UNIVERSITY OF MALAWI

KAMUZU COLLEGE OF NURSING

A STUDY ON KNOWLEDGE, ATTITUDES AND PRACTICE TOWARDS POSITIVE LIVING AMONG WOMEN ATTENDING ART CLINIC AT BALAKA DISTRICT HOSPITAL

DONE BY

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DECLARATION

I hereby declare that this research is an original form of my own work and it has never been done before.

Signature of researcher....A. Mota.....Date....04/12/08

Signature of supervisor....D. Kamwendo.....Date....4/12/08.

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I would like to thank almighty God for his protection and guidance throughout the research project.

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ABSTRACT

Living positively requires some basic support: access to health information and services, good nutrition, therapeutic counseling, advice about how to support your family into the future, including children who may be orphaned and some home based care for those who have eventually become weakened and sick. Also critically needed is access to treatment i.e. antiretroviral drugs (ARVs). If appropriately prescribed, properly taken and supported by a healthy style, ARVs can massively prolong the health and wellbeing of people who are HIV positive. However, there has been problems in following positive living which was evidenced by drug incompliance among HIV positive women at Balaka District Hospital.

The purpose of this study was to explore the knowledge, attitudes and practice towards positive living among women attending ART clinic. A qualitative study using in depth interviews was conducted and a convenient sample of 10 women was recruited at Balaka district hospital. Data was analysed manually after developing codes which were grouped to form themes.

The findings show that almost all participants knew positive living and the activities which are involved in it though not all activities were mentioned during discussion. All participants expressed their willingness to live positively since they know the importance. The participants practice positive living by eating nutritious diet, taking ARVs everyday and practicing safe sex.

The study has also shown that shortage of adequate food and distance hinders participants from practicing positive living.

Based on the study findings, the following recommendations are made:
It is recommended that the hospital should provide supplementary food to people living with HIV and AIDS that have problems finding food and the government should consider establishment of ART clinics in distant areas of more than 5km away from the hospital among others.

ABBREVIATIONS

AIDS	Acquired immuno-deficiency syndrome
ART	Antiretroviral Therapy
ARV	Antiretroviral drugs
CBO	Community Based Organisation
CHBC	Community Home Based Care
DHS	Demographic and Health Survey
FBO	Faith Based Organisation
FGD	Focus Group Discussion
HIV	Human immunodeficiency virus
KCH	Kamuzu Central Hospital
MOH	Ministry of Health
MICS	Multiple Indicator Cluster Survey
MMH	Mulanje Mission Hospital
NAC	National AIDS Commission
NAF	National HIV and AIDS Action Plan
NGO	Non-GovernmentalOrganisation
NSF	National HIV and AIDS Strategic Framework
OPC	Office of President and Cabinet
PCP	Pneumocystic Carinii Pneumonia
PLWH	People living with HIV
PLWHA	people living with HIV AIDS
PSI	Population services international
PMTCT	Prevention of mother to child transmission
QUEENS	Queen Elizabeth Central Hospital
STI	Sexually transmitted infection
TB	Tuberculosis
WHO	World Health Organisation

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CHAPTER ONE

1.0 INTRODUCTION

The HIV pandemic is still on increase in Malawi. The Malawi HIV and AIDS Monitoring and Evaluation Report, 2007 shows that there were about 30.8 million adults living with HIV at the end of 2007.q

To counteract this, with help from international donors, the government and other organizations within Malawi have taken a number of positive steps towards minimizing the spread of HIV (NAF, 2005). One of the strategies to improve the quality of life of PLWHA and others affected by the epidemic was through provision of home based care services (National CHBC Policy and Guidelines, 2005).

In almost all the districts of Malawi PLWHA receive help from ART clinics which are in almost all district hospitals, central hospitals and some health centres. This has increased accessibility to ARVs and health education on positive living.

People who are found HIV positive are counselled on how to live positively with their present status in order to promote their health and reduce stress (MOH April, 2004).However, there have been problems in following positive living which was evidenced by poor adherence to ART at Balaka District hospital (Balaka District Hospital records,2008), and this has prompted the researcher to conduct a study to find out the knowledge level, attitude and practice towards positive living on HIV positive individuals at Balaka District Hospital

1.1 BACKGROUND

Worldwide there are 39 million people who are currently living with HIV(WHO,2006). According to estimates from the UNAIDS/WHO AIDS Epidemic update (November 2007), around 30.8 million adults and 2.5 million children were living with HIV at the end of 2007 (Malawi HIV and AIDS Monitoring and Evaluation Report, 2007).
The area in Africa south of the Sahara desert, known as sub-Saharan Africa, is by far the worst-affected in the world by the AIDS epidemic (Avert, 2005). The region has just over

10% of the world's population, but is home to 68% of all people living with HIV (Avert, 2005). An estimated 1.7 million adults and children became infected with HIV during 2007 (Avert, 2005). This brought the total number of people living with HIV/AIDS in the region to 22.5 million by the end of the year. HIV prevalence varies considerably across this region - ranging from less than 1% in Madagascar to over 30% in Swaziland (Avert, 2005)

The first AIDS case in Malawi was diagnosed in 1985 (NAF, 2005). In response to this, there were a number of mechanisms that were put in place. The National AIDS Committee was established at the end of the 1980's, which was tasked with the responsibility of coordinating the national response (HIV&AIDS Monitoring and Evaluation Report, 2007). VCT centres were established and the government also started awareness campaigns through health education and the media. In 2006, the national AIDS commission estimated that 1,000,000 adults and children were living with HIV and AIDS in Malawi (NAC, 2006). To counteract this, with help from international donors, the govemment and other organizations within Malawi have taken a number of positive steps towards minimizing the spread of HIV (NAF, 2005). In 1999/2000, Malawi developed a National Strategic Framework for HIV/AIDS which had priority areas, one of which was the provision of equitable treatment for PLWHA and mitigation of the impact of HIV/AIDS including improvement of quality of life of PLWHA and others affected by the epidemic and one of the strategies to achieve this goal was through the provision of home based care services (National CHBC Policy and Guidelines, 2005).

CHBC is the approach Malawi is using in managing PLWHA. It is the care provided to chronically or terminally ill patients such as HIV and AIDS, TB and cancer; clients affected by the illness of their relatives and friends; vulnerable and at risk groups in their homes by family and community members using the available resources and support from the formal health care (National CHBC Policy and Guidelines, 2005). The care provided includes basic nursing care, management of common ailments in the homes/community, palliative care, psychosocial and spiritual care (this includes enrollment of PLWHA to support groups where they help each other how to live positively), provision of basic equipment, drugs and supplies, skill transfer to primary

caregivers, infection prevention and control in the home, nutrition education and food supplementation where feasible, monitoring of patients on ARV, discharge planning and referral along a continuum of care, and care of carers at all levels of care (National CHBC Policy and Guidelines, 2005). CHBC services are provided by family members, community members, health workers, teachers and other social workers (CHBC Service Provider Training Manual, 2005). In Malawi CHBC services are provided by NGOs, CBOs, FBOs and community support groups in different parts of the country (National CHBC Policy and Guidelines, 2005). In order to ensure coordination, equity and standardization of the quality of care, national policy and guidelines on CHBC were developed (National CHBC Policy and Guidelines, 2005).

Since 2000, when the implementation of the NAF began, Malawi developed several policies and guidelines that are supportive to the national response and these include the National HIV and AIDS Policy (2003), the orphans and other vulnerable children policy, ARV Guidelines, VCT Guidelines and ARV equity policy (NAF, 2005). NAC was established in 2001 under the office of president and cabinet (OPC) and it is the overall coordinating authority of the HIV and AIDS response in Malawi (NAF, 2005). It guides the NAF private sector, NGOs, FBOs, and CBOs to work together in implementing the NSF.

In 2003, National HIV and AIDS policy was developed which serves as an important milestone in the fight against HIV and AIDS, to reduce infections and vulnerability to improve provision of treatment, care and support for PLWHA and to mitigate the socio-economic impact of the epidemic (NAF, 2005).

Recently many policies have been developed and Programme initiated to combat the infection and ensure that there is also accommodation of PLWHA in Malawi. Most PLWHA were started on antiretroviral therapy through health facilities and CHBC service which has increased accessibility and support. In 2002, the number of people treated with ARVs was 1220 at Queens, 904 at KCH and 316 at Chiradzuru district hospital (MOH Malawi, 2003). In 2004, the government announced a five year plan to make ARVs widely available and began to distribute them to hospitals and clinics around

the country (Avert, 2005). Unfortunately, while the HIV awareness is high, behaviour change has been limited (Malawi HIV and AIDS Monitoring and Evaluation Report, 2007). Social and practical considerations often stop people from taking measures to prevent infection even when they know the risks involved. This coupled with lack of human and financial resources means that prevention campaigns have so far failed to curtail the AIDS epidemic in Malawi (Avert, 2005). However, the researcher is interested in looking at the knowledge, attitude and practice of HIV positive women towards positive living.

1.2 STATEMENT OF THE PROBLEM

According to the policy on management of HIV,AIDS, every individual goes for voluntary or hospital counseling before during and after the HIV test to prepare the individual psychologically for the test and the results (MOH, 2005). People who are found HIV positive are counseled on how to live positively with their present status in order to promote their health and reduce stress (MOH April, 2004). However, there have been problems in following positive living which was evidenced by poor adherence to ART at Balaka District hospital (Balaka District Hospital records,2008), and this has prompted the researcher to conduct a study to find out the knowledge level, attitude and practice towards positive living on HIV positive individuals at Balaka District Hospital.

1.3 SIGNIFICANCE OF THE STUDY

The findings of the study would be very important as they will;

- Identify the factors that influence HIV positive women to live positively so that the negative factors should be eradicated and positive factors be promoted to help them to change their behaviour and start living positively with their status.
- Help nurses to improve the approach in the management of PLWHA in hospitals and communities e.g. Establishing a lot of home based care programmes where patients are monitored in their homes if they are following healthful practices which includes adherence to ART to promote their health.

- Give the general public an insight on problems faced by PLWHA which affect positive living so that appropriate measures are taken to eliminate the problems.
- Give policy makers more clues on areas that need emphasis regarding positive living when making policies.

1.4 OPERATIONAL DEFINITIONS

HIV status: It is a positive or negative blood result for HIV testing.

Attitudes: It is settled ways of thinking i.e. how women feel, think or behave towards positive living.

Knowledge: Women's understanding of HIV/AIDS transmission treatment and prevention.

Antiretroviral therapy: This is the HIV treatment with drugs which help to reduce the further multiplication of HIV.

1.5 OBJECTIVES

BROAD OBJECTIVE

To explore the knowledge, attitude and practice towards positive living among women attending ART clinic at Balaka District Hospital.

SPECIFIC OBJECTIVES

- To assess knowledge of HIV positive women on positive living
- To determine the attitudes of HIV positive women towards positive living practice
- To identify factors that hinder and promote positive living

CHAPTER TWO

2.0 LITERATURE REVIEW

Positive living is defined as living with HIV and AIDS in such a way that one takes control of his or her own physical, emotional, social and spiritual life. It is the best management for PLWH (NAF, 2005). Positive living includes, adherence to ART, good nutrition, coping with stress and anxiety and behavior change towards health promotion (NAF, 2005).

This section will discuss some of the studies and related articles that have been done on knowledge, attitudes and practice towards positive living. It contains studies done in Malawi and in other countries.

2.1 KNOWLEDGE ABOUT POSITIVE LIVING

Knowledge on positive living is very important to promote health and prolong life of people living with HIV. Some people may be positive and on ART but may not know how they can live to promote health and prolong life

Counseling is very important in HIV/AIDS as it allows individuals to accept their status and to know the best way they can live with their present status. During post-counselling of an HIV positive patient, efforts are made to explain how the person can live positively with the present status to enable the person to have knowledge on positive living which promotes health in PLWHA (National AIDS Policy, 2003)

In Malawi, there is an increased awareness among Malawians about HIV and AIDS pandemic and positive living both on television and radio programmes (HIV and AIDS Monitoring and Evaluation Report, 2005). In 2004/05 there were 365 HIV and AIDS programmes which were aired in 297.3 hours on radio and 36 programmes were aired in 245.2 hours (HIV and AIDS Monitoring and Evaluation Report, 2005). In 2006/07, there were 1633 programmes which were aired in1528.4 hours on radio and 631 programmes on television were aired in 750 hours (HIV and AIDS monitoring and evaluation Report,

2005). This shows that people have received information o how to promote their health by practicing good health practices as well as preventing reinfection.

However, there are no studies found which were done to explore the knowledge on positive living both in Malawi and in other countries

2.2 ATTITUDES TOWARDS POSITIVE LIVING

Attitudes of people towards positive living determine how they behave towards HIV and AIDS and this can be seen towards the people who are affected by the infection and these contribute to how one lives management for PLWHA and those affected e.g. orphans of people who die with AIDS.

NAC,(2005) Malawi HIVand AIDS National Action Framework (NAF) 2005-2009

In the DHS and MICS was done to find out the percentage of people expressing accepting attitudes towards PLWHA. The respondents were asked whether they would be willing to take orphaned children of relative who died of AIDS, whether they would be willing to buy vegetables from vendors who have HIV, whether they believe a female teacher who has HIV should be allowed to continue to teach and whether they would want the HIV positive status of a family member to remain secret.

The results were as follows; in 2003 29.7% expressed accepting attitudes towards PLHIV and this increased to 46.2% in 2004 and then decreased to 44.3% in 2006. Among females it has been decreasing: in 2000 it was 36.8% and this decreased to 30.8% in 2004 and then 20.3 % in 2006. This trend is also observed among both rural and urban females. Among rural males 43.3 % expressed accepting attitudes towards PLHIV and this decreased to 30.5% in 2004 and then increased to 41.8% in 2006. The corresponding proportions among urban males were 59%, 27.6% and 54.8% respectively.

The results illustrates that males are more accepting than females throughout the years and urban residents also had more accepting attitudes than rural residents. This explains

why women are more subjected to stigma and discrimination as this is started by their fellow women who have negative attitudes towards them hence this brings an impact on positive living among HIV positive women.

2.3 POSITIVE LIVING PRACTICE

Positive living can be evaluated by looking at how one is coping with the HIV and adherence to ART. Stigma and discrimination are major factors that affect positive living practice and this has also been described below

Makaoea LN et al (2008) Coping with HIV- related stigma in five Africa countries. Available at (http:// hinari-gw.who.int/whalecomwww.ncbi, nlm-gov/whalecom0/pubmed/18328964) retrieved on 20/05/08

This study was done to examine how PLWHA cope with HIV related stigma in the five southern African countries of Lesotho, Malawi, South Africa, Swaziland and Tanzania.

A descriptive qualitative research was done to explore the experiences of HIV related stigma of PLWH and nurses in 2004. A total of 43 focus group were conducted with 251 participants (114 nurses, 11PLWH, and 26 volunteers). In describing incidents of stigma, respondents reported strategies used or observed to cope with those incidents. Nurse reports of coping strategies that they used as well as observed in HIV- infected patients were coded. Coping strategies used by PLWH in dealing with HIV- related stigma were coded.

The findings show that a total of 17 different self- care strategies were identified: seeing oneself as alright, letting go, turning to God, hoping, changing behavior, keeping oneself active, using humor, joining a support or social group, disclosing one's HIV status, speaking to others with same problem, getting counseling, helping others to cope with the illness, educating others, learning from others, acquiring knowledge and understanding about the disease and getting help from others. Coping appears to be self- taught and only modestly helpful in managing perceived stigma.

The results show that PLWHA can do a lot of things, which will help them to reduce the anxiety and to live happy again hence positive living. However, there have been increased reports of failure to modify their behavior to live positively, which was evidenced by the increased sexual immorality and poor adherence among HIV patients and more especially women at Mulanje Mission Hospital as observed by the researcher.

Vyavaharkar M et al (2007) social support, coping and medication adherence among HIV- positive women with depression living in rural areas of the southern United States. Available at (http://hinari gw.who.int/whalecomwww.ncbi.nlm-gov/whalecom0/pubmed/17919094) retrieved on 30/05/08

This study was done to examine the relationships among socio-demographic factors, social support, coping and adherence to antiretroviral therapy (ART) among HIV-positive women with depression. The analyses reported here were limited to the 224 women who were receiving ART out of 280 recruited from community -based HIV/AIDS organizations serving rural areas of three states in the south eastern United States. Two indications of medication adherence were measured; self report of missed medications and reasons for missed medications in the past month. Descriptive statistics, correlation and regression analyses were performed to systematically identify socio-demographic, coping, and social support variables that predicted medication adherence. In regression analysis, three variables were determined to be significant predictors accounting for approximately 30% of the variability in the self report of reasons for missed medications. Coping focused on managing HIV disease was negatively associated, while coping focused on avoidance/ denial and numbers of children were positively associated with reasons for missed medications. Coping by spiritual activities and focusing on the present mediated the effect of social support on self-reported missed medications. The relationship of predictor variables to self-report of missed medications was assessed using t test statistics and logistic regression analysis to determine the odds of self-reported medication adherence. Satisfaction with social support and coping focused on

managing disease were the best positive predictors, whereas number of children was the lone significant negative predictor of medication adherence.

The above results show that there is a problem with ART adherence which is one of the activities done in positive living, hence there is need to explore some more factors that can influence adherence in Malawi.

Michael J(2003) cultural practices and positive living among people living with HIV/AIDS in Malawi, PSI/Malawi (http://comminit.com/en/node/215854/36) retrieved on 15/05/08.

This qualitative research study was done to explore Malawian cultural practices that promote positive living, on the one hand, and those that hinder positive living among people with HIV/AIDS on the other hand.

A desk research was commissioned which was aimed at exploring Malawian cultural practices that promote the spread of HIV/AIDS and those that have a bearing on positive living among people with HIV/AIDS.

The major goal of the research was to incorporate the effects (positive or negative) of some cultural practices on living positively with HIV/AIDS and the spread of HIV in living positively with HIV/AIDS booklet with the aim of removing cultural barriers and exploiting cultural opportunities to positive living among people with HIV/AIDS.

The findings show that there is little or no cultural practice that promotes positive living among people with HIV/AIDS. This shows that not much has been studied on positive living hence the need to conduct this study to explore the other dimensions of positive living like the attitude, practice or knowledge level on positive living.

2.4 SUMMARY OF LITERATURE REVIEW

In Malawi no studies were found that directly describe the knowledge, attitudes and practice towards positive living among women on ART. The studies which were doe focussed mainly on those practices that promote the spread of HIV and AIDS because for the past two decades, the approach that Malawi has taken in the fight against HIV and AIDS was to prevent the spread of the disease (Michael J, 2003). As such efforts were made to explore all ways through which the disease can be spread, and find ways to curb the problem. Of late, however, the fight has taken a new twist whereby Malawi is accepting the fact that the problem is here with us and the question that still remains is that how are we going to deal with it, as such there are efforts aimed at helping those who are living with HIV and AIDS to live positively e.g. the current NAC theme is 'stigma and discrimination'. More efforts have to be put in place therefore to explore Malawian practices that can help those who are already HIV positive or suffering from AIDS to live positively (Michael J, 2003).

CHAPTER THREE

THEORETICAL FRAMEWORK:

3.0 THE HEALTH BELIEF MODEL

The health belief model is based on the understanding that a person will take a health related action (i.e. to live positively with HIV) if that person;

1. Feels that a negative health condition can be avoided e.g. death
2. Has a positive expectation that by taking a recommended action, he or she will avoid a negative health condition.
3. Believes that he or she can successfully take a recommended health action (Etr Associates, 2007).

The health belief model provides a framework for exploring why some people who are illness free take action to avoid illness, while others fail to take such protective actions. The major concern was the widespread reluctance of individuals to take preventive measures that were often free or provided at nominal charge. The model is useful in predicting those individuals who would or would not use preventive measures and to suggest interventions that may increase predisposition of resistant individuals to engage in preventive or health protecting behaviour (Stanhope and Lancaster, 2000).

The health belief model is beneficial in assessing health protection or disease prevention behaviour. It is also useful in organizing information about client's views of their state of health and what factors may influence them to their behaviour. The health belief model when used appropriately provides organized assessment data about client's abilities and motivation to change their health status (Salazar, 1991 as cited in Stanhope & Lancaster, 2000)

The health belief model is a framework for motivating people to take positive health action that uses the desire to avoid a negative health consequence as the prime motivation. The health belief model is based on the six key concepts namely; perceived susceptibility, perceived severity, perceived benefits, perceived barriers, cues to action and self efficacy (Etr Associates, 2007).

Perceived susceptibility: this is an individual's belief of the chances of getting a condition.

Perceived severity: this is one's belief of how serious a condition and its consequence are.

Perceived benefits: this is an individual's belief in the efficacy of the advised action to reduce risk or seriousness of impact. This refers to the patient's or client's belief that a given treatment will cure the illness or help prevent it.

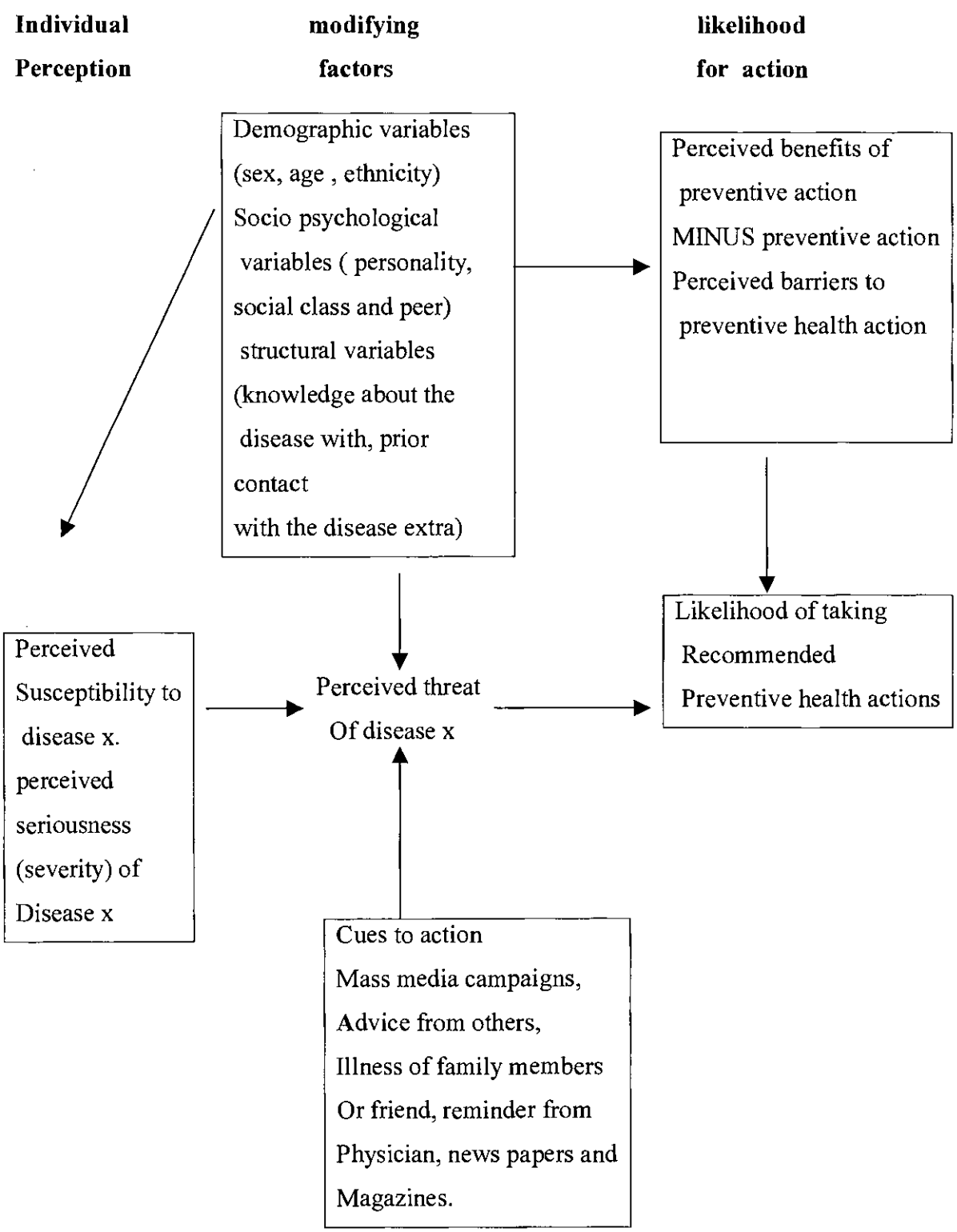
Perceived barriers: this is an individual's belief in the tangible and psychological costs of the advised behaviour. Costs refer to complexity, duration and accessibility of the treatment (Pilot and Hungler, 1991). Therefore, the likelihood that the person will take any action is influenced by the perceived benefits of the action, weighed against the barriers to acting.

Cues to action: strategy to activate readiness. These include the mass media campaigns, advise from others, reminder postcards from health care providers, illness of family members or friends and newspaper or magazine, they may help motivate clients to take action (Salazar 1991 as cited in Stanhope and Lancaster, 2000).

Self efficacy: confidence in one's ability to take action. This is a concern about health matters in general, willingness to seek and accept health care, and engagement in positive health activities (Polit and Hungler, 1991). It includes the desire to comply with treatment and a belief that people should do what is prescribed by health care personnel.

Within the six concepts, there are also contributory factors (modifying factors). These include demographic variables as age, sex, race, ethnicity, personality, social class and pressure from reference group (Stanhope, 1992). Other factors also include knowledge about the disease and prior contact. Even when one recognises personal susceptibility, action will not occur unless the individual believes that becoming ill would have serious organic or social implications.

3.1 HEALTH BELIEF MODEL CONCEPTUAL FRAMEWORK



(Craven and Hirnle, 1992)

3.2 APPLICATION OF THE HEALTH BELIEF MODEL TO THIS STUDY

Understanding the determinants of health is very important for development of effective interventions that the public can use to assist HIV positive people change their behaviour towards good health practices, which promote health and prolong life. Understanding how HIV positive women view positive living is very important and it influences them in their living i.e. whether to adopt positive living with HIV in their day to day lives or not. HIV positive people are viewed as individuals who are susceptible to many health problems including opportunistic infections such as persistent diarrhea, TB, PCP e.t.c. HIV positive women have increased risks as they may get pregnant which further decrease their body's immunity.

HIV positive women who do not see themselves as susceptible to many health problems are likely to quit or not live positively with their status. This may be due to lack of knowledge on positive living which makes them not to know what they are supposed to do to promote their health or prolong life which include eating a balanced diet, adherence to medications, exercises and reporting to hospital early whenever they have any health problem. It might also be due to low education levels which makes it difficult for them to understand health issues. HIV positive women who do not believe that following the advices to live positively will prolong their lives will have problems living positively as such efforts need to be put in place to ensure that the women know what positive living is all about and its importance and this will promote their cooperation.

It is also very important to explore the factors that may influence women whether to practice or not practice positive living. The factors that may act as barriers e.g. cost or lack of income, inconvenience or unpleasant, cultural values can lead to women not to practice positive living hence there is need to clarify and minimize such barriers to make it possible for women to practice positive living. Likewise factors that can promote practice such as accessible health services, convenient, available services need to be increased and maintained so that barriers are decreased for women to practice positive living.

CHAPTER FOUR

4.0 RESEARCH METHODS

INTRODUCTION

This section describes the research methods that were used in the study to explore the knowledge, attitudes and practices of women towards positive living with HIV and AIDS. It includes the research design, sample selection, study setting, data collection and instruments, pre testing and data analysis.

4.1 RESEARCH DESIGN

Since the study is trying to explore the women's experiences, a descriptive qualitative research that uses in-depth interviews was used. This is a systemic, interactive, subjective approach used to describe life experiences (Burns & Grove 2005).

This type of research is conducted to describe and promote understanding of human experiences such as pain, caring and comfort. It is a more effective method investigating human emotional responses.

4.2 STUDY SETTING

The study was conducted at ART clinic at Balaka District Hospital. The place was chosen because it is where women were identified not adhering to ART. The place is convenient as it is where PLWHA go for medication and other advices from health personnel. Therefore, the place is convenient for both participants' privacy and researcher's safety.

4.3 SAMPLE SELECTION

The subjects of the study were selected by convenient sampling of 10 HIV positive women on ART. A convenient sample of 10 was chosen due to limited resources, and the study was done for academic purposes. The criteria for selection was based on age that is excluding women below the age of 20 years. The study included women only.

4.4 PILOT STUDY

A pilot study is a trial run of a measure that is undertaken prior to the major study and this provide information regarding the method reliability validity to reveal the problems relating to its content, administration and scoring. Three women on ART were chosen for pilot study. Colleagues were consulted to comment on the instruments, content and validity before undertaking the pilot study.

4.5 DATA COLLECTION PROCEDURE

An interview guide was used to collect data through in depth interview. In depth interviews were conducted in Chichewa and notes were taken from the interviews. The interviews took an average of 15 minutes on each participant.

4.6 DATA ANALYSIS

The data was analyzed manually through content analysis, analytical induction and organizing aggregate formalized meaning into themes after translating the Chichewa responses into English.

4.7 ETHICAL CONSIDERATION

Permission to conduct research was sorted from the ethics committee of Kamuzu College of Nursing and the District Health Officer of Balaka District Hospital. The participants were informed as regards to the purpose of the study, the procedures, and benefits to them. Informed consent was obtained, and participants were allowed to ask questions and withdraw from the study. Confidentiality and privacy was maintained by conducting the interview in a closed private room and by allowing information to accessible only to the researcher and research supervisor. Privacy enables a person to think and to behave without interference and some of the rights of the participants include; self determination, privacy, confidentiality and the right to participate in a study or withdraw (Burns et al, 2001). Upon completion of the study, a letter of consent and interview guides were destroyed and erased.

CHAPTER FIVE

PRESENTATION OF FINDINGS

5.0 INTRODUCTION

This chapter discusses the findings of the research pertaining to the knowledge, attitude and practice towards positive among women. It includes narrative findings from the participants on knowledge, attitude and what they are doing to live positively.The section also includes the diagrammatic presentation of data.

5.1 DEMOGRAPHIC DATA (N=10)

The study involved interviews of ten participants who were all women on ART. All the participants were coming from the southern region of Malawi. The rest of demographic data is displayed in the table below.

Sample characteristics (N=10)

Age	**Percentage (%)**
30-34	30(3)
35-39	50(5)
40-44	20(2)
Tribe	**Percentage (%)**
Chewa	20(2)
Lomwe	30(3)
Ngoni	50(5)
Education	
Did not attend	10(1)
Primary school	80(8)
Secondary	10(1)
Marital status	
Married	50(5)
Divorced	20(2)
Widow	10(1)
Single	20(2)

The table shows that the age of the participants ranged from 30 to 40 years with the majority in the range of 35 to 39 years. The majority of the participants belong to the Ngoni tribe. Out of these participants, one did not go to school because of other reasons. All the participants belong to a faith community with the majority being Christians.

5.2 KNOWING THE HIV STATUS

The participants were asked about when they knew their status and they have lived up to now. This was asked to identify their acceptability of the status hence willingness to live positively with the status. The findings reveal that all the participants had known their status a year ago or more starting from 2007 to 2003. They also showed acceptance of the status and were not worried. One of the participants said

'I knew that I was HIV positive in 2003 and since that day I have always lived a normal life i.e. doing whatever I was doing to promote health'

Another participant also said,

'I knew that I was HIV positive last year in 2007 and I know that it's the will of God and so I do not worry but live a normal life.'

5.3 KNOWLEDGE ON POSITIVE LIVING

The participants were also asked about what they know about positive living. The knowledge of positive living with HIV was sought to find out whether the participants were aware of the various activities involved in positive living or what they should do to live positively. The participants knew what positive living is and some of the responses given were;

One participant said, *'positive living involves eating a balanced diet to prevent frequent illnesses, practicing safe sex by using condoms to prevent adding more viruses into the body and taking ARVs everyday.*

Another participant who was known to be inadherent to ART said,

'when I was taking ARVs daily I was not getting sick frequently but after I stayed a month because I went to a far place I started having

diarrhea frequently'

She continued to say that *'this shows that positive living is being adherent to ART and eating a balanced diet as well as stopping other lifestyles such as smoking and drinking alcohol which further lowers one's immunity.'*

The participants were also asked how the activities involved in positive living help them to promote health and prevent illness and they gave the following responses.

One participant said *'I eat a balanced diet to boost my immunity and use condoms to prevent adding more viruses into my body.*

5.4 SOURCES OF INFORMATION

The participants were also asked of the different sources of information where they heard or learnt about positive living. The findings revealed that all the participants knew something about positive living through group counseling and they gave similar responses like;

One participant said *'when I was found HIV positive, I was scheduled for group counseling which involves the patient and the guardian and we are told what we should do to live positively and this includes eating nutritious diet and being adherent to A*RT.

5.5 POSITIVE LIVING PRACTICE

The participants were also asked on what they do in their day to day lives to promote health or prevent illness. This was sought to find out if specific activities were followed to live positively. The findings show that all participants were doing something to promote their health. One participant said

'I eat mixed diet and take ARVs everyday and because I'm married, I and my husband use condoms when having sexual intercourse'

Another participant who was single said

'I do my daily household chores, I play netball and abstain from sex to keep healthy'

Another participant also added that,

'I try to find nutritious food to eat but I have problems finding food to eat since I don't have money. Besides all these problems I take drugs everyday.'

5.6 INVOLVEMENT IN SUPPORT GROUP

The participants were also asked if they are in any support group and what they do in their support groups. This was asked to find out other agencies where they can learn about positive living and to encourage each other living with HIV positively. Out of all participants which were asked only one participant belonged to a support group.

One participant who belonged to a support group said,

'in our support group we do drama to educate people on good living habits. We have a garden where we grow maize and sell the harvest to find money to help one another and we encourage each other.'

One of the participants who did not belong to a support group said that

'I am not in any support group because we don't have one in our village.'

5.7 ASSISTANCE FROM OTHER ORGANIZATIONS

The participants were asked if they receive any help from other organizations like money and food which could help in positive living. The findings reveal that all participants were not receiving any help from any organizations.

5.8 DRUG ADHERENCE

Participants were also asked if they have ever missed doses and why, as this is a major component of positive living. This was done to determine their adherence levels to ART and identify major problems contributing to missing doses. The majority of the

participants were adhering to ART. However three participants admitted to have ever missed doses due to different reasons. One participant said,

One participant said *'I missed my dose once because I forgot'*

Another participant said '*I missed my doses for a month because I wanted to visit my sick brother in Lilongwe and I was unable to access medication'*

The other participant also said '*I missed my dose for a week because I had no transport as I come from a distant village.*

5.9 IMPORTANCE OF POSITIVE LIVING

Participants were also asked about their perceived importance of living positively with HIV and AIDS. The findings revealed that all the participants knew the importance of positive living as to promote good health. They gave similar responses as follows:

One participant said, *'I follow what I was advised at group therapy about positive living because I know it helps to promote health, prevent frequent illnesses and I become strong to work even in the garden.*

Another participant also said, '*I have learnt that positive living helps so much to reduce stress so that you can carry out daily activities as you used to.*

Another participant confirmed the response by saying, '*I know that adhering to drugs and eating different kinds of food has helped me to have a long life because I once was very sick in 2003 when I was just diagnosed HIV positive and I knew I was going to die. But when I started taking drugs and eating different kinds of food, I recovered and became strong again and I know I have so many years ahead of me.*

5.10 HINDRANCES TO POSITIVE LIVING

When asked what they think can hinder them from living positively with HIV and AIDS, the majority gave the following responses: inadequate food and distance.

> One participant said '*I came from very far and I use a bicycle because I can not afford a minibus. Sometimes I fail to come for ART clinic when my husband is engaged with other activities hence having no-one to take me to the hospital'*

> Another participant also said '*though I take drugs everyday, my body does not look healthy because I have problems finding food since I'm poor and this puts me back. I feel like there is nothing I'm doing but rather troubling myself'*

Participants were also asked if they are subjected to any kind of stigma or discrimination. This was sought to find out one of the contributing factors that can hinder positive living. Out of these participants , one participant admitted to have been descriminated verbally where she lives in the following manner.

> She said '*it was when i was passing by some women in our village said I'm already dead since I'm HIV positive.*

5.11 SUMMARY OF FINDINGS

In summary, this section has presented the findings from the interviews on positive living. All the respondents seemed to have knowledge and were practicing positive living

A major problem contributing to poor compliance to positive living was identified as distance. A lot of clients on ART were coming from very distant villages.

The results also show that there was no stigma and discrimination in villages hence people are free to do activities to promote their health.

CHAPTER SIX

6.0 DISCUSSION OF FINDINGS

This section will discuss the findings of the research and their interpretations. The discussion is based on the sample characteristics and the knowledge, attitude and practice towards positive living of the women. This section will also include conclusion, recommendations and implications of the study.

SECTION A

6.1 SAMPLE CHARACTERISTICS

The findings of the research showed that more women in the age range of 35 to 39 years were the ones who were attending the clinic. This confirms the findings that HIV is more prevalent in reproductive age of 15 to 49 years in Malawi (NAF 2005-2009).The findings also show that the participants were from different tribes however there were no distinct variations in how they were living positively which shows that one' tribe does not influence positive living practice.

SECTION B

6.2 KNOWLEDGE ON POSITIVE LIVING

In this study, participants were not able to give an explanation of the term positive living but when asked what they know can promote their health they were able to give the activities involved in positive living such as eating nutritious diet, taking ARVs everyday, doing household chores and few included the use of condoms. There was only one participant who identified reducing stress as also part of positive living. However there was no mentioning of follow-up care, early treatment of minor ailments and exercises as part of positive living.

These results show that the participants know how to live positively. This means that there is increased awareness on positive living among participants. The National AIDS Policy (2003) explains that counseling is done to enable HIV positive people to know how to live positively with their status and this may be one of the contributing factors for increased knowledge on positive living among participants.

Failure of the participants to give a full description of positive living may mean that they forget some of the information given with time and it may mean that the health care providers fail to implement provision of education on positive living every six months as indicated in the booklet *'guidelines for the use of antiretroviral therapy in Malawi'* by Ministry of Health, (3003).

6.3 KNOWING THE HIV STATUS

The study shows that the majority of participants went for HIV testing upon their own decision i.e without being told by anyone or being influenced by anything. The other participants were influenced by pregnancy (PMTCT), illness and death of spouses or their own illnesses. Voluntary counseling and testing is very important in people living with HIV and AIDS as it shows that the individuals are taking charge of their lives hence making it easy for them to change their behavior independently towards health promotion. Individuals who are forced into doing something without self drive have been known to quit or cheat from whatever they are being forced to. This may also be a reason why there is a high percentage practice of positive living among the participants

The findings also reveal that these participants are coping well with their status as they all said that they are not worried about their condition but rather willing to live positively so that they may promote their health and prolong life. This also contributes to positive living compliance.

6.4 SOURCES OF INFORMATION

The source of information is very important as it determines whether true information was given or not. In this study, all participants said they received information about positive living at the hospital where they attended group counseling. This shows that the participants were not misled in any way and they were given true information by a qualified health personnel. The findings also show that the main source of information is the hospital hence the reason why participants are knowledgeable about positive living. This is a unique finding.

The study findings also supplements the *HIV and AIDS monitoring and evaluation report, (2005-2009),* which stated that there has been increased awareness on positive living in Malawi through radio and television programmes. This is due to the reason that the participants come from villages where there is no electricity such that there is little or no access to listening to the radio or watching television and may be they don't have enough time to attend to such programmes. This may also suggest that the participants are satisfied with the information given at the hospital.

6.5 POSITIVE LIVING PRACTICE

In this study, all participants admitted to have been doing something to promote their health. One participant said that she takes ARVs everyday, eats nutritious diet, practice safe sex and does her daily household chores. Another one who once missed her doses admitted that distance is a problem for her to access the ARVs.

The findings show that participants are practicing positive living regardless of the religion or cultural values and this is in consistent with a study which was done by Michael, (2003) to explore Malawian cultural practices that have a bearing on positive living among people with HIV and AIDS, and the findings were that there are no cultural practices that have an impact on positive living.

The findings are also consistent with the health belief model which state that people are motivated to take appositive health action that uses the desire to avoid a negative health consequence as the prime motivation (Etr Associates, 2007).

6.6 INVOLVEMENT IN SUPPORT GROUP

Support groups play a vital role in positive living as they provide social support to PLHIV. Being involved in a support group allows one to be encouraged and if any problems, they are shared and solved in the group hence promoting psychological care and reducing stress as well.

The study shows that there is minimal involvement of the participants in support group as a result of not having support groups in their areas. This may result in poor coping with the status as social and psychological support is enhanced in support groups. However, the participants did not present with failure to cope with their present status and this may be because of increased public awareness and acceptance of the pandemic hence the society is taking part in supporting those living with HIV and AIDs. The NAF, (2005-2009), reported that there has been an increase in the society expressing accepting attitudes towards PLHIV from 29.7% in 2003 to 41.8% in 2006.

6.7 ASSISTANCE FROM OTHER ORGANISATIONS

In this study, there was no participant who indicated that she receives assistance from any other organization. Assistance was sorted in terms of financial and food or nutritional assistance. The participants stated that Balaka District Hospital only provides plumpy nuts to those patients who have a definite weight loss or are malnourished. Nutritional assistance is very vital for good health in PLHIV because it facilitates recovery if a person was wasted in the first place. Though the drugs can be taken in absence of food, good nutrition status will depend on good nutrition

Lack of adequate food has also been identified as one of the reasons preventing participants from living positively because a person who has not had food is subjected to stress, can not work or do exercises hence even when on ART can not improve her health and other people may decide to stop medication as they may think that they are troubling themselves.

6.8 DRUG ADHERENCE

In the study few participants reported to have ever missed their doses with the following reasons. One participant said she went away, the other one said she had no transport to access to the clinic and the other one said that she had forgotten. This means that there is a problem in drug adherence. Missing doses can bring serious problems to clients as the HIV is given chance to multiply hence increasing the viral load which further depletes the immunity leading to serious illness and death (MOH, 2003 *Guidelines for the use of*

antiretroviral therapy in Malawi) . Missing doses will also result in poor effectiveness of the ARVs as the virus may gain resistance to the drugs hence increasing mortality rate of PLHIV.

These findings may also be indicating that people forget the importance of taking ARVs daily as time goes and has resulted to missing doses or withdrawing themselves from medication knowingly without worrying about their health and this is why one participant admitted to have stopped taking ARVs for a month without a tangible reason. It may also mean that somewhere health workers are failing their work by supporting or giving health education to clients even during the therapy because it was observed that health education is given at the start of the ARV therapy and patients are observed with poor adherence for more than once or for a long period of time. This is in contrary with the MOH, (2003), *Guidelines for the use of antiretroviral therapy in Malawi* which states that it is recommended that every six months patients receive education about strict adherence to therapy.

6.9 IMPORTANCE OF POSITIVE LIVING

In this study almost all participants knew the importance of positive living and they stated that it promotes good health. Other participants said that it prolongs life. This is a unique finding and it shows that participants are knowledgeable about positive living. By being able to identify the importance of positive living may mean that they have a positive attitude and hence willing to practice it. This brings in the importance of education every six months with emphasis on the importance of strict adherence to ARVs so that reports of missing doses or deliberate withdrawal from therapy can be reduced.

6.10 HINDRANCES TO POSITIVE LIVING

In the study participants identified the factors that can hinder them from positive living as food and distance. Considering that poverty is still a problem in Malawi, people of low socio-economic status find it very difficult to find adequate and nutritious food which helps to boost the immune system of the body. They also fail to afford a reliable transport

system and affect positive living practice as explained earlier in this section. These results are new because no studies were found to show such results.

One factor which was predicted to hinder positive living and tested was stigma and discrimination. Stigma and discrimination prevents people from doing things freely. They may fail to go to ART clinic to take drugs, they are always worried and may fail to eat hence their health deteriorates. In this study there was only one woman who reported to have been verbally discriminated by fellow women who said to her that she is already dead since she has the virus. This shows that there is still a problem among women to accept their friends who have the virus otherwise there has been an increase of people expressing accepting attitudes towards PLHIV in Malawi according to NAF (2005-2009).

In agreement with the problems faced by women to be accepted by fellow women, the National AIDS Commission (NAF, 2005-2009), in a study to find out the percentage of people expressing accepting attitudes towards PLHIV. The results were that among females, accepting attitudes have been decreasing from 36.8% in 2000 to 20.3% in 2006. This shows that discrimination is high among women whom fellow women can get support.

6.11 CONCLUSION

From this discussion, it can be concluded that all participants know positive living and the activities which are involved in it though not all activities were mentioned during discussion.

The study has also shown that positive living practice is not influenced by cultural practices and that the participants are willing to practice positive living since they know the importance.

It has also been shown that shortage of adequate food and distance hinders participants from practicing positive living. Failure of health workers to provide education during

therapy also contributes to positive living incompliance and more especially on drug incompliance.

7.0 RECOMMENDATIONS OF THE STUDY

- The hospital should provide supplementary food to people living with HIV and AIDS that have problems finding food by lobbying from the MOH.
- The hospital should establish ART clinics in distant areas of more than 5km away from the hospital.
- There is need to mobilize the community to establish support groups in their areas of residence.
- The health workers at ART clinic should provide health education on the importance of strict adherence to ART.
- The general public should promote positive attitudes towards PLHIV. There is need for the society to provide support to those that are infected and affected.

8.0 LIMITATIONS OF THE STUDY

- The study involved women only as such it could not give a whole representation of the findings as it was gender biased.
- The study took place together with other course, which made time to be a limiting factor.
- There were very few studies both locally and internationally and this created problems in coming up with thorough literature review.

9.0 AREAS FOR FURTHER RESEARCH

- Factors leading to decrease in accepting attitudes among females towards PLHIV

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APPENDIX A: CONSENT TO PARTICIPATE IN A STUDY

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

Dear participants,

I am Alice Mataya, a final year student at Kamuzu College of Nursing, doing Bachelor of Science in nursing.

The purpose of is to request your consent to request your consent to participate in the above mentioned research study. In partial fulfillment of the programmme, I am required to conduct a research study. The title of the study is knowledge, attitudes and practice towards positive living among HIV positive women attending ART clinic at Balaka District Hospital.

The study aims at exploring the knowledge attitude and practice among women attending ART towards positive living.

Participation in the study is voluntary. No penalty will be imposed for not participating in the study but your participation will greatly assist me in my education. You can withdraw from the study at any time and you are free to ask questions about the study.

An interview guide with instructions will be given to you. Notes will be taken from the responses in the interview. No names will be used in the study. The information obtained will be kept in confidential and will be used by the researcher for the educational purposes.

You are required to sign the attached consent form if willing to participate in the study.

Looking forward to your participation.

Thank you

CONSENT FORM
I hereby give consent to participate in the study after understanding the above explanations about the study.

Signature of Participant ..... Date .....
Signature of Researcher ..... Date.....

APPENDIX B: INTERVIEW GUIDE FOR HIV POSITIVE WOMEN

Instructions: answer all questions

Code number: .....

Date: .....

SECTION A:

Demograghic data

1. How old are you?
    a) 20-29
    b) 30-34
    c) 35-39
    d) 40 and above

2. What is your tribe?
    a) Lomwe
    b) Chewa
    c) Tumbuka
    d) Others.....

3. What is your religion?
    a) Roman catholic
    b) CCAP
    c) Anglican
    d) Others .....

4. What is your education level?
    a) Never gone to school
    b) Standard 1-8
    c) Form 1-4
    d) Tertiary qualification

5. Where do you live?.....

6. Who do you live with?
   a) Alone
   b) Family members
   c) Spouse
   d) Others .....

SECTION B:

Questions on knowledge of women about positive living

7. When did you know you are HIV positive?

8. How have you lived with the status from the day you knew it?

9. What do you know about positive living with HIV and AIDS?

10. How did you know about positive living?

SECTION C

Questions on positive living practice

11. What are you doing on positive living with HIV and AIDS?

12. Are you in any support group? (name) If Yes, what activities are carried out in your support group? If No, why?

13. Do you get any support from any organisation? If yes what type of support and from which organisation(s)?

14. Have you ever missed taking ARVs? If yes, why and how often?

15. Are you subjected to any type of stigma and discrimination? If yes, what type and from who?

SECTION D

Questions on what women think regarding positive living

16. What is your viewed importance of living positively with HIV and AIDS?

17. What do you think are factors that are promoting positive living among women?

18. What do you think problems can hinder one from living positively with HIV?

University of Malawi
Kamuzu College of Nursing

RESEARCH AND PUBLICATIONS COMMITTEE

APPROVAL CERTIFICATE

TITLE: KNOWLEDGE, ATTITUDES AND PRACTICES TOWARDS POSITIVE LIVING AMONG HIV POSITIVE WOMEN ATTENDING ART CLINIC AT MULANJE MISSION HOSP.

INVESTIGATOR(S): ALICE MATAYA

YEAR OF STUDY: 4 GENERIC

REVIEW DATE: 7TH AUGUST 2008

DECISION OF THE COMMITTEE: APPROVED: PLEASE CHECK SPECIAL COMMENTS IN DOCUMENT.

SIGNATURE:.....**DATE**.....
DEAN OF POSTGRADUATE STUDIES AND RESEARCH

CC: supervisor: DR. A. KAZEMBE

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)**.....

Telephone No: 01 552344
Fax No. : 01 552347

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

6th October, 2008

Miss Alice Mataya
Kamuzu College of Nursing
P/Bag 1
LILONGWE

Dear Madam,

PERMISSION TO CONDUCT A STUDY

I received your letter requesting to conduct a study at this hospital on 2nd October, 2008.

So I hereby give an approval to do so.

I hope the results will be communicated to this institution for better management of our clients.

Looking forward to meeting you here.

M.W. Mhango
DISTRICT HEALTH OFFICER