MODEL FOR MITIGATING STIGMA AND DISCRIMINATION AGAINST WOMEN LIVING WITH HIV IN RURAL ZIMBABWE

by

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DECLARATION

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DEDICATION

I take off my hat to you for your patience, hard work, and tolerance to all the rural women out there.

ACKNOWLEDGEMENTS

I give praise and gratitude to Jesus for enabling me to complete this work.

"… His steadfast love endures forever" Psalm 107:1

His blessings upon me are beyond measure.

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LIST OF ACRONYMS AND ABBREVIATIONS

AIDS	Acquired Immunodeficiency Syndrome
ART	Antiretroviral therapy
ARV	antiretrovirals
CDC	Centers for Disease Control and Prevention
CHW	Community health worker
FGD	Focus group discussion
GBV	Gender-based violence
GoZ	Government of Zimbabwe
HIV	Human immunodeficiency virus
HTC	HIV testing and counselling
IPA	Interpretative Phenomenological Analysis
MDG	Millennium Development Goal
MoHCC	Ministry of Health and Child Care
MRCZ	Medical Research Council in Zimbabwe
NAC	National AIDS Council
NGO	Non-governmental organization
PhD	Doctor of Philosophy degree
PLHIV	People living with HIV and AIDS
PMTCT	Prevention of mother to child transmission
PrEP	Pre-exposure prophylaxis
SCT	Social Cognitive Theory
SDGs	Sustainable Development Goals
SRH	Sexual and reproductive health

STI	Sexually transmitted infection
TB	Tuberculosis
TPB	Theory of Planned Behaviour
TRA	Theory of Reasoned Action
UN	United Nations
UNAIDS	Joint United Nations Programme on HIV and AIDS
UNDESA	United Nations Department of Economic and Social Affairs
UNESCO	United Nations Educational, Scientific, and Cultural Organisation
UNFPA	United Nations Population Fund
WHO	World Health Organization

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ABSTRACT

Background: Stigma and discrimination affect the daily lives of people living with HIV, with women living in rural areas being more affected than those in urban areas. Existing evidence pointed to the ineffectiveness of the existing framework used to formulate interventions to mitigate HIV stigma and discrimination. It was therefore deemed important to propose a model to strengthen the Zimbabwe government's efforts to mitigate stigma and discrimination against women living with HIV in the social context of rural Zimbabwe. This was also the main question that this study attempted to answer. The researcher argued that such understanding was deemed necessary for proposing an evidence-based model to support the Zimbabwe government's efforts in fighting stigma and discrimination against women living with HIV in rural areas.

Purpose of the study: The purpose of the study was to propose an evidence-based model for mitigating stigma and discrimination against women living with HIV in rural Zimbabwe.

Methods: This was a two-phase study conducted within the social constructivism paradigm and qualitative approach. A qualitative approach was more appropriate to this study as it allowed the researcher to merge various data collection methods and reach a holistic understanding of the phenomenon of interest. The researcher combined Hermeneutics Phenomenology with qualitative meta-analysis and theoretical triangulation as a design in this study. Hermeneutics Phenomenology allowed the researcher to address the first two objectives of the study (Phase 1) by focusing on the meaning and interpretation of the lived experiences of women living with HIV within the social, cultural, political, and historical context in which those experiences occur. At the same time, qualitative meta-analysis and theoretical triangulation allowed the researcher to use the findings from Phase 1 and the existing literature to design the intended evidence-based model (Phase 2). The research was conducted in rural areas in the Province of Matabeleland South in Zimbabwe. Data was collected through individual in-depth interviews and focus groups from women 18 years old and above living with HIV and AIDS in Zimbabwe's rural areas.

Findings: The researcher developed two frameworks from the findings of Phase 1. The first framework described the lived experiences of women living with HIV in rural Zimbabwe, while the second one explained the meaning they attached to these experiences.

Recommendations: The findings of this study have implications for public health policymakers, public health professionals, health sciences education institutions, and for further research. The model is to guide interventions aimed at mitigating stigma and discrimination against women living with HIV in rural Zimbabwe through behavioural change.

KEY TERMS:

Stigma and discrimination, HIV and AIDS, Interpretative phenomenology, Mitigation Model, Rural women, Zimbabwe

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CHAPTER 1

ORIENTATION OF THE STUDY

1.1 INTRODUCTION

The first chapter provided an orientation of the study. It included the background and rationale, the statement of the research problem, the purpose and objectives of the study, the significance of the study, the ethical and methodological statements, the definition of key concepts, and the outline of the report.

1.2 BACKGROUND AND RATIONALE FOR THE STUDY

Over the past decades, HIV and AIDS has been recognised as a global public health problem (Mpofu, 2019). Although it affects every section of the population, some are more vulnerable than others (Mpofu, 2019). The global HIV statistics by UNAIDS (2021) have indicated that 37.7 million [30.2 million–45.1 million] people globally were living with HIV in 2020, and 53% of all people living with HIV were women and girls. In 2020, around 1.5 million [1.0 million–2.0 million] people were newly infected with HIV, and women and girls accounted for 50% of all new infections in the same year. The National AIDS Council (NAC) of Zimbabwe has also reported that more than 15% of the population aged 15-49 years were living with HIV and AIDS (NAC, 2016). According to Avert, Zimbabwe’s HIV/AIDS statistics indicate that around 1.3 million people are infected with HIV/AIDS, with women accounting for 58% of those affected (Avert, 2020). More still, in 2017, the United Nations AIDS Agency (UNAIDS) report indicated that 1.3 million people were living with HIV in Zimbabwe, and 720 000 of them were adult women (above 15 years), 510,000 were adult men, and 17,000 were children under 14 years (UNAIDS, 2017a). In Zimbabwe, reports showed differences in the prevalence of HIV among women in terms of urban and rural geographical distribution. Women living in rural areas were more affected by HIV than their counterparts living in urban areas. For example, 21.6% of women living in the rural province of Matabeleland South were HIV positive compared to 12.2% of women living in Harare (NAC, 2016; UNAIDS, 2016).

The high prevalence of HIV among women is often associated with the patriarchal nature of society and socio-economic disparities, amongst others. Globally, 32.0% of men believe in having the sexual right over women and the right to multiple partners, while women are expected to be faithful and submissive (UNAIDS, 2014). A study on HIV stigma reduction intervention for people living with HIV and their families conducted in South Africa showed that men do not respect the sexual and reproductive health rights of women and have no power to take independent decisions on sexual issues affecting their health (Pretorius, Greeff, Freeks & Kruger, 2016). Meanwhile, in Zimbabwe, economic migration was identified as the main driver of the high prevalence of HIV amongst women, specifically those living in rural areas. The socio-economic hardship in the country compels most men to move outside of the country or from rural areas to cities for employment opportunities, leaving their families back home. While in cities, they often engage in risky sexual behaviours while expecting their wives or partners to remain faithful to them (Zimbabwe National Statistics Agency, 2016).

Over the past decades, living with HIV is no longer a life-threatening event due to the availability and the use of antiretroviral drugs (Phiri, Haas, Msukwa, Tenthani, Keiser & Tal, 2018; Wirawan, 2019). According to UNAIDS reports, the annual mortality due to AIDS-related illness declined from a peak of 1.9 million (1.4–2.7 million) in 2004 to 940,000 (670,000–1,300,000) in 2017 with the increased use of antiretroviral drugs (UNAIDS, 2018). Despite this progress, people living with HIV still experience adverse social effects and unfair treatment, such as stigma and discrimination (Brinsdon, Abel & Desrosiers, 2017:185). Generally, stigma and discrimination take place within a context of differential power between the stigmatising and stigmatised group and involve stereotypes, the endorsement of those stereotypes as real (prejudice), and a desire to avoid or exclude the stigmatized persons (discrimination) (Stangl, Earnshaw, Logie, van Brakel, Simbayi, Barré, and Dovidio, 2019). Social interaction is socially constructed, expressed, and influenced by social values, norms, and beliefs that influence how people respond to stigmatized behaviour (Major, Dovidio, Link, and Calabrese, 2018).

Despite increased HIV and AIDS awareness and the limited ways of contracting it, social isolation remains a reality for many people living with HIV. Authors (Pretorius et al., 2016:188) argued that misconceptions and judgments from close family and friends could make nurturing relationships difficult and lead to social isolation and fear of disclosing one's status in the first place. Stigma can lead to low self-esteem, social rejection, and negative consequences for those associated with stigmatized individuals (Mavhandu-Mudzusi & Ganga-Limando, 2014). Stigma and discrimination affect the prevention, management, and treatment efforts of HIV worldwide (Wirawan, 2019). It reduces testing-seeking behaviour, limits HIV-positive individuals' willingness to disclose their status, and changes healthcare providers' attitudes toward people living with HIV (Brinsdon, Abel, and Desrosiers, 2017: 186).

Mitigating HIV-related stigma and discrimination is an essential component of the fight against HIV and AIDS (UNAIDS, 2014). Positive social support is viewed as one of the primary responses in the fight against HIV-related stigma and discrimination. The lack of positive social support increases the likelihood of one feeling hopeless, depressed, low self-esteem, suicidal thoughts, or worthlessness (Mhode & Nyamhanga 2016; Parcesepe, Tymejczyk, Remien, Gadisa, Kulkarni, Hoffman, Melaku, Elul & Nash, 2018). Like many other African countries, Zimbabwe incorporated the fight against stigma and discrimination in their national HIV and AIDS strategies (NAC, 2014; UNAIDS, 2014). The country uses a multi-level approach to stigma and discrimination reduction. The approach looks at the intrapersonal, interpersonal, community, institutional, and governmental or structural levels (NAC, 2014; UNAIDS, 2014).

In a systematic review of interventions based on the multi-level approach to stigma and discrimination, authors Rao, Elshafei, Nguyen, Hatzenbuehler, Frey, and Go (2019), revealed that the multi-levels approach enables the understanding of how stigma and discrimination manifest and cannot be used to formulate effective interventions. They argued that effective interventions for mitigating HIV stigma and discrimination should derive from the lived experiences of people living with HIV. This concurs with the study (Meleis, 2010), which indicated that the living experiences of HIV women living in rural areas are different from those living in urban areas. HIV-positive women in rural Zimbabwe live in a social environment with people sharing the same social values, beliefs, and social role expectations (Panda, Das, Maruf & Pahari, 2015:363). It is therefore essential to look at a model for mitigating stigma and discrimination against women living with HIV in rural Zimbabwe.

1.3 STATEMENT OF THE RESEARCH PROBLEM

The importance of mitigating stigma and discrimination against women living with HIV in rural areas of Zimbabwe cannot be overemphasised. Epidemiological reports showed that the prevalence rate of HIV is still unacceptably high despite the ever-increasing awareness and knowledge about the spread and prevention of HIV. Women, specifically those living in rural areas, are most affected than their urban counterparts (NAC, 2016; UNAIDS, 2017a). Factors associated with this high prevalence rate of HIV among rural women are well documented (NAC, 2016; UNAIDS, 2014; Pretorius, et al., 2016:188). It is also reported that the increasing use of antiretroviral drugs has improved the quality of life of people living with HIV, as supported by the reduced mortality rate due to HIV-related diseases (UNAIDS, 2018).

It appears that as socially constructed concepts, stigma and discrimination affect the daily life of people living with HIV, with women living in rural areas being more affected than those in urban areas (Wirawan, 2019). Existing evidence pointed to the ineffectiveness of the existing framework used to formulate interventions to mitigate HIV stigma and discrimination (Mhode & Nyamhanga, 2016; Parcesepe et al., 2018; NAC, 2014; Rao et al., 2019; UNAIDS, 2014). The main question that this study attempted to answer was what model can be proposed to strengthen the Zimbabwe government’s efforts to mitigate stigma and discrimination against women living with HIV in the social context of rural Zimbabwe.

The researcher argued that a model for mitigating stigma and discrimination against women should be based on evidence from understanding the realities and accumulated experiences of being a woman living with HIV within the social context they live in. However, there is little understanding of how women living with HIV view their new realities of being HIV positive and their accumulated lived experiences within the rural socio-cultural context of Zimbabwe. Such understanding was deemed necessary for proposing an evidence-based model to support the Zimbabwe government’s efforts in fighting stigma and discrimination against women living with HIV in rural areas.

1.4 PURPOSE OF THE STUDY

The purpose of the study was to propose an evidence-based model for mitigating stigma and discrimination against women living with HIV in rural Zimbabwe. This was based on their understanding of being a woman living with HIV in the rural context of Zimbabwe.

1.5 OBJECTIVES OF THE STUDY

The study was conducted with the following objectives:

1. To explore and describe the lived experiences of women living with HIV in the rural context of Zimbabwe.
2. To explore and describe the meaning women living with HIV in rural Zimbabwe attached to their lived experiences.
3. To design and describe an evidence-based model for mitigating stigma and discrimination against women living with HIV in the rural context of Zimbabwe

1.6 SIGNIFICANCE OF THE STUDY

An evidence-based model for mitigating HIV-related stigma and discrimination against HIV-positive women living in rural areas is significant for the existing body of knowledge, public health practice and policies, and public health researchers. Stigma and discrimination negatively impact one’s ability to perform the expected social roles, the quality of life, and the efforts to prevent the spread of HIV and AIDS and reduce HIV-related mortality. By proposing a mitigation model based on empirical evidence from the lived experiences of HIV-positive women living in rural areas of Zimbabwe, public health practitioners and policymakers can use the model as a framework to design evidence-based interventions and policies to mitigate HIV-related stigma and discrimination against HIV positive women living in rural areas.

This study's results will significantly contribute to the existing body of knowledge by bringing new insight into the lived experiences of HIV-positive women living in rural areas, the types of stigmas and discrimination they experience, and how they respond to these challenges. The results will contribute to the body of evidence to support the efforts of the Zimbabwe government to improve the quality of life of HIV-positive women living in rural areas. The public health researchers can use the results of this study as baseline information to conduct a large-scale study in the country.

1.7 ETHICAL AND METHODOLOGICAL STATEMENTS

1.7.1 Ethical statement

The researcher observed the research and ethics policies of the University of South Africa and the universal ethical principles that guide social and human research (anonymity, autonomy, rights to privacy and confidentiality, justice, and protection from risk and harm). The researcher obtained ethical clearance to conduct the study from the Health Research Ethics Committee of the University of South Africa (UNISA) and the Medical Research Council of Zimbabwe (MRCZ). Permission to access the participants was obtained from the community gatekeepers. Each participant signed an informed consent form. The researcher and the participant signed a confidentiality agreement form.

1.7.2 Methodological statement

This was a two phases study conducted within the social constructivism paradigm and qualitative approach. Social constructivism is based on the assumptions that reality is constructed through human interaction (ontological assumption) and that knowledge is socially and culturally constructed (epistemological assumption) (Creswell 2014:9). Social constructivists argue that individuals create meaning through their interactions with others and the environment in which they live. With the understanding of stigma and discrimination being socially constructed, the researcher viewed social constructivism as more appropriate to guide this study. A qualitative approach was more appropriate to this study as it allows the researcher to merge various methods of data collection and reach a holistic understanding of the phenomenon of interest.

The researcher combined Hermeneutics Phenomenology with qualitative meta-analysis and theoretical triangulation design in this study. This approach was deemed relevant as the researcher intended to propose an evidence-based model for mitigating stigma and discrimination against women living with HIV in the rural context of Zimbabwe. Hermeneutics Phenomenology allowed the researcher to address the first two objectives of the study (Phase 1) by focusing on the meaning and interpretation of the lived experiences of women living with HIV within their social, cultural, political, and historical context in which those experiences occur. At the same time, qualitative meta-analysis and theoretical triangulation allowed the researcher to use the findings from Phase 1 and the existing literature to design the intended evidence-based model (Phase 2).

1.8 DEFINITIONS OF KEY CONCEPTS

Behaviour is “anything an individual does in response to internal or external events. Overt action (motor or verbal) is directly measurable; acts are physical events that occur in the body and are controlled by the brain” (Davis, Campbell, Hildon, Hobbs, & Michie, 2015:329). This study will refer to the actions taken by women living with HIV in rural Zimbabwe to respond to and manage HIV-related stigma and discrimination.

Mitigation of stigma and discrimination in this study refers to actions aimed at preventing or dealing with the social impacts related to HIV.

Model: A set of concepts and statements with specification of how phenomena relate to each other. The theoretical framework describes “a system that accounts for what is known and explains and predicts phenomena” (Davis et al., 2015:330). A model helps people objectively structure how they view a situation, event, or group of people and “may be used to plan for or intervene in a particular health problem” (Chinn & Kramer, 2013:157; Kgole, 2009:16). It is a simplification, conceptualisation, or abstraction of reality often presented in a diagram to assist people in knowing, understanding, or simulating a subject the model represents (Squires, Chilcott, Akehurst, Burr & Kelly, 2016: 590). This study will simplify and conceptualise and present the model in a diagrammatic way to help people in knowing, understanding or simulating the mitigation of stigma and discrimination.

HIV discrimination. This study defines it as any discriminatory actions directed at people perceived to have AIDS or HIV and at the individuals, groups, and communities with which they are associated.

HIV stigma in this study is a social construct characterized 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 by others.

Stigma and Discrimination include the “socially devalued status of people living with HIV (PLHIV), manifested in prejudice, discounting, discrediting, and discrimination directed at people perceived to have HIV and the individuals, groups, and communities with which they are associated” (Steward et al. 2008: 1226). In this study, stigma and Discrimination referred to any behaviour perpetrated against women living in rural Zimbabwe due to their HIV-positive status and experienced as socially dehumanising.

1.9 STRUCTURE OF THE THESIS

Chapter 1: Orientation of the study

This chapter presents an overview of the study. The study introduces the context and background, followed by the problem statement. The purpose of the study, as well as the objectives, are presented in this chapter. The chapter presents Questions to be answered by this study and the methodological/ethical statement.

Chapter 2: A literature review

Chapter 2 explores the social impacts posed by HIV from a rural woman’s perspective. The purpose of the chapter was to review and examine what other researchers have done in the area of HIV-related stigma experiences, theories, and models, situate the current study and realize any gaps that this study needs to fill.

Chapter 3: Methodology

In this chapter, the researcher outlined the Methodology in detail, taking the reader through the design and approaches. The section describes the setting, population, sampling methods, and the data collection and analysis of the study.

Chapter 4: Presentation of Findings and Discussion of Results

This chapter takes the two phases into cognizance, identifies the themes, and discusses them.

Chapter 5: Description of the conceptual model.

This chapter describes and draws a conceptual model for the study.

Chapter 6: Conclusion, recommendations, and limitations.

This chapter concludes the study, giving recommendations and limitations.

CHAPTER 2

LITERATURE REVIEW

2.1 INTRODUCTION

HIV disproportionately affects women and girls because of their unequal cultural, social, and economic status in society (UNAIDS, 2017, 2019). Intimate partner violence, inequitable laws, and harmful traditional practices reinforce unequal power dynamics between men and women, particularly disadvantaged young women. (UNAIDS, 2017). HIV is not only driven by gender inequality, but it also entrenches gender inequality, leaving women more vulnerable to its impact (WHO, 2017). Over half of women live with HIV worldwide (Logie, Wang, Lacombe-Duncan, Wagner, Kaida, Conway, Webster, Alexandra de Pokomandy & Loutfy, 2018). HIV-related stigma is also highly prevalent among people living with HIV (PLWH) (Rueda, Mitra, Chen, Gogolishvili, Globerman, Chambers, Wilson, Logie, Shi, Morassaei, & Rourke, 2016). There is a shortage of studies on the stigma experienced by HIV-positive rural women in Zimbabwe. Addressing stigma as part of the global HIV response remains a priority for national and international funding, policy development, and programs (Mpofu, 2019). As a major cause of discrimination and exclusion, stigma affects people's self-esteem, disrupts relationships, and limits people's ability to socialize and access housing and employment (WHO, 2020). Stigma also contributes directly to human rights abuses (WHO, 2020). More than two decades into the HIV epidemic, stigma and discrimination continue to hamper efforts to prevent new infections and engage people in HIV treatment, care, and support programs (Stangl, Lloyd, Brady, Holland & Baral, 2013; Katz, Ryu, Onuegbu, Psaros, Weiser, Bangsberg & Tsai, 2013; Rueda et al., 2016). In Zimbabwe, out of 1.3 million people living with HIV, more than half of that population are adult women (above 15 years) (UNAIDS, 2017a). Logie et al. (2018) posit that HIV is an epidemic fuelled by racial, gender, and class inequities. Antiretroviral treatment's advent saw the shift of HIV to a manageable chronic condition; however, these people may still experience adverse social effects and unfair treatment (Brinsdon, Abel & Desrosiers, 2017:185). Thus, the global AIDS response success relies on identifying effective interventions to reduce stigma and discrimination (Stangl et al., 2013).

2.2 WOMEN AND HIV AND AIDS IN THE CONTEXT OF ZIMBABWE

2.2.1 Epidemiological overview

Evidence shows that since the start of the global HIV epidemic, women in many regions have been disproportionately affected by HIV. (UNAIDS, 2017a; 2021; Avert, 2020). Today, women constitute more than half of all people living with HIV (UNAIDS, 2019). Feminist researchers argue that women are more vulnerable to HIV than men because of their greater biological susceptibility if exposed to HIV and their greater social vulnerability to an HIV-positive partner (Vitali, Wessels & Kaushic, 2017:1). Surveillance statistics also showed that heterosexual transmission accounted for more infections among women than men, suggesting that women might be at higher risk of disease if exposed through heterosexual intercourse (UNAIDS, 2017). Biology already ‘feminizes’ the epidemic (McClelland, Lingappa, Srinivasan, Kinuthia, John-Stewart, Jaoko, Richardson, Yuhas, Fiedler, Mandaliya & Munch, 2018; UNAIDS, 2017). Heterosexually, vaginal intercourse, male-to-female HIV transmission is double that of female-to-male, because of the more receptive contact surface of the vagina, a higher concentration of HIV in semen compared to vaginal fluid, and cervical ectopy (Vitali, et al. 2017:1; McClelland et al., 2018). Accordingly, UNPFA (2011:2) also says that about 90% of adult HIV infections in Zimbabwe arise from heterosexual transmission. The transmissions occur mainly from multiple (including concurrent) sexual relationships, low levels of circumcision, and inconsistent condom use (UNPFA, 2011:2).

2.2.2 Factors contributing to women's vulnerability to HIV

Women living in rural Zimbabwe are affected by HIV more than those living in urban areas. For example, the prevalence rate of HIV in the rural province of Matabeleland South, where the study took place, was 21.6%, compared to 12.2% in Harare (NAC, 2016; UNAIDS, 2016). Thus, HIV has poorly impacted Zimbabwe, affecting many sectors like the health sector, the economy (labour and firms), education, and food security (MoHCC, 2015:5). Economic insecurity among PLHIV associates HIV-related stigma with food and housing insecurity (WHO, 2020). A study commissioned by the Ministry of Women Affairs, Gender, and Community Development and the National Aids Council (ZAACA, 2015) identified several socio-economic, cultural, and religious factors that increase women's vulnerability to HIV. These factors militated against women and girls concerning addressing HIV. In an article by Arrey, Bilsen, Lacor, and Deschepper (2015:14), stigma and discrimination associated with an HIV-positive status and fear of violence from partners deterred women from acting on prevention and treatment information.

The Minister of Women's Affairs, Gender, and Community Development also confirmed that “A lot of potential recipients have failed to access services such as HIV counselling and testing as well as prevention of Mother-to-Child Transmission on such grounds” (GoZ, 2015:1). Arrey and colleagues also say that the fear of violence influences women negatively because they become unable to demand safe and satisfactory sex (Arrey et al. 2015). Another issue that increases vulnerability in Zimbabwe is child marriages. Although forced early marriage and rape violate human rights, some cultures still practice it (Mpofu, 2022:3). According to Majaha (2015), 31% of girls are married before their eighteenth birthday. The constitution of Zimbabwe defines a child as every boy and girl under 18 years (Constitution of Zimbabwe, 2013). The constitution of Zimbabwe also states that every child has rights, which are listed as protected from economic and social exploitation, child labour and maltreatment, neglect, or any form of abuse (Constitution of Zimbabwe, 2013). In Zimbabwe, the age of consent is 12 years, which makes a girl child more vulnerable, exposing her to rape, sexual abuse, and early marriage (Mpofu, 2022). These increase the risk of being infected by HIV and related diseases, as these young girls are often powerless to demand the use of contraception during sex (Mpofu, 2022). With the above narration, addressing stigma, discrimination and human rights violations at such levels can be through creating a protective and empowering legal environment and the strict rule of law for both the AIDS response and the broader 2030 Agenda for Sustainable Development (UNAIDS, 2017:14).

The weak formulation of policies fuels the blame for the above issues, leaving women and young girls vulnerable (UNAIDS, 2020). A good example is in the sentencing of these crimes. To flashback to the Zimbabwean chronicle newspaper and violence against women, an ex-wife was raped all night by an HIV-positive man while her baby cried on the bed, unattended (Sunday News 20 October 2019). The same paper reports that the man was asked to pay a $100 bond fine, equivalent to R400 or 90 days in prison at the time. Although Zimbabwe used to criminalize HIV/AIDS's wilful transmission to a partner, the sentence imposed on these sex offenders is minimal because it’s not consensual, rape it’s a severe crime, and the penalty should have been stiffer (Mpofu, 2022). Thus, women and girls experience violence in various contexts within the family, the community, and broader society (Dlamini, 2020). For crimes involving stock theft, stiffer penalties were introduced to curb the rampant stock theft in Zimbabwe (Mpofu, 2014). For example, one cow's theft can attract a mandatory sentence of nine years, stretching to 25 years. Mpofu posits that disparity and logic are something that needs to be addressed by lawmakers as sexual crimes are not deterrents despite the victims' likelihood of suffering physical and emotional trauma (Mpofu, 2012).

2.3 HIV-related stigma and discrimination

2.3.1 Understanding stigma and discrimination

Stigma is an attribute that profoundly discredits a particular social interaction that accompanies this HIV. HIV-related stigmatization is a devaluation process of the people living with HIV (PLHIV). Women are labelled, and this label is always connected with undesirable behaviour. The tagged people face stereotyping, experience status loss, and discrimination (Yuh, Ellwanger, Potts & Ssenyonga, 2014). The consequences of stereotyping and discrimination entail lowered self-esteem, reluctance to seek treatment, social rejection, and adverse effects for those associated with stigmatized individuals (Corrigan, Druss & Perlick, 2014:38; Knaak, Mantler, & Szeto, 2017:111).

Discrimination “is a behaviour or an action in which a distinction against people results in the person being treated unfairly or unjustly, based on belonging, or perceived to belong to a particular group” (Wodajo, 2015:9). According to Yuh et al. (2014:582), “most HIV infections are through heterosexual transmission, a mode of transmission closely linked to sexual promiscuity and the resultant HIV related stigma.” Discrimination refers to action due to stigmatization (Thupayagale-Tshweneagae & Mokomane, 2012:63). HIV stigma is a social construct that devalues individuals living with HIV. It is noticeable negative behaviours of prejudice, discounting, discrediting, and discrimination toward people perceived to have HIV and any individuals, groups, and communities with which they are associated (Yuh et al.,2014:582). HIV-related stigma has been a persistent problem among societies for several years. Some termed it a disease as the term now refers to physical disorders given to a person assumed to be harmful or deeply discredited (Arrey, 2015:2). HIV-related stigma is more devastating than the other types of illnesses, as “It is not an acceptable disease” (Ziersch, Walsh, Baak, Rowley, Oudih & Mwanri, 2021).

Stigma and Discrimination are socially constructed and expressed through social interaction. Its essence lies in the “rules,” which guide behaviour at particular points in time and place by defining it as acceptable, customary, “normal,” or expected—as such, ameliorating these social, interpersonal, and structural injustices should be a social priority with the end goal of their elimination (Mavhandu-Mudzusi & Ganga-Limando, 2014).

2.3.2 Types of stigmas and Discrimination

HIV-related stigma is a universal phenomenon, but it differs from one country to another, and specific target groups for HIV and AIDS vary significantly among the population (Kharsany & Karim, 2016:37). Many stigma issues are illustrated in the literature; however, the researcher picked a few instances to show the stigma's manifestations. In Jordan, for example, medical students displayed a negative attitude towards PLWHA (Sallam, Alabbadi, Abdel-Razeq, Battah, Malkawi, Al-Abbadi, Mahafzah, 2022). As these medical students are future physicians, they represent a core group that should be targeted with focused knowledge and adequate training to provide patient care without prejudice. And as such, stigmatizing attitudes toward people living with HIV/AIDS (PLWHA) can be a significant hurdle to effective patient care.

Again, in a pilot study in Cameroon, Jacobi and colleagues did an intervention study using the people living with HIV to educate the students on multiple aspects of HIV/AIDS and stigma, after which they gave them “True/False” examinations on HIV/AIDS and stigma and compared their results with a group that had not participated in the intervention. The researchers found that the students who took part in the intervention improved by almost 20% compared to the other students who had not taken part. (Jacobi, Atanga, Bin, Fru, Eppel, Mbome, Etonde, Bogner, and Malfertheiner, 2020).

Similarly, a cross-sectional study in Botswana examined the relationship between HIV/AIDS knowledge and stigmatising attitudes toward people living with HIV/AIDS

(PLWHA). The researchers found out that HIV/AIDS knowledge score significantly predicted stigma towards PLWHA score, suggesting that increasing HIV/AIDS knowledge may reduce stigmatising attitudes held towards PLWHA in Botswana (Letshwenyo-Maruatona, Madisa, Boitshwarelo, George-Kefilwe Kingori, Ice, Bianco, Marape, and Haile, 2019).

In a study by Memish, Filemban, Bamgboyel, Hakeem, Elrashied, and Al-Tawfiq (2015), they found that HIV knowledge was a significant predictor of high stigma. In South Africa, Haffejee, Maughan-Brown, Buthelezi, and Kharsany (2018) perceived that people living with HIV experience some form of stigmatisation in the home community and university environment.

From these few studies, it can be noted that HIV/AIDS-related stigma is a significant problem in curtailing the spread of HIV, and so research on HIV stigma needs to shift attention to the HIV uninfected and consider the mechanisms through which HIV stigma impacts on people and a vague understanding of the psychological, behavioral, and health outcomes of HIV stigma.

2.4 FACTORS INFLUENCING HIV-related STIGMA AND DISCRIMINATION

2.4.1 Social and cultural norms

In Zimbabwe, women are viewed as perpetual minors through the eyes of customary law (Mpofu, 2022). Women are either under their father's authority or their husbands when they marry. Mpofu (2022) also laments Zimbabwean women’s inability to negotiate and make decisions about their sexuality. Such behaviour renders Zimbabwe's social environment degrading and devalues women’s social worth, “making a woman unable to seek and enjoy good health” (McCloskey, Boonzaier, Steinbrenner, & Hunter, 2016:279). According to UN Women, 2020a, so deep-rooted is perpetual minors' teaching those men have difficulty acknowledging female individuals as equal to them. Such teachings promote HIV-related stigma. Subjective norms about the perception that women are minors reinforce the socio-cultural attitude of the community (Mwambene, 2018). This attitude limits females from reaching out for safe sexual reproductive health, making them susceptible to HIV and AIDS (UN Women, 2020a:78). In Zimbabwe, marriage is highly esteemed, a norm, and a priority in life; thus, women do all means to get attached to a man in marriage. Marriage is an expectation that society looks towards seeing from a grown-up woman (Mwambene, 2018). Such hope puts pressure on women who want to get married at whatever cost lest they become social outcasts. According to Mpofu (2022) getting married is traditionally encouraged, exposing young women to HIV and AIDS.

In such settings, where Sexual and reproductive health (SRH) and HIV services exist, they are primarily for married women with children. They do not meet the specific needs of unmarried young women and adolescent girls (UNAIDS, 2017). Healthcare providers often lack the training and skills to deliver youth-friendly services and do not fully understand laws around the age of consent (WHO, 2017).

A person's perception of the opinions of significant others concerning a particular action affects subjective norms. "Subjective norms refer to the belief that an important person or group of people will approve and support a particular behaviour" (Ham, Jeger & Frajman Ivković, 2015:740). For instance, culturally in Zimbabwe, decision-making is for men, and women must just subdue and submit to their decision-makers. Even in some churches, "women cannot talk when men are there" (Majaha, 2015). Women's role in society has been culturally stereotyped. Although it is vital for women to make their own choices, the Zimbabwean culture takes no heed. For example, in the case of rural Zimbabwean women living with HIV, subjective norms from the support group or peers, family or society could be thoughts such as feeling suspicious of people's intentions towards the person living with HIV.

Lew, Huen, Yu, Yuan, Wang, Ping, Abu Talib, Lester, and Jia (2019:2) say that "subjective wellbeing factors, such as those related to meaning in life and limited coping abilities, are also potential predictors of suicidality." In Barlett's (2019) words, theorizing one's perception regarding the acceptability of behaviour has been more important than objective assessments. Barlett says that this showed that personal risk, such as the belief that one is at risk for influenza, was the strongest predictor of receiving vaccinations for influenza than objective variables (being placed in a high-risk group for flu using CDC recommendations) (Barlett, 2019). To use the subjective normative beliefs, Barlett explains that if the parent and peer approval of smoking behaviours were to be used as a source of subjective norms (smoking), then the parents or peers could shape unacceptable or acceptable behaviour beliefs. That means that personal opinions are a significant predictor of behaviour even though other sources may cause subjective normative beliefs to shift (Barlett, 2019). The Normative view would be when an individual's perception of normative social pressures or relevant others' beliefs should or should not perform such behaviour. Normative beliefs are individuals' beliefs about the extent to which other people who are important to them think they should or should not perform particular actions (Ham et al., 2015).

Another research into attitudes towards sexual and reproductive health among adolescent girls in Ghana found varying degrees of harmful social and community norms, attitudes, and beliefs about teenage girls’ sexuality. The study found that adolescent girls tended to endorse these stigmatizing attitudes and regularly observed or experienced Sexual and reproductive health (SRH) related stigma (Hall, Morhe, Manu, Harris, Ela, Loll, Kolenic, Dozier, Challa, Zochowski, & Boakye, 2018).

2.4.2 Significant others

Significant others may play a role in the normative beliefs of the community of people living with HIV. Normative beliefs can turn into subjective norms that may influence the reduction of HIV-related stigma practices. The social aspects of women render rural Zimbabwean women more vulnerable to HIV and AIDS than men. In Zimbabwe, a family is a unit for reproduction and production, but the primary political entity was the village, which also assumed a decisive economic role in irrigation management. In some studies, peer influences formed stigmatizing attitudes. And one’s morals and emotions; peers, family, and community powers developed subjective norms regarding stigma in addition to societal social pressures to stigmatizing behaviours (or not), and it derives perceived Behavioural control from aspects of the societal environment (Pabian & Vandebosch, 2014).

2.4.3 Traditional family structure

A strictly hierarchical order reigned within the family where influence has less energetic imprints on family ideology and social relations norms. While women's subordinate role calls for women to respect men, the young generation also obeys their elders. They should follow “the three obedience”- to obey their fathers as daughters, their husbands as wives, and their oldest sons when their husbands die. Husbands should teach and control their wives as they did their younger brothers and children.

The traditional family was the central institution supporting its members throughout the cycle. In this Matabeleland or rural Zimbabwe, agrarian society, having many children was a blessing and a fortune. Children were needed to help in agricultural work, and they were the only old-age insurance for the parents. In Zimbabwe, little girls were loved and nurtured before colonization, but the boys received more attention, as the girls would disappear from their paternal family at marriage. Kinship was and still is patrilineal. In Zimbabwe, the inheritance of land is predominantly patrilineal and patrilocal at marriage (Jacobs, 2000). The bride typically starts to live with the husband’s family, to whom she owes her primary allegiance. After some years in the parental home, the marital family often sets up their household in the same compound or the parental home's vicinity.

The family concept is the deep respect and devotion children show their parents and reverence, expressed in the most potent and deeply rooted rural rituals: ancestral worship. Deceased parents need their children's worship to be happy in the afterword. In return, they will protect their descendants and bring them happiness. Only the male child could perform ancestral rituals. Therefore, the worst filial impieties were for a man to die without a son; then, his whole lineage, including ancestors and unborn descendants, would die with him. Only with a male child's birth did the man attain a full standing, fulfilling his filial duty. Women's identity centred around their roles as wives and mothers (Jacobs, 2000). Without a son, a woman’s status in the family would be in danger-she was held responsible for not getting a male heir, and she could expect the husband to take a second wife to ensure that a son was born. As seen from all these cultural ideologies, the girl child’s rights were entirely denied. Their risk of contracting HIV increases with their vulnerability because of such factors as a low likelihood of secondary education and employment, the threat of violence in conflict or post-conflict situations and being married while they are still children. The lack of education and jobs fuels poverty and creates a dependency on men, making women even more vulnerable to the direct or indirect effects of HIV and AIDS. Such issues hugely contributed to gender inequalities. These are part of society's socio-cultural, economic, and political makeup (UNAIDS & AU, 2015:2). Despite the achievements of the AIDS epidemic, adolescent girls and young women are still left behind.

2.4.4 Gender relations

Gender relations are the social relationships between women and men (co-operation, connection, mutual support, conflict, separation, competition, difference, and inequality) (Sánchez-López & Gras, 2016). Gender relations concern the power distribution between the sexes (and amongst sexes) (Mpofu, 2022). They create and reproduce systemic differences in men's and women's positions in a given society (i.e., power dynamics) (WHO, 2020). These power dynamics are derived from social, economic, and sociohistorical status. Gender power dynamics are not one-directional and trouble-free as men can have a power advantage over women (Manandhar, Hawkes, Buse, Nosrati & Magar, 2018; Smith, Gaston, & Id, 2018). Men can also have a power advantage over men (Smith et al., 2018). Women can also have a power advantage over women (Smith et al., 2018), or women can have a power advantage over men (Manandhar et al., 2018). Gender itself "refers to the roles, behaviours, activities, attributes, and opportunities that any society considers appropriate for girls and boys, and women and men" (Manandhar et al., 2018: 644). Manandhar and colleagues say that gender interacts with but is different from the binary categories of biological sex (Manandhar et al., 2018) because sex is a biological classification based primarily on reproductive potential. In contrast, gender is the social explanation of biological sex. Gender builds on biological sex, but it exaggerates physical differences and carries biological differences into domains that are entirely irrelevant (UNECSO, 2012:11). This means that "gender is socially constructed characteristics of women and men – such as norms, roles, and relationships of and between groups of women and men" (UNECSO, 2012:11). It varies from society to society and can be changed. While most people are born either male or female and learn appropriate norms and behaviours – including how they should interact with others of the same or opposite sex within households, communities, and workplaces (WHO, 2017a). Gender equality and empowerment issues target women mainly (UN Women, 2020a).

Being male or female involves learning to look and act in particular ways, participate in specific ways in relationships and communities, and see the world from a different perspective. Habits, preferences, and beliefs result from history and not as a result of the social order. However, habits, preferences, and beliefs develop in response to experience. This social order structures the knowledge and is likely to be patterned to who creates what. Women or men are not necessarily from the same groups: Not everyone will adopt the same stance; some men may cry readily, while some women may never shed tears. Such reactions to circumstances differ because of individual exposure to norms, expectations, and opportunities that depend on gender and other social categories. From an early age, in most societies, gender plays a crucial role in how and what men and women know and what attitudes to adopt in sexual matters. Thus, promoting responsible and respectful sexual behaviour for both women and men is the foundation of HIV and AIDS prevention. According to Logie et al. (2018), physical and mental health inequities among women relative to men are due, in part, to sexism and gender discrimination. These researchers also cited intrapersonal impacts (e.g., chronic stress), and interpersonal impacts (e.g., violence), gender discrimination as limiting factors to access to economic security for women globally (Gradín, Del Río, and Cantó, 2010) with particularly harmful impacts among women living with HIV and AIDS (Olowu, 2014).

2.4.5 Poverty

In most cases, rural women have limited relationships and living circumstances than women in the middle class. These women live in poverty and are economically and emotionally dependent on men. For such dependent women, what prevails more for them is usually the shelter, food, and care for their children more than the threat of HIV and AIDS (Mpofu, 2012). Men can easily coerce such women as they are vulnerable. Such vulnerability exposes them to HIV and AIDS, as their focus is on short-term survival techniques of getting food, shelter, and care, not HIV prevention, as they view it as a luxury. Gender inequality, power imbalances, and higher intimate partner violence and discrimination make them more vulnerable. This becomes even worse for marginalized women, for example, those with disabilities, migrants, sex workers, and transgender (UNAIDS & AU, 2015:13). Other factors that make young women and adolescent girls vulnerable to HIV infection include transactional and unprotected age-disparate sex (emanating from poverty, lack of opportunity, and lack of material goods), conflict, and post-conflict settings (UNAIDS & AU, 2015:13). Employment-related discrimination also limits options for financial security and reduces access to housing and food security, which may, in turn, harm physical and mental health (Banet-Weiser, Gill, & Rottenberg, 2020).

2.4.6 Violence

Violence can take any form. It can be non-sexual or sexual, either outside or inside a marriage setting. In high prevalence settings, women exposed to intimate partner violence are 50% more likely to be infected by HIV than those not exposed to violence (UNAIDS & AU, 2015:11). According to the UNAIDS (2014), young women and adolescent girls have the highest intimate partner violence (UNAIDS & AU, 2015:11). In Zimbabwe, the prevalence of intimate partner violence among 15-24-year-old women is 35% and 24% among those aged 25-49 and lower for older women (UNAIDS & AU, 2015:11). The Documentation of Community strategies to combat intimate partner violence shows a relationship between intimate partner violence and HIV (Wagman, Gray, Campbell, Thoma, Ndyanabo, Ssekasanvu, Nalugoda, Kagaayi, Nakigozi, Serwadda, & Brahmbhatt, (2015).

Sex stories are familiar in Matabeleland, as reported by the Chronicle Newspaper.
The following examples from the Chronicle newspaper of 2019 show that violence towards women will always be ongoing because of these men's cultural upbringing, leaving women and girls at risk: 1) HIV-positive man rapes ex-wife without protection. The man had forcefully taken the woman’s phone to lure her into his house and then sexually assaulted the woman on the floor while her baby cried all night on the bed. Such is violence that portrays no remorse or feelings for the baby. In another incident, a man from Bulawayo raged and assaulted his ex-wife, accusing her of infecting him with HIV. Another story had a man instructing his HIV-positive family to quit taking ARVs. At the man’s instigation, the family stopped taking ARVs because, according to their culture, “a man is always right as the head of the family.” During conflict and post-conflict emergencies, women and girls face unique risks. These special risks heighten HIV vulnerability for women (UNAIDS & AU, 2015:12). For example, a man from Bulawayo got arrested for allegedly attacking his wife. His wife hid her HIV-positive status from him. Violence under these types of situations also needs addressing. The community's social values, norms, and beliefs influence how people respond to stigmatized behaviour (Major et al., 2018). Women living with HIV in rural Zimbabwe live in communities where people share the same social values, norms, and beliefs. Understanding how these women live in such an environment is vital in designing a mitigating stigma and discrimination model. HIV-positive women impose stigma on themselves because of their economic dependence on men as daughters, partners,

and spouses. According to one study, women may not disclose their HIV status because of fear of separation, divorce, or violence (DeCapua, 2015).

2.4.7 Health-seeking behaviour

According to Munro, Lewin, Swart, and Volmink (2007), an individual’s readiness to take action and engage in health-related behaviour relative to a particular health condition is a function of three factors. The perceived seriousness and susceptibility to a disease influence an individual's perceived threat of disease. Secondly, perceived benefits and barriers influence perceptions of health behavior's effectiveness. Thirdly, the Perceived threat is influenced by cues to action, which can be internal (e.g., symptom perception) or external stimuli in the environment (e.g., health communication). These cues can trigger appropriate health Behaviour (WHO, 2003).

2.4.8 Perceived behavioural control

According to Montano and Kasprzyk (2015), Behavioural control is similar to Bandura’s self-efficacy concept, which refers to an individual’s faith in their ability to perform a particular behaviour under various conditions. Thus, a person with strong control beliefs about factors that facilitate behaviour will have high perceived control, translating into an increased intention to perform the act (Montano & Kasprzyk, 2015). It results from a decision-making process involving individuals processing the information available to them and then deciding on a course of action after reflecting on the consequences of performing the behaviour and their beliefs about what others expect them to do. Beliefs and attitudes are significant in people’s choice of action. Control beliefs are an individual's beliefs about the presence of factors that may facilitate or hinder the behaviour (Bimenyimana, Poggenpoel, Temane, & Myburgh, 2016).

HIV and AIDS continue to sabotage the possibility of an AIDS-free generation as stigma undermines primary and secondary prevention efforts in rural Zimbabwe. The social aspects of women render rural Zimbabwean women more vulnerable to HIV and AIDS than men. Lessening the influence of stigma is critical to rural Zimbabwean women because Zimbabwe's history has seen women losing social gains and falling into poverty in more significant numbers than men (France, Macdonald, Conroy, Chiroro, Cheallaigh, Nyamucheta, Mapanda, Shumba, Mudede & Byrne 2019). The greatest losers were the single women or women without husbands at home, as they often lacked the necessary working force in the family to reap the fruits of new economic opportunities. Women's positions shifted back towards low-paid and labour-intensive jobs. In the agricultural sector, statistics on female employment declined, suggesting that either women ‘s work was becoming more invisible to statistics or that younger women were moving from agriculture to urban areas searching for more lucrative employment.

The Zimbabwe economy's backbone is the agricultural sector, affecting economic growth, food security, and poverty eradication. In 2013 the agricultural industry had severe challenges due to a lack of agricultural financing, affordable inputs, and prolonged drought caused by climate change (GoZ, 2013:20). The high-perceived threat, low barriers, and high perceived benefits to action increase the likelihood of engaging in the recommended behaviour (Munro et al., 2007). The direct determinants of people’s Behavioural choices are their attitudes towards performing the practice and the subjective norms associated with the procedure. A person’s beliefs determine temperament about the outcomes or attributes of performing a specific behaviour (that is, Behavioural beliefs), weighted by evaluations of those outcomes or characteristics. In combination, the attitude toward the behaviour, the subjective norm, and the perceived behavioural control led to behavioural intention (Ajzen, 2015). In particular, perceived behavioural control affects actual conduct directly and indirectly through behavioural intention. The more favourable the attitude toward action and the subjective norm, the greater the perceived behavioural control (Ajzen, 2015). The stronger the person's intention to perform the behaviour should be. Thus, if given sufficient control over the action, people are expected to carry out their purposes when the opportunity arises (Bimenyimana et al., 2016).

2.5 IMPACTS OF HIV-RELATED STIGMA AND DISCRIMINATION

HIV-related stigma reduces HIV prevention, early access to treatment, and ongoing care (Loggie et al., 2018). These researchers say that Meta-analyses show associations between HIV-related stigma and delayed access to HIV care, low social support, poor physical and mental health, and low income (Gesesew, Gebremedhin, Demissie, Kerie, Sudhakar, & Mwanri, 2017; Rueda et al., 2016). Social isolation starts in the family and friends, posing a challenge to disclose one’s status in the first place

(Pretorius et al., 2016:188). More still, some studies have revealed an association of HIV-related stigma with depression and some direct effect on self-rated health or poor self-rated mental and physical health among PLHIV as well as reduced quality of life (Loggie et al., 2018; Rueda et al., 2016; Alsayed, Sereika, Albrecht, Terry & Erlen, 2017).

Arrey et al., 2015 posits that women usually only disclose their status to healthcare professionals because of their needed treatment and care. They attribute this selective disclosure to the taboo of HIV disease in sub-Saharan African culture, and that stigma significantly impedes HIV disclosure. Arrey and colleagues recommend techniques to systematically incorporate HIV disclosure into post-test counseling and primary care services.

Further, still, Logie and colleagues found that intersecting stigma rooted in fear, misinformation, blame and shame, legal precarity, and healthcare mistreatment constrain current HIV testing strategies for urban refugee youth (Logie, Okumu, Kibuuka, Musoke, Hakiza, Mwima, Kyambadde, Abela, Gittings, Musinguzi, Mbuagbaw and Baral, 2021). They concluded that such findings could inform multi-level strategies to foster enabling HIV testing environments with urban refugee youth, including tackling intersecting stigma and leveraging refugee youth peer support. In Zimbabwe, Campbell, Nhamo, Scott, Madanhire, Nyamukapa, Skovdal, and Gregson (2013a) explored how Zimbabwean children represented HIV/AIDS-affected peers in the interest of examining whether or not they stigmatize, and the forms stigma could take. Logie et al. (2018) discuss HIV-related stigma about racial and gender discrimination in Canada.

Adverse psychological disorders such as depression, anxiety, stress, anger, sadness, loneliness, hopelessness, and reduced physical well-being have been demonstrated to impact the mental health of people living with HIV (Miller, Solomon, Varni, Hodge, Knapp & Bunn, 2016). HIV-related stigma has also been linked to lower quality of life, reduced use of health services (Rueda et al., 2016), and reduced medication adherence (Sweeney, Mitzel, & Vanable, 2015). Several longitudinal studies have substantiated the enduring impact of HIV stigma, linking HIV-related stigma with subsequent adverse health outcomes. For example, Miller and colleagues (2016) found that HIV-related stigma predicted distress and wellbeing measured three and six months later. Similarly, Hatzenbuehler, O'Cleirigh, Mayer, Mimiaga, and Safren (2011) found that HIV stigma predicted higher depression, anxiety, panic, and transmission risk behavior, three months later. Rendina et al. (2017) found that baseline levels of internalized HIV stigma predicted sexual compulsivity, anxiety, depression, and HIV transmission risk behaviors six months later. The impact on mental health and transmission risk behaviors was partially mediated by emotion dysregulation. Cook and colleagues (2016) found that greater average rates of HIV stigma experiences reported in a 10-week daily diary study predicted greater exhaustion and inertia at the end of the ten weeks. Turan and colleagues found that individuals with higher global HIV stigma scores showed stronger links between poorer social support and lower treatment self-efficacy (Turan, Fazeli, Raper, Mugavero & Johnson, 2016).

Stigma and Discrimination are central to the mandate for health systems to ensure and improve quality-of-service delivery. HIV-related stigma and Discrimination in a rural setting may represent a potent barrier to reaching the 95-95-95 targets (Kruk, Gage, Arsenault, Jordan, Leslie, Roder-DeWan, Adeyi, Barker, Daelmans, Doubova, & English, 2018). It also frustrates broader efforts to expand high-quality universal health coverage, particularly in rural areas with low-income streams, particularly for women. Ideally, health systems should be designed to optimize and distribute health outcomes equitably and efficiently to ensure that the health users' needs, preferences, and identities are met to achieve particular aspirations (Ikeda, Nyblade, Srithanaviboonchai, & Agins, 2019). The health ministry's intervention may stimulate the development of policy changes and integration of stigma and discrimination reduction into national quality programming that seeks to disassemble barriers of stigma and discrimination that hinder adequate access to universal health coverage, including HIV prevention and treatment services.

2.6 EFFORTS TO MITIGATE HIV-related STIGMA AND DISCRIMINATION

This section presents efforts to mitigate HIV-related stigma and discrimination. The Joint United Nations Programme on HIV/AIDS (UNAIDS) laments the insufficient access to comprehensive sexuality education, as it denies these women the services and knowledge they need. Moreso, women often face criminalization and high levels of stigma and discrimination (UNAIDS, 2017:14). UNAIDS then suggested some intensified efforts that will convince men to reject harmful versions of masculinity and to reach and empower women and girls, young people and key populations, to enhance their agency and to ensure their human rights are respected and protected. The section discusses the various strategies to mitigate stigma and discrimination as below.

2.6.1 Community-based interventions

Different strategies are often used to serve as interventions to reduce HIV-related stigma. Such interventions are tailored to suit particular settings and situations. At a community level, studies have highlighted educational campaigns for caregivers and individuals living with HIV (McHenry, Winstone, Nyandiko, Scanlon, Fischer, McAteer, Aluoch, Naanyu, and Vreeman, 2017). The researchers believed that once the caregivers were knowledgeable, they would educate their people in the rural areas (McHenry et al., 2017). In some areas where there has been some segregation of people living with HIV and those claiming to be noninfected, opportunities and venues for interaction have been encouraged. For example, in Kenya, HIV/AIDS-related stigma reduction strategies among those infected and affected by HIV are centred on increasing family and peer support and clinic-level services like counselling (McHenry et al., 2017). Treatment access, adherence, and economic security were associated with decreased vulnerability to stigma and discrimination and seemed to be related to the idea that improved physical appearance reduced the likelihood of experiencing stigma. Not disclosing their own or their child's (in the case of caregivers) HIV status was an important strategy to avoid stigma and discrimination for many participants.

In Southeast Asia (Cambodia, Lao People's Democratic Republic, Thailand, and Vietnam), a study reported that the integration of clinic services reduced the stigma associated with care-seeking among PLWH in some settings. The researchers saw the need to ensure care is delivered to PLWH even outside of standalone HIV clinics to be free of stigma and discrimination (Nyblade, Srinivasan, Mazur, Raj, Patil, Devadass, Radhakrishna & Ekstrand, 2018). In their studies, these researchers found that the integration of clinic space and patient flow can assist in normalizing care-seeking for PLWH, but without changes to organizational practices that 'mark' PLWH—such as dedicated equipment, patient charts, and queues— stigma may persist (Bond, Nomsenge, Mwamba, Ziba, Birch, Mubekapi-Musadaidzwa, Vanqa, Viljoen, Pliakas, Ayles, and Hargreaves, 2019). Thus, they adopted an approach that engages all Healthcare workers who may have regular contact with PLWH—including nurses, physicians, pharmacists, laboratory technicians, registration staff, porters, cleaners, security staff, and hospital leadership. Such an approach sensitized them to stigma and discrimination (Nyblade et al., 2018). This approach also considers how processes in other hospital departments may fuel stigma and discrimination. Participatory training was among the challenges cited by the researchers that can hamper or thwart stigma and discrimination, as it maximizes the impact of a facility-wide approach amid resource constraints.

2.6.2 Multi-level interventions

A systematic review of multi-level stigma interventions by Rao et al. (2019) revealed that stigma reduction might result in policy changes at the structural level (Rao et al., 2019). These authors claim that the critical direction for developing multi-level interventions is to incorporate policy-level interventions to address stigma at the institutional and structural levels (Rao et al., 2019). The authors Rao et al. 2019's multi-level stigma interventions mainly focused on education alone or combined with other strategies. These strategies include contact (an approach that provides people living with HIV participation in delivering stigma and discrimination-reduction interventions. Contact can effectively promote empathy, empower PLWH to demand action, buffering the effects of internalized stigma, and deconstructing HIV-related stereotypes (Nyblade et al., 2018). Even though educational programs alone are often ineffective in reducing stigmatizing attitudes in public members, the slight resulting stigma reduction may be short-lived and superficial. However, other authors like Corrigan and colleagues found that stand-alone educational programs can lead to stereotype suppression. Members of the society suppress—rather than reject—stereotyped beliefs upon learning that such beliefs are socially undesirable (Corrigan et al., 2014). There is evidence that knowledge is a crucial driver of stigma in some settings, such as healthcare. However, the improvements in knowledge do not always translate into sustained change (Ikeda et al., 2019). The authors ascertained that to be effective, interventions that attempt to change individual behaviours must also carefully consider the organizational and cultural contexts from which these individuals, and their behaviours, derive meaning and support (Ikeda et al., 2019). The authors further suggested that system-level changes [i.e., the reorganization of workflow, improving privacy, structured interactions between health care workers and people living with HIV (PLWH), cultivation of a welcoming, respectful work environment, routine pre-service and in-service assessments of stigma and discrimination, and evidence-informed responses to these assessments], represent effective ways to bridge the gap between knowledge and action (Ikeda et al., 2019). They support the development of an organizational culture in which stigma and discrimination-reduction activities are normalized, expected, and championed as a central component of quality of care. To best understand the nature of HIV-related stigma and discrimination, survey and experience data need to be further analysed and unpacked through disaggregation of data according to crucial population and behavioural characteristics. To address underlying drivers of HIV-related stigma, a clearer understanding of rural women (living with HIV), attitudes, and beliefs is needed. This requires eliciting their characteristics and behaviours that can be used to understand better where the roots of stigma lie so that they can be addressed most effectively.

The policymakers have tried to accommodate women; hence the Chairperson of the Women’s Coalition of Zimbabwe has stated that in taking measures against HIV, it is vital for women to make their own choices (Majaha, 2015). She was aware of the hurdle to accomplishing the goal: decision-making being rendered to men while women are just subordinates. Others' perceived social pressure determined personal criteria to behave in a specific manner and their motivation to comply with those people's views. Even in instances where women might know where to obtain SRH information and services, a study of young women in Soweto, South Africa, found that the shared experiences of providers’ unsupportive attitudes, power dynamics in relationships, and communication issues with parents and community members prevented respondents from accessing and using the information and services they needed (Lince-Deroche, Hargey, Holt & Shochet, 2015).

2.6.3 Gender equality and empowerment

The Sustainable Development Goals (SDGs) have prioritized women's empowerment by dedicating a stand-alone goal to them — Goal Five ‘Achieve gender equality and empower all women and girls’ (UNDESA [s.a.]). To achieve gender equality, women need empowerment to manage their own lives (UNFPA, 2015). The issue of gender equality is a human rights issue based on the right of women to live in dignity and with freedom from want and fear. Women who are empowered can contribute to the health and productivity of whole families and communities, improving prospects for the next generation and, by so doing, advancing development and reducing poverty. (Langer, Meleis, Knaul, Atun, Aran, Arreola-Ornelas, Bhutta, Binagwaho, Bonita, Caglia, and Claeson, 2015). Even though there is overwhelming evidence of how women's empowerment can address the world's most urgent challenges, this ideal has not yet been achieved (UNFPA, 2015). In Zimbabwe, the Government considered the efforts to empower girls and women. Programs and projects cover women empowerment, gender mainstreaming, and economic development. Empowering girls can make them responsive to HIV and AIDS information to make use of the information needed to protect themselves (Fleischman & Peck, 2015:3-4). Men take advantage of some women's socioeconomic status, which propagates the spread of HIV and AIDS (Langer et al., 2015). There are also sex workers in Zimbabwe, especially in the border provinces like the one under study. A country's border is where people can cross from one country to another. In such situations, there is a lot of mobility and an opportunity for HIV to spread. Therefore, the Government has embarked on income-generating projects to empower sex workers (Busza, Mtetwa, Mapfumo, Hanisch, Wong-Gruenwald, and Cowan, 2016). These various initiatives eradicate sex and stop them from visiting beer gardens, empowering women.

Further, some studies assert that to empower people living with HIV to confront stigma and discrimination, it is essential to continuously and actively involve people living with HIV and AIDS in decision-making (Ikeda et al., 2019). They suggest that this should be done to plan and implement stigma and discrimination reduction activities. Such involvement can be in the form of feedback —through surveys, comment boxes, exit interviews, community advisory boards, and other mechanisms—as a vital component of stigma and discrimination-reduction efforts.

2.6.4 Individual empowerment

Researchers also postulate that the involvement of people living with HIV in co-creating interventions might go a long way in thwarting HIV-related stigma and discrimination (Nyblade et al., 2018). In addition, leveraging existing platforms to exchange information and plans related to stigma and discrimination reduction, such as grand rounds, weekly staff meetings, and PLWH support groups, can further drive the routinization of stigma and discrimination-reduction activities and enable the active engagement of all Health care workers (Ikeda et al. 2019).

2.6.5 Perceived behavioural control

Perceived behavioural control beliefs refer to the psychological propensity to approve or disapprove of attempting a task based on a person's ideas about the consequences of performing that particular task (Ajzen, 2015). The researcher believed that the perceived behavioural control beliefs about women's changing status and work might reduce HIV-related stigma practices among the community for the women living with HIV and AIDS. As the women face the challenges of living with HIV and AIDS, they may have certain perceptions of their acceptability as living with HIV in their community. The control beliefs may dictate the actions taken by these rural women living with HIV.

2.7 CONCLUSION

Different sources of literature have been reviewed in this chapter. These sources included journal articles, books, web documents, and relevant dissertations and theses. The existing gaps in knowledge, attitudes, and practices associated with HIV-related stigma have also been identified. The researcher investigated the various studies regarding HIV-related stigma to develop reduction interventions for rural Zimbabwean women. The research methods and design of the study are described in chapter three.

CHAPTER 3

RESEARCH METHODOLOGY

3.1 INTRODUCTION

Research methodology implies the complete plan for the study (Grove & Gray, 2018:320). In this chapter, the researcher discussed the methodology in terms of the scientific foundation of the study, the research design, the setting, the study population, the sample and sampling techniques, data collection methods, scientific rigour, data analysis, and ethical considerations. A summary of the research methodology was provided at the end of the chapter.

3.2 SCIENTIFIC FOUNDATION OF THE STUDY

3.2.1 The methodological or philosophical foundation

Authors (Polit and Beck, 2013) refer to the methodological foundation in research as a statement of the philosophical assumptions underpinning the way researchers approach the research problem. In this study, the researcher used social constructivism as a philosophical foundation to answer the research question. Social constructivism ascertains that reality is constructed through human interaction (ontology) and that knowledge is socially and culturally constructed (epistemology) (Creswell 2014). According to Crotty in Creswell (2014), social constructivism is based on the following three main assumptions: “human beings construct meanings as they engage with the world they are interpreting; human beings engage with their world and make sense of it based on their historical and social perspectives; and the basic generation of meanings is always social, arising in and out of interaction with a human community” (Creswell 2014:9).

Social constructivists believe that multiple realities are constructed through individuals’ lived experiences and interactions with others (ontological assumption) and that reality is co-constructed between the researcher and the participants and shaped by individual experience (epistemological assumption) (CresWell 2013:36). Van Rooyen (2015:39) argued that social constructionism focuses on the process of describing and explaining the socially constructed world. In social constructivism, the researcher considers the interaction between individuals, groups, and societies in their social contexts through language (Christensen, Johnson, Turner, & Christensen, 2011).

The choice of social constructivism was based on the understanding that women living with HIV developed new meaning about the realities of being HIV positive and accumulated knowledge through their lived experiences and interactions with others in their social, cultural, and socio-economic context of rural areas in Zimbabwe. Consequently, the researcher can interact with them to depict and interpret these realities and their meaning.

3.2.2 Research approach

The researcher conducted the study in two phases using a qualitative approach. A qualitative approach was congruent with the social constructivism paradigm, the purpose of the study, and, more importantly, relevant to the research problem. A qualitative approach was more appropriate to this study as it allows the researcher to merge various data collection methods and reach a holistic understanding of the phenomenon of interest (Polit & Beck, 2012:487). As stated in Chapter 1, the researcher intended to propose a model based on understanding the participants' meaning they ascribe to their lived experiences within the social, cultural, and socio-economic context in which they live. Phase 1 focused on the first two objectives of the study. Phase 2 addressed the last objective of the study.

3.2.3 Conceptual framework

This study was conducted with the aim of proposing a model for mitigating stigma and discrimination against women living with HIV in the rural context of Zimbabwe based on the understanding of their lived experiences and the meaning attached to being a woman living with HIV in the rural context of Zimbabwe. The researcher followed the common six steps used in public health to develop models and the criteria of model evaluation described by Chinn and Kramer (2013:235–248) as a framework to guide the model development process. It assisted the researcher in structuring the research process from the problem statement and purpose of the study, the literature reviews up to the presentation of the model.

The researcher used the revised six steps of model development proposed by Squires, Chilcott, Akehurst, Burr, and Kelly in 2016. Researchers looking at developing a model to address public health issues should first and foremost clarify the context and situations in which the model would be helpful (step 1) and the scope of the problem under investigation, which allows identifying clear boundaries of the focus (step 2). Secondly, they should identify the key concepts that will be used to construct the model (step 3) and the relationships between these concepts (step 4). Finally, the researchers should document the evidence of sources, the essential questions, and assumptions used in the development of the model (step 5) and review and refine the model (step 6). These steps are interrelated and may not necessarily be implemented sequentially (Squires, Chilcott, Akehurst, Burr, and Kelly, 2016). The choice of these steps was justified by the fact that they deal with each element of the research process.

3.2.4 Social cognitive theory

The social cognitive theory forms the basis of a further model of the determinants of health behaviour (Middleton, Hall & Raeside, 2019). This approach assumes that human motivation and action are based on three expectancies: situation-outcome, action-outcome, and perceived self-efficacy. Under situation outcome expectancies, there are beliefs about which consequences will occur without interfering with personal action. For example, an individual perceives himself to be susceptible to a health threat from health risk. The individual will be motivated to consider different measures to minimize that risk.

On the other hand, action-outcome expectancy is the belief that a given behaviour will or will not lead to a given outcome (Conner, & Norman, 2015). For example, disclosing your HIV status to family and friends will reduce sexual risk behaviour and transmission of the virus, decrease the stigma associated with HIV, and increase access to support and care. Thus, they impact behaviour via their influence upon goals or intentions to engage in the behaviour and upon self-efficacy expectancies. Action-outcome expectancies impact self-efficacy because individuals believe they can produce the responses necessary to produce desired outcomes.

Self-efficacy expectancy is the belief that behaviour is or is not within an individual’s control (Abraham, Sheeran & Henderson, 2011:624). An individual’s belief that they cannot perform a particular behaviour, such as exercising regularly, would constitute self-efficacy expectancy. Situation-outcome expectancies, in conjunction with consideration of action-outcome expectancies, lead to the formation of preferences to take specific actions. Action-outcome expectancies impact self-efficacy because individuals believe they can produce the responses necessary to produce desired outcomes. Behaviours perceived to be efficacious in reducing a perceived risk lead to intentions to engage in such behaviours. The Social Cognitive Theory (SCT) played an essential role in this thesis as it was used in 5.3.4 to identify the concepts of the model. Optimistic self-beliefs predict actual behavioural performance and demonstrate that individuals typically intend to perform behaviours they perceive to be within control (Conner, & Norman, 2015).

3.3 RESEARCH DESIGNS

3.3.1 Phase 1

The researcher used hermeneutic Phenomenology to address the first two objectives of the study. Phenomenological research design is based on the understanding that experience is a valid, rich, and rewarding source of knowledge (Morrissey &Higgs, 2006:162). In phenomenology, human experience is viewed as a reliable source of data and the cornerstone of knowledge about a human phenomenon (Morrissey &Higgs, 2006:162). Phenomenology enables researchers to construct realities as lived and described by the participants (Polit & Beck, 2012). According to Van Manen (2016), phenomenology allows researchers to generate data on the informants' experiences and lived shared experiences and derive meaning from these descriptions. The Phenomenology design has been widely used in HIV-related stigma research (Van Manen, 2016; Myers, 2019). Hermeneutics uses lived experiences to understand better the social, cultural, political, or historical context in which those experiences occur (Polit & Beck, 2012:490). In hermeneutics phenomenology, the researcher plays a dual role of being a participant and the researcher. In her role as a participant, the researcher acts as a human being drawing on everyday human resources to make sense of the world. In her role as a researcher, the researcher has only access to the participant’s experience through what the participant reports about it and sees this through the researcher’s own experientially lens (Alase, 2017: 11).

The researcher believed the hermeneutic phenomenology design was more appropriate for this study. She intended to propose a model based on the meaning and interpretation of the lived experiences of women living with HIV within the social, cultural, political, and economic context in which those experiences occur.

3.3.2 Phase 2

The researcher used qualitative meta-analysis and theoretical triangulation to address the last objective of the study. A qualitative meta-analysis is an empirical approach to conducting a rigourous secondary qualitative analysis of primary qualitative findings (Timulak, 2009:560). Theoretical triangulation allows a researcher to look at the phenomenon of interest from multiple theoretical perspectives (Cameron 2009:150).

In this study, the researcher combined qualitative meta-analysis and theoretical triangulation to provide the empirical foundation of the model, identify and define the model's key concepts, and represent the model's structure.

3.4 STUDY SETTING AND POPULATION

This section applied only to Phase 1 of the study. The researcher conducted the study in one (Matabeleland South Province) of the provinces of Zimbabwe. Matabeleland South Province shared borders with South Africa and four ports of entry (Beit Bridge Border Post, Plumtree, Maitengwe, and Mphoengs). The province is divided into six districts.

The selection of this province was informed by the rate of HIV and the social and cultural homogeneity of the population. Matabeleland South Province has the highest prevalence rate of HIV (21.6%). The population shares the same culture and language. The geographical situation was also crucial for this study as most males in these bordering areas migrate to South Africa for employment.

Finally, considering the qualitative interpretive phenomenological methodological perspective, the researcher viewed this province as ideal research setting as she shared the same cultural values and language with the population.

The study population included all women living with HIV in rural Matabeleland South Province. Authors (Polit and Beck, 2012:51; Grove & Gray, 2018:290) refer to the population as the entire group of elements sharing some common characteristics relevant to the research purpose.

3.5 SAMPLE AND SAMPLING TECHNIQUES

Authors (Polit & Beck, 2012:51, 275) define a sample as a subset of the study population and sampling as the process of selecting eligible cases/subjects from the subset of the study population. In phenomenology, the researcher selects participants who have experienced the phenomenon of research interest. They must be able to clearly articulate what it is like to have lived that experience (Polit & Beck, 2012:523).

All women living with HIV in rural areas/villages of Matabeleland South Province were eligible to participate in the study. In Zimbabwe, people living with HIV are cared for at the community level by community health workers attached to the respective district health. Each community health worker keeps a register of the people living with HIV under their care and records of the care provided.

The researcher used non-probability purposive sampling techniques to select the participants. In purposive sampling, the researcher uses her judgment to select knowledgeable participants about the phenomenon of interest (Grove & Gray, 2018:325). The selection of the participants is often guided by a set of predetermined inclusion and exclusion criteria (Polit & Beck, 2012:279). This type of sampling was congruent with the qualitative interpretive design. The researcher intended to select participants who could best articulate their experiences with the phenomenon of interest.

The researcher used the following inclusion criteria to select eligible participants:

(1) be an adult woman (18 years and above) living with HIV,
(2) be tested HIV positive for at least one year from the date of the data collection,
(3) be living permanently in the village for at least one year after being tested HIV positive, and
(4) be able to give a good account of herself.

The researcher excluded all men living with HIV and women living with HIV who were on treatment for any psychiatric condition from the study.

The researcher identified eligible participants from the community health workers' registers. The researcher sent an individual invitation to the eligible participants via the community health workers. The researcher met individually with those who responded to the invitation, where they received further information about the study. At the end of the meeting, each participant was asked if she was willing to participate in the study. In total, forty (40) women living with HIV were included in the sample. The researcher selected the participants from six different villages (one village per district) of Matabeleland South Province.

3.6 DATA COLLECTION METHODS

Data collection refers to how the researcher gathers information from the selected participants to answer the research question (Grove & Gray, 2018:361). In this study, the researcher combined individual in-depth face-to-face interviews and focus groups to collect data. Due to the topic's sensitivity, the researcher allowed the participants to select the methods they felt more comfortable with. The researcher conducted twenty-two (22) individual in-depth interviews and three (3) focus groups with six (6) participants each.

According to the literature, in-depth interviews allow the participants to freely talk about intimate and confidential issues without fear. Focus groups, on the other side, offer the participants who are afraid and uncomfortable answering questions the opportunity to rely on the support of others, which will motivate them to talk (Polit & Beck, 2012). In-depth interviews are the primary data collection method in phenomenology (Polit & Beck, 2012:533). A Focus group enriches data by adding inter-subjective experiences to the subjective experiences from in-depth interviews (Hennink, Hutter, & Bailey, 2020).

3.6.1 Data Collection tools for Phase 1

The researcher used interview schedules to guide data collection. The schedule was divided into two sections. The first section dealt with general information. The second section contained one open grand tour question.

Exploration and description of the lived experiences was achieved through face-to-face interviews using an interview schedule. Thus, for individual in-depth face-to-face interviews, the participants were asked the following question: “Tell me about your life experiences as a woman living with HIV in this village.” Probing questions focused on seeking information about significant events/situations that illustrate their experiences and how they responded to these events/situations (see Appendix 1a).

For focus groups, the discussions were guided by the following question: “What does it mean to you as a woman living with HIV in this village?”. Probing questions focused on the lived experiences that emerged from the individual in-depth face-to-face interviews (see Appendix 1b). Grand tour questions allow the participants to freely account for their personal experiences from their perspectives rather than an objective truth (Lentoor, 2017; Van Manen, 2016).

3.6.2 Data Collection Procedures for Phase 1

This section applied to Phase 1 only.

The researcher collected data over a period of six months. Focus groups started after the individual in-depth face-to-face interviews. Individual and focus groups were conducted in venues selected by the participants. While all participants of individual interviews opted to be interviewed at their homes, participants of focus groups opted for venues at the nearest clinics. The participants used these clinics to collect their antiretroviral drugs and attend support group meetings for people living with HIV. The researcher secured the focus group venues with the support of the community health workers.

The researcher offered the participants the choice to express themselves in English or Ndebele (the local language spoken in the province). All of them opted for English with the option to express themselves in Ndebele when needed. This was not a problem as the researcher also speaks fluently the local language as a native of the province. Individual interviews lasted for 60 minutes on average. FG lasted an average of 90 minutes on average.

The researcher observed the principles of sound qualitative research interviewing and facilitation, such as interactive questioning, clarification, reflexivity, summarizing, and member checking (Polit & Beck, 2012: 585 & 586). She started the interviews with general questions to establish rapport with the participants. Establishing a connection is essential in building trust between the interviewer and the interviewees and facilitating active participation.

After establishing the rapport, the researcher moved to the main question, probing where appropriate. The researcher allowed the participants to speak freely and paid attention to what the participants were narrating. This attention was expressed through body language and cultural communication gestures that symbolise the receiver's interest in the message from the communicator. Probing was seldom used throughout the interviews and discussions.

The tape recorder was tested for functionality before use in order to record all the interviews. Tape recording allowed the researcher to take fewer notes, concentrate on the discussions, and observe nonverbal responses. The researcher documented all the emotional expressions and body language when necessary.

The researcher transcribed the recorded data (verbatim) 24 hours after each interview and focus group. The transcribed manuscripts were double-checked by a researcher from the local university who is fluent in Ndebele and English. Data redundancy was monitored and ensured the accuracy of the transcripts and coding. The final report of the findings was submitted to the same local expert for verification and confirmation of themes. This last process equals the cross-validation of data, consistent with IPA (Van Manen, 2016).

3.7 DATA ANALYSIS FOR PHASE 1

Data analysis is a technique used to reduce, organize, and give meaning to data (Grove & Gray, 2018:94; Polit & Beck, 2012:52). This study used Interpretative Phenomenological Analysis (IPA) to guide data management and analysis. In IPA, the researcher uses an inductive approach to understand how a participant, in a given context, makes sense of the phenomenon of interest (Van Manen, 2016). The search for meaning is central to the IPA analysis. The researcher should try to understand the content and complexity of those meanings rather than measure their frequency. This process involves the researcher engaging in an interpretative relationship with the transcript (Van Manen,2016).

Researchers conducting IPA are advised to follow the steps proposed by Moustakas in 1994. In this study, the researcher used the simplified version of these steps presented by Cresswell in 2013. It includes six main steps: (i) the researcher's description of their own experience of the phenomenon; (ii) the researchers develop a list of significant statements from the participants'' description; (iii) grouping of the multiple reports into themes; (iv) textural description of the experience and inclusion of verbatim examples; (v) structural description or the description of how the encounter happened; (vi) writing of a composite report of the phenomenon incorporating the textural and structural stories (Creswell, 2013:193).

In addition to the Theoretical triangulations, the researcher used Chinn and Kramer model's evaluation criteria to guide the refinement of the model. These evaluation criteria include clarity, simplicity, generality, accessibility, and importance (Chinn and Kramer (2013:235–248).

Clarity allows the researcher to determine the intended meaning of the concepts' connectedness by assessing the semantic clarity and consistency, structural clarity, and the entire design approach (Chinn and Kramer, 2013:198).

Simplicity as a criterion looks at the focus, the user-friendliness of the model, the number of concepts, and the descriptions of each concept with the interconnectedness of interrelationships (Chinn & Kramer, 2013:201).

Generality refers to the breadth of the scope and purpose of a model (Chinn & Kramer, 2013:202).

Accessibility refers to the flow of ideas in the model, the applicability of the model to public health, and the feasibility of the model (Bimenyimana et al., 2016).

The importance of the model in public health is closely linked to the model's credibility in improving overall health and reducing risks to a population (Bimenyimana et al., 2016).

3.8 TRUSTWORTHINESS

In a qualitative study, trustworthiness or scientific rigour refers to the processes and measures put in place to ensure that the data quality is trustworthy (Polit & Beck, 2012:754). It is ensured through credibility, dependability, transferability, and confirmability (Taylor, 2013). The researcher ensures trustworthiness through credibility, dependability, transferability, and confirmability.

Credibility is concerned with the confidence in the truth of data generated and their interpretation. It involves using steps that will enhance the integrity and quality of the study (Polit & Beck, 2012:585). Credibility was ensured through prolonged interaction with participants, member checking, triangulation of data, and purposefully recruiting participants who met the study's inclusion criteria. The researcher had extended interactions with the participants that lasted a period of six months in the field to collect data. In member checking, the researcher validated participants’ responses through repetition of sentences to affirm what participants were trying to communicate. Triangulation of data was done by combining data from the audiotapes and the field notes. This ensured that non-verbal cues that the audiotape could not capture were recorded in the field diary. This was done effectively through concurrent data collection and transcription.

Transferability refers to the extent to which findings can be transferred to or have applicability in other settings or groups (Polit & Beck, 2012:585). The researcher ensured transferability by thoroughly describing the setting and methodology of the study.

Dependability refers to the stability or instability of data patterns over time. In a quantitative sense, it is referred to as the internal consistency of a study (Polit & Beck, 2012:585). Authors (Polit & Beck, 2012:585) stated that dependability in qualitative research could be achieved by allowing independent researchers to use the same instrument for data collection to collect and analyse data that other respondents would give with similar characteristics like that of the current study respondents (Polit & Beck, 2012:585). Using the same data collection tool for both individual and focus groups allowed the research to assess the dependability in this study. The analysis of these two sets of data showed consistencies with the emerged themes.

Confirmability refers to the level of congruence between independent people, groups, or bodies about the accuracy and meaning of a study. Confirmability is ensured when different researchers can reach a consensus on conducting the study (Polit & Beck, 2012). In this study, the researcher ensured confirmability by submitting the research proposal for scientific and ethical reviews to the Department of Health Studies Health Research Ethics Committee of the University of South Africa and the Zimbabwe Medical Research Council.

3.9 ETHICAL CONSIDERATIONS

The researcher observed the research and ethics policies of the University of South Africa. The researcher obtained ethical clearance to conduct the study from two ethics committees. The Health Research Ethics Committee of the University of South Africa (UNISA) (see Appendix 5) and the Medical Research Council of Zimbabwe (MRCZ) (see Appendix 6). The researcher adhered to the steps outlined in the approved proposal.

The researcher reviewed the participants' information sheet (See Appendix 2) with all the participants before data collection. Each participant signed informed consent (see Appendix 3) and a confidentiality binding agreement with the researcher (see Appendix 4).

The researcher maintained permanent contact with the supervisor, and the final report was based on the collected data, data analysis, and development of the model. The researcher sought informed consent from each participant and ensured that participation in the study was based on their informed decisions. The researcher reviewed the information sheets (see Appendix 2) with the participants before the interviews. The explanation was also given in the local language where it was needed. Before the interviews, informed consent (see Appendix 3) and a confidentiality binding agreement (see Appendix 4) were signed. The researcher gave the participants time to ask questions for clarification. They were also informed of their rights to withdraw from the interviews at any time without prejudice.

The researcher asked for permission from participants before interviews were audiotaped. Only the researcher, trained research field workers, and the participants were present during the interviews. Identifiable data such as consent forms, tapes, and transcripts were only made available to the researcher, her supervisor, and any authorised persons deemed necessary. Consent forms and the primary data were kept in such a way that the names of participants could not be traced to specific information/data. Participants were also coded to protect personal identity in ensuring confidentiality and anonymity. All electronic data were kept secured on a computer with a secure password. The password was known to only the researcher. Hard copies of the interview guide, raw data, field notes, and signed consent forms were kept in a secured cabinet under a lock.

Finally, the researcher adhered to the universal ethical principles described below:

Beneficence involves the responsibility of the researcher to minimize harm and maximize benefits to participants imposed by the principle of beneficence (Polit &

Beck, 2012:152). In the information sheet, the researcher indicated no risks involved in participating in the study (see Appendix 2). Liamputtong (2009:38) suggests that the researcher have a counselor available if the participants' debriefing became necessary. No signs of psychological trauma or distress were noted in participants that could have necessitated referral for a debriefing session by a counselor for support.

Non-Maleficence requires researchers to avoid, prevent, or minimize harm (non-maleficence). This harm and discomfort can be physical, social, emotional, and financial (Grove & Gray, 2018:118). Thus, participants must not be subjected to unnecessary risks of harm and discomfort. Their participation in research must be essential to achieve vital aims for science and society. In this study, the researcher minimized psychological damage and discomfort. The researcher ensured the availability of social, mental, and even medical intervention post-interview should a need arise. The right not to be harmed is the right of each study participant. Feelings of guilt and loss of esteem, though transient, were minimized by applying the following confidentiality measures: interviews were conducted in the comfort of their homes, away from the gatherings. People could quickly stigmatize or negatively label someone. If the participant could not continue the interview, the researcher would stop the conversation immediately and refer for debriefing by the counselor or inform the head of the hospital, who is also a psychologist and counselor.

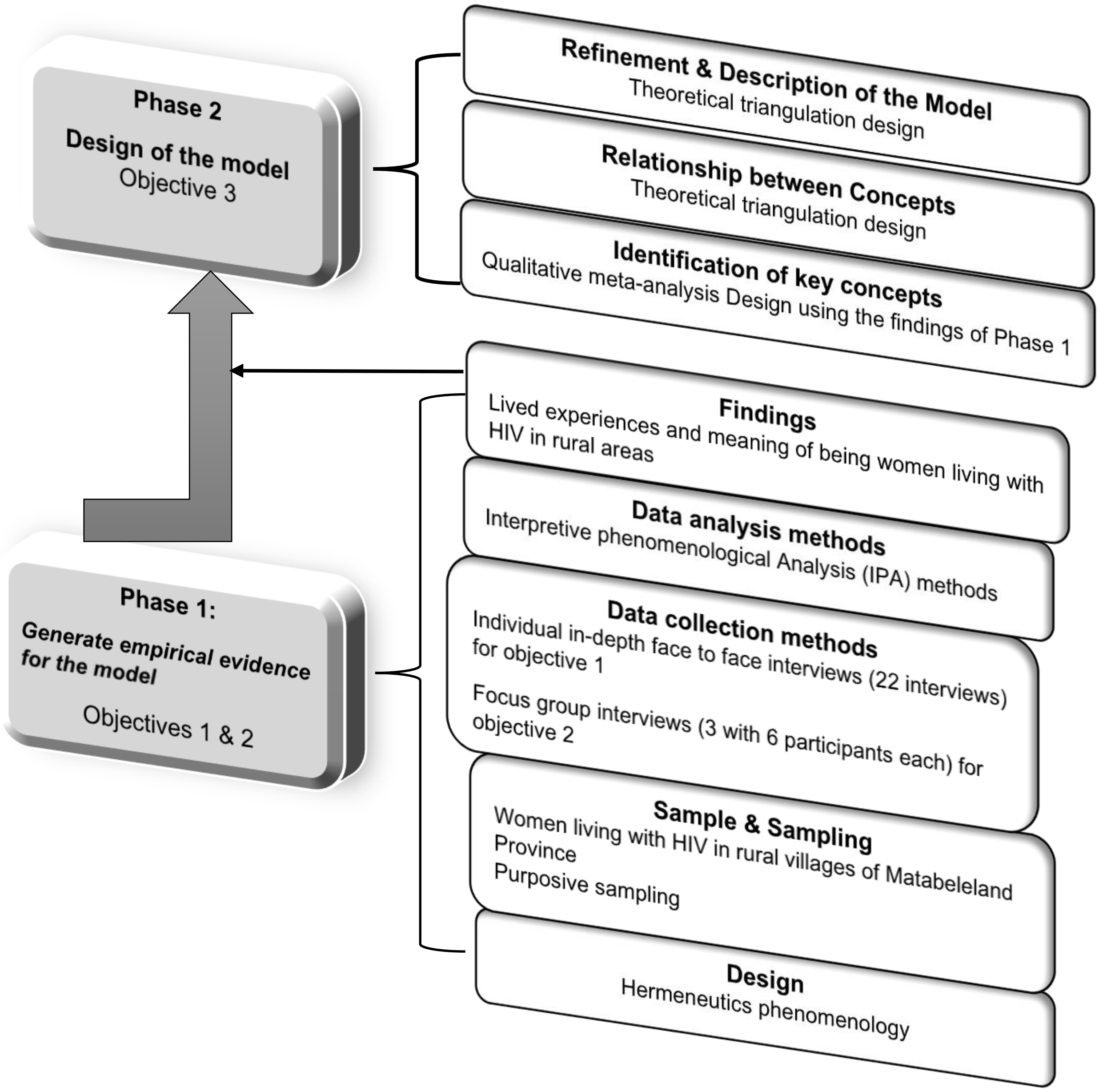
The right to protection from exploitation requires the researcher not to place the participants at a disadvantage or expose them to situations they have not been prepared for (Grove & Gray, 2018:118). In this study, the researcher reassured respondents that the information they revealed would not be used against them in any way.

Justice connotes fairness and equity, which relates to the participants' rights to fair treatment and their right to privacy. This means that the participants should be selected somewhat based on research requirements, not because they are vulnerable (Gray, Grove & Sutherland, 2016:118). Participants' right to decline to participate or withdraw from a study was respected in this study, and there were no penalties. The researcher demonstrated sensitivity and respect for different backgrounds and cultures' norms, beliefs, and lifestyles. The researcher ensured that rural women living with HIV, as vulnerable persons, were not targeted to participate in the study for the researcher's convenience but to contribute to a public health benefit. The researcher focused on women with different clinical stages of HIV, different ages, different marital statuses, different villages in the province, and different levels of education and employment status to ensure that all participants meeting the criteria were given a chance to participate and benefit from attending.

Self-determination involves the participants' right to decide whether to participate in a study without voluntarily risking any penalty or prejudicial treatment. Participants could withdraw their participation without penalty (Polit & Beck, 2012:154). The researcher explained to participants that they were free to withdraw from participation even after they had signed the consent form and that no one would penalize them for withdrawing. That is the principle of self-determination. It means that humans should be treated as autonomous agents, capable of controlling their activities, having a right to ask questions, refusing to give information, or withdrawing from the study. In this study, the researcher informed participants that they had a right to decide whether or not to participate in a study voluntarily; they had a right to withdraw at any time and to refuse to give information, especially on sensitive issues like HIV and AIDS. If the women did not want to partake in the study, they were not compelled to do so. Giving your voluntary consent did not tie any participant in any way; hence, all the respondents who had given their voluntary consent were also free from constraints and coercion of any kind. The participants could withdraw from the interview at any time.

3.10 CONCLUSION

This chapter provided detailed information on the methodology that guided the study. It explained the theoretical foundation of the study and the process followed in answering the research question. This process is illustrated in Figure 1. Chapter 4 will focus on the findings and discussion of the findings.



Scientific Foundation:

1. ***Methodological approach*:** Social constructivism paradigm
2. ***Research approach***: Two Phases Qualitative Approach
3. ***Conceptual framework*:** Common six-steps used in public health to develop models and the criteria of model's evaluation criteria described by Chinn and Kramer (2013:235–248)

Purpose of the study

Propose a model for mitigating stigma and discrimination against women living with HIV in the rural context of Zimbabwe based on the understanding of their lived experiences and the meaning attached to being a woman living with HIV in the rural context of Zimbabwe.

Figure 1: Summary of the research process

CHAPTER 4

PRESENTATION AND DISCUSSION OF PHASE 1

4.1 INTRODUCTION

Phase 1 of this study focused on the lived experiences of women living with HIV in rural Zimbabwe. The researcher used hermeneutic phenomenology to explore and describe (1) the lived experiences of women living with HIV in the rural context of Zimbabwe (Objective 1) and (2) the meaning attached to being a woman living with HIV in the rural context of Zimbabwe (Objective 2). As stated in Chapter 3, the researcher used individual in-depth face-to-face interviews and focus groups to generate data for Phase 1 of the study.

The researcher conducted twenty-two (22) individual in-depth face-to-face interviews. Individual in-depth face-to-face interviews allowed the researcher to address the study's first objective. Three focus groups with 18 participants (six per group) allowed the researcher to address the study's second objective. The findings of these two objectives were summarised to provide a framework (Figure 5) for understanding the realities of being a woman living with HIV in the social context of rural Zimbabwe.

4.2 LIVED EXPERIENCES OF WOMEN LIVING WITH HIV IN RURAL ZIMBABWE

Participants were asked one grand tour question: “Tell me about your life experiences as a woman living with HIV in this village.” Probing questions focused on seeking information about significant events/situations that illustrate their experiences and how they responded to these events/situations.

It emerged from the qualitative analysis of the participants’ descriptions of their lived experiences that women living with HIV in rural Zimbabwe have accumulated new life experiences deriving from their interactions with significant others in their communities.

Thirteen sub-themes were derived from the descriptions of these accumulated new life experiences of women living with HIV in rural Zimbabwe. They were classified into the following three themes: (1) social prejudice, (2) social discrimination, and (3) psychosocial dysfunction. Table 1 summarises the three themes with the related sub-themes.

From these accumulated lived experiences, ***it was deduced that women living with HIV in rural Zimbabwe are psychosocially dysfunctional because of the social prejudice and social discrimination perpetrated against them by significant others in their communities.***

Table 1: Lived experiences of women living with HIV in rural Zimbabwe

Themes	Sub-themes
Social Prejudice	1. Blame and shaming
	2. Social avoidance
	3. Social rejection
	4. Undignified treatment
	5. Gender stereotype
Social discrimination	1. Loss of independent decision-making power
	2. Unfair labour practice
	3. Gender-based discrimination
Psychosocial dysfunction	1. Blaming oneself
	2. Cognitive avoidance
	3. Hopelessness
	4. Worthless
	5. Social isolation or withdrawal

4.2.1 Theme 1: Social prejudice

Social prejudice as a new social reality for women living with HIV in rural Zimbabwe refers to any dehumanising behaviour displayed by significant others toward women living with HIV because of their HIV-positive status. Women living with HIV experienced these behaviours contrary to their communities' accepted prevailing socio-cultural norms.

Five sub-themes were derived from the participants' descriptions of behaviours they experienced as dehumanising. It emerged that the interaction between women living with HIV and their significant others in the community was characterised by (1) blame and shaming, (2) social avoidance, (3) social rejection, (4) undignified treatment, and (5) gender stereotype. Significant others identified by the participants as perpetrators of these dehumanising behaviours included partners, close family members, in-laws, friends, and the community.

From the above lived social prejudice experiences, ***it was deduced that women living with HIV in rural Zimbabwe are socially victimised and treated in degrading manner for being HIV positive and women.***

Sub-theme 1: Blame and shaming

As a sub-theme, blame and shaming referred to any dehumanising behaviour characterised by accusation and name-calling. Women living with HIV were blamed for being responsible for their HIV-positive status and labelled as evil, prostitutes, unfaithful, immoral, disobedient, defiant, etc.

Blame and shaming behaviour was mainly perpetrated by in-laws, friends/fellow women, and community members. It was based on the belief that women are the ones who bring HIV to their male partners.

In-laws

A 42-year-old woman was treated by her mother-in-law as defiant and uncaring for bringing AIDS to her matrimonial home. She felt so bad that her mother-in-law told her children that she killed her husband because of her insensitive behaviour toward her family.

> *My biggest concern and pain is the way my mother-in-law treated me after the death of my husband due to HIV and AIDS. She blamed me for being responsible for the death of her son. She even told my children that I killed my husband because of my uncaring and defiant behaviour.* (IDI04)

Friends/fellow women

Friends were viewed as unsupportive, which made women living with HIV change how they viewed themselves. This is what a 22-year-old woman has to say:

> *Do you know one thing about friends…they quickly judge and blame you to the point of making you believe that being HIV positive is a sin.* (ID03)

Blame and shaming was also expressed through finger-pointing. This was often done by fellow women, as stated in the quote below from a 39-year-old woman:

> *You know, when these people knew about my status, they started to call me "maGCI" (meaning the mother of HIV) [saying it in disbelief as if she is looking for my reaction to it]. When I go out, other women point fingers at me and call me a prostitute.* (IDI20)

Community at large

A 32-year-old woman has this to say about the community after she lost her husband due to HIV and AIDS-related illness, who lamented:

> *I do not understand that in this community, women are always blamed for bringing HIV to their matrimonial homes. When my husband died, it was so bad the way they treated me. They accused me of killing my husband with AIDS as they believed that only promiscuous women bring HIV to their matrimonial homes.* (ID08)

A similar experience was described by a 36-year-old woman who was accused by the community after the death of her husband due to HIV and AIDS-related disease. She was labelled as an evil who brought HIV to her matrimonial home to kill her husband.

> *When they heard that he (referring to her husband) died of HIV, some said, I told you so. She brought it upon herself. That evil who brought the disease home to kill her own husband. Yet, he (referring to her husband) got it from South Africa.* (ID02)

The community accused a 33-year-old unmarried woman of being responsible for her HIV status due to what they said was “immoral sexual behaviour.”

> *You see, I tested HIV positive when I was 28. I was not married at that time and still not married up to now. Therefore, my life has been full of blame. This community thinks I contracted HIV through immoral behaviour.* (ID07)

The unmarried women living with HIV were socially devalued and subjected to several harmful, negative stereotypes. A 38-year-old unmarried woman shared her experience as follows:

> *So, when the community saw me not introducing anyone, they began to gossip behind my back. The open ones would be coming to me to ask jokingly about*

> *when I would get married. So, you see what my status as an unmarried woman living with HIV does to me in this village. According to the people in my village, I got HIV because I was a rebel and a prostitute. This community can make you even commit suicide. Most lack the knowledge, I think.* (ID09)

Sub-theme 2: Social avoidance

Avoidance as a sub-theme referred to any behaviour displayed by significant others toward women living with HIV, which they experienced as an excuse for refusing to interact with them.

This type of behaviour was derived from the participants' interaction with their in-laws, close family members, and the community at large.

In-laws

According to the participants, mothers-in-law did not want anything to do with them after disclosing their HIV status. They avoided associating themselves with anything done by them. A 42-year-old woman had this to say:

> *My mother-in-law's behaviour toward me changed after telling her that we tested HIV positive. Before we tested positive, my mother in–law would not let anyone cook for her except me. Since she learned about my HIV-positive status, she did not eat or touch the food I prepared. (ID04)*

However, it emerged that the mothers-in-law did not treat their children who were also HIV positive in the same manner. A 42-year-old woman narrated:

> *Before testing HIV positive, I used to do everything for my mother-in-law. We will do things together and even eat together. Things changed completely after she knew about our HIV-positive status. But what surprises me…, when her son comes to visit in December, she embraces him, and they even eat together.* (IDI01)

Close family members

The social avoidance behaviour displayed by close family members was based on the belief that a person living with HIV can easily transfer the disease to family members through physical contact and sharing things. In one of the focus groups, women narrated:

> *You see, even our family members see us as people with the potential to infect everybody in the household. (FGD 01)*

A 40-year-old woman has this to say about her close family members about her experiences after being tested HIV positive:

> *My family members do not even want to come close to me. They are so uncomfortable when I am cooking food, and some would not even eat when I cook. This was not the case before being tested HIV positive. I was the one coordinating all family events.* (ID06)

A 49-year-old participant has this to say about her close family members when she visits them:

> *No one shared their blankets with me because of my HIV-positive status. When I visit, I have to carry my blankets*. (ID18)

Community at large

Community members did not want to be associated with women living with HIV. They avoided any form of physical contact as much as possible—a 48-year-old woman shared her experience related to making her hair.

> *Before testing HIV positive, I was not struggling with my hair as people were freely offering to do my hair without paying. After being HIV positive, no one wanted to do my hair even when I offered to pay. Those who accept are very hesitant to touch my hair without wearing gloves.* (ID20)

Avoidance was also extended to the children of women living with HIV. This type of behaviour often happens at schools where other children and teachers avoid them. A 49-year-old woman described her experience with a teacher at her child's school*:*

> *Even at school, one particular teacher who used to send my child around stopped doing so when he learned that I was HIV positive.* (ID10)

Sub-theme 3: Social rejection

As a sub-theme, social rejection referred to any social behaviour displayed by significant others toward women living with HIV, which they experienced as affecting their interpersonal and social interactions.

Social rejection was often expressed through the discontinuation of relationships that the participants enjoyed before being tested HIV positive. Significant others initiated this discontinuation without giving any reasons besides their HIV-positive status. It was mainly perpetrated by partners, in-laws, friends, and church gatherings.

Partners

Women living with HIV experienced social rejection at the hands of their boyfriends /and husbands. A 22-year-old woman narrated her experience with her boyfriend after being tested HIV positive. However, the boyfriend refused to test for HIV.

> *As it is now, my long-standing boyfriend ran away from me when I told him about my HIV-positive status. I asked him also to test, but he refused. Since then, I have never seen or heard from him anymore.* (ID03)

For married women, social rejection went to the extent of divorce. This was common in a serodiscordant couple. This is what a 39-year-old married woman who was in a serodiscordant couple has to say about her husband:

> *My husband divorced me after I tested HIV-positive. Lucky for him, he tested HIV negative. I told him he must look after himself and live without me. I tried everything to keep him, but I failed. He clearly said to me that he could not continue his life with an HIV-positive woman.* (ID 20)

In-laws

In-laws often sent women living with HIV packing after their husbands' deaths. A 38-year-old woman stated:

> *My in-laws told me to move and set up our homestead after my husband had died.* (ID16)

Friends/fellow women

Friends often distanced or completely discontinued their relationships with women living with HIV. Women living with HIV experienced social rejection from friends they grew up with and even friends from work.

This is what a 50-year-old woman described her experience with friends she grew up with as follows:

> *All my friends I grew up with stopped our friendship when they learned about my HIV-positive status. Some said that they would no longer associate themselves with a woman who used to sleep around with men. Others said that they did not know that I was a lesbian and could not be friends with such people.* (ID05)

A 40-year-old woman shared her experience with her friends from work as follows:

> *I don't have any friends now, even from work. All my friends from work and those I grew up with have abandoned me because of my HIV-positive status. My only friends now are people we are attending the support groups together as people living with HIV.* (ID06)

Community at large

Churches were identified as places with high social rejection. Women were often rejected after the disclosure of their HIV status. A 47-year-old married woman had this to say:

> *The common social activity in this village is church gathering. Since I disclosed my HIV-positive status, I was singled out as a prodigal son. Having occupied a senior position in this village, made it even more challenging to survive in this community. The church uses me as an example of a rebel against church norms. Members do not socialize with me.* (ID21)

Sub-theme 4: Undignified treatment

As a sub-theme, undignified treatment referred to any social behaviour displayed by significant others toward women living with HIV, which they experienced as affecting their self-esteem and social respect.

Women living with HIV felt they were not treated with the dignity and respect they deserved as human beings and responsible members of the household and community.

Undignified treatment involved a complete disregard for women living with HIV. A 40-year-old married woman narrated:

> *Being HIV in this community means loss of dignity and respect. Before we were tested as HIV positive, we had all the respect due to our status as women and responsible community members. Even our parents and relatives used to respect us. But now, we do not have any dignity and respect. People talk to you as they wish… they give you degrading nicknames.* (ID 06)

This was worse with young ones, who were sometimes verbally abused by friends and family members, as reported by a 32-year-old unmarried woman.

> *You know, it is so bad. Sometimes you feel like you are going out of your mind. They talk to you in a very degrading way, and they do not care about how you feel. They go to the extent of saying bad and horrible things about you under your nose. And the mockery of young ones? Even when both of you (referring to the partners) are HIV positive, only you as a woman get these attacks and insults.* (ID 08)

These experiences were described with a lot of emotions and disbelief. It was best captured with the following narrative from a 40-year-old married woman:

> *Things that bothered us the most were the lack of consideration of our humanness. They talk to you as if you are not a human being. We are treated like lepers or polluted sources that need to be dumped far away. We are treated as outcasts and do not have the right to belong and be respected.* (ID 04)

This sub-theme also emerged from the individual in-depth face-to-face interviews. A 33-year-old unmarried woman had this to say:

> *I feel humiliated, assassinated, and hurt because they think I got HIV through bad behaviour. These rumors spread very fast. What pained me most was when they (referring to community members) claimed that I was targeting the herd boys [in a trembling voice]. It's pretty sad indeed.* (ID07)

A 40-year-old married woman had this to say about her experience with the sister-in-law after being tested HIV positive.

> *Before being tested HIV positive, I was respected in my household and my in-laws. I was in charge of my household. After being tested HIV positive, everybody seemed to disrespect me. Specifically, my sisters' in-laws will come and do whatever they want in my house and go. I find it disrespectful for anyone to come into your house and take over everything without asking you.* (ID06)

Sub-theme 5: Gender stereotype

As a sub-theme, gender stereotype refers to any social prejudice experienced by women living with HIV because of their gender. This sub-theme derived from how women living with HIV were treated compared to men living with HIV.

Women living with HIV experiences more labelling, and stereotype compared to their male counterparts living with HIV. A 38-year-old unmarried woman shared her experience as described below:

> *As a woman living with HIV and AIDS in this community, we are treated as immoral, prostitutes, sinners, and all the bad names you can think of. But They do not even pay attention to our feelings. But this is not the same with men living with HIV. They are not called all these derogatory names. They are respected as human beings.* (ID 21)

Being a beautiful woman living with HIV was more dehumanizing than a handsome man living with HIV. For a beautiful woman living with HIV, community members attributed the beauty to her HIV-positive status. A 30-year-old beautiful woman who was born HIV positive shared her experience as follows:

> *In this community, people always used the proverb "Akukho geza elingela siyinga"- meaning that there is nobody perfect and beautiful and that people always have flaws of one sort or another' referring to a beautiful woman living with HIV. They often used my beauty to explain my HIV-positive status and call me names, even though some know I was born HIV-positive.* (ID17)

Churches did not treat HIV-positive women in the same manner as men living with HIV. A 47-year-old married woman shared her experience with her husband, with whom they attend the same church.

> *The common social activity in this village is church gathering. Since I disclosed my HIV-positive status, I was singled out as a prodigal son. Having occupied a senior position in this village made it even more challenging to survive in this community. The church uses me as an example of a rebel against church norms. Surprisingly, my husband, who attends the same church, is not treated in the same way. Church members seem to be sympathising with him but do not socialise with me.* (ID21)

4.2.2 Theme 2: Social discrimination

Social discrimination as a theme referred to any social behaviour displayed by significant others toward women living with HIV, which they experienced as violating their individual and social rights because of their HIV-positive status. Women suffered social discrimination at the hands of their partners, close family members, in-laws, friends, and the community at large.

Three sub-themes emerged from the analysis of the participants' descriptions. These were classified as (1) loss of independent decision-making power, (2) unfair labour practices, and (3) gender-based discrimination.

From the above lived social discrimination experiences, ***it was deduced that women living with HIV in rural Zimbabwe are denied their social rights because of their HIV-positive status and gender.***

Sub-theme 1: Loss of independent decision-taking power

As a sub-theme, the loss of independent decision-making power was defined as any behaviour displayed by significant others toward women living with HIV, which they experienced as affecting their personal ability to take a decision. It focused on issues they usually take a decision on without depending on significant others.

From the descriptions of their experiences, women were deprived of their rights to take independent decisions on their education, sexual and reproductive health, family, and social matters.

Education related matters

Women living with HIV, particularly those depending on their parents or siblings for support with their studies, were not involved in any decision about continuing with their education after being tested positive.

A typical account came from a 22-year-old young woman who was studying at a tertiary institution when she was tested HIV positive. After disclosure, the sibling who was supporting her study decided not to continue paying for her education. In the process, he arranged for her to marry an older man as part of the cure for HIV.

> *It is so sad how people can just decide on an important matter that concerns your future without your involvement. I was in my first year of university when I was tested HIV positive. After sharing the news with my legal guardian, who was paying for my study, he just told me to come back home. He stated that he would not waste his money paying for the education of someone who is HIV positive. The worse part of it is that when I finally came back home, he forced me to marry an older man. According to him, getting married to an older man will assist me in curing my HIV.* (ID03)

Sexual and reproductive health matters

The right to take the decision on sexual and reproductive health issues was often exercised by husbands, family members, and healthcare professionals. Pregnant women living with HIV were forced by their husbands to go for an abortion. Family members restricted them from falling pregnant. A 32-year-old woman narrated:

> *I seriously wanted to have a child after being tested HIV positive. But my family strongly opposed the idea, treating me as a cruel and uncaring person. I tried to convince even my friends to support me, but none of them could support me.* (ID08)

A 50-year-old lamented about the family members' decision not to have her adopt a child and even to have a child from relatives to live with her. They categorically said that as HIV positive person, she has no right to adoption or guardianship.

> *In this community, you cannot adopt a child or get a relative child to come to stay with you because you are HIV positive. We are treated as if we have no right to have a child. Look at me now; my son is working in town. I feel deserted and unwanted and even blamed my relatives for not giving me a child to stay with.* (ID05)

Healthcare professionals coerced women living with HIV to have their uterus or tubes removed, not to have children.

Participants were terrified by such behaviour coming from professionals, as expressed by a 42-year-old woman:

> *I could not believe my ears when a healthcare professional told me at the clinic to have my tubes removed after testing HIV positive. She kept pressuring me every time I went to the clinic for my medication. I was so afraid to go to that clinic alone because of that pressure.* (ID04)

Family-related matters

Family-related matters were experienced after the deaths of the participants' husbands. They focus on the decision about the place to stay and the disposal of material possessions. Married women living with HIV were not given the opportunity to decide where to stay after the deaths of their husbands. They were forcefully sent back to their parent's homes or taken by their parents. This is what a 39-year-old woman said about her experience after the death of her husband. She was taken back home by her people without asking her own view.

> *Three weeks after my husband died of HIV and AIDS-related illness, my people came and took me back home without discussing it with me. They said that they have to take me away from my husband's family for protection.* (ID20)

The situation was worse for women who did not have a male child. Women had no land rights, which means that there had limitations in using the property and were at the mercy of the husband's surviving relatives. They were not given the opportunity to say what they thought. This is what transpired from one of the FGDs.

> *You know, when your husband dies of HIV and AIDS-related disease, you as a surviving spouse have nothing to say because of your HIV-positive status. No matter the number of years you lived with your husband, you are stripped of everything. You are not given an opportunity to express your opinion with all decisions being taken for you.* (FGD 02)

Social gatherings

Women living with HIV were put behind the scenes and denied decision-making roles at social gatherings. A 41-year-old woman who has belonged to a woman club for years talked of her experience after disclosing her HIV-positive status.

> *The changes that happened when I told members of my HIV-positive status were unbelievable. Those appointed to positions want to make decisions for me, yet I used to make my own decision. They excluded me from all decision-making processes.* (ID15)

Sub-theme 2: Unfair labour practices

As a sub-theme, unfair labour practices referred to any professional practice/conduct displayed by significant others toward women living with HIV, which they experienced as contrary to the country's labor laws.

Comparing her life before and after being tested HIV positive, a 38-year-old woman shared her experiences in the following terms:

> *Before being tested HIV positive, I worked in several households as a maid. I accumulated tremendous experiences with high demands for my services. After disclosing my HIV-positive status, I do not get even a single call from people seeking my services. She jokingly said, “the only calls I get are about people announcing deaths that occur in the village.* (ID16)

A 49-year-old woman narrated her experience of being demoted after disclosing her HIV-positive status to her boss.

> *I told my boss about my HIV positive status hoping to get the necessary support from him. Instead, he spread the news to everyone in my workplace. After that, he reduced my working hours, although I did not have any symptoms and performed my usual duties. But he did not end there because I was demoted from my position a few months later.* (ID10)

Sub-theme 3: Gender-based discrimination

As a sub-theme, gender-based discrimination referred to any practices that deprived women living with HIV of their rights because of gender.

Unmarried women living with HIV felt discriminated against because of being unmarried and HIV positive. A 41-year-old woman narrated:

> *There is a lack of recognition as an equal community citizen. Mostly, you have to be married to earn respect.* (ID15)

Unmarried women living with HIV were also deprived of their right to the freedom of expression. Decisions are often taken on their behalf. A 38-year-old woman living with HIV shared her experience in these terms:

> *In this community, it's culturally taboo for women to air their views in meetings. This is even worse for a woman with no husband and living with HIV. I am literally excluded from all important meetings. You know that even if they call us (widows) to their meetings, we would be passive participants as we are not allowed to deliberate issues with the men. We have to adhere to all the decisions they will take.* (ID09)

Married women living with HIV were often dispossessed of their property and assets. Although of common occurrence in these communities, the participants stated that the situation was worse for women living with HIV.

A 50-year-old woman shared her experience as follows:

> *Ahh [sighing], you don’t own any assets as a woman. Since my husband died, I have been the head of this home, but I don’t have anything I can claim. We go through our uncle (my husband’s brother) for permission to use the land. You see this garden behind the cattle pan [pointing in the direction of her garden]. I had to ask first before I put it up. As a widow and being independent with my*

> *own home like this, I expect my people to consider that and let me decide my life with my children.* (ID11)

But the situation was different if a woman living with HIV had a male child with her husband. Having a male child was a means of securing property and assets. It also means having representation at the family meetings as the male child was given the authority to represent his father. A girl child did not have the same privilege.

A 49 year old married woman living with HIV, who had only girls shared her experience on how it affected their lives after the death of her husband.

> *You see, my husband passed away five years ago. Unfortunately, we only had girls. So, I have no rights to land and assets in this community. I could not send my girls to tertiary education because everything was taken away from me. My girls were so brilliant, and it pains me not to be able to send them to further their education. Maybe if I had the land rights, I would do something for my children.* (ID11)

4.2.3 Theme 3: Psychosocial dysfunction

Psychosocial dysfunction as a theme refers to a set of negative cognitive, emotional and social mechanisms used by women living with HIV in response to the social prejudice and discrimination perpetrated against them by significant others in their communities.

Women living with HIV were confused about effectively dealing with the social prejudice and discrimination perpetrated against them by significant others. The extract below from a 49-year-old married woman exampled the state of confusion experienced by most women living with HIV in rural Zimbabwe:

> *Knowing my status affected me psychologically. Just the thought of the community's boundaries regarding how I should love my children saddened me. Because they dictate and limit the interaction between my children and me, I needed to be careful about how I mingle with them. People's eyes are always on me in the name of protecting the children. I could feel the scorn in their voice and face. People are so bitter. I don't know what I had done wrong.* (ID10)

Five sub-themes emerged from the qualitative analysis of the participants' descriptions. These included: (1) blaming oneself, (2) cognitive avoidance, (3) hopelessness, (4) worthless, and (5) social isolation/withdrawal.

From the above-lived experiences, ***it was deduced that women living with HIV in rural Zimbabwe developed a set of cognitive, emotional, and social dysfunction due to social prejudice and discrimination perpetrated against them by significant others in the communities where they live.***

Sub-theme 1: Blaming oneself

Blaming oneself as a sub-theme referred to a cognitive response characterised by self-condemnation for being HIV positive. Self-condemnation was often accompanied by inward anger, self-hate, and rationalisation.

A 33-year-old unmarried woman expressed inward anger for being HIV positive and could not have children because of gender-based discrimination.

> *I am angry at myself. I feel sad and disappointed with myself. The worse is that I am not married and will never have children because of what people think of an HIV-positive woman in this community.* (ID07)

A 32-year-old pregnant woman hated herself for being HIV positive. This self-hater was due to the anticipated embarrassment that would follow the delivery.

> *I hate myself. Sometimes, I wish I was someone else. I hate myself so much. Many things came to mind when I fell pregnant with my second child after being tested positive. The embarrassment from what my people and other mothers would see me. I asked myself questions such as "how would I face other mothers if I do not breastfeed my baby? If I do not breastfeed, they will see I am HIV positive. At the same time, I wanted a second child, and I couldn't opt for an abortion*. (ID08)

Rationalisation referred to the justification of social prejudice and discrimination perpetrated against them. Rationalisation was well illustrated with the extracts from a 23-year-old and 50-year-old married women, respectively.

The 23 year old thought that it was customary to be labelled by the members of the community because she deserved it.

> *Sometimes, I do not blame the community for giving me names. I am the one who brought this HIV to their son.* (ID14)

The 50-year-old believed that she contracted HIV because of striving for economic independence.

> *I blame myself too much. I feel like a burden to my people. I was not going to contract HIV if I listened to my in-laws. They did not allow me to take up employment. ...But I disobeyed them and took up a job without their approval. My act landed me where I am today (referring to her HIV-positive status).* (ID12)

Sub-theme 2: Cognitive avoidance

Cognitive avoidance as a sub-theme referred to a cognitive response characterised by a deliberate effort to avoid talking or discussing about HIV or to avoid doing certain things because of being HIV positive or the social prejudice related to HIV.

Avoidance to talk or discuss anything related to HIV and AIDS was best captured from an extract from a 50-year-old married woman. Her husband was also living with HIV. Despite being HIV positive, they deliberately decided not to talk or discuss HIV matters in their matrimonial home.

> *My husband and I do not talk or discuss HIV or AIDS in our house. My husband believes that only prostitutes speak about HIV and AIDS. So, we do not talk about it in this home.* (ID12)

A 30-year-old unmarried woman narrated how she avoids taking on certain responsibilities or engaging in friendships because of social prejudice against women living with HIV in their community.

> *I do not even consider or think of taking any responsibility or making friends because of how people treat us in this community. I avoid going through that humiliation of being HIV positive. It is horrible because they treat you like a sick person who is mentally unstable.* (ID17)

Sub-theme 3: Hopelessness

Hopelessness as a sub-theme referred to an emotional response characterised by feelings of despair, desperation or lack of hope for the future due to HIV status or the social prejudice and discrimination against women living with HIV.

Despite access to antiretroviral drugs, women living with HIV did not have hope for the future. A 36-year-old married woman expressed her state of hopelessness as follows:

> *I had a completely new outlook on life after I tested HIV positive. I do not look that far into the future anymore. I just don't look that far ahead. I do not think about getting old. Even though there are antiretroviral drugs, there's a possibility that I'm not going to get to see my grandchildren.* (ID02)

A 44-year-old married woman living with HIV, who was sent back to her village by her in-laws after the death of her husband, narrated:

> *I feel useless. I can't do anything by myself. It looks like am dying, my sister. I came home after my husband's death but didn’t even have the energy to think about tomorrow.* (ID19)

Sub-theme 4: Worthless

Worthless as a sub-theme is an emotional response characterised by feelings of a good for nothing or useless or valueless due to HIV status or the social prejudice and discrimination against women living with HIV.

Those feelings were associated with suicidal ideation, as narrated by a 44-year-old woman.

> *I am just living because I am still breathing. I died long ago. I have been sick for some years. Now it has become worse. It is better to die. My husband has since died, but I am still living. I wish it were me who had died first.* (ID19)

A 50-year-old married woman had this to say:

> *Being diagnosed with HIV had a significant effect on my life. It made me feel so sad and saw no reason to live. I contemplated taking my life and tried it several times.* (ID11)

Another 50-year-old woman shared her experience as follows:

> *The illness got the best of me. I do not see even the importance of living. You know, I could not even concentrate anymore because my mind shifted to this disease.* (ID12)

A 32-year-old married woman shared her experience of feeling worthless due to her HIV status as follows:

> *I am worthless. I will not have children at this tender age because of my HIV status.* (ID08).

Sub-theme 5: Social isolation/withdrawal

Social isolation/withdrawal as a sub-theme referred to a social response characterised by self-removal from interaction with significant others in the community due to HIV status or the social prejudice and discrimination against women living with HIV.

It emerged that women living with HIV found it difficult to interact with significant others because of the social prejudice against them by members of their communities. They turned to social isolation or withdrawal to avoid social discrimination by significant others in their communities.

A 41-year-old married woman shared her experience with sadness:

> *I decided not to interact with people in my community because of their negative behaviour toward people living with HIV. It is painful, indeed. I contemplated leaving this village several times to escape the shame and judgment. I couldn't cope with the torture of being reminded of my HIV status. I always stay behind closed doors.* (ID15)

A 32-year-old unmarried woman decided to isolate herself after being tested positive because of what people will think of her.

> *I withdrew and isolated myself from my community after testing HIV positive. I knew that the community would think the worst of me. From my experience as a member of this village, I knew that people in this village believed that you could contract HIV only through promiscuity.* (ID08)

Some women living with HIV stopped their businesses in response to social prejudice and discrimination against them. This was best illustrated in the extract from a 38-year-old who was breeding chickens for commercial purposes. She stopped her business after testing HIV positive.

> *I stopped my chicken business because of people's behaviour toward me after testing HIV positive. You know, I was breeding and selling chickens in my village. I was doing well in my business, but things changed after people became aware of my HIV status. I could not continue because of their name-calling, and others were avoiding me. So, I completely withdrew from people and stopped my business.* (ID16)

4.3 MEANING OF BEING A WOMAN LIVING WITH HIV IN RURAL ZIMBABWE

Participants were asked one grand tour question: “What does it mean to you as a woman living with HIV in this village?”. Probing questions focused on the lived experiences that emerged from the individual in-depth face-to-face interviews.

The meaning participants ascribed to being a woman living with HIV in rural Zimbabwe was closely linked to their lived experiences. It means that women living with HIV in rural Zimbabwe shared the same lived experiences. Despite the negative lived experiences, the descriptions of the meaning attached to those experiences provided a more positive perspective. While recognising the struggle for being women living with HIV, they were more solution-focused on what it means to live with HIV in the social context.

Four sub-themes are derived from the meaning women living with HIV ascribed to their experiences. They were classified into the following two themes: (1) struggle for social acceptance and (2) struggle to maintain the quality of life and wellbeing. Table 2 summarises the two themes with the related sub-themes.

From the participants' descriptions of the meaning attached to their experiences, ***being a woman living with HIV in rural Zimbabwe means a perpetual struggle to maintain one’s humanness and quality of life.***

Table 2: Meaning attached to the lived experiences of women living with HIV

Themes	Sub-themes
Struggle for social acceptance	1. Loss of social belonging
	2. Reduced access to community-based empowerment opportunity
Struggle to maintain the quality of life	1. Lack of need-based community health
	2. Food insecurity

4.3.1 Theme 1: Struggle for social acceptance

As a theme, the struggle for social acceptance refers to the views of women living with HIV regarding their social status and rights as members of the communities they live in following the disclosure of their HIV-positive status.

The above theme derived from two sub-themes: (1) loss of social belonging and (2) reduced access to community-based empowerment opportunities. From the views expressed by women living with HIV in rural Zimbabwe**, *it was deduced that being a woman living with HIV in rural Zimbabwe means a struggle for social acceptance due to the loss of social belonging and reduced access to community-based empowerment opportunities in the communities that they live.***

Sub-theme 1: Loss of social belonging

Loss of social belonging as a sub-theme referred to the views of women living with HIV regarding social interaction with significant others and using the available social support system in their community.

Social interaction with significant others and utilising of the existing social support system was viewed as an expression of the sense of belonging to the community. Participants defined themselves as social beings with social interaction with significant others and fully utilising the social support system when needed to express social belonging.

However, the social prejudice and discrimination perpetrated against women living with HIV by significant others excluded them from enjoying their rights of social belonging. For women living with HIV in rural Zimbabwe, the HIV-positive status made them lose their social identity as community members. These views emerged from the discussions of all three focus groups. It was best illustrated with this narrative from the first focus group.

> *We were taught to interact freely with others since our birth. This interaction is proof of our social identity as members of this community. It makes one feel that she is a member of the community with full rights as recognised by our culture. But everything changed with our HIV-positive status. People, including your own close family members, distance themselves from you. becomes difficult for people living with HIV, specifically for us women.* (FGD1)

For women living with HIV in rural Zimbabwe, the loss of social belonging also included the exclusion from the existing social support system. They were not accepted or allowed to use the existing social support system available in the community where they lived.

> *Being HIV positive woman means everything terrible that you can think of. Before testing positive for HIV, we enjoyed everything in this community. We were recognised and considered as full members of the family and the village. We received support from everybody in the family and community. We were invited to join all the social activities and play active roles. With the HIV-positive status, we no longer get support from our families and communities. Social support is critical in assisting you in building confidence to conquer anything. But now…we are excluded from using all those resources. Yes, my sister (referring to the researcher), this is what it means to be a woman living with HIV in this community.* (FGD2)

Sub-theme 2: Reduced access to community-based empowerment

Reduced access to community-based empowerment opportunities as a sub-theme referred to women living with HIV participation in community-based capacity-building training. These trainings were designed to empower women through skills development in various areas.

After disclosing their HIV status, women were seldom invited to attend those training.

> *You know, we used to attend many trainings organised to empower women in the community. We applied the skills learned to achieve financial independence and fulfil our basic needs. We also applied the skills learned to establish our small businesses in the communities. Oh yes, we spend the income generated from these activities on food, health, and education. Now with our HIV-positive status, we are no more invited to these trainings. They only invite us to trainings that talk about HIV and AIDS-related matters.* (FGD3)

The reduced access to community-based empowerment opportunities included also support for continuing education, as transpired in the discussion from FG 2.

> *You know the role of education for women in this country. The financial gains from educating girls are huge. But the gender gap in education is still significant. Unfortunately, once you are tested HIV positive as a girl, no one wants to spend money on your education. It is unfortunate. For some members of our families and communities, HIV is still a death sentence.* (FGD)

4.3.2 Theme 2: Struggle to maintain the quality of life

Struggle for preserving the quality of life as a theme referred to the views women living with HIV held about meeting their health and basic needs.

The above theme is derived from two sub-themes: (1) lack of need-based community healthcare and (2) food insecurity. From the views expressed by women living with HIV in rural Zimbabwe**, *it was deduced that being a woman living with HIV in rural Zimbabwe means a struggle to maintain the quality of life due to the lack of need-based community healthcare and food insecurity in the communities that they live.***

Sub-theme 1: Lack of need-based community healthcare

Lack of need-based community healthcare as a sub-theme referred to the views of women living with HIV regarding the availability of healthcare services on their quality of life within their social context.

For women living with HIV in rural Zimbabwe, the existing healthcare services do not address their specific health needs as rural people living with HIV. This situation influences how they view themselves as women living with HIV.

> *You know, we need regular health check-ups as people living with HIV. The existing services are far away, but we have problems even accessing those services. We need a door-to-door medical check-up. The health workers/caregivers who go around do not provide information on the importance of living healthy with HIV. They do not know how to deal with us and reduce HIV-related stigma.* (FGD2)

Sub-theme 2: Food insecurity

Food insecurity as a sub-theme referred to the views of women living with HIV regarding the impact of being HIV on food security within their social context.

For women living with HIV in rural Zimbabwe, HIV-positive status means food insecurity. Social discrimination has been particularly singled out as the primary basis for food insecurity.

> *We all need to have enough food in our households to maintain our quality of life. This is so important with our health status. But the discrimination we suffer daily makes it difficult for one to continue the economic activities she was doing before being tested HIV positive.* (FGD2)

4.4 SUMMARY AND DISCUSSION OF PHASE 1 FINDINGS

The overall purpose of this study was to propose a model for mitigating stigma and discrimination against women living with HIV in the rural context of Zimbabwe based on the understanding of their lived experiences and the meaning attached to being a woman living with HIV in the rural context of Zimbabwe. One of the arguments of this study, as articulated in the research problem statement, was the limited understanding of how women living with HIV view their new realities of being HIV positive and their accumulated lived experiences within the rural socio-cultural context of Zimbabwe. The findings of Phase 1 of this study addressed the above challenge by providing two frameworks derived from the lived experiences to increase our understanding of the new realities of living with HIV in the rural context of Zimbabwe.

4.4.1 Lived experiences of women living with HIV

From the qualitative analysis of the women's lived experiences, it emerged that women living with HIV in rural Zimbabwe were socially victimised and treated in a degrading manner. It denied their social rights because of their HIV-positive status and gender. In response to the social prejudice and discrimination, women living with HIV in rural Zimbabwe developed a set of cognitive, emotional, and social dysfunction. The researcher used the above findings to develop a framework of women's lived experiences living with HIV in rural Zimbabwe (see Figure 2). As illustrated in Figure 2, this framework included the themes, sub-themes, and the exhaustive and descriptive meaning of the emerged experiences.

As illustrated in Figure 2, women living with HIV in rural Zimbabwe experience both social HIV-related stigma and discrimination as well as self-inflated stigma and discrimination.

The social HIV-related stigma and discrimination were classified as social prejudice and social discrimination. Significant others perpetrated them within the family, workplace, schools, churches, healthcare settings, and the community social network. The social stigma and discrimination experienced by women living with HIV in rural areas were reported by previous studies on HIV-related stigma and discrimination (Dos Santos, Mellors, Wolvaaradt & Van der Rys, 2014; Mavhandu-Mudzusi & Ganga-Limando, 2014).

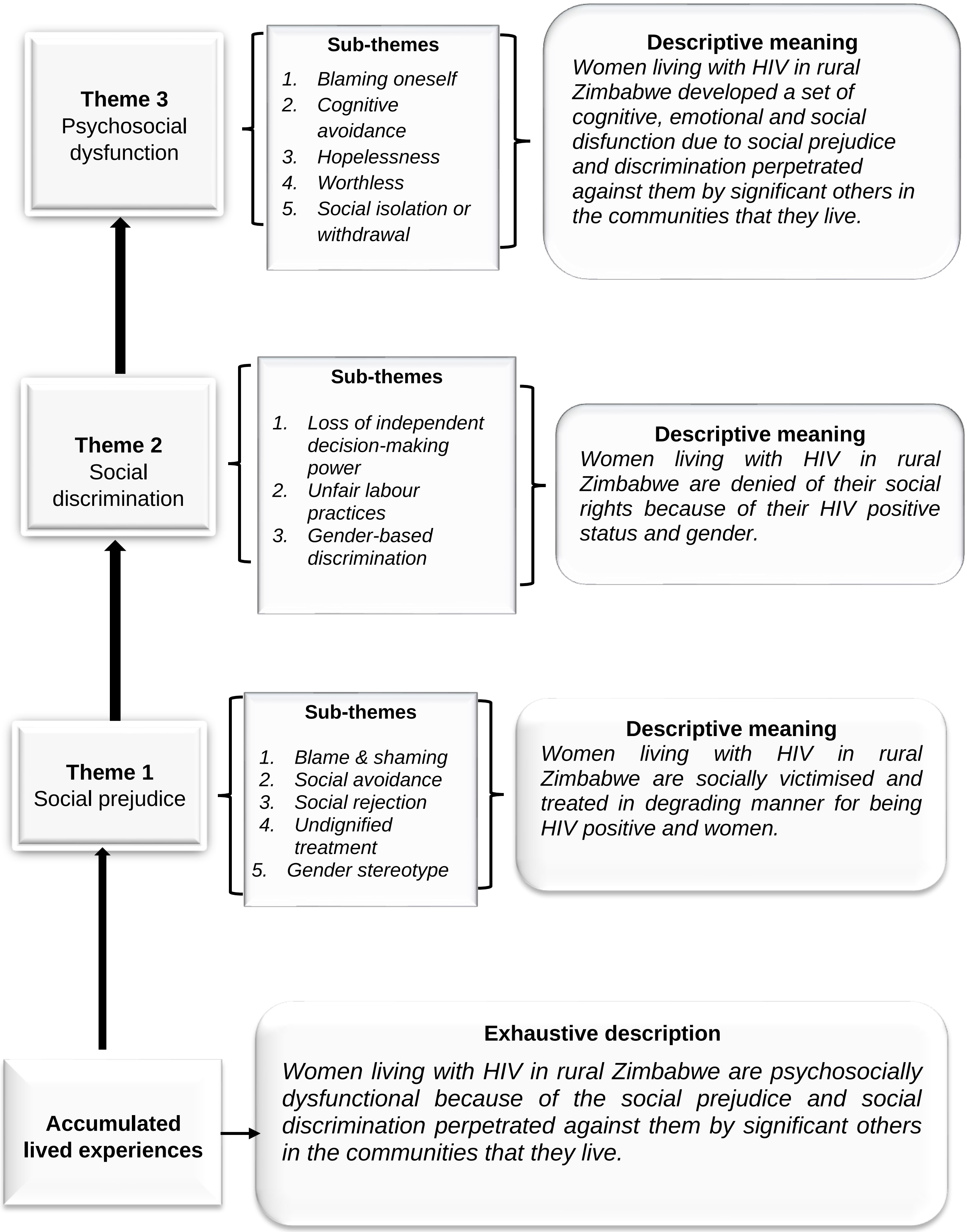


Figure 2: Framework of the lived experiences of women living with HIV

The role of significant others (partners, close family members, in-laws, friends, and community at large) as the drivers of social stigma and discrimination is in line with the social nature of stigma and discrimination. As socially constructed concepts, stigma and discrimination are perpetrated by significant others in the social environment of the victims (Wirawan, 2019). As socially constructed concepts, stigma and discrimination are shaped by the cultural beliefs and norms governing society (Logie et al., 2011). This is similar to this study's findings, where women living with HIV were judged and labelled according to the cultural values and norms of the communities.

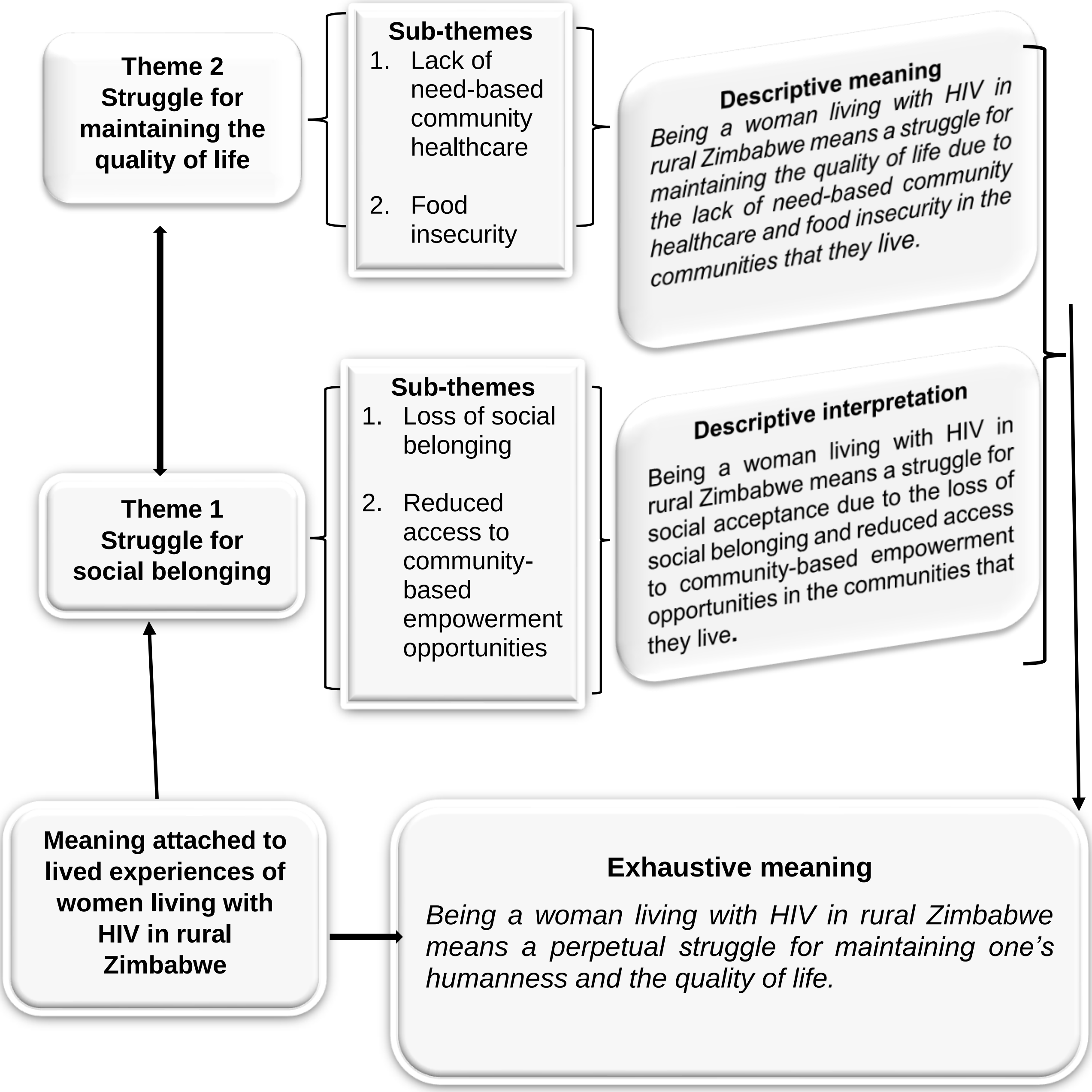
The gender stereotype and gender-based discrimination pointed to the prevailing patriarchal nature of the society (Ham, Jeger & Frajman Ivković, 2015:740; Majaha, 2015). This is also supported by the lived experiences of women living with HIV in this study. They pointed out that the level of social prejudice and discrimination perpetrated against women living with HIV was not the same as that of men living with HIV.

The self-inflated stigma and discrimination resulted in psychosocial dysfunction expressed through blaming oneself, cognitive avoidance, hopelessness, worthless, and social isolation or withdrawal are consistent with previous studies (Naigino, Makumbi, Mukose, Buregyeya, Arinaitw, Musinguzi, and Wanyenze, 2017; Than, Tran, Nguyen, Truong, Thai, Latkin, Ho & Ho, 2019). Previous qualitative studies have suggested that self-stigma is related to various negative emotions such as stress, guilt, and shame (Logie et al., 2021; Sallam et al., 2022), which are risk factors for depression.

4.4.2 Meaning attached to the lived experiences

The meaning attached to the lived experiences of women living with HIV in rural Zimbabwe highlighted how women living with HIV viewed themselves regarding their accumulated lived experiences of being HIV positive.

Women living with HIV in rural Zimbabwe viewed life as a perpetual struggle to maintain one’s humanness and quality of life. The battle to maintain humanness aims to overcome the loss of social belonging and reduced access to community-based empowerment opportunities. At the same time, the struggle for preserving the quality of life targeted the lack of need-based community healthcare and food insecurity attributed to their HIV-positive status. The researcher used the findings of the second objective to develop a framework of the meaning attached to the lived experiences of women living with HIV in rural Zimbabwe (see Figure 3).



Descriptive meaning

Being a woman living with HIV in rural Zimbabwe means a struggle for maintaining the quality of life due to the lack of need-based community healthcare and food insecurity in the communities that they live.

Descriptive interpretation

Being a woman living with HIV in rural Zimbabwe means a struggle for social acceptance due to the loss of social belonging and reduced access to community-based empowerment opportunities in the communities that they live.

Exhaustive meaning

Being a woman living with HIV in rural Zimbabwe means a perpetual struggle for maintaining one's humanness and the quality of life.

Figure 3: Framework of the meaning attached to the lived experiences of women living with HIV in rural Zimbabwe

The perpetual struggle for maintaining one’s humanness and quality of life as the meaning attached to the lived experiences of women living with HIV are increasingly recognised as the daily reality of people living with HIV. Previous studies indicated that in a resource-limited environment, people living with HIV are often defined in terms of social support and the desire to maintain their quality of life (Logie et al., 2018; Busza, Simms, Chikwari, Dauya, Bandason, Makamba, McHugh & Ferrand, 2018).

Access to empowerment opportunities for women living with HIV and women in resources-limited environments is associated with economic independence and reduction of gender equality across the globe (Bettio & Ticci, 2017). Economic freedom increases the capacity of women to make real choices about their lives through full and equal participation in all spheres of life (Mora, Peña, Fernández Darraz, Vivallo Urra & Constanzo, 2019).

4.5 CONCLUSION

Phase 1 provided a basis for developing an evidence-based model for mitigating stigma and discrimination against women living with HIV in rural Zimbabwe.

From the presentation and discussion of the Phase 1 results, the existing interventions against HIV-related stigma and discrimination in Zimbabwe are not producing the expected outcomes. Women living with HIV in rural Zimbabwe are still experiencing stigma and discrimination that negatively impact their quality of life and wellbeing.

CHAPTER 5

PRESENTATION AND DISCUSSION OF PHASE 2 FINDINGS

5.1 INTRODUCTION

Phase 2 of the study dealt with the third objective: to design and describe an evidence-based model for mitigating stigma and discrimination against women living with HIV in rural Zimbabwe.

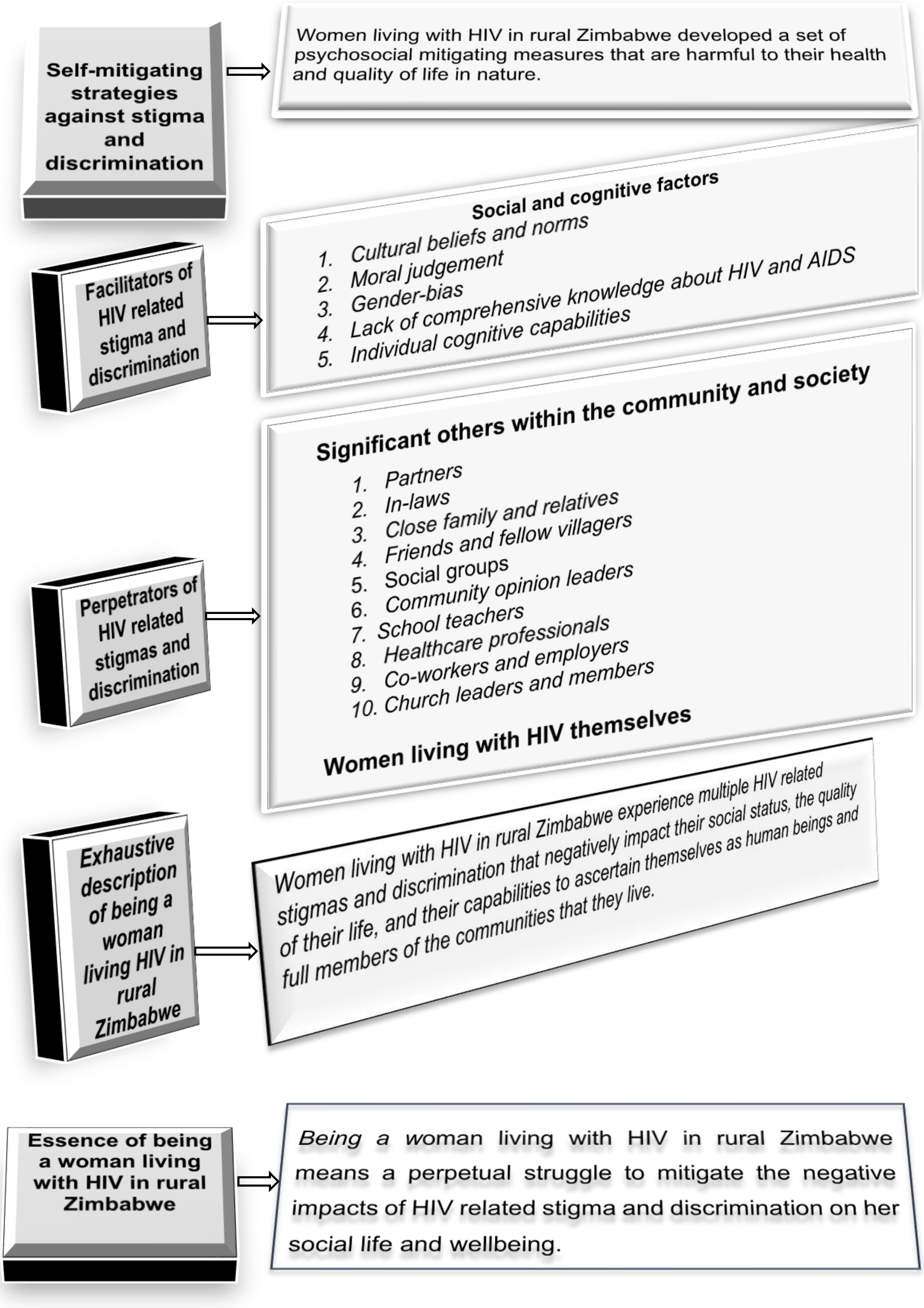
In this study, the researcher combined qualitative meta-analysis and theoretical triangulation to provide the model's empirical foundation, identify and define the model's key concepts, and represent the structure of the model (Figure 5).

5.2 EMPIRICAL FOUNDATION OF THE MODEL

In this study, the researcher argued that a model for mitigating stigma and discrimination against women living with HIV in rural Zimbabwe should be based on evidence amassed from the understanding of the meaning of being a woman living with HIV in the rural context of Zimbabwe.

The empirical foundation of the model is derived from the qualitative meta-analysis of Phase 1 findings. The results allowed the researcher to develop a framework for understanding the meaning of being a woman living with HIV in the rural context of Zimbabwe (see Figure 4). As illustrated in Figure 4, the framework described the essence of the meaning of being a woman living with HIV, the detailed description of the lived experiences, the perpetrators, and facilitators of stigma and discrimination experienced by women living with HIV.

In this section, the researcher described and discussed the framework's constructs.



Self-mitigating strategies against stigma and discrimination

Women living with HIV in rural Zimbabwe developed a set of psychosocial mitigating measures that are harmful to their health and quality of life in nature.

Facilitators of HIV related stigma and discrimination

Social and cognitive factors

1. *Cultural beliefs and norms*
2. *Moral judgement*
3. *Gender-bias*
4. *Lack of comprehensive knowledge about HIV and AIDS*
5. *Individual cognitive capabilities*

Perpetrators of HIV related stigmas and discrimination

Significant others within the community and society

1. *Partners*
2. *In-laws*
3. *Close family and relatives*
4. *Friends and fellow villagers*
5. *Social groups*
6. *Community opinion leaders*
7. *School teachers*
8. *Healthcare professionals*
9. *Co-workers and employers*
10. *Church leaders and members*

Women living with HIV themselves

Exhaustive description of being a woman living HIV in rural Zimbabwe

Women living with HIV in rural Zimbabwe experience multiple HIV related stigmas and discrimination that negatively impact their social status, the quality of their life, and their capabilities to ascertain themselves as human beings and full members of the communities that they live.

Essence of being a woman living with HIV in rural Zimbabwe

Being a woman living with HIV in rural Zimbabwe means a perpetual struggle to mitigate the negative impacts of HIV related stigma and discrimination on her social life and wellbeing.

Figure 4: Framework for the understanding of being a woman living with HIV in rural Zimbabwe

5.2.1 Essence of being a woman living with HIV in rural Zimbabwe

It has emerged from the qualitative meta-analysis that *women living with HIV in rural Zimbabwe are in a perpetual struggle to mitigate the negative impacts of HIV-related stigma and discrimination on their social life and wellbeing.*

The essence of being a woman living with HIV in rural Zimbabwe resulted from the interplay between the attitude of the significant others, the social and cognitive facilitators of stigma and discrimination, and the cognitive capabilities of HIV-positive women in the acquisition of the accumulated lived experiences of women living with HIV and the meaning attached to these experiences. Evidence from studies looking at stigma and discrimination recognised the influence of these factors on the formation and type of stigma and discrimination (Barlett, 2019; Hall et al., 2018; Ham et al., 2015). Similar views transpired from a qualitative synthesis of stigma, HIV, and health (Chambers, Rueda, Nico Baker, Wilson, Deutsch, Raeifar, Rourke, and The Sigma Review Teams, 2015).

The essence of being a woman living with HIV was essential in setting the goal of the model for mitigating stigma and discrimination against women living with HIV in rural Zimbabwe.

5.2.2 Exhaustive description of being a woman living with HIV in rural Zimbabwe

As illustrated in Figure 4, it emerged that w*omen living with HIV in rural Zimbabwe experience multiple HIV-related stigmas and discrimination that negatively impact their social status, the quality of their life, and their capabilities to ascertain themselves as human beings and full members of the communities that they live in.*

The exhaustive descriptions of being a woman living with HIV in rural Zimbabwe resulted from the accumulated lived experiences of women living with HIV and their meaning to these experiences. Previous studies Gesesew et al., (2017); Logie & Gadalla, (2009); Loggie et al., (2018); Pabian & Vandebosch, (2014); Pretorius et al., (2016:188); Rueda et al., (2016) support those women living with HIV in developing countries experience HIV related enacted and felt stigmas and discrimination perpetrated by others in their immediate and large social environment that they live.

Understanding the lived experiences of women living with HIV in rural Zimbabwe was crucial in identifying the key concepts that should be included in the model.

5.2.3 Perpetrators of stigmas and discrimination

As illustrated in Figure 4, significant others within the social system of HIV-positive women played an essential role in perpetuating and maintaining stigma and discrimination. Existing evidence confirmed that significant others' negative behaviour toward people living with HIV compromises efforts to mitigate HIV-related stigma and discrimination and the fight against HIV in general (Gesesew et al., 2017; Logie & Gadalla, 2009; Loggie et al., 2018; Pabian & Vandebosch, 2014; Pretorius et al., 2016:188; Rueda et al., 2016).

Figure 4 also highlights the role of HIV-positive women in perpetuating stigmas. The role of the women living with HIV in perpetuating stigma against themselves can be explained by the social cognitive theory because optimistic self-beliefs predict actual behavioural performance and demonstrate that individuals typically intend to perform behaviours they perceive to be within the control (Conner, & Norman, 2015). From the perspective of the social cognitive theory, an individual is both a member of the social system they live in and a determinant of the continuity of that system (Middleton et al., 2019).

Understanding the perpetrators' stigmatising and discriminatory behaviours allowed the research to identify the social system in which stigma and discrimination were operating.

5.2.4 Facilitators of stigmas and discrimination

Figure 4 showed that the multiple HIV-related stigmas and discrimination were driven by the lack of comprehensive knowledge about HIV and AIDS, cultural beliefs and norms, moral judgment, and gender bias. Previous studies identified these factors as facilitators of HIV-related stigma and discrimination (Fauk, Ward, Hawke & Mwanri, 2021; Logie et al., 2018).

Understanding the facilitators of stigma and discrimination was crucial in determining the theory that assisted the research in conceptualising and identifying the relevant concepts of the model.

5.2.5 Self-mitigating strategies against stigmas and discrimination

Figure 4 describes the mitigating strategies women living with HIV in rural Zimbabwe use to deal with stigma and discrimination. They mainly use cognitive avoidance and social withdrawal to mitigate the impacts of stigmas and discrimination on their life. The Oxford dictionary defines mitigation as the action of reducing the severity, seriousness, or painfulness of something (Oxford English Dictionary). Authors agreed that efforts to mitigate stigma and discrimination among women living with HIV and AIDS should prevent the harmful impacts of HIV-related stigma and discrimination (Logie et al., 2018). Previous studies identified the mitigating strategies used by women living with HIV in rural Zimbabwe as being the standard measures used by people living with HIV to mitigate the impacts of stigmas and discrimination (Fauk, Ward, Hawke & Mwanri, 2021; Logie et al., 2018). The ineffectiveness of these interventions is also documented in the literature (Mhode & Nyamhanga, 2016; Parcesepe et al., 2018; NAC, 2014; Rao et al., 2019; UNAIDS, 2014).

Understanding the mitigating strategies was important in selecting concepts that could enhance the self-efficacy of women living with HIV to respond to the impacts of stigma and discrimination adequately. In Social cognitive theory, self-efficacy is essential in learning and skill acquisition (Middleton et al., 2019).

5.3 DESIGN AND DESCRIPTION OF THE MODEL

5.3.1 The Context

The ineffective government efforts to mitigate stigma and discrimination against women living with HIV have led to the development of this model. The model mitigates stigma and discrimination against women living with HIV in rural Zimbabwe. It is based on their understanding of being a woman living with HIV in rural Zimbabwe.

Since the advent of antiretroviral drugs, there has been a significant reduction in the mortality rate due to HIV-related diseases and improved quality of life for people living with HIV. This gain seems to be eroded by stigma and discrimination, compromising the fight against HIV and AIDS (UNAIDS, 2018). Women living with HIV in rural Zimbabwe are more affected by stigma and discrimination than women living with HIV in urban areas (Wirawan, 2019).

Evidence from this study confirmed that women living with HIV in rural Zimbabwe experience multiple HIV-related stigmas and discrimination that negatively impact their social status, life quality, and capabilities to ascertain themselves as human beings and full members of the communities that they live. These stigmatising and discriminatory behaviour are driven by factors in the social systems and perpetrated by significant others. Consequently, women living with HIV in rural Zimbabwe are constantly struggling to mitigate the impacts of these negative behaviors on their social life and wellbeing.

5.3.2 Basic assumption guiding the model

According to the literature, a model is a purposeful representation of reality with a narrow scope and often more objective, commonly applied to a particular aspect of a specific theory, proving a more local description or understanding of a phenomenon (Fried, 2020). Researchers use models to provide an objective structure of how they view a phenomena/situation/event (Chinn & Kramer, 2013:157; Kgole, 2009:16).

From the understanding of the empirical foundation as illustrated in Figure 4 and discussed in Section 5.2, the researcher assumed that HIV related stigma and discrimination against women living with HIV in rural Zimbabwe is a learned behaviour rooted in the interplay between the accumulated social experiences and cognitive responses within the social system that they live. With this understanding, the researcher decided to use the social cognitive theory as a framework to conceptualise the intended model.

Social cognitive theory (SCT) explains how individuals within social systems use multiple human processes, including knowledge, information acquisition, and adoption (Middleton et al., 2019). As a social learning theory, SCT recognises the role of interactions between social and cognitive learning factors as determinants of behaviour (Palsdottir,

2013). From the perspective of social cognitive theory, behaviour is the outcome of the interactions between social and cognitive factors (Middleton et al., 2019).

5.3.3 Overall purpose of the model

As stated in Chapter 1, the purpose of this study was to propose an evidence-based model for mitigating stigma and discrimination against women living with HIV in rural Zimbabwe based on the understanding of being a woman living with HIV in the rural context of Zimbabwe. However, the overall purpose of this model is to guide interventions aimed at mitigating stigma and discrimination against women living with HIV in rural Zimbabwe through behavioural change.

5.3.4 Identification of concepts

Based on the above empirical understanding, the researcher believed that the concepts of an evidence-based model for mitigating stigma and discrimination against women living with HIV in rural Zimbabwe should consider the facilitators of stigma and discrimination, the social systems in which stigma and discrimination operate, and the capabilities of the women living with HIV.

The above understanding allowed the researcher to select the following four key concepts of the model:

1. Positive social behaviour
2. Supportive social systems
3. Reinforcement of self-efficacy
4. Readiness for change

Owing to the social cognitive theory, the researcher argued that the learning process should be central to a model for mitigating stigma and discrimination against women living with HIV in the social context of rural Zimbabwe. According to the social cognitive theory (Middleton et al., 2019), learning is a social process that involves a dynamic and reciprocal interaction of the person (with a set of learned experiences), the environment (external social context), and the behaviour (responses to stimuli to achieve goals).

5.3.5 Definition of concepts

Table 3 provides a summary of the definition of each concept.

5.3.5.1 Positive social behaviour

The concept of positive social behaviour refers to any social cognitive action/intervention aimed at changing the attitude and behaviour of significant others toward women living with HIV in rural Zimbabwe.

Positive social behaviour corresponds to the reinforcement construct of the social learning theory. Reinforcement as a construct is closely linked to the reciprocal relationship between behaviour and environment. Social cognitive theory refers to the internal or external responses to a person's behaviour that affect the likelihood of continuing or discontinuing the behaviour (Bandura, 2002).

5.3.5.2 Supportive social systems

The concept of positive social systems refers to any social cognitive action/intervention aimed at changing factors that drive HIV-related stigmas and discrimination in the community and increasing access to resources required to create a supportive social environment for women living with HIV in rural Zimbabwe.

Supportive social systems correspond to the behavioural capability construct of the social cognitive learning theory. In social learning theory, the construct behavioural capabilities refer to the actual ability of an individual to perform a behaviour through knowledge and skills (Bandura, 2002).

5.3.5.3 Enhancing self-efficacy

Enhancing self-efficacy as a concept refers to any social cognitive action/intervention aimed at building the confidence and capabilities of women living with HIV to control the impacts of stigma and discrimination on their quality of life.

Enhancing self-efficacy corresponds to the self-efficacy construct of the social cognitive learning theory. In social learning theory, self-efficacy refers to an individual's confidence level in their ability to perform a behaviour successfully. It is influenced by individual capabilities, other individual factors, and the environmental factors that may inhibit or facilitate the performance of a given behaviour (Bandura, 2002).

5.3.5.4 Readiness for change

Readiness for change as a concept refers to any social cognitive action/intervention aimed at correcting the impacts of accumulated stigma and discrimination and fostering the benefits of eliminating stigma and discrimination against women living with HIV and the social systems in the communities.

Readiness for change corresponds to the construct of expectations in the social cognitive theory. According to the theory, individuals anticipate the consequences or outcomes of their actions before engaging in the behaviour, and these consequences expected can influence the successful completion of the behaviour. The expectation in social cognitive theory refers to the anticipated results of a person's behaviour (Bandura, 2002).

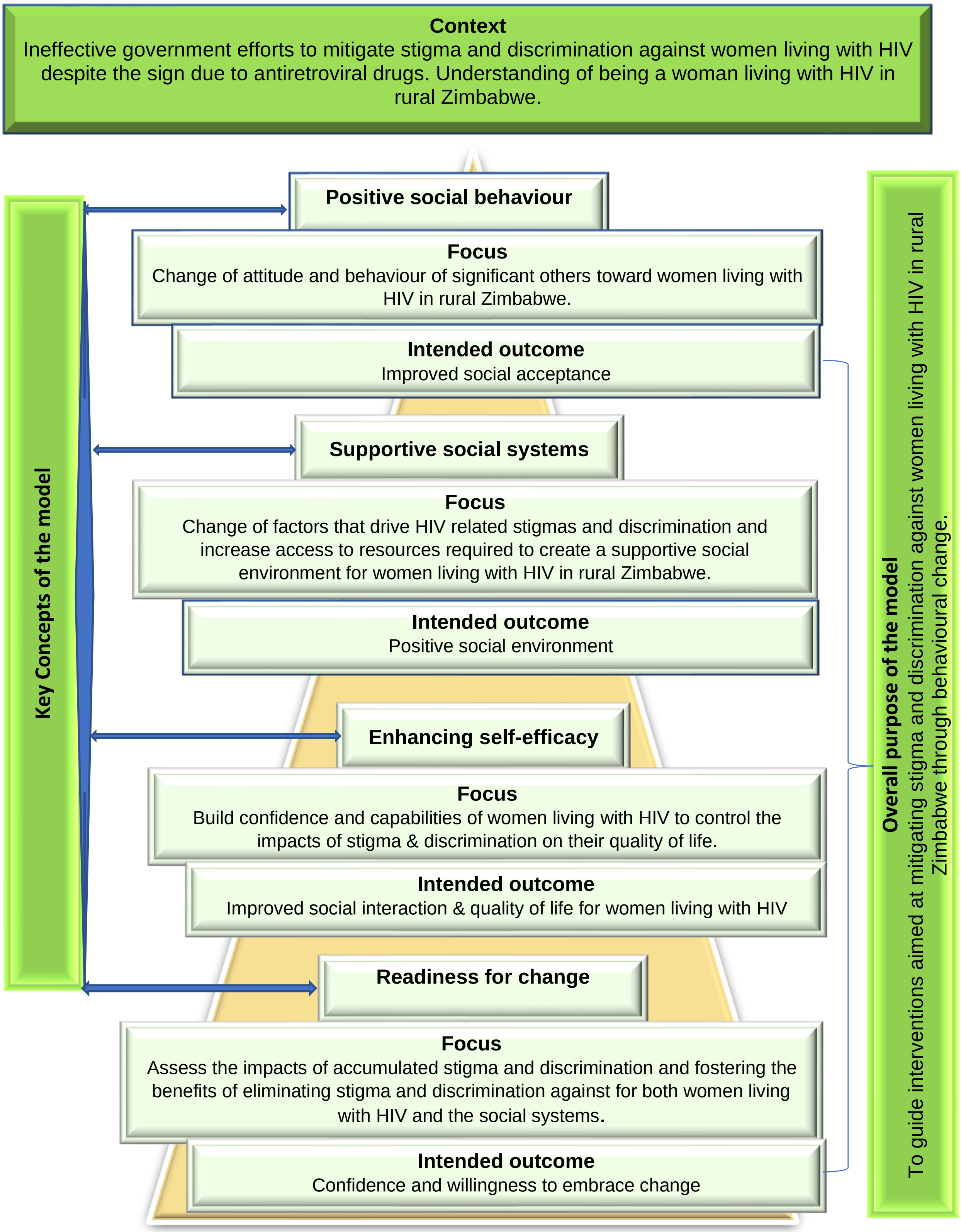
The social cognitive theory differentiates expectations from expectancies. Although both are derived from past experiences, expectations primarily depend on previous experiences. At the same time, expectancies are subjective to the individual and focus on the value placed on the outcome of a behaviour (Middleton et al., 2019).

Table 3: Summary of the key concepts

Key Concepts	**Definition**
Positive social behaviour	It refers to any social cognitive action/intervention aimed at changing the attitude and behaviour of significant others toward women living with HIV in rural Zimbabwe.
Supportive social systems	It refers to any social cognitive action/intervention aimed at changing factors that drive HIV-related stigmas and discrimination and increasing access to resources required to create a supportive social environment for women living with HIV in rural Zimbabwe.
Enhancing self-efficacy	It refers to any social cognitive action/intervention aimed at building the confidence and capabilities of women living with HIV to control the impacts of stigma and discrimination on their quality of life.

Readiness for change	It refers to any social cognitive action/intervention aimed at assessing the impacts of accumulated stigma and discrimination and fostering the benefits of eliminating stigma and discrimination against both women living with HIV and the social systems in the communities.

5.3.6 Structure of the model



Context
Ineffective government efforts to mitigate stigma and discrimination against women living with HIV despite the sign due to antiretroviral drugs. Understanding of being a woman living with HIV in rural Zimbabwe.

Key Concepts of the model

Positive social behaviour

Focus
Change of attitude and behaviour of significant others toward women living with HIV in rural Zimbabwe.

Intended outcome
Improved social acceptance

Supportive social systems

Focus
Change of factors that drive HIV related stigmas and discrimination and increase access to resources required to create a supportive social environment for women living with HIV in rural Zimbabwe.

Intended outcome
Positive social environment

Enhancing self-efficacy

Focus
Build confidence and capabilities of women living with HIV to control the impacts of stigma & discrimination on their quality of life.

Intended outcome
Improved social interaction & quality of life for women living with HIV

Readiness for change

Focus
Assess the impacts of accumulated stigma and discrimination and fostering the benefits of eliminating stigma and discrimination against for both women living with HIV and the social systems.

Intended outcome
Confidence and willingness to embrace change

Overall purpose of the model
To guide interventions aimed at mitigating stigma and discrimination against women living with HIV in rural Zimbabwe through behavioural change.

Figure 5: Evidence-based model for mitigating stigma and discrimination against women living with HIV in rural Zimbabwe

5.3.6 Relationships between concepts

The proposed evidence-based model for mitigating stigma and discrimination against women living with HIV in rural Zimbabwe should be viewed as a social cognitive model. Although the model was primarily designed to guide interventions at mitigating stigma and discrimination against women living with HIV in rural Zimbabwe, it can also be used to explain stigma and discrimination against women living with HIV in rural Zimbabwe.

According to the proposed model, stigma and discrimination against women living with HIV in rural Zimbabwe is a social cognitive learned behaviour deriving from the interplay between people's accumulated negative social experiences and knowledge about HIV, social systems that perpetuate stigma and discrimination, the inability of women living with HIV to control the impact of stigma, and people's fear and unwillingness to adopt new behaviours.

The model, as illustrated in Figure 5, showed that interventions aimed at mitigating stigma and discrimination against women living with HIV in rural Zimbabwe should be based on the beneficiaries' readiness to change, enhancing the self-efficacy of the HIV-positive women, creating supportive social systems, and building positive behaviour among significant others. The researcher believed that an effective intervention should consider all these four concepts.

Readiness for change forms the basis of the model. It prepared beneficiaries to build confidence and willingness to embrace change through the assessment of the impacts of previous accumulated stigma and discrimination and fostering the benefits of eliminating stigma and discrimination against women living with HIV and the community's social systems. According to social cognitive theory, people anticipate the consequences of their actions before engaging in a particular behaviour, and these consequences expected can influence the successful completion of the behaviour (Bandura, 2002). Since these expectations derive primarily from people's previous accumulated experiences, the model views this concept as the basis of any effective intervention informed by this model.

Enhancing self-efficacy is interlinked with the other concepts. Its use will improve women living with HIV's social interaction with others and their quality of life. It can be achieved through building their confidence and capabilities to control the impacts of stigma and discrimination on their quality of life. According to the social cognitive theory, self-efficacy is viewed as people’s beliefs in their capabilities to exercise control over their own functioning. In this model, the success of the intervention aimed at mitigating stigma and discrimination should enhance the self-efficacy of the women living with HIV.

Supportive social systems provide an environment conducive to change by focusing interventions on factors that drive HIV-related stigmas and discrimination and increasing access to resources required to create a supportive social environment for women living with HIV in rural Zimbabwe. These factors are strongly linked to the behaviour displayed by significant others. In social cognitive theory, the environment in which a behaviour occurs is vital in facilitating a particular behavior's performance or performance (Bandura, 2000). Increasing social support is documented as a measure for mitigating the impacts of stigma on mental health (Busza et al., 2018; Logie et al., 2018). Studies Galvan, Davis, Banks, and Bing (2008); Li et al., (2017) on the impact of social support among People Living with HIV and AIDS assert that People Living with HIV and AIDS who receive ongoing social support are more likely to experience a higher quality of life and a greater sense of self-esteem.

Positive behaviour of significant others toward women living with HIV will lead to less stigmatising and discriminatory behaviour, and consequently to social acceptance. From the perspective of social cognitive theory, it is argued that individuals do not behave randomly. Still, they strive to conform to the expectations of significant others and the social norms set as standards or rules that provide the accepted standards of behaviour in a particular social group or culture (McLeod, 2008).

5.4 CONCLUSION

Chapter 5 described and discussed the findings of Phase 2. It included the empirical foundation of the model and the design and description of the evidence-based model for mitigating stigma and discrimination against women living with HIV in rural Zimbabwe. The proposed model was described and discussed in terms of the context, the basic assumptions, the overall purpose, identification and definition of concepts, and the structure and relationships between the concepts.

CHAPTER 6

CONCLUSION, RECOMMENDATIONS, AND LIMITATIONS

6.1 CONCLUSION

As stated in Chapter 1, the purpose of this study was to propose an evidence-based model for mitigating stigma and discrimination against women living with HIV in rural Zimbabwe based on the understanding of being a woman living with HIV in the rural context of Zimbabwe. The above purpose was achieved through three objectives, which were (1) to explore and describe the lived experiences of women living with HIV in the rural context of Zimbabwe; (2) to explore and describe the meaning of women living with HIV in rural Zimbabwe attached to their lived experiences; (3) to design and describe an evidence-based model for mitigating stigma and discrimination against women living with HIV in the rural context of Zimbabwe.

The researcher used social constructivism as a philosophical foundation to guide the study. The study in two phases using a qualitative approach. Phase 1 focused on the first two objectives of the study. Phase 2 addressed the last objective of the study. The researcher followed the common six steps used in public health to develop models and the criteria of model evaluation described by Chinn and Kramer (2013:235–248) as a framework to guide the model development process.

In Phase 1, the researcher used a hermeneutics phenomenology design. Qualitative meta-analysis and theoretical triangulation were used as designs in Phase 2.

Two frameworks emerged from the results of Phase 1. There were illustrated in Figure 1 and Figure 2. In Phase 2, the researcher used the findings of Phase 1 to propose a framework for understanding being a woman living with HIV in rural Zimbabwe (see Figure 4), which serves as a baseline to inform the initial step of the model design. The evidence-based model for mitigating stigma and discrimination against women living with HIV in Zimbabwe is illustrated in Figure 5. Although primarily developed to guide interventions aimed at mitigating stigma and discrimination against women living with HIV in rural Zimbabwe, the model can also be used to explain stigma and discrimination against these women in the context of rural Zimbabwe.

6.2 RECOMMENDATIONS

Implementing the proposed model can mitigate stigma and discrimination against women living with HIV in rural Zimbabwe and improve their social acceptance and quality of life in the community where they live.

The model has implications for public health policymakers, public health professionals, health sciences education, and further research.

6.2.1 Public health policymakers

Public health policymakers could use the model to strengthen current efforts to mitigate stigma and discrimination by:

1. Initiating the review of the current programmes to include specific strategies related to the lived experiences of women living with HIV in rural areas.

2. Supporting the development of a need-based capacity-building training package for communication for behavioural change with a specific focus on HIV-related stigma and discrimination.

3. Including community opinion leaders in the national programmes for the fight against HIV related stigma and discrimination.

4. Advocating for financial assistance to support women living with HIV to further their studies

5. Advocating for resources to support women living with HIV in rural areas.

6. Sponsoring research for developing intervention packages based on the proposed model.

7. Strengthening policies to fight HIV-related stigma at public and private institutions.

6.2.2 Public health professionals

Public health professionals should support efforts to mitigate stigma and discrimination at community levels by:

1. Increasing awareness about general knowledge about HIV and AIDS.
2. Offering social cognitive training to community-based organisations, community leaders, and community health workers
3. Organising frequent social and interpersonal skills training for healthcare professionals working with women living with HIV.
4. Advocating and mobilising additional resources (human and financial) to strengthen community support groups for people living with HIV

6.2.3 Health sciences education institutions

Health sciences education institutions should facilitate the fight against HIV related stigma and discrimination by:

1. Paying more attention to the mechanisms and impacts of stigma and discrimination.
2. Including social cognitive skills training into the relevant training modules.
3. Reinforcing the importance of social support for improving the quality of life of people living with HIV
4. Stressing gender issues and the right to health care as human rights issues.
5. Reinforcing the importance of social and interpersonal skills in mitigating HIV-related stigma and discrimination.

6.2.4 Further research

Further research is needed to:

1. Develop an assessment tool for readiness for change.
2. Develop a framework to operationalise the proposed model.
3. Conduct a big-scale study to explore the mitigation strategies women living with HIV use to mitigate HIV-related stigma and discrimination.

6.3 LIMITATIONS

The model is based on the lived experiences of women living in rural Zimbabwe; however, the researcher did not interview all the rural women living with HIV in Zimbabwe. The researcher is aware that the socio-economic conditions for the Ndebeles in Matabeleland South might differ from that of rural women in Harare or any other province in Zimbabwe.

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Yuh, J.N., Ellwanger, K., Potts, L., and Ssenyonga, J., 2014. Stigma among HIV/AIDS patients in Africa: a critical review. *Procedia-Social and Behavioural Sciences*, *140*, pp.581-585.

Ziersch, A., Walsh, M., Baak, M., Rowley, G., Oudih, E. and Mwanri, L., 2021. “It is not an acceptable disease”: A qualitative study of HIV-related stigma and discrimination and impacts on health and wellbeing for people from ethnically diverse backgrounds in Australia. *BMC Public Health*, *21*(1), pp.1-15.

APPENDIX 1A: INDIVIDUAL INTERVIEW GUIDE

Date of the Interview ____
Duration: ____
Age: ___________________________________
Marital status: _____________________________
Number of years living with HIV: ___________________________________
Language used for facilitation: _____________________________

Grand tour question

Tell me about your life experiences as women living with HIV in this village.

Probing questions

Focused on seeking information about significant events/situations that illustrate their experiences and how they responded to this events/situation

THANK YOU

APPENDIX 1b: FOCUS GROUP SCHEDULE

Date of the FGD: ___________________________________
Duration: ____
Number of participants: _______________________________
Language used for facilitation: ___________________________

Grand tour question

What does it mean to you as a woman living with HIV in this village?

Probing questions

Focused on the lived experiences that emerged from the individual in-depth face to face interviews

THANK YOU

APPENDIX 2: INFORMATION SHEET

Title of Study: MODEL FOR MITIGATING STIGMA AND DISCRIMINATION AGAINST WOMEN LIVING WITH HIV IN RURAL ZIMBABWE

What is the research about?

This research is being conducted by Limkle Mpofu, a Doctoral student at the University of South Africa. You are invited to participate in this research because you are a woman living with HIV in the rural areas of Zimbabwe. The purpose of the study is to propose an evidence-based model for mitigating stigma and discrimination against women living with HIV in rural Zimbabwe based on the understanding of being woman living with HIV in the rural context of Zimbabwe.

This study is for academic purposes.

What will I be asked to do if I agree to participate?

You will be invited to participate either in a group discussion with other women living with HIV or in a face-to-face individual interviews (with the researcher at your own convenience. During these interviews, you will be given the opportunity to share your personal opinions and views regarding your life as a woman living with HIV in rural Zimbabwe. The interviews (Focus groups or individuals) will not take more than 90 minutes. The interviews will be conducted by the researcher. The interviews will be audio-recorded, and notes will also be taken in order to allow the researcher to analyze and write the final report for the study. The recorded data would be kept for a maximum of five years.

Would my participation in this study be kept confidential?

The information you will share with the researcher or fieldworker will be kept confidential as much as possible. Your name or address is not required. The tape will be locked away by the researcher for a period of three years. No individual names or identity will be used in the report. Should an article be written about this research project, **your identity will not be disclosed.**

What are the risks of this research?

There are no known risks associated with your participation in this research. However, you have the right to refuse to answer any question that makes you feel uncomfortable.

In case you prefer the interview to be held outside of your house, the researcher will cover your transport cost and will supply you with refreshment.

What are the benefits of this research?

This research will not have any monetary benefit to you as a participant. However, your experiences will assist the researcher to make recommendation for improvement in the fight against HIV related stigma and discrimination. Your participation will contribute to the learning process of the researcher.

Do I have to be in this research, and may I stop participating at any time?

Your participation in this research is completely voluntary. You may choose not to take part in the research. You may choose to withdraw your participation at any time should you decide to participate in the research, and you will not be penalized or lose any benefits which you otherwise qualify for.

What if I have questions?

If you have any questions about the study itself, please contact me (LIMKILE Mpofu) on Telephone: +26377816v4839. Should you wish to report any problems you have experienced in relation to the study, please contact Prof Makombo Ganga-Limando, the Research Supervisor on Tel number: +27-(12)-4294131 or E-mail: gangam@unisa.ac.za. You can also contact the chairperson of the Department of Health Studies Research Ethics Committee, Prof J Maritz on Tel: +27 12 4296534 or email: maritje@unisa.ac.za

Would I be compensated for my time?

You would be provided with water and snacks to compensate you for your time.

APPENDIX 3: INFORMED CONSENT

Declaration by the participant

I .... voluntarily consent to participate in the above-mentioned research project. The background, purpose, risks, and benefits of the study have been explained to me. I also understand that I may withdraw from the study at any time without consequences. I understand that my participation in the study will be acknowledged, although my identity and the identity of the health facility will be withheld. I agree to be audiotaped during my participation in this study. I understand that my participation in the study is voluntary.

………………………. ……………………..

Participants' signature Date

....

Witness Date

Declaration by the facilitator

I, L Mpofu declare that:

- I explained the information in this document.
- I encouraged her to ask questions and took adequate time to answer them.
- I am satisfied that she adequately understands all aspects of the research, as discussed above.
- I did/did not use an interpreter. (*If an interpreter is used, then the interpreter must sign the declaration below.*

Signature of investigator **Date**

Declaration by the interpreter

I certify that the nature and purpose, potential benefits, and possible risks associated with participating in this research have been explained to the participant. All questions were answered, and the participant has agreed to participate in the research study.

Signature of interpreter **Date**

APPENDIX 4: CONFIDENTIALITY BINDING FOR FGD

This confidentiality binding agreement is between **L Mpofu (**Facilitator/Principal Investigator) and the participants of the Focus Group Interviews:

We, participants of the FGI facilitated by **L Mpofu** agree to strictly adhere to the following:

1. To freely express our opinions and views during the group discussions
2. To show respect for each other views
3. Not to share the views and opinions of individual members to other people outside of the group.

The facilitator **(L Mpofu)** has agreed to the following:

1. To respect the views and opinions of the members
2. Translated and transcribed data would be verbatim without the researcher's biases concerning the issue under discussion.
3. Data in the form of transcripts and audiotapes would be kept under lock and key.
4. Electronic (Soft) copies of data would be kept on her personal computer and that of her research supervisor with passwords.
5. Data would be kept for at least five years before they would be discarded.
6. During the publication of data, members' real names would not be reported to protect their identity.

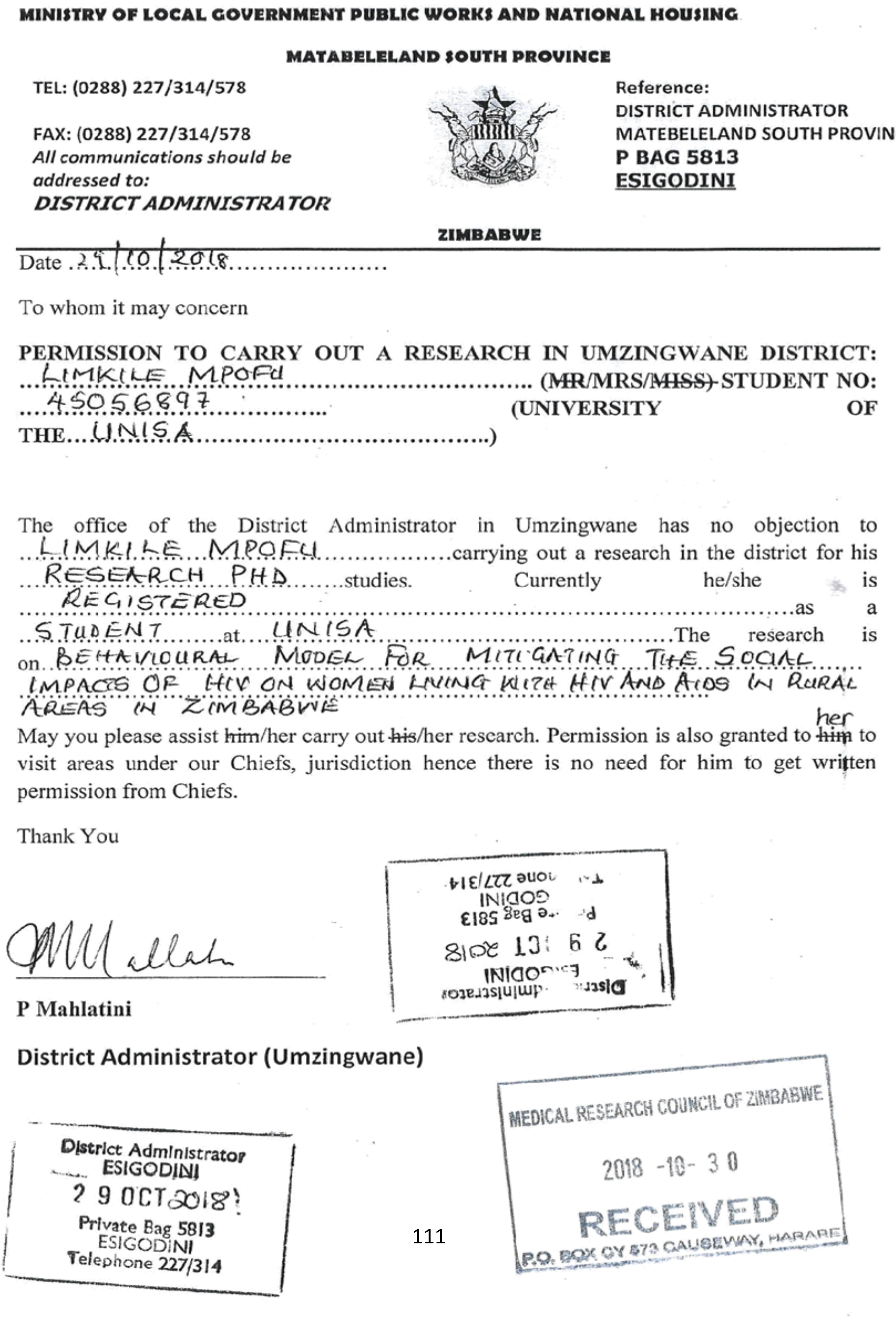
……………………………… ______________________

Signature of investigator **Date**

……………………………… ______________________

Signature of participant **Date**

APPENDIX 5: LETTER OF PERMISSION



MINISTRY OF LOCAL GOVERNMENT PUBLIC WORKS AND NATIONAL HOUSING

MATABELELAND SOUTH PROVINCE

TEL: (0288) 227/314/578

FAX: (0288) 227/314/578
All communications should be addressed to:
DISTRICT ADMINISTRATOR

Reference:
DISTRICT ADMINISTRATOR
MATEBELELAND SOUTH PROVINCE
P BAG 5813
ESIGODINI

ZIMBABWE

Date ..25/10/2018....................

To whom it may concern

PERMISSION TO CARRY OUT A RESEARCH IN UMZINGWANE DISTRICT: ...LIMKILE MPOFU.. (~~MR~~/MRS/~~MISS~~) STUDENT NO: ...45056897..................... (UNIVERSITY OF THE...UNISA..)

The office of the District Administrator in Umzingwane has no objection to ...LIMKILE MPOFU.................carrying out a research in the district for his ...RESEARCH PHD.......studies. Currently he/she is ...REGISTERED...as a ...STUDENT.........at...UNISA......................................The research is on..BEHAVIOURAL MODEL FOR MITIGATING THE SOCIAL IMPACTS OF HIV ON WOMEN LIVING WITH HIV AND AIDS IN RURAL AREAS IN ZIMBABWE

May you please assist ~~him~~/her carry out ~~his~~/her research. Permission is also granted to ~~him~~ her to visit areas under our Chiefs, jurisdiction hence there is no need for him to get written permission from Chiefs.

Thank You

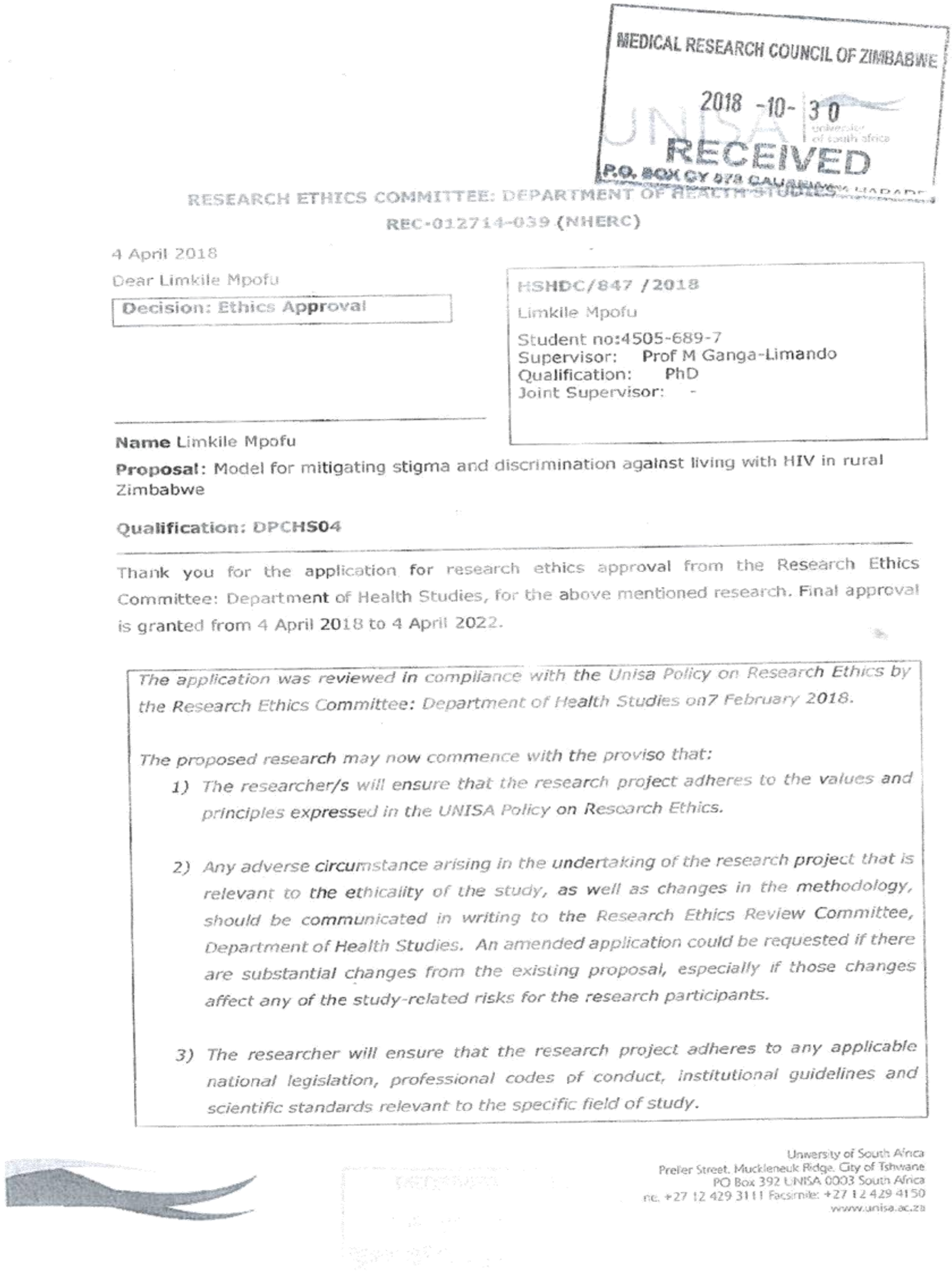
P Mahlatini

District Administrator (Umzingwane)

District Administrator
ESIGODINI
29 OCT 2018
Private Bag 5813
ESIGODINI
Telephone 227/314

MEDICAL RESEARCH COUNCIL OF ZIMBABWE
2018 -10- 30
RECEIVED
P.O. BOX CY 573 CAUSEWAY, HARARE

APPENDIX 6: ETHICAL CLEARANCE CERTIFICATE-UNISA



MEDICAL RESEARCH COUNCIL OF ZIMBABWE
2018 -10- 30
RECEIVED
P.O. BOX CY 573 CAUSEWAY, HARARE

RESEARCH ETHICS COMMITTEE: DEPARTMENT OF HEALTH STUDIES
REC-012714-039 (NHERC)

4 April 2018

Dear Limkile Mpofu

Decision: Ethics Approval

HSHDC/847 /2018
Limkile Mpofu
Student no:4505-689-7
Supervisor: Prof M Ganga-Limando
Qualification: PhD
Joint Supervisor: -

Name Limkile Mpofu

Proposal: Model for mitigating stigma and discrimination against living with HIV in rural Zimbabwe

Qualification: DPCHS04

Thank you for the application for research ethics approval from the Research Ethics Committee: Department of Health Studies, for the above mentioned research. Final approval is granted from 4 April 2018 to 4 April 2022.

The application was reviewed in compliance with the Unisa Policy on Research Ethics by the Research Ethics Committee: Department of Health Studies on7 February 2018.

The proposed research may now commence with the proviso that:

1) *The researcher/s will ensure that the research project adheres to the values and principles expressed in the UNISA Policy on Research Ethics.*
2) *Any adverse circumstance arising in the undertaking of the research project that is relevant to the ethicality of the study, as well as changes in the methodology, should be communicated in writing to the Research Ethics Review Committee, Department of Health Studies. An amended application could be requested if there are substantial changes from the existing proposal, especially if those changes affect any of the study-related risks for the research participants.*
3) *The researcher will ensure that the research project adheres to any applicable national legislation, professional codes of conduct, institutional guidelines and scientific standards relevant to the specific field of study.*

University of South Africa
Preller Street, Muckleneuk Ridge, City of Tshwane
PO Box 392 UNISA 0003 South Africa
Telephone: +27 12 429 3111 Facsimile: +27 12 429 4150
www.unisa.ac.za

4) *You are required to submit an annual report by 30 January of each year that the study is active. Reports should be submitted to the administrator, HSREC@unisa.ac.za. Should the reports not be forthcoming the ethical permission might be revoked until such time as the reports are presented.*

Note:
The reference numbers [top middle and right corner of this communiqué] should be clearly indicated on all forms of communication [e.g. Webmail, E-mail messages, letters] with the intended research participants, as well as with the Research Ethics Committee: Department of Health Studies.

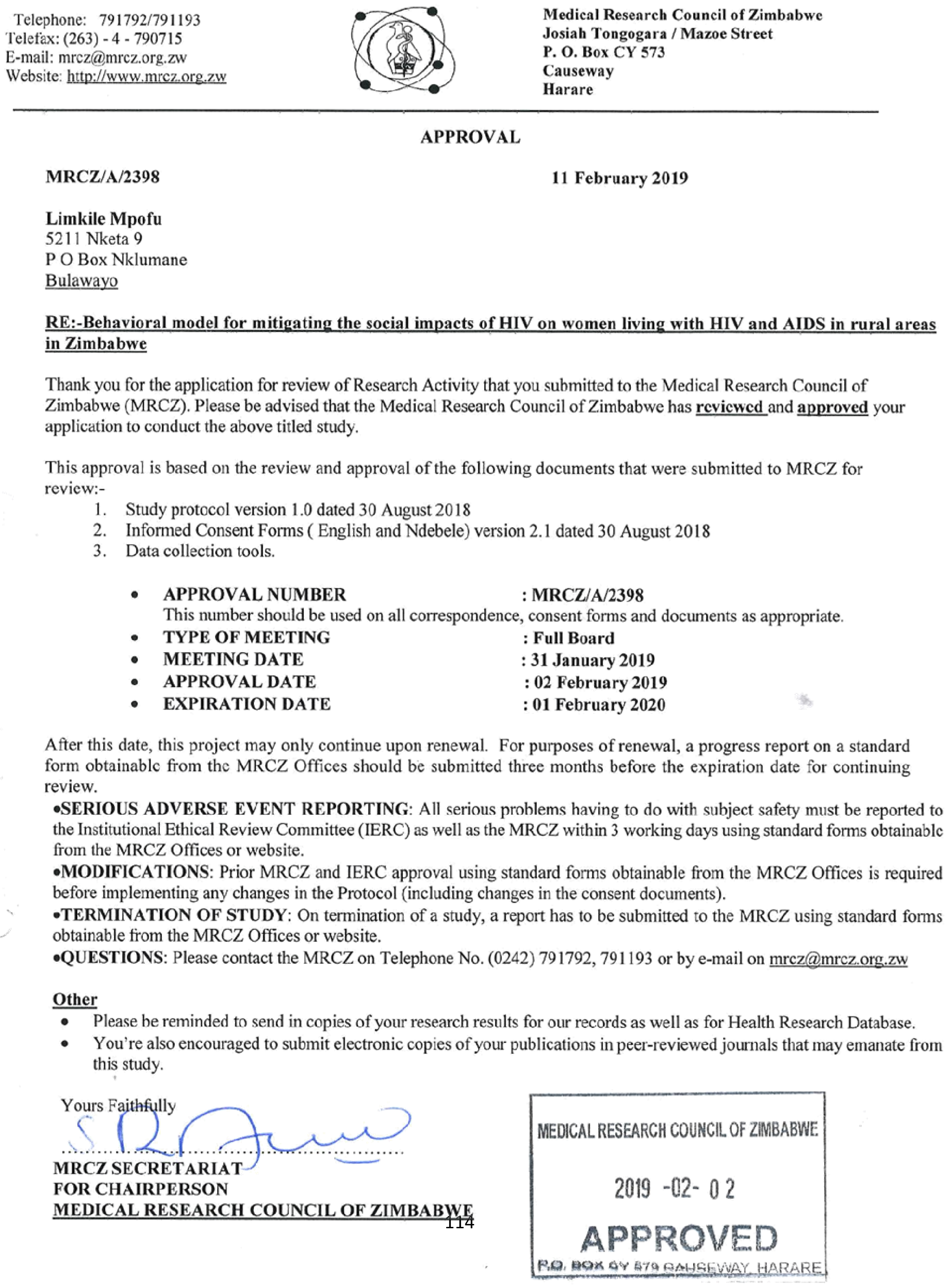
Kind regards,

Prof JE Maritz
CHAIRPERSON
maritje@unisa.ac.za

Prof LV Monareng
ACTING ACADEMIC CHAIRPERSON
monarlv@unisa.ac.za

Prof A Phillips
DEAN COLLEGE OF HUMAN SCIENCES

APPENDIX 7: ETHICAL CLEARANCE CERTIFICATE-ZIMBABWE



Telephone: 791792/791193
Telefax: (263) - 4 - 790715
E-mail: mrcz@mrcz.org.zw
Website: http://www.mrcz.org.zw

Medical Research Council of Zimbabwe
Josiah Tongogara / Mazoe Street
P. O. Box CY 573
Causeway
Harare

APPROVAL

MRCZ/A/2398 **11 February 2019**

Limkile Mpofu
5211 Nketa 9
P O Box Nklumane
Bulawayo

RE:-Behavioral model for mitigating the social impacts of HIV on women living with HIV and AIDS in rural areas in Zimbabwe

Thank you for the application for review of Research Activity that you submitted to the Medical Research Council of Zimbabwe (MRCZ). Please be advised that the Medical Research Council of Zimbabwe has **reviewed** and **approved** your application to conduct the above titled study.

This approval is based on the review and approval of the following documents that were submitted to MRCZ for review:-

1. Study protocol version 1.0 dated 30 August 2018
2. Informed Consent Forms (English and Ndebele) version 2.1 dated 30 August 2018
3. Data collection tools.

- **APPROVAL NUMBER** : **MRCZ/A/2398**
  This number should be used on all correspondence, consent forms and documents as appropriate.
- **TYPE OF MEETING** : **Full Board**
- **MEETING DATE** : **31 January 2019**
- **APPROVAL DATE** : **02 February 2019**
- **EXPIRATION DATE** : **01 February 2020**

After this date, this project may only continue upon renewal. For purposes of renewal, a progress report on a standard form obtainable from the MRCZ Offices should be submitted three months 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 Institutional Ethical Review Committee (IERC) as well as the MRCZ within 3 working days using standard forms obtainable from the MRCZ Offices or website.

•**MODIFICATIONS**: Prior MRCZ and IERC approval using standard forms obtainable from the MRCZ Offices is required before implementing any changes in the Protocol (including changes in the consent documents).

•**TERMINATION OF STUDY**: On termination of a study, a report has to be submitted to the MRCZ using standard forms obtainable from the MRCZ Offices or website.

•**QUESTIONS**: Please contact the MRCZ on Telephone No. (0242) 791792, 791193 or by e-mail on mrcz@mrcz.org.zw

Other

- Please be reminded to send in copies of your research results for our records as well as for Health Research Database.
- You're also encouraged to submit electronic copies of your publications in peer-reviewed journals that may emanate from this study.

Yours Faithfully

……………………………………………………

MRCZ SECRETARIAT
FOR CHAIRPERSON
MEDICAL RESEARCH COUNCIL OF ZIMBABWE

MEDICAL RESEARCH COUNCIL OF ZIMBABWE
2019 -02- 02
APPROVED
P.O. BOX CY 573 CAUSEWAY HARARE