SOCIAL STIGMA ATTACHED TO HIV/AIDS AND ITS DETERMINANTS IN DIREDAWA TOWN

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Dedication

This thesis is dedicated to my sister, late Kidist Ayele, and my only brother, late Mekbib Ayele (both died during my two years stay in the department) whose deaths were sudden, unbearable, and unforgettable.

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LIST OF ABBREVIATIONS

AIDS	Acquired Immunodeficiency Syndrome
ANOVA	Analysis of Variance
EJHD	Ethiopian Journal of Health Development
FGD	Focus Group Discussion
HIV	Human Immunodeficiency Virus
PLWHA	People Living With or Affected by HIV/AIDS
STI	Sexually Transmitted Infection
UNAIDS	Joint United Nation's Program on HIV/AIDS
VCT	Voluntary Counseling and Testing
WHO	World Health Organization

ABSTRACT

A cross sectional study was carried out from April to June 2001 among residents of Diredawa town aged 18 year and above to assess the magnitude and determinants of stigma related to HIV/AIDS and PLWHA. A multistage sampling procedure was used to select 845 study subjects. Both qualitative and quantitative data collection methods were utilized. Although majority of respondents were well aware about HIV/AIDS, there is still misconceptions about its casual transmission. Most respondents manifest at least some form of stigma towards PLWHA. Majority 527(68.7%) of the respondents agreed that PLWHA should not have child and 463(60.4%) of them to keep the HIV positive status of their family member secrete. Three hundred ninety six (51.6%) of the respondents said that PLWHA should never be trusted and 363(47.3%) respondents believed that PLWHA deserve the disease. More than a quarter of them 275(35.9%) also had an attitude of separating PLWHA from others to safeguard the public and 269(35.1%) reported their unwillingness to let their children learn in a school where one of the students is known to be HIV positive. Significant ($P<0.05$) negative correlation between stigmatizing attitude and knowledge of HIV/AIDS, belief about its casual transmission and income was established. On multivariate analysis, level of education, income, knowledge of HIV/AIDS, and belief about casual transmission of HIV were found to be significant ($P< 0.05$) negative predictors of stigmatizing attitude towards HIV and PLWHA. Addressing the issues of stigma in all activities that advocate disclosure of HIV status, encouraging PLWHA to disclose their HIV status, IEC regarding casual transmission of HIV and further studies to enrich knowledge about stigma surrounding HIV/AIDS and PLWHA are recommended.

INTRODUCTION

Throughout the history of humanity, stigmatization, prejudice and discrimination have accompanied diseases. To far greater extent than other illnesses, Acquired Immunodeficiency Syndrome (AIDS), has elicited highly prejudicial, fearful and, at times almost hysterical responses from the public (1,2). To this effect, PLWHA have to cope both with the manifestations of the disease, complex treatment regimen and societal stigma at the same time. Different studies (3,4) reported that PLWHA are stigmatized because their illness is associated with deviant behavior, the disease is viewed as the responsibility of the individual, perceived as contagious, associated with an undesirable and unaesthetic form of death, not well understood by the lay community and viewed negatively by health care providers.

HIV/AIDS related stigma and discrimination can be directed at infected people as well as their friends, families, care takers and others who are suspected of being infected or otherwise associated with the epidemic by virtue of their occupation, lifestyle, gender, sexual orientation, ethnic origin or physical appearance may be the target of hostility and discrimination (5,6). When PLWHA happen to be in a family, the household often also suffers disproportionately from stigma and discrimination. A single AIDS related illness or death can devastate the entire household through the loss of family income, the strain caused by prohibitive medical and funeral costs, or the stigma attached to families affected by AIDS. In some cases, serving family members have been abandoned, abused or attacked, while struggling to cope with their own family members and friends. Thus, as the number of individuals and households affected by HIV multiplies, the social impact of the epidemic also both widens and deepens (6).

Stigma and discrimination are concern of AIDS Control Programs for two main reasons (7). First, they make life unbearable to those who live with the disease and second; they affect prevention and

care efforts. As the epidemic is affecting all nations and all ages, national AIDS control efforts alone are no more adequate in overcoming the epidemic. Therefore, community members at grass root level and PLWHA have to participate in the control endeavors (8). Despite this major role expected from communities, the stigma attached to it has impaired their ability to assist PLWHA and to prevent further transmission of the disease. Therefore, community members need help to overcoming the fear and stigma attached to HIV/AIDS (8).

Reduction of stigma and discrimination against those who have AIDS and those perceived as being in high-risk groups is one of the goals of educational programs (9). Public health efforts are often designed to educate and to reduce fear in the minds of the public. Given the expansive and dynamic nature of the HIV epidemic, scrutiny of the public understanding of the disease and the components of stigmatizing and discriminatory attitudes towards PLWHA become crucial. However, these are not well studied in Ethiopia. Though concrete studies are lacking, the stigma attached to HIV/AIDS in the community is assumed high. Thus, this study attempted to assess pervasiveness of AIDS stigma and explores its determinants in urban community. The findings will be useful for policy makers and interested groups that are devoted to the care of PLWHA by identifying target groups for intervention effort of breaking the social stigma and controlling the epidemic.

LITERATURE REVIEW

Current situation of HIV/AIDS

The human immunodeficiency virus has brought about global epidemic far more extensive than what was predicted even a decade ago. The joint United Nations program on HIV/AIDS (UNAIDS) and the World Health Organization (WHO) now estimate that the

number of PLWHA at the end of the year 2000 stands at 36.1 million. More people died of AIDS in the year 2000 than in any previous years. The 3 million deaths in 2000 brought the estimated total number of deaths since the beginning of the epidemic to 21.8 million. It is also estimated that 5.3 million people became infected with HIV during the same year (10).

The AIDS epidemic affects people of all ages. About half of all people who contract AIDS are under 25 years of age. Over 90 percent of the children under the age of 15 years who contract HIV are born to mothers with HIV. Women can pass HIV to their children during pregnancy, delivery and breast-feeding. Over the course of the epidemic, AIDS has left over 11.2 million children under age of 15 years without their mothers and many of those same children without fathers (11).

Although no nation has escaped the epidemic, infection rates are not equally distributed around the globe. According to the December 2000 UNAIDS report, although Africa accounts for only 10% of the global population, it represents 80% of all deaths (2.4 million dead) in 2000. The continent is the home to 70% of all adults living with the virus, 80% of all infected children, and 95% of all orphans; at least 25.3 million Africans currently live with the HIV (12). In Botswana, one of every three adults is HIV positive, and in South Africa, one of every five citizen (12). By contrast, Asia contains 61 % of world population and 20% of HIV infected people. The Americas have 14% of world population and 8% of HIV infected people. Europe contributes 12% of world population and 8% of population lives with an HIV infection. Half of 1% of world population lives in Oceania and these countries have an even lower percent of HIV cases worldwide 0.1 % (12).

In Sub-Saharan Africa, about one in every 30 people is infected with HIV. Just over half of these people live in Eastern African countries; 1.2 million in Mozambique, 1.4 million in Tanzania, 1.5 million in Zimbabwe, 1.6 million in Kenya, and 2.6 million in Ethiopia. In Western Africa, Nigeria has the largest population of PLWHA. Nearly three million (2.5 million) people in South Africa are infected with HIV- the highest number of any country in Africa (12).

HIV probably started in Ethiopia in early 1980s. The first evidence of HIV infection was found in 1984 and the first AIDS case was reported in 1986 (13,14). Although HIV prevalence was very low in Ethiopia during early 1980s, it has been increasing rapidly since early 1990s. It was estimated that by 1989, adult prevalence had increased to 2.7%. The estimated prevalence of 7.1 % in 1997 has increased to 7.3% today in 2000 (11). The current HIV prevalence in urban Ethiopia is estimated to be 13.4, (16.8% in Addis). This figure is much higher than estimates in rural areas where current adult prevalence is estimated to be about 5%. Currently, the 2000 HIV prevalence estimate in Ethiopia show that there are 2.6 million people infected with HIV out of which 2.4 million are adults and 250,000 are children. The national average prevalence is estimated to be 7.3% (11). In terms of absolute numbers of the infected, Ethiopia ranks third next to South Africa and Nigeria, which have about 4.2 and 2.7 million infected people respectively (11).

HIV prevalence among sex workers showed subsequent increase in the town. Reports indicated prevalence of 18%, 32.1%, and 48.1% during 1998,1989 and 1990 respectively.

AIDS case reporting in Ethiopia has started in 1986 (11). By March 2000, 83,487 cases have been reported to the ministry of health. Among the reported cases, 3,322 (3.97%) were from Diredawa (11). Sentinel antenatal care based report in Diredawa town indicated prevalence of 12.3% during the year 1992/93 (11). During 1999/2000, HIV prevalence among young women (15-24 years of age) attending antenatal care was 14%. Infection in this group accounted for 57% of he total infected women (11).

HIV/AIDS and stigma

The term stigma has originated from a Greek word, which describes signs that indicate something out of the ordinary or bad about the person (15). It generally refers to a negatively perceived defining characteristic, apart from the normalized social order, and this separation implies devaluation (16). It is also a powerful discrediting and tainting social label that radically changes how individuals view themselves and are viewed as persons. When individuals fail to meet normative expectations because of attributes that are different and /or undesirable, they are reduced from accepted people to discounted ones. Thus, the discrepancy between what is desired and what actually 'spoils' the social identity isolates the individual from self as well as societal acceptance (17).

Goffman argued that stigma embraces a double perspective; that of the "discredited" an individual whose deference is evident or known about; and the "discreditable" one whose differentness is not immediately apparent (17). The problem with discreditable individuals according to Goffman is deciding how to deal with information that leads to being discredited. Jones has also identified six dimensions of stigma and suggested that those dimensions affect interpersonal roles of the stigmatized (18). These dimensions include: concealability, the course of the condition, stain the

stigma places on interpersonal relationships, aesthetic quality, the causes of the stigma, and danger associated with stigmatized person.

Societies have historically reacted with fear to disfiguring, debilitating, and fatal diseases and have translated this aversion into discriminatory actions against the infected (3). Unlike other diseases, sexually transmitted infections (STIs) have always been filled with stigma due to their association with behaviors considered deviant or immoral (16,19). Although most STIs are subject for stigmatization, HIV is far more stigmatized than they are even when they share many of the same modes of transmission (15).

AIDS is almost a paradigm of stigmatization and disease (2). Its association with socially unsanctioned activities such as prostitution and sex with multiple partner is subject to misconceptions about how it spreads and generates a high level of fear of suffering, disability, family disintegration and death. Moreover, the fact that AIDS is mainly heterosexually transmitted disease in Africa worsens the stigma because its presence implies to some people promiscuity or loose moral (4).

AIDS stigma is a social construction that dramatically affects the life experiences of the individuals infected with HIV and their partners, family and friends (3). Beiger defined social stigma as a physical, mental, or social attribute of an individual or group that elicits an aversive or discriminatory response from others (20). The trauma of the diagnosis of HIV or AIDS stems not only from the fact that the disease is known to be fatal, but also from that it is often accompanied by social stigma and rejection (21). Moreover, unlike other diseases, PLWHA are not only to cope with

the nature of the disease such as chronic fatigue, debilitating and fatal illness, but also with complex treatment regimens and societal stigma at the same time (21).

HIV/AIDS related stigma may be the actual infection or it may be based on behaviors believed to lead to infection. As the global pandemic first received international recognition in populations of homosexuals, injection drug users, and sex workers, these already socially marginalized groups began to face additional stigmatization. Thus, the stigma attached to AIDS as an illness was layered upon preexisting stigma (22). The association with an incurable disease in them was also used as medical justification for established patterns of exclusion of groups already deemed morally questionable (23). Conversely, PLWHA may become implicitly associated with stigmatized behaviors, regardless of how they actually became infected (24).

Stigma towards HIV and affected people has many roots; among them is the association of the disease in the public eye with marginalized groups and with the 'bad behavior' or wrong doing such as promiscuity (15). Katz stated that individuals are devalued less because they display attributes that violate accepted standards than because some communities have chosen to call certain attributes deviant (25). Thus, a given attribute that is stigmatized is not inherently pathological, immoral or deviant but derived from culturally embedded meanings. Thus, various forms of deviance are stigmatized in the context of a particular historic period and cultural perspective.

Studies in many parts of the world consistently reported that different population groups experienced negative attitude towards PLWHA. For example, more than one third of the English-speaking adults in Calcutta said that they would not like to have dinner or work with someone who had AIDS (26). Similarly, 24% of a Scottish sample believed that AIDS patients should be quarantined despite the fact that the majorities were well aware that casual contact was not dangerous (27). Many countries deny entry of PLWHA, insurance companies deny life insurance and people with HIV have been imprisoned in United States for “knowingly” infecting another person (28). In Cambodia, rejection of HIV positive people by family, forced isolation from the community, and refusal by monks to provide traditional burials for PLWHA have all occurred (29).

Dismissal from work on grounds of sero status has been noted in Thailand, Singapore, Malaysia, Indonesia, and in many other countries of Southeast Asia (30). HIV positive women were strongly pressured to undergo surgical contraception or, if already pregnant, to have abortion (21). Similarly, there is evidence that one in ten people with HIV interviewed in Denmark about dental care were refused treatment (28). In another study, over one quarter of sample of gay men in London reported some negative or discriminatory response on disclosing their HIV status, most notably from employers or dentists (31).

Kelly and colleagues reported hostility in a group of health care providers in United States of America (USA) manifested by unwillingness to interact with AIDS patients even when non of the interaction described would carry any risk for HIV transmission (1). Similarly, Barbara reported that physicians in USA would not like treating intravenous drug users and almost half of the respondents believed that physicians infected with the HIV should stop working (32). Furthermore, Blendon indicated that people in USA believed that PLWHA

deserve punishment for offensive or immoral behavior (33). Many said they would refuse to work alongside someone who had AIDS. Many parents also said they would take their child out of school to avoid contact with classmate with AIDS (33). A quarter of the respondents in a random sample of patients reported that they would switch physicians if they believed their doctor was treating people with AIDS or HIV (34). Furthermore, Herek indicated that most respondents in USA manifested some form of stigma towards HIV/AIDS and showed strong desire to support policies to avoid these people (7). Presence of a wide spread fear of social contact with HIV infected persons among the Swedish was also reported (35).

Similarly, Demeke mentioned the presence of tremendous amount of fear or social stigma by the patient and families in Ethiopia (36). He further stated that AIDS is stigmatized in Ethiopia through fear mostly by health workers and through feeling of shame which was manifested as fear of social isolation or fear of being exposed by the community and to a higher degree by the patients and families. Report from DHS in Ethiopia (37) reported that nearly twice as many men as women believed that a person who knows that she/he has AIDS virus should be allowed to keep this information secret. Similarly, 45% and 50 % of women and men respectively were willing to care for relatives who were infected with HIV in their house. This shed some light on the extent of stigma associated with HIV/AIDS and discrimination against PLWHA. Nnko in his study explained that stigma is strong and persisting in the community and its persistence appears to be a complex blend of traditional, religious, and medical other societal factor (38). In such circumstances, the inevitable outcome of marked societal stigma with HIV/AIDS is prejudice and discrimination against PLWHA (3). Increasingly negative attitude may lead to the dismantling of social support system of AIDS (39).

AIDS related stigma and its consequences

HIV/AIDS is manifestations of an extra ordinary illness in terms of its potentials for multidimensional stigmatization (9). This stigma and discrimination present a serious challenge to effectiveness of prevention and care programs. The resulting fears of consequences of open disclosure and self-identification have created silence that threatens all of us (35,40). A fundamental requirement for breaking the silence and overcoming the HIV/AIDS pandemic is eradication of denial, stigmatization and discrimination (41).

It is important to reduce stigma about being HIV positive for a variety of highly practical reasons. In practice where stigma is strong, asking a partner to practice safe sex may be such an admission that one is HIV positive and as has doubts about the partner's infection status. Another reason to attack stigma is that it makes people reluctant to seek HIV services including voluntary counseling and testing (VCT) (42,43). In addition, when pervasive stigma and discrimination exist, concerned individuals feel reluctant to be tested due to fears of discriminatory repercussions. If s/he realizes that a positive test result will result in isolation, harassment, loss of employment, and denial of health services, a person fearing that s/he may have been infected in the past will prefer to remain in ignorance, especially in circumstances where confidentiality cannot be ensured. If at all they were tested, they would prefer to conceal their status.

By concealing one's HIV status, the individual attempts to protect his or her self-esteem by avoiding enacted stigma. However, there may be other negative consequences of concealing their HIV sero status (3). First, the vigilance required to maintain a lie can be emotionally draining experience. Second, by keeping the diagnosis secret, the individual is deprived of social support from his or her social network that presumably would normally be available to him or her. Third, the individual develops the hostility of others who will finally learn that he/she is HIV positive without informing them. Fourth, the individual may be motivated to refrain from activities that signal diagnosis, such as delaying in seeking appropriate health care or participation in HIV support group. Finally, the individual may be highly motivated to sustain participation in social and occupational activities so as let others know his or her HIV status. The individual may engage in activities that dismiss and deny the diagnosis such as unprotected sex with unknown partners or sharing needles. In so doing, the individual essentially deny his or her HIV positivity but this will necessarily come at the cost of placing others at risk.

PLWHA are great potential in the fight against HIV/AIDS. No campaign to address the challenges of HIV/AIDS can possibly succeed without their full participation at all levels including policymaking and policy implementation. They must be valued as resources in and of themselves, and as crucial allies in the common struggle to overcome HIV/AIDS. More importantly, they are significant factor in the process of behavioral change (41).

Despite the challenges faced by PLWHA in response to disclosure of their HIV status, disclosure of HIV sero positivity has demonstrated marked change in AIDS related perceptions (34). Change in awareness due to celebrity disclosure may lead to increased

readiness to reduce risk and could be viewed as window of opportunity for prevention effort (41). In a study conducted to gather public attitude towards celebrity disclosure (42), significant increase in concern about AIDS, interest in AIDS information and talking with friends about AIDS has been reported after celebrity disclosure of HIV infection. Generally, educating and informing people corrects the misinformation and enhances positive living of the infected and the affected people as well as reduces the stigma associated with HIV/AIDS (42).

Stigma and discrimination continue to affect PLWHA through to the end of their lives, hampering the ability of community to normalize the disease and integrate it into shared coping strategies as might occur with other terminal illness. If care and support mechanisms are not present or people are too afraid to utilize them, communities do not address the issues surrounding HIV, nor are they exposed to PLWHA before the most debilitating phases of their illness. Not only is this detrimental to PLWHA, but it interrupts the cycle where care can directly influence future prevention (30). For effective care provision, relatives and families must be able to provide emotional, psychological and socioeconomic support to PLWHA. The capacity of the relatives to cope with the burden of an individual with HIV/AIDS may be a major determinant for acceptance or rejection of the HIV/AIDS individual (44). To shoulder the responsibility, community members need help in overcoming the fear and stigma and bridge the geographical distance between PLWHA and the community. If families are to cope with the AIDS crisis and all the responsibilities it entails, a comprehensive system of support will be required to meet the families' growing needs. The forms that this support will take will vary according to specific demographic, social, cultural and economic condition.

PLWHA who are acknowledged, visible and accepted in their communities do much to aid ongoing prevention efforts within the community. Existing literature throughout the world indicates that knowing PLWHA can have a strong preventive impact, but when care and support are weak, people tend not to reveal their HIV status (45). The increased visibility of people with the disease in the community can result in greater community acceptance and support (46). As PLWHA become active members throughout the society, stigma and discrimination against them would be reduced, and this encourages more people to publicly identify themselves as HIV positive (30). Despite scarcity of research on the topic, it is increasingly becoming acknowledged that effective prevention and treatment strategies require an understanding of cultural frameworks, including stigmatization.

Available studies that explored the extent and impact of HIV related stigmas are not targeted in identifying its determinants. Moreover, they were done in the context of specific geographic areas. Available evidences, however, indicates that nature of stigma differs according to the social, cultural and other factors of a given population. Therefore, it is now crucial to investigate the extent and determinants of HIV related stigma in our context. Identifying these would be useful to break the stigma, fear and prejudice attached to HIV/AIDS and foster supportive community to PLWHA. Hence, this study was designed with the objectives of filling the existing gap in this area.

OBJECTIVES OF THE STUDY

General objective

The general objective of this study is to assess the magnitude of social stigma attached to HIV/AIDS and PLWHA and identify its determinants in an urban community.

Specific objectives

- To assess pervasiveness of stigmatizing attitudes, behaviors and practices related to HIV /AIDS and PLWHA in Diredawa town.
- To identify determinants of stigmatizing attitudes towards PLWHA
- To assess peoples' beliefs about HIV transmission through casual contact and its effect on their attitude towards PLWHA.
- To assess knowledge of HIV/AIDS and its effect on peoples' attitude towards PLWHA.

RESEARCH METHOD

Study design: Both cross sectional (descriptive) and qualitative study designs were used.

Study area: This study is conducted in Diredawa town (which is selected because of its convenience). The town is located 520 Kilometers from Addis Ababa in the eastern part of Ethiopia. It consists 4 “Kefitegnas” and 24 “kebeles”. According to the Central Statistics Authority 164,851, people (49.8% male and 50.2% female) are estimated to live in the town in 2001(47). Among them, 86% of the total population are aged 18 years and above. There were 34,681 housing units in the town and an average of 4.6 persons per housing unit. Orthodox, Muslim and Protestants represent 51.9, 44.5, and 12.5% of religions of the residents respectively.

Source population: The source population was dwellers of Diredawa town (both males and females) during the study period

Study population: Were individuals (male and female), who were residents of Diredawa town for at least six months before the date of interview, aged 18 years and above, systematically selected and enrolled in the study.

Sample size: The sample size was estimated using sample size determination formula for single population proportion using the following assumptions. Since there were no previous studies which estimate the prevalence of stigmatizing attitude in the area, a prevalence level that estimate maximum sample size (50%) was considered, margin of error (d)= 0.05, non-response rate of 0.1, design effect of two with 95 % confidence certainty and alpha 0.05.

Based on these assumptions, the total sample size calculated using the formula indicated below gives 845 respondents.

$$n = Z^{2}_{(\alpha/2)} \frac{p(1-p)}{d^{2}} = 384$$

384X2 = 768 (Design effect of 2)

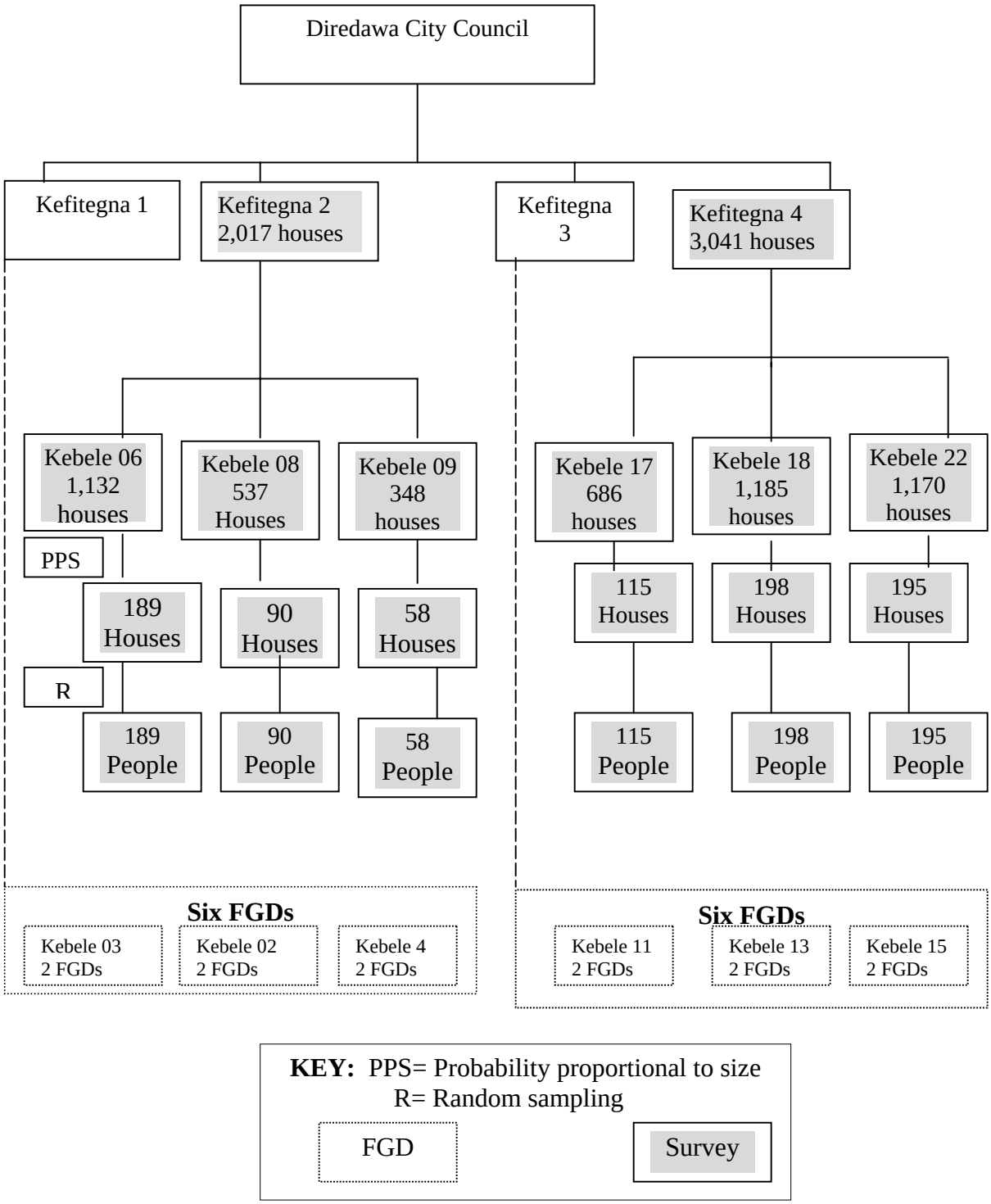
768 X10% = 77 (Non response rate of 10%)

Total sample size = (384 X 2) + (768X 10%) + (768 X10%) = 845

Sampling Procedure

The study subjects were selected using multistage sampling technique (Fig. 1). The town was classified in to four Kefitegnas (Administration units composed of six smaller administrative units called “kebele”). These strata were used for selection. From the four Kefitegnas, two of them were selected randomly for the survey. Three kebeles from each Kefitegna were selected randomly and enrolled in the study. Sampling fraction was allocated using probability proportional to the size of housing unit in each kebele and 845 housing units were identified using systematic sampling technique by dividing the total number of houses (H) by the required number of houses (h). The number “k” obtained by dividing H/h=k was used to identify the interval among each housing units. A random number was drawn between one and “k” to identify the first housing unit, which was used as a starting point in the process of data collection. Finally, from each housing unit one individual (845 individuals) was selected by a lottery method for the interview. Three repeated attempts were made before labeling an individual is unavailable for the study. When there was no eligible in the given household, no substitution was made. When more than one eligible were found in a household, one of them was selected by a lottery method.

Fig. 1 Schematic presentation of sampling procedure for the survey and FGDs



DATA COLLECTION PROCEDURE

Questionnaire development

Survey questionnaire was synthesized in English from different literatures developed for similar purposes (7,15,28,48) and adapted to the local context. It was organized into four main categories (Socio-demographic variables, knowledge variables, belief about casual transmission of HIV, and stigma variables). The stigma variable contained 18 questions and was further classified into four sub categories, (Feeling towards people living with HIV/AIDS, support for hypothetical coercive AIDS related policies, blaming PLWHA for acquiring the disease and avoidant behavioral intentions).

Pre test

English version of the questionnaire was translated into Amharic and back to English by two individuals (an Environmental health expert and a Nurse) who are fluent in speaking and reading of both languages to check its conceptual equivalence. Pretest of the Amharic version of the questionnaire was carried out at Melkajebdu, a town that shares similar geographic and socio demographic characteristics with Diredawa town and located 17 kilometers from the study area. Eighty-five respondents were participated in the pretest. During the pretest, the questionnaire was assessed for its clarity, understandability, completeness reliability and sensitivity of the subject matter. During the pretest, repeated questions, problem on the order and response options, skip patterns and difficult sentence constructions were identified. Based on the finding rearrangement of sentences, correction of wording of questions, removal and modifications of statements and skip patterns were made and time for completing each questionnaire was determined.

Qualitative data

Semi structured focus group discussion (FGD) guide was prepared by the principal investigator, reviewed by an expert and was used during the discussion. Twelve focus

group discussions were conducted in six kebeles of the two “Kefitegnas” that were not included in the survey. All the FGDs were conducted after the survey was completed. The purpose of the FGD was to obtain in-depth information on people’s attitude towards PLWHA. Each session was tape-recorded after getting consent from the participants. Key informants in the selected kebeles identified groups for FGD. Grouping of the participants was made based on three age categories (18-24 years, 25-49 years, and 50 years and above) and gender. Two groups were formed for each category therefore there were 12 groups. The principal investigator and an experienced FGD facilitator (who is a medical doctor with masters degree in public health) together with one more note keeper conducted all the FGDs. Each focus group had an average of seven (Maximum 8 and minimum of 5) participants and took an average of an hour (maximum 1:15, minimum 0:45). The inclusion criteria in the FGD included people who are able to express their ideas, and living in Diredawa town for at least six months before data collection.

VARIABLES

Dependent variable

Stigmatizing attitude (Feeling towards PLWHA, Avoidant behavioral intention, Support for hypothetical coercive AIDS related policy and Blaming PLWHA for acquiring HIV).

Independent variables

Socio demographic and socio economic variables: age, sex, marital status, religion, Number of children, ethnicity, average monthly income, occupation, and educational status

Cognitive variables: individual's knowledge about HIV/AIDS and belief about its casual transmission.

Management of data collection

Twelve data collectors (six males and six females) and two supervisors were recruited from the study area and were trained for four days by the principal investigator. All the data collectors have completed 12^{th} grade and had past experience of data collection. Strict daily supervisor of the data collection process was maintained throughout the data collection period. Each supervisor was responsible for three groups of data collectors composed of three males and three females. Supervisors collected questionnaire from data collectors daily, make checks of each questionnaire for completeness, and received completed questionnaires. Completed questionnaires were then submitted to the principal investigator

for final check. The principal investigator after making checks to each questionnaire accepted the completed ones. Incomplete questionnaires were returned to the specific data collector to be corrected by revisiting. During data collection, data collectors were not able to locate 25 (3%) housing units. Thirty-eight (5%) respondents (22 male and 16 female) were not willing to give consent for the interview. Fourteen individuals (1.7%) were not available for the interview after three repeated attempts. This gave a total sample of 767 individuals.

Data entry and analysis

After ensuring completeness of each questionnaire, data were entered into a computer and data cleaning was made using SPSS (Statistical Package for Social Sciences) version 10. This was followed by recoding of variables. Respondents were classified to have non-stigmatizing attitude to a particular item if their response to that variable was ‘disagree’ or ‘strongly disagree’ for the positive worded item, and ‘agree’ or ‘strongly agree’ for a negative worded item. Responses were scored as follows. Strongly disagree =1, disagree=2, undecided=3, agree=4, and strongly agree=5. Disagree and strongly disagree responses were coded together to obtain non-stigmatizing response and were given a value of zero, while agree and strongly agree responses were coded together to indicate stigmatizing responses and given a value of two. Undecided responses were given a value of one. Therefore, responses were recoded into stigmatizing, undecided, and non-stigmatizing options. Hence, respondents with higher stigma mean score were assumed to hold more stigmatizing attitude towards PLWHA than their counterparts do.

Knowledge was measured by the correct responses (based on contemporary knowledge) given for each knowledge variable. Correct response for a given variable was given a value of “1” and if not “zero”. The overall correct responses were aggregated and the mean knowledge score was used to

compare respondents with their personal characteristics. Respondents who obtained higher mean score were considered to have more knowledge while those who obtained lower mean score were considered to have less knowledge.

Variable regarding belief about casual HIV transmission were measured by five scales (Infection very likely, infection somewhat likely, not sure, infection very unlikely and infection impossible). Based on the nature of the questions in this category, those respondents who answered very likely or somewhat likely were categorizes as having wrong belief about HIV casual transmission and those respondents who answered very unlikely or impossible as holding correct belief about HIV casual transmission. Those respondents who were not sure or indifferent in responding to the questions were left out from the analysis as their numbers were few (less than 1.5%).

The data was then summarized and analyzed for the necessary associations. Frequency and percentages were used to present the findings. T-test, correlation, Analysis of variance (ANOVA) and multivariate analysis using multiple linear regressions were used to analyze the data. P-value <0.05 was used to indicate significance of association.

The recordings of the FGD were first transcribed in Amharic. Then, it was translated into English by the principal investigator to identify main concepts and categories. Major findings of the discussion, which were different from the survey result, were selected and summarized under the theme of the discussion guide. Finding from the note keeper was also considered when appropriate.

The recordings of the FGD were transcribed in English by the principal investigator and main concepts and categories were identified. Finding from the note keeper were also considered when appropriate. The findings, which were different from the survey result, were summarized and presented in the thesis.

Ethical Considerations

Ethical clearance was secured from the Faculty of Medicine of the Addis Ababa University and the Research Committee of the Department of Community Health. Permission to proceed with the study was obtained from administration council, HIV/AIDS secretariat, administration of kefitegnas and kebeles of Diredawa town. Moreover, the survey questionnaire was anonymous; interview was conducted in a private setting (to maintain privacy of respondents for sensitive questions) and respective data collector secured verbal consent for interview from each respondent. Verbal consent for recording of the focus group discussion was also obtained from each group.

Operational Definitions

A. **Stigmatizing attitude:** Negative feeling toward people with HIV/AIDS, support for coercive AIDS related policies, blaming a person with HIV/AIDS for acquiring the disease, and intention to avoid PLWHA from social relationship.

B. **Attitude:** Constant feeling that is directed toward a person, idea, object or situation (49).

C. **People living with or affected by HIV/AIDS (PLWHA):** includes individuals who are infected by HIV or living with the symptoms of AIDS (50).

D **Blaming PLWHA:** Fixing responsibility of acquiring HIV/AIDS on persons who acquired the infection regardless of the route through which they got it.

E **Discrimination:** An action or treatment based on the stigma and directed toward the stigmatized

E **Feeling:** The extent to which respondents felt angry at, afraid of and disgusted by PLWHA.

F **Support for hypothetical coercive AIDS related policy:** Respondents' agreement to those hypothetical statements revealing forceful measures regarding PLWHA. Such statements include quarantine, making names of PLWHA public and restriction of the rights of PLWHA.

G **Avoidant behavioral intention:** The intention to get PLWHA away or avoid them from social interaction, workplaces, and related areas (51).

RESULTS

A total of 767 (90.5% of the anticipated) study subjects, 322(42%) males and 445(58%) females from residents of Diredawa town were selected and participated in the study.

Sociodemographic characteristics

The sociodemographic characteristics of the respondents are summarized in Table 1. Majority of the respondents, 448(59%) were between the ages of 18-34 years. The mean ± SD age was 34.3 ±14.1 years, with a median of 30 years. Majority, 615(80%) of the study subjects reported attending formal education. More than half, 453(59%) of them were married. Amhara, Oromo, and Somali represent 441(44.5%), 213(27.8%), and 88(11.5%) of the population. Sixty three percent of them, that is, 483, were Christians and 284(37%) were Moslems, The average number of children per family was 2.2 and the average income level was 102 Birr with maximum of 2000 and minimum of zero.

Table 1. Socio-demographic characteristics of respondents of Diredawa town June 2001 n=767

Variables	Male n=322 (42%))		Female n=445(58%)		Total n=767(100%)	
	Freq	%	Freq	%	Freq	%
Age in years						
18-24	101	31.4	118	26.5	219	28.6
25-29	43	13.4	71	16.0	114	14.9
30-34	45	14.0	70	15.7	115	15.0
35-39	29	9.0	47	10.6	76	9.9
40-44	31	9.6	48	10.8	79	10.3
45-49	21	6.5	24	5.4	45	5.9
50-54	15	4.7	19	4.3	34	4.4
55-59	8	2.5	11	2.5	19	2.5
60+	29	9.0	37	8.3	66	8.6
Education						
Illiterate read/write	35	10.9	117	15.2	152	19.8
Grades 1-6	31	9.6	67	8.7	98	12.8
Grades 7-8	41	12.7	55	7.2	96	12.5
Grades 9-12	170	52.8	182	23.7	352	45.9
Grades 12+	45	14.0	24	3.1	69	9.0
Occupation						
Unemployed	127	39.4	303	68.1	430	56.1
Employed	193	59.5	131	29.4	324	42.2
Others	2	0.6	11	2.5	13	1.7
Marital status						
Never married	165	51.2	149	33.5	314	40.9
Currently married	143	44.4	201	45.2	344	44.9
Divorced/Widowed	14	4.3	95	21.3	109	14.2

Table 1. Cont'd. Socio-demographic characteristics of respondents of Diredawa town

June 2001 n=767

Variables	Male n=322 (42%)		Female n=445(58%)		Total n=767(100%)	
	Freq	%	Freq	%	Freq	%
Ethnicity						
Amhara	91	28.3	222	49.9	341	44.5
Oromo	119	37.0	122	27.4	213	27.8
Somali	44	13.7	44	9.9	88	11.5
Gurage	33	10.2	18	4.0	51	6.6
Adere	23	7.1	24	5.4	47	6.1
Others	12	3.7	15	3.4	27	3.5
Religion						
Christian	117	36.3	306	68.8	483	63.0
Moslem	145	45	139	31.2	284	37.0
Average monthly						
income	64	19.9	101	22.7	165	21.5
No income	97	30.1	178	40.0	275	35.9
0-100	117	36.3	132	29.7	249	32.5
101-500	37	11.5	31	7.6	68	8.9
501-1000	7	2.2	3	0.7	101	0.3
1001+						
Number of children						
1-3	228	70.8	307	69.0	535	69.8
4 -7	80	24.8	118	26.5	195	25.8
8 and above	14	4.3	20	4.5	34	4.4

Knowledge about HIV/AIDS

Eighteen questions (Annex 1, Question numbers 206-223) were asked to measure respondent's knowledge about HIV/AIDS. The full content of the questions is presented in Table 2 along with the frequency distribution of the responses to each question.

The result indicated that 74(9.6%) of the respondents have answered all the questions correctly. The overall mean ± SD knowledge score was 14.1±2.6 with a maximum of 18 and a minimum score of zero. Mean score for males and females indicated that males with mean ± SD knowledge score of 14.4±2.6 obtained slightly higher than the females with mean score of 13.8±1.8 ($t=3.1$, $p<0.05$). Three hundred forty five (45%) respondents reported that a person who is tested and was known to be free of the HIV cannot get the virus some other time while 33.2 % of them said that AIDS has cure. Nearly half (49.3%) of the respondents answered that donating blood will result in acquiring HIV. Nevertheless, 726(95%) of them quite correctly knew that one could acquire HIV by having sexual intercourse with infected person and 91.3% by sharing injection needles. Regarding risky behaviors, 91.7% of them reported that the chance of acquiring HIV can be increased by having sex with many partners, while 83% of them believed that the chances of getting HIV are reduced by having sex with one faithful partner and 88% by abstaining from sex. Higher knowledge mean score was found among singles ($t=3.5$, $P<0.05$), Christians ($t=5.7$, $P<0.05$) members of organizations working towards HIV prevention ($t=2.8$, $P<0.05$) and respondents who personally knew people living with HIV ($t=3.5$, $P<0.05$) and / or died with HIV/AIDS ($t=5.6$, $P<0.05$).

Table 2: Knowledge about HIV/AIDS among study subjects of Diredawa town June 2001 n=767

Variables	Correct		Incorrect	
	Freq.	%	Freq.	%
A healthy looking person can have HIV	644	84	123	16
A healthy looking person can transmit the virus to others	682	88.9	85	11.1
A person can get HIV by wearing clothes of infected person	442	57.6	325	42.4
A pregnant woman can transmit the virus to her fetus	669	87.2	98	12.8
Infected woman can transmit HIV to her infant through breast- feeding	600	78.2	167	21.8
A person can get HIV by donating blood	389	50.7	378	49.3
HIV can be transmitted by sharing injection needles	700	91.3	167	8.7
A person can get HIV through sexual intercourse with infected person	726	94.7	41	5.3
A person can get HIV through a bite of mosquito or other insects	431	56.2	336	43.8
A person get HIV by shaking hands of infected person	631	82.3	136	17.7
Chance of getting HIV infection can be increased by having sex with many sexual partners	703	91.7	64	8.3
Chance of getting HIV can be reduced by having sex with only one faithful partner	637	83.1	130	16.9
A person can protect himself by using condom properly and always when having sex	622	81.8	145	18.2
A person can protect him/her self by abstaining from sex	674	87.9	93	12.1
People can prevent themselves from HIV by having sex with only one faithful partner	671	87.5	96	12.5
Once infected, a person transmit the virus for life	637	83.1	130	16.9
If a person is tested for HIV and found to be negative, s/he will not get the virus some other time	422	55.0	345	45.0
AIDS has cure	512	66.8	255	32.2

Table 3. Mean knowledge score compared with personal characteristics of study subjects in Diredawa town June 2001.

Variables	n	Mean	SD	t-test	95% CI for the Mean difference
Sex					
Male	322	14.4	2.6	3.10	0.23, 1.01*
Female	445	13.8	1.8		
Education					
Attended formal education	615	14.4	2.5	6.12	1.16, 2.26*
Illiterate/Read and write	152	12.7	3.2		
Marital status					
Never married	314	14.5	2.4	3.51	0.03, 1.05*
Ever married	453	13.8	2.9		
Religion					
Christian	483	14.5	2.3	5.66	0.80, 1.66*
Moslem	284	13.3	3.2		
Attendance to religious events	678	14.0	2.8	-1.89	-1.19, 2 .31
Yes	89	14.6	2.6		
No					
Frequency of attendance					
Regular	607	14.06	2.74	-0.24	-0.72, 0.57
Irregular	78	14.14	2.71		

*** P <0.05**

Table 3. Cont'd. Mean knowledge score compared with personal characteristics of study subjects in Diredawa town June 2001.

Variables	n	Mean	SD	t-test	95% CI for the mean difference
Membership to HIV prevention Organizations					
Yes	113	14.8	2.2	2.78	0.22, 1.29*
No	631	14.0	2.7		
Knows someone living with HIV					
Yes	83	14.8	2.0	3.54	0.37, 1.33*
No	667	14.0	2.8		
Number of persons living with HIV that respondent knows					
Single	27	15.0	1.8	0.54	-0.67, 1.17
Multiple	56	14.8	2.0		
Knows someone died of AIDS					
Yes	170	15.0	2.1	5.62	0.73, 1.52*
No	578	13.8	2.8		
Number of persons died with HIV that respondent knows					
Single	42	14.7	2.1	-0.84	-1.06, 0.43
Multiple	128	15.0	2.1		

*** P<0.05**

3 Belief about HIV transmission through casual contact

The mean ± SD score for the six questions related to this variable was 10.9 ± 0.4 with maximum 11 and minimum score of 8. Most (90%) respondents believed that HIV would not be transmitted by being coughed on or sneezed on by someone who has HIV/AIDS, 90% by kissing someone who has HIV/AIDS on his cheeks, 93% by eating food together and 90% by sharing toilet. However, 20.9% of them believed that mosquito or other insects could transmit the infection and 12% of them through sharing drinking glasses. Males and females obtained mean ± SD score of 10.8±0.3 and 10.8±0.4 respectively. This was not, however, statistically significant ($t=1.9$, $P>0.05$). Respondents who attended formal education were found to carry correct belief about HIV transmission compared with illiterates and respondents who are able to read and write only ($t=3.8$, $P<0.05$). Table 4 shows the proportion of respondents who carry correct belief and misconceptions about HIV transmission through casual contact.

Table 4 Response to questions related to belief about HIV transmission though casual contact among residents of Diredawa town June, 2001.n=767

Variables	Correct belief[1]		Incorrect belief[2]	
	Freq.	%	Freq.	%
How likely is it that a person could get AIDS or HIV infection by				
➢ **Being coughed on or sneezed on**	691	90.1	58	7.6
➢ **Mosquito or other insect bites**	605	78.9	160	20.9
➢ **Kissing a person with HIV on cheeks**	690	90.0	72	9.4
➢ **Sharing drinking glass**	668	87.0	93	12.1
➢ **Sharing toilet with a person with HIV**	687	89.6	70	9.1
➢ **Eating food with a person with HIV**	714	93.1	44	5.7

NB: Total may not add up to 100 because some respondents were not sure about the transmission

[1] Correct belief category combines responses “not likely” and “impossible”.
[2] Incorrect belief category combines “very likely” and “somewhat likely” responses.

Overall Stigmatizing attitude

Eighteen questions were asked to measure respondents' attitude towards PLWHA. (Table 5). The mean ± SD score computed from the 18 questions was 10.7±5.3 with maximum 29 and minimum score of 2. Statistically significant associations were established between stigmatizing attitude and being female ($t= 2.1$, $P<0.05$), illiterate ($t= -5.6$, $P<0.05$), not being member of organizations working towards HIV prevention ($t=-3.9$, $P<0.05$), and not knowing some one who is infected ($t= -4.3$, $P<0.05$) or died with HIV/AIDS ($t= -3.7$, $P<0.05$). Stigmatizing attitude towards PLWHA had no significant association with the number of people living or died with HIV/AIDS known by respondents ($P>0.05$). (Table 6).

Table 5 Stigmatizing and non-stigmatizing responses to stigma variable among residents of Diredawa town. June 2001. n=767

	Non-stigmatizing n (%)	Stigmatizing n (%)
Feelings towards PLWHA		
• Angry	593 (77.3)	174 (22.7)
• Afraid	562 (73.3)	198 (25.8)
• Disgusted	637 (83.1)	118 (15.4)
Support for hypothetical coercive AIDS related policy		
• PLWHA should be separated from others	483 (63)	275 (35.9)
• PLWHA should be restricted of their rights	618(80.6)	143 (18.6)
• PLWHA should not have child	233(30.4)	527 (68.7)
• Names of PLWHA should be publicized so that others can avoid them	487(63.5)	272 (35.5)
Blaming PLWHA for acquiring the infection		
• PLWHA deserve the disease	397 (51.8)	363 (47.3)
• PLWHA should never be trusted	364 (47.5)	396 (51.6)
• People get HIV because of their own failure	409 (53.3)	346 (45.1)
Avoidant behavioral intention		
• Suppose your child is attending school where one of the students was known to have HIV	495(64.5)	269 (35.1)
• If a close friend had HIV	652 (85)	114 (14.9)
• Willingness to work with PLWHA in the same office	680 (88.7)	86 (11.2)
• Willingness to shop from grocery where the shop-keeper is HIV+	651 (84.9)	97 (12.6)
• Willingness to care for a relative with HIV at home	734 (95.7)	32 (4.2)
• Keeping HIV status of the family member secret	297 (38.7)	463 (60.4)
• Allowing an HIV+ teacher to continue teaching	11 (92.7)	47 (6.1)
• Willingness to eat food with PLWHA	645 (84.1)	115 (15.0)

NB: Total may not add up to 100% because some respondents were not willing to respond

Table 6 Mean stigma score compared with personal characteristics of residents of Diredawa town. June 2001

Variables	n	Mean	SD	t-test	95% CI for the mean difference
Sex					
Male	322	10.22	5.23	2.06	1.56, 3.66*
Female	445	11.02	5.38		
Education					
Attended formal education	615	10.10	4.99	-5.61	-3.99, -1.91*
Illiterate/ Read and write	152	13.05	5.99		
Marital status					
Never married	314	10.07	5.26	-2.64	-1.80, -0.27*
Ever married	453	11.10	5.34		
Religion					
Christian	483	9.85	4.70	-5.42	-3.07, -1.43*
Muslim	284	12.10	6.00		
Attends religious ceremonies					
Yes	678	10.78	5.36	1.35	-0.34, 1.99
No	89	9.97	5.06		
Frequency of attendance					
Regular	607	10.6	5.3	0.28	-1.00, 1.36
Irregular	78	10.4	4.9		
Membership to HIV prevention organization					
Yes	113	9.05	4.55	-3.40	-2.86, -0.97*
No	631	10.97	5.39		

*** P<0.05**

Table 6 Cont'd. Mean stigma score compared with personal characteristics of residents of Diredawa town. June 2001

Variables	n	Mean	SD	t-test	95% CI for the mean difference
Knows someone infected with HIV					
Yes	83	8.69	4.32	-4.35	-3.28, -1.23*
No	667	10.94	5.40		
Number of infected persons Known by respondents					
Single	27	.56	4.07	-0.19	-2.22, 1.83
Multiple	56	8.75	4.47		
Knows someone died with AIDS					
Yes	170	9.39	4.73	-3.67	-2.60, -0.79*
No	578	11.08	5.45		
Number f People died with AIDS Known by respondents					
Single	42	9.45	5.03	0.10	-1.58, 1.75
Multiple	128	9.37	4.65		

*** P<0.05**

Feeling towards PLWHA

Three questions were asked to study what respondents feel about PLWHA. The mean ± SD score for the three questions was 1.3±1.9, with maximum of six and minimum score of zero. The result showed that 118(15.4%) respondents feel disgusted, 174(22.7 %) feel angry and 198(25.8%) afraid of PLWHA. Only 57(7.4%) study subjects reported stigmatizing attitude while 465(60.6%) reported non-stigmatizing attitude to all the three questions.

Support for hypothetical coercive AIDS related policy

For the four questions related to this variable, the mean ± SD score was 3.21± 2.41 with maximum of 8 and minimum score of zero. Few, 62 respondents showed support for all hypothetical coercive AIDS related questions while 142 reported not supporting policies that avoid PLWHA indicating a non-stigmatizing attitude. More than a quarter, (35.9%) of the respondents supported policies that separate PLWHA from the public, while 527(68.7%) reported that PLWHA should not have children. Moreover, 35.5% of them supported policies that publicize names of PLWHA. Variables that were significantly associated with avoidant behavior were illiteracy ($t=-3.0$, $P<0.05$) and being married ($t=-0.4$, $P<0.05$). Respondents who do not support coercive hypothetical AIDS related policies were members of organizations that work towards HIV prevention ($t=3.7$, $P<0.05$) and those who know someone who are infected with ($t=-4.3$, $P<0.05$) or died with HIV/AIDS ($t=-2.3$, $P<0.05$).

Blaming PLWHA for acquiring HIV

Three questions were asked in relation to this variable. The mean± SD score for the variable was 2.9± 1.5 with maximum of 6 and minimum score of zero. 7.3 and 9.6 percent of the respondents gave stigmatizing and non-stigmatizing response to all the three questions respectively. More than half (52%) of the respondents reported that PLWHA should never be trusted, 47.3 % of them said PLWHA deserve the disease and 45.1 % that PLWHA acquired the disease due to their failure to control their behaviors and feelings. Nevertheless, equal proportion of them sympathize that PLWHA do not deserve the disease and 53 % of them agreed that PLWHA got the disease not because of their failure to control their behaviors and feelings. Being female, illiterate, single, not attending religious ceremonies, and being member of organizations working towards HIV prevention favors stigmatizing attitudes. However, all of them were statistically insignificant (P>0.05).

Avoidant behavioral intentions

The mean± SD score for the eight questions asked to study respondents' avoidant intentions was 3.3± 2.8 with maximum of 16 and minimum score of zero. Two hundred sixty nine (35.1%) respondents were not willing to send their children to school where one of the students was known to be HIV positive. More than half, (60.4%) of the respondents also reported to keep the HIV positive status of family member secrete. In addition, 115(15%) of the respondents reported that they would quit their friendship if they learn their friend is HIV positive. Although 93.1% of the respondents believed that eating food together with PLWHA could not transmit the virus, 15% of them were not willing to eat with someone

who is known to have HIV. One hundred thirty six (17.7%) respondents reported non-stigmatizing attitude while only one (0.1%) respondent showed stigmatizing attitude to all the questions related to this variable. Statistically significant associations were established between avoidant behavior and being female ($t=2.4$, $P<0.05$), and illiterate ($t=-4.7$, $P<0.05$). In addition respondents, who are not member of organizations working towards HIV prevention ($t=-3.9$, $P<0.05$), and who do not know someone who is living with HIV ($t=-2.2$, $P<0.05$) or someone who has died with HIV/AIDS ($t=-3.1$, $P<0.05$) held avoidant behaviors towards PLWHA.

Result of the correlation analysis

Result from the correlation analysis indicated that knowledge of HIV/AIDS ($r=-0.41$, $P<0.05$) belief about HIV casual transmission ($r=-0.22$, $P<0.05$) and income status($r=-1.12$, $P<0.05$) were significantly, negatively correlated with stigmatizing attitude. Knowledge about HIV/AIDS was also significant for both males and females when assessed separately. Income level was significant when assessed for overall sample, while belief about casual transmission of HIV was significant for female respondents only when assessed between sexes. (Table 7).

Table 7. Correlation of knowledge, belief about HIV casual transmission and income with stigma variable among respondents of Diredawa town June 2001.

	Stigmatizing attitude		
	Male	Female	Both sexes
	r	r	r
Age	0.007	-0.069	-0.03
Knowledge of HIV/AIDS	-0.43**	-0.390**	-0.41**
Belief about HIV transmission	-0.87	-0.309**	-0.22**
Income	-0.102	-0.126	-1.12*

* Correlation is significant at 0.05 levels ** Correlation is significant at 0.01

r = Spearman's correlation coefficient

Result of the Analysis of Variance (ANOVA)

One-way ANOVA was performed taking stigmatizing attitude as dependent variable and various levels of age, education, employment, income, marital status, ethnicity and religion as independent variables. The result indicated that mean stigma scores were significantly ($p<0.05$) different among various levels of education ($F_{4,762} = 16.307$, $p<0.05$), employment ($F_{2,764} = 6.858$, $P<0.05$), income level ($F_{4,762} = 5.253$, $P<0.05$) and ethnicity ($F_{5,761} = 3.857$, $P<0.05$). When multiple comparisons (using Bonforoni test) were performed, significant differences were found among illiterates and those respondents who were at the junior and secondary levels of education, i.e., (7-8, 9-12, 12 and above). Similarly, significant differences ($P<0.05$) were found among categories of respondents who earn an income of 1-100 Eth. Birr and those who earn an income of 101-500, and 501-1000. Significant difference ($P<0.05$) in stigmatizing attitude between the Somali and other ethnic groups was also identified.

Result from multivariate analysis

Multivariate analysis was done to see the effects of individual explanatory variables while controlling the others. In the regression model, knowledge about HIV/AIDS, belief about its casual transmission, age, sex, levels of education, occupation ethnicity, income level, marital status, religion, frequency of attendance to religious events, and knowing people who are infected or died with HIV/AIDS were entered as independent variables. Over all stigma score, feeling towards PLWHA, Support for coercive AIDS related hypothetical policy and avoidant behavioral intention were entered separately as dependent variables. The result indicated that knowledge about HIV/AIDS, belief about casual transmission of HIV/AIDS, income level and level of education were significant ($P<0.05$) negative predictors of stigmatizing attitude. Contribution of each variable to each sub category of the stigma variables (feeling, blame, avoidant behavioral intention, support for hypothetical AIDS related coercive policy) was also assessed. Both knowledge about HIV/AIDS, belief about HIV casual transmission, income status and level of education were significant negative predictors in all cases. The result of the finding is summarized in table 8.

Table 8. Multivariate analysis (Multiple linear regression) of different personal characteristics of the respondents in Diredawa town compared with stigma variables. Diredawa 2001.

Variables	Overall stigma		Feeling		Avoidant behavior		Blame		Support for coercive Policy	
	β	t-ratio	β	t-ratio	β	t-ratio	β	t-ratio	β	t-ratio
Intercept	42.4	7.64*	10.19	4.82*	23.39	7.91*	4.87	2.60*	3.96	1.40
Belief about HIV transmission	-1.7	-3.57*****	-0.7	-3.79*****	-1.1	-4.32*	-0.1	-0.67	0.2	0.80
Income	-0.6	-2.76*****	-0.2	-2.39*	-0.01	-0.12	-0.1	-0.72	-0.3	-3.03*
Age	-0.1	-0.23	-0.03	-0.28	-0.14	-0.92	0.1	1.14	-0.1	-0.05
Sex	-0.2	-0.57	-0.1	-0.81	0.1	0.62	-0.1	-0.84	-0.1	-0.59
Marital status	0.2	0.52	0.2	1.87	-0.3	-1.97*	-0.1	-0.83	0.3	2.25*
Education	-0.7	-3.41*****	-0.2	-2.47*****	-0.3	-2.33*	0.01	0.15	-0.3	-2.52*
Ethnicity	-0.2	-1.15	0.004	-0.09	-0.1	-0.91	-0.01	-0.42	-0.1	-0.95
Religion	0.9	2.37	0.6	4.12	0.2	1.10	-0.2	-1.14	0.2	1.19
Attending religious events	-0.2	-0.35	0.01	0.38	-0.2	-0.78	0.01	0.05	-0.1	-0.18
Knows someone living with HIV	0.5	0.95	0.004	1.69	-0.1	-0.23	-0.3	-1.94	0.6	2.13*
Knows someone died of AIDS	-0.1	-0.28	-0.2	0.03	-0.1	-3.21	-0.1	-0.06	-0.04	-0.19
Occupation	-0.2	-0.55	-0.2	-1.03	-0.3	-1.93	0.1	1.03	0.2	1.02
Knowledge of HIV/AIDS	-0.7	-0.99*****	-0.1	-3.78*****	-0.4	-11.13*	-0.01	-0.67	-0.2	-4.79*

P<0.05*

FINDING FROM THE FGDs

1. Knowledge about HIV/AIDS

All groups of the FGD participants expressed hearing about HIV/AIDS. Although they know that young age groups are most affected, they also stated that the problem is not restricted to the youth but all individuals should be aware of its existence and safeguard themselves. Presence of people who question the existence of HIV/AIDS, as most of them agree is also mentioned. Majority of the participants said that there are people who say *"there is no AIDS after 10 PM"* and most of these people are alcohol drinkers and promiscuous ones who used to drink after 10 PM.

2. Knowing PLWHA

Most participants (males aged 50 and above) reported seeing few PLWHA through television and few younger participants reported seeing personally 1-2 PLWHA. However, most of them mentioned hearing a rumor that some people had HIV. In addition, majority of them said that people who died of any disease after having been sick with cough and weight loss are believed to die of HIV/AIDS. Most of the older participants (both sexes) who know PLWHA said, *"They are physically like ourselves and even some of them look physically better than us."* This idea was also supported by most of other participants. Majority of the participants agreed that if someone were having HIV (tested or by rumor), their family members would also be labeled HIV positive. One participant (women 25-49) added saying, *"I know a child both parents of whom have died of AIDS and who has been himself labeled as victim of HIV."*

3. Public reaction to HIV/AIDS

Most participants believed that, disclosing HIV status is challenging to PLWHA because of the existing poor support to PLWHA, knowledge and preventive practices. Majority of them agreed that PLWHA are very important in creating behavioral change about the public and prevention of HIV transmission. It was stated by younger participant (aged 18-24 years) that *"PLWHA should disclose their HIV status after the public had got adequate awareness about the ways by which HIV could not be transmitted, otherwise, these people will automatically be isolated from the community."*

Only few participants showed their willingness to disclose their HIV status if they were HIV positive while majority of them disagrees. One of the participant (aged 54 years) said *"I personally am not willing to disclose my HIV status if I knew I am HIV positive because I want to maintain my social relationship with my community members and neighbors"*. Other (young girl 18-24 years) also mentioned about a case of a woman in Awassa, and added saying *"we heard through a media that a woman who was infected with HIV has been denied living in her house (where she lives renting it) for being HIV positive. I am not sure this would not occur in our community too if someone who rented a house were HIV positive."*

Participants aged 25-49 years of both sexes, however, clearly expressed their view by saying *"I will avoid having any contact with PLWHA because I am not sure whether they really know how to prevent transmitting their disease to me"*. Other participants, a 50-year-old woman who added by stating *"I am not willing to visit a neighbor who has fallen sick*

with HIV/AIDS. If at all I have to visit, I will sit near the door side and stay only for few minutes. I do not want to eat or drink from that house" shared this idea. Almost half of the (25-49 years, and 50 years and above both sexes) participants expressed their fear of shopping from a grocery where the owner is known to be HIV positive and few of them reported their fear to be treated by a health worker whom they know is HIV positive. All of the participants agreed that the community at large discriminate PLWHA and tries to avoid them. Most of them expressed their view that PLWHA who got the disease by having sex with multiple sexual partners, particularly those who know its modes of transmission and prevention for example, health workers, deserve the disease. A 50 year old men and women participants sympathize PLWHA who got the infection by other routes than having it from being promiscuous and considered them as being *"innocent victims."*

Majority of the participants (both sexes and age group) agreed that stigmatizing and discriminating PLWHA is solely related to poor knowledge about HIV/AIDS in general and of the ways by which it will not be transmitted in particular. Most of the participants have mentioned lack of continuous education on HIV/AIDS and requested the same in the form of discussions where PLWHA participate personally. They also emphasized the need for active anti-AIDS clubs that mobilize the community.

DISCUSSION

This study provided important information regarding public attitude towards HIV/AIDS and its determinants after nearly two decades of the HIV epidemic in Ethiopia. It also described the study population with regard to their knowledge, beliefs about HIV and its transmission through causal contact.

The findings showed that most respondents had high awareness of HIV/AIDS with males obtaining higher score compared with females. Result from the FGDs also indicated that although few people were still questioning existence of the virus, majority of them heard about HIV/AIDS. Similar results were also reported in different studies (40,52,53). Other studies, however, reported lack of association between knowledge score for males and females. For example, Gebre reported no difference in mean knowledge score between males and females of high school students (54). The difference in this study could be attributed to the fact that more males have attended formal education than female respondents in the study area (50).

The pattern of higher knowledge with increasing education indicated in this study was also supported by findings of other studies (40,55,56). This could result from group interaction among students, education about HIV/AIDS in schools, inclusion of AIDS in school curricula for formal education and the input from school anti-AIDS clubs.

Significant association between respondents who know people living or died with HIV/AIDS and increased knowledge of AIDS was established in this study. Similarly, higher knowledge score was obtained among respondents who are members of organizations working towards HIV prevention and PLWHA including Anti-AIDS clubs. This difference might indicate that people who have social contact with PLWHA would be more eager to read and ask about HIV/AIDS among themselves than their counter parts. This finding is similar to Seth C. who reported significant increase in concern about AIDS, interest in AIDS information and talking with friends about AIDS after celebrity disclosure of HIV infection (45). Therefore, finding of the present study could be considered as an indication of the need for encouraging more people to participate in organizations that are working towards control of the HIV epidemic and enforcing more PLWHA to disclose their HIV status.

Misconceptions regarding HIV transmission through casual contact were identified in this study. Similarly, Fajans reported that more than 60% of respondents in Indonesia believed sharing drinking glasses would favor HIV transmission (56). Alonzo reported misconceptions about disease transmission and poor knowledge about a disease would be a cause for stigma associated with a disease (6). The result of the FGDs also stressed that the major reason for holding negative feelings, avoidant and stigmatizing attitude towards PLWHA is lack of knowledge about the ways through which HIV could not be transmitted. Similar results were also reported by other studies (6,18,21). Therefore, it could be possible to postulate that people who believe HIV could be transmitted through casual contact are more likely to stigmatize PLWHA than those who clearly know the ways through which it could not be transmitted do. The multivariate analysis indicated that belief about casual HIV transmission was significant determinant of respondent's attitude towards PLWHA. In

circumstances where people believe that HIV could be transmitted through casual contact, they would become fearful of any contact with infected people. In addition, any one who may have been in contact with a person with HIV or AIDS would be considered as a threat and may thus be discriminated against. This further results in deepening the stigma and widening the existing gap between PLWHA and the “normal” community.

The present study indicated significant association between gender and stigmatizing attitude towards PLWHA. A Meta analysis conducted to evaluate gender and attitude towards PLWHA showed little association between gender and attitudes about HIV (57). Marked gender differences have also been reported in different studies (58,59,60). Available researches reported the relation of poor knowledge with stigmatizing attitudes. Therefore, it could be said that the fact that female hold more stigmatizing attitudes could be attributed to their lower knowledge and lower educational status compared to male respondents in the study area (50) However this was not significant in multivariate analysis.

Our present study indicated that illiteracy is significantly associated with stigmatizing attitude. The multivariate analysis also indicated education as significant negative predictor of stigmatizing attitude (as one goes from illiterate to literate, stigmatizing attitude decreases). Although various studies reported relationship of educational status with anti-permissive attitudes towards PLWHA, these results are not consistent. Horsman reported relationship between level of education and knowledge of HIV/AIDS, but this does not strongly affected HIV relevant attitudes (61). Positive correlation between knowledge and attitudes towards and perceived confidence in caring for an HIV infected individuals was also reported. More knowledgeable community health workers have been shown to regard

PLWHA more positively and be more willing to treat them. However, no relationship was found between knowledge of and attitudes towards AIDS in study of medical students (55). It can perhaps be said that discussion about HIV/AIDS and related issue in formal education, eagerness to read and access to different information sources and involvement in anti-AIDS clubs at schools could be a reason for holding favorable attitude towards PLWHA.

Finding of the present study has indicated more than a quarter (25.8%) of the respondents feel that PLWHA are persons to be afraid of and less a quarter (22.7%) of them as feel angry with them. The threat of such negative feeling towards PLWHA is significant obstacle to progress in HIV prevention. It also indicates the extent of stigma attached to HIV and to its victims. In multivariate analysis, negative feeling towards PLWHA was associated with poor knowledge about HIV/AIDS and levels of education. Thus, increasing HIV knowledge of the public and expanding the same at lower formal education level would improve the feeling of the public towards PLWHA.

In our present study, an indication for support for hypothetical coercive AIDS related policy was evidenced. More than a third (35.9%) of the respondents reported that PLWHA should be separated from the public so that they will not infect “others” and similar proportion (35.5%) of them reported that names of PLWHA should be made public so that other could avoid them. This might indicate the stigma, fear and discrimination related to HIV and PLWHA. In the presence of such anti permissive attitude, those PLWHA who

disclose their HIV status might be stigmatized and discriminated. It also indicates that people would support any restrictive and forceful policy regarding PLWHA. This could infact be and indication of the challenge related to HIV prevention as the community is distancing from PLWHA.

In addition, more than half of the respondents think PLWHA should not be trusted. Such labeling of PLWHA as mistrusted individuals may be associated with a common misclassification of them according to their lifestyle and behavior, commonly promiscuity. In different studies (36,59), respondents considered AIDS as being a result of promiscuity and that married individual are not at risk of acquiring HIV. Nearly half of the respondents and FGD participants believed that PLWHA who got the infection through sex deserve the disease. Such blaming may however creates obstacle in overcoming the epidemic by avoiding those who harbor the disease to disclose their status and subsequently take appropriate preventive measures. More than one third of the study subjects believed that people got HIV because of their failure to control their behaviors and feelings. In another study, it was reported that respondents believed AIDS as easy to get if one's lifestyle is more promiscuous (59). This indicates that people believed HIV/AIDS as being a self-inflicted disease because it is peoples' own fault that they got AIDS. In general, victim blaming may lead to continued high incidence, as those who are really infected do not come forward, not identified, and therefore continue to transmit the virus.

Regarding respondent's intention to avoid PLWHA, the study revealed that more than a quarter of the study subjects would not like to send their children to school where one of the students was HIV positive to avoid contact with classmate and 11.2% of the

respondents said they would not want to work with PLWHA in the same office. Similar finding was also reported by different studies (21,36). Blendon reported that many respondents refused to work along side some one who had AIDS (36). Results from the FGDs of the present study also indicated that most respondent (both younger and older) hesitated to shop from a grocery where the shopkeeper was HIV positive and to be treated by a health worker who is known to be HIV positive. Therefore, it could be said that PLWHA are discriminated and would have loose social interaction if they disclose their HIV status to the public.

Most (60.4%) of the study subjects reported to keep HIV positive status of their family member secret. The results of the 2000 Demographic and Health Survey of Ethiopia (40) also reported similar finding. This could perhaps be related to fear of the consequences of disclosing the HIV positive status of the family member because of the stigma that would be resulted from being family member of a person who is HIV positive. Although result of the present study revealed that 93.1% of the respondents believed eating food together with someone with HIV/AIDS would not transmit the disease, only 15% of them showed their willingness to do so. This may indicate respondents' intention to avoid PLWHA from routine interactions in the family. Result from the multivariate analysis also indicated significant negative association between avoidant behavior and belief about casual transmission of HIV. This might indicate unwillingness of the public to have social interaction with PLWHA and their attempt to avoid them even though they believed these interactions carried no risk of transmitting the virus. Moreover, the result testified that people who disclose their HIV status would be avoided from social interaction even with

their friends and families. Thus, it would be important to emphasize about reducing stigma attached with HIV/AIDS in order to expand disclosure and control HIV epidemic.

When effects of other variables were controlled for potential confounding, result from the multivariable analysis of variance revealed that education, knowledge about HIV/AIDS, belief about casual transmission of HIV, and income were associated with stigmatizing attitude and retained their significance both in bivariate and multivariate analysis.

STRENGTH AND LIMITATIONS OF THE STUDY

Strength

There were no similar community based studies, which explored extent of stigma. Therefore, this study gives base line information concerning pervasiveness of social stigma attached to HIV/AIDS and PLWHA in an urban community. Use of the quantitative and qualitative methods of data collection in such type of study where responses might be compromised by the stigma itself could be sited as strength of the study. The sample size, sampling procedure and analysis methods utilized were appropriate to the study and considered as one of the strength of the study.

Limitations

The study suffers form all the limitations pertaining to all cross sectional studies. The major drawback of the study was that since the study was compromised by the stigma itself, respondents might not report their genuine attitude towards a given question. Moreover, the investigator could not be sure whether the responses given to the stigma variables are heartily and realistic to the real situation. The study therefore, could be confounded by social desirability biases. Paucity of similar studies in this area also has made comparison of the result difficult. In addition, since it was not possible to get informants to discuss the issue of stigma and discrimination with or to make an in-depth interview with the actual victims of the problem (PLWHA) the conclusions made should be considered with precautions.

CONCLUSION AND RECOMMENDATION

CONCLUSIONS

Majority of the respondents in the present study had sufficient awareness about HIV/AIDS. There were, however, misconceptions about HIV transmission through casual contact. Widespread stigma attached to HIV/AIDS was indicated in the community, which was manifested by intentions of avoiding PLWHA, blaming them for acquiring the infection, showing negative feeling towards them, and supporting coercive AIDS related policies. Because of this, only few people disclosed their HIV status to the public. Level of education, knowledge about HIV/AIDS, belief about casual transmission of HIV, and income were significant determinants of people's attitude towards PLWHA. However, any single determinant (for example knowledge alone) is not adequate to influence people's attitude towards PLWHA. Activities related to HIV/AIDS prevention were not adequate in bringing behavioral changes and overcoming the stigma. Presence of pervasive stigma in the present study indicated the need for public awareness and strengthening mechanisms to support PLWHA who disclose their status to challenge the repercussion that may follow disclosure.

RECOMMENDATIONS

1. Programs that are targeted to prevent the HIV/AIDS epidemic, such as VCT should address the issue of stigma and discrimination by tackling the problem by acting up on the determinants that are identified in this study.

2. Since knowing PLWHA favors HIV related knowledge, despite pervasive stigma attached to HIV/AIDS in the study area PLWHA should be encouraged to disclose their status and to teach at different settings (schools, churches, mosques, public gatherings etc,). Governmental and non-governmental organizations should provide social and economic support for those who may be subjected for stigmatization.

3. Institutions working towards prevention of the HIV epidemic and those working with PLWHA should target their IEC program at increasing awareness in general and advocating ways through which HIV could not be transmitted in specific so as to reduce fear and misconceptions attached to HIV/AIDS there by the stigma and discrimination.

4. Further studies, to build knowledge about stigma and discrimination and its determinants in specific population groups should be encouraged.

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ANNEX 1 Survey questionnaire (English version)

Addis Ababa University, Medical Faculty Department o f Community Health.

Survey Questionnaire on

Social stigma attached to HIV/AIDS and its determinants in urban community.

001. Questionnaire Identification number __/__/__ House Number _____

002. City _____003. Region _____004. Kebele _____

Introduction:

My name is _____. I am working for a thesis research project conducted in collaboration of the Addis Ababa University and Alemaya University. We are interviewing people in Diredawa town in order to find out what people feel about HIV/AIDS in urban community.

Confidentiality and consent:

" I am going to ask you some very personal questions that some people find difficult to answer. Your name will not be written on this form, and will never be used in connection with any of the information you tell me. You do not have to answer any questions that you do not want to answer, and you may end this interview at any time you want to. However, your honest answers to these questions will help us better understand what people think, say and do about certain kinds of behaviors. We would greatly appreciate your help in responding to this survey. The survey will take about 40 minutes to ask the questions."

Would you be willing to participate? (Indicate by ticking the appropriate response)

Yes _____No _____

Signature of interviewer certifying verbal informed consent _____

Interviewer visit

	Visit 1	Visit 2	Visit 3
Date			
Interviewer			
Result			

Result codes: 1. Completed 2. Respondent not available 3. Refused
4. Partially completed 5. Others

005. Interviewer: Code __/__/ Name _____

006. Date of interview ___/___/___ Time _____

007. Checked by supervisor: Signature _____ day _____ month_____year

1 SOCIO -DEMOGRAPHIC VARIABLES (circle one)			
No	Questions	Suggested option for the questions	Skip
101	How old are you? (Enter in the space)	_____ Years	
102	When were you born?	Year_____Month _____ Day __	
103	What is the sex of the respondent? Don't ask this question	1. Male 2. Female	
104	For how long have you lived in this town	_____	
105	Have you ever-attended school?	1.Yes ⟶ 2. No ⟶ 3. No response	106 107
106	What is the highest level of school you completed? (Enter in the space)	_____	
107	What is your current occupation?	1 Unemployed 2. Civil servant 3. Student 4. House wife 5. Private worker 6 Pensioned 7. Others, Specify _____	
108	What is your average monthly income? (Enter in the space)	_____	
109	What is your marital status?	1. Never married 2. Currently married 3. Divorced/separated/widowed 4. No response	
110	How many are you in your family? (Enter in the space)	_____	
111	How many children do you have? (Enter in the space)	_____	

112	To which ethnic group do you belong?	1. Oromo 2. Amhara 3. Adere 4. Somali 5. Gurage 6. Others, specify___	
113	Which religion are you following?	1. Orthodox 2. Other Christianity 3 Muslim 4. No religion 5. Others, specify _____ 6. No response	
114	Do you attend religious ceremonies?	1. Yes ⟶ 2. No ⟶ 3. No response	115 116
115	How frequently do you attend religious events?	1. Daily 2. Weekly 3. Monthly 4. Irregularly 5. Others, specify _____	
116	Are you member of any organization working for the HIV control and or well being of people living with HIV/AIDS including anti-AIDS clubs?	1. Yes 2. No 3. No response	

Part Two: - Knowledge about HIV/AIDS transmission

II. Knowledge about HIV/AIDS			
201	Have you ever heard about a disease called AIDS?	1. Yes 2. No 3. No response	
202	Do you know anyone who is infected with HIV?	1. Yes → 2. No → 3. No response →	203 204 204
203	How many such people do you know? (Enter in the space)	1. I know _____people 2. No response	
204	Do you know some one died with HIV/AIDS?	1. Yes → 2. No → 3. No response →	205 206 206
205	How many such people do you know? (Enter in the space)	1. I know_____ people 2. No response	
206	Can one get AIDS by shaking hands of people living with HIV or /AIDS?	1. Yes 2. No 3. Don't Know 4. No response	
207	Can a healthy looking person be infected with HIV?	1. Yes 2. No 3. Don't Know 4. No response	
208	Can a person who looks healthy but has the HIV, pass it to another person?	1. Yes 2. No 3. Don't Know 4. No response	
209	Can a person get HIV by getting injection with a needle that was used by someone else?	1. Yes 2. No 3. Don't Know 4. No response	
210	Can a person get AIDS by having sex with someone who has the AIDS virus?	1. Yes 2. No 3. Don't Know 4. No response	
211	Can a person get AIDS by donating blood?	1. Yes 2. No 3. Don't Know 4. No response	
212	Can a person get AIDS by wearing clothes used by someone who has the HIV?	1. Yes 2. No 3. Don't Know 4. No response	

213	Can a pregnant woman who is infected with HIV or AIDS transmit the virus to her unborn child?	1. Yes 2. No 3. Don't Know 4. No response	
214	Can a woman with HIV /AIDS transmit the virus to her infant through breast-feeding?	1. Yes 2. No 3. Don't Know 4. No response	
215	Can AIDS be cured?	1. Yes 2. No 3. Don't Know 4. No response	
216	Can a person get HIV from mosquito bite, which has already fed on a person with AIDS?	1. Yes 2. No 3. Don't Know 4. No response	
217	Can the chances of being infected by HIV be reduced by having sex with only one faithful partner?	1. Yes 2. No 3. Don't Know 4. No response	
218	Does having many sexual partners increase a person's risk of being infected with HIV?	1. Yes 2. No 3. Don't Know 4. No response	
219	Can people protect themselves from HIV, by using a condom correctly every time they have sex?	1. Yes 2. No 3. Don't Know 4. No response	
220	Can people protect themselves from HIV by abstaining from sexual intercourse?	1. YES 2. No 3. Don't Know 4. No response	
221	Can people protect themselves from HIV by having one uninfected faithful sex partner?	1. Yes 2. No 3. Don't Know 4. No response	
222	Once infected with HIV, can a person infect others for the rest of his/her life?	1. Yes 2. No 3. Don't Know 4. No response	
223	If a person take an HIV test and found to be negative, does it means that you cannot get AIDS in the future?	1. Yes 2. No 3. Don't Know 4. No response	

3. BELIEF ABOUT HIV TRANSMISSION THROUGH CASUAL CONTACT (circle one)			
	These next questions are about the different ways some people think AIDS might be spread. As I read each of the following, please tell me how likely you think it is that a person could get AIDS or HIV in that way.		
301	Kissing someone who has HIV on the cheek	1. Very likely 2. Some what likely 3. Not sure 4. Very unlikely 5. Impossible	
302	Sharing drinking glass with person who is known to have AIDS.	1. Very likely 2. Some what likely 3. Not sure 4. Very unlikely 5. Impossible	
303	Sharing toilet with a person with AIDS.	1. Very likely 2. Some what likely 3. Not sure 4. Very unlikely 5. Impossible	
304	Mosquito or other insect bites	1. Very likely 2. Some what likely 3. Not sure 4. Very unlikely 5. Impossible	
305	Being coughed at or sneezed on by a person with HIV	1. Very likely 2. Some what likely 3. Not sure 4. Very unlikely 5. Impossible	
306	Sharing a meal with someone who is infected with HIV, would you say if someone does that they are:	1. Very likely 2. Some what likely 3. Not sure 4. Very unlikely 5. Impossible	

Part 4 STIGMA ITEMS			
4.1	**Feeling:** People have many different feelings when they think about people who have AIDS. As I read each of the following feelings, please tell me how you personally feel. (Circle one)		
401	Would you say you feel angry with them?	1. Very angry 2. Some what 3. Not sure 4. Little 5. Not at all	
402	Would you say you feel afraid of them?	1. Very angry 2. Some what 3. Not sure 4. Little 5. Not at all	
403	Would you say you feel disgusted by them?	1. Very angry 2. Some what 3. Not sure 4. Little 5. Not at all	
4.2	**Support for Coercive hypothetical AIDS related policies:** .Now I am going to read list of statements people have made. As I read each one, please tell me how much you agree or disagree. (Circle one)		
404	People with AIDS should be legally Separated from others to protect public health.	1. Strongly agree 2. Agree 3. Not sure 4. Disagree 5. Strongly disagree	
405	The names of people with AIDS should be made public so that others can avoid them	1. Strongly agree 2. Agree 3. Not sure 4. Disagree 5. Strongly disagree	
406	People with HIV, a virus that cause AIDS, must expect some restriction on their rights	1. Strongly agree 2. Agree 3. Not sure 4. Disagree 5. Strongly disagree	
407	People with HIV, a virus that cause AIDS, should not have child	1. Strongly agree 2. Agree 3. Not sure 4. Disagree 5. Strongly disagree	

4.3	**Blaming a person with HIV/AIDS for acquiring the infection (circle one)**		
408	People who got AIDS through sex or drugs have gotten what they deserve	1. Strongly agree 2. Agree 3. Not sure 4. Disagree 5. Strongly disagree	
409	Most people become HIV positive by being weak-willed or foolish.	1. Strongly agree 2. Agree 3. Not sure 4. Disagree 5. Strongly disagree	
410	People with HIV are not to be trusted.	1. Strongly agree 2. Agree 3. Not sure 4. Disagree 5. Strongly disagree	
4.4	**Avoidant behavioral intention (circle one)**		
411	Would leave your young child in the same school or send him to another school if one of the students attending school with him was known to have HIV?	1. Leave him in the same school 2. Send him to another school 3. I am not sure 4. No response	
412	Would you be willing to continue your friendship if you learn that your close friend had HIV/AIDS?	1. Yes 2. No 3. I am not sure 4. No response	
413	Would you be willing to work with your colleague in the same office if you knew that he/she had HIV/AIDS?	1. Yes 2. No 3. I am not sure 4. No response	
414	Suppose you found out that the owner of a neighborhood grocery store where you like to shop had HIV, would you continue to shop there or go some place else to shop?	1. Continue to shop there 2. Go some place else 3. Don't know 4. No response	

415	If relative of yours became ill with the HIV, would you be willing to care for her in your household?	1. Yes 2. No 3. I am not sure 4. No response
416	If a member of your family became sick with HIV, would you want it to keep it secret?	1. Yes 2. No 3. I am not sure 4. No response
417	If a female teacher has HIV but is not sick, should she be allowed to continue aching?	1. Yes 2. No 3. I am not sure 4. No response
418	Would you be willing to share meal with a person you knew had HIV or AIDS?	1. Yes 2. No 3. I am not sure 4. No response

This is the end of our questions. Thank you again for giving us your time to respond to our questionnaire.

ANNEX 2 Amharic version of the questionnaire

በአዲስ አበባ ዩኒቨርስቲ የህክምና ፋኩልቲ
የህብረተሰብ ጤና የትምህርት ክፍል
ከኤች አይ ቪ ኤድስ ጋር በተያየዘ ህብረተሰቡ ለበሽታውና ቫይረሱ በደማቸው ውስጥ ስለሚገኝ ሰዎች ያለውን አመለካከት ለማጥናት የተዘጋጀ መጠይቅ።

001- **የመጠይቁ መለያ ቁጥር** ----------/---------- **የቤት ቁጥር** .....

002 **መጠይቁ የተካሄደበት ከተማ** ----------
003 **መጠይቁ የተካሄደበት ክልል** ----------
004 **መጠይቁ የተሞላበት ቀበሌ** ----------

<u>መግቢያ፤</u> **እራስን ለማሥተዋወቅ ይህንን አንቀፅ አንብብ/ቢ**

እኔ ስሜ ---------- **ይባላል። የመጣሁት ከድሬዳዋ አስተዳደር ካውንስል ሲሆን የመጣሁበት ምክ ንያትም በአዲስ አበባ ዩኒቨርስቲ እና በአለማያ ዩኒቨርሲቲ ትብብር በመሰራት ላይ ላለው ሳይንሳዊ ጥናት መረጃ ለመሰብሰብ ነው። የጥናቱ ዋና ዓላማ ህብረተሰቡ ስለ ኤች.አይ.ቪ. ኤድስ በሽታና ቫይረሱ ጋር ስለሚኖሩ ሰዎች ያለውን አመለካከት በማጥናት ለሚመለከታቸው ክፍሎች መረጃ ለመስጠት ነው።**

<u>የስምምነት ማረጋገጫ</u>
እኔ በዚህ ቃለ መጠይቅ ውስጥ አንዳንድ ጥያቄዎችን አቀርብልዎታለሁ። ከጥያቄዎቹ መካከል አንዳንዶቹ የግል ህይወትዎን የሚመለከቱ ሊሆኑ ይችላሉ። አንዳንዶቹም ጥያቄዎች መልስ ለመስጠት የሚያስቸግርዎ ሊሆኑ ይችላሉ። ሆኖም ግን በዚህ ቃለ መጠይቅ ላይ ትክክል ወይም ስህተት የሚባል መልስ የለም። ። በመረጃ መሰብሰቢያው ቅፅ ላይ ስምዎ በምንም አይነት አይጠቀስም። እንዲሁም ከተገኘው መረጃ ጋር በተያየዘ ለማንም በምንም ሁኔታ አይገለፅም። በቃለ መጠይቁ ወቅት መልስ ሊሰጡባቸው ያልፈለጓቸውን ጥያቄዎች አለመመለስ መብትዎ ነው። በተጨማሪም ቃለ ምልልሱ እንዲቋረጥ በፈለጉ በማንኛውም ጊዜ ማቋረጥ ይችላሉ። ሆኖም በእርስዎ የምናገኘው ትክክለኛ መረጃ በጥናታችን መጨረሻ ማወቅ ስለምንፈልገው ግኝት ከፍተኛ ጠቀሚታ ያለው መሆኑን ልንገልፅልዎ እንወዳለን። ቃለ ምልልሱን ለመፈፀም የሚፈጀው 40 ደቂቃዎችን ነው።

የሚቀርቡልዎትን ጥያቄዎች ለመመለስ ፈቃደኛ ነዎት? (ይህንን ምልክት "✓" በማድረግ አመልክት)
አዎን ---------- **አይደለሁም** ----------

ፈቃደኛነትን ያረጋገጠው መረጃ ሰብሳቢ ስምና ፊርማ
ስም ---------- **ፊርማ** ---------- **ቀን**.....

<u>የመረጃ ሰብሳቢው የጉብኝት ሰሌዳ</u>

	ጉብኝት 1	ጉብኝት 2	ጉብኝት 3
ቀን			
መረጃ ሰብሳቢ			
ውጤት			

	ጉብኝት 1	ጉብኝት 2	ጉብኝት 3

ውጤት ። 1 የተጠናቀቀ 2 ተጠያቂው አልተገኘም 3 የተቃወመ 4 በከፊል የተመለሰ 5 ሌላ

005 የመረጃ ሰብሳቢው መለያ ቁጥር _____

006 ቃለ ምልልሱ የተሞላበት ቀን _____ወር_____ ዓ.ም_____ ሰአት_____

007 ትክክለኛነቱን ያረጋገጠው ተቆጣጣሪ

ፊርማ_____ቀን _____ወር__ ዓ.ም___

ክፍል አንድ ። አጠቃላይ የተጠያቂው መረጃ ። (አንዱን በመክበብ አሳይ)

ተቁ	መጠይቅ	አማራጭ መልስ	ዝለል
101	እድሜዎ ስንት ነው ?	_____	
102	መቼ ተወለዱ ? (በተሰጠው ክፍት ቦታ ላይ ይሞላ)	ዓ.ም ---------- ወር ---------- ቀን ----	
103	የተጠያቂው ፆታ ምንድነው ? (ይህ ንን ጥያቄ አትጠይቅ)	1 ወንድ 2 ሴት	
104	ለምን ያህል ጊዜ እዚህ አገር ኖረዋል ? (በተሰጠው ክፍት ቦታ ላይ ይሞላ)	አመት ---------- ወር ---------- ቀን----------	
105	ትምህርት ተምረዋል ?	1 አዎን _____ 2 አልተማርኩም _____ 3 መልስ የለኝም	106 107
106	ያጠናቀቁት ከፍተኛ የትምህርት ደረጃ ስንት ነው? (በተሰጠው ክፍት ቦታ ላይ ይሞላ)	_____	
107	የመተዳደሪያ ስራዎ ምንድነው ?	1 ምንም ስራ የለኝም 2 የመንግስት ተቀጣሪ 3 ተማሪ 4 የቤት እመቤት 5 በግል ስራ ላይ የተሰማራ 6 ጡረተኛ 7 ሌላ ከ ሆነ ይጠቀስ _____	
108	የወር ገቢዎ በአማካይ ስንት ብር ነው?	_____	

ተቁ	መጠይቅ	አማራጭ መልስ	ዝለል
	(በተሰጠው ክፍት ቦታ ላይ ይሞላ)		
109	የጋብቻ ሁኔታ	1 ያላገባ 2 ባለትዳር 3 የተለያዩ / የተፋቱ 4 ባለቤትዋ የሞተች / የሞተ 5 መልስ የለኝም	
110	የቤተሰብዎ ቁጥር ስንት ነው ?	_____	
111	ስንት ልጆች አለዎት?(የወለዱአቸው)	_____	
112	የየትኛው ብሄረሰብ አባል ነዎት?	1 ኦሮሞ 3 አደሬ 2 አማራ 4 ጉራጌ 5 ሱማሌ 6 ሌላ ከሆነ ይጠቀስ_____ 7 መልስ የለኝም	
113	የየትኛው ሀይማኖት ተከታይ ነዎት?	1 ኦርቶዶክስ ክርስትና 2 ሌላ ክርስትና 3 እስልምና 4 ሀይማኖት የለኝም 5 ሌላ ከ ሆነ ይጠቀስ_____ 6 መልስ የለኝም	
114	የሀይማኖት ፕሮግራሞችን ይከታተላሉ ?	1 አዎን_____ 2 አልከታተልም_____ 3 መልስ የለኝም	115 116

115	የሀይማኖት ፕሮግራሞችን በየምን ያህል ጊዜ ይከታተላሉ ?	1 በየቀኑ 2 በየሳምንቱ 3 በየወሩ 4 ባልተወሰነ ጊዜ 5 ሌላ ካለ ይጠቀስ_____ 6 መልስ የለኝም	
116	ከኤድስ አምጪው ቫይረስ (ኤች.አይ.ቪ.) ጋር ለሚኖሩ ሰዎች እንክብካቤ ከሚያደርጉ ድርጅቶች ጋር በአባልነት ይሰራሉ? (የፀረ ኤድስ ክበባትንም ይጨምራል)	1 አዎን 2 አልሰራም 3 መልስ የለኝም	

ክፍል ሁለት ፤ ስለ ኤድስ አምጪው ቫይረስ (ኤች.አይ.ቪ.) እና ኤድስ ያለውን ግንዛቤ በተመለከተ

201	ኤድስ ተብሎ ስለሚጠራው በሽታ ሰምተው ያውቃሉ ?	1 አዎን 2 አላውቅም 3 መልስ የለኝም	
202	በኤድስ አምጪው ቫይረስ (ኤች አይ ቪ) የተጠቃ ሚያውቀት ሰው አለ?	1 አዎን——— 2 የለም——— 3 መልስ የለኝም	203 204 204
203	ስንት የዚህን አይነት ሰዎች ያውቃሉ? (በተሰጠው ክፍት ቦታ ላይ ቁጥር ይሞላ)	1 ——— ሰው አዉቃለሁ 2 መልስ የለኝም	
204	በኤድስ አምጪው ቫይረስ (ኤች.አይ.ቪ.) የሞተ ሰዎች ያውቃሉ ?	1 አዎን——— 2 አላዉቅም——— 3 መልስ የለኝም	205 206 206
205	ስንት የዚህን አይነት ሰዎች ያውቃሉ ? (በተሰጠው ክፍት ቦታ ላይ ቁጥር ይሞላ)	1 ——— ሰው አዉቃለሁ 2 መልስ የለኝም	
206	አንድ ጤነኛ ሰው የኤድስ አምጪው ቫይረስ (ኤች.አይ.ቪ.) በደሙ ውስጥ ያለበትን ሰው እጅ ቢጨብጥ በሽታው ወደጤነኛው ሰው ሊተላለፍ ይችላል ?	1 አዎን 3 አላውቅም 2 አይችልም 4 መልስ የለኝም	
207	ጤነኛ የሚመስሉ ሰዎች የኤድስ አምጪው ቫይረስ (ኤች.አይ.ቪ.) ሊኖርባቸው ይችላል?	1 አዎን 2 አይችልም 3 አላውቅም 4 መልስ የለኝም	
208	ጤነኛ የሚመስሉ ሰዎች የኤድስ አምጪው ቫይረስ (ኤች.አይ.ቪ.) ቢኖርባቸው ቪይረሱን ለሌላ ሰው ሊያስተላልፉ ይችላሉ?	1 አዎን 3 አላውቅም 2 አይችሉም 4 መልስ የለኝም	
209	አንድ ሰው ሌላ ሰው በተወጋበት የመድሀኒት መስጫ መርፌ ቢወጋ የኤድስ አምጪው ቫይረስ (ኤች.አይ.ቪ.) ሊይዘው ይችላል?	1 አዎን 3 አላውቅም 2 አይችሉም 4 መልስ የለኝም	

210	ሰዎች የኤድስ አምጪው ቫይረስ (ኤች.አይ.ቪ.) በደማቸው ውስጥ ካለ ሰዎች ጋር የግብረ ስጋ ግንኙነት ቢያደርጉ በበሽታው ሊያዙ ይችላሉ ?	1 አዎን 3 አላውቅም 2 አይችሉም 4 መልስ የለኝም	

211	አንድ ሰው ደም በመለገሱ የኤድስ አምጪው ቫይረስ (ኤች.አይ.ቪ.) ሊይዘው ይችላል?	1 አዎን 3 አላውቅም 2 አይችልም 4 መልስ የለኝም
212	አንድ ሰው የኤድስ አምጪው ቫይረስ (ኤች.አይ.ቪ.) ያለበትን ሰው ልብስ ቢለብስ በቫይረሱ ሊያዝ ይችላል?	1 አዎን 3 አላውቅም 2 አይችልም 4 መልስ የለኝም
213	አንዲት በደምዋ ውስጥ የኤድስ አምጪው ቫይረስ (ኤች.አይ.ቪ.) ያለ ነፍሰጡር ሴት ቫይረሱን ለፅንሱ ልታስተላልፍ ትችላለች?	1 አዎን 3 አላውቅም 2 አትችልም 4 መልስ የለኝም
214	አንዲት በደምዋ ውስጥ የኤድስ አምጪውን ረስ (ኤች.አይ.ቪ.) ያለ አራስ ልጅዋን ጡት ብታጠባ ቫይረሰን በጡትዋ ወተት አማካይነት ለልጅዋ ልታስተላልፍ ትችላለች?	1 አዎን 3 አላውቅም 2 አትችልም 4 መልስ የለኝም
215	የኤድስ በሽታ ፈዋሽ መድሀኒት አለው ?	1 አዎን 3 አላውቅም 2 የለዉም 4 መልስ የለኝም
216	አንድ ሰው በኤድስ በሽታ የተያዘን ሰው በነደፈች የወባ ትንኝ ቢነክስ ቫይረሱ ሊተላለፍበት ይችላል?	1 አዎን 3 አላውቅም 2 አይችልም 4 መልስ የለኝም
217	ክአንድ ክሚተማመኑባት/በት ሰው ጋር ብቻ የግብረ ስጋ ግንኙነት በመፈፀም በኤድስ አምጪው ቫይረስ (ኤች.አይ.ቪ.) የመጠቃት እድልን መቀነስ ይቻላል?	1 አዎን 3 አላውቅም 2 አይቻልም 4 መልስ የለኝም
218	አንድ ሰው ክአንድ በላይ የወሲብ ጓደኞች ቢኖሩት (ቢኖሩአት) በኤድስ አምጪው ቫይረስ (ኤች.አይ.ቪ.) የመጠቃት እድሉ/ልዋ ክፍ ሊል ይችላል?	1 አዎን 3 አላውቅም 2 አይችልም 4 መልስ የለኝም
219	ሰዎች ሁል ጊዜና በአግባቡ የግብረስጋ ግንኙነት ሲፈፅም ኮንዶም (በወንድ ብልት ላይ የሚጠለቅ ላስቲክ) በመጠቀም እራሳቸውን በኤድስ አምጪው ቫይረስ (ኤች.አይ.ቪ.) ሊጠብቁ ይችላሉ?	1 አዎን 3 አላውቅም 2 አይችሉም 4 መልስ የለኝም
220	ሰዎች ክግብረ ስጋ ግንኙነት በመታቀብ እራሳ ቸውን ክኤድስ አምጪው ቫይረስ (ኤች.አይ.ቪ.)	1 አዎን 2 አይችሉም 3 አላውቅም 4 መልስ የለኝም

	ሊጠብቁ ይችላሉ?	
221	ሰዎች ክአንድ(ክአን(ዲት) ክሚተማመኑበት(ባት) ጓደኞቸው ጋር ብቻ የግብረ ስጋ ግንኙነት በመፈፀም እራሳቸውን ክኤድስ በሽታ ሊጠብቁ ይችላሉ?	1 አዎን 3 አላውቅም 2 አይችሉም 4 መልስ የለኝ ም
222	አንድ ሰው በኤድስ አምጪው ቫይረስ (ኤች አይቪ) ክተጠቃ ቀሪ ህይወቱን በሙሉ ቫይረሱ ን ለሌሎች ሊያስተላልፍ ይችላል?	1 አዎን 3 አላውቅም 2 አይችልም 4 መልስ የለኝ ም
223	አንድ ሰው የኤድስ አምጪው ቫይረስ (ኤች.አይ.ቪ.) በደሙ ውስጥ እንዳለና እንደሌለ ለማወቅ ምርመራ ቢያደርግና ቫይረሱ በደሙ ውስጥ እንደሌለ ቢረጋገጥ ይህ ሰው በሌላ ጊዜ ቫይረሱ ሊይዘው አይችልም ማለት ነው ?	1 አዎን 3 አላውቅም 2 አይደለም 4 መልስ የለኝ ም

ክፍል ሶስት፤ የኤድስ አምጪው ቫይረስ (ኤች.አይ.ቪ.) በእለት ተእለት ግንኙነት አማካኝነት መተላለፉን በተመለከተ የቀረበ። (አንዱን በመክበብ አሳይ)

301	የኤድስ ህመምተኛ የሆነን ሰው ጉጩ ላይ በመሳም	1 በከፍተኛ ሁኔታ ይተላለፋል 2 ይተላለፋል 3 ሊተላለፍም ላይተላለፍም ይችላል 4 አይተላለፍም 5 በጭራሽ አይተላለፍም
302	የኤድስ ህመምተኛ የሆነ ሰው የተጠቀመበትን የውሀ መጠጫ ብርጭቆ በጋራ በመጠቀም	1 በከፍተኛ ሁኔታ ይተላለፋል 2 ይተላለፋል 3 ሊተላለፍም ላይተላለፍም ይችላል 4 አይተላለፍም 5 በጭራሽ አይተላለፍም
303	የኤድስ ህመምተኛ ከሆነ ሰው ጋር መፀዳጃ ቤትን በጋራ በመጠቀም	1 በከፍተኛ ሁኔታ ይተላለፋል 2 ይተላለፋል 3 ሊተላለፍም ላይተላለፍም ይችላል 4 አይተላለፍም 5 በጭራሽ አይተላለፍም
304	በወባ ትንኝና በሌሎች ተናዳፊ ነፍሳት አማካኝነት	1 በከፍተኛ ሁኔታ ይተላለፋል 2 ይተላለፋል 3 ሊተላለፍም ላይተላለፍም ይችላል 4 አይተላለፍም 5 በጭራሽ አይተላለፍም
305	የኤድስ ህመምተኛ የሆነ ሰው ቢያነጥስብዎና ቢስልብዎ	1 በከፍተኛ ሁኔታ ይተላለፋል 2 ይተላለፋል 3 ሊተላለፍም ላይተላለፍም ይችላል 4 አይተላለፍም 5 በጭራሽ አይተላለፍም
306	የኤድስ ህመምተኛ ከሆነ ሰው ጋር አብሮ ምግብ በመመገብ	1 በከፍተኛ ሁኔታ ይተላለፋል 2 ይተላለፋል 3 ሊተላለፍም ላይተላለፍም ይችላል 4 አይተላለፍም 5 በጭራሽ አይተላለፍም

ክፍል አራት፤ የኢድስ ህመማንንና የኢድስ አምጪው ቫይረስ (ኤች አይ ቪ) በደማቸው ውስጥ የሚገኝ
ሰዎችን ማግለልና መፀየፍን በተመለከተ የቀረበ

4ቸ1	**የተለያዩ ሰዎች የኢድስ ህመማንንና የኢድስ አምጪው ቫይረስ (ኤች.አይ.ቪ.) በደማቸው ውስጥ የሚገኝ ሰዎችን በተመለከተ የተለያዩ አመለካከቶች አሉአቸው። እኔ ከዚህ በመቀጠል እነዚህን አመለካ ከቶች ሳነብልዎት እርስዎ በግልዎ ምን እንደሚሰማዎት ይገልፁልኛል።**		
401	**በደማቸው ውስጥ የኢድስ አምጪው ቫይረስ (ኤች.አይ.ቪ.) ባለባቸው ሰዎች መናደድን በተመለከተ ያለዎት ስሜት ም ንድነው?**	1 በጣም ያናድዱኛል 2 ያናድዱኛል 3 ሀሳብ የለኝም 4 አያናዱኝም 5 በጭራሽ አያናድዱኝም	
402	**በደማቸው ውስጥ የኢድስ አምጪው ቫይረስ (ኤች.አይ.ቪ.) ያለባቸውን ሰዎች መጥላት በተመለከተ ያለዎት ስሜት ምን ድነው?**	1 በጣም ያስጠሉኛል 2 ያስጠሉኛል 3 ሀሳብ የለኝም 4 አያስጠሉችም 5 በጭራሽ አያስጠሉኝም	
403	**በደማቸው ውስጥ የኤድስ አምጪው ቫይረስ (ኤች.አይ.ቪ.) ያለባቸውን ሰዎች መፍራት በተመለከተ ያለዎት ስሜት ምን ድነው?**	1 በጣም እፈራቸዋለሁ 2 እፈራቸዋለሁ 3 ሀሳብ የለኝም 4 አልፈራቸውም 5 በጭራሽ አልፈራቸውም	
o	**የኢድስ አምጪው ቫይረስ (ኤች አይ ቪ) በደማቸው ውስጥ ያለባቸውን ሰዎች በተመለከተ የተለያዩ ሰዎች የሰጡአቸውን አስተያየቶች ቀጥዬ አነብልዎታለሁ። እርስዎ በእያንዳንዱ አረፍተነገር የቱን ያህል እንደሙስማሙና እንደማይስማሙ ይግለፁልኝ ።**		
404	**የኢድስ አምጪው ቫይረስ (ኤች.አይ.ቪ.) በደማቸው ውስጥ ያለባቸውን ሰዎች በህግ ከሌሎች ሰዎች በመለየት የሌሎች ሰዎችን ደህንነት መታደግ ያስፈልጋል**	1 በጣም እስማማለሁ 2 እስማማለሁ 3 እርግጠኛ አይደለሁም 4 አልስማማም 5 በጭራሽ አልስማማም	
405	**የኢድስ አምጪው ቫይረስ (ኤች.አይ.ቪ.) በደማቸው ውስጥ ያለባቸውን ሰዎች የስም ዝርዝር ህዝቡ እንዲያውቀው**	1 በጣም እስማማለሁ 2 እስማማለሁ 3 እርግጠኛ አይደለሁም 4 አልስማማም	

	በማድረግ በቫይረሱ ያልተጠቃው የህብረተሰብ ክፍል ከእነዚህን ሰዎች በመራቅ እራሱን ከቫይረሱ ሊከላከል ይገባዋል	አልስማማም 5 በጭራሽ አልስማማም	
406	የኤድስ አምጪው ቫይረስ (ኤች.አይ.ቪ.) በደማቸው ውስጥ ያለባቸው ሰዎች ከሌሎች ቫይረሱ ከሌለባቸው ሰዎች በተለየ ሁኔታ በአ ንዳንድ መብቶቻቸው ላይ ማእቀብ መደረግ አለበት	1 በጣም እስማማለሁ 2 እስማማለሁ 3 እርግጠኛ አይደለሁም 4 አልስማማም 5 በጭራሽ አልስማማም	
407	የኤድስ አምጪው ቫይረስ (ኤች.አይ.ቪ.) በደማቸው ውስጥ ያለ ሰዎች ልጆች እን ዳይወልዱ በህግ መ ከልከል አለባቸው	1 በጣም እስማማለሁ 2 እስማማለሁ 3 እርግጠኛ አይደለሁም 4 አልስማማም 5 በጭራሽ አልስማማም	

o	የኤድስ አምጪው ቫይረስ (ኤች.አይ.ቪ.) በደማቸው ውስጥ ያለባቸውን ሰዎች ስለበሽታው ተጠያቂ ስለማድረግ (አንዱን በመክበብ አሳይ)	
408	ልቅ በሆነ የግብረስጋ ግንኙነት አማካይነት በኤድስ በሽታ የተያዙ ሰዎች ቫይረሱ የያዛ ው በራሳቸው ጥፋት በመሆኑ በሽታው ይገባቸዋል	1 በጣም እስማማለሁ 2 እስማማለሁ 3 እርግጠኛ አይደለሁም 4 አልስማማም 5 በጭራሽ አልስማማም
409	ሰዎች በኤድስ አምጪው ቫይረስ (ኤች.አይ.ቪ.) የሚጠቁት በራሳቸውን ዝሀላልነትና ፍላጎታቸውን መግታት አለመቻል የተነሳ ነው	1 በጣም እስማማለሁ 2 እስማማለሁ 3 እርግጠኛ አይደለሁም 4 አልስማማም 5 በጭራሽ አልስማማም
410	በኤድስ አምጪው ቫይረስ (ኤች.አይ.ቪ.) የተጠቁ ሰዎች በምንም አይነት እምነት ሊጣልባቸው አይገባም	1 በጣም እስማማለሁ 2 እስማማለሁ 3 እርግጠኛ አይደለሁ 4 አልስማማም 5 በጭራሽ አልስማማም
4.4	በኤድስ አምጪው ቫይረስ (ኤች አይ ቪ) የተጠቁ ሰዎችን ስለማግለል	
411	የኤድስ አምጪው ቫይረስ (ኤች.አይ.ቪ.) በደሙ ውስጥ ያለ አንድ ተማሪ ሚማርበት ትምህርት ቤት ውስጥ የሚማር ልጅ ቢኖርዎ ልጅዎን በተባለው	1 እዚያው አስቀጥለዋለሁ 2 ሌላ ትምህርት ቤት አዛውረዋለሁ. 3 እርግጠኛ አይደለሁም 4 መልስ የለኝም

	ትምህርት ቤት ውስጥ ትምህርቱንእ ንዲቀጥል ያደርጋሉ ወይስ ሌላ ትምህርት ቤት ያዛውሩታል?	
412	የቅርብ ጓደኛዎ የኤድስ አምጪው ቫይረስ (ኤች.አይ.ቪ.) የተጠቁ መሆናቸውን ቢያውቁ የነበረዎትን ጓደኝነት ይቀጥሉበታል?	1 አዎን 3 አላውቅም 2 አልቀጥልም 4 መልስ የለኝም
413	በአንድ ቢሮ ውስጥ አብሮዎት የሚሰሩ ባልደረባዎ በኤድስ አምጪው ቫይረስ (ኤች.አይ.ቪ.) መጠቃታቸውን ቢያውቁ ከተባሉት ሰው ጋር በአንድ ቢሮ ውስጥ ለመስራት ፈቃደኛ ነዎት?	1 አዎን 2 አይደለሁ ም 3 አላውቅም 4 መልስ የለኝም
414	ለምግብ አገልግሎት የሚውል ጥሬ እቃ የሚገዙበት ግሮሰሪ(ሱቅ) ባለቤትየሆነ ደን በኛዎ በኤድስ አምጪው ቫይረስ (ኤች አይ ቪ) መጠቃታቸውን ቢያውቁ ከደንበኛዎ የምግብ ጥሬ እቃዎች መግዛትዎን ይቀጥላሉ?	1 አዎን 2 አልቀጥልም 3 አላወውቅም 4 መልስ የለኝም
415	ከቤተሰብዎ መካከል አንድ ሰው በኤድስ አምጪው ቫይረስ (ኤች.አይ.ቪ.) ቢጠቃ/ ብትጠቃ በቤትዎ ውስጥ ሊያስታምሙት/ ሚት ፈቃደኛ ነዎት?	1 አዎን 3 አላውቅም 2 አይደለሁም 4 መልስ የለኝም
416	ከቤተሰብዎ መካከል አንዱ በኤድስ አምጪው ቫይረስ (ኤች አይ ቪ) ቢጠቃ /ብትጠቃ መጠቃታቸውን ሌሎች እን ዳያውቁት በሚስጢር እንዲጠበቅ ይሻሉ?	1 አዎን 2 አልሻም 3 አላውቅም 4 መልስ የለኝም

417	በአንድ ትምህርት ቤት ውስጥ የምታስተምር መምህርት በደሟ ውስጥ የኤድስ አምጪው ቫይረስ (ኤች.አይ.ቪ.) ቢኖርባትና ሆኖም ግን የበሽታው ምልክት ባይታይባት መምህርትዋ ሚስተማሯን መቀጠል አለባት ይላሉ?	1 አዎን 3 አላውቅም 2 የለባትም 4 መልስ የለኝም
418	በደሙ ውስጥ የኤድስ አምጪው ቫይረስ (ኤች.አይ.ቪ.) ካለበት ሰው ጋር አብረው ምግብ ለመመገብ ፈቃደኛ ነዎት?	1 አዎን 2 የለም 3 አይደለሁም 4 መልስ የለኝ

ጥያቄያችንን እዚህ ላይ ጨርሰናል። ጊዜዎን ሰውተው ለጥያቄያችን መልስ በመስጠት ስለተባበሩን ከልብ
እናመሰግናለን።

Annex 2 Focus Group Discussion Topic Guide

Theme 1: Introduction

Would you introduce your names and from where you are for the participants. Let me start by the research team (Let the research team introduce their name, occupation. … Etc.)

Theme 2: Warm-up questions

- Would you tell us about HIV/ AIDS?
- What are the main modes of transmission? Ways of prevention? Who are affected most?

Theme 3: Community response to AIDS

- Have you ever seen PLWHA? Where? In what circumstance?
- What does People living with HIV mean to you? What impression do your colleagues, neighbors, etc.? What are they called in your community?
- What are your feelings towards people living with HIV/AIDS? What about your colleagues, neighbors etc?

Why do people living with HIV/AIDS do not come forward and disclose their HIV sero status? Suppose a person had HIV, should he or she disclose his/her HIV status? Why? Why not?

- Some people say that people living with HIV/AIDS should be legally separated from the public, some do not support this view. Which one do you favor? Why?
- Suppose the government has a plan to develop policies regarding people living with HIV, what should be included in the policy in relation to these people would you say?

Some people say that people living with HIV/AIDS be blamed for acquiring HIV/AIDS. What is your opinion in this regard?

- Suppose your son was attending a school where one of the children in the school is known to be HIV positive, would you allow your son to continue learning in the same school? Why or why not?
- What should the social interactions between people living with HIV/AIDS and those people who do not know their HIV sero status "normal" should look like? (For example teachers, shopkeepers, health workers, office workers etc.)
- How do the public treat people living with HIV/AIDS?

Probing statements include

Would you elaborate your idea a bit further?

Why? How? Have I grasped your point correctly?

Theme 4: Recommendations

So far, we have discussed about HIV/AIDS, PLWHA and community response to HIV/AIDS. Based on what we have discussed so far, what recommendations or suggestions would you make on HIV /AIDS its prevention and PLWHA.

We would like to thank each of you for giving your time to discuss on this important issue. We also appreciate all your comments.

Annex 3 Key findings from FGDs.

1. Knowledge or knowing people living with or died of AIDS

" We saw few people who are infected with HIV when they teach in public. However, they are

few 1-2. They look like ourselves and even physically look better than we are". (All age groups

and both sexes).

"We know lots of people who are said to die due to AIDS. The problem is that any one who is

sick, coughing and loosing weight dies, he or she will be considered to die of AIDS".

(25 years old male).

"In our community, if someone die of any disease after loosing weight or having cough, it is said

that the cause of death is AIDS. We know several people died in this way. (Male 50 years old)"

2. Reasons for refraining from disclosing ones HIV status:

"I personally am not willing to disclose my HIV status even if I know that I am HIV positive

because I want to maintain my social relationship with my friends". (Male 55 years old)

" PLWHA should disclose their HIV status to the public, after the public got adequate awareness

about the disease. Otherwise, they will be discriminated and isolated ” (female 18 years old)

“Currently, disclosure of HIV status is risky” (female 22 years old)

“Disclosure will result in discrimination from the social network” (female 52 years old)

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“PLWHA are discriminated and the community tries to avoid them as much as possible” (female

50 years old)

“I know a child whose both parents are said to die of AIDS, who has been labeled as victim of

AIDS. The implication was that his parents were prostitutes” (female 40 years old)

3. Community response to AIDS

“I don’t think knowing about HIV/AIDS alone is adequate to bring about behavioral change

especially to create supportive community to PLWHA” (male 30 years old)

“I can say our community at large discriminate PLWHA” (male 45 years old)

“Awareness creation is important but it is limited to few people who are selected at the kebele

level. There should be a network to address the issue at grass rot level” (male 28 years old)

“Not only human beings, even thin animals, now a days, are said to have HIV/AIDS” (male 55

years old)

“People who got HIV infection through injection or mother to child transmission should deserve

better care than those who got it by multiple sexual practice” (male 50 2 years old)

“Poor knowledge about transmission of HIV favors stigma and discrimination, in addition to long illness period, lack of treatment and vaccine” (male 18 years old)

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“There should be a continuous education of the public at the grass root level”

(women 53 years old) “There are people who do not believe even the existence of HIV” (male 58 years old)

4. Public attitude towards PLWHA

4.1. Feelings towards PLWHA

“As the disease is knocking every ones household, I feel there is improvement in accepting PLWHA.” (Male 60 years old)

4.2. Avoidant behavioral intention

“I don’t mind purchasing goods from a shop keeper whom I know have HIV”(Male 55 years old)

“I am not willing to be treated by a doctor whom I know have HIV”.” (Male 45 years old)

“If someone who is said to die of AIDS, I am not comfortable to prepare the body for burial because I am not sure whether the infection can be transmitted by dead body or not”

(Male 58 years old)

"I don't want to shop from a grocery where the shopkeeper is HIV positive"

(Female 24 years old)

"Those who got the infection through multiple sexual contact deserve the disease"

(Female 58 years old)

"Those people who have contact with many people should be avoided from their work to protect

the public from getting infection". (Female 60 years old)

"I will avoid having any contact with PLWHA because I am not sure whether they know

methods to avoid transmitting their disease to others" (female 55 years old)

"I am not willing to visit someone who is sick with HIV. If at all I have to go, I will sit

near the door side and stay for few minutes only. I do not want to eat or drink any thing from that house" (female 60 years old)

4.3. Blaming PLWHA for acquiring the infection

"Those people who are knowledgeable about HIV/AIDS and got the infection through multiple

sexual contact deserve the disease. For example, health personnel" (Female 50 years old)

"One woman infected with HIV has been dragged out of her home because of her HIV positive

status. I am not sure this would not occur in our community if someone who rented a house

were HIV positive. (Female 24 years old)

"Blaming PLWHA will aggravate the discrimination and stigma" (Female 20 years old)

"People who know better about HIV/AIDS provide better support an are to PLWHA" (Female 23years old)

4.4. Support for coercive AIDS related policies

The names of PLWHA should not be made public to avoid discrimination of these people.

Those who are courageous enough should teach the public" (Male 34 years old)

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"There shouldn't be any regulation regarding PLWHA as this may force them to take revenge

against the public. The solution is to council or teach them" (Male 45 years old)

Declaration

I, the undersigned, declared that this is my original work, had not been presented as a thesis work for a degree in this or any other university and that all sources of materials used for the thesis have been acknowledged.

Name Yared Kifle

Signature _____

Place Addis Ababa, Ethiopia

Date of Submission _____

This thesis has been submitted for examination with my approval as university advisor.

Name _____

Signature