Table 8: Experienced HIV-related stigma and discrimination (N=51)

Variables	Frequency and percentage (%)	
	Yes	No
<i>Statements related to experienced stigma In the past 12 months:</i>		
1. Colleagues talking bad about you because you care for patients living with HIV	2 (4.0%)	49 (96.0%)
2. Being avoided by colleagues because you care for patients living with HIV	2 (4.0%)	49 (96.0%)
3. Being labeled by colleagues to be HIV positive because you care for patients living with HIV	2 (4.0%)	49 (96.0%)
4. Friends and/or families talking bad about you because you care for patients living with HIV	2 (4.0%)	49 (96.0%)
5. Being avoided by friends and/or family because you care for patients with HIV	2 (4.0%)	49 (96.0%)
6. Being labeled by friends and/or families to be HIV positive because you care for patients with HIV	2 (4.0%)	49 (96.0%)
<i>Statements related to discrimination</i>		
1. I would never test a patient for HIV without his/her inform consent	44 (86.0%)	7 (14.0%)
2. No matter my views or feelings, it is my professional responsibility to maintain the confidentiality of patients living with HIV	46 (90.0%)	5 (10.0%)

4.4.3 Discussion

In this study HIV-related stigma was regarded as a social construct characterised by a deviation from an ideal or expectation, contributing to a powerful discrediting social label that reduces the way individuals see themselves and are viewed as persons (Visser, Makin, Vandormael, Sikkema & Forsyth 2009). While HIV-related discrimination referred to discriminatory actions directed at people perceived to have AIDS or HIV, and at the individuals, groups and communities with which they are associated (Lekas et al, 2011). The study looked at three types of HIV-related stigma (anticipated stigma, perceived stigma, and experienced stigma), and discrimination.

The results of this study showed that the majority of the respondents (between 82.0%, n=42 to 98.0%, n=50) did not notice or experience any forms of HIV-related stigma. Similarly, 86.0% (n=44) to 90.0% (n=46) admitted to none-discriminatory acts toward people living with HIV. Could this be attributed to the training or the length of working at this hospital which has policies protecting patients with HIV or to the government efforts to combatting stigma against people living with HIV? These results are supported by recent studies which indicate great progress in the reduction of HIV-related stigma in the general population between 2002 and 2013 (Stangl, Lloyd, Brady, Holland, & Baral 2013). Such progress has been attributed to various interventions including awareness campaigns, community support groups, training, health education and counselling (Jain, Nuankaew, Mongkholwiboolphol, Banpabuth, Tuvunun, Ayuthaya & Richter, 2013; Mburu, Ram, Skovdal, Bitira, Hodgson, Mwai et al. 2013; Sengupta, Banks, Jonas, Milles & Smith 2011). The results of this study could also be attributed to the government's HIV Workplace Policy that promotes and reinforces equal treatment of people living with HIV at the workplace (NAC 2014).

4.5 RELATIONSHIPS BETWEEN FACILITATORS AND TYPES OF STIGMA & DISCRIMINATION

This section deals with the third and last objective of the study which was to determine the strength of association between the actionable drivers and facilitators of HIV-related stigma and discrimination and the different types of HIV-related stigma and discrimination among healthcare professionals. As stated in Chapter Three, the researcher used the binary logistic regression to model the relationships between the 32 items of the actionable drivers and facilitator and the 22 items of the type of stigma and discrimination. The relationship was deemed significant at the P-value of < 0.05. Only significant results are reported in this section.

The results are structured according to actionable drivers. Table 9 provides the results of the binary logistic regression analysis.

4.5.1 Knowledge regarding HIV-related stigma and discrimination

Five of the six items used in this study to explore and describe the knowledge regarding stigma and discrimination were positively associated with discrimination. Knowledge regarding HIV-related stigma and discrimination decreases the likelihood of discrimination against patients with HIV.

As indicated in Table 9, the respondents who know that (i) disclosing the HIV status of a patient to others without his/her consent is a form of stigma and discrimination are 27.3 times less likely to discriminate against patients with HIV, (ii) taking unreasonable extra precaution when dealing with patients is a form of stigma and discrimination are 20.5 times less likely to discriminate against patients with HIV, (iii) delaying the provision of care to a patient because of his/her HIV status is a form of stigma and discrimination are 20 times less likely to discriminate against patients with HIV; (iv) refusing treatment and care to a patient because of his/her HIV status is a form of stigma and discrimination are also 20 times less likely to discriminate against patients with HIV; and (v) those who know that providing poor quality care to a patient because of his/her HIV status is a form of stigma and discrimination are 11.1 times less likely to discriminate against patients with HIV.

4.5.2 Social judgement against people living with HIV

There was statistical significant relationship between social judgement and perceived stigma. Respondents who believe that people living with HIV have had many sexual partners were 22 times more likely to test pregnant women without

their consent; and those who believe that people living with HIV are sinners were 16 times more likely to deny treatment and or left unattended patients with HIV.

Table 9: Results of the Binary Logistic Regression Analysis

Variables	OR	P-value	95% CI
<i>Positive knowledge regarding stigma & discrimination vs Discrimination</i>			
1. Delaying the provision of care to a patient because of his/her HIV status	20	0.006	2.3-169.9
2. Refusing treatment and care to a patient because of his/her HIV status	20	0.006	2.3-169.9
3. Disclosing the HIV status of a patient to others without his/her consent	27.3	0.01	1.8-359.2
4. Providing poor quality care to a patient because of her HIV status	11.1	0.01	1.4-83.5
5. Taking extra precautions that you would not take if dealing with a patient with similar problem	20.5	0.01	1.8-230
<i>Social judgement and Perceived stigma</i>			
1. PLHIV have had many sexual partners vs testing pregnant women without consent	22	0.05	0.9-494.7
2. PLHIV are sinners vs denial of treatment or neglect because of HIV status	16	0.03	1.2-209.9
<i>Legal & policy environment and Anticipated stigma</i>			
1. Existence of policy against discrimination vs reluctance of workers to test for HIV	4	0.001	.006-.30
2. Fear of being punished by management for stigmatising behaviour vs reluctance of workers to test for HIV	7	0.01	.008-.55
<i>Legal & policy environment and Perceived stigma</i>			
1. Existence of policy against discrimination vs discriminatory used of gloves	11	0.03	0.01-.81

4.5.3 Legal and policy environment

Legal policy environment showed significant statistical relationships with perceived and experienced stigma. The respondents who were aware of the existence of the hospital policies on discrimination against patients with HIV are 4 times less likely to take unreasonable precautions when performing simple medical procedures on patients with HIV. Respondents with fear of being punished by the hospital management if they engage in stigmatising behaviour are 7 times less likely to stigmatise colleagues undertaking voluntary HIV testing.

The respondents who were aware of the existence of the hospital policies on discrimination against patients with HIV are 11 times less likely to take unreasonable precautions when performing simple medical procedures on patients with HIV.

4.5.3 Discussion

The results show that the respondents with positive knowledge regarding HIV-related stigma and discrimination were less likely to have discriminatory attitude towards people living with HIV. These results are in agreement with the findings of the study done by Feyissa et al 2012 which indicated that healthcare professionals with high level of basic HIV knowledge had lower stigma scores when compared to those who had low basic HIV knowledge. These findings are of paramount importance as addressing these issues will lead to good progress towards achieving zero HIV related stigma and discrimination.

Social judgement showed statistical relationship with perceived stigma. Those who held judgemental attitude that people living with HIV have had many sexual partners were more likely to have perceived stigma translated by testing without consent

(OR=22, p=0.052). On the other hand those who believed that people living with HIV are sinners were 16 times more likely to deny treatment and or leave patients with HIV unattended because of his/her status (p= 0.035). Although perceived stigma does not necessarily mean having intent to discriminate, based on the findings, one may argue that PLHIV may have been denied treatment which could lead to serious consequences. The findings are, however, similar to the results found in the stigma index study conducted in 2010 (GNP+ & MANET+ 2012).

Awareness of workplace legal and policy protecting people living with HIV against stigma and discrimination showed statistical significant relationship with both perceived stigma and anticipated stigma. Respondents who were aware of the above policy were more likely to avoid stigmatising and discriminating against people living with HIV. These results confirm the literature which states that HIV-related stigma and discrimination at healthcare facilities are determined by certain individual and institutional factors that act as actionable drivers or facilitators (Strive 2012).

The results of the current study are supported by previous studies that associated HIV-related stigma and discrimination perpetrated by healthcare professionals to high level of irrational fear, type of clinical facility, level of education, involuntary disclosure of serostatus, lack of comprehensive knowledge about HIV and AIDS (Bwirire, Fitzgerald, Zachariah, Chikafa, Massaquoi, Moens, Kamoto & Schouten 2008; Chinkonde, Sundby & Martinson 2009; Hossain & Kippax 2010; Reach Trust 2008; NAC 2014).

CHAPTER FIVE

CONCLUSION, RECOMMENDATIONS AND LIMITATIONS OF THE STUDY

5.1 CONCLUSION

This study was conducted with the understanding that HIV-related stigma and discrimination do exist in healthcare facilities across the world and their impacts on HIV prevention, treatment, care and support are well-documented. It was further acknowledged that certain individual and institutional factors such as knowledge about stigma and discrimination, fear of infection, social judgement, legal and policy environment act as actionable drivers or facilitators of HIV-related stigma and discrimination (Strive 2012).

The study was conducted with the purpose of determining the actionable drivers and facilitators strongly associated with the different types of HIV-related stigma and discrimination among healthcare professionals at a district hospital in Malawi. The results of the study as presented and discussed in chapter five suggest that equipping healthcare providers with knowledge on HIV and HIV-related stigma and discrimination, formulating policies on reducing stigma and discrimination are of paramount importance in reducing stigma and discrimination against people living with HIV in healthcare settings in Malawi.

5.2 RECOMMENDATIONS

Taking into account what have already been outlined in this report, we would like to forward the following recommendations:

- Orienting/training healthcare providers on HIV-related stigma and discrimination
- HCP should strive to update their knowledge in HIV and AIDS especially in transmission to address their fears
- Ministry of Health should integrate HIV related Stigma and Discrimination topics into the curricula in nursing and medical schools.
- Further, the study should be conducted on a large scale involving a large number of HCP in different health facilities.

5.3 LIMITATIONS OF THE STUDY

One of the potential limitations of the study was the use of self-completion questionnaire. When responding to questions, especially those related to stigma and discrimination, there was possibility of HCP providing responses that are socially acceptable or within hospital /national guidelines leading to bias termed social desirability. This would therefore underestimate the presence of stigma and discrimination. However, this was minimised by encouraging them to be honest and not to indicate their names on the questionnaires. The study focused on a small sample drawn from one hospital, therefore generalisation of the results to the rural hospital should be done with caution.

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APPENDIX 1: DATA COLLECTION INSTRUMENTS

Questionnaire No: _____ (for office use)

Instructions:

- This questionnaire consists of three main sections. It will take you a maximum of 20 minutes to complete.
- Please answer all the questions with honesty and without assistance.
- Do not write your name or personal details on the questionnaire.
- Please do not write on the column marked “**official use only**”
- Remember to drop the completed questionnaire with the attached consent form at the box provided at the entrance of your unit.
- I will appreciate if you could return the completed questionnaire within one week.

Section I: Biographical and general information

Please enter your answers in the space provided under the answer column

#	Questions	Answers			Official use only
1.	What is your age (in years)?				
2.	What is your Gender? (Put a cross (X) in the appropriate box)	Male <input type="checkbox"/>	Female <input type="checkbox"/>	Other <input type="checkbox"/>	
3.	What is your current religious affiliation? (e.g. Christian)				
4.	What is your ethnic group?				
5.	What is your highest level of education? (e.g. certificate, diploma, ect)				
6.	In which capacity are you working in this hospital? (e.g. hospital servant, nurse, medical doctor etc.)				
7.	For how long have you been working in this hospital?				
8.	Have you been provided training on the following aspects by your hospital:	Yes	No	Not applicable	
8.1	Mode of transmission of HIV				
8.2	Prevention of HIV				
8.3	Treatment, care and management of HIV and AIDS				
8.4	HIV related stigma and discrimination				
8.5	Universal precautions of infections				

Section II: Activators or facilitators of HIV stigma and discrimination

#	Questions	Answers			Official use only
		Yes	No	Not applicable	
Q 1.	Do you think that the statements below indicate the presence of HIV related stigma and discrimination?				<i>Knowledge of S&D</i>
1.1	Name calling and/or labeling				
1.2	Delaying the provision of care to a patient because of his/her HIV status				
1.3	Refusing treatment and care to a patient because of his/her HIV status				
1.4	Disclosing the HIV status of a patient to others without his/her consent				
1.5	Providing poor quality care to a patient because of her HIV status				
1.6	Taking extra precautions that you would not take if dealing with a patient with similar problem				
Q 2.	Do you fear that you could contract HIV if you do the following:				<i>Fear of contracting HIV</i>
2.1	Shaking hands with a patient with HIV				
2.2	Cleaning the linen used by a patient with HIV				
2.3	Cleaning the room used by a patient with HIV				
2.4	Taking vital signs of a patient with HIV				
2.5	Conducting clinical examination (physical or gynaecological) of a patient living with HIV				
2.6	Dressing wounds of a patient living with HIV				
2.7	Drawing blood from a patient living with HIV				
2.8	Recapping needles after injecting a patient with HIV				
2.9	Assisting a woman with HIV positive status in labour and delivery				
2.10	Assisting a woman with unknown HIV status in labour and delivery				
Q 3.	Do you agree (Yes) or disagree (No) with the following statements regarding people living with HIV (PLWH):				<i>Social judgement</i>
3.1	People living with HIV could have avoided it if they wanted to				
3.2	People living with HIV should feel ashamed of themselves				
3.3	People living with HIV do not care if they infect others				
3.4	People living with HIV have had many sexual partners				
3.5	People living with HIV are sinners				
3.6	People living with HIV should not be allowed to have children				
3.7	People living with HIV must not be treated with other patients in the same wards				
3.8	People living with HIV should not have the same rights like other patients				
3.9	People living with HIV should not have the right to take their own decision				
3.10	I would not maintain a relationship with a colleague of a friend living with HIV				
Q 4.	Do you agree (Yes) or disagree (No) with the following statements regarding your hospital:				<i>Legal & policy environment</i>
4.1	My hospital has policies in place to protect patients with HIV against discrimination				
4.2	I will get in trouble with the hospital management if I talk badly to a patient because of his/her HIV status				
4.3	I will get in trouble with the hospital management if I refuse to attend to a patient because of his/her HIV status				
4.4	I will get in trouble with the hospital management if I provide poor services to a patient because of his/her HIV status				
4.5	I will get in trouble with the hospital management if I do not protect the rights of a patient because of his/her HIV positive status				
Q 5.	In the past 12 month, have you confronted and/or educated a staff who was talking badly or mistreating a patient because of her/his HIV status				<i>Resilience</i>

Section III: HIV related stigma and discrimination

#	Questions	Answers			Official use only
		Yes	No	Not applicable	
Q 6.	Do you agree (Yes) or disagree (No) with the following statements:				<i>Anticipated stigma</i>
6.1	Workers in my hospital are reluctant to work together with a colleague living with HIV				
6.2	Workers in my hospital are reluctant to test for HIV due to fear of colleagues' reaction if the result is positive				
Q 7.	In the past 12 months, have you observed the following in your hospital:				<i>Perceived stigma</i>
7.1	Client being called names and/or labelled because of his/her HIV status				
7.2	Client being asked to wait until last because of his/her HIV status				
7.3	Client being refused admission because of his/her HIV status				
7.4	Client being denied treatment and/or left unattended because of his/her HIV status				
7.5	Client being refused surgery because of his/her HIV status.				
7.6	Client with HIV being discharged from the hospital while still needing treatment and care				
7.7	Pregnant women being neglected during labour and delivery because of her HIV status				
7.8	Pregnant women being tested for HIV without her informed consent				
7.9	Disclosure of the HIV status of patient without his/her consent				
7.10	Physical contact with a patient living with HIV being avoided without gloves				
7.11	Workers wearing double gloves to perform simple medical procedures on patients with HIV but they don't do the same when performing the same procedures with other patients				
7.12	Staff disposing or burning linen used by patients with HIV on discharge				
Q 8.	In the past 12 months, have you experienced the following:				<i>Experienced stigma</i>
8.1	Colleagues talking bad about you because you care for patients living with HIV				
8.2	Being avoided by colleagues because you care for patients living with HIV				
8.3	Being labeled by colleagues to be HIV positive because you care for patients living with HIV				
8.4	Friends and/or families talking bad about you because you care for patients living with HIV				
8.5	Being avoided by friends and/or family because you care for patients with HIV				
8.6	Being labeled by friends and/or families to be HIV positive because you care for patients with HIV				
Q 9.	Do you agree (Yes) or disagree (No) with the following statements:				<i>Discrimination</i>
9.1	I would never test a patient for HIV without his/her inform consent				
9.2	No matter my views or feelings, it is my professional responsibility to maintain the confidentiality of patients living with HIV				

Do you have any suggestions regarding the study?

Thanks

APPENDIX 2: UNISA ETHICAL CLEARANCE



**UNIVERSITY OF SOUTH AFRICA
Health Studies Higher Degrees Committee
College of Human Sciences
ETHICAL CLEARANCE CERTIFICATE**

REC-012714-039

HSHDC/435/2015

Date: 9 September 2015

Student No: 4644-745-8

Project Title: Determinants of HIV related stigma and discrimination among healthcare professionals at a health facility in Malawi.

Researcher: Stephen Emilio Njolomole

Degree: Masters in Public Health

Code: DLMPH95

Supervisor: Prof M Ganga-Limando

Qualification: PhD

Joint Supervisor: -

DECISION OF COMMITTEE

Approved

Conditionally Approved

**Prof L Roets
CHAIRPERSON: HEALTH STUDIES HIGHER DEGREES COMMITTEE**

**Prof MM Moleki
ACADEMIC CHAIRPERSON: DEPARTMENT OF HEALTH STUDIES**

PLEASE QUOTE THE PROJECT NUMBER IN ALL ENQUIRES

APPENDIX 3: NHRSC ETHICAL CLEARANCE

Telephone: + 265 789 400
Facsimile: + 265 789 431
e-mail mohdoccentre@gmail.com
All Communications should be addressed to:
The Secretary for Health



In reply please quote No. MED/4/36c

MINISTRY OF HEALTH
P.O. BOX 30377
LILONGWE 3
MALAWI

16/10/15

Stephen Emilio Njolomole
Malawi Blood Transfusion Service

Dear Sir/Madam,

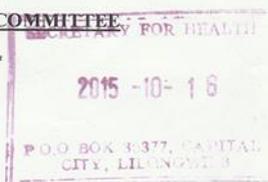
Re: Protocol # 15/9/1494: Determination of HIV associated stigma and discrimination among healthcare professionals at a health facility in Malawi

Thank you for the above titled proposal that you submitted to the National Health Sciences Research Committee (NHSRC) for review. Please be advised that the NHSRC has reviewed and **approved** your application to conduct the above titled study.

- **APPROVAL NUMBER** : NHSRC # 15/9/1494
The above details should be used on all correspondence, consent forms and documents as appropriate.
- **APPROVAL DATE** : 16/10/2015
- **EXPIRATION DATE** : This approval expires on 16/10/2016
After this date, this project may only continue upon renewal. For purposes of renewal, a progress report on a standard form obtainable from the NHSRC secretariat should be submitted one month before the expiration date for continuing review.
- **SERIOUS ADVERSE EVENT REPORTING** : All serious problems having to do with subject safety must be reported to the National Health Sciences Research Committee within 10 working days using standard forms obtainable from the NHSRC Secretariat.
- **MODIFICATIONS**: Prior NHSRC approval using standard forms obtainable from the NHSRC Secretariat is required before implementing any changes in the Protocol (including changes in the consent documents). You may not use any other consent documents besides those approved by the NHSRC.
- **TERMINATION OF STUDY**: On termination of a study, a report has to be submitted to the NHSRC using standard forms obtainable from the NHSRC Secretariat.
- **QUESTIONS**: Please contact the NHSRC on Telephone No. (01) 789314, 0888344443 or by e-mail on mohdoccentre@gmail.com
- **Other**:
Please be reminded to send in copies of your final research results for our records as well as for the Health Research Database.

Kind regards from the NHSRC Secretariat.

FOR CHAIRMAN, NATIONAL HEALTH SCIENCES RESEARCH COMMITTEE



PROMOTING THE ETHICAL CONDUCT OF RESEARCH
Executive Committee: Dr. B. Chilima (Chairman), Prof. E. Molymux (Vice Chairperson)
Registered with the USA Office for Human Research Protections (OHRP) as an International IRB
(IRB Number IRB00003905 FWA00005976)

APPENDIX 4: INSTITUTIONAL PERMISSION TO CONDUCT STUDY

All correspondence should be addressed to

THE DISTRICT HEALTH OFFICER
Telephone No: 01552344
Fax No : 01552347



In reply please quote Ref No BDH/...

The District Health Officer
Balaka District Health Office
P.O. Box 138
BALAKA

7th September 2015

Dr S Njolomole
Malawi Blood Transfusion Services
P.O. Box 2681
BLANTYRE

Dear Dr Njolomole

LETTER OF APPROVAL TO CONDUCT RESEARCH STUDY AT BALAKA DISTRICT HOSPITAL

I am pleased to inform you that your request to conduct research study titled "Determinants of HIV associated stigma and discrimination among healthcare professionals at a Health Facility in Malawi" has been granted. However, this approval has been made on the grounds that you will also seek ethical approval from the National Research Committee.

Lastly, we hope you will share your finding with the institution.

Yours faithfully


B Chikuse

DISTRICT HEALTH OFFICER



APPENDIX 5: RESPONDENTS INFORMATION SHEET AND CONSENT FORM

Introduction:

My name is **Stephen Njolomole**; I am conducting a study entitled: ***Determinants of HIV-related stigma and discrimination among healthcare professionals at a District Hospital in Malawi*** as partial requirements for the fulfillment of Master degree in Public Health at the University of South Africa.

Reason for selection

You have been chosen to participate in this study because of your involvement in the provision of care as a healthcare professional in this hospital.

Participation

Participation in this study is strictly voluntary and failure to volunteer will not result in any disciplinary action by the hospital management. Your answers are anonymous. Your name will not be written on the questionnaires. Your names will never be used in connection with any of the information you tell us. You do not have to answer any questions that you do not want to answer. You may withdraw from this study at any point. However, your honest answers to these questions will help us better understand determinants of HIV and AIDS related stigma and discrimination among healthcare professionals towards PLHIV. We would greatly appreciate your help in responding to this survey. The Questionnaire may take about 20 minutes to complete.

Benefits

Participating in this study may not benefit you directly, however potential benefit for participating in this study is personal satisfaction that the information provided will help us and the rest of the hospital staff to understand the determinants of HIV - related stigma and discrimination at the hospital.

Risks

There are no risks attached to your participation to this study.

If you have any questions about this study, please contact:

Dr Stephen NJOLOMOLE, Principal Investigator on

Cellphone:0888364201, Email : 46447458@mylife.unisa.ac.za or
ste_njo@yahoo.co.uk

INFORMED CONSENT FORM

I have read the foregoing information. I have had the opportunity to ask questions about it and any questions that I have asked have been answered to my satisfaction. I consent voluntarily to participate as a respondent in this research.

Signature of Participant _____

Date _____
Day/month/year