An Assessment of Societal Outlook & Social Services for HIV/AIDS Patients: The Case of Addis Ketema Subcity, Addis Ababa.

By Worreta Assefa Addisu

Submitted To

Indra Gandhi National Open University (IGNOU) For Partial Fulfillment of

Master of Social Work (MSW) Degree in Social Work

Advisor: Abera Degefe (Phd Candidate)

Addis Ababa, Ethiopia

January, 2015

DECLRATION

I hereby declare that the desecration entitled **"An Assessments' of Societal Outlook & Social Services for HIV AIDS Patients". The Case of Addis Ketama Subcity, Addis Ababa, Ethiopia.** Submitted by me for the partial fulfillment of the MSW to Indra Gandhi National Open University (IGNOU) New Delhi is my Original work and has not been submitted earlier either to IGNOU or to any other Institution for the requirement for any other program of study. I also declare that no chapter of this manuscript in a whole or parts is taken and incorporated in this report from any earlier work done by me or others.

Place: Addis Ababa, Ethiopia.

Date_____

Signature _____

Reg.No: ID_____

Name _____

Address: _____

Phone. No. _____

CERTIFICATE

This is to certify that Mr. Worreta Assefa student of MSW from Indra Gandhi National University, New Delhi has been working under my supervision and guidance for his/ project work for the course **MSWP-001**. His project work entitled An **Assessments of Societal Outlook & Social Services for HIV/AIDS' Patients: The Case of Addis Ketama Subcity Addis Ababa, Ethiopia** which he is submitting is his genuine and original work.

Place: _____.

Date _____.

Signature: _____

Name: _____

Pone No._____

ACKNOWLEDMENT

Primarily I would like to thank the Almighty of God who gave me the strength and patience to accomplish the project dissertation successfully.

I wish to express my deep felt appreciation and gratitude to my advisor Mr. Abera Degefa (PhD candidate) for his genial patience and invaluable guidance and supervision in writing this paper.

Subsequently, I would like to express my deep felt appreciation to Addis Ketema subcity Administration Office, Addis Ketema Subcity Health office and Addis Ketema People Living with HIV/AIDS and St. Marry Library staff members for their kind cooperation from inception to completion of the study.

I am most grateful to Mr. Daniel Deresea who helped me by editing the paper from beginning up to end.

In the meantime, I would like to express my deepest thanks to Abdi Biya Abafogi for his endless moral encouragement for the success of the study.

Above all, I would like to express my thanks to my family, without them the successful completion of the study would not have been possible.

TABLE OF CONTENTS

Content **Page**

LIST OF MAPS AND TABLES

ACRONYMS

AIDS----------Acquired Immunodeficiency syndrome

ANC ---------- Anectal Clinics

ART----------Anti Retroviral Therapy or Treatment

BCC----------Behavioral Change of Communication

ENA….. Essential Nutrition Actions

HAPCO----------HIV/AIDS Prevention and Control Office

HIV----------Human Immunodeficiency Virus

IEC----------Information, Education, Communication

MOH----------Ministry of Health

NGO----------Non Governmental Organization

PLWHAS----------People Living with HIV/AIDS

UNAIDS----------United Nations AIDS Program

UNFPA----------United Nations Population Fund

VCT----------Voluntary Counseling and Testing

WHO----------World Health Organization

GLOSSARY

Addis Ababa: The capital city of Ethiopia

Birr: The local currency of Ethiopia. Notes are issued in denomination of1, 5, 10, 50 and 100. Birr and five different coins 1, 5,10,25,50 cents and one Birr.

Worreda (Districts) the lowest administrative unity in the country.

ABSTRACT

Despite the fact that there is a constitution to safeguard citizens from any forms of discrimination due to social misconstruction about HIV/AIDS, peoples living with it, continue to face various forms of stigmatization. Therefore the aim of this study was, to assess the manifestations and experiences of AIDS stigma and discrimination in Addis Ketema Subcity, Addis Ababa.

It specifically assessed how these experiences affected social interactions of the patients and service giving providers living in Addis sub city.

This study utilized social stigma theories (Goffman, 1963) to illuminate the living realities in Addis Ketema subcity and divulge relevant implications. The study utilized purposeful sampling criteria and accordingly selected 50 participants. Data were collected using qualitative in-depth interview, focus group discussion with pertinent samples, participant observation and document analysis. Emerging data from interview, observations and focus group discussion were analyzed into themes. Owing to the participant's vulnerability and sensitive nature of this study, confidentiality was maintained at all levels and where it is found necessary false names were used for all participants.

The results indicated that stigma and discrimination were visible in the sub city and negatively impacted the social interactions and daily living of PLWHA. Because of lack of empowerment, inadequate resources and mishandling/misconception of service providers, PLWHA suggested that they receive limited support and issues of stigma and discrimination were poorly addressed.

The studies however have shown that support was critical in enhancing social integration of PLWHA into the public arena. Based on the finding of the study, collaborative effort and policies are necessary to enhance effective intervention aimed at reducing stigma and discrimination in the sub city and for directing government to prepare community based policies and practices towards improving the right of living, empowerment and support for PLWHA.

CHAPTER ONE

INTRODUCTION

1.1 BACKGROND INFORMATION

Plausible to say is that, stigma and discrimination evolved parallel to love and affection along with, and on the courses of co living of humans in the community.

However, in his book **"Stigma: Notes on the Management of Spoiled Identity "Goffman** (Goffman, 1963) has explained "Stigma "as a quality that is discrediting ". Hence, an individual thought to possess that quality is used to be considered as unwanted in the public eyes. Emphasizing this assumption, that being is considered as dangerous, bad, weak and to the extreme not human (Ibid.,)

Thus since the eruption of HIV/AIDS epidemic in 1980s,similar social implication has been attached to people living with HIV/AIDs (PLWHA)often associating it with immorality and other practices. So, as Parker & Eagleton rightly said, the difference that is shown in the acts of discrimination that often is followed by stigma thereafter is directed against specific groups and individuals.

Taking the argument further, Jonathan Mann who then has been the Director World Health Organization (WHO) has demonstrated three phases which HIV undergoes before getting established as stigma. These phases are the form it will take before its full recognitions, gradual development into AIDs and the third phase and important is, its characterization by high level of stigma and discrimination which at a time has been common to the global AIDs and challenge as the disease itself (Mann, 1987).

Over decade later, that stigma was a persisting challenge, over which the global community was summoned to engage in severe action to combat it (ibid,)

On similar fashion, Brown (Brown, 2003)insisted that HIV /AIDs as pandemic has evoked a wide range reaction from individuals, communities and nations from sympathy and caring to denial, fear, anger and avoidance (Ibid.,p.49) Indeed, AID stigma and discrimination

exists world wide but differently manifested across countries, communities, religious groups and individuals.

Stigma makes it more difficult for people trying to come to terms with HIV and manage their illness on personal level and also interferes with attempt to fight the HIV epidemic as a whole. On a national level, the stigma associated with HIV can deter government from taking fast and effective action against the epidemic, while on a personal level; it can make individuals reluctant to access themselves to HIV testing, treatments and care.

Asserting this fact United Nation Secretary General in one of his messages to international community have the following to say.

> *Stigma remains the single most important barrier to public action. It is a main reason why too many people are afraid to seek a doctor to determine whether they have disease to seek treatment if so… It helps make AIDs the silent killer, because people fear the social disgrace of speaking about it, … Stigma is a chief reason why the AIDs epidemic continues to devastate societies around the world (Ban ki Moon, 2008).*

Actually, stigma and discrimination of PLWHA is embittered by ignorant about the disease and misunderstanding about HIV transmission venues and limited access to treatment, report about the incurability of the disease and fears and prejudices relevant to socially sensitive issue, perception that HIV/AIDs is a life threatening disease with commonly held view that PLWHA as invading agents(Varas- Diaz,2005) the difference which evoked various forms of negative treatment including social exclusion. The metaphor of early AIDs such as death, , punishment, guilt and exclusion worsened these fears ,reinforcing and legitimizing stigmatization & discrimination(Ibid.,)

As a global phenomenon, stigma and discrimination usually occurred at various settings: at family, community, religious organization, work places social service centers and educational institutions (Nwanna, 2005, Nyblade & Carr, 2011). However, as Avert (Avert, 2010) argued, stigma and discrimination are manifested differently in different countries. Even within the same individuals and the groups, the reaction to HIV/AIDs varies. In some countries AIDs stigma was legalized by practice like forced testing and treatment, forced

disclosure of one's status and forbidding entering certain profession including exclusion (Hirer, 1999). But important point worthy of noting is that, HIV/AIDs stigma itself is not static. But through changes over time with infectious levels decrease and with the increased knowledge about the disease and increased treatment, obviously the static nature of the disease could be changed.

Infect, White & Carr (Wite & Carr, (ibid.) concluded that, stigma and discrimination impact physical and emotional wellbeing of PLWHA and consequently negatively affects their strength to adaptation to disease and adjustment of status. Having shared this conclusion Parker & Eggleton (Ibid.) stated that, stigma & discrimination are one of the major obstructions to HIV protection, access to treatment, care and support and vocation.

In order to facilitate positive attitude and acceptance of PLWHA, some government and non government organizations have initiated educational plans that involve PLWHA as a way of creating awareness. Although these efforts are in one way or another has contributive role, still much remains in this regard.

Similarly, HIV/AIDs related stigma and discrimination have more serious consequences in health care settings. Service providers are expected to provide social and psychological support for the People Living with HIV/AIDs. In developed countries where social facilities are amply found, economically self reliant, awareness about the transmission of the disease is high; the impact of the problems of stigma and discrimination is minimal. But in developing countries like that of ours where there are no sufficient social services, Social service providers themselves do not have much knowledge about the ways the disease is transmitted, there have been many reports from health care settings of HIV testing without consent ,breaches of confidentiality, labeling ,verbal harassments, gossip, differential treatment are common. People who feel stigmatized by health care providers face problems in getting tested for HIV and accessing optimal health care services. The fear of stigma impedes prevention efforts including discussion of safer sex.

Being that as it may, one study made in South West Ethiopia, in Jimma (2011) has shown that there was an estimate of 1.2 million PLWHA with prevalence of 2.4% among the adults and with significant heterogeneity between regional states and population groups. It was

found that major transmission mode has been heterosexual which accounts for 87% of the infections (Ibid.,)

In Ethiopia, although the first HIV/AIDs was evolved into generalized epidemic in 1986 which compelled the establishment of the Department of the Disease Prevention & Control in 2005. Ministry of Health (Ministry of Health Report, 2005) awareness of health service providers on issues of stigma discrimination is minimal. This undoubtedly has impacted the persistence of the disease.

In Ethiopia, stigma and discrimination have taken lion-share in influencing negative attitude toward PLWHA at personal and community level, at different places like schools, work medical service areas. Confirming this premise the former president of South Africa, Nelson Mandela on one of the international forum has remarkably pointed out that " Many people suffering from HIV/AIDs not killed by the disease itself but are killed by the stigma surrounding everybody who has HIV/AIDs"(Barcelona Conference,2002).

Addis Ketema sub-city is one of the ten sub-cities in Addis Ababa, densely populated in which are living substantial number of PLWHA. Plus to that, it is at the center of market in Addis Ababa and usually known as 'Markato". In this sub-city, from 2009 – 2014, it is estimated that 30519 peoples were living with HIV/AIDs. However, we do not have any static data for the death for the fact that either the Addis Ketema Health Office or the HIV/AIDs Control & Prevention Office lack Proper registered death account.

Thus, this study has specifically assessed theoretical origin of stigma and discrimination and the impact of the practices on People Living with HIV/AIDs & health service providers and has recommended also ways and means's to mitigate the impacts of these attitudes.

1.2 STATEMENT OF THE PROBLEM

Health care providers, people living with the HIV/AIDs and family & the community each should play active role in mitigating the impact of stigma and discrimination that has been perpetrated against people living with HIV/AIDs.

Above all, Health care providers need to be armed with the correct knowledge and have the right attitude not only with medical support of the disease but also the psycho-social issues

affecting peoples living with HIV/AIDS, because they play a decisive role in HIV prevention, care treatment and support. They should also aware of the stigma and discrimination and how these social issues have negative impact on the victims'. Few research done on the issue have shown that nurses and service providers working service providing institution in Addis Ketema sub-city lack sufficient information and knowledge and exposure and often comprehend HIV care and treatment as' end of life care'. They have not gained sufficient experience that people living with HIV may require holistic approach, support and care long before the onset of the visible signs of AIDs (Health & Development Network, 2006). Without such profound knowledge and preparation health service workers often rely on their religious and socialization background as referents for dealing with the HIV patients and this is not adequate to deal since it is obstacle and hinders their attitude towards and perception of the HIV victims'.

Similarly, as the result of the weakness of the above mentioned actor i.e. the family and community are not well aware of the ways in which the disease is transmitted and also have erroneous prejudice that the disease is incurable which necessities the exclusion of the HIV victims, attitude of which developed to stigma and discrimination. These made desperate the victims', the family and the community and made possible the survival of this epidemic disease.

Last but not least, laws and regulation relevant to stigma and discrimination have not been taken down to the grass root level of the patients, social service providers, and family as well to the community. The absence of clear policies for mitigation of stigma and discrimination have created fear contagion ,lack of self confidence and get hidden behind the curtain of the disease. Moreover, the recommendations of few studies on the problem have not been put to practice these factors motivated the researcher to conduct the study.

In Addis Ketema Sub city, the community has often stigmatized and discriminated People Living With HIV/AIDS and invariably held moralistic view that PLWHA were sinners, promiscuous, unfaithful, sleeping around, and taken as impurities. Ignorance and misconceptions of the people and fear of physical contact with PLWHA in the words "fear of infection" which targeted gender and poverty have exposed women and poor people to more stigma and discriminatory practices. These practices are manifested by ways of name

calling, finger pointing, teasing, ridiculing, labeling and blaming. There are also other forms of stigma like self stigma, self blaming, isolation oneself, stigma by looks or appearances.

In the sub city the rapid increasing destitute AIDS orphans are not only at high risk of being exposed to stigma and discrimination, street life, prostitution and other maladaptive behavior but also have become the main route for the spread of HIV/AIDS. High degree of vulnerability to HIV/AIDS, STDS and other sexual reproductive health problems were high among adolescent & school aged youth which all in all exacerbated the situation.

To make PLWHA productive citizen and free from HIV/AIDS related stigma and discrimination, the most important effort that should be done is reducing HIV/AIDS related stigma and discrimination practices, through intensive research and strategic solution should be sought by providing continued sanitization education for the community on the detrimental effects of stigma. Besides, It is only when the recommendation at hand is cross checked with new findings and implemented that that the welfare, and the security of the community at grassroots level is kept and consolidated that the change of such attitude is affected.

1.3 OBJECTIVE OF THE STUDY

1.3.1 GENERAL OBJECTIVE

The main objective of the study was to assess the societal outlook and social service for HIV/AIDS patients and to recommend ways to combat stigma and discrimination. It is important to quantify them, to understand their magnitudes, to explore their associated factors and to explore how they vary across groups, settings and cultural contexts. Furthermore, no single published study has addressed the issue of HIV/AIDS-related stigma and discrimination amongst the societies &healthcare providers in Addis in Addis Ketema subcity.

1.3.2 SPECIFIC OBJECTIVES

The specific objectives are the followings.

- To assess experiences of people living with HIV/AIDs (PLWHA) in the selected woredas.

- To assess experiences of health service providers in dealing with HIV patients at health facilities.
- To assess the experiences of family and community of the people living with HIV/AIDs.
- To asses and explore the forms of HIV related stigma and discrimination in Addis Ketema sub-city and to provide scientific explanations on the issue.
- To critically assess the current strategies and policies those prohibit HIV/AIDs related stigma and discrimination at health facilities and other social services institution in the sub-city.
- To make recommendation based on the findings

1.4. RESEARCH QUESTIONS

In order to analyze the major issues raised in the specific objectives of the study, the researcher used the following guiding research questions.

- Do people perceive HIV related stigma and discrimination to be a problem in Addis Ketema sub-city?
- Do health workers stigmatize and discriminate People Living with HIV/AIDs (PLWHA)?
- How do people living in the sub-city perceive People Living with HIV?
- How do Health workers perceive People living with HIV?
- What are the shortcomings in the efforts to reduce stigma and discrimination of PLWHA?
- What possible solutions should be recommended?

1.5 SIGNIFICANCE OF THE STUDY

There are many researchers who conducted research in the areas of HIV/AIDS particularly in VCT, care and support, attitude and behavioral change of the youth toward HIV/AIDS. However, there is a gap of research in reducing stigma and discrimination on people living With HIV/AIDS Due to this reason, the researcher was motivated to assess the outlooks and impacts and ways of reducing HIV/AIDS related stigma and discrimination among people

living with HIV/AIDS, health service providers, family and community. Moreover, assessment of the practicality of the policies issues in this regard was very important. The recommendations of some research conducted on the issues have not been also implemented. In fact, there is increasing accusation through intermittent reports that health care professionals stigmatize and discriminate People Living with HIV by refusing provide care and treatment. Along with that, people living with HIV/AIDs do complain informally that they are not only discriminated by the community alone but even by their own family.

I hope that this study will provide a baseline for future studies by the relevant researchers. I have also assessed the impact of stigma and discrimination for persistence of the epidemic and policy issue which requires assessment. This assessment will contribute to reduction of the stigma and discrimination and may call attention of government and nongovernment organization to give special emphasis to the areas of stigma and discriminations and may also assist develop new intervention methods.

1.6 OPERATIONAL DEFINITION OF TERMS

The following are the definition of selected terms used in the study.

- **AIDS**: Acquired Immunodeficiency Syndrome. It is the complex of symptoms caused by HIV infections, which results in progressive depletion of the immune system leading to opportunistic infections. Certain types of infection must be present for a person to be diagnosed as having AIDS. A person can be infected with HIV for years without having AIDS. Having Aids does not mean some body has AIDs
- **Attitude**: A tendency expressed by evaluating a particular entity with some degree of favor /disfavor (Eagly & Chaiken, 1993).

  A learned evaluative (like or dislike) responses directed at specific objects which is relatively enduring and influence behavior in a generally motivating way. It is relatively enduring and is similar to personality trait (Lipp, 1990).
- **Confidentiality:** is the responsibility of VCT counselors or health care workers in keeping the secrets of People Living with HIV/AIDS. Confidentiality is essential for establishing and maintaining client trust. A private space should be used for all discussions of HIV related matters particularly HIV test results

- **Discrimination**: which can be expressed as both negative attitudes or particular behaviors or action, is often described as a distinction that is made about a person that results in their being treated unfairly and unjustly on the basis of their belonging, or being perceived to be belong, to a particular group. For example stigma can lead to prejudice and active discrimination directed toward persons who are actually, or are simply perceived to be, infected with HIV, and the social groups and persons with whom they are associated
- **Forms of Stigma:** Stigma is divided into four parts. These are:

  Social stigma- Isolation from the community, mockery, loses of social role, lose of standing respect.

  Physical stigma- isolated, shunned, abandoned, separate living space and eating materials.

  Verbal stigma- (Gossip, taunting, scolding, labeling in Africa: "Morning Skeleton", "Walking Corpse… "

  Institutional Stigma- Denial of health service, ban from jobs…etc
- **HIV**: Human immune deficiency virus that is transmitted from person to person through the exchange of body fluids such as blood, semen and vaginal secretions. This is most often associated with sexual contact but can also be transmitted by exposure to infected blood through transfusion or sharing needles to inject drugs. HIV is the virus that leads to AIDS defining illness
- **Informed consent**: is the process during which the client receives clear and accurate information about HIV testing in order to make an informed about whether to accept or decline testing.
- **Perception:** The process used by the individuals to judge the traits (stable internal disposition) and characters of others It is an essential part of everyday social interaction (Lipp,1990)
- **Prejudice:** A negative judgment that is often unwarranted and is based on a limited, insufficient evidence (Ibid.,)
- **Qualitative Research Method**: As defined by Patten (1990) qualitative study is " detailed description of situations, events, people interactions, observed behaviors,

direct quotations from people about their experiences, attitudes, beliefs and thoughts and excerpts or entire passage from documents

- **Stigma**: is defined as an understandable or discrediting attribute that a person's or group posses that result in the reduction of that persons or group's status in the eyes of society. Stigma can result from physical characteristics such as the visible symptoms of a disease, or from a negative attitudes toward the behavior of a group such as homosexual or prostitutes
- **Voluntary Counseling and Testing**; the process by which an individual under goes counseling to enable him or her to make an informed choice about being tested for HIV (The National AIDS Council Secretariat 2000, p.3).
- **Window period**: the stage at which the virus is introduced into the body, it could be followed by an acute disease stage which may pass unnoticed, as symptoms are non specific.

1.7 LIMITATION OF THE STUDY

There were some problems that hampered the detailed study of the dissertation since there is lack of previous studies on the topic and moreover the reluctance of some staff members to give the needed information regarding HIV/AIDS related data because they didn't want to reveal their clients information without the clients consent. However, the researcher has exerted all efforts to find out the vital information for the study by building a strong relationship from Addis Ketema subcity Health Office, HIV/AIDs prevention and Control Office and the 4 targeted Woredas Office service providers as well as the client themselves.

Despite all the efforts made to accomplish the study, some practical problems or limitation were expected to appear. The sensitive nature of HIV/AIDS and its related stigma and discrimination created challenge on the researcher during data collection. The first challenge was the high expectation of incentives from People Living with HIV/AIDS for interview and questioning session may challenge fully access to get the real data. This problem confined the research work to some extent. But the researcher exerted all possible

ways to lobby the study population to get the right information and to minimize the sources of biases.

The second challenge was that there was no updated comprehensive data on attitude and perception of the samples in health service providing institution. Moreover, since one of the modes of HIV transmission is through unprotected sex people in Addis Ketema do not talk openly about sex. So the information provided by the respondent may not be accurate for the privacy nature of the issue. The much information collected is obtained from young victims as the adults were reserved from speaking openly. Besides, the researcher couldn't get access to audio record information in which such important data could have been omitted.

1.8. ORGANIZATION OF THE STUDY

The thesis is divided into six chapters. The first chapter deals with the introduction of the study. The next chapter reviews related literatures. The third chapter is concerned with research area, research design and methods. In subsequent, the fourth chapter deals with data analysis of Qualitative and Quantitative studies. The fifth chapter deals with discussion and findings. Finally the last chapter is on conclusion and recommendations. At the end is found bibliographies and annexes attached.

CHAPTER TWO

2. REVIEW OF RELATED LITRATURE

The purpose of this literature review was to retrace theoretical findings on HIV- related stigma and discrimination globally, regionally and in the local context with particular emphasis on the topic: " **The Assessment of Societal Outlook & Social Services For HIV AIDS' Patients: The Case of Addis Ketema Subcity".**

Indeed, the study does not bring to attention all what has been written on the subject but rather highlights those pertinent issues and areas of prejudices which contribute to stigma & discrimination.

2.1. KNOWLEDGE OF HIV-RELATED SIGMA & DISCRIMINATION

Many studies have shown that People Living with HIV/AIDS (PLWHA) face stigma and discrimination in the family, community and in health-settings. Many studies have documented stigma associated with HIV/AIDS in communities and also stigma experienced by PLWHA at health facilities. Studies conducted in India and Mexico provides evidence that PLWHA have, in extreme cases, been physically attacked or murdered in their communities. Stigma can lead to discrimination and other violations of human rights which affect the well-being of people living with HIV in fundamental ways. Violations of the rights of those living with HIV have been documented worldwide included denial of medical care, breaches of the right to privacy and discrimination in health institutions.

Stigma and discrimination may occur at various levels. There is discrimination at household level, in the community, workplace, and educational institutions and even at health care facilities. Stigma and discrimination related to HIV/AIDS at health care facilities have negatively affected the effective execution of HIV/AIDS programs since the early days of the HIV/ AIDS pandemic.

Hence, the following are the main causes of stigma: Insufficient knowledge, misbelieves and fears about how HIV is transmitted; and the life potential/capacity of people living with HIV/AIDS (no immediate death), moral judgments' about people whom we assume have

been sexually promiscuous, fear about death and disease, lack of recognition of stigma are among few to mention.

Under international law, governments are obligated to respect, protect, and fulfill the human rights of people vulnerable to HIV, those living with HIV/AIDS, and those affected by the disease.

2.2 GLOBAL OVERVIEW OF HIV/AIDS RELATED STIGMA AND DISCRIMINATION

Stigma and discrimination are associated with many chronic health conditions, including leprosy, mental illness, tuberculosis and HIV/AIDS. The effects of stigma cause indescribable suffering to those stigmatized. In many countries people living with HIV/AIDS are often seen as shameful. The stigma and discrimination they face can extend from family, community to the extent of hospital setting, where it can lead to the denial of care, differential treatment and disregard for the right to patient confidentiality. Studies that have been conducted in other countries like India and Mexico have found evidence of HIV-related stigma and discrimination at health facilities.

In December 2003, UNAIDS posted a Fact Sheet on stigma and discrimination on their website (www.unaids.org) which provides a useful summary definition of stigma and discrimination. The following is taken from this fact Sheet.

> *HIV/AIDS related stigma can be described as a "process of devaluation" of people either living with or associated with HIV/AIDS. This stigma often stems from the underlying stigmatization of sex and intravenous drug-two of the primary route of HIV infection. In addition, the fact sheet says that, discrimination follows stigma and is the unfair and unjust treatment of an individual based on his or her real or perceived HIV status. Discrimination occurs when distinction is made against a person that results in being treated unfairly and unjustly on the basis of belonging or being perceived to belong, to a particular group.*

From this definition, it is possible to say that “discrimination” as the “form” and “manifestations” of stigma.

The conceptualization of HIV/AIDS stigma underlies most of the literature today mirrors the stigma concept utilized for a broader set of health and social issues, such as mental illness, or unemployment (Link B., & Phelan J (2001). In the HIVAIDS stigma literature, the concept of stigma is often not explicitly defined, but rather is referred to cursorily as” a mark of disgrace” Link B.,&Phelan J. (2001) Conceptualizing stigma. In addition Link, B., &Phean, J (2001) defined stigma existing” when elements of Labeling, stereotyping, separation, status loss and discrimination occur together in a power situation that allows them”. According to (UNAIDS 2005) definition HIV/AIDs related discrimination refers to the unfair and unjust treatment (act or omission) of an individual based on his or her real or perceived HIV status**.**

Findings straight forwarded definitions of social stigma, the more complex of the two concepts, is one of the many problems for researcher, for while some harmful attitudes are clearly identifiable, many are veiled. According to Sociologist Erving Goffman, in his 1963 book, stigma; Notes on the Management of spoiled Identity, the term commonly refers to “undesirable attributes” that are “incongruous with our stereotype what a given type of individual should be.” Discrimination focuses on the actions, treatment, and policies that arise from such attitudes and which may violate the human rights of people living with HIV/AIDS and those close to them. The term refers to any form of distinction, restriction, or exclusion a person may encounter because of inherent personal characteristics (UNAIDS 2000).

According to Bos, A. E. R.,Schaalma, H.P.,& Pryor,J.B. (2008) stigmatization involves cognitive (e.g. beliefs or attitude towards the disease and those affected, emotional (e.g. fear, pity), and behavioral (e.g. behaving in unfair and or discriminatory ways. In addition, Link and Phelan also tried to distinguish between individual discrimination in which a person acts in a discriminatory way toward another person, and institutional discrimination resulting from stigmatized environments (physical, social, cultural and/or policy) that disadvantages a group. Thus stigma can affect people living with HIV in many ways, both individual contact with others and in negotiating environments in which they live day to day.

People living were considered sinners, promiscuous, unfaithful, and sleeping around. People also held strong beliefs about pollution , contagion, impurity, ignorance and misconceptions made people fear physical contact with PLWHV as reflected in the words “fear of infection” “ fear of the unknown” “ fear of death” subtle issues such as gender, poverty figured out considering the fact that women and poor people more stigmatized than men and the rich. There are a variety of forms of stigma, stigma acted as in the following forms of discriminatory practices name calling, escape gloating, finger pointing, teasing, ridiculing, labeling, blaming, shaming and judging,

In fact, several humanitarian organizations, national and worldwide leaders have been making significant efforts to end these stigmas and discrimination directed against individuals affected by the HIV/AIDs and their families. In the attainment of this objective, (2001) one international conference that had taken place in Bangkok, Thailand have strongly recommended increasing and sustained efforts in all actions against HIV/AIDs by which a global action was started on HIV related stigmas’ and discrimination. Stigmatizing family and friends for simple reason of being associated with the HIV positive.

In individual context, on Individuals base HIV/AIDs related stigma and discrimination are manifested through fear, isolation, lack of access social services and supports they need (Daniel and Parker 1993). This is called internalizing stigma. In extreme cases, this has lead to premature death through suicide (Gilmore and Somerville 1994; Hassan. Farag & Elkerdawi 1994).

As many researches showed, HIV/AIDS is a major public health concern and cause of death in many parts of Africa. In fact, it is estimated that the continent is home to about 15.2 percent of the world’s population (current world population 2012). Thus Sub-Saharan Africa alone accounted for an estimated 70 percent of all people living with HIV (Global Fact Sheet 2012) and 70 percent of all AIDS deaths in 2011(UNAID Report 2012). In comparison, North Africa and the Horn of Africa have significantly lower prevalence rates. This is due to the fact that, the cultural pattern of the people restricts sexual contact which to some extent limited spread of the virus while in Sub-Sahara Africa laissez-faire approach to

sex have worsened the spread of the virus (UNAID 2010). Southern Africa is the worst affected region on the continent. Anyway, even if there were some indicative reports (UNAID/WHO 2010) that some of largest epidemic in sub-Sahara-Africa is on decline; stigma & discrimination towards Peoples Living with HIV/AIDs have never been subsidized at all.

Similarly, a number of governmental and nongovernmental initiatives launched an outreach programs to educate the public on HIV/AIDS like that of "Desmond Tutu' HIV Foundation" as a combination of prevention programs have contributed a lot to the reduction of the spread of the virus. However, according to a 2013 special report issued by the Joint United Nations Programs on HIV/AIDS, the number of HIV positive people in Africa receiving anti-retroviral treatment in 2012 was over seven times the number receiving treatment in 2005, "with nearly 1 million added in the last year alone"(UNAIDS 2013). And with that, the number of AIDS-related deaths in Sub-Saharan Africa in 2011 was 33 percent less than the number in 2005 (UNAIDS 2013).The number of new HIV infections in Sub-Saharan Africa in 2011 was 25 percent less than the number in 2001(UNAIDS 2012).

In general, even if there is a decrease in the number of deaths, there is paradoxical increase in the number of HIV positive people in Africa receiving anti-retroviral treatment, there have been persisted stigma and discrimination towards people living with HIV/AIDs.

2.3 OVERVIEW OF HIV/AIDS ACTIVITIES IN ETHIOPIA

Based on a single point estimate, there are nearly 1.2 million people living with HIV/AIDS in Ethiopia. The adult prevalence rate is estimated at 2.4% and the incidence rate is 0.29%. The prevalence and incidence rates significantly vary between geographical areas and gender. The urban prevalence rate is estimated at 7.7%, while the rural prevalence rate is 0.9%. The prevalence rate is 1.7% for males and 2.6% for females (MOH, 2011).

With 90 000 HIV-positive pregnant women, there are an estimated 14 000 HIV-positive births and a total of 28 000 AIDS death and an estimated 800 000 AIDS orphans annually (Ibid.,)

Following the approval of the declaration on HIV/AIDS known as Resolution 60/262 in June 2006 ,Ethiopia accepted the Resolution " *Multisectoral Plan of Action for Universal Access to HIV Prevention, Treatment, Care and Support in Ethiopia, 2007–2010''*[1] *has been developing and implementing the action.. The program is guided by the principle of the HIV Strategic Plan for Multispectral Response, universal access commitment, and the ''Three Ones'': one HIV/AIDS action framework, one national AIDS coordinating authority and one monitoring and evaluation system*[2]

The responses to the HIV/AIDS epidemic showed considerable progress and achieved encouraging results. However, the nature of the epidemic and its fuelling factors like that of stigma & discrimination towards people living with HIV/AIDs creates a complex challenge to the ability of health and other sectors to meet the targets for HIV/AIDS control in Ethiopia

Antiretroviral treatment coverage reached 62.3%, which is above the sub-Saharan African regional average (53%). However, prevention of mother-to-child transmission of HIV coverage was only 9.3 %.

In addition, major programmes were implemented for care and support of orphans and vulnerable children. These consisted of educational programmes, food, shelter, and guidance and training on income-generating activities.

HIV/AIDS awareness is universal in Ethiopia with 97% of women and 99% of men being aware of the disease. Awareness does not vary much by background characteristics with the exception of education; those with no education are less likely to know about HIV/AIDS. Overall, women residing in urban areas are more likely to be knowledgeable about HIV prevention methods than women residing in rural areas. The same pattern is true for men. Higher educational attainment is positively associated with an increased awareness of HIV prevention methods for both women and men. However much there is increasing awareness about the disease in the society, stigmatizing and discriminating people living with HIV has become commonly accepted attitude by all strata of the population with no exception.

2.4. HIV/AIDS ACTIVITIES IN ADDIS ABABA IN GENERAL & ADDIS KETEMA SUB- CITY IN PARTICULAR

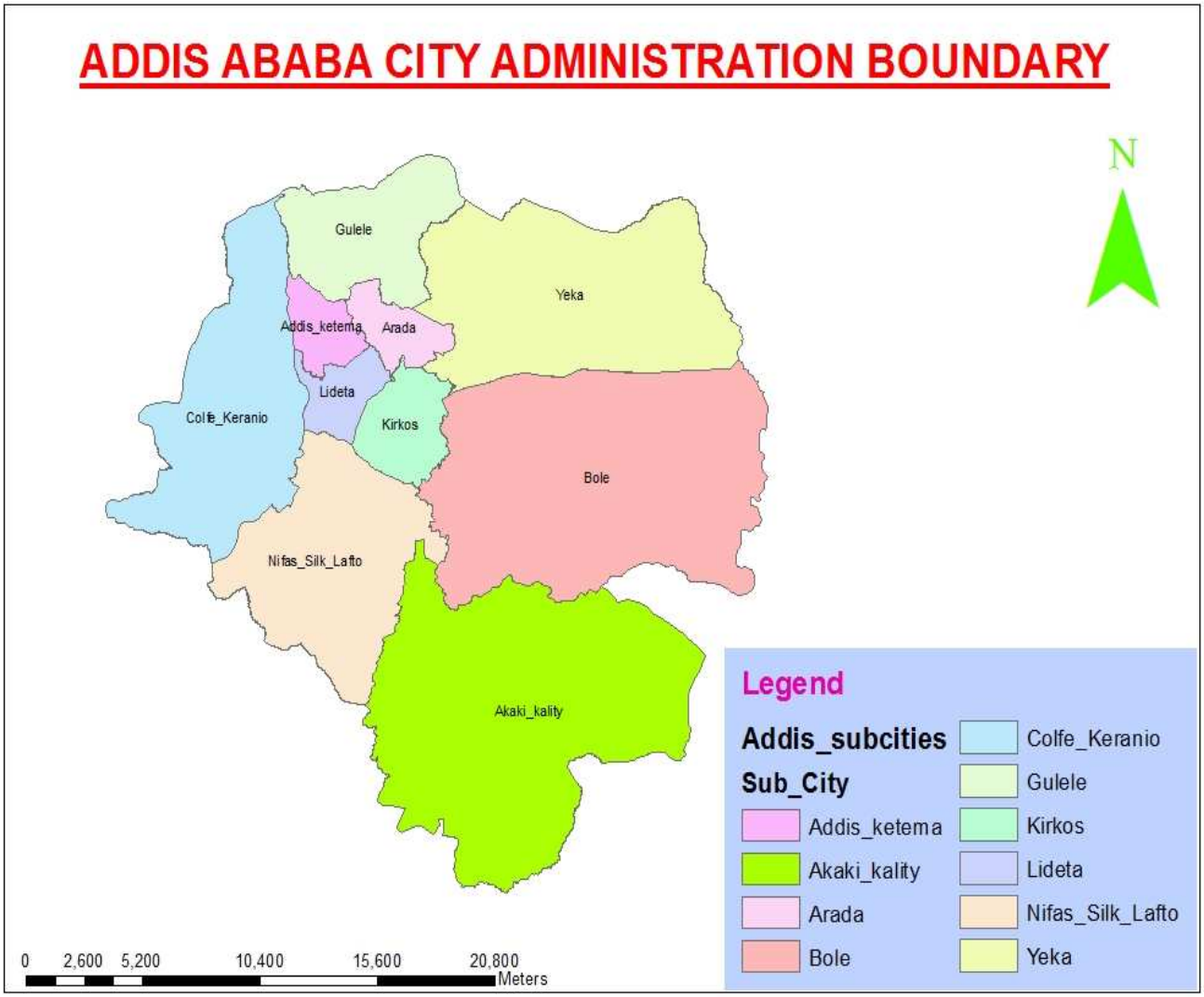
It was estimated that there were a total of 109,130 orphans in Addis Ababa in 2012(AHAPCO, 2012) Out of which approxmately15, 375 are said from Addis Ketema sub-city. According to ANC Surveillance data conducted for several years in Addis Ababa in 2003, it was estimated that the incidents' rate is 11.7% with alarming increasing rate.

CHAPTER THREE

3. RESEARCH AREA, DESIGN AND METHODOLOGY

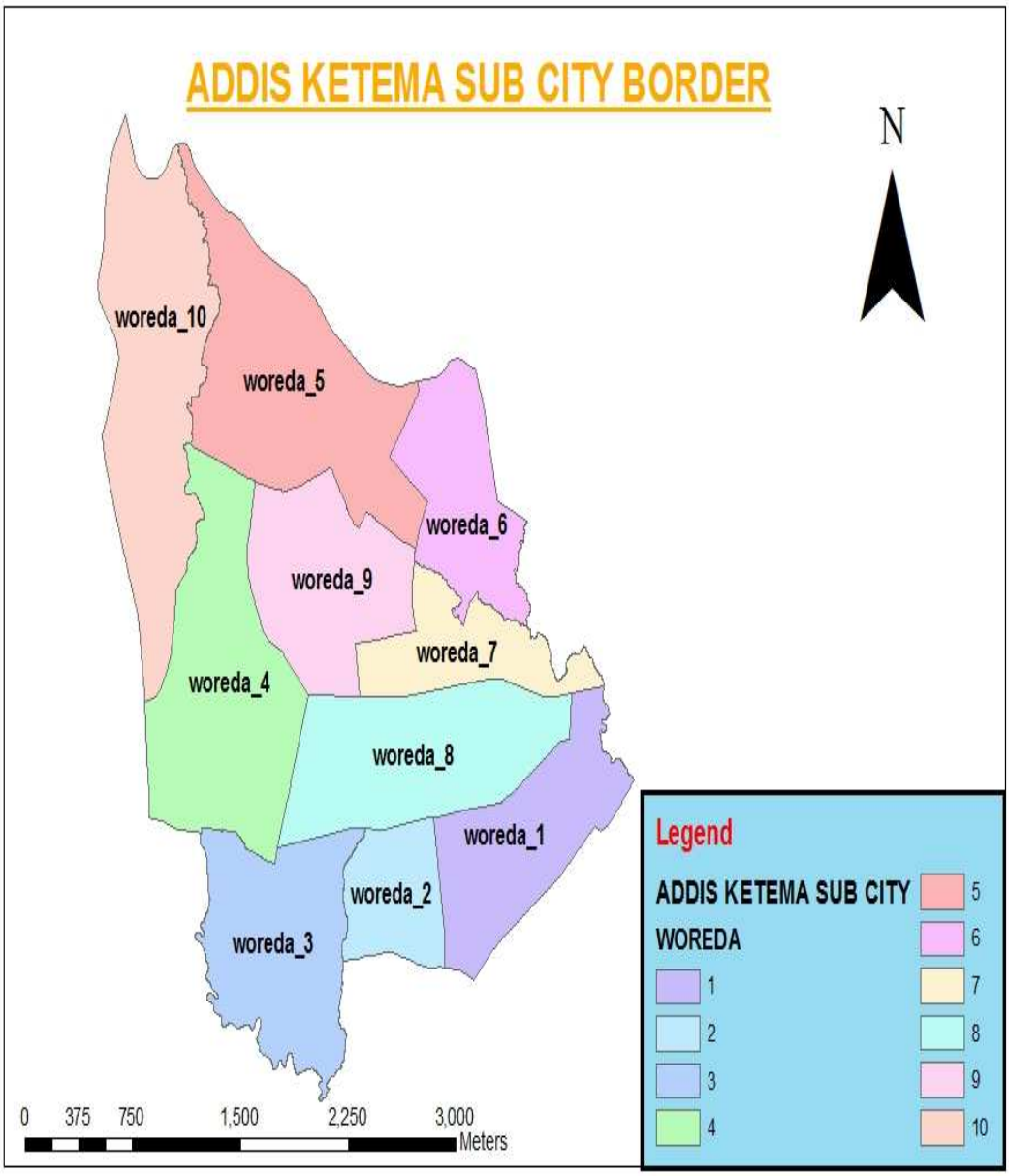
3.1 RESEARCH AREA

Addis Ketema is one of the 10 sub cities in Addis Ababa city administration. It is situated in the center of Addis Ababa, bounded from south-east by Lideta, from West by Kolfe Keranyo, from North-east by Arada and Gulale sub cities. At present, the sub city is divided into 10 woredas & 28 sub woredas, 84 Sefers and 302 blocks. Addis Ketema subcity altitude is ranged from 23443 to 2564 meters above sea level which has ranged of 203 meters.



Map1 .Map Of Addis Ababa City Administration

(Source: Addis Ababa City Administration Integrated Land Information Center)



Map 2: Map of Addis Ketema Subcity
(Source: Addis Ababa City Administration Integrated Land Information Center)

Table (1) Geographical Location and Administrative Division of Addis Ketema Subcity

No	Woreda	Area (Ha)	No of sub woredas	No of Sefers	No of Blocks
1	01	76.7	2	8	28
2	02	37.8	2	4	16
3	03	89	3	9	32
4	04	119.9	4	11	44
5	05	126	4	12	46
6	06	61.9	2	6	23
7	07	49	2	6	18
8	08	99.7	3	10	36
9	09	78.5	2	8	29
	Total	863.9	28	84	302

(Source: Addis Ababa City Adminstration Integrated Land Information Center)

Addis Ketema is characterized by a homogenous type of topography with insignificant elevation difference. Generally speaking, in the sub city the altitude ranged from 2343 to 2546 meters above sea level which has range of 203 meters (Ibid.,)

Table (2) **Land Area and Population Distribution of Addis Ketema by Woreda Level**

No	Woreda	Land Area (Ha)	% of the total Sub city Area	Total Population			% of the total subcity population	P0pulation Density (peoples/Hr)
				Male	Female			
1	Wo1	76.7	8.91	16,543	16662	33205	12.39	432.9
2	Wo2	37.8	4.4	13029	14058	27087	10.1	716.5
3	Wo3	89	10.3	14529	14520	29049	10.84	326
4	Wo4	119.9	13.88	16825	16230	33055	12.33	275.6
5	Wo5	126	14.58	9533	10250	19783	7.38	157
6	Wo6	61.9	7.17	14032	14597	28629	10.68	461.7
7	Wo7	49	5.67	13514	15008	28522	10.64	582
8	Wo8	99.7	11.57	15713	16904	32617	12.17	327
9	Wo9	78.5	9.02	11023	12122	23145	8.63	294.8
10	Wo10	125.4	14.46	6480	6527	13007	4.85	103.7
	Total	863.9	100	131,221	136,878	268,099	100	310,3

Source: (Ibid.)

As could be dedicated from the above table, the number of female population is higher in woreda with exception in Woreda 3 and 4 which possess 14520 and 16230 respectively.

Regarding the distribution of education in Addis Ketema subcity, there are 44 kindergartens out of which 16 belonged to the government and 28 to private and other institutions(Source: Addis Ababa City Education Bureau,2013). Besides, there are 40 Primary Schools and only 7 secondary schools in the subcity. However, the subcity has only 5 preparatory schools which accounts to about 3.7% of the total education distribution in Addis Ababa (Ibid.,)

Although it is inadequate both in quality & quantity, in Addis Ketema subcity social services that benefit and promote the well being of community such like parking, street cleanings, sanitation, housing, water supply, power supply, health care planning and zoning fire and ambulance services and other related public works are on being accomplished (Ibid.,)

In addition ,In Addis Ketema Subcity there are 8 Health Centers, 35 Medium Clinics,16 higher Clinics,2 Hospitals and 33 pharmacies (Source: Addis Ketema Subcity Health Office).

3.2 RESEARCH METHODOLOGY& DESIGN

This study was conducted among Communities & Health workers living in four (4) Woradas of Addis Ketema Subcity based on purposive sampling method. The selected 4 woredas in the subcity are known at large by stigma and discrimination towards people living with HIV/AIDs. Three major actors in these situations are community (Parents, neighborhoods'), People Living with HIV/AIDs and Health workers. The study was both qualitative and quantitative type.

The purpose of the research was to assess and explore societal outlook across the issue or claim that stigma and discrimination exist among the society and health care professionals in Addis Ketema Subcity. In an effort to explore this phenomenon, the attitudes and perceptions of the communities, the victims and professional health care workers towards People Living with HIV were examined.

Approval to conduct this study was sought from the Addis Ketema Health office and the victims living in the area. The quantitative (survey) and qualitative (focus groups) approaches were used for data collection and analysis.

According to Green (2005) research topics in public health often generates a lot of questions that requires more than one method to address them adequately. Therefore, for this research, the qualitative method was used in close with the quantitative data collected to help validate the research finding. The data collected was validated using ***triangulation***. Triangulation is utilized on the assumption that using two different 'readings 'of one phenomenon will improve accuracy (Wolff et al. (1993) and he further posited that when survey and focus groups are concurrently designed and implemented they provide asymmetrical but

independent observations of the study population and strengthen the ability to draw conclusion and as well built confidence in the conclusion itself. This theory was substantiated by Newman (2003) who posited that these methods or styles have different complementary strengthens as there could be few overlaps; utilizing both methods will make the study fuller and more comprehensive.

3.2.1 THEORETICAL BASE OF THE RESEARCH

The theoretical underpinnings in this study were symbolic interactionism and positivism. Symbolic interactionism explores the understanding of culture. It is an approach of understanding and explaining the society and human world (Crotty, 2006). It deals with the use of language as a tool for verbal communication and also includes non-verbal communication. This theory stems from pragmatist philosopher and social psychologist, George Herbert Mead whose work was accredited to Blumer, (1969). Symbolic interactionism has its genesis in pragmatism (way of rendering ideas clear). According to Blumer 1969 cited in Crotty 2006, there are three basic interactionist assumptions: This theory stems from pragmatist philosopher and social psychologist, George Herbert Mead whose work was accredited to Blumer, (1969). Symbolic interactionism has its genesis in pragmatism (way of rendering ideas clear). According to Blumer 1969 cited in Crotty 2006, there are three basic interactionists' assumptions:

- Human beings act toward things on the basis of the meanings that these things have for them.
- The meaning of thing is derived from, and arises out of the social interaction that one has with one's fellows.
- The meanings are handled in, and modified through, an interpretive process used by the person in dealing with things he encounters.

The symbolic interactionism approaches utilized in this study were the dramaturgical approach, which is associated with Goffman (1963) which seeks to explain interaction between individuals (actors) and society. This theory views the actors and society as an active process and it indicates that, it is the responsibility of the actors to interpret the social world in which they live. Indeed, social meaning of things is derived from interactions

between individuals (actors) and society. The adherents' of the theory argue that human behaviors' are based on symbols and HIV/AIDS is one such symbol. Therefore, one can conclude that HIV/AIDS can have different meanings based on the social context and way it is conceived & interpreted by individuals. The research thus, should identify these different meanings of reality and recommend alternate solution for the common good of the society.

This theory stems from pragmatist philosopher and social psychologist, George Hebert Mead whose work was accredited to Blumer, (1969). Symbolic interactionism has its genesis in pragmatism (way of giving clear idea). According to Blumer 1969 cited in Crotty 2006 there are three basic interactionists:

- Human being act toward things on the basis of the meanings that things reflected to him.
- The meaning of thing is derived from and arises out of the social interaction
- The meanings are handled in, and modified through, an interpretive process used by the person in dealing with things he encounters.

The symbolic interactionism approaches utilized in this study were the dramaturgical approach, which is associated with Goffman (1963) which seeks to explain interaction between individuals (actors) and society. This theory views the actors and society as an active process and it indicates that, it is the responsibility of the actors to interpret the social world in which they live. Indeed, social meaning of things is derived from interactions between individuals (actors) and society. The adherents' of the theory argue that human behaviors' are based on symbols and HIV/AIDS is one such symbol. Therefore, one can conclude that HIV/AIDS can have different meanings based on the social context and the ways it is conceived & interpreted by individuals. The research thus, should identify these different meanings of reality and recommend alternate solution for the common good of individuals in the society.

As Green rightly stated (Green, 2005) my methodological approach is based on positivist philosophical outlook which assert that reality is always the same whatsoever, and researcher should search toward that reality. Moreover, also my approach of the study is

after the theory of Newman (Newman, 2003) which states that researcher should began with general cause-effect relationship and logically draws important ideas from it.

Despite the fact that both are different theories, they are jointly supporting my studies. They are also pertinent to my aims and viable to conduct my studies. Certainly, they would improve the accuracy and validity of my data's. Undoubtedly utilization multi-method is important. That is why I employed dual approach in my studies.

The social issue I have addressed in this study was HIV related Stigma & Discrimination. This issue can affect communities' attitude and perception towards People Living with HIV/AIDs (PLWHA), behaviors & attitude of PLWHA and also health workers (not wanting to access care and treatment). Generally, it can influence the perceptions and attitude of social service and Health care providers

- Human beings act toward things on the basis of the meanings that these things have for them.

- The meaning of thing is derived from, and arises out of the social interaction that one has with one's fellows.

- The meanings are handled in, and modified through, an interpretive process used by the person in dealing with things he encounters.

The symbolic interactionism approaches utilized in this study were the dramaturgical approach, which is associated with Goffman (1963) which seeks to explain interaction between individuals (actors) and society. This theory views the actors and society as an active process and it indicates that, it is the responsibility of the actors to interpret the social world in which they live. Indeed, social meaning of things is derived from interactions between individuals (actors) and society. The adherents' of the theory argue that human behaviors' are based on symbols and HIV/AIDS is one such symbol. Therefore, one can conclude that HIV/AIDS can have different meanings based on the social context and way it is conceived & interpreted by individuals.

From Design point of view, the study is a descriptive and analytical. Attempts have been made to identify the major causes of Stigma & discrimination towards Peoples Living with HIV/AIDs (PLWHA). The attitude and perception of community ,of the victims' themselves and that of social and Health care providers have been assessed by making use questionnaires, in-depth interview and focus group discussion. Both Primary and secondary sources on the issues have been consulted. However, the large part, relevant and supportive data have been gathered by qualitative methods.

Questionnaires for the quantitative components of this study were developed according to the objective and need of the research. There were twenty (20) questions per questionnaire which included demographic and stigma type questions using the Likert type rating scale was chosen because it is commonly used in studies and even according to (Green, 2005), the scale is the most appropriate method used when measuring attitudes (see appendix 1). For each questionnaire, four choices were given for respondents to rate. The questionnaires were divided into two (2) sections: Demographics and the stigma type questions which basically addressed attitudes towards People Living with HIV, knowledge of HIV and fear of transmission.

In fact, the researcher have found the instruments very useful since they were used in previous research efforts to gather information on stigma and discrimination and measure attitudes and perceptions towards People Living with HIV. These instruments are effective when measuring respondents' attitude since they allow the respondents to express themselves.

An interview guide was developed for 10 selected informants Ten (10) interview questions were used to ascertain the interviewees understanding of stigma and discrimination; manifestation of stigma and discrimination which include lack of confidentiality, isolation, fear of transmission and values, norms and moral judgment; and consequences of stigma and discrimination which include fear of disclosure and self-stigma (see appendix 2).

The focus group discussion comprising ten members drawn from the community, People Living with HIV/AIDs, Addis Ketema Subcity Health Office and social & Health care providers was conducted. 10 questions were prepared and put for initiating and coxing the discussion.

However, disadvantages of these instruments are: for questionnaires - low levels of literacy and unfamiliarity in filling questionnaire and focus group discussions – data collected can be time consuming to analyze and it is time consuming.

3.2.2 Sampling Selection, Sample Size Determination & Procedure

The primary purpose of sampling is to collect specific cases, events, or actions that can clarify and deepen understanding (Neuman, 2003). For the purpose of this study, the researcher used the non-probability or *nonrandom* sampling method to gather data. The purposive or judgmental sampling technique was selected for this study.

In an effort to conduct the research, a request was made to the Addis Ketema Subcity Health Office, The Associations of the People Living with HIV/AIDs found in the subcity, The Addis Abeba HIV/AIDS Prevention and Control Office and The Subcity Administration... The total numbers of participants in the research were fifty-six (56) drawn from four woredas in the sub city. To the maximum, there were Fourteen (18) respondents' from the Woredas. See breakdown of sample size below:

1. Fourteen (14) – Woreda 1
2. Ten (10) - Woreda 3
3 Fourteen (14) - Woreda 5
4. Eighteen (18) - Woreda 7

Subsequently, the researcher was introduced to the participant in the research. After the introduction, a background on the purpose of the study and some personal information about the researcher as well as the research assistant were given. After the introductions, the participants were encouraged to ask questions about the research, the researcher and the research assistant. The researcher felt this would have made them comfortable and willing to participate in the study.

The interviewees were assured of confidentiality prior to the commencement and the assistant researcher conducted the interview as it was planned.

The researcher initiated the focus group discussions, and the discussion lasted for approximately forty five (45 minutes and has been very interactive with a few wanting to dominating the discussion. After the focus group discussions, structured self–administered

questionnaires were distributed for completion. Fifty-six questionnaires were distributed to the respondents and all were completed and returned to the researcher.

3.4 DATA PROCESSING & ANALYSIS

Having been completed the data gathering operation in the field; the variables were defined coded. The data collected was inputted into the database. The data was presented and analyzed using tables and charts. The transcripts of the data collected by the researcher and assistant for the qualitative component of the study were collated and typed electronically. The researcher then printed and read a hard copy of the data in detail making line by line notes and highlighting the notes based on the aspect of stigma and discrimination the respondent was referring to e.g. fear of infection, isolation of patients, lack of confidentiality. Upon completion of this aspect, the researcher transcribed to the electronic copy and then the data were reduced, organized and interpreted in cyclical process.

3.5. ETHICAL CONSIDERATIONS

In concrete term, Stigma & Discrimination towards People Living with HIV/AIDs are crimes committed against humanity and unpalatable deed .So, as sensitive information seeks great attention and focus. Therefore, on issues around such problem, serious attention for ethical consideration has no option. As is often the case, questions on the issues of Stigma & Discriminations require great care and the researcher has respected the individual's right to privacy.. Not to upset, embarrass, or even galvanize the discussant, the biased, inappropriate and culturally offensive questions have been eliminated care has been taken in designing questions. Thus, the authors of this paper have unearthed important information through full consent of the participants. Accordingly, the participants' permission in the study had been requested before putting the questions for the participants.

They have also been informed of their full right to discontinue or refuse to participate in the study in case they felt something discomfort. Furthermore, the importance of the study has been briefed to the informants that could help to utilize their time properly.

CHAPTER FOUR

4.1 ANALYSIS OF DATA

The research questions were analyzed from survey and focus group discussions conducted among communities, People Living with HIV/AIDs and social service providers. The research questions are as follows:

- Do people perceive HIV related stigma and discrimination to be a problem in Addis Ketema sub-city?
- Do health workers stigmatize and discriminate People Living with HIV/AIDs (PLWHA?
- How do people living in the sub-city perceive People Living with HIV/AIDS?
- How do Health workers perceive People living with HIV/AIDS?
- What are the shortcomings in the efforts to reduce stigma and discrimination of PLWHA? What possible solutions should be recommended?

The analysis comprises two sections: Section one deals with the quantitative analysis of the data collected and section two deals with the qualitative analysis. In section one; HIV-related stigma and discrimination were examined in three (3) main categories. These were attitudes of community People Living with HIV; attitudes of family toward their own people living with HIV/AIDs, knowledge of HIV and fear of transmission. In addition to these categories, demographic data along with data on self stigma were collected and analyzed. The data on self stigma was collected since the researcher felt that most of the stigmas reported were often directed at self stigma which is self-hatred, guilt and shame that can be expressed as depression and despair and can lead to withdrawal from family and social life. The demographic data provided background information on the respondents. For section one, the analysis of the data collected was presented on table using uni-varite analysis. The uni-varite analysis examines one variable at a time the responses were analyzed based on each question in the questionnaire. In the uni-variety analysis responses were qualified using numerical data. The outputs of the data were expressed in percentages. These percentages were used to interpret the data's. In section two HIV related stigmas and discrimination were analyzed under various themes in accordance with qualitative data analysis.

Section One

4.1 SOCIO-DEMOGRAPHIC CHARACTERISTICS OF THE RESPONDENTS

Data collected on the socio-demographic of the respondents were analyzed and presented in the Table 1 below.

Table 3: Socio demographic characteristics of respondents

Demography			**Frequency (n=56)**	**percentage**
Sex	Male		8	14.2
	Female		48	85.8
Marital Status	Married		6	10.7
	Unmarried (single)		25	44.6
	Divorce		25	44.6
Religion status	Christian	Orthodox	17	30.3
		Catholic	3	5.4
		protestant	8	14.3
	Muslim		25	44.7
	Other		2	3.6
	Not Stated		1	1.7
Attend Religious Services	Never		12	22.2
	Occasionally		14	31.1
	Fairly Regular		24	53.3
	Single		43	79.6
Have Children			18	19.3
Ethnicity	Silte		18	31.03
	Gurage		13	22.41
	Amhara		13	22.41
	Oromo		12	21.41
Educational status	Primary school completed (1-8)		20	35.7
	Secondary school completed (9-12)		27	48.2
	Certificate and diploma		3	5.3
	Degree and above		6	10.8
Monthly income	Br.400-800		35	62.5
	Br.900-1100		12	21.5
	Br.1200-1500		5	8.9
	Br.1600-2000 and above		4	7.1

As could be seen from the above table, 85.8% of the respondents' were females and 44.6 % of them were either unmarried or divorcées. It is less probable that their martial conditions might have exposed them to HIV/AIDs.

As far as the religion status of the respondents are concerned, 44.7 %(25) of the total respondents are Muslims and in subsequent, 30.3 % (Orthodox Christians). Nevertheless, 79.6 % (43) attend services single. Besides, 19.3% (18), of the total respondents have children.

With regard to the ethnicity of the respondents, the Gurages' and the Amharas comprise 22.4% (13) each, while Silte remained the largest having comprised 31.3% (18), of the total respondents.

As it is observable on similar table, 48.2 % (27), respondents were Secondary school (9 – 12) completes.

Regarding the monthly income of the respondents, 62.5 % (35), of the total respondents earn very low monthly income i.e. Br. 400 – 800 as daily laborers.

Section Two

4.2 ASSESSMENT OF HIV AIDS RELATED STIGMA AND DISCRIMINATION AGAINST PEOPLE LIVING WITH HIV AIDS

Table (4) Assessment of experience of stigma and discrimination

Have you ever experienced stigma and discrimination**?**		Yes	Frequency=56	In Percentage
			50	89.2
		No	4	7.2
		Not responded	2	3.6
In what form?	Open insulting	15	_	26.8
	Indirect talk	10	_	17.9
	Being isolated	25	_	44.6
	All	6	_	10.7
By whom?	Family	20	_	35.71
	community	15	_	26.78
	Peers	15	_	26.78
	All	6	_	10.71
Do they often discriminate you?	Yes	45	_	80.35
	No	11	_	19.64
In your family who often discriminate you?	Brother	25	_	44.6
	Sister	10	_	17.9
	Father	10	_	17.9
	Mother	5	_	8.92
	Other relatives	6	_	10.71
In which area you faced stigma and discrimination?	Work place	10	_	17.9
	At school	10	_	17.9
	At home	25	_	44.6
	Health center	5	_	8.92
	HAPCO	6	_	10.71

The above table shows the assessments of experiences of stigma and discrimination that were directed against PLWHA. 89.2% (50), of the total respondents have confirmed that they were stigma and discrimination. And 44.6 % (25), of the total respondents have said

that this was manifested by isolating the victims'. Even 17.9% (10), have said that the stigma went as far as open insulting of PLWHA.

Infact, 35.7% (20), of the respondents witnessed that family take the largest share in stigmatizing and discriminating their members living with HIV/AIDs. However, 26.78% (15), of the total respondents confirm that community takes large share next to that of the family.

Regarding whether the PLWHA were often discriminated, 80.35 % (45), of the total respondents say that, they were often discriminated. As is shown in the table above, 44.6 (25), of the respondents agree that brothers' are the most discriminators against the members of the family living with HIV/AIDs. Moreover, it is shown that mothers are the most important in the family towards members of the family failed victim.

The same table shows that, 44.6 % (25), of the respondents agree that homes are the main areas where often stigma and discrimination is directed against the victims. In fact, Work places, Schools, Health Care Centers and HAPCO also were areas where stigma and discrimination usually takes place.

Table (5) Issues related to stigmatized languages, consequence and response of the victims

		Frequency=56	**% Percent**
What are the main stigmatized languages PLWHA faced?	AIDs victim	20	35.71
	Slim disease	10	17.85
	AIDs sufferer	9	16.07
	High risk group	5	8.92
	Bad blood	2	3.57
	On death gate	15	26.78
What are the consequences of stigma and discrimination?	Shame	20	35.71
	Suicide	10	17.85
	Self isolation & Alcoholism	5	8.92
	Denial & depression	56	100
	Lonliness, neglect, lose of hope, resignation.	15	26.78
What is your response when people stigmatize and discriminate you?	Shame	25	44.64
	Attempt to commit Suicide	25	44.64
	Loneliness	56	100
	Lose of hope		

Table (5) above illustrates about stigmatized languages used against PLWHA, Its consequence and victim's reaction. 37.5% (20), of the total respondents say that "AIDS Victim "was the stigmatized language which the victims face often. The stigma language "slim disease "was also stigmatized language used several times against the victims.

Moreover, as can be seen in the above table, 100% (56), of the respondents confirm that, its consequence is that the victims became loneliness, neglect, lose of hope and resignation. However, still, most of the PLWHA attempt to commit suicide when faced with stigma and discrimination.

Table (6).The type of intervention mechanism of HIV/AIDS Prevention and Control Office (HAPCO) use to reduce HIV/AIDS related stigma and discrimination and the type of care and support provided for the PLWHA

		Frequency=56	%percentage
What type of intervention mechanism HAPCO use to reduce HIV related stigma and discrimination?	IEC	6	10.71
	Advocacy	20	35.71
	Community education	30	53.57
	All	56	100
What type of care and support you benefited from HAPCO as PLWHA?	Job creating support	2	3.57
	Psychological support	20	35.71
	Financial support	20	35.71
	Nutritional support	10	17.85
	All	30	53.57
Do you think that HAPCO is effective and successful in reducing HIV related stigma and discrimination?	Yes	10	17.86
	No	45	80.36
	No response	1	1.88

The above table is about the intervention mechanism necessary by HAPCO to reduce stigma and discrimination against PLWHA, 35.71% (20), of the total respondents suggest that HAPCO should make use of intensive advocacy. Infact, 53.57% (30), of the total respondent suggest extensive community awareness.

With regard to the kind of care and support the PLWHA enjoyed from HAPCO, 37.71% (20), of the total respondent, said that financial and psychological support has been available by HAPCO. The fact that almost all of the respondent were poor, they couldn't afford/ the food intake that is required by the PLWHAs. As they couldn't get access to employment their living condition has remained appalling.

Over the issues whether HAPCO is effective and successful in reducing HIV/AIDs related stigma and discrimination 80.36 % (20),of the total respondents have witnessed that HAPCO was not successful.

Table (7) On Qualification of Service Providers

		Frequency=56	% Percentage
Do you think that service providers are qualified?	Yes	35	62.3
	No	10	17.9
	I don't know	11	19.8

As is shown in the preceding Table 5, 62.3% (35), of the total respondents said that, Health Service providers are qualifies. However,(11),19,8% of the respondents insisted that they know nothing about their qualification whereas,17.9% (10) of the respondents strongly refuted having qualification of Health Service Providers.

Section Three

4.3 ANALYSIS AND RESULT OF THE INTERVIEW

Fifteen (15) initiating questions were administered with ten (10) service providers and thus, the interview assessment and results presented as follows.

- Ten service providers were drawn from the four woredas in Addis Ketema subcity. Only two of them have served long in the Health Centers. Most of them are new employees hence were unable to tell extensive experience on the issue.
- When asked about the complaints of the PLWHAs when visiting the service center, the service providers agreed that the victims were extremely concerned about the stigma and discrimination perpetrated to them by the family and community at large.
- Despite the fact that there is advocacy program every morning at the Health posts and center, the service providers insisted that the stigma and discrimination has never been part of the orientation. Rather, the focus was on rhetoric awareness on its transmission means's.
- The interviewee have confirmed that back in the 1980s and 1990s,out of fear to get seized by the virus ,service providers used to stigmatize the patients. But they say that, now, that there is increasing improvement in the outlook of service providers.
- With regard to stigmatized languages used against PLWHAs, most of service providers say they don't make use of stigmatized languages. But as community member they say that they often see and hear when community uses stigmatized languages against the PLWHA.
- About the care and support the service providers give for PLWHA, the interviewee said that they give counseling, and medicinal treatments. But they have strongly argued that PLWHA should be given employment opportunity to sustain themselves in the face of the disease.
- When asked the success of their duties, most of the service providers have said that, though there is increased improvement they are not successful as there is persistence of stigma and discrimination towards PLWHA which undoubtedly have contributed for the spread of the virus and continued death of PLWHA.

- Regarding the strategies needed to be developed to reduce the stigma and discrimination towards PLWHA, the service providers recommended that the content should be included in their professional training and that awareness creation program should be carried among the community in general, and family in particular. Equally important is, awareness and continued sensitization program should be carried among the People Living with HIV/AIDS. On the top of that the service providers added that IEC and BCC interventions should be encouraged to combat stigma and discrimination.
- Concerning the care and support services provided to the PLWHA, the service providers mentioned the following types of services like counseling service A, psychosocial help, nutritional support, financial support and job creating support.

Section Four

4.4 ANALYSIS AND RESULT OF FOCUS GROUP DISCUSSION

A) Sources and contents of stigma and discrimination of PLWHA

1) Sources of stigma and discrimination

A) Fear of casual contact

One participant from the PLWHA explained that stigma and discrimination has variety of sources. She said that the family stigmatized and discriminated because of fear of casual contact with her can cause infection. She added that it is impossible to eat in one plate together with non HIV+ family and neighborhood since they fear causal contact infection even if they know that HIV is not transmitted by eating and drinking. According to her people stigmatized and discriminated due to fear of casual contact with the PLWHA can cause infection.

The second participant of the FGD from the community said that knowingly or unknowingly people stigmatized and discriminated the PLWHA due to fear of HIV transmission even by eating and drinking. Families and communities are well trained about the modes of HIV/AIDS transmission and prevention but still some families and communities strongly believe that physical contact with the PLWHA can cause HIV infection on them.

Concerning fear of casual contact a 32 years old HIV+ woman said that

> *Some people in the community strongly believe that HIV/AIDS can transmit through kissing, shaking hands, sleeping together and eating together with PLWHA. As a result of this misconception belief, the family and the community isolate HIV/AIDS patients.*

One participants of the FGD from the community explained that

> *When somebody comes to my home for renting purpose first I see the physical condition of that person if his/her face is damaged by HIV/AIDS, I will not rent him/her my house. Because if he/she rents my house we may eat or drink*

together and there are so many things that may bring us together and I might be infected along with my family.

B) Lack of insufficient knowledge

As the participants of the FGD explained that the family and the community stigmatize and discriminate against PLWHA due to lack of insufficient knowledge about the modes of HIV transmission and prevention. They added that those families and communities who have lower socioeconomic status don't know the ways of HIV/AIDS transmission. As a result of this the PLWHA are stigmatized and discriminated at home and work place. All the participants of the FGD concluded that lack of insufficient knowledge about HIV/AIDS transmission is the source of stigma and discrimination.

As a participant of a focus group discussion PLWHA females said that: "The disease is very frightening, terrible and people who have less awareness about the transmission of HIV stigmatize and discriminate us." Others echo this theme, including how the lack of knowledge of HIV transmission leads to people isolating and shunning those with HIV.

A 37 old year's HIV+ woman explained that

When fluids come out from us like diarrhea, vomit, and high fever. The family and the wider community stigmatize and discriminate us. This is because of lack of awareness. They do not know that it won't be transmitted through these fluids unless there is blood and sexual contact occur.

C) Poverty

One participant of the FGD from the service providers said that poverty is also another sources of stigma and discrimination. She added that poor women cannot hide their HIV status by eating malnourished foods. As a result they are highly stigmatized and discriminated at family and community level. Other participants of the FGD agreed that poverty is also one of the main sources of stigma and discrimination.

One participants of the FGD from the from the service provider said that

> *In our community most of the PLWHA came from the lower socioeconomic family background. Due to this the PLWHA are exposed for HIV/AIDS related stigma and discrimination.*

2) The manifestation of stigma and discrimination

All participants of the FGD from the PLWHA explained that HIV/AIDS related stigma and discrimination take different forms and are manifested at different levels societal, community and individual context

a) policy and legal context
b) institutional context
c) health care setting

3) Physical, psychological, social impacts of stigma and discrimination

As participants of the FGD the PLWHA, the community members and the services providers mentioned the physical, psychological and social impacts of HIV/AIDS related impacts of stigma and discrimination on PLWHA. According to them the physical impacts of S&D include slim face, loss of hair, becoming thin or lose of weight and wounded face.

A 42 years old HIV+ woman explained the physical impacts of HIV/AIDS related S&D

> *HIV/AIDS is incurable disease. It changed my physical appearance and makes me very ugly. It makes my face dark, pale and wound on the body and on the lips. Due to this people fear to see me and talk to me.*

The FGD participant has also tried to mention the psychological impacts of HIV/AIDS related stigma and discrimination on PLWHA as follows.

- ✓ Depression
- ✓ Anxiety
- ✓ Isolation, loneliness, loss of hope and disparate
- ✓ Loss of reputation, shame

29 years old HIV+ participants of the FGD said that

> *Before a month I went to my family home to visit them.… I came across my mother that was protected children at home…She refused to allow me to enter and see my brothers and sisters and told me that she has no HIV positive daughter. I was sad, felt very bad, shame and felt isolation. In the future I don't want to visit my family.*

The participants of the FGD listed out some of the major social impacts of HIV/AIDS related stigma and discrimination as follows

- ✓ Loss of marriage and child rearing options
- ✓ Withdrawal of care giving in the home
- ✓ Conflict with the family
- ✓ Drop out of school
- ✓ Breakup relationship

One female PLWHA described her difficulties in finding someone willing to rent housing to her in the village:

> *I was searching for a house to rent in my village I used to live before in. But it was unthinkable to find who was voluntary because of the rumor that I live with HIV has spread across the village. When the house owners heard the rumor, they cancel the deal and told me that they do not want me to rent their room…After I went through many ups and downs to get the present house I am living in and the owners still do not know that I live with HIV.*

Another PLWHA female participant explained that

> *I am living with a wide village with many children's are presenting. All my neighbors know that as I am living with the virus. All children's of the village loves me. One day few children's came to my home and kissed me turn by turn. Many of the parents of the children shouted at me to stop kissing them. Immediately they washed their children's face where I kissed them. The villagers asked me to leave the village soon before their children infected.*

4) Who are the perpetrates of stigma and discrimination on PLWHA

All the participants of the study synonymously mentioned that the family and the community are the perpetrates of stigma and discrimination.

In relation to this one female PLWHA participant explained that

> *My mother is a traditional midwifery. She went in every village to help those women who give birth. She didn't knew each woman whether they are HIV positive woman or not unless she heard by rumors. I was pregnant. My giving birth date approached. I told to my mother to come to with me during delivery but she refused to help me since she knew as I am HIV positive woman.*

Similarly, other PLWHA participant of the FGD said that

> *I have a problem with my family, especially with my father. He does not want me to participate in any kind of social life…He always tells me, 'Please do not show your face to others and do not be close to our relatives.' And I think he says this for the sake of his family reputation.*

On the contrary one male participants of the FGD from the community said that

> *Before five years ago I used to stigmatize and discriminate a person who is HIV positive. At that time, I did not have awareness about HIV and AIDS. But now after I took training about HIV and AIDS, if a person disclosed his HIV status, I won't isolate him. I will be close to him.*

All participants of the FGD agreed that stigma and discrimination is decreasing orally or by word but still the problem is intensified across the family and the community practically. The government, nongovernmental organizations, anti HIV/AIDS clubs and other community based associations are providing training concerning the modes of HIV/AIDS transmission and prevention. As a result of this HIV/AIDS stigma and discrimination decreased at school, work place and in other institutions however at the family and village level is still persistent.

B) On action to be taken to avoid stigma and discrimination (the problem)

1) Action taken by service providers

All participants of the FGD listed out the following actions that should be taken by service providers to reduce HIV/AIDS related stigma and discrimination.

- ✓ Community mobilization and participation in reducing stigma and discrimination at institutional level at institutional level
- ✓ Expanding psychosocial services for PLWHA
- ✓ Educating youth
- ✓ Encouraging Care and support services for the PLWHA
- ✓ Expanding peer education developing family based interventions
- ✓ Encouraging the community to take blood test and to be close friends how are getting HIV positive

2) Measure to be taken by the People Living with HIV/AIDS

- ✓ Opens about their HIV/AIDS status
- ✓ Asking the government to access basic social services
- ✓ Avoiding loneliness and isolation

3) Measure to be taken by the government, the family and community.

Government

- ✓ Encouraging governmental and nongovernmental organizations to include the PLWHA issue in their plan.
- ✓ Designed policy that can benefit the People Living with HIV/AIDS.
- ✓ Providing intensive psychosocial education to the wider community about the bad effects of stigma and discrimination particularly to the People Living with HIV/AIDS and generally to the wider community.

Family

- ✓ Family should know the modes of HIV/AIDS transmission and should stop S&D at home. If the family clearly knows the means of HIV/AIDstransmission, stigma and discrimination become decreasing at individual, family and community level. This is, therefore, the family must provide positive response for the People Living with HIV/AIDS to tackle spread of the epidemic.
- ✓ Family should increase their knowledge of HIV/AIDS and should know the benefit of reducing stigma and discrimination and its advantage to control the spreading of HIV/AIDS at family and community level.
- ✓ The family is the first hand and most important immediate supporter of People Living with HIV/AIDS in their physical, psychological and moral building. This is, therefore, the family should be trained and educate about the impacts of HIV/AIDS related stigma on PLWHA, the family and to the larger community.

Community

- ✓ The community should provide the opportunity for the PLWHA to participate in IDIR and other societal associations
- ✓ Strengthening anti-AIDS clubs and home based care would help in reducing stigma and discrimination.
- ✓ The community should be cooperative to empower People Living with HIV/AIDS economically as well as psychologically by avoiding stigma and discrimination from the ground to create HIV/AIDS free generation.

CHAPTER FIVE

5. CONCLUSION AND RECOMMENDATIONS

There is doubt that stigma and discrimination will continue to act as formidable barriers in dealing effectively with the HIV/AIDS pandemic in that they lead to people not accessing resources out of fear of being further stigmatized or discriminated. Access to treatment, both to medicines to treat opportunistic diseases and antiretroviral therapy may help reduce stigma by enabling people living with HIV to live positively and productively longer. Such intervention is likely to increase their quality of life significantly, as well as reducing other's fear of AIDS by helping people to understand that it is possible to manage and live with the disease. People are more likely to use health services if the staffs are friendly and communicate well.

Prevention strategies will continue to be compromised if stigma and discrimination against HIV infected persons persists. Health care workers especially professionals have the responsibility to help normalize HIV so that the modes of transmission and prevention can be addressed without the emotional and attitudinal overlay that limits open dialogue about HIV/AIDS. Effective and dignified care can only be given where respect and compassion for others is the norm.

Stigmatization and discrimination are profoundly unethical. They reverse the principles of beneficence to non-mal-efficiency as they positively contribute towards the stigmatized person's demise.

5.1 CONCLUSION

The aim of the research was to explore HIV/AIDS related stigma and discrimination towards People Living with HIV/AIDs (from family, Community and service providers) and PLWA towards themselves (self Stigma in Addis Ketema sub-city, in Addis Abab). The study has assessed and confirmed the evidence HIV/AIDS related stigma and discrimination among the families, communities, service providers living in the four woredas of Addis Ketama sub-city as well self stigma of People Living with HIV/AIDs. The study revealed some discriminatory and unethical HIV/AIDS related behaviors' among families, communities and health professionals. On the part of the community discriminatory acts included: open

insulting, escape goating, indirect talk, isolating teasing, ridiculing, labeling and blaming. On the other hand, the PLWHA when isolated feel self stigma in the form of self denial, suicidal attempt, loneliness etc. Similarly, Health service providers stigmatize PLWHA by non-attendance of some health care and diagnosing the patients, denial of care, delay checking, making unnecessary referral to other Health institution. Disclosure of sero-status especially on HIV-positive patients or breaches of confidentiality.

As the finding clearly shows,

- The majority of the people living with HIV/AIDs were women and most of them were in the age group 26-45years old.

- The study confirms that most People living with HIV/AIDs are highly stigmatized and discriminated at home by the family, at school by school community, at Health Center by health care providers and at work place by co-workers.

- This finding demonstrated that despite the service provision by HIV/AIDS Prevention and Control Office to PLWHAs some of the beneficiaries the support they are obtaining from the Organization is not satisfactory.

- PLWA, experience different forms of stigma: Verbal-such as scolding, taunting, naming, gossiping, blaming; Social exclusion-such as separation from friends and families, dislocating from home or rented house, separation of household utensils, loss of identity, rights and status; loss of access to resources –such as employment and health care. Stigma and discrimination against PLWHA occurs first in the household, followed by neighborhood, health facilities and places of warship, families and relatives for fear of infection, getting tired of care and support for their PLWHA member and at times forcing the victim to leave home; neighbors consider PLWHA shameful and for fear of infection distance themselves from the victims.

- The present scenario of stigma and discrimination against PLWHA can be abated by new technologies without risking the infection.

5.2 RECOMMENDATION

In view of the above findings, the following recommendations are put forward:

- ✓ There is need to formulate appropriate and clear policies, legislation and codes of conduct to address issues of stigma and discrimination both in public affairs and health facilities on the basis of HIV-positive status.

- ✓ Sanctions for family, community and health workers who do not comply with codes of conduct or policies should be implemented by regulatory bodies and health care institutions.

- ✓ Health facilities should provide an excellent opportunity to some areas that require attention for improvement like setting standards to protect human rights and establishing a supportive environment at the health facilities for those living with HIV/AIDS.

- ✓ There should be a multi-sectoral, participatory approach to reduce stigma and discrimination at family, community level health facilities in order to improve the health care environment for PLWHA.

- ✓ The non-medics, who are HSAs in this context, should have comprehensive training on respecting patient rights and maintaining confidentiality. Appropriate education and training programmes and materials on HIV/AIDS related stigma and discrimination should be designed and facilitated by all organizations dealing with HIV/AIDS prevention and care.

- ✓ Training and education curricula for health professionals should include important content/information on HIV/AIDS related stigma and discrimination reduction in health facilities.

- ✓ Health facility strategies to reduce HIV-related stigma and discrimination should mainly focus on ant-discrimination policies and HIV prevention activities and management.

- ✓ Health care facilities should examine their institutional practices in order to avoid misperceptions and incorrect information about HIV/AIDS related stigma and discrimination.

- ✓ The Ministry of Health which is at the highest level should stress the need to confront HIV-related stigma and discrimination in health services.
- ✓ The PLWHA should play a central role in policy dialogue, programme planning and implementation of HIV activities at any level.
- ✓ Stigma audit tools can be developed to identify stigmatizing attitudes and actions at all places.
- ✓ Managers should provide proper leadership and institute systems that promote and facilitate ethical conduct.
- ✓ Health care workers and managers should make appropriate decisions of distributive justice on individual basis, i.e. the practice of providing food supplements to PLWHA in government institutions should extend to non government organizations as well.
- ✓ The HIV/AIDS Prevention and Control Office should give intensive and extensive education on HIV/AIDs and the skill to provide care and support to PLWHA as a way to control the spread of the epidemic and reducing stigma and discrimination against the victims.
- ✓ To reduce stigma that is exacerbated by poverty the government in cooperation with donors need to focus on job creation programmes where the poor can get training in skills that enable earn decent income by doing decent job.
- ✓ Laws need to be reinforced to protect the right of PLWHA to be free from stigma and discrimination. Laws that protect PLWHA at the individual, family and community level should be legal established institutions (public, private and civic) need to be formulated specifically addressing discriminatory acts enacted explicitly. The access of PLWHA to resources, information about HIV/AIDS related stigma and discrimination reduction interventions, employment opportunity, housing opportunity, protection of confidentiality by the service providers and rights to health care need special legal protection. The right to demanding or negotiating safer sex by women needs to be recognized and legalized under the framework of the laws.

- ✓ Strengthening and building capacity of stigmatized individuals and groups, e.g. thorough skill building campaigns, network building campaigns, network building, counseling training, income generation, participation and interactive education. Providing training on non discrimination to health care providers and establishing codes of conduct for service providers.

- ✓ Institutional reform e.g. addressing discrimination in courts, work places, health care settings, schools etc. social mobilization strategies for social, legal and economic support and action in advance or in response to stigmatizing speech or discrimination practices should be focused.

- ✓ In the fight against stigma and discrimination, active and participatory education needs to be enhanced; care and support to people living with HIV/AIDS and orphans of AIDS needs to be focused on, particularly access health care and retroviral drugs. These would reduced stigma and make VCT services desirable. People living with HIV/AIDS need to be encouraged to lead active role in society particularly in educating the community on HIV/AIDS. PLHA need legal protection from government bodies and access to livelihood options. The gender disparity makes men and women vulnerable to the pandemic. Focus needs to be made on how to empower women to negotiate safe sex and ensure the realization of their basic human rights. This would require change 9in cultural norms, values and practices on gender which, in turn would require intensive and extensive community based discussions.

REFERENCE

Aggeleton, P. and I. Warwick.(1999) Household and community Responses to HIV and AIDS in developing countries: findings from multi-site studies: Geneva, UNAIDS.

Aggleton, P., Parker R., & Maluwa M. (2003). *Stigma, Discrimination and* HIV*/AIDS in Latin America and the Caribbean*. Washington, DC: Inter-American Development Bank.

Banki-Moon op-ed (2008, 6th August)" the stigma factor "http//www.washington times. Com/news/2008/aug/06/the-stigma-factor/) the Washington times

Bos, A.E.R., Schaalama, H.P., & pryor, J.B. (2008). Reducing AIDS related stigma in developing countries

Brown, Macintyre, K., & Trujillo, L. (2003). Interventions to reduce HIV/AIDS stigma: what we have learned? AIDS Education and prevention, 15, 49-69

Crotty, M.(2006). *The Foundation of Social Research: Meaning and Perspective in the Research Process*. London: Sage Publication Lippa, Richard A., (1990). *Introduction to Social Psychology*. California: Wadsworth Inc.

Current World population (2012) National Online.

Eagly, A. H. & Chaikan, S. (1993). *The psychology of attitudes*. Fort Worth: Harcourt Brace College Publishers

Eagly, A. H. & Chaikan, S. (1993). *The psychology of attitudes*. Fort Worth: Harcourt Brace College Publishers

Ethiopian demographic and health survey, 2011 (pdf 683.08kb). Addis Ababa, Central Statistics Agency; Calverton Maryland, ICF Macro

Gilmore, N. and M. A. Somerville. (1994) "Stigmatization, scapegoating and discrimination in sexually transmitted diseases, overcoming 'them' and 'us'," social science and medicine 39:1339-1358.

Global Fact Sheet, (20, November, 2012) joint United Nations Programme on HIV/AIDS.

Goffman, E. (1963). *Stigma: Notes on Management of spoiled identity*. Englewood Cliffs, NJ: Prentice-Hall.

Green, J. & Browne, J. (2005). *Principles of Social Research*. London: 92 Open University Press.

Hasan, M.A., A.B. Farag. And M.M. Elkerdawi. (1994). Human rights of HIV infected person/PLAsin Egypt abstract, Xth international conference on AIDS, Yokohama, Japan.

Health and Development Networks and the AIDS –Care Watch Campaign (2006). *Unveiling the truth, Shedding light on HIV stigma and* Discrimination, A report from the XVI International AIDS Conference: Toronto, Canada.

Health and Development Networks and the AIDS –Care Watch Campaign (2006). *Unveiling the truth, Shedding light on HIV stigma and* Discrimination, A report from the XVI International AIDS Conference: Toronto, Canada.

Health Sector Development Programme IV. Annual performance report. Addis Ababa, Government of Ethiopia, Ministry of Health, 2010

International Center for Research on Women (2006). *HIV/AIDS Stigma: Finding solutions to Strengthen HIV/AIDS Programs.* Washington DC: Author.

Lawson, E. et al (2006). *HIV/AIDS Stigma, Denial, Fear and* Discrimination*: Experiences and responses of people from* African *and Caribbean Communities in Toronto*. Canada: University of Toronto.

Link, Phelan.J. (2001) conceptualizing stigma. Annual Review of sociology, 27, 363-385.

Ministry of Health (2006) AIDS in Ethiopia six reports. Ministry of Health national HIV/AIDS prevention and control office, Addis Ababa, Ethiopia

Ministry of Health (2002). National Technical Guideline: Integrated Disease Surveillance and response, Addis Ababa, Ethiopia

Ministry of health (MOH). (1998) AIDS in Ethiopia. Epidemiology and AIDS dept., Ministry of Health, Addis Ababa, Ethiopia

Nyblade L. Disentangling HIV and AIDS stigma in Ethiopia, Tanzania and Zambia. International Center for Research on Women, Washington DC; 2003. [Accessed 7th July, 2007] Available from: http://www.icrw.org/docs/stigmareport093003.pdf.

Pan American Health Organization (2005). *Understanding and responding* to *HIV/AIDS-related Stigma and Discrimination in the health* sector, Washington DC: Author.

Stigma and discrimination against people living with HIV by healthcare providers, Southwest Ethiopia Garumma T Feyissa garummatolu@yahoo.com

UNAIDS (2010). UNAIDS report on the Global AIDS Epidemic retrieved 2011-06-2014

UNAIDS (2010). UNAIDS report on the Global AIDS Epidemic retrieved 13 May 2014

UNAIDS (2010). UNAIDS report on the Global AIDS Epidemic retrieved 27 May 2014

UNAIDS (2010). UNAIDS report on the Global AIDS Epidemic retrieved from http://www.unaids.org

UNAIDS, (26th meeting) of the UNAIDS programme coordinating, Geneva, Switzerland, 22-24 June 2010, Non- discrimination in HIV response, May 3, 2010, UNAIDS/PCB (26)/10.3 paragraph 35. Geneva, Switzerland,

Who (2011)"Global HIV/AIDS response Epidemic update and health service progress toward universal access progress report 2011(http):who.int/hiv/pub/progress report 2011/en/inde.htm)"

Wolff, B., Knodel, J. & Sittitari, W. (1993). Focus groups and surveys as complementary research methods. In Morgan DL (ed) *Successful* Focus *Groups: Advancing the State of Art*. Newbury Park, CA: Sage.

World Bank, (1997), confronting AIDS public priorities in a global Epidemic New York; oxford University press, www.unaids.org