

ADDIS ABABA UNIVERSITY
SCHOOL OF GRADUATE STUDIES, COLLEGE OF
EDUCATION DEPARTMENT OF PSYCHOLOGY

**A STUDY OF UNIVERSITY STUDENTS' KNOWLEDGE
AND ATTITUDE AND THEIR EXPERIENCES IN
RELATION TO STIGMA AND DISCRIMINATION
ATTACHED TO HIV AND AIDS**

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the Master of Arts Degree in Counseling Psychology**

By
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Acronym

ACORD- Agency for Cooperation and Research Development
AIDS- Acquired ImmunoDeficiency Syndrome
ART- Anti-Retroviral Therapy
BBC- British Broadcasting Corporation
BSS- Behavioral Surveillance Survey
CD₄- Cluster of Differentiation 4
CDC- U.S. Centers for Disease Control and Prevention
CSA- Central Statistical Authority
CSWs- Commercial Sex Workers
df- Degree of Freedom
 α - alpha value
FGD- Focus Group Discussion
FSWs- Female Sex Workers
HAPCO- HIV / AIDS Protection and Control Office, Ethiopia
HIV- Human ImmunoDeficiency Virus
ICRW- International Center for Research on Women
JUAC- Jimma University Ambo College
MHRC- Miz-Hassab Research Center
MOH- Ministry of Health, Government of Ethiopia
PLWHA- People Living With HIV and AIDS
STI- Sexually Transmitted Infections
TASO- HIV Support Organization in Uganda
TB- Tuberculosis
UN- United Nations
UNAIDS- The Joint United Nations Program on HIV and AIDS
UNICEF- United Nations Children's Emergency Fund
VCT- Voluntary Counseling and Testing
WHO- World Health Organization

Abstract

This study was conducted to investigate the students' knowledge on HIV and AIDS and to assess if they have discriminatory attitude attached to HIV and AIDS and towards PLWHA in Ambo town. The study also attempted to compare the level of stigma and discrimination between female and male students. Moreover, the study aimed at examining the experience of PLWHA in relation to stigma and discrimination attached to HIV and AIDS. 264 JUAC students and three PLWHA participated in this study. Questionnaire, focus group discussion and case study were used as an instrument for the data collection. The collected data were treated with percentage and using Chi-square. The findings of these study shows that JUAC students have adequate knowledge and awareness about HIV and AIDS issues and the students did not hold stigmatizing and discriminatory attitudes on HIV and AIDS and towards PLWHA. In addition, the study revealed that female and male students did not manifest significantly different stigmatizing and discriminatory attitudes in relation to HIV and AIDS and towards PLWHA. The non-discriminatory attitude of the students can also be attributed to the awareness and knowledge on issues of HIV and AIDS. The study also found out that, even though, PLWHA are found to be subject to different types and forms of discrimination in the community, the magnitude of the stigma and discrimination is reducing. The study also uncovered that, the basis for HIV and AIDS related stigma and discrimination were found to be misconception and lack of knowledge about HIV and AIDS, fear of contagion through causal contact and insensitive media reporting on the pandemic. Therefore, to minimize the stigma and discrimination attached to HIV and AIDS it was suggested that, well-designed and participatory awareness creation programs need to be strengthened and professional pre and post test HIV counseling for those affected and infected with HIV needs to be given. In addition the content of the information provided through the media should be carefully evaluated and checked for its appropriateness not to inflict stigma and discrimination before broadcasting.

CHAPTER I

INTRODUCTION

1.1 Background of the Study

It has been more than 25 years since the first AIDS case was reported in the United States, Democratic Republic of Congo and the shores of Lake Victoria, East Africa. Since then the pandemic is expanding all over the world in an alarming rate. It was in 1985, that AIDS cases started to be reported in every regions of the world (UNAIDS, 2006). In Ethiopia the 1st evidence of HIV infection was found in 1984 and the first AIDS case was reported in 1986. By the end of 2001 HIV infection claimed the lives of over 160,000 Ethiopians (UNAIDS, 2002).

The recent UNAIDS Global report on AIDS epidemic (2006) ascertain that: An estimated 38.6 million (33.4 million-46.0 million) people world wide were living with HIV in 2005. An estimated 4.1 million (3.4 million- 6.2 million) became newly infected with HIV and an estimated 2.8 million (2.4 million -3.3 million) lost their lives because of AIDS.

According to Kofi Annan secretary- General of the United Nations:

“AIDS has fundamentally changed our world-killing more than 25 million men and women, orphaning millions of children, exacerbating poverty and hungers, and in some countries, even reversing human development altogether. Nearly 40 million people are living with HIV today-half of them women. What was first reported as a few cases a mystery illness is now a pandemic that poses among the greatest threats to global progress in the 21st century” (UNAIDS, 2006). The above statement warns us that all of us must play a responsible role in combating this pandemic.

Overall, however, despite some notable achievements, the response to the AIDS epidemic to date has been nowhere near adequate. In just 25 years, HIV has spread relentlessly from a few widely 'scattered spots' to virtually every country in the world, infecting 65 million people and killing 25 million (UNAIDS 2006). As noted in the Declaration of commitment on HIV and AIDS, five years latter, Report of the Secretary- General, "A quarter century into the epidemic, the global AIDS response stands at cross-roads. For the first time ever the world possesses the means to begin to reverse the epidemic. But success will require unprecedented willingness on the part of all actors in the global response to fulfill their potential, to embrace new ways of working with each other and to sustain the response over the long term" (Ibid).

The UNAIDS report of 2006, stated certain barriers to providing widespread HIV prevention and treatment, such as lack of infrastructure, poor transportation or shortage of trained workers are substantial and can only be overcome through our greatest collective efforts. As we mobilize to address these, however, we must not forget that stigma, discrimination and denial about issues such as sexuality and drug use may be as great as any other barriers to an effective response to AIDS.

Stigma and discrimination remain key barriers to the successful implementation of prevention, treatment and support programs. Stigma is an especially serious obstacle to the success of HIV prevention programs, success of HIV prevention programs, including services for vulnerable populations and for preventing mother-to-child transmission. According to civil society reports from over 30 countries, stigma and discrimination against people living with HIV remains widely pervasive.

Stigma and discrimination are not only obstacles to HIV prevention, care and treatment for people living with HIV, but among the epidemic's worst consequences. HIV related stigma consists of negative attitudes towards those

infected with HIV and those affected by AIDS by association, such as orphans or the children and families of people living with HIV. Discrimination, as defined by UNAIDS protocol for identification of discrimination against people living with HIV, refers to any form of arbitrary distinction, exclusion or restriction affecting people because of their confirmed or suspected HIV- positive status. Both, stigma and discrimination place a burden on human development by denying hundreds of thousands of people the chance of reaching their full potential.

HIV related stigma and discrimination are found in all parts of the world, but their manifestation varies from place to place. Half of the participants in a study in an eastern Chinese coastal city believed that punishment was an appropriate response towards those living with HIV, over half that is 56% were unwilling to be friends with HIV- positive people and 73% thought that those living with HIV should be isolated (Lee et al, 2005 cited in UNAIDS, 2006).

Research in other parts of the country shows that to avoid stigma and discrimination, some HIV-positive people refuse to get information about HIV and sexually transmitted diseases, staying away from health-care professionals and shunning those suspected of risk behavior in an effort to blend in with community norms (Lieber et al, 2005 cited in UNAIDS 2006).

In Ethiopia very few researches have been conducted to understand the nature and the impact of stigma and discrimination related to HIV and AIDS. According to Haileom and Aklilu, (2004) Ethiopian society, which is very much traditional in its socio-cultural make up, has belief systems, power relations and psychological predispositions that are conducive to the practice of stigma. Stigma is therefore, hindering HIV and AIDS programs and an effective response to the epidemic. Incomplete and incorrect information are mostly the sources of stigma and discrimination. About 15% of respondents think that HIV can be transmitted through kissing, 30% think it can be transmitted through mosquito

bites and about 10% through sharing food, and 7% by sharing toilet. This lack of knowledge fueled by HIV –related stigma, contributes to continuing stigma and discrimination.

In this same study people's misconception about the origins of the HIV epidemic itself create opportunities for stigma and discrimination. The two most common beliefs about the origins of HIV are that it came from foreigners, and that it is a punishment from God. Several respondents said that foreign countries and their "bad" behaviors are to blame for being the source of HIV and AIDS. Due to this beliefs associated with HIV and AIDS; Fearing the stigma and discrimination that result from disclosure of an HIV positive status, those with the virus don't disclose their status. Thus do not get early treatment, care and support, eventually leading to a full blown AIDS, associated with severe symptoms of opportunistic infections leading to death. Therefore, the stigma and discrimination will fuel on the problems of HIV and AIDS epidemic and is a huge barrier in responding to HIV and AIDS.

This study attempts to investigate the nature; causes and level of HIV and AIDS related stigma and discrimination among university students and tries to explore the experience of people living with HIV and AIDS (PLWHA).

1.2 Statement of the Problem

In Sub-Saharan Africa, home to over 70% of the global population HIV and AIDS has reached pandemic proportion. With over 28 million people estimated to be living with HIV in this region alone, the impact of HIV and AIDS on communities has been devastating (ACORD, 2004). The devastation and suffering caused by HIV and AIDS to individuals, families, communities and entire nations are beyond words.

A wide range of factors has come together to take up the challenge of confronting the HIV and AIDS crisis head on. However, the biggest challenge that remains to

be overcome is that of HIV and AIDS related stigma and discrimination. Despite concerted efforts to demystify and enhance awareness and understanding, many people still associate HIV and AIDS with moral decadence and promiscuity, ultimately passing moral judgment on those infected and affected (Ibid)

As a result people living with the virus face resentment, isolation, ridicule and are often denied access to their rights and basic services. Such attitudes and behaviors do not only infringe on the rights of PLWHAs to respect and dignity, they also act as a strong disincentive for them to make use any existing services for fear of being 'branded'.

There is no longer any dispute or disagreement over the fact that challenging stigma and discrimination constitutes a critical part of the assignment in the fight against HIV and AIDS. This is even truer in the light of recent developments that have helped by some of poorest and most needy people living in Sub-Saharan Africa. However, unless, stigma and discrimination are challenged and addressed in appropriate manner, they are unlikely to access and make proper use of these encouraging Anti-retroviral therapies (ART).

Stigmatizing attitudes and discriminatory behaviors were found to pervade all spheres of life from the home, the family, the workplace, the school, health settings and the community at large. According to the study conducted in Uganda and Burundi (ACORD 2004), because HIV is associated with 'immoral behavior' and sexual promiscuity, people with HIV are often blamed for their condition and denied the sympathy and support given to people with other life threatening diseases. Women and girls are disproportionately affected by these forms of victimization, which are compounded by gender-based discrimination.

People with HIV also experience neglect and lack of care, even within their own homes. They are also excluded from community gatherings and feasts. The children of people living with HIV and AIDS are subjected to cruel teasing at

school and excluded from games and social interactions with their peers. These stigmatizing attitudes tend to be internalized by people living with HIV and can have serious adverse consequences on their emotional, as well as physical health. Stigma also deters people from being tested or even using condoms for fear of being 'branded' as HIV-positive.

After 25 years of breath taking efforts to combat the HIV and AIDS epidemic the infection is increasing in an alarming rate all over the world. The global AIDS epidemic shows no sign of abating. Among the main reason associated to the persistence of HIV and AIDS is the persistence of stigma and discrimination (ACORD, 2004 UNAIDS, 2001, 2005) against those infected and affected by HIV/AIDS. This outrageous violation of basic human rights drives the disease underground, fuels the incidence and risk of HIV infection, crippling efforts for prevention and care (ACORD, 2004).

The problem aggravates in developing countries like Ethiopia, where many superstitions, cultural and traditional out looks and attitudes prevail and associated to problems like HIV and AIDS. Therefore, this study attempts to explore the extent, causes; levels and forms of stigmatizing attitudes and discriminator behaviors related to HIV and AIDS among university students and examines the experience of stigma and discrimination by persons living with HIV and AIDS (PLWHA).

With this background the present study was attempted to answer the following research questions.

1. Do University students have adequate knowledge and awareness about HIV and AIDS issues?
2. Do University students have stigmatizing and discriminatory attitudes towards HIV and AIDS and towards PLWHA?
3. Is there any significant difference in the level of stigma and discrimination between female and male students?

4. What is the day to day experience of PLWHA in relation to stigma and discrimination?

1.3 Objectives of the Study

The following are the objectives of this study.

1. To investigate the University students' knowledge on HIV and AIDS.
2. To find out if there is a stigmatizing and discriminatory attitude attached to HIV and AIDS among University students.
3. To compare the level of stigma and discrimination between Female and Male University students.
4. To explore the experience of stigma and discrimination by PLWHA.
5. To recommend and suggest intervention strategies to minimize the impact of stigma and discrimination in the response to HIV/AIDS?

1.4 Significance of the study

It is evident that stigma and discrimination is one of the major barriers in the prevention of HIV and AIDS. Understanding the effect, the nature and causes of stigma and discrimination related to HIV and AIDS will have its own contribution in the fight against HIV and AIDS pandemic.

Therefore, this study hoped to be an input to different governmental and non-governmental organization to design and formulate a working policy and programs to address the problem of stigma and discrimination in the fight against HIV and AIDS. In addition the study is believed to be helpful to different sectors of our society who are working to avert the impact and damage HIV and AIDS related stigma and discrimination is putting to the overall anti- HIV/AIDS effort. Particularly PLWHA, counselors and researchers can use this study as a source of objective information to avoid self stigmatization and live risk free and productive life, for professional counseling and as a source of empirical information respectively.

When a clear understanding about the nature causes and effects of stigma and discrimination will be at hand, then means of addressing the issue will not be as problematic as the ignorance about the condition itself. Therefore, this study will be attempting to explore this crucial issue, which is hindering the effort of tackling the prevention of HIV and AIDS. Many of HIV and AIDS programs are affected by the stigma and discrimination associated to HIV and AIDS: Voluntary counseling and testing for the general public, treatment, care and support for those who are living with the virus, using condoms for fear of 'branded' are all under serious problems. This is mainly because of fear, stigma and discrimination. Hence this study will be having greater significance in addressing this major problem that hampered the over all effort each actors in HV prevention, care, treatment and support are aspiring for.

1.5 Delimitation of the Study

This study was delimited to second and third year regular students of Jimma University, Ambo College and to some selected PLWHA.

1.6 Limitation of the study

As in any self-reporting data it is possible that the respondents may not have accurately answered some of the sensitive questions with the intentions to comply with the scholarly norms than their actual attitudes and opinions, or may have had difficulty in recalling information.

Approaching PLWHA for the purpose of the study was very difficult for many reasons. Due to this only three individuals were contacted for this study. Since the sampling is selective and purposive it cannot be generalized to the general population.

Lack of adequate funding and the inability to communicate with either English or the 'Amharic' languages effectively by some University students can be mentioned as the limitation to this study.

1.7 Operational Definition of Terms

Stigma: It is the initial negative attitude and response against HIV and AIDS and PLWHA by individuals, communities or society. Rejection, denial, discrediting, disregarding, underrating, social distance, and avoidance characterize it.

Discrimination: It is the actual and visible experienced behavior as a result of stigma attached to HIV/AIDS and towards PLWHA. It is characterized by arbitrary distinction, exclusion, restriction and a violation of human rights.

University students: It refers to those students who completed their University Preparatory Secondary Education and enrolled in Ambo College (Jimma University) in the regular program.

Person living with HIV (PLWHA): is a person whose HIV-status is confirmed by blood testing and found to be HIV-positive.

CHAPTER II

REVIEW OF RELATED LITERATURE

2.1. HIV and AIDS Epidemic an Overview

One of the greatest paradoxes is that, although it causes 11,000 new infections and nearly 8,000 deaths daily, in many ways the epidemic remains hidden. Overall globally, the HIV incidence rate (the annual number of new HIV infections as a proportion of previously uninfected persons) is believed to have peaked in the late 1990s and to have stabilized, subsequently, not with standing increasing incidence in a number of countries. In several countries, favorable trends in incidence are related to changes in behavior and prevention programs. Changes in incidence along with rising AIDS mortality have caused global HIV prevalence (the proportion of people living with HIV) to level off. However, the numbers of people living with HIV have continued to rise, due to population growth and, more recently, the life prolonging effects of antiretroviral therapy (UNAIDS, 2006)

The sub- Saharan Africa is the region with the largest burden of the AIDS epidemic. New survey data under score the disproportionate impact of the AIDS epidemic on women, especially in sub-Saharan Africa where, on average, three women are HIV- infected for every two men. Among young people (15-24 years), that ratio widens considerably to three young women for every young man (UNAIDS, 2006). However the epidemics in this region are highly diverse and especially severe in Southern Africa.

According to the same report, sub- Saharan Africa remains the worst affected region in the world. Across the region, rates of new HIV infections peaked in the late 1990s, and a few of its epidemics show recent declines, notably in Kenya, Zimbabwe and in urban areas of Burkina Faso. Overall, HIV prevalence in this region appears to be leveling off, albeit at exceptionally high levels in Southern

Africa. Such apparent 'stabilization' of the epidemic reflects situations where the number of people being newly infected with HIV roughly matches the number of people dying of AIDS-related illnesses.

A little more than one - tenth of the world's population live in sub-Saharan Africa which is home to almost 64% of all people living with HIV - 24.5 million [21.6 million -27.4 million] . Two million [1.5 million - 3.0 million] of them are children (younger than 15 years) living with HIV in sub-Saharan Africa. An estimated 2.7 million [2.3 million -3.1 million] people in the region became newly infected, while 2.0 million (1.7 million -2.3 million] adults and children died of AIDS. There were some 12.0 million [10.6 million - 13.6 million] orphans living in sub-Saharan Africa in 2005. Three-quarter of all women [15 years and older] living with HIV are in sub-Saharan Africa. In most of the region, women are disproportionately affected by AIDS, compared with men- expressions of the often highly unequal social and socioeconomic status of women and men. Women comprise and estimated 13.2 million [11.4 million -15.1 million] or 59% of adults living with HIV in Africa south of Sahara, (UNAIDS, 2006)

An estimated 930,000 [790,000-1.1 million] adults and children died of AIDS in Southern Africa in 2005 - one third of all AIDS deaths globally. Access to antiretroviral therapy has increased more than eight- fold since the end of 2003, with about 810,000 people on treatment in December 2005. About one in six (17%) of the 4.7 million people in need of antiretroviral therapy in this region now receive it. Progress is uneven however, with coverage reaching or exceeding 50% in only three countries. (Botswana, Namibia and Uganda) but remains below 20% in most others. South Africa accounts for one- quarter of all people receiving antiretroviral therapy in sub-Saharan African (WHO/ UNAIDS, 2006) cited in UNAIDS, (2006). However, it is worth mentioning that HIV prevalence varies significantly between and within sub regions and countries.

Southern Africa remains the global epicentre of the epidemic almost one in three people infected with HIV globally live in this sub region about 43% (860000 [560000 - 1.4 million] of all children (Under 15 years living with HIV are in Southern Africa, as are approximately 52% (6.8 million [5.9 million -7.7 million]) of all women (15 years and older) living with HIV.

In the countries of East Africa, HIV prevalence has either decreased or remained stable in the past several years. Here, too women face considerable high risk of HIV infection than men, especially at younger ages. The epidemics are varied, with HIV prevalence among pregnant ranging from approximately 2% in Eritrea to 7% in Kenya, Uganda and United Republic of Tanzania. (UNAIDS, 2006)

According to (MOH, 2004) cited in UNAIDS, (2006) in Ethiopians urban areas, HIV prevalence among women seeking antenatal care has remained stable at high levels since the late 1990s (almost 15% in Addis Ababa and 12% in other urban areas in 2003), the exception being among 15-24 years - old pregnant women where prevalence fell from 15.0% in 2000 to 11.5% in 2003. Mean while, the epidemic appears to have intensified in some rural areas in recent years, with rising HIV infection levels in women attending antenatal clinics in Ethiopia (2.6% in 2003, up from 1.9 % in 2000).

Ethiopia is one of the hardest hit countries by HIV and AIDS epidemic (AIDS in Ethiopia No.5. MOH, 2004). Ethiopia hosts the fifth largest number of people living with the virus globally. The cumulative number of people living with HIV/AIDS is about 1.5 million (3.8% male and 5% female, 12.6% urban and 2.6% rural) out of which about 96,000 are children under 15 years. The estimated number of new AIDS cases in the adult population in 2003 was 98, 000 (46% male & 54% female) while that in children was 25,000. The major mode of HIV transmission is heterosexual which accounts for 87% of infections. Another 10 % of infections occur due to mother to child transmission. In addition, empirical evidence suggests that utilization of unsafe sharp and skin piercing instruments

play a role in HIV transmission in the rural setting in particular. According to the same report, some 245,000 people living with HIV/AIDS (PLWHA) were in need of antiretroviral treatment (ART) and some 90,000 adults and 25,000 children had died of AIDS also, there were an estimated 539,000 AIDS orphans in 2003. Of 15,580 blood donors from different parts of Ethiopia in 2003, 4.7% (3.8% female and 5.0% male) were positive for HIV. So were 3.6% of the 68,273 Visa applicants, 16.7% (14.6% male & 19.5% female) of the 26,355 VCT clients; and 46.7% (46% females & 54% male) of the 16,264 (male 58% and Females 42%) suspected AIDS cases reported.

According to the (MOH, 2004; UNAIDS, 2006) the national HIV incidence rate in Ethiopia is leveling off and the rate at which it is progressing is declining over the last few years and the epidemic appears to be stabilizing, particularly in urban areas, indicating some behavioral change in the population. This is also supported by the level of awareness about the disease, the tremendous increase in condom distribution and the increasing utilization of VCT services by different social groups.

The (MOH, 2004), report shows that as there is a significant gap between the estimated number of AIDS cases and the number of AIDS cases actually reported in 2003. Based on the estimated number of AIDS cases, it appears that only 6% of the estimated AIDS cases sought health institution service and were reported. This can be partly because of fear, denial stigma and discrimination attached to HIV and AIDS. According to the reports by routine and service related reporting sources that reached MOH in 2003, out of the 16,264 patients (58% male and 42% females) that were suspected and tested, 47% (7,614) were confirmed to have HIV and AIDS. Males constituted 54% of the patients, while 46% were females. The highest number of AIDS Patients was seen in the 20-39 years-olds. A total of 147,314 AIDS cases have been reported to the MOH since 1986. Male's account

for 52% (76,653), females for 48% (70,661) of cases. The majority of cases (69%) were reported in the age group between 20 to 39 years.

HIV prevalence among VCT clients indicates that, the HIV status of 26,355 VCT clients (14,824 males and 11,531 females) was reported to MOH in 2003. Of these 2,128 (14.4%) male and 2,250 (19.5%) females VCT clients tested HIV-Positive. Overall, 4,378 (16.5%) of the clients were HIV - Positive. Female HIV prevalence was persistently higher from the age of 15 years onwards, except for in the 45-49 year age group. The highest prevalence is reported among 30-34 year old women and among 35-39 year-olds in both sexes.

According to the behavioral surveillance survey (BSS) 2002 cited in (MOH, 2004) designed to track trends in HIV/AIDS related knowledge, attitudes and behaviors in sub population at particular risk of infection conducted between December 2001 and May 2002, Ten different population groups were sampled: The groups included in-school youth (15-19 years olds, currently enrolled in school) out- of -school youth (15-24 years olds, currently not enrolled in school), uniformed services (ground force and Air force), transport workers (truckers intercity bus drivers, and Minibus drivers and their assistants) farmers, Pastoralists , factory workers, and female sex workers (FSWs): The final report was published in December 2003, indicate that: Amongst all youth, 17.4% reported having had risky sex with a commercial or non - commercial partner, in the previous 12 months. Male youth were engaged more in risky sex than female youth, and less than 4% of the surveyed youth reporting risky sex in the last year accessed VCT services. Most youth respondents (93.5%) felt not at risk or at low risk for HIV infection. Few rural respondents were aware that an HIV infected pregnant women could transmit the virus to her unborn child, and few knew that antiretroviral medication exists to reduce the risk of transmission (9.9% and 2.9% of pastoralists and farmers, respectively had the knowledge). A total of (2487) female sex workers were interviewed in BSS 2002, of these 7.7% (191) were

tested for HIV. Majority of the FSWs i.e., 81.9% said they would be willing to undergo VCT if the services were made available to them. The majority (86.5%) of FSWs who perceived their risk as nil or low, said they always used condoms and 35% said sterile needles had been used whenever they had received injections. Among adult respondents who reported that they had engaged in unprotected sex in the previous 12 months, only 27% perceived themselves to be at moderate or high risk of HIV infection. Very few youth (4.6%) reported ever having had an HIV test. Generally, the findings of the 2002 (BSS) cited in the MOH, 2004 indicated low - risk perception, yet high-risk activities.

2.2. Impacts of HIV and AIDS in Ethiopia

Possible impact analysis on different variables shows that HIV and AIDS have a visible effect and detrimental impact on Ethiopia's society and economy. HIV and AIDS accounted for an estimated 38% or 54,000 of all TB cases incidence in 2003. This proportion is expected to continue to rise in the coming years, contributing to a total projected TB caseload of 180,000 in 2008. The population lost to AIDS was about 900,000 by 2003 and is projected to reach 1.8 million by 2008 if present trends continue. Young adult (15-49 years) deaths due to AIDS are expected to rise tremendously, in the coming years and already account for about a third of all young adult deaths in the country. AIDS also has a severe impact on life expectancy. HIV and AIDS on average is expected to reduce life expectancy in Ethiopia by 4.6 years in 2003 (MOH, 2004). According to the same report access to ART can have a potential impact on AIDS deaths and AIDS orphans. High level, of effective antiretroviral treatment (ART) coverage can be expected to immediately impact on AIDS-related mortality, preventing 78,000 AIDS deaths in the first year if all eligible PLWHA were to receive ART.

ART reduces mortality and prolongs life expectancy of AIDS patients (UNAIDS, 2006), leading to an increase in the number of PLWHA. This effect is most pronounced if all AIDS patients were to receive ART, raising prevalence to 5.8%

by 2008, assuming the present trend of infection will continue. ART provided to only 30% or fewer AIDS patients would barely alter the estimated prevalence (MOH, 2004) (5.0% - 5.1%) of HIV. Increases in the number of AIDS orphans is also largely due to past high level of HIV Prevalence, AIDS cases, and AIDS deaths in the past, and partly due to population growth. Full ART coverage (100%) would lead to 332, 000 fewer AIDS orphans by 2008.

The 2004, report by the MOH makes it clear that two large population groups are carrying the brunt of the disease- rural Ethiopians and women. While the relative burden of AIDS cases and AIDS deaths) is increasingly borne by rural Ethiopia, despite the relatively lower rural prevalence and incidence rates. So also are women, who are increasingly bearing the brunt of the disease and its impact because of the significant gender inequalities (lower socio-economic standings) resulting in higher stigma, discrimination and poorer access to public health services. Moreover, in most Ethiopian societies, it is the responsibility of women and girls to care for the sick at the family level (MOH, 2004). According to the same report the HIV and AIDS epidemic continues to pose a threat to the development of Ethiopia currently infecting 1.5. Million people and accounting for 79,000 (30%) of the adult (15-49) deaths in 2003.

The adjusted HIV prevalence for Ethiopia in 2003 is 4.4% (urban 12.6% and rural 2.6%) while the highest HIV prevalence still occurs in the age group 15-24 years. Also (MOH, 2004) report indicated that HIV prevalence is higher among females than males and in urban areas than rural areas. In Urban areas, the HIV epidemic seems to have peaked and stabilized (MOH 2004, UNAIDS 2006) at high prevalence level. While in rural areas infection is increasing gradually though at a much lower level and at a reduced rate. AIDS accounts for an estimated 30% of all young adult deaths and is expected to bring about a significant reduction in life expectancy. If the present trend continues, the number of TB cases, AIDS orphans, and AIDS deaths will markedly increases.

2.3. Stigma and Discrimination

2.3.1. Stigma

Stigma is as old as human history. The concept is universal, although the origin of the word is Greek and refers to the physical mark made by fire or with knives on individuals considered outsiders, inferiors and or evildoers. Through time the physical marks have gone, but stigma remains, based on one or more factors, such as age, caste, class, color, ethnicity, religious belief, sex, and sexuality (Foreman et al., 2003)

Stigma, defined as a "deeply discrediting" attribute in the landmark study by Goffman (1963) is applied by society and borne or possessed by groups and individuals. Stigma may be associated with specific acts, such as adultery or criminal behavior, with inherent qualities such as sex or skin color, or with quasi-inherent qualities, Such as religion or nationality (Ibid) some diseases and other health conditions often lead to stigma, affecting particularly people with mental illness and physical disabilities. In additions stigma is sometimes associated with social stereotypes; the sometimes positive, sometimes negative, " short hand" images that we all use to identify strangers and which determine our reactions to the stigma is a means of social control, defining social norms and punishing those who deviate from the norm. At the heart of stigma lies the fear that those who are stigmatized threaten society underlying that fear is often ignorance, such as ignorance of the way of life of HIV and AIDS stigmatized groups or ignorance of the realities of sexual behavior or the way in which disease spread.

The word stigma is used by social scientists more than the general public. In English, in every day speech, it has been replaced by such words as sexism and racism, which carry related but different meanings. And while in some societies some stigmas have weakened-it is, for example, much easier to be openly homosexual in an urban society in the West now than it was fifty years ago- in other societies stigma persists. Lower caste remains a mark of stigma in Indian

culture. Women are stigmatized in many societies and homosexual men are still the subject of ridicule and violence in many parts of the world. Stigma can be additive, to be a poor illiterate woman, for example is worse than any of these condition taken individually (Foreman et al., 2003)

Although the concept is negative, stigma can have positive consequences. It can create a sense of community among stigmatized individuals, motivating them to support each other and make changes that will improve their lives. Stigma and persecution have been the cause of such migration, such as that of Jew to the United States in the late nineteenth and early twentieth centuries. In more recent years, dalits (untouchables) in India and homosexual men in many parts of the world have responded to stigma by demanding the right to live as full and equal citizens in their own societies. Even though stigma may appear constant it is more accurately described as a process (Parker and Aggleton 2001) cited in Foreman et al., (2003). New stigma arises and others fade as changing knowledge and power structures lead to new hierarchies and social norms. The stigma against Jews in many western societies is considerably weaker than it was a hundred or a thousand years ago. And the stigma form and intensity of HIV and AIDS related stigma continues to fluctuate.

2.3.2. Basic Stigma Theory

It is widely accepted that self-respect is an essential human good, something we need in order to live our lives in affirmative way. This enables an individual to value the self and to having realistic confidence in the ability to fulfill once aspirations. Generally we sustain self-respect by having the acceptance and approbation of an individual or a group. Self- respect is undermined by stigma and discriminations (Rankin et al., 2005) - directly by inducing shame and other self-denigrating feelings within the individual, and indirectly by weakening or destroying the social support, sometimes the community support needed by their family and survivors. As Rankin et al., (2005) stated that: Goffman's work

on stigma has been the primary point of reference on the topic since it was published. He defines stigma as "an attribute that is significantly discrediting", stigmatizing is typically enacted against a person or group out of prejudice and it functions in relationships to prejudice and it functions in relationships to diminish the person or group being targeted social notions of deviance, or sometimes only difference, mean that the stigmatized person becomes devalued. It is helpful to define certain theoretical terms when discussing stigma theory: "Enacted stigma" directed against a person by others may first be perceived by the target, then felt and finally internalized so that in the end the target colludes in her or his own oppression by self-stigmatization. Internalized discrediting may be experienced as shame. The term "perceived stigma" has come into recent use in some social science literature, it is apparently meant to be an synonym for "felt stigma," careful comparison of the two terms shows different connotations. Perceived stigma implies stigmatized person's awareness of externally imposed discrediting; where as felt stigma implies experiencing the pain of stigma. "Courtesy" stigmatization - Goffman's term occurs as it is cited in Rankin et al., (2005) when a person or group associated with the target is included within the field of people being stigmatized. Recently theoreticians of stigma have analyzed how the stigmatizing process functions in social structures to subordinate individuals or groups, while reinforcing hierarchical patterns of privilege Parker, et al., (2003). In this view the struggle for privilege entails the oppression of others through social relations of domination and subordination.

A common example of stigmatization reinforcing hierarchical patterns of privilege is that of punishment theories of illness causation Allen (2000), Avolos (1999), Rankin (1994) as cited in Rankin et al., (2005), these includes notions that an aroused deity, ancestor, or witch brings an illness upon an individual because of some kind of offense committed by the person, such ideas buttress tendencies to stigmatize people living with illness and they serve as explanations and

enforcers of dominance and subordination. They enable communities for whom purity matters (like some religious groups) to purge the "impure" people whose illness, "sinfulness" would contaminate the whole - - While feeling reassured that their own virtue will protect the righteous from harm (Ibid). The social inequalities within religious groups and in the wider social order may predispose oppressive human relations in general.

2.3.3. Discrimination:

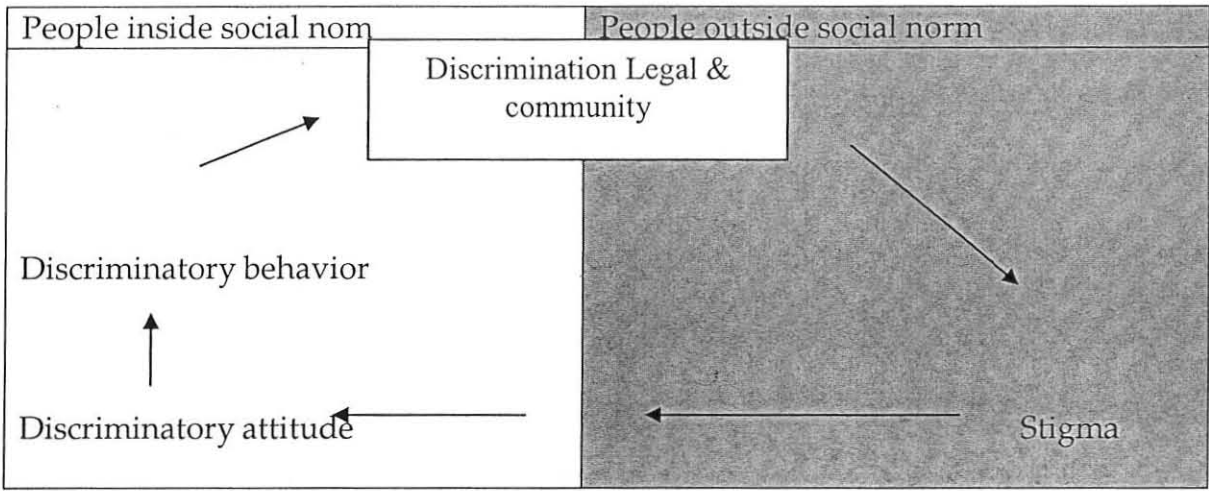
According to Foreman et al., (2003) the original meaning of "discriminate" was to note differences. Overtime, however, the word has come to mean to perpetrate an unjust action or inaction against individuals who belong, or are perceived to belong, to a particular group, in particular stigmatized groups.

Discrimination can be legislative enshrined in law or policy or community-actions or inactions in less formal contexts, such as the workplace or social settings such as a market place, sports center or bar.

International norms also provide definitions for discrimination the "Inter-American convention on the Elimination of all forms of Discrimination Against person with Disabilities" considers discrimination to be: any distinction, exclusion or restriction that violates the human rights and fundamental freedoms of the person.

Foreman et al., (2003) explained discrimination as it has three components: discriminatory attitudes (also known as prejudice), discriminatory behavior and discrimination. The first two (discriminatory attitudes and behavior) apply to individuals in the social norm, while the last one (discrimination) applies to the relationship between those within the social norm and those who are stigmatized (see figure 1).

Figure 1: Stigma and Discrimination an overview-adapted from Foreman et al., (2003).



As figure 1 suggests, stigma and discrimination exists in a vicious circle. Stigma allows or encourages discriminatory attitudes these attitudes are often reflected in discriminatory behavior that results in acts of discrimination acts of discrimination drew attention to or increase stigma.

However sometimes the pattern of stigma and discrimination is broken (Foreman et al., 2003). It is possible for someone to suffer stigma but not discrimination, for example when legislation prevents stigmatized groups, such as ethnic minority, being treated differently from other members of society. And attempts to reduce stigma may reinforce it, for example when university quotas are reserved for members of underprivileged communities. Even though this argument, that positive discrimination can increase stigma, is not universally accepted.

Attempts to analyze stigma and discrimination have led to narrow definitions that are not always universally understood, such as the distinction between "felt" and "enacted" stigma (Scrambler and Hopkins 1986, Jacoby 1994, UNAIDS, 2001) as cited in Foreman et al., (2003). "Felt" stigma - which has also been referred to as self-stigmatization and as fear of stigma - refers to the expectations of

stigmatized individuals as to how others will react to their condition. Felt stigma leads people to hide the stigmatizing condition, if possible, which limit the extent to which they experience discrimination.

Meanwhile, enacted stigma is defined as actual experience of stigma and discrimination. However, while, "felt stigma" is a useful term according to Foreman et al., (2003) that describes internal perceptions of stigma, "enacted stigma" is no more than an alternative term from discrimination. Furthermore, it can lead to confusion since it is the individual outside the social norm who "feels" stigma. But the individual or institution inside the social norm that "enacts" it, that is discriminates. "Experienced stigma" is a more appropriate term to describe discrimination from the affected individuals' point of view and it is better to be used in place of "enacted stigma"

In other words, felt stigma is internal how people outside the social norm perceive their status - while experienced stigma is external - how the same people experience discriminatory acts.

According to Bunting (1996), cited in Busza (1999) Discrimination is composed of the actions or treatment based on the stigma and directed toward the stigmatized "the stigmatized find themselves ostracized, rejected, and shunned Alonzo et al., (1995) cited in Busza (1999) and may experience sanctions, harassment, scapegoat, and even violence based on their infection or association to HIV and AIDS. Discrimination may spring from social disapproval of the infection and its implied behaviors, or from fears due to lack of knowledge about how HIV and AIDS can or cannot be transmitted,. Because the HIV pandemic emerged so suddenly and progressed so quickly, in many countries discrimination could result from people's belief "... that not enough time remains to weigh carefully the strengths and weaknesses of various alternatives solutions to an AIDS- related problem (Herek and Glunt, 1988) cited in Busza (1999) and

the reaction is thus to err on the side of caution, even at the expense of individual rights.

However, since the concept stigma and discrimination are closely linked and stigma eventually resulted in discrimination; stigma is considered as the initial negative attitude against HIV and AIDS and PLWHA while discrimination is the actual and visible experienced behavior as a result of stigma attached to HIV and AIDS throughout this paper.

2.4. Stigma and discrimination attached to HIV and AIDS

The response to HIV and AIDS is increasingly conceptualized as a continuum between prevention and care, and the effects of stigma and discrimination can also be framed with in this model (Busza 1999, cited in UNAIDS 2005). Ideally, people seek counseling and testing to identify their HIV status with out fear of repercussions. Those who test positive then receive available care, and are encouraged to change their behaviors to protect others from infection. Their communities can support people living with HIV and AIDS (PLWHA), and their integration in to society personalizes the risk to others, aiding prevention efforts. A stigmatizing social environment, however, poses barriers at all stages of this cycle. People fear discrimination and this refrain from seeking testing. Identified PLWHA may refuse to disclose their status to partners or change their behaviors to avoid negative reactions. Thus they do not seek care and support, nor do they contribute to reducing future transmission these reaction hamper the efforts of HIV and AIDS intervention.

The stigma and discrimination associated with HIV and AIDS also mean that (PLWHA) are much less likely to receive care and support. Even those not actually infected but associated with the infected, such as spouses, children, and caregivers, are victims of stigma and discrimination. This stigma and discrimination needlessly increase the personal suffering associated with the disease (UNAIDS, 2005).

According to the same report the shame associated with AIDS – a manifestation of stigma that has been described by some writers as internalized stigma may also prevent people living with HIV from seeking treatment, care and support and exercising other rights, such as working, attending school, etc. Such shame can have powerful psychological influence over how people with HIV see themselves and adjust to their status, making them vulnerable to blame depression and self-imposed isolation.

From the inception of the AIDS epidemic, stigma and discrimination have fuelled the transmission of HIV and have greatly increased the negative impact associated with the epidemic. HIV-related stigma and discrimination continue to manifest in every country and region of the world, creating major barriers to preventing further infection, alleviating impact and providing adequate care, support and treatment (UNAIDS, 2005; UNAIDS, 2006)

The stigma associated with AIDS has silenced open discussion, both of its causes and of appropriate responses. Visibility and openness about AIDS are prerequisites for the successful mobilization of government, communities and individuals to respond to the epidemic. Concealment encourages denial that there is a problem and delays urgent action. It causes people living with HIV to be seen as a problem; rather than as a solution to containing and managing the epidemic. Stigmatization associated with AIDS is underpinned by many factors including lack of understanding of the illness, misconception about how HIV is transmitted, lack of access to treatment, irresponsible media reporting on the epidemic, the incurability of AIDS, and prejudice and fears relating to a number of socially sensitive issues including sexuality, disease and death and drug use (UNAIDS, 2005).

Stigma can lead to discrimination and other violations of human rights, which affect the well being of people living with HIV (PLWHA) in fundamental ways.

In countries all over the world, (UNAIDS, 2005) there are well documented cases of people living with HIV (PLWHA) being denied the right to health care, work, education, and freedom of movement, and subjected to harassment, physical abuse and even murder among others.

The London Declaration, issued in 1988 by the world summit of Ministers of Health on programs for HIV prevention, was one of the first international statements to recognize that "discrimination against and stigmatization of HIV infected people and people with AIDS and population groups undermines public health and must be avoided." (Cited in Foreman et al., 2003).

This principle has been accepted by many international bodies since then, including the World Health Organization and the Commission on Human Rights and was confirmed by the United Nations General Assembly special session on HIV/AIDS held in 2001.

The Declaration states that:

"Confronting stigma and discrimination is a pre requisite for effective prevention and care, and reaffirms that discrimination on the grounds of one's HIV status is a violation of Human rights."

According to UNAIDS (2006) report, stigma, discrimination and denial is noted as greater barriers for effective response to HIV and AIDS and also a fundamental driver of the epidemic while "human compassion" is an important element needed for effective response.

According to the report by UNAIDS (2005) not only is HIV-related discrimination a human right violation, but it is also necessary to address such discrimination and stigma in order to achieve public health goals and over come the epidemic.

2.5. Constitutional Provisions that Safeguard the Rights of PLWHA in Ethiopia:

Policy on HIV and AIDS of the Federal Democratic Republic of Ethiopia (1998) reiterated the UN Declaration to protect citizens against discrimination on the grounds of one's HIV status stated under Article 8. HIV/AIDS and Human Rights:

- 8.1 The rights of an individual for confidentiality in HIV serologic testing and diagnosis shall be respected.
- 8.2 The right of HIV/AIDS individuals for access to employment and associated privileges, educational and/or training facilities, public facilities such as places of entertainment, public eating and drinking places, sporting facilities etc. shall be ensured.
- 8.3 People living with HIV/AIDS shall have the right to live wherever they want to and shall not be subjected to any forms of restrictions.
- 8.4 Prisoners, persons under measures entailing restriction on personal liberty and other institutionalized persons, like trainees, orphans, military personnel---etc. Shall be treated in a manner similar to other members of the community with the same access to educational programs, serological testing, inpatient and out patient care, and shall not be subjected to discrimination practices on the basis of HIV/AIDS.
- 8.5 Children living with HIV/AIDS shall be safeguarded against any form of discrimination and stigmatization.
- 8.6 People living with HIV/AIDS need to have full understanding of the problems involved and come to grips with mechanisms to handle the situation, verifying their concern in protecting the community. Involvement in reckless transmission shall impose them to punitive legal measures.

2.6. Stigma and Discrimination in Africa

Even if stigma and discrimination related to HIV and AIDS exhibited in all parts of the world, the implication and the condition seems worse in developing countries and particularly in Africa.

According to Rankin et al., (2005) HIV- related stigma might be more prevalent and potent in African Villages than in urban areas; this is mainly government educational programs and other sources of information under serve many rural settings. In addition in villages people rely heartily upon others, the same families have frequently lived together for several generations, and much is known about neighbors. Gossip for good or ill can greatly affect social standing. Sometimes PLWHA are condemned for having gone outside their community, where they presumably contracted the virus and then introduced it locally; because AIDS is regarded, as a disease of foreigners and or strange people " not like us".

Some people with stigmatizing attitudes and behaviors openly and enthusiastically indulge these as in the case of certain (but by no means all) religious leaders who promulgate punishment theories of illness causation Goldin (1994) cited in Rankin et al. (2005). Other people who stigmatize are unconscious doing so.

It is possible, for instance, to find individuals who state the importance of accepting all people, but who use stigmatizing language to describe a PLWHA, ICRW (2002). Both stigmatization and respectful caring can occur in the same community and in the same person. According to the same report, some African countries have no term for stigma, which make attempt to raise consciousness a bit more difficult, though usually there are words meaning discrimination.

In the close context of family and neighbor in village life, fear of being stigmatized engenders denial that one is or may be living with HIV. This fear

feeds a culture of silence, as people are reluctant to disclose their sero-status lest they be rejected or because they have internalized stigma as dis-empowering shame. Fear of being stigmatized militates against being counseled, tested, and/or treated for HIV, since in the village everyone knows who visits a clinic. Due to fear of stigma and discrimination some of them even go further from their villages to seek treatment and testing. Stigma related fear may inhibit condom use because the individual may be in denial, or may want to convey falsely that he is not infected.

Fear of stigma may lead a pregnant woman to expose the fetus to increased risk of viral infection, rather than being tested and receive medications to reduce the infection risk to the baby. Etiebe, et al., (2004); Ekanem and Gbadege (2004); Thorne and Newell (2003) cited in Rankin et al., (2005). It may cause a mother to expose her infant to HIV through breast milk, rather than be tested and receive medications to reduce the infection risk to the baby Shapiro et al., (2003); Harvard AIDS Institute Update (2001) cited in Rankin et al., (2005).

Within a family discrimination against a PLWHA is not uniform, some can entail ostracism, blaming, rejection, and even physical abuse. While others are accepted and given proper care and support by family members. Husbands have beaten and/or abandoned wives thought to be living with HIV, even though many women contract the virus from their husbands, others may be forced to eat alone, may be isolated by family and/or community, or may be dispossessed ICRW (2002).

While some individuals, however, are treated well by family and/or neighbors after their health status is known.

"It is rather now that they hold me like an egg. Even before they didn't handle me like that. They realized if they didn't handle their sister like that, she would disappear from them."

(African Women with HIV who disclosed her status
Mill J. (2003) cited in Rankin et al., 2005).

Women, sex workers, and youth --- according to various studies are frequently blamed for bringing illness in to the family or community. "Courtesy" stigma may lead to community disdain for or rejection of one's family members and survivors.

Language ("She is an HIV," "he is a walking corpse,") conveys stigmatizing attitudes. Seven categories of stigmatizing terms were found in Zambia to describe a PLWHA, ICRW (2002). The words variously connoted deviance, death, and physical limitation.

According to Haileom and Aklilu (2004) an emerging vocabularies are used to describe HIV and AIDS in Ethiopia. Most of the words are found in the urban sites than the rural. HIV and AIDS is depicted as mercilessness, cruel and tricky as the names indicate. But words that describe the actual person living with HIV and AIDS are rare.

In anticipation of felt or internalized stigma many people, especially in high HIV prevalence areas, live with anxiety concerning themselves or a family member being diagnosed, discovered and then stigmatized as living with HIV, Rankin et al., (2005).

Fear of stigmatization inhibits people from being tested for HIV, which partly accounts for the so far disappointing results in attempts to connect people with free medications.

A 2004 Reuters report from Botswana, for instance, indicates that despite the many millions of dollars poured into the country by the Merck Foundation and the Gates Foundation, People still resist being tested (and then treated) for HIV infection. Hirschler B. (2004) cited in Rankin et al., (2005).

In Ethiopia after the free ART Program was officially launched on 24, January 2005, It was targeted that to enroll 100, 000 PLWHA in the program at the end of 2006. (MOH, Disease prevention and control Department Road map 2004-2006) however, with only few months left the number of people ever enrolled to the ART program is less than 50,000. MOH and HAPCO (2006), which is half of the expected. This can be partly due to fear, stigma and discrimination that is attached to HIV and AIDS.

Self-stigma is most potent just after one learns her or his sero- status. If the person already has low self esteem, and/or already holds punitive views of HIV infection, and/or if she or he has an inadequate system of social support, then internalized stigmatization can be especially devastating Rankin et al., (2005). Self- stigma frequently causes isolation of self from friends, services, and community, one may strive harder to prove one's worth; he or she may maintain silence about his or her health; and the individual may engage in a fierce struggle with fears of being exposed as a PLWHA as it is cited in Rankin et al., (2005) we have heard anecdotally that a common strategy is to explain visible skin lesions as insect bites or allergies, weight loss as caused by poverty, and so forth. Such denial and/or deceit of course undermine the integrity of self and of self- in-relationships.

Self-stigma may cause a person to give up on love, or be unavailable, or be reluctant to open the self to it out of a sense of unworthiness and fear of rejection; ICRW (2003). Added to shame is the guilt some feel when they test positive, due to the possibility that they have infected others, perhaps including spouse and/or children.

Felt stigma, like the external kind, makes disclosure of sero - statuses difficult for PLWHA. Although self -disclosure may be personally empowering, away to fight back against stigma and discrimination; it can also be risky since it opens the possibility of losing relationships with family members and the community. Many Africans do disclose to some family members or partners ---- frequently to a close family member in the same generation (Ibid) many men divulge their HIV status to their mothers. Many do not tell their partners, which can of course be dangerous among HIV discordant couples (the spouse is not living with HIV).

2.7. The Basis of HIV and AIDS- Related Stigma in Africa

The basis of HIV and AIDS related stigma in Africa is fear of contagion, particularly through causal contact, and thus it is powered by inaccurate understandings of HIV transmission ICRW (2003). Casual contact fears are deeply rooted, even among people who presumably know better. They may persist, for instance among health care providers, so that working with patients living with HIV may be very difficult for them. Not infrequently they will stigmatize their patients out of fear of contagion.

The care givers in many families of a PLWHA are frequently concerned about contracting HIV through casual contact. Alubo, Ogoh, et al., (2002) cited in Rankin et al., (2005), Others in the community may refuse to purchase vegetables or poultry, for instance, from someone living with HIV and AIDS or even from a spouse or child of the same.

The same condition applies in Ethiopia, according to Haileom and Aklilu, (2004) a male member of Anti HIV and AIDS club in the rural site says:

"Here in our village 'Shashamane', there was one family who earn their living by selling milk to the community. However, after the community member identified a member of the family is living with HIV, people stopped to buy their milk. Even those, who were their regular customers, break their earlier contract. The family is the highly stigmatized and suffering economically.

Similarly, the same report revealed that 61% of respondent would not buy food from a vendor with HIV or AIDS. In impoverished area this has a serious impact up on the family's economic survival chances. The PLWHA is made to eat alone and is sometimes secluded in a separate room away from family members.

In African villages traditional culture and religious notions of illness causation may be deeply rooted, Stadler (2003) cited in Rankin et al., (2005). Traditions frequently teach that supernatural forces cause certain types of illness in particular, and such illnesses are strongly associated with stigma. These include illnesses that deform infectious diseases where the vector is not understood, serious illnesses and instances in which the individual breached a societal norm. Punishment theories involving the deity or an avenging ancestor or community member are invoked to explain some illnesses.

When witchcraft theories of illness causation are put forth or where illness is attributed to poisoning by presumed enemies, stigma usually follows. Since many PLWHA and their family members visit traditional healers before or instead of consulting western health care personnel, traditional attitudes reinforcing HIV and AIDS related stigma may be magnified rather than mitigated, Rankin W et al., (2005).

Indeed, some people will not be seen near an Organization or institution working on HIV and AIDS, out of fear of being stigmatized. "We are happy with the services provided to us --- But I feel a bit uncomfortable when TASO (HIV support organization in Uganda) Staff come in their vehicles to visit me. I prefer to come to TASO but not TASO come to my home" PLWHA, Kampala (UNAIDS, 2001). Many will not seek VCT, or stay after a blood sample is taken to learn test results, or return for treatment, even if available free, out of the same fear, some villagers do not want HIV and AIDS workers in them, for fear of being stigmatized.

Another most important basis of stigma and discrimination could be silence about sexuality, which is considered taboo in most African culture and tradition. Large number of African families will not discuss male and female sexual behaviors in general. BBC News (June 8, 2001) cited in Rankin et al., (2005).

The silence throughout society concerning human sexuality works against people with STI. These are scapegoat because of issues that cannot be dealt with openly, for instance, husbands contract HIV through extra marital associations and then pass the virus to their wives. The wife becomes stigmatized, as a presumed sex worker while the community is silent about male promiscuity. Amazingly Silence and denial is not only the characteristics of individuals and communities, But in some cases silence and denial is exhibited by governments: According to the American council for the United Nation University (2001) cited in Rankin et al., (2005) there is speculation that certain Islamic countries may under report HIV prevalence due to concerns that the nation as a whole will be stigmatized by other nations in the world community, or by other nations predominantly Islamic faith.

2.8. Forms and Context of Stigma and Discrimination

Since the onset of the HIV epidemic, discrimination has tended to fall into two basic categories: legislative forms of discrimination which reflect stigma that has been officially sanctioned and legitimized through laws or policies; and community level forms, in which marginalized groups experience discrimination in a variety of less formal contexts often those related to family and other structures of civil society. Widespread negative attitudes perpetuated through shared social discourse, such as by the media, could be said to constitute a third, societal level form of discrimination (Busza J, 1999). As Busza states it for the purpose of this paper, however, the influence of pervasive and stigmatizing media images will be considered within the rubric of discrimination at the community level.

In reality, these forms of discrimination may not be easily delineated (Ibid) laws and policies can mirror community beliefs, and civil society operates within institutional norms. As a result, interventions that try to reduce discrimination may also blur the distinction.

2.8.1. Legislative

Forms of legislative discrimination include restriction on travel, enforced isolation, and mandatory testing and reporting among other. Many of these disciplinary practices, whether inflicted on PLWHA or other marginalized groups, have been condemned through international agreements on universal human rights, which are founded on the principles of non-discrimination (Gruskin, Hendriks, and Tomasevski et al., (1996) cited in Busza (1999)). The policy on HIV and AIDS of the Federal Democratic Republic of Ethiopia in a way stated as such kinds of discrimination is a violation of the human right of the individual and the group affected and infected. Nevertheless, discrimination prevails in environments where one cannot address or protect it through legislation, which is the community level especially in the family.

2.8.2. Community level

Most people participate in many “communities” either simultaneously or at different times throughout their lives. As a result, to consider social responses to HIV and AIDS at the community level requires scrutiny of numerous contexts. The table below lists community level contexts where HIV –related discrimination has been experienced in South East Asia and example of how this discrimination has been manifested.

Contexts of discrimination (adapted from Malcom et al., (1998), cited in Busza (1999))	Examples
Family/Immediate community (e.g., Village)	▪ Isolation of both infected and affected due to fears of causal contact ▪ Restrictions on participation in local communities events ▪ Refusal to allow affected children in local schools ▪ Lack of support for affected bereaved family members, including orphans.
Workplace	▪ Mandatory testing before hiring, refusal to employ ▪ In voluntary periodic testing dismissal on grounds of HIV status. ▪ Violations of confidentiality ▪ Refusal to work with infected colleagues out of fear of contagion
Health service	▪ Violation of confidentiality ▪ Refusal to treat ▪ Provision of care in specific establishments (such as STI clinics) that further stigmatize the client. ▪ Behavior with clients that clearly identifies their HIV status, instead of using universal precautions. ▪ Advice given presume applied for HIV + Person to under go treatment that would not be emphasized for others. (eg. Abortion, sterilization)
Religion	▪ Denial of traditional rituals e.g. funeral practices, restricted access to marriage ▪ Restrictions on participation in religious activities
Media	▪ Demonization by public health campaigns of specified “transmitters” such as SW, reinforcing division between “guilt” and innocent PLWHA ▪ Depiction of HIV/AIDS as death perpetuating fear and anxiety rather than normalization. ▪ Reinforcement of stereotypical gender roles that perpetuate women’s vulnerability to sexual coercion and HIV infection.

A study on HIV and AIDS -related stigma conducted in four countries, Ethiopia, Tanzania, Zambia and Vietnam, (Ogden and Nyblade, 2005), cited in Tedla,(2005) categorized the forms and expressions of stigma in to four, loosely defined groups such as: physical stigma which refers to forms of stigma such as marking and separating shared objects like eating utensils and clothes at home and isolating them from public places; social stigma that includes social isolation, loss of identity and role, and voyeurism; verbal stigma that holds the direct practice like pointing fingers, insulting, taunting or blaming or more indirect practice like gossip and rumors; and institutional stigma that refers to differential treatment defined institutional setting that causes negative outcomes to the person living with HIV (PLWHA)

2.8.3 Causes of Stigma and Discrimination

Stigma has long been associated with diseases that provoke strong emotional responses through their association with disfigurement, such as leprosy and polio, and disease such as cholera. Foreman et al., (2003), As the cause of both disfigurement (wasting syndrome, Kaposi's sarcoma etc) and death, HIV and AIDS provide fertile ground for stigma to take root.

The stigma increases where there is ignorance as to how HIV is transmitted, leading individual and communities to fear casual contagion through such actions as shaking hands, coughs and sharing eating and toilet facilities.

Disease-related stigma can be reduced by education. A consistent finding in studies is that people who have little knowledge or are misinformed about HIV transmission are much more likely to hold discriminatory attitudes than those who are well informed. In other words, people who are aware that casual contagion is impossible are less likely to hold discriminatory attitudes towards people living with HIV and AIDS. CDC (2000); Herek et al., (2002) cited in Foreman et al., 2003. However as Rankin et al., (2005) pointed out, people's apparent "knowledge" of HIV and AIDS does not necessarily mean that they

understand, or have appropriated, such data as how being infected with HIV differs from having AIDS symptoms, how one can be HIV positive and transmit the virus to others while appearing healthy, that opportunistic infections are treatable if drugs are available, that some forms of presumed transmission - through caring for a PLWHA, for instance do not occur if a person follows simple precautions, and so forth.

According to the report by Foreman et al., (2003), a weakening of the association between HIV and AIDS and death also reduce stigma. Anecdotal evidence from several communities suggests that discrimination falls where people with the virus have access to antiretroviral and other drugs that prolong life and make disfigurement less likely. However, while some sources of prejudice fall away, others remain. HIV and AIDS are linked to long standing stigmas of sexual misconduct and, in some communities, illicit drug use. "People with HIV and AIDS are often believed to have deserved what has happened by doing something wrong --- Men who become infected may be seen as homosexual, bisexual or as having sex with prostitutes. Women with HIV and AIDS are viewed as having been 'Promiscuous' or as having been sex workers." UNAIDS (2002) cited in Foreman et al., (2003).

Such stigma persists, irrespective of the reality. In the United States, where sex between men accounted for less than 40% new cases of HIV transmission in 1997, up to 67% of one sample in a public survey admitted that they primarily associated the disease with homosexual men. Heterosexual men who contracted the virus were the subjects of less disapproval than homosexual men in the same position. Capitanio (1999) as cited in Foreman et al., (2003)

Disease and pre-existing stigma are considered by some commentators as two components of HIV and AIDS - related stigma; as instrumental AIDS stigma and symbolic AIDS stigma. The former reflects fear of HIV and AIDS as a communicable and fatal disease; the latter results from the association the

disease has with groups already stigmatized, (Capitanio 1999) cited in Foreman et al., (2003).

In rural Zambia, powerful imagery, metaphors and euphemisms for HIV and AIDS include terms associated with immorality, illness, death, denial, innocence and guilt. "Dominant in such discourse is the balance assigned to people with HIV and AIDS, and assumptions made about their past sexual history. Exceptions (are) grandmothers who assist women in labor and 'deserve pity' if they become infected "(Panos/UNICEF, 2000). (Ibid)

2.8.4. Those Affected

HIV and AIDS related stigma affects men and women, young and old, rich and poor. It affects people known to have contracted the virus, people suspected of having contracted it or of being vulnerable to the virus, such as sex workers and homosexual men, and the families and caregivers of those who are ill. It occurs in every country, irrespective of the extent and impact of the extent and impact of the epidemic itself.

"One of the most surprising elements of AIDS stigma is its ubiquitous nature even where the epidemic is widespread and affecting so many people, such as in sub-Saharan Africa". (Brown et al., (2003) cited in Foreman et al., (2003).

According to the same report stigma and discrimination affect different groups in different ways and at different stages of the disease. However women are most stigmatized and discriminated than men in most societies.

Women who sell sex are stigmatized in most societies, whether or not they have contracted HIV. That stigma is after extended to the many women who contract HIV from their husband or long term partner. HIV infection is so strongly associated with promiscuity that women with the virus are frequently assumed to be promiscuous, irrespective of their sexual history. When HIV is diagnosed, "Men are likely to be accepted by family and community. Women--- are more

likely to be blamed, even when they have been accepted by their husbands in what for them have been monogamous relationship," UNAIDS (2001).

However, according to Foreman (1999), cited in Foreman et al., (2003), even though women face greater stigma, anecdotal evidence suggests that in communities where sex between men and women is the primary form of HIV transmission, women with the virus have stronger support networks and are likely to live longer after diagnosis than men. In communities where sex between men is the primary source of transmission, men tend to have stronger support networks.

Homosexual men are groups who encountered persistent stigma and discrimination. Homophobia, which is generally defined as fear, hatred or disapproval of sex between homosexual men, preceded HIV and AIDS related stigma and discrimination. The stigma and discrimination associated with sex between men affects such men in two different ways – lack of service and reluctance to access services. According to Foreman et al., (2003), HIV and AIDS services for men are either absent in many communities, particularly in Africa and parts of Asia, or are insufficient as in Latin America, where who have sex with men comprise less than 10% of the population but 35% - 65% of reported cases of HIV. Where services are available, stigma and discrimination related to sex between men prevents many from accessing appropriate HIV and AIDS counseling testing and care services. (Chakrapani (2002) Positivo (2002), cited in Foreman et al., (2003).

In some circumstances, homophobia even affects men who have only sex with women. There are several reports of heterosexual men, particularly in Latin America, who are reluctant to work with people with HIV and AIDS or who are afraid of contracting the virus in non-sexual setting (Such as occupational exposure in a hospital) because they fear others will suspect they are homosexual (Ibid). Another group of people who are subjects of stigma and discrimination

are injecting drug users. According to the same report there is considerable anecdotal and statistical evidence that underline the extent to which injecting drug users are the victims of stigma and discrimination, irrespective of HIV and AIDS. Drug users are often unable to access appropriate HIV and AIDS prevention and care services. Children infected with HIV in the womb are also theoretically less stigmatized as those people who contracted HIV through contaminated blood products. However, in practice both children and hemophiliacs with HIV and AIDS report incidents of discrimination and stigma irrespective of their condition or how they contracted the virus.

2.9. The Impact of Stigma and Discrimination

Foreman et al., (2003) pointed out that whether the result of specific legislation or policy, or the spontaneous act of individuals within the social norm, discrimination against people living with or associated with HIV is widespread and takes many forms. In addition to discrimination in health care settings, discriminatory acts include: Refusal of education; refusal of or removal from employment; denial of the right to marry; requirement to submit to an HIV test for work, travel or other purposes; lack of or reduced confidentiality; detention; deportation; demonization in the media; rejection by families, friends and communities; physical attack including murder.

According to the same report from Forman et al., (2003), although the majority of health workers report neutral or positive attitudes, the experiences of people living with HIV and AIDS in health care settings suggest that discrimination is widespread. Reported discriminatory actions and inactions in health care settings include: Treatment delayed; treatment withheld; inappropriate treatment provided; other forms of care (example, presentation of food hygiene) delayed or withheld; premature discharge; refusal to admit patients to health care facility; non attendance to patients in beds; non attendance to individuals in out patient clinics; testing without consult; breach of confidentiality within the

health care system; breach of confidentiality out of the health care system; inability to diagnose the clinical manifestations of AIDS; inability to give news of HIV positive result; inappropriate comments; inappropriate behavior (e.g., shouting, rudeness, etc); use of excessive precautions. Such acts have negative impact on the community and individual health. In some cases they may constitute an obstacle to the exercise or enjoyment of human rights and fundamental freedoms. In other instances, they are per se a violation of such rights and freedom.

2.9.1. Individual and public health

In an ideal world, prevention and care exist on a continuum whereby those at risk are encouraged to test for HIV infection, those who are found positive receive appropriate counseling services and those who are cared for are accepted by the community, creating an appropriate environment where those at risk are encouraged to test for infection and so on. The following figures adapted from Busza (2001), cited in Foreman et al., (2003) will describe the phenomenon.

Figure 2: The prevention to care continuum: Ideal Scenario

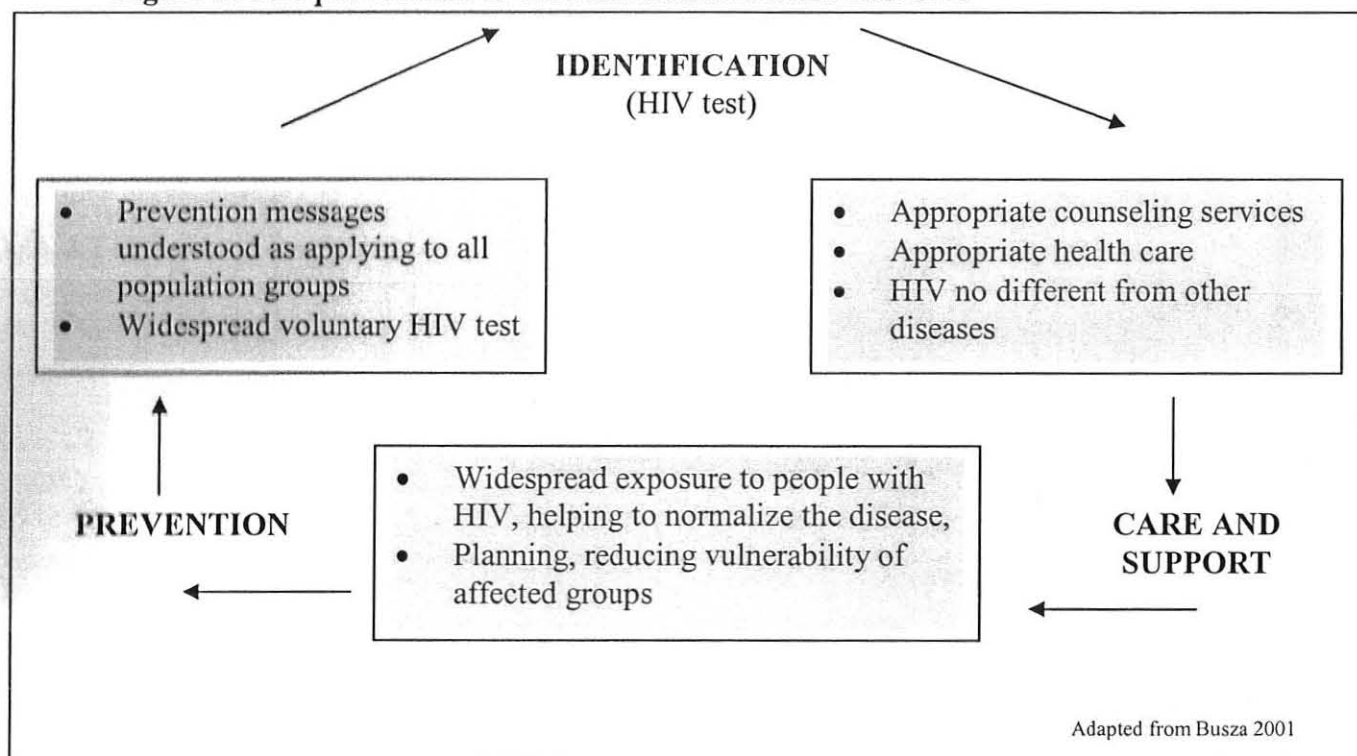
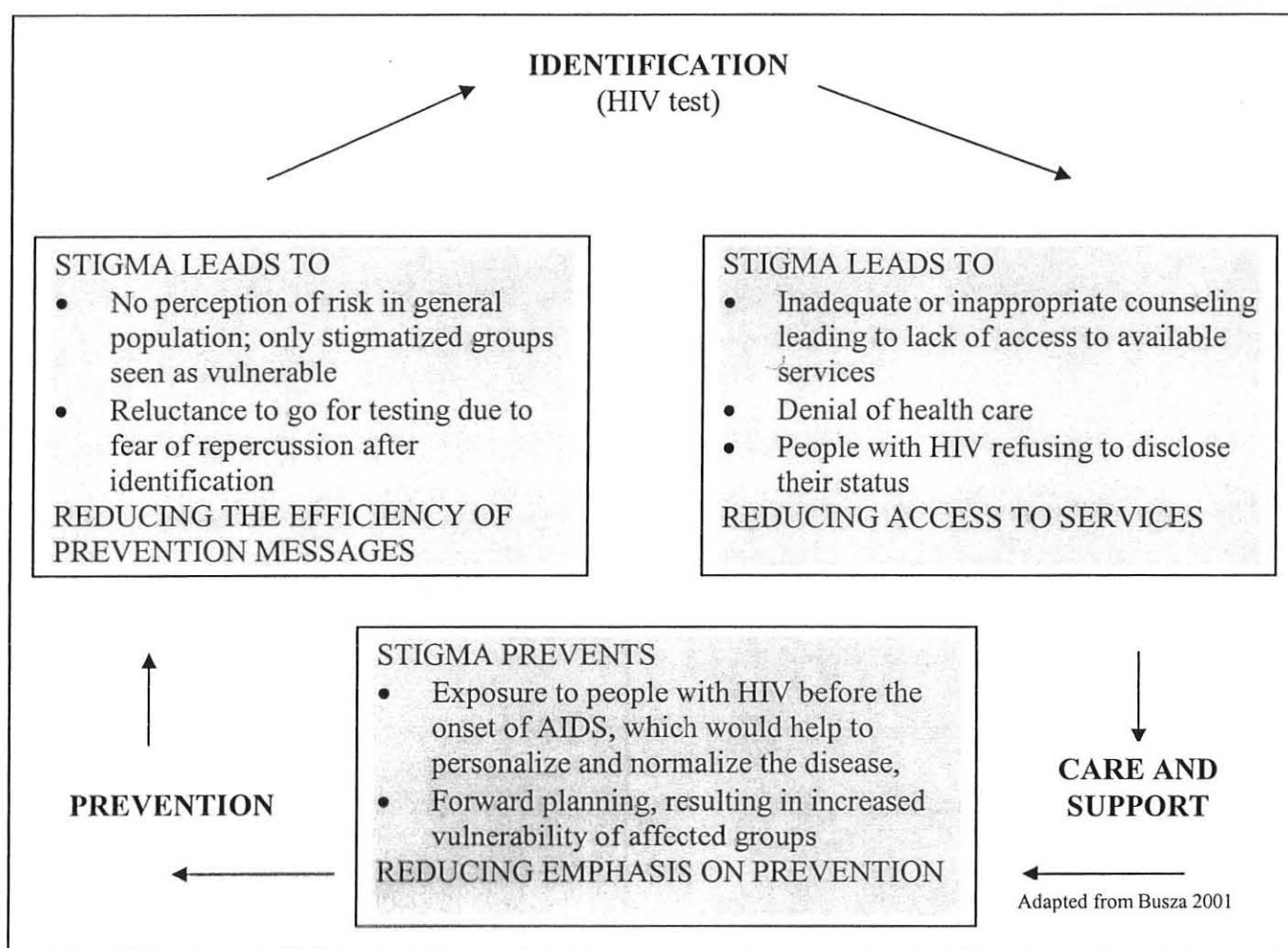


Figure 3: The impact of stigma on the prevention to care continuum



Stigma and discrimination allow HIV to spread, with serious consequences for both the individual and the community. Because it reduces the motivation to get tested and to look after one's own health. Furthermore, stigma and discrimination may have strong psychological consequences on those who are HIV-positive, increasing social isolation and depression (Lichtenstien et al., 2002, UNAIDS 2002a) cited in Foreman et al., (2003).

2.10. HIV and AIDS Related Stigma, Discrimination, and Human Rights Violations

According to UNAIDS (2005), because of the intimate connection between stigma, discrimination and human right violations, and the fact that PLWHA are stigmatized and discriminated against in many different settings, simultaneous, multi-pronged action is needed and must be sustained over time. In order to create an environment in which stigma, discrimination, and human rights violations are no longer tolerated and practiced, the following actions are necessary.

- The implementation of programs that deal with stigma at collective and community level programs need to be proactive in addressing stigma before it is manifested or enacted in various kinds of discriminatory action rather than merely responding to it after it has occurred.
- The development and implementation of laws and policies to protect against discrimination and protect the right of PLWHA. These approaches are interdependent and mutually reinforcing responses in one setting (e.g., in health care services or work places) may have consequences for the way in which people react in others (e.g., at home). As a tool for tackling stigma and discrimination, legal and policy reforms have limited impact unless supported by the values and expectations of communities and society as a whole. Regulating the discriminatory actions that are the outcome of stigma, without addressing the understanding and attitudes that give rise to such actions leads inevitably to an inadequate response. Stigmatization frequently occurs in contexts and settings not regulated by legislation, such as within families and everyday social encounters and urgent action are needed in these environments to combat its occurrence. Overall freedom from discrimination empowers individuals and communities to act, to mobilize their resources and to respond collectively and positively to the HIV epidemic. Ultimately, stigma, discrimination and human rights provide

three key entry points for successful work: preventing stigma; challenging discrimination when it occurs and promoting and protecting human rights, including monitoring and redressing human rights violations.

Therefore, in line with this, according to UNAIDS (2005) effective programs will result in indicators of stigma and discrimination reduction in selected three settings, such as in community settings, health settings, and the work place.

In community settings

- Increased willingness of relatives and community members to care for HIV-positive people;
- Enhanced care resulting in better quality of life for people living with HIV (PLWHA);
- Increased willingness of community members to volunteer in HIV prevention and AIDS care programs;
- Increased disclosure of sero-positivity by people living with HIV and their increased involvement in, and leadership of, prevention care and advocacy efforts;
- Reduction in self stigma and increased confidence living with HIV; and
- A more open expression positive attitudes within communities towards people living with and affected by HIV and AIDS.

In health settings

- Increased uptake of HIV counseling and testing;
- Increased access to, and uptake of, treatment;
- Reduced numbers of complaints of discrimination by PLWHA and their families;
- Improved quality of care of HIV positive patients resulting in enhanced quality of life;
- Increased willingness on the part of health works to deal constructively with PLWHA; and

- Increased expression of positive attitudes towards people living with HIV by health workers in non health care settings.

In employment and in the work place

- Reduction in complaints of discrimination;
- Increased in volunteers within work places participating in specific AIDS programs;
- Increased openness of HIV-positive employee about their status;
- Increased willingness of employees alongside people known to be living with HIV;
- Increased uptake of voluntary counseling and testing;
- Enhanced uptake of treatment service offered by workplaces; and
- Supportive HIV work place policies and practice.

CHAPTER III

METHODOLOGY

3.1. Method of the Study

To realize the objectives of the present study a cross-sectional survey method was used.

3.2. Research Site and Study Population

The study was conducted in Ambo town (West Shoa Zone, Oromia state). Ambo town is located some 120 km from Addis Ababa. Ambo town is the seat of the West Shoa zone administration in Oromia state. According to the (CSA, 1994) the town has an estimated total population of about 27,636 (14,256 female and 13,380 male). The town has one federally owned college. Formerly known as Ambo Agricultural College, but now renamed as Ambo College, Jimma University. The college enrolls students who completed their University preparatory education from all over the country under the Ministry of Education.

According to the information obtained from the registrar's office, the targeted total population of Ambo College students is 1190 (919 male and 281 female). Out of which 599 (459 male and 140 female) are 2nd year while 601 (460 male and 141 female) are 3rd year students.

Ambo is selected as the study site because:

1. Due to working exposure in the area by the researcher, (Ambo College, Jimma University).
2. The researcher's ability to communicate with the local language considered being an advantage for the interview with PLWHA.

3.3. Ethical Consideration

Since the issue under investigation is highly sensitive, ethical clearance was obtained from the Oromia Regional Health Bureau before conducting the research. At the same time the college's administration permission was granted before collecting the data in Ambo College. Moreover informed consent from the research participants was obtained by ensuring confidentiality and privacy of their information.

3.4. Sampling and Sample Size

264 students from Ambo College, Jimma University, which was about 20% of the target population, and three PLWHA were participated in this study. Out of this 248 (184 male and 64 female) students were participated in filling the questionnaire while 16 (8 female and 8 male) students participated in the FGD. The three PLWHA took part in the case study.

In all the sampling proportion of both sexes was attempted to be maintained. Furthermore, in the case of PLWHA attempts were made to include those who disclose their HIV-status to the public openly and those who do not want to disclose their HIV-status. This was done with the help of the counselor working as research assistant.

Stratified random sampling method was used for selecting University students. Sex was the strata used for selecting the research participants. Before the sampling, the list of all male and female students in the target population was collected from the registrar office of the College. Since it was 20% of the population that was planned to be included in the sample, a lottery method was used to decide the first person to be included in the study for both female and male students. After the first person was identified, every fifth student below and above the selected student was taken randomly from the entire list as the research participant. Out of this 16 students were purposely selected for FGD and excluded from filling the questionnaire. In the case of PLWHA participated

in the case study convenience and/or purposive sampling method were used, due to the nature of the setting and the sensitivity of the issue under study.

3.5. Instruments

Different instruments were employed in this study. These are: **Questionnaire, Focused Group Discussion Guide (FGD) and Case Study (personal profile).**

Questionnaire was the primary instrument employed to gather information from University students regarding, knowledge about HIV and AIDS and their attitudes in relation to stigma and discrimination attached to HIV and AIDS. The questionnaire includes three parts, the first part comprises 6 items regarding socio-demographic characteristics of the research participants and the second part is organized on HIV/AIDS knowledge of the respondents contains 8 items stated as yes/no and in multiple response formats. The third part of the questionnaire which was organized to elicit the respondents' attitude in relation to stigma and discrimination attached to HIV and AIDS includes 27 differently stated items, where some are stated in the form of yes/no, the others structured in to four points scale, strongly agree, agree, disagree and strongly disagree and others stated in multiple response type. Numbers were represented to each alternatives with 4 representing strongly agree and 1 strongly disagree. Some of the items in this section were negatively phrased, scores for these items being recorded in the reverse way, that is 1 for strongly agree and 4 for strongly disagree. After structuring the items in the above format, the questionnaire was given to three psychology instructors specialized in measurement and evaluation for assessment on the face and content validity of the items as well as for any instances ambiguity. Based on the comments received from the instructors certain modifications were made on some items.

Moreover, **Focused Group Discussions (FGD)** held separately for female and male University students to elicit more information about the issue under investigation.

Case study (personal profile) of PLWHA was explored to examine the stigma and discrimination experienced by the respondents in their day-to-day life.

The instruments were adapted from the Miz-Hassab Research Center (MHRC) by permission and from instruments used in the UNAIDS general population survey. The final instrument was translated to the local language 'Amharic' for ease of understanding.

3.6. Procedure of Data Collection

A total of four research assistants were employed for data collection. A half-day orientation was given to the research assistants about the study and data collection techniques. Research assistants were recruited from both sexes.

The research assistants had been drawn from:

1. Group 1 the college community - Involved 2 individuals
 - One female student
 - One male student
2. Group 2 the case study (personal profile)- Involved 2 individuals
 - One Person living with HIV (PLWHA) who disclosed his/her HIV status openly to the public
 - One Counselor working with PLWHA in the area

Data through the questionnaire was collected with the help of the classroom instructors and the research assistants with in the classroom environment. All instructors cooperated by giving one hour of their time to collect the data from the research participants. The FGD was held in the college conference room separately for female and male research discussants. Refreshment was served during the discussion to create a relaxing atmosphere. Interviews with PLWHA were conducted in different places according to the preference of the research participants.

3.7. Data Analysis

The data was processed using SPSS statistical program for social sciences version 10.0 for window. The processed data was analyzed using frequency distribution, percentage and Chi-square. In line with this quantitative analysis the data generated using interview and FGD were analyzed qualitatively.

CHAPTER IV

DATA ANALYSIS, INTERPRETATION AND DISCUSSION

4.1. Socio-Demographic Characteristics

In this section Table 1, below results pertaining to the socio-demographic characteristics of the research participants are presented. It was noted in the methodology section that, efforts were made to maintain the proportion of male and female participants in the sampling. The total research participants in the survey were 264 university students. The socio-demographic characteristics include: sex, year of attending class, marital status, religion, ethnicity and parents' living place are described below.

Table 1: Demographic characteristic of respondents by selected characteristics

Background Characteristics	N	%
Sex		
Male	192	73
Female	72	27
Total	264*	100
Parents' current living place		
Rural	121	46
Urban	143	54
Total	264*	100
Year of attending class		
2nd year	125	47
3rd year	139	53
Total	264*	100
Marital Status		
Married	36	14
Unmarried	221	84
Not mentioned	7	2
Total	264*	100
Religion		
Muslim	36	14
Orthodox Christian	167	63
Protestant Christian	45	17
Others	16	6
Total	264*	100
Ethnicity		
Oromo	90	34
Amhara	92	35
Tigray	45	17
Others	37	14
Total	264*	100

* The figure refers to all students who participated in FGD and in filling the questionnaire.

As indicated in table 1, above 72 (27%) female and 192(73%) male students were participated in this study. Regarding parents' current living place 143(54%) were urban while 121(46%) were rural. Information collected on their years of attending class showed that 125(47%) are in second year while the rest 139(53%) are third year students. The majority of the research participants 221(84%) are single while 36(14%) are married and 7(3%) not mentioned their marital status. Information obtained on religious affiliation of the research participants shows that 167(63%) are Orthodox Christians while 45(17%) are Protestants, 36(14%) are Muslim and 16(6%) belongs to other different religious groups. Concerning ethnicity 90(34%) of the respondents are Oromo, while 92(35%) are Amharas, 45(17%) are Tigray and 37(14%) belongs to other different ethnic groups.

4.2. Knowledge about HIV and AIDS

Table 2: Do you know about HIV/AIDS?

Response	Female		Male		Total	
	Frequency	%	Frequency	%	Frequency	%
Yes	62	96.88	184	100	246	99.19
No	0	0	0	0	0	0
No Response	2	3.13	0	0	2	0.81
Total	64	100	184	100	248	100

As the above Table 2, shows almost all the participants 96.9% of females and 100% of the male respondents knew about HIV/AIDS. Generally speaking, nearly all the research participants 99.2% ascertained that they knew about HIV/AIDS.

Compared to the earlier years, the knowledge and the awareness about HIV/AIDS is becoming promising. This is mainly because there are many awareness creation activities in schools and higher learning institutions. As the FGD discussants confirmed that, while they were in high school information regarding HIV/AIDS was used to be given repeatedly. However, in Ambo College the awareness creation activities were not as it was expected to be. Nevertheless, almost all the students knew about HIV/ AIDS.

Table 3: In what ways can HIV be transmitted?

Responses	Frequency	%
Mother to child	225	90.73
Sex with someone who is HIV+	238	95.97
Sex with multiple partners	172	69.35
Sex with CSWs	164	66.13
Sex with homosexuals	107	43.15
Intra-venous drug use	116	46.77
Blood transfusion	200	80.65
Kissing someone who is infected	12	4.84
Mosquito bites	12	4.84
Sharing sharp materials, razors/blades	219	88.31
Sharing food/drinks with a person who has AIDS	2	0.81
Using public toilets	1	0.40
N	248	

Note: the total percentage adds to more than 100% due to the respondents gave multiple responses.

According to Table 3, 90.7% said HIV can be transmitted from mother to child, while the majority of the respondents 96% responded that HIV can be transmitted by having sex with someone who is HIV positive as a major mode of HIV transmission. The same table indicated that 80.7% and 88.3 % of the respondents asserted as blood transfusion and sharing sharp materials as a means of HIV transmission respectively. While sex with multiple partners 69.4%, sex with CSWs 66.1%, and sex with homosexuals 43.2% and intravenous drug use 46.8% were mentioned as a means where HIV can be transmitted. However, 12(4.8%) of the respondents claimed that as HIV can be transmitted through mosquito bites and by kissing someone who is infected. Very insignificant number of the respondents (2) and (1) said HIV can be transmitted through sharing foods or drinks and public toilet respectively.

Regarding the HIV mode of transmission the majority of the students stated the correct means where HIV can be transmitted. However, sex with multiple partners and sex with commercial sex workers were under reported. This shows the students risky behavior.

Contrary to the male, the Female FGD participants claimed that sex with CSWs and having multiple partners are the major causes for HIV transmission. Similar report from the (MOH, 2004) ascertained that male youth were engaged more in risky behavior than female youth supports the above finding.

Only less than half of the respondents rated, intravenous drug use and homosexuality as a means for HIV transmission can be attributed to cultural differences.

Table 4: Is there a cure for AIDS?

Responses	Female		Male		Total	
	Frequency	%	Frequency	%	Frequency	%
Yes	13	20.31	31	16.85	44	17.74
No	47	73.44	140	76.09	187	75.40
Don't know	2	3.13	9	4.89	11	4.44
No response	2	3.13	4	2.17	6	2.42
Total	64	100	184	100	248	100

As can be seen from Table 4, 20.3% of female and 16.9% of male respondents had revealed that, there is a cure for HIV/AIDS while 73.4% of the female and 76.1% of the male respondents said HIV/AIDS has no cure. A very few respondents 3.1 % of female and 4.9% of male respondents asserted that they do not know if HIV/AIDS has a cure.

Table 5: If there is a cure, it is:

Responses	Female		Male		Total	
	Frequency	%	Frequency	%	Frequency	%
Modern medicine	1	7.69	3	9.68	4	9.09
Traditional medicine	2	15.38	5	16.13	7	15.91
Religious practice	9	69.23	23	74.19	32	72.73
No response	1	7.69	0	0.00	1	2.27
Total	13	100	31	100	44	100

Among who said HIV/AIDS has a cure Table 5 above, a large majority 9(69.2%) female and 23(74.2%) of male respondents confirmed that the cure for HIV/AIDS is religious practice, while 2(15.4%) of the female and 5(16.1%) of the male respondents revealed traditional medicine as a cure for HIV/AIDS. Only very few reported as modern medicine can cure HIV/AIDS.

Concerning the cure about HIV/AIDS both male and Female FGD discussants revealed that, there is no modern medicine to cure HIV/AIDS. However, FGD participants from the Orthodox background believe that Holy water ('Tebel') can cure HIV/AIDS for those who have a firm faith in God. While the Protestants claim prayer as a source of cure for HIV/AIDS.

Even though religious practices can be a source of relief from psychological problems and tension, it is unlikely to cure the infection that caused by viruses and bacteria. This kind of agitation can also undermine the intention for PLWHA to seek professional treatments like ART.

Table 6: Is it possible for a healthy looking person to have HIV, the virus that causes AIDS?

Responses	Female		Male		Total	
	Frequency	%	Frequency	%	Frequency	%
Yes	55	85.94	175	95.11	230	92.74
No	2	3.13	0	0	2	0.81
Don't know	3	4.69	0	0	3	1.21
No response	4	6.25	9	4.89	13	5.24
Total	64	100	184	100	248	100

As shown in Table 6 above, 85.94% of female and 95.1% of the male respondents said that a health looking person can have HIV, the virus that causes AIDS. However, unlike the male, 7.8% of the female respondents reported that they did not know if a health looking person can have HIV or not.

Table 7: How do you think can people protect themselves from getting HIV?

Responses	Frequency	%
Use condoms	204	82.26
Have fewer partners	24	9.68
No casual sex	195	78.63
No sex at all	219	88.31
No commercial sex	168	67.74
Use sterilized needles	204	82.26
Seek protection from traditional healers	31	12.50
Avoid contaminated blood transfusion	207	83.47
Don't know	0	0
N	248	

Note: the total percentage adds to more than 100% because the respondents gave multiple responses.

With a little exception, which failed to answer to this item, a great majority of the research participants claimed to identify proper known means of protecting themselves from HIV infection. As Table 7 above shows, no sex at all (abstinence) 88.3% is believed to be the best means of protection from HIV infection. Similarly, a large majority of the respondents said they can protect themselves from HIV infection by avoiding contaminated blood transfusion 83.5%, condom use and using sterilized needles 82.3% by refusing to engage in casual sex 78.6% and by avoiding commercial sex 67.7% respectively. However, unlike the majority a very few 9.68% of the respondents said having fewer partners can be the means of protection from getting HIV, which indicates risky behavior.

Participants in the FGD also supported abstinence from sex; until one gets married to one faithful partner is the best means of HIV protection.

If abstinence is not possible, said the discussants having one faithful sexual partner can be the second option. Most male students mentioned condom use as the 3rd option. However, Female FGD participants greatly differ with the idea of using condoms as a means of protecting HIV.

“... Condom use will obviously result in carelessness. It’s also not 100% perfect. Every time one uses condom there is always risk. Why risk then?” Female FGD participant.

Table 8: What is the source of information for you to learn about HIV and AIDS?

Responses	Frequency	%
Radio	229	92.34
Television	229	92.34
Newspaper/Magazine	211	85.08
Health workers	206	83.06
Instructors	178	71.77
Neighbors/Friends	182	73.39
N	248	

Note:: The total percentage adds to more than 100% because the respondents gave multiple responses.

Table 8 is organized to indicate the university students' source of information to learn about HIV and AIDS. Accordingly, radio and television 92.34% is claimed to be the main source of information for the majority of the respondents to learn about HIV and AIDS. Similarly, newspaper and or magazine 85%, health workers 83%, neighbors and or friends 73.4% and instructors 71.8% is reported to be the source of HIV and AIDS information for the respondents respectively.

According to the above data, and many anecdotal evidences, media is the main source of information to learn and create awareness about HIV/AIDS. However, the data collected from the FGD and the experience of PLWHA confirmed that, media is also the main source and causes of stigma and discrimination attached to HIV/AIDS.

Table 9: Have you ever-discussed HIV and AIDS issues with other people?

	Female		Male		Total	
Responses	Frequency	%	Frequency	%	Frequency	%
Yes	54	84.38	141	76.63	195	78.63
No	6	9.38	35	19.02	41	16.53
No response	4	6.25	8	4.35	12	4.84
Total	64	100	184	100	248	100

As it is known silence about HIV/AIDS is one of the acute barriers in the work against HIV and AIDS. Table 9 above summarizes the respondents experience about raising HIV and AIDS issues with others.

Accordingly, while a great majority of the respondents revealed that, they discussed HIV and AIDS issues with others; females are more positive to discuss 84.38% compared to males 76.6%. Similarly, 19% of the male respondents said they never discussed HIV and AIDS issues while only 9.38% of the female said they didn't discussed about AIDS.

Both Female and Male FGD participants reported their preference in discussing HIV/AIDS issues with same sex friends and parents than opposite sex friends and parents.

As one male FGD participant stated:

"How can you raise about HIV/AIDS to your mother? In doing that it can raise a negative suspicion towards once behavior. Because HIV/AIDS is considered as immoral issues to be raised in front of the family."

4.3 Attitude Of University Students in Relation to Stigma and Discrimination Associated to HIV and AIDS and Towards PLWHA

In the following section the data collected to examine the University students' attitude in relation to stigma and discrimination associated to HIV and AIDS and PLWHA is presented using tables, showing frequency distribution and percentage.

For some selected items Chi-square was calculated to compare the stigma and discrimination level between male and female respondents. The Chi-square was calculated to accept or reject the null hypothesis with the alpha level of 0.05.

The null hypothesis and the alternative hypothesis are stated as:

H₀: Level of stigma and discrimination is independent of sex (stigmatizing and discriminatory attitude is unrelated to the sex of the students).

H₁: Level of stigma and discrimination is not independent of sex (Stigmatizing and discriminatory attitude is related to the sex of the students).

Decision rule: reject null hypothesis if χ^2 calculated is greater than χ^2 critical.

For fear of stigma and discrimination most people prefer to keep their HIV sero-status private. However, silence and denial is believed to be one of the major obstacles in HIV protection programs. People have differing opinions whether a person living with HIV should keep his/her HIV sero-status private or the information could be available to the community. Some people have a sincere concern towards the PLWHA while others have a stigmatizing attitude and discriminatory behavior.

Table 10, below is organized to indicate the university students' response in percentage and frequency distribution for the item stated as "if a person learns that he/she is infected by the virus that causes AIDS should the person be allowed to keep this fact private or this information be available to the community? And what is the reason for the person to keep the fact private or make it available to the community."

Table 10: Should some bodies HIV/AIDS status be kept private or available to the community?

<i>If a person learns that he or she is infected by the virus that causes AIDS, should that person allowed to keep this fact private or this information be available to the community?</i>			
Responses	Respondents	Frequency	
		No	%
Be kept private	Female	6	9.4
	Male	25	13.6
Made available to the community	Female	48	75
	Male	148	80.4
No response	Female	10	15.6
	Male	11	6
Total	Female	64	100
	Male	184	100
<i>If kept private, why? Check all that applies</i>			
Responses	Respondents	Frequency	
		No	%
People would act differently to the person if they found out	Female	6	100
	Male	25	100
That person would be isolated, neglected or avoided if others found out	Female	6	100
	Male	25	100
The person would be a source of discomfort to the community	Female	-	-
	Male	-	-
<i>If made available to the community, why? Check only one.</i>			
Responses	Respondents	Frequency	
		No	%
This person deserves the care and support of the community	Female	43	89.6
	Male	120	81.1
This person is a threat to others and could infect others so to isolate from others	Female	5	10.4
	Male	28	18.9

As indicated in Table 10 above, a great majority of the respondents 75% female and 80.4% male said that if the person is infected with HIV and knows his/her HIV status the information should be available to the community. While very few of the respondents female 9.4% and male 13.6% claimed that the information should be kept private. However another 15.6% of the female and 6% of the male university students failed to respond to this item. Those who said the information should be kept private justified their reason, as people would act differently against the person infected with HIV and the person would be isolated, neglected or avoided if others found out shows the respondents compassion towards PLWHA. Similarly those who said the information should be kept private responded positively saying people would act differently towards the person infected with HIV and the person would be isolated, neglected and or avoided if others found out shows a sincere concern showing the prevalence of stigma and discrimination in the community towards PLWHA. And none of them said the person could be a source of discomfort to the community.

However, the majority of those said the information should be available to the community 89.6% of the female and 81% of the male respondent gave their reason saying that the information should be available to the community because the person deserves care and support of the community and very few 5(10.4%) of the female and 28(18.9%) of the male respondents responded as the person is a threat to others.

The above data illustrates the non-discriminatory attitudes of the research participants while the data collected from the FGD and the case study indicates the prevalence of prejudice and stigma towards PLWHA by individuals with in the social norm.

Table 11: In your community, how do people find out if some one has HIV?

Responses	Frequency	%
The infected person discloses his/her status	100	40.32
From general rumors	125	50.40
From the HIV positive person's family	92	37.10
From the HIV positive person's employer	67	27
From the HIV positive person's friends and neighbors	124	50
From the health center/health workers where the person got tested	104	41.90
The person looks ill and has lost a lot of weight	98	39.5
N	248	

Note: the total percentage adds to more than 100 due to the respondents gave multiple responses.

Due to fear of stigma and discrimination PLWHA doesn't want to disclose their HIV sero-status to the public. Table 11 shows how the respondents believed to be learned about the HIV infected person indicates the same situation. The majority of the research participant 50.4% and 50% revealed that they found out about some bodies HIV status from the general rumors and from friends or from neighbors of the person living with HIV respectively. Another 41.9% declared as they had the information from health workers, while 39.5% of the respondent attributed the person's loss of weight and health condition (illness) as a means of identifying some bodies HIV/AIDS status. With the exception of the information obtained from the health workers (which could be realistic but unethical to expose some one's HIV sero-status with out consent) most of the information would be unrealistic, because it is based on rumors and gossip rather than fact. Only, 40.3% of the respondents asserted as they found about the HIV infected person's status when the infected person discloses his /her status.

The above data asserted as people are not willing to disclose their HIV, sero-status to the public. The data, which was also obtained from the PLWHA, illustrated that, due to stigma and discrimination enacted on them and their families they have regretted for disclosing their HIV status. While others are reluctant to disclose their HIV sero status due to perceived stigma and discrimination.

Table 12: Reactions of University students towards families affected and infected by HIV/AIDS.

Do people in your community behave differently towards people suspected of having HIV/AIDS (or families affected by HIV/AIDS treated differently)?		
Responses	Frequency	%
Yes	163	65.73
No	64	25.81
Don't Know	17	6.85
No Response	4	1.61
N	248	100
If yes, how do you think are people suspected of having HIV/AIDS or families affected by HIV/AIDS might be treated differently?		
Response	Frequency	%
Neglected, isolated, avoided	102	62.6
Verbally abused, teased	86	52.8
Physically abused	22	13.5
Not allowed to go to work/school	52	31.9
Not allowed to go to church/mosque	35	21.5
Not allowed to be in public places	42	25.8
Property is taken away	13	8.0
N	163*	100

Note: The total percentage adds to more than 100 due to the respondents gave multiple responses.

* The figure refers to those who answered 'yes' to the above question.

Table 12 above shows the research participants opinion about people's reaction in their community towards people suspected of having HIV/AIDS or families affected by HIV/AIDS. Regarding the above item, majority of the respondents 65.7% claimed that people suspected of having HIV/AIDS and families affected by HIV/AIDS have been treated differently than others. While 25.8% doesn't

agree as people suspected of having HIV/AIDS and families affected by HIV/AIDS have been treated differently.

Those respondents who answered individuals suspected of having HIV/AIDS and families affected by HIV/AIDS treated differently by others replied their opinion as follows. According to the respondents rating, people suspected of having HIV/AIDS have been victims of isolation, neglect and avoidance 62.6% by people in the social norm. In addition 52.8% said verbally abused and teased while 31.9% said not allowed going to work or school and 25.8% said not allowed going to public places, 21.5% replied as not allowed going to church or mosque respectively. However, very few 13.5% and 8% ascertained that physically abused and property is taken respectively.

Both, Female and Male FGD discussants claimed that people suspected of having HIV/AIDS and families affected by HIV/AIDS treated differently and negatively by others. The FGD participants mentioned as those people are expelled from the house they rented and also not allowed to house rent as:

... individuals also not willing to rent a house formerly been used by PLWHA as another FGD discussant explained.

This kind of stigma and discrimination is also supported by the data reported in the case study. Where families infected and affected was subject to an act of discrimination in house rent and at school.

As one FGD discussant explained involuntary HIV testing and loosing one's job based on the result of the test is visible especially in the lower social classes.

A housemaid in our house was suspected as having HIV and my father forced her to get tested. She became positive for HIV. The next morning she was expelled from our home. Surprisingly the news about her situation reached almost all the villagers, and no body wanted to give her a job. Eventually she was disappeared from town. (Male FGD participant)

In the following section the data organized to show the research participants' attitude towards people infected and affected by HIV and AIDS is presented.

The summery of the data given to these nine items are presented in two Tables. The first table is organized to show the Chi-square computation (Table 13a) and the second which is going to be presented below shows the frequency distribution and percentage has been described as follows.

Table 13a, The Chi-square Values Comparing the Responses Given by Female and Male University Students

NO	Item	Response	Respondents			X ² calculated	df	α	X ² Critical
			Male	Female	Total				
7	For most people living with HIV, it is their own fault that they got HIV.	SA	30 (25.2)	4 (8.8)	34	4.6502	3	0.05	7.81
		A	31 (31.9)	12 (11.1)	43				
		D	54 (57.9)	24 (20.1)	78				
		SD	69 (69)	24 (24)	93				
		Total	184	64	248				
8	People living with HIV/AIDS should be ashamed of themselves.	SA + A	20 (18.5)	5 (6.5)	25	0.9799	2	0.05	5.99
		D	32 (34.1)	14 (11.9)	46				
		SD	132 (131.3)	45 (45.7)	177				
		Total	184	64	248				
9	People living with HIV/AIDS can remain productive members of the society.	SA+A	175 (172.9)	58 (60) ¹	233	1.5757	1	0.05	3.84
		D +SD	9 (11)	6 (3.9)	15				
		Total	184	64	248				
10	People with HIV/AIDS should be blamed for bringing the disease in to the community.	SA	19 (17)	4 (6)	23	1.315	3	0.05	7.81
		A	25 (24)	7 (8)	32				
		D	39 (40)	15 (14)	54				
		SD	101 (103)	38 (36)	139				
		Total	184	64	248				
11	People with HIV/AIDS deserve treatment and care.	SA	163 (160)	53(56)	216	5.33	2	0.05	5.99
		A	10 (14)	9(5)	19				
		SD +D	11(10)	2(3.4)	9				
		Total	184	64	248				
12	The family of the PLWHA should be cursed, avoided or isolated.	SA +A	13 (14)	5 (5)	18	2.9565	2	0.05	5.99
		D	10 (13)	8 (5)	18				
		SD	161(157)	51(55)	212				
		Total	184	64	248				
13	People with HIV/AIDS are promiscuous.	SA	24 (21.5)	5 (7.5)	29	6.786	3	0.05	7.81
		A	29 (25.22)	5 (8.8)	34				
		D	56 (46)	21 (19.9)	77				
		SD	75 (80.12)	33 (27.8)	108				
		Total	184	64	248				
14	People living with HIV/AIDS should be legally separated from others to protect public health.	SA+ A	25 (24)	7 (8)	32	0.2791	1	0.05	3.84
		D+ SD	154 (155)	54 (53)	208				
		Total	179	61	240 ¹				

Note: The figures in parenthesis are the expected values. ¹Eight responses are missing.

KEY: 4- Strongly Agree, 3-Agree, 2-Disagree, 1-Strongly Agree

Table 13b, Frequency and Percentage Distribution for items 7-14

No	Statements	Respondents	Frequency and Percentage				
			4	3	2	1	N
7	For most PLWHA, it is their own fault that they got HIV.	Female	4(6.25)	12(18.5)	24(37.5)	24(37.5)	64(100)
		Male	30(16.3)	31(16.85)	54(29.35)	69(37.5)	184(100)
		Total	34(13.7)	43(17.34)	78(31.45)	93(37.5)	248(100)
8	PLWHA should be ashamed of themselves.	Female	-	5(7.81)	14(21.88)	45(70.31)	64(100)
		Male	12(6.52)	8(4.35)	32(17.4)	132(71.74)	184(100)
		Total	12(4.84)	13(5.24)	46(18.55)	177(71.37)	248(100)
9	PLWHA can remain productive members of the society.	Female	52(81.25)	6(9.38)	3(4.69)	3(4.69)	64(100)
		Male	157(85.33)	18(9.78)	4(2.17)	5(2.72)	184(100)
		Total	209(84.27)	24(9.68)	7(2.8)	8(3.2)	248(100)
10	PLWHA should be blamed for bringing the disease in to the community.	Female	4(6.25)	7(10.94)	15(23.44)	38(59.38)	64(100)
		Male	19(10.33)	25(13.59)	39(21.2)	101(54.89)	184(100)
		Total	23(9.27)	32(12.9)	52(20.97)	139(56)	248(100)
11	PLWHA deserve treatment care.	Female	53(82.81)	9(14.06)	2(3.13)	-	64(100)
		Male	163(88.59)	10(5.43)	7(3.8)	4(2.17)	184(100)
		Total	216(87.1)	19(7.66)	9(3.63)	4(1.63)	248(100)
12	The family of the person living with HIV / AIDS should be cursed, avoided or isolated.	Female	3(4.69)	2(3.132)	8(12.5)	51(79.69)	64(100)
		Male	9(4.89)	4(2.17)	10(5.43)	161(87.5)	184(100)
		Total	12(4.84)	6(2.42)	18(7.26)	212(85.5)	248(100)
13	People with HIV / AIDS are promiscuous.	Female	3(4.69)	7(10.94)	21(32.81)	33(51.56)	64(100)
		Male	24(13.04)	29(15.76)	56(30.43)	75(40.76)	184(100)
		Total	27(10.89)	36(14.5)	77(31.04)	108(43.55)	248(100)
14	PLWHA should be legally separated from others to protect public health.	Female	2(3.28)	5(8.2)	3(4.92)	51(83.61)	61(100)
		Male	22(12.3)	3(1.68)	11(6.15)	143(79.89)	179(100)
		Total	24(10.0)	8(3.3)	14(5.8)	194(80.8)	240(100)

KEY: 4- Strongly Agree, 3-Agree, 2-Disagree, 1-Strongly Agree

Item 7, for most people living with HIV, it is their own fault that they got HIV.

Regarding the above item 68.95% (31.45 plus 37.5) percent of the research participants disagree and strongly disagree that PLWHA is their own fault that they got HIV. In this same item 65% (37.5 plus 37.5) percent of female students and 66% (29.35 plus 37.5) percent male reported as they disagree and strongly

disagree, as PLWHA is their own fault that they got HIV. This shows that the research participants are not blaming PLWHA for their condition.

Moreover, to determine whether the response given for the above item is not related to sex (independent of sex), Chi-square was calculated. As it can be seen in (Table 13a) item 7, the calculated Chi-squares value 4.6502 at $\alpha 0.05$ and $df= 3$ is less than the critical value 7.81. Therefore, the null hypothesis is accepted showing blaming the PLWHA for their condition is independent of sex.

Item 8, People living with HIV/AIDS should be ashamed of themselves.

According to the data collected regarding the above item a great majority of the university students 89.92% (71.37 plus 18.55) percent said strongly disagree and disagree with the idea that PLWHA should be a shamed of themselves respectively. For the same item females 92.19% and males 89.14% responded either they strongly disagree or disagree that PLWHA should be ashamed of themselves. This shows that the research participants do not hold an attitude of finger pointing towards; PLWHA or they disagree with the idea that PLWHA should feel ashamed and guilty with their condition.

In addition, to examine whether the response given to the above item is not related to sex (independent of sex), Chi-square was calculated (see Table 13a) item 8. The calculated Chi-square value 0.9799 at $\alpha 0.05$ and $df= 2$ is less than the critical value 5.99. Therefore the null hypothesis is accepted. Hence we can conclude that female and male university students have no significant attitudinal difference in this issue.

Item 9, People living with HIV/AIDS can remain productive members of the society.

Table 13b shows the data concerning the above item, illustrates that almost all 93.95% (female 90.63% and male 95.11%) confirmed that, they strongly agree and agree with the idea that PLWHA can remain productive members of the society.

This can be taken as an indication that the respondents unprejudiced attitude towards people living with HIV.

To determine whether this attitude is not related to sex (independent of sex); Chi-square was calculated (See Table 13a, item 9). The calculated Chi-square value 1.5757 at $\alpha 0.05$ and $df=1$, is less than the critical value 3.84. Hence, the null hypothesis is accepted. Therefore, we can conclude that the attitude reflected, as PLWHA can remain productive members of the society is independent of sex (is not related to the sex of the respondents). Meaning both female and male respondents do believe that PLWHA can remain productive member of the society.

Item 10, People with HIV/AIDS should be blamed for bringing the disease into the community.

Regarding the above item the majority of the research participants 77.7% (female 82.82% and male 76.09%) revealed that they strongly disagree and or disagree with the idea that PLWHA should be blamed for bringing the disease to the community. While about 23% of the university students agree and strongly agree with the statement that PLWHA should be blamed for bringing the disease to the community. Even though some of the respondents show a negative attitude towards PLWHA in this issue most of the respondents are against the idea that PLWHA should be blamed for bringing the disease in to the community showing a very positive attitude towards people infected with HIV.

The Chi-square calculated to determine whether the response given to this statement is independent of sex shows; (Table 13a item 10). The calculated Chi-square value 1.315 at $\alpha 0.05$ and $df=3$ is less than that of the critical value 7.81. Hence, the null hypothesis is accepted. Therefore, we can conclude that the response given by female and male respondents regarding the idea stated, as PLWHA should be blamed for bringing the disease into the community is independent of sex (not related to sex).

Item 11, People living with HIV/AIDS deserve treatment and care.

Table 13b illustrate a summary of the data regarding the aforementioned statement shows that the research participant (96.06% female and 94.02% male) either strongly agree or agree with the idea that PLWHA deserve treatment and care.

To determine whether the responses given to the item, PLWHA deserve treatment and care is not related to sex (independent of sex), Chi-square was calculated (See Table 13a, item 11). The calculated Chi-square value 5.33 at α 0.05 and $df=2$ is less than the critical value 5.99. Hence the null hypothesis is accepted. Therefore, it can be concluded that male and female students do not exhibit significant attitudinal difference regarding the above item.

Item 12, the family of the person living with HIV/AIDS should be cursed, avoided or isolated.

As many anecdotal evidence pointed out that people affected with HIV were subject, to certain stigmatizing behaviors, such as isolation, avoidance and curse with in the community because of the family members HIV / AIDS status.

Table 13b, item 12 summarizes the university students' response in this issue. Accordingly, a great majority 92.76% (92.19% female and 92.93% male) participants revealed that they do not agree with the idea of the family of the PLWHA should be cursed, isolated or avoided. This shows the respondents' positive attitude towards the family affected by HIV / AIDS.

To assess whether the response given to the idea that says isolating, cursing and avoiding the family of the PLWHA is not related to sex (independent of sex), Chi-square was calculated. Accordingly, as it can be seen in (Table 13a item, 12) the Chi-square calculated value 2.9565 at α 0.05 and $df= 2$ is less than the critical value 5.99. So the null hypothesis is accepted. Therefore, we can conclude that isolation, cursing and avoidance of the family of the PLWHA are not related to sex.

Item 13, People living with HIV/AIDS are promiscuous.

As indicated in Table 13b, the majority of the university students (84.37% and 71.19%) female and male responded that they disagree or strongly disagree with the idea that people living with HIV/AIDS are promiscuous respectively. While about 25% of the total (15.53% female and 28.8% male) respondents either agree or strongly agree to the idea that PLWHA are promiscuous. In this particular item female respondents are found to be relatively more positive than male towards PLWHA.

To determine whether the response given to the idea that says PLWHA are promiscuous is not related to sex (independent of sex), Chi-square was calculated. Accordingly, as it can be seen in (Table 13a, item 13) the Chi-square calculated value 6.786 at $\alpha 0.05$ and $df=3$ is less than the critical value 7.81. Hence the null hypothesis is accepted. Therefore, we can conclude that the response given to this issue is independent of sex (not related to sex)

Item 14, People living with HIV/AIDS should be legally separated from others to protect the public health.

Regarding the above item a great majority 86.6% (80.8 plus 5.8) percent of the research participants strongly disagree and disagree that PLWHA should be legally separated from others to protect the public health. In this same item 88.52% (83.61% plus 4.92%) female and 86.04 (79.89% plus 16.15%) male students said that, they strongly disagree and disagree with the idea of separating the PLWHA from others for the sake of protecting the public health. This shows non-discriminatory attitude of the respondents. However about 24 (10%) of the student said they strongly agree that PLWHA should be legally separated to protect the public health.

In addition, to examine whether the response given to the above item is not related to sex (independent of sex), Chi-square was calculated (see Table 13a item 14). The calculated Chi-square value 0.2791 at $\alpha 0.05$ and $df=1$ is less than the

critical value 3.84. Thus, the null hypothesis is accepted. Therefore we can conclude that the response given to the idea of legally separating PLWHA from others to protect the public health is independent of sex.

Table 14 below is organized to summarize the research participants' attitude and reaction in relation to HIV and AIDS and PLWHA. As it can be seen from the table, the data is organized in the form of frequency distribution and percentage across each item. In addition Chi-square was calculated to compare the responses given by male and female participants.

Table 14: Frequency, Percentage and Chi-square Values of University Students' reaction towards PLWHA.

Key: Female N=64, Male N=184 Total N =248

****statistically significant at α 0.05 and df=1**

NO	Item	Response	Respondents			X ² Calculated	df	α	X ² Critical
			Male	Female	Total				
15	If a student has HIV, should he or she be allowed to continue attending school?	Yes	180(97.83)	62(96.87)	242(96.77)	0.2333	1	0.05	3.84
		No	4(2.7)	2(3.13)	6(2.42)				
		N	184	64	248				
16	If you know that shopkeepers or food sellers had HIV, would you buy food from them?	Yes	142(77.17) (143.8)	52(81.25) (50.06)	194(78.23)	0.3756	1	0.05	3.84
		No	42(22.83) (40.2)	12(18.75) (13.8)	54(21.77)				
		N	184	64	248				
17	In your opinion, would you feel comfortable to shake hands with a relative, friend or any other person whom you know has HIV/AIDS?	Yes	140(76) (147.6)	59(92.1) (51.4)	199(80)	7.6859**	1	0.05	3.84
		No	44(23.9) (36.4)	5(7.8) (12.6)	49(20)				
		N	184	64	248				
18	In your opinion, would you feel comfortable eating from the same plate with a relative, friend or any other person whom you know has HIV/AIDS?	Yes	141(76.6) (147.6)	58(90.6) (51.4)	199(80)	5.7964**	1	0.05	3.84
		No	43(23.4) (36.4)	6(9.3) (12.6)	49(49)				
		N	184	64	248				
19	In your opinion, would you feel comfortable to share work tools with a relative, friend or any other person whom you know has HIV/AIDS?	Yes	116(63) (116.5)	41(64) (40.5)	157(63)	0.0226	1	0.05	3.84
		No	68(37) (67.5)	23(36) (23.5)	91(37)				
		N	184	64	248				
20	In your opinion, would you feel comfortable to share the same toilet with a relative, friend or any other person whom you know has HIV/AIDS?	Yes	148(80.4) (152.1)	57(89) (52.9)	205(83)	2.4696	1	0.05	3.84
		No	36(19.5) (31.9)	7(10.9) (11.1)	43(27)				
		N	184	64	248				
21	In your opinion, would you feel comfortable to travel in the same vehicle with a relative, friend or any other person whom you know has HIV/AIDS?	Yes	154(83.7) (156.5)	57(89) (54.3)	211(85)	1.0398	1	0.05	3.84
		No	30(16.5) (27.5)	7(10.9) (9.5)	37(15)				
		N	184	64	248				
22	In your opinion, would you feel comfortable to give care and support to a friend and relative who is an AIDS patient?	Yes	122(66.3) (130.6)	54(84.4) (45.4)	176(71)	7.5567**	1	0.05	3.84
		No	62(33.7) (53.4)	10(15.6) (18.6)	72(29)				
		N	184	64	248				
23	If a member of your family contacted HIV/AIDS would you want it to remain a secret?	Yes	51(27.7) (55.9)	24(38) (19.1)	75(30.4)	2.4204	1	0.05	3.84
		No	133(72.3) (128.1)	39(62) (43.9)	172(69.6)				
		N	184	63	247 ¹				

Note: The figures in parenthesis, below the frequency and the percentage are the expected values

¹-One response is missing

The above table shows a summery of selected items organized in yes and no format with their frequency distribution and Chi-square values.

Item 15, If a student has HIV, should he or she be allowed to continue attending school?

According to the reply given to this particular item almost all the research participants 97.59% believed that a student, who has HIV, should be allowed to continue attending school, while very few 2.42% said a student living with HIV, should not be allowed to continue attending school.

To determine the responses given to the item stated as: a student infected with HIV should be allowed to continue attending school is independent of sex (not related to the sex of the respondents), chi-square was calculated. As indicated in Table 14, item 15 the calculated Chi-square value 0.233 at $\alpha 0.05$ and $df=1$ is less than the critical value 3.84. Hence the null hypothesis is accepted. Therefore, it can be concluded that there is no varying difference in the response given by female and male University students. So both female and male students have a positive attitude towards a student infected with HIV be allowed to continue attending school.

Item 16, If you know that shopkeepers or food sellers had HIV, would you buy food from them?

A great majority 78.23% of the research participants (77.17% male and 81.25% female) confirmed that they would buy food from a food seller who had HIV and some of the respondents 21.77% said (male 22.83% and female 18.75%) they would not buy food from food sellers who had HIV.

To see whether the idea of buying or not buying food from food sellers is independent of sex Chi-square was calculated. As indicated in Table 14 item 16 the calculated Chi-square value 0.3756 at $\alpha 0.05$ and $df=1$ is less than the critical value 3.84. Hence the null hypothesis is accepted. There fore, we can conclude that there is no difference between female and male University students in buying food from a food seller who had HIV.

In relation to buying food items from the person who has HIV, most of the FGD discussants supported the data obtained from the questionnaire, and confirmed as they will buy food items from the PLWHA.

But, two of the FGD participant, one female and another male refuted the idea of buying food from the person who is living with HIV.

The Female FGD participant said that:

"I know, I will not be infected with HIV due to this but, it is simply disgusting to buy food items from the person whom I knew has HIV."

Item 17, In your opinion would you feel comfortable to shake hands with a relative, friend or any other person whom you know has HIV/AIDS?

As it is indicated in Table 14 the majority 80% of the research participants (female 92% and male 76%) reported that they are comfortable to shake hands with the person who is believed to be living with HIV/AIDS. While only 20% of them, female 7.8% and male 23.9% said they are not comfortable in hand shaking with the person whom they know has HIV/AIDS.

To assess whether the level of comfort in shaking hands with the person whom they knew has HIV/AIDS is independent of sex, Chi-square was calculated. Accordingly, as it can be seen in the above table the calculated Chi-square value 7.6859 at α 0.05 and $df=1$ is greater than the critical value 3.84. Hence, the null hypothesis is rejected. Therefore, we can conclude that, there is difference of opinions between female and male university students regarding the comfort during hand shaking the person whom they knew has HIV/AIDS. (i.e. female are more positive and more comfortable to shake hands with the PLWHA than their male counterparts).

Item 18, In your opinion would you feel comfortable eating from the same plate with a relative, friend or any other person whom you know has HIV/AIDS?

As it is shown in Table 14 above item 18 a great majority 80% of the respondents (90.6% female and 76.6% male) confirmed as they are comfortable in eating from the same plate with the person whom they knew has HIV/AIDS. However, some 20% of the University students 23.4% male and 12.6% female ascertained that they are not comfortable to eat from the same plate with person whom they know has HIV/AIDS.

To examine the level of comfort in eating from the same plate, with person known to have HIV/AIDS is independent of sex, Chi-square was calculated. Accordingly, as it can be seen in Table 14, the calculated Chi-square value 5.7964 at $\alpha 0.05$ and $df=1$ is greater than the critical value 3.84. Hence, the null hypothesis is rejected. Therefore, we can conclude that, there is difference of opinion between female and male participants (i.e. eating from the same plate with person known to have HIV/AIDS is sex dependent). Females are more positive to eat from the same plate with the PLWHA than their male counterparts.

Item 19, In your opinion, would you feel comfortable to share work tools with a relative, friend or any other person whom you know has HIV/AIDS?

For the above item a majority, 63% of the research participants (64% female and 63% male) revealed that they are comfortable to share work tools with person known to have HIV/AIDS. But more than one third 37% of the University students confirmed as they are not comfortable to share work tools with the person known to have HIV/AIDS.

To assess whether sharing work tools with a person known to have HIV/AIDS is not related to sex (independent of sex), Chi-square was calculated. Accordingly, as it can be seen in Table 14, item 19, the calculated Chi-square value 0.0226 at $\alpha 0.05$ and $df=1$ is less than the critical value 3.84. Hence, the null hypothesis is

accepted. Therefore, we can conclude that there is no difference in the opinion given by male and female respondents in sharing work tools with the person known to have HIV/AIDS (i.e., The idea of sharing work tools with the person who is known to have HIV/AIDS is independent of sex).

Item 20, In Your opinion, would you feel comfortable to share the same toilet with relative, friend or any other person whom you know has HIV/AIDS?

Regarding the above item a great majority 83% of the research participants 89% female and 80.4% male confirmed that they are comfortable to share the same toilet with a friend, relative, or any other person whom they know has HIV/AIDS but, some of the respondents 17% of which 19.5% male and 11% female said they are not comfortable to share the same toilet with the person who is known to have HIV/AIDS.

To determine, whether sharing the same toilet with the person known to have HIV/AIDS is not related to sex, (independent of sex), Chi-square was calculated. Accordingly, as it can be shown in Table 14 item 20, the calculated Chi-square value 2.4696 at α 0.05 and $df=1$ is less than the critical value 3.84. Hence, the null hypothesis is accepted. Therefore, we can conclude that the willingness in sharing the same toilet with the person known to have HIV/AIDS is independent of sex.

Item 21, In your opinion would you feel comfortable to travel in the same vehicle with relative, friend or any other person whom you know has HIV/AIDS?

As it is illustrated in Table 14 a great majority, 85% of the research participants, of which 89% female and 83.7% male ascertained that they feel comfortable to travel with the same vehicle with a relative, friend or any other person whom they known has HIV/AIDS. However, some 15% of the respondents (16.5% female and 10.9% male) are not feeling comfortable to travel with any person whom they knew has HIV/AIDS.

To assess the comfort of traveling in the same vehicle with the person known to have HIV/AIDS is not related to sex, (i.e. independent of sex), Chi-square was calculated. Accordingly, as presented in Table 14 item 21 the calculated Chi-square value 1.0398 at α 0.05 and $df=1$ is less than the critical value 3.84. Hence, the null hypothesis is accepted. Therefore, we can conclude that the comfort of traveling with the same vehicle with the person known to have HIV/AIDS is independent of sex.

Item 22, In your opinion, would you feel comfortable to give care and support to a friend or a relative who is an AIDS patient?

As indicated in Table 14, the majority 71% of the university students, (female 84.4% and male 66.3%) reported as they would feel comfortable to give care and support to a friend or a relative who is an AIDS patient.

To evaluate whether the intention of giving care and support to a friend or relative is not related to sex (i.e. independent of sex), Chi-square was calculated. Accordingly, as it can be seen in the same Table item 22 the calculated Chi-square value 7.5567 at α 0.05 and $df=1$ is greater than the critical value 3.84. Hence, the null hypothesis is rejected. Therefore, we can conclude that the attitude and level of comfort to give care and support to a friend or a relative who is an AIDS patient is related to sex (dependent on sex). That is, female are more positive towards giving the necessary care and support to a friend or a relative who is an AIDS patient. This data is also supported by the experience given from the PLWHA in the case study, where sisters are more compassionate than brothers to give care and support to the infected person in the family.

Item 23, If a member of your family contracted HIV/AIDS would you want it to remain a secret?

Concerning the above item about two third, 69.6% of the respondents, 72% male and 62% female reported that they do not want the condition of a family member who is supposed to be living with HIV to remain a secret. Unlike the majority,

30.4% of the University students 38% female and 27.7% male said they want it to remain secret.

To determine whether remaining secret about family members HIV/AIDS status is not related to sex (i.e. independent of sex), Chi-square was calculated. Accordingly, as it is presented in Table 14 item 23 the calculated Chi-square value 2.4204 at α 0.05 and $df=1$ is less than the critical value 3.84. Hence, the null hypothesis is accepted. Therefore, It can be concluded that the idea of remaining secret about family members HIV/AIDS status is not related to sex (i.e. independent of sex)

Table 15: If a close friend of you is infected with HIV and or become an AIDS patient, will you continue your friendship as usual?

Responses	Female		Male		Total	
	Frequency	%	Frequency	%	Frequency	%
Yes	60 (54.7)	93.75	151 (156.3)	82.07	211	85.08
No	4 (9.3)	6.25	32 (26.7)	17.39	36	14.52
No response	-	-	1	0.54	1	0.4
N	64	100	184	100	248	100

Not: The figures in parenthesis show the expected value.

As indicated in Table 15, above a great majority of the students 85.08% (female 93.75% and male 82.07%) declared that, as they would continue their friendship as usual with a close friend who is infected with HIV. Unlike the majority, 14.52% of the total participants (6.25% and 17.39%) female and male respectively reported, as they would not continue their friendship as usual.

To examine whether the attitude of continuing friendship with a close friend who was known to be infected with HIV is not related to sex (independent of sex) Chi-square was calculated. The calculated Chi-square value 4.7657 at α 0.05 and $df = 1$ is greater than the critical value 3.84. Hence, the null hypothesis is rejected. Therefore, we can conclude that continuing friendship with a friend who was found to be infected with HIV is related to sex. That is, females are

more positive to continue their friendship as usual with their friends regardless of his/her HIV status than males.

Table 16: Do you think you can get HIV?

Responses	Female		Male		Total	
	Frequency	%	Frequency	%	Frequency	%
Yes	40 (38.8)	62.5	111 (112.2)	60.33	151	60.89
No	8 (10.5)	12.5	33 (30.5)	17.93	41	16.53
May be	14 (12.6)	21.88	35 (36.4)	19.02	49	19.76
No response	2	3.13	5	2.72	7	2.82
N	64	100	184	100	248	100

Note: The figures in parenthesis show the expected value.

As presented in Table 16, the majority 60.89% (female 62.5% and male 60.33%) confirmed as they can get HIV. Showing their risk perception while 19.67% responded as they cannot be sure and 16.53% said that they are not at risk at all.

To determine whether the respondents risk perception is independent of sex (not related to sex), Chi-square was calculated. The calculated Chi-square value 1.0693 at α 0.05 and df = 2 is less than the critical value 5.99 hence, the null hypothesis is accepted. Therefore, we can conclude that risk perception to get HIV is not related to sex or it is independent of sex.

Table 17: What would you do if you thought you had HIV?

Responses	Female		Male		Total	
	Frequency	%	Frequency	%	Frequency	%
Get tested	54	84.38	170	92.39	224	90.3
Be depressed, worry and angry	30	46.8	75	40.76	105	42.3
Blame partner	7	10.94	34	18.48	41	16.5
Change life style	47	73.44	126	68.48	173	69.8
Think about suicide	2	3.13	7	3.80	9	3.6
Isolate myself from family and community	8	12.5	25	13.59	33	13.3
Fearful of others' reaction	12	18.75	55	29.89	67	27
N	64		184		248	

Note: The percentage adds to more than 100 because the respondents gave multiple responses.

Table 17 summarizes the responses given by the students to the item stated above, a great majority 90.3% of the research participants (female 84.38% and male 92.39%) replied as they will get tested if they suspected themselves as they had HIV. While, 69.8% (73.44 female and 68.48% male) responded, as they would change life style. Another 42.3% (female 46.8% and male 40.76.%) revealed that they would worry, be angry and depressed, while 27% (18.75 female and 29.89% male) confirmed, as they are fearful of others' reaction. However, very few, (16.5%, 13.3% and 3.6%), said as they will blame partner, isolate themselves from family or community and think of suicide respectively.

As the data presented above shows the majority of the research participants are positive to undergo HIV testing and accept what ever the test result could be, they show the intention of living a healthy life than blaming partner and think of suicide. However, still a reasonable number of the students, 27% are fearful of others' reaction with the very idea and thought of having HIV and consequently they would be subjected to different psychological problems like depression, worry and anger as they reported it.

Table 18: About Sharing HIV test result to Others:

<i>If you got tested for HIV and found to be HIV positive, would you share your test result to any one?</i>			
		Frequency	
Responses	Respondents	N	%
Yes	Female	55	85.94
	Male	159	86.41
	Total	214	86.29
No	Female	6	9.38
	Male	20	10.87
	Total	26	10.48
No response	Female	3	4.69
	Male	5	2.72
	Total	8	3.23
N	Female	64	100
	Male	184	100
<i>If yes, with whom would you share the test results? Check all that applies.</i>			
		Frequency	
Responses	Respondents	N	%
With partner	Female	45	81.82
	Male	134	84.28
	Total	179	83.64
With parents	Female	49	89.09
	Male	132	83.02
	Total	181	84.58
With family/relatives	Female	37	67.27
	Male	113	71.07
	Total	150	70.09
With neighbors	Female	16	29.09
	Male	91	57.28
	Total	107	50
With friends	Female	36	65.45
	Male	124	77.99
	Total	160	74.77
With religious leaders	Female	32	58.18
	Male	109	68.55
	Total	141	65.89
N		214	-----

Note: - The percentage adds more than 100 because the respondents gave multiple responses.

As indicated in Table 18 above most of the University students, female 85.94% and male 86.41% replied that, if they were tested for HIV, they would share their test result to others even if the test result were positive. Unlike the majority very few 10.48% said they would not share the test result to others. The willingness to share the test result indicates a growing confidence among the students to share their test result to others.

As it is presented in the same Table above, among those who confirmed they would share their test result to others rated their preference with parents, 84.58% (female 89% and male 83%), With partner 83.64% (female 81.8% and male 84%) with friends 74.77% (female 65.45% and male 78%), with family or relatives 70% (female 67% and male 71%), with religious leaders 65.9% (female 58% and male 68.5%) and with neighbors 50% (29% female and 57% male) respectively.

In most of the responses the percentage of female and male are relatively similar. However, female seems to differ with their male counterparts in sharing their test results with neighbors, where male students were more positive while female were a little reluctant to share their test result to neighbors.

4.4 The Experiences of PLWHA

To understand the experiences of PLWHA in relation to stigma and discrimination, as per the objective of this research, the personal profiles of three PLWHA are presented hereunder.

Case one: Mr. Z

Background Story

The researcher contacted Mr. Z with the help of a nurse and counselor (a friend to the researcher) who is working in a private clinic in Addis Ababa.

The nurse told the author, that Mr. Z was a kind of person who doesn't want to disclose his HIV status to the public. "Even when he needs any medical attention", said the nurse, "Mr. Z prefers to come to Addis than be treated in Ambo, in his hometown, for fear, of stigma and discrimination". The researcher asked the nurse to arrange a meeting with Mr. Z for the purpose of this study. Finally Mr. Z agreed to meet the researcher in the clinic in Addis Ababa. On the first session after a brief discussion and introduction by the nurse on the purpose of our contact, Mr. Z gave his consent to cooperate in giving information for the purpose of the research. The researcher told Mr. Z that the information will be kept confidential and will only be used for the purpose of the research. This statement gave the client a relief and motivated to participate in the study. Then Mr. Z and the researcher had lunch together and discussed different social issues in an objective to establish a good rapport.

Life before HIV testing

Mr. Z described his personal life as follows: I am the eldest son in the family. I had many responsibilities to take at home and at the family business. I used to help my father in almost everything: accounting, shop keeping, paying electric and telephone bills etc. Besides, I was a good student at school, ranking 1st – 3rd in class up to grade 11. Since I was in charge of the family business, I had no

monetary problems. I was the one who used to pay for my friends' refreshment expense at school. I enjoy swimming like most Ambo town youngsters. During the summer vacation one Saturday afternoon, I went to the Ambo Ethiopia Hotel, for swimming with my friends as usual.

It was there that I met one very beautiful girl. She was struggling to learn how to swim and asked me to give her help. Later on, the more we stayed in the pool to train her how to swim, I developed a new feeling towards her. This girl had come from Jimma to visit her relatives in Ambo and stayed for 2 months there. From that day on, we used to meet regularly and fell in love. She was my first girl friend. Before that, I didn't have the feeling for girls. She was about my age and enjoyed to chew 'Khat' and drink beer. I started to enjoy everything she did. Through time, I thought, she enjoyed our relationship, so she convinced her parents and transferred to Ambo for her School. Until then, nobody from my family knew our relationship. But later when she joined our School, almost every body learned our relationship. Therefore, I introduced her to my mother. Neither she nor I raised the issue of using condoms at the start. We never used condoms during our relationship (we had no time for that). I lost appetite for school, and my first semester result was really bad. Finally, we took the school leaving examination and the summer vacation came. My girl friend went to Jimma to visit her family. During the summer, I kept hanging out with my friends in town. My school leaving examination result was not as my family expected.

Both of us (my girl friend and I) couldn't qualify for higher learning education. This really became a source of discomfort for my parents, especially to my father, who was eager to see me join a university.

After my girl friend left for Jimma, I almost used to contact her every day and chat over telephone. She was supposed to come to collect her transcript after the vacation. But, almost unexpectedly I couldn't reach her over telephone as usual. We were disconnected. I couldn't stand the situation, because I was in love and

she was supposed to come back to Ambo. After 15 days of painful waiting, I decided to go to Jimma. However, since my father was angry with me due to my behavior and my school result, he did not trust me as usual in his business and I didn't have the money I needed for transportation and other expenses to travel to Jimma.

One day, I had a chance to steal about 5,000 Birr from my father and I left for Jimma. I didn't tell any body about the condition. When I reached Jimma, it was almost a blow; I learned my girl friend had left the country for Beirut.

I was shocked and angry about the situation. I couldn't believe what happened. I started to drink to forget her. Later, I planned to go back to Ambo. But I was ashamed of going back because I lost all the money with in a month and half. I sold every belonging I had for hotel bill. Later, I decided to work in the hotel I stayed for one month as a guest and became a waiter for 100 Birr a month. The owner of the hotel was a very nice person and gave me a place to sleep. I stayed for six months in Jimma. During my stay in Jimma, I met another girl who was working in that hotel and became friends.

One day about 10:00 in the morning, my father came to the hotel I was working while I was serving customers. I didn't expect any family member could reach me. My father was sorry about my condition. I told him I was working in the hotel. He told me he knew everything. He kindly asked me to go back home. I agreed and the next morning I left Jimma for Ambo after six months.

Why and how I got tested for HIV and the reaction of my family members.

Soon after I got back to Ambo, from Jimma I was terribly sick for months. I was told that it was TB. In the meantime, without my knowledge, my father made me test for HIV in Addis. As they told me later the result turned out positive, but they were afraid to tell me. I was treated for TB and cured, and my health condition improved dramatically. Even though, I was cured from my illness, my

parents' reaction towards me was different. They were very much negligent and they became reluctant to involve me in the family business. They usually avoided my ideas during discussion. Further more, I heard my mother and father gossiping about me.

I heard my father once saying, *"He got what he deserves; he is not my son any more. He is useless."* This remark, my sickness and the over all reaction my parents had towards me brought my suspicion and I decided to test for HIV.

Having in mind the idea of testing, I started to closely observe my mothers reaction. I found that she was extremely precautious towards me. She even usually served me with the separate plate and cup. Finally, I got tested for HIV and the result was found to be positive. I was shocked and couldn't believe the situation. Regretted about my past life, I decided to discuss the issue with my parents. First, I told my mother about the condition. Surprisingly, all the family members knew before me. *"It's a family secret"* my mother told me so she warned me not to tell any body as doing so will heart the family pride among the society.

I told my mother what I knew about HIV with the intention to reduce her fear of contagion through causal contact and demanded that if they are going to treat me differently like before, I said, I will tell everyone in the town. I knew they will not bear the idea of the son of *"...Mr./Mrs. Z had HIV"*, so every one agreed to treat me the way I wanted, and they almost begged me not to disclose my HIV status public to maintain the family pride and honor. Besides, I myself was not ready and interested to disclose my HIV status to any one for fear of others' reaction.

Then my situation became a family secret. We had a deal with my family: they would give me the necessary care and support at home and in return I will keep the family pride and honor by keeping quite about my condition.

My friends

Nowadays things are improving regarding stigma and discrimination. This is mainly because almost each family is affected by HIV, one way or another. My friends usually indulge themselves in risky behaviors as usual. They are also insensitive towards PLWHA. They don't know that their friends could have been infected too. They tease and joke on people living with HIV. Therefore my situation doesn't allow me to be with them when they used to chew 'Khat', drink alcohol and go after girls. So, eventually I isolated myself from them by pretending to be busy in the family business, because it is painful to stay with them sometimes.

My sister and my brothers

As to my observation, females are more sensitive and caring than males. My sister never showed a different face from the start. She was almost the same throughout my ups and downs. She is the one who helped me in washing my clothes. But my brothers are not like her. They are disgusted with my condition.

Once my brother was washing his clothes and I gave him my two shirts to help me in the washing. When I returned home, I found my shirts on the sofa unwashed. He told me he doesn't want to wash my clothes because he is afraid of my condition.

Health workers and my health condition

It's been almost seven years since I learned I had HIV, and my health condition is very good. I had never started anti-retroviral therapy (ART) because my CD₄ count was above the limit for that. Except for some diarrhea and headaches at times, I am okay with my health because I have got good meals at home and

exercise regularly. From the start I have been following my health condition in a private clinic. There, nobody knows what my sickness is except the health workers, usually the physicians. But if you go to the government hospitals, they discriminate you from the start by sending you to the special clinic for HIV/AIDS. This is discrimination by itself.

In my opinion, it's the media that contributed a lot to the stigma and discrimination attached to HIV and AIDS. I believe it will improve in the future, but as the media is the most important instrument to teach people, it can also be used to disseminate discrimination and stigma (due to insensitive reporting).

About disclosing

Finally I believe that the scientist will come with a better means to address our problems. Until then I prefer to shut my mouth about this thing because, I am doing fine with my condition right now. If I told people that I am an HIV Positive person, people will stigmatize and discriminate me without even knowing that they are discriminating like my mother is doing.

"Once I suggested pursuing my education in the evening in one of the private college in town, but my mother was the first to refuse my proposal, saying it's useless for me to be educated anymore".

Case Two: Mr. X

Introduction

Mr. X. was born in a small village around Ambo. While he was a 9th grade student, in 1974 at the age of 20, he joined the military force. In 1983, when he was 29 years old he was expelled from the Army due to regime change. He came back to Ambo and engaged in every ordinary job he obtained. Finally, he was employed as a guard in one government organization. Currently Mr. X is promoted to work as a driver in the same organization. He is married and has an 8-year-old son.

Personal profile

Soon after my wife gave birth to our child, she was seriously sick. Later, after a year or so, I was also sick with a kind of disease similar to that of my wife. Then the health workers advised me to get tested for HIV. I discussed the situation with my wife. After a thorough discussion about our condition, we decided to get tested. Unfortunately, the result turned out to be positive for both of us.

My wife is a very strong person so she has encouraged me to cope up with the condition in a positive manner. With a close consultation with the health workers, we started a new way of life.

We were worried about our son, after we learned that HIV could be transmitted from mother to child. We had never taken any precautions to prevent our son from infection until that time. With the advice from the health workers, we fearfully let our son be tested for the same. Fortunately, our son's HIV result found out to be negative. Our son's situation became a source of encouragement to live longer, and deep inside, we were motivated to be around him.

The problem with the community

Since my wife and I was occasionally sick, we decided to inform our situation to the family who rented us the house, hoping they will give us the necessary care and support because we were closely related to each other.

At first they were very shocked and seemed sympathetic to our condition. However, things turned out the other way round. One day, my wife told me that it is better to look for another house in the village. I asked her why? Then she told me that the family who rented us their house didn't seem happy with us.

Later, I learned that, they were pretending to be okay outwardly, but they did not seem interested to let us continue live in their house. They used to nag my wife with silly matters during the day in my absence. Therefore, we decided to leave for another house. But unfortunately it was not an easy matter to get a house rent, for one thing we are a family, and for another we are a family living with HIV. The news of our HIV status spread like 'Tsunami' (ፋካሚ), the news are all around the village about our condition, even though we never told any one except the people we were living with. My son was about three years at that time. The only option left for me was to get a house rent from 'kebele'. So, I informed my condition to the authority and cried out to let me a house. The 'kebele' administrators were so kind and sympathetic; they provided me a small house with a decent price.

The Health Workers and the Work Place

The health workers are very nice to our family. Now we are even taking anti-retroviral therapy (ART) free of charge. Our health condition is promising.

My employers and the people I am working with are very much understanding. They usually give me a leave of absence when I am sick.

The most amazing things I experience at work were: *"No body wanted to discuss about HIV in front of me"*

The situation at school

Since people knew about my family's HIV status, our son is very much affected by his schoolmates at school. They finger pointed at him as an HIV boy. And some of the kids are not interested to play with him because of our condition, even if he is negative. I discussed the issue with the school administration and still the problem is there.

"...If this situation is not changing, I am planning to transfer to another town, to protect my son from stigma and discrimination..."

Mr. X compared the situation with the previous years. Now things are improving, he said, I am coming to believe that it's entirely the media's fault for the prevalence of stigma and discrimination. The programs they broadcast are very much insensitive towards the PLWHA. They disseminate fear and hopelessness. Almost all the programs are pessimistic about our situation. Most people also fear not to be infected with HIV through causal contact. I believe, the more people knew about the mode of transmission the problem with stigma and discrimination, will be minimized, in the future.

Advantage and Disadvantage of Disclosing.

Some times I regret for disclosing our HIV-status to the public. Because hadn't we disclosed our condition, my son could not have been subjected to discrimination and stigma he is facing at this tender age.

Disclosing also has its own advantage. The very important thing is to get proper health services, secondly disclosing is an advantage for PLWHA, as a source of relief from psychological tension (ከአእምሮ ጭንቀት፡ ይገለግላል፤ ተንፈስ ትላለህ፤ የሚያሳስብህ ነገር ይቀንሳል፡፡)

Regarding discrimination and stigma you find some people who are very much understanding and helpful to PLWHA, while others are full of prejudice. The stigma and discrimination people impose on us differs from person to person regardless of his/her sex and socio economic status.

Case Three: Mrs. T

Mrs. T is a 28 years old woman, who lost her husband due to HIV four years ago. Her husband was a truck driver. Before she married, she was working as commercial sex worker in different places.

My husband was a regular customer in the Bar I was working. One day he invited me to go out with him. He then, took me to his house. Then, we regularly went out together. One day, he asked me to live with him as his wife. That was how I became married to him.

His parents were not happy about our relationship from the beginning. But, we happened to be happy at home. He usually left out of town for fieldwork, for days, even for a month at time. He was a kind of person loved to entertain, and drink too much. For two years we had a decent life. But, suddenly, he became seriously sick. He almost drained all his money for medical attention and sold some house belongings for his treatment. But every thing was useless and he died.

After the death of my husband, rumors spread that he has died of AIDS. So, there fore, I came to Ambo from 'Nekemte' to test for HIV. The reason for my coming to Ambo was not because there was no testing center in 'Nekemte', but I was afraid of people's reaction and the family of my husband. The result of my blood test turned out to be positive. I was shocked and confused and returned back to Nekemte to collect my belongings to disappear from that area. When I reached there the family of my husband refused to give me anything. Nobody knows who infected who but everyone blamed me for the death of my husband. His family members even threatened me that they would kill me if I was not leaving the town.

I was very much afraid and left the town (Nekemte) that very night to Ambo. The next day, I returned to my former work in one of the bar in Ambo. Even if I was working as a commercial sex worker, I refused to go with men who are very

much intoxicated and drunk to negotiate for use of condoms for fear not to infect them. I tried to hide my identity and worked for about six months to save some money.

One day, two gentle men came to me and asked me if I was happy with my life. I told them, I was not happy at all. They gave me the necessary counseling and advised me to under go HIV testing. They promised me that whatever the result might be, their organization will help me. Even if I knew my HIV-status by then, I agreed with their proposal and get tested again. The result was the same. As they promised they helped me to start a new kind of life. They introduced me to a contact person from whom I will be receiving 200 Birr per month.

I had a little saving my self at that time, together with the 200 Birr those people are giving me, I have rented a house and started a little business in the open market. In our culture, it said that when some one is in trouble, God will prepare the way-out. Therefore, I some time consider the people helping me was sent from Creator to rescue me.

No body knows I have HIV except the health workers and my counselor who convinced me to contact the researcher. People are kind to me, so I should be kind to people in return. That is why I am giving you this information. I want you to keep my HIV status and my identity secret. I am afraid to be discriminated by people. If people in the village found out my condition, my business would collapse because no body is going to buy the things I am selling (Tomato, Cabbage and Onion)

In the community I am living, there was a woman who was selling 'Injera', tea and bread to daily laborers. She used to have many customers. When rumors that she had HIV spread like a wind, every body refused to buy from her the things she was selling. Finally, to feed her three kids she started to beg on the street. This is frightening. While you have the energy and the ability to do things, people can simply

*consider you as if you are useless and unproductive because of your
HIV status.*

Therefore, I have decided not disclose my HIV status unless I am forced to do so, because of the stigma and discrimination attached to HIV and AIDS in our society.

CHAPTER V

SUMMARY, CONCLUSION AND REGOMMENDATIONS

5.1 Summary

The purpose of this study was to investigate the university students' knowledge and attitude and the experience of PLWHA in relation to stigma and discrimination attached to HIV and AIDS.

The survey was conducted at Jimma University, Ambo College form February 8 to February 26, 2007. A total of 264 students were participated. The main instrument used to collect the data was questionnaire. In addition, two focus group discussions and three case studies were held to substantiate the data.

In line with this, the study attempted to answer the following research questions;

1. Do the university students have adequate knowledge and awareness about HIV and AIDS issues?
2. Do University students have stigmatizing and discriminatory attitudes towards HIV and AIDS and towards PLWHA?
3. Is there any significant difference in the level of stigma and discrimination between female and male students?
4. What is the day to day experience of PLWHA in relation to stigma and discrimination?

The major findings of the study were summarized as follows.

Knowledge about HIV and AIDS.

- It was found out that the majority of the JUAC students had adequate knowledge about HIV and AIDS. They described accurate ways where HIV is believed to be transmitted. However, sex with commercial sex workers and sex with multiple partners had been under reported as a means of HIV transmission.

- The majority of the JUAC students did not believe as AIDS has a cure. But those who reported as AIDS has a cure said not a modern medicine but religious practices like the Holy water “Tsebel” and prayer.
- Most of the JUAC students confirmed that a healthy looking person can have HIV.
- Abstinences from sex, having one faithful partner is reported as the best means of HIV protection respectively. However, while condom use is believed to be the next better means to protect oneself from HIV by most male students, female students refuted the idea as it is risky and will result in carelessness.
- The media was reported as the main source of information to learn about HIV and AIDS. The JUAC students also confirmed that they used to discuss HIV/AIDS issues with others.

Attitude in relation to stigma and discrimination associated to HIV and towards PLWHA.

- According to the finding, most JUAC students claimed that the information about somebody’s HIV status should be available for the community because they believed that the person needs and deserves care and support from the community t because the individual is not a threat to others. Even those who said the information should be kept private were concerned about the individual's right than showing any discriminatory attitude.
- As it is reported people found out about some ones’ HIV status mainly from general rumors and from the HIV positive person’s friends and neighbors.
- The JUAC students’ were reported their experience of different treatment towards people infected and affected by HIV/AIDS. Hence, neglect,

avoidance and isolation were mentioned as the major discriminatory act while verbal abuse and teasing were reported next to that.

- The JUAC students' attitude towards people infected and affected by HIV and AIDS indicated that, the great majority of the students show compassion and acceptance than discrimination towards people affected and infected by HIV.
- The Chi-square calculated value to compare the responses given by female and male students depicted with the exception of very few items, female and male students didn't manifest significant difference towards people affected and infected with HIV. Female students found to be relatively positive against their male counterparts towards the person living with HIV on issues like hand shaking, eating from the same plate, in giving care and support for an AIDS patient and continuing their friendship with a close friend who is infected by HIV or an AIDS patient.
- Most of the research participants were found to be positive about HIV testing and claim to live a healthy and productive life even if the result of the test were turned out positive. In line with this most of the JUAC students claimed to share their test results with others no matter the test result could be. Most of the students preferred to share their test results to their parents, partner, friends and family respectively. However, female students found to be reluctant to share their test results to neighbors than their male counterparts.

The Experience of PLWHA

As the finding from the case study illustrated PLWHA experienced different types of stigma and discrimination.

The context of the discrimination varies from person to person. However, some had been discriminated by their own family members at their own home; others discriminated in the community by people in the social norm.

Even if they believe that disclosing one's HIV status public has many advantage, most of them prefer not to disclose their HIV status public for fear of others reaction. Those who disclosed regretted for doing so, because of the stigma and discrimination enacted on them and their family members. Most agree that the basis of stigma and discrimination is fear of contagion through causal contact resulted from misconception and lack of knowledge about HIV/AIDS and aggravated by insensitive media reporting.

Stigma and Discrimination Vs the Media

Even if most of the research participants conform to the idea that media had been the main source of information about HIV and AIDS issues. It is also considered as the major source of stigma and discrimination attached to HIV and AIDS due to misinformation and insensitive reporting.

5.2 Conclusion

Based on the finding of the study the following can be concluded

1. JUAC students have adequate knowledge and awareness about HIV and AIDS issues.
2. JUAC students do not have stigmatizing attitude and discriminatory behavior on HIV and AIDS and toward PLWHA
3. Female and male students didn't manifest a significant difference in relation to stigma and discrimination about HIV and AIDS and towards PLWHA.
4. Even though the magnitude of stigma and discrimination is minimizing, still there is a stigmatizing and discriminatory attitude attached to HIV and AIDS in the community. PLWHA are subjected to different types and forms of stigma and discrimination in the community and by the media.
5. JUAC students' non-discriminatory attitude can be attributed to their awareness and adequate knowledge about HIV and AIDS. The more people are informed about the pandemic (i.e. about the mode of transmission, means of protecting oneself etc) the lesser stigma and discrimination attached to HIV and AIDS.
6. The basis for the stigma and discrimination were found to be:
 - a. Misconception and lack of adequate knowledge about HIV and AIDS
 - b. Fear of contagion through causal contact.
 - c. Insensitive media reporting.

5.3 Recommendations

The following recommendations were suggested based on the findings of the study.

1. The more people are informed about the pandemic the lesser will be the stigma and discrimination towards people infected and affected by HIV and AIDS. Therefore, well-designed and participatory awareness creation programs need to be strengthened, targeting the people in the social norm to enhance their knowledge about HIV and AIDS.
2. Timely, professional pre and post test counseling for those affected and infected with HIV should be given due attention.
3. Organized efforts are indispensable by people affected and infected with HIV to support each other, to struggle for their rights and eventually make changes that will improve their life and to stand against stigma and discrimination enacted on them.
4. The development and implementation of laws and policies to protect against stigma and discrimination and to protect the rights of PLWHA should be given considerable attention.
5. Information provided through media regarding HIV and AIDS should be carefully evaluated and checked for their appropriateness before broadcasting. Continuous awareness creation training should also be given to the people working in the media for accurate and sensitive reporting.
6. Further problem-oriented studies are essential to address the problems of stigma and discrimination attached to HIV and AIDS and towards PLWHA in different settings.

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APPENDIX A

Addis Ababa University School of Graduate Studies Department of Psychology

A survey questionnaire designed to be filled by University Students'

Dear Participants:

This study is designed to investigate the knowledge and attitude of University students in relation to stigma and discrimination attached to HIV and AIDS and towards PLWHA. Based on the research information obtained from this study possible solution will be suggested to reduce the impact and effect of stigma and discrimination in HIV/AIDS prevention program and in improving the well being and the life condition of PLWHA. Your kind cooperation for giving genuine and honest information is highly valuable for the successful completion of the study.

The information obtained will only be used for the research purpose and will be kept confidential. You do not need to write your names and if you have any ambiguous and unclear question do not hesitate to ask.

The questionnaire has three parts: the first part is about the socio-demographic characteristics consisting of six items; the second part comprises eight questions about knowledge of HIV and AIDS and the third part contains 27 items about attitudes in relation to stigma and discrimination attached to HIV/AIDS and towards PLWHA.

Thank you Very Much

Questionnaire for University Adolescents

Part I: Background Information

No	Questions	Coding Categories
1.	Year of attending class?	II1 III.....2
2.	Sex	Male 1 Female2
3.	What is your current marital status?	Married.....1 Unmarried.....2
4.	What is your religion?	Muslim1 Orthodox Christian2 Protestant Christian.....3 Others.....4
5.	What is your ethnicity?	Oromo.....1 Amhara.....2 Tigray.....3 Others.....4
6.	Where are your parents currently living?	Rural.....1 Urban.....2

Part II: HIV and AIDS Knowledge and Misconceptions

No	Questions	Coding Categories	Skip Patterns
1.	Do you know about HIV/AIDS? If the respondent does not know about HIV/AIDS, end the survey?	Yes.....1 No2	→End
2.	In what ways can HIV/AIDS be transmitted? (How do people get HIV/AIDS?) (Check all that apply)	Mother to child transmission 1 Sex with someone who is HIV+ 2 Sex with multiple partners3 Sex with commercial sex workers (CSWs).....4 Sex with homosexuals.....5 Intra-venous drug use.....6 Blood transfusions7 Kissing someone who is infected8 Mosquito bites9 Sharing sharp materials, razors/blades10 Sharing food/drink with a person who has HIV/AIDS11 Using public toilets12 If other (specify)	
3.	Is there a cure for AIDS?	Yes.....1 No.....2 Don't know.....3	→ 5 → 5
4	If there is cure, it is:	Modern medicine1 Traditional medicine2 Religious practice.....3 If other specify	
5.	Is it possible for a healthy-looking person to have HIV, the virus that causes AIDS?	Yes.....1 No.....2	

	Questions	Coding Categories	Skip Patterns
6.	How do you think You can people protect yourself from getting HIV? (Check all that apply)	Use condoms1 Have fewer partners2 No casual sex3 No sex at all4 No commercial sex5 Use sterilised needles6 Avoid contaminated blood transfusions.....7 Don't know.....8 If other specify	
7.	What is the source of information for you to learn about HIV and AIDS? (Check all that apply)	Radio1 T.V.2 Newspaper/magazines 3 Health worker4 Instructors5 Neighbours/friends6 If other specify	
8	Have you ever discussed HIV and AIDS issues with other people?	Yes 1 No2	

**Part III: Attitudes and behavior scale in relation to stigma and discrimination
associated with HIV and AIDS**

	Questions	Coding Categories	Skip Patterns
1.	If a person learns that he/she is infected with the virus that causes AIDS, should the person be allowed to keep this fact private or should this information be available to the community?	Be kept private1 Made available to the community.....2	→ 3
2.	If kept private, why? (Check all that apply)	People would act differently towards the person if they found out1 That person would be isolated /neglected/avoided if others found out2 The person would be a source of discomfort to the community3	} → 4
3.	If made available to the community, why? (Check all that apply)	This person deserves the care and support of the community.....1 This person is a threat to others /could infect others/ so to isolate from others2 If other specify.....	
4.	In your community, how do people find out if someone from the community has HIV/AIDS? (Check all that apply)	The infected person discloses his/her status1 From general rumors 2 From the HIV+ person's family3 From the HIV+ person's employer4 From the HIV+ person's friends/neighbors5 From the health center/health worker where the person got tested6 The person looks ill and has lost a lot of weight7 If other, specify	
5.	Do people in your community behave differently toward people suspected of having HIV/AIDS or families affected by HIV/AIDS treated differently?	Yes1 No2 Don't know3	→7 →7
6.	How do you think are people suspected of having HIV/AIDS or families affected by HIV/AIDS might be treated differently? (Check all that apply)	Neglected, Isolated, Avoided1 Verbally abused, teased2 Physically abused3 Not allowed to go to work/school4 Not allowed to go to church/mosque5 Not allowed to be in public places6 Property is taken away7	

Q. How much do you agree/disagree about the following statements? Please put an “X” mark to one of your choice in the space provided.

4-Strongly agree, 3 –Agree, 2- Disagree, 1-Strongly Disagree

Items	4	3	2	1
7. For most people with HIV, it is their own fault that they got HIV				
8. People with HIV/AIDS should be ashamed of themselves				
9. People with HIV/AIDS can remain productive members of society				
10. People with HIV/AIDS should be blamed for bringing the disease into the community				
11. People with HIV/AIDS deserve treatment and care				
12.. The family of the person with HIV/AIDS should be cursed, avoided or isolated				
13. People with HIV/AIDS are promiscuous				
14. People living with HIV/AIDS should be legally separated from others to protect the public health.				

Please put an "X" mark to one of your choice in the space provided for item 15-25.

No	Items	Coding Categories	
		(1) Yes	(2) No
15	If a student has HIV/ should he or she be allowed to continue attending school?		
16	If you know that a shopkeepers or food sellers had the HIV virus, would you buy food from them?		
17	In your opinion would you feel comfortable To shake hands with relative/ friend or any person whom you know has HIV/AIDS?		
18	In your opinion would you feel comfortable Eating from the same plate with a relative /friend or any other person whom you know has HIV/AIDS?		
19	In your opinion would you feel comfortable To share work tools with a relative/ friend or any person whom you know has HIV/AIDS?		
20	In your opinion would you feel comfortable To share the same toilet with a relative/ friend or any person whom you know has HIV/AIDS?		
21	In your opinion would you feel comfortable To travel in the same vehicle with a relative/ friend or any person whom you know has HIV/AIDS?		
22	In your opinion would you feel comfortable to give care and support to a friend and relative who is an AIDS patient?		
23	If a close friend of you is infected with HIV and or became an AIDS patient, will you continue your friendship as usual?		
24	Do you think you can get HIV?		

25.	What would you do if you thought you had HIV? (Check all that apply)	Get tested1 Be depressed, worry and angry.....2 Blame partner3 Live a healthy life by using ART.....4 Change lifestyle5 Think about suicide6 Isolate myself from family and community7 Fearful of other's reaction8 If other, specify
-----	--	--

26	If you got tested for HIV found to be HIV positive would you share your test results to anyone?	Yes.....1 NO.....2
27.	If yes, with whom would you share the test results? (Check all that apply)	With partner1 With parents2 With family or relatives.....3 With neighbors4 With friends5 With religious leader6 If other, specify.....

Appendix B

በአዲስ አበባ ዩኒቨርሲቲ የሳይኮሎጂ ትምህርት ክፍል ለድህረ ምረቃ ፕሮግራም ጥናታዊ ፅሁፍ የቀረበ መጠይቅ

ውድ የጥናቱ ተሳታፊ፡

የዚህ ጥናት አላማ በዋነኛነት ከኤች አይ ቪ እና ኤድስ ጋር በተያያዘ በሰዎች ላይ የሚደርሰውን መድልዎ እና መገለል በተመለከተ የዩኒቨርሲቲ ተማሪዎችን አመለካከት ለማጥናት ነው ። በተጨማሪም ተማሪዎች ስለ ኤች አይቪ ና ኤድስ ያላቸውን ግንዛቤ ለመረዳት ይፈለጋል። ከጥናቱ በሚገኘው መረጃ መሠረትም ከኤች አይቪ ጋር በተያያዘ ያለውን መድልዎ እና መገለል ለመቀነስ ጥረት ያደርጋል። በመሆኑም የዚህ ጥናት ተሳታፊ ለመሆን ፍቃደኛ ስለሆኑ ከልብ አመሰግናለሁ።

መጠይቁ ሶስት ክፍል አለው ፣ የመጀመሪያው ስድስት ጥያቄ የተሳታፊዎችን አጠቃላይ መረጃ የሚመለከት ነው ። ሁለተኛው ክፍል ስምንት ጥያቄዎች ያሉት ሲሆን የተማሪዎችን የኤች አይቪ ና ኤድስ እውቀት ይመለከታል። የመጨረሻው ክፍል ያካተተው ሃያ ሰባት ጥያቄዎችን ሲሆን የተሳታፊዎችን አመለካከት ከመድሉና ከመገለል ጋር ይመለከታል።

ትክክል የሆነ ወይም የተሳሳተ መልስ የለም። በእርስዎ አመለካከት ሚያውቁትን፣ የሚሰማዎትንና የሚመስልዎትን መልስ ብቻ በቅንነትና በታማኝነት እንዲሰጡ እጠይቃለሁ ።

የሚሰጡት መረጃ ለጥናቱ አገልግሎት ብቻ ስለሚውል ሚስጥሩ በሙሉ የተጠበቀ ነው ።

ስምዎን መፃፍ አያስፈልግም።

ለጥናቱ መሳካት ስለተባበራችሁኝ በድጋሚ በጣም አመሰግናለሁ ።

ሰለሞን አለመ.

ለዩኒቨርሲቲ ተማሪዎች የቀረበ መጠይቅ
ክፍል አንድ፡- አጠቃላይ መረጃ

	ጥያቄዎች	መመዝገቢያ
1	ስንተኛ አመት ተማሪ ነህ/ነሽ	II-----1 III-----2
2	ፆታ	ወንድ-----1 ሴት-----2
3	የጋብቻ ሁኔታ	ያላገባ/ች-----1 ያገባ/ች-----2
4	ሃይማኖት	ሙስሊም-----1 ኦርቶዶክስ ክርስቲያን-----2 ፕሮቴስታንት ክርስቲያን ----- 3 ሌላ ካለ ይገለፅ-----4
5	ብሔር ወይም ብሔረሰብ	ኦሮሞ-----1 አማራ-----2 ትግራይ-----3 ሌላ ካለ ይገለፅ-----4
6	ቤተሰቦችህ/ሽ አሁን የት ነው የሚኖሩት	ከተማ-----1 ገጠር -----2

ክፍል ሁለት፡- ስለ ኤች አይ ቪ ኤድስ ዕውቀትና የተሳሳተ ግንዛቤ

ተ.ቁ	ጥያቄዎች	መመዝገቢያ
1	ኤች አይ ቪ ወይም ኤድስ የሚባል በሽታ ያውቃሉ መላሹ ስለኤች አይ ቪ ወይም ኤድስ የማያውቁ ከሆነ የሚከተሉትን ጥያቄዎች ይዘለሏቸው፡፡	አዎ-----1 አላውቅም -----2
2	የኤች አይ ቪ መተላለፊያ መንገዶች ምንድን ናቸው / ኤች አይ ቪ ሰዎችን እንዴት ይይዛቸዋል?	ከእናት ወደ ልጅ-----1 ቫይረሱ ካለበት ሰው ጋር የግብረሰጋ ግንኙነት በመፈፀም-----2 ከተለያዩ ሰዎች ጋር ወሲብ ማድረግ -----3 ከሴተኛ አዳሪዎች ጋር የግብረ ሰጋ ግንኙነት በመፈፀም-----4 ከግብረሰዶማውያን ጋር ግብረ ሰጋ ግንኙነት በመፈፀም -----5 በደም ስር የሚሰጥ ዕፅ በመጠቀም-----6 በደም ልገሣ እና ንክኪ-----7 ቫይረሱ ያለበትን ሰው በመሣም -----8 በቢንቢ ወይም በትንኝ በመነከስ-----9 የሚቆርጡ ነገሮችን /መላጫ፣ምላጭ በጋራ በመጠቀም-----10 ኤች አይ ቪ ካለበት ሰው ጋር መመገብ-----11 ሽንት ቤትን በጋራ በመጠቀም-----12 ሌላ ካለ ይገለፅ-----13
3	የኤድስ መፈወሻ አለ	አዎ-----1 የለም-----2 አላውቅም -----3
4	መፈወሻ ካለ ምንድን ነው	ዘመናዊ መድኃኒት -----1 ባህላዊ መድኃኒት -----2 ሀይማኖታዊ ስርዓት /ፀሎት፣ፀበል/-----3 ሌላ ካለ ይገለፅ-----
5	ጤናማ መስሎ የሚታይ ሰው የኤድስ ቫይረስ ሊኖረው ይችላል	አዎ ይችላል-----1 አይችልም-----2
6	እራስህን/እራስሽን እንዴት ከኤች አይ ቪ መከላከል ትችላለህ/ሽ	ከንደም በመጠቀም-----1 በቁጥር ትንህ ከሆኑ ሰዎች ጋር ብቻ በወሲብ ግንኙነት መወሰን-----2 ጥንቃቄ በጉደለው ድንገተኛ ወሲባዊ ግንኙነት በመቆጠብ-----3 ከግብረሰጋ ግንኙነት በመታቀብ-----4 ለገንዘብ ማስገኛ የግብረሰጋ ግንኙነት ባለማድረግ-----5 ንፅህናቸው የተጠበቀ መርፌዎችንና ስለታማ ነገሮችን መጠቀምን በማስወገድ -----6 የደም ንክኪን በማስወገድ -----7 ሌላ ካለ ይገለፅ-----
7	ስለ ኤች አይ ቪ እና ኤድስ መረጃ የሚያገኙት በየትኞቹ መንገድ ነው፡፡ / ከአንድ በላይ መልስ ሊሰጡ ይችላሉ/	ከሬዲዮ-----1 ከቴሌቪዥን-----2 ከጋዜጣና መፅሔት-----3 ከጤና ባለሙያ-----4 ከመምህር -----5 ከጉረቤት/ከጓደኛ-----6 ሌላ ካለ ይገለፅ-----7
8	ስለ ኤች አይ ቪ እና ኤድስ ከሌሎች ሰዎች ጋር አውርተው ያውቃሉ	አዎ-----1 አላውቅም-----2

ክፍል ሁለት ከማግለልና መድሎ ጋር በተያያዘ በአኤች አይ ቪ ኤድስና ከባይረሱ ጋር ስለሚኖሩ ሰዎች ያለ ግንዛቤና አመለካከት

ተ.ቁ	ጥያቄዎች	መመዝገቢያ	
1.	አንድ ሰው በኤች አይ ቪ ኤድስ መያዙን ቢያረጋግጥ ይህን ጉዳይ በሚስጥር መያዝ አለበት ወይስ ለማህበረሰቡ መግለፅ አለበት	በምስጢር መያዝ አለበት-----1 ለማህበረሰቡ መግለፅ አለበት-----2	
2.	ከላይ ለጥያቄ ቁጥር 1 መልስዎ በሚስጥር መያዝ አለበት ከሆነ ለምን	ሰዎች ግለሰቡ በቫይረሱ የተያዘ መሆኑን ካወቁ ከበፊቱ ያልተለመደ ባህርይ ያሳዩታል -----1 ሰዎች በቫይረሱ የተያዘውን ግለሰብ ያገሉታል፤ የቸልተኝነት ስሜት ያሳዩታል ወይም ይሸሹታል -----2 ግለሰቡ የማህበረሰቡን ምቹት ስለሚቀንስና ለሌሎችም ስጋት ስለሚሆን -----3	
3.	ከላይ ለጥያቄ ቁጥር 1 መልስዎ ለማህበረሰቡ መግለፅ አለበት ከሆነ ለምን	ይህ ግለሰብ ከማህበረሰቡ ድጋፍና እንክብካቤ ማግኘት ስለሚገባው -----1 ይህ ግለሰብ ለሌሎች አስጊ ሊሆን ስለሚችን ግለሰቡን ከሌሎች መለየት ስለሚያስፈልግ-----2	
4.	እርስዎ በሚኖሩበት ማህበረሰብ አካባቢ አንድ ሰው በኤች አይ ቪ ወይም ኤድስ ቢያዝ ማህበረሰቡ እንዴት ሊያውቅ ይችላል፡፡	ግለሰቡ በግልፅ ለማህበረሰቡ ስለሚናገር-----1 በአካባቢው ከማወራው ወሬ /ጭምጭምታ/-----2 በኤች አይ ቪ ከተያዘው ግለሰብ አሠራ-----3 በኤች አይ ቪ ከተያዘው ጓደኛ/ጎረቤት-----5 ግለሰቡ ከተመረመረበት የጤና ተቋም/ባለሙያ-----7 ሌላ ካለ ይገለፅ-----	
5.	እርሶ ባሉበት ማህበረሰብ/አካባቢ አንድ ኤች አይ ቪ ወይም ኤድስ አለበት ተብሎ የሚጠረጠርን ሰው በኤች አይ ቪ /ኤዲስ የተያዘን ሰው ወይም ቤተሰቡን ማህበረሰቡ በተለየ መልኩ ይመለከተዋል፡፡	አዎ-----1 አይደለም -----2 አላውቅም-----3	-----7 -----7
6.	ከላይ ለጥያቄ ቁጥር 5 መልስዎ አዎ ከሆነ እነዚህ በኤች አይ ቪ የሚጠረጠሩ ሰዎችን ወይም በቫይረሱ የተያዙ ሰዎችን የቤተሰብ አባላት ማህበረሰቡ እንዴት ይመለከታቸዋል፡፡	ያገኟቸዋል፤ ያወግዟቸዋል ገሽሽ ደርጉዋቸዋል፡፡-----1 በቃላት ይዘለፋቸዋል፤ ያሾፋቸዋል-----2 አካላዊ ጥቃት ያደርሱባቸዋል -----3 ወደ ትምህርት ቤት መሄድ አይችሉም ይከለክላሉ -----4 ወደ ማምለኪያ ስፍራ፤ ቤተክርስቲያንና መስጊድ መሄድ አይችሉም -----5 ህዝብ የሚጠቀምባቸው ቦታዎች መጠቀም -----6 ንቀሣቀስ አይችሉም -----6 ንብረታቸው/ንብቃቸውን ይነጥቁዋቸዋል፡፡-----7	

ከጥያቄ ቁጥር 7 አስከ 14 ለተመለከቱት ጥያቄዎች /X/ ምልክት በማድረግ መልስ ያስቀመጡ

ከዚህ ቀጥሎ ለተመለከቱት ጥያቄዎች ምን ያህል ይስማማሉ ወይስ አይስማሙሉ

4. በጣም አስማማለሁ 3. አስማማለሁ 2. አልስማማም 1. በጣም አልስማማም

ተ.ቁ	ጥያቄዎች	4 በጣም አስማማሁ	3 አስማማለሁ	2 አልስማማም	1 በጣም አልስማማም
7	ከኤች አይ ቪ ጋር አብረው የሚኖሩ ሰዎች ቫይረሱ የያዛቸው በገዛ ጥፋታቸው ነው				
8	ከኤች አይ ቪ ወይም ኤድስ ጋር የሚኖሩ ሰዎች በራሳቸው ሊያፍሩ ይገባል				
9	ከኤች አይ ቪ ወይም ኤድስ ጋር የሚኖሩ ሰዎች ከህብረተሰቡ ጋር እየሰሩ አምራች ዜጋ መሆን ይችላሉ				
10	ከኤች አይ ቪ ወይም ኤድስ ጋር የሚኖሩ ሰዎች በሽታውን በማህበረሰቡ ላይ በማምጣታቸው ተወቃሽ ናቸው				
11	ከኤች አይ ቪ ወይም ኤድስ ጋር የሚኖሩ ሰዎች ድጋፍና እንክብካቤ ማግኘት ይገባቸዋል				
12	ከኤች . አይ. ቪ ወይም ኤድስ ጋር የሚኖሩ ሰዎች ቤተሰቦች መወገዝ ፣ መገለልና ከሌሎች መለየት ይገባቸዋል።				
13	ከኤች አይ ቪ ወይም ኤድስ ጋር የሚኖሩ ሰዎች ከማንም ጋር የሚልከሰከሱ ሴሶች ናቸው				
14	ከኤች አይ ቪ ወይም ኤድስ ጋር የሚኖሩ ሰዎች የሌላውን ህብረተሰብ ጤና ለመጠበቅ ሲባል በህግ ከሌላው ህብረተሰብ ሊገለሉ ይገባቸዋል				

ለጥያቄ ቁጥር 15-25 አዎ ወይም አይደለም በማለት በተሰጠው ቦታ ላይ 'X' መልስ ይስጡ፡፡

		አዎ	አይደለም
15	አንድ በኤች አይ ቪ የተያዘ ተማሪ አቅሙ እስከፈቀደ ድረስ ትምህርቱን መከታተልና መቀጠል ሊፈቀድለት ይገባል፡፡		
16	ከአንድ ባለሰቅ ወይም የምግብ ነጋዴ ኤች አይ ቪ ያለበት መሆኑን እያወቁ ምግብ ትገዛለህ/ሽ		
17	በእርስዎ አመለካከት ከኤች አይቪ ጋር የሚኖር /የምትኖር ዘመድ ወይም ጓደኛ ቢኖርዎት እጅለአጅ በሚጨባበጡ ጊዜ የተለየ ስሜት ይሰማዎታልን		
18	በእርስዎ አመለካከት ከኤች አይቪ ጋር የሚኖር /የምትኖር ዘመድ ወይም ጓደኛ ቢኖርዎት ከአንድ ማዕድ ምግብ በሚመገቡበት ጊዜ የተለየ ስሜት የሰማዎታል		
19	በእርስዎ አመለካከት ከኤች አይቪ ጋር የሚኖር /የምትኖር ዘመድ ወይም ጓደኛ ቢኖርዎት የሥራ መሣሪያ በሚዋዋሱበት ጊዜ የተለየ ስሜት ይሰማዎታልን		
20	አንድ ሽንት ቤት በጋራ በሚጠቀሙበት ጊዜስ የተለየ ስሜት ይሰማዎታልን		
21	በእርስዎ አመለካከት ከኤች አይቪ ጋር የሚኖር /የምትኖር ዘመድ ወይም ጓደኛ ቢኖርዎት በአንድ መኪና አበረው በሚጓዙበት ጊዜስ የተለየ ስሜት የሰማዎታልን		
22	ታሞ ለማስታመም፤ አንክብካቤና ድጋፊ ለማድረግ ከሌላው ሰው በተለየ መጥፎ ስሜት ይሰማዎታልን		
23	በእርስዎ አመለካከት ከኤች አይቪ ጋር የሚኖር /የምትኖር ዘመድ ወይም ጓደኛ ቢኖርዎት ወይም የቅርብ ጓደኛህ/ሽ በኤች አይ ቪ የተያዘ/ች ወይም የኤድስ ህመምተኛ ቢሆን/ብትሆን ጓደኝነቱን እንደበፊቱ ትቀጥላለህ/ሽ		
24	ኤች አይ ቪ ይይዘኛል ብለው አስበው ያውቃሉ ?		

	ጥያቄ	መመዝገቢያ
25	ኤች አይ ቪ ወይም የኤድስ ህመምተኛ ነኝ ብለው ቢያስቡ ምን ያደርጋሉ / ከአንድ በላይ መልስ ሊሰጡ የችላሉ/	እመረመራለሁ-----1 እናደዳለሁ-----2 አዝናለሁ፣ እጨነቃለሁ እናደዳለሁ-----3 ጎደኛዬን አወቅሳለሁ-----4 ፀረ ኤች አይ ቪ መድሐነት በመጠቀም ጤናማ ህይወት እኖራለሁ-----5 አኗኗሬን አስተካክላለሁ እለውጣለሁ-----6 ራሴን ለማጥፋት/ለመግደል እሻለሁ-----7 ከቤተሰብ እና ከማህበረሰቡ ራሴን አገላለሁ-----8 ሌሎች ስለኔ የሚኖራቸውን ምላሽ በማሰብ እፈራለሁ-----9
26	የኤች አይ ቪ የደም ምርመራ ቢያደርጉና የምርመራው ውጤትም ኤች. አይ. ቪ እንዳለዎት ቢረጋገጥ የምርመራውን ውጤት የሚነግሩት ሰው ይኖራልን?	አዎ-----1 አይደለም-----2
27	ከላይ ለጥያቄ ተራ ቁጥር 26 መልሰዎ አዎ ከሆነ ነማን ይነግራው /ከአንድ በላይ መልስ ሊሰጡ ይችላሉ/	ለፍቅር ጓደኛ -----1 ለወላጅ-----2 ለቤተሰብ /ለዘመድ/-----3 ለጎረቤት -----4 ለጓደኞች -----5 ለህይማኖት መሪ-----6 ሌላ ካለ ይገለፅ-----

Appendix C

Focus Group Discussion Guide

Introduction

Hello, my name is Solomon Alemu and I am a postgraduate student at Addis Ababa University in the department of Psychology. I am working my thesis in the areas of stigma and discrimination attached to HIV and AIDS and in relation to PLWHA. You are here because of your interest and the valuable insights and perspectives you can share. We will be discussing your ideas about the knowledge, attitude, behavior, stigma and discrimination attached to HIV and AIDS and in relation to PLWHA. There are no right and wrong answers. I am interested in your opinions and you do not have to agree with one another. I will be delighted in hearing different opinions. I am also interested in your own opinions; in other words, what you think and feel about each topic. Every thing you say in this discussion will be kept private and no names will be used in my report. This focus group discussion is confidential. Just in case we cannot get everything down on paper we are tape recording this session.

Thank You

Knowledge about HIV and AIDS

- ❖ What do you know about HIV and AIDS? Is there difference b/n HIV and AIDS?
- ❖ Mode of transmission (probe for possible misconception)
 - Sexual intercourse, mother to child, mosquito bites, handshake, sharing toilet.
- ❖ Means of HIV prevention and treatment Traditional healers, Modern medicine abstinence, Faithfulness, Condom use.

HIV testing, disclosure, stigma and discrimination

- ❖ Tell me about HIV voluntary counseling and testing (Probe: for the advantage and disadvantage of testing)
- ❖ What will be your reaction if you find yourself an HIV-Positive (Probe: for suicide attempt, worry, anger, isolate oneself, accept and live etc)
- ❖ If a person learns he/she is infected with the virus that causes AIDS, should the person be allowed to keep this fact private or should this information be available to the community? Why? Probe: for negative and positive reaction.
- ❖ Are you willing to buy vegetables, fruits or any other food items from a vendor whom you know is living with HIV?
- ❖ Are you willing to share work tools, shake hands, eat together etc with a person living with HIV. (Probe for possible HIV infection due to this)
- ❖ Do you discuss about HIV and AIDS with your parents? With whom do you discuss Mostly? Friends (opposite or same sex)
- ❖ In your community how do people find out if some one has HIV / AIDS?
- ❖ Do people infected and affected with HIV treated differently? How? Why?

❖ What is your reaction towards PLWHA? Probe for positive and negative reactions.

❖ If a member of your family is infected with HIV-are you willing to give care and support? What will be your reaction if the person wanted to disclose his /her -HIV status probe (for negative and positive reaction in both cases)

❖ If you are infected with HIV-do you think you can get care and support from your family members? Who do you think can give you the best support? Probe: for friends, Girl/boy friend, religious leaders, instructors, neighbors etc.

❖ If your close friend is found to be HIV positive will you stop or continue your friendship as before? (Probe: for possible discomfort in the relationship)

❖ Do you think people infected and affected with HIV are stigmatized and discriminated? Why? How?

❖ What should be done about the stigma and discrimination attached to PLWHA and HIV and AIDS?

APPENDIX D

Date 18-1-99
Ref. Number BEFO/1-4/9092

Minister of Health
Oromia
Addis Ababa

To: Solomon Alemu
Finifine

The ethical review committee of the Oromia Health Bureau has reviewed the research proposal A Study of Young People's Attitude and Behavior and the Experience of PLWHA in Relation to Stigma and Discrimination Attached to HIV/AIDS

Please find attached here with the two pages reviewed result of approval of the proposal.



With Regards,

Dr. Zenebech Yadete (MD. MPH)
Deputy Head, Oromia
Health Bureau

OROMIA REGIONAL HEALTH BUREAU ETHICAL REVIEW COMMITTEE

ETHICAL REVIEW FORM

Tel 251 5510808

P.O.Box 24441

Finifine

CRITERIA/ITEM	RATING
1. consent form Does the consent contain all the necessary information that the subject should be aware of?	-----Yes -----Requires revision -----No -----Not applicable ----✓----Not attached
2. Are the objectives of the study clearly stated?	---✓----Yes -----No
3. Are the methods ethically sound? - Justice - Beneficence - Respect for a person	---✓----Yes -----Not well described -----No
4. Are provisions to overcome risks well described and accepted?	---✓----Yes -----No -----Not applicable
5. Are there provisions to provide standard/best proven care?	---✓----Yes -----No -----Not applicable
6. Are the safety procedures in the use of vaccines, drugs and other biological products acceptable?	-----Yes -----No ---✓----Not applicable
7. Are the procedures to keep confidentiality well described?	--✓-----Yes -----No -----Not applicable
8. Are the proposed researchers competent to carry out the study in a scientifically sound way?	---✓----Yes -----No -----Not applicable -----Unable to assess
9. Does it have material transfer agreement?	-----Yes -----No ---✓----Not applicable
Recommendation	---✓-Approved -----Approved on condition ----Not approved
Remarks	Attach the consent form with Thesis proposal

ETHICAL COMMITTEE MEMBERS

Name

Signature

1. Mr. Hayele Ayana
2. Dr. Taye Tolera
3. Mr. Dawit Teshome
4. Dr. Gudeta Tibesso







Declaration

I, the undersigned, declare that this thesis is my original work and has not been presented for a degree in any of other universities and all source materials used for the study have been duly acknowledged.

Name: Solomon Alemu

Signature: Solomon Alemu

Date: July 26 2007

Addis Ababa University, Addis Ababa, Ethiopia

The thesis has been submitted for examination with my approval as a University advisor.

Name: Bidiyadhar Sa (Ph.D)

Signature: [Signature]

Date of submission: July 26, 2007

Place: - Addis Ababa University, Addis Ababa, Ethiopia