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Title: Self-Stigma among Sex Workers Living with HIV in Mazowe District, Zimbabwe:



Experiences of Sex Workers Implementing Key Populations (KP) Programme under National Aids Council (NAC)

By

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A dissertation report submitted to Bindura University of Science Education, Faculty of Social Sciences and Humanities, Department of Social Work, in partial fulfilment of the requirements for the Bachelor of Science Honors Degree in Social Work.

June, 2026

Bindura, Zimbabwe

DECLARATION FORM

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Supervisor

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Chairperson

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God bless you all.

DEDICATION

This dissertation is dedicated to my mother Florence Mberekai for her effort, hard work and resilience during this journey and it can never be forgotten.

I also want to dedicate this project to my baby girl, Nicole Tabeth Mushunje, when I was failing, she gave me strength because I do not want to let her down.

LIST OF ACRONYMS

AIDS	Acquired Immunodeficiency Syndrome
ART	Antiretroviral Therapy
CBT	Cognitive Behavioural Therapy
HIV	Human Immunodeficiency Virus
NAC	National Aids Council
MoHCC	Ministry of Health and Child Care
NGOs	Non-Governmental Organisations
PLHIV	People Living with HIV
UNAIDS	Joint United Nations Programme on HIV/AIDS
ZNNP+	Zimbabwe National Network of People Living with HIV
ZNASP	Zimbabwe National Aids Strategic Plan

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ABSTRACT

The study examined the concept of self-stigma amongst sex workers living with HIV in Mazowe District, Zimbabwe. Self-stigma is a significant psychosocial issue for PLHIV, especially vulnerable groups like sex workers who face multiple forms of stigma, related both to HIV and sex work. This study aimed to explore the manifestations of self-stigma, its perceived impacts and explore coping strategies used by sex workers with HIV. The theory employed was Cognitive Behavioral Theory explaining the relationship between negative patterns and emotions and behaviors. A qualitative research approach was used to get an insight into the participants lived experiences. Data was collected through in-depth interviews conducted with fifteen sex workers living with HIV and five key informants from organizations that deliver HIV programming and support services in Mazowe District. The results show that self-stigma was experienced in the form of internalized shame and guilt, fear of disclosure and social withdrawal and isolation. The study further revealed that self-stigma had negative effects on participants' mental health and well-being contributing to disengagement from healthcare services, poor ART adherences and delayed health seeking behaviors. The study revealed that the participants practiced different coping strategies to deal with self-stigma and these consisted of peer support networks, counselling and psychosocial support, community empowerment programmes that assisted participants in increasing their self-esteem, self-confidence, social support networks and adherence to treatment. The study concluded that self-stigma continues to be a major barrier to psychological well-being, social inclusion and effective healthcare engagement among sex workers living with HIV. The study recommends increasing the efforts on stigma reduction programmes, increasing psychosocial support, increasing peer support interventions and implementing community empowerment programmes aimed at improving the wellbeing of sex workers living with HIV. The study further recommends the involvement of several institutions such as government, health care, social workers, Non-Governmental Organizations and communities to address stigma and discrimination.

Key words: self-stigma; commercial sex worker; HIV

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CHAPTER ONE

INTRODUCTION AND BACKGROUND TO THE STUDY

1.0 Introduction

This chapter forms the basis of this study by giving the background, and the context of self-stigma among sex workers living with HIV in Mazowe District, Zimbabwe. Self-stigma is the internalisation of negative societal attitudes and stereotypes that tend to lead to feelings of shamefulness, guilt and worthlessness. Self-stigma has been identified globally as a significant psychosocial issue contributing to health-seeking behaviour, mental health and social functioning among the vulnerable populations. This chapter comprises of the background of the study, statement of the problem, objectives of the study, research questions, assumptions of the study, significance of the study, limitations of the study, delimitations of the study and definition of key terms and the chapter summary.

1.1 Background of the Study

Globally, HIV/AIDS remains one of the most significant public health challenges despite decades of interventions aimed at prevention, treatment, and care. According to UNAIDS (2016) the world over, HIV/AIDS remains one of the greatest epidemics among human beings with an estimation of 36.7 million people living with HIV worldwide in 2015 of which two thirds live in sub-Saharan Africa. According to the Joint United Nations Programme on HIV/AIDS (UNAIDS,2024), the global median HIV prevalence among sex workers was estimated at approximately 3% in 2023 ranging from 0% to 62% across 72 reporting countries, reflecting significant regional and structural inequalities in HIV risk and access to prevention services. Sex workers face a much higher relative risk of acquiring HIV, which was 9 times

higher globally in 2022 compared to the general population (Joint United Nations Programme on HIV/AIDS (UNAIDS),2023).

Despite significant global progress and treatment, including expanded access to antiretroviral therapy, UNAIDS acknowledges that persistent barriers, stigma to be particular, continue to impede the progress toward the UNAIDS 95-95-95 targets. One of the most critical yet often overlooked forms of stigma is self-stigma, also referred to as internalised stigma which occurs when individuals living with HIV internalize negative societal attitudes, stereotypes, and moral judgements about HIV and their social identity (Corrigan, 2004). Among key populations such as sex workers, self-stigma is often compounded by stigma related to both HIV status and engagement in sex work. This internalization manifests through feelings of shame, guilt fear of disclosure, and diminished self-worth. For example, a sex worker living with HIV may avoid attending HIV clinics or disclosing their status to healthcare providers due to fear of judgement, even in settings where the services are available, thereby limiting effective engagement in HIV care despite care policy and programmatic advances (Nyblade et al, 2019).

In addition, empirical studies highlight that self-stigma presents a number of consequences among sex workers living with HIV. Evidence in the Northern Uganda indicates that female sex workers face significant self-stigma which increases mental health issues such as depression and anxiety and making it harder for them to access health care and psychosocial support services (Kabunga, Bongmin, Ayugi and Kigongo,2025). This finding is particularly important in post conflict settings such as the Northern Uganda, where social conservatism, poverty, and weak health systems further intensify stigma. The study underscores how self-stigma operates not merely as an individual psychological experience but as a phenomenon that discourages timely HIV testing, disclosure, and consistent treatment engagement among sex workers.

Similarly, a high prevalence of HIV of about 40.7% among sex workers has been reported in Namibia alongside pervasive experiences of self-stigma, according to the Ministry of Health and Social Services, through the National Strategic Framework for HIV and AIDS (Ministry of Health and Social Services (MoHSS, 2017). In Namibia, self-stigma has had profound consequences for HIV care among sex workers. Internalised feelings of shame and fear of discrimination have been linked to delayed HIV testing, poor linkage to care, inconsistent antiretroviral therapy adherence and reduced utilization of sexual and reproductive health services. Self-stigma also discourages sex workers from openly engaging with healthcare providers or participating in peer-support initiatives, thereby weakening continuity of care and viral suppression outcomes. These dynamics undermine national HIV response efforts and perpetuate high prevalence rates among key populations, despite the availability of free HIV treatment services (MoHSS,2017).

Moving on closer to home, the prevalence of HIV among sex workers in Zimbabwe is exceptionally high with an estimated percentage of 42,2% (UNAIDS, 2021). In Zimbabwe, the high prevalence among sex workers is further increased by the co-existence of public stigma and self-stigma. Public stigma is expressed through discriminatory attitudes, social exclusion, and moral condemnation from communities, law enforcement agents and healthcare providers, while self-stigma arises when sex workers internalize these negative perceptions. The Zimbabwe People living with HIV(ZNNP+) stigma index 2.0 report shows that 77,7% of sex workers experienced stigma in various forms. This high prevalence of stigma illustrates how social and institutional environments continue to marginalize sex workers, reinforcing secrecy, fear, and disengagement from HIV services (ZNNP+, 2021).

According to the ZNNP+ Stigma Index 2.0, the most prevalent form of stigma experienced by sex workers living with HIV in Zimbabwe is self-stigma, characterised by self-blame, fear of

disclosure and internalized shame. This internalized shame often stems from repeated experiences of public discrimination and moral judgment, demonstrating the cyclical relationship between public stigma and self-stigma within highly stigmatized populations (ZNNP+,2021). Self-stigma among people living with HIV in Zimbabwe has significant negative consequences for both individual wellbeing and public health outcomes. Internalized stigma has been associated with poor adherence to antiretroviral therapy, missed clinic appointments, delayed disclosure of HIV status, and increased psychological distress including depression and anxiety. Among sex workers, these effects are intensified by criminalization and social marginalization leading to reduced trust in healthcare systems and weakened social support networks. Consequently, self-stigma undermines national HIV response efforts by impeding viral suppression, increasing the risk of onward transmission and limiting progress toward achieving the UNAIDS 95-95-95 targets (UNAIDS, 2022).

In response, Zimbabwe has implemented community-led and peer-based interventions to address both high HIV prevalence and stigma among sex workers. Programmes supported by National Aids Council and implementing partners emphasize peer education, community mobilization, and sex worker-friendly service delivery models. These interventions empower sex workers to act as peer educators, improve literacy on HIV, promote treatment adherence, and reduce self-stigma through collective support and shared lived experiences. Evidence suggest that peer-driven approaches enhance trust in health services and improve uptake of HIV testing and treatment among sex workers (Shannon, 2015). The Zimbabwe National HIV and AIDS Strategic Plan incorporate rights-based approaches aimed at reducing stigma and discrimination against key populations, including sex workers. Policy measures focus on strengthening stigma-free healthcare environments, training healthcare workers on non-discriminatory practices and integrating psychosocial support into HIV services. These policy interventions recognize stigma as a structural driver of HIV vulnerability and emphasize the

need to address legal, social and institutional barriers that perpetuate self-stigma and exclusion among sex workers living with HIV (National Aids Council, 2021).

Despite these efforts, research focusing on self-stigma among sex workers living with HIV in peri-urban and rural settings such as Mazowe District, remains limited. This study seeks to address this gap by exploring the lived experiences, impacts and coping mechanisms associated with self-stigma among this population.

1.2 Statement of the problem

Self- stigma has emerged as a critical yet insufficiently addressed global phenomenon affecting individuals across diverse social, health, and economic contexts. Empirical studies have shown that a substantial proportion of individuals belonging to stigmatized groups internalise negative societal attitudes. Livingstone and Boyd (2010) stated that self-stigma is highly prevalent and mostly associated with reduced self-esteem, poor coping mechanisms and adverse mental health outcomes. Similarly broader evidence suggests that between 40% and 70% of individuals with stigmatized conditions experience some level of internalised stigma, thus denoting its widespread nature (Corrigan et al, 2009).

Self-stigma is hypothesised to be critical, yet often unaddressed factor undermining the effectiveness of existing HIV/AIDS interventions. Key populations, female sex workers to be specific have a significantly higher HIV prevalence compared to the general population. Globally, studies are indicating that sex workers living with HIV experience disproportionately high levels of both external and internal stigma of which many are reporting feelings of shame, guilt and social isolation (Scambler, 2009). According to UNAIDS (2020) a majority of sex workers living with HIV experience self-stigma which negatively affects their ability to access healthcare services, adherence to ART and participation in support networks.

In Zimbabwe, while studies have documented high levels of stigma related to HIV, particularly among vulnerable populations like sex workers living with HIV, there remains limited context specific research focusing explicitly on self-stigma. In districts such as Mazowe which is characterised by mining activities, commercial farming and socio-economic vulnerability, presents a unique context in which individuals may experience compounded forms of marginalisation that reinforces self-stigma. While external stigma from healthcare providers and the community is widely documented, the internalised form self-stigma is less understood and insufficiently addressed. This gap is particularly evident in rural and peri-urban contexts such as Mazowe District where socio-economic inequalities, cultural norms and limited access to services may intensify internalised stigma.

Furthermore, although various stigma reduction interventions have been implemented, many do not specifically address the psychological and internal dimensions of stigma (Earnshaw and Chaudoir, 2009). Without a clear understanding of how self-stigma manifests and influences behaviour at individual level such intervention may fail to produce meaningful and sustainable outcomes. Therefore, there is need for research that focuses specifically on self-stigma as a distinct phenomenon. This study seeks to address this gap by exploring the experiences, impacts and copings mechanisms associated with sex workers living with HIV.

1.3 Aim of the Study

This study aims to identify the psychological factors and impacts associated with self-stigma among sex workers living with HIV in Mazowe District, Zimbabwe.

1.4 Research Objectives

1) To explore the manifestations of self-stigma among sex workers living with HIV in Mazowe, Zimbabwe.
2) To explore the perceived impact of self-stigma on the lives of sex workers living with HIV in Mazowe, Zimbabwe.
3) To explore the coping mechanisms used by sex workers living with HIV to manage self-stigma in Mazowe, Zimbabwe.

1.5 Research Questions

1) What are the manifestations of self-stigma among sex workers living with HIV in Mazowe?
2) What is the perceived impact of self-stigma on the lives of sex workers living with HIV in Mazowe, Zimbabwe?
3) What coping mechanisms do sex workers living with HIV in Mazowe use to manage and respond to self-stigma?

1.6 Significance of the Study

The study is important as it will produce new and context specific evidence on the psychological impact of self-stigma following the HIV status and sex work among sex workers in Mazowe. By focusing on self-stigma, the study addresses a critical gap in existing literature which has largely overlooked, localized, lived experiences of key populations in peri-urban and rural Zimbabwean contexts. The research will contribute to the knowledge of the manifestation, experience and internalisation of self-stigma among sex workers with HIV. This understanding is critical in informing the culturally sensitive and population specific interventions to cope with the psychosocial issues encountered by this marginalised group. Moreover, the results will give evidence-based and practical recommendations to the National Aids Council and its implementing partners. These recommendations will inform the inclusion

of effective self-stigma reduction interventions into the existing HIV prevention, treatment and care programmes targeting sex workers. It is especially significant to enhance the adherence to antiretroviral therapy, strengthen mental health outcomes, and enhancing overall wellbeing. At a broader level, the research will contribute to the national HIV response initiatives by supporting the achievement of the Zimbabwe's HIV strategic goals, particularly those related to stigma reduction, retention in care and improved quality of life of key populations.

1.7 Assumptions of the Study

The study is based on the following assumptions:

- The participants will provide honest and accurate responses regarding their experiences.
- Health-seeking behaviour is greatly affected by self-stigma in sex workers living with HIV.
- Existing HIV interventions may not address internalised stigma properly.

1.8 Limitations of the Study

The constraints that can be encountered in this research can be:

- Sensitivity of the topic which could influence the willingness of the participants to share personal experiences.
- Limited generalisability due to the focus on Mazowe District.

1.9 Delimitations of the Study

The research is confined to Mazowe District that includes those of Mvurwi, Glendale, Concession and Mazowe and some of the commercial farms and mining settlements. The Mazowe District is typified by the high rate of population mobility, economic vulnerability and

low access to holistic health and social services. The proposed study intends to create context specific information within a particular socio-economic and cultural context, by concentrating on Mazowe. However, this geographical delimitation implies that the findings may not be generalisable to other areas especially in urban context where structural and social processes are different.

The research is confined to internalised stigma among sex workers living with HIV as Corrigan (2004) defines it and it does not go beyond that to include other forms of stigma that have been tackled like the public stigma or structural stigma. Although these forms can be recognized as the factors that influence, they are not the main focus of the study. The study also looks particularly at internalisation of negative societal beliefs and stereotypes, psychological consequences, the role of self-stigma and the coping mechanisms applied to deal with internalised stigma.

To maintain this focus, the study prioritises sex workers living with HIV's subjective experiences and internal perceptions in Mazowe District important and concentrates specifically on self-stigma and not on the external manifestations of stigma. The data collection procedures will be developed so as to obtain personal narratives and psychological process that will guarantee a clear distinction between the self-stigma and other stigmas (Corrigan and Watson, 2002).

1.10 Definition of Key Terms

(i) Self-stigma

According to Corrigan (2004), self-stigma is the internalised of negative societal stereotypes and prejudices about a particular characteristic, condition, or group membership leading to diminished self-esteem, self-efficacy and increased psychological distress.

(ii) Sex workers

Sex workers are adults of both sex, transgender, gender-diverse females, and males receiving money or goods in exchange of sexual services regularly or occasionally (UNAIDS,2024)

(iii) HIV-positive

According to WHO (2016), HIV positive is a condition in which human immunodeficiency virus (HIV) has attacked the body's immune system particularly the white blood cells known as the CD4 cells.

1.11 Dissertation Outline

The first chapter provides the introduction of the study which is self-stigma among sex workers living with HIV in Mazowe district, Zimbabwe and the background of the study. It specifies the statement of the problem, the research objectives, research questions, the significance of the study, assumptions, delimitations, and definition of limitations and definition of keys terms and the dissertation outline.

Chapter Two discusses the related literature on self-stigmatization among sex workers with HIV. The chapter addresses both theoretical and empirical literature pertinent to the study, outlines knowledge gaps and provides the theoretical framework of the research.

Chapter Three outlines the research methodology followed in the research. It describes the research approach, research design, study population, sampling procedure, data collection methods, data analysis procedures, ethical considerations and measures to ensure trustworthiness.

Chapter Four outlines, discusses and analyzes the study findings. The results are structured into themes and sub-themes based on the data and are addressed in accordance with the objectives of the study and theoretical framework.

Chapter Five gives a summary of the study results, conclusions, recommendations, implications on the social work practice and future research.

1.12 Chapter Summary

In this chapter, the author has provided the context of the study by giving a detailed description of the background of the study, the problem statement, study aim, research questions and objectives. This preliminary chapter also outlined the justification of the study, the study limits and assumptions of the study.

CHAPTER TWO

LITERATURE REVIEW AND THEORETICAL FRAMEWORK

2.0 Introduction

This chapter describes the existing literature on HIV-related stigma, self-stigma and the lived experiences of sex workers living with HIV. Literature to be reviewed in this chapter encompasses the theoretical framework that underpins this study and a synopsis of the recent self-stigma among sex workers in Zimbabwe. The international, regional and local overviews of stigma, self-stigma to be specific among sex workers living with HIV, the effects of self-stigma to ART adherence, mental well-being and the effectiveness of existing support programmes for addressing self-stigma are reviewed as well. The review also identifies the research gaps that that justifies the current study in Mazowe District, Zimbabwe.

2.1 THEORETICAL FRAMEWORK

2.1.1 *Cognitive Behavioural Therapy*

The researcher used cognitive behavioural therapy which was propounded by A. Beck in 1960. The idea of the CBT is to identify and challenge negative thoughts on individuals and it aims on helping individuals recognize their distorted mind and replace them with positive and realistic thoughts. The CBT will help the researcher to understand the drivers to self-stigma among sex workers living with HIV and solutions to reduce the internalised stigma.

Cognitive behavioural therapy is highly collaborative, person-centered and it strengthens the beliefs of hope and purpose thus doing away with negative thoughts that leads to internalised

stigma (Beck ,2020). CBT is relevant to this study as it provides a framework for understanding how self-stigma develops and how it can be addressed through cognitive restructuring and behavioural interventions.

2.1.2 *Strengths of the Cognitive Behavioural Theory*

Cognitive Behavioural Theory is grounded in the principle that individuals' thoughts, emotions, and behaviours are interconnected (Beck, 2020). The theory posits that maladaptive or distorted thinking patterns influence emotional responses and behavioural outcomes. In the context of HIV-related stigma, CBT is particularly relevant in explaining how external societal attitudes are internalised to form self-stigma. HIV-positive individuals, especially those engaged in sex work, are frequently exposed to negative societal messages that portray them as immoral, irresponsible, or dangerous.

The relevance of CBT to this study lies in its ability to explain how stigma becomes internalised and translated into behaviour. It provides a useful framework for understanding why individuals may avoid healthcare services, fail to adhere to treatment, or withdraw from social support systems. This internalisation process is central to understanding self-stigma. According to Corrigan (2004), self-stigma occurs when individuals accept and apply negative stereotypes to themselves, resulting in diminished self-esteem and self-efficacy. CBT explains this phenomenon through cognitive distortions, where individuals begin to interpret their identity through a negative lens shaped by societal judgement. For example, a sex worker living with HIV may come to believe that they are undeserving of care or support, leading to emotional distress and behavioural avoidance. Empirical evidence supports this link, showing that internalised stigma is associated with poor mental health outcomes, reduced health-seeking behaviour, and lower adherence to antiretroviral therapy (Nyblade et al., 2019).

Furthermore, CBT is not only explanatory but also intervention-oriented. It underpins psychosocial interventions aimed at challenging negative thought patterns and promoting positive coping mechanisms. Studies have demonstrated that CBT-based interventions can significantly reduce internalised stigma and improve both psychological wellbeing and treatment adherence among people living with HIV (Beck, 2020). CBT provides concrete techniques such as cognitive restructuring, behavioural activation and problem-solving skills that can be used to challenge negative beliefs and promote positive coping mechanisms. Therefore, CBT is highly appropriate for this study as it offers both a theoretical lens and a practical foundation for addressing self-stigma.

2.1.2 *Weaknesses of the Cognitive Behavioural Theory*

CBT assumes that individuals have the capacity and emotional readiness to identify and challenge distorted thoughts while underplaying the role of persistent external stigma. In contexts such as HIV and sex work where stigma is reinforced by societal norms and legal systems, individualistic focus may be insufficient. Tural et al (2019), emphasise that structural and intersectional stigma create persistent environments that continuously reproduce internalised stigma making it difficult for individuals to sustain cognitive and behavioural change. Sex workers living with HIV may experience several psychological distress, trauma or low levels of education which can limit their ability to engage effectively with cognitively demanding interventions. This makes CBT less accessible for some vulnerable populations without adaptation.

CBT may also be limited in resource constrained settings due to the need of trained professionals. In low resource settings such as Mazowe district there is a shortage of mental health services and trained personnel. The effectiveness of psychosocial interventions in HIV

programming is often limited by weak health systems and insufficient investment in mental health services (Nyblade, 2019). This restricts the scalability and accessibility of CBT based interventions.

2.2 The Concept of Stigma

The concept of stigma has been extensively examined within sociology and public health, particularly in relation to health conditions such as HIV. Goffman (1963) provides a foundational definition, describing stigma as an attribute that is deeply discrediting, reducing an individual from a whole and usual person to a tainted, discounted one. In the context of HIV, stigma manifests through negative societal attitudes, discriminatory practices, and social exclusion directed at people living with HIV. These manifestations are not merely symbolic, they have tangible consequences for individuals' access to healthcare, social relationships, and overall wellbeing. Subsequent scholars have expanded Goffman's work by highlighting that stigma is not static but is socially constructed and reinforced through ongoing interactions and institutional practices (Link & Phelan, 2001).

HIV-related stigma operates across multiple, interconnected levels. At the individual level, stigma is internalised, resulting in self-stigma characterised by shame, guilt, and diminished self-worth (Corrigan, 2004). At the interpersonal level, stigma is expressed through discriminatory attitudes and behaviours from family members, peers, and communities, often leading to rejection and social isolation. At the structural level, stigma is embedded in laws, policies, and institutional practices that disadvantage people living with HIV, such as discriminatory healthcare practices or the criminalisation of behaviours associated with HIV risk. These levels are mutually reinforcing for instance, structural discrimination can legitimise

interpersonal stigma, which in turn contributes to internalised stigma (Earnshaw & Chaudoir, 2009).

Importantly, scholars such as Parker and Aggleton (2003) argue that stigma must be understood within broader systems of power and inequality. They emphasise that stigma is not simply an individual attitude but a social process that sustains existing hierarchies and marginalisation. This perspective is particularly relevant for key populations such as sex workers, who experience layered or compounded stigma due to both their HIV status and their occupation. Moral judgments surrounding sex work, combined with legal frameworks that criminalise it, intensify stigma and limit access to essential health services (Shannon et al., 2015). As a result, HIV-related stigma among sex workers living with HIV is not only a matter of personal perception but is deeply rooted in structural and cultural contexts that perpetuate exclusion and vulnerability.

2.3 Understanding self-stigma

Self-stigma, also referred to as internalised stigma, occurs when individuals absorb and accept negative societal beliefs and stereotypes about themselves, leading to diminished self-worth and psychological distress (Corrigan, 2004). Among people living with HIV, self-stigma is commonly manifested through feelings of shame, guilt, fear of disclosure, and reduced self-esteem. These internalised perceptions are shaped by persistent exposure to societal stigma, including discrimination and moral judgement, which over time become embedded in an individual's self-concept. Link and Phelan (2001) argue that stigma is not only externally imposed but can be internalised in ways that reinforce social inequality, making self-stigma a powerful mechanism through which marginalisation is sustained at the individual level.

Research indicates that self-stigma is particularly prevalent among sex workers living with HIV and has significant implications for health behaviours. According to UNAIDS (2020), internalised stigma remains a major barrier to accessing HIV prevention, treatment, and care services among key populations. Individuals who experience self-stigma are more likely to avoid HIV testing, delay treatment initiation, and disengage from care due to fear of judgement and disclosure. Hoang et al. (2024) further highlight that self-stigmatisation discourages help-seeking behaviour and contributes to broader social challenges, including mental health disorders and vulnerability to gender-based violence. This underscores the interconnected nature of psychological, social, and health outcomes associated with self-stigma.

Empirical evidence from sub-Saharan Africa reinforces the significance of self-stigma as a public health concern. For instance, a study in Northern Uganda found that female sex workers experience high levels of internalised stigma, which negatively affects their access to healthcare services and psychosocial support (Kabunga et al., 2025). These findings demonstrate that self-stigma extends beyond individual psychological experiences to influence broader health outcomes and service utilisation. As such, addressing self-stigma requires targeted interventions that combine psychological support with structural and community-based strategies. Without such efforts, self-stigma will continue to undermine HIV response programmes and limit progress toward improving the wellbeing of key populations.

2.4 Sex Work, HIV and Intersectional Stigma

Sex workers living with HIV experience what is widely conceptualised as intersectional stigma, a condition in which multiple stigmatised identities overlap and interact to produce compounded forms of discrimination. Intersectionality theory, introduced by Kimberlé Crenshaw (1989), provides a critical framework for understanding how individuals

simultaneously experience multiple forms of oppression based on intersecting identities such as gender, occupation, health status, and socio-economic position. In the context of HIV, this means that sex workers are not only stigmatised for living with HIV but also for engaging in sex work, which is often socially and morally condemned. These overlapping stigmas do not operate independently rather, they interact in ways that intensify marginalisation and vulnerability. As Link and Phelan (2001) argue, stigma is deeply embedded within systems of power and inequality, and intersectionality helps to reveal how these systems disproportionately affect already marginalised populations.

For sex workers living with HIV, stigma arises from multiple sources, including their HIV status, involvement in sex work, gender inequality, and socio-economic marginalisation. These intersecting factors create layered barriers that significantly affect health behaviours and outcomes. Shannon et al. (2015) emphasise that structural conditions such as poverty, gender-based violence, and criminalisation increase vulnerability to HIV and limit access to essential healthcare services. Intersectional stigma manifests in various ways, including discrimination in healthcare settings, social exclusion, and fear of disclosure. These experiences discourage sex workers from seeking HIV testing, adhering to antiretroviral therapy (ART), and engaging with support services. Furthermore, intersectional stigma has been linked to adverse mental health outcomes, including depression and anxiety, which further undermine health-seeking behaviours (Turan et al., 2019). This demonstrates that stigma is not merely a social issue but a critical determinant of public health outcomes.

In Zimbabwe, the situation is further complicated by the legal and socio-cultural context in which sex work is criminalised. Criminalisation not only exposes sex workers to legal risks but also legitimises societal discrimination, increasing their vulnerability to abuse, exploitation, and violence. Studies have shown that punitive legal environments exacerbate stigma and

reduce access to healthcare by driving sex workers underground and limiting their interaction with formal health systems (Decker et al., 2015). This legal context reinforces both public stigma and self-stigma, creating a cyclical pattern of marginalisation in which external discrimination is internalised, leading to reduced self-worth and avoidance of care. As Parker and Aggleton (2003) argue, stigma is sustained through social and institutional structures that perpetuate inequality. Therefore, addressing HIV among sex workers in Zimbabwe requires not only individual-level interventions but also structural changes that challenge legal and societal barriers. Understanding intersectional stigma is thus essential for developing comprehensive and contextually relevant responses to HIV among this population.

2.5 HIV-Related Self-Stigma among Sex Workers

Self-stigma among sex workers living with HIV is shaped by a complex interaction of societal attitudes and individual lived experiences. It emerges when persistent exposure to stigma, discrimination, and negative social narratives is internalised, becoming part of an expressed self-concept. According to Nyblade et al. (2019), repeated encounters with stigma in communities, healthcare settings, and social institutions can lead individuals to adopt these negative perceptions, resulting in self-blame, shame, and diminished self-worth. This process is particularly pronounced among sex workers, who are already positioned at the margins of society due to moral judgements surrounding their occupation. Consequently, self-stigma is not merely an individual psychological response but a reflection of broader social inequalities that shape how individuals perceive themselves and their place in society (Link & Phelan, 2001).

In Zimbabwe, evidence from the Zimbabwe Stigma Index (ZNNP+, 2021) indicates that self-stigma is the most prevalent form of stigma experienced by sex workers living with HIV. It commonly manifests through fear of disclosure, feelings of guilt, and internalised shame. These

experiences are reinforced by dominant societal narratives that portray sex workers as immoral or socially deviant, further deepening internalised negative beliefs. Such narratives are often embedded in cultural norms and institutional practices, making them difficult to challenge. As Corrigan (2004) notes, internalised stigma can significantly reduce self-efficacy and limit individuals' ability to seek help or engage with support systems. In this way, self-stigma becomes a barrier not only to psychological wellbeing but also to social participation and access to essential services.

Critically, self-stigma operates in a cyclical manner, where public stigma and internalised stigma continuously reinforce each other. Public stigma expressed through discrimination, exclusion, and judgement creates an environment in which individuals are likely to internalise negative beliefs. In turn, self-stigma influences behaviour, leading individuals to withdraw from healthcare services, avoid disclosure, and disengage from community support. This withdrawal can reinforce societal stereotypes, as reduced visibility and engagement of sex workers living with HIV may perpetuate assumptions about irresponsibility or non-compliance. Turan et al. (2019) emphasise that this cycle of stigma significantly undermines HIV response efforts by reducing uptake of testing, treatment adherence, and retention in care.

The implications of this cyclical relationship are profound for both individual and public health outcomes. Self-stigma not only affects mental health contributing to depression, anxiety, and social isolation but also limits participation in HIV programmes and reduces the effectiveness of interventions. As Parker and Aggleton (2003) argue, stigma must be understood as a social process that is deeply embedded in power relations and institutional structures. Therefore, breaking the cycle of self-stigma requires comprehensive approaches that address both external discrimination and internalised beliefs. Interventions must integrate psychosocial support,

community empowerment, and structural reforms to effectively reduce stigma and improve health outcomes among sex workers living with HIV.

2.6 Psychological and Social Impacts of Self-Stigma

Self-stigma has profound psychological consequences for individuals living with HIV, particularly among already marginalised populations such as sex workers. When individuals internalise negative societal beliefs, it often results in emotional distress characterised by depression, anxiety, low self-esteem, and feelings of worthlessness. These psychological effects are not isolated but are deeply interconnected, reinforcing one another and creating a cycle of vulnerability. According to Earnshaw and Chaudoir (2009), internalised stigma significantly undermines mental health by shaping how individuals perceive themselves and their illness, ultimately reducing their ability to cope with chronic conditions such as HIV. This diminished coping capacity can lead to maladaptive behaviours, including denial, avoidance of care, and disengagement from treatment, further worsening health outcomes.

Among sex workers living with HIV, the psychological impacts of self-stigma are often intensified by broader socio-economic challenges, including poverty, gender inequality, and limited access to support services. These intersecting vulnerabilities exacerbate feelings of shame and hopelessness, making it more difficult for individuals to seek help or maintain treatment adherence. Kabunga et al. (2025) found that self-stigma among female sex workers is strongly associated with increased psychological distress, including symptoms of depression and anxiety, as well as reduced utilisation of healthcare and psychosocial support services. This highlights the dual burden faced by this population, where both internalised stigma and structural disadvantages interact to undermine mental wellbeing and health-seeking behaviours.

In addition to its psychological effects, self-stigma has significant social implications. Individuals who internalise stigma are more likely to withdraw from social relationships and community networks due to fear of judgement, rejection, or disclosure. This social withdrawal can lead to isolation, reduced social support, and weakened coping mechanisms. As social support is a critical factor in managing chronic illnesses, its absence can further exacerbate both psychological distress and poor health outcomes (Link & Phelan, 2001). Among sex workers, this isolation may be particularly severe, as stigma related to both HIV status and occupation limits their ability to access family, community, and institutional support systems. Consequently, self-stigma not only affects individual mental health but also disrupts social integration, reinforcing cycles of marginalisation and vulnerability.

2.7 Self-Stigma and ART Adherence

Adherence to antiretroviral therapy (ART) is a cornerstone of effective HIV management, enabling viral suppression, improving quality of life, and reducing HIV-related morbidity and mortality. Sustained adherence also plays a critical role in preventing onward transmission, aligning with global treatment-as-prevention strategies. However, despite the availability of ART, adherence remains uneven, particularly among key populations such as sex workers. One of the most significant barriers identified in the literature is self-stigma, which undermines individuals' willingness and ability to consistently engage with treatment and care services (UNAIDS, 2022).

Self-stigma affects ART adherence through multiple behavioural pathways. Individuals who internalise negative beliefs about their HIV status often experience shame, fear, and denial, which can lead to avoidance of healthcare services. According to UNAIDS (2022), people experiencing high levels of internalised stigma are more likely to miss clinic appointments,

delay treatment initiation, and default on medication. These behaviours are often driven by fear of disclosure and the anticipation of being judged or discriminated against. In this way, self-stigma operates as a psychological barrier that disrupts the continuity of care, even when treatment is accessible. Earnshaw and Chaudoir (2009) further argue that internalised stigma diminishes self-efficacy, making it more difficult for individuals to adopt and sustain health-promoting behaviours such as medication adherence.

The relationship between self-stigma and ART adherence is particularly pronounced among sex workers, who face additional layers of stigma related to their occupation. Nyblade et al. (2019) note that fear of being identified as HIV-positive discourages individuals from accessing healthcare services, especially in contexts where confidentiality is not guaranteed. For sex workers, this fear is compounded by concerns about discrimination or mistreatment by healthcare providers, which has been documented in several studies across sub-Saharan Africa. Experiences or expectations of stigma within healthcare settings can lead to delayed care-seeking, inconsistent follow-up, and reduced trust in health systems (Shannon et al., 2015). As a result, even when ART services are available, uptake and adherence may remain low due to the psychosocial barriers created by stigma.

Poor adherence to ART has serious implications not only for individual health outcomes but also for broader public health efforts. Inconsistent treatment can lead to viral rebound, increased risk of opportunistic infections, and the development of drug resistance. Furthermore, individuals who are not virally suppressed have a higher likelihood of transmitting HIV, thereby undermining efforts to control the epidemic. As Parker and Aggleton (2003) argue, stigma is a fundamental driver of health inequalities, and its impact extends beyond individual experiences to affect population-level outcomes. Addressing self-stigma is therefore essential for improving ART adherence and achieving global HIV targets. This requires integrated

interventions that combine psychosocial support, stigma reduction within healthcare settings, and structural changes aimed at creating more inclusive and non-discriminatory health systems.

2.8 Coping Mechanisms for Self-Stigma

Coping mechanisms play a critical role in mitigating the psychological and social effects of self-stigma among people living with HIV, particularly among sex workers who face compounded vulnerabilities. These strategies can broadly be categorised into adaptive and maladaptive coping mechanisms, depending on whether they promote wellbeing or reinforce negative outcomes. Adaptive coping mechanisms include peer support groups, counselling and psychosocial support, and community empowerment programmes. These approaches aim to strengthen resilience, enhance self-acceptance, and improve individuals' capacity to manage stigma-related stress. In contrast, maladaptive coping mechanisms such as social withdrawal, substance abuse, and denial or non-disclosure may provide short-term relief but ultimately exacerbate psychological distress and hinder engagement with healthcare services (Earnshaw & Chaudoir, 2009).

2.8.1 *Peer support groups*

Among adaptive strategies, peer-led interventions have been identified as particularly effective in addressing self-stigma. These groups are typically composed of individuals with shared lived experiences creating a non-judgmental environment where members can openly discuss challenges related to stigma, disclosure and treatment adherence. Peer support groups create safe spaces where individuals can share experiences, receive emotional support, and develop positive coping strategies. Shannon et al. (2015) argue that peer-based approaches enhance

self-efficacy, reduce social isolation, and improve health-seeking behaviour among sex workers.

2.8.2 *Counselling and Psychosocial support*

Similarly, psychosocial counselling, especially when grounded in cognitive and behavioural approaches, helps individuals challenge internalised negative beliefs and build self-esteem (Corrigan, 2004). This approach focuses on improving mental health, strengthening coping capacity and promoting self-acceptance among sex workers living with HIV. Counselling particularly when grounded in CBT enables individuals to identify and challenge distorted beliefs associated with self-stigma such as feelings of shame, guilt and worthlessness.

2.8.3 Community empowerment programmes

Community empowerment programmes further complement these efforts by addressing structural barriers and fostering collective agency among sex workers living with HIV, enabling them to advocate for their rights and access services more confidently (Kerrigan et al., 2015). These programmes focus on building agency, social cohesion and collective identify enabling individuals to actively participate in decisions that affect their health and livelihoods. These platforms help reduce self-stigma by fostering a sense of belonging and challenging internalised negative beliefs thus improving access to healthcare services, increase use of condoms and reduced vulnerability to violence. Together, these adaptive mechanisms not only reduce self-stigma but also contribute to improved mental health and treatment adherence.

Despite the proven effectiveness of these interventions, access to supportive coping mechanisms remains uneven, particularly in rural and peri-urban areas such as Mazowe

District. Limited availability of mental health services, inadequate funding, and weak health infrastructure constrain the reach of peer support and counselling programmes. As a result, individuals in these settings may be more likely to rely on maladaptive coping strategies, including withdrawal from social networks and avoidance of healthcare services. Nyblade et al. (2019) emphasise that without accessible and contextually appropriate support systems, efforts to reduce self-stigma are unlikely to succeed. This highlights the need for expanding community-based and peer-led interventions in underserved areas, ensuring that coping support is both accessible and responsive to the lived realities of HIV-positive sex workers.

2.9 Programmes Support and Policy Responses to HIV-Related Stigma

In Zimbabwe efforts have been made in trying to address self-stigma among sex workers and there is need for more comprehensive interventions. NAC (2015) found out self-stigma among sex workers living with HIV can be reduced thorough support groups, peers, family members and the community at large hence they fund for programmes that target key populations such as sex workers for HIV treatment, care and support interventions. There is need for more strategies that can be used in trying to understand how to reduce or end self-stigma among sex workers living with HIV and these strategies can be implemented or strengthened through the already existing programmes that are aiming on reducing the stigma.

Zimbabwe has made notable progress in addressing HIV-related stigma through a combination of national policies and targeted programmes, particularly those coordinated by the National AIDS Council (NAC). These efforts are aligned with global commitments to reduce stigma and discrimination as part of comprehensive HIV responses, including the UNAIDS 95–95–95 targets. Given the disproportionate burden of HIV among key populations such as sex workers, stigma reduction has increasingly been recognised as a critical component of effective

prevention, treatment, and care strategies. However, while these interventions have yielded measurable gains, critical gaps remain particularly in addressing internalised or self-stigma.

2.9.1 *Peer led and peer education*

A central feature of Zimbabwe's response has been the implementation of peer education programmes, which are widely regarded as effective in reaching marginalised populations. Peer education involves training individuals from within key populations to deliver HIV-related information, provide support, and facilitate linkage to services. Among sex workers, peer educators play a crucial role in building trust, reducing fear, and encouraging uptake of HIV services. Evidence suggests that peer-led interventions improve HIV knowledge, increase testing uptake, and enhance adherence to antiretroviral therapy (ART) (Shannon et al., 2015). In addition, peer support can help reduce feelings of isolation and shame, thereby indirectly addressing self-stigma. However, while peer education has demonstrated success in improving behavioural outcomes, its impact on deeply internalised stigma remains less consistent, as it often prioritises information dissemination over psychological transformation.

2.9.2 *Community mobilization and empowerment approaches*

Closely related to peer education are community mobilisation initiatives, which aim to empower sex workers living with HIV collectively and challenge structural barriers to health. Community mobilisation involves organising sex workers into networks or groups that advocate for their rights, provide mutual support, and engage with health systems. This approach is grounded in the recognition that stigma is not only an individual experience but also a social and structural phenomenon (Parker & Aggleton, 2003). Studies have shown that community empowerment interventions can lead to improved access to healthcare, increased

condom use, and reduced experiences of violence among sex workers living with HIV (Kerrigan et al., 2015). In the Zimbabwean context, such initiatives have contributed to strengthening social cohesion and resilience among sex workers. Nevertheless, their effectiveness may be constrained in settings where sex work is criminalised and highly stigmatised, limiting the visibility and sustainability of such collective efforts.

2.9.3 *Public awareness and Stigma reduction campaigns*

Another key strategy has been the implementation of stigma reduction campaigns, often conducted at community and national levels. These campaigns typically aim to raise awareness, challenge misconceptions about HIV, and promote non-discriminatory attitudes. Public health messaging has focused on normalising HIV as a manageable chronic condition and encouraging acceptance of people living with HIV. While these campaigns are important for addressing public stigma, their impact on self-stigma is more indirect. According to UNAIDS (2022), reducing societal stigma is a necessary but insufficient condition for eliminating internalised stigma, as individuals may continue to hold negative self-perceptions even in less discriminatory environments. This highlights a limitation of awareness-based approaches, which may not adequately address the psychological dimensions of stigma.

2.9.4 *Psychosocial Support and Counselling Interventions*

In recognition of the need for more holistic approaches, Zimbabwe has increasingly sought to integrate psychosocial support into HIV services. This includes counselling, mental health support, and the establishment of support groups for people living with HIV. Psychosocial interventions are particularly relevant for addressing self-stigma, as they focus on emotional

wellbeing, self-acceptance, and coping strategies. Evidence indicates that participation in support groups can significantly reduce internalised stigma by providing safe spaces for sharing experiences and fostering a sense of belonging (Nyblade et al., 2019). Similarly, counselling interventions grounded in cognitive behavioural approaches have been shown to help individuals challenge negative beliefs and improve self-esteem (Corrigan, 2004). In Zimbabwe, NAC-supported programmes have incorporated such elements, recognising the importance of addressing both the social and psychological aspects of HIV.

2.10 Gaps in Literature

Despite a substantial body of literature on HIV-related stigma, significant gaps remain in understanding the complexity of self-stigma among sex workers living with HIV, particularly in specific local contexts such as Mazowe District, Zimbabwe. A critical review of existing studies reveals several limitations, including an overemphasis on public stigma, limited qualitative inquiry into lived experiences, an urban bias in research, insufficient attention to self-stigma interventions, and a lack of context-specific evidence. These gaps not only constrain theoretical development but also undermine the effectiveness of interventions aimed at improving health outcomes among key populations.

One of the most prominent gaps in the literature is the overemphasis on public stigma at the expense of internalised or self-stigma. Much of the existing research has focused on enacted stigma such as discrimination by healthcare providers or community members and anticipated stigma, which relates to fear of discrimination (Parker & Aggleton, 2003). While these dimensions are undoubtedly important, they do not fully capture the internal psychological processes through which stigma becomes embedded in individuals' self-concepts. Self-stigma,

defined as the internalisation of negative societal beliefs, has been shown to have profound effects on mental health, self-esteem, and health-seeking behaviour (Corrigan, 2004). However, it remains relatively underexplored compared to public stigma. This imbalance in the literature creates a narrow understanding of stigma, limiting the development of interventions that address the internal barriers to care. As noted by Turan et al. (2019), internalised stigma is a critical determinant of HIV outcomes and requires greater scholarly attention.

Closely related to this is the limited use of qualitative research methods to explore lived experiences of self-stigma. A significant proportion of HIV-related stigma studies rely on quantitative approaches, such as surveys and stigma scales, which, while they are useful for measuring prevalence and correlations, they often fail to capture the depth and complexity of individuals' experiences (Earnshaw & Chaudoir, 2009). Self-stigma is inherently subjective and deeply embedded in personal narratives, emotions, and social interactions. Without qualitative approaches such as in-depth interviews and phenomenological studies, it is difficult to understand how individuals interpret and respond to stigma in their daily lives. Nyblade et al. (2019) emphasise that qualitative research is essential for uncovering the nuanced ways in which stigma operates within specific contexts, including how it influences decision-making related to disclosure, treatment adherence, and social relationships. The lack of such approaches in existing studies represents a significant gap, particularly for marginalised populations like sex workers whose voices are often underrepresented in research.

Another critical limitation is the urban bias in HIV stigma research. The majority of studies on HIV and stigma have been conducted in urban or peri-urban settings, where healthcare infrastructure, support services, and research institutions are more accessible (Shannon et al.,

2015). While these studies provide valuable insights, their findings may not be generalisable to rural or semi-rural areas, where socio-cultural dynamics, economic conditions, and access to healthcare differ significantly. In rural contexts such as Mazowe District, factors such as limited healthcare facilities, stronger adherence to traditional norms, and heightened social visibility may intensify stigma and its effects. The urban bias in research therefore creates a gap in understanding how self-stigma manifests in less-studied settings. As a result, interventions developed based on urban data may not be appropriate or effective in rural contexts, highlighting the need for location-specific research.

In addition, there is an insufficient focus on interventions specifically targeting self-stigma. While many HIV programmes aim to reduce stigma broadly, they often prioritise public stigma reduction through awareness campaigns, healthcare worker training, and policy reforms (UNAIDS, 2022). Although these strategies are important, they do not directly address the internalised beliefs and emotional experiences associated with self-stigma. Interventions that specifically target self-stigma such as cognitive behavioural therapy, peer support groups, and psychosocial counselling remain relatively limited in both research and practice. Evidence suggests that such interventions can significantly improve mental health outcomes and treatment adherence (Nyblade et al., 2019), yet they are not widely implemented or evaluated, particularly in low-resource settings. This gap indicates a disconnect between theoretical understanding of self-stigma and practical intervention strategies, underscoring the need for more targeted and evidence-based approaches.

There is a notable lack of context-specific evidence, particularly in relation to smaller or less-studied regions such as Mazowe District. Much of the existing literature on HIV-related stigma in Zimbabwe and sub-Saharan Africa tends to focus on national-level data or studies conducted

in major urban centres such as Harare and Bulawayo. While these studies provide a general overview, they may overlook local variations in culture, economic activity, and social structures that influence experiences of stigma. For instance, Mazowe District, characterised by mining and commercial farming activities, presents a unique socio-economic environment that may shape the experiences of sex workers differently from those in urban settings. Context-specific research is essential for developing culturally appropriate interventions that respond to the realities of the target population. Parker and Aggleton (2003) argue that stigma is deeply embedded in local social contexts, and therefore cannot be fully understood or addressed without contextually grounded research.

The literature on HIV-related stigma, while extensive, exhibits several critical gaps that limit its applicability to understanding self-stigma among sex workers living with HIV in specific contexts. The overemphasis on public stigma, limited qualitative exploration of lived experiences, urban bias, insufficient focus on self-stigma interventions, and lack of context-specific evidence all point to the need for more nuanced and locally grounded research. Addressing these gaps is essential for developing comprehensive and effective interventions that not only reduce stigma but also improve health outcomes and overall wellbeing among marginalised populations. This study seeks to contribute to this gap by providing an in-depth, context-specific analysis of self-stigma among sex workers living with HIV in Mazowe District, Zimbabwe.

2.11 Chapter Summary

This chapter has reviewed literature on HIV-related stigma, with a focus on self-stigma among sex workers. It has highlighted the complex and multi-dimensional nature of stigma and its

significant impact on health outcomes. While existing research provides valuable insights, gaps remain in understanding self-stigma in specific local contexts. This study seeks to fill these gaps by providing in-depth, context-specific evidence to inform interventions aimed at reducing self-stigma and improving the wellbeing of sex workers living with HIV.

CHAPTER THREE

RESEARCH METHODOLOGY

3.0 Introduction

This chapter gives an outline of this study's research methodology which is a qualitative research approach within a case study design to allow for an in-depth exploration of participant's perceptions, emotions, and coping mechanisms in their natural social context. Therefore, this chapter outlines a breakdown of components of the qualitative research methodology adopted by the study including the research design, population of the study, sampling procedures, data collection procedures and instruments, data analysis and presentation as well as research ethics observed in undertaking this study.

3.1 Research Philosophy

The study was guided by the interpretivist research philosophy. Interpretivist is based on the assumption that reality is socially constructed and that individuals assign different meanings to their experiences based on their social, cultural and personal contexts. The human philosophy seeks to understand human behaviour rather than through objective measurement. According to Creswell and Poth (2018), interpretivism enables researchers to explore participants' subjective meanings, beliefs and lived experiences in their natural settings. The interpretivist philosophy was suitable for this study because it sought to understand how sex workers living with HIV perceive, experience, and cope with self-stigma. Self-stigma is a subjective phenomenon shaped by individual experiences, emotions and social interactions. Therefore, understanding participants' interpretations of their realities was essential in

gaining insight into the manifestations, impacts and coping mechanisms associated with self-stigma.

Interpretivism emphasizes direct engagement with participants to explore participants' feelings of shame, fear of disclosure, social isolation and experiences with healthcare services. The philosophy also enabled the researcher to understand the meanings participants attached to their HIV status and involvement in sex work within their social and cultural environment. According to Saunders, Lewis and Thornhill (2019), interpretivism acknowledges that reality is multiple and socially constructed, making it suitable for qualitative studies that aim to understand complex social phenomena. Since self-stigma is influenced by personal beliefs, social relationships and societal attitudes, the interpretivist philosophy provided an appropriate framework for exploring participants' lived experiences and understanding the meanings they attached to those experiences. Therefore, the interpretivist philosophy was adopted because it enabled an in-depth exploration of the subjective experiences of sex workers living with HIV and facilitated a deeper understanding of self-stigma within the context of Mazowe District.

3.2 Research Approach

A research approach refers to the overall plan and frame work that guides how a study is conducted, including the assumptions about knowledge, the type of data collected and the methods used to analyse the data (Creswell and Creswell, 2018). The researcher used qualitative research in trying to understand the internalised stigma among sex workers living with HIV. Qualitative research is defined as an approach that seeks to explore and understand the meanings individuals or groups ascribe to social or human problems through the collection of non- numerical data such as interviews, observations and narratives (Creswell, 2014). This approach will be used to explore the drivers, impacts of self-stigma and effectiveness of the

existing NAC supported programmes in trying to reduce the stigma among sex workers living with HIV. Moreso, the qualitative approach enables an in-depth exploration of how sex workers living with HIV experience, interpret and respond to self-stigma within the socio-cultural context of Mazowe.

In addition, the qualitative research approach is best suited for this study for several reasons. Firstly, the study seeks to explore the lived experiences, feelings, beliefs and coping mechanisms related to self-stigma among sex workers living with HIV. Such phenomena are deeply personal and context-specific, making qualitative inquiry the most appropriate approach (Denzin and Lincoln, 2018). Moreover, HIV-related self-stigma among sex workers is influenced by intersecting factors such as gender, health status, poverty, criminalization of sex work, and societal norms. Qualitative research allows for a nuanced understanding of these intersecting forms of stigma and how they shape everyday experiences and decision-making, including ART adherence and healthcare utilization. The approach allows participants to express their voices in their own words, which is particularly important when researching marginalised and stigmatized populations whose experiences are often under-represented in policy and programme design. This aligns with the study's objective of generating localised, context specific knowledge that can inform stigma reduction interventions.

3.3 Research Design

A research design denotes the work plan of carrying out research in pursuit of the research objectives (Nind et al, 2016). A case study design is embraced for this study. According to Yin (2018), a case study encompasses an exhaustive analysis of a certain phenomenon. In the view of Nind et al (2016), case study research may be defined as a type of research strategy that seeks to resolve the problems that are observed in practice through investigations of the day-

to-day settings and conditions of a given scenario or situation. A case study design was used for this study because it permitted the constricting of a wider arena by concentrating on a researchable subject like the life experiences of sex workers and factors that lead to self-stigma. Additionally, a case study brought an in-depth appreciation of an intricate problem via a thorough examination of the research variables such as reasons of self- stigmatising.

3.4 Study Setting

The research was conducted in Mazowe District, Mashonaland Central, Zimbabwe and focused on known sex work hotspots and clinics linked to NAC supported key population programmes. Mazowe district is situated approximately 30-40 kilometres north of Harare and is characterised by a mix of rural, peri-urban, mining settlements and farming communities. The district has a diverse population largely dependent on commercial agriculture, mining activities, informal trading and seasonal labour which contribute to high population mobility. Mazowe has several growth points, transport corridors, farming estates and mining areas that have led to the emergence of sex work hotspots, particularly around farms, business centres, truck routes and mining settlements. These areas are associated with increased transactional sex, heightened HIV vulnerability and a concentration of key populations, including female sex workers. Health facilities within the district are linked to National Aids Council supported key population programmes providing HIV prevention, treatment and care services. Geographically the district's proximity to Harare and its semi-rural nature present unique social and cultural dynamics where traditional norms, gender inequality, poverty and stigma strongly influence health seeking behaviour and social inclusion. These characteristics make Mazowe a relevant and appropriate setting for exploring experiences of HIV-related self-stigma among sex workers. The researcher purposively selected Mazowe District

because it hosts a significant population of sex workers living with HIV who are actively engaged with NAC supported programmes, making it feasible to access participants ethically and safely

3.5 Target Population

A target population refers to the entire group of individuals who share specific characteristics and to whom the findings of a study are intended to apply (Creswell and Creswell, 2018). Similarly, Polit and Beck (2021) define a target population as a group of people with common attributes that of direct relevance to the research problem. Corbin and Strauss (2015) state that a study population refer to individuals or groups with shared characteristics, and which are of the interest to the researcher. The target population of this study constituted of sex workers living with HIV aged 18 years and above who are living and working in Mazowe district as well as key informants drawn from the National Aids Council (NAC) and partner organisations implementing HIV programmes for sex workers. The researcher selected sex workers living with HIV as the primary participants because they are directly affected by self-stigma related to both HIV status and sex work. As a key population disproportionately impacted by HIV, sex workers experience layered stigma that influences their mental health, social relationships, ART adherence and engagement with healthcare services. Including participants who are 18 years and above ensures ethical compliance and allows participants to provide informed consent. Their lived experiences are central to addressing the study objectives, which seek to explore the manifestations, impacts, and coping mechanisms of self-stigma. Qualitative engagement with this group enables the collection of good, in-depth data that cannot be adequately captured trough secondary sources.

Key informants of this study included NAC officials, programme coordinators, healthcare workers, and outreach staff involved in the implementation of HIV prevention, treatment and

psychosocial support programmes for sex workers in Mazowe district. Key informants are individuals who possess specialised knowledge, experience or insight relevant to the research topic (Kumar, 2019). These informants provided valuable perspectives on the design and implementation of reduction interventions, observed challenges related to self-stigma among sex workers, gaps in existing HIV programmes, and policy and programmatic responses to HIV-related stigma. Their inclusion enhances data triangulation, strengthens the credibility of the findings and links individual lived experiences with institutional and policy level realities.

3.6 Sampling

Sampling is the process of selecting a subset of participants or individuals from the target population to generate data that adequately addresses the research objectives. In qualitative research, sampling focuses on selecting "information-rich" cases to gain an in-depth understanding of the phenomenon under investigation rather than statistical generalization (Ahmad & Wilkins, 2024).

3.6.1 *Sampling Procedure*

This study utilized a mixed purposeful sampling strategy, combining both purposive and convenience sampling techniques. This combined approach is effective for selecting participants in qualitative studies, particularly when dealing with specific populations that might be considered hidden or hard-to-reach (Gerassi et al., 2016; Nyimbili & Nyimbili, 2024).

3.6.2 *Purposive Sampling*

Purposive sampling was the primary method employed to select participants who are judged to be knowledgeable about the issues under investigation and meet specific eligibility criteria (Sarfo et al., 2022). This deliberate process involves selecting individuals or groups based on their ability to provide needed information and their essential knowledge on the phenomenon (Gerassi et al., 2016; Makhakhe et al., 2022; Sebele-Mpofu, 2021). Given that this qualitative study aims to explore the lived experiences of self-stigma among sex workers living with HIV, purposive sampling is highly appropriate. It ensures that individuals with direct experience of the phenomenon are intentionally selected, allowing for the collection of rich, detailed insights crucial for an in-depth understanding of complex social processes and emotions (Ahmad & Wilkins, 2024; Islam et al., 2021). This method is commonly employed in studies concerning sexual exploitation and sex work, especially when the goal is to examine phenomena that are rare or hidden from general view (Gerassi et al., 2016). By focusing on sex workers living with HIV who are aged 18 years and above, the study prioritizes the depth and quality of data from participants who can offer unique and valuable information (Suen et al., 2014).

Sex workers living with HIV were recruited through existing networks and programs, specifically NAC-supported clinics, outreach programs, and identified sex work hotspots in Mazowe district. Healthcare workers and outreach staff facilitated the identification of eligible participants, while ensuring confidentiality and voluntary participation are maintained throughout the process. Purposive sampling was also used to select all key informants, including NAC officials, healthcare workers, and program coordinators, based on their professional roles, experience, and direct involvement in HIV and stigma reduction interventions targeting sex workers (Sarfo et al., 2022; Sebele-Mpofu, 2021).

3.6.3 *Convenience Sampling*

Convenience sampling was used as a complementary strategy to purposive sampling, allowing for the selection of participants who are readily accessible to the researcher (Islam et al., 2021; Sebele-Mpofu, 2021). The use of convenience sampling is pragmatically justified in this study due to the inherent challenges associated with recruiting individuals from a vulnerable and often stigmatized population, such as sex workers living with HIV (Stratton, 2021). This method can be practical, not costly, and less time-consuming, particularly when participants are already engaged in accessible programs (Stratton, 2021). While convenience sampling can introduce selection bias and may limit the generalizability of findings to broader populations (Stratton, 2021, Subedi, 2023, Suen et al., 2014), its application in this study is specifically for a subset of participants who also meet the purposive criteria and are available through existing NAC-supported programs. This dual approach ensures that while the focus remains on information-rich participants, practical considerations for access to a hard-to-reach group are also addressed. The potential for limited generalizability will be acknowledged, and conclusions will be cautiously applied to the specific local context of the study (Robinson, 2013).

Participants who are sex workers living with HIV and are already engaged in NAC-supported programs were approached for inclusion. Their selection was based on their convenient accessibility, provided they also meet the specific criteria established for purposive sampling, ensuring they can contribute meaningfully to the study's objectives.

3.6.3 Sample Size

A research sample is a specimen or part of the whole drawn to represent the rest (Pandey and Pandey, 2015). In qualitative research sample size is not predetermined statistically but is

guided by the principle of data saturation, which occurs when no new themes or insights emerge from additional data collection (Guest, Bunce and Johnson, 2006). This study recruited 15 female sex workers living with HIV. The range is considered adequate for achieving depth and thematic saturation in qualitative studies exploring lived experiences. Additionally, 5 key informants from NAC and partner organisations were included to provide institutional and programmatic perspectives. The final sample size may vary depending on the point at which data saturation is reached. This flexible approach ensures that the study prioritises the quality and richness of data over numerical adequacy. In qualitative research the adequacy of sample size is guided by the principle of data saturation. Data saturation occurs when the additional data collection no longer yields new information, themes or insights relevant to the research objectives (Guest, Bunce and Johnson, 2006). At this point further interviews become repetitive and do not contribute significantly to the understanding of the phenomenon. The concept of saturation is rooted in grounded theory and has been widely used across qualitative research designs including case studies (Corbin and Strauss, 2015). The researcher recruited participants until thematic saturation was achieved, meaning that patterns related to self-stigma, its impacts and coping mechanisms among sex workers living with HIV are fully developed and well understood. Flexibility in sample size is essential in this study because the final number of participants depend on when the saturation is reached during data collection. This approach ensures credibility and depth of analysis.

3.7 Data Collection Techniques

Data collection techniques refer to the systematic methods used to gather information relevant to the research objectives (Kumar, 2019. In qualitative research, data collection focuses on obtaining rich, detailed and contextualised information that captures participants ‘experiences, meanings, and perspectives (Creswell, 2014). This study adopts a qualitative case study which

allows for an in-depth exploration of a bounded social phenomenon within its real-life context (Yin, 2018) a case study design is particularly suitable for investigating complex and sensitive issues such as HIV related self-stigma among sex workers, as it enables the use of multiple qualitative data collection techniques to gain a holistic understanding of the phenomenon.

3.7.1 *In-depth Interviews*

In-depth semi-structured interviews involve the use of open-ended question guided by the interview schedule, allowing participants the flexibility to express their experiences in their own words (Kvale and Brinkmann, 2015). An interview is a way of assembling evidence by the inquiring numerous questions from informants (Yin, 2018). In this study, in-depth interviews were conducted with sex workers living with HIV to explore their lived experiences of self-stigma, its perceived impacts, and coping mechanisms. This technique is appropriate for discussing sensitive topics, as it creates a safe and confidential environment that encourages openness and trust. The researcher used interviews to collect data from other research subjects.

3.7.2 *Key Informant Interviews*

Key informant interviews were conducted with NAC officials, healthcare providers and programme implementers involved in HIV services for sex workers in Mazowe. According to Kumar (2019), key informants provide expert knowledge and contextual insights that enhance institutional practices and policy responses. These interviews provided complimentary perspectives on stigma reduction interventions, programme effectiveness and service delivery services.

3.8 Trustworthiness of the Research

In qualitative research trustworthiness is important as it explains how rigor was ensured in the study. According to Lincoln and Guba (1985), trustworthiness is used to evaluate the quality, rigor and credibility of qualitative findings. The concept of trustworthiness consists of four criteria namely credibility, transferability, dependability, and confirmability.

3.8.1 *Credibility*

Credibility refers to the confidence that can be placed in the truthfulness of the findings (Lincoln and Guba, 1985). It is concerned with ensuring that the participants' experiences and perspectives are accurately represented by the researcher. To enhance credibility the researcher conducted in-depth interviews with sex workers living with HIV and key informants who have relevant knowledge regarding HIV programming and stigma reduction initiatives. Data triangulation was achieved through the inclusion of both primary participants and key informants. In addition, the researcher used probing questions during the interviews to obtain detailed information and ensure accurate interpretation of participants' experiences.

3.8.2 *Transferability*

Transferability refers to the extent to which the findings can be applied to other contexts with similar characteristics (Cresswell and Poth, 2018). The researcher enhanced transferability by providing detailed descriptions of the study setting, participants, sampling procedures and data collection methods. Such descriptions aloe readers to determine whether the findings can be applicable to other populations or settings experiencing similar challenges related to self-stigma and HIV.

3.8.3 *Dependability*

Dependability is concerned with the consistency and stability of the research findings over time (Given, 2008). To ensure dependability, the researcher maintained a detailed record of the research process including the study design, sampling procedures and data analysis procedures. An audit trail was maintained to document all stages of the research process, allowing other researchers to follow and assess the procedures used in the study.

3.8.4 *Confirmability*

Confirmability refers to the extent to which the findings are shaped by the participants' experiences rather than the researchers bias or personal assumptions (Cresswell and Poth, 2018). To enhance confirmability, the researcher used verbatim quotations from participants and key informants to support the findings. Furthermore, reflexivity was practiced throughout the research process to minimize personal biases and ensure that interpretations remained grounded in the data collected from participants.

3.9 Data Collection Tools

Data collection tools refer to the instruments or devices used by a researcher to systematically gather information relevant to the research objectives (Kumar,2019). In qualitative research, data collection tools are designed to facilitate the exploration of participants' experiences, perceptions, and meanings through flexible and open-ended inquiry rather than fixed measurement (Creswell, 2014). This research utilised interview guides as the primary data collection tools, specifically an in-depth interview guide for institutional stakeholders.

3.9.1 *In-depth Interview guides*

An in-depth interview guide is a semi-structured instrument consisting of open-ended questions that guide the interview while allowing flexibility for probing and follow up questions (Kvale and Brinkmann, 2015). The in-depth interview guide for this study comprised of approximately 10 open-ended questions designed to get rich and detailed narratives from sex workers living with HIV. The guide focused on participants' understanding and experiences of HIV-related stigma, manifestations and sources of self-stigma linked to HIV status and sex work. It also focused on perceived effects of self-stigma on mental health, relationships and healthcare-seeking behaviours, experience with disclosure, discrimination, and social exclusion and coping strategies and support mechanisms used to manage self-stigma. The questions were phrased in clear, non-judgemental language to ensure cultural sensitivity and to encourage open and honest responses. Probing questions were used to deepen understanding and clarify participants accounts.

3.9.2 *Key informant interview guide*

A separate key informant interview guide was used to collect data from NAC officials, healthcare providers and programme implementers. This guide consisted of 8 open-ended questions and these questions focused on observed patterns and forms of self-stigma among sex workers, existing stigma-reduction interventions and support services. They also focused on challenges in addressing self-stigma within HIV programmes, gaps in policy and service delivery, and recommendations for strengthening psychosocial and stigma-reduction strategies. Using separate interview guides ensures that questions are tailored to the knowledge and roles of different participant groups, thereby enhancing the relevance and quality of the data collected.

3.10 Data Collection Procedure

Data collection procedure refers to the systematic and sequential steps followed by a researcher to gather data in a consistent, ethical and methodologically sound manner (Kumar, 2019). According to Creswell and Poth (2018), a clearly defined data collection procedure enhances the credibility and transparency of qualitative research by ensuring that data are collected in an organised and replicable way. Data collection is the 'how' part or the procedures used to collect data (Vaus, 2016). The primary instruments for collecting data were interview guides. The researcher personally administered English-written questionnaires with standardised and closed questions on hard copies to sex workers living with HIV. The researcher shall interpret the questions in Shona language; the vernacular and dominant language used in Mazowe district. Prior to data collection, ethical clearance was obtained from the university. Permission to conduct the study was also sought from the National Aids Council and relevant local authorities in Mazowe district. Ethical approval ensures that the study adheres to accepted principles of research ethics including respect for persons, beneficence, confidentiality and voluntary participation (Bryman,2016). Following the ethical approval, participants were recruited through NAC supported clinics, outreach programmes and community-based networks working with sex workers in Mazowe district. Eligible participants were informed about the purpose of the study, procedures involved, potential risks and benefits, and their rights to withdraw at any stage without penalty. Interviews were scheduled at times and locations convenient and safe for participants to ensure privacy and comfort. Appointments were arranged in advance and flexibility was maintained to accommodate participants' availability.

Informed consent was obtained from all participants prior to data collection. Participants were provided with an information sheet explaining the study in a language they understand. Written

consent was sought, however where literacy or confidentiality concerns arise, verbal consent was documented. Participants were assured of anonymity, confidentiality, and the secure handling of all data. Data was collected through in-depth semi-structured interviews with sex workers living with HIV and key informant interviews with the NAC officials and programme implementers. With participants' permission interviews was audio-recorded to ensure accurate capture of information. Audio recording is recommended in qualitative research to enhance data accuracy and allow for detailed analysis (Kvale and Brinkmann, 2015). In addition to audio recording, the researcher took field notes during and immediately after interviews. Field notes captured non-verbal cues, contextual observations, emotional expressions, and reflective insights that may not be evident in audio recordings alone. According to Cresswell (2014), field notes are essential for enriching qualitative data and supporting reflexivity. All interviews were conducted in a respectful and non-judgemental manner.

3.11 Data Analysis Techniques

Data analysis techniques refer to the systematic processes used to organise, examine, interpret and make meaning of collected data in order to address the research objectives (Kumar, 2019). In qualitative research, data analysis involves identifying patterns, themes, and meanings within textual data such as interview transcripts, field notes and documents (Creswell and Poth, 2018). This study employed thematic analysis as proposed by Braun and Clarke (2006), to analyse qualitative data generated through in-depth interviews and key informant interviews. Thematic analysis was used to make an analysis of qualitative data by identifying repetitive and essential facts from participants who in this study were key informants. According to Thematic analysis is flexible and rigorous qualitative analytic method used to identify, analyse, and report patterns within data. It is particularly suitable for exploring lived experiences and

perceptions, making it appropriate for understanding self-stigma among sex workers living with HIV. The thematic technique helped the researcher in summarising crucial features from the data assembled. Yin (2018) asserts that the thematic approach to data analysis enhances order and meaning to the bulk of facts congregated.

The researcher analysed data guided by the six steps of thematic analysis outlined by Braun and Clarke (2006) which are familiarising with the data which is the first step involving immersing oneself in the data by repeatedly reading interview transcripts and reviewing field notes to gain overall understanding of the content. Audio recorded interviews were transcribed verbatim and initial observations and ideas were noted. Second step is generating initial codes and, in this phase, the researcher systematically coded interesting features of the data across the entire data set. Coding involved identifying meaningful segments of texts related to experiences of self-stigma, its impacts, and coping mechanisms. Codes were applied manually or with the aid of qualitative analysis techniques.

Furthermore, the third step is combining codes into themes and this involves examining the codes and collating them into potential themes. Related codes were grouped together to form broader patterns that reflect significant aspects of the data relevant to the research questions. reviewing themes is the fourth step and at this stage, identified themes were reviewed and refined to ensure they accurately represent the coded data and the entire data set. Some themes may be merged, modified or discarded if they lack sufficient supporting data. The fifth step is, defining and naming themes and in this phase, the researcher clearly defined and named each theme by identifying its core meaning and scope. Detailed analysis was conducted to explain how each theme relates to the research objectives and the phenomenon of self-stigma. reporting of findings is the final step which involves writing up of the analysis by integrating themes with relevant verbatim quotations from participants and linking the findings to existing literature. This phase results in a coherent, logical and analytic narrative that addresses the

study objectives. Thematic analysis is suited for this study because it gives a systematic yet flexible framework for analysing qualitative data and allows participants voices to remain central to the findings.it is appropriate for examining complex and sensitive issues such as self-stigma, where patterns of meaning emerge from participants lived experiences.

3.12 Ethical Considerations of the Study

According to Robson and McCartan (2015), research ethics are wide-ranging considerations undertaking by the research(s) in protecting and preserving the integrity and dignity of research subjects.

3.12.1 *Ethical Approval*

Beauchamp and Childress (2019) define ethical approval as a mandatory institutional procedure that evaluates whether a study adheres to ethical guidelines before data collection begins, particularly in relation to participants' rights and welfare. The researcher sought approval to conduct the study from the National Aids Council and was granted.

3.12.2 *Informed Consent*

According to Beauchamp and Childress (2019) informed consent is a process by which an individual voluntarily confirms their willingness to participate in a particular activity after having been informed of all aspects that are relevant to the decision to participate. The researcher sought respondents' written consent from the participants before they participate in the study.

3.12.3 *Confidentiality*

Confidentiality is the assurance given to research participants that identifiable information collected during a study will not be shared, disclosed, or linked to them in any way (Bryman, 2016). The researcher exercised confidentiality as recommended by Robson and McCartan (2015) that handling respondents' evidence as confidentially and defending their secrecy is one of many main tasks of the researcher. The research subjects who took part in this study were assured that the information they will provide will strictly be used for academic purposes only without being divulged to their spouses or anyone else.

3.12.4 *Anonymity*

According to Wiles et al (2008) anonymity is a condition in which a participant's identity is unknown and cannot be linked to the information they provide. The researcher used pseudonyms because participants belong to a highly stigmatised and vulnerable population. Given the sensitive nature of the research which was involving sex workers living with HIV the use of pseudonyms made sure that the information they provided will not trace back to them. Real names and any identifying information were omitted from interview, field notes and the final research report. Participants were assigned pseudonyms such as Participant 1 and Participant 2 to safeguard them from potential stigma or social exclusion. Key informants were also given pseudonyms such as Key Informant 1 and Key Informant 2 to maintain anonymity.

3.13 Chapter Summary

The chapter has outlined the research design adopted by the study and provided the justification for adopting the qualitative research methodology. The target population,

sampling procedures, sample size, data collection procedures and the research instruments were also were described. The chapter outlined the data analysis and presentation methods used in the study as well as the study's observed research ethics.

CHAPTER FOUR

ANALYSIS, PRESENTATION AND DISCUSSION OF FINDINGS

4.0 Introduction

This chapter shows the findings of a study focused on self-stigma among sex workers living with HIV in Mazowe District, Zimbabwe. It starts with a demographic overview of the participants, then moves on to a thematic analysis and discussion of the results. The results are grouped under three main themes aligned with the research objectives that manifestations of self-stigma, the perceived impacts of self-stigma, and coping mechanisms employed to manage self-stigma. Themes are then broken into three sub-themes and linked to the theoretical framework of the study which is Cognitive Behavioral Therapy.

4.1 Demographic profile of the participants

4.1.1 Primary Participants

The main subjects of this study were 15 sex workers living with HIV aged 18 years and older who lived and worked in Mazowe District. These were intentionally selected because of their first-hand experience with self-stigma of having HIV and being a sex worker. They were recruited through clinics supported by NAC, outreach initiatives, and known sex work areas in the district. The participants in the study were all female aligning with the study's emphasis on female sex workers who are significantly impacted by HIV in Zimbabwe. The ages of the participants ranged from young adult to middle age, and they had different levels of formal education and years of experience in sex work. Each participants had been living with HIV for different durations, ranging from recent diagnosis to long-term management of the illness.

4.1.2 Key Informants

The study involved five key informants who had specialized knowledge and experience related to HIV programmes and stigma reduction efforts aimed at sex workers in Mazowe District.

These informants included National AIDS Council officials, healthcare providers at local clinics, program coordinators at partner organizations providing HIV services to key populations and outreach workers who had direct contact with sex worker communities. They were selected for their professional roles, as well as their experience in HIV programming and involvement in the development or implementation of interventions to reduce stigma among sex workers. Data triangulation and credibility were improved by the insights and institutional and programmatic perspectives offered by these key informants to complement the personal experiences of the primary participants.

4.1.3 Demographic Distribution of Study Participants

Table 1: Key Participants (Sex Workers Living with HIV)

Age	***18-25***	***26-35***	***36-45***	***46+***
	4	**7**	**3**	**1**
Gender	**Female**		**Male**	
	15		**-**	
Level of Education	**No formal**	**Primary education**	**Secondary education**	**Tertiary education**
	2	**5**	**7**	**1**
Years in Sex work	**Less than 1 yr**	**1-3 yrs**	**4-6 yrs**	**7+ yrs**
	2	**5**	**4**	**4**
Years living with HIV	**Less than 1 yr**	**1-3 yrs**	**4-6 yrs**	**7+ yrs**
	2	**5**	**4**	**4**
		Key informants		
Age	**25-30 yrs**	**31-35 yrs**	**35-40 yrs**	**41-46 yrs**
	1	**1**	**1**	**2**

Profession	**Nurse**	**Program Assistant/ coordinator**	**Outreach worker**	**District Aids Coordinator**
	1	**2**	**1**	**1**
Gender	**Male**		**Female**	
	2		**3**	
Organization	**NAC**	**Pangea Zimbabwe**	**CERSHHAR**	**Concession Hospital**
	2	**1**	**1**	**1**
Years of experience				
	4-6 yrs		**7-10 yrs**	**10+ yrs**
	2		**2**	**1**
Level of Education	**Certificate**		**Diploma**	**Degree**
	1		**2**	**2**

4.2 PRESENTATION OF FINDINGS

4.2.1 Manifestations of self-stigma

This theme focuses on the initial research objective which aimed to investigate how self-stigma appears among sex workers living with HIV in Mazowe District. The results show that self-stigma is manifested in various psychological and behavioural ways, highlighting the internalization of negative social perceptions about sex work and HIV status.

4.2.1.1 *Internalized Shame and Guilt*

Internalized shame and guilt were significant indicators of self-stigma among sex workers living with HIV. The participants conveyed strong feelings of shame regarding their HIV status

and guilt over their involvement in sex work, frequently perceiving themselves as morally deficient or deserving of their situation.

The internalization of shame and guilt illustrates how societal stigma becomes ingrained in a person's self-identity. Participants shared that constant exposure to discriminatory views and moral judgment from their communities, healthcare professionals, and even family members caused them to internalize these negative beliefs about themselves. This led to ongoing feelings of shame regarding their HIV-positive status and guilt related to their profession, with many believing they had caused their condition due to their perceived immoral lifestyle. The intertwining of shame and guilt created a complicated emotional burden that impacted how participants viewed themselves and their everyday lives.

Participant 3 said that

"I feel so ashamed whenever I go to the clinic. I think everyone is looking at me and judging me. I know I am HIV-positive and I do this work, so I feel like I deserve this. It's my fault."

Participant 7 explained that

"Sometimes I can't even look at myself in the mirror. I feel guilty about what I do to survive, and having HIV makes it worse. I think God is punishing me for my sins."

Participant 12 stated:

"*The shame is inside me. Even when nobody says anything, I feel it. I feel dirty and unworthy because of my status and my work. I blame myself for getting infected."*

The internalized shame and guilt observed in participants correspond with the principles of Cognitive Behavioral Theory (CBT), which explains how negative thought patterns form and

become ingrained. CBT posits that thoughts, emotions, and behaviors are interconnected, with harmful cognitive distortions affecting emotional reactions and behavioral results (Beck, 2020). In this scenario, participants have absorbed societal stereotypes that label sex workers as immoral and view HIV as a form of punishment. This leads to cognitive distortions like overgeneralization (*"I deserve this")* and personalization *("It's my fault")*. Such distorted thinking fosters feelings of shame and guilt, which further entrench negative self-views and perpetuate a cycle of self-stigmatization.

4.2.1.2 *Fear of Disclosure*

Fear of disclosure emerged as a significant manifestation of self-stigma, with participants expressing intense anxiety about revealing their HIV status to others, including family members, sexual partners, healthcare providers, and community members.

Participants shared that the fear of revealing their HIV status affected various areas of their lives, shaping their social interactions, healthcare-seeking habits, and intimate relationships. This fear stemmed from the anticipated stigma, or the belief that others would respond negatively if they learned about their condition. Many felt that disclosing their status could result in rejection, discrimination, abandonment, or even violence. This anxiety was especially strong regarding family members, whom they worried might disown them, and sexual partners, whom they feared might leave or become abusive. Even in healthcare environments, where confidentiality is supposed to be guaranteed, participants voiced concerns about healthcare professionals gossiping about their status or treating them differently upon discovering they were both HIV-positive and sex workers.

Participant 2 remarked:

"I haven't told anyone in my family about my status. If they find out, they will start treating me differently from others. My mother will die of shame, she doesn't want her reputation to be destroyed at church. So, I keep it a secret, even from my own children."

Participant 5 stated:

"I never tell my clients about my HIV. They will never pay me again, and some might even beat me. I just use protection and pray. I live in constant fear that one day they will find out."

Participant 9 added:

"Even at the clinic, I'm scared. What if the nurse tells other people? I see them whispering sometimes, and I think they are talking about me. The way they will be looking at me gives me a scare that they will tell someone who knows me that's why I prefer to go to a clinic far away where nobody knows me."

These findings show that fear of disclosure is deeply rooted in anticipated stigma and internalized negative beliefs. The findings are complimenting with UNAIDS (2022), which denotes that individuals experiencing self-stigma often avoid disclosure due to fear of discrimination and rejection. The findings also support Corrigan (2004), who argues that internalized stigma leads to individuals concealing their identity to avoid negative reactions from society. From the perspective of Cognitive Behavioral Theory, participants developed distorted negative thoughts about themselves based on societal attitudes which reinforced secrecy and avoidance behaviors.

4.2.1.3 *Social Withdrawal and Isolation*

Social withdrawal and isolation emerged as a significant manifestation of self-stigma, with participants describing how they had distanced themselves from family, friends, and community networks due to shame, fear of disclosure, and anticipation of rejection. They described that they avoided social gatherings because they feared discrimination and judgement from others.

Participants reported that self-stigma had led them to withdraw from social relationships and limit their interactions with others. Many described avoiding family gatherings, community events, and social activities because they feared being judged or having their status discovered. Some participants had cut ties with family members and friends entirely, preferring isolation to the risk of rejection. The social withdrawal was often gradual, with participants initially reducing their social interactions and eventually becoming increasingly isolated. This isolation was described as lonely and painful, with some participants expressing that they had no one they could talk to about their struggles. The withdrawal affected both existing relationships and the formation of new ones, with participants avoiding romantic relationships and close friendships due to fear of intimacy and disclosure.

Participant 3 stated:

"I don't go to family functions anymore. I make excuses because I'm scared they will find out. I miss my family, but I can't face them. I am all alone in this."

Participant 10 explained:

"I used to have friends, but I pushed them away. I didn't want them to know my secret. Now I have nobody. I just stay in my room when I'm not working. It's very lonely."

Participant 13 added:

"I can't have a boyfriend or a husband. Who would want me? I don't even try to date because I'm scared of rejection. I am better off alone. At least nobody can hurt me if I'm by myself and people can be very judgmental towards sex workers with HIV."

The finding demonstrates that self-stigma reinforces social exclusion and weaken social support networks among sex workers living with HIV. The findings correspond with Link and Phelan (2001), who denote that internalized stigma often results in social withdrawal and reduced participation in community life. The findings also resonate with Nyblade et al. (2019), who found that internalized stigma discourages individuals from seeking psychosocial support and engaging with support systems. Social withdrawal and isolation experienced by participants can be interpreted through Cognitive Behavioral Theory (CBT) as negative thought patterns influenced avoidant behaviors and reinforced emotional distress and loneliness. interactions that could help challenge those beliefs.

4.2.2 Perceived Impacts of Self-Stigma

This theme addresses the second research objective which sought to explore the perceived impact of self-stigma on the lives of sex workers living with HIV in Mazowe District. The findings reveal that self-stigma has far-reaching consequences affecting participants' psychological wellbeing, social relationships, and engagement with healthcare services.

4.2.2.1 *Psychological Distress*

Psychological distress emerged as a significant impact of self-stigma, with participants reporting symptoms of depression, anxiety, and emotional instability that they attributed directly to their internalized stigma.

Participants shared how self-stigma led to ongoing psychological distress, which was evident through feelings of sadness, hopelessness, excessive anxiety, irritability, and emotional breakdowns. Many expressed a sense of depression and despair regarding their future, with some even voicing suicidal thoughts. Anxiety was prevalent as well, with participants mentioning persistent worries about their health, fear of revealing their struggles, and unease in social situations. This psychological distress was often described as overwhelming, impacting their daily functioning, including work, relationships, and self-care routines. Some noted that the distress was especially intense at night or when they were alone, as these moments allowed for reflection on their circumstances and the internalization of negative thoughts.

Participant 1 remarked:

"I cry almost every night. I feel so sad and hopeless. Sometimes I think about ending it all because I can't handle the pain inside, at one point I thought of throwing myself into our nearby dam. The shame and the guilt are eating me alive."

Participant 6 stated:

"I am always anxious. I worry about everything my health, my children, what people will say if they find out. I can't sleep properly at night. My mind is always racing with negative thoughts."

Participant 11 explained:

"Sometimes I just break down and cry for no reason. I feel empty inside. The depression is heavy, and I don't know how to make it go away especially with what I hear people saying about people living with HIV, I feel trapped in this life like there is no way out."

The psychological distress reported by participants aligns with the principles of Cognitive Behavioral Theory (CBT), which explains how negative thought patterns can lead to emotional disorders. CBT suggests that ongoing negative automatic thoughts and unhealthy core beliefs about oneself can result in conditions like depression and anxiety (Beck, 2020). In this case, the internalized stigma experienced by participants leads to negative automatic thoughts such as "*I am worthless*," "*Nobody will ever love me*," and "*My life is hopeless,"* which contribute to depressive symptoms. Likewise, catastrophic thinking regarding disclosure and rejection exacerbates anxiety symptoms. The cognitive distortions linked to self-stigma thus create a psychological environment that fosters depression and anxiety.

Moreover, the findings are consistent with existing research on the mental health impacts of HIV-related stigma. Studies show that internalized stigma is closely linked to psychological distress, including depression and anxiety, among individuals living with HIV (Corrigan, 2004). For sex workers, these effects are often magnified by the additional stigma associated with their profession, resulting in a compounded burden that negatively affects their mental health (Kabunga et al., 2025). Therefore, the psychological distress experienced by participants is not just an individual issue but a public health concern that necessitates targeted interventions to address both HIV-related and sex work-related stigma.

4.2.2.2 *Disengagement from Healthcare Services*

Disengagement from healthcare services emerged as a critical impact of self-stigma, with participants describing how internalized stigma had led to poor ART adherence, missed clinic appointments, delayed care-seeking, and avoidance of healthcare facilities.

Participants indicated that self-stigma had a considerable impact on their interaction with healthcare services. Many shared experiences of missing appointments or not adhering to medication regimens due to feelings of shame or concerns about being judged by healthcare professionals. Some individuals postponed seeking medical attention for health issues, waiting until their conditions worsened before seeking help. Others chose to completely avoid healthcare facilities, opting instead to manage their health independently or through informal channels. This disengagement was especially evident regarding HIV-specific services, with some participants steering clear of HIV clinics in favor of general healthcare settings where they felt their status would be less noticeable. Even when they did seek healthcare, many participants reported withholding full health information or refraining from asking questions out of shame and fear of being judged.

Participant 5 explained:

"I miss my clinic appointments sometimes because I feel ashamed. When I go there, I feel like everyone is looking at me and judging me. So, I just don't go. I know it's bad for my health, but I can't help it."

Participant 7 said that

"When I get sick, I don't go to the clinic immediately. I wait and hope it will go away on its own. I'm scared the nurses will treat me badly if they know I'm a sex worker with HIV. I only go when I can't handle it anymore."

Participation 15 added:

"I don't take my medication properly sometimes. I skip doses when I'm feeling down or when I don't want people to see me taking pills. I know I should take it every day, but the stigma makes it hard."

The participants' withdrawal from healthcare services reflects the principles of Cognitive Behavioral Theory (CBT), which emphasizes how cognitive and emotional factors affect health behaviors. CBT suggests that individuals' beliefs about themselves and their circumstances can impact their motivation and capacity to engage in health-promoting activities (Beck, 2020). In this case, participants' negative self-views *("I am unworthy of care"),* fears of stigma (*"Healthcare workers will judge me"),* and emotional distress (such as shame and anxiety) create obstacles to accessing healthcare. These cognitive and emotional issues result in avoidance behaviors, like missing appointments, delaying seeking care, and not adhering to medication, which negatively affect health outcomes.

The results align with existing research on the effects of HIV-related stigma on healthcare engagement. Studies show that internalized stigma significantly hinders adherence to antiretroviral therapy (ART), attendance at clinics, and retention in care for individuals living with HIV (UNAIDS, 2022). For sex workers living with HIV, these challenges are often compounded by additional stigma associated with their profession, leading to dual barriers to accessing healthcare (Shannon et al., 2014, 2015). Therefore, the participants' disengagement from healthcare services is not just an individual issue but also a structural barrier to effective

HIV treatment and care, necessitating comprehensive interventions that address both the psychological and social aspects of stigma.

4.2.2.*3 Poor ART Adherence*

Participants showed that self-stigma affected their adherence to antiretroviral therapy (ART) negatively. Many participants reported that they missed doses, delayed taking medication, or defaulted treatment because they feared being identified as HIV-positive.

Participants explained that they feared taking medication in the presence of others because they would expose them to possible disclosure or judgement. Some participants also mentioned that emotional distress and hopelessness caused by internalized stigma reduced their motivation to adhere to treatment consistently. Some participants mentioned that the medication is said to have side effects and also it is easily noticeable so they did not want their clients to know that they are on treatment so they defaulted.

Participant 3 stated that

"*When I visit my other relatives and friends, I do not take my medication because I do not want people to suspect that I have HIV, the container that we store our treatment is very obvious for people to know that I am on ART."*

Participant 10 remarked:

"There are other days I don't go to the hospital to collect my medication especially on those days where a lot of people go for their clinic appointments because I fear that I might meet some people who know me from the community."

Participant 13 added:

"I stop taking my pills sometimes because I will be feeling depressed and ashamed so I will be tired of everything and just want to be free, and at one point I got sick and I was admitted at the hospital for close monitoring ."

These findings demonstrates that self-stigma creates barriers to consistent ART adherence among sex workers living with HIV. Fear of disclosure and internalized shame contributed to treatment interruption and poor medication management. The findings align with UNAIDS (2022) which highlights that self-stigma affects treatment adherence and retention in HIV care negatively. Similarly, Earnshaw and Chaudior (2009), found that self-stigma reduces self-efficacy and discourages health-promoting behaviors such as medication adherence. From the CBT perspective, negative thought patterns influenced participants' behaviors towards treatment and reinforced avoidance practices.

4.2.3 Coping Mechanisms for Sex Workers

This theme addresses the third research objective which sought to explore the coping mechanisms used by commercial sex workers living with HIV to manage self-stigma in Mazowe District. The findings reveal that participants employ both adaptive and maladaptive coping strategies to deal with the psychological and social burdens of self-stigma.

4.2.3.1 *Peer Support Networks*

Peer support networks emerged as an adaptive coping mechanism, with participants describing how connecting with other HIV-positive sex workers provided emotional support, practical assistance, and a sense of belonging that helped mitigate self-stigma.

Participants reported that peer support networks were a valuable resource for coping with self-stigma. These networks included formal support groups organized by NGOs or health facilities, as well as informal connections with other sex workers living with HIV. Through these networks, participants found spaces where they could share their experiences without fear of judgement, receive emotional support from others who understood their struggles, and access practical assistance such as information about healthcare services or material support. Many participants described how peer support helped reduce their sense of isolation and shame, as they realized they were not alone in their experiences. The solidarity and mutual understanding within peer networks provided a counter-narrative to the internalized stigma, helping participants challenge negative self-perceptions and develop more positive identities.

Participant 2 said that

"The support group changed my life. When I meet other women like me, seeing them doing so well gives me hope and I don't feel so alone. We share our stories and support each other. It helps me accept myself and my status."

Participant 8 stated that

"I have friends who are also sex workers with HIV. We talk about our challenges and help each other even financially when one is in need of money, we just help other. When I'm feeling down, they encourage me. We remind each other that we are still human and deserving of love."

KI1 stated:

"Peer support groups have helped many sex workers living with HIV regain their confidence and improve adherence to treatment because they feel by people with similar experiences.

Some sex workers have accepted their status and line of work so they encourage their peers in many ways that are very helpful."

The utilization of peer support networks as a way to cope aligns with the principles of Cognitive Behavioral Theory (CBT), which highlights the significance of social support in overcoming negative thought patterns and enhancing psychological well-being. CBT posits that social support can offer different viewpoints that assist individuals in recognizing and challenging cognitive distortions (Beck, 2020). In this regard, peer networks allow participants to share their experiences, understand that their negative thoughts are not universally applicable, and cultivate more balanced and realistic self-views. The emotional backing and affirmation received from peers also help mitigate the shame and isolation linked to self-stigma, fostering a more positive emotional atmosphere that supports cognitive restructuring.

The results align with research demonstrating the effectiveness of peer-led interventions in combating HIV-related stigma. Studies show that peer support groups can significantly lessen internalized stigma and enhance mental health outcomes for individuals living with HIV (Earnshaw and Chaudoir, 2009). For sex workers, peer-based methods are especially beneficial as they create safe environments for individuals to share their experiences without fear of judgment and to develop collective coping strategies for dealing with stigma (Shannon et al., 2014, 2015). Therefore, the peer support networks mentioned by participants serve as an effective coping strategy that addresses both the psychological and social aspects of self-stigma.

4.2.3.2 *Counselling and Psychosocial support*

The study further demonstrated that counselling and psychosocial support services played a significant role in helping participants cope with self-stigma. Participants reported that counselling sessions helped them deal with emotional pain, stress and negative thoughts associated with HIV and sex work.

Participants explained that counselling gave them an opportunity to express their feelings and receive guidance on positive coping strategies. some participants also stated that psychosocial support improved their self-esteem and encouraged them taking ART medication. Participants reported that counselling helped them deal with self-stigma as some mentioned steering clear of thoughts about their HIV status or sex work, actively trying to push these thoughts away whenever they surfaced and also others acknowledged the reality of their situation, downplaying its importance or rejecting their status altogether.

Participant 11 remarked:

"Counselling really helped to stop having negative thoughts about myself and I started to focus on my health and wellbeing the thoughts of ending it all have faded and now I have other new goals I feel I need to live and achieve."

Participant 4 said that:

"After attending counselling sessions, I became more confident and accepted my HIV status and I was encouraged not to lose hope and I was given advice on how to manage stress, these days am also encouraging others not to feel guilty about their status and work."

KI 4 who worked as a healthcare provider explained that:

"Psychosocial support is very important because many sex workers living with HIV suffer from depression, anxiety and fear of refection. Counselling helps them cope better with self-stigma and other forms of stigma."

These findings suggest that counselling and psychosocial support contribute significantly to emotional healing and improving self-worth among sex workers living with HIV. The findings align with that of Corrigan (2004), who argues that counselling interventions help individuals challenge internalized stigma and improve self-esteem. The findings also support Beck (2020), who emphasis that Cognitive Behavioral Therapy-based approaches are effective in changing negative thought patterns and promoting positive coping behaviors. Through counselling, participants were able to restructure negative beliefs and develop healthier emotional responses.

The results emphasize the importance of interventions aimed at helping participants cultivate more effective coping strategies to replace negative thoughts. Interventions based on Cognitive Behavioral Therapy can be particularly beneficial, as they assist individuals in recognizing and challenging negative thought patterns, fostering more balanced self-perceptions, and acquiring adaptive coping skills (Beck, 2020). It is crucial that these interventions are implemented in a way that is sensitive to stigma, acknowledging the genuine challenges faced by sex workers living with HIV while equipping them with tools to manage self-stigma more effectively.

4.2.3.3 *Community Empowerment Programmes*

Participants highlighted the importance of community empowerment programmes in reducing self-stigma and improving their wellbeing. Participants explained that

empowerment programmes provided education, economic opportunities and awareness campaigns that strengthened their confidence and social inclusion.

Some participants stated that participating in community activities and income-generating projects made them feel valued and respected. Others indicated that empowerment initiatives helped challenge negative stereotypes associated with sex work and HIV. Many found solace in doing community projects, helping other vulnerable populations, and also being part of the income-generating projects such as soap making. For some, these engagements with other community members fostered a sense of purpose that countered feelings of despair and worthlessness. Engaging in community empowerment programmes also provided social support and fostered a sense of community, which helped lessen feelings of isolation.

Participant 1 stated:

"The empowerment programmes such as the poultry keeping project helped me realize that I still have value in society despite my HIV status and making my own money eases some of the economic hardships that we once encountered."

Participant 9 said

"*Being involved in community projects improved my confidence and reduced my fear of people and the training programmes taught us and encouraged us to speak openly about stigma. The project I was involved in of soap making helped link with other women who also helped me to start my own project."*

KI 3 also explained that:

"Community empowerment programmes help sex workers living with HIV build confidence, improve livelihoods and reduce dependence which indirectly reduces self-stigma. Many sex

workers living with HIV especially those who are now of older age they have means of survival instead of depending on sex work alone since age is catching up with them."

These findings reveal that community empowerment programmes promote self-confidence, social participation and resilience among sex workers living with HIV. The findings are consistent with Kerrigan et al. (2015), who found that empowerment approaches improve social, access to healthcare and overall wellbeing among sex workers living with HIV. The findings also support Parker and Aggleton (2003), who argue that stigma should be addressed through both individual and structural interventions. From the CBT perspective empowerment programmes help participants replace feelings of helplessness with positive beliefs about their identity and abilities. The use of community empowerment programmes as coping interventions aligns with Cognitive Behavioral Theory (CBT), which emphasizes the significance of finding meaning and reframing thoughts to manage psychological distress. According to CBT, an individual's beliefs about themselves, their circumstances, and their future play a crucial role in their emotional health (Beck, 2020). In this framework, community empowerment programmes offer participants alternative ways of thinking that help them reinterpret their experiences in more meaningful and hopeful manners.

These findings are in line with research highlighting the role community empowerment programmes in coping with HIV-related stigma. Studies show that community empowerment programmes as coping interventions can serve as a vital resource for individuals living with HIV, offering comfort, hope, and social support that help alleviate the psychological effects of stigma (Corrigan, 2004). For sex workers, who often encounter moral judgment from community, finding supportive social environments can be particularly difficult yet immensely beneficial when successful. Therefore, community empowerment programmes as coping strategies shared by participants may represent an adaptive way to address the existential and emotional aspects of self-stigma.

4.3 Chapter Summary

This chapter has outlined the results of a study examining self-stigma among HIV-positive commercial sex workers in Mazowe District, Zimbabwe. The first theme, concerning manifestations of self-stigma, showed that participants experienced feelings of internalized shame and guilt, fear of being outed, and a reduced sense of self-worth as key indicators of self-stigma. The second theme focused on the perceived impact of self-stigma, revealing that it had significant repercussions on participants' mental health, social connections, and interactions with healthcare services. The third theme addressed coping mechanisms, indicating that participants utilized effective strategies to deal with self-stigma. Throughout the chapter, the findings were discussed in relation to the study's theoretical framework, which is Cognitive Behavioral Theory. The following chapter will present the study's conclusions, recommendations, and implications.

CHAPTER FIVE

CONCLUSIONS AND RECOMMENDATIONS

5.0 Introduction

This chapter presents the final synthesis and concluding insights for the study examining the psychological factors and effects of self-stigma among sex workers with HIV in Mazowe District, Zimbabwe. The main aim of this study was to explore the lived experiences of a highly marginalized group to understand how the internalization of societal bias impacts their mental health and access to essential healthcare services. Mazowe District, with its mining and agricultural activities, offers a unique socio-economic context where the combination of poverty, transient populations, and high HIV rates creates a complex environment conducive to stigma. This chapter wraps up the research by summarizing the key findings, drawing important conclusions that enhance the fields of psychology and public health, and providing a comprehensive set of recommendations for policymakers, healthcare providers, and community leaders. It also highlights significant gaps for future research, ensuring that the perspectives of sex workers in Mazowe inform a broader evidence-based approach to the HIV epidemic in Zimbabwe.

5.1 Summary of Findings

The research findings offer an in-depth look at the psychological situation of sex workers living with HIV in Mazowe. These findings are summarized below in relation to the three specific objectives that guided the study.

5.1.1 Objective One: Manifestations of Self-Stigma among Sex Workers Living with HIV in Mazowe

The primary aim of the study was to investigate how self-stigma is experienced by sex workers living with HIV. The findings indicated that self-stigma is a complex issue that affects various aspects of an individual's life, including cognitive, emotional, and behavioral dimensions.

Cognitively, self-stigma was evident in the adoption of a tarnished identity. Participants expressed a significant change in their self-worth, often viewing themselves as morally compromised or less than human due to their dual roles as sex workers and individuals living with HIV. This internalization of societal labels, such as promiscuous or disease carriers, resulted in a continual state of self-blame. The study revealed that these cognitive distortions were not just passive thoughts but active obstacles that influenced how individuals perceived their daily interactions.

Emotionally, the most common experiences were profound shame and fear of rejection. The analysis using the Stigma Index 2.0 framework confirmed that many participants felt internalized shame even when they did not face direct discrimination. This emotional weight was intensified by a persistent fear of being outed. The anxiety surrounding the potential of being discovered by family or community members in Mazowe led to ongoing psychological stress.

Behaviourally, self-stigma was reflected in social withdrawal and self-exclusion. To shield themselves from the anticipated judgment of others, many participants chose to distance themselves from community activities, religious events, and peer networks. This self-imposed isolation was seen as a protective strategy to avoid the discomfort of others' scrutiny, but it

ultimately resulted in significant loneliness and the erosion of essential social support systems necessary for managing a chronic condition like HIV.

5.1.2. Objective Two: Perceived Impacts of Self-Stigma on the Lives of Sex Workers Living with HIV in Mazowe

The second objective examined the psychological and physical effects of self-stigma. The research demonstrated that internalizing stigma is a significant factor contributing to poor health outcomes, directly hindering the achievement of the 95-95-95 global goals for HIV management.

Psychologically, the effects were marked by high levels of depressive symptoms and generalized anxiety. The study identified the "why try" effect, as described by Corrigan, where individuals believe they are unworthy, leading to a lack of motivation to seek employment, improve their living conditions, or adhere to medical treatment. The data suggested that the ongoing struggle with a stigmatized identity depletes cognitive resources, making participants more susceptible to mental health crises.

In terms of physical health, the effects of self-stigma on healthcare engagement were devastating. The research indicated that the fear of stigma from healthcare providers in local clinics was a more significant obstacle to adhering to antiretroviral therapy (ART) than factors like the distance to the clinic or the cost of services. Participants reported missing appointments or switching clinics to avoid being recognized or lectured by staff. This avoidance behavior resulted in inconsistent treatment, heightening the risk of opportunistic infections and viral rebound. Additionally, the concern that their HIV status would expose their hidden profession

as sex workers made many participants reluctant to participate in any form of sexual health screening, thus perpetuating a cycle of poor health and increased risk to the wider community.

5.1.3 Objective Three: Coping Mechanisms used by Sex Workers Living with HIV to Manage Self-Stigma in Mazowe

The final objective was to identify the strategies employed by sex workers to cope with and lessen the effects of self-stigma. The study differentiated between maladaptive coping strategies, which offered temporary relief but worsened stigma, and adaptive strategies that fostered resilience.

Maladaptive coping often manifested as substance abuse (including alcohol and drugs) and complete social withdrawal. Many participants described using alcohol to numb the shame associated with their profession and HIV status. While this provided a brief escape from negative self-views, it frequently led to risky behaviors and further marginalized these individuals within their communities.

Conversely, adaptive coping was closely linked to peer-led support systems. Participation in support groups for key populations helped sex workers realize they were not alone in their experiences. These groups offered a counter-narrative to societal stigma, enabling members to rebuild a sense of dignity and agency. The study also found that those who had access to professional psychological counseling were better able to recognize and challenge the cognitive distortions that contribute to self-stigma. However, access to such specialized mental health services in Mazowe remains critically low, leaving most participants dependent on informal and often unstable peer networks.

5.2 Conclusions

Based on the synthesis of the results and their correlation with existing research, the following conclusions can be drawn:

5.2.1 The Structural Basis of Internalized Stigma

A key finding of this study is that self-stigma among sex workers in Mazowe stems directly from the structural and legal context in Zimbabwe. The criminalization of sex work provides both moral and legal grounds for societal bias, which sex workers then internalize as a personal failing. It is concluded that as long as the legal system views sex work as a crime, individuals in this field will continue to perceive themselves through a lens of criminality and shame, irrespective of the quality of HIV services available. Self-stigma is not merely a mindset but a psychological manifestation of an oppressive social reality.

5.2.2 The Clinical Failure of Clinical Neutrality

The study concludes that the current healthcare model in Mazowe, and likely throughout Zimbabwe, fails to address the anticipated stigma that deters sex workers from seeking care. Although clinics may provide free ART, the psychological burden of accessing these services is too great for many. The absence of tailored, sensitive, and confidential services for key populations means that healthcare facilities often unintentionally perpetuate the stigma they

aim to combat. Without a transition to stigma-sensitive care, achieving the UNAIDS 95-95-95 targets will remain unattainable in mining communities like Mazowe.

5.2.3 The Transformative Power of Peer Spaces

The study concludes that peer-led interventions serve as the most effective psychological defense against self-stigma. The shared experiences of sex workers create a unique form of social capital that professional healthcare providers cannot easily replicate. These environments act as stigma-free zones where individuals can shift from a damaged identity to an empowered one. Strengthening these networks is not only a social intervention but also a psychological necessity for the survival and well-being of sex workers living with HIV.

5.2.4 Cognitive Distortions as Barriers to Adherence

From a clinical psychology standpoint, the study concludes that the cognitive distortions observed in participants, particularly overgeneralization and labeling, are significant contributors to medication non-adherence. When individuals believe they are already doomed or beyond help due to their dual stigma, their rational motivation to take daily medication diminishes. This indicates that HIV programs must extend beyond education to include cognitive restructuring to tackle the psychological barriers to health.

5.3 Recommendations

To address the findings and conclusions of this study, a multi-sectoral approach is necessary. The following recommendations are suggested for various stakeholders.

5.3.1 Recommendations for the National Aids Council

1. The National AIDS Council (NAC) should ensure that the upcoming version of the Zimbabwe National HIV and AIDS Strategic Plan incorporates specific, measurable goals aimed at decreasing internalized stigma among key populations. Funding should be specifically allocated for mental health initiatives that address self-stigma, rather than merely promoting general awareness.

2. Given the evidence that criminalization exacerbates self-stigma, the NAC should initiate discussions with the Ministry of Justice and Parliament regarding the decriminalization of sex work as a necessary public health measure. Alleviating legal stigma will have a direct positive effect on the mental health of many Zimbabweans.

5.3.2 Recommendations for the Ministry of Health and Child Care

1.The Ministry of Health and Child Care (MOHCC) should establish a stigma-free certification program for clinics in the Mazowe District. This program should require all staff, including security and reception personnel, to undergo training on the rights of sex workers and the psychological effects of judgmental attitudes.

2. HIV clinics at the district level should employ mental health professionals or stigma-reduction officers trained in Cognitive Behavioral Therapy. Every sex worker who is newly diagnosed with HIV should receive a psychological health assessment in addition to their physical health evaluation.

3. The MOHCC should collaborate with NGOs to set up drop-in centres in mining areas such as Glendale and Concession, moving away from traditional clinic environments. These centres should offer HIV testing, ART refills, and counseling in a peer-led, non-clinical setting.

5.3.3 Recommendations for Non-Governmental Organizations

1. Organizations like the Zimbabwe National Network of People Living with HIV (ZNNP+) should receive support to extend their Stigma Index initiatives into rural mining communities. Peer support groups should be formalized and provided with small grants to conduct community-based stigma reduction efforts.

2. Since poverty often compels sex workers to remain in high-risk situations that contribute to self-stigma, NGOs should incorporate economic empowerment and vocational training into their HIV support initiatives. Reducing economic reliance on sex work can help lessen some of the moral pressures that lead to self-stigma.

5.3.4 Recommendations for Community Leaders and Religious Leaders

1. Religious leaders in Mazowe should participate in workshops focused on the theology of inclusion. By minimizing the moral judgments often expressed from the pulpit, religious organizations can transform into places of healing instead of sources of shame.

2. Traditional leaders ought to lead community discussions that humanize sex workers and highlight their rights as citizens and members of the community, thereby diminishing the public stigma that contributes to self-stigma.

5.3.5. Recommendations for further research.

1. Research should be undertaken to assess the long-term effectiveness of a tailored CBT-based counseling manual specifically designed for sex workers in Zimbabwe.
2. With the rise in mobile phone usage, future research should investigate whether digital peer support through encrypted platforms can help reduce self-stigma for individuals who are too afraid to join in-person groups.
3. A detailed study comparing self-stigma levels in mining towns such as Mazowe with those in large agricultural estates could shed light on how different economic environments affect the severity of stigma.

5.4 Implications for Social Work Practice

The findings of this study have significant implications for the Social Work practise. Social workers play a critical role in addressing psychosocial challenges experienced by the vulnerable populations such as sex workers living with HIV. The study shows that there is need for social workers to adopt new empowerment-based and stigma sensitive interventions that need to address both individual and structural factors that contribute to self-stigma. Social workers should provide counselling and therapeutic interventions that help clients challenge internalised negative beliefs and develop positive coping strategies. In addition, social workers should advocate for social justice, human rights and non-discriminatory healthcare services for sex workers living with HIV. The study also demonstrates the importance of community-based interventions such as peer support groups and empowerment programmes in improving the wellbeing of vulnerable

populations. Therefore, social workers should collaborate with healthcare providers, NGOs and communities to strengthen support systems for sex workers living with HIV.

5.5 Chapter Summary

This chapter presented the summary, conclusions and recommendations of the study on self-stigma among sex workers living with HIV in Mazowe District, Zimbabwe. The study showed that self-stigma or internalized stigma affects the psychological wellbeing, healthcare engagement and social relationships of sex workers living with HIV. The findings further revealed that peer support, counselling and community empowerment programmes are important coping strategies that help reduce self-stigma and improve wellbeing. The chapter also highlighted recommendations aimed at addressing stigma through community awareness, psychosocial support, empowerment programmes and inclusive healthcare services. Finally, the chapter proposed areas for future research.

REFERENCES

Beauchamp, T. L., & Childress, J. F. (2019). *Principles of biomedical ethics* (8th ed.). Oxford University Press.

Beck, A. T. (2020). *Cognitive therapy and the emotional disorders*. Penguin Books.

Beck, J. S. (2020). *Cognitive behavior therapy: Basics and beyond* (3rd ed.). Guilford Press.

Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology*, 3(2), 77–101.

Bryman, A. (2016). *Social research methods* (5th ed.). Oxford University Press.

Corbin, J., & Strauss, A. (2015). *Basics of qualitative research: Techniques and procedures for developing grounded theory* (4th ed.). Sage Publications.

Corrigan, P. W. (2004). How stigma interferes with mental health care. *American Psychologist, 59*(7), 614–625.

Crenshaw, K. (1989). Demarginalizing the intersection of race and sex. *University of Chicago Legal Forum*, 139–167.

Creswell, J. W. (2014). *Research design: Qualitative, quantitative, and mixed methods approaches* (4th ed.). Sage Publications.

Creswell, J. W., & Creswell, J. D. (2018). *Research design: Qualitative, quantitative, and mixed methods approaches* (5th ed.). Sage Publications.

Creswell, J. W., & Poth, C. N. (2018). *Qualitative inquiry and research design: Choosing among five approaches* (4th ed.). Sage Publications.

Denzin, N. K., & Lincoln, Y. S. (2018). *The Sage handbook of qualitative research* (5th ed.). Sage Publications.

Earnshaw, V. A., & Chaudoir, S. R. (2009). From conceptualizing to measuring HIV stigma. *AIDS and Behavior, 13*(6), 1160–1177.

Gerassi, L., Edmond, T., & Nichols, A. (2016). Design strategies from sexual exploitation and sex work research. *Journal of Interpersonal Violence*, 31(13), 1–26.

Goffman, E. (1963). *Stigma: Notes on the management of spoiled identity*. Prentice-Hall.

Guest, G., Bunce, A., & Johnson, L. (2006). How many interviews are enough? *Field Methods*, 18(1), 59–82.

Hoang, T., Pham, M., Sterk, C., Evans, W., Miedema, S., & Yount, K. (2024). HIV stigma and mental health among sex workers. *Social Science & Medicine, 320*, 115678.

Kabunga, A., Bongmin, Y., Ayugi, J., & Kigongo, J. (2025). Self-stigma and mental health among female sex workers in Northern Uganda. *Journal of Social Health Studies, 12*(2), 45–60.

Kabunga, A., et al. (2025). Mental health burden among sex workers living with HIV:The role of stigma and discrimination. *Journal of HIV/AIDS and Social Services, 24*(1), 45–60.

Kerrigan, D., Kennedy, C. E., Morgan-Thomas, R., Reza-Paul, S., Mwangi, P., Win, K. T., McFall, A., & Fonner, V. A. (2015). A community empowerment approach to the HIV response among sex workers: Effectiveness, challenges, and considerations for implementation and scale-up. *The Lancet, 385*(9963), 172–185.

Kumar, R. (2019). *Research methodology: A step-by-step guide for beginners* (5th ed.). Sage Publications.

Kvale, S., & Brinkmann, S. (2015). *Interviews: Learning the craft of qualitative research interviewing* (3rd ed.). Sage Publications.

Link, B. G., & Phelan, J. C. (2001). Conceptualizing stigma. *Annual Review of Sociology, 27*, 363–385.

Ministry of Health and Social Services (MoHSS). (2017). *National strategic framework for HIV and AIDS response in Namibia*. Windhoek: MoHSS.

National AIDS Council (NAC). (2015). *HIV programme report for key populations*. Harare: NAC.

National AIDS Council (NAC). (2021). *Zimbabwe National HIV and AIDS Strategic Plan*. Harare: NAC.

National AIDS Council. (2023). *Zimbabwe HIV and AIDS strategic report*. National AIDS Council Zimbabwe.

Nind, M., Curtin, A., & Hall, K. (2016). *Research methods for pedagogy*. Bloomsbury.

Nyblade, L., Stockton, M. A., Giger, K., Bond, V., Ekstrand, M. L., Lean, R. M., Mitchell, E. M. H., Nelson, L. R. E., Sapag, J. C., Siraprapasiri, T., Turan, J., & Wouters, E. (2019). Stigma in health facilities: Why it matters and how we can change it. *BMC Medicine, 17*(1), 25.

Nyblade, L., Stockton, M. A., Giger, K., et al. (2019). Stigma in health facilities: Why it matters and how we can change it. *BMC Medicine, 17*(25), 1–15.

Pandey, P., & Pandey, M. M. (2015). *Research methodology: Tools and techniques*. Bridge Center.

Parker, R., & Aggleton, P. (2003). HIV and AIDS-related stigma and discrimination. *Social Science & Medicine, 57*(1), 13–24.

Robson, C., & McCartan, K. (2015). *Real world research* (4th ed.). Wiley.

Shannon, K., Crago, A.-L., Baral, S. D., Bekker, L.-G., Kerrigan, D., Decker, M. R., Poteat, T., Wirtz, A. L., Weir, B., Boily, M.-C., Butler, J., Carr, R., Kazatchkine, M., Sidibé, M., Beyrer, C., & the Lancet HIV Series Study Group. (2015). The global response and unmet actions for HIV and sex workers. *The Lancet, 385*(9962), 274–286.

Shannon, K., Goldenberg, S. M., Deering, K. N., & Strathdee, S. A. (2015). HIV among female sex workers. *Current Opinion in HIV and AIDS, 10*(2), 174–182.

Shannon, K., Strathdee, S. A., Goldenberg, S. M., Duff, P., Mwangi, P., Rusakova, M., Reza-Paul, S., Lau, J., Deering, K., Pickles, M. R., & Boily, M.-C. (2014). Global epidemiology of HIV among female sex workers: Influence of structural determinants. *The Lancet, 385*(9962), 55–71.

Saunders, M., Lewis, P., & Thornhill, A. (2019*). Research methods for business students* (8th ed.). Pearson Education.

UNAIDS. (2016). *Global AIDS update*. Geneva: UNAIDS.

UNAIDS. (2020). *Global AIDS update*. Geneva: UNAIDS.

UNAIDS. (2021). *Zimbabwe HIV and AIDS estimates*. Geneva: UNAIDS.

UNAIDS. (2022). *Global AIDS update 2022*. UNAIDS.

UNAIDS. (2022). *In danger: Global AIDS update*. Geneva: UNAIDS.

UNAIDS. (2022). *In danger: UNAIDS global AIDS update*. Geneva: UNAIDS.

UNAIDS. (2023). *Global AIDS update 2023*. Geneva: UNAIDS.

UNAIDS. (2024). *Global HIV statistics*. Geneva: UNAIDS.

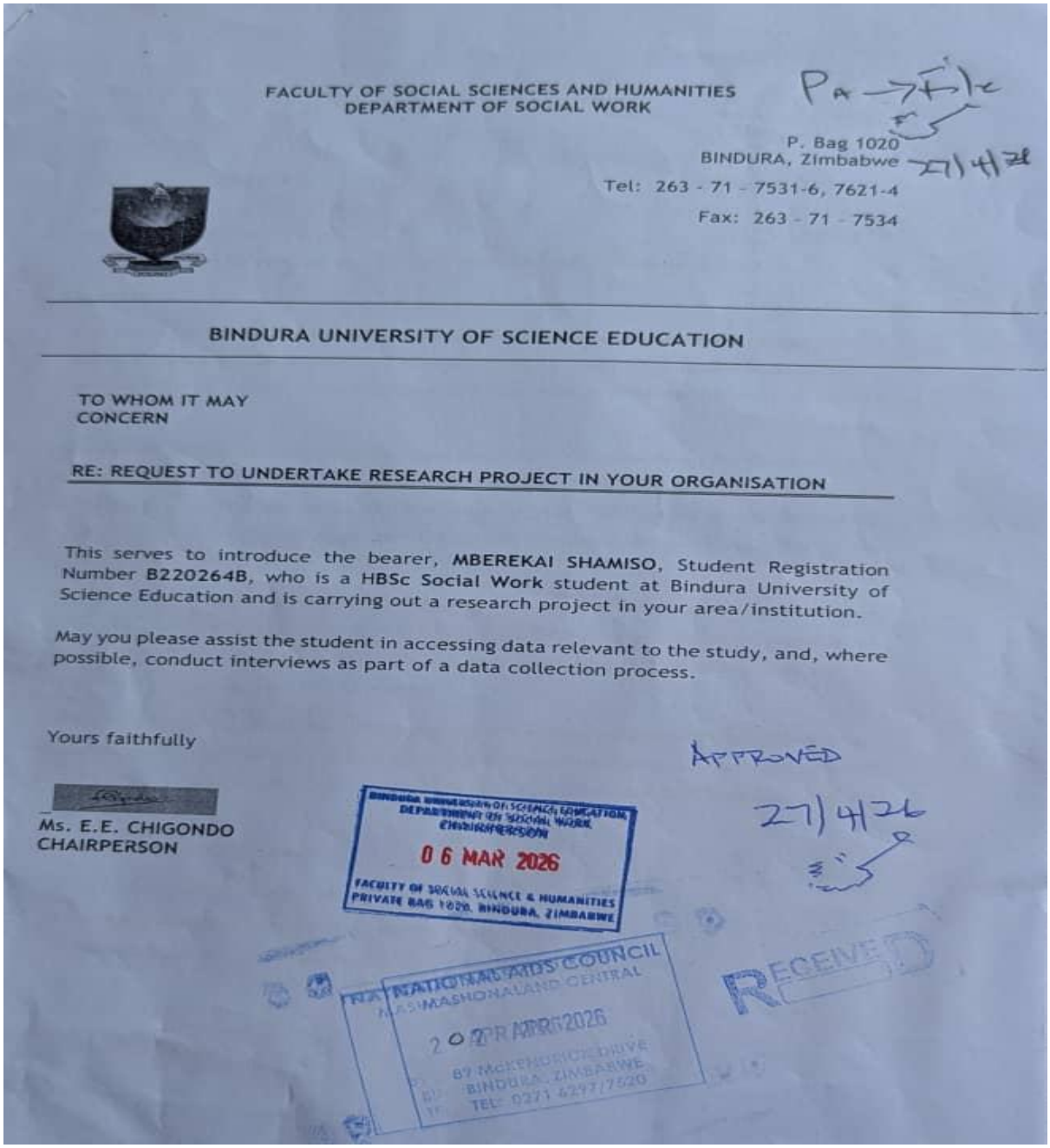
Wiles, R., Crow, G., Heath, S., & Charles, V. (2008). The management of confidentiality and anonymity in social research. *International Journal of Social Research Methodology*, 11(5), 417–428.

Yin, R. K. (2018). *Case study research and applications: Design and methods* (6th ed.). Sage

Zimbabwe National Network of People Living with HIV (ZNNP+). (2021). *Stigma index 2.0 report*. Harare: ZNNP+.

APPENDICES

Appendix A: Data Collection Approval



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BINDURA UNIVERSITY OF SCIENCE EDUCATION

TO WHOM IT MAY CONCERN

RE: REQUEST TO UNDERTAKE RESEARCH PROJECT IN YOUR ORGANISATION

This serves to introduce the bearer, **MBEREKAI SHAMISO**, Student Registration Number **B220264B**, who is a **HBSc Social Work** student at Bindura University of Science Education and is carrying out a research project in your area/institution.

May you please assist the student in accessing data relevant to the study, and, where possible, conduct interviews as part of a data collection process.

Yours faithfully

Ms. E.E. CHIGONDO
CHAIRPERSON

APPROVED

06 MAR 2026

FACULTY OF SOCIAL SCIENCE & HUMANITIES
PRIVATE BAG 1020, BINDURA, ZIMBABWE

NATIONAL AIDS COUNCIL
MASHONALAND CENTRAL

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Appendix B: Participant Consent Form
INFORMED CONSENT FORM

Study Title:

Self-Stigma among Sex Workers Living with HIV in Mazowe District, Zimbabwe: Experiences of sex workers implementing key populations programme under National Aids Council

Researcher:

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Bachelor of Science Honours Degree in Social Work
Bindura University of Science Education

Supervisor:

Mr Shoniwa

Introduction

You are invited to participate in a research study. Before agreeing, please read the information below carefully. You may ask questions at any time for clarification.

Stigma refers to negative, attitudes, beliefs and discrimination directed towards based on certain conditions or characteristics which may include involvement in sex work or HIV status. Internalised stigma which can also be called self-stigma occurs when individuals internalise these negative perceptions which can affect their mental health, self-esteem and willingness to seek healthcare services. This study seeks to better understand these experiences among sex workers living with HIV.

Voluntary Participation

Your participation in this study is entirely voluntary. You are free to refuse to participate or withdraw at any time without any negative consequences.

Purpose of the Study

The purpose of this study is to explore the experiences of self-stigma among HIV-positive commercial sex workers in Mazowe District and how it affects their wellbeing and access to health services.

Procedures

If you agree to participate:

- You will be asked to provide informed consent by signing this consent form before the interview begin.
- You will take part in a one-on-one interview.
- With your permission the interview will be audio recorded to ensure accuracy of the information collected.
- You have the right to decline the audio recording and still participate in the study.
- The interview will last approximately 30–45 minutes
- You will be asked questions about your experiences, feelings, and coping strategies

Risks and Discomforts

Some questions may make you feel uncomfortable or emotional. You may choose not to answer any question or stop the interview at any time.

Benefits

There are no direct financial benefits. However, your participation may help improve HIV programmes and support services for sex workers.

Confidentiality and Anonymity

- Your identity will remain confidential
- No names will be recorded
- A pseudonym (fake name) will be used in reports
- Information will not be shared with anyone outside the research team

Audio Recording (Optional)

☐ I agree to the interview being audio recorded

☐ I do NOT agree to audio recording

Right to Withdraw

You may withdraw from the study at any time without giving a reason and without any consequences.

Consent Statement

I confirm that:

- I have read and understood the information provided above
- I have had the opportunity to ask questions
- I understand that participation is voluntary
- I agree to participate in this study

Participant Name: _____

Signature: _____

Date: _____

Researcher Name: _____

Signature: _____

Date: _____

Contact number:_____

Appendix C: Interview Guide for Sex Workers Living with HIV

INTERVIEW GUIDE FOR SEX WORKERS LIVING WITH HIV

Section A: Background information

Pseudonym	
Gender	
Highest level of education	
Period as a sex worker	

Section B: Experiences and understanding stigma

5. What does HIV mean to you personally?
6. How did you feel when you found out about your HIV status?
7. In what ways if any do you feel judged or blame yourself because of your HIV status and sex work?

Section: Manifestations of self-stigma

8. How do these feelings affect how you see yourself as a person?
9. Can you describe any situations where you have avoided people or services because of HIV status or sex work?

Section D: Impact of self-stigma

10. How has self-stigma affected your emotional or mental wellbeing?
11. In what ways has self-stigma influenced your relationships with family, friends or clients?
12. How has self-stigma affected your use of health services or adherence to ART?

Section E: Coping mechanism and support

13. What strategies do you use to cope with negative feelings about yourself?
14. What support if any do you receive from health workers, organisations or your peers?

Section F: Recommendations

15. What do you think can be done to help reduce self-stigma among sex workers living with HIV in Mazowe?

Closing

Is there anything else you would like to share about your experiences that we have not discussed?

Thank you for your participation.

Appendix D: Interview Guide for Key Informants

INTERVIEW GUIDE FOR KEY INFORMANTS

Section A: Professional Background

Pseudonym	
Gender	
Profession	
Agency and Occupation	
Years of Work Experience	

Section B: Understanding of Self-Stigma and its Impact

1. From your professional experience working with sex workers living with HIV, could you elaborate on what you have observed regarding their lived experiences of self-stigma?

2. How does this self-stigma appear to impact various aspects of their lives, such as their well-being, relationships, or engagement with services?

3. What factors do you think contribute most to self-stigma among this population?

Section C: Programme and Service Delivery

4. What programs or interventions are currently in place to address HIV-related stigma among sex workers?

5. How effective do you think these programs have been in addressing self-stigma?

Section D: Challenges and Gaps

6. What challenges do you face in addressing self-stigma among sex workers living with HIV?

7. In your view, what gaps exist in current policies or programs related to self-stigma reduction?

Section E: Recommendations

8. What strategies would you recommend to strengthen self-stigma reduction among sex workers?

9. How can NAC and its partners better integrate mental health and psychosocial support into HIV programs for sex workers?

Closing

Is there anything else you would like to add regarding self-stigma and HIV programming in Mazowe?

Thank you for your participation.