EXPLORING LIVED EXPERIENCES OF COVID- 19 SURVIVORS WITHIN THEIR COMMUNITIES IN LUSAKA, ZAMBIA

BY

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A Dissertation Submitted to the University of Zambia in partial fulfilment of the Requirement for the Award of a Degree of Master of Education in Guidance and Counselling

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DECLARATION

I, Lydia Nyondo, declare that this dissertation is a representation of my own work and has not been previously submitted either in its entirety or in part for a degree at the University of Zambia or any other University.

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CERTIFICATE OF APPROVAL

This dissertation by Lydia Nyondo is approved as fulfilling the requirements for the award of a degree of Master of Education in Guidance and Counselling by the University of Zambia.

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ABSTRACT

The study explored the lived experiences of COVID-19 survivors within their communities in Lusaka District, Zambia. The exploration of the lived experiences was guided by three objectives which were; To explore experiences of COVID-19 survivors in terms of stigma from their communities during and after the illness, to ascertain experiences of COVID-19 survivors in terms of discrimination from their communities during and after the illness and to establish experiences of COVID-19 survivors in terms of support received from their communities during and after the illness. In order to have an in-depth understanding of the lived experiences of COVID-19 survivors within their communities in Lusaka District, Zambia, the study used the interpretive phenomenological design within a setting of qualitative methodologies. The population of the study comprised male and female COVID-19 survivors who lived and worked in Lusaka District, Zambia. Typical case purposive sampling procedure and snowball was used to come up with a sample size of ten (10). Data was collected through semi-structured interviews and analyzed using thematic analysis. The semi-structured interview guide was used as the research instrument. The study established that COVID-19 survivors had varied experiences in terms of stigma, discrimination and support in the communities. These experiences oscillated between presence and absence of stigma, discrimination and support in the communities. The experiences of stigma included humiliation, blame, condemnation, rejection, reprimands, and prejudice while forms of discrimination included avoidance, deprivation, isolation, neglect and abandonment. In terms of support, survivors received encouragement, love, care and warmth. The study's findings thus supported the assertions made in the literature that COVID-19 survivors had encountered stigma, discrimination and community support both during and after their illness. The provision of counselling services to stigmatization and discrimination victims was one of the recommendations made because the victims acknowledged being emotionally impacted. Additionally, in order to encourage behavior change and responsible actions toward COVID-19 survivors, the Ministry of Health should coordinate with the Ministry of Education to undertake awareness campaigns about the dangers of discrimination and stigma.

Key words: COVID-19 survivors, stigma, discrimination, counselling and communities

DEDICATION

To God Almighty, my late father Mr. Musaku Nyondo, my mother Mrs. Christina Nachinga Nyondo, my dear husband Nelson and my sons Lubuto Chibalo and Mukundwe Angel Chibalo. This could not have been possible without your love, help, support and encouragement. Thank you so much for being there for me and always know that you mean the world to me.

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LIST OF ACRONYMS

COVID19	Coronavirus Disease discovered in 2019.
NHIMA	National Health Insurance Management Authority
SARS-CoV-2	Severe Acute Respiratory Syndrome Coronavirus 2.
WHO	World Health Organisation.

CHAPTER ONE: INTRODUCTION

1.0 Overview

This chapter provides the context within which the study on the lived experiences of COVID-19 survivors in Lusaka, Zambia was conducted. It presents the background to the study, statement of the problem, purpose of the study, research objectives and research questions. The chapter also discusses the significance of the study, delimitation and limitations. Additionally, the chapter provides definitions of key terms used in the study. It finally ends with a summary.

1.1 Background

COVID-19 is an acronym, which stands for Coronavirus Disease discovered in 2019 in China (Spagnuolo et al., 2020). The World Health Organisation [WHO] (2020) defines COVID-19 as an infectious respiratory viral disease caused by a virus known as Severe Acute Respiratory Syndrome Coronavirus 2 (SARS-CoV-2). Transmission of the disease is through droplets of infected persons when they sneeze or cough.

The COVID-19 outbreak begun in Wuhan, China, in December 2019 (Sohrabi et al., 2020) and rapidly spread to all the countries of the world. In March 2020, the World Health Organisation officially declared the Coronavirus outbreak a global pandemic, triggering a public health emergency worldwide (Abdullah, 2020).

By February 4, 2024, there were about 702,701,106, confirmed cases and 6,978,673 deaths because of the COVID-19 pandemic (Worldometerhttps://www.worldometers.info ›coronavirus). The total number of recoveries stood at 673,609,184 (Worldometerhttps://www.worldometers.info › coronavirus). In Zambia statistics indicated that about 349,304 people had suffered from COVID -19 and out of these cases, 4,069 patients died while 341,316 patients recovered from the pandemic (https://www.worldometers .info/coronavirus/country/Zambia/). In May, 2023, the WHO declared that COVID-19 was no longer a public health emergency due to the development of COVID-19 vaccines and the majority of nations achieving herd count immunity.

Common symptoms for COVID-19 are fever, cough and fatigue. Further symptoms such as difficulty in breathing, diarrhea, decreased sense of smell or taste, brain or memory fog, palpitations, ear pain, headache, muscle or body aches, dizziness and lack of appetite are also experienced though these are considered to be less common (Rothan & Byrareddy,2020).

Worldwide so far, there is no cure for COVID -19 (Lu, 2019). It should, however, be noted that to prevent Coronavirus infections and reduce the risk of hospitalization and deaths significantly, COVID-19 vaccines have been developed except that some people still have reservations on being vaccinated and therefore have not taken the vaccine (Troiano &Nardi,2021) .The National Center for Immunization and Respiratory Diseases however cautions that the COVID -19 vaccine does not guarantee a life free of infections from the Coronavirus as available literature has shown cases of vaccinated persons though very few, who have been infected by Coronavirus (https://www.cdc.gov/coronavirus/2019-ncov/vaccines/effectiveness/why-measure-effectiveness/breakthrough-cases.html).

Missel et al. (2022) postulate that research on COVID -19 infection has reported data on clinical presentation and features, epidemiological risk, and pathophysiology studies performed within a biomedical paradigm. They contend that while medical science has extensive knowledge about the mechanisms of the disease, there is a limited understanding of the subjective experience of individuals navigating the trajectory of illness. Aligned with this perspective is the argument made by Prioleau (2021), asserting that the experiences of COVID-19 survivors worldwide remain mostly unknown, as they are not comprehensively studied and documented. Similarly, in Zambia, experiences of COVID- 19 survivors from the social perspective remain largely unknown. Therefore, there was need to understand lived experiences of persons who survived from the COVID- 19 pandemic in terms of stigma, discrimination suffered and support received within their communities in Lusaka, Zambia. According to Missel et al. (2022), delving into the perspective of patients through research could enhance our comprehension of how individuals with COVID-19 navigate challenges during their illness, potentially leading to improved future support strategies. Furthermore, such research within the COVID-19 population may furnish additional proof for crafting patient-centered support interventions that policymakers could extend to manage other life-threatening diseases. Exploring the lived experiences of COVID-19 survivors, particularly regarding stigma, discrimination, and support, holds significance in the counselling domain. This is because the study has the potential to yield valuable insights that can enhance the efficacy of counselling interventions, thereby contributing to the overall well-being of survivors. For instance, survivors who encountered stigma or discrimination might develop trauma-related symptoms, prompting counsellors to adopt a trauma-informed approach in helping them cope with the emotional aftermath of such experiences.

1.2 Statement of the Problem

Missel et al. (2022) stated that research on COVID -19 infection had reported data on clinical presentations and features, epidemiological risks, and pathophysiology studies performed within a biomedical paradigm but less about what it meant to be a person living through the illness trajectory. Prioleau (2021) shared a similar perspective and acknowledged that despite months into the COVID-19 pandemic, there were still many unknowns about the experiences of people who contracted the virus. He added that though millions of people worldwide contracted the virus with some dying and others surviving, there was a critical gap in knowledge about the survivors' experiences with the COVID-19 pandemic. Similarly, in Zambia, experiences of COVID- 19 survivors be it in terms of stigma, discrimination suffered or support received within their communities were unknown. The absence of adequate knowledge about the challenges faced by these survivors could contribute to the perpetuation of stigma, discrimination, and insufficient support systems within the community. Furthermore, COVID-19 survivors may encounter mental health issues like anxiety, depression, or post-traumatic stress, and without community comprehension, they might not receive the understanding and assistance necessary for their recovery. Therefore, it was imperative to understand the experiences of COVID-19 survivors within their communities in Lusaka District of Zambia.

1.3 Purpose of the Study

The purpose of the study was to explore experiences of COVID-19 survivors in terms of stigma, discrimination suffered and support received in their communities in Lusaka District, Zambia. This purpose was addressed through the following study objectives:

1.4 Study Objectives

1. To explore experiences of COVID-19 survivors in terms of stigma from their communities during and after the illness.
2. To ascertain the experiences of COVID-19 survivors in terms of discrimination from their communities during and after the illness.
3. To establish experiences of COVID-19 survivors in terms of support received from their communities during and after the illness.

1.5 Study Questions

To achieve the specific objectives, answers to the following questions helped to bring out the information that was relevant to the research:

1. What were the experiences of COVID-19 survivors concerning stigma from their communities during and after the illness?
2. Ascertain the experiences of the COVID-19 survivors concerning discrimination in their communities during and after the illness.
3. What were the experiences of the COVID-19 survivors concerning support received in their communities during and after their illness?

1.6 Significance of the Study

A study of this nature was relevant as its findings were expected to raise public awareness on the lived experiences of COVID-19 survivors in terms of stigma, discrimination and support received during and after their illness from COVID-19. Such insights could contribute to the creation of counselling interventions aimed at assisting individuals who may contract COVID-19 and encounter mental health challenges such as anxiety, depression, or post-traumatic stress. Furthermore, the findings of the study may play a crucial role in informing policy decisions and providing solutions to the challenges confronted by those who have survived COVID-19. By delving into the nuanced experiences of these survivors, there is potential for the development of effective interventions addressing the management of stigma and discrimination arising from encounters with the coronavirus.

1.7 Delimitation of the Study

The study focused on male and female COVID-19 survivors who tested positive for COVID-19 and experienced either mild, moderate or severe symptoms. The selection of these participants was purely because the study intended to explore the experiences of the COVID-19 survivors.

1.8 Limitations of the study

The emotional impact on certain COVID-19 survivors was so profound that they found it challenging to articulate and share their adverse experiences entirely. As a result, it is important to acknowledge that the study's findings may not be universally applicable, given the potential limitation in the comprehensive disclosure of these individuals' negative encounters.

1.9 Operational definition of terms used in the study

COVID -19 Survivors: People who remain alive and continue to function during and after overcoming the COVID-19 pandemic.

Lived experiences: Stigma, discrimination and support received by the survivors during and after their illness.

Communities: Home, neighbourhood and workplace.

Stigma: Negative labels, blame, accusation, reprimands, humiliation, rejection, prejudice, insults and unjust treatment of COVID-19 survivors

Discrimination: Avoidance, harassment, abandonment, deprivation, persecution, mockery and isolation of a COVID -19 survivor by family, neighbours and workmates.

Support: Encouragement, non-avoidance, warmth, acceptance, affection, love, attention and care by family, neighbours and workmates.

1.10 Theoretical Framework

The study was guided by the Phenomenology Theory, which was initiated by Edmund Husserl in 1931. As a theory, Phenomenology is aimed at understanding the context of lived experiences of people and the meaning of their experiences (Giorgi & Giorgi, 2003). Phenomenology Theory is supported by several Phenomenology theorists such as Manen (1997) who has propounded the notion of Lifeworld, comprising four dimensions through which lived experiences can be explored and understood. The four dimensions are the lived body(corporeality), lived time (temporality), lived space(environment) and lived human relation (rationality) (Khodabakhshi-Koolaee & Pourebrahimi ,2020). Manen (2002) illuminates that the notion of the lifeworld is in essence the world of lived experience. It is the everyday world in which human beings live and experience naturally and pre-reflectively, through their daily interactions and activities. Consequently, the lifeworld and world of lived experience is what individuals experience before they have begun to label or conceptualize it (Laverty,2003). Rich et al. (2013) educate that the lived body refers to the human physical body or bodily presence in our everyday lives. This includes all that we feel, reveal, conceal, and share through our lived bodies. As a people, we are always present in the world through our body thus it is through our lived body that we communicate, feel, interact, and experience the world. In relation to our study, the lived body refers to the participants, who are the survivors of COVID-19. Lived time denotes the time at which the phenomena are experienced. It

comprises a subjective understanding of time as opposed to the more objective or "factual" time, and it refers to the ways in which we experience our world on a temporal level (Khodabakhshi-Koolaee & Pourebrahimi ,2020). In the context of this study, lived time refers to the period during and after suffering from the COVID-19 disease. The third lifeworld existential which is lived space refers to the environment in which the experience takes place. Lived space explores both the way in which the space we find ourselves in can affect the way we feel and, conversely, how the way we feel can affect the way we experience a particular space (Rich et al., 2013). The lived space for this study refers to the home, neighbourhood and workplace. Lived human relations on the other hand refers to the relations made or maintained with others in the lifeworld. The human relations include the communications and relationships experienced with others through the spaces and interactions shared and created with them (Manen, 1997). In relation to this study, Lived Relations denote the interactions COVID-19 survivors had with their families, neighbours and workmates. Consequently, these four dimensions of Lifeworld shall be brought together to explore and understand the lived experiences of the COVID-19 survivors.

1.11 **Chapter Summary**

This chapter comprised an overview, background of the study, statement of the problem, purpose of the study, objectives, research questions, significance of the study, delimitation, limitations of the study, and definitions of key terms in the study. Key to the chapter is the definition of COVID-19, which is a respiratory viral disease, transmitted through droplets from an infected person when he/ she sneezes or coughs. The chapter has also revealed that COVID-19 originated from China and was declared a global pandemic by the World Health Organisation in March ,2020. Furthermore, the chapter has highlighted that a study of this nature might help us gain insights on the experiences of the COVID-19 survivors. In addition, research involving the patients' perspective might help to improve our understanding of how the COVID-19 patients managed problems during and after the period of their sickness and lead to better ways of supporting them in the future. Additionally, the chapter has indicated that the Phenomenology Theory shall guide the study. The next chapter presents the reviewed literature on experiences of COVID-19 survivors.

CHAPTER TWO: LITERATURE REVIEW

2.0 Overview

This chapter presents relevant literature reviewed about experiences of COVID-19 survivors in terms of stigma, discrimination suffered and support received within their communities. The literature review is guided by the following study questions: (i) What were the experiences of COVID-19 survivors concerning stigma from their communities during and after the illness? (ii) Ascertain the experiences of the COVID-19 survivors concerning discrimination in their communities during and after the illness (iii) What were the experiences of the COVID-19 survivors concerning support received in their communities during and after their illness?

2.1 Experiences of COVID-19 survivors concerning stigma within their communities during and after the illness

2.1.1 Within their homes

Concerning the experiences of COVID-19 survivors in terms of stigma in the home, Prioleau (2020) in the United States found that COVID-19 survivors experienced stigma in the form of reprimands from household members, who felt at risk of exposure. Nonetheless, being a web-based survey, a thorough exploration of participants' emotions, experiences, and nuances related to COVID-19 recovery may not have been allowed thus restricting the depth of understanding and the richness of qualitative data in comparison to methods such as interviews or focus groups.

In the same vein, Adom et al. (2021) in Ghana revealed that several survivors experienced stigma, which took the form of humiliation and unjust treatment at the hands of their family members during and after their illness. The study brought out several incidences of stigmatization, one being that following her self-quarantine, a female survivor was prevented from visiting her biological mother by her elder sister who believed that the survivor was still infectious despite being declared fit by the doctors. Another female survivor equally reported that upon her recovery, she faced humiliation from her family members as they did not want her close and maintained that she was still contagious. According to the survivor's family members, COVID-19 patients would always carry the virus once infected. Despite the existing literature, experiences of COVID-19 survivors in terms of stigma within their homes in Lusaka District, Zambia, were unknown. Furthermore, the study by Adom et al. (2021) offered a descriptive account of stigma experiences without delving deeply into the underlying factors contributing to this phenomenon. Examining the stigma

through a more comprehensive lens that takes into account societal, cultural, and psychological factors would enrich the discourse, fostering a more nuanced comprehension.

A qualitative study conducted in Uganda by Amir (2021) on 'COVID-19 and its related stigma among survivors' equally established that COVID-19 survivors experienced stigma in their homes. One participant of the study for example attested hearing insensitive comments about him by people in the family while another reported that he was taunted by his brother, who kept telling him that he had brought a killer disease to the family. One more participant reported that he was rejected by his cousin to a point where she even took her children to the village because she believed the survivor would give them Coronavirus.

2.1.2 **Within their neighbourhood**

As regards to the experiences of COVID-19 survivors in the neighbourhood in terms of stigma, Prioleau (2021) established that just like in the home setup, COVID-19 survivors experienced stigma also in their neighbourhoods both during and after their illness in the United States. He revealed that survivors experienced stigma in various forms such as shame and name-calling, people undermining the illness or experience with COVID-19 in the sense that they claimed the pandemic was not as severe as it was being portrayed and being blamed for several reasons such as contracting and spreading Coronavirus, the stay-at-home orders and the economic impact. The researcher furthermore reported that COVID-19 survivors experienced resentment and dismissal in the neigbourhoods. The study recognized the presence of stigma but fell short in detailing how individuals who survived COVID-19 managed or coped with the stigma in their communities. Incorporating such insights would enhance the understanding of survivors' experiences and could inform potential interventions or support systems. Furthermore, the study did not provide a relevant theoretical framework that could enrich the analysis. For instance, integrating theories from social psychology concerning stigma or adopting sociological perspectives on illness could have offered a theoretical framework for interpreting the experiences of COVID-19 survivors within their local communities.

Abuhammad et al. (2021) in Jordan equally showed that COVID-19 survivors experienced stigma in their neighbourhoods. The account of the study mirrored reports of stigma experienced by COVID-19 survivors in Mexico, India and China (Barbosa-Camacho et al., 2020; Neto et al., 2020). In these countries, the survivors of COVID-19 faced insults, rejection and physical

violence. Bagcchi (2020) in India equally reported stigma and revealed that the survivors were being greeted with hostile stares from neighbours upon their return to the community.

Similarly, a study by Dar et al (2020) in Srinagar, India brought out reports of stigmatization. The study revealed that the common type of stigma experienced by COVID-19 survivors in their neighbourhoods was that nobody wanted them around, not even near their children - everybody was uncomfortable around them. The researchers established that this type of behavior was because of the irrational fears of contagiousness among people about COVID-19 survivors, even after their recovery. Losing friends, being unfriended on various social media platforms, being verbally abused, being called by names, and being critically commented were equally reported by participants of the study. Dar et al. (2021) noted that the nature of stigma reported by their study was congruent with the common forms of stigma reported by other infectious disease survivors in the literature worldwide as shown by James et al. (2019) in their study on Post Ebola experiences.

Adom et al. (2021) in Ghana brought out similar reports of stigmatization. They informed that COVID-19 survivors experienced stigma in various forms which included rejection, verbal abuse, stereotyping, mockery, finger pointing and insults. A participant of their study for example reported that members of his community despised him and ran away from him upon returning from the isolation center. Another participant reported that he and his entire family had to deal with stigmatization from members of the community. He explained that despite recovering fully from COVID-19, some members of his community labeled his house as a COVID-19 infested house. Atinga et al. (2021) added that social stigma took the form of offensive descriptions. They for example revealed that some survivors received emotionally charged labels such as 'Mr. or Mrs. Coronavirus'.

A qualitative study conducted in Uganda by Amir (2021) on 'COVID-19 and its related stigma among survivors' equally concluded that COVID-19 survivors experienced social stigma such as rejection, labelling and community ostracism. A participant of his study for example reported that he suffered harassment in the place of his residence because the community still considered him contagious despite being declared fit by the hospital authorities. Additional revelations of the study were that COVID-19 survivors were subject to peoples' conversations as typified by a response from a participant who stated that despite being certified fit and discharged from the hospital, her neighbours looked at her with suspicion. The study further established that COVID-19 survivors

were being considered as outcasts and were referred to with belittling terms such as 'corona family' or 'COVID-19' patients by the community. Furthermore, Amir (2021) found that stigmatization was not only experienced by the survivors but also their family members. A female survivor for example recounted how her child was mistreated when she went to a shop in the neighbourhood to buy a box of matches. The survivor explained that the shop attendant rudely received her child, whom she told to drop the money in a container and not come closer to the shop. Thereafter, the item she had gone to buy was thrown at her. In spite of the available literature, it was unknown whether the experience of stigma described in the neighbourhood aligned with the encounters of individuals who had survived COVID-19 in Lusaka District, Zambia.

2.1.3 **Experiences at work places**

With regards to the experiences of COVID-19 survivors in the workplace, Prioleau (2021) found that COVID-19 survivors experienced stigma. He expounded that one of the forms of stigma suffered by the survivors involved organisations expressing unjust entitlement to medical information, thus invading the survivors' privacy. In the same vein, Gardner et al. (2021) found that Asian COVID -19 survivors living in the United States were subjected to workplace prejudice. Corroborating the reports on stigma in the workplace was a report by Atinga et al. (2021), which brought out an incidence of a survivor who joined fellow workers in search of official documents reportedly missing in the office. When the survivor found the documents, his manager murmured that they were no longer needed. The manager later returned fully covered in a face shield and mask, requested for the documents, sanitized them thoroughly and placed them in a locker cabinet. Despite the existing body of literature, the question of what the experiences of COVID-19 survivors in Lusaka District, Zambia were in terms of stigma in the workplace remained unanswered, prompting the need for this study. Moreover, the referenced literature drew from sources up to 2021, and given the dynamic nature of the pandemic, it was imperative to confirm the continued relevance and accuracy of the information in reflecting the current situation.

2.2 **Experiences of COVID-19 survivors in terms of discrimination within their communities during and after their illness**

2.2.1 **Within their homes**

Bagcchi (2020) in India concluded that COVID -19 survivors experienced discrimination in the homes. He illuminated that survivors faced discrimination in various forms which included

avoidance and abandonment. The researcher brought out an incident of a female COVID-19 survivor, who was abandoned by her husband and family members after she delivered a baby at a hospital, and was found positive. His report resonated with the account of Atinga et al. (2021) in Ghana, who informed that the experienced discrimination in the home by COVID-19 survivors was in the form of deprivation in the use of household items, exclusion from the family meetings and victimization to a point where the survivors were being asked to vacant the family homes and rent accommodation elsewhere in order not to infect other members of the family. Similar reports of discrimination were given by Adom et al. (2021) who illuminated that a Ghanaian COVID-19 survivor felt isolated by his relatives because during his illness, his mother-in-law did not allow him to self-quarantine at home because two of her children were there. The mother in law instead told the survivor to go to his mother's home. In addition, the survivor's younger sister could not let him live in their home also. The survivor explained that he was sad especially that everyone in his family was avoiding him. While the literature offered valuable perspectives on the discrimination faced by COVID-19 survivors within household settings in India and Ghana, the specific experiences of survivors in Lusaka District, Zambia, in this context remained unexplored. Consequently, the identified gap in the current body of literature underscored the need for additional research to comprehend the subtle variations in discrimination faced by survivors across different geographical locations.

2.2.2 **Within their neighbourhood**

Concerning experiences of COVID-19 survivors in terms of discrimination in the neighbourhood, Abuhammad et al. (2021) and Barbosa-Camacho et al (2020) in Mexico, Jordan, India and China concluded that survivors experienced discrimination. In these countries, COVID-19 survivors faced evictions from rented houses or public places and were denied access to public transport.

Bagcchi (2020) in India equally found that COVID-19 survivors experienced discrimination. He explained that one of the forms of discrimination experienced by the survivors both during and after their illness was persecution. The researcher brought out an incidence of persecution, where patients and survivors of the pandemic were bullied on social media. The researcher further revealed that the COVID-19 survivors experienced mockery from their communities and were in some cases just like in the report of Abuhammad et al. (2021) and Barbosa-Camacho et al. (2020) asked to vacate houses by property owners, or denied access to private transport. Bagchhi (2020) in Harare, Zimbabwe further documented a media report of discrimination where a survivor was

shocked to learn that during the period of his illness, the road in front of his house was named 'Corona Road' and some individuals opted to avoid using the same road for fear of possible infection.

Corresponding with the reports of discrimination in the neighbourhoods was the account of Atinga et al. (2021) in Ghana. The researchers reported that despite recovering fully, COVID-19 survivors were denied access to community public goods such as toilet facilities, parks and recreational areas just because they were once infected by Coronavirus. One of the incidences brought out by their study involved a male survivor who was asked to leave the pitch where he had gone to watch football because some spectators felt that he was still contagious. Another incident involved a survivor who was forcefully withdrawn from a community keep fit and fun walk event involving about 40 participants. The report further indicated that the reported social exclusion did not just affect the survivors but also the immediate members of their families, especially the children. A participant, for example, narrated that on several occasions, her three children were prevented from playing with their peers in a community playground. In addition, her neighbours also sternly instructed their children to avoid all her kids who were described as 'unsafe to play with'. Adom et al. (2021) in Ghana validated the reports of discrimination and went further to reveal that some COVID-19 survivors, including their family members were not allowed to buy things from retail shops as there was a claim that the survivor's money was infected with COVID-19. Similarly, two market women who had recovered from COVID-19 indicated that their fellow market women meted discrimination against them. This is because they were refused entry into the market to sell their products as everyone thought they were infected with COVID-19. The study by Amir (2020) likewise gave reports of avoidance by neighbours as one of the experiences of the COVID-19 survivors in the neighbourhood. It is yet to be known whether this experience resonates with the experiences of the COVID-19 survivors in Lusaka District, Zambia.

2.2.3 **Experiences at workplaces**

Concerning the experiences of COVID-19 survivors in terms of discrimination in the work places, Praveen and Ittamalla (2020) in North America and Asia reported that survivors experienced discrimination. However, the researchers did not delve into the nature of the discrimination experienced, which could have offered a more nuanced comprehension. This gap in information may be attributed to their study's primary focus on exploring the psychological challenges

encountered by COVID-19 survivors, with workplace discrimination identified as a contributing factor to the emotional distress these individuals faced. Bagcchi (2020) in India equally discussed discrimination as one of the experiences of the survivors in their workplaces. He revealed that some COVID-19 survivors lost their jobs as a result of being infected by Coronavirus. Despite acknowledging the occurrence of job loss, the researcher did not provide detailed explanations or specific circumstances that led to the termination of employment. This omission could have enhanced the comprehensiveness of the analysis.

Atinga et al. (2021) in Ghana likewise found that survivors experienced discrimination, which took the form of unfair treatment. The researchers reported that this form of discrimination was more pronounced as its manifestation cut across different sectors of the labour economy. Two participants of their study, for example, stated that their immediate managers treated them unfairly when they reported for work. Of the two, one indicated that he was denied an opportunity to participate in a mandatory staff meeting because everyone at the workplace was told to be careful with him. The other participant shared that despite presenting results to his manager indicating that he was negative, he was still ordered to leave the workplace immediately and report back when called. The other participant reported that after her recovery, there were all manner of negative rumors spreading about her at her workplace. As such, keys were produced for everyone at the workplace to access the staff toilet. However, when she requested for a copy of the key to produce one for herself, her colleague informed her that staff at her workplace were under strict orders from their supervisor not to give her access to the keys since she was considered to be contagious. This made her feel so discriminated against that her commitment to work was affected. In spite of the available literature, the experiences of COVID-19 survivors in terms of discrimination in the workplace still remained unknown in Lusaka District, Zambia hence the study.

2.3 Experiences of COVID-19 survivors in terms of support received from their communities during and after their illness

2.3.1 Support received in their homes

Concerning the experiences of COVID-19 survivors in terms of support in the home, Kirby (2021) in Dublin, Ireland found that survivors were supported. He for example gave a report of a female survivor who narrated that her husband, daughter and other family members stood with her and made sure they helped around the house during her road to recovery. Correspondingly, Adom et

al. (2021) found instances where survivors experienced support in that they were shown love, empathy and care by their family members. The researchers for example brought out a report of a female survivor, who indicated that she was taken care of by her husband and son during her illness with love and patience. The researchers further brought out a report of a female survivor who explained that she received encouragement from her husband during the course of her illness. The participant added that when there was a shortage of hospital beds, her husband tried his best to find someone to help her during her sickness. On the contrary, Atinga et al. (2021) in Ghana concluded that several COVID -19 survivors lacked support from their family members during the time of their illness. The researchers established that upon testing positive for Coronavirus, some survivors were ordered to vacant their homes by family members and those who refused received poor attention from their family members. Whether these experiences were true for the COVID-19 survivors in Lusaka District, Zambia was yet to be explored.

2.3.2 **Support received in their neighbourhood**

Atinga et al. (2021) in Uganda concluded that some COVID-19 survivors were not supported in the neighbourhood. This is because community members were so cold towards them that they could not even visit their homes to see and know how they were fairing. In the same vein, reports by Abuhammad et al. (2021) and Barbosa-Camacho et al (2020) in Mexico, Jordan, India and China; Adom et al. (2021) in Ghana indicated that COVID-19 survivors were not supported. Instead of showing the survivors love and care, the communities chose to stigmatize and discriminate them. In spite of the available literature, the question of whether survivors in Lusaka, Zambia received support within their neighbourhood remained unanswered, as it was yet to be established.

2.3.3 **Support received at their workplaces**

Contrary to the reports of stigma and discrimination in the work places by Praveen and Ittamalla (2020); Bagcchi (2020) and Prioleau (2021) was a report by Kirby (2021) in Dublin, Ireland, who found that COVID-19 survivors were supported by their employers. The researcher brought out a report of warmth and care from one of the participants of his study who stated that upon her return to work as a sales woman in a shop, she was not the same person that her colleagues remembered. She explained that despite feeling that she was almost back to her normal self, she was understandably very nervous around crowds, and became immediately anxious when she saw

people not observing physical distancing or wearing a mask in her workplace. This survivor however recollected that every time panic gripped her and was overcame with fear, her supervisors were very understanding and let her go home and return when things were quieter again. In spite of the available literature, experiences of COVID-19 survivors at their workplaces in Lusaka, Zambia in terms of support received still remained unknown. Furthermore, it is important to highlight that while there is a positive experience reported in Dublin, individual experiences may differ, and a single positive narrative does not necessarily reflect the overall reality.

2.4 Conclusions drawn from the literature reviewed

Although the available literature endeavours to report the experiences of the COVID-19 survivors within their different communities namely: home, neighbourhood and the workplace, the question of what the survivors in Lusaka District, Zambia experienced within their communities in terms of stigma, discrimination and support received during and after their illness remains unanswered, hence the need for this study.

2.5 Notable gaps in the literature

The study by Praveen and Ittamalla (2020) highlighted experiences of survivors at the work place in terms of discrimination. However, the study did not explore the experiences of the COVID-19 survivors in terms of discrimination in the home and neighbourhood. Moreover, the research centered on the psychological challenges experienced by COVID-19 survivors, briefly touching on discrimination without delving into the specific nature of the discriminatory experiences they faced. Bagcchi (2020) centered his attention on the encounters of COVID-19 survivors regarding discrimination within communities, omitting consideration of the support they received. While highlighting job loss as a manifestation of discrimination, the author did not delve into specific reasons or circumstances that precipitated employment termination. Including such details could have enhanced the comprehensiveness of the analysis.

Kirby (2021) focused on just the experiences in the home and workplace in terms of support. He left out the aspects of stigma and discrimination in the community. Notable about the literature reviewed was also the fact that there was a gap concerning the lived experiences of COVID-19 survivors in Lusaka District, Zambia in terms of stigma, discrimination and support received during and after their illness. Due to the foregoing, there was therefore need to carry out a study

in Lusaka District, Zambia on the lived experiences of COVID-19 survivors for a broader understanding of their experiences.

2.6 **Chapter Summary**

The literature reviewed reveal the lived experiences of the COVID-19 survivors as recounted by the victims. Individual reports showed that COVID -19 survivors experienced stigma and discrimination in their communities during and after their illness. However, reports of being shown love, kindness and compassion by the communities were also recorded from the survivors. These studies contained important findings relevant to the current study. This is because they brought out various experiences as lived by the survivors in various parts of the world. However, these studies did not bring out the lived experiences of the COVID-19 survivors in Lusaka District, Zambia hence the need for this research.

CHAPTER THREE: RESEARCH METHODOLOGY

3.0 Overview

This chapter presents the methodology that was used in the study. The chapter describes the following themes; Research Paradigm, Research Design, Study Population, Sample Size, Sampling Techniques, Research Instrument, Data Collection Procedure, Data Analysis, Trustworthiness of the Research and Ethical Considerations. The chapter ends with a summary.

3.1 Research Paradigm

Brown and Dueñas (2020) define a research paradigm as a shared set of beliefs or agreements among researchers regarding how problems should be comprehended and addressed. Research paradigms encompass aspects of ontology, epistemology, and methodology (Ponterotto, 2005). Ontology relates to the nature of reality, while epistemology pertains to how researchers acquire knowledge (Klakegg, 2016). Machacha (2012) elucidates research methodology as the systematic procedure researchers follow in selecting appropriate research methods for a study, addressing how research problems are methodically solved. This study was guided by the interpretivism paradigm, asserting the idea that reality is subjective. It posits that meaning is inherently tied to specific perspectives or contexts, and since individuals or groups often have diverse viewpoints and contexts, the world encompasses multiple meanings, none inherently more valid or truthful than another (Gay et al., 2012). In terms of epistemology, the researcher acquires knowledge about reality by immersing themselves in the study (Kelly, 2012). The choice of the interpretivism paradigm was motivated by the fact that the explored reality existed exclusively in the realm of COVID-19 survivors, who directly lived through the pandemic. Moreover, the researcher interacted with the natural setting represented by the COVID-19 survivors to extract information and gain insights into their experiences, aligning with interpretivism principles.

3.2 Research Design

Considering the fact that the study was intended to understand the lived experiences of COVID-19 survivors through interpretation of experiences, the study used the interpretative phenomenological design. The interpretative phenomenological design is one of the qualitative designs in which the researcher concentrates on capturing the experience of an activity or concept from the participants' perspective (Gay et al., 2009). This design gives insight into an experience that is not understood and occurs rarely or in a widely scattered population (Ivey, 2013). Smith

and Osborn (2015) expound that the interpretive phenomenological design produces an account of lived experience in its own terms rather than the terms prescribed by pre-existing theoretical preconceptions. Lopez and Willis (2004) add that the interpretive phenomenology goes beyond mere descriptions of the core concepts and essences to look for meanings embedded in common life practices.

3.2.1 Dimensions of lifeworld in interpretative phenomenological design

The four dimensions of lifeworld in Interpretative Phenomenological Design that guided the study are the lived body (corporeality), lived time (temporality), lived space (environment) and lived human relation (rationality) (Khodabakhshi-Koolaee & Pourebrahimi ,2020). As already illuminated in our chapter one under the theoretical framework, the participants who were COVID-19 survivors were the lived body. Whilst in the environment (lived space), the COVID-19 survivors interacted with others (lived relations) both during and after their illness (lived time). Consequently, these four dimensions of lifeworld were brought together in this study to explain the lived experiences of the COVID-19 survivors.

3.3 Study population

The population of the study comprised male and female COVID-19 survivors who lived and worked in Lusaka District, Zambia. The COVID-19 survivors were chosen because they were the ones with experiences of COVID-19.

3.4 Sample Size

According to Kothari (2004), sample size is the number of items to be selected from the universe to constitute a sample. The sample size for this study was ten. This was adequate as it allowed the researcher to reach data saturation. In addition, the chosen sample size is supported by Creswell (2014) as he has indicated that data saturation can be reached between the 5^{th} and 25^{th} interview.

3.5 Participants' Brief Profiles

For confidentiality and anonymity purposes, codes were used to represent each participant as indicated in Table 1. The codes used were MP for male participants and FP for female participants.

Table 1: Participants' Brief Profiles

Description	Profile
FP1	Aged 48, married, and a mother of three. She is employed as a junior officer in a semi-autonomous organisation and has a master's degree. She was unwell for two weeks .She lives in Lusaka District and isolated from home .
FP2	**A**ged 51, married, and has four kids. She has one dependent living with her. She resides in Lusaka District. She was unwell for about three weeks. She holds a certificate and is employed by the government in a junior capacity. She isolated from home.
FP3	Aged 49 and is married with four children. She holds a certificate and works as a junior officer in a quasi-government. She was sick for close to one month. She isolated from home.
FP4	Aged 45 and is married with two children. Keeps two dependents in the home. Was sick for almost three weeks. She holds a first degree and works for a quasi-government in middle management. She lives in Lusaka District and isolated from home.
FP5	Aged 46. She has one daughter and two other dependants in the home. She holds a degree and works for one of the Government Ministries as a manager. She was sick for close to two weeks and isolated from home.
MP1	Aged 44 and is married with four children. He keeps three dependents in the home. He holds a degree and works for one of the Government Departments as a senior manager. He was sick for about two weeks. He lives in Lusaka District and isolated from home.
MP2	Aged 55, married and a father of four children. He is a senior manager in one of the Government Ministries. He holds a master's degree and resides in Lusaka District. He was sick for almost three weeks but isolated from home.

MP3	Aged 42, married, and has three children. He has two dependents living with him. He has a degree and works for one of the Government Ministries in middle management. He was sick for about two weeks and resides in Lusaka District. He isolated from home.
MP4	Aged 40 and is married with three children. He holds a degree and works for one of the Government Departments in middle management. He lives in Lusaka District. He was sick for about eight days and isolated from home.
MP5	Aged 45 and is married with two children. He keeps one dependent in the home. He holds a diploma and works for a private institution as a junior officer. He was sick for a period of ten days. He isolated from home.

3.6 **Sampling Techniques**

Typical case purposive and snowball sampling procedures were used to select the sample for the study. Typical case purposive sampling was chosen because it was appropriate for choosing typical cases like the COVID -19 survivors for this study. Nonetheless, it was not feasible to use solely for selecting all participants because the known COVID-19 survivors to the researcher did not meet the required sample size. Therefore, Snowball sampling was incorporated. Given the sensitive and individualistic nature of surviving COVID-19, Snowball sampling emerged as a more effective approach in achieving the desired sample. This method relies on referrals from established contacts, fostering a deeper level of trust and rapport between researchers and participants. Consequently, survivors felt more comfortable sharing their experiences candidly. Seven participants were chosen using typical case purposive sampling while three were selected through snowballing. The sampling techniques used to select each participant are shown in table 2 below:

Table 2: Sampling techniques used for each participant

Name of participant	Sampling Design	Sampling Technique
FP1	Purposive	Typical case
FP2	Snowball	Linear
FP3	Purposive	Typical case

FP4	Purposive	Typical case
FP5	Purposive	Typical case
MP1	Purposive	Typical case
MP2	Purposive	Typical case
MP3	Purposive	Typical case
MP4	Snowball	Linear
MP5	Snowball	Linear

3.7 Inclusion/Exclusion Criteria

In choosing the research participants, the researcher was guided by the inclusion /exclusion criteria comprising the four dimensions of the life world namely; lived body, lived space, lived relations and lived time (Khodabakhshi-Koolaee & Pourebrahimi ,2020). In addition, the criteria included participants' willingness to participate in the study. Consequently, participants meeting the following criteria were brought on board.

(1) Lived with COVID -19 (Corporeality)

(2) Lived with COVID-19 within the Communities (Lived space)

(3) Interacted with the communities during and after their illness (Lived relations)

(4) Interacted with the communities during and after the period of illness (lived time).

(5) Was willing to participate in the study through face-to-face interviews

This criterion was important to the study as lived experience takes place in the lifeworld existential, which are lived body, lived space, lived relations and lived time.

3.8 Research Instrument

The Research Instrument used in the study was the semi-structured interview guide comprising nine questions. The chosen instrument was ideal as it allowed for follow up questions.

3.9 Procedure for Data Collection

Before going into the field to collect data for the study, the researcher firstly obtained ethical clearance from the Directorate of Research and Graduate Studies, University of Zambia as per requirement. Secondly the researcher obtained consent from all the participants of the study. This was done not only to meet legal and ethical standards but also to uphold the principles of respect,

transparency, and trust within the research process. Thereafter, the researcher collected data from the participants using semi –structured interviews. Interviews were ideal because they allowed for follow up questions thus enabling the researcher to have in–depth understanding of the topic at hand.

During interviews, the first thing that the researcher did was to introduce herself to the interviewee. She did this by stating her name, position, institution she was coming from and later explained the aim of the research to familiarize the interviewee with the research topic. The purpose of the introduction was to help foster trust, set expectations, show respect, create a professional atmosphere, and build credibility, all of which are crucial for successful data collection and analysis. The researcher then gave the interviewee a guarantee of confidentiality regarding the information they were about to divulge. The interviewees' biographical information and the roles they held in their organisations were then discussed. This was done in an effort to learn more specific information from the interviewee while also building a strong rapport with them. Each interview lasted for roughly 45 minutes, and the participants shared a range of knowledge on the subject of the study. All interviews were audio recorded with consent from each participant in order to aid the researcher in recalling the dialogue. In addition, the researcher took notes of the interviewees' responses throughout the interview. All interviews were transcribed and analyzed as shown in the next sections of this chapter.

3.10 Data analysis

Singh (2006) expounds that data analysis involves studying of the tabulated material in order to determine inherent facts and what they mean. In this study, thematic analysis defined as a method for identifying and analyzing patterns of meaning in a data set (Braun & Clarke, 2006) will be used to analyze the data. The following six steps in thematic analysis suggested by Braun and Clarke (2015) guided the study:

Step One: Familiarization

This entails knowing the data in order to have a thorough overview of it. This process involved transcribing the audios recorded, reading the texts and taking down initial notes.

Step Two: Coding

This step involved generation of initial codes by way of highlighting sections of the text –phrases or sentences and then coming up with codes to describe their content.

Step Three: Searching for themes

This step involved examination of the codes generated, identification of patterns among them and coming up with themes thereafter.

Step Four: Reviewing the themes

This involved making sure that the generated themes were useful and an accurate representation of the data collected.

Step Five: Defining and naming the themes

Defining and naming the themes comprised framing exactly what was meant by each theme and figuring out how the theme helped the reader to understand the data. Naming themes included coming up with a concise and easily understandable name for each theme.

Step Six: Writing the report

This step entailed writing the analysis of data, starting with the introduction to establish the research questions, aims and approach. The step also included the methodology section (describing how data was collected), the results and the conclusion.

3.11 Trustworthiness of the data collected

Gunawan (2015) defines trustworthiness or rigor of a study as the degree of confidence in data, interpretation, and methods used to ensure the quality of a study. The criteria outlined by Lincoln and Guba (1985) as constituting trustworthiness include credibility, dependability, confirmability, and transferability. These concepts and how the study established them are explained in the subsequent paragraphs.

Credibility denotes the confidence of the data (Lincolin & Guba, 1985). To establish it in this study, participants with COVID-19 experience were purposively sampled and data was collected until saturation. Further, participants' statements were audio-recorded and transcribed verbatim. Having done so, the transcripts were reviewed against the recordings to ensure the accuracy of the text. Based on the interviews, the researcher described the experiences of the COVID-19 survivors and thereafter showed the participants the results so that they were able to verify whether the descriptions accurately captured their experiences.

Dependability refers to the stability of the data over time and over the conditions of the study (Gasson,2004). This study established dependability through peer-debriefings with colleagues and maintenance of an audit trail of process logs (researcher's notes of all activities that happened

during the study and decisions about aspects of the study like who was to be interviewed and what was to be observed). (Lincolin & Guba, 1985).

Confirmability on the other hand refers to the neutrality or the degree to which findings are consistent and could be repeated (Curtin & Fossey ,2007). In this study, the researcher established confirmability through keeping detailed notes of all her decisions and analysis as the study progressed. In addition, the researcher had her notes reviewed by a colleague and discussed in peer-debriefing sessions with a qualitative researcher. The discussions held were intended to prevent biases from the researcher's perspective on the research. Furthermore, the researcher conducted member- checking with study participants.

By and large, transferability refers to the extent to which the findings are useful to persons in other settings or context (Maxwell,2002). The study established transferability through the provision of thick descriptions of the phenomenon.

3.12 **Ethical Considerations**

Qualitative research demands that the researcher should have close interaction with the participants to a point where he /she enters the private spaces of the participants (Silverman, 2000). Such a demand raises numerous ethical issues that should be addressed during and after the research has been carried out or else the research risks being unethical in its design, questions, methods, analysis, presentation and findings (Nalube, 2014). In this vein, the researcher should concern himself/herself with moral integrity to ensure the trustworthiness and validity of the research process and findings (Biber, 2005). Gay et al. (2012) educate that some of the ethical issues that the researcher should consider as he undertakes his research should include the following:

(a) Informed consent (Are the participants having full knowledge of what is involved and are they entering research out of their free will?) As regards to this study, participants were informed of the purpose of the study, procedure for data collection and their right in the process of the study. Thereafter, written informed consents were obtained from the participants.

(b) Harm and risk (Can the study hurt the participants in any way?) In this study, participants were informed that the study would not cause harm or pose any risk to them.

(c) Privacy, confidentiality, and anonymity (Is the study going to intrude too much

into behaviour of participants?) As regards this study, participants were assured of confidentiality and their identity remained anonymous.

(d) Intervention and advocacy (What should a researcher do in an event where participants display harmful or illegal behaviour?) In this study, participants were informed that they would be respected and in turn, they were expected to conduct themselves with respect.

Creswell (2009) equally posits that ethical issues should be anticipated and dealt with by the researcher. In this vein, the study ensured that rights of participants were respected and that privacy of data collected from participants was upheld. In addition, the researcher upheld confidentiality as advocated for by Chew (2000). Furthermore, consent was sought from the participants, who were also informed that the data collected would be used for academic purposes only.

3.13 **Chapter Summary**

The chapter on methodology revealed that the study was guided by the interpretivism research paradigm and employed the interpretive phenomenological study design. Data was collected through in-depth interviews. The chapter also highlighted that typical purposive sampling method was used to come up with a sample population of ten (10). The interview guide was used as the research instrument.

CHAPTER FOUR: RESEARCH FINDINGS

4.0 Overview

This chapter presents the findings of the study which aimed at exploring the lived experiences of COVID-19 survivors in their communities in Lusaka, Zambia. The findings are presented according to the research objectives which were; (1) To explore experiences of COVID-19 survivors in terms of stigma from their communities during and after the illness; (2) To ascertain the experiences of COVID-19 survivors in terms of discrimination from their communities during and after the illness; and (3) to establish experiences of COVID-19 survivors in terms of support received from their communities during and after the illness.

4.1 EXPERIENCES OF COVID-19 SURVIVORS CONCERNING STIGMA FROM THEIR COMMUNITIES DURING AND AFTER THE ILLNESS

Three themes came out from the experiences of COVID 19 survivors in terms of stigma in their communities. These included experiences of COVID-19 survivors in terms of stigma in the home during and after illness, experiences of COVID-19 survivors in terms of stigma in the neighbourhood during and after illness and experiences of COVID-19 survivors in terms of stigma in the workplace during and after illness.

4.1.1 Experiences of COVID-19 survivors in terms of stigma in the home during and after illness

The research revealed diverse encounters with stigma among COVID-19 survivors within their households, both during and after their illness. These encounters ranged from instances of facing stigma to instances of not encountering any stigma.

4.1.1.1 Experiences of being stigmatized during illness at home

The study established that some COVID-19 survivors had experiences of stigma during illness from their spouses and dependents. These experiences took the form of humiliation, blame, condemnation, rejection, reprimands, accusations and prejudices. The study further revealed that survivors experienced self-stigma which manifested in the form of self-blame and guilt

for contracting the virus.

a) Experience of humiliation and reprimand from husband during illness

One of the female participants (FP2) narrated how she was stigmatized by her husband. She said that,

> I faced severe stigma from my husband while I was unwell. He demeaned and treated me as if I was a leper. Whenever I attempted to step out of my bedroom, even just to answer the call of nature, he would reprimand me. On a particular occasion, I ventured into the kitchen to get warm water for my blood pressure medication because I was feeling extremely unwell at night. The moment my husband realized I had left my room and was in the kitchen, he admonished me, exclaiming; Now you are roaming all over the house! Are you trying to spread the illness to everyone?! The way he spoke to me was so humiliating that it left me feeling stigmatized. (FP2)

b) Experience of blame and resentment from wife during illness

One of the male participants, (MP1) narrated his experiences of blame and resentment from his wife during illness from COVID 19 as follows;

> After learning that I had COVID, I thought that it would be easy for me at home. However, the opposite was true as my wife stigmatized me. She resented me and throughout the period of my illness blamed me for contracting Coronavirus. She would say to me 'mwaona manje kukonda kuyendayenga' (see what your careless movements have brought!), you have brought COVID-19 in the home. This depressed me and left me with no strength. She would tell me to keep to myself and justify that it's better I die alone so that at least one of us remains to look after the children. I felt really depressed and rejected. Almost every other day of my illness, she would tell me we always tell you not to move around and to put on your mask. Mwaona manje mwaleta COVID munyumba (see now you have brought COVID in the house). (MP1)

c) Experiences of scorn from son during illness

FP 2 also narrated how the son scorned at her during the time she was sick from COVID 19. She reported that,

> Each time I met my son in the corridor of our house during my illness either when going to the bathroom or outside to sunbath as advised by the doctor, he would disrespectfully ask me or say "Why can't you stay in your room? Mum, stay in your room!!! To be honest, my son's behavior towards me was very stigmatizing. (FP2)

d) Experience of accusation from dependent during illness

One of the male participants (MP5) narrated how his young brother accused him of being careless. He narrated that**,** "My young brother whom I keep in my home would without regard accuse me of not taking care of myself hence the contraction of the disease. He told me I was careless with my life." (MP5)

e) Experiences of self-stigma in the form of blame and guilt during illness

Unlike the reports of FP2, MP1 and MP5 which revealed that COVID-19 survivors experienced stigma under the hands of other people, the study established that in some cases, survivors experienced self-stigma in the home during the time they suffered from COVID 19. A case in point was of a male participant (MP2) who informed the study that, "I had this feeling that it was my fault that I had COVID-19. I felt ashamed of myself." Similar sentiments were expressed by a female participant (FP4) who shared that, "I was seeing myself as this contaminated human being, who failed to take enough precautions so as to avoid the infection" (FP4).

4.1.1.2 **Experiences of being stigmatized after illness at home**

Survivors of COVID-19 encountered stigmatization not only during their illness but also persisted post-recovery within their homes. Much like the experiences during the illness, these instances were perpetuated by the survivors' spouses and dependents. Those who faced stigma after recuperation endured ongoing blame for contracting the virus and restrictions on using personal items, such as the beddings utilized during isolation.

a) Experience of stigma from wife in form of continuous blame after illness

One of the male participants, (MP5) narrated his experiences of continuous blame from his wife after illness from COVID 19 as follows;

> Despite recovering fully from the sickness, my wife continued to blame me for having contracted the virus. My wife continuously accused me of deliberately putting my life and that of my family in danger. As far as she was concerned, I went out there looking for the virus to catch me and lo and behold, I accomplished my mission! (MP5)

b) Experience of stigma from husband in the form of prohibition in the use of personal items.

One of the female participants (FP1) described how her husband forbade her from using the beddings she used while she was isolated. She stated that,

> My husband stigmatized me after recovery. When I returned to my matrimonial bedroom, for example, my husband bluntly told me that he did not want the beddings I was using during the period of my sickness to be in our bedroom. This was despite me washing the beddings. He said that they had COVID-19. My husband ordered that I either throw them away or give them to the maid. In addition, my husband ordered that I abandon my pillow, which I was using during my sickness. He told me we should just buy a new one. I found this to be disturbing. (FP1)

4.1.1.3 **Experiences of non-stigmatization at home during and after illness**

The study found that whereas reports of being stigmatized in the household were common both during and after sickness, there were also accounts of its absence. One male participant (MP4) for example reported that, "I was not stigmatized be it during or after my illness at home. My family treated me well." (MP2). In the same vein, a female participant (FP 5) indicated that "No one stigmatized me at home." When probed about the reasons for their experiences of non-stigmatization, one male participant (MP4) said, "I am sure it is because both my wife and I were sick at the same time. So no one had the time or energy to mete out stigma on the other." (MP4) Similarly, one female participant (FP3) said, "The disease was accepted in the house especially that at some point, everybody except my daughter was sick. So we had to be there for each other." (FP3)

4.1.2 **Experiences of COVID-19 survivors in terms of stigma in the neighbourhood during and after illness**

The study revealed that all participants, with the exception one female participant (FP5), were not stigmatized in the neighbourhood, either during or after illness from COVID-19.

4.1.2.1 **Experiences of non-stigmatization during and after illness in the neighbourhood**

Experiences of non-stigmatization were prominent during and after the survivors' illness from COVID-19. While some participants attributed the lack of stigma to the fact that they lived in gated communities where interaction with nearby neighbours was uncommon, others explained that they chose to be discreet about their COVID-19 status out of fear of stigmatization in the neighbourhood. The study further revealed that even when close neighbours knew about the survivors' COVID-19 status, they treated them decently.

a) Experiences on non-stigmatization due to living in gated communities

One male participant (MP1) narrated how he was spared of stigma in the neighbourhood because of being a resident of a gated community as follows:

> I live in a gated community and only have few neighbours. The two neighbours that knew about my status treated me with respect. Through the phone, one would regularly check on me, and I can confess that she was very considerate. The other neighbour would also jokingly ask, 'are you in this world?' each time he saw me sunbathing outside our yard. After recovery, my interactions with my neighbours continued to be normal. (MP1)

Similarly, one female participant (FP2) recounted that "No stigma was placed on me. I believe it is because of the neighbourhood I live in. There is little interaction with the neighbours. Nikumayandi (It is located in a low-density area) so everyone minds their own business."

b) Experiences of non-stigmatization as a result of being discreet about their COVID-19 status

One male participant (MP2) described how by keeping his condition a secret, he avoided stigmatization in his neighbourhood. He said as follows:

> According to my observation, people were reacting negatively to individuals who tested positive for COVID-19. This was perhaps due to a lack of knowledge about the disease itself. So, I did not share my condition with my neighbours. I did this to protect my children and family. I did not want them to be stigmatized. So, experiences of stigma were not present both during and after my illness. (MP2)

In yet another testimony, one female participant(FP1) disclosed that,

> I did not share about my illness with my neighbours. This is because contagious diseases such as COVID-19 come with stigma. So, I did not want either myself or my family to be stigmatized. As a result, my neighbours, except for one whom I had informed, did not know that I was actually sick with COVID.In this way, I was treated in a normal way. My neighbour whom I had informed equally did not stigmatize me in any way. (FP1)

4.1.2.2 **Experiences of being stigmatized during and after illness in the neighbourhood**

The aforementioned quotes demonstrate that the COVID-19 survivors' experiences in the neighbourhood were not stigmatized. One female participant (FP 5) did, however, offer a different perspective. She described how the people in her neighbourhood were brutal to her and passed comments that were offensive. She said the following:

> The period of my sickness was a nightmare. The people in my neighbourhood stigmatized me. They had no regard for me. Immediately they learned that I had tested positive, they came to my home to close the tap of water, which the community and myself were drawing water from. They claimed it was infected by COVID-19. This was despite them disinfecting it. That tap remained closed for the whole period I was sick. Everybody around my neighbourhood was instructed not to come near the tap or my home. There was no consideration of where I could be drawing water from, regardless of my condition. As if to add salt to injury, I was even ordered to keep my windows closed during the period of isolation, regardless of how much I needed some fresh air in my room. My immediate neighbour treated me like an outcast. Once in a while, when he remembered, he would pass by my house but stand afar from my window, which remained closed for the whole period I was sick, and begin to ask how I was feeling. I really felt rejected and condemned.After recovery, people in the community would pass negative comments like 'you have lost weight, hmm madam, mwezodwala? Naimwe bo punzila muma dwala COVID?' (Madam, you also had COVID despite your education?) Their facial expressions whilst talking to me left much to be desired. (FP5)

4.1. 3 **Experiences of COVID-19 survivors in terms of stigma in the workplace during and after illness**

The experiences of survivors at work were comparable to those at home. While some participants described encounters with stigma, others claimed that they were not stigmatized. However, some participants were unable to express their opinion on the matter.

4.1.3.1 **Experiences of being stigmatized during illness at the workplace**

Experiences of stigmatization at the work place during illness from COVID-19 were reported by

some survivors. They manifested in many forms such as unjust treatment, condemnation, and accusations from the survivors' coworkers and supervisors.

a) Experience of stigma from colleagues in the form of unjust treatment

One female participant (FP 2) described her experience of stigma in the form of unjust treatment. She said, "My workmates stigmatized me during my illness. They treated me as if I no longer existed. Can you imagine that at the time I was sick, none of them bothered to call me? I felt unjustly treated mwandi (seriously)." (FP2)

b) Experience of stigma from colleagues in the form of judgment /condemnation

In describing his experience of stigmatization in the form of judgment and condemnation, one male participant (MP2) stated that,

> I was stigmatized by some of my colleagues during my illness. This was in the manner they interacted with me on the phone. They would tell me you were not taking care of yourself and that is why you got the virus. I felt like I was being judged because as far as I know, I did take care of myself. (MP2)

c) Experience of stigma from colleagues in the form of blame/accusation

One male participant (MP4) whose experience of stigmatization constituted elements of blame and accusation provided the following narrative:

> I experienced stigma during the period of my illness. When my colleagues learnt that I had tested positive, they blamed me that I was inconsiderate. According to them, I knew about my status even before testing and instead of staying away from the office, I continued reporting for work. I felt very bad as this was not true. They openly confronted me and said I should have stayed away. There was a lot of negative talk surrounding my illness. Once in a while, some colleagues would call me but not to find out how I was doing but to complain that I put their lives in danger by not isolating myself earlier. Even when I tried to explain that I did not know, they did not understand. The accusations were unbearable (MP4).

d) Experience of stigma from both colleagues and supervisors in the form of verbal abuse and offensive descriptions

One of the male participants (MP5) described how his colleagues and supervisor blamed and

resented him while he was ill with COVID-19. He said,

> My supervisor and coworkers stigmatized me. They claimed that because I could not get away from the pandemic, I was not a serious human. Their words hurt. Whilst in isolation, my friend would inform me that I was always a subject of discussion in their meetings that I did not take precautions and so risked their lives as well as the lives of the clients in my care deliberately. Whenever they called to check on me, I could overhear comments from even my supervisor like ‘alibwanji munthu wa COVID, "How is this person with COVID-19," as if I did not have a name. I found this to be offensive (MP5).

4.1.3.2 **Experiences of stigmatization after illness at the workplace**

Stigmatization experiences at work occurred not just when participants were ill but also after illness. While some survivors encountered unwelcoming behaviours and prejudiced treatments, others described being so overcome by self-stigma to a point where they could not cough freely as they feared that their colleagues would conclude they still had the infection.

a) Experience of stigma from colleagues in the form of unwelcoming behaviours

One female participant (FP1) described how her colleague stigmatized her by acting in an unwelcoming manner. She said that,

> When I resumed work, a colleague who knew about my status was behaving funny towards me. Whenever I entered his office, he would quickly grab his mask and put it on. It made me realize that with these colleagues, it did not matter whether I was okay or not. As far as they were concerned, I still had COVID-19 (FP 1).

When probed whether the colleague’s action was really stigma or just a way of ensuring his safety, FP1 maintained that she was being stigmatized. She argued that the “Colleague was just stigmatizing me. Why only wear a mask when he sees me entering his office?” The female participant (FP1) further added that at another point, she visited yet another office and when she entered, the colleague rudely uttered “Let me put on my mask. I am told you had COVID.”

One of the male participants (MP2) also reported that “Upon my return to the workplace, a few people were scared of me. They did not believe that I was fully recovered. In some cases, some people would see me and then ran for their masks.” Likewise, another male participant (MP1) recounted that:

> I experienced stigma from some of my colleagues after recovering. As you are aware, the recommended social distance was one meter, but for some of my colleagues, the distance between me and them would be two meters each time they came through to talk to me. To me this was stigmatization and it felt awkward. How honestly would they do that especially that I had presented test results that showed that I was healed? In addition, each time some people saw me, they would quickly want to mask up. Remember these are people that are chatting with their masks off but immediately they see you, they want to mask up! This behavior was so humiliating to a point where I felt like I should be moving with the test results from office to office so as to erase people's suspicions (MP1).

b) Experience of stigma from colleagues and supervisors in form of prejudice

One of the male participant (MP4) recounted how his supervisor and colleagues treated him with prejudice after recuperation. He narrated that,

> When I was about to resume work, I was requested by the office secretary to pass through her office to collect something. To my surprise, what I was being asked to collect were actually completed and approved leave forms. I was given a ten-day leave, which I did not apply for. When I asked why this was the case, my supervisor said they just wanted me to be away so that my body could get enough rest. As far as I was concerned, this was nothing but stigmatization. Why on earth would they assume that I still needed to rest? Making a decision without consulting me? I found this gesture to be very unfair. That to me did not sound like a good reason. It affected me psychologically and I was thinking to myself this was not love. As far as the people at my workplace were concerned, I was still contagious. I went away and when the ten leave was over, I reported back for work. However, to my surprise, the office organized people from the Ministry of Health to come and test people for COVID. I am very sure this gesture was targeted at me because why on earth would they only do this test after I had gone back? They were just hiding in the name of saying it was for everyone. I am very sure I was the target. My colleagues equally were heard passing negative comment like we only hope you have really recovered because we do not want to die because of you (MP4).

c) Experiences of self-stigma

One female participant (FP4) explained that her experience amounted to self-stigma. She narrated that,

> I did not have any experience of stigma during or after my illness from my colleagues or supervisors. However, I should confess that I had self-stigma. This is because after resuming work, I still had some lingering symptoms. I was coughing. Each time I felt like coughing, I suppressed it for fear that my colleagues would hear me and conclude I was still sick (FP4).

4.1.3.3 **Experiences of non-stigmatization during and after illness at the workplace**

The study found that while experiences of stigmatization were common both during and after sickness, experiences for some survivors were entirely free of stigma. One male participant (MP5) who received fair treatment for instance, said that,

> I cannot recount any experience of stigma from my workmates either during or after illness. They treated me justly. Probably because most of my colleagues did not know that I was sick. The few that knew were my friends and so maybe they did not want to injure my feelings (MP5)

Another male participant (MP 3) equally reported that, "When I resumed work, the treatment I received from my colleagues was just. There was not even a mention of my illness. Colleagues were happy that I was back". In the same vein, one female participant (FP 5) recounted, "When I returned for work, the stigma was not there. I believe it is because at some point, I hear almost everyone at my workplace, including my boss had contracted the virus and it humbled them. So they were cordial with me." One more male participant (MP 4) gave a similar account. He said,

> I can confirm that experiences of stigma were not present during or after my illness at the workplace. This is because when I for example informed my supervisor that I had tested positive for COVID-19 on the phone, he sympathized with me and said oh, I have taken note. Please take your bed rest. I felt this was positive in the sense that other supervisors would have said bring proof to my office that you are sick -like doubting me. He added that the moment you report back, bring proof that you have recovered. To me this was the right approach as there was need to prevent the spread of the virus. Of course I sometimes received comments/questions like "mwapola zoona imwe (Are you sure you have recovered fully?) I again did not take offense as people just wanted to be sure if I was fine**.** Once or twice, I walked into my colleague's offices. They did not have their masks on but the moment they saw me, they grabbed their masks and put them on. I saw nothing wrong with this. To me my colleagues were just being careful. Once in a while I would also see my supervisor being careful by way of wearing a mask when in contact with me but I guess he was taking precautions so that the virus does not infect him. (MP4)

4.2.3.4 **Unaware of their experiences at the workplace**

Although it was rare, the study found that occasionally survivors were unable to say whether they had encountered stigma at work. This was so for one female participant (FP3) who stated:

> If experiences of stigma were there during or after my illness, then I cannot tell because I did not feel or experience them. At the time I was leaving, my office mates in fact wished me well. They said to me go well and get well soon. When I resumed work, I equally felt embraced. If my colleagues stigmatized me, then I do not know. (FP3)

4.2 EXPERIENCES OF COVID-19 SURVIVORS CONCERNING DISCRIMINATION IN THEIR COMMUNITIES DURING AND AFTER THE ILLNESS

In terms of discrimination in their communities, three themes emerged from the experiences of COVID 19 survivors. These were experiences of COVID-19 survivors in terms of discrimination in the home, experiences of COVID-19 survivors in terms of discrimination in the neighbourhood and experiences of COVID-19 survivors in terms of discriminations in the workplace.

4.2.1 Experiences of COVID-19 survivors in terms of discrimination in the home

Regarding survivors' encounters with discrimination in their homes during and after illness, the research revealed varied experiences among COVID-19 survivors. These oscillated between instances of discrimination to those of non-discrimination.

4.2.1.1 Experiences of discrimination during illness at home

Several survivors experienced discrimination while they were ill with COVID-19. Perpetrated by the survivors' spouses and dependents, experiences of discrimination took many different forms which included avoidance, deprivation, isolation, neglect, and abandonment.

a) Experiences of discrimination from wife in the form of avoidance

One male participant (MP1) described his experience of discrimination in the form of avoidance as follows;

> Elements of discrimination in the home were present during the period of my illness. I say so because my wife avoided me through and through. She actually made me move out of the bedroom to the spare bedroom. (MP1)

In response to questions about whether his wife's request that he moves to the spare bedroom while he was sick of COVID-19 was discriminatory or merely a precaution, MP1 maintained:

> It was discrimination because my wife was angry with him for being a patient. She actually forbade me to have any contact with anybody in the home. I longed to see my children even from a distance but this was not possible because my wife instructed the children to avoid me as much as they could. I felt deprived. (MP1)

The male participant (MP1) added, "Human beings are social beings. So regardless of one's condition, they still need contact. So it's difficult to accept the situation. That was unfair."

b) Experience of discrimination from wife in form of deprivation

In describing how he suffered discrimination from his wife in the form of deprivation, one male participant (MP5) narrated that, "My wife forbade me to leave the room, not even for the purposes of sunbathing as recommended by the doctors."

c) Experience of discrimination from husband and child in the form of unfair treatment

One female participant (FP2) reported that she was treated unfairly by both her husband and son. She recounted that "Experiences of discrimination were present during my illness. My husband and son did not want to have any contact with me. They did not even hide it." When probed whether the husband and son's alleged mistreatment represented discrimination or was merely a way to make sure COVID-19 regulations were followed, FP2 argued "No, it had nothing to do with that. These people were just being cruel. Can you imagine, in their angry voices, the duo would say ensure you keep to yourself!!" The participant added,

> I anticipated my spouse or someone else in the house to be there for me, despite the fact that COVID-19 is fatal. I remember being quite ill one night, but nobody bothered to check on me the next day or even consider bringing me water so I could take my medications. I was really hurt. (FP 2)

d) Experience of discrimination from sibling in form of abandonment

One male participant (MP5) described how his sibling discriminated against him by way of abandoning him. He shared that,

> My young brother, whom I take care of with my own money, discriminated against me. He made it clear that he did not want to have anything to do with me. He avoided me throughout the period of my illness and at some point, even left home and said he would only come back after my recovery**.** This was despite him knowing that I needed him around my home. (MP5)

4.2.1.2 **Experiences of discrimination after illness at home**

Experiences of discrimination were equally reported by some survivors after illness from COVID-19. These experiences manifested in several ways which included unfair treatment and restrictions in the use of house hold property by the survivors' spouses and dependents as was the case during the period of illness.

a) Experiences of discrimination from husband in the form of unfair treatment

One female participant (FP1) narrated how she was discriminated against by her husband who subjected her to unfair treatment. She said, “My husband did not just stigmatize me but also discriminated against me after my illness. This is because each time I either sneezed or coughed, he would chase me from the bedroom. So I was even afraid to cough in his presence.” (FP1)

b) Experience of discrimination from dependent in the form of restriction in the use of the kitchen /utensils

One female participant (FP2) reported that she was discriminated against by her sister. She said that,

> Despite recovering, my young sister did not want me in the kitchen for fear of me touching the kitchen utensils. Each time she found me she would angrily say to me muzatidwalika. Osakata ma poto (You will make us sick, do not touch the pots). As far as my sister was concerned, I was still contagious. (FP2)

4.2.1.3 **Experiences of non- discrimination during illness at home**

Even though some survivors encountered discrimination during the period of illness from COVID-19 at home, the majority did not. They received good treatment and were not shunned or subjected to any sort of persecution.

a) Experience of non-avoidance

One female participant (FP 4) described her non-discriminatory experience as follows:

> The children and the other dependents in the home did not discriminate against me during illness. Despite instructing them to keep their distance from me, they did not do so. The youngest boy in the family would in fact rush to meet me in the passage each time he heard our bedroom door open. Similarly, my nephew in the home would also say to me I know you want me to keep away from you but that I shall not do. What you are suffering from is just a disease like any other. It shall surely go away. In any case, even if I catch it, I will just take my medication and feel better. (FP4)

b) Experience of courtesy /consideration

One male participant (MP3) described how his wife was considerate and courteous towards him. He narrated that,

> Upon informing my wife that I had tested positive, she suggested that for the sake of precaution, I should not interact with the children. Considering the nature of the disease, I understood and so did not consider this as discrimination. All my wife was doing was for the safety of the family. However, each time my kids saw me; they would run away and chant "Daddy has COVID". This again did not feel like discrimination. It was funny and just looked like a game and I understood because my children needed to be safeguarded. In the same vein, my mother was scheduled to travel but she said she was not coming. She cancelled her trip. Again I will say it, this was not discrimination but just a way of protecting herself. (MP3)

c) Experiences of good treatment

One male participant (MP4) reported that he was treated well by his family during the period of his illness. He narrated that,

> I had no experience of discrimination in the home. I was treated well. My children in fact, were the ones coming to knock on our door requesting that we come out. But off course, we maintained our distance from them because we did not want them to be infected. (MP4)

Likewise, one more male participant (MP2) described how he was treated well. He explained that "My family was impartial towards me. They tolerated me through and through. My wife in fact did not avoid me. She would enter my room to serve me and attend to my needs." In the same way, one female participant (FP3) recounted, "The whole family except our daughter was sick. So no one had time or energy to discriminate against the other. We ensured that we were there for each other by being each other's keeper."

Further findings of the study were that in instances where some spouses had some discriminatory tendencies towards the participants, their extended families treated them with impartiality. One female participant (FP1) for example reported that:

> Despite my own husband discriminating against me, family members from my side did not. Can you imagine, in spite of knowing that I was sick with COVID-19, my brother sent his children to my home for a holiday. He told me COVID-19 has come to stay so at one point or another, we shall all get it. (FP1)

4.2.1.4 **Experiences of non-discrimination after illness at home**

The study revealed that the majority of the participants did not encounter discrimination after illness. This was so for MP 2, MP3, FP3, MP4 and MP5 who reported that their families treated them well much like they had done during the period of their illness. The study also found that after recovery, participants who had experienced discrimination while unwell no longer had those

experiences. This was the case for one male participant (MP1), who stated that "Life resumed to normal after the physicians certified me fit. My wife began to treat me nicely." The study furthermore, established that participants who attempted visiting their extended families after being declared fit were welcomed. A case in point was one female participant(FP4) who shared that, *"*When I recovered, I passed through my sister in-law's place from somewhere and when I told her not to come close to me, she was like "awe, mulibe COVID. (No, you have no COVID), just mingle with us."

4.2.2 **Experiences of COVID-19 survivors in terms of discrimination in the neighbourhood**

Survivors' experiences in the neighbourhood were characterized mainly by absence of discrimination. A report involving experiences of discrimination was however received from one of the participants.

4.2.2.1 **Experiences of non-discrimination during and after illness in the neighbourhood**

Absence of discrimination in the survivors' experiences was prominent both during and after illness in the neighbourhood. When probed why this was the case, some participants said that it was largely because they were discreet about their COVID-19 status, while others said that they barely interacted with the neighbourhood residents. One female participant (FP1) for example stated that, "The experiences of discrimination in the neighbourhood were absent from my life both during and after my illness. This is because my neighbours except for one were unaware of my condition and the one who knew did not subject me to any unfair treatment." Correspondingly, another female participant (FP2) narrated that,

> I had no experience of discrimination in the neighbourhood. Of course it is maybe because none of my neighbours knew about my condition except for one and she kept the information to herself. In addition, I hardly have contact with the people in my neighbourhood. (FP2)

The response from one of the male participants (MP 2) was not different. He said, "As I have indicated, my neighbours were not aware of my status thus I was not subjected to any discrimination*."* In the same vein, another male participant (MP4) recalled that, **"**Experiences of discrimination were not there both during and after my illness. Well, this was because the community did not know about my status." The responses obtained from these participants resonated with the response from one female participant(FP3) who said, "I did not experience

discrimination from the community. This is because I did not share with my neighbours that me together with my family had COVID-19. I did so to protect my family. You cannot be sure with these contagious diseases." One more male participant (MP1) equally produced a similar response. He narrated that,

> Considering that I hardly have contact with my neighbours, I do not think I had any experience of discrimination. In fact, after my recovery, the few neighbours I am in contact with were so excited to reunite with me. They hugged me and told me they were happy that I had recovered. (MP1)

In the same regard, one male participant (MP4) narrated that, **"**I hardly interact with my neighbours. So even when I was sick, they did not know. In fact, we hardly mingle in the neighbourhood. It is each man for himself and God for us all. So experiences of discrimination were not present."

4.2.2.2 **Experience of discrimination during and after illness in the neighbourhood**

Contrary to the above reports of non-discrimination experiences during and after illness in the neighbourhood was a report from one female participant(FP5) who informed the study that, "The entire community avoided me. They treated me like a person suffering from leprosy. None of my neighbours wanted to have anything to do with me." One more female participant (FP4) reported that her home [family] was discriminated against. She narrated that, "My neighbour's son who was always at our home playing with my son stopped coming during the period of my illness. He was stopped by his parents for fear that he would be infected. However, after recovery, he started coming to play." When asked whether this was really discrimination, FP4 replied "Well, I think it was and targeted at the house[family] which had COVID-19 patients."

4.2.3 Experiences of COVID-19 survivors in terms of discriminations in the workplace during and after illness

Concerning experiences of COVID-19 survivors in terms of discrimination in the work place during and after illness, the study found that some participants experienced discrimination while others did not. The study also showed that some participants experienced both non-discrimination and discrimination following their illness from COVID-19.

4.2.3.1 **Experiences of discrimination during illness at work**

Some COVID-19 survivors were discriminated against during illness at work These experiences included unfairness from coworkers and superiors as well as acts of abandonment.

a) Experiences of discrimination from workmates in the form of abandonment

One female participant (FP2) described how she was discriminated against in that she was abandoned. She disclosed that,

> None of my workmates cared to call to see how I was doing during my illness. I did not anticipate them coming to my house, but I did want them to at least call to express their worry. To them, I was no longer there simply because I had COVID-19. It appears that they believed they could contract COVID-19 even over the phone. I experienced severe discrimination. Even my friends did not bother to ask how I was doing. Not even a simple hello call and yet they are my second family. They abandoned me. (FP2)

b) Experiences of discrimination from workmate in the form of unfair treatment

One male participant (MP5) reported that his workmates discriminated against him by treating him unfairly. He narrated that,

> Prior to my sickness, my colleagues and I were given an assignment. A What's Up Group was created for the same purpose. Each time somebody submitted their work, there were acknowledgements from the members but surprisingly, when I posted mine, no one commented. Later on, I even noticed that my submissions were not even incorporated in the report. I felt very bad. (MP5)

4.2.3.2 **Experiences of discrimination after illness at the workplace**

Some survivors' post-illness lives included encounters with workplace discrimination. The study's afflicted participants disclosed that they experienced, among other things, isolation and rude looks from their workmates and supervisors in some cases.

a) Experience of discrimination from workmates in the form of rude looks

One male participant (MP2) reported that he was discriminated against because several of his coworkers gave him rude looks. His account was "I did experience discrimination from one or two of my colleagues. This could be read from their facial expressions which communicated that they did not want me close. These colleagues could frown each time they saw me coming." (MP2)

b) Experience of discrimination from colleagues and supervisor in the form of isolation

One female participant (FP5) revealed that she experienced isolation from both her supervisor and workmates after illness. She recalled that,

> My workmates, including my supervisor did not want to have anything to do with me. They made sure that I was really isolated from them. When attending meetings, none of them wanted to sit next to me and on one or two occasions, they left me out on an educational tour" (FP5)

4.2.3.3 **Experiences of non- discrimination during illness at the workplace**

The study established that some survivors were generally treated well during the period of their illness. Points of reference included one female participant (FP1) who narrated that,

> When I informed my supervisor that I had tested positive for COVID -19, her reaction to me was just normal. She wished me well and told me to ensure that I took care of my self during the period of my illness. The other workmates learnt of my illness later on whilst I was in isolation. I called them myself. Even them, they did not make me feel discriminated against. (FP1)

One male participant (MP 1) equally stated that, **"**I did not experience discrimination. In my view, there was acceptance." This account matched that of a different male participant (MP 3), who stated that, "Despite being aware of my COVID-19 status, my colleagues were cordial and respectful. Even though they were not physically in my house, I could tell they had regard for me."

4.2.3.4 **Experiences of non-discrimination after illness at the workplace**

The study discovered that some survivors did not experience discrimination at the workplace as shown by the verbatim quotes below, which emphasize embracement, fair treatment, and acceptance of participants after illness:

a) Experiences of embracement

One female participant (FP4) reported that rather than encountering discrimination, her coworkers embraced her. She said that,

> As far as I can recall, I personally did not experience discrimination. Life went on as usual after returning to the office. On the first day of my return, I was even invited for a departmental meeting. Back in the office, my colleagues gathered in my office to chat with me and one excitedly announced to someone who was just passing, "why are you passing

> like that, come in and greet our survivor here. We laughed about it and they said they were happy to see me. (FP4)

b) Experiences of fair treatment

A male participant (MP1) stated that his experience at work was characterized by fair treatment. His description was that, "I was not subjected to any partial treatment. Immediately I reported back, I joined my team mates in doing the assignments for the day. No one asked me to leave the group or denied me access to the office equipment. In short, there was acceptance." In the same vein, a female participant (FP2) reported that, "After my recovery, the Deputy Head Teacher called me. That was the only time he established contact with me. The other workmates also tried to contact me. Nonetheless, this was not the case during the period of my illness."

c) Experience of acceptance

One female participant (FP3) said that she did not experience discrimination at work; rather, she was accepted. Her account was,

> My colleagues did not discriminate against me. I get the impression that personnel from the other departments did not even care whether I was fully recovered or not. To them, it was good that I had resumed work so that their load of work could reduce. They had a laissez faire attitude towards me. (FP3**)**

4.2.3.5 **Combined experiences after recovery at work**

Some participants shared their experiences of discrimination and non-discrimination in tandem. While some coworkers welcomed and treated them well, others avoided and showed them hostility.

a) Experience of both embracement and avoidance from workmates

A female participant (FP1) shared her dual experience in terms of discrimination in the work place. She said,

> When I resumed work, the treatment I received from most of my workmates was pleasant but a few colleagues discriminated against me. For example, a colleague whose office is close to mine did not want to have any contact with me. Each time we met along the corridors or anywhere, he would turn and go in the opposite direction. (FP 1)

b) Experiences of cruel and unjust treatment from subordinates and supervisor

One male participant (MP4) stated that his subordinates and supervisors treated him unfairly and cruelly after his illness. He narrated that,

> I observed that a couple of my coworkers were avoiding me after I got back to work. They were hesitant to interact with me, and they only did it out of necessity. However, some of the members of my team embraced me especially those who also had the experience of COVID-19. Working as an investigator, I am sometimes required to appear in court but even after I had recovered, I would just receive word that your matter has been adjourned because the boss requested that we do so. I wondered and found this to be very demeaning and cruel. I was already fine and yet people up there would make decisions on my behalf that I was not fit to appear before the courts. In some cases, I would be given lighter jobs instead of the work I am employed to do. This I did not appreciate. I felt discriminated. (MP4)

4.3 EXPERIENCES OF THE COVID-19 SURVIVORS IN TERMS OF SUPPORT RECEIVED IN THEIR COMMUNITIES DURING AND AFTER THEIR ILLNESS

Three themes surfaced when exploring the experiences of COVID-19 survivors in terms of support received within their communities. These were experiences of COVID-19 in terms of support received in the home during and after illness, experiences of COVID-19 in terms of support received in their neighbourhood during and after illness and experiences of COVID-19 in terms of support received in the workplace during and after illness

4.3.1 Experiences of COVID-19 survivors in terms of support received in the home during and after illness

Survivors' experiences in terms of support received in the home both during and after the illness ranged between experiences of support and experiences without support.

4.3.1.1 Experiences of support received during illness

All of the participants except one received support at home while they were unwell. Forms of support received included encouragement, affection, and care from the survivors' spouses, children, family members and house helpers.

a) Experience of support from husbands in the form of care

One female participant (FP1) acknowledged that she received support from her husband during illness. She said,

> Though my husband did not treat me well at some point, I am alive to the fact that he tried in his own way to support me. For example, he would prepare me the home remedy for steaming and place it by the door of the room I isolated from. To me that was care and I appreciated. (FP1)

b) Experiences of support from husbands in the form of understanding and provision

One female participant (FP2) reported that her husband showed support by providing for her and being understanding. She narrated that

> My husband showed me support especially after I indicated to him that I needed to be supported. Remember I mentioned to you that he was angry with me for being found in the kitchen. But after I explained to him the reason why I was there, he understood and straight away went ahead to buy me a flask. He made sure I had warm water all the time thereafter. At some point my husband even started buying me fruits and food. (FP2)

c) Experiences of support from husbands in the form of love and encouragement

One female participant (FP4) reported that her husband showed her love and encouraged her throughout the period of her illness. Her report stated,

> Despite his own illness, my darling husband, cared for me and showed me love. He always encouraged me to take my medicine. Whilst I would be worrying about him during his illness, he was also busy worrying about me and only disclosed that to me much later after we had been declared fit by the hospital. Even though I did not want to, he persuaded me to have a sunbath. He would gently remind me how important vitamin C is. My husband prayed for me as well. From the beginning, he showed me attention. I can recall a time when I was merely feeling unwell and had no plans to visit the hospital. I believed I could simply buy some medication and take it. But he made me go to the hospital and immediately informed my family about my illness. My husband gave me even more support by answering my calls while I was ill. I didn't want to communicate with anyone. I was very irritated by the calls. (FP4)

d) Experiences of support from wife in the form of care

One male participant (MP2) described how his wife cared for him during illness. He said, “My wife supported me during the period of my illness. For example, she would give me home remedies and always forced me to eat. In addition, she cared for me to a point were in the process, she got infected too.”

e) Experiences of support from wife in the form of maintaining adherence to drug taking

One male participant (MP3) shared that his wife supported him in so many ways which included reminding him to take his drugs on time. His account was,

> My wife cared for me during my illness. In the process, she ended up having the disease. She was very supportive in so many ways. For example, I am not good at taking medicine. My wife would monitor and administer my medication. She in addition administered traditional medicines such as steaming. She encouraged me and also took care of my nutritional part. (MP3)

f) Experiences of support from wife in the form of self-sacrifice and encouragement

One male participant (MP4) narrated that in supporting him, his wife sacrificed her life to a point where she even got infected. In addition, her support was not void of encouragements. His narrative was,

> My wife was very supportive to a point where in caring for me, she ended up contracting the virus. In my low moments, my wife encouraged me and told me it shall be well. At some point after learning that two of my friends had succumbed to COVID-19, I lost hope but my supportive wife encouraged me and urged me not to lose hope. She gave me reason to remain strong. She would tell me I will pull through. (MP4**)**

g) Experiences of support from husbands in the form of provision and care

One male participant (MP1) narrated that his wife took care of his needs during illness. He said,

> Despite stigma and discrimination against me, my wife supported me. For example, never did I go hungry in my isolation room. My wife prepared the meals and served me by the door. She would always signal to me each time the food was ready. So she didn't just prepare the meal and expect me to guess that it was served. She informed me through the phone. My wife further took charge of our chicken business. Usually, I am the one that takes care of the chickens but at that time, my wife took charge. Talking of the home remedies, my wife also ensured that water for steaming was available. (MP1)

h) Survivors' experiences of support from children in the form of care, provision of meals and prayer

One female participant (FP1) narrated that her children supported her during her illness. She explained that,

> My daughter supported me through and through. Despite being diabetic, she was not scared of having contact with me. In fact, she helped me to heal quickly. She braved herself and was always saying if I don't take care of you or if I am not there for you, who is going to take care of you? Remember that you have always been there for me. Throughout the illness, my daughter was the one cooking for me and ensuring that my needs whilst in

> isolation were attended to. You can imagine, this is a child with a medical condition-diabetes but she could even attend to me without wearing a mask. (FP1**)**

Another female participant (FP2) reported that, "My daughter was supportive. She would serve me breakfast, lunch and super. She could even enter my room though masked up of course." One more female participant (FP4) shared how her children stood with her during her illness. She said,

> My children supported me during the time of my sickness. They kept asking how their sick dad and I were feeling every other time they heard the bedroom door open. They would tell me mummy you will be fine. We are praying for you. My children looked forward to our recovery and the day of our review. When we came back from the hospital and informed them that the doctor had discharged us, I could see relief in the faces of my sons, especially the older one. They were really concerned for us**.** (FP4)

Equally, another female participant (FP3) narrated that "My daughter, who was the only one spared of COVID-19 in the home showed us care. She was always preparing our meals and doing the entire house hold chores." (FP3**)**

i) Survivors experiences of support from parents

FP1, MP2, MP1, and MP5 all reported that even though their parents were not physically present, they nevertheless supported them by expressing worry about their situation and calling frequently to see how they were doing.

j) Survivors experiences of support from extended members of family

COVID-19 survivors were equally supported by extended family members by way of regularly calling them on the phone. However, this support was sometimes not welcome as was in the case of one female participant (FP4) who said:

> My extended family showed me support. They always checked up on me through the phone. However, in as much as I appreciated the gesture, there were times when I would find this infuriating especially the times when I was feeling very sick. I would then be ignoring the calls from family members and then at times my husband would just answer the call and tell them I would call them later. Then my family would say we are worried about her, please tell her to return the call. (FP4)

One other female participant (FP1) equally reported how her brother and aunties supported her. She said

> My brother and aunties were there for me. They showed me love and care. You can imagine, they supported me to a point where they went out of their way to provide me with

> medicines which the hospital was not giving. Each time they heard that this medicine is curing COVID-19, they would use their own money to buy for me. (FP1)

Probed on the reasons why her extended family supported her, FP1 disclosed that "I believe it was easier for them to support me because they also had patients in their homes or were at some point victims of COVID-19. So they showed me care."

FP 2 also indicated that "Relatives from my side were equally there for me. They would call or text just to know how I was fairing." Probed on whether the relatives from her husband's side equally supported her, the participant said "No, they rarely called to inquire about my health."

k) Experiences of support from house helpers

The study found that in the home, COVID-19 survivors were not only supported by family members but also house helpers to a point where one of the helpers even got infected. One female participant (FP4) for example reported that, "The maid equally showed us support by preparing our meals and water for steaming. She was so committed to a point where she even contracted the virus from us." One more female participant (FP3) similarly reported that, "The maid braved herself to take care of us. She did not stop coming to our home to attend to our needs."

l) Experiences of collective support during illness

One female participant (FP3) shared a report about receiving group assistance. This was true in her situation because COVID-19 struck her entire family at the same time. She narrated that,

> At the time of my illness, we were all sick in the home. However, we ensured that we supported each other as a family. Those with energy or strength would be looking after those who were severely sick. While others especially my husband moved around to look for drugs, others would be seen disinfecting the house so that we are not re-infected. We also prayed for each other.

4.3.1.2 **Survivors experiences in terms of support after illness**

All participants received support in the home after illness. Participants disclosed that after recovery, their families continued showing them love, care, and encouragement. One female participant (FP4) for example reported that, "When the doctors declared me fit, my children rejoiced with me. They hugged me and assured me of their continued prayers for me." Likewise, one male participant (MP5) narrated that, "After I had healed, my wife took me out for dinner. She

said she sympathized with me for the pain I went through and just wanted me to know that she still loved me. At some point, my wife even organized a thanksgiving service which was done right in my home."

4.3.1.3 **Survivor's experience of no support during illness at home**

As can be evidenced from the above quotes, almost all survivors were supported during illness. However, one female participant (FP5) did not receive support from her family at the onset of her illness as she was all alone at home. She recalled that the period of her illness was rough. She however stated that her family members who knew about her illness would call her though at some point her phone switched of as the battery became flat. "There was no one to charge it for me. Later on I left my place to stay with my relative who was living elsewhere," She charged.

4.3.2 **Experiences of COVID-19 survivors in terms of support in the neighbourhood during and after illness**

With regards to experiences of support in the neighbourhood, the study found that experiences of support were not just present in the home but also in the neighbourhood both during and after illness. One participant however informed the study that she was not supported.

4.3.2.1 **Experiences of support in the neighbourhood during illness**

COVID-19 survivors were supported by the few individuals in their neighbourhoods who knew about their illness. Calling the survivors, meeting their nutritional needs, encouraging them, and giving them advice on home remedies were just a few of the neighbourhood's supportive actions.

a) Support in the form of phone calls

One female participant (FP1) narrated that she received support in the form of calls from her neighbour. "My neighbour, who knew about my sickness would phone me every day to check on me," she said. In the same vein, another female participant (FP2) recounted, "Though not physically present, my neighbour whom I had informed about my illness was there for me and gave me a listening ear on the phone."

b) Support in the form of meeting the survivors' nutritional needs

One female participant (FP3) recounted of how her neighbours took care of her nutritional and medical needs. She said, "A few neighbours, who happen to be my church mates, were there for me. They would bring me fruits and I remember that one day my husband's friend brought us fruits and medicine from China."

c) Support in the form of advice

The support received by the survivors was not short of advice. One female participant (FP4) for example said that, "My neighbour was so supportive. She would call to advise that I do a lot of steaming using leaves from a neam tree. She further encouraged me to take a lot of ginger and lemon tea."

d) Support in the form of encouragement

One male participant (MP1) described how his neighbours offered him support through words of encouragement. He said, "My neighbours would send me messages of encouragement and greetings. They would tell me it is not the end of the World."

e) Support in the form of care

One male participant (MP4) described how his neighbour showed him care when he was critically ill. He said, "Once, when things became bad and I was having trouble breathing, my neighbour was alerted, and he came running over and drove me to the hospital. He waited for me until the doctors cleared me to return home."

4.3.2.2 **Experiences of support in the neighbourhood after illness**

Similarly, the study found that almost all the participants were supported after illness. One male participant (MP4) for example revealed that after his neighbours heard that he had recovered, "They visited his home and immediately they saw him, they hugged him." One of the female participants (FP3) equally indicated that, "Two of my neighbours actually prepared some nice food which they brought for me to eat. I felt loved." One more male participant (MP4) also explained that, "I was supported. The people in my neighbourhood visited me. They told me they came to celebrate my healing with me."

4.3.2.3 **Experience of lack of support during illness in the neighbourhood**

Despite reports about survivors being supported being prominent during illness, one of the female participants (FP5) gave a contrary report. She said,

> My neighbours treated me harshly. They did not support me. During the four days that I stayed in isolation, no neighbour offered to prepare me meals, draw water or prepare the remedies for steaming for me. This was despite them knowing that I was alone at home. They did not show me any empathy. (FP5)

4.3.2.4 **No position on the issue of support in the neighbourhood**

One of the male participants (MP3) could not state his position regarding support received in the neighbourhood. His narrative was, "I hardly interact with my neighbours. So I would not say that I expected any support from them. So the aspect of support was neither here nor there."

4.3.3 **Experiences of COVID-19 survivors in terms of support at the workplace during and after illness**

Concerning experiences of survivors in terms of support at the workplace, the study found that in most cases, survivors had experiences of support from their workplace both during and after illness. However, a few isolated incidences which showed that the survivors were not supported were also recorded.

4.3.3.1 **Experiences of support from the workplace during illness**

Throughout their illness, some survivors got assistance in numerous ways from their coworkers and managers. These included phone calls, words of encouragement, gestures of concern, and displays of love.

a) Experiences of support in form of encouragement from supervisor

One of the female participant (FP1) shared how her supervisor supported her through encouragements. She said, "My supervisor supported me. She would call me and give me encouragement and reassurances that I would be fine." A male participant (MP3) shared a similar report. He said, "My supervisor encouraged me to follow the timings for my medication. He even encouraged me to continue taking my bed rest and only report after the doctor certified me fit." In the same line, one more female participant(FP3) stated that, "The department I belong to supported

me. They encouraged me and said I would be fine. They would call me to find out how I was feeling. (FP3)

b) Experiences of support from the workplace in form of gestures of love

One female participant (FP4) who shared her experience of support in the form of consideration, guidance and help narrated that,

> Throughout the period of my illness, my workmates supported me. They called to check on my well-being. Despite the fact that occasionally I did not answer the phone. Nevertheless, they persisted. Sometimes they would simply text. When one of my workmates learnt that I had tested positive for COVID-19, she expressed worry and said, "Actually, I'm at Soweto Market; let me get you some red onion." She was really considerate. At one point she called and before she could say anything, she apologized for calling. She said she was aware that some COVID-19 sufferers did not enjoy receiving calls. However, she wanted to know how I was doing. That was thoughtful of her. (FP4)

c) Experiences of support from the workplace in form of provision of medical facility

In addition to the previously described methods of support for COVID-19 survivors, one male participant revealed how his company made sure that they supplied a medical facility. His report was, “My employers were there for me. They kept the medical scheme for COVID-19 testing active all the time. So I did not use my money for the tests that I did.” (MP1)

4.3.3.2 **Experiences involving support after illness at the work place.**

Reports of COVID-19 survivors receiving support after illness were also received. The statements that follow illustrate how participants described receiving support from coworkers, supervisors, and subordinates in many ways, including warm gestures, promises of continuous assistance, and consideration:

a) Experience of support in the form of warm gestures

One female participant (FP1) recalled how much warmth she received from her coworkers. She said, “When I reported for work, most of my colleagues including my supervisor came through to my office to welcome me and inquire about my health.” A male participant (MP10) recounted a similar experience. He said, “I was supported. When I returned for work, my colleagues passed through my office to check on me. They told me they were happy to see me.”

b) Experience of support in form of assurance of continued support

A female participant (FP4) described how her immediate supervisor gave her a promise of ongoing support. Her account was, "My supervisor assured me of his continued support especially that he was also a COVID-19 survivor. In addition, he told me not to hesitate to inform him whenever I felt sick so that he could grant me permission to go home."

c) Experience of support in form of consideration

One of the male participants (MP1) reported that, "Upon resuming work, my supervisor told me to be knocking off in an event where I felt sick. This was very considerate of him."

4.3.3.3 **Conflicting experiences during illness**

Some survivors reported having conflicting experiences while they were unwell. On the one hand, the survivors felt supported, while on the other, it was the complete reverse. An illustration of this was provided by a male participant (MP2) who stated that,

> I was supported by my workmates during my illness to some extent. I say so because a few of my workmates would call me to find out how I was feeling. On the other hand, however, I feel I did not receive support. This is because one or two occasions my colleagues called me, their questions would be focused on how I got COVID or whether I was taking care of myself. This made me feel judged. The questions were not what I needed at that time; I needed encouragement or to be asked how I was feeling. I felt there was a lack of emotional support. (MP2)

Correspondingly another male participant (MP4) narrated that,

> Yes, I was supported but on the other hand, I was not. Yes, in the sense that once in a while, my immediate supervisor would call me to check up on me. I believe she understood what I was going through because at some point, her brother died of COVID-19. The Administration Department, which is in charge of staff welfare, would also call me, maybe out of duty or not, I don't know but they would call me. At some point, the Director General also called me to find out how I was doing. A few of my colleagues would also do the same. However, the team that I work with together with my immediate supervisor, whom I actually expected to support me did not do so. They never called me during the time of my illness." (MP4)

4.3.3.4 **Experiences not involving support during illness**

In as much as the survivors received support from the workplace during illness, the report from one female participant (FP5) was different. She said "All I received from my workmates during my illness was stigma and discrimination. I was not supported."

4.4 SUGGESTIONS ON HOW COVID-19 PATIENTS AND SURVIVORS SHOULD BE TREATED GOING FORWARD.

In addition to describing their experiences in terms of stigma, discrimination and support received in the communities during and after their illness from COVID-19, survivors made the following suggestions on how COVID-19 patients and survivors should be treated in the communities:

4.4.1 Support COVID-19 patients and survivors

The study's participants demanded assistance for COVID-19 patients and survivors. They urged communities to make sure that COVID-19 patients and survivors receive emotional, physical, spiritual, and social support. These factors help the victims feel loved and cared for. This lessens the isolation and rejection they experience as a result of the disease. Participants stressed the importance of treating patients and survivors with compassion, care, and encouragement as it promotes healing in the case of the patients and self-worth in the case of the survivors. Encouragement also provides patients with hope and a spirit of resistance. Participants emphasized the importance of support by stating that:

> Not that we expect the communities to risk their lives but at least find out even on the phone how the patient or survivor is doing. While it is a requirement that the COVID-19 patient should be isolated, let the people in the homes or health centers not neglect the patients as doing so can lead to death. There are times when the patient requires just some water to take his/her medication and if such a one is abandoned on condition that he/she is contagious, their condition can worsen and eventually cause death. (FP2)

Participants further guided that communities should have a positive attitude towards COVID-19 patients and survivors and not treat them like are already condemned to death. Such acts were detrimental as they could lead to feelings of despair, depression and if not properly handled may lead to death (MP4).

4.4.2 Do not stigmatize or discriminate against COVID-19 patients or survivors

Participants submitted that COVID-19 patients should not be stigmatized or discriminated against as doing so can lead to death or induce other medical conditions in the victims. In supporting this suggestion, one male participant (MP5) informed the study that, “Each time I was stigmatized during illness, my BP would go up.” In the same vein, COVID-19 survivors should not be subjected to stigma or discrimination after illness. This is because they were no longer carrying the virus and even if they were, there was no justification for discriminating against them because

humanity demanded that every person should be treated with respect. Furthermore, participants pleaded that communities should ensure that they treat patients and survivors justly so that they realize that they are valued especially that suffering from such a disease may affect one emotionally (MP1).

4.4.3 **Maintain communication**

Participants suggested that communities should not cut communication with the COVID-19 patients as doing so would cause them depression. They added that "Instead of cutting communication, communities should actually be working towards improving it for the wellbeing of both the patient and the survivor." MP3)

4.4.4 **Avail accurate information to COVID-19 patients**

Participants submitted that COVID-19 patients should have access to accurate information about the pandemic and its cure as misinformation confuses the patients and leads to anxiety. They added that the information should be made readily available on various social media platforms and the originators should be medical personnel.

4.4.5 **Do not impose admission on patients**

Participants noted that medical staff appeared anxious while patients were unwell. They were terrified of contracting the illness and passing away, just like everyone else. As a result, the patients in their care, particularly the hospitalized ones, were ignored and in some other way did not get the care they needed. As a result, participants proposed that hospitals should be places of choice so that people are not forced to be in hospitals where there is no proper care. Other avenues should be provided so that comfort and care needed by the patients to pull through is available.

4.4.6 **Do more research about the COVID- 19 pandemic**

Participants observed that there was a lot of trial and error when administering medication because this pandemic was new and had no known cure. As a result, they demanded additional study in this field so that the ideal medication might be manufactured.

4.4.7 **Be patient with COVID-19 patients**

Participants recommended that communities should show the COVID-19 patients tolerance and patience. This is due to the fact that sometimes the agony associated with the disease is so severe that the patient may not even want to communicate with or be bothered by others, including family members. This was demonstrated by one female participant (FP4) who said, "Just because COVID-19 patients are not answering your calls does not indicate that they do not want to talk to you. They can be acting in this way because they are in so much agony right now that all they want to do is sleep."

4.4.8 **Provide counselling services to COVID-19 patients and survivors**

Participants requested that counseling services should be made available to the COVID-19 patients and survivors and that the availability of this service should be made known to the victims. This is because COVID-19 is deadly and comes with issues of stigma and discrimination; it affects one's mental health - talk of depression or feelings of rejection. Consequently, counselling was necessary to assist the victims in coping with their sentiments and emotions. Participants added that communities should not assume that survivors were emotionally and psychologically secure and only experienced physical hardship as that was untrue.

4.4.8 **Health officials to commence treatment immediately one tests positive**

Participants submitted that COVID-19 patients should be put on treatment immediately they test positive to avoid the spread of the virus or the condition of the patient worsening.

4.4.9 **Learn from survivors**

Participants submitted that communities should listen to the COVID-19 survivors so that they learn from them. They asserted that survivors had a wealth of knowledge to provide on how to take care of oneself whilst unwell, how to maintain optimism while suffering from the disease or when facing stigma or discrimination. The finest teacher, they said, was experience.

4.5 **SUMMARY**

The chapter on the findings revealed that COVID-19 survivors had varied experiences in terms of stigma, discrimination and support in the communities. These experiences oscillated between presence and absence of stigma, discrimination and support in the communities. Forms of stigma

experienced involved humiliation, condemnation, rejection, reprimands and prejudices while experiences of discrimination included avoidance, deprivation, isolation, neglect and abandonment. In terms of support, survivors were given encouragement and shown love, care and warmth by the communities.

CHAPTER FIVE: DISCUSSION

5.0 Overview

This chapter discusses the findings of the study which aimed at exploring the experiences of COVID-19 survivors in terms of stigma, discrimination suffered and support received in their communities in Lusaka District, Zambia. The discussion of findings is presented based on the objectives of the study which were; to explore experiences of COVID-19 survivors in terms of stigma from their communities during and after the illness, to ascertain experiences of COVID-19 survivors in terms of discrimination from their communities during and after the illness and to establish experiences of COVID-19 survivors in terms of support received from their communities during and after the illness.

5.1 EXPERIENCES OF COVID- 19 SURVIVORS IN TERMS OF STIGMA IN THEIR COMMUNITIES DURING AND AFTER ILLNESS

Three themes emerged from the experiences of COVID-19 survivors regarding stigma in their communities. These were experiences of COVID-19 survivors in terms of stigma in the home during and after illness, experiences of COVID-19 survivors in terms of stigma in the neighbourhood during and after illness and experiences of COVID-19 survivors in terms of stigma in the workplace during and after illness.

5.1.1 Experiences of COVID-19 survivors in terms of stigma in the home during and after illness

The study established that experiences of COVID-19 survivors in terms of stigma in the home during and after illness varied. These experiences spanned from instances of facing stigmatization to instances of not encountering any stigma.

5.1.1.1 Experiences of being stigmatized during illness at home

Stigmatization from their spouses and dependents throughout the illness was a defining aspect of some COVID-19 survivors' experiences at home. These individuals endured humiliation, reprimands, blame, resentment and accusations for having contracted the illness. The study received descriptions of stigmatization that included one instance in which a female participant was constantly reprimanded and humiliated by her son and husband for leaving her bedroom, even

for valid reasons like answering the call of nature or fetching water from the kitchen for her medicine. This case exemplified how stigmatization permeated even the most basic aspects of daily life, intensifying the already arduous experience of battling the illness. Furthermore, it highlighted the extent to which the lifeworld is shaped by interpersonal dynamics, with the home becoming a site where stigma is actively reinforced. In another scenario, two male participants were accused by their wives of contracting the virus due to perceived lack of caution. These accusations not only contributed to the survivors' emotional distress but also highlighted the interpersonal dynamics within the family as a crucial factor influencing the lifeworld. The attitudes and behaviors of close family members significantly influenced the survivors' perceptions and experiences, demonstrating that the lifeworld is a complex and dynamic space shaped not only by the physical environment but also by the social interactions and relationships that unfold within it.

The study corroborated Prioleau's (2020) research, which demonstrated that family members, at risk of exposure, chastised COVID-19 survivors and held them responsible for contracting and spreading the disease. Adom et al. (2021) similarly disclosed that survivors faced stigma from household members. Amir (2021) documented cases where COVID-19 survivors were mocked by their siblings, who continually reminded them of bringing a deadly disease to the family. In other instances, survivors were labeled and ostracized, aligning with the findings of the current study.

Although most of the stigma faced by research participants stemmed from external sources, there were a few exceptional cases where individuals exhibited self-stigma. In these instances, the affected survivors experienced feelings of guilt for contracting the illness and held themselves responsible. This finding corroborated Scambler's (2004) argument that individuals with contagious diseases may internalize stigma, leading to emotions such as shame, blame, and worthlessness. The study further strengthened the findings of Yadav et al. (2021) by confirming that COVID-19 survivors indeed encountered internalized stigma.

5.1.1.2 **Experiences of being stigmatized after illness at home**

Stigmatizing incidents were not confined to the period of the survivors' illness but extended even after their recovery. Perpetrated by the survivors' spouses and dependents, these occurrences manifested as continuous blame for contracting the Coronavirus, biased attitudes, and restrictions

on personal items such as beddings used during isolation. For example, one female participant faced the demand from her husband to discard or give away the pillow, bed sheets, and blanket she had utilised during her illness, despite having thoroughly washed and disinfected them. This action could be perceived as stigmatization, considering the items were clean and posed no infectious risk, and the survivor was free of the virus. Nevertheless, it is crucial to acknowledge that there might be other motivations prompting such behaviour from the participant's husband. While not always rooted in stigma, these justifications could stem from concerns about potential lingering infection on the beddings, even after cleaning and disinfection. These accounts illustrated how lived time and lived relations intersect to create a complex narrative of post-COVID stigmatization. The survivors' ongoing experiences of blame and restrictions represented a temporal continuity that extends beyond the immediate period of illness. At the same time, the negative dynamics within their relationships highlighted the profound influence of lived relations on their overall well-being. The negative behaviors, such as constant blame, prejudices, and restrictions on personal items, underscored the impact of these lived relations on the survivors' well-being. The betrayal by spouses and dependents during the post-recovery period demonstrated how lived relations could become sources of distress and contribute to the overall negative experience of the survivors. The study's results aligned with those of Adom et al. (2021), who documented various instances of stigmatization. One example involved a female survivor being prohibited from meeting her biological mother by her older sister, who believed the survivor was still contagious. Another case highlighted a female survivor enduring stigma from her family, who insisted that she remained contagious despite her recovery.

5.1.1.3 **Experiences of not being stigmatized during and after illness at home**

Despite the fact that experiences of stigmatization were relatively common among several participants during and after illness in the home, reports confirming the absence of stigma in the experiences of some COVID-19 survivors were documented. In these cases, participants indicated that they were treated fairly and respectably by family members. The equitable treatment was attributed to the fact that the participants' families were aware of the pandemic because they had either personally experienced it or at the very least were ill at the same time as the participants. Therefore, the illness and its victims were accepted. Phenomenology highlights the role of intentionality, which refers to the directedness of consciousness towards objects or experiences. In

the provided context, the intentionality of the participants' families played a crucial role. The families' awareness of the pandemic and their personal experiences with it created a shared understanding, fostering an environment where the illness and its victims were accepted rather than stigmatized. This shared intentionality contributed to the positive experiences of the participants. The report also demonstrated how the marriage vow 'for better or worse' was actualized in the lives of the participants whose spouses respected and treated fairly. Phenomenologically, this could be seen as a commitment to shared experiences, acknowledging that the illness was a part of the collective lived reality. The spouses' respect and fair treatment further reflected the intentional commitment to support each other through challenging times.

The outcome also showed that families typically stick together in good and bad. Times. This aligned with the phenomenological concept of inter-subjectivity, which emphasizes the shared and communal aspects of human experience. The participants' positive experiences were not only individual but also embedded in the collective context of family relationships.

5.1.2 **Experiences of COVID-19 survivors in terms of stigma in the neighbourhood during and after illness from COVID 19**

Experiences of survivors in terms of stigma in the neighbourhood were characterized mainly by absence of stigmatization. However, a report concerning an experience of stigmatization was received.

5.1.2.1 **Experiences of being stigmatized during illness in the neighbourhood**

In relation to this research, experiences of stigma were infrequent. Only one female survivor living in a high density area shared her encounters with stigmatization, describing it as an act of cruelty. The participant revealed that when news spread about her positive COVID-19 test, her water supply was disconnected, and community members were advised against entering her premises, where the water tap was situated. No consideration was given to where she could obtain water. The participant further mentioned that community members instructed her to keep her windows closed throughout the isolation period, despite her need for fresh air. This account revealed how social interactions played a pivotal role in shaping her experience. The disconnection of her water supply and the community's avoidance of her premises for example highlighted the immediate consequences of social stigma. The lack of empathy or support from community members created a hostile social environment for the participant. The account further demonstrated the impact of

community attitudes on her lived space. The advice given to community members to stay away from her premises reflects a breakdown in social cohesion and support. The community's stigmatizing behavior not only affected the participant directly but also contributed to a sense of isolation and exclusion within her own community. In the same vein, the built environment, represented by the participant's home and immediate surroundings equally became a space where the effects of stigma were materialized. The disconnection of water supply and the instruction to keep windows closed during isolation are examples of how the built environment can be manipulated to further stigmatize an individual. This revealed how societal attitudes can permeate physical spaces, affecting the individual's ability to access basic necessities and maintain a healthy living environment. In this context, the findings underscored how the stigma associated with COVID-19 can profoundly influence an individual's life world. The participant's account sheds light on the emotional and practical challenges she faced, highlighting the interconnectedness of the social, communal, and physical aspects of her life.

In terms of the literature examined, this finding resonated with the accounts of Abuhammad et al. (2021) and Barbosa et al. (2021), who documented instances of physical abuse, insults, and rejection as forms of stigma experienced by COVID-19 survivors in their communities. It is important to note that, in the case of these researchers, experiences of stigma within the neighbourhood were widespread, affecting numerous survivors.

5.1.2.2 **Experiences of being stigmatized after illness in the neighbourhood**

The study established that only the female participant who had described encounters with stigma whilst unwell also encountered stigma after illness. The participant indicated that after her recovery, neighbours were heard making disparaging remarks about how an educated person like her contracted the illness. From time to time, she also saw people in her neighbourhood making rude and taunting facial expressions towards her. This finding was consistent with the report of Bagcchi (2020) which revealed that COVID-19 survivors were labelled and greeted with hostile stares when they returned to the community. It is important to highlight that the female participant in question resided in a densely populated area, fostering regular interaction within the community. Nonetheless, survivors residing in low density areas did not face the same level of stigma. This result underscored the significance of community dynamics and social interactions in molding individuals' experiences during periods of crisis.

5.1.2.3 **Experiences of not being stigmatized during illness in the neighbourhood**

The study established that experiences of non-stigmatization were prominent among the COVID-19 survivors in the neighbourhood during the period of the survivors' illness. All the participants with the exception of one, reported encounters of non-stigmatization. While some participants ascribed the absence of stigma to living in gated communities where social interaction with neighbours was uncommon, others claimed the absence was brought on by the fact that they were discreet about their COVID-19 status out of fear of stigma. This observation led to the conclusion that stigmatization had harmful repercussions, which included sufferers of contagious diseases not disclosing their status, a state that enhanced the virus's ability to spread, particularly if the afflicted engaged in social interaction. The study, however, found that even when close neighbours knew about the survivors' COVID-19 status, they treated them decently. This result stood in contrast with the report of Prioleau (2021) which demonstrated that the majority of COVID-19 survivors experienced stigmatization in their neighbourhoods in a variety of ways such as downplaying their illnesses or COVID-19 experiences, shame and name-calling, and being held responsible for the stay-at-home orders. The result also refuted claims made by Abuhammad et al. (2021) and Barbosa et al. (2021) that physical abuse, insults, and rejection were common stigmatization experiences for COVID-19 survivors in the neighbourhoods both before and after their illness.

5.1.2.4 **Experiences of not being stigmatized after illness in the neighbourhood**

Absence of stigmatization among the COVID-19 survivors characterized the experiences of almost all the participants of this study. This finding was at odds with the report of Bagcchi (2020) which revealed that COVID-19 survivors were labelled and greeted with hostile stares when they returned to the community. The finding further contradicted the accounts of Adom et al. (2021), Amir (2021), and Atinga (2021) who documented experiences of stigma in various forms such as ridicule, accusation, rejection, and exclusion among the survivors in the communities.

5.1.3 **Survivors' experiences in terms of stigma at the workplace during and after illness from COVID 19**

Experiences of COVID-19 survivors at work were comparable to those at home. While some participants described encounters with stigma, others said that they were not stigmatized. However, one female participant was unable to voice her feelings on the subject.

5.1.3.1 **Experiences of being stigmatized during illness at the workplace**

The study established that some COVID-19 survivors experienced stigma from their work places during the period of their illness. These experiences comprised unjust treatment, condemnation, accusations, prejudices, verbal abuse and derogatory descriptions from the survivors' workmates and supervisors. These results supported Prioleau's (2021) assertion that COVID- 19 survivors were stigmatized in that the companies they worked for claimed an unfair right to their medical records.

5.1.3.2 **Experiences of being stigmatized after illness at the workplace**

Experiences of stigmatization in the work place were not only present during the survivors' illness but also after. Survivors reported being met with unwelcoming behaviours and prejudiced treatment. One female participant and two male participants described how each time they emerged, their co-workers promptly grabbed their masks and put them on. One could claim that the co-workers' choice to cover their faces whenever they saw the participants appear was not driven by stigma but rather served to ensure their safety and uphold the COVID-19 preventive measures. This argument is supported by a report from one of the male participants who experienced a similar encounter. He argued that he saw nothing wrong with the behavior and that his co-workers were just being cautious. However, the fact that the survivors' co-workers did not always wear their masks but only did so when they saw the survivors led to the conclusion that the

survivors were being stigmatized. The variation in interpretation of these incidences demonstrated that the universe has diverse meanings and that reality exists in the participants' worlds as asserted by Gay et al. (2009). This diversity reflected the richness and complexity of human experiences, reinforcing the idea that individuals bring their own background, beliefs, and context to their understanding of a situation. The variation further underscored the idea that reality is not an objective, fixed entity but rather a subjective and multifaceted construction.

In some accounts of stigmatization, survivors were forced to maintain unusual social distances, such as two meters apart, whenever their co-workers or superiors sought to interact with them. This went against the World Health Organisation's recommendation of a social distance of one meter (WHO Dash Board, 2021). Other incidents included survivors being given extra sick-off days by their employers without their consent and having COVID-19 tests performed on all employees including the survivors on the day they resumed work. In light of the information provided, it may be argued that giving the survivors more sick-off days after exhausting the ones they were given by the hospital was a kind and considerate act rather than a means of stigmatizing them. Another defense could be made that the fact that health officials were present in the workplaces and conducting mandatory COVID 19 tests on the day that participants reported for duty was merely a coincidence. This researcher disagrees because if organisations had the best of intentions, they should have discussed the issue of extending the survivors sick leave with the participants, especially since they were of sound mind and able to decide whether or not they needed extra time to rest for themselves. The researcher further argues that the mandatory COVID-19 tests conducted by Health Officials in the workplaces on the day the survivors reported might not have been a coincidental event but rather a planned activity driven by concerns that the

participants were still ill or simply to verify the accuracy of the certificates of fitness provided by the participants.

The study's findings, which showed that survivors experienced workplace stigmatization as a result of their disease, were consistent with Atinga et al. (2021) description. For instance, they described an incident where a survivor joined other employees in looking for official documents that were allegedly missing in the office. When the survivor found the documents, his manager murmured that they were no longer needed. The manager later returned fully covered in a face shield and mask, requested for the documents, sanitized them thoroughly and placed them in a locker cabinet. Praveen and Ittamalla (2021) equally provided an account of workplace prejudice. Based on these reports, it is the conclusion of the researcher that once a person has a contagious disease—in this case, COVID-19 they sometimes continue to be seen as a patient by those around them even after they have fully recovered. This conclusion was drawn from the reports that COVID-19 survivors were still stigmatized despite full recovery.

In extremely rare instances, survivors recounted experiences of self-stigma. A point in reference was one female participant who indicated that when she resumed work, she still had some lingering symptoms, such as a cough. However, she was not able to clear her throat despite the irritation for fear that her co-workers would think she was still contagious. She also resisted the temptation to sneeze.

5.1.3.3 **Experiences of not being stigmatized before or after illness at the workplace**

Despite the fact that stigmatization incidents frequently occurred at work, some survivors reported not being stigmatized while they were unwell or afterward because they were treated fairly and without labels. One male participant supposed that this was the case because most of his co-workers were uninformed of his illness, and the few that did were his friends, who may have been unwilling to stigmatize him out of fear of upsetting him. On the basis of this data, it can be argued that stigmatization depends on the degree of friendship that exists between the victim and the

normal. One more participant (female) attributed the absence of stigma to the fact that nearly everyone at her workplace had at some point been infected and had subsequently recovered from the illness and been humbled by it. Consequently, they treated her with kindness. This comment implies that COVID-19 survivors find it easy to accept others who may be suffering from the sickness. The finding of this study resonated with the account of Atinga et al. (2021), who reported decent treatment of COVID-19 survivors' in the workplace.

5.1.3.4 **Unaware of their experiences**

Despite many participants giving their position as regards stigma in the work place either during or after illness, one female participant failed to do so. She asserted that because she did not feel or encounter sensations of stigma, she was unable to tell whether they existed during, or after her illness. The female participant added that her employees had actually wished her well as she was leaving. They urged her to maintain good health and make a speedy recovery. She also felt embraced when she resumed working. The participant ended her report by denying that none of her co-workers had ever stigmatized her. Concerning this report, the researcher concluded that the female participant was not stigmatized despite not expressing a position as one cannot miss the stigmatization tendencies when they are present in their experiences.

5.2 **EXPERIENCES OF COVID -19 SURVIVORS REGARDING DISCRIMINATION IN THEIR COMMUNITIES DURING AND AFTER ILLNESS**

Three themes concerning discrimination in their communities came out of the experiences of COVID 19 survivors. These were experiences of COVID-19 survivors in terms of discrimination at home during and after illness, experiences of COVID-19 survivors in terms of discrimination in the neighbourhood during and after illness and experiences of COVID-19 survivors in terms of discrimination at work during and after illness.

5.2.1 **Experiences of COVID-19 Survivors in terms of discrimination at home during and after illness.**

Survivors' experiences with discrimination in the community during and after sickness varied. They fluctuated between encounters with discrimination and non-discrimination.

5.2.1.1 **Experiences of being discriminated against during illness at home**

The study found that a number of COVID-19 survivors encountered discrimination at home when they were unwell. People close to them, in this case the survivors' spouses, children and siblings, were responsible for these experiences. The survivors reported experiencing avoidance, deprivation, isolation, neglect, and abandonment as forms of discrimination. In one instance, a male participant reported that he was avoided and prevented from remotely speaking with or seeing his children by his wife. In addition, he was ordered to relocate to the guest room; he claimed that this was done not out of love but rather out of resentment because his wife was upset with him for becoming infected with the epidemic. One could contend that the male participant's claim of discrimination against him was legitimate given the possibility of using alternative methods like phone or video conversations to enable connection and conversations between the male participant and his children. However, it might also be claimed that by making sure that her children did not interact, the male participant's wife was merely attempting to protect their lives. The researcher also makes the case that, given the contagiousness of COVID-19 and the medical authorities' expert recommendations that all victims be isolated, the decision to move the male participant to the guest room by his wife may not have been made with the intention of discriminating against him but rather with the goal of protecting her family and halting the spread. In support of this, another male participant who had a similar experience in which he was asked to shift to the spare bedroom contended that his wife was only being cautious to protect his family from contracting the illness and not discriminating against him. He added that at one time his mother was scheduled to visit him but cancelled her trip after learning he had COVID-19. The male participant insisted that this was not discrimination as his mother was merely preserving her life.

One of the other instances forbade a male participant from leaving the room, even to engage in sunbathing as advised by doctors. Another victim was abandoned by his young brother, who made a pledge to only come back once the participant had recovered. In a similar vein, a female participant experienced mistreatment and brutality. As she made her way to the bathroom, she would frequently cross paths with her husband and son, who would rudely request that she keeps to herself. She added that on certain days, the family was unable to even put a jar of water next to her bedroom door so that she could take her medication. The study's reports of experiences of discrimination in the home were consistent with the literature that was read. As an illustration,

Bagcchi (2020) discovered that discrimination against COVID-19 survivors took place in the homes during illness. He cited a COVID-19 survivor who was abandoned by her spouse and family after giving birth and being diagnosed with the virus. Similar to this, Atinga et al. (2021) noted that COVID-19 victims were told to vacate their family homes and pay rent elsewhere until their relatives could verify their full recovery. Correspondingly, reports of discrimination were made by Adom et al. (2021), who detailed how a COVID-19 sufferer felt shunned by his family when his mother-in-law stopped him from self-quarantining at home while he was ill because two of her children were there.

5.2.1.2 **Experiences of being discriminated against after illness at home**

Discrimination experiences were prevalent not just during the period of illness but also after. Deprivation and unfair treatment from the survivors' spouses and dependents were just two of the ways these experiences presented themselves. In one case, a female participant was ejected from her husband's presence in the bedroom whenever she coughed or sneezed. She eventually became hesitant to clear her throat whenever need arose. Considering that the participant had already recovered despite the lingering symptoms, she posed no threat to anybody. Therefore, it could be argued that chasing her out of her bedroom each time she coughed was unfair. This account highlighted several key phenomenological themes the first being the embodied experience of illness and recovery. The participant's body, still bearing the symptoms of illness even after recovery, became a site of tension and conflict within her social environment. Her husband's reaction reflected a particular understanding of illness and contagion, where coughing or sneezing is associated with threat and danger. Secondly, there is the intersubjective dimension of discrimination. The participant's husband's actions not only affected her bodily experience but also shaped her sense of self and her relationships. Being ejected from the bedroom communicated a message of exclusion and rejection, impacting the participant's sense of belonging and intimacy within her marital relationship. Thirdly, there was the temporal aspect of discrimination. The participant's experiences of discrimination extended beyond the period of illness itself, indicating how discriminatory practices can persist even after the physical symptoms have subsided. This highlighted the enduring impact of discrimination on individuals' lives and underscored the importance of considering the long-term consequences of discriminatory behavior.

In another case, one female participant was not allowed to use the kitchen or any of the utensils there. Her young sister would irritatingly question whether she had fully recovered each time she found her in the kitchen. Based on these reports, the researcher reiterates that even after being released from the hospital and being deemed pandemic-free, some people may still view you as contagious. The findings of Atinga (2021), who discovered that COVID- -19 survivors were still victimized even after recovering from the pandemic, corroborated the findings of this study. He observed that survivors were denied access to household objects and excluded from family gatherings. Equally, Adom et al. (2021) documented instances of COVID-19 survivors being avoided in the home.

5.2.1.3 **Experiences of not being discrimination against during illness at home**

Even though some participants spoke about encounters with discrimination, descriptions of other participants did not include such incidents. The study found that several participants were treated well and were not avoided or persecuted in any way during the time of their illness. One female participant for instance shared that despite telling her children and other dependents in the house to keep their distance from her, they did not do so. In reality, every time the children heard her bedroom door open, the youngest son in the family would run to greet her in the hallway. The participant's nephew did not want to avoid her either. A male participant also explained that he received favorable treatment and despite his warnings to his children or wife to stay away from him, they disobeyed. His children would knock on his bedroom door and ask him to come out. Another male participant explained that his wife would enter his room to bring him meals and respond to his other needs. This report contradicted the reports of Bagcchi (2020); Atinga (2021) and Adom et al. (2021) who asserted that COVID-19 survivors were discriminated against in the home. The study also revealed that in some cases where spouses showed some discriminating behavior toward the participants during the period of illness, their extended family members treated them well. This was the case for one female participant whose young brother visited and left his children with her in spite of her illness. The proverb "blood is thicker than water" comes into play in this description because, while the participant's husband chose to treat the wife unfairly, her brother opted to stand by her side. The researcher also argues that despite the requirement for couples to uphold their 'for better or worse' vows, COVID-19 forced some spouses to violate them.

5.2.1.4 **Experiences of not being discriminated against after illness at home**

Experiences of some of the COVID-19 survivors were void of discrimination after their illness. These participants reported being treated well by their families, just as they had done during the time of their illness. The study further established that for survivors who were subjected to discrimination during illness, life returned to normal as was the case with one male participant. He explained that after the doctors declared him fit, his wife stopped discriminating him. This aspect added a temporal dimension to the lifeworld, emphasizing the evolving nature of individuals' experiences and interactions in the aftermath of illness. The change in attitude towards this participant could be attributed to the fact that the fear of being infected through him was no longer there as the participant had healed. This report confirmed the assertion by Dar et al. (2021) that stigmatization and discriminatory tendencies against the survivors of communicable diseases are minimized or eliminated completely after recovery.

5.2.2 **Survivors' experiences in terms of discrimination in the neighbourhood during and after illness from COVID 19**

Absence of discrimination was a key factor in the experiences of survivors in the neighbourhood. Nonetheless, a complaint detailing instances of discrimination was received.

5.2.2.1 **Experiences of non-discrimination during and after illness in the neighbourhood**

The Majority of the participants had non-discriminatory experiences. They received good treatment both during and after their illness in the neighbourhood. While some argued that this situation resulted from them hiding their COVID-19 status, others claimed it was because they seldom interacted with the locals. Given that several participants admitted to concealing their illness status, this created a risk to the neighbourhood residents. The study further demonstrated the stigma associated with communicable illnesses, which is why individuals were being subtle about the pandemic. This finding refuted the reports of Abuhammad et al. (2021) and Barbosa-Camacho et al (2020) who concluded that survivors experienced discrimination. They reported that survivors faced evictions from rented houses or public places and were denied access to public transport. The report further contradicted the account of Bagcchi (2020) who reported incidences of persecution, where patients and survivors of the pandemic were bullied on social media. He further documented a media report of discrimination where a survivor was shocked to learn that during the period of his illness, the road in front of his house was named 'corona road' and some

individuals opted to avoid using it for fear of possible infection. Furthermore, the results contradicted the report of Adom et al. (2021) which found that two market women who had recovered from COVID-19 were refused entry into the market to sell their products as everyone thought they were infected with COVID-19.

5.2.2.2 **Experiences of being discriminated against during and after illness in the neighbourhood**

Although many participants expressed satisfaction with their interactions with the community, few participants' tales were different; In one case, a female participant was avoided to a point where no one wanted to interact with her. Put differently, the participant was treated as though she had leprosy. The results of this study were consistent with the account of Atinga et al. (2021) who documented that despite recovering fully, COVID-19 survivors were denied access to community public goods such as toilet facilities, parks and recreational areas just because they were once infected. In one of their reports, a male survivor was asked to leave the pitch where he had gone to watch football because some spectators felt that he was still contagious. Their other report detailed how another survivor was forcefully withdrawn from a community keep fit and fun walk event involving about 40 participants.

In another case, a female participant of the study reported that her close neighbours forbade their son to play with her child for fear of contracting the illness. After her recovery however, the neighbours allowed their son to play with the participant's child. This incident supported the assertion that as soon as a disease is eradicated, its victims are re-embraced (Dar et al.,2021). In addition, the result resonated the account of Atinga et al. (2021) who reported that the discrimination did not just affect the survivors but also their immediate members of their families, especially the children. One of their participants for example, narrated that on several occasions, her three children were prevented from playing with their peers in a community playground. In addition, her neighbours also sternly instructed their children to avoid all her kids who were described as 'unsafe to play with'. Adom et al. (2021) in Ghana validated the reports of discrimination and went further to reveal that some COVID-19 survivors, including their family members were not allowed to buy things from retail shops as there was a claim that the survivor's money was infected with COVID-19.

5.2.3 **Survivors' experiences in terms of discrimination at the workplace during and after illness from COVID 19**

The study found that while some COVID-19 survivors experienced discrimination in the workplace, others did not. It was also clear from the narratives given that some survivors had experienced both discrimination and non-discrimination as a result of their illness.

5.2.3.1 **Experiences of being discriminated against during illness at the workplace**

Experiences of discrimination during illness included abandonment and unfair treatment from supervisors and co-workers. Those affected included a female and male participant. The female participant related how the adage "out of sight, out of mind" came true in her life because no one tried to call her when she was ill. In the case of the male participant, neither her supervisor nor her co-workers ever acknowledged or used the work he provided to the what's up group. The report was in line with Bagcchi (2020), who discovered that employees were subjected to different forms of discrimination, which included being fired for suffering from coronavirus. In a similar vein, Praveen and Ittamalla (2020) documented instances of discrimination at work while employees were ill.

5.2.3.2 **Experiences of being discriminated against after illness at the workplace**

Discrimination was still an issue for some COVID-19 survivors in their post-occupational disease lives. Describing their experiences, participants explained that discrimination suffered manifested in various forms such as offensive facial expressions like frowning, as was the case for one male participant, isolation and exclusion from educational tours, as was the case for a female participant, whose co-workers and supervisor refused to interact with. The report's conclusions concurred with those of Atinga (2021), who detailed numerous instances of unfair treatment, including survivors being denied the chance to participate in mandatory staff meetings, being instructed to leave the workplace immediately and return when contacted, and being denied access to the staff restrooms.

5.2.3.3 **Experiences of non-discrimination during illness at the workplace**

Even though there were occasional cases of discrimination, the study found that some survivors received favourable treatment when they were unwell. This was true for a female participant as well as two male participants, whose interactions were characterized by polite reception, acceptance, and regular treatment from co-workers and managers. The reports of Praveen and

Ittamalla (2020) and Bagcchi (2020) which documented the existence of discrimination in the workplace, were disputed by this report.

5.2.3.4 **Experiences of non- discrimination after illness at the workplace**

Several participants did not experience discrimination after illness. One female participant for example shared that her experience was characterized by embracement while one male disclosed that he was treated so fairly that invitations to join his colleagues for assignments were extended to him. One more female expressed similar sentiments.

5.2.3.5 **Combined experiences after recovery**

Several survivors noted that while some welcomed them back for work, others did not. Workmates who discriminated against them avoided and treated them with hostility. This was true for one female participant, who received kind treatment from many co-workers but experienced discrimination from another in that every time she ran into him in the hallways or anywhere else, he would turn and walk away, leaving the participant feeling bad. A participant who was male had a similar experience. While some people, notably those who had COVID-19 before, treated him well, others treated him harshly and unfairly. Being an investigator, he was required to appear in court. Nevertheless, he would only learn that his matter had been postponed at his boss's request. The participant was puzzled by this and felt denigrated by it. In other situations, he would receive easier tasks in place of the labour he was hired to complete. The survivors' experiences of discrimination and hostility from certain workmates revealed a fundamental aspect of phenomenology, which is the intersubjective nature of human existence. In the workplace, interactions with others shaped one's experience of belonging and acceptance. The participants' encounters with discrimination highlighted the importance of interpersonal relationships in shaping their sense of self-worth and inclusion. The hostile behavior of certain colleagues contributed to a sense of alienation and otherness, contrasting with the kindness and acceptance demonstrated by others. These interpersonal dynamics illustrated the complex interplay between individual subjectivities within the shared context of the workplace. Furthermore, the participants' feelings of being denigrated and puzzled by their treatment underscored the phenomenological concept of intentionality-the inherent directedness of consciousness towards objects or phenomena. In this case, the participants' consciousness was directed towards their experiences of discrimination and unfair treatment, prompting reflections on their own sense of worth and dignity.

The discrepancy between their expectations of fair treatment and the reality of discrimination disrupted their sense of coherence and meaning in the workplace, leading to feelings of confusion and distress.

Additionally, the participants' encounters with institutional barriers, such as the postponement of court appearances and the assignment of easier tasks, highlighted the structural dimensions of their experiences. Phenomenology acknowledges the influence of socio-cultural and institutional contexts on individual experiences, emphasizing the significance of these broader structures in shaping the possibilities and constraints of lived experience. The participants' frustration and sense of injustice stemmed not only from interpersonal interactions but also from systemic factors that perpetuated inequality and marginalization.

5.3 EXPERIENCES OF COVID -19 SURVIVORS REGARDING SUPPORT FROM THEIR COMMUNITIES DURING AND AFTER ILLNESS

From the reports of COVID 19 survivors, three themes regarding their experiences in terms of support received from their communities emerged. These included experiences of COVID-19 survivors in terms of support at home during and after illness, experiences of COVID-19 survivors in terms of support from the neighbourhood during and after illness, and experiences of COVID-19 survivors in terms of support in the place of employment.

5.3.1 Experiences of COVID-19 survivors in terms of support in the home during and after illness

In this study, the participants received support in various forms, such as expressions of love, care, understanding, encouragement, reminders for medication, and acts of selflessness, even to the extent of family members exposing themselves to the virus. This aligned with the findings of Kirby (2021) and Adom et al. (2021), who also observed the provision of support to survivors during their illness, emphasizing the sensations of love, empathy, and care. However, a notable contrast emerged in the account of one male participant who experienced abandonment by his brother during his illness. This narrative resonated with the findings of Atinga et al. (2020) who reported that some COVID-19 survivors faced a lack of support at home, leading to situations where victims were instructed to leave their homes and received no attention from family members when they disobeyed such orders. This discrepancy highlighted the multifaceted nature of lifeworld

experiences and the impact of interpersonal dynamics on the support networks available to individuals during times of illness.

5.3.2 **Experiences of COVID-19 survivors in terms of support in the neighbourhood during and after illness**

The presence of support in the neighbourhood permeated the experiences of nearly all the survivors. Support was shown in the form of phone calls with good wishes, words of encouragement, and suggestions for all-natural pandemic treatments. The research by Atinga et al. (2021) found that survivors were not assisted in the neighbourhood, which was in contrast to this conclusion. In a similar vein, Adom et al. (2021); Abuhammad et al. (2021) and Barbosa-Camacho et al. (2020) reported the same outcome since the survivors received no affection. The story of one female participant of this study who was left to fend for herself despite the neighbourhood being aware of her illness and her inability to care for herself at the time of her illness was however consistent with the contradictory reports of the former and latter.

5.3.3 **Experiences of survivors in terms of support in the workplace**

Most COVID-19 survivors received support from co-workers and supervisors during the period of their illness from COVID-19. Nevertheless, reports that some survivors were not assisted also came through.

5.3.3.1 **Experiences of being supported from the workplace during illness**

Many COVID -19 survivors acknowledged being supported in so many ways which included loving gestures, phone calls to check on their well-being, encouragements, and care. Further forms of assistance included co-workers' advice on how the survivors should treat COVID-19 symptoms and employers' free access to the medical plan as was the case for one female participant and one male participant respectively. The support received by COVID-19 survivors exemplified how the lifeworld shapes and is shaped by interpersonal relationships, cultural norms, and institutional practices. It underscored the importance of understanding the holistic context in which individuals navigate their experiences, especially during times of crisis like the COVID-19 pandemic.

5.3.3.2 **Experiences of not being supported from the workplace during illness**

Despite many survivors recounting experiences of support, one female participant reported that she received no help from her employer because neither her boss nor her coworkers phoned to

check on her during the entire time she was ill. This finding was consistent with the report of Praveen and Ittamalla (2020) who found that some employees lost their jobs.

5.3.3.3 **Experiences of being supported after illness at the workplace**

After their illness, all participants were supported at the workplace. Forms of support received included cordial greetings, promises of ongoing assistance, considerate deeds, and a general acceptance of the survivors. The study's finding resonated with the account of Kirby (2021) who found that survivors were supported by their employers in a similar manner.

5.3.3.4 **Combined experiences during illness at the workplace**

In a few rare instances, survivors reported a variety of experiences in which some co-workers showed them support while others opted not to. Instead, they condemned the survivors, and in some cases they did not even try to call to see how they were doing. This was true for one male participant.

5.4 **Summary**

This chapter discussed the findings on the lived experiences of COVID-19 survivors within their communities in Lusaka District, Zambia. The discussion focused on the survivors' experiences in terms of stigma, discrimination and support received in the home, neighbourhood and workplace. The study revealed that COVID-19 survivors encountered a spectrum of experiences within their communities, encompassing both instances of stigmatization and acceptance, discrimination and fair treatment, as well as encounters with both support and absence of support. The discrepancies highlighted the diverse and sometimes contradictory nature of lifeworld experiences. They further demonstrated that the lifeworld was a complex and dynamic space shaped not only by the physical environment but also by the social interactions and relationships that unfolded within it. The study's results were comparable to the works of previous studies conducted on the study topic elsewhere. It can thus be contended that the present study has brought out some insights and new knowledge on the lived experiences of COVID-19 survivors in Lusaka, Zambia. The next chapter deals with conclusion, recommendations and further research recommendations.

CHAPTER SIX: CONCLUSION AND RECOMMENDATIONS

6.0 Overview

This chapter provides the Conclusion and Recommendations. Suggestions on areas for future research are also presented.

6.1 Conclusion

This study set out to explore the lived experiences of COVID-19 survivors in their communities in Lusaka District, Zambia. The study found that COVID-19 survivors' lived experiences in the communities included experiences of stigmatization and non-stigmatization, discrimination and non-discrimination, as well as experiences of support and lack of support.

Experiences of stigmatization included humiliation, condemnation, rejection, reprimands, accusations, and prejudices. In the home environment, the survivors' spouses and dependents were the stigmatizers, whereas at work, the survivors' co-workers and managers were the perpetrators. In some cases, survivors had self-stigma as they blamed themselves for getting the Coronavirus. In contrast to the prevailing pattern, occurrences of stigmatization in the neighbourhood were relatively infrequent. Some participants associated this phenomenon with the distinctive features of residing in gated communities. In this scenario, the limited frequency of neighbourly interactions served as a moderating element, curbing the proliferation of stigma. This result underscored the significance of community dynamics and social interactions in influencing individuals' experiences during periods of crisis.

Various forms of discrimination were encountered within the home environment, encompassing actions such as avoidance, deprivation, isolation, neglect, and abandonment by both spouses and dependents. Discriminatory experiences in the workplace manifested as unfair treatment, exclusion, and insulting remarks from colleagues and managers. Conversely, some participants expressed feelings of being welcomed, treated fairly, and accepted in certain instances. Notably, the study identified a shift in treatment based on the health status of survivors, with those who had previously faced discrimination while unwell experiencing a more positive reception once they had recovered. This observation introduced a temporal dimension to the individuals' lifeworld, emphasizing the evolving nature of individuals' experiences and interactions in the aftermath of

illness. The study further found that the experiences of the survivors in the neighbourhood comprised little to no discrimination. Some participants asserted that the decision to conceal their COVID-19 status was the reason behind the non-discrimination experiences.

Finally, COVID-19 survivors received support both during and after their illness. Encouragement, affection, and care were provided by their husbands, children, extended family members, and housekeepers. The workplace provided support in the form of phone calls, encouragements, medical facilities, care, and displays of affection. A few individuals, though, did not receive any support from their employers during their illness. This discrepancy highlighted the diverse and sometimes contradictory nature of lifeworld experiences. Experiences of support were also recorded in the neighbourhood. However, a single report was received where a participant complained of a lack of help. In some circumstances, survivors had contradictory experiences; on the one hand, they received assistance, but on the other, the experience was the complete reverse. This underscored the variability in lifeworld experiences and the importance of considering individual perspectives

6.2 Recommendations

In light of the discoveries made in the present exploration, the researcher presents several recommendations below. These suggestions aim to serve as a reference for the appropriate treatment of individuals who have survived COVID-19 in society, offering guidance on effectively addressing any challenges, they may encounter as patients or survivors.

6.2.1 The research revealed that certain communities subjected COVID-19 survivors to stigmatization and discrimination, posing a risk of increased mortality or exacerbation of pre-existing medical conditions. One study participant for example experienced elevated blood pressure whenever confronted with stigma. Considering this, the government should utilize its public health communication system to create diverse messages discouraging the stigma and discrimination of COVID-19 patients and survivors.

6.2.2 The COVID-19 patients and survivors should be provided with counselling services, and the victims should be made aware of this service's availability. These services should be made available at all public health facilities and those accredited under NHIMA as part of an overall policy.

6.2.3 The experiences of survivors should be used in developing training resources for counsellors and public health personnel.

6.3 Future Research Areas

The study focused on the lived experiences of the survivors in terms of stigma, discrimination and support in the communities. While not extensively explored, the survivors' accounts did shed light on certain impacts of stigma and discrimination on their well-being. Consequently, forthcoming studies should prioritize the investigation of how enduring stigma and discrimination affects the mental well-being of survivors and explore the coping strategies they utilized.

REFERENCES

Abdullah A.B. (2020). COVID-19 pandemic: a new chapter in the history of infectious diseases. *Oman medical journal*, *35*(2), e123.

Abuhammad, S., Alzoubi, K. H., & Khabour, O. (2021). Fear of COVID-19 and stigmatization towards infected people among Jordanian people. *International Journal of Clinical Practice*, *75*(4), e13899.

Adom, D., Mensah, J. A., & Osei, M. (2021). The psychological distress and mental health disorders from COVID-19 stigmatization in Ghana. *Social sciences & humanities open*, *4*(1), 100186.

Amir, K. (2021). COVID-19 and its related stigma: A qualitative study among survivors in Kampala, Uganda. *Stigma and Health***.**

Atinga, R. A., Alhassan, N. M. I., & Ayawine, A. (2021). Recovered but constrained: narratives of Ghanaian COVID-19 survivors' experiences and coping pathways of stigma, discrimination, social exclusion and their sequels. *International Journal of Health Policy and Management*.

Bagcchi, S. (2020). Stigma during the COVID-19 pandemic. *The Lancet Infectious Diseases*, *20*(7), 782.

Barbosa-Camacho, atel (2020). Comparison of fear of COVID-19 in medical and nonmedical personnel in a public hospital in Mexico.

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

Brooks, atel (2020). The psychological impact of quarantine and how to reduce it: rapid review of the evidence. *The lancet*, *395*(10227), 912-920.

Brown, M. E., & Dueñas, A. N. (2020). A medical science educator's guide to selecting a research paradigm: building a basis for better research. *Medical Science Educator*, 30(1), 545-553.

Charlick, atel (2015). Interpretative phenomenological analysis: Implementing research to influence breastfeeding education. *International Journal of Childbirth Education*, *30*(2), 49-54.

Chew, F. (2000). Cut from the same cloth? Communications researcher ethics. *Journal of Mass Media Ethics*, *15*(2), 115-126.

Chipatu, L. (2017). *Environmental learning for coping with drought among small-scale farmers of Luangwa District, Zambia* (Doctoral dissertation, The University of Zambia).

Clarke, atel (2015). Thematic analysis. *Qualitative psychology: A practical guide to research methods*, *222*(2015), 248.COVID-19 after Vaccination: Possible Breakthrough Infection..

Curtin, M., & Fossey, E. (2007). Appraising the trustworthiness of qualitative studies: Guidelines for occupational therapists. *Australian occupational therapy journal*, *54*(2), 88-94.

Dar, S. A. atel (2020). Stigma in coronavirus disease-19 survivors in Kashmir, India: A cross sectional exploratory study. *Plos one*, *15*(11), e0240152.European Centre for Disease Prevention and Control.

James, P. B., atel (2019). Post-Ebola psychosocial experiences and coping mechanisms among Ebola survivors: a systematic review. *Tropical Medicine & International Health*, *24*(6), 671-691.

Gardner, atel (2021). It is your fault: workplace consequences of anti-Asian stigma during COVID-19. *Equality, Diversity and Inclusion: An International Journal*, *41*(1), 3-18.

Gasson, S. (2004). Rigor in grounded theory research: An interpretive perspective on generating theory from qualitative field studies. In *The handbook of information, systems research* (pp. 79-102). IGI Global.

Gay, L. R.atel (2009). *Educational research: Competencies for analysis and applications*. Merrill/Pearson.

Gay, L. R.atel (2012). *Educational research: Competencies for analysis and applications:* Pearson Higher Ed.

Giorgi, A., & Giorgi, B. (2003). *Phenomenology*. Sage Publications, Inc. Gunawan, J. (2015). Ensuring trustworthiness in qualitative research. *Belitung Nursing Journal*, *1*(1), 10-11.

Hennink, M., Hutter, I., Bailey A (2020). *Qualitative Research Methods*. SAGE Publication Ltd.

Ivey, J. (2013). Interpretive phenomenology. *Pediatric nursing*, *39*(1), 27.

Kasonde N'gandu, S. (2013). *Writing a Research Proposal in Educational Research*. Lusaka, Zambia: UNZA Press.

Kelly, G. J. (2012). Epistemology and educational research. In *Handbook of complementary methods in education research* (pp. 33-55). Routledge.

Kirby, T. (2021). COVID-19 survivor experiencing long-term symptoms. *The Lancet Respiratory Medicine*, *9*(6), 570-572.

Kivunja, C. (2018). Distinguishing between theory, theoretical framework, and conceptual framework: A systematic review of lessons from the field. *International Journal of Higher Education, 7*(6), 44-53.

Klakegg, O. J. (2016). Ontology and epistemology. In *Designs, methods and practices for research of project management* (pp. 87-96). Routledge.

Khodabakhshi-Koolaee, A., & Pourebrahimi, M. (2020). Analyzes of life world of a young girl with myasthenia gravis: Qualitative case study. *Journal of Arak University of Medical Sciences, 23*(3), 412-421.

Kothari, C. R. (2004). *Research methodology: Methods and techniques*. New Age International.

Lai, C. C. atel (2020). Severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) and coronavirus disease-2019 (COVID-19): The epidemic and the challenges. *International journal of antimicrobial agents*, *55*(3), 105924.

Laverty, S. (2003). Hermeneutic phenomenology and phenomenology: A comparison of historical and methodological considerations. *International Journal of Qualitative Methods, 2*(3), 1–29.

Chen, L. (2021). Psychological experience of patients with confirmed COVID-19 at the initial stage of pandemic in Wuhan, China: A qualitative study. *BMC Public Health*, *21*(1), 1-12.

Lincoln, Y. S., & Guba, E. G. (1985). *Naturalistic inquiry*. Sage.

Lopez, K. A., & Willis, D. G. (2004). Descriptive versus interpretive phenomenology: Their contributions to nursing knowledge. *Qualitative health research*, *14*(5), 726-735.

Lu, H. (2020). Drug treatment options for the 2019-new coronavirus (2019-CoV). *Bioscience Trends*, *14*(1), 69-71.

Levering, B., & Manen, M. V. (2002). Phenomenological anthropology in the Netherlands and Flanders. In *Phenomenology worldwide* (pp. 274-286). Springer, Dordrecht.

Maxwell, J. (2002). Understanding and validity in qualitative research. *Harvard educational review*, *62*(3), 279-301.

Mendelson, atel (2021). Long-COVID: An evolving problem with an extensive impact. *SAMJ: South African Medical Journal*, *111*(1), 10-12.

Missel, M.atel (2022). The marked body–a qualitative study on survivors embodied experiences of a COVID-19 illness trajectory. *Scandinavian Journal of Caring Sciences*, *36*(1), 183-191.

Nalube, P. P. (2014). *Student teachers learning mathematics for teaching: Learner thinking and sense making in algebra* (Doctoral dissertation, University of the Witwatersrand, Faculty of Humanities, School of Education).

Neto, M. L. atel (2020). ar., Nobre CB, Pinheiro WR, de Oliveira CRT, et al. When health professionals look death in the eye: the mental health of professionals who deal daily with the 2019 coronavirus outbreak. Vol.288. *Psychiatry Research*.

Ponterotto, J. G. (2005). Qualitative research in counseling psychology: A primer on research paradigms and philosophy of science. *Journal of counseling psychology*, *52*(2), 126.

Praveen Sv., & Ittamalla, R. (2021). Psychological issues covid-19 survivors face a text analysis study. *Journal of Loss and Trauma*, *26*(4), 405-407.

Prioleau, T. (2021). Learning from the experiences of COVID-19 survivors: Web-based survey study. *JMIR formative research*, *5*(5), e23009.

Rich, S., atel (2013). Navigating the terrain of lived experience: The value of lifeworld existentials for reflective analysis. *International Journal of Qualitative Methods*, *12*(1), 498-510.

Rothan, H. A., & Byrareddy, S. N. (2020). The epidemiology and pathogenesis of coronavirus disease (COVID-19) outbreak. *Journal of autoimmunity*, *109*, 102433.

Saunders, M., Lewis, P. & Thornhill, A. (2012). *Research Methods for Business Students*. 6th edition, Pearson Education Limited.

Scotland, J. (2012). Exploring the philosophical underpinnings of research: Relating Ontology and epistemology to the methodology and methods of the scientific, interpretive, and critical research paradigms. *English language teaching*, *5*(9), 9-16.

Silverman, D. (2001). *Interpreting qualitative data: Methods for analysing talk, text and interaction*. London: Sage.

Singh, Y. K. (2006). *Fundamental of research methodology and statistics*. New Age International.

Smith, J. A., Flowers, P., & Larkin, M. (2009). Interpretative phenomenological analysis: Theory, method and research. London: Sage Publications Ltd.

Sohrabi, C., atel (2020). World Health Organisation declares global emergency: A review of the 2019 novel coronavirus (COVID-19). *International journal of surgery*, *76*, 71-76.

Spagnuolo, G., De Vito, D., Rengo, S. and Tatullo, M., 2020. COVID-19 outbreak: an overview on dentistry. *International journal of environmental research and public health*, *17*(6), p.2094.

Troiano, G., & Nardi, A. (2021). Vaccine hesitancy in the era of COVID-19. *Public health*, *194*, 245-251.

Van Manen, (1997). Phenomenological pedagogy and the question of meaning. *Phenomenology & education discourse*, 41-68.

World Health Organisation (2020). Coronavirus disease (COVID-19), 21 September 2020.

APPENDICES

APPENDIX 1: INTERVIEW GUIDE

Introductory Remarks

- Introduction of myself by name
- Indication of the university I am coming from and the programme I am pursuing
- State the purpose of the interview and the research topic.
- Express gratitude to the participant for their availability
- Assure the participant of confidentiality and anonymity.
- Seek permission to record the interview and take notes.

A. **Questions related to experiences of the COVID-19 survivors within their communities during and after their illness.**

Home Set up

1. What were your experiences in terms of stigma at home at the time and after your illness from COVID-19?
2. What was your experience at your home in terms of discrimination during and after your illness?
3. What was your experiences in terms of support from your family/home during and after the period of your illness?

Neighbourhood

4. What was your experience in terms of stigma from you neighbours at the time and after your illness from COVID-19?
5. What was your experience in terms of discrimination from you neighbours during and after your illness?
6. What was your experiences in terms of support from your neighbours during and after the period of your illness?

Work place

7. What were your experiences in terms of stigma at your workplace at the time and after your illness from COVID-19?
8. What was your experience at your work place in terms of discrimination during and after your illness?

9. What was your experiences in terms of support from your workplace during and after the period of your illness.

B. **Insights from the COVID-19 survivors**

10. Share with me any suggestions about how you would like COVID-19 survivors to be treated in their communities.

Express gratitude to the participant for his/her participation in the study

APPENDIX 2: CONSENT FORM

PRINCIPAL INVESTIGATOR
Lydia Nyondo

School of Education, University of Zambia

Mobile phone: +260977584523

Email address: mukundwe2014@gmail.com

PURPOSE OF STUDY

You are being asked to take part in a research study. The purpose of the study is to explore experiences of COVID-19 survivors in terms of stigma, discrimination suffered and support received in their communities in Lusaka District of Zambia. Before you decide to participate in this study, it is important that you understand why the research is being done and what it will involve. Please read the following information carefully. Please ask the researcher if there is anything that is not clear or if you need more information.

STUDY PROCEDURES

You will be asked to participate in a one-on-one interview with the investigator which will take about one hour. For the purpose of accuracy of data to be collected, the interview will be recorded on an audiotape. You can skip any question that you do not want to answer. In addition, if you think you cannot continue with the interview for some reasons, you have the right to do so.

RISKS

Please note that this research may get you emotional and uncomfortable as questions asked will be about the experiences of stigma, discrimination suffered and support received during and after illness from COVID-19 within your home, neighbourhood and work place. When you feel uncomfortable you can decline to answer any or all questions and you may terminate your involvement in this study at any time if you choose.

BENEFITS

There will be no direct benefit to you for your participation in this study. However, we hope that the information obtained from your participation will, firstly help the investigator to obtain a master's degree at the University of Zambia, and secondly, your participation will increase the knowledge on the experiences of COVID-19 survivors in terms of the symptoms, stigma, discrimination suffered and support received in their communities in Lusaka District of Zambia. This may help to come up with counselling interventions to help other people who may get ill from COVID-19.

CONFIDENTIALITY

Information obtained from you shall not be given to anyone unaffiliated with the study in a form that could identify you without your written consent, except as required by law. Your responses to this study will be anonymous. Please do not provide any identifying information during the interview. Every effort will be made by the researcher to preserve your confidentiality including the following:

- Assigning code names/numbers for participants that will be used on all research notes, recordings and documents
- Keeping notes, interview transcriptions, and any other identifying participant information in a safe and confidential closet of the researcher.
- Participant data will be kept confidential except in cases where the researcher is legally obligated to report specific incidents. These incidents include, but may not be limited to, incidents of abuse and suicide risk.

VOLUNTARY PARTICIPATION

Your participation in this study is voluntary. It is up to you to decide whether or not to take part in this study. If you decide to take part in this study, you will be asked to sign a consent form. After you sign the consent form, you are still free to withdraw at any time and without giving a reason. Withdrawing from this study will not affect the relationship you have, if any, with the researcher. If you withdraw from the study before data collection is completed, your data will be returned to you or destroyed.

CONSENT

I have read and I understand the provided information and have had the opportunity to ask questions. I understand that my participation is voluntary and that I am free to withdraw at any time, without giving a reason and without cost. I understand that I will be given a copy of this consent form. I voluntarily agree to take part in this study.

Participant's signature_____ Date_____

Investigator's signature _____ Date _____

APPENDIX 3: BUDGET

The table below illustrates the approximated budget for the research study. The amounts are in the Zambian Kwacha.

ITEMS	QUANTITY	UNIT COST	TOTAL COST
a. Stationery			
i. Ream of papers	1	K100.00	K100.00
ii. Writing pad	6	K15.00 each	K90.00
iii. Pens	2	K1 each	K2.00
			K192.00
Sub – total			
b. Cost of equipment for data collection	1	K1500	K1500
i. Digital Camera			
Sub – total			K1500
c. Cost of data analysis			
i. Printing draft report	65 pages	50n per page	K32.50n
ii. Printing final copy	195 pages	K5.00	K106.50n
iii. Binding	1	K120	K120
Sub – total			K259.00
Total			**K 1,951.00**

APPENDIX 4: WORK PLAN

SEQUENCE OF WORK PLAN	JAN-FEB	MAR APR	MAY JUN	JUL. AUG	SEP	OCT	NOV	DEC
Development of Proposal	XX	XX	XX					
Presentation and defence of Proposal				X				
Presentation and submission of research proposal for ethical clearance				X				
Data collection					X			
Data analysis and presentation of findings			X					
Writing and submission of draft report			X					
Correction, binding and submission of final report for examination				X	X			
Examination defense						X		
Graduation								X