

**STIGMA, DISCRIMINATION AND COPING STRATEGIES AMONG  
PEOPLE LIVING WITH HIV/AIDS IN GAMBELLA TOWN,  
GAMBELLA PEOPLE NATIONAL REGIONAL STATE**

**MA THESIS**

**KAHSAY MEHARY GEBREKIDAN**

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**STIGMA, DISCRIMINATION AND COPING STRATEGIES AMONG  
PEOPLE LIVING WITH HIV/AIDS IN GAMBELLA TOWN, GAMBELLA  
PEOPLE NATIONAL REGIONAL STATE**

**A Thesis Submitted to Department of Psychology, College of Education and  
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Social Psychology**

**Kahsay Mehary Gebrekidan**

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**Haramaya University, Haramaya**

## HARAMAYA UNIVERSITY

As thesis research advisor, we hereby certify that we have read and evaluated this thesis prepared under our guidance by Kahsay Mehary titled “*Stigma and Discriminations among People Living with HIV/AIDS in Gambella Town, GPNRS*”. We recommend that it is submitted as fulfilling the thesis requirement.

Mr. Yirgalem Alemu (Assi. Prof)	_____	_____
Major Advisor	Signature	Date

Mr. Gemechu Abera (Assi. Prof)	_____	_____
Co-Advisor	Signature	Date

As members of the board of examiners of the MA Thesis open defense examination, we certify that we have read and evaluated the thesis prepared by Mr. Kahsay Mehary and examined the candidate. We recommend that the thesis is accepted as fulfilling the Thesis requirement for the degree of *Master of Arts in Social Psychology*.

_____	_____	_____
Chairperson	Signature	Date

_____	_____	_____
External Examiner	Signature	Date

_____	_____	_____
Internal Examiner	Signature	Date

## STATEMENT OF THE AUTHOR

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Name: KahsayMehary

Signature-----

Date of submission:

Schools/Departments: Psychology

### **BIOGRAPHICAL SKETCH OF THE AUTHOR**

The author was born on August 1989 G.C in Gambella Town, Gambella Peoples National Regional State. He attended primary education from grade (1-6) at Wibur Primary School, and grade 7 and 8 at Ras-Gobena Junior School. The author attended secondary and preparatory school education from grade, 9-12 at Gambella Senior Secondary and Preparatory School. The author received Bachelor of Arts Degree in Psychology from Aksum University in 2011 G.C. Currently, he is working at Gambella University as assistant lecturer and he joined the Postgraduate Program Directorate of Haramaya University in 2015/2016 G.C in order to pursue further study

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## **ABBREVIATIONS AND ACRONYMS**

<b>AIDS</b>	Acquired Immune-Deficiency Syndrome
<b>ARVs</b>	Antiretroviral drugs
<b>FBO</b>	Faith-Based Organizations
<b>GPNRS</b>	Gambella Peoples National Regional State
<b>HACC</b>	HIV/AIDS Coordinating Committee
<b>HIV</b>	Human Immune-Deficiency Virus
<b>MARPs</b>	Most – at-Risk- Populations
<b>NAA</b>	National AIDS Authority
<b>NGO</b>	Non Governmental Organizations
<b>PLWHA</b>	People Living with HIV/AIDS
<b>SD</b>	Stigma and Discrimination
<b>SPSS</b>	Statistical Package for Social Sciences
<b>UNAIDS</b>	United Nations Joint Program on AIDS

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## **ABSTRACT**

STIGMA, DISCRIMINATION AND COPING STRATEGIES AMONG PEOPLE LIVING WITH HIV/AIDS IN GAMBELLA TOWN, GAMBELLA PEOPLE NATIONAL REGIONAL STATE

KAHSAY MEHARI GEBREKIDAN

*Since the beginning of the HIV epidemic, stigma and discrimination had been identified as the major obstacles in the way of effective responses to HIV. The main objective of this thesis was to assess stigma and discriminations among people living with HIV/AIDS in Gambella Town, GPNRS. The researcher employed a descriptive research design. The participants of the study were people living with HIV/AIDS living in Gambella Town. Questionnaires and interview were used as data collection instruments and data was analyzed using SPSS statistic software version 20 to make full meaning of the information. The study revealed that people living with HIV/AIDS blame themselves (mean score= 3.95) and SD (1.11) with a t-test (.000) and ANOVA*

*result (.017) showed there are statistically significant difference between male and female respondent  $p < 0.05$ , respectively. They held a sense of withdrawal from school/training or rejection of such opportunities (mean score= 4.27) and SD (0.63) with a computed comparison of a t-test(.000) and ANOVA results (.053) showed there are statistically significant difference between male and female respondent  $p < 0.05$ , respectively. Because of such stigma and they reported to display self-discrimination problem, like hiding themselves (mean score= 3.68) and SD (1.10), Restricting themselves from social events and activities are manifested. Such stigma and discrimination prevented PLWHA from seeking treatments for AIDS or disclosing their status openly. This tendency is likely to increase HIV transmission further and exacerbates impacts of HIV and AIDS related stigma and discrimination. It is recommended that in order to cope with self-stigma and discrimination, people living with HIV/AIDS, the communities, government, and non-governmental organizations must work closely together with technical support, funding, participation, and awareness creation*

## **1.**

## **INTRODUCTION**

This chapter deals with the components of the introduction namely the background of the study, statement of the problem, research questions, objective of the study, significance of the study, scope of the study, limitation of the study and operational definitions of key terms.

### **1.1. Background of the Study**

Since the early days of the AIDS epidemic, stigma and discrimination have been recognized as obstacles to HIV prevention, treatment and support (UNAIDS, 2007). The epidemic and the Human immunodeficiency virus remain a complex and incurable disease which continues to devastate the lives of millions of individuals worldwide, and affect communities and nations.

HIV-related stigma and discrimination is a complex social process that interacts with, and reinforces, the pre-existing stigma and discrimination associated with sexuality, gender, race and poverty. HIV can be deemed as one of the greatest threats to human development.

HIV-related stigma and discrimination are substantive impediments to successful responses to the epidemic (Rao 2001; and UNAIDS, 2005a). Reducing and controlling HIV/AIDS related stigma and discrimination are the way for effective HIV prevention, care and treatment programmers. Stigma and discrimination associated with HIV & AIDS have been the greatest barrier to preventing further transmission, providing adequate treatment, care and

support and alleviating the impact (UNAIDS, 2002a). “HIV-related stigma and discrimination are more difficult to address than the actual virus, and tend to be an afterthought. We can no longer claim that stigma and discrimination are abstract and intangible concepts”. (Eka Esu Williams, as cited in Health & Development Networks, 2007, p. 48).

HIV/AIDS related stigma is fuelled by assumptions about lack of moral integrity and values of a person. According to Piot (2006), Executive Director of UNAIDS, “Since the beginning of the epidemic, stigma, discrimination and gender inequality have been identified as major obstacles to effective responses to HIV” (UNAIDS, 2007, p, 1). However, it was found through studies, program assessments and anecdotal information that health care providers often fail to provide confidential services and exhibit stigmatization and discriminatory attitudes/behaviors towards people living with HIV (Walton, Jones, Pereira, Skette, Tross and La Fleur, 2005; Cummings, Gobin, Narine, Ramlall, Pasram, Glasgow, Reddy, Conway and Sue-Chee, 2005). In addition, HIV AIDS has been considered as a killer disease for which there is no treatment. Ethiopia is a multi-ethnic, multi-cultural society; and stigma and discrimination can result due to people’s socialization and value-system.

There are various reasons for people to stigmatize and discriminate. It often relates to fear and shame because-HIV is perceived as devastating, deadly and transmitted by sex which is deemed taboo in the Ethiopian society. The fear and shame are often derived from lack of knowledge and understanding of people living with HIV/AIDS situation. All these factors lead to stigma and discrimination. Protection of human rights, particularly protection against discrimination, is the core principle in the prevention of HIV/AIDS (International Labour Office, 2000). Stigma, denial, and fear of disclosure due to discrimination among HIV/AIDS-affected persons continue to fuel the epidemic and remain a serious impediment to any control efforts in Ethiopia and other African countries. According to Pan American Health Organization (2005), health

professionals have a tremendous influence on the physical and emotional welfare of people living with HIV or who are vulnerable to infection since they could grant or deny access to life-saving treatment.

In a study done in Nigeria, it was found that health professionals refused to care for patients with AIDS and also refused to admit HIV positive patients in hospitals Letamo (2005). These negative behaviors can affect the HIV positive person's view of health care professionals and may discourage them from accessing medical care which can prolong their lives. More often, however, stigmatization causes a kind of social death in which individuals no longer feel part of civil society, and are no longer able to access the services and support they need (Daniel and Parker, 1990).

The rights, especially, to non-discrimination and equality before the law, access to social services including health and education, participation, employment, to marry and start a family, the right to privacy, dignity and reputation are particularly significant in terms of promoting and protecting the rights of PLHIV (Fikremarkos, 2007). In order 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 within a country. This study was conducted to assess how stigma, discrimination and coping strategies among people living with HIV/AIDS in Gambella town, GPNRS. If HIV/AIDS is to be treated successfully, stigma and discrimination have to be better understood.

It is therefore necessary to research into this phenomenon to ascertain the validity of this assertion held by people living with HIV/AIDS against one's self to help fight this pandemic and also contribute to knowledge. The main reasons that motivate the researcher to conduct this research was because, according to the Gambella regional HIV/AIDS prevention and control office, stigma and discrimination is one of the most serious issues facing people living with HIV/AIDS in Gambella town.

## **1.2. Statement of the Problem**

Research has documented that fear of stigma and discrimination represents an important barrier to treatment and care (Heijnders and van der Meij, 2006). HIV-related stigma and discrimination still remains one of the setbacks to self-disclosure of sero status and early treatment seeking behavior. According to Sok (2010), people behave badly toward PLWHAs

and that behavior force them to live with hopelessness, uncertainty, and isolation. Studies on stigma and discrimination have found that people who have minimal education or misperceptions regarding HIV transmission are more likely to hold discriminatory attitudes (Shulman, & Mantell, 1988; Siminoff, Erlen & Lidz, 1991). Because of unacceptability and disharmony by the community, it was deemed that internal stigma including fear, depression, and soreness, fuels a general sense of despair and suicidal thoughts; is pervasive and has negative impacts against the quality of life of PLWHAs.

Previous studies have said that the association of HIV with generally stigmatized social groups has a halo effect that impacts all persons living with HIV (Carr, 2002; White and Carr, 2005). PLWHA are not only stigmatized by others but they also stigmatizes themselves due to perceived stigma or experience of discrimination which can have serious consequences such as low self esteem, depression and self isolation. Roseval (2007), in his study on HIV/AIDS stigma and discrimination among Nurses in Suriname found similar traits where some nurses in the study had passed information about patients HIV status to their colleagues and members of the public. Responses to stigma may vary in different cultures, so understanding local values and beliefs are essential, and especially when designing programmes (Weiss, 2001). There is also evidence that stigma, denial, and fear of disclosure of HIV/ AIDS affect Ethiopian immigrants after they settle in industrialized countries (Kaplan, 1998).

According to UNAIDS (1997), in Beneshangul-Gumuz, the stigma attached to the diagnosis of HIV/AIDS was found to be so strong that health workers were afraid to pronounce the diagnosis of AIDS; thus, no clinical or serological diagnosis was attempted. Abdul (2000), argued that the first and the biggest challenge is political leadership to overcome HIV/AIDS related stigma in the country by mobilizing people in an open, frank, creative and unhesitating way. He further added that every single government institution, every school, every kebele office, every church and mosque should teach about AIDS. According to Gambella regional HIV/AIDS prevention and control office (2015), HIV/AIDS related stigma and discrimination occurs frequently in urban areas rather than rural areas. Furthermore, women are more likely to be discriminated than men, and they have fear of disclosure of their HIV status. It cannot be denied that HIV/AIDS is the most deadly infectious in Gambella town in particular and the world at large.

According to Gambella regional HIV/AIDS prevention and control office (2015), the number of people living with HIV/AIDS is 301. So, standing from this, the researcher focused on stigma and discrimination in urban areas. In addition, HIV/AIDS related stigma & discrimination affects their individual socioeconomic status so that people living with HIV/AIDS have to confront their livelihood. Furthermore, the perspective and attitude of the community against people living with HIV/AIDS has shown that PLWHAs were remarkably discriminated in the form of limited accessibilities of employments, housing, expression freedom, community involvements and other events.

All the above listed research findings focused on how community leaders, the general public, health care professionals, youth's and others stigmatize and discriminate against PLWHA. Even if there is a research conducted on self-stigma and discrimination specifically, much study has not been conducted on stigma, discrimination and coping strategies among people living with HIV/AIDS in Gambella town. Therefore, this research is different from the previous studies which focus on how people living with HIV/AIDS stigmatize and discriminate themselves and coping strategies.

### **1.3. Research Questions**

Based on the statement of the problems, the following major research questions are developed to carry out the study:

1. What are the demographic characteristics of people living with HIV/AIDS in Gambella Town?
2. How do people living with HIV/AIDS stigmatize themselves in Gambella Town?
3. How are discriminations manifested among people living with HIV/AIDS in Gambella Town?
4. What are the coping strategies used by people living with HIV/AIDS and stigma and discrimination in Gambella Town?

### **1.4. Objectives of the Study**

In this part, the researcher discusses briefly the general and specific objectives of the study on stigma and discrimination among people living with HIV/AIDS in Gambella Town, GPNRS.



#### 1.4.1. General objective

The general objective of the study was to assess the stigma and discrimination experiences among people living with HIV/AIDS in Gambella Town, GPNRS.

#### 1.1.2. Specific objectives

Specifically, the specific objectives of the study were to:

- To know the demographics characteristics of people living with HIV/AIDS in Gambella Town.
- Assess self stigma among people living with HIV/AIDS in Gambella Town.
- Examine manifestation of discrimination among people living with HIV/AIDS in Gambella Town.
- Assess the coping strategies used by people living with HIV/AIDS to alleviate the problems of stigma and discrimination in Gambella Town.

### **1.5. Significance of the Study**

The study will be helpful in identifying HIV/ AIDS related stigma and discrimination and how the people living with HIV/AIDS can live fearlessly in the normal population in Gambella town. It helps to fight this pandemic and also contributes to knowledge. It creates and raises awareness about stigma and discrimination of people living with HIV/AIDS. The results of the research will also influence policy makers to scale up government programmes on HIV/AIDS prevention. The study results had been useful in reducing stigma and discrimination of people living with HIV/AIDS and they were more willing to disclose their status as well as access to health services without restrictions by creating and raising awareness.

The results of this research provide useful information to stakeholders as reference, government, non-governmental organizations (NGO), Faith-based Organizations (FBO), and other parastatals, and health care providers to create more awareness to prevent/reduce stigmatization and discrimination among people living with HIV/AIDS by providing awareness creation workshops. In addition, this study contributes to support the regional HIV/AIDS efforts in compacting the virus as an alternatives solution. This study will mainly benefit people

living with HIV/AIDS by identifying the manifestation of HIV/AIDS related stigma and discrimination and coping strategies. This study will also provide a baseline for future studies to be undertaken by other researchers by providing a soft and hard copies and also publishing it on internationally reputable journals.

## **1.6. Delimitation of the Study**

The study was delimited only to Gambella town which is the most populated capital city of the region. The capital city has diversity of population from the different parts of the country. According to the regional HIV/AIDS prevention and control office (2015/16), in this area there is high number of HIV positive incidence and prevalence when compared to other town of the region. The study does not cover other areas of the region even if the researcher conducts a study on the same issues on other town due to time and financial constraints the researcher was delimited to this area. In terms of content, the study was limited to assess how people living with HIV/AIDS make stigma and discrimination against one's self in Gambella town, GPNRS. This study focused on answering demographics characteristics of people living with HIV, discrimination among people living with HIV/AIDS and how people living with HIV/AIDS stigmatize themselves in Gambella Town.

It also dealt with identifying the coping strategies in which people living with HIV/AIDS cope with stigma and discrimination in Gambella Town. This research involved both qualitative method to collect the qualitative data and quantitative methods of data collection for the quantitative data. The researcher used quantitative and qualitative data analysis method to analyze the collected data. The main participants of the study were people living with HIV/AIDS at Gambella town. Questionnaires and interview were used to gather primary and secondary data during the field research period. All analyses had been conducted using SPSS version 20. Furthermore, it was also incorporated mean, percentage, frequency, ANOVA, t-test, and cross tabulation was used in analysis part.

## **1.7. Limitation of the Study**

There are some limitations to this study. Although plenty of publications were found on the topic, very few published papers were available about stigma and discrimination at Gambella

town as well as Gambella region. In addition, this study failed to include sample representative of other woredas and towns of the region.

## **1.8. Operational Definitions of Key Terms**

**Acquired Immune Deficiency Syndrome (AIDS)** is the late stage of the infection when people living with HIV/AIDS immune system are weakened and the individual becomes more susceptible to a variety of infections.

**Stigma** refers to the negative beliefs, feelings and attitudes of people living with HIV/AIDS toward themselves associated with being HIV positive.

**Self stigma** refers to when people living with HIV/AIDS develop internalization of shame, blame, hopelessness, guilt and fear of discrimination associated with being HIV-positive to toward themselves.

**Discrimination** is an aspect of stigma that people living with HIV/AIDS exclude, or restrict one's self from expression, marginalize or prevent oneself from access to something or services.

**Human immunodeficiency virus (HIV)** is a retrovirus that infects cells of the human immune system (mainly CD4 positive T cell and macrophages – key components of the cellular immune system) and destroys or impairs their function (CAREC, 2002, p. 2).

**People living with HIV/AIDS** are the people who are HIV positive and have symptoms of AIDS.

**Coping strategies** imply application of any coping mechanism to checkmate negative psychological and physical feelings.

## 2.

## REVIEW OF RELATED LITERATURE

This chapter focuses on literature of stigma and discrimination experiences of those living with HIV/AIDS. First, the general overview of stigma and discrimination will be discussed by defining stigma and discrimination. This chapter also describes the sources of HIV/AIDS related stigma and discrimination in the context of the individuals themselves and their families, communities and how each relates to health care, and employment. Furthermore, previous studies on stigma and discrimination also identified, analyzed, and discussed the situations and the factors causing stigma and discrimination. These studies were selected to create benchmarks to which the results and findings of this research can be compared. Finally, this literature review provides a conceptual framework of the study.

### **2.1. General Overview of Stigma and Discrimination**

When talking about HIV/AIDS, many people become concerned with their own sexual history often panicking or appearing nervous out of a fear of becoming infected with viruses and ailments. However, HIV/AIDS related stigma and discrimination has many more problems in addition to those mentioned above. According to UNAIDS; 2000) and Malcolm, Aggleton, Bronfman, Galvao, Mane, and Verrall, 1998), the issue of stigma and discrimination was undermined by public health efforts since there was not enough effort against stemming the spread of the disease. In addition to this, stigma and discrimination were shown in the form of inequality of human dignity when people were treated with prejudice against marginalized groups including homo and bisexuals, drug users, sex workers, prostitutions, and so on. According to Goldin (1994), the risky behavior of seeking unprotected sex was associated with immoral or deviant manner which led to stigma and discrimination.

In reality, HIV/AIDS related stigma and discrimination has been shown to be a major challenge among PLHIVs to access social services health care treatment, and social support. According to Piot (2000), the former executive director of UNAIDS, stigma and discrimination has interfered with PLHIVs' ability to take part in social development at the community, national, and regional levels. Similarly, the former director of the WHO global program on

AIDS, (Mann, 1987), claimed that the HIV/AIDS epidemic could be classified into three stages: the stage of HIV epidemic, AIDS epidemic, and the epidemic of stigma, discrimination and denial. Indeed, the last phase was considered as central to the global AIDS challenge as the disease itself. Somerville and Orkin (1989), expressed a similar view that not only there is intense concern over the HIV pandemic itself, but there was also worried about the stigma and discrimination consequences which was also dubbed as a second phase of the AIDS epidemic. Also, due to a misconception about the disease, Alonzo, Angelo and Nancy (1995), pointed out that historically people reacted to the fear of embarrassing, incapacitating, and fatal diseases by discriminating against infected people. Simultaneously, CCSO (2011) mentioned that stigma and discrimination is perpetuated by lack of awareness and understanding about PLWHAs and MARPs issues among the general population and among social and political leaders in particular. According to Goldin (1994), felt that the effectiveness of HIV/AIDS strategies against prevention and treatment programs, cultural, and social stigma should be included in the greater fight against the disease. According to Aggleton (2000) and the Center for research on Women (2000), discrimination against PLWHAs was unjust and inhibit public health program effectiveness.

Researchers have opened that, there are many similarities between HIV- related stigma and discrimination and stigma and discrimination related to other diseases such as tuberculosis, leprosy, mental illness, physical disabilities, cancer and even suicide (Sontag, 1998; Pan American Health Organization, 2005). According to Aggleton, Parker and Maluwa (2003), the stigma and discrimination associated with HIV/AIDS are more manifestly expressed than to other health conditions. They stated, all over the world and especially in Latin America and the Caribbean, stigma and discrimination have systematically played to, and reinforced existing prejudices. Stigma and discrimination were also recognized as barriers to the provision of adequate health care, psychological and social support, and appropriate medical treatment (Kohi, Makoae, Chirwa, Holzemer; Phetlhu, Uys, Naidoo, Dlamini and Greeff, 2006). Stigma and discrimination are interrelated and often the terms are used synonymously.

## **2.2. Concepts of Stigma and Discrimination**

This part focuses on giving brief explanation on the concept of stigma and discrimination. First,

an explanation will be given on the definition of stigma and the type of stigma. Then, the concept of discrimination and type of discrimination will be discussed. The issue of HIV-related stigma and discrimination remains a serious obstacle to the HIV responses. Stigma and discrimination occurs in all societies, and it is created by individuals and communities in a response to their own fears (Brimlow, Cook and Seaton, 2003). It is remarkably consistent across all cultural contexts (Ogden and Nyblade, 2005). A studies conducted in Asia have shown inaccurate beliefs about HIV transmission are related to fear and stigmata (Boer and Emons, 2004). In this study, having an adequate knowledge about HIV/AIDS was not associated with HIV/AIDS-related stigmata or discriminatory attitudes. Similar to a study conducted in the United States, moral judgment or societal norms play an important part in stigma and discriminatory attitudes toward people living with HIV/AIDS (Herek and Capitanio, 1997).

#### 2.2.1. Stigma and its types

There are many definitions related to stigma. Goffman (1963), one of the world's most recognized thinkers on stigma, defines stigma as a 'discrediting attribute', constituting a "discrepancy between virtual and actual social identity" (p.3). According to Jonna (1999), stigma is defined as tangible or intangible characteristic distinguished by negative emotion. More often, however, stigmatization causes a kind of social death in which individuals no longer feel part of civil society and are no longer able to access the services and support they need (Daniel & Parker, 1990). Furthermore, Goffman (1963), claimed that: stigma is a concept of disgrace that people attributed as an undesired difference which is an obstacle for a person or individuals to display certain traits.

In HIV/AIDS context, stigma refers to all unfavorable attitudes and beliefs directed toward people living with HIV/AIDS or those perceived to be infected, and toward their own and loved ones, close associates, social groups, and communities. Similarly, according to the Population Council (2008), stigma is a given to infected people who have to live apart from society and need to escape from the reaction of others. Other researchers have separately classified the definitions of stigma into two types, Malcolm et al (1998) & Scrambler, (1998) & Jacoby, (1994). Felt stigma refers to the association between internal feeling of undesirable attribute of scare against social attitudes and surrounding environment where infected people

dwell. By comparison, enacted stigma was defined as the authentic experience of discrimination.

Moreover, Gilmore & Somerville (1994), expressed a similar view that the characteristics of stigma are associated with individual features leading to discrimination, which results in limitations, prohibitions, and negative distinction. HIV/AIDS related stigma is fuelled by assumption about lack of moral integrity and values of a person; people tend to associate AIDS with moral impropriety (International Center for Research on Women-ICRW, 2006a). Researchers such as Inzlicht, McKay, and Aronson (2006) and Aggleton, Wood, and Malcolm (2004), have endeavored to identify different categories of stigma in order to understand the phenomenon and to guide interventions to reduce its effects.

#### 2.2.1.1. Self stigma

Self stigma is stigma that is accepted and internalized by a person so that he/she takes on the attitudes and perceptions of others, which become the belief system. Evidence suggests that internalized stigma may aggravate psychiatric morbidity among people living with HIV (Van Brakel, 2006). The person can then restrict his/her behavior and develop self-blame and self-pity (UNAIDS, 2000), fatalism, self-loathing and isolation (Rankin, Brennan, Schell, Laviwa, and Rankin, 2005, p. 2). This internalized stigma means that the person may not seek medical attention. It can have a profound psychological effect, and leads to depression, and isolation (Aggleton et al., 2004); and Anderson, Elam, Gerver, Solarin, Fenton and Easterbrook, 2008). It infects your mental state, resulting in behaviors beyond your own ability to comprehend.”

#### 2.2.1.2. Dyadic and instrumental stigma

In addition to the stigma which affects the individual, there is dyadic stigma described by Wight, Aneshensel, Murphy, Miller-Martinez, and Beals, (2006), which may include the stigma felt by the person who has HIV/AIDS, combined with caregiver stigma, (being associated with someone who has HIV/AIDS); plus the overlap in stigma which represents the individual perceptions of the person with HIV/AIDS and the caregiver. Herek (1999), uses the term instrumental stigma to describe the fear and apprehension that are likely to accompany any deadly or transmissible disease. Instrumental stigma is a reflection of the fear and apprehension that are likely to be associated with any deadly transmissible illness. Because HIV/AIDS is a potentially fatal condition, this stigma is another facet of the layers of stigma felt by a person

with this disease.

#### 2.2.1.3. Symbolic and courtesy stigma

Symbolic stigma may be used as a vehicle to express hostility towards already marginalized groups (Herek, 1999). Groups such as commercial sex workers, men who have sex with men or injecting drug users endure such stigma. It is associated with the meanings that have been attached to the disease with marginalized groups. It is also used to express attitudes toward the social group or lifestyles perceived to be associated with the disease. Bharat, Aggleton, and Tyrer (2001), use the term *courtesy stigma* which arises from the association of family members or medical workers, whereby they are branded for working or helping people living with HIV/AIDS (Anderson et al., 2008; Health and Development Networks, 2006). Objects also may be associated with stigma, and become 'tainted'. Thus, family members may isolate cooking and eating utensils used by the person with HIV/AIDS even though there is no risk of contamination. Courtesy stigma refers to shared stigma by anyone associated with the condition, even if uninfected.

#### 2.2.1.4. Structural stigma

This occurs in organizations or institutions or structures where they work. They may suffer stigma from their co-workers and employers, such as social isolation and ridicule, or experience discriminatory practices, such as termination or refusal of employment. Fear of an employer's reaction can cause a person living with HIV anxiety. It is always at the back of their mind: "If I get a job, should I tell my employer about my HIV status? There is a fear of how they will react to it. It may cost them their job. Structural stigma derives from institutions such as the media when they spread stigmatizing messages (Corrigan, Watson, Gracia, Slopen, Rasinski and Hall, 2005). Reporting can be responsible, but is often sensational and insensitive. It is used the term *public stigma* in examining institutions and funding. They argue that this affects public policy and resource allocation.

#### 2.2.1.5. Re-stigmatization

This can occur when one group is singled out already, such as homosexuals (Herdt, 2001). It is important to understand this type of stigma, as it may lead to covering up, or passing as normal. There is always the possibility in publicizing situations of stigma and discrimination, that the



person is restigmatised. Bharat and Aggleton (1999), assert that stigma leads to loss of social status and prestige, and affects a person's self-worth.

#### 2.2.1.6. Prejudice

Prejudice, according to Chambers Dictionary (2008) is [“a biased opinion based on insufficient knowledge”p.38]. It is unreasonable dislike or preference for a person, a group based on insufficient knowledge. This insufficient knowledge creates stigma and discrimination. People who have more prejudice may believe that PLWHA should be placed under control of the State, in order to prevent spread of the disease; or that compulsory testing from high-risk groups may ensure control and prevention of further spread in the community (Kippax, Tiller, Crawford and Cregan, 1991). The expression of such views establishes the prejudiced person as being firmly against the deviant or different and helps the prejudiced person to understand, and make sense of AIDS. Punishment and retribution may be enacted at an institutional and individual level; in the form of refusal of treatment, incarceration, isolation and avoidance of people suspected of having AIDS (Kippax et al., 1991). Prejudice serves a purpose for the individual, according to Katz (1960).

#### 2.2.2. Discrimination and its types

There are various definitions raised about discrimination. When stigma is acted upon, the result is discrimination. Discrimination consists of actions or omissions that are derived from stigma and directed towards individuals who are stigmatized. Discrimination, as defined by UNAIDS (2000), in the protocol for identification of discrimination against people living with HIV, refers to any form of arbitrary distinction, exclusion, or restriction affecting a person, usually but not only by virtue of an inherent personal characteristic or perceived belonging to a particular group- in the case of HIV and AIDS: a person with confirmed or suspected HIV-positive status - irrespective of whether or not there is any justification for these measures. Discrimination can also be defined as a behavior in which a distinction is made against people, that results in the person being treated unfairly or unjustly on the basis of them belonging or perceived to belong to a particular group.

According to Population Council (2008), discrimination is shown as a negative action amongst general people against marginalized groups. Also, Jonna (1999), expressed a similar view that:

Discrimination is the process of social dissatisfaction of HIV infected people who were displayed in the form of limited knowledge, behavior, belief, and fear from community members. Besides, it was further described as dominance and oppression against a particular group for the purpose of power and privilege (Marshall, 1998). According to Bunting (1996), also drew attention to the fact that the components of discrimination consisted of pessimistic practice and treatment that were directly transformed to stigma.

In HIV/AIDS context, discrimination refers to the unfair and unjust treatment (act or omission) of an individual based on his or her real or perceived HIV status. Perhaps in consequence, numerous countries have now enacted legislation to protect the rights and freedoms of people living with HIV/AIDS and to safeguard them from discrimination (Mann, Tarantola and Netter, 1992; Mann, Tarantola and Netter, 1996). This part discusses the types of discriminations such as discrimination by age, sex and institutional settings.

#### 2.2.2.1. Discrimination by age and sex

A young person living with HIV/AIDS is often treated with discord and contempt rather than an elderly person because it is believed that the young person got it through sexual promiscuity. Women with HIV or AIDS may be treated differently from men in some societies where they are economically, culturally and socially disadvantaged. They are sometimes mistakenly perceived to be the transmitters of sexually transmitted diseases. Men are more likely than women to be excused for the behavior that resulted in their infection. In such a male-dominated society no-one ever accepts that the man is actually the one who did something wrong.

#### 2.2.2.2. Discrimination in institutional settings

Discrimination in institutional settings particularly seen in work places, health care services, prisons, educational institutions and social-welfare settings. Such discrimination crystallizes enacted stigma in institutional policies and practices that discriminate against people living with HIV, or indeed in the lack of discriminatory policies or procedures of redress. This occurs in the forms of denial of access to care and treatment, denial of employment based on HIV-positive status, and exclusion from collective activities. Examples of this kind of discrimination against PLWHAs include the following: health-care services: reduced standard of care, denial of access to care and treatment, HIV testing without consent, breaches of

confidentiality including identifying someone as HIV-positive to relatives and outside agencies, negative attitudes and degrading practices by health-care workers. Workplace: denial of employment based on HIV-positive status, compulsory HIV testing, exclusion of HIV-positive individuals from pension schemes or medical benefits. Schools: denial of entry to HIV-affected children, or dismissal of teachers. Prisons: mandatory segregation of HIV-positive individuals, exclusion from collective activities.

### **2.3. Sources of HIV/AIDS-related to Stigma and Discrimination**

People's behaviors and attitudes toward stigmatized individuals are numerous, distinct and varies in terms of severity and levels of condemnation. Stigma is often manifested through cognitive behaviors and can be measured along a continuum from the subtle and unobservable to the very overt and damaging. Generally, overt damaging behavioral manifestations of stigmatization include dehumanization, discrediting, discounting, aversion, avoidance, ostracization, social rejection and depersonalization of persons through labeling and branding (Bos, 2001, citing Dovidio, Major and Crocker 2000; UNAIDS 2005a and Herek and Capitano 1998). Subtle stigmatizing behaviors are less observable, and are sometimes expressed as non-verbal signs of discomfort during interactions between stigmatized and non-stigmatized individuals (Bos, 2001 citing Hebl et al. 2000). Bos further posited that human behavior is by nature complex and because of this people rarely behave in purely negative or positive ways towards stigmatized individuals.

The Weiner's attribution-emotional model was used by Bos to describe how pity and anger, motivate certain social reactions by perceivers, towards marked individuals. For example, emotional reactions of pity usually evoke "prosocial" behaviors, such as sympathy and support; whereas anger often motivates hostile and stigmatizing behaviors (Bos, 2001 citing Weiner, et al., 1998). In order to find out the sources of HIV/AIDS related stigma and discrimination against PLHIVs, Aggleton (2000), showed that as the HIV/AIDS pandemic has spread around the world, there are misconceptions about the disease. It was assumed that HIV/AIDS was associated not only with death, but also horror, punishment, guilt, shame, and so forth. Furthermore, due to these stereotypes, people infected with HIV were likely to hide their status from others.

However, (De Bruyn, 1999), pointed out that there were five factors causing HIV/AIDS related stigma and discrimination; - HIV/AIDS was considered a life threatening disease - due to their limited knowledge, people were still afraid of contracting HIV/AIDS - due to their risky behavior, MARPs already discriminated against by society - PLWHAs were seen as having contracted the disease as their own responsibility. Infected people were considered to have deserved punishment of the disease because they are seen as having disobeyed the rules of religious belief and morality.

## **2.4. Context of HIV/AIDS-related Stigma and Discrimination**

The manifestation of HIV/AIDS related stigma and discrimination has been seen in contexts ranging from the infected individual themselves, their families, the local community, their work place environment, and in the health care system. Families may reject sero positive members not only because of the stigma associated with HIV/AIDS, but also because of the connotations of homosexuality, drug use and promiscuity that HIV/AIDS carries (Panos, 1990; Misra, 1999; and Mujeeb, 1999). HIV/AIDS related stigma is a process of deviation of people either living or association HIV/AIDS. Stigma always aggravated preexisting stigmatized condition such illicit sex and anti-retroviral drug which are two primary routes of HIV transition.

The stigma associated with HIV/AIDS is underpinned by many factors, including lack of understanding of the illness, misconceptions about how HIV is transmitted, lack of access to treatment, irresponsible media reporting on the epidemic, the incurability of AIDS, and prejudice and fears relating to a number of socially sensitive issues including sexuality, serious illness and illicit drug-use. HIV /AIDS discrimination is an action result from stigma. It is accrued when the person treats unfairly an unjustified on the basis their actual HIV status, or being perceived particular group.

### **2.4.1. Individual context**

Not only does discrimination occur but infected people also face internal stigma or negative internal feelings. PLWHAs were attributed to have stigma in either family or community when their HIV status disclosure was unaccepted by societies. According to Daniel and Parker (1993), when people are afraid of HIV infection, it leads to discrimination that caused PLWHAs to feel isolated, hopeless, ignored, and suffers. Due to this continuing process of

internal feeling, infected people were unable to access any kind of social support or public services they need. In some cases, some infected people decided to commit suicide to end these issues (Gilmore and Somerville, 1994). Others who learnt about this internal stigma decided to hide their HIV status in order to prevent themselves from the reactions and fear from others (Public Media Center, 1995).

#### 2.4.2. Family context

Generally, in developing countries, there have been similar reports about the role of family members in caring of people living with HIV/AIDS as they played a fundamentally important role in providing basic needs and care to sick members. According to World Bank (1997) and Warwick, Bharat, Castro, García, Leshabari, Singhanetra-Renard and Aggleton (1998), the main function of family members is to care PLWHAs for either emotional or physical support. Nonetheless, it was not for all family members since some infected or affected people reported that they were unequally treated within the home stays. Once again, Bharat and Aggleton (1999), drew attention to the fact that women and homosexual family members were more likely to face discrimination than men and children. Also, people living with HIV/AIDS were more likely to be refused not only due to their HIV status but also their negative action such as promiscuity, drug user, and homosexuality. This view was supported in the work of Misra (1999). However, HIV/AIDS related stigma and discrimination in the family environment is seen to have spread to their neighbor, friends, and others.

#### 2.4.3. Community context

Due to the lack of knowledge, misconception, and fear of HIV/AIDS disease, PLWHAs faced stigma & discrimination while the society including cultural belief against HIV/AIDS disease accused infected people of bringing the HIV virus into their community. Those who were infected by HIV virus were believed to be immoral people and were judged as deviant. This type of conceptualization would, therefore, manifest the way, which community people reacted against stigma & discrimination. At the same time, it has been commonly observed that stigma & discrimination in either family or community is frequently illustrated in the form of guilt, blame, punishment, gossip, and others. Nardi and Bolton (1991), notes that stigma and discrimination sometimes manifested in violence just as it was pointed out that sex workers and

street children were also abused (Public Media Center, 1995).

#### 2.4.4. Job Employment and workplace context

Discrimination against people living with HIV/AIDS in the work places has limited the ability of people living with HIV/AIDS to earn an income in order to support them. According to Gostin and Lazzarini (1997) and Omangi (1997), stigma and discrimination in the workplaces took the form of denied employment, pre-employment HIV testing, dismissal from jobs, and job harassment. Sometimes it was reported that some colleagues resist working with or sitting near PLWHAs. Hughes (1988), concluded that in developing countries, few countries set up a policy to fight against HIV/AIDS related stigma and discrimination and that there was little attention given to infected people at their workplaces.

#### 2.4.5. Health care context

HIV/AIDS related stigma and discrimination also occurs in the health care system when infected people seek health care support and treatment. According to Ogola (1990), found that people living with HIV/AIDS were ignored and turned away while hospitalized. Herek et al (1998), stated that stigma occurs due to a lack of knowledge and unawareness of how HIV/AIDS is transmitted. Stigma and discrimination led to fear because of the diseases, which in turn leads to a generally weakened health care system. A study conducted by UNAIDS in India has shown that health care setting was the major source of stigma and discrimination in India. (UNAIDS, 2001).

### **2.5. Consequences of HIV-related Stigma and Discrimination**

Stigma and discrimination can result in many negative consequences for people living with HIV. Some of these consequences which the researcher will address in this research are fear of finding out one's serostatus; fear of disclosure and self-stigma. HIV-related stigma also results from fear of becoming infected through casual contact such as shaking hands, eating from the same utensils and sharing toilet facilities. Stigma and discrimination also impact on the care and support of people living with HIV/AIDS, undermining capacity to provide support and reassurance to those infected and affected, in the community, in workplaces and in health care settings.

Stigmatization of those affected, but not infected, by HIV/AIDS, such as family care-givers and

relatives, can affect the quality of care given to infected people and may deter professional and volunteer care-workers from providing and participating in care. Such fear is perpetuated by misinformation and lack of knowledge about HIV transmission. Fear of death also adds to the sources of HIV-related stigma, which can render the perceiver powerless to enact different attitudes towards People Living with HIV (Mc Lean, 2004; Brown, Trujillo and Macintyre, 2001).

#### 2.5.1. Fear of finding out one's sero-status

Leary and Schreindorfer (1998), posited that people may hesitate or resist to be tested for HIV, because they are afraid to become stigmatized and of the social repercussions if they are tested positive. This could result in persons infecting others and not accessing treatment in time for the infection. Studies have found that people who do get tested sometimes do not return for their results for fear of being seen at a clinic, which could raise suspicions about their health (ICRW, 2006 and Bos, 2001).

#### 2.5.2. Fear of disclosure

People living with HIV fear disclosure for a number of reasons. These include becoming the target for gossip and taunts, loss of social contact, loss of personal income, loss of jobs and lack of understanding on the part of the person he/she discloses to. According to Bos (2001), individuals need to decide to whom they will disclose. Disclosure of serostatus is normally higher among symptomatic than asymptomatic persons. Studies found, stigma to be a contributory factor to the low levels of access to testing, care and treatment sites by people living with HIV (White and Carr, 2005; ICRW, 2006). The studies have found that individuals did not disclose their status to their most intimate partners and significant others for fear of physical violence and abandonment (ICRW, 2006; Choy, Jacobs, Thomas and UNAIDS, 2001). However, in Guyana, it was found that reactions to disclosures were improving (National AIDS Commite, 2008).

#### 2.5.3. Self stigma

Our behavior along with environmental and personal factors interacts with each other to influence how we interact with each other. Bandura (1970), in his Social Cognitive Theory

(SCT) explains how people learn not only through their own experiences, but also by observing the actions of others and the results of those actions. Hence people living with HIV/AIDS may see themselves different from other non-infected persons. People living with HIV often reduce contact with people who are close to them. They perceive themselves as victims of a deviant behavior. Emotions such as anxiety, depression or hostility are psychological consequences that may be demonstrated by patients (Bos, 2001 citing Jones et. al., 1984). This process is painful as the individual is forced to act against his or her natural character.

Shin (2000), suggests that in the Ethiopian community, HIV-related stigma tends to be firmly linked in people's minds to sexual behavior. This is regarded as promiscuous that places people living with HIV/AIDS into an unnecessary hostile and embarrassing situation, making the government's strategy to fight against the epidemic very difficult. Further, the awareness that one's identity is devalued in the eyes of others may also be a threat to one's self-esteem (Bos 2001 citing Crocker et al., 1998).

## **2.6. Coping Strategies used by People Living with HIV/AIDS Stigma and Discrimination**

Coping prevents damaging emotions which can render immune system inactive (Scheck and Kinicki, 2000). HIV and AIDS related stigma and discrimination interacts within a broader social, cultural, political and economic framework. It is not an individual action but it is a social process which creates and maintains social control and structural inequalities (Parker and Aggelton, 2002). Therefore, a single intervention or initiative such as individual psychological approach or legal reform does not have much impact on reducing stigma and discrimination. The studies reviewed have shown that intervention should be multi-targeted and oriented at multiple levels (Heijnders and Meij, 2006). They should aim at social, environmental and structural change to tackle various aspects of HIV and AIDS related stigma and discrimination simultaneously (Parker and Aggelton, 2002). The fear of stigma and discrimination may influence people living with HIV to reject or postpone care, prevent exercising other rights such as working, attending schools etc. (UNAIDS, 2007b)



## **2.7. HIV/AIDS Policies and Strategies Responses**

The response to the AIDS epidemic in Ethiopia has been a collective effort of the government, multilateral and bilateral donors, national and international non-governmental organizations, community-based organizations, faith-based organizations, the private sector, associations of PLWHA and individuals. The Federal Democratic Republic of Ethiopia issued the first HIV/AIDS policy in 1998 and this is still in use. The policy addresses issues of prevention, treatment of patients, care and support for orphans and vulnerable children (OVC), the protection of human rights of people living with HIV (PLHIV) and coordination issues. The policy underscores the need for a multi-sectoral response and calls for a harmonized approach by government and non-government organizations, the private sectors and communities.

The National AIDS Prevention and Control Council was established in 2000 and charged with implementing the strategic framework for the National Response to HIV/AIDS in Ethiopia for 2000-2004.

The council, chaired by the president of Ethiopia and comprising members from government, NGOs, religious bodies, and civil society, has declared HIV/AIDS a national emergency. The National HIV/AIDS Prevention and Control Office (HAPCO) were established by proclamation in June 2002, and replaced the National AIDS Council (NAC). This was important, and provided an enabling environment and ample opportunities for all those already involved and potential actors in the prevention and control of HIV/AIDS to align for a concerted effort. In 2000-2004, the National Policy on HIV/AIDS (1998) and the strategic framework for the National Response to HIV/AIDS (2001-2005) guided the national response to the epidemic. The overall objective of the Policy and Strategic Framework was to guide the implementation of successful programs to prevent the spread of the disease, decrease vulnerability of individuals and communities to HIV/AIDS, to care for those living with HIV/AIDS and to reduce the adverse socio-economic consequences of the epidemic.

An important development that took place in 2005 concerns the launching of the Strategic Plan. On the 24th of January 2005, the Federal Democratic Republic of Ethiopia (FDRE) launched the second strategic plan for intensifying multi-sectoral HIV/AIDS response (2004-2008),

along with the free Anti-retroviral treatment program and a number of documents strategically important for the strategic plan implementation, namely: Social mobilization strategic document; Anti-retroviral therapy implementation guidelines; and the report “AIDS in Ethiopia – fifth edition”. The new strategic plan builds upon achievements so far, and takes into consideration lessons learned through the implementation to date of the response to HIV/AIDS in Ethiopia.

The strategic plan for intensifying multi-sectoral HIV/AIDS response (2004-2008) is based on guiding principles such as: multi-sectoralism, empowerment, shared sense of urgency, gender sensitivity, involvement of PLHIV, result oriented interventions and best use of resources through allocation, harmonization, efficiency and accountability. Thus, it is critical to develop a policy and strategy to reduce stigma and discrimination, both for the sake of mitigating the direct effects of stigma and discrimination on PLHIV, and for allowing resources and programs directed at HIV/AIDS treatment and prevention to reach their full, unhindered potential. There are various instruments at international, regional and national level that urge governments to take legal, policy and administrative measures to protect PLHIV from violation of human rights and ensure that they have access to basic services including anti-retroviral treatment. Therefore, Ethiopia has established policies and strategic plan in response to HIV/AIDS.

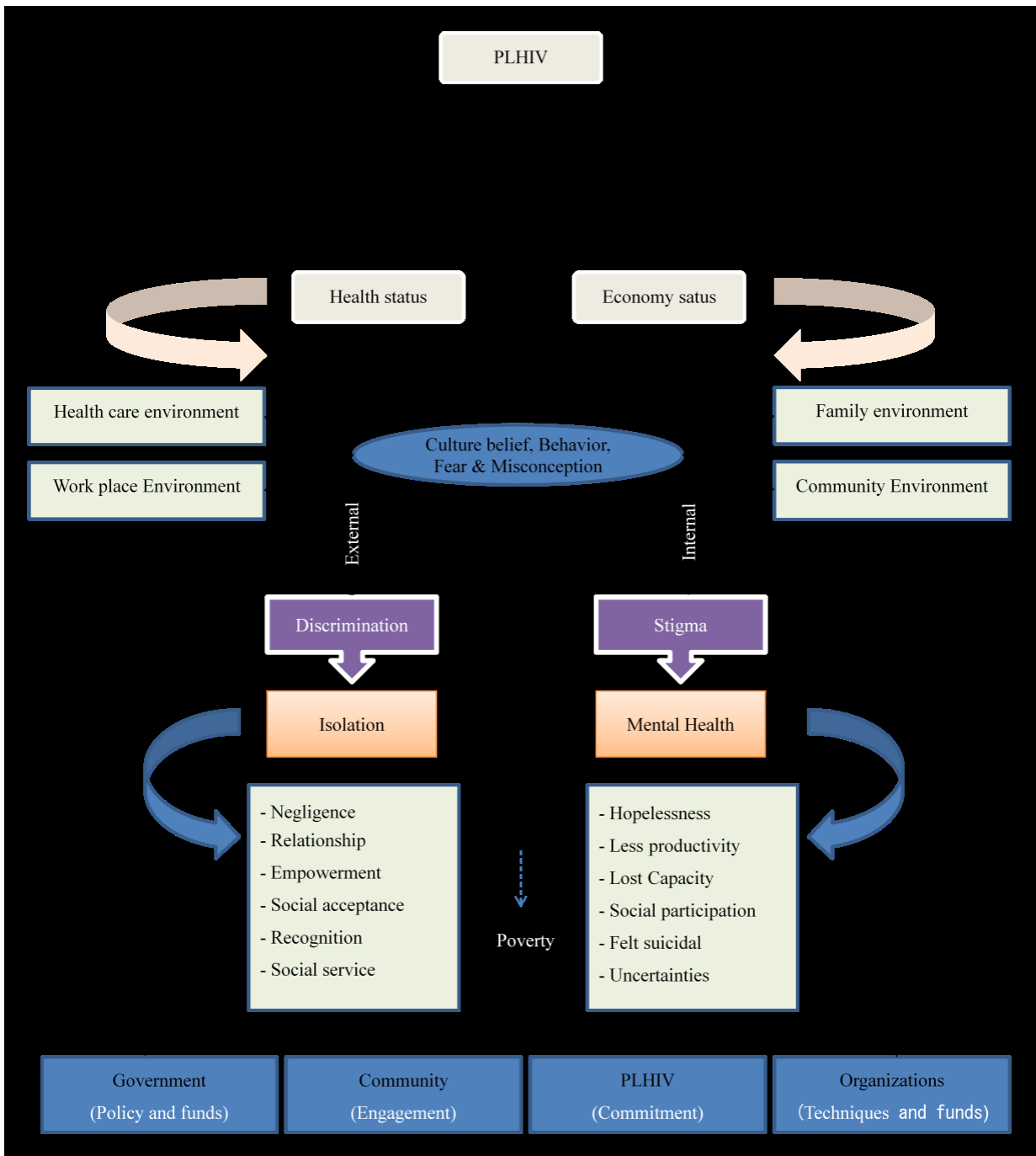
## **2.8. Conceptual Framework**

The conceptual framework was designed; figure 1, below not only describes the causes of stigma and discrimination but also demonstrates the overall consequences and options of people living with HIV/AIDS. Furthermore, it also supports all the issues mentioned in the research problems. Figure 1. Illustrates that when stigma and discrimination happen, people living with HIV/AIDS face two main factors, which is health condition and economy status including income and expenditure, which these two factors were interactive each other. Owing to this negative concept, people started discriminating against people living with HIV/AIDS by showing their bad behavior, gossiping, class separation, verbal abuse, denying them food, excluding them from community events, and so on.

The cultural belief and individual behavior, according to Tesch, Simpson and Kirby (1990) and Masini and Mwampeta (1993), were considered as the main issues in causing stigma &

discrimination. Moreover, while people living with HIV/AIDS received discrimination, they felt isolated; besides, stigmatization coincidentally occurred and led to mental health problems. In fact, people living with HIV/AIDS face negative consequences whether physically or emotionally that hinders their quality of life. As discrimination caused isolation, it gave negative results in the form of negligence, limited personal relationships, disempowerment, minimized social acceptance, low social status recognition, exclusion from social services, and so forth.

To sum up, stigma and discrimination against people living with HIV/AIDS still exist whether in urban or rural areas since general public as well as social and political leaders have limited awareness of HIV/AIDS, which causes those people to mistreat people living with HIV/AIDS and change their personal behavior. As stigma & discrimination still continues, it will affect people living with HIV/AIDS daily life and health conditions. In order to cope with the issues above, people living with HIV/AIDS, their communities, government, and organizations must closely work together with technical support, funding, participation and awareness promotion.



The major indigenous population groups are Nuer (46.6%), Anyuak (21.2%), and Majang (4%) while other indigenous ethnic groups account for less than 0.5% of the population (population census, 2007). The remaining 27.7% is composed of other multi-ethnic groups locally called “high-landers” to indicate that they are originally from outside the region. The dominant language which is spoken and medium of instruction in the region is Amharic. It is significantly important to make selection of the study convenient before starting the field survey.

### **3.4. Research Design**

The research employed a descriptive survey design. Descriptive survey design is used to describe the characteristics of a particular individual or a group. Descriptive survey design helps researchers to describe the present picture of a phenomena or phenomena under study (Gupta, 2007). In descriptive survey design, the researcher is able to define clearly, what he wants to measure and must find adequate methods for measuring it along with a clear cut definition of 'population' he wants to study. Moreover, it is economical, rapid and turns around the data collection and identification attributes of a large population from a small group of individuals (Creswell, 2003).

This research is mainly focused on a quantitative approach; meanwhile, it is also enhanced by some qualitative information that was gathered. To such end, a questionnaire was the major techniques employed to collect the quantitative data. The qualitative research paradigm was also employed in order to understand the topic from the perspectives of the population involved since they are able to talk about their personal feelings, opinions and experiences. Therefore, this research was used both qualitative and quantitative methods of data analysis to study stigma and discrimination among people living with HIV/AIDS.

### **3.5. Sources of Data**

Primary and secondary sources of data were used in this research for the purpose of getting appropriate and real data.

#### **3.5.1. Primary sources**

Primary data had been collected through distributing questionnaires for people living with HIV/AIDS and interview was used to collect data from key informants such as network of HIV positive association focal person, people living with HIV/AIDS respondents living in Gambella town.

#### **3.3.2. Secondary sources**

Secondary data was collected from documents of network of HIV positive association and other relevant recorded materials.

### 3.6. Population, Sample Size and Sampling Techniques

According to the study conducted in 2015 by the Gambella regional state HIV/AIDS prevention and control office, the total number of population living with HIV/AIDS is 301 (female 128 and male 173). Out of this number, 172 (101 male and 71 female) respondents were selected using simple random sampling method. The sample size is determined by using the Slovin's formula (1967): Sample size (n):  $N_i = \text{total population}$ ,  $e = \text{sampling error (0.05)}$ ,  $n_i = \text{total sample size}$ .

The total population is 301 from this total population the total sample size of the respondent is 172 calculated using Slovin's formula. Therefore, the sample size for this research was 172 respondents. In addition key informants that included, one representative from network of HIV positive association and five representatives from people living with HIV/AIDS in Gambella town was purposively selected for more intensive interviews. Those key informants have more knowledge about the issues being studied because, they spent a lot of time working on the issues of the association and are also a senior specialist.

*Table. Population, Sample Size and Sampling Techniques*

S. №	Populations	Sample Size		Sampling techniques
1	Male	173	101	Simple random Sampling
2	Female	128	71	Simple random Sampling
3	Key informants (PLWHA & network of HIV positive associ ation focal person).	6	6	Purposive Sampling
TOTAL		<b>301</b>	<b>172</b>	

Source: Own design from sample size

### **3.7. Data Collection Instruments**

Questionnaires and interview were used to gather primary data during the field research period for the quantitative and qualitative information. Qualitative information was collected through interviews. The items of the instruments were all written in English and translated into Amharic. With the above techniques, the researcher has opportunities not only to collect data but also to investigate directly and deeply the situation and circumstances facing the respondents.

#### **3.5.1. Questionnaire**

Questionnaires were developed as guideline tools to get information and data from 172 people living with HIV/AIDS. The researcher used questionnaire to answer the research question concerning the demographic characteristics of people living with HIV/AIDS, how does discrimination manifests among people living with HIV/AIDS and how do people living with HIV/AIDS stigmatize themselves and also coping mechanism of people living with HIV/AIDS from stigma and discrimination. According to Martin (2007), questionnaires are one of the most useful tools in collecting primary data since it provide genuine information from the respondent; therefore, the researcher can make conclusion based on the raw data provided. The researcher used enumerators and translator for administering questionnaires. To maintain the consistency of the questionnaire, the researcher used open ended question that needs further explanation.

The items of the questionnaire was multiple choose and rated on a 5-point Likert-type scale ranging from 1 (never) to 5(always all the times) in which the degree of agreement and disagreement respondents was indicated. A pilot study was conducted prior to distributing the questionnaires for 10 respondents which were out of the participants to check the reliability of the questionnaires. The type of questionnaires that was used to test as a pilot study was 5-point Likert type scale. The overall structures of these questionnaires examine the general situation of stigma, discrimination experience, and coping mechanisms among PLWHAs. Moreover, the questionnaire was also designed based not only on stigma and discrimination experience but also on the current situation issues related to PLWHAs in Gambella town. This research study employed a questionnaire adapted from the People Living with HIV Stigma Index jointly developed in 2005 by: the Global Network of People Living with HIV/AIDS (GNP+), the

International Community of Women Living with HIV/AIDS (ICW), the International Planned Parenthood Federation (IPPF) and the Joint United Nations Programme on HIV/AIDS (UNAIDS).

### 3.7.2. Interview

The interview was aimed at gathering information on stigma and discrimination among people living with HIV/AIDS in Gambella Town. Furthermore, it was used to collect data on coping strategies to stigma and discrimination by people living with HIV/AIDS in the study area of Gambella town. In conducting the interview, the researcher used tape recorder and note taking. According to Kumar (1996), interviews require that there is interaction between two persons for that specific purpose. Furthermore, Martin (2007), has expressed a similar view on the purposes of the research interview which is to enhance the environment of interview process and environment so that the respondents was willing or satisfied to respond and express their opinion freely.

Data was not only collected from PLWHAs but also from key informants such as network of HIV positive association focal person and people living with HIV/AIDS to get more information. Similar to the individual interviews with PLWHAs, the interview process had been taken for 20 minutes per respondent and was conducted at their designated institution. The medium of communication for the interview was Amharic.

## **3.6. Data Collection Procedure**

The researcher asked for permission and recommendation from the college of Education and Behavioral Sciences, postgraduate program directorate and Gambella Town Network of HIV positive association to conduct the research before starting to collect data. After completing the field survey, the questionnaire was immediately and carefully checked in order to make sure that the given information had been responded properly. Then, the researcher distributed questionnaires for respondents and conducted interview with the interviewees. Errors or unanswered questions were edited using inference technique, according to the procedure outlined by Kumar (1996). Based on consultations with NGOs staff, political authority, other researchers and stakeholders, the criteria in determining the study areas was proposed. Those criteria were availability, accessibility, affordability, and acceptability. Therefore, the researcher



was analyzed, interpreted, discussed the result and then concluded to forward possible recommendations at the end.

### **3.7. Methods of Data Analysis**

After data collecting from the respondents, it was analyzed using SPSS statistic software version 20 to make full meaning of the information. Data had been summarized using percentage and tables to make ease understanding of responses from respondents. Yin (2003), states that data analysis consists of categories such as tabulating, testing or otherwise recombining both quantitative and qualitative evidences to address the initial propositions of the study. In addition, for analyzing data frequency, mean score, standard deviation, t-test, and ANOVA statistical tools was also used. For qualitative analysis using content analysis, the information was classified based on the interview respondent's answer.

The questionnaires have closed ended quantitative questions which included dichotomous, categorical, ordinal, and continuous variables. Also, open ended questions called qualitative questions was asked and coded for classification. For open-ended qualitative questions, the researcher read all of the responses and categorized them. A qualitative analysis was used to understand respondents' behavior, perception, and reasons regarding stigma & discrimination. To get results from qualitative interview, group data was basically applied in order to search for resemblance and distinction of responses (Priscilla, Elizabeth and Elizabeth, 2005) and Martin (2007).

### **3.8. Ethical Considerations**

The researcher was wrote a permission letter to get approval by the College of Education and Behavioral Sciences and Postgraduate Program Directorate of Haramaya University to conduct the study. A permission letter was also written to the Network of HIV positive association and Gambella Peoples National Regional State HIV/AIDS prevention and control office to obtain permission and cooperation for data collection. A written informed consent was also obtained from each study participant. Participants were informed about the main aims of the study prior to their participation and questionnaire was finally administered. The right of the study participants to refuse participation or withdraw from the study at any point was respected and the importance of providing the right information. Moreover, the researcher assured the study

participants about the confidentiality, protection and anonymity of data.

#### **4. RESULTS AND DISCUSSION**

In this section, the data were tabulated, presented and analyzed by dividing them into sections based on the specific objectives of the study.

## 4.1. Demographics Characteristics of Respondent

The following table describes demographic characteristic of PLWHA participated in the study.

*Table . Demographic Characteristics of Study Participants*

<b>Demographic Characteristics of Participants</b>	<b>Frequency</b>	<b>Percent</b>
<b>Gender</b>		
<b>Valid</b> Male	101	58.7
Female	71	41.3
<b>Current marital status</b>		
Married and living with spouse	12	7.0
Married or have partners but not living together	75	43.6
Having a relationship but not living together	44	25.6
Single (no sexual activity)	30	17.4
Divorced or separated	11	6.4
<b>Highest level of education</b>		
Not have formal education	31	18.0
Primary education	51	29.7
Secondary education	39	22.7
Vocational/University	23	13.4
<b>Current employment position</b>		
Full-time employment	18	10.5
Part-time employment	22	12.8
Full-time but not employed (i.e. having own business)	34	19.8
Occasional jobs(having own business)	53	30.8
Unemployed	45	26.2
<b>Locality of where you live</b>		
Country/rural	36	20.9
Semi-urban	42	24.4
Urban/city	94	54.7
<b>Physical disabilities</b>		
Yes	103	59.9
No	69	40.1
<b>Total</b>	<b>172</b>	<b>100.0</b>

From the above table 2.on gender issue majority of respondents are male 58.7% and the rest 41.3% of respondents were female. Hence, men may be blamed for infecting their female partners with HIV, and this may explain lower levels of internalized stigma among women.

Researcher survey result on current marital status of respondent showed that majority of respondents are married or have partners but not living together in the first level 43.6 % and 25.6 % of them are having a relationship but not living together in the other respondent 17.4% of them are which are single (no sexual activity). They maintain close family ties; in fact, female kin make conscious efforts to get married in the same region in order to support each other in times of need.

From above survey result on table 2, majority the highest level of education, for the majority of the respondents (29.7) % of them are primary education taker and the second highest participants(22.7 %) of them are secondary education holder and 18.0% of them have no educational background and the rest 16.3.of them have vocational and university educational qualifications. When asked about how they felt societal stigma and discrimination could be reduced, over four-fifth of respondents felt that there is a need to improve awareness on modes and non modes of transmission of HIV to the general public using traditional and community means of educational background lowness is basics factor. From above table 2, survey respondents result, majority of respondents 30.8% of them have occasional jobs (having own business, 26.2 % of them are unemployed, 19.8% of them are full-time but not employed (i.e. having own business).This result showed if stigma and discriminations can be come over with 26.2 % unemployment, what will happen?

The participants spoke of difficulties to get a job and keep it, and the theme of discrimination appeared as a discussion articulator. Discrimination was understood as a major obstacle to the well-being of participants, something that affects their male and female identity, with implications for being unemployed by 26.2 % that are little considered in the planning of assistance. "I think discrimination with is something that, most times, is not explicit. Know you're being discriminated, but the guy doesn't say it, 'you're being unemployed and dismissed because of this.' and it's a very delicate issue. I know this happened, why? Because I didn't have a promotion, my scholarship was close and it was turned down (participant1).Specifically, based on the well-established finding that unemployment duration is directly related to decreased likelihood of securing employment. From table 2, majority of respondents (54.7%) live in urban city and secondly 24.4 % of them are live in semi urban and the rest 20.9% of them are live in country side. Urban experience significant difference in felt HIV stigma over

time. Results on “Do you have any physical disabilities (excluding general HIV-related illness)?” The majority 59.9 % of respondents living with HIV AIDS has agreed that they had disability and the rest 40.1% of them did not have physical injuries and disabilities. In this research based on respondents have physical disabilities.

In summary, the findings of the current study have indicated that, HIV/AIDS related stigma and discriminations can be influenced by some socio- demographic characteristics like sex, marital status, urban/rural, educational status and occupation. However, very little research has been done on demographic characteristics related to HIV/AIDS stigma and discriminations. Therefore, extensive works should have been done in the future.

## 4.2. Self-stigmatization of people living with HIV/AIDS

Analysis and discussion was attempted to present about how PLWHA stigmatize themselves.

*Table . Descriptive statistics on self-stigmatization of people living with HIV/ AIDS*

No Self-stigmatization of PLWHA	Test value 0.05% with confidence interval of the difference				
	<i>One sample t-test result</i>				<i>ANOVA</i>
	Mean	SD	df	Sig.	Sig.
1. I feel shame because of my HIV status.	2.76	1.39	171	.000	.000
2. I feel a sense of guilt.	3.53	1.05	171	.000	.000
3. I blame myself.	3.95	1.11	171	.000	.017
4. I blame others.	2.31	1.30	171	.000	.000
5. I have low self-esteem.	3.41	1.13	171	.000	.018

6. I deserve punishment.	3.95	0.81	171	.000	.000
7. I always think not to join social events and activities.	3.90	0.60	171	.000	.070
8. I feel a sense of isolation from family and friends.	2.73	1.20	171	.000	.000
9. I decided to quit employment.	2.37	1.14	171	.000	.000
10. I hold a sense of withdrawal from school/training or rejection of such opportunities.	4.27	0.63	171	.000	.053
11. I feel a sense of Gossip	4.30	0.52	171	.000	.002
12. I decided not to have sex.	2.59	1.21	171	.000	.585
13. Avoiding going to local hospital when needed.	2.57	0.92	171	.000	.082
14. I feel paranoid and stigmatize myself	2.70	1.00	171	.000	.000
15. I have fear of disclosure.	2.37	0.93	171	.000	.057
16. Fear of losing honor and social standing.	3.06	1.20	171	.000	.319
17. Religious beliefs or judgment based on moral standards.	3.02	1.30	171	.000	.001
18. I developed sense of verbal harassment, assault or threat.	3.29	1.34	17	.000	.008
19. Because of stigma problem, I feel a sense of hiding my HIV status from others.	3.68	1.10	171	.000	.008

Source: Field Survey result, 2017. Critical value of 0.05 is 95% t=t, distribution, df=degree of freedom, m=mean, SD=standard deviation.

From the above table 3, the result on issue of the self-stigmatization of people living with HIV/AIDS; for feeling shame because of HIV status is (mean score=2.76 and standard deviation=1.39). The comparison of t-test result is (.000) and ANOVA result (.000) showed there are statistically significant difference between male and female respondent  $p < 0.05$ , respectively. Shame leads to secrecy, in order to protect one's reputation (Menadue, 2006). Also, computed mean score (3.53) and standard deviation (1.05) indicate that the respondents feel a sense of guilt due to being HIV positive. Moreover, the comparison of t-test is (.000) and ANOVA result (.000) showed there are statistically significant difference between male and female respondent  $p < 0.05$ , respectively. They blame themselves ( mean score,3.9) and standard deviation (1.11), the score of t-test (.000) and ANOVA result (.017) showed there are statistically significant difference between male and female respondent  $p < 0.05$ , respectively.

The above (table 3), item 5, shows that they have low self-esteem with mean score of (3.41) and standard deviation (1.13). Moreover, the comparison of t-test (.000) and ANOVA result (.018) showed there are statistically significant difference between male and female respondent  $p < 0.05$ , respectively. The calculated mean score (3.95) and standard deviation (0.81), they feel to deserve punishment. Furthermore, t-test (.000) and ANOVA result (.000) showed there are statistical significant difference between male and female respondent  $p < 0.05$ , respectively. They always think not to join social events and activities in mean score (3.90) and standard deviation (0.60). The result of t-test (.000) and ANOVA (.070) showed there are statistically insignificant difference between male and female respondent  $p < 0.05$ , respectively. Results on feeling of a sense of isolation from family and friends mean score (2.73) and SD (1.20). Moreover, the comparison of t-test (.000) and ANOVA result (.000) showed there are statistically significant difference between male and female respondent  $p < 0.05$ , respectively.

Item 10 shows that, they hold a sense of withdrawal from school/training or rejection of such opportunities in mean score (4.27) and that of standard deviation (0.63). The result of t-test (.000) and ANOVA result (.053) show that there are statistically insignificant difference between male and female respondent  $p < 0.05$ , respectively. The study found that the fear of stigma experienced by people feel a sense of gossip show a mean score(4.30) and SD(0.52) with t-test (.000) and ANOVA result (.002) showed there are statistically significant difference between male and female respondent  $p < 0.05$ , respectively through a number of ways. Firstly, it was noted that they hold a sense of withdrawal from school/training or rejection of such opportunities available near to their homes, thereby risking irregular replenishment think not to join social events and activities. This is because they fear being seen by people who know them as friends and neighbors. Similar findings have been reported in other African countries, where many respondents were unwilling to seek treatment at the nearest health facility. Secondly, the study has shown that stigma reinforced the concealment of HIV status. In item 14, feeling paranoid and stigmatize myself indicate a mean score (2.70) and SD (1.00) and comparing the t-test (.000) and ANOVA result (.000) showing statistically significant difference between male and female respondent  $p < 0.05$ .

*Another respondent (Male respondent, 30 years old) said, "Stigma occurs when a person is identified as tainted or less desirable and results in the individual*

*being devalued in the eyes of society”.*

Religious beliefs or judgment based on moral standards mean score indicate 3.02 and SD, 1.30. Additionally, the comparison of t-test (.000) and ANOVA result (.001) showed that there are statistically significant difference between male and female respondent  $p < 0.05$ , respectively. Item 18, shows that people living with HIV/AIDS had been developed sense of verbal harassment, assault or threat with mean score, 3.29 and SD, 1.34, by computing the t-test(.000) and ANOVA result (.008) show that there are statistically significant difference between male and female respondent  $p < 0.05$ , respectively.

Because of stigma problem, I feel a sense of hiding my HIV status from others. 3.68 in mean score and 1.10 of SD, following a t-test(.000) and ANOVA result (.008) which is statistically significant difference between male and female respondent  $p < 0.05$ , respectively. Stigma and discrimination also affect the decision to disclose HIV status (Yoshioka and Schustack, 2001). Not wanting to tell others about an HIV positive status have been found to be a major impediment to the optimal uptake the study area. The fear of stigma experienced by people on ART resulted in no adherence to medication through a number of ways. Firstly, because of stigma, a substantial number of respondents revealed that they attend a care and treatment clinic that is far away from their homes.

*A similar concern was expressed by the interviewee: “It really pained me and I cried a lot. I asked myself, where did I get this disease? But then I realized that I got it from my parents. One day I went to visit my aunt and I saw my young brother (who was taken in by my aunt after the death of our mother) using antiretroviral drug/s. I asked my aunt and then I knew I also got HIV from our parents. I noticed I’m HIV positive in 2006 but I did not let anybody know because I feared how they would regard the circumstances that made me get infected. (Female respondent, 23 years old).”*

A diagnosis of HIV in the United States (US) has been associated with social stigma since the beginning of the epidemic, in part given the historical association of the disease with commonly stigmatized groups such as men who have sex with men (MSM) and injection drug users. Perceived and experienced stigma may negatively affect HIV testing, retention in care and adherence through fear that being seen at HIV clinic, missing work to attend appointments or being observed taking medication will inadvertently disclose one’s HIV status. Experienced,



perceived and internalized stigma may lead to depression, low self-esteem, isolation and feelings of hopelessness or loss of control, which may in turn result in lost motivation to remain in care and to be adherent to treatment. Stigma surrounding HIV has been hypothesized to be a contributing factor to poor patient outcomes including treatment adherence and retention in care.

The perception that HIV infection is associated with social deviance and immorality may result in greater stigma towards people living with HIV/AIDS. Evidence suggests that lower levels of HIV knowledge, common factors, also contribute to increased HIV stigma. The findings of this study indicate that the respondents experienced different forms of HIV-related stigma, including verbal, social, and perceived stigma (the fear of stigma associated with disclosing HIV status). Previous stigma studies focusing on rural African American women and barriers to sexually transmitted infection testing among men in the south have documented high levels of perceived, experienced, and internalized stigma among participants (Miller and Rubin, 2017). Understanding the impact of HIV stigma in a diverse population of people living with HIV/AIDS is an important first step towards developing tools to improve retention, adherence, and quality of life.

### 4.3. Manifestation of Discrimination among People living with HIV/AIDS

In this part, a brief discussion of the result is being made in an attempt to present about manifestation of discrimination among people living with HIV/AIDS.

No Manifestation of discrimination among PLWHA		Test value 0.05% with confidence interval of the difference				
		One sample t-test result			ANOVA	
		Mean	SD	Df	Sig.	Sig.
1.	1. I have been refused participation in community events of activities.	2.70	1.03	171	.000	.000
2.	2. I have been refused or hindered participation in religious activities or refused entrance to a religious place.	2.17	0.82	171	.000	.000
3.	3. I have been refused participation in family activities.	3.50	1.12	171	.000	.000
4.	4. In the last 12 months, I faced harassment	2.80	1.33	171	.000	.000
5.	or intimidation.					

6.	5. In the last 12 months, I have been physically assaulted.	3.38	1.32	171	.000	.000
7.	6. In the last 12 months, I have been experienced pressure or psychological hassle from my spouse because of HIV status.	3.82	0.95	171	.000	.000
8.	7. In the last 12 months, I have been refused having sex because of HIV status.	2.90	1.58	171	.000	.002
9.	8. I have been discriminated against by other positive people.	2.95	1.42	171	.000	.151
10.	9. People living with HIV/AIDS face discrimination from family, friends, health care settings & Society.	3.54	1.06	171	.000	.001
11.	10. Separation and loss of contact with family.	3.10	1.14	171	.000	.000
12.	11. I loss respects from my family.	2.25	1.21	171	.000	.000
13.	12. Physical and social restrictions.	2.72	1.04	171	.000	.003
14.	13. Discrimination on ownership of property	2.60	0.92	171	.000	.000
15.	14. I loss respects from society.	2.22	0.85	171	.000	.006
16.	15. Not involving in rituals.	3.44	1.11	171	.000	.008
17.	16. I have been denied treatments in health care settings.	2.80	1.33	171	.000	.031
18.	17. Poor quality of health care services.	3.49	1.29	171	.000	.001
19.	18. I have experience of HIV Test	3.80	0.98	171	.000	.076
20.	without consent					

*Table . Descriptive Statistics on Manifestation of Discrimination among PLWHAS*

Source: Field Survey result, 2017. Critical value of 0.05 is 95% t=t, distribution, DF= degree of freedom, m=mean, SD=standard deviation.

From the above table 4, survey result on manifestation of discrimination among people living with HIV/AID from 18 items released and portrayed information's on the result of have been refused participation in community events of activities in mean score (2.70) with standard deviations (1.03).Moreover, the comparison of t-test (.000) and ANOVA result (.000) shows there are statistically significant difference between male and female respondent  $p < 0.05$ , respectively. Result on, have been refused participation in family activities show that mean score, 3.50 and standard deviations,1.12 with t-test(.000) and ANOVA result indicated (.000) are statistically significant difference between male and female respondent  $p < 0.05$ , respectively.

In item 4 which states, I faced harassment or intimidation majority of the respondents with mean score, 2.80 and SD, 1.33.The t-test and ANOVA result (.000 and.000) showed that there

are statistically significant difference between male and female respondent  $p < 0.05$ , respectively. Concerning this issue, in the last 12 months, people living with HIV/AIDS have been physically assaulted showing mean score, 3.38 with standard deviations, 1.32. Additionally, results on t-test and ANOVA (.000 and .002) showed there are statistically significant difference between male and female respondent  $p < 0.05$ , respectively. Survey result on manifestation of discrimination among people living with HIV/AIDS from 18 items portrayed information's with highest mean score a heading the result, they had been experienced pressure or psychological hassle from their spouse because of HIV in mean score (3.82) with standard deviations( 0.95). Results of t-test and ANOVA (.000 and .000) showed there are statistically significant difference between male and female respondent  $p < 0.05$ , respectively.

Main findings in the 12 months, they have been experienced pressure or psychological hassle from their spouse because of HIV of large-scale increases in the kind of extreme social phenomena, such as child-headed households. In the last 12 months, I have been refused having sex because of HIV status mean score. 2.90 and standard deviation 1.58. The computed results on t-test and ANOVA (.000 and .002) showed there are statistically significant difference between male and female respondent  $p < 0.05$ , respectively. Item 8, show they have been discriminated against by other positive people (mean score=2.95 and standard deviation=1.42). Moreover, the comparison of t-test (.000) and ANOVA result (.151) shows there are statistically insignificant difference between male and female respondent  $p < 0.05$ , respectively. In item 9 which states, people living with HIV/AIDS face discrimination from family, friends, health care settings and society result show that in mean score(3.54) with SD (1.06). The computed results on t-test and ANOVA (.000 and .001) showed there are statistically significant difference between male and female respondent  $p < 0.05$ , respectively. The respondents expressed fear of being morally judged for being HIV positive and on ART. Their fear was based on the observation that community members tend to associate HIV positive status with engagement in immoral behaviors, as expressed by one of the respondents:

*“I was scared because I was worried about the response of my partner and other people close to me. I was concerned that they would want to know how I got infected. So I asked myself, how will my husband regard me? Will he understand me? But I believe I got infected with HIV when I had a blood transfusion. I have never been a prostitute. (Female respondent, 35 years old).”*

The participants, particularly women, attributed social stigma to community members' perceptions that all HIV positive people were prostitutes or engaged in sex carelessly and that being on medication means one is about to die. Respondents expressed a fear of being stigmatized; that is, they felt that they might be treated negatively by family and community members, as expressed by one of the respondents:

*"I have not taken my medication on two occasions when relatives and neighbors were in my house and have never disclosed my status to them. I did not have time to take out the medicine from my drawer. I frequently face this problem of trying to hide my medicine from others because I am living in a rented single room and I feared if they see my ARVs they will tell others I am infected. (Male respondent, 42 years old)."*

Respondent's feared negative consequences if their HIV status became known to their close relatives. They had experienced friends and relatives gossiping and ostracizing people living with HIV. Indeed, it was reported that the fear of stigma prevented some users of antiretroviral drugs (ARVs) from seeking support, even when they were seriously sick, and this also may affect their adherence to ARVs:

*"The society does not know my HIV status because I have not told them and will not, since they have a negative attitude towards people on ARVs. One day, when I came to clinic, there was a woman who was very sick who stays in Gambella but she had come alone to a clinic in a neighboring Keble because she did not want anyone to know where she was going. People are still isolating us. (Female respondent, 42 years old)."*

On other way from result calculated in mean score (3.10) with standard deviations (1.14) on separation and loss of contact with family. Additionally, the comparison of t-test(.000) and ANOVA result (.000) showed that there are statistically significant difference between the respondent  $p < 0.05$ , respectively. On the other hand, of the cycle from family formation are the events and processes associated with the dissolution of families and households. While there is a tendency in the HIV and AIDS impact research to describe separation and loss of contact with family as a wholly negative event, such a characterization fails to recognize that dissolution is an intrinsic part of the normative household life-cycle. Separation and loss of contact with family will often be unrelated to HIV and AIDS, for example, upon divorce or as older people move in with younger relatives.

Even if related to HIV and AIDS, the separation and loss of contact with family can in some

cases be a successful strategy on the part of its members to ameliorate its adverse consequences. HIV and AIDS have been postulated to increase the risk of separation and loss of contact with family and migration through several pathways including: adult death (death of the last adult member or death of a household head, main income earner and primary caregiver); economic vulnerability due to increased costs/reduced income (household members disperse either through migration and/or joining other households); widowhood and survival (surviving partner joins another household); and widowhood and subsequent remarriage (surviving partner (and children) joins another household upon re-marriage). As pointed out in the above table 4, physical and social restrictions calculated mean score (2.72) and SD (1.04). Moreover, the comparison of t-test and ANOVA result (.000 and .003) showed that there are statistically significant difference between male and female respondent  $p < 0.05$ , respectively. We all suffer when we are not accepted socially. This, in turn, leads to loneliness (Williams, 1997). In item 16 which states, have been denied treatments in health care settings mean score (2.80) and SD (1.33). Furthermore, comparison of t-test (.000) and ANOVA result (.000, and .031) showed that there are statistically insignificant difference between male and female respondent  $p < 0.05$ , respectively. This suggests that both intrapersonal and interpersonal fears still exist, despite nearly a decade of increasing the provision of ARV. Poor quality of health care services in means score result, 3.49 with standard deviations, and 1.29. Additionally, t-test (.000) and ANOVA result (.001) showed that there are statistically significant difference between male and female respondent  $p < 0.05$ , respectively. In this research study, result on experience of HIV testing without consent show in mean score (3.80) standard deviations (0.98) in comparison of t-test (.000) and ANOVA result (.076) showed that there are statistically insignificant difference between male and female respondent  $p < 0.05$ , respectively. *Respondent said on issues of HIV testing without consent:*

*“One day I heard one person telling a patient who was on ART that she was key to mortuary because she believed that, once person know on ART you are about to die. (Female respondent, 34 years old).”*

From the interview the researcher has depicted participants identified two major sources of stigma, fear of contracting the virus due to misperception of transmission mechanisms; and presumptions regarding the source of infection among PLWHA. The study respondents experienced loss of dignity and friendship and they are experienced various forms of

discrimination, including relational discrimination, blame and rejection by their spouses, workplace discrimination, and mistreatment by health care workers. This suggests that, despite improvements in health status as a result of being on entitlements as a result of deliberate actions or omissions by spouses, family members, friends, and/or health care workers.

## 20.4. Coping Strategy Adopted to Deal HIV/AIDS Stigma and Discrimination

In this part, data was analyzed, interpreted and discussed on how PLWHA use coping strategies adopted to deal with HIV/AIDS stigma and discrimination.

*Table . Descriptive statistics of coping strategies response*

No Coping Strategies adopted to deal HIV/AIDS stigma and discrimination	<i>Test value 0.05% with confidence interval of the difference</i>				
	<i>One sample t-test result</i>				<i>ANOVA</i>
	Mean	SD	DF	Sig.	Sig.
1. I have a community support	2.73	1.43	171	.000	.000
2. I have family support.	3.26	1.21	171	.000	.005
3. I have received support from NGOs	3.84	1.10	171	.000	.071
4. I standby myself.	2.83	1.47	171	.000	.000
5. In the last 12 months, I have received health program support	2.20	1.24	171	.000	.000

6. In the last 12 months, I have been received loan provision	3.56	1.04	171	.000	.000
7. In the last 12 months, I have received training on skill building.	3.56	0.94	171	.000	.864
8. In the last 12 months, the community helps me to make participation.	2.61	1.15	171	.000	.000
9. PLWHA do not receive support from community, family, friend & health setting	2.74	1.24	171	.000	.000
10. Problem focused(seeking professional help)	3.83	1.13	171	.000	.001
11. Emotion focused	4.05	0.92	171	.000	.000
12. Distraction-positive	3.01	1.28	171	.000	.014
13. Acceptance	2.74	1.16	171	.000	.002
14. Religion/faith	2.63	1.10	171	.000	.011
15. Denial/blame	3.59	1.16	171	.000	.006
16. Problem & emotion focused	2.64	1.33	171	.000	.003

Source: Field Survey result, 2017. Critical value of 0.05 is 95% t=t, distribution, DF= degree of freedom, m=mean, SD=standard deviation.

From the above table 5, results on coping strategies adopted to deal with HIV/AIDS stigma and discrimination; a mean score (2.73) and SD (1.43) show concerning community support. Furthermore, comparison of t-test (.000) and ANOVA result (.000) showed that there are statistically significant difference between male and female respondent  $p < 0.05$ , respectively. Studies have considered some coping styles, for example social support, to predict health (Berkman, 1995: Ryff& Singer, 2000). Social support groups seemed to play an important role in handling stigma and discrimination. Such groups constitute a forum for learning about challenges related to living with HIV and taking ARVs. The following quote is illustrative of this:

*“We discuss with my fellow support group members different challenges related to taking ARVs and how to cope. In this way, we comfort each other. We meet weekly in our support group. Also, my wife comforts me. She is a hospital employee so she knows these things well. (Male respondent, 32 years old).”*

In item 2 of the above table, respondents gave answer to the question regarding family support in mean score (3.26) and SD (1.21) with comparison of t-test(.000) and ANOVA result (.005) showed that there are statistically significant difference between male and female respondent

$p < .05$ , respectively. They must be encouraged to talk with their family members. (Shorter and Onyancha, 1998). Because we have no cure for HIV/AIDS, we have to focus our interventions on caring for the physical as well as the psychological welfare of the HIV positive individual and his or her significant others. A mean score (3.84) and SD (1.10) for having received support from NGO showed a t-test (.000) and ANOVA (.071). Item 4 of the above table, I stand by myself was one questionnaire raised to the respondent and answered (mean score=2.83) and (SD=1.47) following t-test (.000) and ANOVA result (.000) showed that there are statistically significant difference between male and female respondent  $p < .05$ , respectively.

In replying to item six that states that PLWHA have been received loan provision (mean score= 3.56 with 1.04 standard deviation) and the computed t-test (.000) and ANOVA result (.000) showed that there are statistically significant difference between male and female respondent  $p < .05$ , respectively. In the last 12 months, PLWHA have received training on skill building in the mean score (3.56) with standard deviation (0, 94). The above table 5, showed that PLWHA do not receive support from community, family, friend & health setting (mean score =2.74) and (SD=1.24) by computing the t-test (.000) and ANOVA result (.000) showed that there are statistically significant difference between male and female respondent  $p < .05$ , respectively.

They are problem focused in coping strategy from HIV/AIDS related stigma and stigma (mean score= 3.83) and SD (1.13). Moreover, the comparison of t-test (.000) and ANOVA result (.001) showed there are statistically significant difference between male and female respondent  $p < .05$ , respectively. Earlier studies have shown that problem-focused coping and information avoidant coping are related (Carver, Scheier and Weintraub, 1989). This suggests that PLWHA seek professional help in coping from HIV stigma and discrimination. The other concept dealt in the above table, they are highly emotional focused with the mean score (4.05) and SD (0.92). A t test (.000) and ANOVA result (.000) shows there are statistically significant difference between male and female respondent  $p < .05$ , respectively. People living with HIV/AIDS accept the problem (mean score=2.74 and standard deviation =1.16, respectively. As indicated in the above table 5, the compute t-test and ANOVA result (.002) showed there are statistically significant difference between male and female respondent  $p < .05$ , respectively.

One of the respondents shared his feelings as follows:

*"I see HIV as any other disease and I do not think that I will die because of it. When I die, I will know it is God's will, not because of AIDS. If I were to die, I*



*could have died when I was very sick those days. (Male respondent, 19 years old)."*

*A similar concern was expressed by another respondent: "My conscience has agreed to the problem so I regard it as just any other common disease. (Male respondent, 30 years old)."*

Some respondents spoke of the support they received from their families as having contributed to the peace of mind they were experiencing.

Some respondents spoke of the support they received from their families as having contributed to the peace of mind they were experiencing. From the interview, key coping mechanisms that emerged from respondents' narrations included spiritual devotion, acceptance of the illness, seeking information and/or exchanging views about the illness, preemptive disclosure, putting ART in an unlabelled envelope, and swallowing ARVs in the wash room. The majority of respondents on responses of religion/faith based support from their religious leaders indicated that their faith in God gave them courage to adhere to medication and spiritual devotion appeared to be a strong coping strategy among study respondents:

*"I pray to God every time I take my medicine and I believe one day Jesus Christ will cure me. (Female respondent, 30 years old)."*

*The following quote illustrative: "I get comfort from my religion because God is the one who enables us to live. In general, I perceive AIDS as a common disease and death is not necessarily caused by AIDS. You can sleep without being sick and still die. So I believe if I die, then it is God's will and not AIDS. (Male respondent, 41 years old)."*

The study revealed that respondents' belief in the healing power of God had better health outcomes as their belief reduced their self-stigma. Indeed, their level of faith in the healing power of God was so high that some thought that, even if they died, it would not be because of HIV; it would be God's will. Respondents stated that, in the face of stigma and discrimination, they are compelled to conceal the identity of ARVs by putting them in an unlabelled envelope, or one bearing a drug name that is unfamiliar to most lay people. This measure was well expressed by one of the respondents:

*"I remove ARVs from their original container and put them in a plain envelope from where I take them, even in the presence of other people. (Male respondent, 28 years old)."*

Some people on ART disclose their HIV status to family members, neighbours, and/or work colleagues and talk very freely about it and the challenges they face, so preempting gossip. This coping mechanism was well narrated by one of the respondents:

*“I have disclosed my status to almost everybody because I am sometimes seen on the television or heard on the radio revealing that I am HIV positive. At my workplace everybody knows I am infected. It helped me a lot to disclose my status because I sometimes feel unable to work and I just tell my boss by phone that I am sick. One day, one of my colleagues told me that some of workers were saying that I didn’t come yesterday because viruses were harassing me, but I just told her, I don’t care (she laughs). (Female respondent, 46 years old).”*

People of this kind, who disclose and talk freely about their HIV+ status, can strengthen others living with HIV by helping them overcome internalized stigma, cope with stigma, rebuild their self-esteem, and develop skills to they are highly emotional focused in ant-stigma and discrimination education and action. People adopt other dimensions of coping while in different experiences of life. According to Kalichman, Benotsch, Weinhardt, Austin, Luke, and Cherry, 2003; Kalichiman and others, 2006) two broad dimensions of coping exist e.g. problem-focused and avoidant coping. This involves taking direct action to solve the problem or making efforts to reduce the negative emotional reactions to stress, for example, by distracting oneself from the problem, or relaxing; again information seeking and avoidant coping which refers to seeking information that will be relevant for the solution of the problem or avoid information that will cause harm or emotional problem or distress. According to Devins and Binik (1996), information coping is associated with health benefits and increased access to information as coping strategy may empower people to become more engaged in their health care.

## **5. SUMMARY, CONCLUSION AND RECOMMENDATION**

In this section, based on the study result a brief summary, conclusion and recommendation were presented which are related to research question.

### **5.1. Summary**

The main objective of the study was to assess stigma, discrimination and coping strategies among people living with HIV/AIDS in Gambella Town, GPNRS. In order to achieve the objectives, efforts were made to seek possible answers for the basic questions which stressed the demographic characteristic, self stigmatization of people living with HIV/AIDS, discrimination among people living with HIV/AIDS and coping strategies. The research employed a descriptive survey design. This research mainly focused on a quantitative approach; meanwhile, it is also enhanced by some qualitative information that was gathered. A simple random sampling technique was used to select the sample size. In attempt to seek for appropriate solutions, the researcher reviewed a related literature. Data was collected through questionnaire and interview. Regarding the analysis of the data, statistical tools were employed such as percentage, frequency, mean score, standard deviation, t-test and ANOVA.

To come with the finding on demographic characteristics of respondent, it generalized that on gender issue majority of respondents were male 58.7% (101) and the rest of respondents 41.3(71) are female. Researcher survey result on current marital status of respond showed that majority of respondents are married or have partners but not living together in the first level 43.6 % and 25.6 % of them are having a relationship but not living together, the other

respondent 17.4% of them are single (no sexual activity). Majority of the highest level of education, 29.7 % of them are primary education taker and the second highest level 22.7 % of them are secondary education holder and 18.0 % of them had no educational back ground and the rest 16.3 % of them have vocational and university educational qualifications. Majority of respondents 54.7 % of them are living in urban city and secondly, 24.4 % of them are living in semi urban and the rest 20.9% of them are living in country side.

The findings on self-stigmatization of this study indicate that the respondents experienced different forms of HIV-related stigma, including verbal, social, and perceived stigma (the fear of stigma associated with disclosing HIV status). Result on issue of the self-stigmatization of people living with HIV/AIDS; they blame themselves in mean score (3.95) and SD (1.11). The results of the compute t-test (.000) and ANOVA result (.017) showed there are statistically insignificant difference between male and female respondent  $p < 0.05$ , respectively. Feeling a sense of guilt result show that a mean score, 3.53 and SD, 1.05, with a computed t-test(.000) and ANOVA result (.000) showed there are statistically significant difference between male and female respondent  $p < 0.05$ , respectively. PLWHA feel a sense of gossip, they hold a sense of withdrawal from school/training or rejection of such opportunities. Because of stigma problem, they feel a sense of hiding their HIV status from others and always think not to join social events and activities.

Survey result on manifestation of discrimination among people living with HIV/AIDS from 18 item released and portrayed information's indicate in the last 12 months, they have been experienced pressure or psychological hassle from their spouse because of HIV (mean score= 3.82 with standard deviations= 0.95) and t-test (.000) and ANOVA result (.000) showed there are statistically significant difference between male and female respondent  $p < 0.05$ , respectively. Main findings 12 months, they have been experienced pressure or psychological hassle from their spouse because of HIV of large-scale increases in the kind of extreme social phenomena, such as child-headed households. On other way result was obtained that people living with HIV/AIDS experience separation and loss of contact with family. People living with HIV/AIDS face discrimination from family, friends, health care settings & society in their daily activities and the rest they have been refused participation in family activities.

Result on coping strategies adopted to deal with HIV/AIDS stigma and discrimination; they had received support from NGO and they are problem focused seeking professional help to cope from stigma and discrimination problem. Finally, they are highly emotional focused being concentrating on their feeling in order to cope from the situations. From the interview, key coping strategies that emerged from respondents' narrations included spiritual devotion, acceptance of the illness, seeking information and/or exchanging views about the illness, preemptive disclosure. Many also have fears of cross infection and because of this; those infected with the HIV virus are maltreated as if they are not part of the general population. Participants reported that if one is suspected of being HIV positive and on ART, he/she is given names that imply that his/her days of staying alive are numbered.

## **5.2. Conclusions**

The research findings have shows that stigma and discrimination in Gambella Town is prevalent. The study concerning on discriminations and stigma has put among HIV positive discussants under study and decline in relating with NGO supports. Other, the studies in which HIV status was found to isolate people from the community, thus affecting the overall quality of life blaming them self. The study revealed that, still experience of verbal and social stigma, relational discrimination, blame and rejection by spouses, and/or mistreatment by health care workers, albeit to a smaller extent compared to the study. Individuals live in proximate environs, share a common culture and are interlocked in overlapping social networks in Gambella Town. The researcher considering this research utilizing more refined when asked about their perception of what the general public feels about them being HIV positive, most respondents described it as "bad".

Participants reported that if one is suspected of being HIV positive and on ART, he/she is given names that imply that his/her days of staying alive are numbered. Totally, the misperception of HIV knowledge among the general population, HIV stigma continues to impact people living with HIV/AIDS in Gambella Town. Research participants felt that disclosing their status could result in losing friends, family support, or even their jobs. Coping strategies was assessed from the respondents' narrations including becoming secretive, spiritual devotion, acceptance of the

illness, seeking information and/or exchanging views about the illness through support groups, and preemptive disclosure and self-isolation, which may have negative implications for mental and physical health. Measuring enacted/experienced HIV stigma proved difficult in this population as many participants did not disclose their status for fear of discrimination.

As a result, further clarification may be needed regarding how best to measure discrimination, fear of discrimination, and anxiety about disclosure. As no efficacious stigma reduction programs have been scaled up effectively in this region, more work needs to be done to assist people living with HIV/AIDS with coping strategies other than self-isolation. These unhealthy experiences have a negative impact on treatment adherence. Efforts to reduce stigma and discrimination that started earlier (in the period) with the purpose of encouraging HIV testing are still relevant now and should be given more impetus so as to maximize positive treatment outcomes. Such efforts should contribute to apply adaptive coping strategies. Therefore, stigma and discrimination is occurred in Gambella town among people living with HIV/AIDS. This has increased the number of HIV positive transmission in the region especially in Gambella town.

### **5.3. Recommendations**

Based on the research finding of the study, the following recommendations were drawn as follow:

- Efforts should be made by government to help people living with HIV/AIDS to apply adaptive coping strategies, such as those identified in this study that include accepting the illness, seeking information and/or exchanging views about the illness through support groups, and preemptive disclosure.
- Government and Non-governmental Organization should improve the existing support available to enhance effective intervention method to reduce stigma and discrimination throughout the year in the Gambella Town.
- People living with HIV/AIDS should have access to health care services in Gambella town without being maltreated, and that HIV positive clients should come out in public to speak against discrimination and to tell the public that they could live positively.

- Discriminators and stigmatizes in the area should be confronted and reported promptly to concerned regulatory body at the governmental and community levels by establishing policies.
- To overcome the barriers of stigma and discrimination, people living with HIV/AIDS should take the efforts themselves as much as possible.
- Government should provide awareness creation and raising training to build the capacity of people living with HIV/AIDS to confront the problem of stigma and discrimination.
- In order to cope with the issues above, people living with HIV/AIDS, their communities, government, and organizations must closely work together with technical support, funding, participation, and awareness promotion.
- Further research needs to be conducted by other researchers on HIV related stigma and discrimination in the region as well as in the town.

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## **7. APPENDENCIES**

### **APPENDIX**

**HARAMAYA UNIVERSITY**

**POSTGRADUATE PROGRAM DIRECTORATE**

**College of Education and Behavioral Sciences**

**Department of Psychology**

Dear respondents'

The purpose of this questionnaire is to together information about stigma and discrimination among people living with HIV/AIDS in Gambella Town for partial fulfillment of the requirement for the degree of Master of Art in Social Psychology in Haramaya University.

General Directions:

1. You are kindly requested to give genuine response.
2. You do not need to provide your identification. Eg. Name, address and others.
3. The study is entirely academic and all responses are confidential.
4. Feel free to respond.

Your participation in this study is purely voluntary and you are free to accept and refuse your consent to participate. The researcher promises to treat all information you provide as strictly confidential and will not disclose individualized information to any one unrelated to this study.

THANK YOU IN ADVANCE!!!

**Part I. Demographics characteristics of people living with HIV/AIDS.**

1. Gender Male 1 Female 2

2. Age \_\_\_\_\_

3. How long have you been living with HIV? \_\_\_\_\_

4. Your current marital status (can choose only one).

Married and living with a spouse 1 Married or have partners but not living together 2

Having a relationship but not living together 3 Single (no sexual activity) 4 Divorced or separated 5 Widowed by any reason 6

5. Based on #4, how long has the relationship been, if any? \_\_\_\_\_

6. Do you still have sexual desire?

Yes 1

No 2

7. Do you have any physical disabilities (excluding general HIV-related illness)?

Yes 1

No 2

If yes, please provide details.

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8. What highest level of education did you have (including formal admission into school) (choose only one choice)?

Not have formal education 1 Primary education 2 Secondary education 3

Vocational/University 4

9. Please choose the most relevant choice to your current employment. (Choose at least one choice and can choose more than one).

Full-time employment 1 Part-time employment 2 Full-time but not employed (i.e. having own business) 3 Occasional jobs (having own business) 4 Unemployed 5

10. How many members are there in your family now? \_\_\_\_\_

11. Are there children or youths affected because of the death of positive parent(s)?

12. Locality of where you live (choose only one).

Country/rural 1 Semi-urban 2 Urban/city 3

## Part II: Self stigmatization of people living with HIV/AIDS.

**INSTRUCTIONS:** The following 19 statements refer to self stigmatization of people living with HIV/AIDS. You are to indicate, on a five-point scale, the five points are: Never, Rarely, Sometimes, Often, and All the time).

Scale	Items	Never	Rarely	Someti mes	Often	All the time
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		<i>1</i>	<i>2</i>	<i>3</i>	<i>4</i>	<i>5</i>
<b>1</b>	I feel shame because of HIV status.					
<b>2</b>	I feel a sense of guilt.					
<b>3</b>	I blame myself.					
<b>4</b>	I blame others.					
<b>5</b>	I have low self-esteem.					
<b>6</b>	I deserve punishment.					
<b>7</b>	I always think not to join social events and activities.					
<b>8</b>	I feel a sense of isolation from family and friends.					
<b>9</b>	I decided to quit employment.					
<b>10</b>	I hold a sense of withdrawal from school/training or rejection of such opportunities.					
<b>11</b>	I feel a sense of Gossip					
<b>12</b>	I decided not to have sex.					
<b>13</b>	Avoiding going to local hospital when needed.					
<b>14</b>	I feel paranoid and stigmatize myself					
<b>15</b>	I have fear of disclosure.					
<b>16</b>	Fear of losing honor and social standing.					
<b>17</b>	Religious beliefs or judgment based on moral standards.					
<b>18</b>	I developed sense of verbal harassment, assault or threat.					
<b>19</b>	Because of stigma problem, I feel a sense of hiding my HIV status from others.					

**Part III: Manifestation of discrimination among people living with HIV/AIDS.**

**INSTRUCTIONS:** The following 18 statements refer to the experiences that people have in their daily life. You are to indicate, on a five-point scale, the five points are: Never, Rarely,

Sometimes, Often, and All the time). The extent of agreement between the feeling expressed in each statement and your own personal reactions. So, please, put this Mark (x) on one of the five alternatives based on your agreement.

Scale	Items	Never	Rarely	Sometimes	Often	All the time
		<i>1</i>	<i>2</i>	<i>3</i>	<i>4</i>	<i>5</i>
1	I have been refused participation in community events or activities.					
2	I have been refused or hindered participation in religious activities or refused entrance to a religious place.					
3	I have been refused participation in family activities.					
4	In the last 12 months, I faced harassment or intimidation.					
5	In the last 12 months, I have been physically assaulted.					
6	In the last 12 months, I have been experienced pressure or psychological hassle from my spouse because of HIV status.					
7	In the last 12 months, I have been refused having sex because of HIV status.					
8	I have been discriminated against by other positive people.					
9	People living with HIV/AIDS face discrimination from family, friends, health care settings & Society.					
10	Separation and loss of contact with family.					

11	I loss respects from my family.					
12	Discrimination on ownership of property.					
13	Physical and social restrictions.					
14	I loss respects from society.					
15	Not involving in rituals.					
16	I have been denied treatments in health care settings.					
17	Poor quality of health care services.					
18	I have experience of HIV Testing without Consent					

**Part IV: COPING STRATEGIES RESPONSE**

**INSTRUCTIONS:** The following 15 statements refer to the coping response of people living

with HIV/AIDS from stigma and discrimination in their daily life. The five points are: Never, Rarely, Sometimes, Often, All the time). So, please, put this Mark (x) on one of the five alternatives.

Scale	Items	Never	Rarely	Sometimes	Often	All the time
		1	2	3	4	5
1	I have a community support.					
2	I have family support.					
3	I have received support from NGOs.					
4	I standby myself.					
5	In the last 12 months, I have received health program support.					
6	In the last 12 months, I have been received loan provision.					
7	In the last 12 months, I have received training on skill building.					
8	In the last 12 months, the community helps me to participation.					
9	PLWHA do not receive support from community, family, friend & health setting.					
10	Problem focused(seeking professional help)					
11	Emotion focused Distraction-positive					
12	Acceptance					
13	Religion/faith					
14	Denial/blame					
15	Problem & emotion focused					

This is the end of the questionnaires. Thank you very much for your answering the question.

**HARAMAYA UNIVERSITY**  
**POSTGRADUATE PROGRAM DIRECTORATE**  
**College of Education and Behavioral Sciences**  
**Department of Psychology**

**INTERVIEW GUIDE**

Key informants Interview with concerned body (people living with HIV/AIDS and GPNRS, Network of HIV/AIDS Association). Interview on stigma and discrimination among people living with HIV/AIDS in Gambella Town, Gambella National Regional State. Please answer the following questions as fully as possible.

Sex: ----- Position: ----- Age: -----

1. What are the demographics characteristics of people living with HIV/AIDS in Gambella Town?
2. How does discrimination manifest among people living with HIV/AIDS in Gambella Town? In your opinion, what are the common forms of HIV and AIDS related stigma and discrimination in your area?
3. How do people living with HIV/AIDS stigmatize themselves in Gambella Town?
4. How do people living with HIV/AIDS cope from stigma and discrimination? What are your suggestions to improve living condition of people living with HIV/AIDS?
5. Beside stigma and discrimination, do people living with HIV/AIDS have any problems? What kinds of problems do people living with HIV/AIDS face?

**This is the end of our interview. Thank you very much for your participation in the interview.**









