Stigma associated with people living with HIV/AIDS in Mahwelereng, Limpopo Province

By

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DECLARATION

I declare that the mini-dissertation hereby submitted to the University of Limpopo, for the degree of Master of Arts in Clinical Psychology has not previously been submitted by me for a degree at this or any other university; that it is my work in design and in execution, and that all material contained herein has been duly acknowledged.

_____   _____

Surname, Initials (title)   **Date**

DEDICATION

This dissertation is dedicated to the following people:

- My parents, Johannah and Godley Tsebe.

- My brother Kholofelo Tsebe.

- My husband, Enoch Diketana.

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ABSTRACT

In this study, the researcher aimed to discover stigma associated with people living with HIV and AIDS in Mahwelereng, Limpopo province. The researcher sampled five males and five females and they were between the ages of 18 and 35. In-depth interviews were a method of choice during data collection. Thematic content analysis was used to analyse data.

The results show negative perceptions towards PLWHA. The community discriminate PLWHA because of fear of being infected, with females being at a higher risk because they are perceived to be promiscuous. Participants also highlighted that black people lack knowledge of how to treat and behave towards HIV/AIDS infected individuals.

It is recommended that there should be studies that focus on availability of interventions that aim to combat HIV/AIDS stigma. Lastly, the future studies should explore which race groups have more knowledge and perception about HIV and AIDS.

KEY CONCEPTS:

Acquired Immune Deficiency Syndrome; Human Immunodeficiency Virus; People Living with HIV and AIDS; Stigma.

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LIST OF ABBREVIATIONS AND ACRONYMS

AIDS   Acquired Immune Deficiency Syndrome

HIV   Human Immunodeficiency Virus

HSRC   Human Sciences Research Council

PLWHA   People Living with HIV and AIDS

UNAIDS   United Nations programme on AIDS

USSR   Union of Soviet Socialist Republics

WHO   World Health Organization

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CHAPTER 1: GENERAL ORIENTATION OF THE STUDY

1.1. Introduction

Human Immunodeficiency Virus (HIV) and Acquired Immunodeficiency Syndrome (AIDS) remains a major health problem, as the number of individuals with the disease across the globe has been increasing since the early 1980s when the disease was identified (Kallings, 1993). Currently, the African population represents almost 70% of total HIV cases worldwide where the majority is young Africans aged between 6-24 (United Nations AIDS, 2010).

HIV and AIDS present threats to human life and cause significant morbidity and mortality in human societies throughout the world. HIV and AIDS affect physical, mental, emotional, social and spiritual dimensions of human life. People Living with HIV and AIDS (PLWHA) disease poses physical and psychological challenges to their families and health care providers (Grant, 2002). Sowell (2004), state that HIV and AIDS reduce the life expectancy of infected persons, increasing the number of orphaned children, creating turbulence in health care systems and contributing to economic insecurity, potentially leading to political instability.

Over the last two decades the subject of AIDS related stigma has received a substantial amount of attention in the academic literature, largely because the harmful effects of stigmatisation are often cited as major obstacles in the global fight against HIV and AIDS (Bond, Chase & Aggleton, 2002). Research noted associations between HIV knowledge deficits and stigmatizing attitudes in community and clinical samples, arguing that educational interventions should be a high priority (Kalichman & Simbayi, 2004). Although gains have been reported with educational, skills-building and counselling interventions (Brown, Macintyre & Trujillo, 2003), some argue that these behavioural approaches alone are inadequate because they fail to address the structural factors that contribute to HIV stigma and discrimination such as poverty, gender inequality, marginalization of certain populations and barriers to health care access (Farmer *et al*., 2001).

1.2. Background of the study

1.2.1 Problem statement

AIDS related stigma has had an intense effect on the epidemic's course. The World Health Organization (2008) cites fear of stigma and discrimination as the main reason why people are reluctant to be tested, to disclose their HIV status or to take antiretroviral drugs. HIV related stigma creates social distance that cuts off people living with HIV and AIDS (PLWHA) from social interaction and support and strengthens existing inequalities of class, race and sexuality (Parker & Aggleton, 2003). According to Nyblade *et al*. (2003), socio-economic status, age and gender all influence the experience of stigma. Furthermore, PLWHA sometimes receive unkind treatment from the community, according to Nyblade *et al*. (2003), they are excluded from family and community special events.

There are a number of social and cultural factors that encourage AIDS related stigma with its specific character. These factors are often related to the degree or types of knowledge individuals or communities have about AIDS. In rural and urban African communities, social constructions of HIV are commonly guided by culture, traditional; religious beliefs or myths about disease and illness (Kalichman & Simbayi, 2004). In many cases, PLWHA are typically blamed for, or seen to deserve their status. They may be perceived as cursed victims of witchcraft, or immoral or sinful and deserving of some due punishment delivered by a spirituality or moral being (Kopelman, 2002).

It is apparent in the literature that there have been many quantitative studies done (Ragimana 2006; Genberg *et al*., 2008), there are few qualitative studies done on stigma associated with people living with HIV/AIDS. Thus, there is a need for research on this topic using qualitative method to get in depth information about stigma associated with people living with HIV/AIDS. Thus the current study addresses this gap in the area.

1.3. Aim of the study

The aim of this study was to explore the stigma associated with people living with HIV and AIDS in Mahwelereng, Limpopo Province.

1.4. Objectives of the study

The objectives of this study were:

1.4.1. To identify what participants think of people living with HIV/AIDS.

1.4.2. To identify how participants treat people living with HIV/AIDS.

1.4.3. To identify what participants think are the factors related to HIV/AIDS stigma.

1.5. Research questions

1.6.1. What do you think of people living with HIV/AIDS?

1.6.2. How do you treat people living with HIV/AIDS?

1.6.3. What do you think are the factors related to HIV/AIDS stigma?

1.6. Scope of the study

The study was conducted in Mahwelereng area. Mahwelereng is a middle-class suburb situated in Waterberg District, Limpopo province.

1.7. Operational definition of terms

Stigma

According to Seale (2004), HIV/AIDS related stigma means a real (enacted stigma) or felt/imagined (internalized stigma) negative response to a person or persons by individuals, communities or societies.

For the purpose of this study, stigma refers to negative attitude towards PLWHA or being discriminated against for HIV status.

HIV/AIDS

According to Drugs.com (as cited in Makgahlela, 2010), HIV damages or destroys the cells of the immune system making the body less able to fight infections and more susceptible to often life threatening opportunistic infections. The term Acquired Immunodeficiency Syndrome (AIDS) refers to the latter stages of HIV infection. Most individuals infected with HIV will progress to AIDS if not treated; however, there are very few patients who develop AIDS very slowly or not at all (Drugs.com, as cited in

Makgahlela, 2010). Therefore, for the purpose of this study HIV is a virus that leads to AIDS.

1.8. Motivation of the study

Stigma against PLWHA is a common phenomenon in South Africa. According to MacQuarrie, Eckhaus and Nyblade (2009), an overabundance of quantitative studies confirm that HIV related stigma and discrimination are highly prevalent and feature prominently in the lives of PLWHA in settings with epidemics as diverse as the United States, Vietnam and South Africa. PLWHA are sometimes made to feel like they deserve their status and also become isolated in communities. Which is what inspires this study is to explore the stigma associated with people living with HIV/AIDS in Mahwelereng, Limpopo province. In addition, the study explores what participants think and how they treat people living with HIV/AIDS and learn more about demographic factors related to HIV/AIDS stigma as well.

1.9. Significance of the study

Undertaking this study will help to better understand the attitude of the community members towards PLWHA. It will also assist in developing intervention programs that are aimed at alleviating stigmatization against PLWHA. In addition, it is important to fully understand the community's attitude in order to come up with prevention strategies and also help PLWHA.

1.10. Conclusion

This chapter has introduced the study by providing a background and a rationale for the study. The aim, objectives and questions of the study as well as problem statement were given. A brief outline of the study site was provided and finally the definitions of terms used throughout this study were provided.

CHAPTER 2: THEORETICAL FRAMEWORK

2.1. Introduction

This section discusses the theoretical perspectives which attempt to explain stigma. Two theoretical frameworks which are consensus theory and social identity theory will be discussed. Both theories were chosen because they explain stigma appropriately.

2.2. Theoretical perspectives

2.2.1. Consensus theories

Functionalism, also referred to as consensus theory explains society holistically. It assumes that the social world exists in a state of harmony. Functionalists see society as a "body", composed of many different institutions which all functions together for the benefit of the whole.The functionalist perspective is based mainly on the works of Spencer, Durkheim and Parsons (as cited in Mooney, Knox & Schacht, 2007). According to their perspective, society is a system of interconnected parts that work together in harmony to maintain a state of balance and social equilibrium for the whole. Basically, each of the social institutions contributes important functions for society. For instance, family provides a context for reproducing, nurturing, and socializing children. Education offers a way to transmit a society's skills, and knowledge and religion provides moral guidance and an outlet for worship of a higher power (Mooney, Knox & Schacht, 2007).

Furthermore, functionalist perspective emphasizes on the interconnectedness of society by focusing on how each part influences and is influenced by other parts. For example, the increase in single parent and dual earner families has contributed to the number of children who are failing in school because parents have become less available to supervise their children's homework (Mooney *et al.*, 2007).

Furthermore, Durkheim (as cited in Macionis, 2011) was concerned about how certain societies maintain internal stability and be able to survive. He then proposed that such societies tend to be segmented, with equivalent parts held together by shared values and common symbols. Durkheim used the concept "mechanical solidarity" to refer to these types of social bonds that are based on shared values and morals. In modern

societies members perform different activities that lead to interdependence (Macionis, 2011).

Moreover, Spencer (as cited in Macionis & Gerber, 2010) compared society to a human body. The same manner each part of the body works in harmony with other parts, each part of society works in harmony with other parts as well. For instance, in order to be able to understand the importance of the heart for helping the body function properly, it is crucial to understand how it relates to other parts. In order to be able to analyse the functions of some aspects of society such as education, one can learn how it impacts the other parts of the system (Macionis & Gerber, 2010).

Parsons (as cited in Macionis & Gerber, 2010) viewed society as a system. He argued that any social system has four basic functional fundamentals: adaption, goal attainment, integration, and pattern maintenance. They can be seen as problems that society must solve in order to survive. The function of any part of the social system is understood as its contribution to meeting the functional fundamentals. He believes that order, stability and cooperation in society are based on value consensus. In essence, it is the general agreement by members of society concerning what is good and worthwhile (Macionis & Gerber, 2010).

Consensus theories indicate that stigma and stereotypes are transferred to the society through communication, and also by individual's options to conform to the opinions of others. Fundamental to the assumption of the consensus theory, is the principle that individuals are motivated to belong to the group and that sharing beliefs allows them to be accepted in such groups. According to the consensus theories of stigma, there are generally accepted beliefs which are held by the majority. Most people conform to such normative beliefs due to their innate need to belong. Basically, beliefs are transmitted both actively through communication and socialisation and passively through indirect exposure to such ideas (Stangor & Crandall, as cited in Heatherton, Kleck, Hebl & Hull, 2000).

Consensus theories further postulate that stigmatisation is not an individual act, but rather something which occurs at a more societal and community level. Such stigma then becomes transmitted actively and passively through channels of communication and media to the individuals. Individuals conform to such beliefs due to their need to belong to the majority (Lekganyane, 2010). Beliefs about stigma become consensual

within a society because individuals are motivated to share their beliefs with others and that allows them to be accepted. Therefore, sharing beliefs provides positive impact, as well as a sense of security and validity (Heatherton, Kleck, Hebl & Hull, 2000).

Lawson (2008) shows how the South African apartheid government adopted this practice when they legislated the compulsory testing for Malawian migrant miners which led to a point where the Malawians were stigmatised as the group who brought the disease into South Africa. From the onset, HIV and AIDS were linked to marginalised groups such as homosexual men, commercial sex workers, and injecting drug users. Then the belief that such groups are responsible for the general spread of the disease to the population at large.

Social belief including those about stigma are transmitted within the members of the society in both an active and passive sense. In some cases an individual may relatively passively assimilate the beliefs that are culturally available through exposure to those messages. The mass media, particularly television depicts interaction between stigmatized and non-stigmatised individuals in stereotyped ways. Stigma is also common sources of humour and thus; they are highly likely to be consensually transmitted (Heatherton, Kleck, Hebl & Hull, 2000).

2.2.2. Social identity theory

Social identity theory (SIT) is a theory that attempts to explain cognitions and behaviour with the help of group-processes. It assumes that individuals tends to show group behaviour such as solidarity within the groups and discrimination against out-groups as a part of social identity processes with the aim being to achieve positive self-esteem and self-enhancement. Categorization to a group makes individuals to discriminate against the designated out-group and favour the in-group. The theory bases its assumptions on the social group which is made up of a number of individuals who feel and perceive themselves as belonging to a given group and who are said to be in a group with others. There are four underlying principles of SIT which are outlined: social categorization, social comparison, social identity, and self-esteem (Lodder, 2004).

The theory further indicates that important group memberships form an integral part of individual's identities or self-concept. It further suggests that individuals are motivated to establish and maintain their self-esteem, and that group memberships have positive consequences. In addition, it indicates that several psychological processes concerning enhancing of self-esteem result from the act of categorizing oneself and others into groups. For example, group categorization leads to an attention of differences between one's own group and other groups (Lodder, 2004).

Tajfel and Turner (1986), indicate that positive self-esteem is achieved and maintained through intergroup comparisons along characteristics that favour the in-group. Individuals search for inter-category differences that favour the group to which they belong or with which they identify. This competitive orientation leads to perceptual biases and discriminatory behaviour, which functions as attempts to differentiate between the in-group and the out-group in a manner favouring the in-group. As a result, differences favouring the in-group are exaggerated, while differences favouring the out-group are minimized or ignored.

Tajfel and Turner (1986) further indicate that these categorization processes lead to affective and motivational outcomes. That is, when people feel they belong to a certain social group, they can be expected to experience positive effects on behalf of the in-group and be moved to act toward in-group goals. Equally, negative emotions can be directed toward the out-group. Such emotions, experienced in response to group-based outcomes, can be considered social, as opposed to personal emotions.

HIV/AIDS related stigma seems to be completely intertwined with social identities and the motivation to maintain positive social identities. Negativity toward PLWHA arises out of uninfected people's need to protect their identity as healthy and non-deviant. Therefore, interactions with PLWHA simultaneously define and threaten social identities that involve personally important moral and religious values. Stigmatising PLWHA has a major social function of protecting the in-group members by derogating the out group members (Lodder, 2004).

Out-group members can be perceived by in-group members as a threat to their social identities. These threats can provoke social emotions from in-group members that can range from contempt to disregard. When it became clear that the disease spread outside the defined risk groups, a need for protection arose among the uninfected.

Thus, their concern derived not from worry about the well-being of those infected with the disease (who were generally perceived as dirty and immoral), but rather from fear of the disease's potential to affect the general public (perceived as clean, acceptable and moral). Viewed as such, the disease endangered both the health and the social identities of the (so-called) general public (Tajfel 1981).

2.2.3. Conclusion

This chapter contextualizes the theoretical framework in this study. It shows a theoretical understanding of how stigma associated with people living with HIV/AIDS will be understood in terms of the consensus and social identity theories.

CHAPTER 3: LITERATURE REVIEW

3.1. Introduction

This chapter covers the prevalence and incidents of HIV/AIDS stigma. It further discusses the types of stigma, contributory factors and effects of HIV/AIDS stigma and also strategies to prevent HIV/AIDS. It finally explores on the stigma experienced by people living with HIV/AIDS and the demographic factors that are related to HIV stigma.

3.2. The prevalence and incidence of HIV/AIDS

The total number of persons living with HIV in South Africa increased from an estimated 4,02 million in 2002 to 6,19 million by 2015. For 2015, an estimated 11, 2% of the total population is HIV positive (Statistics South Africa, 2015).

The estimated overall HIV prevalence rate is approximately 10,2% of the total South African population. In addition, the total number of PLWHA is estimated at approximately 5,51 million in 2014. Furthermore, an estimated 16,8% of the adult population (15-49 years) is HIV positive (Statistics South Africa, 2014).

The national estimate for HIV prevalence among South Africans in 2012 was 12.2%. This is statistically significantly different from the 2008 national estimate of 10.6%. There has been a significant increase of almost 1.2 million more PLWHA in South Africa, an increase from 5,253,493 PLHIV in the 2008 to 6,422,179 PLHIV in 2012 (South African National HIV Prevalence, Incidence, Behaviour and Communication Survey, 2012).

UNAIDS (2008), estimated that in 2007, 33 million people were living with HIV globally. In the same year 2.7 million people became infected with HIV and 2 million people died of HIV related causes. Of the 2.7 million new infections it was estimated that 1.9 million occurred in sub-Saharan Africa. The region accounts for two-thirds (67%) of the global total of 33 million people living with HIV. Southern Africa continues to bear a disproportionate share of the global burden of HIV with 35% of HIV infections occurring in this sub-region (South African National HIV Prevalence, Incidence, Behaviour and Communication Survey, 2008).

A decline in HIV prevalence at national level has been observed among children aged 2–14, from 5.6% in 2002 to 2.5% in 2008. In addition, there was a slight decrease of HIV prevalence among youth 15–24, from 10.3% in 2005 to 8.6% in 2008. HIV prevalence remains disproportionately high for females in comparison to males, and peaks in the 25–29 year age group, where one in three (32.7%) were found to be HIV positive in 2008 (South African National HIV Prevalence, Incidence, Behaviour and Communication Survey, 2008). This proportion has remained unchanged since 2002 and it was at the same level in all three surveys. HIV prevalence levels in the age group 15–49 years slightly increased from 15.6% in 2002 to 16.2% in 2005 and 16.9% in 2008 (South African National HIV Prevalence, Incidence, Behaviour and Communication Survey, 2008).

The 2008 HIV prevalence is lowest in the Western Cape followed by Northern Cape, Limpopo and Eastern Cape. The highest HIV prevalence remains in KwaZulu-Natal, Mpumalanga and Free State province respectively. The North West and Gauteng provinces fell in between these two groups (South African National HIV Prevalence, Incidence, Behaviour and Communication Survey, 2008).

Available information indicates that HIV prevalence rates for the Waterberg District increased from approximately 5% in 1996 to 14,3% in the Waterberg District Municipalities and 9,6% in the Mogalakwena and Mookgophong Municipalities in 1999. Subsequent, survey's showed a further increase in 2000 to 10,3% and 10,2%, respectively in these municipal areas (Mogalakwena Local Municipality 2011/12 IDP Review).

Based on the statistics provided, it is clear that the prevalence of HIV/AIDS is increasing every year. Exploring on the types of stigma can assist in gaining a better understanding.

3.3. Types of stigma

There are two types of stigma, namely: internal and external stigma. According to Bond, Chase and Aggleton (2002), internal or self-stigma exist when people internalize the negative stereotypes towards themselves. These can lead to self-blame and self-depreciation. On the other hand, external stigma refers to the experience of unfair treatment by others. It can lead to withdrawal and restriction of social support (Brouard

& Wills, 2006). There are factors that that contribute to HIV/AIDS-related stigma include: HIV/AIDS is a life-threatening disease and most people become infected through sex (Brouard & Wills, 2006).

3.4. Contributory factors of HIV/AIDS stigma

It is important to analyse some of the fundamental underlying causes of AIDS stigma. AIDS stigma primarily result from unawareness, misconception or fears about the disease. AIDS stigma has perpetuated moral judgements and assumptions about the sexual behaviour of people with AIDS, as well as questions about their associations with illicit sex, alcohol and drugs (Valdiserri, 2002). In some cases, stigma and discrimination have links with religion and the belief that HIV/AIDS is a punishment from God. AIDS stigma is the result of many factors including ignorance, intolerance, prejudice, absence of widespread treatment or cure, irresponsible portrayal of the epidemic in the media, fears and deep rooted taboos about sexuality, illness and drug use (Morisky, Jacob, Nsubuga & Hite, 2006).

In a review of HIV/AIDS stigma in four countries (Ethiopia, Tanzania, Vietman, Zambia), Ogden and Nyblade (as cited in Parker & Birdsall, 2005) explored the root causes of individual perceptions of stigma. They found fundamental similarities in the development and expression of stigmatising ideas in all contexts. These included fear of infection through everyday contact, a preoccupation with unlikely modes of transmission and an association of the disease with immorality. The multi-country study found that, although knowledge of ways HIV could be transmitted was high in general, there was a lack of understanding about how HIV could not be transmitted. This was found to be exacerbated by fear-based public messages and sensationalism. Perceptions of morality were linked to promiscuity, moral transgression, choosing to engage in 'bad' behaviour and punishment from God. This is contrasted with social values to do with what is considered normative, appropriate or good behaviour (Ogden & Nyblade, as cited in Parker & Birdsall, 2005).

3.5. Effects of HIV/AIDS stigma

AIDS stigma has devastating effects, ranging from aggression to serious violence and even death. At the individual level, AIDS stigma takes the form of behaviours, thoughts, and feelings that express prejudice against people living with HIV or AIDS,

and can also be experienced by persons perceived to be living with HIV/AIDS (Tomaszewski, 2012). It perpetuates isolation, dropping out of school, depression, suicide, alcoholism, violence, loss of employment and diminished self-esteem. Stigma limits an individual's ability to get tested for HIV and thus affects that individual's ability to get tested for HIV and have access to treatment and care (Mill, 2003). In cases where quality counselling has not been provided, stigma can lead to break up of families and relationships. It therefore, jeopardizes the potential of infected and affected people to live positively with HIV/AIDS. Stigma and discrimination breed silence about the deadly virus and yet the first weapon needed is openness. In addition, individuals become reluctant to open up for fear of the consequences and cannot therefore, seek needed help and support. Unsafe behaviour and practices could be perpetuated and as a result, further promote the risk of infection (Morisky, Jacob, Nsubuga & Hite, 2006).

3.6. Stigma towards people living with HIV and AIDS

The following subsections discuss the differential treatment that PLWHA encounter. It further explains how PLWHA get spoken about in the community.

3.6.1. Differential treatment

The most common forms of differential treatment are physical or social exclusion from the family and community, changes in care and support by the family and community. According to UNAIDS (2015), PLWHA are being denied to access health services because of stigma and discrimination). Social exclusion usually manifests itself as the reduction of daily social interaction with family, neighbours, exclusion from family; community events and rejection or turning away by the public (Nyblade *et al*., 2003).

3.6.2. Gossip and mocking and loss of identity and role

According to Nyblade *et al.* (2003), talking unpleasant about PLWHA is described as one of the most common and feared manifestations of stigma. People recognize the use of language as a stigmatizing tool and its negative power. They speculate and spread rumours about whether a person is suspected to have HIV, how that person is assumed to have contracted HIV, that they deserve HIV and how they are now "useless" and going to die soon. Furthermore, people living with HIV and AIDS are viewed by the community as having no future or hope and are no longer considered

productive members of society (Nyblade *et al*., 2003). In addition, once their positive HIV status is known, PLWHA are sometimes treated as if they suddenly have lost the ability to function, both physically and mentally (Nyblade *et al*., 2003).

3.7. Strategies to counter HIV/AIDS stigma

The general health sector and its service organization should be encouraged to review their policies, professional code of conduct and practices to prevent and redress stigma and discrimination (Mill, 2003). According to Morisky, Jacob, Nsubuga and Hite, (2006), training of health care providers is necessary to deal with HIV/AIDS stigma and policies also need to be established in order to take action against those who breach the policies. In the work place, employees and employers should be sensitive to issues regarding stigma, discrimination, and people's right with respect to HIV and AIDS. This will help reduce stigma and promote the positive attitudes necessary for an effective work environment and above all, a healthier life. People need to know the basic facts about HIV transmission, prevention and management. There is also continuous need to provide accurate information to decrease misconception and fight discrimination (Morisky, *et al*, 2006).

There can be programs that consist of community interaction and focus group discussions involving PLWHA and populations vulnerable (sex workers, people who inject drugs) to HIV infection. In addition, the media can be used in advertising campaigns, entertainment designed to educate as well as to disseminate non-stigmatizing messages into TV and radio shows. Furthermore, there can also be an engagement with religious and community leaders and celebrities. Additionally, peer mobilization and support developed for and by PLWHA aimed at promoting health, well-being and human rights can be implemented (UNAIDS, 2012).

In a nutshell, there are various levels at which stigma reduction strategies are used: intrapersonal, interpersonal, community, organisational and governmental levels. At the intrapersonal level, strategies used include: treatment, counselling, self-help, empowerment and support groups. At the interpersonal level, strategies includes home care teams and community based rehabilitation. Training programs and policies are approaches used at the organisational level. Finally, the strategies that are used at the governmental level includes rights-based approaches, legal and policy interventions (Restall & Gonzalez, 2014).

3.8. Demographic factors related to HIV stigma in the community

There are quite a number of factors that are related to HIV/AIDS. Youth is blamed for spreading HIV through what is perceived as highly risky sexual behaviour. While both men and women are stigmatized for breaking sexual norms, gender-based power results in women being blamed more easily. At the same time, the consequences of HIV infection, disclosure, stigma and the burden of care are higher for women than for men (Nyblade *et al.*, 2003).

Gender

A study carried out in Kenya shows that 56% of women are commonly viewed to be targets of stigma compared with 12% of men (Amuyunzu-Nyamongo, Okeng'o, Wagura & Mwenzwa, 2007). A study has shown that women who share HIV test results with their partners may experience a range of reactions from support and understanding to accusations, discrimination, physical violence and abandonment (Maman, Mbwambo, Hogan, Kilonzo, & Sweat, 2001).

On the other hand, a study carried out in South Africa showed that men were more likely than women never to have discussed AIDS with friends (Simbayi *et al.*, 2007). They are more likely to have been treated differently after testing, more likely to report experiencing internalized stigma and more likely to have suffered loss of a place to stay or job due to AIDS. Part of the explanation for this could be the fact that men are more likely to have been working before the sickness and are primarily responsible for providing shelter (Strebel *et al.*, 2006).

In old South African beliefs women are seen as the carriers of HIV/AIDS (Boerjan, 2013). In addition, HIV prevalence is very high for women. According to Boerjan (2013), the majority of the people living with HIV in sub-Saharan Africa are women. Additionally, 76% of all HIV/AIDS related stigma is on women in Kwazulu-Natal. Furthermore, HIV positive women in the world live in South Africa (UNAIDS, 2010). Most importantly, within the South African society, women are often unequal to men. Fundamentally, gender inequalities in terms of low socio-economic, political status, unequal access to education and fear of violence contribute to the vulnerability of women and girls being infected with HIV (UNAIDS 2010). In addition, South Africa is a highly gender-inequitable country and has a strong patriarchal society. The

masculinity influence that prevails in the country mobilizes and legitimates the subordination and control of women (Jewkes & Morrell, 2010).

Simbayi *et al.* (2007), indicate that HIV/AIDS is associated with risk behaviours and therefore it is considered an 'immoral' disease that happens to people who do not conform to social norms. In addition, Duffy (2005) states that even though women contracted HIV from their husbands, women are often abandoned by husbands or family because they regard the women as promiscuous.

Religious affiliation

Religious institutions have been documented as playing both supportive and negative roles toward PLWHA. Religious leaders have the possibility as leader in position to be tempted to exercise power over others (Campbell, Nair, Maimane & Nicholson, 2007). One of the strategies used by some churches to regain their lost moral authority is strongly linking sexual transgressions and AIDS with sin and immorality (Campbell, Foulis, Maimane & Sibiya, 2005).

The religious approach warrants stigmatizing people as "saved'' or "sinner'', "pure'' or "impure'', "us'' or "them'', and it strengthens the broader social stratifications within which stigma flourishes (Rankin, Brennan, Schell, Laviwa, & Rankin, 2005). PLWHA are distanced, disempowered or controlled. In Zambia, churches sometimes impose mandatory HIV testing before allowing marriage and individuals with HIV have been expelled from churches because they were deemed "sinners''(Campbell *et al.*, 2007).

Religious activities, communities, and beliefs frame the daily behaviours and attitudes of many people living in countries with high rates of HIV/AIDS. On the community level, religious organizations are influential social networks that have the power to support or stigmatize people living with HIV/AIDS, promote or inhibit HIV education and endorse or reject medical treatment of HIV (Zou *et al*., 2009).

Christian practices and religious leaders have had a profound effect on the social construction of the HIV/AIDS epidemic across the African continent. Christian messages often results in the creation of stigma. Like in Islamic religion, HIV/AIDS is mostly associated with sexual promiscuity, which in both religions, is forbidden (Speakman, 2012). Additionally, preachers often preach a message of fear, harping on lessons learned from the fall of humankind and its impurity, rather than focusing on

a message of compassion. This often leads the creation of an unshakeable stigma; to have contracted HIV means to have committed a great sin. This stigma has created a sense of fear to individuals, and studies show that the fear of being stigmatized with AIDS is fuelling the HIV epidemic. Furthermore, the lack of a message of compassion also leads to harsh treatment of HIV patients and the stigmatizing of their family members and caretakers (Speakman, 2012).

Christian religious discourse often also results in misguided epidemiological understandings about HIV/ AIDS. In essence, popular religious interpretations of HIV risk are misleading, posing potential dangers to youth underestimating their risk. For instance, Nigerian Christians link HIV/AIDS with sinful behaviour (Smith, 2011). Research reports that the role of religious morality plays a major part in popular understanding of HIV/AIDS and individual risk assessment in Christian youth in Nigeria (Smith, 2011).

Moreover, religious leaders within Islamic regions of Africa greatly influence the social construction of HIV/AIDS within Muslim populations. According to Makhlouf (2006), widespread homophobia has also contributed to stigmatizing the disease. Harsh anti-homosexuality laws instil fear and discourage people from being tested because they are afraid they would be accused of being homosexual. This fear; however, was not limited among the men who have sex with-men populations. In a survey of university students in the United Arab Emirates (UAE), there appeared to be a real fear, as well as misunderstanding, of the epidemic and its facts. For example this fear lead to people hiding their behaviours, further putting themselves at risk. In the same study, 90% knew the main routes of infection but there were misconceptions about transmission. Only 31% knew there was no vaccine and only 34% knew there was no cure (Makhlouf, 2006).

The public response in Muslim communities has been dominated by religious discourse. Recently, many Islamic countries denied the existence of HIV in the Middle East, instead they said it is brought in from other countries that were sexually promiscuous. In these highly conservative societies, they taught obedience to Islam as the best protection (Makhlouf, 2006).

Race

The stigmatization of the African American identity in relation to diseases in the early twentieth century shows continuity today in the context of HIV/AIDS at the turn of the century. For instance, an illustration of this is the stigmatization and harassment of the Haitian people in the early 1980s, who were accused of having brought AIDS into the USA (Farmer & Kim, 1991).

AIDS related stigma and discrimination are complex social issues. They usually build upon and reinforce pre-existing fears, prejudices and social inequalities relating to poverty, gender, race, sex and sexuality. In essence, racist attitudes and racial discrimination linked to HIV/AIDS status are only playing into, and reinforcing, already existing racial stereotypes and inequalities (Bharat, 2002).

In the beginning of the epidemic, travel restrictions were established on `foreigners' most of whom belonged to racial or ethnic, minorities. For example, African students traveling to Union of Soviet Socialist Republics and parts of Western Europe were imprisoned, isolated or even expelled from their university programs for reasons that included their HIV status (Sabatier, 1988). In addition, in the Gulf countries there is mandatory testing for all foreign nationals (Bharat, 2002).

Racism and racial discrimination linked to HIV status may be categorized as symbolic' stigma as the already stigmatized and marginalized racial groups are stigmatized further on account of their association with HIV. Conversely, HIV is assumed to be high among certain racial or ethnic groups on the basis of their past association with diseases such as cholera, plague and hookworm (Wailoo, 2001). Kenyon, Buyze and Colebunders (2013), concluded that the difference in sexual behaviour in general and the prevalence and the number of sexual partners in particular, offer a plausible cause to explain a part of the differentiating prevalence of HIV between South Africa's racial groups.

Moreover, societal stigma related to race or ethnicity eventually contributes to and maintains racial or ethnic HIV disparities through its manifestations at the structural and individual levels. Furthermore, as depicted by bidirectional arrows within the model, societal stigma is sustained through the co-occurrence of its manifestations (Link & Phelan, 2001).

Racial or ethnic minorities at risk of and living with HIV often possess other stigmas beyond their race or ethnicity, including HIV itself and related stigmas. These include factors such as sexual minority orientation; transgender identity or expression; illicit drug use; sex work; incarceration and immigration. Although the role of societal stigma associated with race or ethnicity can be studied independently, it is important to consider how multiple stigmas interact with each other to provide a fuller understanding of the impact of societal stigma on racial/ethnic HIV disparities (Earnshaw, Bogart, Dovidio & Williams, 2013).

An intersectional framework clarifies several key insights for understanding how stigma contributes to racial or ethnic HIV disparities. Firstly, people at risk of and living with HIV typically experience discrimination stemming from multiple facets of their identity beyond their race or ethnicity. Second, the different combinations of these stigmatized identities can produce distinctive responses and experiences. For example, because some inter sectional identities are much more prototypical (such as HIV-positive gay White men); they may be the main target of social discrimination at the individual level. This can be more so than intersectional identities that are less prototypical (e.g., HIV-positive gay Native American men), which may be more socially "invisible" (Earnshaw, Bogart, Dovidio & Williams, 2013).

In addition, a third insight is the dynamic nature of stigma and how the basis and nature of stigma can vary for the same person across contexts. For instance, Black men living with HIV who have sex with men may be stigmatized in White communities due to their race. In Black and gay communities it can be due to their status (Earnshaw, Bogart, Dovidio & Williams, 2013).

Socio-economic status

Some studies indicate that people with lower literacy from poor families are exposed to a higher risk of contracting HIV and that poverty might increase the likelihood of people engaging in risky behaviour. For instance, poor women may exchange sex for money and might be less likely to insist on condom use. It is also argued that households affected by HIV/AIDS may face terrible health expenditures that could decrease their SES (Murthy, 2008).

In most countries, relatively rich and better educated men and women have higher rates of partner change because they have greater personal autonomy. Although the richer and better educated are likely to have better access to reproductive health care, condom use is generally low in Africa and other parts of the developing world (Gillespie, Kadiyala & Greener, 2007). Therefore, the sexual behaviour patterns make the richer and the better educated more vulnerable to HIV infection, especially in the early stages of the epidemic, when information about the virus and how to protect oneself is usually low. At a later stage, however, it has been argued that individuals with higher socioeconomic status tend to adopt safer sexual practices (Gillespie *et al*., 2007).

Another postulated dynamic is that poverty (possibly fuelled by AIDS) is increasingly placing individuals from poor households at greater risk of exposure to HIV via the economically-driven adoption of risky behaviours. Poverty and food insecurity are thought to increase sexual risk taking, particularly among women who may engage in transactional sex to procure food for themselves and their children. Women's economic dependence on their partners may also make it difficult for them to insist on safer sex (e.g. condom use) (Gillespie *et al*., 2007).

In addition, poor people are more likely to be food insecure and malnourished. Malnutrition is known to weaken the immune system, which in turn may lead to greater risk of HIV transmission in any unprotected sexual encounter. This strand of literature on HIV transmission in Africa stresses the reversal in the distribution of the epidemic across population subgroups as the epidemic advances within country. Therefore, those of lower socioeconomic status experience a higher subsequent rate of HIV transmission (Gillespie *et al*., 2007).

Growing empirical evidence suggests the prevalence of HIV/AIDS is concentrated among wealthier rather than poorer individuals in Sub-Saharan Africa (SSA). Historically, this may be a consequence of the HIV/AIDS epidemic first emerging in urban areas in SSA and then spreading to the other regions (Andoh, Umezaki, Nakamura, Kizuki, & Takano, 2006). Additionally, epidemiologic evidence suggests wealthier individuals may engage in riskier behaviours, such as having multiple sexual partners that increase the probability of HIV transmission (Kongnyuy, Wiysonge, Mbu, Nana & Kouam, 2006).

Socioeconomically advantaged individuals may also have improved access to treatment for HIV/AIDS, as well as ability to adhere to treatment, prolonging survival and increasing HIV/AIDS prevalence among wealthier individuals (Wang & Sulzbach, 2011).

3.9. Conclusion

This chapter has discussed the prevalence and incidents of HIV/AIDS from the African content, then looked at South Africa and Limpopo province specifically. Two types of stigma which is internal and external stigma were discussed. It was shown that one of the contributory factors of HIV/AIDS stigma is unawareness and misconception about the disease. It is noted that HIV/AIDS stigma can lead to psychological consequences. It is further noted that there is a number of strategies that can be put into place in order to combat stigma against PLWHA. Finally, there are numerous demographic factors that are related to HIV/AIDS stigma in the community.

CHAPTER 4: METHODOLOGY

4.1. Introduction

This chapter details all the methods that were utilized in the study. It provides explanation about design, sample, the method of data collection, methods of data analysis and ethical considerations.

4.2. Research approach

The study adopted a qualitative research approach. The method allowed obtaining in-depth information from the participants.

4.3. Research design

The research followed an explorative type of study. This permitted to discover ideas and gain insight into the phenomenon.

4.4. Population and location

The study was conducted in Mahwelereng area. Mahwelereng is situated in Limpopo Province in Waterberg District under Mogalakwena local municipality. The township is bordered by areas such as Pola Park, Sekgakgapeng, GaMichele, Moshate and GaMadiba.

4.5. Sampling

Purposive sampling was a method of choice in the study. According to Babbie (2010), purposive sampling is a type of non-probability sampling in which the units to be observed on the basis of the researchers judgement about which ones will be the most useful or representative. Thus, the researcher identified ten (10) participants for the participation in this study. The researcher sampled five males and five females of different age groups in the community. Therefore, participants 1, 4, 8, 9 & 10 are females and participants 2, 3, 5, 6 & 7 are males. All of the participants are between the ages of 18 and 35. The following table illustrate participant's demographic variables.

Participants	Age	Gender	Relationship status	Educational level	Employment Status
Participant 1	20	Female	Single	Matric	Unemployed
Participant 2	26	Male	In a relationship	Degree	Employed
Participant 3	31	Male	Single	Grade 11	Unemployed
Participant 4	22	Female	Single	Matric	Unemployed
Participant 5	27	Male	Engaged	Diploma	Employed
Participant 6	18	Male	Single	Matric	Unemployed
Participant 7	30	Male	Married	Diploma	Unemployed
Participant 8	24	Female	Single	Degree	Employed
Participant 9	24	Female	Single	Matric	Employed
Participant 10	35	Female	Married	Diploma	Unemployed

4.6. Research instrument

The researcher made use of questionnaire in which participants had to choose a language of preference between Sepedi and English. All the participants chose to be interviewed in Sepedi. The questionnaire had four main questions which also include sub-questions that allows for probing. Open ended questions were a method of choice during data collection. This method engaged participants and the researcher at a level critical to established rapport, the established rapport contributed greatly to obtaining reliable and valid data. The rapport generated a sense of trust and created a conducive environment for data collection. Participants were interviewed in the community hall; this allowed free flowing thoughts. Further, participants were advised to ask for clarity when they did not understand the question. During this period, participants were made aware that the data does not implicate them in anyway, as it is purely a research project that needed honest society opinions thus only the truth should be mentioned as there was no wrong or correct respond.

Interviews took maximum of 25 minutes, the duration was shortened to avoid participants losing interest, and focus during the interview, however the data collected was not compromised. This was achieved by spending minimal time on ice breaking questions and dwelled much on core interview questions. All the interviews were

recorded on a Dictaphone and participants were made aware of the use of a Dictaphone while making appointments for data collection.

4.7. Entry negotiation

Participants were approached across the streets of the township. They were explained about the nature and purpose of the study.

4.8. Pretesting

The researcher tested the accuracy of the instrument prior interviewing the participants. Three people were interviewed in order to assess if the questions were accurate and clear.

4.9. Data analysis

Thematic content analysis was used to analyse data. This method allowed data to be classified in a clear and simpler manner. Virginia & Clarke (2006) identified six step by step guides to thematic analysis:

- Familiarizing with the data→ this entails re-reading the material and transcribing.

- Generating initial codes→ this involves organizing and gaining meaningful parts of data, data reduction, and data complication.

- Searching for themes → this involves having a list of themes and beginning to focus on broader patterns in the data.

- Reviewing and refining themes→ this entails searching for data that supports or refutes the proposed theory.

- Defining and naming themes → this entails identifying which aspects of data are being captured and what is interesting about the themes.

- Producing the report→ this involves writing up clear, concise and straightforward logical report with themes that make meaningful contributions to answering research questions.

4.10. Reliability and validity

In order to ensure reliability and validity in qualitative research, the following criteria of trustworthiness were applied as adapted from Shenton (2004):

- **Credibility→** in order to ensure credibility the researcher adopted well recognised research methods, debriefed participants, and also described the phenomenon under scrutiny.

- **Conformability→** the researcher was objective and spontaneous in order to ensure that they don't affect the research process.

The following measures were used to enhance validity:

- Giving a description of the method used and the way data was collected in order to allow comparison with the existing studies.

- The length of the interviews was also outlined to participants.

In order to enhance reliability, the researcher adhered very closely to the interview schedule and behaved with as little variation as possible between interviews.

4.10.1. Bias

To minimise bias during this study, the following was applied:

- The researcher used minimal probes throughout the course of the interview.

- The researcher adhered to the ethical standards when interpreting data as well as during the interview session.

- The researcher consulted regularly with the supervisor for guidance.

- The researcher faithfully transcribed the recordings and applied data analysis techniques consistently with each transcribed interview.

4.11. Ethical consideration

In the study, the researcher abided by the following social ethics:

Informed consent

The researcher explained to the participants about the nature and the purpose of the study. In addition, the participants were informed that participation is voluntary and they are free to withdraw at any time they wish to.

Permission for the study

The researcher requested permission from the University of Limpopo, Turfloop Campus Research Ethics Committee (REC) and the Mogalakwena Municipality.

Confidentiality

To ascertain confidentiality, the participants' information is kept confidential and the researcher did not disclose any information shared during the interview. In addition, the tape records were stored in a password-protected folder and the researcher destroyed them after transcribing.

Anonymity

The participants were assured that their identity would be protected. In essence, they were assured that their identity will not be disclosed, numbers will be used to identify them instead.

Aftercare for participants

The researcher adopted this principle and referred participants who showed some psychological distress to Clinical Psychologists and Trauma Counsellors at Mokopane Hospital to get help.

4.12. Conclusion

This chapter has highlighted the background to the research methodology where qualitative research design was introduced. A brief discussion of population and sampling, data collection methods, data analysis and interpretation, validity and reliability and ethical principles was given.

CHAPTER 5: RESULTS

5.1. Introduction

In this chapter the results from the recorded interviews will be presented and discussed. The term participant was used in the place of real names for ethical purposes. Therefore, each participant was represented by means of a numerical digit.

5.2. Preliminary Data Analysis

Thematic analysis was chosen as a method of analysis in the study; the researcher followed all the steps provided to meet the criteria.

5.3. Familiarization with data

This step was achieved by the researcher from data collection stage. Interviewing participants assisted the researcher to be familiar with the data. Furthermore, this step was enhanced when the researcher transcribed the data, finally the researcher read through several times also listening to the audio for accuracy and familiarization with the data.

5.4. Generating Initial Code

5.4.1. What do you think of people living with HIV/AIDS?

> **P1:** "I think they are people like us, it's only because they are positive, and there is no difference. You cannot spot a person and say that's the person. So I think they are people like us. Oh it's because HIV it's a chronic illness that requires one to take medication every single day and this can be tiring. But they do not have a choice they should take medication for their life. "

> **P2:** "Eh according to me I do not think they are living well because it's hard to live with the illness. I understand they are different because they are not healthy; they are living with a chronic illness. You find in some families they start to discriminate you, you start to use your own plate when you eat and you bath alone".

P3: "According to me, I do not think is there any problem with people living with HIV/AIDS. It's a disease which we must live with and its existence because it is caused by sex".

P4: "I view them as ill people, who are suffering from a normal illness like flu. But they are fine, they are fine. I see them normal people. I do not take them otherwise I just see them as people".

P5: "I think they are people as they are living like others. They live like anyone. I do not see anything wrong with them. I just see them as normal people".

P6: "I think they are people like everyone. If someone is HIV positive it does not mean they are different from us, all it says just that we suffer from different symptoms in life so they must be treated the same".

P7: "I do not have much to say but truly speaking I think they are just normal people just that they had it rough and they got sick with HIV. But after all I just think we all the same. We are equal".

P8: "I think they are different because they are living with a chronic illness. HIV is a dangerous illness which is killing a lot of people in South Africa. They always live with fear of dying".

P9: "I think they are like everyone the only difference is that they live with medication. They always have to drink pills so that they can be healthy".

P10: "I think they are sick people who run the risk of dying because of they are sick, they have HIV. When you are HIV positive you run the risk of dying unlike someone who is healthy who does not have HIV".

- Extracted themes (Females): Normal living people with a manageable condition compared to HIV free peoples (3).

- Extracted theme (Males): Normal perception of PLWHA.
- Extracted themes: Sick people vulnerable to death (2).

5.4.1.1. Probe: What influenced you to hold these views?

P1: "Uhm it's because when you have that illness you change, you become somehow. No you are still able like anyone, there is no difference, you still live the same. It's just that you have that feeling, as a person you change yourself and say I have HIV so I should live in a certain manner and it's not like that. You must live like other people".

P2: "Eh (Sign of surprise) what I am saying to you I know it, I have seen it. Because most people if they were eating with you, now you use yours separately. You sleep alone and so forth. Once they know you are positive, then they start to isolate you".

P3: "My reason is that there is no way one can run from it. There is no other way. So it's either you abstain, even if you abstain. So what influence me is that we should get used to it and try to live with it".

P4: "I know people who are living with this illness but they are just fine according to my…my…my (stutters) eyes".

P5: "Eish it's the way other people treat them, they treat them like they are different from us. But according to me I see them as normal people like us".

P6: "Most like to isolate those living with HIV/AIDS because they think they are going to infect them. So it's not like that, you can have a friend who is HIV positive and you find that you do not have it".

P7: "Like now for example, someone can be HIV positive and that I am not but you find that I die before him or her. After all we are all going to die".

P8: "They are living with an illness that makes them prone to death. Like I said when you are positive you always have fear that you can die anytime".

P9: "Oh it's because HIV it's a chronic illness that requires one to take medication every single day and this can be tiring. But they do not have a choice they should take medication for their life".

Extracted themes (Males): Normal perception of HIV, educated on HIV and infection process. Project second person to be uneducated about HIV infection process

5.4.1.2. Probe: Are your views shared by others in the community?

P1: "No, it's not the same because even, the way I see things in the hospitals, there is something it seems they want to isolate them but I see our views are not the same Yes they differ because even when there is functions in the community. Like the one of World Aids day, people do not attend. ".

P2: "Because I think, I know most people who are HIV positive. In most families, once they found out that your HIV positive they start to dish you foods in your own plate for example. They will not use it, it belongs to you".

P4: "No no, because people when they hear that you are positive they start to treat you somehow, they ill-treat them. They think you are sick or something then they do not treat you well like they did. If she was your friend she cut the friendship with them because they do not want to be associated with them. It's one of those that I hang out with someone who is sick, things like that".

P5: "I do not think so because when I look at the community there seems to be people who fear them, that is how I see it. They think they can be infected by being close to them".

P6: "No, because we have different knowledge. But most people in the community discriminate those who are HIV positive".

P7: "Not necessary. You see here in Mahwelereng they are judgemental people. In the community if they found out that you are HIV positive they are quick to judge you, they think you are promiscuous not knowing that you got infected by your partner. You find that your partner did all that. People are judgemental hence people do not want to disclose their status".

P8: "Yes, most people think that when you are HIV positive you are at higher risk of dying, as a result they start to discriminate you. It is not easy to live with HIV people".

P9: "Not really, I'm saying this because most people in the community thinks that when you are HIV positive you sleeps around with many people then after they start to discriminate you".

P10: "Yes they do, we all view HIV as a dangerous illness which can kill you at any time. In the community if you are HIV positive they discriminate you. Like

you find that your family plus friends start to isolate you, they do not treat you the same, they fear you".

- Extracted themes (Females): Concur that HIV clients are rejected, discriminated and ill-treated in the community.

- Extracted themes (Males): Observation made from communities and hear say.

5.4.2. How do you treat people living with HIV/AIDS?

P1: I treat them well; I treat them like human beings. I do not discriminate them.

P2: "Okay, by…let me say I take you as a person like me. If it's a family member I can look after you. I treat them well as if we are related; I share with them my things and look after them. If we bath we use the same thing, and we eat together. Then I take care of the person".

P3: "Uhm (Participant thinks) I do not think so. Some people cannot live with people who are HIV positive. Some they fear them, some discriminate them. So it's not the same".

P4: "How do I treat them? I treat them well, I just treat them normal. Like I said it's like flu, I treat them well".

P6: "I once had a classmate who was HIV positive; I treated him well with love and respect but I did not know that he has that disease. These are the people we treat well".

P7: "I treat them fairly so, I treat them normal I treat them well, I do not discriminate them. I just think they are normal people".

P8: "I try to treat them with respect although I fear I can get infected especially when they cough. I always have a fear that they can infect me. So I keep distance most of the time".

P9: "Eish myself… (Participant kept quiet for a moment) to be honest I am afraid of people who are HIV positive; I fear them. I try to stay far from them".

P10: "To be honest with you, I actually prefer not to be close to people who are HIV positive. I am scared that they can infect me. Maybe I am rude but I do not want to be close to them who know they can infect me".

- Extracted themes (Females): Treatment is normal and no discrimination and fear towards infected PLWHA and preference of no or less contact (2).

- Extracted themes (Males): Fair treatment across all participants.

5.4.2.1. Probe: What are some positive things done in your community that are in support of PLWHA?

P1: To be honest, I have never seen positive things happening in the community in support of people living with HIV/AIDS.

P2: "To give them support is through taking them to the hospital because they cannot take care of the person at home".

P3: "I am not really sure but I think at the clinic they offer them counselling and stuff. They are able to sit down with them and talk".

P4: There are many awareness programs that that encourage youths to test for HIV. Like in clinics and taverns there is access and availability of condoms. Things like that".

P5: "I do not know what is being done but what I know is that at times there are awareness programs that aim to educate the community, to understand this illness and not to fear and discriminate people living with HIV. To give them support, there is awareness, and like thing, what do they call it, campaigns".

P6: "They help them by giving them food; they cook for them, like having food parcels. They try by all means to help them".

P7: "I have never seen anything positive done to support them like I do want to lie".

P8: "They are encouraged to attend classes at the nearby clinics. They teach them about their disease which is good because this can help increase their days of life".

P9: "So far I have not seen anything being done to support them".

P10: "I have seen the social workers visiting their homes, they provide counselling to them".

- Extracted themes (Females): various awareness campaigns in the community. Nothing positive is noted in the community.

- Extracted themes (Males): Moral and physical support for PLHWA

5.4.2.2. Probe: What are some negative things done in your community that is against PLWHA?

P1: "Uhmmmm (She thinks) I just hear people saying how much they hate people living with HIV/AIDS. A person speaks as if he or she won't be positive I mean you never know what will happen tomorrow".

P2: "They give you your own room then you stay alone, things are no longer the same. In the community, they start to isolate them and stop loving them as well".

P3: "Ill-treatment is number one. Self-respect, they no longer respect them. Their dignity as well, if someone does not respect you your dignity will be affected. So but some that are knowledgeable about HIV tries to treat them well".

P4: "What can I say about negative things though? The bad things are that they treat people differently. When you are HIV positive they start to discriminate you. They start to look at you somehow as a result people develop low self-esteem. People start not to feel good about them and avoid talking about this illness. Some even make it a point that they spread it; they do not have a single partner".

P5: "Negative things I can say, which I see is discrimination, name calling and gossiping about them. They hurt them, they call them names. They treat them like they should not be part of the community. This is what I see, calling them by names, this impact their self-esteems. They call them with names…like Z3".

P6: "You find that a female child in some homes they speak in advance that they do not need a child who is sick, once they discover that you are HIV positive they kick you out of the house because they would say they do not want an ill child".

P7: "Firstly those people are being judged then in a ways they make them feel small. So they try to show them that they are different from us".

P8: "Its bad to be HIV positive honestly my sister (researcher)…Like in most cases, they gossip about you and also avoid being close to you. People fear that they can get infected".

P9: "They normally discriminate you and lose respect for you. Many people do not feel free to associate with those who are HIV positive".

P10: "In most cases they discriminate you, they gossip about you. People will treat you bad when your HIV positive to be honest".

Extracted themes (Females): Discrimination and no association with PLWHA. Dislike of PLWHA.

Extracted themes (Males): Theme: Isolation and discrimination of PLWHA.

5.4.3. When you look at things, do you think there is a link between HIV/AIDS stigma and gender?

P1: "Yes. In the community, ladies are discriminated because people think they are the one who make sure that they spread it".

P2: "Females prefer dating older, rich men and look down on males of their age. Therefore, females become more discriminated".

P3: "No, I do not think so".

P4: "Females are being mostly discriminated because they talk about their HIV status unlike males. Females are exposed because they talk a lot about it unlike males".

P5: "In most cases men are treated badly and discriminated because they believe they are the one spreading the illness. Females get much support from the community".

P6: "I do not think so".

P7: "Yes, for example when a girl is sick they would say she is promiscuous without wanting to know where did she get the illness especially us black people we have this thing of saying a man can do as he wishes, they portray this thing of expecting females to be well mannered".

P8: "I think females are at a high risk of being discriminated because they are viewed as having many partners".

P9: "I do not think so".

P10: "No, I do not think so".

Extracted themes (Females): Ladies are discriminated as they are perceived to be promiscuous.

Extracted themes: (Males) PLWHA perceived promiscuous, No link

5.4.4. Do you think there is a link between HIV/AIDS stigma and religious belief?

P1: "Yes, normally Christians like to discriminate those who are HIV positive. When you are positive it's like you sleep around with many people".

P2: "There is no relation".

P3: "No, there is no link".

P4: "I do not think there is a relationship between the two".

P5: "In other religions, they believe that when you pray you can heal from HIV. They believe if you pray to shall heal".

P6: "Christians do not expect to be infected by illnesses such as HIV because you are viewed as being irresponsible. Like they judge you when you are HIV positive".

P7: "Some people think they know religion more than others. Most Christians like to discriminate those who are HIV positive because they think they are saints".

P8: "No, I do not think there is a relation".

P9: "Christians like born again views illnesses like HIV as the one that infect those who are sleeping around with many people. You are somehow viewed as careless".

P10: "No there is no relation".

- Extracted themes: No link on religion (5); Christians are judgmental towards PLWHA (4); Promiscuous lead to PLWHA (3).

5.4.5. Do you think there is a link between stigma and race?

P2: "There is not association".

P3: "No, there is not relationship".

P4: "Yes how can I put this, like black people…Youth in the black community once you are positive, they discriminate you and think you will die. They do not do follow ups and check-ups. When you do check-ups you are viewed as someone who thinks she knows better".

P5: "According to my observation, there is no relation. People lack knowledge. This is why there is discrimination".

P6: "No, there is not relationship".

P7: "Most of the black people like to discriminate each other unlike white people".

P8: "No, I do not think there is a relationship".

P9: "There is no relationship".

P10: "Yes, white people have more knowledge about HIV unlike blacks as a results they do not discriminate each other. Only black people discriminate each other".

- Extracted themes: No link on race (6); Race v/s knowledge on PLWHA (3); Discrimination against PLWHA (2).

5.4.6. Is there anything that you would like to say before we end our interview?

P1: "Yes, I would like to say encourage people to support people living with HIV/AIDS, there should also be educational campaigns because old people do not really know about HIV/AIDS. They just know that it can kill you but as for after what happened they do not know. HIV it does not kill you but AIDS and other illnesses such as flu and TB can kill you if it finds that your immune system is weak, and then it can defeat you. It's not like you are killed by HIV. So I would like if old people get some form of education about the illness like in ABET schools".

P2: "Eh what I can say is that lets use protection then take care of our health. When one is seek feel free to talk about your illness on time so that we see what we can do rather than when it's late".

P3: "Good luck!"

P4: "There is nothing I would like to say, thanks".

P5: "Let's treat people who are HIV positive well, let's look after them as they are people like us, we love them".

P6: "No, thanks!"

P7: "What I would say in our community is if we had campaigns that teach people about HIV, help people to accept that they are sick".

P8: "No, thank you for the interview".

P9: "Yes, I think us as people need to learn a lot about HIV".

P10: "No!"

- Extracted themes: No comment (5); measures to combat HIV/AIDS.

5.5. Discovering themes or searching for themes

5.5.1. Research question 1

5.5.1.1. What do you think of people living with HIV/AIDS?

- Extracted positive themes: Majority (70%) perceive HIV diagnosed people normally (7 participants).
- Acknowledgments of HIV positive status; Impossible to diagnose HIV by looks; Sex is normal and so in HIV; and Equality amongst all regardless of HIV status.
- Extracted negative themes: Minority (30%) Risk of death, Rely on medication for survival, HIV is a fatal disease; and Chronic disease.
- Extracted positive themes: Normal people like everyone, Death occurs to anyone despite HIV status
- Extracted negative themes: ill treatment from society; prone to death.
- Extracted themes: Discrimination against PLWHIV, Less or no association with PLWHIV, discrimination against PLWHIV, Isolation for PLWHIV, promiscuity, Associate the pandemic with HIV.

5.5.2. Research question 2

5.5.2.1. How do you treat people living with HIV/AIDS?

- Extracted themes: Fear towards PLWHIV (3); HIV perceived as contagious (2); Normal treatment as other people (4); Isolation for PLWHA.
- Extracted themes: Hesitation on any positive support (4); Educational programs against HIV (2); Clinics support (3); Counselling to PLWHA.
- Extracted themes: Discrimination towards PLWHA (6); Isolation of PLWHA (3); ill treatment towards PLWHA; Name calling of PLWHA (2).
- Extracted themes: Females at higher discrimination risk v/s males at lower risk (5); males at risk for spreading H/A (2); No link amongst variables (2); cultural expectation v/s modern world on females and multiple partners (3).

5.5.3. Research question 3

5.5.3.1. What do you think are the factors that are related to HIV/AIDS stigma?

- Extracted themes: Females at higher discrimination risk v/s males at lower risk (5); males at risk for spreading H/A (2); No link amongst variables (2); cultural expectation v/s modern world on females and multiple partners (3).

- Extracted themes: No link (5); Christians are judgmental towards PLWHA (4); Promiscuous lead to PLWHA (3).
- Extracted themes: No link (6); Race v/s knowledge on PLWHA (3); Discrimination against PLWHA (2).

5.6. Discovering themes or searching for themes

5.6.1. Research question 1

Theme: PLWHA are perceived as normal part of the society

- Subtheme: Participants acknowledge everyone is vulnerable to HIV
- Subtheme: Participants believe all are equal regardless of HIV status
- Subtheme: HIV cannot be diagnosed by mere looks

Theme: PLWHA are at risk of death

- Subtheme: PLWHA rely on medication for survival
- Subtheme: HIV is a chronic fatal disease

Theme: PLWHA are as normal as everyone

- Subtheme: Death occurs to everyone regardless of HIV status

Theme: Ill-treatment towards PLWHA

- Subthemes: Less or no association with PLWHA
- Subthemes: Discrimination of PLWHA
- Subtheme: Isolation of PLWHA
- Subtheme: Promiscuity leading cause of HIV

5.6.2. Research question 2

Theme: Fear of PLWHA

- Subtheme: HIV perceived contagious
- Subtheme: Isolation of PLWHA

Theme: Normal treatment of PLWHA

- Subtheme: Association of PLWHA

-   Subtheme: Pity for PLWHA

Theme: Hesitation for PLWHA support structure

-   Subtheme: Not sure if there are support structures in the community for PLWHA

Theme: Support structure for PLWHA functional

-   Subtheme: Education programs for PLWHA
-   Subtheme: Clinic facilities offer full support for PLWHA
-   Subtheme: Available counselling for PLWHA

Theme: Discrimination for PLHWA

-   Subtheme: Isolation of PLWHA
-   Subtheme: Ill-treatment towards PLWHA
-   Subtheme: Name calling towards PLWHA

5.6.3. Research question 3

Theme: HIV positive females at higher discrimination risk

-   Subtheme: Males likely to spread the pandemic
-   Subtheme: Females perceived as promiscuous
-   Subtheme: Males are culturally expected to have more than one partner

Theme: No link on gender and HIV stigma

Theme: No link on race and HIV stigma

Theme: Race versus knowledge towards PLWHA

-   Subthemes: Black peoples are discriminative

5.7. Reviewing Themes

5.7.1. Research question 1

Theme: PLWHA are perceived as normal part of the society

- Subtheme: Participants acknowledge everyone is vulnerable to HIV
- Subtheme: Participants believe all are equal regardless of HIV status
- Subtheme: Death occurs to everyone regardless of HIV status

Theme: PLWHA are at risk of death

- Subtheme: PLWHA rely on medication for survival
- Subtheme: HIV is a chronic fatal disease

Theme: Ill-treatment towards PLWHA

- Subthemes: Less or no association with PLWHA
- Subthemes: Discrimination of PLWHA
- Subtheme: Promiscuity leading cause of HIV

5.7.2. Research question 2

Theme: Fear and discrimination towards PLWHA

- Subtheme: HIV perceived contagious
- Subtheme: Ill-treatment of PLWHA

Theme: Normal treatment of PLWHA

- Subtheme: Association with PLWHA

Theme: Hesitation for PLWHA support structure

- Subtheme: Not sure if there are support structures in the community for PLWHA

Theme: Support structure for PLWHA functional

- Subtheme: Education programs for PLWHA
- Subtheme: Clinic facilities offer full support for PLWHA
- Subtheme: Available counselling for PLWHA

5.7.3. Research question 3

Theme: HIV positive females at higher discrimination risk

- Subtheme: Cultural expectation versus modern world

- Subtheme: Males are culturally expected to have more than one partner

Theme: No link on gender and HIV stigma

Theme: No link on race and HIV stigma

Theme: Race versus knowledge towards PLWHA

- Subthemes: Black suffer stigma on HIV

5.8. Defining and naming themes

5.8.1. Research Question 1

- HIV status makes no difference
- PLWHA vulnerable to death
- Ill-treatment towards PLWHA

5.8.2. Research Question 2

- Fear and discrimination towards PLWHA
- Normal treatment of PLWHA
- Hesitation for PLWHA support structure
- Support structure for PLWHA functional

5.8.3. Research Question 3

- HIV positive females at higher discrimination risk
- No link on gender, race,   and HIV stigma
- Race versus knowledge towards PLWHA

5.9. Writing the Analysis

Diagram 1 below interprets findings for research question number one. Participants concur that HIV treatment status should be prioritised to take centre stage. However, participants identified some of the obstacles as the ill-treatment towards PLWHA and HIV individuals perceived as vulnerable to death at any time.
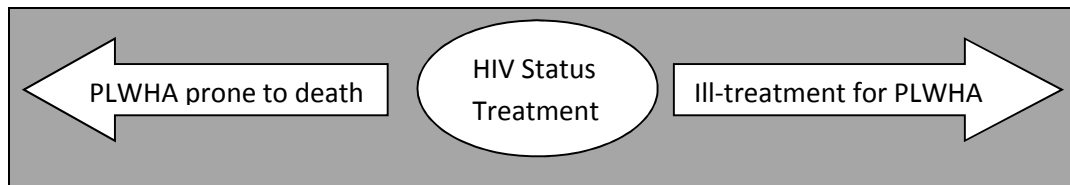
Diagram 1 Perception towards PLWHA

Diagram 2 below interprets the results for research question number two. Participants' treatments were segmented in two streams. Those who treated PLWHA normally were of the opinion the support structure are available and functional while participants with negative treatment towards PLWHA thought the supporting structures are not visible or operating to a dissatisfactory point.
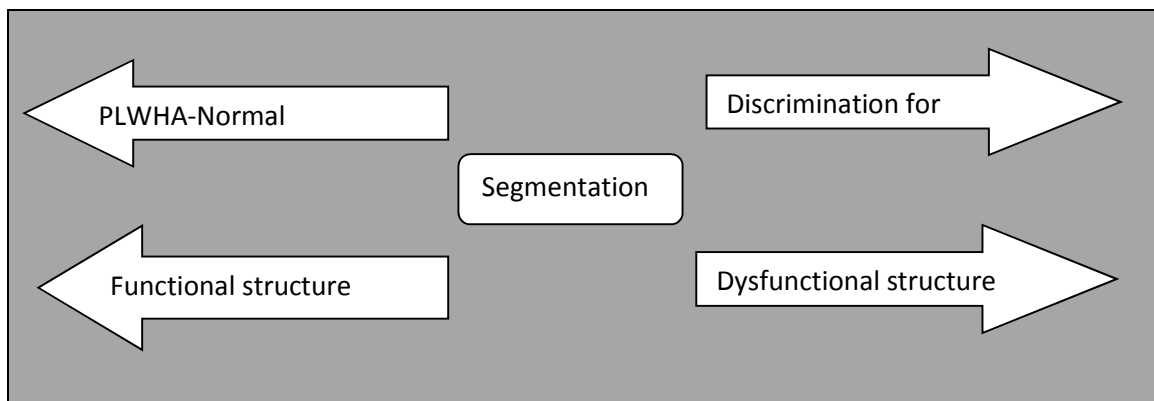
Diagram 2 Treatment towards PLWHA

Diagram 3 below reflects the analysis of research question number three. Some of the participants suggest no link on demographic variables with HIV, furthermore black people are perceived to lack knowledge on HIV while females were considered to likely be discriminated for being HIV positive.
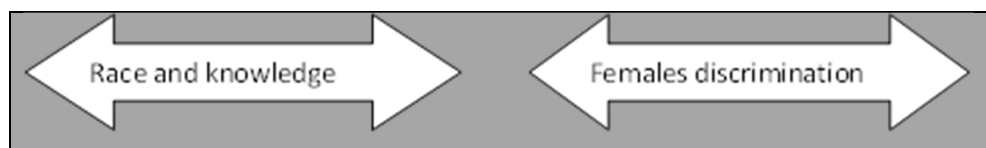
Diagram 3 Demographic variables

5.10. Conclusion

This chapter provided an analysis and interpretation of the participants' stories. It is clear that HIV/AIDS related stigma is still a problem. It is also apparent that HIV and AIDS related stigma manifested itself in various dimensions.

CHAPTER 6: DISCUSSION AND CONCLUSION

6.1. Introduction

This chapter has focused on interpreting the results obtained from the chapter above and relate it to answer the research questions using literature reviewed and the theory of choice. At the end, the chapter has research conclusions and recommendations for future studies in the same field.

6.2. Research question 1: What do you think of people living with HIV/AIDS?

The perception of HIV and AIDS remains a critical issue to be evaluated. In the current study responses have shown that part of the community has negative perceptions towards PLWHA while part retain positive perceptions.

Despite the efforts taken by the government and NGOs (Non-Governmental-Organization) to curb negative stigma and perception of HIV and AIDS by engaging in vigorous educational workshops from work places to the community at large, the results show negative perceptions. The vast responses have shown that the community postulates PLWHA are at risk of death. While this could be true, what is rather not is that the community suggest PLWHA are likely to die immediately after the diagnosis. As such the research has concluded that the community associate HIV with death.

> *Participants quote: "I think they are different because they are living with a chronic illness. HIV is a dangerous illness which is killing a lot of people in South Africa. PLWHA always live with fear of dying".*

The mentality; as quoted above, leads to the reflection of negative behaviour such as ill treatment, name calling and less association with PLWHA within the community. Some community members are of the opinion that HIV and AIDS is caused by promiscuity, therefore everyone who is diagnosed HIV positive is perceived promiscuous (Morisky, Jacob, Nsubuga & Hite, 2006; Parker & Birdsall, 2005; Simbayi *et al* 2007). This is a segregation of good and bad sexual behaviour, thus as a results of promiscuity people acquire HIV. Unfortunately, the behaviour may be from one generation to the next mainly because of the perception in the community. Consensus theories stipulate individuals are likely to act negatively towards PLWHA because the

majority of the community believe so (Stangor & Crandall, as cited in Heatherton, Kleck, Hebl & Hull, 2000).

While popular responses illustrate negative perceptions, fewer individuals within the community understand PLWHA can have a future with possible life longevity like those who are HIV negative. This group of thoughts acknowledges that besides the pandemic, each person is susceptible to death any time, thus all should be given same treatment because those who are HIV positive may live longer than those negative.

> *Participant quote: "Someone can be HIV positive and that I am not but you find that I die before him or her, after all we are all going to die".*

It was discovered that male and females perceive PLWHA as normal and see them equal to everyone belonging to the community. Only few females raised a different opinion that PLWHA are at risk of death as they live with the pandemic and that makes their life different

The results from research question 1; suggest a void of knowledge within the community. This may also be a stereotypical behaviour, this would suggest the community is aware of the pandemic status but rather the indoctrination of HIV status dominate their judgmental wellbeing. While the majority may have inappropriate and incorrect attitudes towards PLWHA, only few have the right understanding of HIV status, however the latter is outweighed by the first.

6.3. Research question 2: How do you treat people living with HIV/AIDS?

The results were further segment in to two (2) categories of thoughts; deleterious and optimistic thoughts.

Participants reflected negative treatment towards PLWHA in the community. It is disturbing to note the treatment extend to families of PLWHA within communities, the implication is PLHWA possibly do not have social support from the two most important institutions (family and community). These implicate treatment from social institutions as more detrimental than the pandemic itself which lowers defence mechanism for PLWHA.

The treatment towards PLWHA mainly reflects lack of knowledge about HIV and AIDS. Participants fear the likeliness of being infected by merely interacting with PLWHA.

The basic assumption could be participants are aware of how the pandemic is transmitted but they are reluctant to have anything to do with HIV and AIDS at all levels including support. It is notably disturbing that participants' lack of knowledge extends to the acquisition of HIV through coughing and sharing meals, similar results were obtained by Ogden and Nyblade (as cited in Parker & Birdsall, 2005).

> *Participants quote "I try to treat them with respect although I fear I can get infected especially when they cough, so I keep my distance most of the time".*

A possible cause contributing to lack of knowledge in the community would be lack of involvement. Community involvement is a critical part of learning and reinforcing knowledge, participant's stereotypical treatment, stigma and lack of knowledge would be due to lack of involvement in HIV curbing and combating programs. Involvement does not have to be limited to community level but extended to work places as well. According to Morisky, Jacob, Nsubuga and Hite (2006) when individuals collectively and willingly oppose discrimination and non-stigma behaviour at work towards HIV and AIDS, then ramifications becomes bearable amongst PLWHA.

A set of participants thought PLWHA are susceptible to isolation and discrimination. Regrettably, this treatment is experienced in most communities, however this also extend to the families of PLWHA. The implication therefore leaves PLHWA with no form of vital support. The outcomes above are supported by Kalichman and Simbayi, (2004) whom postulate that such behaviour as mentioned above is guided by cultural, traditional, religious beliefs, myths about the disease and illness particularly in rural and urban African communities.

> *Participants quote: "You find that a female child in some homes they speak in advance that they do not need a child who is sick, once they discover that you are HIV positive they kick you out of the house because they would say they do not want an ill child".*

Despite the deleterious results above, some participants are erudite about the pandemic. This is a group of thoughts which is familiar with the causes, treatments and have generally accepted the disease just as they have accepted PLWHA. According to Morisky, Jacob, Nsubuga and Hite (2006), participants seek ways to reach out to PLWHA in the community from work, socializing and personal matters,

hence participants believe the support system is well structured and efficiently functionally to aid PLWHA in the community.

The participants consider the treatment of PLWHA is reflected towards treatment of any other person in the community, furthermore participants' mental state considers that the support systems are in place and in a good functional state. These behaviours support the consensus theory, which assumes society is a system of interconnected parts that work together in harmony to maintain a state of balance and social equilibrium for the whole (Mooney, Knox & Schacht, 2007).

> *Participants quote: "Social workers visit homes to provide counselling for PLWHA".*

6.4. Research question 3: What do you think are the factors that are related to HIV/AIDS stigma?

Cultural practise and indoctrination supports males to have more than one partner while rebuking females to do so. This culture is slowly faced out by modern beliefs and circumstances however the mentality and partial pragmatism still incurs, particularly in a rural area like Mahwlelereng. As such males and females who have tested HIV positive are not perceived the same, participants sustain females are likely to be perceived and characterised by multiple sexual partners. Although research supports that most females are HIV positive as compared to males in South Africa, it concurrently support the notion that females have mostly been stigmatized for being HIV positive (Boerjan, 2013; Simbayi, Kalichman, Strebel, Cloete et al., 2007; UNAIDS, 2010; Maman, Mbwambo, Hogan, Kilonzo et al., 2001 & Amuyunzu-Nyamongo, Okeng'o, Wagura & Mwenzwa, 2007). A culturally orientated justification could be that males are perceived as the head of the family and bread winners in most households; as such they are allowed to have multiple sexual partners (Strebel, Crawford, Shefer, Cloete, et al., 2006).

> *Participants quote: "In the community, ladies are discriminated because people think they are the one who surely spread HIV".*

6.4.1 Race

Race was identified as a factor leading to stigmatization towards PLWHA or the disease itself. The results claim that black people lack knowledge where matters of HIV and AIDS are concerned as compared to white people. The results reflect poor knowledge in terms of how the pandemic is transmitted, care, stigma and treatment in the community or even beyond the current community. This may also serve as an explanation for why some of the blacks feel the need for physical separation of PLWHA from the community at large. If good knowledge and understanding existed such acts as isolation merely due to HIV positive status would not prevail in communities.

According to Earnshaw, Bogart, Dovidio and Williams (2013) racial groups may be susceptible to stigma and prejudice when HIV positive, mostly because they are the minority.

> *Participants quote: "White people have more knowledge about HIV unlike blacks as a result they do not discriminate each other".*

6.4.2. Socio Economic Status

Socio economic status has constantly been a predictor for HIV and AIDS especially in South Africa. This is mainly because the prevalence of HIV is higher in South Africa than any other country. Apart from this, South Africa is a developing country with a higher number of youth unemployment.

Literature suggests that if people get good education and jobs then the prevalence of HIV would likely deteriorate (Gillespie, Kadiyala & Greener, 2007). This is because educated people are more likely to use protection or find alternative means to adopt a safer sexual experience (Gillespie *et al* 2007). As matters stand, the geographical area where the research was conducted is under developed, under resourced and has no job opportunities.

The situation stated above in the area may lead to multiple partners as people spend the entire day at home with the likelihood of no activities to keep busy (Kongnyuy, Wiysonge, Mbu, Nana & Kouam, 2006). Although alcohol was not mentioned, but it is likely that participants would use it as a form of entertainment, which may pose a lot of threat in the acquisition of HIV and AIDS. Literature also shows that people who are economically disadvantaged are likely to be under pressure when insisting to use protection against the economically powerful (Gillespie, Kadiyala & Greener, 2007).

Amongst others, to secure longevity when one is exposed to the HIV and AIDS pandemic, health diet, exercising and no reinfection (Murthy, 2008). Although the argument stated above reflect merely to the maintenance and acquisition of HIV and AIDS. But it is the maintenance of HIV which community members use to deduce other people's HIV status and start spreading rumours about the observed symptoms to postulate an HIV positive status. However, when people have exposure to gym, great health diet, less or no reinfection, treatment and emotional support; they are likely to leave longer and keep healthy at most times with no or less symptoms (Wang & Sulzbach, 2011). Less symptoms or higher ability CD4 count allows no symptoms to show which then lead to no risk of stigma towards HIV status.

> *Participants quote "When one has money, he or she can afford to live a better life and signs of HIV/AIDS will not be seen".*

6.4.3. Link to gender

Participants established that it's a common practise that females are mostly discriminated against when diagnosed with the pandemic and their status is made public to the community. Both genders concur that females are perceived to be promiscuous when diagnosed with HIV. Females are generally blamed for spreading the pandemic and accused of having multiple partners even without any evidence, the findings above are supported by studies from Amuyunzu-Nyamongo, Okeng'o, Wagura & Mwenzwa, (2007) and Maman, Mbwambo, Hogan, Kilonzo, & Sweat, (2001) who postulated that women who share HIV test results with their partners may experience a range of reactions from support and understanding to accusations, discrimination, physical violence and abandonment. From the results of the current study, only few males indicated that there is no link between gender and stigma towards PLWHA.

6.5. Conclusions

In a nutshell, the results predict negative perceptions towards PLWHA as well as the disease itself. Although there are some people in the community who have the right

information about HIV and AIDS, they are outnumbered and overshadowed by those individuals who lack or have no information at all. Participants indicated that PLWHA are at risk of being discriminated and isolated as the community fears they would be infected. This is primarily a coping strategy by communities and families who lack understanding of the disease and still perceive the root of HIV and AIDS as purely promiscuity. Females are at a higher risk of discrimination when diagnosed HIV positive, they are perceived to be promiscuous.

Females are more at risk of discrimination when tested HIV positive and their status is known to the community at large. Mainly this is as individuals believe females intentionally spread the disease so they do not suffer and die alone. Participants show black people lack knowledge towards HIV and AIDS, this is generally because black people isolate and discriminate against those HIV positive.

It will be critical to educate the community in issues of HIV and AIDS as a key factor to combat the pandemic and its stigma. As part of the key factor, it might be important to involve the community in HIV programs, this would privilege the community to learn more about the pandemic and eventually turn around the perception to a positive one. Those with changed perception about HIV and AIDS may in the future play a role to eradicate the stigma towards PLWHA by educating part of the community.

6.6. Recommendations

Further studies should conduct a triangulation study to support the views with descriptive statistics of the community. More studies should be conducted on the availability of interventions that involve the community in curbing and combating HIV and AIDS. The studies should consider also the feasibility of the interventions programs against demographics most prevalent in the community. Lastly, studies should explore which race groups have more knowledge and perception about HIV and AIDS. It would be fascinating to discover if geographical areas play a major role in coping strategies amongst those HIV positive.

6.7. Limitations

Although literature supports some of the findings obtained in the study, the results of the current study are only applicable to Mahwelereng community unless a confirmatory study with the same methodology is conducted in a different environment or location.

The study did not use a large population to gather more and different perceptions of matters of HIV and AIDS perception. Lastly the researcher only conducted a qualitative study; as such participants' responses could be not measured against their thought.

6.8. Conclusion

This study focused on the perception of community members towards PLWHA. It further explored on how the community members treat PLWHA and also on the demographic factors that are related to HIV and AIDS stigma.

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APPENDICES
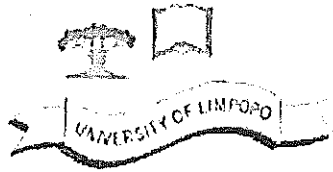
University of Limpopo
Research Development and Administration Department
Private Bag X1106, Sovenga, 0727, South Africa
Tel: (015) 268 2212, Fax: (015) 268 2306, Email:noko.monene@ul.ac.za

TURFLOOP RESEARCH ETHICS
COMMITTEECLEARANCE CERTIFICATE

MEETING: 03 September 2014

PROJECT NUMBER: TREC/20/2014: PG

PROJECT:

Title: Stigma associated with people living with HIV/AIDS in Mahwelereng, Limpopo Province

Researcher: Ms KB Tsebe

Supervisor: Dr S Govender – University of Limpopo

Co-Supervisor: N/A

Department: Psychology

School: Social Science

Degree: Masters in Clinical Psychology

PROF TAB MASHEGO
CHAIRPERSON: TURFLOOP RESEARCH ETHICS COMMITTEE

The Turfloop Research Ethics Committee (TREC) is registered with the National Health Research Ethics Council, Registration Number: REC-0310111-031.

Note:

i)   Should any departure be contemplated from the research procedure as approved, the researcher(s) must re-submit the protocol to the committee.

ii) The budget for the research will be considered separately from the protocol.
PLEASE QUOTE THE PROTOCOL NUMBER IN ALL ENQUIRIES.

Appendix ii Request for permission to use an office in the community hall

Letter to the municipal manager

P.O. Box 770

Mahwelereng

0626

10 February 2014

The Municipal Manager

Mogalakwena local Municipality

P.O. Box 34

Mokopane

0600

SUBJECT: REQUEST FOR PERMISSION TO USE AN OFFICE IN THE COMMUNITY HALL.

Dear sir or madam.

I hereby request permission to use one of your offices at the community hall to conduct research. I am currently studying towards Masters in Clinical Psychology at the University of Limpopo, Turfloop Campus. As part of my qualification, I am required to submit a research mini-dissertation. The title of my study is "*Stigma associated with people living with HIV/AIDS in Mahwelereng, Limpopo province*". The study will be highly ethical. The participants' identity and information shared will be kept confidential.

Yours sincerely,

Tsebe Koketjo Biggy (Miss)

....

Appendix iii Permission to use an office to conduct research

APPLICATION FORM- LEASE OF HALLS
MOGALAKWENA MUNICIPALITY

MOGALAKWENA MUNICIPALITY

Application and undertaking for the lease of the
___Van Van Rensburg___ and other facilities in the hall.

To: The Manager
Corporate Support Service
MOKOPANE
0600
Sir/ madam

I/We, the undersigned, hereby make application to lease the above-mentioned facilities
for the purpose of (describe in full)
___Research Interviews___

___

From _12:00_ on _02/07/2015_ to _12:00_ on _02/07/2015_

I / We hereby declare that I/We am/are aware of the provisions of the council's by-laws

regarding the lease of halls, an/are fully conversant with the content thereof and I /we

undertake to comply with the provisions thereof.

The council accepts no responsibility or liability for any damage or loss of property

articles or goods of whatever nature which the lease places or leaves on the property or

for the injury or death of any person or damage to the clothing of any person who enters

upon the property or who uses the equipment therein or thereon and it is an explicit

condition that the lease indemnifies the council from any claim of whatever nature

instituted by any person on whatever grounds having any bearing on this lease and

matters incidental thereto.

Scanned by CamScanner

Name of Lessee: Koketjo Biggy Tsebe
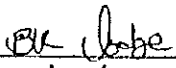
Address: P.O Box 770

Mahwelereng

0626

Telephone number: 078 518 1117

_____
Signature of Lessee

_____
Received copy of bylaws.

30-06-2015
Date

FOR OFFICIAL USE ONLY

Tariffs Payable: **Vote Number:**

Deposit   R 1585-85   91 00 03 3 03 04 02

Rental: "Van"   R 529-cc   00 62 36 2 15 00 20

Noordsaal   R _____   00 02 36 2 15 00 20

Aboo Tayob   R _____   00 02 34 2 15 00 20

Mahwelereng   R _____   00 02 33 2 15 00 20

Auditorium   R _____   00 02 64 2 15 00 20

VAT   R 74.06   91 00 03 3 30 03 33

TOTAL   R 2188-91
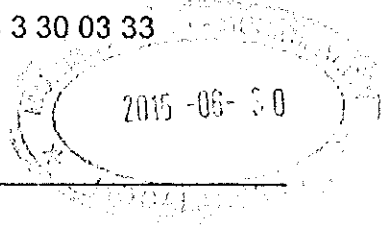
Receipt number 62476c - 67   Date _____

2015 -06- 30

_____
Cashier

Appendix iv Informed Consent form (English version)

This is a research study of Tsebe Koketjo Biggy for the fulfillment of Masters' degree in Clinical Psychology at the University of Limpopo, Turfloop Campus. The purpose of this study is to *"Explore stigma associated with people living with HIV/AIDS in Mahwelereng, Limpopo Province"*. Please provide honest answers, note that there is no right or wrong answer and you will not be judged. Your response will remain anonymous and confidential. Taking part in this study is voluntary, should you wish to discontinue, kindly note again that you have a right to withdraw at any time without punishment. Kindly endorse below if you agree to participate in the study.

I participant number................has read and fully understood the nature of the study. I hereby consent to participate in this research study.

Participant's Signature.............................   Date........................

Researcher's Signature.............................   Date ....

Appendix v Informed Consent form (Sepedi version)

Ye/ Se ke thuto ya dinyakišišo ya Tsebe Koketjo Biggy go tšweletša Masters wa Clinical Psychology Yunibesithing ya Limpopo, Turfloop Campus. Nepokgolo ya dinyakišišo tše ke go "*nyakišiša megopolo yeo e fošagetšego ka batho bao ba phelago ka HIV/AIDS mo Mahwelereng, Porofenseng ya Limpopo*". O kgopelwa, go fa dikarabo tša nnete, elelwa gore ga gona karabo ya nnete goba yeo e fošagetšego ebile oka se ahlolwe ke motho. Dikarabo tša gago e tla ba sephiri ebile di ka se tšweletšwe nyanyeng. Go tšea karolo mo dinyakišišong tše ke ka go ithaopa, ge oka kwa o nyaka go emiša go tšwela pele, ona le tokelo ya go ikgogela morago nako efe kapa efe ntle le kotlo. Ka boikokobetšo laetša ka mo fase ge eba o dumela go tšea karolo mo dinyakišišong.

Nna motšeakaralo wa bo............. ke badile ebile ke kwešišitše bohlokwa bja dinyakišišo. Ke itlama go tšea karolo mo dinyakišišong tše.

Mosaeno   wa   motšeakarolo.............................Letšatšikgwedi
....

Mosaeno   wa   monyakišiši..................................Letšatšikgwedi
....

Appendix vi English Questionnaire Guide

1. What do you think of people living with HIV/AIDS?

Probe: What influenced you to hold these views?

Probe: Are your views shared by others in the community?

2. How do you treat people living with HIV/AIDS?

Probe: What are some positive things done in your community that are in support of PLWHA?

Probe: What are some negative things done in your community that is against PLWHA?

3. What do you think are the main factors that are related to HIV/AIDS stigma?

Probe about demographic factors that are associated with HIV/AIDS stigma; such as gender, religion and race.

4. Is there anything else you would like to add before we close our interview?

Thank you for participating in this study.

Appendix vii Sepedi Questionnaire Guide

1. O nagana eng ka batho bao ba phelago ka HIV/AIDS?

Botšišiša: keng seo se hueditšego maikutlo a gago?

Botšišiša: A naa maikutlo a gago a swana le a batho ba bangwe mo motseng?

2. O swara bjang batho bao ba phelago ka HIV/AIDS?

Botšišiša: Ke dilo dife tše di botse mo motseng wa geno tšeo di dirwago go thekga batho bao ba phelago ka HIV/AIDS?

Botšišiša: Ke dilo dife tše di mpe mo motseng wa geno tšeo di dirwago gomme dile kgahlanong le batho bao ba phelago ka HIV/AIDS?

3. O nagana gore ke dilo tše dife tšeo di tswalanang kudu le megopolo yeo e fošagetšego ka HIV/AIDS?

Botšišiša ka maemo a bong, bodumedi le tekatekano semorafe mo motse selegae.

4. A naa go nale se sengwe seo o ratang go ka se bolela pele re ka tswalela poledišano ye?

Ke leboga go tšea karolo ga gago mo dinyakišišong tše.

Appendix viii Editor's confirmation letter

REF: EDITING OF MINI-DISSERTATION

DATE: January 26, 2016

TO WHOM IT MAY CONCERN

This letter serves to confirm that Mrs Tsebe Koketjo Biggy (Student Number █████████) submitted her Master of Arts in Clinical Psychology mini-dissertation entitled "STIGMA ASSOCIATED WITH PEOPLE LIVING WITH HIV/AIDS IN MAHWELERENG, LIMPOPO PROVINCE" for language editing to the undersigned. Hence, the document has been duly proof-read and edited for grammatical and technical errors. It is hoped that if all the editorial aspects addressed and recommended therein are to be meticulously attended to, the target readers of this work will find the document free from error, enjoyable to read and easy to understand.
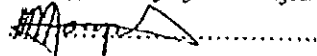
FOR ANY ENQUIRIES RELATING TO THE ABOVE, PLEASE CONTACT ME ON:

0722339433 and 0736662354

Kind regards,

Mafeye Morapedi (Independent Editor)

(BAH Applied Language & Multilingual Studies, BA Contemporary English and Multilingual Studies)

Appendix ix   Transcripts

Participant 1

Researcher: Tell me here, what do you think of people who are living with HIV/AIDS?

Participant: I think they are people like us, it's only because they are positive, and there is no difference. You cannot spot a person and say that's the person. So I think they are people like us.

Researcher: What influenced yours views?

Participant: pUhm it's because when you have that illness you change, you become somehow. No you are still able like anyone, there is no difference, you still live the same. It's just that you have that feeling, as a person you change yourself and say I have HIV so I should live in a certain manner and it's not like that. You must live like other people.

Researcher: Ok. When you look at your views, do you think they are the same as other people in the community of Mahwelereng?

Participant: No, it's not the same because even, the way I see things in the hospitals, there is something it seems they want to isolate them but I see our views are not the same.

Researcher: It's not the same as compared to views hold by community members?

Participant: Yes they differ because even when there is functions in the community. Like the one of World Aids day, people do not attend.

Researcher: Ok. So tell me how do you treat people who are living with HIV/AIDS?

Participant: I treat them well; I treat them like human beings. I do discriminate them.

1

Researcher: Ok. What are the positive things in your community that are being done to support people living with HIV/AIDS?

Participant: To be honest, I have never seen positive things happening in the community in support of people living with HIV/AIDS.

Researcher: Yes...

Participant: I have never seen anything positive happening.

Researcher: Ok. So what are the negative things that are done in your community which are against people living with HIV/AIDS?

Participant: Uhmmmm (She thinks) I just hear people saying how much they hate people living with HIV/AIDS. A person speaks as if he or she won't be positive I mean you never know what will happen tomorrow.

Researcher: Ok. When you look at things, do you think there is a link between HIV/AIDS stigma and gender?

Participant: Yes. In the community, ladies are discriminated because people think they are the one who make sure that they spread it.

Researcher: Ok. Do you think there is a link between HIV/AIDS stigma and socioeconomic status?

Participant: No I do not think there is a link.

Researcher: Ok. Do you think there is a link between HIV/AIDS stigma and religious belief?

Participant: Yes, normally Christians like to discriminate those who are HIV positive. When you are positive it's like you sleep around with many people

Researcher: Ok. Do you think there is a link between HIV/AIDS stigma and race?

Participant: No, I do not think is a link.

Researcher: Is there anything that you would like to say before we end our interview?

2

Participant: Yes, I would like to say encourage people to support people living with HIV/AIDS, there should also be educational campaigns because old people do not really know about HIV/AIDS. They just know that it can kill you but as for after what happened they do not know. HIV it does not kill you but AIDS and other illnesses such as flu and TB can kill you if it finds that your immune system is weak, then it can defeat you. it's not like you are killed by HIV. So I would like if old people get some form of education about the illness like in ABET schools.

Participant 2

Researcher: What do you think of people who are living with HIV/AIDS?

Participant: Is it about what I think of people living with HIV/AIDS?

Researcher: Yes.

Participant: Eh according to me I do not think they are living well because it's hard to live with the illness. I understand they are different because they are not healthy; they are living with a chronic illness. You find in some families they start to discriminate you, you start to use your own plate when you eat and you bath alone.

Researcher: What influenced yours views?

Participants: Eh (Sign of surprise) what I am saying to you I know it, I have seen it. Because most people if they were eating with you, now you use yours separately. You sleep alone and so forth. Once they know you are positive, then they start to isolate you.

Researcher: Are your views shared by other community members at large?

Participant: Uhmm (Participant thinks) yes.

Researcher: Why do you say that?

Participant: Because I think, I know most people who are HIV positive. In most families, once they found out that your HIV positive they start to dish you foods in your own plate for example. They will not use it, it belongs to you.

Researcher: So tell me, how do you treat people living with HIV/AIDS?

Participant: Okay, by...let me say I take you as a person like me. If it's a family member I can look after you. I treat them well as if we are related; I share with them my things and look after them. If we bath we use the same thing, and we eat together. Then I take care of the person.

Researcher: What are the positive things that are being done in Mahwelereng as a way of making sure that people living in the community get proper support?

Participant: To give them support is through taking them to the hospital because they cannot take care of the person at home.

Researcher: What are the negative things that are being done then that are against people living with HIV/AIDS?

Participant: They give you your own room then you stay alone, things are no longer the same. In the community, they start to isolate them and stop loving them as well.

Researcher: Ok. Do you think there is a link between HIV/AIDS stigma and gender?

Females prefer dating older, rich men and look down on males of their age. Therefore, females become more discriminated.

Researcher: Ok. Do you think there is a link between HIV/AIDS stigma and socioeconomic status?

Participant: When one has money, he or she can afford to live a better life and signs of HIV/AIDS will not be seen.

Researcher: Ok. Do you think there is a link between HIV/AIDS stigma and religious belief?

Participant: There is no relation.

4

Researcher: Ok. Do you think there is a link between HIV/AIDS stigma and race?

Participant: There is not association.

Researcher: Is there anything that you would like to say before we end our interview?

Participant: Eh what I can say is that lets use protection then take care of our health. When one is seek feel free to talk about your illness on time so that we see what we can do rather than when it's late.

Participant 3

Researcher: I want to know what do you think of people living with HIV/AIDS?

Participant: According to me, I do not think is there any problem with people living with HIV/AIDS. It's a disease which we must live with and its existence because it is caused by sex.

Researcher: What influence yours views?

Participant: About what?

Researcher: For you to say there is no problem.

Participant: My reason is that there is no way one can run from it. There is no other way. So it's either you abstain, even if you abstain. So what influence me is that we should get used to it and try to live with it.

Researcher: okay. So are your views shared by other members in the community of Mahwelereng?

Participant: Uhm (Participant thinks) I do not think so. Some people cannot live with people who are HIV positive. Some they fear them, some discriminate them. So it's not the same.

Researcher: So, I would like to know how do you treat people who are living with HIV/AIDS?

5

Participant: I treat them normal like any other person.

Researcher: Ok. What are the positive things that are being done in Mahwelereng to support people living with HIV/AIDS?

Participant: I am not really sure but I think at the clinic they offer them counselling and stuff. They are able to sit down with them and talk.

Researcher: Ok. So what are the negative things that are done in your community which are against people living with HIV/AIDS?

Participant: Ill-treatment is number one.

Researcher: Okay...

Participant: Self-respect, they no longer respect them. Their dignity as well, if someone does not respect you your dignity will be affected. So but some that are knowledgeable about HIV tries to treat them well.

Researcher: Ok. When you look at things, do you think there is a link between HIV/AIDS stigma and gender?

Participant: No, I do not think so.

Researcher: Ok. Do you think there is a link between HIV/AIDS stigma and socioeconomic status?

Participant: Poor people are the victims of always discriminated as opposed to those who are rich.

Researcher: Ok. Do you think there is a link between HIV/AIDS stigma and religious belief?

Participant: No, there is no link.

Researcher: Ok. Do you think there is a link between HIV/AIDS stigma and race?

Participant: No, there is not relationship.

Researcher: Is there anything that you would like to say before we complete our interview?

Participant: Yes, good luck.

Participant 4

Researcher: I want to know what do you think of people living with HIV/AIDS?

Participant: I view them as ill people, who are suffering from a normal illness like flu. But they are fine, they are fine. I see them normal people. I do not take them otherwise I just see them as people (Participant 4)

Researcher: What influences yours views t say you see them as people?

Participant: I know people who are living with this illness but they are just fine according to my...my...my (stutters) eyes.

Researcher: okay. So are your views shared by other members in the community of Mahwelereng?

Participant: No no, because people when they hear that you are positive they start to treat you somehow, they ill-treat them. They think you are sick or something then they do not treat you well like they did. If she was your friend she cut the friendship with them because they do not want to be associated with them. It's one of those that I hang out with someone who is sick, things like that.

Researcher: So how do you treat people who are living with HIV/AIDS?

Participant: How do I treat them? I treat them well, I just treat them normal. Like I said it's like flu, I treat them well.

Researcher: Ok. What are the positive things that are being done in Mahwelereng to support people living with HIV/AIDS?

Participant: Myself?

Researcher: No I meant in the community.

7

Participant: Up to so far I do not know, what can I say they do?

Researcher: When you look in the community what is being done.

Participant: There are many awareness programs that that encourage youths to test for HIV. Like in clinics and taverns there is access and availability of condoms. Things like that.

Researcher: Ok. So what are the negative things that are done in Mahwelereng which are against people living with HIV/AIDS?

Participant: Negative things...

Researcher: Yes

Participant: What can I say about negative things though? The bad things are that they treat people differently. When you are HIV positive they start to discriminate you. They start to look at you somehow as a result people develop low self-esteem. People start not to feel good about them and avoid talking about this illness. Some even make it a point that they spread it; they do not have a single partner.

Researcher: Ok. So when you look at gender, do you think there is a link between HIV/AIDS stigma and gender?

Participant: Females are being mostly discriminated because they talk about their HIV status unlike males. Females are exposed because they talk a lot about it unlike males.

Researcher: Ok. Do you think there is a link between HIV/AIDS stigma and socioeconomic status?

Participant: Yes most people believe females from disadvantaged families become reckless and have sex with men for money. They sell their body in exchange of money as well.

Researcher: Ok. Do you think there is a link between HIV/AIDS stigma and religious belief?

Participant: I do not think there is a relationship between the two.

Researcher: Ok. Do you think there is a link between HIV/AIDS stigma and race?

Yes how can I put this, like black people... Youth in the black community once you are positive, they discriminate you and think you will die. They do not do follow ups and check-ups. When you do check-ups you are viewed as someone who thinks she knows better.

Researcher: Is there anything that you would like to say before we complete our interview?

Participant: There is nothing I would like to say, thanks.

Participant 5

Researcher: Okay I would like to know what do you think of people who are living with HIV/AIDS?

Participant: You mean what I think, what do you mean?

Researcher: Yours thoughts.

Participant: I think they are people as they are living like others. They live like anyone. I do not see anything wrong with them. I just see them as normal people.

Researcher: What influenced yours views you are sharing with me?

Participant: Influence you mean?

Researcher: What influenced you to say you see them as normal people?

Participant: Eish it's the way other people treat them, they treat them like they are different from us. But according to me I see them as normal people like us.

Researcher: are your views shared by other community members at large?

9

Participant: I do not think so because when I look at the community there seems to be people who fear them, that is how I see it. They think they can infected by being close to them.

Researcher: So you tell me, how do you treat people living with HIV/AIDS?

Participant: I treat them well like anyone, the way I treat those who are not HIV positive.

Researcher: what are the positive things that are being done in Mahwelereng as a way of making sure that people living in the community get proper support?

Participant: I do not know what is being done but what I know is that at times there are awareness programs that aim to educate the community, to understand this illness and not to fear and discriminate people living with HIV. To give them support, there is awareness, and like thing, what do they call it, campaigns.

Researcher: What are the negative things that are being done then that are against people living with HIV/AIDS?

Participant: Negative things I can say, which I see is discrimination, name calling and gossiping about them. They hurt them, they call them names. They treat them like they should not be part of the community. this is what I see, calling them by names, this impact their self-esteems. They call them with names...

Researcher: Names like?

Participant: Names like Z3.

Researcher: Ok. So when you look at gender, do you think there is a link between HIV/AIDS stigma and gender?

Participant: In most cases men are treated badly and discriminated because they believe they are the one spreading the illness. Females get much support from the community.

Researcher: What do you think is the reason females get more support as compared to females?

Participant: Because females are being seen as more responsible.

Researcher: Ok. Do you think there is a link between HIV/AIDS stigma and socioeconomic status?

Participant: Those from poor families cannot afford to eat healthy food. People can see that there are not healthy and therefore discriminate them. Like when you are living with HIV you must eat healthy food so the poor people cannot afford that.

Researcher: Ok. Do you think there is a link between HIV/AIDS stigma and religious belief?

Participant: In other religions, they believe that when you pray you can heal from HIV. They believe if you pray to shall heal.

Researcher: Ok. Do you think there is a link between HIV/AIDS stigma and race?

Participant: According to my observation, there is no relation. People lack knowledge. This is why there is discrimination.

Researcher: Before we end our interview, is there anything you would like to add before we end our interview.

Participant: Lets treat people who are HIV positive well, let's look after them as they are people like us, we love them.

Participant 6

Researcher: Okay I would like to know what do you think of people who are living with HIV/AIDS?

Participant: I think they are people like everyone. If someone is HIV positive it does not mean they are different from us, all it says just that we suffer from different symptoms in life so they must be treated the same.

Researcher: What influenced yours views?

Participant: I do not understand your question.

Researcher: isn't you just mentioned that they are normal people like anyone. so I'd like to know what makes you say that? What makes you say they are like the rest of us.

Participant: Most like to isolate those living with HIV/AIDS because they think they are going to infect them. so it's not like that, you can have a friend who is HIV positive and you find that you do not have it.

Researcher: are your views shared by other community members in Mahwelereng?

Participant: No, because we have different knowledge. But most people in the community discriminate those who are HIV positive.

Researcher: How do you treat people living with HIV/AIDS?

Participant: I once had a classmate who was HIV positive; I treated him well with love and respect not knowing that he has that disease. These are the people we treat well.

Researcher: what are the positive things that are being done in Mahwelereng as a way of making sure that people living in the community get proper support?

Participant: They help them by giving them food; they cook for them, like having food parcels. They try by all means to help them.

Researcher: What are the negative things that are being done then that are against people living with HIV/AIDS?

Participant: Negative things...

Researcher: Yes...

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Participant: You find that a female child in some homes they speak in advance that they do not need a child who is sick, once they discover that you are HIV positive they kick you out of the house because they would say they do not want an ill child.

Researcher: Ok. When you look at things, do you think there is a link between HIV/AIDS stigma and gender? Is there a specific gender that gets more discriminated than the other?

Participant: I do not think so.

Researcher: Ok. Do you think there is a link between HIV/AIDS stigma and socioeconomic status?

Participant: Sometimes it does exist. Like the rich people get sick but are less criticized because they have money. Only the poor receive bad treatment.

Researcher: Ok. Do you think there is a link between HIV/AIDS stigma and religious belief?

Participant: Christians do not expected to be infected by illnesses such as HIV because you are viewed as being irresponsible. Like they judge you when you are HIV positive.

Researcher: Ok. Do you think there is a link between HIV/AIDS stigma and race?

Participant: No,there is not relationship.

Researcher: Before we end our interview, is there anything you would like to say.

Participant: No, thanks

Participant 7

Researcher: Okay I would like to know what do you think of people who are living with HIV/AIDS?

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Participant: Thinking, in what way?

Researcher: How do you view them?

Participant: I do not have much to say but truly speaking I think they are just normal people just that they had it rough and they got sick with HIV. But after all I just think we all the same. We are equal.

Researcher: What influenced you to say we are the same?

Participant: Like now for example, someone can be HIV positive and that I am not but you find that I die before him or her. After all we are all going to die.

Researcher: so do you think your views are shared by other community members in Mahwelereng?

Participant: Not necessary. You see here in Mahwelereng they are judgemental people. In the community if they found out that you are HIV positive they are quick to judge you, they think you are promiscuous not knowing that you got infected by your partner. You find that your partner did all that. People are judgemental hence people do not want to disclose their status.

Researcher: How do you treat people living with HIV/AIDS?

Participant: I treat them fairly so, I treat them normal I treat them well, I do not discriminate them. I just think they are normal people.

Researcher: what are the positive things that are being done in Mahwelereng that support people living with HIV/AIDS?

Participant: I have never seen anything positive done to support them like I do want to lie.

Researcher: OK then what are the negative things that are being done then that are against people living with HIV/AIDS?

Participant: Firstly those people are being judged then in a ways they make them feel small. So they try to show them that they are different from us.

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Researcher: Ok. When you look at things, do you think there is a link between HIV/AIDS stigma and gender? Do you think the stigma varies according to gender?

Participant: Yes, for example when a girl is sick they would say she is promiscuous without wanting to know where did she get the illness especially us black people we have this thing of saying a man can do as he wishes, they portray this thing of expecting females to be well mannered.

Researcher: Ok. Do you think there is a link between HIV/AIDS stigma and socioeconomic status?

Participant: Yes, when you are rich people are less likely to judge you unlike when you are poor.

Researcher: Ok. Do you think there is a link between HIV/AIDS stigma and religious belief?

Participant: Some people think they know religion more than others. Most Christians like to discriminate those who are HIV positive because they think they are saints.

Researcher: Ok. Do you think there is a link between HIV/AIDS stigma and race?

Participant: Most of the black people like to discriminate each other unlike white people.

Researcher: Before we end our interview, is there anything you would like to add before we end our interview.

Participant: What I would say in our community is if we had campaigns that teach people about HIV, help people to accept that they are sick.

Participant 8

Researcher: What do you think of people who are living with HIV/AIDS?

Participant: I think they are different because they are living with a chronic illness. HIV is a dangerous illness which is killing a lot of people in South Africa. They always live with fear of dying.

Researcher: What influenced yours views?

Participant: They are living with an illness that makes them prone to death. Like I said when you are positive you always have fear that you can die anytime.

Researcher: Ok. When you look at your views, do you think they are the same as other people in the community of Mahwelereng?

Participant: Yes, most people think that when you are HIV positive you are at higher risk of dying, as a result they start to discriminate you. it is not easy to live with HIV people.

Researcher: Ok. So tell me how do you treat people who are living with HIV/AIDS?

Participant: I try to treat them with respect although I fear I can get infected especially when they cough. I always have a fear that they can infect me. So I keep distance most of the time.

Researcher: Ok. What are the positive things in your community that are being done to support people living with HIV/AIDS?

Participant: They are encouraged to attend classes at the nearby clinics. They teach them about their disease which is good because this can help increase their days of life.

Researcher: Ok. So what are the negative things that are done in your community which are against people living with HIV/AIDS?

Participant: Its bad to be HIV positive honestly my sister... Like in most cases, they gossip about you and also avoid being close to you. People fear that they can get infected.

Researcher: Ok. When you look at things, do you think there is a link between HIV/AIDS stigma and gender?

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Participant: I think females are at a high risk of being discriminated because they are viewed as having many partners.

Researcher: Ok. Do you think there is a link between HIV/AIDS stigma and socioeconomic status?

Participant: when you are poor you can't afford to buy ARVs. Poor people are always discriminated in the communities because they cannot afford to buy medications as well yet they are irresponsible. They do not think like rich people.

Researcher: Ok. Do you think there is a link between HIV/AIDS stigma and religious belief?

Participant: No, I do not think there is a relation.

Researcher: Ok. Do you think there is a link between HIV/AIDS stigma and race?

Participant: No, I do not think there is a relationship.

Researcher: Before we end our interview, is there anything you would like to add before we end our interview?

Participant: No, thank you for the interview.

Participant 9

Researcher: What do you think of people who are living with HIV/AIDS?

Participant: I think they are like everyone the only difference is that they live with medication. They always have to drink pills so that they can be healthy.

Researcher: What influenced yours views?

Participant: You mean why am I saying this?

Researcher: Yes

Participant: Oh it's because HIV it's a chronic illness that requires one to take medication every single day and this can be tiring. But they do not have a choice they should take medication for their life.

Researcher: Ok. When you look at your views, do you think they are the same as other people in the community of Mahwelereng?

Participant: Not really, I'm saying this because most people in the community thinks that when you are HIV positive you sleeps around with many people then after they start to discriminate you.

Researcher: Ok. So tell me how do you treat people who are living with HIV/AIDS?

Participant: Eish myself....(Participant kept quiet for a moment) To be honest I am afraid of people who are HIV positive; I fear them. I try to stay far from them.

Researcher: Ok. What are the positive things in your community that are being done to support people living with HIV/AIDS?

Participant: So far I have not seen anything being done to support them.

Researcher: So what are the negative things that are done in your community which are against people living with HIV/AIDS?

Participant: They normally discriminate you and lose respect for you. Many people do not feel free to associate with those who are HIV positive.

Researcher: Ok. When you look at things, do you think there is a link between HIV/AIDS stigma and gender?

Participant: I do not think so.

Researcher: Ok. Do you think there is a link between HIV/AIDS stigma and socioeconomic status?

Participant: The rich people in most cases they do not get discriminated because they are respected in the community. Like people fear those who are rich they treat them we but the poor people are discriminated.

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Researcher: Ok. Do you think there is a link between HIV/AIDS stigma and religious belief?

Participant: Christians like born again views illnesses like HIV as the one that infect those who are sleeping around with many people. You are somehow viewed as careless.

Researcher: Ok. Do you think there is a link between HIV/AIDS stigma and race?

Participant: There is no relationship.

Researcher: Before we end our interview, is there anything you would like to add before we end our interview.

Participant: Yes, I think us as people need to learn a lot about HIV.

Participant 10

Researcher: What do you think of people who are living with HIV/AIDS?

Participant: I think they are sick people who run the risk of dying because of they are sick, they have HIV.

Researcher: What else can you say?

Participant: When you are HIV positive you run the risk of dying unlike someone who is healthy who does not have HIV.

Researcher: okay. So are your views shared by other members in the community of Mahwelereng?

Participant: Yes they do, we all view HIV as a dangerous illness which can kill you at any time. In the community if you are HIV positive they discriminate you. Like you find that your family plus friends start to isolate you, they do not treat you the same, they fear you.

Researcher: Ok. So tell me how do you treat people who are living with HIV/AIDS?

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Participant: To be honest with you, I actually prefer not to be close to people who are HIV positive. I am scared that they can infect me. Maybe I am rude but I do not want to be close to them who know they can infect me.

Researcher: Ok. What are the positive things in your community that are being done to support people living with HIV/AIDS?

Participant: I have seen the social workers visiting their homes, they provide counselling to them.

Researcher: What else is being done?

Participant: Nothing else.

Researcher: So what are the negative things that are done in your community which are against people living with HIV/AIDS?

Participant: In most cases they discriminate you, they gossip about you. People will treat you bad when your HIV positive to be honest.

Researcher: Ok. When you look at things, do you think there is a link between HIV/AIDS stigma and gender?

Participant: Yes there is a relationship. Males are normally blamed for the spread of HIV because they have many partners, they sleeps around.

Researcher: Ok. Do you think there is a link between HIV/AIDS stigma and socioeconomic status?

Participant: No, I do not think so.

Researcher: Ok. Do you think there is a link between HIV/AIDS stigma and religious belief?

Participant: No there is no relation.

Researcher: Ok. Do you think there is a link between HIV/AIDS stigma and race?

Participant: Yes, white people have more knowledge about HIV unlike blacks as a results they do not discriminate each other. Only black people discriminate each other.

Researcher: Before we end our interview, is there anything you would like to add before we end our interview?

Participant: No.