University of Malawi

Kamuzu College of Nursing

COPING MECHANISMS AGAINST STIGMA FOR PEOPLE LIVING WITH HIV AND AIDS IN BALAKA

A RESEARCH DISSERTATION SUBMITTED TO THE FACULTY OF NURSING IN PARTIAL FULFILLMENT OF BACHELOR OF SCIENCE IN NURSING DEGREE

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DECLARATION

I here by declare that this dissertation is as a result of my own work and effort and that it has never been presented anywhere for a degree.

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Signature:..... **DATE:**.....

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Signature:..... **DATE:** 01.12.08

DEDICATION

I dedicate this work to my wife Jenipher. Your patience and endurance during the years of my study have not been taken for granted.

God bless you!

ACKNOWLEDGEMENTS

Appreciation should go to Mrs.O. Mtema and Mr. H.E. Maliwichi for their support, caring, and endurance during the development of this dissertation. The researcher does not take this for granted. The researcher would like to extend appreciation to Mr. Ngwale for knowledge imparted to the researcher which has assisted him to develop the dissertation.

Finally, the researcher would like to thank the Almighty Lord for good life that he provides unto us. Father, please continue showing your love.

ABSTRACT

The study aimed to explore the coping mechanisms of PLWH against stigma in Balaka. Roy adaptation Model was adopted to guide the researcher in the research process. A qualitative research design was used with a sample size of 10 people both men and women to explore the coping mechanisms. The researcher used random sampling in the selection of the participants. A semi-structured interview guide was used for the purpose of data collection and the data was analysed through content analysis where three themes from the results were identified. These include; knowledge on positive living, forms of stigma and coping strategies e.g. rationalization, seeing oneself as ok, concentrating on other things, acceptance, turning to God, joining a group, disclosing, educating others, changing one`s lifestyles and going for counselling. The identified coping strategies have been labeled action based strategies or emotion based coping strategies. Coping appears to be self taught in managing stigma.

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ABBREVIATIONS

AIDS	Acquired Immunodeficiency syndrome
ART	Antiretroviral Therapy
ARV	Antiretroviral
BDH	Balaka District Hospital
HIV	Human Immunodeficiency virus
KCH	Kamuzu Central Hospital
MANET +	Malawi Network for People Living with HIV and AIDS
MIAA	Malawi Interfaith AIDS Association
NAPHAM	National Association of People Living with HIV and AIDS in Malawi
PLWH	People Living with HIV and AIDS
UNAIDS	United Nations AIDS Information Dissemination Services
UNICEF	United Nations Children's Fund
VCT	Voluntary Counseling and Testing
WHO	World Health Organisation

OPERATION DEFINITIONS

- **Positive living knowledge:** the focus is on the ability of PLWH to accept their status and ability to interact freely.
- **Serostatus:** the state of ones blood/serum in relation to HIV and AIDS. This can either be negative or positive.
- **Seropositive:** having a positive serologic test in this case.
- **Stigma:** refers to all unfavorable attitudes, beliefs, and policies directed towards people perceived to have HIV and AIDS as well as towards their significant others.

CHAPTER 1

1.0 INTRODUCTION

Acquired Immunodeficiency syndrome (AIDS) has killed over 25 million people since it was first recognized in 1981, making it one of the most destructive epidemics in recorded history. Despite recent improved access to antiretroviral treatment and care in many regions of the world, the AIDS epidemic claimed about 3.1 million lives in 2005 (UNAIDS, 2005).

From the moment scientists identified Human Immunodeficiency Virus and Acquired Immunodeficiency Syndrome (HIV and AIDS), social responses of fear, denial, stigma, and discrimination have accompanied the epidemic (Fredricksson and Kanabus, 2008). Across the world people living with HIV (PLWH) and their families have been subjected to prejudice, discrimination, abuse and hostility related to the stigmatization of AIDS (Holzemer and Uys, 2004). Since PLWH continue to be isolated from social and spiritual support, they need to be provided with the necessary support to recover their self-esteem; and need to be taught techniques required to manage stress, which is the major immune system suppressor (Brown et al, 2001).

According to Brown et al (2001), stigma has been defined as a common human reaction to disease. Throughout history many diseases have carried a considerable stigma including leprosy, tuberculosis, mental illnesses and many sexually transmitted infections (STIs). However, HIV and AIDS is the latest disease to be stigmatized.

This study therefore, was intended to explore how PLWH cope with HIV and AIDS related stigma in Malawi especially in Balaka.

1.1 BACKGROUND

1.1.1 GLOBAL BURDEN OF HIV AND AIDS

AIDS has become a major worldwide epidemic. At the end of 2002, global estimates revealed that 42 million adults and children were living with HIV and AIDS, 5 million were newly infected and there were 3.1 million AIDS deaths (Ministry of Health and Population, 2003). The total number of children orphaned by AIDS and living at the end of 2001 was 14 million (Ministry of Health and Population, 2003). Although the prevalence of HIV dropped to 33.2 million in 2007 (UNAIDS, 2007), the majority are struggling to live positively because of stigma associated with HIV and AIDS.

1.1.2 HIV AND AIDS IN SUB-SAHARAN AFRICA AND MALAWI

Sub-Saharan Africa is the epicenter of this epidemic. Approximately 3.5 million new infections occurred in the region in 2002 (Ministry of Health and Population, 2003). Since the beginning of the epidemic, more than 15 million Africans have died from AIDS (Fredricksson and Kanabus, 2008). The estimated number of children orphaned by AIDS living in the region is estimated at more than 11 million (Ministry of Health and Population, 2003). During 2006 alone, an estimated 2.1 million adults and children died as a result of AIDS in sub-Saharan Africa (Fredricksson and Kanabus, 2008).

According to the Ministry of Health and Population (2003), Malawi has one of the highest HIV/AIDS prevalence rates in the world, with 15% of those aged 15-49 years infected; while the national prevalence is estimated at 8.4%. According to Fredricksson and Kanabus (2008), it is estimated that about one million adults and children are living with HIV/AIDS in the country. About 300,000 adults and children were estimated to have died of AIDS related diseases. The cumulative number of orphans, directly related to the AIDS epidemic is approximately 400,000.

1.1.3 STIGMA AND DISCRIMINATION

Stigma and discrimination constitute one of the greatest barriers to effectively deal with the epidemic. Research has demonstrated that HIV related stigma can have a number of effects on health behaviour such as seeking HIV testing, willingness to disclose HIV

status, accessing health care and quality of health care given or received (Brown et al 2001 and UNAIDS, 2008).

According to MANET + (2003), Malawi has experienced denial and silence about HIV and AIDS. Stigma and discrimination are rampant, making it difficult for PLWH to seek and access medical, psychosocial and spiritual services. Due to the increase in AIDS related diseases or illnesses, education sector, which is critical for Malawi's national development, has been severely affected (AVERT, 2005). The pressures of having to care for parents and siblings while trying to earn an income, can cause children to drop out of school, even while there parents are still alive. The pressure to abandon schooling intensifies when one or both parents die (Maqoko and Dreyer, 2007).

Economically, Malawi has registered acute declines in productivity related to child – headed families and single parent at household level. Stigma around HIV and AIDS shows how important it is to look at the impact of the virus on communities such as increase in widow or child-headed households and an increase in chronically or acutely sick house holds. These households either are discouraged from or drop out from community activities thereby contributing to no or slow community development (Maqoko and Dreyer, 2007). The isolation is associated with increased psychological distress such as anxiety, depression, and poor adjustment and these contribute to poor quality of life (AVERT, 2005).

1.2 STATEMENT OF THE PROBLEM

Despite decades that have passed since the first cases of HIV and AIDS clients were identified, and all efforts to stop the epidemic, the Malawi National AIDS Commission in its annual monitoring and evaluation report for 2004 indicated that stigma is still a challenge to the country's efforts and for PLWH. Stigmatization by communities, families and partners negatively affect preventive behaviours such as condom use, HIV test seeking behaviour, care-seeking behaviour upon diagnosis and quality of the care given to HIV and AIDS positive clients. While a number of surveys have indicated the magnitude of HIV and AIDS stigma, little is known on how HIV and AIDS stigma is

constructed in the Malawian urban setting. The study was specifically conducted at Balaka District hospital among clients attending Antiretroviral Therapy (ART) Clinic. The study was therefore, designed to explore the coping mechanisms that are being employed by the PLWH in the fight against HIV and AIDS related stigma.

1.3 SIGNIFICANCE OF THE STUDY

The results of the study will help the Government and all Non-governmental organizations concerned with PLWH and HIV and AIDS in general to emphasize on the coping mechanisms that are effective. It will also help PLWH live positively and thereby developing good measures to reduce stigma so that they (PLWH) become very useful to the society as before or as any body. Through this study the government, Ministry of Health and other Public Health Experts will also become aware of the current forms of stigma in the community. This will help to develop strategies or programmes that focus on reduction of the stigma

1.4 OBJECTIVES OF THE STUDY

1.4.1 GENERAL OBJECTIVE

The main objective of the study was to find out the coping mechanisms against stigma for people living with HIV and AIDS.

1.4.2 SPECIFIC OBJECTIVES

(i) To asses clients' knowledge on positive living.

(ii) To explore the lifestyles of clients living with HIV and AIDS.

(iii) To identify forms of stigma people living with HIV and AIDS face.

(iv) To identify the challenges faced by people living with HIV and AIDS in attempt to live positively.

CHAPTER 2

2.0 LITERATURE REVIEW

2.1 INTRODUCTION

Literature review has been defined as an extensive, exhaustive, and systematic examination of publications relevant to the research project (Seaman and Verhonick, 1982). It is done for the purpose of locating information on a topic, synthesizing conclusions, identifying areas for future study, and developing guidelines for clinical practice (Polit and Hungler, 1991). This literature review has explained the concepts of stigma and discrimination, positive living, life styles of PLWH, forms of stigma and challenges faced by PLWH. The challenges faced by PLWH have been outlined in the description of stigma and discrimination.

2.2 STIGMA AND DISCRIMINATION

HIV-related stigma refers to all unfavorable attitudes, beliefs, and policies directed towards people perceived to have HIV and AIDS as well as towards their significant others and loved ones, close associates, social groups, and communities (Fredriksson and Kanabus, 2008). Patterns of prejudice, which include devaluing, discounting, discrediting, and discriminating against these groups of people, play into and strengthen existing social inequalities—especially those of gender, sexuality, and race—that are at the root of HIV-related stigma (Information Bulletin, 2002).

Guni (2005) defined discrimination as a prejudicial act that is fastidiously selective based on a distinct stigmatizing work, theory, fear, or perception. Guni (2005) further stated that discrimination is a differential act based on prejudice, emanating from distinguishing features of stigma. In agreement, (Maqoko and Dreyer, 2007) referred discrimination essentially as the different, and most commonly negative, treatment of an individual or group of individuals because of one or more factors attributed to them. Stigma and discrimination are therefore; intimately linked as stigmatization often leads to

discrimination and discrimination can take many forms. However discrimination does not exist in the absence of stigma and therefore the two will be used interchangeably.

According to the report by the National AIDS Trust (2005), HIV stigma is expressed in many ways such as through social ostracism, personal rejection, direct and indirect discrimination and laws that deprive people living with, and affected by HIV and AIDS of their basic rights. In the United Kingdom, HIV and AIDS-related discrimination in employment, health care, insurance and education have all been widely reported since the beginning of the epidemic.

Research has demonstrated that the undesirable differences and spoiled identities due to HIV related stigma do not just naturally exist but are created by individuals and communities. As a result, HIV related stigma simply builds upon and reinforces already existing prejudices (MANET+, 2003). The harassment of individuals suspected of being HIV infected has been widely reported. It is often motivated by the need to blame and punish and in extreme circumstances has extended to acts of violence and murder. AIDS related murders have been reported in countries as diverse as Brazil, Colombia, Ethiopia, India, South Africa and Thailand (AVERT, 2005). According to Brown (2008), Tanzania has not been spared as albinos are being hunted for body parts. The fear now is that the stigma attached to HIV and AIDS can extend into the next generation, placing an emotional burden on those left behind (Fredriksson and Kanabus, 2008).

However, denial goes hand in hand with discrimination, with many people continuing to deny that HIV exists in their communities (AVERT, 2005). At the end of the year 2007, 33.2 million people in the Sub-Saharan region were living with HIV and during the very same year, 2.1 million died from AIDS-related illness (Guni, 2005). Therefore, combating the stigma and discrimination against people who are affected by HIV and AIDS is as important as developing the medical cures in the process of preventing and controlling the global epidemic (Fredriksson and Kanabus, 2008).

HIV-related stigma and discrimination in Malawi remains an enormous barrier to effectively fight the HIV and AIDS epidemic (AVERT, 2005). Fear of discrimination

often prevents people from seeking treatment for AIDS or from admitting their HIV status publicly. However, studies have indicated that as a result of HIV related stigma a number of challenges have arisen such as; denial of HIV status (individually, socially, and nationally leading to delayed treatment, care and support), fear, anxiety, depression, apathy, anger, suicidal attempts and revengeful behaviours, disrupted social integration process for PLWH and marginalization of certain groups (MANET +, 2003; Fredricksson and Kanabus, 2008).

Studies have also demonstrated that after a person tests positive, he or she faces decisions that include how to enter and adhere to care and whether to disclose HIV seropositivity to partners, friends, family, colleagues, employers, and health care providers. At each level, a decision to disclose seropositivity may either enhance access to support and care or expose the individual to stigmatization and potential discrimination (Guni, 2005).

According to Fredriksson and Kanabus (2008), some of the factors which contribute to HIV and AIDS-related stigma are as follows:

-HIV and AIDS is a life-threatening disease

-People are scared of contracting HIV

-The disease is associated with behaviours (such as sex between men and injectable drug-use) that are already stigmatized in many societies

-People living with HIV and AIDS are often thought of as being responsible for becoming infected

-Religious or moral beliefs lead some people to believe that having HIV and AIDS is the result of moral fault (such as promiscuity or 'deviant sex') that deserves to be punished.

Population Council's studies and activities on stigma and discrimination in 2008 indicate that there are a number of practical approaches that can be undertaken to reduce the basis for these fears, including providing information, counseling, skills acquisition, and

increasing the opportunities for contact with people living with HIV and AIDS (Population Council, 2008).

2.3 KNOWLEDGE ON POSITIVE LIVING

Literature shows that, only a few studies have been conducted on knowledge of positive living by PLWH both globally and in the Sub-Saharan Africa.

Madise and MANET+ (2003), defined positive living as making choices in one's life that are good for one's health, living as normally as possible, looking after one's spiritual and mental health as well as making the best of one's life as a person with HIV or AIDS. Initially, this must involve an element of counselling and support; education on how to live well with HIV, required medical tests, and medications. PLWH must also learn about HIV transmission and safer sex, for two reasons - they need to know how to live positively without passing the virus on to anyone else, and also avoid coming into contact with a strain of virus that differs from the one they already have (Jana PSI/Malawi, 2003).

For the past two decades most studies in Malawi dwelled on practices that promote HIV and AIDS awareness and the approach that Malawi took in the fight against HIV and AIDS was to prevent the spread of the disease. However, efforts have been made to explore ways through which the disease is spread, and find ways to curb the problem. In conjunction with this, Malawi has come to accept that HIV and AIDS are amongst us and therefore, there are efforts aimed at helping those who are living with HIV and AIDS to live positively. For example the National AIDS Commission (NAC) has a theme called "Stigma and Discrimination" and is looking at the way forward to combat this stigma and discrimination (AVERT, 2005). More effort has to be put therefore to explore Malawian practices that can help those who are already HIV positive or suffering from AIDS to live positively (Jana PSI/Malawi, 2003).

In helping and supporting PLWH, the National Association of PLWH in Malawi (NAPHAM) has a drama troupe and a poultry farm. The drama group assists in HIV

awareness and reduction of HIV related stigma and discrimination while the farm helps in buying ARVs for those in need. It also provides employment for HIV positive people who may otherwise find it difficult to find a job (Guardian News Media Limited, 2008).

The faith based organizations also have taken part in fighting of HIV related stigma and helping PLWH live positively through prayers and asking the congregation to contribute something to help PLWH (MIAA Newsletter, 2007). However, NAPHAM Advocacy Officer, Deidre Madise says that the solution to the matter (stigma and discrimination) is moral support on how PLWH can cope with the virus. Madise emphasizes that a person with HIV can live normally like any other person; can be ill and get cured (MIAA Newsletter 2007).

According to NAPHAM, living positively requires some basic support: Access to health information and services, good nutrition, therapeutic counselling, advice about how to support a family, including children who may be orphaned and home based care for those who have eventually become weakened and sick. Also critically needed is access to treatment; anti-retroviral drugs or ARVs. If appropriately prescribed, properly taken, and supported by a healthy lifestyle, ARVs can massively prolong the health and well being of people who are HIV positive in Malawi (Guardian News and Media Limited, 2008).

2.4 LIFESTYLES OF PLWH

A study that was conducted in Alberta, Canada to examine the experiences of HIV-positive Aboriginal individuals in the period following diagnosis, indicated that receiving and adapting to a positive HIV diagnosis was a difficult process for most people. This resulted in a number of potentially harmful behaviours and painful emotions (Mill et al, 2008). For example it was common for PLWH to equate their HIV diagnosis with a death sentence. This is in agreement to what was found by UNAIDS that when one is found HIV positive, there are beliefs that are mixed with thoughts of suicide, self imposed isolation, increased use of drugs and alcohol, and other high risk behaviours (UNAIDS, 2001).

The results of a study conducted in Togo by Oppong and Moore (2006) on sexual risk behaviour among PLWH reviewed that although PLWH may be aware of infecting their sexual partners, they deliberately ignore the risk because of other factors such as wanting a baby or take precedence (Oppong and Moore, 2006).

Fear of stigma can cause pregnant women to avoid HIV testing, the first step in reducing mother-to-child transmission. It may force mothers to expose babies to HIV infection through breast-feeding because the mothers do not want to arouse suspicion of their HIV status by using alternative feeding methods. Fear of stigma, and the resulting denial, may even inhibit condom use in HIV discordant couples (Rankin etal, 2005).

2.5 FORMS OF STIGMA

The results of a research carried out by National Association of People with Aids (2005), on HIV stigma and discrimination reviewed that there are two basic forms of stigma manifestation. These are; institutionalized and individualized stigma. Institutionalized stigma is when an institution such as a hospital or a church practices stigma either passively or actively. For example making HIV testing a precondition for marriage or designing areas specifically for provision of preferred services that the public is aware of. Malawi for example has institutions that are meant specifically for PLWH such as ART Clinics. This may also create barriers for accessing ART services by PLWH for fear of being stigmatized. On the other hand individualized stigma is the acting out of the stigmatizing attitudes directed towards an individual. It can be one person or a group being stigmatized based on the societal attitudes and perceptions of the sin committed (Guni, 2005).

Guni (2005) also mentioned two types of stigma as "felt" and "enacted". He described felt stigma as internal and is manifested as unwillingness to seek help and access to resources. This is as a result of impact of shame, guilt, withdraw and self-stigmatization. On the other hand Guni described enacted stigma as external stigma which relates to experiences. In this type of stigma individuals can be denied access to information, health

services, association (friendship, involvements) and the support they need. They can also face loss, violence and quarantine (AVERT, 2005).

2.6 CONCLUSION

From the literature review, it has been noticed that most studies Globally, Sub-Saharan Africa and Malawi have only targeted HIV related stigma and discrimination and little is known on how PLWH cope with this stress.

Reducing stigma and discrimination as well as developing good coping mechanisms will therefore empower PLWH to recognize the benefit of the various services. Many people may also be willing to seek voluntary counselling and testing (VCT), access care, support and treatment, and disclose their sero-status as well as learn how to live positively.

CHAPTER 3

3.0 CONCEPTUAL FRAMEWORK

3.1 INTRODUCTION

When nursing research is performed within the context of the theoretical framework, its findings are significant and are utilized in nursing (Polit and Hungler, 1995). This study was guided by Sister Callista Roy's Adaptation Model (1976). The model guided the researcher to understand the variables under study and their relationship; and how these relationships affect their outcome (Fig.1).

3.2 ROY ADAPTATION MODEL

Sister Callista Roy developed the model in 1976. This model is comprised of four domain concepts of a person, nursing, health and environment (Andrews and Roy, 1991). Roy's model sees the person as "a biopsychosocial being in constant interaction with a changing environment" (Rambo, 1984). The person is an open, system who uses coping skills to deal with stressors (Harjit, 2002). In this case, the individual and the environment are the sources of stimuli that require modification to promote adaptation. Sister Callista Roy's model states that all possible factors affect the individual's health, including the physiological aspects and the coping mechanisms of the individual (Fig.1).

3.2.1 DESCRIPTION OF THE CONCEPTS

3.2.1.1 PERSON

The concept of person is said to be a holistic adaptive system which is in constant interaction with the environment (Andrews and Roy, 1991).The person is believed to be an adaptive system with the regulator and cognator acting to maintain adaptation in the four adaptive models namely physiologic function, self concept, role function, and interdependence (Whall and Fitzpatrick, 1991). Therefore, the concept of person is not just limited to the individual but can also include groups, families, organisations, communities and society as a whole.

3.2.1.2 NURSING

Roy described nursing as a scientific discipline with a practice orientation (Whall and Fitzpatrick, 1991). The science of nursing is interested in understanding life processes which promote adaptation and health, how persons cope with health and illness, and nursing interventions to promote or enhance adaptive coping and health. As a practice discipline, nursing uses this scientific knowledge to enhance the interaction of the person with the environment to promote adaptation (Roy 1990).

3.2.1.3 HEALTH

Roy defined health as a state and process of being and becoming an integrated and whole person (Andrews and Roy, 1991). Being integrated is a state which reflects the adaptation process and which can be described at any given point in time as it is manifested in the wholeness and integration of the four adaptive models: physiological, self-concept, role function, and interdependence. Becoming integrated is a continuous process consisting of a systematic series of actions directed towards both individual goals and purposefulness of human existence (Roy, 1990; Andrews and Roy, 1991).

Being an integrated and whole person implies a soundness or unimpaired condition that can lead to completeness or unity and the highest possible fulfillment of human potential. Thus, integration is health, whereas the absence of integration is lack of health (Whall and Fitzpatrick, 1996). Health is without reference to illness and includes emphasis on states of well being (Roy, 1990).

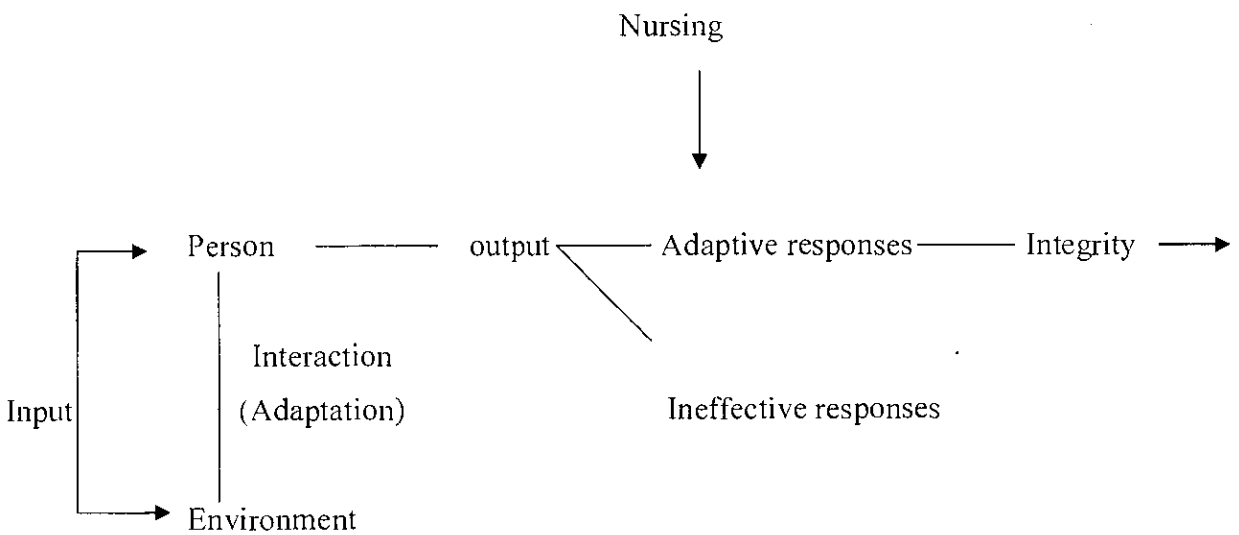
3.2.1.4 ENVIRONMENT

Environment is defined as all conditions, circumstances, and influences that surround and affect the development and behaviours of the person (Andrews and Roy, 1990). The environment again is viewed as input for the person as an adaptive system and may be described as internal and external stimuli (Andrews and Roy, 1991). Once exposed to external or internal stimuli there is attention and the person expends energy to deal with it. Through feedback processes, behaviour can now be judged as adaptive or ineffective.

3.2.1.5 ADAPTATION

This concept is the core component for adaptation model and is closely linked to the concept of health. The person- environment is known as adaptation and it reflects the person's health (Whall and Fitzpatrick, 1996). Adaptive responses promote integrity relative to the goal of the human system-survival, growth, reproduction, and mastery thereby promoting health. Adaptive responses again free energy from ineffective coping and allow the person to respond to other stimuli. This freeing of energy can promote healing and enhance health. On the other hand, ineffective responses do not promote integrity or contribute to goals of adaptation (Andrews and Roy, 1991; Wall and Fitzpatrick, 1996).

Fig.1 Diagrammatic representation of Roy Adaptation Model



(Adapted from Whall and Fitzpatrick 1996).

3.2.2 APPLICATION OF THE MODEL TO THE STUDY

Roy adaptation model explores the adaptive responses that an individual employs soon after exposure to a stressor (stimuli). The end result being integrity or disintegrity. Since the adaptive responses come in due to interaction between the individual and the environment, the environment acts as a stressor, stimuli, or input. If the output after the stressor causes no harm to the individual then the person is said to have adapted to the

environment and is health. However, if the end result produces ineffective response then the person is said to have poor adaptation such that he or she cannot work effectively. In other words, the person is unhealthy. This then invites nursing interventions for the purpose of affecting health positively.

In this study, the model has helped the researcher to determine the response of people living with HIV and AIDS (PLWH) to external stimuli such as stigma and explore how they cope or adapt to these stressors. In case of poor adaptive responses then nursing intervention to assist them to develop good coping mechanisms can be suggested. On the other hand, if individuals adapt effectively to stigma or their HIV status, the adaptive responses need to be reinforced. This will also mean that the individual is healthy such that he or she can work effectively towards development and achievement of self esteem.

To maintain the equilibrium, it is also important to consider regulation of the input. For instance, if stigma is predisposing PLWH to stressor then measures to stop stigma can be employed so that physiologic, role function and self concept are maintained. Absence of stressor, in this case, stigma will enable PLWH develop good health thereby working towards achievement of their various goals.

3.3.7 CONCLUSION

Interventions focusing on the person-environment interaction will therefore help to produce good adaptive responses other than ineffective responses. Since the adaptive responses come in due to interaction between the individual and the environment, the environment acts as a stressor, stimuli, or input. If the output after the stressor causes no harm to the individual then the person is said to have adapted to the environment and is healthy.

CHAPTER 4

4.0 METHODOLOGY

4.1 INTRODUCTION

This chapter aims at describing the research methodology that the researcher employed to carry out the study. It includes information on the study design, setting, sampling, pre testing, data collection tool, data analysis, ethical consideration and limitations of the study.

4.2 STUDY DESIGN

The study used a descriptive qualitative research design using in-depth interviews. Qualitative descriptive studies aim at discovering important underlying characteristics of a person, situations, groups, and the frequency in which they occur (Polit and Hungler, 1991). It does not manipulate the subjects such that they are able to freely give information.

4.3 SETTING

The study was conducted in Balaka at Balaka District Hospital (BDH) among clients attending ART clinic. This place was chosen because of its availability of PLWH.

4.4 SAMPLING AND SAMPLE SIZE

The sample included PLWH aged 15-49 attending ART clinic at Balaka District Hospital. Random convenience sampling was used in the selection of the participants. Convenience sampling means that the participants are available at the right place on the right time. Subjects are simply recruited in the study until the desired sample size is reached and have met the researcher's criteria for the purpose and have given consent to participate in the study (Burns and Grove, 2005). A maximum number of 10 people were recruited in the study since a qualitative method uses a small sample and yield significant data (Polit and Hungler, 1991).

4.5 PRE TESTING

The interview guide was piloted at Kawale Health centre. This place was chosen because it provides similar services as Balaka ART clinic.

4.6 DATA COLLECTION TOOL

An in-depth interview guide was developed by the researcher. The questions in the guide were formulated from the study objectives in English (Appendix 1a) and translated to Chichewa (Appendix 1b). The interview guide was used to collect data.

4.7 DATA COLLECTION METHOD

The data was collected using an in-depth interview guide. The researcher interviewed the participants alone so that validity and reliability of the data are maintained. Random convenience sampling was used in the selection of the participants. Again the researcher also made sure that the interview guide was reviewed by experts in HIV and AIDS and piloted before usage to ensure desirable data is collected. Probing and prompting guided the respondents in answering the questions where misunderstanding arose. This ensured that purposeful answers were given (Cormack, 1991). For the purpose of privacy, each participant was interviewed separately on a private place and each interview session lasted for 40 minutes.

4.8 ETHICAL CONSIDERATION

To ensure human protection, consent and ethical clearance were sought from Kamuzu College of Nursing Research Committee (Appendix 2). Permission to pilot the study was sought from the in charge of Kawale Health Centre (Appendix 3) and permission to use the study setting was sought from the District Health Officer through a letter (Appendix 4). In addition, verbal and written consent (Appendix 5) was obtained from the study participants after giving them adequate information for informed consent. This information included purpose, significance and benefits of the study to the individual and the nation as a whole. They were assured of referral to a counselor in case of anxiety and that participation was voluntary as such they could withdraw any time they felt like without any penalty.

The participant's confidentiality and privacy were maintained by the use of identity codes or numbers on interview guide. The participants were told that the information would not be accessed by anybody else except the researcher or those who are directly involved in the study. Participants were also told that after data analysis the interview guides would be burnt for the confidentiality's sake.

4.9 DATA ANALYSIS

The data was analyzed manually through content analysis. According to Burns and Groove (1997); content analysis involves analyzing a content of a narrative data to identify prominent themes and pattern among the themes. Themes are structural meaning units of data (Streubert and Carpenter, 1995). Themes helped the researcher to cluster information and discover the meanings intended in what was heard. Once all themes relevant to the study were explicated, the researcher wrote them up in a way that was meaningful to the participants.

CHAPTER 5

5.0 PRESENTATION OF FINDINGS

5.1 INTRODUCTION

This chapter gives the results of the study. During the in-depth interview 10 participants were interviewed. Three themes which included knowledge on positive living, forms of stigma and coping strategies were identified. Examples of the coping strategies identified include rationalization, seeing oneself as a person free from HIV, joining a group, disclosing, educating others, concentrating on other things, acceptance, turning to God, changing one's lifestyle and going for counseling.

5.2 DEMOGRAPHIC DATA

The age group of 41-45 years was the majority of the participants in the study with a percentage of 60 (Table 1). Out of the ten participants interviewed 8(80%) participants ware primary school drop outs and only 2 (20%) went as far as secondary school level but only one (10%) did rich form four. The results have also shown that the majority were married people 8 (80%) while the minority of the participants were not married (Table 1). Out of the 20% of the unmarried group one person did not even get married while the other one her husband passed away.

TABLE 1.

DEMOGRAPHIC CHARACTERISTICS OF THE SAMPLE (N=10)

AGE	**PERCENTAGE (%)**	**NUMBER OF PEOPLE**
30-35	10	1
36-40	30	3
41-45	60	6
SEX		
Male	50	5
Female	50	5
EDUCATION		
Primary school	80	8
Secondary school	20	2
MARITAL STATUS		
Married	80	8
Single	20	2

5.3 KNOWLEDGE ON POSITIVE LIVING

Out of the 10 participants interviewed the majority (70%) did not have any knowledge on positive living. 30% of the interviewed participants showed some degree of knowledge on positive living. During the interview 2% of the respondents said they had never heard the word positive living while half of the respondents said they knew the meaning of positive living but the explanations were out of context. For example others replied:

'It means waiting for visitors.'

'I don't know what it means and have never heard it.'

5.4 FORMS OF STIGMA

The notable form of stigma is the institutionalized one whereby clients on ART are attended to their own clinic. However, all of the respondents 100% had no problems with the set up as reflected in the following statements:

'I am happy because we get treatment without struggling.'

'There is no problem except that the clinic is too small for all of us.'

'I am happy because people of the same illness are treated on the same place and we are free to interact.'

On the other hand individualized form of stigma was noted in 80% of the respondents. The most common type of stigma experienced is the 'felt' stigma which is internal as noticed in unwillingness to disclose HIV serostatus to other people outside the family for fear of stigma.

'I have never disclosed my serostatus as a matter of giving myself respect.'

'Apart from my wife nobody has been told about my status.'

The other type of stigma which is external 'enacted' was reported in one person who was free to explain her condition.

'I am usually referred to as a walking copse.'

5.5 COPING STRATEGIES

The coping strategies used by PLWH have been categorized into two namely; action based coping strategies and emotional based coping strategies. Action based coping strategies involve dealing with the problem causing the stress in order to adapt to the environment or it involves engaging with others. On the other hand, emotional coping strategies involve reducing symptoms of the stress without addressing the source.

5.5.1 EMOTIONAL BASED COPING STRATEGIES

(i) Rationalization

Rationalization was used to reduce stress or pain upon the diagnosis and the stigma attached. It was used as a defense mechanism by cognitive process to reduce anxiety associated with intrinsic desires as reflected in the following statements:

'It didn't hurt me because I knew all of us are going to die. Nobody is an angel.'

'After all AIDS is like any other disease whereby you can be cured or die.'

(ii) Seeing oneself as a person free from HIV

Seeing oneself as a person free from HIV strategy included ideas where the respondents regarded themselves as normal thus people free from an illness as someone said:

'I live like any other person and do household chores and any other activity like any other person.'

(iii) Concentrating on other things

Concentrating on other things was a strategy used to divert harmful thoughts and feelings associated with the diagnosis and stigma. Self distraction or diverting attentions from illness to other facets of living prevents one from being idle and helps to maintain self concept thereby remaining always active. This is because as a means of dealing with otherwise continuous thoughts about the illness. This has been reflected in the following statements:

'I don't think about it so I live normally.'

'When I know I'm about to think of it I quickly change the subject or start doing something else which can divert the feelings.'

(iv) Acceptance

Acceptance was used as the respondents were coming to terms with their condition or changed circumstance. Most of the respondents used this category to alleviate pain and sufferings associated with the diagnosis as seen in the following statements:

'I accepted the disease because I know it is impossible to remove the virus.'

'I accepted because I know the virus is in me and has no treatment.'

(v) Turning to God

This category focused on spirituality and included activities such as praying to God, joining religious groups, depending and building hope in God in response to the illness. The majority of the respondents also built their hope in God because it is the thing that keeps them on going as seen in the following statements:

'At first I was a womanizer but upon realizing that I was HIV positive I decided to give my heart to God.'

'I know it is only God who can help me thus why I always pray.'

'I used to have so many friends but now my only hope is God.'

5.5.2 ACTION BASED COPING STRATEGIES

(vi) Joining a group

Joining a group focused on social interaction with people of the same category such as HIV infected individuals or joining a support group.

'After I was found positive I decided to join a support group because my friend told me about the group.'

'We have a group of PLWH individuals inorder to encourage each other.'

(vii) Disclosing

Disclosing was used as a coping strategy to solicit love from the beloved ones and others disclosed to get support from the community and family members while others disclosed to get public support. For example others replied that:

'I am usually hired by NAC group to convince people that HIV exists.'

'I told my wife about my status so that she could also get tested.'

'I am not afraid of revealing my HIV status that is why I am usually hired.'

(viii) Educating others

Educating others was also another coping strategy which referred to active teaching of others to reduce anxiety and help others to cope as seen below:

'I normally organize the youth and teach them on the importance of practicing abstinence and using a condom.'

(ix) Changing of one's lifestyles.

Changing of one's lifestyle focused on behaviour change from risky behaviours such as drinking beer and others that were usually liked to behaviours that could prolong life. Participants reported that change of one's lifestyles helped them a lot as seen in the following statements:

'I used to have so many partners but now I have realised that it will not take me anywhere.'

'I was taught about the effects of alcohol and smoking and now I stopped.'

(x) Going for counseling

Going for counseling referred to reaching out to receive formal and informal counseling from health workers, counselors, or from peer counseling by other PLWH. Respondents reported that counseling helped them feel better and made them understand their illness better.

'We normally come here on Fridays for group counseling.'

'Sometimes we also meet to discuss some issues affecting us.'

'Before we get treatment we are taught about the importance of drug compliance and at times we counsel each other on good ways of living.'

CHAPTER 6

6.0 DISCUSSION OF THE FINDINGS

6.1 DEMOGRAPHIC DATA

In Malawi HIV prevalence is higher in ages of 15-49 years according to the Ministry of Health (2003). This explains why 100% of the respondents fall within the range. The greater population of the respondents was ranging from 41-45 years representing 60% of the respondents. According to the Malawi Demographic and Health Survey (2004), prevalence of HIV and AIDS peaks among adults. For one to get HIV and AIDS and start showing symptoms it takes time 10-15 years and in Malawi the adolescents are sexually active groups such that when they contract the disease the signs are noticed late and with the issue of ART life is further prolonged.

6.2 KNOWLEDGE ON POSITIVE LIVING

The study has revealed that most of the people (80%) don't have knowledge on positive living. This is consistent with literature. According to Jana PSI/Malawi (2003), more effort in Malawi has been placed on the ways through which the disease is spread and on AIDS awareness such that Malawi came to accept the problem. However, very little effort has been placed to explore Malawian practices that can help those who are already HIV positive or suffering from AIDS to live positively.

According to NAPHAM, living positively requires some basic support, access to health information and services, good nutrition, therapeutic counseling and advice about how to support the family including how to care for orphaned children. PLWH also need to know how to live as normally as possible, looking for one's spiritual and mental health and making the best of one's life as a person with HIV or AIDS. Many HIV positive people are willing to work with their communities as peer educators, members of home based care teams or counsellors (AVERT 2005) hence reduction of stigma and educating these people on life skills can assist them to live positively.

6.3 FORMS OF STIGMA

The study has also revealed that the most common type of stigma that HIV infected people face is individualized or the felt stigma which is internal and is manifested by unwillingness to disclose serostatus. According to Guni (2005) felt stigma is as a result of shame, guilt, withdraw and self stigmatization. Decisions about disclosure affect infected individual's physical and mental health, access to social support and spread of HIV to sexual partners and needle sharing partners (AVERT 2005). According to Guni 2005 the pathway from a lack of knowledge to increased stigma and decreased intentions to disclose may be related to continuing practice of HIV risk behaviours.

Other studies have also demonstrated that after a person tests positive, he or she faces decisions that include how to adhere to care and whether to disclose HIV seropositivity to partners, friends, family, colleagues, employers and health care providers. At each level, a decision that one has to disclose seropositivity may either enhance access to support and care or expose the individual to stigmatization and potential discrimination (Guni, 2005).

6.4 COPING STRATEGIES

Rationalization seems to be the most common coping response which uses meaning based coping to induce positive emotion. The process involves interpretation of a stressful situation in a personally meaningful way. Coping by rationalization is consistent with literature. For example, Faber, Mirsalimi, Williams, and Mc Daniel (2003) reported that finding positive meaning in illness had beneficial effects on psychological adjustment to the disease and suggested it may even be associated with protective health effects.

Social support can influence how people adapt psychologically to stressful events such as a significant health or illness. For example Glanz, Rimer and Lewis (2002) say that the

availability of friends with who to talk to could affect a person's perception of personal risk or the severity of illness. These interactions could also booster beliefs about one's ability to cope with the situation and manage difficult emotions. There is substantial evidence that social support has beneficial effects on the psychological and physical well being. This is in line with what Clanz et al (2002) wrote and believes that a mechanism by which social support may benefit physical wellbeing is the promotion of active coping behaviours such as adherence to recommended health behaviours. Alternatively, by enhancing expression of the negative feelings such as suicide, social support may have direct physiological and immunological benefits since stress is reduced.

The education component included sharing experiences among club members and exchanging information with the general public. Dimond et al (2003) found that the clubs had positive effects on the attitudes of patients. Patient's reactions to the first diagnosis improved, misconceptions on the cause and treatment were reduced, social isolation of patients lessened and compliance to treatment increased.

Going for counseling provides social reinforcement for positive attitudes, behaviour change and maintenance of safe behaviour. In a study that was conducted by Brown et al (2003) on counseling approaches it was found that after counseling 90% of the participants revealed their serostatus to at least one other person. They concluded that to reduce the effects of stigma on PLWH group counseling is a time- efficient and productive method of counseling, but that counseling alone will not eradicate stigma.

Disclosure was used as a coping strategy depending on the consequences. For example some could disclose to gain attention from the public or to solicit love from the family members or loved ones. Others could disclose to the public to gain public support. If there was a perceived threat to disclosing serostatus, an individual could remain quite to avoid stigma association. Brown et al (2001) reported that non-disclosure, denial and hiding could also be a way of coping, especially if it protected one from stigma.

Coping by becoming more religious and getting comfort through immersing oneself in religion is a common coping strategy (Nyblade et al, 2003). Religion plays a vital role in the care of HIV infected individuals and their families. Religious activities participation and turning to God provides emotional support, offering religious leaders an opportunity to incorporate ways to reduce stigma. Spirituality in this study was manifested through prayers and building hope in God. According to Miller, (1983) people feel that God challenges people with tasks He knows they can handle. When individuals interpret handling the challenge as an expectation of God, they establish a self-expectation to be successful.

6.5 CONCLUSION

The study has illustrated the complexities of stress and coping and their effects on psychological well being, health behaviour and health. The study also suggests that the outcomes of stress and coping process are determined by interplay of situational factors, individual appraisals and coping strategies. No particular pattern of relationships among these factors has been related consistently to positive outcomes of the coping process. Rather the effects of stress and coping process depend on context (for example controllability of stress), timing (short-versus long term adaptation) and individual characteristics (for example information processing styles and meaning based coping processes).

The findings of this study can also be used as a positive mechanism for stigma reduction to people who care for HIV infected individuals such nurses, other health care providers and their families so that they develop a greater understanding of the challenges faced when coping with HIV disease. Further incorporation of coping styles assessments into health promotion and psycho educational interventions will facilitate the tailoring of these strategies to individual needs. Research on stress, coping and health behaviour suggests that interventions that are tailored to individual appraisals and coping behaviours are likely to be most effective in terms of enhancing coping, reducing stress, and improving health behaviour and physical well-being.

LIMITATION OF THE STUDY

The main limitation of the study is that the sample size is so small such that it has not represented the whole population. As a result this has made it difficult to generalize the findings of the study at the national level. Since it was difficult to carry out the study on a large scale due to limited resources such as transport, then this may not be a true reflection of the whole situation on the ground.

Time for conducting the research was also limited because it was placed with other courses. As a result it was hard to concentrate much on the research.

Due to lack of funds the research findings will not be disseminated to the research beneficiaries and others hence the copies of the report will be available in the Kamuzu College of Nursing Library.

RECOMMENDATIONS

The government of Malawi and other non governmental organisations concerned with PLWH should intensify messages on stigma and discrimination and their effects on the health of PLWH.

There should also be support from government, non governmental organisations, communities and families in fighting against stigma.

Formulation of support groups in the communities should be encouraged since this has proven to be more effective in reducing HIV related stigma.

Hospitals' ART clinics should also dwell much on providing counseling services to PLWH other than just providing ART services.

Nurses should be in the forefront in protecting those with or suspected to have HIV and AIDS from condemnation and discrimination.

AREAS FOR FURTHER STUDY

Since the study has been conducted on a small scale some more studies are required to be conducted on a larger scale to identify other coping mechanisms which might be good or harmful for PLWH.

The study has also revealed that little is known on positive living hence studies on positive living are required to generate some more knowledge on this topic.

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APPENDIX 1a

INTERVIEW GUIDE

Country: Malawi Participant code No. ----------

Title: Coping mechanisms against stigma for people living with HIV/AIDS

Date:----------

Time start: ---------- Time finish: ----------

SECTION A
DEMOGRAPHIC DATA

Age.....
Sex.....
Marital status.....
Level of education.....
Religion.....
Tribe.....
Occupation .....

SECTION B
KNOWLEDGE ON POSITIVE

1. Do you know what it means by positive living?

.....

2. If yes, what do you know about positive living?

.....
.....
.....

3. Do you accept that you are HIV positive?

.....

4. If no why?

.....
.....

CHALLENGES FACED BY PEOPLE LIVING WITH HIV/AIDS

5. Have you ever disclosed your sero status?

.....

6. If yes, what prompted you to disclose your sero status?

.....
.....
7. What was the reaction of the person(s) when you disclosed your sero status?
.....
.....
8. How did you feel after disclosing your sero status?
.....
.....
9. What prevented you from disclosing?
.....
.....

LIFESTYLES OF PEOPLE LIVING WITH HIV

10. When were you found HIV positive?
.....
11. How did you feel or react when you were told that you were HIV positive?
.....
.....

12. What do you think you were doing before that you are not doing now after being found HIV positive?
.....
.....
13. Do you think your current behaviour has been influenced by your current sero status?
Explain.....
.....

FORMS OF STIGMA

14. How do you feel about your current condition?
Probe. What do people say about your current sero status?
.....
.....
15. Do people know about your current medication?
Probe. What do people say about your medication?
.....
.....
.....
16. What has been your experience with your routine hospital visits?
.....
.....
17. How do you feel the fact that (PLWH) have their own clinic for receiving medication (ARV)?
Explain.....
.....

.....
.....

18. How are you welcomed when you come for your refill of medication or when you are sick?

Explain.....
.....
.....

19. Are you allowed to participate in household chores, community activities and church services?.....

If no,

explain.....
.....

20. Do you think you deserve certain information that you have never been told?

If yes, explain.....
.....
.....

21. How do you feel about the following services?

a). HIV test as a prerequisite for marriage.

.....
.....
.....

b). HIV test before enrolment into school.

.....
.....

c). HIV test and Antenatal care.

.....
.....

22. Any other comments.

.....
.....
.....
.....
.....

APPENDIX 1b

INTERVIEW GUIDE IN CHICHEWA

Dziko: Malawi Nambala ya otenga mbali.....

Mutu: Mmene anthu ali ndi kachilombo ka HIV/AIDS akugonjetsera mchitidwe wosalana.

Tsiku: .....

Nthawi yoyambira: ..... Nthawi yomalizira.....

GAWO LOYAMBA

Mbiri yanu

a). Muli ndi zaka zingati?

.....

b). Mwamuna kapena mkazi

.....

c). Kodi muli pabanja?

.....

d). Kodi munaphunzira kufikira patali bwanji?

.....

e). Ndinu a mpingo wanji?

.....

f). Ndinu a mtundu wanji?

.....

g). Kodi mumagwira ntchito yanji?

.....

GAWO LACHIWIRI

Kukhala mchiyembekezo.

1. Kodi mumadziwa tanthauzo la kukhala ndi chiyembekezo?

.....

2. Ngati mukudziwa longosolani.

.....

.....

.....

.....

3. Kodi munavomereza kuti muli ndi kachilombo koyambitsa matenda a edzi?

.....

4. Ngati ayi, fotokozani.

.....

.....

.....

ZOVUTA POLIMBANA NDI MCHITIDWE WOSALANA

5. Kodi munaululira wina aliyense za mmene muliri?

.....

Ngati eya, pitani pa (8-10). Ngati ayi, pitani pa (11).

6. Ngati munaulula, chinakupangitsani ndi chiyani kuti mufotokoze za mmene muliri?

.....

.....

.....

7. Nanga mutafotokoza, munthuyo anaulandira bwanji uthengawo?

Fotokozani.....

.....

.....

8. Nanga mutaulula munamva bwanji mumtima?

Fotokozani.....

.....

.....

9. Ngati simunaululepo, chifukwa chiyani?

Fotokozani.....

.....

.....

Makhalidwe

10. Kodi munapezeka ndi kachilombo koyambitsa matenda a edzi liti?

.....

11. Kodi mutauzidwa zotsatira zanu munamva bwanji mumtima?

Fotokozani.....

.....

12. Kodi ndi chiyani chomwe mwayamba kuchita chomwe simumachita mulibe kachilombo koyambitsa matenda a edzi? Probe. Kodi moyo wanu wasintha bwanji kuyambirla nthawi yomwe munapezeka ndi kachilombo koyambitsa matenda a edzi?

.....

.....

.....

13. Kodi mukuganiza kuti khalidwe lanu lasintha chifukwa cha matendawa?

.....

.....

Mitundu ya kusalana

14. Kodi nanga mumamva bwanji kuti muli ndi kachilombo koyambitsa matenda a edzi? Probe. Kodi anthu amanena chiyani zokhudzana ndi mmene muliri?

.....

.....

.....

15. Kodi anthu akudziwa za mankhwala omwe mukumwa panopa? Probe. Anthu amanena zotani zokhudza ndi mankhwalawa?

.....

.....

.....

16. Nanga ndizovuta zotani zimene mumakumana nazo kumbali yobwerabwera kuno kuchipatala?

.....
.....
.....
.....

17. Kodi ndinu wokondwa kuti anakupangirani chipatala chanuchanu cholandilira mankhwala a ma ARV?
Fotokozani.....
.....
.....

18. Kodi mumalandiridwa bwanji mukafuna chithandizo kuno kuchipatala?

.....
.....
.....

19. Kodi nanga mumaloledwa kugwira ntchito za pakhomo, zapamudzi monga zachitukuko, ndi kutchalichi?
Fotokozani.....
.....
.....
.....

20. Kodi mukuganiza kuti pali uthenga wina wokhudzana ndi za kachilombo koyambitsa edzi omwe simunauzidwepo koma mukuyenera kuuzidwa?.....

Ngati ndichoncho
fotokozani.....
.....
.....

21.Kodi muganiza bwanji ndizotsatirazi?

a). kuyezetsa magazi musanalowe m'banja.

.....
.....

b). Kuyezetsa magazi munthu asanayambe sukulu.

.....
.....

c). Kuyezetsa magazi munthu ali woyembekezera.

.....
.....

22. Zowonjezera ngati zilipo.

.....
.....
.....
.....

University of Malawi
Kamuzu College of Nursing

RESEARCH AND PUBLICATIONS COMMITTEE

APPROVAL CERTIFICATE

TITLE: Coping mechanisms against Stigma for people living with HIV/AIDS in Lilongwe

INVESTIGATOR(S):

Chikondi Nyson

YEAR OF STUDY:

4 Generic

REVIEW DATE:

7 August 2008

DECISION OF THE COMMITTEE: Approved. Check specific comments in the document

SIGNATURE:.....**DATE**.....

DEAN OF POSTGRADUATE STUDIES AND RESEARCH

UNIVERSITY OF MALAWI
KAMUZU COLLEGE
OF NURSING
-08- 2008
DEAN'S OFFICE
PRIVATE BAG 1, LILONGWE

CC: supervisor: Mrs O. Mtena

DECLARATION OF INVESTIGATOR(S)

I/We fully understand the conditions under which I am/we are authorized to carry out the above mentioned research and I/We guarantee to ensure compliance with these conditions. In case of any departure from the research procedure as approved, I/We will resubmit the proposal to the committee.

DATE.....**SIGNATURRE(S)**.....

APPENDIX 3

University of Malawi
Kamuzu College of Nursing
Private bag 1,
Lilongwe.

The Hospital In Charge,
Kawale Health Centre
P.O. Box
Lilongwe.

Dear sir/Madam,

RE: REQUEST TO CONDUCT A PILOT STUDY AT THE HEALTH CENTRE

I write to ask for a permission to conduct a study at the clinic. I am a fourth year student at the above mentioned college, currently pursuing Bachelor of Science in Nursing. This study will be done in partial fulfillment of the programme.

The title of the study is "Coping mechanisms against stigma for people living with HIV/AIDS". The study is aimed at exploring the coping mechanisms that people living with HIV/AIDS use to fight against stigma. The study will involve a sample size of 10 people both men and women attending ART clinic.

Your favourable consideration will be greatly appreciated.

Yours faithfully,

Chikondi Nyson.

Telephone No: 01 552344
Fax No. : 01 552347

Balaka District Hospital'
P.O. Box 138,
BALAKA

13th October, 2008

To Whom It May Concern:

PERMISSION TO CONDUCT RESEARCH IN BALAKA DISTRICT CHIKONDI NYSON

Permission has been granted to the bearer of this letter to conduct a study in Balaka on **Coping mechanisms against stigma for people living with HIV/AIDS**.

Any assistance rendered would be appreciated.

BALAKA DISTRICT HOSPITAL
P.O. BOX 138, BALAKA

M.W. Mhango
DISTRICT HEALTH OFFICER

APPENDIX 5

University of Malawi
Kamuzu college of Nursing
Private bag 1,
Lilongwe.

Dear sir/Madam,

CONSENT TO PARTICIPATE IN A STUDY

I am a student at Kamuzu College of Nursing currently pursuing Bachelor of Science in Nursing and I am in fourth year. In partial fulfillment of the programme, it is a requirement that we conduct research. I intend to conduct a study on the coping mechanisms against stigma for people living with HIV/AIDS among clients attending ART clinic at Balaka District Hospital.

I am therefore requesting you to participate in this study. You will be required to answer questions that I have prepared. Please feel free to express any pertinent views and ideas that have not been covered in the questionnaire. You are also free to participate or withdraw from the study when you feel like without any penalty. Be assured that all your contributions will be treated in strict confidence and that you will not be required to indicate your name.

Indicate your acceptance to participate in this research by signing the form below.

Thanks for your cooperation and good luck.

Yours truly,

Chikondi Nyson (Mr.)

CONSENT FORM

I have red and understood the contents of the consent and have accepted to participate in the study.

Name.....

Signature..... Date: .....