LIVED EXPERIENCES OF STIGMA AND DISCRIMINATION AMONG PEOPLE ON ANTIRETROVIRAL THERAPY: A QUALITATIVE STUDY IN ILALA MUNICIPALITY, DAR ES SALAAM

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Master of Public Health Dissertation
Muhimbili University of Health and Allied Sciences
October, 2013

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By

Maisara Mhode

**A Dissertation submitted in partial fulfillment of the Requirement for the Degree of Master of Public Health of
Muhimbili University of Health and Allied Sciences**

**Muhimbili University of Health and Allied Sciences
October, 2013**

CERTIFICATION

The undersigned certifies that he has read and hereby recommends for acceptance by Muhimbili University of Health and Allied Sciences a dissertation entitled: ***Lived Experiences of Stigma and Discrimination among People on Antiretroviral Therapy: A Qualitative study in Ilala Municipality, Dar es Salaam***, in partial fulfillment of the requirements for the degree of Master of Public Health of Muhimbili University of Health and Allied Sciences

Dr. Tumaini M. Nyamhanga

(Supervisor)

Date

DECLARATION

AND

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I, **Maisara Mhode**, declare that, this **dissertation** is my own original work and that it has not been presented and will not be presented to any other university for similar or other degree award.

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ACKNOWLEDGEMENTS

Writing is generally a solitary task which requires peace of mind, time and cooperation of many individuals so as to convert their idea into a text.

First, I give glory to Almighty God for protecting, giving me strength and courage throughout the whole course. Without him, I wouldn’t have passed through all this difficult period and finally have this manuscript. For sure, I can do all things through Almighty Allah.

I would like to extend my sincere gratitude to the International Clinical Operations Health Research in Tanzania (ICOHRTA) for their sponsorship which enabled me to pursue my MPH course.

My heart felt thanks go to all members of accademic staff of the School of Public Health and Social Sciences, the Muhimbili University of Health and Allied Sciences, Dar es Salaam. It was from them that the foundation of this work grew.

My sincere thanks go to my supervisor, Dr. Tumaini Nyamhanga for his valuable assistance and tireless effort in directing me on writing this research. I have benefited immersely from him and he provided me the enthusiasm to complete this study.

My appreciation to my supportive husband Hassan I. Mwamwetta for being patient and understanding. He provided the support and encouragement that enabled me to finish the study. Special thanks go to my son, Hafidh H. Mwamwetta, my daughter Saum H. Mwamwetta and my mother Mrs. Maliasa Mussa Mhode who provided me with words of encouragement when I felt tired. Their encouragement really provided the fuel that powered me to complete this study.

I also wish to thank all staffs of Mnazi mmoja ART clinic for their support that enabled me to collect data that has made this manuscript complete.

I wish to express deep appreciation to the patients at Mnazi mmoja CTC for their willingness to participate, contribution of their experiences and time to this study. This work would not have been possible without their thoughts.

Lastly, I would like to thank all those who have not been mentioned by their names but in one way or another contributed to my success. May Almighty God bless you all.

DEDICATION

This work is dedicated to my husband Hassan I. Mwamwetta, my son Hafidh H. Mwamwetta, my daughter Saum H. Mwamwetta, the family of Mr. & Mrs. Juma Bakari Mhode and the family of Mr. & Mrs.Idd Mussa Mwamwetta for their love and tireless support which has immeasurably contributed to my success. Thank you for your prayers. May Almighty God bless you.

LIST OF ABBREVIATIONS

AIDS	Acquired Immune Deficiency Syndrome
ARV	Anti Retroviral
ART	Antiretroviral Therapy
CTC	Care and Treatment Clinics
HIV	Human Immune Virus
MUHAS	Muhimbili University of Health and Allied Sciences
PLHIV	People Living with HIV/AIDS
ICOHRTA	International Clinical Operations Health Research in Tanzania
VVU	Virusi Vya Ukimwi
WHO	World Health Organization
UNAIDS	Joint United Nations Programme on HIV and AIDS
IPPF	International Planned Parenthood Federation
ATLIS	AIDS Treatment for Life International Survey
MoHSW	Ministry of Health and Social Welfare
ICRW	International Centre for Research on Women

ABSTRACT

Background: There is little qualitative research on lived experiences of stigma and discrimination among the growing cohort of people in resource-limited settings who have had their health restored by Antiretroviral Therapy (ART).

Broad objective: To explore lived experiences of stigma and discrimination among people on antiretroviral therapy attending care and treatment clinic.

Methodology: This study employed a phenomenological approach. It took place at Mnazi mmoja Care and Treatment Clinic in Ilala Distict, Dar es Salaam Region. A total of 26 PLHIV who have been on ART for more than two months, aged 18 years old and above were interviewed. A non probability, purposive sampling method was employed. Data were collected through in-depth interviews. Interviews were audio recorded, transcribed verbatim, translated and analyzed using thematic analysis.

Results: The study found that, participants experienced different forms of HIV-related stigma such as verbal stigma, social stigma, and perceived stigma (fear of stigma associated with disclosing HIV status). Furthermore, the participants experienced various forms of discrimination, including: relational discrimination, mistreatment by health care workers, blame and rejection by spouses and workplace discrimination. It was also found that HIV related stigma and discrimination compromised ART adherence by reinforcing concealment of HIV status and undermining social suppport. The main coping mechanisms that emerged from participants' narrations included: spiritual devotion, becoming secretive; acceptance of the illness; seeking information and/or exchanging views about the illness; and pre-emptive disclosure.

Conclusions: After nearly a decade of scaling up provision of ART in Tanzania, PLHIV still experience various dimensions of stigma and discrimination – albeit to a smaller extent compared to the pre-ART era. Overall, this study has provided useful information for managers of HIV care and treatment services about the dimensions of stigma and discrimination and coping strategies being applied. This understanding will enable planning of supportive interventions.

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CHAPTER ONE: INTRODUCTION

1.1 Background information

Worldwide in 2011, approximately 34 million people were living with HIV of which 69% were from Sub-Saharan Africa and 1.6% from Tanzania. Nearly 30 million people have died of AIDS-related causes since the beginning of the epidemic. In 2011 alone, HIV/AIDS killed 1.7 million people, 1.2 million of whom were living in sub-Saharan Africa and 83,528 from Tanzania (WHO, 2011; UNAIDS, 2012; UNICEF, 2011-12).

AIDS-related stigma and discrimination have considerable influence on health and are recognized as a major confounding problem on people who are on ART, particularly in sub-Saharan Africa, where the burden of HIV/AIDS is so significant. Issues of stigma and discrimination are still poorly understood and often marginalized within national and international programs and responses. (UNAIDS, 2011)

The development of antiretroviral (ARV) medications in the late 1990s in developed countries altered the face of HIV/AIDS, transforming it from a fatal disease into a manageable chronic illness. This development resulted into dramatic reductions in morbidity and mortality. Despite the universal access of antiretroviral treatment, PLHIV experience stigma and discrimination throughout their life time. Studies showed that, HIV patients often experience a decline in quality of life due to factors other than disease stages.

The number of people accessing antiretroviral therapy (ART) globally continues to climb rapidly, and the target of reaching 15 million people with this life-saving treatment is within grasp. In the European Region, 199 000 people were receiving ART in 2012, 45% more than the 137 000 people in 2011. More than 9.7 million people living with HIV in low and middle income countries were receiving ART at the end of 2012 (represented 65% of that 15 million target, up from 54% at the end of 2010). This is over 30-fold increase in the number of people receiving ART in developing countries between 2003 and 2012, and close to a 20% increase in just one year (from 8 million in 2011 to 9.7 million in 2012). (WHO/UNICEF/UNAIDS 2013). However, people who have access to ART vary greatly between countries. In Africa for example, Botswana pioneered the provision of

ARVs , started its national treatment programme in January 2002 and had a coverage rate of around 93 percent. Other countries that have achieved more than 80 percent treatment coverage are Rwanda and Namibia.

Access to ART increased also in Western and Central Africa, where the number of people receiving ART increased by more than one fifth in Algeria, Benin, Cape Verde, Chad, Congo, Côte d'Ivoire, Gambia and Ghana in 2012 compared with 2011. **(**WHO/UNICEF/UNAIDS 2013). That is, in 2011**,** Cameroon, Côte d'Ivoire, Nigeria, Chad and Ghana were some of the countries in sub-Saharan Africa where between 20-39 percent of people requiring antiretroviral drugs were receiving them. Countries where treatment coverage was less than 19 percent included the Republic of Congo, Djibouti, Somalia and Madagascar. Access to treatment was extremely low in Somalia where it was estimated that only 878 people out of an estimated 25,000 individuals needing antiretroviral therapy were receiving it; a coverage of only 3 percent. (WHO/UNAIDS/UNICEF, 2011). South Africa's ART programme is the largest in the world, with about 2.2 million people on HIV treatment in 2012 – almost 450 000 more than in 2011.

In Tanzania, the Tanzania Commission for AIDS (TACAIDS) coordinates the nation's response to the HIV and AIDS epidemic. In 2004, the government began providing free ART to patients with CD4 counts less than 200 cells/uL or who were WHO stage 3 or 4. However, in 2010 change in WHO guidelines recommended that people living with HIV should start treatment at an earlier stage. The recommended CD4 count at which treatment should begin was changed from a CD4 count of <200 cells/mm3 to <350 cells/ mm3 (WHO/UNAIDS/UNICEF,2010). But again, in 2013, WHO changed the ARV guidelines and recommended initiating ART earlier – at CD4 count ≤500 cells/mm3– and immediately initiating ART for serodiscordant couples, pregnant women living with HIV, people with TB and HIV, people with HIV and hepatitis B, and children living with HIV who are younger than five years, irrespective of CD cell count. These changes underscore the need to intensify efforts globally to expand access to ART. Treatment also includes preventive and active treatment of opportunistic infections. Since that time there has been an increse in the number of care and treatment clinics (CTC) and the number of people on ART (The National Bureau of Statistics Tanzania and Macro, 2008: TACAIDS, 2012).

In June 2012 in Tanzania, the number of people on ART was 626,444 which is higher than the anticipated target of 440,000 by 2011 (MoHSW, 2012). Many believed that as more people gained access to ARV treatment, and as the disease itself was transformed, stigma and discrimination would decline. However, while there has been a great deal of success, still many people are becoming infected with HIV, getting sick and dying from AIDS and those who survive experience a decline in quality of life. Reasons of decline in quality of life, morbidity and mortality might have been contributed by stigma and discrimination.

The study done by Agnarson (2013) in Rural Tanzania which looked at sexual relationships and the stigma associated with anti-retroviral therapy found that, ART coverage increased during each year of the program (2005- 2010) for women over the age of 25 years, but decreased for men and those younger than 25 years. During the program, about 825 CTC were providing HIV care and treatment services in the country and the national adult ART coverage was at 42% (WHO/UNAIDS/UNICEF, 2011)

Subsequent researchers have viewed stigma and discrimination more as social processes that create or perpetuate social inequities. While this is generally true, stigma and discrimination can also be primal human response particularly in the case of fearing a disease that is transmissible and potentially incurable.

1.2. Statement of the problem

Studies have shown that HIV/AIDS related stigma and discrimination are still a major problem despite the increased access to ART in both developed and developing countries (UNAIDS 2008; IPPF, 2009; UNAID, 2010; South & Roura (2011), 2011; Hassan, 2011) That is, improving access to antiretroviral treatment may be a factor in reducing stigma, but it does not eliminate stigma altogether and does not lessen the fear of stigma and discrimination amongst HIV positive because the level of stigma and discrimination remains high (Wolfe, et al, 2008; Peltzer, 2012).

In Tanzania, the level of stigma and discrimination is also high according to some studies which have looked at the impact of increased access to HIV treatment. These studies (Makoae et al 2009; Evidence for Action 2011; UNAIDS 2012) have revealed that tens and thousands of Tanzanians become infected and die of AIDS every year despite the availability of effective treatment which has transformed HIV into a manageable condition. For example, according to the United Nations Aids day report 2012, Tanzanians who died of Aids-related deaths were 48,000.

Contrary to the assumptions by scholars and practitioners, access to ART has had no sufficient impact on stigma and discrimination reduction. Other factors contributing to stigma and discrimination among people on ART identified include cultural constructions, behaviours such as homosexuality, drug addiction, prostitution or promiscuity that are already unaccepted in many societies (Thi et al., 2008; Mbonu et al., 2009; UNAIDS 2010; Nachega et al., 2012). Consequently, stigma and discrimination can result into loss of hope and feelings of worthlessness, loss of marriage, loss of willingness to disclose HIV status, poor care within the health sector, loss of reputation, less social support solicited and received, and can affect mental health, physical health and can result into mortality risk (Najarkolaei et al., 2010).

Given the negative effects that stigma and discrimjnation pose on treatment uptake and general quality of life of the ART clients, a thorough understanding of how they are experienced is important. Nevertheless, most of studies on stigma among people on ART have used quantitative approach. Consequently, there is little qualitative research on lived experiences of stigma and discrimination among the growing cohort of people in resource-limited settings who have had their health restored by Antiretroviral Therapy (ART). This study has made a contribution towards addressing this gap.

1.3. Objectives

1.3.1 Broad objective

To explore lived experiences of stigma and discrimination among people on antiretroviral therapy in Ilala Municipality.

1.3.2 Specific Objectives

1. To describe forms of stigma experienced by people on antiretroviral therapy.
2. To describe forms of discrimination experienced by people on antiretroviral therapy
3. To describe how stigma affect adherence to antiretroviral therapy
4. To identify coping strategies against stigma and discrimination applied by people on antiretroviral therapy.

1.4. Research questions

1.4.1. Main research question

What are the lived experiences of stigma and discrimination among people on antiretroviral therapy?

1.4.2. Specific research questions

1. What are the forms of stigma experienced by PLHIV on antiretroviral therapy?
2. What forms of discrimination are experienced by PLHIV on antiretroviral therapy?
3. How does stigma affect adherence to antiretroviral therapy?
4. What are the coping strategies against stigma and discrimination among PLHIV on antiretroviral therapy?

1.5. Rationale of the study

This study is intended to explore lived experience of stigma and discrimination among people on antiretroviral therapy. Exploring lived experience of stigma among people on ART is vital as it will lead to evidence based interventions resulting to improve treatment outcomes. Hence, the study will provide evidence based recommendations to the program planners and managers who need a greater understanding of the relationship between HIV stigma, discrimination and ART from the perspective of their clients.

1.6. Operational definitions

1.6.1. Experiences as defined by online dictionary refer to the conscious events that make up an individual life i.e something personally encountered, undergone, or lived through.

1.6.2. Stigma has been defined as “an undesirable or discrediting attribute that an individual possesses, thus reducing that individual’s status in the eyes of society. It is a labeling of an individual or group as different or deviant (Goffman, 1963)

1.6.3. HIV/AIDS-related stigma is defined as an attribute or quality which “significantly discredits” PLHIV who are on ART in the eyes of family, community and health care providers. Importantly, stigma is a process. Within a particular culture or setting, certain attributes are seized upon and defined by others as discreditable or unworthy” (UNAIDS, 2002).

1.6.4. Discrimination as defined by Oxford dictionary refers to the practice of treating somebody or a particular group in society less fairly than others.

1.6.5. HIV/AIDS-related Discrimination as defined by UNAIDS (2003) refers to the unfair and unjust treatment of an individual based on his or her real or perceived HIV status. Discrimination occurs when a distinction is made against a person that results in being treated unfairly and unjustly on the basis of belonging, or being perceived to belong, to a particular group.

Discrimination is said to have occurred if an individual has reported to have been excluded, isolated, abandoned, lost job or goods or threatened because of their HIV status.

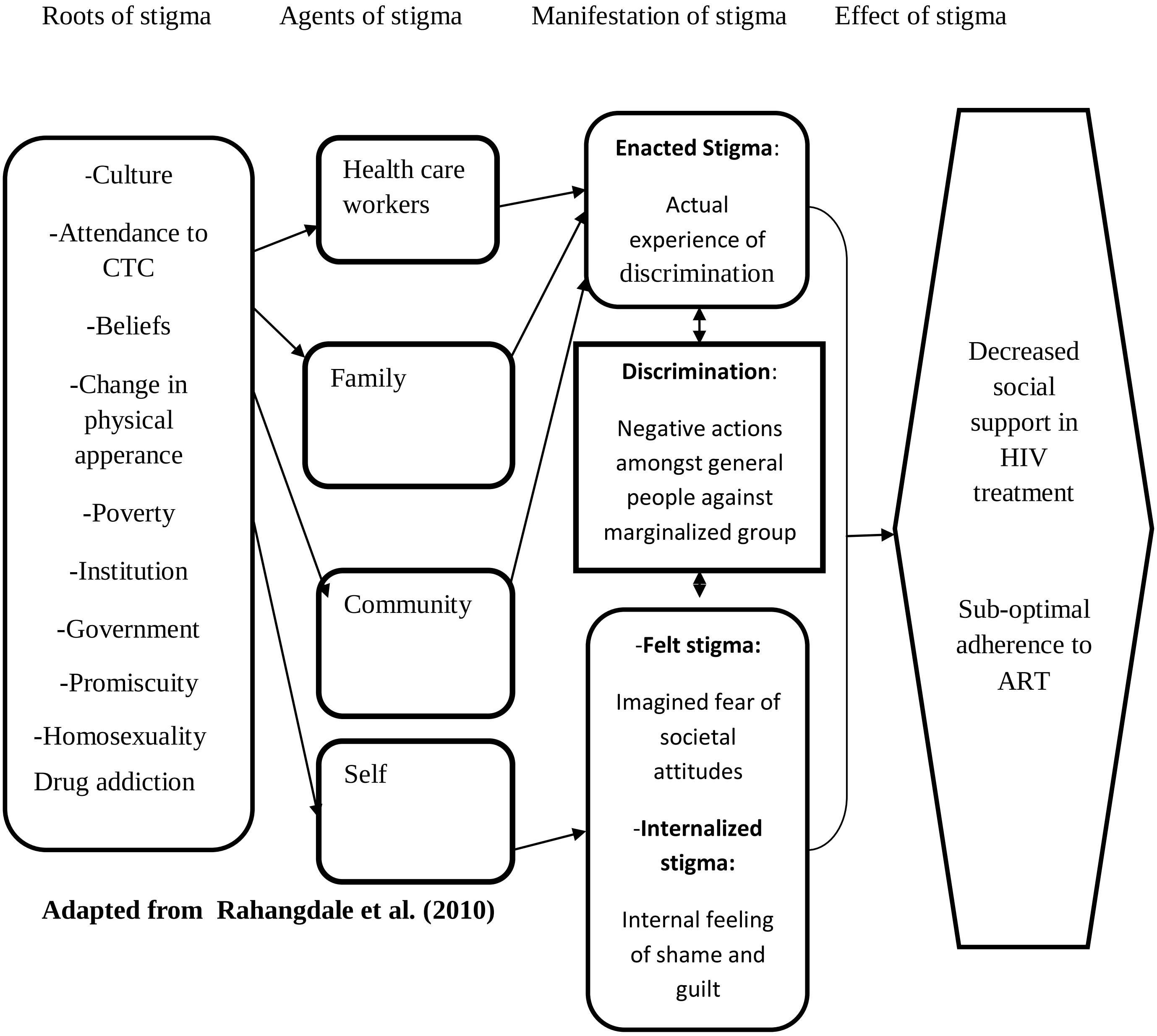
1.6.6. Antiretroviral Therapy (ART): Refers to multiple drugs that act on different viral targets that inhibit the replication of HIV /decreases the patient's total burden of HIV, maintains function of the immune system, and prevents opportunistic infections that often lead to death. (Wikipedia, the free encyclopedia, 2012)

1.6.7. The relationship and the difference between stigma and discrimination

Stigma and discrimination are two different aspects of the same response . That is, stigma and discrimination are interrelated, reinforcing and legitimizing each other. In other words, stigma lies at the root of discriminatory actions, leading people to engage in actions or omissions that harm or deny services or entitlements to others. Discrimination can be described as the enactment of stigma (stigma that one experiences from an external source). In turn, discrimination encourages and reinforces stigma. Researchers have viewed stigma as a social process that creates or perpetuates social inequities and which is used to legitimise discrimination.

It is vital to distinguish between what we call HIV/AIDS stigma (negative things people believe about HIV/AIDS and people living with HIV/AIDS), and what we call HIV/AIDS discrimination (what people do to unfairly disadvantage people living with HIV/AIDS). In addition, stigma does not always have to result in discrimination to have a negative impact and that discrimination can result from stigma but could also stem from other factors. Hence the cycle of experiences of HIV/AIDS related stigma can be broken before it is manifested or enacted in various kinds of discriminatory action.

1.7. A Theoretical framework*:* Lived experiences of stigma and discrimination among people on Antiretroviral Therapy.



Adapted from Rahangdale et al. (2010)

Description of components of the framework

The framework assumes that HIV stigma and discrimination begin at the societal level where inequalities in social, political, and economic power/ environment enable stigmatization. It is considered that, HIV/AIDS-related stigma and discrimination are the cyclical processes that begin with a trigger, for example a positive HIV test or attendence to CTC for ART refill, and progresses to stigmatizing behavior such as avoiding or accusing someone. Key factors affecting the nature and degree of stigma and discrimination include the stage of the disease (those in more advanced stages experience greater stigma) and gender (on the whole women are more adversely affected by the experience of stigma than men). The agents of stigma and discrimination i.e families, communities, health care workers and individuals fuel and exacerbate HIV related stigma and discrimination, hence influence the nature and degree of stigma and discrimination experienced by an individual person living with HIV/AIDS who are on ART.

The agents use hurtful language when referring to or speaking with a person living with HIV and AIDS; isolate them which lead to self-stigma/ internalized stigma. But again, felt normative stigma may be experienced to PLHIV as a protective mechanism (i.e PLHIV are passing as persons who are not infected or have some other non stigmatized disease. For example, if PLHIV have significant weight loss, they tell their community that they have cancer). Consequently, the model hypothesizes that, taking ARV pills may trigger stigma behaviors that result in negative outcomes, such as hiding medications, discourage people from disclosing their status, which has an impact on uptake of treatment, that is, decrease social support in HIV treatment, cause sub-optimal adherence to ART and can increase morbidity (e.g., wasting), which can in themselves become new stigma triggers. According to this theoretical model, anything that identifies the person as being infected with HIV and the fact that he/she is on ART can be a trigger for stigma and discrimination.

CHAPTER TWO: LITERATURE REVIEW

2.0. Introduction:

This chapter review literature on stigma and discrimination experiences against HIV-infected individuals. It is organized into the following sections: Overview on HIV related stigma and discrimination (2.1); Forms of stigma experienced among people on antiretroviral therapy (2.2); Forms of discrimination experienced among people on antiretroviral therapy (2.3); Impacts of stigma on adherence to antiretroviral therapy (2.4); Experiences on coping strategies against stigma and discrimination applied by people on antiretroviral therapy (2.5) and Conclusion (2.6)

2.1. Overview on HIV related stigma and discrimination

2.1.1. Meaning of Stigma

Goffman (1963) defines stigma as “an undesirable or discrediting attribute that an individual possesses, thus reducing that individual’s status in the eyes of society. It is a labeling of an individual or group as different or deviant”. Parker and Aggleton (2002) added that, HIV related stigma is reinforced by the association of HIV and AIDS with already marginalized behaviors, such as promiscuity, sex work, drugs use and homosexual practices. Consequently, individuals living with HIV are often believed to deserve their HIV positive status as a result of having done something wrong. De Bruyn (1999) has identified five factors as contributing to HIV/AIDS-related stigma:

- The fact that HIV/AIDS is a life-threatening disease
- The fact that people are afraid of contracting HIV
- The disease’s association with behaviors (such as sex between men and injecting drug use) that are already stigmatized in many societies
- The fact that people living with HIV/AIDS are often thought of as being responsible for having contracted the disease
- Religious or moral beliefs that lead some people to conclude that having HIV/AIDS is the result of a moral fault (such as promiscuity or “deviant” sex) that deserves punishment.

2.1.2. Meaning of discrimination

Nghifikwa (2011) argues that discrimination results when stigma is acted upon. That is, discrimination consists of actions or omissions that are derived from stigma and directed towards those individuals [PLHIV] who are stigmatized. UNAIDS (2002) added that discrimination involves arbitrary distinction, exclusion, or restriction affecting a PLHIV.

UNAIDS (2000) argues that AIDS-related discrimination may occur at various levels – including family and community settings. Discrimination in such settings is also known as ‘enacted stigma’. It involves what individuals do either deliberately or by omission so as to harm others and deny to them services or entitlements. Further, enacted stigma against PLHIV involve behaviors such as: ostracization, such as the practice of forcing women to return to their kin upon being diagnosed HIV-positive, following the first signs of illness, or after their partners have died of AIDS; shunning and avoiding everyday contact; verbal harassment; physical violence; verbal discrediting and blaming; gossip; and denial of traditional funeral rites. Moreover, discrimination does occur in institutional settings — in particular, in workplaces, health-care services, prisons, educational institutions and social-welfare settings. For instance, in health-care services discriminatory tendencies include: reduced standard of care, denial of access to care and treatment, HIV testing without consent, breaches of confidentiality including identifying someone as HIV-positive to relatives and outside agencies, negative attitudes and degrading practices by health-care workers.

2.2. Forms of stigma experienced among people on antiretroviral therapy.

The availability of ART has somehow led to a normalisation of HIV hence some forms of stigma has been reduced. South & Roura (2011) in their paper showed that, burden-related stigma has decreased because ART patients were recovering and able to look after themselves. Furthermore, the brief paper found that, self-stigma has also decreased as people realised that they are not the only ones with HIV, through interaction with health professionals and other people living with HIV at the clinic.

However, other types of stigma are not decreasing as noted by South & Roura (2011) . For instance blame-related stigma, denial and fear related stigma were found to persist.

This is because, HIV is still associated with behaviours that are perceived as degrading and as people are concerned that the physical recovery of people with HIV after receiving ART will lead to increased sexual activity and transmission because treatment users put on weight and can no longer be visually identified as ill. Moreover, denial of HIV in Tanzania was reported in this paper to persist with illness blamed on witchcraft or evil forces rather than HIV.

The fear of stigma plays a significant role in patients' experiences throughout the disease trajectory as some studies reported, yet, demonstrates that there are indications that ARVs are transforming the experience of living with HIV/AIDS and a process of normalisation is taking place. Patients see the ARVs as 'life saving' and express their long-term commitment to adhere to the drug regimen (Gilbert & Walker, 2009: pages 139-146).

A similar concern of fear of stigma was found by Abrahams & Jewkes (2012) which found that, many participants feared the possibility of stigma and a few who had experienced that resulted into loss of social status with daily conflicts whereby together created tension in relationship. Furthermore, the study found that, the most stigma experienced by participants were gossips and insults, but these were often resisted. Moreover, Hong et al., (2008); Mshana et al., (2006) found that, participants had fear of stigma due to negative social consequences and moral judgment.

Hassan et al (2011) in Bangladesh in their study found that, much has been written about Internalized HIV/ AIDS stigma which is experienced by those people who are on ART. They noted that there is a high percentage of felt ashamed in PLHIV who are on ART, followed by felt guilty because of their HIV status especilly among female. The study further reported that, more male blamed themselves for their HIV status while many of them felt that they should be punished.

The study done by Makoae, et al., (2009) found that, the increased stigma reported by people who were taking ARVs in some of the communities is the belief that, those who are taking medications means that, the disease is in more advanced stages of the illness, thus, taking medications is seen as an indication of severity of illness that might, in itself, increase stigma, since it increases fear among individuals .

Experiences from Tanzania stigma-indicators field test group (2006) and Najarkolaei et al., 2010) have shown that, stigma exist from healthcare providers to PLHIV when they go clinic for ART. The two studies mentioned four major forms of stigma experienced in health care setings, namely; sub-optimal care, excessive precautions and physical distancing and humiliation and blaming. These reactions lead to PLHIV avoid or delay seeking care, not disclosing HIV status when seeking healthcare, and using spiritual healing.

Studies done by Roura et al., (2009) in Tanzanian did not support the argument that ART availability reduces stigma but found that although ART contributed to a degree of normalization of HIV/AIDS-affected people, HIV/AIDS continued to be stigmatized as a moral disease, a label which undermined disclosure and voluntary counseling and testing.

The study done by Midtbo, Shirima, Skovdal & Daniel. (2O12: pg 264) found that, stigma impacts on the lived experiences of HIV-infected adolescents who were enrolled in ART programmes in Tanzania and Botswana**.** Most of the adolescents reported experiencing various forms of HIV stigma, such as verbal abuse (for example, being called degrading names), being labelled (for example, being given a red ribbon to wear as a sign of disease), and being pointed at. The adolescents also felt that people gossiped about their HIV status, and they sometimes felt discriminated against or rejected by friends and family members. This is exemplified by 14-year-old girl from Tanzania:

'My stepmother disclosed my status to everybody. She even told her relatives that I am HIV-positive. It reached a time when I was isolated on a sleeping mat; I was sleeping on the floor while the children of my stepmother were sleeping on the bed. Other times I was served food on a plate that we used for feeding the chickens and sometimes on a plate with a hole, while her children were served on the good plates.'

Carr, et al., (2010) in their study found that, only half of people living with HIV in a Tanzania study had disclosed their status to an intimate partner. Among those who had disclosed, the average time from knowing their status to disclosure was 2.5 years for men and 4 years for women. This is because people living in fear of stigma are less likely to adopt preventive behavior, disclose their sero-status to others, access care and adhere to treatment.

2.3. Forms of discrimination experienced among people on antiretroviral Therapy

Reaction to somebody living with HIV can have an effect on the person’s life. If the reaction is hostile a person may be forced to leave their home, or change their daily activities such as shopping, socialising or schooling.

A study conducted in five African countries by Makoae and collegues (2009) to compare two groups of people who were taking ARVs and those who were not found that, there was a decrease in total HIV discrimination over time, however, people taking ARVs reported significantly higher discrimination at 3 times higher compared to those not taking ARVs. The main forms of discrimination experienced in the study included workplace discrimination, verbal abuse and social isolation. The study demonstrated that, those taking ARVs reported higher scores on these factors.

The quantitative study done by Simbayi and collegues (2007) found that, discrimination experiences is present among 420 HIV-positive men and 643 HIV-positive women recruited from AIDS services in Cape Town, South Africa. The anonymous surveys found that 40% of persons with HIV/AIDS had experienced discrimination resulting from having HIV infection and one in five had lost a place to stay or a job because of their HIV status and the fact that they are on ART.

In the workplace, Jamaica Information Service (2012) found that, people living with HIV experience discrimination from their co-workers and employers, such as social isolation or experience discriminatory practices, such as termination or refusal of employment. This made some of those who started the clinic stop for fear of discrimination because it is difficult to hide one’s status when taking ARVs given the fact that taking ARV medications requires regular visits to health care providers, daily intake of several pills and frequent clinic visits.

Owuor (2009) in the study entitled 'Universal access to antiretroviral therapy has not eradicated HIV-related stigma in Tanzania' found that, treatment availability has not reduced blame stigma because HIV infection is blamed on personal lifestyle choices and behaviours such as alcoholism and sexual recklessness, which are viewed as avoidable and shameful. PLHIV are accused of negligence and irresponsibility especially if they are known to be alcohol users. They are thought to be deserving punishment (HIV). The study further found that the drug side-effects were blamed for aggressiveness (mental health problems), gluttony and greed among PLHIV, and economic and nutritional support offered to PLHIV was questioned by some members of the community – leading to further stigma. The investigators found that in the community where the research was done people still denied HIV and believed in other causes of the AIDS epidemic such as witchcraft.

Maman, et al., (2009) in their study in which they were comparing HIV stigma and discrimination in five international sites found that, in Tanzania , there was a contradiction in how participants perceived HIV risk and communicated associated blame. While many participants blamed PLHIV for getting infected, there were others who used the term ‘‘ajali kazini’’(accident at work) to describe the risk of getting infected. Tanzanian participants who believed that everyone is at risk were more likely to perceive little difference between themselves and PLHIV. The study further found that, behaviors that led to HIV were often described as irresponsible, reckless and immoral. As a result, many individuals felt that PLHIV got what they deserved in terms of being punished for their reckless behavior. Moreover, the study found that, gossip was described by participants in all sites. Community members speculated about who was infected with HIV and the fact that they are on ART, and how they may have become infected. Gossip was usually triggered by visible signs and symptoms of AIDS because stigma prevent people from accessing ART services hence the disease progress to AIDS fast which causes stigma symbols.

The study done in Rural Tanzania by Agnarson and collegues (2013) found that discrimnation against people on ART is still a problem. The result showed that, about 63% of the participants stated that PLHIV are a threat to society and that they intentionally transmit HIV to others because ART patients look healthy after taking ARVs. About 56% considered PLHIV to be dangerous and 55% felt that PLHIV should be isolated.

Moreover, 12% considered PLHIV disgusting, and 11% did not want to be friends with a person infected with HIV. Notably, 94% of individuals perceived ART patients as “dead to be” (a derogatory expression frequently used by participants to delineate a person on ART), and 99% of members believed that these patients would die soon.
Studies showed that, even though PLHIV regain their strength with ART they still face psychological isolation and condemnation from their family, friends and society because people around them are aware of their HIV status simply because they are seen in ART clinics (ATLIS ,2010)

Asia Pacific Regional Analysis (2011) found that, many people living with HIV are without a “safe” home environment, and stigmatizing events is ever present. HIV stigma based exclusion such as psychological pressure, manipulation and harassment by spouse were reported within many family environments . In some instances, in the same study, spouses/partners and family members were supportive when they learnt of their partner’s/ relatives HIV diagnosis.

As noted by Campbell et al., (2007) there is an increasing number of research on HIV-related stigma in Sub-Saharan Africa and it is being increasingly acknowledged, however, that effective treatment and care strategies require an understanding of the cultural context in which stigma exists. For example, experience has shown that, isolation from participating in the sociocultural aspect of food preparation cause women not to disclose their sero status even though they may be on ART because of fear of stigma from family members and community at large (Okoror et al., 2007, Simbayi et al., 2007).

Family members of a person who died of HIV/AIDS or family members who live with PLHIV especially the one who is on ART are highly experiencing discrimination because they can not hide the sero status of their relatives due to the fact that they are seen at CTC . Therefore, family members encourage PLHIV to attend the clinic far away from where they live to avoid social rejection by the community (Wood et al., (2008), Ulasi et al., (2009).

Thi et al., (2008); Mbonu et al., (2009); UNAIDS (2010); Nachega et al.,(2012); on their studies found that, HIV stigma and descrimination experienced by people who are on ART are high and it was found that the cultural construction of HIV/AIDS, based on beliefs that those who are infected are promiscuity, sexual workers or men sex with men (MSM) which cause those who are in need of health care not going because of fear of discrimination. Stigma prevents the delivery of effective social and medical care (including taking antiretroviral therapy) and also enhances the number of HIV infections.

In Vietnam, 54 percent of people surveyed in Cai Khe and 21 percent in Quang Ninh said they would not buy food from a person suspected of being HIV+40. Some community members have suggested that people living with HIV should be “marked” so that others are aware that they are sick because ART make them not to to recognised easely.(ISDS and ICRW, 2006)

Experience from several studies such as the study done by Miller et al (2007; Campbell (2007) ; Ulasi et al., (2009), showed that, religious institutions have been documented as playing both supportive and detrimental roles toward PLHIV in the community in that, they linking sexual transgressions and AIDS with sin and immorality . This is because sexual activity is both biological and socially-constructed behavior which reflects and can challenge strong public and private religious, cultural and political values. On the other side, experience shows that, religion plays a crucial role and contributes to the strength of distancing reactions and discrimination in society

WHO (2008) report said that, in health care settings lack of confidentiality has been repeatedly mentioned as a particular problem. Many people living with HIV/AIDS do not get to choose how, when and to whom to disclose their HIV status. The report further found that, those PLHIV who 'doomed' to die were not given treatment. This means that AIDS patients are not prioritised or are actively discriminated against.

Nurses expressed concern that their professional status would not give them the benefit of the doubt from their colleagues regarding whether they acquired their infection occupationally or through sex or drugs, that’s why they fear being infected . They added that, in their communities they will be regarded as people who violated norms and thus are guilty of being promiscuous (Chan et al., 2009) .

Fear of exposure to HIV as a result of lack of protective equipment is another factor fuelling discrimination among doctors and nurses in under-resourced clinics and hospitals.

However, in those clinics which had enough resources, stigma and discrimination were also confined. For example, in London, UK a women was giving an experience of how health care workers were treating her badly in a dental clinic.

“I have a dental problem and I used to go to this clinic, and I went there, two may be three times. So eventually I told them about my condition. They explained that I would have to be the last appointment of the day. So I went for the last appointment of the day last week and they covered the chair, and the doctors were wearing three pairs of gloves” (Nolen, 2007)

Wolfe et al., (2007); Mills et al., (2008) found that, common forms of discrimination in health facilities were designating patients as HIV positive on charts or in wards, gossiping about patients' status, verbally harassing patients, avoiding and isolating HIV-positive patients.

Nervetheless, the study done by Nghifikwa (2011) has different results in that, the participants reported that the health workers feel empathy for the PLHIV. The study supports the positive experiences the participants have had in health care centre. The results indicated that as health care professional becomes familiar with treating HIV patients hence the discrimination appeared to decline.

2.4. Impacts of stigma on adherence to antiretroviral therapy

Stigma and discrimination to the individuals who are on ART have effect on adherence to medications, that is, taking medications may indicate that someone is HIV-positive. Moreover, studies on medication adherence have documented that some people do not adhere to medication for fear of side effect because not only can the side effects of ARVs be bothersome, but they can also cause visible side effects, or stigma symbols, which add to existing stigma that one may perceive as a person living with HIV infection (Hardon et al., 2007,Holzemer et al., 2007, Mutimura et al., 2007, Rao et al., 2007).

Wolfe et al., (2007) ; Mills et al., 2008) found that, the fear of stigma experienced by people on ART results in postponing or rejecting care, seeking care far from home to protect confidentiality, and nonadherence to medication. The above studies have documented that men who have sex with men and injecting drug users, often avoid or delay accessing HIV-related services, including treatment for other sexually transmittted diseases, for fear of public exposure and discrimination by health workers.

The study done by Wang & Wu (2007); Tam et al (2011) found that, self-stigma may lead to patients being unwilling or fearful of taking medicine when other people are present. They noted that, self-stigma as a pervasive barrier to ART adherence with patients concerned that taking medications in the presence of others could lead to unplanned disclosure of their HIV status . Furthermore, A review of previous researches done by Wekesa (2007) on ART adherence in resource poor settings in sub-Saharan Africa found that, Stigma was a barrier to adherence and by itself can manifests into either subtle behaviour or overt acts of discrimination. PLHIV often face stigma and discrimination from their community, including their own family members. Fear of stigma may force PLHIV to conceal their HIV status even to close members of the family. The failure to disclose leads to non-adherence as they have to hide when taking the pills.

Dlamini et al., (2009) in their study in five African coutries found that, perceived HIV stigma and self-reported missed doses of antiretroviral medications was reported by repeated measures cohort study conducted in Lesotho, Malawi, South Africa, Swaziland, and Tanzania. They found that, social stigma influences medication practices and consequently treatment efficacy and health outcomes. Medication worries were related to stigma as some patients fear to disclose having HIV/AIDS and hence would miss medications since they cannot take it in front of relatives or friends.

Ngarina, et al., (2013) in their study found that, stigma and other factors such as lack of motivation to continue ART after weaning the child and poverty were the reasons for postnatal failure to adhere by mothers put on ART for life during pregnancy. The study further found that, most women did not acknowledge poor adherence until confronted with the viral load figures. Participants of the study said that, their motivation to take ART decreased once they had protected their children from becoming infected and successfully weaned them. Most of them did not take medication because they needed to keep their HIV status a secret and not let anyone see them taking the drugs. Feeling well for some, and a feeling of hopelessness for others, also decreased motivation to continue ART.

Experiences from Tanzania stigma-indicators field test group (2006) and Najarkolaei et al., (2010) found that , the participants reported the effects of stigma and discrimination in ART clinic including feeling undeserving of care hence experiencing emotional stress .

However , Sekoni and collegues (2012) in their study noted that, stigma was lowered after provision of universal access to treatment was introduced and medication adherence of respondents was good . Thus, universal access has become an important intervention against stigma. Moreover, Abadia-Barrero & Castro (2006); Nam et al., (2008); Roura (2009) also found that, acceptance of one's HIV-status helped people avoid internalizing stigma and they were more adherent to their medications.

These findings, however, report the conflicting relationship between HIV stigma and outcome variables of other studies because, other studies reported that , although improving access to antiretroviral treatment may be a factor in reducing stigma, it does not lessen the fear of stigma amongst HIV positive people who are on ARV. (Roura, 2009; Wolfe et al., 2009).

More evidence on how the access of ART has reduced stigma and discrimination is also found in the study done by Okoror et al., (2013), that, in describing their lives before ART, participants reported experiencing self, anticipated and enacted stigmas due to their sicky appearance from HIV-related complications. After initiating ART, participants talked about friends and families returning to them and apologizing for abandoning them once they started looking well. In response to anticipated stigma, many reported sticking to their medication.

2.5. Experiences on coping strategies against stigma and discrimination applied by people on antiretroviral therapy.

The literature suggests that coping strategies against stigma applied by people on antiretroviral therapy are almost similar to those for coping with discrimination because in coping with stigma and discrimination, stigma is often mentioned together with discrimination and the two concepts are related and often interdependent.

The literature on how people living with HIV/AIDS cope with stigma is often descriptive, presenting lists of coping mechanisms. There are different coping strategies of stigma used to help people on ART deal with depression and stress when they think of their HIV status and the fact that they are on ART. For example, Makoae and collegues (2008) in their study in five African countries listed emotional and problem-focused coping strategies that people living with HIV/AIDS use (e.g., turning to God, rationalizing one's situation, helping others).

Lekganyane et al., (2011) found that, the dominant themes in the narrations about coping in various studies were social isolation, silence or secrecy, spontaneous disclosure, or nondisclosure, which may block access to support services, and eliciting support from family. Some PLHIV may prefer to remain isolated instead of being confronted with stigma. To them, self-imposed social isolation is an active coping strategy to overcome discrimination. The study further reported that, some of the participants had become more distant from friends or family to avoid rejection and thus became secretive. They felt embarrassed or ashamed, prompting them to become secretive about their health.

Sekoni and collegues (2012) in their study noted that, stigma was lowed after provision to universal access to treatment was introduced and medication adherence of respondents was good as a result of the coping mechanism, which involves putting ARVs in unlabelled pill boxes

Talking was found to be one of the positive experience coping strategies among people on ART especially youth. Majority of youths admitted that, counselling makes them feel lighter. Talking treatment functioned as a way for people to let out feelings which they might otherwise have bottled up and helped them cope better. Another significant coping strategy for many people was keeping active through exercise and sport. Other HIV positive patient said that, they cope with the condition just by getting out of the house, going for walks and just being out in the fresh air. A few said they would get up middle of the night to go for a walk or on their bike if they felt miserable and unable to sleep. (http://www.youthhealthtalk.org, 2011)

Midtbo, Shirima, Skovdal & Daniel. (2O12: 261-271) in their study done in Tanzania and Botswana found that, HIV-status disclosure enabled adolescents to engage effectively with their ART treatment and support groups, which in turn provided them with a sense of confidence and control over their lives. Although the adolescents in the two studies were still experiencing stigma from peers and community members, most did not internalise these experiences in a negative way, but retained hope for the future and felt pity for those untested and uninformed of their own HIV status. So, disclosure was an important platform for HIV-infected adolescents to resist and cope with HIV stigma and discrimination.

2.6. Conclusion

Stigma and discrimination will continue to exist unless enabling environment is created to increase the visibility of people with HIV/AIDS who are on ART as a normal part of any society. Other strategies parallel with access to ART have to be though of which will eliminate stigma among PLHIV. Tackling stigma and discrimination require a multi-pronged approach, requiring action on the individual, environmental and policy levels. Through qualitative method, the researcher has explored the daily social reality and made detailed comments about individual situations of experiences of stigma and discrimination which do not lend themselves to direct generalisation in the same way which is sometimes claimed for quantitative research.

CHAPTER THREE: METHODOLOGY

3.0. Introduction

In this study, the researcher used qualitative method so as to understand the meaning of human behaviour, the political, social –economic and cultural context of the problem being investigated. Qualitative methodology is a sociological and anthropological tradition of inquiry. In the same line, the method advocates a kind of sustained interaction with the people being studied in their own social, cultural, economic and political setting (Kirk and Miller, 1986**:** 12-13). In other words, the guiding fundermental interest of employing qualitative approach is to asses how the respondent understands the key problem under investigation.

3.1. Study site

The study was conducted at Mnazi Mmoja Care and Treatment Center which is situated in Ilala Municipality, Dar es Salaam.

The city of Dar es Salaam is located within the Dar es Salaam Region and consists of three local government areas/ administrative districts: Kinondoni to the north, Ilala in the centre of the region, and Temeke to the south. The Dar es Salaam Region had a population of 4,364,541 as of the official 2012 census (Population distribution, 2013)

Ilala is the administrative district of the city where almost all government offices and ministries are housed. The Central Business District (locally called "Posta") is also located in this district. Furthermore, it is the transportation hub of the city, as the Julius Nyerere International Airport, Central Railway Station and Tazara Railway Station are all within the district boundaries. The residential areas are mainly middle to high-income.

In response to the global efforts at improving care and treatment, the Tanzania government in collaboration with various partners started the HIV care and treatment and Dar es Salaam was the piloting area.

Dar es Salaam was purposely chosen to be a study area because it is the first region to implement the provision of free ART in June, 2004 with a pilot program at Muhimbili National Hospital when the program of care and treatment started in Tanzania. Since then, care and treatment expanded to cover the entire country. Patients are enrolled and cared for in HIV clinics according to the set National guidelines. Therefore, PLHIV of Dar es Salaam had a good experience of stigma and discrimination because CTC started a long time ago compared to other regions and the results of the study will be compared to the experiences of other developed and developing countries whose data shows that stigma and discrimination are still high although ART provision started as far back as 1990s.

The HIV care and treatment clinic (CTC) of Mnazimmoja was set up in 2006. The clinic provides care and treatment, including provision of free ARV's to eligible PLHIV. The clinic enroll HIV positive patients referred from voluntary counseling and testing centers as well as PMTCT. There is a regular follow up for all registered PLHIV attending the ART clinic and medical evaluation is done by those who had a special training on ART and HIV care.

Mnazi mmoja care and treatment clinic was chosen because it is the only CTC clinic in Dar es Salaam where second line drugs are given. Moreover, the clinic has enough number of patients (approximately 30-80 per day) who attend CTC to meet the number of patients targeted by this study. In addition, patients come for treatment within pre-scheduled time.

3.2. Study design

This study used a cross sectional design for which phenomenological approach was used so as to gather information on lived experiences of stigma and discrimination.

Phenomenological approach seeks to describe the meanings embedded in the human experience and common life practices, explore the individuals' subjective experience as well as the commonalities and differences between a group of participants, hence understand the essence of the phenomena being investigated (Lopez & Willis, 2004).

3.3. Study population

The population under this study included all people living with HIV and AIDS, who were 18 years old and above who attend CTC clinic at Mnazi mmoja and on ART.

3.3.1. Inclusion criteria

Participants with documented HIV positive sero-status in the ART clinic who had been on ART two months and above **(**presumed that, at least this time range i.e two months, could expose the clients to the wider experiences). But also, the participants should be 18 years old and above and should be willing to participate in the study with an informed consent were included in the study.

3.3.2. Exclusion criteria

PLHIV who were too sick to answer the questions were not included in the study

3.4. Sample size

The sample size was based on the saturation principle that, data collection stoped when there was saturation (the point in data collection when new data no longer bring additional insights to the research questions) of the collected information. A total of 26 PLHIV who were on ART participated in this study.

3.5. Sampling procedure

A non probability, purposive sampling method was used to select the study participants. HIV positive people who had been on ARV for more than two months were purposively selected since they had experience of the situation and were able to give more information about stigma and discrimination experience among themselves, in family, community and health care set up . According to Brink (1999) non probability sampling method is advantageous as it allows the researcher to select the sample based on the study topic**.** Furthermore, purposive case sampling enabled the development of a rich description and understanding of the phenomenon under investigation (Liamputtong, 2010).

In order to get the intended study participants, the meeting was held with the nursing officer incharge of Mnazi mmoja CTC and researchers to discuss the aims, inclusion/exclusion criteria and ethical considerations of the study. The incharge of the clinic was asked to identify potential participants determined by their clinical experience and knowledge of their clients.

3.6. Data collection procedures

Data were collected through In-depth Interviews (IDI). The In-depth interview is a qualitative method of data collection, which proceeds as a confidential and secure conversation between an interviewer and a participant. Through this kind of interview it was easy to gain an insight into individual evaluations. In addition, in-depth interview was appropriate in this study for the issues which were controversial, sensitive or tabooed. Also, there was time for the participant to further develop and give reasons for his or her individual point of views without being influenced by the opinions of other participants.

Sessions were audio recorded, transcribed verbatim , translated and finally analyzed for analysis of common themes.In this qualitative study, participants who decided not to be audio recorded, detailed notes were taken.

The IDIs took place in a private and quiete place in order to maximize privacy to participants as well as recording a clear voice to maximize efficiency during transcription. Interview sessions took 30 to 45 minutes .

An interview guide was used to collect information. Besides open ended questions on experiences of stigma and discrimination, the interview guide had introductory questions of social demographic characteristics.

Demographic data were confidential and participants were provided with a special form to fill in their particulars (see appendix IV).

3.7. Data collection instruments

An interview guide was used for collecting data (see appendix IV) . The guide questions were in Kiswahili language to remove the language barrier so as to get more useful information from the participants. Digital audio recorder was used to record the voices during the discussion. Participants were well informed about audio recording prior interview. Inaddition, note books and pens were used to note down some clues which would not be identified in the digital audio recorder. Field- notes were developed during interview. Questions and probes were developed for each of the prior conceptual domain.

Interview guide allows participants more flexibility to express all what they know, richer information can be provided and more probing can be done to get more deeply what the participants think (Giddens, 1993).

At first interviews were transcribed verbatim and translated into English ready for analysis.

3.8. Recruitment and training of research assistants

One research assistant was recruited and trained three days prior the actual fied work. He was introduced to the study, its objectives and the methodology in order to be familiar with the topic. The role of the research assistant was to note down some clues which were not identified in the digital audio recorder eg. drawing upon non-verbal utterances whereas the principal investigator was the main person to conduct the interviews.

3.9. Pre-testing

Pretest was done on 3 subjects before data collection to check the reproducibility of the data collected at Muhimbili National Hospital. Also, pretest enriched interview guide hence gave a preview of what was expected.

3.10. Data management

Data were managed at a high level of confidentiality as nobody who is not directly involved in this study had an access to the collected data. Digital audio recorders, demographic and debriefing forms were kept in the safe box whose access was limited to principal investigator.

3.11. Data analysis

Data were analysed using thematic analysis approach. Thematic analysis was performed through the process of coding in five phases to establish meaningful patterns. These phases are: familiarization with data, generating initial codes, searching for themes among codes, reviewing themes and presenting the results (Daly, Kellehear, & Gliksman, 1997).

Phase 1: Familiarizing with the Data

After completing data collection, the researcher began transcribing the data into written form. The transcribed data and field notes were read and re-read until the researcher gained a thorough understanding of the collected information. In addition, non-verbal utterances noted during the interview were drawn upon in order to get a a richer understanding of the meaning of data (Guest, et al., 2012).

Phase 2: Generating Initial Codes

Coding is a process of breaking data up through analytical ways and in order to produce answers about relationships within and among the data.(Coffey, et al., 1996). It involved reduction of data by developing concepts [categories] that represent meanings contained in particular segments of the data. Development of concepts was done through noticing relevant phenomena in the context of the studuy objectives.

The coding is considered to be cyclical process. This cyclical process involves going back and forth between phases of data analysis as needed until the researcher is satisfied with the final themes. The researcher strived to refine codes by adding, subtracting, combining or splitting potential codes. Start codes were produced through terminology used by participants during the interview and were used as a reference point of their experiences during the interview. Dependability increased when the researcher used concrete codes that are based on dialogue and were descriptive in nature. These codes facilitated the researcher's ability to locate pieces of data later in the process and identify why they included them. Initial coding sets the stage for detailed analysis later by allowing the researcher to reorganize the data according to the ideas that have been obtained throughout the process.(Saldana & Johnny, 2009: p. 19; Guest, et al., 2012).

Phase 3: Searching for Themes

Themes are phrases or sentences that identify what the data means. The themes were developed through examination and interpretation of codes. It involved noticing similarities, differences, and patterns among codes.

Phase 4: Reviewing Themes

A broader meaning of the data was obtained by examining relationships among the identified themes. At this point, some identified themes were collapsed into each other, other themes needed to be condensed into smaller units.

Connections between overlapping themes served as important sources of information on the the possibility of new patterns. By the end of this phase, the researcher had an idea of what themes are and how they fit together so that they convey a story about participants' lived experiences on stigma and discrimination.

Phase 5: Presenting the results

The identified themes were used to guide writing of a concise and logical account of the participants' lived experiences on stigma and discrimination. The researcher presented summarised information and relevant quote(s) connected with each theme.

Table 1: An example of coding of text data and development of themes:

Text	Codes	Basic themes	Organising themes	Global theme
“*Sometimes it is not the disease that kills…it is the bad words and remarks from people. One day I heard one person telling a patient who was on ART that she was a key to mortuary because he believed that, once you are on ART you are about to die*	Gossips Bad words	1.Name calling against PLHIV	Verbal stigma	Dimensions of the Stigma Experience among people on ART
I was scared because I was worried about _the response of my partner and other people close to me. I was concerned that they would want to know how I got infected. So I asked myself_how will my husband_regard me? Will he understand me?how will he judge me?_But I believe I got infected with_HIV when_I had blood transfusion. I have never been a prostitute	-Worry -Fear of how they contacted HIV -Judgement -Afraid of being stigmatised	2. Fear of being morally judged for being HIV-positive and the fact that one is on ART	Social stigma	

3.12. Rigor of the study /Trustworthness

The aim of trustworthiness in a qualitative inquiry is to support the argument that the inquiry’s findings are “worth paying attention to” (Lincoln & Guba, 1985, p.290).

It is concerned with the accuracy and truthfulness of scientific findings. If the soundness of the qualitative research is to be measured, the judgement should be based on credibility, transferability, dependability and confirmability. Inaddition, the tool used to collect the data was reviewed by experienced researchers to ensure that it really measures what was intended as per objectives.

3.12.1. Credibility

Credibility is an evaluation of whether or not the research findings represent a “credible” conceptual interpretation of the data drawn from the participants’ original data (Lincoln & Guba, 1985, p.296). That is, the ability of the study to capture what the research really aimed at studying / measures or tests what is actually intended / capture the multiple realities of study participants. This was achieved by providing rich informtion related to the study. The researcher ensured credibility by identifying suitable participants and giving description before interview. The researcher introduced the aim of the study to the participants and asked permision to participate. This was done to build up a good trustful relationship which increased the willingness to participate and give information. The interviews were recorded and notes taken to ensure that information provided was not missed

3.12.2. Transferability

Transferability refers to the degree to which the results of a study can be applied to a setting or sample other than the one studied (Brink, 1999) , that is, applicability of results to other subjects and other context to address transferability, the researcher included in Appendix I data analysis document used to generate the answer to the research question. This access to the inquiry’s “paper trail” gives other researchers the ability to transfer the conclusions of this inquiry to other cases, or to repeat, as closely as possible the procedures of this study.

The researcher also ensured transferability by describing the study setting and participants. This will make it possible for the results to be applied to other similar context.

3.12.3. Dependability

Dependability refers to getting the same findings if the research is repeated in the same context with the same subjects. That is, assessment of the quality of the integrated processes of data collection and data analysis.

In addressing the issue of reliability, different techniques were employed to show that, if the work was repeated, in the same context, with the same methods and with the same participants, similar results would be obtained. Thus, the research design was viewed as a prototype model, that is, research design and its implementation, describing what was planned and executed and the operational detail of data gathering, addressing the minutiae of what was done in the field like non –verbal cues of participants which were noted and followed up by the researcher during the interview to enrich the process.

3.12.4. Confirmability

Confirmability is a measure of how well the inquiry's findings are supported by the data collected. (Lincoln & Guba, 1985). It is concerned with establishing that, data and interpretations of the findings are not figments of the inquirer's imagination, but are clearly derived from the data**.** Confirmability has to do with the collected data whether they are real and not produced by the researcher being biased. This was achieved by recording the interview and note taking.

Steps were taken to help ensure as far as possible that the work's findings are the result of the experiences and ideas of the informants, rather than the characteristics and preferences of the researcher.

3.13. Dissemination

Research results will be disseminated to stakeholders including my sponsor (ICOHRTA), staff and students at MUHAS. Also the results will be published in national and international journals.

3.14. Ethical consideration

Before undergoing the project, ethical clearance was sought and permission obtained from the MUHAS Research and Publication Commitee. After being granted ethical clearance, Distict and institutional permission was also sought before starting data collection. An informed consent was obtained before interviewing each PLHIV. Confidentiality of the information collected from each participant was ensured. The objectives of the study were explained to the participants. (See appendix II and III informed consent form). Participation was voluntarily. There was no harm which occured due to participation in this study.

CHAPTER FOUR: RESULTS

4.0.Introduction:

This chapter presents the results obtained from the interviews conducted with the study participants. It is organized into three sections. The first section describes socio-demographic characteristics of the participants. The second section summarizes main findings. The third section focuses on the identified themes which emerged from the analysis. The quotes are presented verbatim to support the study findings. Finally, a brief summary of the main findings is given.

4.1. Socio-demographic characteristics of participants

Table 1 summarises participants' socio-demographic characteristics.
More than a half of the study participants were women(16) and only 10 were men. A sizeable majority (12 out of 26) of the sample was between the ages 31 to 40 years. A substantial number of (11) of the participants had secondary O-Level education, and nearly a half of them reported to be bussiness men/women with the highest reportage among the female. More than a half (17) of the participants reported being in a current marital relationship with the majority living with their partners.

Almost half of participants had been on ART for 6 to 9 years while 10 had been on ART for 3 months to 2 years.

Table 2: Summary of Demographic characteristics of study participants

Characteristics	Number of participants
Age (years)	
21-30	**4**
31-40	**12**
41-50	**6**
51-60	**3**
61-70	**1**
Total	26
Sex	
Male	**10**
Female	**16**
Total	26
Level of education	
None	**2**
Primary	**10**
Secondary O-Level	**11**
Secondary A-Level	**1**
Digree	**2**
Total	26
Marital status	
Single	**6**
Married	**17**
Divorced	**2**
Separated	**1**
Total	26
Occupation	
Unemployed	**3**
Self employed	**2**
Housewife	**3**
Govt employed	**1**
Bussness	**11**
Others specify	**6**
Total	26

4.2. Main findings

The study found that, participants experienced different forms of HIV-related stigma such as verbal stigma, social stigma, and perceived stigma (fear of stigma associated with disclosing HIV status). Furthermore, the participants experienced various forms of discrimination, including: relational discrimination, mistreatment by health care workers, blame and rejection by spouses and workplace discrimination. It was also found that HIV related stigma and discrimination compromised ART adherence by reinforcing concealment of HIV status and undermining social suppport. The main coping mechanisms that emerged from participants' narrations included: spiritual devotion, becoming secretive; acceptance of the illness; seeking information and/or exchanging views about the illness; and pre-emptive disclosure.

4.3. Study Themes

The themes for this study emerged out of thematic network analysis process (Appendix 1). The process generated 23 codes covering 9 basic themes. These basic themes were further clustered into 8 organizing themes – which were finally condensed into four main (global) themes. These major themes are: dimensions of the stigma experience among people on ART; dimensions of discrimination experience among people on ART; impacts of stigma and discrimination on adherence to antiretroviral therapy and Coping strategies adopted to deal with HIV/AIDS stigma and discrimination . These themes are relevant to the focus of the study and serve as key sub-headings in the sections that follow.

4.3.1. Dimensions of the Stigma Experience among people on ART

Different forms of HIV-related stigma among people on ART were experienced by participants including verbal stigma, social stigma and perceived stigma (fear of stigma associated with disclosing HIV status) .

4.3.1.1. Verbal stigma

Partcipants reported that, if one is suspected of being HIV-positive and on ART he/ she is given names which imply that his/her days of staying alive are numbered. The stigmatizing names included phrases such as ‘keys to mortuary’. This is what one of the participant said:

> “*Sometimes it is not the disease that kills…it is the bad words and remarks from people. One day I heard one person telling a patient who was on ART that she was key to mortuary because he believed that, once you are on ART you are about to die”(female participant, 34 years old)*

This tendency of labelling people living with HIV or name calling is part of gossips and accounts for most of the stigmatizing behaviours from the community. The paticipants argued that labeling is conceptualized as society's symbolic punishment for those who are considered to have violated sexual moralities.

4.3.1.2. Social stigma

The participants expressed fear of being morally judged for being HIV-positive and the fact that they are on ART. Their fear was based on the fact that community members tend to associate HIV positive status with engagement in immoral behaviors, as expressed by one of the participants:

> *“I was scared because I was worried about the response of my partner and other people close to me. I was concerned that they would want to know how I got infected. So I asked myself how will my husban regard me? Will he understand me? But I believe I got infected with HIV when I had blood transfusion. I have never been a prostitute”(female participant, 35 years old)..*

A similar concern was expressed by another participant:

> “*It really pained me and I cried a lot . I asked myself where did I get this disease. But then I realized that I got from my parents. There is a day I went to visit my aunt and I saw my young brother who was taken by aunt after the death of our mother using antiretroviral drugs. I asked my aunt and it is the same day I knew I also got*

> *HIV from our parents. I noticed I'm HIV positive in 2006 but I did not let anybody know because I feared how they will regard the circumstances that made me get infected" (female participant, 23 years old)*

The partcipants, particularly women attributed social stigma to community members' perception that all HIV positive people were prostitute or they used to party too much and being on medication means you are about to die.

4.3.1. 3. Perceived stigma

Participants expressed fear of being stigmatised, that is, they feel that they might be treated negatively by family and members of the community.

> "*I have not taken my medication for two occasions when relatives and neighbours were in my house and have never disclosed my status to them. I did not get time to take out medicine from my drawer. I frequently face this problem of trying to hide my medicine from others because I am living in a rented single room and I feared if they see my ARVs they will tell others I am infected. (male participant, 42 years old)"*

Participants feared negative consequences which they might experience if their HIV status becomes known to their close relatives. They had the experience of friends and relatives gossiping and ostricizing PLHIV.

4.3.2. Dimensions of discrimination experience among people on ART

The participants experienced various forms of discrimination, including: relational discrimination, mistreatment by health care workers, blame and rejection by spouses and workplace discrimination.

4.3.2.1. Relational discrimination

It was reported that participants experienced changes in relationship when spouses, family members, friends and neighbours discovered that a particular person was on ART. This was well narrated by one of the participants:

> *“ One day when I came back from work I saw something different from my neighbours. I thought about the situation for sometimes but did’t get an answer. Later, one of the neighbours came and tell me what happened a few hours ago. She told me that my son came out with my ARV thinking that it is children’s playing device [locally-manyanga]) because when ARV are in its box and when shaken they produce a certain sound.. That day I forgot the keys of the drawer where I usually keep my medicines. One of my neighbours told my son to give the medicines to her and she went to the pharmacy to confirm if they were truly ARVs or not. After confirming, she brought them back to my son and from that day our friendship changed because at first we used to cook and eat together but nowdays she is no longer interested in sharing anything with me. ... She told other neighbours about it and caused me to be very unhappy. ”(female participant, 36 years old)*

4.3.2.2. Mistreatment by health care workers

Participants reported that, sometimes they experienced discrimination from health care providers - manifested in the form of: neglect ,verbal abuse, overusing protective materials such as gloves, and paying little attention to their concerns. The following quotes illustrate this:

> *“Sometimes if you ask health care providers something they do not respond to your question. They pretend to be busy though most of the time it is not true that they are busy, they just neglect us. Sometimes they use abusive language against us and they delay giving services. They don’t value people on ART anymore in this world. When you arrive late to the clinic you are told that you will be moved closer to where you live . They use it as a way to threaten us because they know most of us are going away to avoid discrimination” (Male participant 43 years old)*

Moreover, four participants complained about care they were given in Mwananyamala CTC (the clinics they used to attend before shifting to Mnazi mmoja CTC). Nurses at Mwananyamala CTC were accused of doing inhuman things. For instance, one of the participants claimed:

> *" At Mwananyamala CTC some nurses sometimes delay in attending to patients and use offensive statements. One day a nurse told me that take your 'bomb'- meaning my file and she continued saying 'I am not the one who gave you HIV'. Whenever I see that nurse or remember those words - it hurts a lot". (female participant, 49 years old)*
> *[The partcipant cried after narrating that painful experience]*

4.3.2.3. Blame and rejection by spouses

Participants complained of less support and blame from their partners once diagonised HIV and the fact that they are on ART.

In spite of the reduction of internalised stigma, some of participants experienced blame-related stigma from spouse, and their community

> *"I was told I have HIV and I had to start treatment. I told my husband, but suddenly he left and and came back after a week and divorced me. He told me to go to my relatives so that they could take care of me when I fell sick because he blamed me to be the source of the problem" [(she spoke with grief]. (a female participants, 39 years old)*

A similar concern was expressed by a male participant:

> *"My wife is the one who brought the disease. I warned her many times about infedelity but she did not care. When I told her that I'm HIV positive she deserted me and went to her parents home . She left me with a 3 years old child". (male participant, 49 years old)*

When stigma was experienced within the family, its consequences could be harder to overcome and even result in treatment interruption

4.3.2.4. Workplace discrimination:

Participants reported that, fear of transmission through casual contact was a potential source of stigma at the workplace. Fear of social isolation and gossip were also experienced by participants at work environment. One of the participants stated:

> *"One day I heard one of my colleague telling one of our new office attendant that, she should be careful when I am using her drinking water glasses to avoid transmitting HIV virus to her. She told her, I am on ART nowadays. But again,in the previous days she was telling another collegue about my HIV status and the guy was not believing and she promised him that one day she would show him my ART. But all I see is low education on HIV/AIDS".(Male participant, 57 years old)*

However, some participants said that, in some instances, employers and co-workers are supportive and refrain from discriminative behaviours.

4.3.3. Impacts of stigma and discrimination on adherence to antiretroviral therapy

The study found that, the fear of stigma experienced by people on ART results in nonadherence to medication through a number of ways. One, because of stigma a substantial number of participants revealed that they do attend care and treatment clinic that is far away from their homes. For instance, a person living in Mbagala which is in Temeke District would prefer going to Mnazimmoja CTC which is in Ilala district. Indeed, one of the participants in this study was a resident of Morogoro region. She decided to come all the way to Dar es Salaam in attempting to conceal her HIV status from people in her district of residence.

> *"I live in Morogoro but I usually refill my ARVs here at Mnazi mmoja CTC. So, sometimes I run short of ARVs because of inability to come to refill in Dar es Salaam" (female participant 23 years old).*

A similar concern was expressed by another participant

> *, "I sometimes worried about meeting my neighbours in hospital for refills ART. What I am doing nowdays is to attend a far away clinic and wear Hijjab and sun-glasses which will not be easy for whoever knows me to recognise who I am.. I am*

> *not a muslim and am not wearing this in my community. I always carry them in my bag and once I see ATM machine I wear them there then I go to the clinic and I do the same once I want to go back home/to work. All the time I worry. One day I did not refill my ART due to bumping into relatives.. (female participant, 35 years old)*

Consequently, because of prefering a distant CTC some ART clients may fail to attend regularly partly due to lack of fare and thereby run short of ARVs.

Two, stigma reinforces concealment of HIVstatus and consequently one may not feel at ease to take ARVs in the presence of family members or work mates, thereby delaying to ingest the drugs. The following remark made by one of the participants is illustrative:

> "*I have not taken my medication for two occasions when relatives and neighbours were in my house and I have never disclosed my status to them. I did not get time to take out medicine from my drawer. I frequently face this problem of trying to hide my medicine from others because I am living in a rented single room and I feared if they see my ARVs they will tell others I am infected." (male participant, 42 years old)*

Three, HIV related stigma and discrimination undermines social support which oftenly culminates in food insecurity and attendant fear to take ARVs on an empty stomach. One of the participants remarked.

> *"ART helps me. But what makes me deteriorate nowdays is the availability of food. I don't get enough food and fruits as I was advised. I am not capable of buying food. I am worried about the side effects of taking medicine in an empty stomach." (Male participant, 49 years old)*

4.3.4. Coping strategies adopted to deal with HIV/AIDS stigma and discrimination

Key coping mechanisms that emerged from participants' narrations included: spiritual devotion, becoming secretive; acceptance of the illness; seeking information and/or exchanging views about the illness; pre-emptive disclosure, putting ART in an unlabled envelope, and swallowing ARVs in the wash room [toilet]

4.3.4. 1. Spiritual devotion

The majority of participants indicated that they believe in God and still adhere to medication. They received spiritual and psychological support from the pastors in the church and sheikhe in mosque. Spiritual devotion appered to be a strong coping strategy among study participants.

> *" I pray to God everytime I take my medicine and I believe one day Jesus christ will cure me.". (female participant, 30 years old)*

The study revealed that, participants' belief in the healing power of the Almighty God had a better health outcomes by reducing self stigma. Indeed, their level of faith in the healing power of God was so high that some thought that even if they die it will not be because of HIV, it will be God's will.. The following quote is illustrative.

> "*I get comfort from my religion because God is the one who enables us to live. In general I perceive AIDS as a common disease and death is not necessarily caused by AIDS. You can sleep without being sick and still die. So I believe if I die, then it is God's will and not AIDS." (Male participant, 41 years old)*

4.3.4. 2. Acceptance of the illness

The study participants accepted the condition of being positive and considered HIV/AIDS as no longer fatal – particularly in this era of ART. One of the participants shared his feelings as follows:

> *"I see HIV as any other diseases and I do not think that I will die because of it. When I die I will know it is God's will not because of AIDS. If I were to die, I could have died when I was very sick those days". (male participant,57 years old)*

A similar concern was expressed by another participant:

> "*My concience has agreed to the problem so I regard it as just any other common disease". (female participant, 30 years old)*

The notion of regarding HIV/AIDS as an ordinary disease has been internalized mainly by the participants who were on ART for three years or more. Some participants spoke of the support they received from their families as having contributed to the peace of mind they were experiencing.

4.3.4. 3. Seeking information and/or exchanging views about the illness:

Social support groups seemed to play an important role in handling stigma and discrimination. Such groups constitute for learning about challenges related to living with HIV and AIDS.

The following quote is illustrative:

> "*We do discuss with my fellow patients different HIV issues and giving comfort to each other. We meet weekly in our support group. Also, my wife comforts me. She is a hospital employee so she knows these things well". (male participant, 52 years old)*

4.3.4. 4. Becoming secretive

It was learnt that, some participants chose non-disclosure as a coping mechanism. One of the participants stated:

> "*I didn't tell my mother and father because they are adults and they have pressure problem so I was afraid I could pursue them into further problems. Neither did I tell my close relatives, I feared they would tell others and let the information spread and it could result into discrimination" (male participant, 41 years old)*

As described in the preceding sections, seeking care far from home – by shunning care and treatment clinic(s) in one's district of residence – is a coping strategy.

4.3.4. 5. Pre-emptive disclosure:

It was leaned that, some people on ART do disclose their HIV status to family members, neighbours, and/or work mates and very freely talk about it and the challenges they face such that they pre-empt gossipings. This coping mechanism was well narrated by one of the participant:

> *“ I have disclosed my status almost to every body because I am sometimes seen on the television or heard on the radio revealing that I am HIV positive (I am an AIDS activist) . At my workplace (school) everybody knows I am infected . It helped me a lot to disclose my status because I sometimes feel not to work and I just tell my boss through phone that I am sick. He always understand the situation but my colleagues are saying’mmmh! today viruses have pierced (locally-Virusi vimekolokochoa) thats why she was not able to report to work . One day, one of the colleage told me that some of teachers were saying that I didn’t come yesterday because viruses were piercing , but I just told her, I don’t care” (she laughs). (Female participant,46 years old)*

People of these kind can strengthen people living with HIV by helping them overcome internalised stigma, cope with stigma, rebuild their self-esteem, and develop skills to take leadership roles in anti-stigma education and action.

CHAPTER FIVE: DISCUSSION

5.0. Overview

This chapter presents discussion of key findings on lived expereinces of HIV/AIDS-stigma and discrimination. It consists of three sections. The first section is on dimensions of stigma and discrimination among people on ART. The second section is about the impact of stigma and discrimnation on ART adherence. The third section discusses coping mechanisms.

5.1 Dimensions of stigma and discrimination among people on ART

Findings indicate that the study participants experienced different forms of HIV-related stigma among people on ART – including verbal stigma, social stigma and perceived stigma (fear of stigma associated with disclosing HIV status) . This suggests that both intrapersonal and interpersonal fears still exist despite nearly a decade of scaling up provision of ARV. That is, the study participants experienced loss of dignity and friendship. The identified forms of stigma are in agreement with manifestations of stigma described in the theoretical framework that guided this study. Similar findings have been reported in other countries (Lekganyane and Gretchen, 2011).

Moreover, the findings show that the participants experienced various forms of discrimination, including: relational discrimination, blame and rejection by their spouses, workplace discrimination and mistreatment by health care workers. This suggests that despite improvement of health status as a result of being on ART, PLHIV are denied services or entitlements as a results of delibarate actions or omissions by spouses, family members, friends, and/or workmates. These findings are supported by those of Mills (2007); WHO (2008); Makoae et al. (2009); UNAIDS (2010) ; ATLIS (2010); Asia Pacific Regional Analysis (2011); Nachega et al (2012); and Agnarson et al (2013).

5.2. The impact of stigma and discrimnation on ART adherence :

The study found that, the fear of stigma experienced by people on ART results in nonadherence to medication through a number of ways. Firsly it was noted that patients prefer a distant CTC to extent of avoiding CTC(s) obtained in their districts of residence. This is because they fear being seen by people who know them such as friends and neighbours thereby risking irregular refill of ARVs. Similar findings have been reported in other African countries where many participants were unwilling to seek treatment at the nearest health facility (Wolfe et al., 2008; Wood et al., 2008 and Ulasi et al., 2009). Secondly, the study has shown that stigma reinforced concealement of HIV status. Not wanting to tell others about HIV positive status has been found to be a major impedment to optimal uptake of ARVs. The results are in aggreement with the effects of stigma and discrimination described in the theoretical framework of the study and has also been documented elsewhere by Wekesa, (2007); Dlamini et al., (2009) ; Tam et al., (2011). Likewise, Nyamhanga (2011) found that non-disclosure of HIV+ to the spouse was due to fear of violence and divorce/ separation and it affected some women's attendance to CTCs as they lacked fare and were unable to justify absence from home on the clinic day. Thirdly, this study found that stigma and discrimination undermined social support which in turn makes the person on ART vulnerable to food insecurity. The relationship between food insecurity and sub-optimal adherence has been reported in Kenya (USAID, 2005) where respondents had fear of taking ART on an empty stomach because they were considered to be "highly toxic drugs"

5.3. Coping strategies adopted to deal with HIV/AIDS stigma and discrimination

Key coping mechanisms that emerged from the participants' narrations included: becoming secretive; spiritual devotion, acceptance of the illness; seeking information and/or exchanging views about the illness through support groups and pre-emptive disclosure**.** These coping mechanisms can be put into two categories, namely: adaptive and maladaptive strategies.

Spiritual devotion, acceptance of the illness; seeking information and/or exchanging views about the illness; and premptive disclosure –can be considered to be adaptive mechanisms as they foster positive living. These findings are consistent with those reported by Makoae et al (2008) who examined how PLHIV cope with HIV-related stigma in the five Southern African countries of Lesotho, Malawi, South Africa, Swaziland, and Tanzania. On the other hand, choosing to be secretive is maladaptive [unproductive] as it may result into an impedement to effective access and adherence to ART – as reported by Lekganyane and du Plessis (2008).

Study Limitation:

Since the study was qualitative in nature and therefore involved purposive selection of the study sample, its findings cannot be generalized. However, being a qualitative study, its goal was not to generalize but rather to provide rich information on dimensions of stigma and discrimination experienced by PLHIV on ART.

CHAPTER SIX: CONCLUSION AND RECOMMENDATIONS

6.1. Conclusion

This study has provided additional evidence on the dimensions of stigma and discrimination among people on ART. That is, after nearly a decade of scaling up provision of ART in Tanzania, PLHIV still experience: verbal stigma; social stigma; relational discrimination, blame and rejection by spouses, and/or mistreatment by health care workers – albeit to a smaller extent compared to the pre-ART era. The study has indicated that these unhealthy expereinces have a negative impact on treatment adherence. These findings suggest that efforts to reduce stigma and discrimination that started earlier (pre-ART period) with the purpose of encouraging HIV testing, are still relevant in the ART period and should be given more impetus so as to maximize positive treatment outcomes. Such efforts should – among other things – support ART clients apply adaptive coping strategies such as those identified in this study: acceptance of the illness; seeking information and/or exchanging views about the illness through support groups; and pre-emptive disclosure.

Overall, this study has provided useful information for managers of HIV care and treatment services about the dimensions of stigma and discrimination and coping strategies being applied. This understanding will enable planning of supportive interventions as the ones recommended below.

6.2. Recommendations

Based on the study findings, it is recommended that:

1. There is a need for the Tanzania Commission for AIDS (TACAIDS) to design and implement Television and Radio programmes on fighting stigma and discrimination. Such programmes should utilize the existing evidence and target appropraite groups such as farmily members, employers, health workers, and PLHIV themselves.

2. There is a need for TACAIDS to promote formation and strengthening of support groups of PLHIV who access ART. These groups can be a rich source of support towards reduction of both self and enacted stigma. Some members of the support groups may visit families of colleagues reporting serious stigmatization and discrimination.

3. There is a need for further research in this area. For instance, there is need to gain a deeper understanding on the role of social support groups in reduction of stigma and discrimination.

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APPENDICES

Appendix 1: Coding of text data and development of themes:

Text	Codes	Basic themes	Organising themes	Global themes
Sometimes it is not the disease that kills…it is the bad words and remarks from people. One day I heard one person telling a patient who was on ART that she was key to mortuary because he believed that, once you are on ART you are about to die	-Gossips -Bad words	-Name calling against PLHIV	Verbal stigma	**Forms of stigma against people on ART**
I was scared because I was worried about _the response of my partner and other people close to me. I was concerned that they would want to know how I got infected. So I asked myself_how will my husband_regard me? Will he understand me?how will he judge me?_But I believe I got infected with_HIV when_I had blood transfusion. I have never been a prostitute	-Worry -Fear of how they contacted HIV -Judgement		Social stigma	
I have not taken my medication for two occasions when relatives and neighbours were in my house and have never disclosed my status to them. I did	-Afraid of being			

not get time to take out medicine from my drawer. I frequently face this problem of trying to hide my medicine from others because I am living in a rented single room and I feared if they see my ARVs they will tell others I am infected	stigmatised -Fear disclosing status -Fear of being seen taking ART -Hide medicine -Fear of telling others about infection		Perceived stigma	

One of my neighbours told my son to give the medicines to her and she went to the pharmacy to confirm if they were truly ARVs or not. After confirming, she brought them back to my son and from that day our friendship changed because at first we used to cook and eat together but nowdays she is no longer interested in sharing anything with me.	Change in relatioship -isolation (including physical and social exclusion)	-Fear of being morally judged for being HIV-positive and the fact that one is on ART	Relational	**Dimensions of the Stigma Experience among people on ART**
I was told I have HIV and I had to start treatment. I told my husband, but suddenly he left and and came back after a week and divorced me. He told me to go to my relatives so that they can take care of me when I fall sick because he blamed me to be the source of the problem.	-Blame -Harassment		Verbal discrimination	

I have not taken my medication at the right time two occasions because relatives and neighbours were in my house and I didn't disclose my status to them. *I am living in Morogoro but I usually refill my ART here at Mnazi mmoja CTC. So, sometimes my ART might be finished but I dont have bus fare to come to refill in Dar es Salaam.*	-Not taking pills at the right time -Concealment -Failure to refill ARVs	- Stigma reinforces concealment of HIVstatus - Concealment of HIVstatus robs PLHIV of freedom to take ARVs in the presence of family members or work mates, thereby delaying to ingest the drugs. Avoidance of CTCs within the district of residence for fear of raising suspicion over HIV+ status to relatives, neighbours, and friends.		**Impacts of stigma and discrimination on adherence to antiretroviral therapy**

I pray to God everytime I take my medicine and I believe one day Jesus christ will cure me. *My concience has agreed to the problem so I regard it as just any other common disease.* *We do discuss with my fellow patients different HIV issues and giving comfort to each other. We meet weekly in our support group. Also, my wife comforts me. She is a hospital employee so she knows these things well.* *I didnt tell And my close relatives, I fear they would tell others and let the information spread and it could result into discrimination.*	- Religious belief - Spiritual healing -HIV is like any other disease -Psychosocial support -Comfort -Relatives tell others about HIV status	Role of spiritual healing HIV/AIDS perceived as not a serious threat social support groups serve as forum for learning and exchange of information	Spiritual divotion Acceptance of the illness Role of social capital	**Coping strategies adopted to deal with HIV/AIDS stigma and discrimination**

Appendix II: Informed Consent Form: English Version

MUHIMBILI UNIVERSITY OF HEALTH AND ALLIED SCIENCES

DIRECTORATE OF RESEARCH AND PUBLICATIONS, MUHAS

INFORMED CONSENT FORM

ID-NO. ☐☐

Greetings,

My name is Maisara Mhode from Muhimbili University of Health and Allied Sciences in Dar es Salaam passuing Master of Public Health

Purpose of the Study

Dear respondent I would like to inform you that this is a research study titled "Lived experiences of Stigma and Discrimination among people on Antirertoviral Therapy: A Qualitative study in Ilala Municipality, Dar es Salaam". I would like to give you information about your participation in the study.

This study aimed at exploring Lived experiences of Stigma and Discrimination among people on Antirertoviral Therapy attending care and treatment clinics. Kindly be honest and true for betterment of the results that could lead to better intervention and recommendations in future.

What Participation Involves

If you agree to join the study, you will be interviewed and the information that you are going to give will be recorded with a digital recorder and the researcher will also note down important points. You will be asked about your lived experiences of stigma and discrimination and challenges you are facing while attending the clinic for care and treatment. It will take about 30 - 45 minutes to complete the in depth interview.

Confidentiality

We will protect and treat the information you will be providing with high confidentiality to the best of our knowledge. We will not write your name on the interview guide or in any report/documents that might let someone identifies you. Your name will not be linked with the research information in any way. The investigators will take care of the data and information collected. However, the final results after the analysis will be shared with the national stakeholders and I will submit the manuscript for publication in scientific journals.

Right and withdrawal alternatives

Your participation is voluntary. You may decline from participation to the study at anytime during interview even if you have consented to participate. Your decision to participate or not will not be associated with your right to come for the clinic. There is no penalty for refusing to participate on the study. You will not experience any loss if you refuse to participate in this study.

Benefits

The information you provide will help to increase our understanding and give a clear picture on the experience of stigma and discrimination among people on antiretroviral therapy attending care and treatments clinics in Ilala, Dar Es Salaam, Tanzania. This can therefore help in providing useful information and provide evidence based recommendations to program planners and managers who need a greater understanding of the relationship between HIV stigma and discrimination and ART from the perspective of their clients

If any damage occurs

It is not expected that there will be any damage for your participation as the participant to this study.

Risks

There is no harm for participating in the study. However, you are free to stop participating at any time during this discussion in the event you feel uncomfortable.

Who to Contact

If you ever have questions about this study, you should contact the **Principal Investigator, Maisara Mhode** (+255 786 546479) of Muhimbili University of Health and Allied Sciences, P. O. Box 65001, Dar es Salaam.

If you ever have questions about your rights as a participant, you may call **Prof. Mainem Moshi, Chairman** (Research and Publications Committee, MUHAS. P.O.Box 65001, Dar es Salaam – Tanzania, Tel +2552150302-6); and **Dr. Tumaini Nyamhanga** who is the **supervisor** of this study (Tel. +255 713 254000)

Signature:

Do you agree?

Participant agrees ………………….. Participant does NOT agree ……...............………

I ………………………………………. have read the contents in this form. My questions have been answered. I agree to participate in this study.

Signature of participant …………………………………

Signature of Researcher …………………….............

Date of signed consent …………………………………

DECLARATION

The above document describes the benefits, risks, and procedures for the research entitled "“Lived experiences of Stigma and Discrimination among people on Antirertoviral Therapy: A Qualitative study in Ilala Municipality, Dar es Salaam”has been read and explained to me and I have agreed to participate. I certify that the nature and purpose, the potential benefits and possible risks associated with participating in this study have been explained to me.

Signature or Right Thumb stamp of the participant........................ DATE...........................

Signature of Researcher......…………………….DATE..

Appendix III: Informed Consent Form: Kiswahili version

CHUO KIKUU CHA SAYANSI ZA AFYA MUHIMBILI

KURUGENZI YA TAFITI NA UCHAPISHAJI

FOMU YA RIDHAA

Namba ya utambulisho ☐☐

Ridhaa ya kushiriki kwenye utafiti

Hujambo! Ninaitwa Maisara Mhode, kutoka Chuo Kikuu cha Afya na Sayansi ya Tiba Muhimbili. Nasoma shahada ya pili ya sayansi ya afya ya jamii.

Madhumuni ya Utafiti

Utafiti huu unafanyika katika kutimiza sehemu ya matakwa ya shahada ya uzamili ya afya ya jamii ya Chuo Kikuu cha Afya na Sayansi ya Tiba Muhimbili. Utafiti unalenga kutathmini uzoefu wa watu wanaotumia dawa za kurefusha maisha dhidi ya unyanyapaa na kutengwa . Unaombwa kushiriki katika utafiti huu kutokana na upeo na ufahamu ulio nao ambavyo ni muhimu kwa utafiti huu. Tafadhali kuwa mkweli na muwazi kwa vile matokeo ya utafiti huu yanaweza yakatoa maamuzi na mapendekezo ya baadaye.

Nini kinahitajika ili kushiriki

Ukikubali kushiriki katika utafiti huu, utasailiwa ili kuweza kujibu maswali toka kwenye dodoso lililoandaliwa kwa ajili ya utafiti huu.

Mambo muhimu katika kushiriki kwenye utafiti huu

Kama utakubali kushiriki katika tafiti hii, utahojiwa na maelezo utakayoyatoa yatarekodiwa na kinasa sauti pia naweza kuandika baadhi ya vitu muhimu.Utaulizwa kuhusu uzooefu wako kutathmini uzoefu wa watu wanaotumia dawa za kurefusha maisha dhidi ya unyanyapaa na kutengwa, na changamoto unazozikabili pindi unapohudhuria clinic. Itachukua takribani dakika 30 hadi 45 kukamilisha majadiliano ya kina.

Usiri

Taarifa zote zitakazokusanywa kupitia dodoso zitaingizwa kwenye ngamizi kwa kutumia namba za utambulisho. Kutakuwa na usiri na hakuna mtu yeyote asiyehusika atakayepata taarifa zilizokusanywa.

Hatari

Hatutegemei madhara yoyote kukutokea kwa kushiriki kwako kwenye kwenye utafiti huu.

Haki ya kujitoa au vinginevyo

Ushiriki katika utafiti huu ni wa hiari. Unaweza kuacha kushiriki katika utafiti huu muda wowote hata kama ulikwishatoa idhini yako. Kukataa kushiriki au kujitoa kutoka kwenye utafiti hakutahusisha adhabu yoyote.

Faida

Kama utakubali kushiriki kwenye utafiti huu taarifa utakazotoa zitatuwezesha kutupa mwanga zaidi juu ya kutathmini uzoefu wa watu wanaotumia dawa za kurefusha maisha dhidi ya unyanyapaa na kutengwa kwenye kliniki za huduma na tiba mkoani Dar es Salaam. Matokeo ya utafiti huu yanaweza kutoa taarifa ambazo zinaweza kusaidi katika kutoa ushahidi na mapendekezo kwa wanamipango na mameneja/ watawala kujua uhusiano kati ya unyanyapaa, kutengwa na utumiaji wa dawa za kurefusha maisha.

Endapo utapata madhara

Hutegemewi kupata madhara yoyote kutokana na ushiriki wako katika utafiti huu.

Nani wa kuwasiliana naye

Kama una maswali kuhusiana na utafiti huu, wasiliana na **Mtafiti mkuu wa utafiti huu, Maisara Mhode** (Tell. +255 786 546479) wa Chuo Kikuu cha Afya na Sayansi ya Tiba Muhimbili, S. L. P. 65001, Dar es Salaam.

Kama una swali kuhusu stahili zako kama mshiriki unaweza kumpiga simu kwa **Mwenyekiti wa baraza la Utafiti na machapisho Prof. Mainem Moshi** S.L.P. 65001, Dar –es Salaam. (Simu: 2150302-6) au msimamizi wa utafiti huu **Dr.Tumaini Nyamhanga** (+255 713 254000)

Sahihi: ....

Je umekubali?

Mshiriki amekubali ……............................ Mshiriki hajakubali ………..................

Mimi .... nimesoma maelezo ya fomu hii.

Maswali yangu yamejibiwa.Nakubali kushiriki katika utafiti huu.

Sahihi ya mshiriki………………………………………………………

Sahihi ya mtafiti ………………………………………………............

Tarehe ya kutia sahihi ya idhini ya kushiriki…………………………..

Appendix IV: Interview guide: English version

Lived experiences of Stigma and Discrimination among people on Antirertoviral Therapy: A Qualitative study in Ilala Municipality, Dar es Salaam.

PART I. SOCIAL DEMOGRAPHIC INFORMATION

The interviewer should administer this part

Number		**Coding categories**	**Answer**
1	Sex	Male……………1	
		Female………….2	[ ]
2	Age	Completed years __________	
3	Level of education	None………………..1	
		Madrasa…………….2	
		Primary…………….3	
		Secondary O-Level....4	
		Secondary A-Level…5	
		Diploma…………….6	
		Digree………………7	
		Postigraduate………..8	[ ]
4.	Religion	Christian……………..1	
		Muslim……………….2	
		None…………………3	
		Others specify………...4	[ ]

5	Marital status	Single……………….1	
		Married……………..2	
		Divorced…………….3	
		Widowed……………4	
		Separated……………5	
		Living with partner…6	[ ]
6	Occupation	Unemployed………..1	
		Self employed………2	
		Housewife…………..3	
		Govt employed……..4	
		Farmer……………....5	
		Bussness…………….6	
		Student……………...7	
		Others specify……...8	[ ]
7	Residential area	Mention ______________________________	
8	When started ART	Mention mm/yy ____________________________	

PART II: STIGMA INFORMATION

9 .How do you think about yourself after being diagonised HIV positive and the fact that you are on ART?

Probe;- Fear

- Ashamed of your HIV status
- Feeling blue most time of the day
- Feeling of suffering until cying
- Feeling hopeless and dying
- Feeling of disappointing and blaming youself
- Loss of self confidence
- Feeling of worthlessness

10 .To whom did you disclose your sero status and the fact that you are on ART ?

Probe ; Who have you not told that you are HIV positive and on ART? Why?

11. Preference on where to go for CTC

Would it be easier or better for you to go in an HIV clinic in you community or would you prefer to go far away from you community

Probe for the rationale.

12. What attitude do you have on antiretroviral treatment ?

Probe: -They may have side effects which cause visible side effects, or “stigma symbols”

- You consider HIV/AIDS as any other treatable disease
- Persons you know have changed their negative views on you since you started attending ART clinic
- ART drugs improve the health of PLHIV

-You do not feel ashamed or afraid to take ART drugs

- You do not feel ashamed or afraid to visit the ART clinic

-Because there is treatment for HIV by ART drugs, you have no more fear disclosing status

PART III: DISCRIMINATION INFORMATION

13. In what ways have you felt discriminated against (treated badly) by your family members once you started ART?

Probe :- Do not support in meeting basic needs

- Not Involved in family affairs
- Do not like you touch them
- Verbally abused
- Physically abuse you
- Don’t eat with you

-Relationship changed

14. How is your current relationship with your friends once you started ART?

15.I n what ways have you felt discriminated against (treated badly) by your community?

Probe- - Excluded from community events (religious rites, social gathering and so on)

- Your children discriminated against in school.
- Nobody played with you children.
- Neighbors stopped visiting your house.
- Neighbors told others about your HIV status.
- Reject to provide job in the community

- Not buying whatever you are selling.

- Verbally insulted

16. In what ways have you felt discriminated against (treated badly) by health care providers such as doctor, nurse, staff and others?

Probe- Refused to access in medical treatment or care

-Given poorer quality health services

- Stopped to access health care services

- Delayed in the provision of health services/treatment

- Forced to pay additional charges for medical service

- Verbally abused

- Treated in bad behavior and attitude

- Receiving less care/attention than other patients.

- Provide expired medicine

-Using latex gloves for performing non-invasive exams .

-Because you are HIV-positive, a senior health care provider assigns the client to a junior provider.

17. In what ways have you felt discriminated at your work environment?

Probe- Experience in job harassment and discomfort

- Customers refuse to buy products or goods

- Discriminated from employers

- Dismissed you

- Treated differently to colleagues

PART IV: ADHERENCE INFORMATION

18. How stigma affect medication adherence?

Probe- Missed taking a dose?

- Thought of stoping HIV pills

19.How comfortable are you when people see you taking ART?

Probe:- Taking ARVs in the presence of the spouse/ partner

- Taking ARVs in the presence of the other family members

-Hide pills from people around you

- Miss dose because people were with you.

PART V: COPING STRATEGIES INFORMATION

20. What coping strategies against stigma are you applying?

Probe :- Find comfort in you religion

-Praying for forgiveness of your sins and healing power of almighty God

-Perceive HIV infectin as the same as other chronic diseases (eg. Hypertension, diabetic mellitus) to make it seem more positive

-Look for best way to live with HIV/AIDS eg. Making regular exercises, mixing with friends

-Tying to be busy with work and get involved in several activities so as to forget your HIV status

-Using alcohol or other drugs to make you feel better from HIV related stress

21. What coping strategies against discrimination are you applying?

Probe:- Seek more information, advice and help from friends, relatives and health care providers about how better you could live with HIV infection.

- Getting emotional support and comfort from friends, partner, relative,health care providers, etc

- Making jokes with friends, relatives or infected colleagues about the HIV disease.

22. What are your suggestions to reduce stigma and discrimination in the future?

Appendix V: Dodosa la Mahojiano ya kina: Kiswahili Version

Kutathmini uzoefu wa watu wanaotumia dawa za kurefusha maisha dhidi ya unyanyapaa na kutengwa katika kliniki za huduma na tiba jijini Dar Es Salaam.

Nambari ya dodoso: ☐☐

Taarifa binafsi

Msaili ajaze sehemu hii

Tarehe ya usaili

Namba ya swali		**Tafsiri ya vipengele**	**Jibu**
SEHEMU YA I: TAARIFA BINAFSI			
1	Jinsia ya msailiwa	Mume…………......1	
		Mke……………......2	[ ]
2	Umri	Umri katika miaka ________	
3	Kiwango cha elimu	Sikusoma …………1	
		Madrasa……………2	
		Shule ya msingi……3	
		Secondari kawaida…4	
		Sekondari ya juu……5	
		Stashahada…………6	
		Shahada……………7	
		Shahada ya udhamili..8	[ ]

4 Dini

Mkristo..……………..1
Muislamu……………..2
Sina dini………………3
Nyingineyo, jaza……...4 [ ]

5 Hali ya ndoa

Sijaoa/Sijaolewa………..1
Nimeoa/Nimeolewa…….2
Nimeachika……………..3
Mjane/Mseja……………4
Tumetengana……………5
Tunaishi bila ndoa………6 [ ]

6. Shughuli ya kuingiza kipato

Sina ajira………………1
Nimejiajiri………………2
Mama wa nyumbani……3
Mwajiriwa serikalini……4
Mkulima………………..5
Mfanyabiashara………...6
Mwanafunzi…………….7
Mengineyo, (taja)……….8 [ ]

7.Makaazi Taja mahali unapoishi _________________

8. Ulianza lini dawa za kurefusha maisha Taja mwezi/mwaka________________

SEHEMU II: UNYANYAPAA

9. Ulijisikiaje baada ya kugundulika una VVU na kwamba sasahivi unatumia dawa za kupunguza makali ya VVU?

Dadisi/ jua undani;

- Uliogopa

-Uliona aibu

-Ulijilaumu

-Ulipoteza ujasiri

-Ulijiona huna thamani

10. Ulimueleza nani kuwa wewe una VVU na umeshaanza kutumia dawa?

Dadisi; Nani hukunueleza na ni kwanini?

11.Je ungependa kuhudhuria klinic iliyo karibu na jamii yako au mbali na jamii yako?

Dadisi; Kwanini kliniki ya mbali au karibu na jamii.

12.Una mtazamo gani kuhusu dawa za kupunguza makali ya VVU?

Tafuta undani: -

-Zina madhara ambayo yanaweza kupelekea unyanyapaa zaidi
-Naona VVU/UKIMWI kama ugonjwa mwingine unaotibika
-Watu tunaofahamiana wamebadilisha mawazo yao hasi tangu nilipoanza kuhudhuria clinic

-Dawa zimeboresha afya yako.

-Huoni aibu au kuogopa kunywa dawa

-Huoni aibu au kuogopa kuhudhuria clinic

-Kwasababu kuna dawa za kurefusha maisha huogopi kuwaambia watu kuwa una VVU

SEHEMU III: KUTENGWA

13.Ni vitu gani ulifanyiwa na familia yako ukaona kama vile wanakutenga mara tu ulipoanza kutumia dawa za kupunguza makali ya VVU?

Dadisi ;

-Waliogopa kukushika
-Walikutukana
-Hawakutaka kuketi na wewe

-Walikuwekea vyombo vya peke yako kwaajili ya chakula

-Hawakutaka kula na wewe

-Uhusiano ulibadilika

14. Elezea uhusiano wako na marafiki zako tangu ulipoanza kutumia dawa za kurefusha maisha

15. Ni vitu gani ulifanyiwa na jamii yako hadi ukahisi wanakutenga mara tu ulipoanza kutumia dawa za kurefusha maisha?

Tafuta undani; -

-Walikutenga na shughuli za kijamii
-Watoto wako walitengwa shule
-Hakuna mtu aliyetaka kucheza na watoto wako

-Jirani waliacha kukutembelea

-Jirani waliwaeleza watu wengine kuwa wewe una VVU

-Ulinyimwa kazi

-Watu walicha kununua vitu ulivyokuwa unauza

-Walikukejeli kwa maneno

16. Ni vitu gani ulifanyiwa na watoa huduma za afya kama daktari, muuguzi na wengineo ukahisi wanakutenga mara tu ulipoanza kutumia dawa za kupunguza makali ya VVU?

Tafuta undani;

- Hawakukupa huduma stahili
- Walikuachisha kupata huduma za afya
- Walikuchelewesha kukupa huduma
- Walikulazimisha kulipa gharama zaidi za huduma ya afya
- Walikutolea lugha chafu
- Hawakukujali ulipohitaji huduma
- Walikupa dawa zilizokwisha muda wa kutumia

17. Ni vitu gani ulifanyiwa katika eneo lako la kazi ukahisi wanakutenga mara tu ulipoanza kutumia dawa za kupunguza makali ya VVU?

Tafuta undani;

- Walikubughudhi na kukukera/ sumbua
- Wateja walikataa kununua bidhaa zako
- Ulitengwa na muajiri
- Ulifukuzwa kazi
- Ulitendewa vitu tofauti na wenzako

SEHEMU IV: UTUMIAJI WA DAWA KAMA ULIVYOSHAURIWA

18. Unyanyapaa unadhuru vipi utumiaji wa dawa kama ulivyoshauriwa?

Tafuta undani;

- Umewahi kuacha/kokosa kunywa dawa kwa wakati
- Umewahi kufikiria kuacha kunywa dawa kwasababu ya madhara madogo ya dawa ambayo yanaweza kuonyesha watu kuwa wewe unaishi na VVU

19. Huwa unakuwa huru kiasi gani/ unajisikiaje watu wakikuona ukiwa unakunywa dawa za kupunguza makali ya VVU ?

Tafuta undani;

- Hupendi watu waone wakati unakunywa dawa
- Unaficha dawa
- Wakati mwingine hunywi dawa kama watu wapo na wewe

SEHEMU V: MIKAKATI YA MTU MWENYE VVU/UKIMWI ILI AWEZE KUISHI MAISHA YA KAWAIDA

20. Mikakati ipi unatumia ili kukabiliana na unyanyapaa dhidi ya watu wanaotumia dawa za kupunguza makali ya VVU?

Tafuta undani;

- Unatafuta faraja kwenye dini yako
- Unasali kuomba msamaha kwa dhambi na uponaji kutoka kwa Mungu
- Kuona VVU/ UKIMWI kama magonjwa mengine sugu kama shinikizo la damu na kisukari
- Kutafuta njia nzuri ya kuishi na VVU kama kufanya mazoezi
- Kuwa unajishughulisha na kazi ili kusahau VVU
- Kunywa pombe au kutumia madawa ya kulevya ili uondoe mfadhaiko

21. Mikakati ipi unatumia ili kukabiliana na kutengwa dhidi ya watu wanaotumia dawa za kupunguza makali ya VVU?

Tafuta undani;

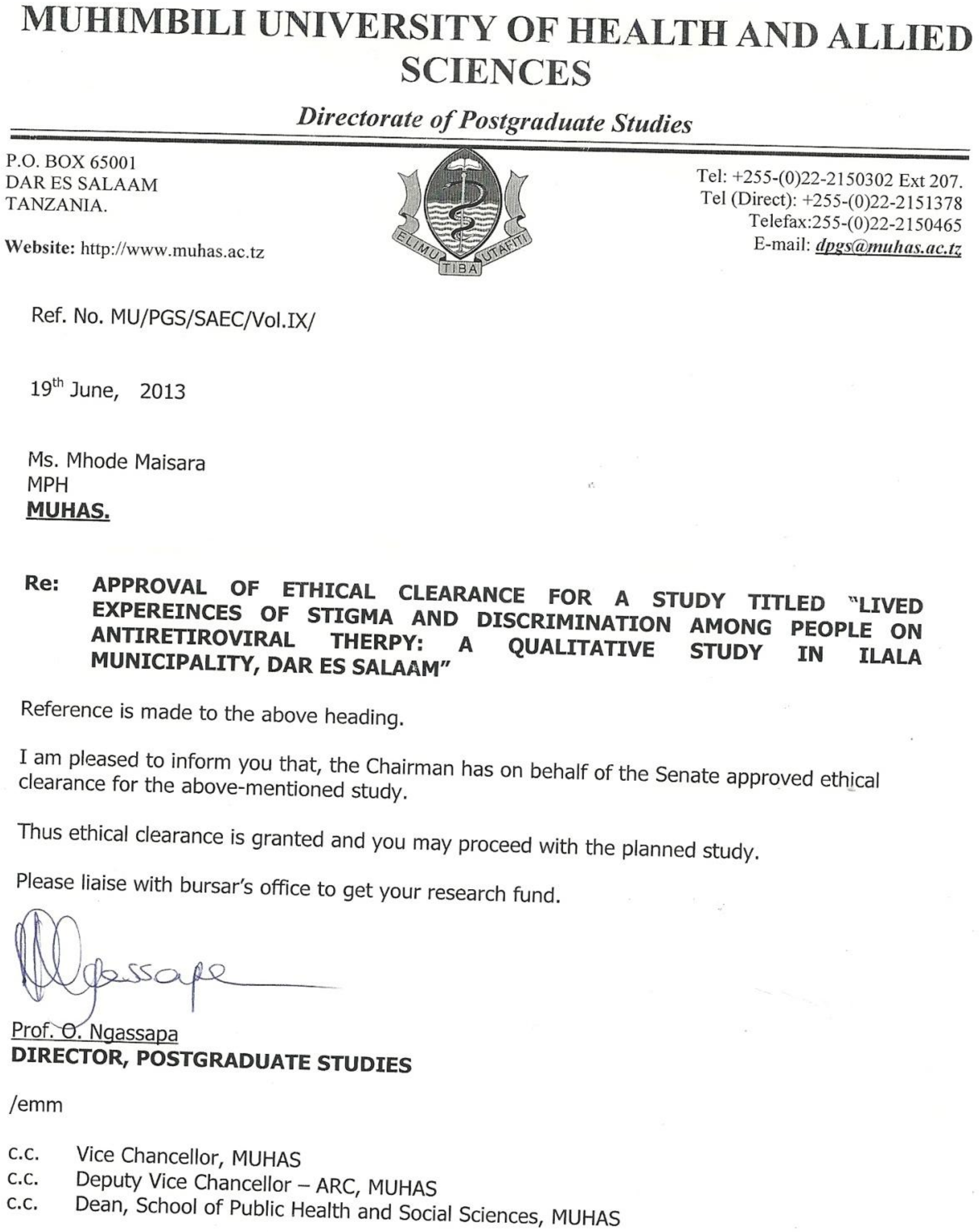
- Unatafuta habari zaidi, ushauri na msaada jinsi ya kuishi na VVU kutoka kwa marafiki, ndugu na wahudumu wa afya.

-Unatafuta faraja kutoka kwa marafiki, mwenza wako, ndugu, watoa huduma wa afya, na wengineo.

- Unafanya utani na marafili, ndugu au watu ambao wameathirika na VVU kama wewe

22. Toa maoni yako jinsi ya kuondoa unyanyapaa na kutengwa dhidi ya watu wanaotumia dawa za kupunguza makali ya VVU hapo baadaye.

Appendix VI: Ethical Clearance



MUHIMBILI UNIVERSITY OF HEALTH AND ALLIED SCIENCES

Directorate of Postgraduate Studies

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E-mail: ***dpgs@muhas.ac.tz***

Ref. No. MU/PGS/SAEC/Vol.IX/

19th June, 2013

Ms. Mhode Maisara
MPH
MUHAS.

Re: APPROVAL OF ETHICAL CLEARANCE FOR A STUDY TITLED “LIVED EXPEREINCES OF STIGMA AND DISCRIMINATION AMONG PEOPLE ON ANTIRETIROVIRAL THERPY: A QUALITATIVE STUDY IN ILALA MUNICIPALITY, DAR ES SALAAM”

Reference is made to the above heading.

I am pleased to inform you that, the Chairman has on behalf of the Senate approved ethical clearance for the above-mentioned study.

Thus ethical clearance is granted and you may proceed with the planned study.

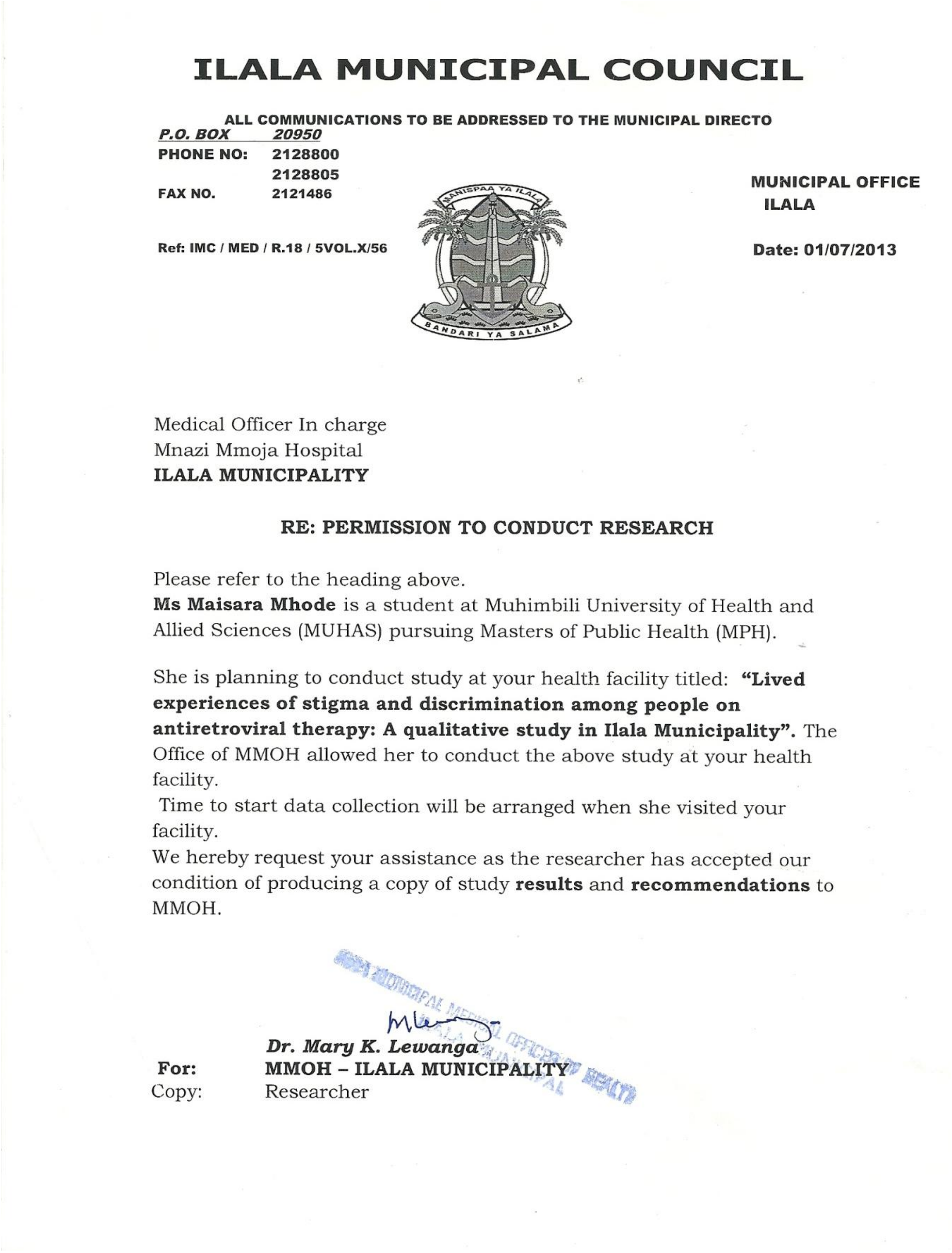
Please liaise with bursar’s office to get your research fund.

Prof. O. Ngassapa
DIRECTOR, POSTGRADUATE STUDIES

/emm

c.c. Vice Chancellor, MUHAS
c.c. Deputy Vice Chancellor – ARC, MUHAS
c.c. Dean, School of Public Health and Social Sciences, MUHAS

Appendix VII: Permission to conduct research



ILALA MUNICIPAL COUNCIL

ALL COMMUNICATIONS TO BE ADDRESSED TO THE MUNICIPAL DIRECTO

P.O. BOX 20950

PHONE NO: 2128800

2128805

FAX NO. 2121486

MUNICIPAL OFFICE

ILALA

Ref: IMC / MED / R.18 / 5VOL.X/56

Date: 01/07/2013

Medical Officer In charge
Mnazi Mmoja Hospital
ILALA MUNICIPALITY

RE: PERMISSION TO CONDUCT RESEARCH

Please refer to the heading above.
Ms Maisara Mhode is a student at Muhimbili University of Health and Allied Sciences (MUHAS) pursuing Masters of Public Health (MPH).

She is planning to conduct study at your health facility titled: **"Lived experiences of stigma and discrimination among people on antiretroviral therapy: A qualitative study in Ilala Municipality".** The Office of MMOH allowed her to conduct the above study at your health facility.
Time to start data collection will be arranged when she visited your facility.
We hereby request your assistance as the researcher has accepted our condition of producing a copy of study **results** and **recommendations** to MMOH.

Dr. Mary K. Lewanga
For: MMOH – ILALA MUNICIPALITY
Copy: Researcher

Appendix VIII: List of care and treatment centers in Dar es Salaam

Municipality	**Government**	**Private**	**Total**
Ilala	Amana	Khan	
	Mnazi mmoja	Agakhan	
	Buguruni	St. Bernard	
	IDC	Tumaini	
	Tabata A	Regency	
	Muhimbili	TMS	
	Ocean Road	Hindu Mandal	
		Buguruni Anglican	
Total			15
Kinondoni	Mwananyamala	TMJ	
	Sinza	Mikocheni	
		Oysterbay	
		IMTU	
		Masana Hospital	
		THI	
		UDSM	
		Emilio Mzena	
Total			10
Temeke	Temeke Hospital	T.O.H.S	
	Mbagala rangi tatu		
Total			3
Grand Total			**28**

Appendix IX: Map of Dar es Salaam City and its Municipalities