

TITLE PAGE

**AN INVESTIGATION INTO THE STIGMATIZATION OF HIV- POSITIVE CLIENTS AT
CLINICS IN THE LERIBE DISTRICT**

by

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DECLARATION

I declare that AN INVESTIGATION INTO THE STIGMATIZATION OF HIV POSITIVE CLIENTS AT CLINICS IN LERIBE DISTRICT is my own work and that all the sources that I have used or quoted have been indicated and acknowledged by means of complete references and that this work has not been submitted before for any other degree at any other institution.

MRS NWOGO IMMACULATA EKEJI

DATE

DEDICATION

I dedicate this work to Jehovah Lord whose everlasting grace enabled me to achieve this.

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ABSTRACT

A quantitative approach was used to investigate the stigmatization of HIV positive clients in the Leribe District of Lesotho. The study population included 5200 HIV positive patients who enrolled for ARV in government clinics. A randomly selected sample of 520 clients responded through a questionnaire and interviews. The statistical package (STATA version 9) was used to analyze data. The objectives of the study were to explore the type and level of stigmatization of HIV-positive clients and to describe ways in which health workers in the PHC can reduce the stigmatization of HIV-positive clients at the clinics. The findings revealed that types of stigmatization included separation, isolation, labeling and discrimination. Ways to reduce the stigma within a community based primary health care facility included educating people living with HIV on how to protect themselves from multiple infection, providing effective counselling to clients and families maintaining confidentiality, and using change strategies to change attitudes of health care providers. The integration of HIV-related activities is a strong recommendation and the importance of the consistent availability of ARV treatment was emphasized.

KEY CONCEPTS

Stigmatization; HIV-positive clients; Integration of services

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LIST OF ABBREVIATIONS

AIDS:	Acquired Immune Deficiency Syndrome
ARV:	Anti- retroviral
CHAL:	Christian Health Association of Lesotho
EGPAF:	Elizabeth Glaser Paediatric Aids Foundation
FGD:	Focus Group Discussion
HIV:	Human Immunodeficiency Virus
ICAP:	Columbia University International Centre for Aids care and Treatment
ICRW:	International centre for research on women.
IEC:	Improved information, Education and Communication.
LFDS:	Lesotho Flying Doctors Services
MSF:	Medicines Sans Frontiers
OPD:	Out Patient Department
PHC:	Primary Health Care.
PIH:	Partners in Health
PLWA:	People Living With AIDS.
PMTCT:	Prevention of Mother to Child Transmission.
STATA:	Statistical Package
STDS:	Sexually Transmitted Diseases.
UNAIDS:	United Nations Programme on HIV and Aids
UNFPA:	United Nations Fund for Population Activities
UNICEF:	United Nations Children Fund
UNISA:	University of South Africa.
WHO:	World Health Organization

CHAPTER 1: OVERVIEW OF THE STUDY

TITLE: AN INVESTIGATION INTO THE STIGMATIZATION OF HIV-POSITIVE CLIENTS AT CLINICS IN THE LERIBE DISTRICT

1.1 INTRODUCTION

Stigma is a deeply discrediting attribute that reduces a person to one who is in some way tainted and can therefore be denigrated (Goffman,1963) It is a pervasive problem that affects health globally, threatening an individual's psychological and physical well-being. Asiedu, (1998:6) describes three types of stigma that individuals face: stigma related to various physical deformities, flaws in individual's character such as dishonesty or ill health and stigma associated with a social group, religion or race.

HIV/AIDS have the characteristics associated with all three types of these stigmatizing conditions. HIV/AIDS is treatable but incurable, disfiguring, degenerative, potentially fatal, and can be contracted through socially improper forms of sex and injection drug use. Therefore, in places where heterosexual transmission of HIV/AIDS is significant, the infection of HIV is associated with female improper sexual behaviors such as prostitution and promiscuity (Asiedu, 1998:7). Men are blamed for heterosexual transmission on the perception that males have multiple partners (Asiedu, 1998:12). This has led to "us" and "them" differences re-enforcing the feeling that HIV belongs to them and not to us.

The type and levels of stigmatization of HIV positive clients at the clinics depend on how one contracted the infection and the level of knowledge about HIV transmission that the health workers have (Ogden & Nyblade, 2005:22-23). Stigma experienced by HIV positive clients ranges from physical, social, verbal, and institutional to isolation, loss of identity, labeling, name calling, insulting and loss of respect.

Stigmatization of HIV positive clients in the Primary Health Care (PHC) has negative effects on the prevention and control of HIV/AIDS. Behaviours such as refusal to test for HIV, lack of condom use, refusal to seek care upon diagnosis, and reluctance in disclosing one's HIV status are noteworthy ; and do lead to multiple increases in new cases of HIV and early deaths. These tendencies have affected the quality of care given to people living with HIV and AIDs in the health settings (HIV/AIDS stigma & discrimination. From:

<http://www.avert.org/aidsstigma.htm> accessed 25th April, 2008; HIV & AIDS stigma and discrimination. From: <http://www.avert.org/aidsstigma.htm> accessed 9th June, 2009).

This study seeks to explore the types and levels of stigmatization of HIV positive clients at the government clinics in Leribe District. However, this chapter contains the background and rationale of the study, aim of the study, objectives of the study and the research questions.

1.2 BACKGROUND AND RATIONALE OF THE STUDY

1.2.1 About Lesotho: The kingdom of Lesotho is a land-locked country in South Africa with a total population of 2, 2 million people. Administratively, Lesotho is divided into 10 districts with emphasis on decentralization. In 2005, the health sector shifted organization of the health care delivery system to the district structure. Previously, health care delivery system of Lesotho was organized in terms of Health service Areas (HSAs). There were 18 HSAs, each with a hospital and a varying number of health centres and health posts. The Lesotho Flying Doctors services (LFDS) were only operational in 9 health centres in the hard - to - access mountainous regions of Lesotho. HIV/AIDS in Lesotho is responded to through a multi-sectoral approach that is supported at the highest level of both political and administrative systems. The Lesotho National AIDS commission oversees the management of HIV/AIDS in Lesotho and is directly supervised by the office of the Prime Minister. The Lesotho Government's focus on PMTCT and pediatrics HIV treatment has enhanced the country's partnership with: The United Nations Organizations (UNICEF, WHO, UNFPA); MSF, Baylor college of Medicine and United States Government (USG) partners such as ICAP, EGPAF, CHAI and PIH (Ramatlapeng, 2007: 5).

1.2.2 HIV in Lesotho: In Lesotho, the prevalence of HIV has continued to increase. In 2001, HIV prevalence was estimated to be up to 270 000 cases. In 2007, it was estimated at 290 000 cases with 13 500 infants born to HIV infected mothers each year (WHO report, 2007). Over 22,000 children in Lesotho are currently living with HIV/AIDS (Ramatlapeng, 2007:5 & UNAIDS, 2002: 190) In 2007, 290000 adults were infected with HIV. Of these, approximately 42,000 are in need of anti-retroviral treatment. The HIV prevalence among pregnant women attending ante-natal care is about 27%, with an estimated 50,000 pregnancies annually, 13,500 infants are born to HIV infected women each year (Ramatlapeng, 2007:5-6; WHO report, 2007; UNAIDS, 2007).). At the end of 2007, 33.2

million people were living with HIV/AIDS world wide and during the same year 2.1 million died of AIDS-related illness (Fredriksson & Kanatus, .2008).

1.2.3. Definition of stigma and stigma related to HIV and AIDS.

Stigmatization is a dynamic process that arises from the perception that there has been a violation of shared beliefs, values and attitudes which can lead to prejudicial thoughts, behaviours and actions against people infected with HIV/Aids by the families, communities, workplace and health centers (Brown, Trujillo & Macintyre, 2001:4)

HIV/ AIDS infects and affects people of all ages and destroys both family, community and the nations' economic growth, security, investment, trade and even leads to extreme poverty. This is mostly because AIDS affects primarily the productive age range of the population where the epidemic is most serious. Parker & Aggleton, (2003) define stigma as a social process that produces, maintains and reproduces relations of power and control. Parker & Aggleton further unearth how stigma is used to turn differences into inequity based on gender, age, sexual orientation, class, and race or ethnicity, making it possible for some people to devalue others based on such differences in the same study.

Stigma can be either "internal"/ "felt" or "external"/ "enacted" (UNAIDS, 2002; Brown, et al, 2001:4; Igor, 2005:20). The HIV/AIDS pandemic has evoked a wide range of reactions from individuals, institutions, communities and even nations. These reactions range from sympathy, care and worry, to silence, denial, fear, anger and even violence.

Although it is difficult to predict the long-term impact of HIV/AIDS on Lesotho, the micro-level impacts on households are immediate (Igor, 2005). The rate of children orphaned by AIDS is increasing alarmingly in Sub –Sahara Africa. People who are living with HIV/AIDS experience unemployment, job insecurity and losses, low wages, exclusion from medical aid, charting and labeling (at the clinics), avoidance and isolation, verbal harassment, gossip and rumours, violence, loss of identity, referrals for HIV testing and rejection by families, loved ones and communities (Ramatlapeng, 2007:5; HIV& AIDS stigma and discrimination. From: <http://www.avert.org/aidsstigma.htm> (accessed 25th April 2008; HIV & AIDS stigma and discrimination; <http://www.avert.org/aidsstigma.htm> (accessed 9th June 2009) Lesotho is not spared any of these stigmas. A multi-country qualitative study in

Lesotho, Malawi, South Africa, Swaziland and Tanzania documented “extensive” verbal and physical abuse and neglect in health services. This was reported by the participants and the nurses respectively (Macquarrie, Eckhaus & Nyblade 2009:4).

An increase in the treatment and preventative measures to get rid of the deadly epidemic which has already claimed over 20 million lives worldwide is urgently needed, but this can be achieved only if the stigmatization of HIV positive clients at the clinics is reduced (Ghandi & Mandela, 2004; <http://www.avert.org/aidsstigma.htm> (accessed 25th April, 2008).

1.2.4 Impact of HIV and AIDS related stigma.

Physical harm to HIV positive clients has been documented in South Africa as well as in the United States (<http://www.avert.org/aidsstigma.htm> (accessed 25th April 2008), North & Rothenbery 1993; Rothenbery & Pasky 1995). Several reports from different countries of the world equally indicate forms of violent reactions towards HIV positive clients. These reactions which can rightly be referred to as stigma have greatly jeopardized the efforts of the public health in combating the epidemic because people tend to develop fear and anxiety which in turn discourage them from testing and disclosing their HIV status.

A study carried out in the United States in 2005; found that 26% of adults living with HIV and AIDS experienced discrimination, while 8% were bluntly refused treatment by the health care providers. Several studies reveal that people living with HIV/AIDS are denied the use of medical facilities, medicines, treatment, admissions and attendance with the intention that it is pointless to offer good quality care to such people since the disease is progressive and incurable (Aggleton, 2000; ICRW, 2006; Avert, 2005; Stigma and Discrimination. From: <http://www.nat.org.uk/Stigma And Discrimination> (accessed 24th September, 2008).

In a study conducted in 2002 among 1000 physicians, nurses and midwives in Nigeria, it was revealed that one in every 10 doctors and nurses had refused to care for people living with HIV/AIDS because of fear of exposure to HIV due to lack of protective equipment (Fredriksson et al 2008: <http://www.avert.org/aidsstigma.htm> accessed 25th April 2008). Again, in a study carried out by W H O in India, Indonesia, and Thailand 29%, 38% and 40% respectively of people living with HIV and AIDS experienced that their HIV – test results were revealed to their friends, relatives and other people without their consent.

1.2.5 Reactions towards stigma

Internal /felt stigma can be defined as the shame associated with HIV/Aids and fear of being discriminated against due to one's HIV status. It can further be explained as a real or imagined fear of discriminatory attitudes from families, friends, co-workers, communities and health care workers against HIV positive persons. This feeling which is stigma in itself is a defensive mechanism which individuals may use to protect themselves from real discrimination. For instance, individuals may refuse to be tested, refuse to disclose their HIV status, deny their HIV status, and show unwillingness to seek care but all in an effort to avoid discrimination (Igor, 2005:21; Brown, et al, 2001:1-5).

External/enacted stigma is the actual experience of discrimination. This type of stigma has the capacity to produce internalization and acceptance of the feeling of inferiority by the HIV positive persons and justification of discrimination by the perpetrators. External /enacted stigma experienced by people living with HIV and Aids includes: gossip, charting and labeling, rejection, isolation, referrals for testing, blame, oppression, devaluation, denial of rights and services, ridicule, resentment, and accusation (Igor, 2005:20; policy project, 2003:4; HIV & and AIDS stigma and discrimination. From: <http://www.avert.org/aidsstigma> (accessed 25th April, 2008); HIV & AIDS stigma and discrimination. From: <http://www.avert.org/aidsstigma.htm>(accessed 9th June, 2009); <file:///C:/documents and settings/USER/My Documents/journal.pmed.htm> (accessed 29th April, 2009); Mahendra, Gilborn, Bharat, Mudoj, Gupta, George, Samson, Daly & Pulerwitz 2007:618; Holzemer & Uys, 2004: 170). Individuals face different types of stigma at different times in different places. This includes stigmas related to various physical deformities, flaws in character such as dishonesty and weak-ill and stigma associated with a social group, race or religion (Goffman, 1963).

1.2.6 Factors contributing to HIV related stigma

Epidemics such as swine flu, HIV /Aids, resistant tuberculosis that spread more rapidly and pose open threat to the community are usually likely to evoke stigma because stigma is used to “enhance or secure social structuring, solidarity, safety and community values by excluding divergent or deviant individuals” (Gilmore, et al,1994).

Many factors are responsible for the stigmatization of people living with HIV/AIDS (PLWA) in the primary health care settings:

1. The nature of HIV infection. HIV is a life-threatening disease which is progressive and incurable. It is associated with opportunistic infections which are caused by microbes that usually do not cause illness in HIV-negative healthy people (Sowadsky, 1999). These opportunistic infections result in physical deformities such as rashes, weight loss, blindness and serious illness which instigates stigma. Although these symptoms only happen when the infection is fully blown, people start experiencing stigma as soon as they are tested HIV positive.
2. Attitudes, beliefs and structural factors lead to the stigmatization of people living with HIV/AIDS in the PHC. Some of these attitudes and beliefs are about PLWA, beliefs about transmission, fear of contracting HIV infection, poor working conditions, perceived risk of workplace infection, lack of training, poor client-provider relationship, inability to address clients needs and lack of professional satisfaction (Igor, 2005:7-9; International Center for Research on Women, 2005:8:20).
People living with HIV and Aids experience stigma at the Primary health care due to the ignorance of the health workers on the HIV transmission (Shapiro, 2005; Smart, 2005; Aggleton, 2001; Brimlow, Cook & Seaton, 2003).
3. Poor knowledge and education on the mode of HIV transmission. Research has shown that health workers who are misinformed, about the mode of HIV transmission show more stigmatizing attitudes to PLWA however, health workers who have proper knowledge about HIV and AIDS have less fear and are more willing to associate with people living with HIV/AIDS (Brown, et al, 2001:15-17; Shapiro, 2005). Many factors lead to the stigmatization of people living with HIV/Aids in the PHC, These include: the nature of HIV infection, negative behaviours associated with HIV infection, beliefs about transmission, working conditions, and perceived risk of workplace infection, lack of training, client-provider relationship, and fear of contagion (Igor, 2005:2-3; Shapiro, 2005; Aggleton, 2001; Asiedu; 1998:8-10).
These studies suggest that increased understanding about how HIV is transmitted will result in the lowering of the levels of stigma experienced by PLWA especially at the PHC level in L District.
4. Blame. People who are infected through drug use and sexual relations with same-sex partners are likely to experience more stigma than those infected through mother-to-child transmission and blood transfusion. Health workers who contract the disease from

work, children and women who contracted HIV from their husbands or parents are likely to receive compassion and fewer stigmas than sexual workers, injection drug users, unmarried women and men who are often blamed for their HIV infection (Ogden & Nyblade, 2005).

5. Lack of confidentiality. There are specific areas designated for HIV positive patients for preferred service provision in the primary health care centre and hospitals, which the general public is aware of. This is affecting clients' care seeking behaviours as there is little or no confidentiality in this practice. (HIV & AIDS discrimination and stigma. From: <http://www.avert.org/aidsstigma.htm>(accessed 25th April, 2008:4; Fredriksson & Kanabus, 2008). Several reports have revealed that health care systems are major sources of stigmatization and discrimination of people living with HIV/AIDS, when they are supposed to be the key players in the prevention and management of the disease (Fredriksson et al, 2008; Herek, et-al, 1997; Asare & Marfo, 1997.).

6. Panic and undue precautions. The situation is made worse by the excessive and unnecessary precautions by health-care providers when treating or touching HIV patients. This often manifests in the misinterpretation and thus misapplication of universal precautions and the inappropriate use of gloves when transporting HIV positive patients from one location to another or when giving them injections, or the practice of placing them in separate wards, rooms, and sometimes in a designated building with a bold inscription 'HIV clinic'. In Thailand hospitals, signs have been placed near HIV- positive patients with words such as 'HIV – positive' and 'AIDS' written on them (HIV & AIDS stigma and discrimination. From: <http://www.avert.org/aidsstigma.htm>(accessed 25th April, 2008).

7. Rejection. Distancing of HIV –patients and the burning of clothes and linen used by those patients which is practiced in Indian hospitals is stigmatization (Mahendra, et al 2007:621-623).

8. Fear. Studies in Ethiopia, Zimbabwe and India have reported that fear of stigma is the main reason why women attending ante-natal clinics refuse to be tested for HIV (Kumbi, Bedri, Abashawl, Sehak, Cobercly & Ruff, 2002; Munhenga, et al, 2002; Chakrapani, Govindan, Balasuramianiam, 2002).

A study conducted in the Indian hospitals revealed that health workers practice mandatory HIV testing prior to any surgery, but this is a violation of patients' rights based on Indian and international guidelines which should involve pre- test counseling and post- test counseling (UNAIDS/WHO, 2004). People living with HIV and AIDS often discover their HIV status at the primary health care settings. It is where HIV patients have the potential to get or gather information on how to care for themselves and prevent transmission to other people, as well as get quality treatment and care. But the fact that health care providers lack specific in-depth information (knowledge) about HIV transmission, lack basic grasp of human rights concepts and are not knowledgeable about appropriate procedures for maintaining patient confidentiality. They are afraid of being infected by the patients. This shortcoming has continued to fuel the stigmatization and discrimination against people living with HIV and Aids (Infante-Xibille, Mera, Hernandez, Melke, Pertzovsky, 2004; Gyasi, 2008 Personal interview 4th April, 2008, HIV & AIDS stigma. From: <http://www.avert.org/aidsstigma.htm> (accessed 25th April, 2008).

The rejection of people infected and affected with HIV holds as true in the rich countries of the north as it does in the poorer countries of the south (Fredriksson, et al, 2008). This simply means that rejection has been experienced by the HIV positive clients every where in the world. Stigmatization against HIV positive clients has been recorded both in the developed countries and in the developing countries such as in the United States of America, India, China, Nigeria, South Africa, Ethiopia, Lesotho and many countries of the world. The stigmatization of HIV positive clients has undermined all public health efforts to combat the epidemic since people refuse to access the health centers for HIV counseling and testing, treatment and adherence to treatment due to the fear that they will be stigmatized based on their HIV status (Malcolm, et-al, 1998; UNAIDS, 2000).

HIV/ AIDS stigma has numerous negative effects on preventative behaviours such as condom use , HIV test-seeking behaviour, care-seeking behaviour upon diagnosis, quality of care, perception and the treatment of people living with HIV/AIDS by communities, families , partners and health workers. (Gerbet, et al, 1991; Herek, 1990; Glunt, 1988). People do not show willingness to go for HIV testing or treatment because they will be stigmatized right from the primary health care (HIV & AIDS stigma and discrimination. From: <http://www.avert.org/aidsstigma.htm> (accessed 25th April, 2008).

Stigmatization of HIV positive clients has led to denial of HIV positive status, unwillingness to disclose HIV positive status, lack of compliance and adherence to treatment (Asiedu,

1998:10-13); HIV & AIDS stigma and discrimination. From:

<http://www.avert.org/aisstigma.htm> (accessed 25th April 2008); HIV & AIDS stigma and discrimination. From <http://www.avert.org/aisstigma.htm> (accessed 9th June, 2009).

Diseases which often generate stigmatizing conditions are those that are potentially fatal, incurable, and degenerative, or diseases that lead to physical disfigurement (Alonzo & Rynolds 1995; Cagan & Herek, 1998; de Bryun, 1998; Gilmore & Somerville, 1994; Ogden et al, 2005).

Stigma is a common reaction to disease. Many diseases have carried some degree of stigma in their history such as tuberculosis, cancer, leprosy, mental illness, many STD's. HIV/AIDS and swine flu are among the most stigmatized diseases in the world (Brown, et al, 2001; News 24, May 2009). This is mainly because these diseases are contagious, therefore can be transferred from an infected person to an uninfected individual. The Method of transmission of these diseases is also a factor contributing to the stigmatization of people with the infection.

People living with HIV/AIDS face different types of stigma depending on the stage of their disease and how they contracted it. For instance, PLWA experience high level of stigma when they start facing physical deformities such as growing lean and having rashes all over the body as a result of the disease progression.

However, a person who has contracted HIV infection will definitely experience some level of stigma depending on how the individual contracted the virus.

Ogden, et al (2005) drafted a model which they called "schematic of innocence- to- guilt continuum" which expresses that there is a kind of continuum from presumed "guilt" to presumed "innocence" in the minds of people. This explains that the intensity of stigma experienced by clients differ based on channel or mode of virus contraction (Phelan, 2001, Ogden, et al, 2005, UNAIDS, 2000, Brimlow, et al, 2003, Smart, 2005).

1.2.7 Factors that contribute to a decrease of stigma related to HIV/AIDS

HIV and AIDS related stigma can be decreased using the following factors:

1. Individual based;

Health services –based: Gyasi (2008) states that the concept of a designated HIV clinic is stigma on its own; the fact that HIV patients are treated in a separate building or site is the start of stigmatization of people living with HIV/Aids by the PHC. If not, why are HIV patients

not being treated together with cancer and hypertensive patients who are not being isolated? Some clinics are constructed separately, fenced with high walls and boldly labelled 'HIV clinic'. This makes clients to feel stigmatized going there for anti retroviral treatment (ART) and for the treatment of other opportunistic infections. At the clinics for example at Khuator HIV-patients' files are kept separately from other patients, their cards are coded in such a way to show that they are HIV positive, HIV positive patients are admitted in a separate ward, outpatients are consulted in a well designated and defined HIV positive consulting rooms. Reports reveal that health care systems are major sources of the stigma experienced by HIV infected persons; and this is hampering the efforts of public health in the fight against HIV/AIDS (Fredriksson et al, .2008). The researcher has therefore deemed it necessary to explore the type and level of stigma experienced by people living with HIV/AIDS who visit the clinics in the Leribe District.

2. Health care giver-based: The Study conducted in Ghana shows that health workers do not follow the general sequence in the counseling process for HIV management. The doctors interviewed argue that the patients had come to them to seek treatment and that requesting a blood laboratory test is part of treatment process as with any other disease, pointing out that after test, if a patient is HIV positive, they would refer the patient for counseling before informing him/her of the test results (Asare et al 1997).

The report of a study carried out in India reveals that 94% of doctors inform the HIV patient's partners and relatives of their positive status without the consent of the patients, claiming that it is their moral and professional responsibility in the area of preventing new cases.

HIV- positive health workers are made to manage people living with HIV infection, care providers use separate medical tools for HIV- patients. They also provide sub-standard treatment to HIV- patients with the intention that HIV is not curable; therefore there is no need to waste their energy, time and money on PLWA. (Gyasi, .2008: personal interview 4th April Maputsoe.

HIV patients are being managed or treated by special doctors, nurses, counsellors and lay counsellors, all these are factors contributing to stigmatization of HIV patients.

When treating hypertensive patients, many doctors and nurses do not remember to wear gloves, but once the patient is HIV positive, they will not touch the patient until they wear

gloves. This makes patients feel that they are already dead. In some cases patients feel like committing suicide and dying rather than to live and be treated like an outcast. (Gyasi, 2008. personal interview, 4th April, Maputsoe)

The attitude of health practitioners towards HIV- patients is a major issue in the stigmatization of HIV-patients and this cannot be handled until such attitudes changed. This will start with changing the concept of treating HIV patients in a conspicuously separate structure or building.

In addition, the health-care workers should improve on confidentiality, politeness strategies and desist from camouflaging services to alleviate the stigma experienced by PLWA within the primary health care facilities (Jackson, Maclean, Leonard, Mill, Reintjes, Austin, Smith & Edwards, 2006).

Health-care providers can alleviate or reduce the level of stigma experienced by PLWA by establishing warmth and flexible relationships with their clients. Although this may take time, trust will be built which will obviously encourage patients to visit for care. Stigma related to HIV/Aids can be alleviated through appropriate provision of services by competent culturally acceptable health workers in the health facilities (Jackson, et al 2006; Nyblade, 2006).

The fact that myths and misconceptions about how HIV/AIDS is transmitted have persisted in promoting the stigmatization and discrimination of people living with HIV calls for urgent need to train, inform, communicate and educate all health care professionals about how HIV can and cannot be transmitted. Universal precautions and the rights of people living with AIDS must be disseminated and adopted by all health care centers. This will, to a large extent, reduce the magnitude of stigmatization and discriminatory practices against PLWA in the PHC and at the same time improve the quality of services rendered by the Primary Health workers.

Health-care providers can be equipped with proper knowledge through workshops and seminars to educate people living with HIV infection on how to protect themselves from multiple infections and how to manage their situations and reduce self stigmatization.

Health-care providers can reduce the stigma related to HIV in the health care settings by using positive images of people with HIV infection instead of the pictures of the dying and terminally ill patients. As this study explores the types and levels of stigma experienced by PLWA in the PHC, it will as well identify the root causes, such as fear of contracting HIV, life threatening disease, its association with stigmatized behaviours (such as

homosexuality, drug addiction, promiscuity or prostitution, inaccurate information about how HIV is transmitted and recommend ways to reduce the stigmatization of people living with HIV/AIDS who visit the primary health care in the Leribe District.

1.3 PROBLEM STATEMENT

A problem statement identifies the key research variables, specifies the nature of the population and suggests the possibility of empirical testing (Polit & Hungler, 1999). Therefore the problem statement for this study is: The nature of health services and attitudes of health care workers' influence in the type and extent of stigma experienced by persons living with HIV and AIDS.

1.4 AIM OF THE STUDY:

To explore the type and level of stigmatization of HIV positive clients within the context of primary health care services

1.5 Research questions:

The research questions are:

- 1.5.1 What types of stigma do HIV positive clients experience within the context of primary health care in the Leribe District?
- 1.5.2 What level of stigma do HIV positive clients experience within the context of primary health care in the Leribe district?
- 1.5.3 What role can health workers in the primary health care facilities play to prevent/alleviate stigma related to HIV and Aids?

1.6 RESEARCH OBJECTIVES:

The research objectives are:

- 1.6.1 To explore and describe the types of stigma related to HIV and Aids as experienced by HIV positive clients attending clinics in the Leribe district.

1.6.2 To explore and describe the level of stigmatization as experienced by HIV positive clients attending primary health care clinics in the Leribe District.

1.6.3 To describe ways/strategies that health workers in a primary health-care context can use to reduce the stigmatization of HIV positive clients.

1.7 SIGNIFICANCE OF THE STUDY

The study explores the type and level of stigmatization of HIV positive clients who visit the clinics (Primary Health Care, PHC) in Leribe District. It also explores ways that can be used to reduce or alleviate the stigmatization of HIV positive clients at the clinics in Leribe District.

- The findings and recommendations of this study will be of great help to people living with HIV and AIDS in terms of strengthening them with the capacity to challenge stigma in their lives, making the clients aware of the government policies and their rights in AIDS issues.
- The outcome of the study will enhance the reduction of the extent of stigma experienced by HIV positive clients, if the Lesotho government implements the recommended training of both the clinic staff and HIV clients.
- The study will significantly, enhance protection to the health care workers since they will be recommended to be wearing gloves as part of their dressing code when treating all patients, as this will reduce both infections and stigma.
- This study will significantly strengthen staff skills in the area of interventions to reduce HIV-related stigma, since the staff will be educated and trained through workshops and seminars on all issues concerning HIV and AIDS.
- It will expose the effects of stigma to the community members. As they realize that it is an ill wind that blows nobody good, it is hoped that their attitudes towards people living with AIDS will change.
- The information explored in this study will go a long way in guiding both the government and health policy makers in making policies that will help to reduce the type and extent of stigmatization of HIV positive clients in the clinics.

- The training will as well help nurses to acquire better knowledge on how to care for people living with HIV/AIDS thereby reducing the stigma experienced by the clients at the clinics. (Refer more of the significance of this study in chapter 5).

1.8 RESEARCH DESIGN AND METHOD

Research design and method comprise the overall plan for data collection and analysis (Devos, 1998:123; Polit & Hungler, 1997:467). Research design is a blueprint for conducting a study; it maximizes control over factors that interfere with the validity of the study findings (Polit, Beck & Hunger, 1997:46). The research design used in this investigation is the quantitative research design. The research design and methodology will be discussed in more depth in chapter 3

1.9 Study population

The study population included 5200 HIV positive clients who enrolled for ARV at the government clinics in Leribe District. (Refer to chapter 3).

1.10 Sample and sampling

A sample of 520 HIV positive clients was selected using systematic convenience sampling method. (Refer to chapter 3).

1.11 Data collection

Data was collected using questionnaire which serves as a structured interview guide (Refer to chapter 3).

1.12 Data Analysis

The data was analyzed using statistical package (STATA version 9) with the help of a statistician. (Refer to chapter 3).

1.13 Validity and reliability

The internal and external validity and reliability were ensured in this study, by pre-testing the questionnaire with similar respondents, repeating items in the questionnaire, translating the questionnaire to the language of the respondents, Then,using random convenience sampling method to select study samples. (Refer to chapter 3).

1.14 Ethical issues

The researcher has followed all ethical guide lines required to carry out this study For instance,the resaercher got approval of the research proposal from the Department of Health studies (UNISA); permission to carryout the study from the Ministry of Health and Social Welfare Lesotho,Got signed written consent of the study respondents before the commencement of the study, The respondents' names, phone numbers, addresses and other contacts were not included in the questionnaire which ensures confidentiality. (Refer to chapter 3).

1.15 STRUCTURE OF THE DISSERTATION

This is a dissertation of limited scope. It has five chapters: Chapter one consists of background of the study, rationale of the study, aim of the study, objectives of the study, research questions and scope of the study. Chapter two contains the Literature review, Chapter three consists of the research methodology which includes the research design, population, sample and sampling techniques, data collection, ethical consideration, Chapter four is about data analysis ,presentation and interpretation, then Chapter five consists of the recommendations, conclusions and references.

The dissertation starts with the cover page, title page, dedication, declaration, acknowledgements and abstract, then table of contents.

1.16 CONCLUSION

In this chapter, the reader has been introduced to an investigation into the stigmatization of HIV-positive clients at the clinics in the Leribe District of Lesotho. This chapter has been

able to discuss the research problem, aim of this study, objectives of the study, research questions and many introductory parts of this investigation which take us to the next chapter of this study.

CHAPTER 2: LITERATURE REVIEW

2.1 INTRODUCTION

In this chapter, the concept of stigma; its relationship to HIV/AIDS, reasons behind stigma, the different types of stigma towards HIV positive clients, the extent or intensity of HIV related stigma and intervention strategies have been discussed. Stigma is a complex phenomenon and often originates from subjective ideas, perceptions and values. Most health-care providers display stigmatizing attitudes and practices against HIV patients due to lack of appropriate knowledge about how HIV is or is not transmitted. Stigmatization is affecting the level of care-seeking by the stigmatized as well as the quality of care and services provided by health workers to these patients (Brown et al, 2001, Holzemer et al, 2004:167; Mahendra, et al, 2007:617-623, Ogden et al, 2005). Combating stigma against people who are infected by HIV/AIDS remains as important as developing the medical cures in the process of preventing and controlling the global epidemic.

Health-care givers often blame the vulnerable individuals or groups (drug users, sex workers, gay men) for being the architects of their disease, but most times this is a ploy used to dodge or shift responsibility for caring and looking after those patients. Health care providers deny HIV patients the services and treatment they need due to lack of appropriate information about HIV/AIDS, poor contact with PLWA and lack of quality training on counseling and confidentiality of HIV information (Ogden, et al, 2005; Fredricksson, et al. 2008 Stigma, Discrimination and Attitudes to HIV & AIDS. From: <http://www.avert.org/aidsstigma.htm> accessed 25th April 2008).

HIV and AIDS threaten the welfare and well-being of people throughout the world. At the end of 2007, 33.2 million people were living with HIV. During the same year 2.1 million died from AIDS related illness (Fredriksson et al, 2008. From: <http://www.avert.org/aidsstigma.htm> accessed 25th April 2008). In high prevalence countries, HIV/AIDS is responsible for up to 58% of child mortality; with 700 000 children newly infected and 570 000 children less than 15 years dying of AIDS- related illnesses in 2005.

Stigma is a common human reaction to disease. History shows that many diseases have carried considerable stigma throughout the world, including tuberculosis, leprosy, mental illness, cancer, sexually transmitted diseases and HIV/AIDS is now among the latest diseases to be stigmatized while swine flu stigma is positioning itself (Brown, Trujilo, Malintyre, 2001:1; France 24 news June 2009).

The HIV/AIDS pandemic has evoked a wide range of reactions from individuals, institutions, communities and even nations. These reactions range from sympathy, care and worry to silence, denial, fear, anger and even violence (Fredriksson 2008). Physical harm to PLWA has been documented in the United States and in different countries of the world (Ogunyombo, 1999, North and Rothenberg 1993; Rothenberg and Pasky, 1995). From: <http://www.avert.org/aidsstigma.htm> accessed 9th June, 2009). These reactions which rightly refer to stigma have jeopardized the efforts of the public health in combating HIV and AIDS. For example, it has negatively affected preventive behaviors such as condom use, HIV testing behavior, care –seeking behavior upon diagnosis, willingness to disclose one’s HIV status, quality of care given to people living with HIV/AIDS, perception and treatment of PLWA by families, partners, health workers and communities (Gerber, et-al, 1991; Herek 1990) HIV and AIDS related stigma and discrimination are among the main obstacles to the prevention, care, and treatment of HIV/AIDS (HIV & AIDS stigma and discrimination. From <http://www.avert.org/aidsstigma.htm> (accessed 25th April, 2008).

2.2 THE CONCEPT OF STIGMA

Stigma is discussed in depth in this chapter. There is substantial amount of literature available on HIV / AIDS stigma in the areas of evolution of HIV/AIDS stigma, policy-related and legal initiatives. However, much less material is available on the types and level of stigma experienced by people living with HIV and Aids, how the health-care providers contribute to HIV-related stigma and strategies to help curb HIV/AIDS stigma at the health facilities. This study will therefore explore the types and levels of stigma experienced by people living with HIV and AIDS and also find out how health workers can help in reducing stigma experienced by these people at the primary health care facilities.

The original Greek meaning of stigma refers to bodily signs designed to expose something unusual and bad about the moral status of a person. ‘The signs were cut or burnt into the

body and advertised that the bearer was a slave, a traitor, a criminal, a ritually polluted, a blemished person, to be avoided especially in public places (Igor, 2005: 19).

Stigma is an attribute that is deeply discrediting and reduces one from a whole and usual person to a discounted, tainted person (Goffman, 1963). Stigmatized individuals or group of persons possess or are believed to possess attributes or characteristics that convey a social identity that is devalued in a particular social context (Crocker, et al, 1998: 505). Goffman's explanation of stigma focuses on the public's attitudes towards a person who possesses or is believed to possess an attribute that falls short of societal expectations. He further explains that stigma can be discussed under three categories:

- Abominations of the body (includes different physical deformities).
- Blemishes of individual character (includes ill health, dishonesty, rigid beliefs, domineering or unnatural passions, treacherous behavior, blemishes of individual character which can be as a result of homosexuality, addiction, alcoholism, suicidal attempts, unemployment or radical political behavior).
- Tribal stigma (of race, religion and nations). This refers to beliefs that are equally transmitted and contaminated to all members of the family, religion or race through lineage (Goffman, 1963).

Researchers have discovered that diseases associated with the highest degree of stigma share the following common attributes:

- The disease is progressive and incurable
- The symptoms of the disease cannot be concealed.
- The person with such disease is seen as responsible for having the illness.
- The disease is not well understood among the public. (Stigma and HIV/AIDS: A Review of the Literature Introduction. From: <http://www.hab.hrsa.gov/publications/stigma/introduction>

.htm (accessed 9th June, 2009); HIV/AIDS related stigma and discrimination: 15th International AIDS Conference. From: <http://www.aegis.com/conferences/iac/2004/MoOrD1021.html> (accessed 23rd August, 2008).

Parker, et al, (2003) define stigma as a social process that produces, maintains and reproduces relations of power and control. They explored how stigma is used to turn differences into inequity based on gender, age, sexual orientation, class, and race or ethnicity making it possible for some people to devalue others based on the above differences. It is a common reaction to disease. Many diseases have carried some degree of stigma in their history such as tuberculosis, cancer, leprosy, mental illness, many sexually transmitted diseases. Now HIV/AIDS and swine flu are among the most stigmatized diseases in the world (Brown, et al, 2001; News 24 May 2009)

Stigma can be seen to as a powerful tool of social control. It has been used to exclude, marginalize and exercise power over individuals who show certain characteristics. Stigma is an undesirable or discrediting attribute that an individual possesses which reduces that individual's status in the eyes of society (Goffman, 1963). Stigma can occur due to a particular behaviour or condition of an individual or group of people which includes physical deformity, sexual orientation (prostitution or homosexuality), dishonesty, race, religion, disease which is progressive and incurable and a disease which is not well understood by the public yet, its symptoms cannot be concealed (Goffman, 1963; Herek & Capitanio, 1999; Seaton, 2003).

Stigma is an act of identifying, labeling or attributing undesirable qualities to people who are perceived as being different or deviant from the social or moral code, seen as a drain on resources (WikiEducator:HIV AIDS/Mental Health and Spirituality/Stigma and discrimination accessed 17th February 2010).

The above definitions are all relevant to stigma associated with HIV/Aids in terms of the types and levels of stigmatization of HIV positive clients in the clinics.

2.3 STIGMA IN RELATION TO HIV AND AIDS

Stigma is a complex phenomenon and often originates from subjective ideas, perceptions and values with no scientific logic or evidence. Although stigma and stigmatization is

worldwide phenomenon, its origin is often difficult to determine or explain. Literature shows that stigma often stems from personal values attached to life style activities such as sex or drug abuse (Ogden, et al; 2005:7) and has a direct association with prejudice, ostracism, disregard and discrimination, rejection and name calling (Herek, Mitnik, Bunis, Chesney, Devine, Fullilove; 1998; Nzioka, 2000:1-14; UNAIDS, 2000a; Aggleton, 2002; Brown, et al, 2000:4). The nature of transmission of HIV and AIDS from one person to another links directly to the above mentioned values. People who are HIV positive are almost always classified as being promiscuous and / or drug addicts. Persons who contracted HIV through blood transfusions, via vertical transmission from their mothers or other ways not linked to their own activities and life styles, are not necessarily excluded from stigmatization. Although studies show that factual knowledge of transmission of HIV may contribute towards a less abusive or bias attitude, stigmatization often happens beyond the logic of logic. (Nzioka, 2000:1-14; Ogden, et al, 2005: 7).

Stigmatization and discrimination of people living with HIV and AIDS is experienced in different ways such as: rejection, isolation, separation, name calling, ostracism, violence, HIV testing without confidentiality protection and revealing of HIV result without clients' consent (USAID & INTRA HEALTH, 2007: 13; HIV & AIDS stigma. From: <http://www.avert.org/aisstigma.htm>. (accessed 25th April, 2008); Nzioka, 2000:1-14; UNAIDS, 2000; Parker, et al, 2002).

HIV-related stigma includes all unfavorable attitudes, beliefs, and policies against people living with HIV/AIDS (PLWA) as well as their loved ones, social groups, close associates and their communities (USAID, et al, 2007:13).

There is evidence that if HIV positive patients open up about their status at work, or are in search of employment, they are often stigmatized. As the burden of HIV / AIDS rises everywhere in the world, the poorer countries have been reported to screen or test people before employment, employer sponsored insurance scheme, medical aid, and pension. For instance, a head of human resource development in India had this to say:

“Though we do not have policy so far, I can say that if at the time of recruitment there is a person with HIV, I will not take him .I will certainly not buy a problem for the company. I see recruitment as a buying – selling relationship. If I don't find the product attractive I will not

buy it” (Fredriksson, et al, 2008. From <http://www.avert.org/aidsstigma.htm> accessed 25th April 2000).

In 2002, a study of 1000 physicians, nurses and midwives conducted in Nigeria indicated that one out of 10 doctors accepted having refused to care for an HIV/AIDS client or had denied HIV/AIDS persons admission to the hospital. The mostly reported factor skyrocketing stigma among doctors and nurses is the fear of exposure to HIV due to lack of protective equipment (HIV & AIDS stigma and discrimination. From: <http://www.avert.org/aidsstigma.htm> 25th April, 2008).

The laws, rules and policies of many societies and countries have been found to encourage the stigmatization of people infected and affected with HIV/AIDS. For instance, compulsory HIV testing, limitations of international travel, refusal of employment, mandatory notification of the HIV/ AIDS status, have created a false sense of security among those whom their HIV status is unknown (Fredriksson, et al, 2008. From <http://www.avert.org/aidsstigma.htm> accessed 25th April 2008). Some have enacted legislation to protect the rights of HIV positive people and save them from discrimination and stigmatization. Such rights include: right to education, confidentiality, employment privacy, treatment, support and access to information (UNAIDS/WHO, 2004:1-4). HIV/AIDS related stigma has precisely been seen as a domestic policy challenge which must be controlled to reduce the number of incidence cases of HIV infection. Therefore, intervention to reduce HIV related stigma is an important element of world’s efforts (UNAIDS, 2001, Kaiser, 2002, Klein, et al, 2002; Institute of Medicine, 2001).

2.4 REASONS BEHIND HIV RELATED STIGMA

Because HIV /Aids share a number of attributes with opportunistic infections that have been found to cause a high degree of stigmatization, HIV –positive individuals are held responsible for being ill, infected individuals are often blamed for being irresponsible by failing to take positive steps to avoid HIV infection.

A study carried out in Ethiopia which explored the attitudes and behaviours of physicians and nurses toward people living with HIV/Aids revealed that 85% of physicians and 83% of nurses reported fearing that they are at risk of HIV infection because of their work, 62% of

physicians and 43% of nurses reported being uncomfortable taking blood from PLWA and assisting in surgery. Half of physicians and nurses who participated in the study reported fearing contagion despite their use of universal precautions. In essence, the use of universal precautions alone cannot change peoples' stigmatizing attitudes towards PLWA (USAID, et al, 2007:12-13)

Stigmatization of HIV – positive people is particularly strong because the illness is associated with religious beliefs and thoughts that HIV is contracted through morally sanctionable behavior (Alonzo, et al, 1995). HIV is progressive, incurable and fatal and its origin and mode of transmission continues to be poorly understood by the public. Standard HIV and Aids messages often focus solely on how HIV is transmitted; the fact that it has no cure and it is fatal.

These fear-based messages in health campaigns are focused not only on death as the outcome of HIV, but also on the depiction of a painful, disfiguring and sometimes shameful death." Many posters use highly emotive symbols such as human skulls or skeletons, bleeding syringes and coffins, or they contrast images of sick and dying drug users with images of robust, healthy people" These types of messages trigger anxiety which causes fear and fear fuels stigma. HIV /Aids messages rarely focus on explaining how HIV is not transmitted- the fact that the virus dies and therefore not easily transmittable outside the blood stream (human body), and the relative infectiousness of HIV. This allows unchallenged and persistent fear of casual transmission (HIV & AIDS stigma and discrimination. From: <http://www.avert.org/aidsstigma.htm> 9th June 2009, International Center for Research on Women, 2005:15-19).

Vague and ambiguous messages about transmission perpetuate the assumption that daily interactions with HIV positive people pose serious risk of infection. Clearly, the lack of clarity in standard messages about how much and through what means, blood poses a transmission risk have left health workers without the information they need to accurately assess the transmission risk of contacts with blood from HIV –positive persons by touching an object or brushing up against someone living with HIV or Aids, versus through a blood transfusion or dirty needle (Bond Chilikwela et- al, 2003; Hong et al, 2004; Mbwambo, et – al, 2004; International Center for Research on Women, 2005:33-40).

Several attitudes, beliefs and structural factors lead to the stigmatization of people living with HIV/Aids in the PHC such as attitudes and beliefs about PLWA, beliefs about

transmission, working conditions, perceived risk of workplace infection, lack of training, client- provider relationship, inability to address clients' needs and lack of professional satisfaction (USAID, et al, 2007:7-9).

In a study carried out in Ethiopia, a female respondent said: "The reason people isolate a person living HIV/AIDs is because they fear HIV/Aids. The reason why they fear HIV/Aids is because they hear from different mass Media such as radio and TV, how horrible this disease is and how it is widespread in the country".

Another Ethiopian woman was reported as saying: "When I watch TV and listen to the radio, HIV/ Aids program presented in the drama scares me and makes me cry... In the drama they show how the disease makes people suffer and changes their physical appearance and looks. It disfigures the face of the patient, changes the colour from dark to pale. This makes me worry much (International Center for Research on Women, 2005:19).

HIV positive clients experience stigma due to the fact that HIV infection has already been stigmatized by certain cultures example: homosexuality, drug addiction, promiscuity and personal irresponsibility. People stigmatize this disease based on the seriousness of the illness, its mysterious nature and its association with behaviours that are either illegal or socially sensitive such as: sex, prostitution, drug use and bad behaviours that can put one at risk of HIV infection (Ogden, et al, 2005:15) In addition, the following factors fuel the stigma experienced by people living with HIV and aids:

- The life threatening nature of the disease for the fact that the disease is progressive and incurable, and people diagnosed with the disease are susceptible to opportunistic infections which may rapidly result in deformities, loss of weight , rashes, blindness et ce tera. HIV infected people and their family members are stigmatized (Gilmore, et al, 1994; Goffman, 1963; Ogden, et al, 2005; Sowadsky, 1999).
- The stigmatization of patients due to fear of contracting the disease. This is caused by their ignorance of how the disease is transmitted (Brimlow, et al, 2003; Aggleton, 2001; Herek, et al, 1993:205; Mahendra, et al, 2006; Ogden, et al, 2005: 15-20; Shapio, 2005; Smart, 2005).Evidence has shown that people who have sufficient knowledge of HIV/AIDS transmission have less fear and are more willing to associate with infected persons (Brown, et al 2001; Shapiro, 2005).

- Religious or moral beliefs lead some individuals or groups to believe that HIV/AIDS is the result or outcome of moral fault (like promiscuity or deviant sex) which deserves punishment because HIV infection is associated with immoral behaviors in the society (Milan, 2005; Aggleton, 2000; De Bryun, 1999).
- Nurses treating HIV positive patients reported being ostracized by other healthcare workers. For example, some complained of being left alone to eat in the canteen and denied transport to visit HIV patients at home (HIV Stigma Burdens Africans. From: [hc2d.co.uk/Healthcare News/hiv/women/discrimination](http://hc2d.co.uk/Healthcare%20News/hiv/women/discrimination) accessed 15th February 2010). This is one of the reasons why HIV and Aids care givers stigmatize their clients. According to Dlamini of the University of Swaziland, many health workers stigmatize their clients because of the discrimination they have suffered for treating people with HIV infection (HIV stigma burdens Africans. From: [hc2d.co.uk/Healthcare News/hiv/women/discrimination](http://hc2d.co.uk/Healthcare%20News/hiv/women/discrimination) accessed 15th February 2010).

The fact that myths and misconceptions about how HIV/AIDS is transmitted have persisted in promoting the stigmatization and discrimination of people living with HIV calls for urgent need to train, inform, communicate with and educate all health care professionals about how HIV can and cannot be transmitted. Universal precautions and the rights of people living with AIDS must be disseminated and adopted by all health care centres.

This will, to a large extent, reduce the magnitude of stigmatization and discriminatory practices against PLWA in the PHC; at the same time improve the quality of services rendered to people living HIV infection.

([http://medicine.plosjournals.org/perlserv/?request=get-document&doi=10.1371/journal.pm15th September 2008](http://medicine.plosjournals.org/perlserv/?request=get-document&doi=10.1371/journal.pm15th%20September%202008)).

The lack of clarity in standard messages about how much or through what means, blood poses a transmission risk, has caused health workers not to have appropriate information they need to accurately assess the transmission risk of coming in contact with the blood of HIV positive individual through blood transfusion, contaminated needle, mother to child transmission, and by touching the individual or an object he/she had used. This makes people remain with the fear of common situations such as coughing, kissing, sneezing, and touching, where transmission risk does not necessarily exist.

This non-specific handling of issues concerning the risk of transmission, especially in the areas of common concern in peoples' daily lives (for instance, non invasive contact with blood, mosquito bites, saliva, sweat, sharing of same fork, same cup, same toilet, same soap, same towel, same food), leaves in peoples' minds and perception that indeed those are risky situations that must be avoided. These perceived fears lead to direct stigmatization of people living with HIV/AIDS (Ogden, et al, 2005; National Aids Trust 2005, [http; // www.onestopenglish.com/section.sp](http://www.onestopenglish.com/section.sp). From: (25th April, 2008). This translates into stigmatization due ignorance about transmission mode of HIV virus (National Aids Trust; <http://www.nat.uk/stigma> and discrimination (accessed 5th April, 2008; Durham, 2008). The problem of not having adequate knowledge about the appropriate procedures for maintaining patients' confidentiality leads to stigmatization of HIV patients. Many health-care providers lack a basic grasp of human right concepts, therefore violate the rights of HIV patients in the areas of denying them care, disclosing their status without their consent, mandatory HIV testing, and being hospitalized in isolated wards. In some hospitals, the beds, cards, and files of HIV/AIDS patients are distinctively identified and marked. These attitudes and practices are based on the lack of adequate information of the laws, rules and human right principles as well as inadequate or non existent care codes by the various clinics (UNAIDS/WHO, 2004: 2; International Aids Conference, 2004).

2.5 TYPES OF STIGMA AND DISCRIMINATION SUFFERED BY HIV POSITIVE CLIENTS

Stigmatization is a dynamic process that arises from the perception that there has been a violation of shared beliefs, values and attitudes, which can lead to prejudiced thoughts, behaviours and actions on the part of the families, communities, workplace, school, government and health centres (Brown, et al, 2001: 4). People living with HIV/AIDS experience different types of stigma though at varied levels. Stigma can be: physical, social, verbal, and institutional (Ogden, et al 2005). Types of stigma experienced by PLWA in the PHC include: physical stigma, social stigma, verbal stigma, and institutionalized stigma. These types of stigma range from avoidance and isolation, to rejection, violence, loss of identity, loss of role, loss of respect, blame, finger pointing, insult, conspicuous labeling of charts and records, name calling, gossips, rumours, verbal harassment, disclosure of clients' HIV status without their consent, indiscriminate wearing of gloves when attending to PLWA, refusal of admission and treatment, burning of linen used by HIV positive clients,

and referrals for testing (Igor, 2005:20; Ogden, et al, 2005:7-10). This stigma can be categorized as Internal and External.

- **Internal and external stigmatization**

Stigma can be internal 'felt' or external 'enacted' (UNAIDS, 2002; Igor, 2005: 20; USAID, et al, 2007:6; Brown et al, 2001:4). Internal / felt stigma can be defined as the shame associated with HIV and Aids and fear of being discriminated against due to one's HIV status. It can further be explained as a real or imagined fear of discriminatory attitudes from the families, communities, friends, co-workers and the health care givers against HIV positive persons. This feeling which is stigma on itself is a defensive mechanism which individuals use to protect themselves from real discrimination. For instance, individuals may refuse to disclose HIV status, refuse to use condoms, deny one's HIV status, show unwillingness to seek help and refuse to be tested. These strategies have been used to avoid, cope, or minimize discrimination though only at the initial stages of HIV infection when the disease has not progressed to AIDS which is physically visible due to the arrival of opportunistic infections that come as a result of reduced immune system (Igor, 2005: 21; Brown et al, 2001:4-5).

External/ enacted stigma is the actual experience of discrimination. This type of stigma has the capacity to produce internalization and acceptance of inferiority by the HIV positive persons and justification of discrimination by the perpetrators. External/ enacted stigma experienced by people living with HIV/Aids include: gossip, name calling and labeling, verbal harassment, avoidance and isolation, referrals for testing, blame, oppression, devaluation, denial, ignorance, the exercise of power or control, categorizing, accusation, exclusion, domination, ridicule, resentment, anger, feeling of inferiority, confusion and social inequality (Brown et al, 2001; Igor, 2005:20; Policy project, 2003: 4; USAID, et al, 2007:6; HIV & AIDS stigma and discrimination. From: <http://www.avert.org.aisstigma.htm> (9th June 2009)

- **How stigmatized individuals react to the various types of stigma**

Self stigma leads to denial, silence, withdrawal, depression and discrimination with friends, families and communities. Some individuals prefer not to be tested to knowing their HIV –

positive status. This is because of reported lack of confidentiality which leads to disclosure of an individual's HIV positive status without his/her consent which exposes the person to stigmatization and discrimination. A commentator in Zimbabwe recently said "why should I go and get tested when I know for a fact I won't be able to get the necessary treatment" (<http://www.hdnet.org/home2.htm>; stigma-aids: Definition and context-19; Brown, et al, 2001:4).

- **How family members, friends, community members, and neighbors react to the various types of stigma**

Family members and relatives can play an important role in providing care and support for people living with HIV/Aids. However, not all families respond positively due to their perception of the disease. Evidence has shown that people living with HIV infection experience stigmatization and discrimination in their families and extended families. Women, sex workers, and homosexuals experience high levels of stigma than men and children from their family members (HIV & AIDS stigma and discrimination. From: <http://www.avert.org/aidsstigma.htm>(accessed 9th June, 2009). Stigma is expressed at home against HIV infected persons by separating household items such as cooking and eating utensils, bed lines, clothes and separate apartments (ICRW 2003, Belsery, 2005). Husbands have abandoned, isolated and rejected their wives and wives have also done same to their husbands due to HIV infection, either blaming the infected partner for bad behaviour or for the fear of being contaminated or infected.

In India, a 23 year old HIV positive woman reported: "My mother in law has kept everything separate for me-: glass and plate. They never discriminated like this with their son. They used to eat together with him. For me it is don't do this or don't touch that and even if I use a bucket to bath, they'll wash it, wash it'. They really harass me. I wish nobody comes to be in my situation and I wish nobody does this to anybody. But what can I do? My parents and brother also do not want me back' (HIV & AIDS stigma and discrimination From:<http://www.avert.org/aidsstigma.htm> (accessed 25th April 2008)

A research participant in Zambia is reported to have said about her husband: "May be when I eat with him, I will swallow a virus and contract the HIV/Aids" (International Center for Research on Women, 2005: 15).

HIV positive persons are isolated and excluded from social interactions and community events such as parties, wedding ceremonies (Ogden, et al, 2005; Belsey, 2005).

People living with HIV and AIDS have suffered ostracism, rejection and physical stigma in their communities, there have been records of HIV and AIDS related killings in many countries of the world such as South Africa, Brazil, Colombia, Ethiopia, India and Thailand. A South African, Gugu Dlamini was murdered in her hometown in Durban after declaring publicly her HIV status in December 1998. PLWA and their families have as well experienced social isolation from their communities. Social isolation can cause PLWA not to have sense of belonging in their communities. (Smart, 2005; UNAIDS, 2001; Link & Phelan, 2001).

Evidence has shown that employers in some countries insist on pre – employment screening of HIV and AIDS. Some employers have denied people employment and employment benefits such as insurance, medical aid and pension to people living with HIV infection (Aggleton, 2000).

People living with HIV/AIDS are stigmatized at their workplaces even when there is no high risk of contracting HIV at work place .For instance, a 25 year old Daljit expressed how he was stigmatized at his workplace. “My friends did not say anything to me, but the whole environment changes automatically, no one wants me. Anywhere I enter, my colleagues vacate immediately. They told me to use a separate glass then I decided to leave the job (Aggleton, 2000)

Institutionalized stigma constitute social isolation and ridicule by co- workers in work places where laws, rules, policies and procedures can rapidly fuel the stigmatization and discrimination of people living with HIV/ AIDS. It can also be expressed by the employer terminating or refusing to offer employment (HIV & AIDS stigma and discrimination. From: <http://www.avert.org/aidsstigma.htm> (accessed 25th April 2008; <http://www.avert.org/aidsstigma.htm> (accessed 9th June 2009; Health & developmental networks, 2006; Milan, 2006; Seaton, 2003).

- **The types of stigma in relation to health services and health care providers**

Many hospitals in the countries in sub Sahara Africa where the burden of HIV/AIDS is increasing daily have specific areas in the hospital or clinics where the public can access HIV service delivery. This has affected care- seeking behavior of HIV positive patients. As a

result, PLWA move from the HIV clinics near their homes and communities to very distant HIV clinics to obtain treatment as a way of avoiding HIV stigma (Gerbert, et al 1991; Herek, 1990).

In 2002, a study conducted among 1000 physicians, nurses and midwives in Nigeria found that one out of every 10 doctors and nurses had refused to care for HIV / AIDS patients because of fear of exposure to HIV, due to lack of protective equipment (Fredriksson, et al, 2008. From: <http://www.avert.org/aidsstigma.htm> accessed 25th April 2008)

In a study carried out by the WHO in India, Indonesia and Thailand, 29%, 38% and 40 % respectively of HIV positive clients admitted that their HIV positive status was revealed to someone else without their consent. Regrettably most hospitals place signs near people with HIV infection with words such as “HIV positive” and” AIDS” (HIV & AIDS stigma and discrimination. From: <http://www.avert.org/aidsstigma.htm>(accessed 25th April 2008); HIV & AIDS stigma and discrimination. From: <http://www.avert.org/aidsstigma.htm>(accessed 9th June 2009)

Fear of being stigmatized, especially at health care institutions limits the efficiency of HIV testing programs across developing countries of sub-Saharan Africa, because in most clinics in the communities everyone knows sooner or later who visited which test site. While people go for HIV testing and access antiretroviral therapy without qualms in the developed world; in the developing countries, stigma is clearly an obstacle to testing even when treatment is available. This is because of serious lack of confidentiality of HIV information among facility staff (Rankin, Brenna, Schell, Laviwa & Rankin, 2005).

However, Studies reveal that service providers across the board deny HIV clients with hospital facilities, medicines, treatment and attendance with the intention that it is pointless to offer good quality care since the disease is progressive and incurable (<http://www.pubmedcentral.nih.gov/artclerender.fcgi?artid=1176246> (accessed 23rd August, 2008; Asare, et al, 1997:271-273; Aggleton, 2000; ICRW, 2006; Avert, 2005; National Aids Trust, 2003; Herek, et al, 1996).In 2005, a study carried out in the US found that 26% of adults infected with HIV experienced perceived discrimination, while 8% were bluntly refused treatment by the health care providers at the health centres.

2.6 LEVELS OR INTENSITY OF STIGMA

It is difficult to determine the intensity of stigma experienced by people living with HIV and Aids, but the model drafted by Ogden, et al, (2005:11) which they called “schematic of innocence- to- guilt continuum” expresses that there is a kind of continuum from presumed “guilt “to presumed “innocence” in people’s minds. This simply explains that HIV positive clients experience stigma from their families, friends and primary health care workers at different intensities depending on their means of contracting HIV infection (World Bank 2003, Ogden, et al, 2005; UNAIDS, 2000; Brimlow, et al, 2003). This model express that people who are infected through drug use and sexual relations with same-sex partners are likely to experience more stigma than those infected through mother – to –child transmission and blood transfusion due to the association of HIV infection with sexual and social misbehaviour. Children, health workers and married women who contracted HIV from their husbands are likely to receive compassion and lower level of stigma than sex workers, injection drug users, unmarried women and men who are often blamed for their HIV infection (Ogden, et al, 2005). The Ogden and Nyblade’s schematic model is very useful and relevant in the interpretation of the intensity of stigma as experienced by HIV positive clients who attend ARV clinic in Leribe District. It helped the researcher to understand why more married women and children attend ARV clinic even when it is nearer their home than the men and unmarried young women who prefer travelling to clinics several kilometers away from their homes.

The level or degree of stigma experienced by people living with HIV/AIDS varies, depending on how one has contracted the infection (Asiedu, 1998:10). Men, unmarried women, sex workers and injection drug users experience high level of stigma. This class of people is referred to as “presumed guilty”. Children, married women who contracted HIV from their husbands, health workers, the police and road traffic workers who contracted HIV while on duty experience lower levels of stigma. This class of people are referred to as “presumed innocence” (Asiedu, 1998:12-13; International Center for Research on Women, 2005:23). The stigma ranges from mild reactions to ostracism and ultimate violence. The schemata continuum of Ogden & Nyblade focuses on the ways in which HIV and Aids related stigma interacts with pre-existing stigma and the extent of stigma when none previously existed. They added that HIV positive clients may experience double stigma as a result of the pre- existing stigma associated with unapproved behavior in combination with

the stigma of living with HIV thereby putting the individual in a high level of stigma. However, all people living with HIV experience some level of stigma.

A study carried out in Ethiopia, Tanzania, Vietnam and Zambia by (Ogden, et al, 2005) reveals that prostitution and injection drug use are widely referred to as social evils (Asiedu, 1998:11), therefore these behaviours are already stigmatized. And the fact that HIV can be transmitted sexually has led people into associating HIV infection with socially improper sex behaviors which have been stigmatized and this leads to high level of blame being placed on people living with HIV infection on the grounds that they got infected due to their immoral behaviours.

In Vietnam, a woman over 50 years of age who was a participant in FGD reported that “in the case of women who unfortunately get infected, we should give them support and educate them so that they can avoid transmitting to others. Regarding the case of drug injectors, the damage is already done and they cannot be educated. We should definitely put them in a separate place because we cannot educate those people. The other group deserves our pity and we should protect them” (International Center for Research on Women, 2005:23).

A TB patient in Zambia stated that “the unfaithful, like in marriage, deserve HIV/AIDS while the faithful ones do not deserve it” (International Center for Research on Women, 2005:23). People living with HIV/Aids experience stigma at different intensities depending on the stage of their disease and how they contracted it. Moreover, the moment opportunistic infections set in or when they begin to grow lean and sickly, PLWA are known to experience isolation.

2.7 EFFECTS OF STIGMA ON THE PREVENTION, CONTROL AND TREATMENT OF HIV/AIDS

The impact and effect of stigmatization covers individuals, families, friends, communities (UNAID; 2007:13) and even populations (Nzioka, 2000:1-14; UNAIDS, 2000a; Aggleton, 2002) and people working with stigmatized people such as nurses and doctors (Fredriksson, et al, 2008. From: <http://www.avert.org/aidsstigma.htm> accessed 25th April 2008). This studies by Fredriksson, et al 2008). further show that stigmatized persons as compared to non-stigmatized persons face increased problems with employment, insurance

coverage and medical aid schemes (Asiedu 1998:1-4) Stigma also poses negative impact on the prevention and treatment of HIV and AIDS. In the areas of HIV test seeking behaviour, willingness to seek health care, quality of health care received, the willingness to seek for social support and the quality of support received (Brown, et al 2001:5).

Stigmatization and Discrimination has cost PLWA their jobs, accommodation, families, relationships, associations, social status, access to services, happiness and social freedom (Stigma and HIV/AIDS: A Review of the Literature- Summary. From:

<http://hab.hrsa.gov/publications/stigma/summary.htm>(accessed 9th June, 2009:1; Asiedu, 1998:18-21). It has also instigated judgmental attitudes and lack of care among nurses and other health care givers, which obviously result in poor medical care or the lack of comprehensive treatment of people living with the disease (Family Health International.

From: [file:///D:/FHI-Epidemics in the world.htm](file:///D:/FHI-Epidemics%20in%20the%20world.htm) (accessed 30th April, 2009:12).

Stigma is a major factor that has led to a continuous increase in the number of new HIV infections (incidence). This is because stigma is negatively affecting the rate at which people get tested, acknowledge their risk of infection, disclose and discuss their status with their needle –sharing and sexual partners (Stigma and HIV/AIDS: A Review of the Literature-Summary. From: <http://hab.hrsa.gov/publications/stigma/summary.htm>(accessed 9th June, 2009:1).

The extent of stigmatization and discrimination experienced by people living with HIV and Aids in the hospitals and primary health care facilities has caused diagnosed or self-suspected HIV-positive individuals to refuse to make themselves available for voluntary counseling and testing at the early stage, refuse to comply with preventive measures such as condom use, and adherence to treatment until they are attacked by opportunistic infections. This problem, has led to an overflow of terminally ill-AIDS patients in the health facilities, occupying more than 60% of the beds in the wards as well as affecting human and material resources and compromising the quality of care received (Family Health International. From: [file:///D:/FHI-Epidemics in the World.htm](file:///D:/FHI-Epidemics%20in%20the%20World.htm) (accessed 30th April, 2009:13).

The UN secretary General Ban Ki Moon states that “Stigma remains the single most important barrier to public action. It is a main reason why too many people are afraid to see a doctor to determine whether they have the disease, or seek treatment. It helps make AIDS the silent killer, because people fear the social disgrace of speaking about it, or taking

easily available precautions. Stigma is the major reason why the AIDS epidemic continues to devastate societies around the world” (HIV & AIDS stigma and discrimination. From: <http://www.avert.org/aidsstigma.htm> (accessed 9th June, 2009)

2.8 THE INFLUENCE OF HEALTH SYSTEMS AND HEALTH WORKERS ON THE EXPERIENCE OF STIGMA BY HIV-POSITIVE CLIENTS

Primary Health Care can be defined as a care that is provided by a health care professional during the first contact of a patient with the health care (From: www.wordnetweb.princeton.edu/perl/webwn. accessed 16th February 2010). It is a term used for the activity of a health care provider who acts as a first point of consultation for all patients which HIV and AIDs are not exempted. WHO defines primary health care as the ultimate goal of better health for all (www.who.int/WHO/Health topics. accessed 16th February 2010). Primary health care therefore is where people living with HIV/AIDS often discover their HIV status as a first point of contact before the hospital. It is where HIV patients have the potential to get or gather information on how to care for themselves and prevent transmission to other people, as well as get quality treatment and care. But the fact that health care providers lack specific in-depth information (knowledge) about HIV transmission, lack basic grasp of human rights concepts and are not knowledgeable about appropriate procedures for maintaining patient confidentiality, they fear being infected by the patients (Ogden et al 2005:15-17) This shortcoming has continued to fuel the attitude and practice of stigmatization and discrimination against people living with HIV and Aids (Infante-Xibille, et al, 2004).

Reports have revealed that health-care systems are major sources of the stigmatization and discrimination of people living with HIV/AIDS, when the system is supposed to link the HIV positive clients to the prevention and management of their infections (Fredriksson, et al, 2008, Herek, et-al, 1997; Asare, et al, 1997:278). HIV- positive health workers are made to treat PLWA, health care providers use separate medical tools for HIV- patients. They also provide sub-standard treatment to HIV- patients with the intention that HIV is not curable; therefore there is no need to waste their energy, time and money on PLWA (Asare, et al, 1997; Effa-Heap 1998:528). HIV clients are seen as a drain on resources (HIV AIDS/ Mental Health and Spirituality/ Stigma and discrimination-WikiEducator (accessed 17th

February, 2010), and this perception has influenced the type and quality of services rendered to PLWAs by the health care workers at the clinics.

1. Maintaining and respecting human rights of the HIV clients: A study conducted in the Indian hospitals revealed that health workers practice mandatory HIV testing prior to any surgery, but this is a violation of a patient's rights based on Indian national guidelines which should involve pre- test counseling and post- test counseling (UNAIDS/WHO, 2004).
2. Counseling and confidentiality of client's health information: The Study conducted in Ghana added that health workers do not follow the general sequence in the counseling process for HIV management. The doctors interviewed argued that the patients had come to them to seek treatment and that requesting a blood laboratory test is part of treatment process as with any other disease, pointing out that after test, if a patient is HIV positive, they would refer the patient for counseling before informing him/her of the test results (Asare, et al, 1997). In addition, the report of a study carried out in India revealed that 94% of doctors inform the HIV patient's partners and relatives of their positive sero status without the consent of the patients, claiming that it was their moral and professional responsibility in the area of preventing new cases.
3. Organization of service delivery to HIV patients in terms of confidentiality and stigma: Gyasi, 2008: personal interview, states that the concept of a designated HIV clinic is stigma on its own. The fact that HIV patients are treated in a separate building or site is the start of stigmatization of people living with HIV/Aids patients by the PHC. If not, why are HIV patients not being treated together as cancer and hypertensive patients who are not being isolated? Some clinics are constructed separately, fenced with high walls and written on the walls HIV clinic. This makes patients going there for anti retroviral treatment (ART) and for the treatment of other opportunistic infections feel stigmatized.

In some clinics, such as clinic "H" in this study HIV-patients' files are kept separately from other patients. Their cards are coded in such a way as to show that they are HIV positive, HIV positive patients are admitted in a separate ward, outpatients are consulted in well-designated and defined HIV positive consulting rooms. HIV patients are managed or treated by special doctors, nurses, counsellors and lay counsellors, all these are factors contributing to stigmatization of HIV patients.

When treating other diseases such as hypertension, many doctors and nurses do not wear gloves, but immediately they come across HIV positive patient, they will not touch the patient until they wear gloves, this makes patients feel that they are already dead. In some cases, patients feel like committing suicide and dying than to live and be treated like an outcast. The attitude of health practitioners towards HIV- patients is a major issue in the stigmatization of HIV-patients. HIV related stigma cannot be handled until the attitude of health practitioners over HIV is changed and the practice of treating HIV patients in a defined separate structure or building is stopped.

2.9 INTERVENTIONS AND STRATEGIES TO REDUCE HIV AND AIDS RELATED STIGMA

The following strategies have proven effective in the reduction of the stigmatization discrimination of HIV positive patients:

2.9.1 Increased knowledge and understanding: .A broad body of data reveals that people with better knowledge of HIV infection tend to exhibit less stigmatizing attitude towards HIV positive patients (Effa, 1997, Mahendra, et-al, 2007:624). The fact that myths and misconceptions about how HIV and AIDS is transmitted have persisted in promoting the stigmatization and discrimination of HIV- patients calls for urgent need to train, inform, communicate and educate all health care professionals about how HIV can and cannot be transmitted.

- Through ongoing support and refresher training, health care providers can be equipped with proper knowledge which will enable them educate people living with HIV infection on how to protect themselves from multiple infections and how to manage their situations and reduce self stigmatization
- Since HIV /Aids-related stigma affects access to care, providers' willingness to treat people living with HIV, mental health of HIV positive people, quality of care and increased incidence of HIV infection, steps need to be taken to provide factual and appropriate information to both health care providers and HIV patients on the mode of transmission of HIV virus and ways of prevention, because this will help to dispel the misconceptions that people tend to hold (Ogden, Khuat, Nguyen,.2004; Joint United

Nations Program on HIV/Aids (UNAIDS) 2001; Henry, Kaiser family foundation, 2002: 44-53).

- Studies in Nigeria, Uganda, India as well as other developing countries of the world show that nurses, midwives and ward attendants need broad education about HIV/Aids, prevention and care.

2.9.2 Legislation and policies: In many countries, legislation and policies are designed in an attempt to control stigmatization and to minimize the effects of stigma (UNAIDS 2004:1-4; UNAIDS 2001; Kaiser, 2002; Klein, 2002:8; Institute of Medicine, 2001). Such legislation and policies cover a wide range of potential sources, effects and factors that may lead to stigmatization. These include amongst others protecting the privacy of an individual, confidentiality, informed consent, human rights and access to information (Nzioka, 2000:1-14; UNAIDS, 2000a; (Stigma and HIV/ AIDS: A review of the Literature- Summary. From: <http://hab.hrsa.gov/publications/stigma/summary.htm> (accessed 9th June 2009; [file:///C:/Documents and settings/Admin/My/Documents/stigma and HIV-AIDS A Review](file:///C:/Documents%20and%20Settings/Admin/My%20Documents/stigma%20and%20HIV-AIDS%20A%20Review) (accessed 9th June, 2009:1-5). In Lesotho, as in other countries in Africa and throughout the world, the following policies and legislations are in place:

- Public health policy is used to enhance the protection of human rights of the patients in terms maintaining confidentiality, and access to information. In 1980's, California voters were asked to enact sweeping AIDS policies such as eliminate anonymous HIV testing which would have subjected people living with HIV infection to many public restrictions. In contrast, the United States enacted early Aids –related public health policies which included privacy, protections and confidentiality of people at risk of HIV and those diagnosed for HIV infection (Herek, 1999:2; <http://hab.hrsa.gov/publications/stigma/summary.htm> (accessed 9th June 2009; [file:///C:/Documents and settings/Admin/My/Documents/stigma and HIV-AIDS A Review](file:///C:/Documents%20and%20Settings/Admin/My%20Documents/stigma%20and%20HIV-AIDS%20A%20Review) (accessed 9th June, 2009:1-5).
- The UNAIDS/WHO, (2004:1) advocates that HIV testing of individuals must be confidential, accompanied by counselling and can only be conducted with the informed consent of the client. This is anchored on a human rights approach to protect HIV positive clients' rights and pay due respect to ethical principles. It further added that

clients should initiate voluntary counselling and testing to know their HIV status, all tuberculosis patients and people with the signs or symptoms consistent with aids clinical diagnosis and management should be tested and clients' test results must be highly confidential.

- The Ryan white care Act (1990) which was passed under president Bush administration is also one of the policies that was enacted to protect people living with HIV infection from stigmatization and discrimination. Before the enactment of this law, the major cause of black male inhabitant's death at the age of 25-44 in USA was AIDS. But this revolutionary piece of legislation has helped to gradually reduce the disproportionately large number of deaths emanating from those infected with HIV (Rowe, 2004. <http://www.drugtext.org/library/articles/peddr0014.htm> (accessed 9th August, 2008).
- UNAIDS report (2008), shows that 67% of countries of the world have put in place some form of legislation to protect people living with HIV/AIDS. (HIV & AIDS stigma and discrimination. From: <http://www.avert.org/aidsstigma.htm>(accessed 9th June 2009:5).
- An intervention program at the hospital settings which should include the activities of both the individual and institutional level will be needed in the areas of policy reforms, training, and development of posters reinforcing infection control procedures. It should equip the health-care providers with proper knowledge of HIV/AIDS, the transmission risk, precautionary measures, and how to manage the patients. These should help in reducing stigma and protecting the rights of patients (Mahendra, et-al, 2007:617-623; World Bank, 2003). Since 1981 when the first HIV infection was discovered, laws and legal protections have been essential to reduce stigmatization and discrimination against people infected with HIV/AIDS. In the bid to encourage early testing, gain access to care and services, practice effective HIV prevention; and for the fact that HIV –related stigma affects both individuals and the public, the public health officials have been enacting some statutory protections for people infected by HIV and Aids which include the confidentiality of HIV information (example HIV test results), the exemption of HIV from the public health traditional practice of contact tracing and partner notification and anonymous HIV testing. Therefore, all health practitioners should be educated or made aware of the existing laws and policies guiding their states or jurisdictions of practice in

relation to the protection of people living with HIV/AIDS from stigmatization and discrimination (www.popcouncil.org/horizons/horizons.htm (accessed 23rd April 2008)).

- The UNAIDS/WHO policy statement on HIV testing must be adhered to by all health-care providers to equip them with the knowledge of conditions under which people undergo HIV testing ,and this must be anchored on a human rights approach which does not violate human rights yet pay due respect to ethical principles. This implies that HIV-testing must be conducted with informed consent of the person, it must be confidential and should be accompanied by both pre-test counselling and post-test counselling(UNAIDS/WHO,..2004). Health workers must not inform families or friends of a patient's HIV- test result without the consent of the patient, because this triggers stigmatization and discrimination against people living with HIV and AIDS.HIV/AIDS should be de-linked from prostitution and drug policy program and legislations and re-enforced by the media disseminating positive images of PLWA.

2.9.3 Programmatic interventions

Although laws and policies are workable interventions to reduce HIV related stigma and discrimination, they have not done much. This war therefore requires the combination of programmatic and pragmatic interventions which are more practical and capable of changing people's attitudes and behaviours toward the PLWAs (Stigma & HIV/AIDS. From: [file:///C:/Documents and settings/Admin/My Documents/stigma and HIV-AIDS A Review](file:///C:/Documents%20and%20Settings/Admin/My%20Documents/stigma%20and%20HIV-AIDS%20A%20Review) (accessed 5th September 2008).

The pragmatic interventions against HIV –related stigma are categorized into four headings namely: counselling, information, contact and coping skills.

- **Counselling.** Counselling is one of the intervention strategies which provide praise and social support for positive attitudes, safe behaviours and behaviour change. People are encouraged through counselling to resolve issues with families, partners, and spouse. Counselling has been shown to reduce anxiety distress of the uptake of HIV –testing and emotional distress after receiving HIV test result. Two studies carried out in Uganda and one study in Zimbabwe have shown an increase of disclosure of HIV positive status and positive community attitudes toward PLWA after counselling.

- **Information strategies to prevent HIV/Aids:** Accurate information is very important in all life's situations. Information is needed in all walks of life. Therefore in the fight against HIV/AIDS -related stigma, factual description of HIV/AIDS, its mode of transmission and the methods of risk reduction should be made known to the entire public through advertisement, leaflets, presentations in a class, workshops, conferences, lecture halls and all forms of media (www.popcouncil.org/horizons/horizons.htm 23rd April 2008).

Studies carried out in the United States, Tanzania, Jamaica and Israel which tested information- based approach in reducing HIV-related stigma have shown increased tolerance of PLWA and positively changed attitudes towards people living with HIV infection.

- **Individual face to face discussion:** Contact is a strategy of intervention which aims at bringing the entire population into contact with the members of the stigmatized group. This can be achieved directly (face to face) or indirectly through media. This intervention strategy creates an environment for personal relationship with people living with HIV/AIDS which can lead into conversations and sharing of testimonies from infected and affected persons thereby discarding misinformation and making ways for empathy which helps to reduce stigma and discrimination (file:///C:/documents and settings/Admin/My Documents/Stigma and HIV-AIDS A Review 5/9/2008). This implies that health workers, family members, friends and all that are concerned should be made to interact with the stigmatized groups, rather than avoidance and isolation since this interaction can lead to a more friendly understanding of their situations and possibly reduce the level of stigma experienced by people infected and affected with HIV/AIDS. Because there is a saying that "the closer the warmer" it is the only one who is close to the mouth that can rightly testify how that mouth smells (Igbomum, 2004:10).
- **Equipping HIV clients and their families with coping skills:** Coping skills strategy is yet another way of reducing the stigmatization and discrimination experienced by people living with HIV/AIDS. It is used to increase positive attitudes towards people infected by HIV/AIDS. Coping skills should be aimed at improving people's knowledge, attitudes and practices through role- play, group discussions on information about HIV/AIDS and risk reduction which in turn should reduce the rate or level of stigma and discrimination experienced by people living with HIV/AIDS.

- **It is also recommended and workable to educate, train, empower and include people living** with HIV and Aids in all the programs concerning HIV/AIDS prevention, treatment, stigma reduction as well as making them aware of their rights to access to care, employment, accommodation, travel and school. This is because this will equip them with the information they need to cope with their situation and also reduce the magnitude of stigma they experience (Stigma & HIV/AIDS. From: [file:///C:/Documents and settings/admin/My Documents/stigma and HIV-AIDS Review](file:///C:/Documents%20and%20Settings/admin/My%20Documents/stigma%20and%20HIV-AIDS%20Review) (accessed 5th September 2008).
- **Universal precautions and the rights of people living with AIDS** must be disseminated and adopted by all health care centers. This will, to a large extent, reduce the magnitude of stigmatization and discriminatory practices against HIV patients by health care workers, improving at the same time the quality of services rendered by the clinics (Letamo, 2005). Some clinics adopt discriminatory standards and control measures which in turn stigmatize HIV positive patients such as information, advice, guidance and learning materials in local languages which they hope would help to combat HIV related stigma since it is capable of improving peoples' knowledge about HIV/Aids and also change peoples attitudes and practices(National Aids Trust 2005; Mahendra, 2007:623-625).

These practices, although very good on principle, do eventually lead to stigmatization by care givers due to the approaches given to them. Low risk activities such as transporting patients, touching or giving injections to HIV patients should not warrant the use of gloves as it makes the patients feel unwanted, hence, triggering stigmatization.

2.9.4 Health care Provider related strategies

The clinical and nonclinical providers, health and human service providers such as (Nurses, doctors, laboratory attendants, clinic cleaners, security guards, drivers and all who work at the health settings) should be educated and trained through workshops and seminars on the topics of HIV/AIDS confidentiality laws and policies, HIV testing procedure, HIV test result reporting and notification of partner, domestic violence, treatment education, gender identity, cultural diversity and support for consumer complaints (Ogden et al, 2005:38-40). This will enhance the reduction of stigmatization of HIV positive people.

Improvement of working conditions of health workers in Lesotho such as their salaries, provision of precautionary measures, accommodation and other incentives will improve their zeal to work, their relationship with all patients including HIV positive patients, quality of care rendered and reduction of stigmatization and discrimination experienced by PLWA (file:///C:/Documents_and_Settings/USER/My_Documents/journal.pmed.htm(accessed 29th April 2009).

Health care providers' right from the grass root (primary health care facilities) should be able to alleviate stigma related to HIV and AIDS using the anti-stigma toolkit. This toolkit is a set of practical tools developed to arrest stigmatization of HIV and Aids; contained within the anti-stigma Toolkit are: understanding and challenging HIV stigma: Toolkit for Action (Ogden et al 2005:41; www.changeproject.org). Health care providers can alleviate stigma related to HIV infection through proper counseling of people living with HIV and AIDS who visit the facility (ICRW, 2005) Health workers can strengthen the capacity of people living with HIV and Aids to challenge stigma in their lives. The health care workers should improve on confidentiality, public greetings and stop camouflaging services in order to alleviate the stigma experienced by PLWA within the primary health-care facilities (Jackson, et al, 2006; XVI International AIDS Conference).

Health-care providers can alleviate or reduce the level of stigma experienced by PLWA when they visit the health-care centers by establishing warmth and flexible relationships with their clients (people living with HIV and Aids). This simply means being friendly with the clients, although this may take time, it will build trust which will obviously encourage patients to visit for care. Stigma related to HIV/Aids can be alleviated through appropriate provision of services by competent culturally acceptable health workers in the health facilities (Jackson, et al, 2006; Nyblade, 2006).

It will enhance the use of positive images of PLWA to paste on the walls instead of the pictures of the dying and terminally ill patients. Care providers build capacity among community and religious leaders based on their positive attitudes toward PLWA when they visit PHC (International Center for Research on Women, 2005:38).

Stigma related to HIV and Aids can be alleviated by health care workers through shared professional values which include the importance of self awareness and professional knowledge, non-discriminatory treatment of PLWA such as (labeling, isolation, avoidance,

indiscriminate wearing of gloves when attending to them), positive and non-judgmental attitudes against PLWA (Holzemer, et al, 2004:171; [file:///C:/Documents and settings/Admin/My Documents. stigma and HIV-AIDS A Review 5th September 2008; wwwpopcouncil.org/horizons/horizons.htm](file:///C:/Documents%20and%20Settings/Admin/My%20Documents/stigma%20and%20HIV-AIDS%20A%20Review%205th%20September%202008/wwwpopcouncil.org/horizons/horizons.htm) (accessed 4th April 2008). They can increase the contacts and interactions with the HIV clients which will as well help in reducing stigmatization (Holzemer, et al, 2004:170). This can be achieved through role-play, and visits to clients.

A study in San Francisco shows that with an increased and improved information, education and communication (IEC), counselling services and government enacted policies, stigmatization and discrimination will likely reduce and this will positively lead to the prevention and control of the HIV/AIDS pandemic especially in developing countries (Sseruwagi & AGULI, 1998).

HIV/ AIDS topics such as definition of HIV and AIDS, mode of transmission of the virus, preventive and control measures, HIV related stigma, how to combat HIV/Aids stigma, understanding the challenges of HIV stigma, myths and misconceptions surrounding HIV and procedures for managing HIV patients at the clinic should be included into the curriculum and continuing education programs of health-care providers to help build their capacity to respond effectively to the HIV and AIDS pandemic rather than the present negative attitudes and practices (Holzemer, et al, 2004: 170).

2.10 SUMMARY

HIV/AIDS attracts negative responses world wide. This is because of its association with negative behaviours which have been stigmatized already by certain cultures, such as: homosexuality, drug addiction, promiscuity and personal irresponsibility. People living with HIV/AIDS are stigmatized based on the seriousness of the illness, its mysterious nature, lack of appropriate knowledge on the means of transmission, which leads to fear of contracting the disease.

HIV-positive clients experience different types of stigma which include isolation, rejection, loss of job, loss of friends, loss of power and authority; denial of medical services at the clinics and hospitals which could be: physical, social and verbal; from families,

communities, schools, workplaces, primary health care centers and hospitals. HIV positive clients have been separated and isolated in the wards with overt labeling of their beds, cards, and files. Service providers wear gloves even when they just need to transfer HIV patient from one location to another, when giving injection and food. All HIV positive clients experience stigma but at different intensities. The clients who are infected through drug use, sexual relations with same-sex partners are likely to experience more stigma than those infected through mother – to –child transmission and blood transfusion. Children, health workers and married women who contracted HIV from their husbands are likely to receive compassion and decreased stigma than sexual workers, injection drug users, unmarried women and men who are often blamed for their HIV infection (Ogden, et al, 2005; Asiedu, 1998:10-12).

The stigmatization and discrimination of people living with HIV and Aids has led to the expansion of the epidemic. The WHO has shown their concern that stigma and discrimination are major reasons why people refuse to be tested, to disclose HIV positive status, to comply with preventive measures such as condom use, and to adhere to treatments in the area of antiretroviral use. It has led to high incidence of HIV infection and early deaths (HIV & AIDS stigma and discrimination. From: <http://www.avert.org/aidsstigma.htm>(accessed 9th June, 2009).

Policies and laws can help to some extent to reduce stigma and discrimination related to HIV/AIDS, PLWA need to be educated on their rights in the society so that they will be able to challenge any form of stigma and discrimination on their way. All health-care workers should be educated, trained, informed and informed about the mode of HIV transmission, the importance of patient's confidentiality, policies protecting people living with HIV and Aids, proper precautionary measures, and patient's management as these will help to change their attitudes and behaviors toward PLWA. Health care workers at the primary health facilities can help to alleviate the level of stigmatization and of HIV positive clients by improving confidentiality of patients, contact with patients, counselling, and educating them on the coping skills. The stigmatization of HIV-positive clients at the clinics in the Leribe district requires the attention of the government, public health policy planners, clinics staff and the HIV positive clients themselves to be able to fight this deadly infection and the stigma associated with it.

CHAPTER 3: METHODOLOGY

3.1 INTRODUCTION

This chapter introduces the methodological strategies of data collection, data analysis, how, when and where the study was carried out. Research methodology is the application of the entire strategies, steps and procedures for gathering and analyzing data in research investigations both in a local and a systematic way (Burns, et al, 2001: 26). It can also be referred to as the techniques used to structure a study, collect and analyze the data in the course of the research investigation (Polit, 2001:465). Research methodology is a set of orderly procedures, strategies and steps in collecting and analyzing data.

3.2 PROBLEM STATEMENT

The nature of health services and attitudes of health care workers influence the type and extent of stigma experienced by persons living with HIV and AIDS.

3.3 AIM OF THE RESEARCH

To explore the type and level of stigmatization of HIV positive clients within the context of primary Health care services

3.4 RESEARCH QUESTIONS

The research questions were formulated in other to achieve the aim and the objectives of this study, which included:

- What types of stigma are experienced by HIV positive clients who attend ARV clinics in Leribe District?
- What levels of stigmatization are experienced by the HIV positive clients visiting primary health care facilities in the Leribe District?
- What role can health workers in the primary health care facilities play to prevent/alleviate stigma related to HIV and Aids?

3.5 OBJECTIVES OF THIS RESEARCH

The research objectives were also formulated as follows:

- To explore and describe the types of stigma related to HIV/AIDS as experienced by HIV positive clients attending clinics in the Leribe District.
- To explore and describe the level of stigmatization of HIV positive clients at the clinics in the Leribe District.
- To describe ways/strategies that health workers in a primary health care context can use to reduce stigmatization of HIV positive clients.

3.6 RESEARCH DESIGN

The research design and method comprise the entire plan for collecting and analyzing data (De vos, 1998:123; Polit, et al, 1997: 467). Polit, Beck & Hungler (2001:167) add that research design is a blueprint for conducting a study, adding that it maximizes control over factors that interfere with the validity of the research findings. Research design guides both the planning and the implementation of the study in a way that it will most likely achieve the aim and objectives of the study (Burns & Grove, 2001:223). Quantitative research is “a formal, objective and a systematic process in which numerical data are used to obtain information about the world” (Burns, et al, 2001:26) Quantitative research design quantifies relationships for explanation, prediction and control. It uses probability sampling technique in data collection, sampling size is pre-determined, structured data collection is used until pre-specified questions are answered. It also uses statistical analysis to analyze data after collection. The result of quantitative research is to some extent generalisable to the entire study population because of the use of randomly selected large representative sample (Burns & Grove 2005).

A Quantitative research design was used in this study, because it is appropriate in exploring the dimensions of a phenomenon, the manner in which it is manifested and the factors with which it is related.(Brink, 2001) for the investigation of the stigmatization of HIV-positive clients at the clinics in the Leribe District. A quantitative approach is appropriate for this study because;

- It explores and describes phenomena that are quantifiable;

- It uses a non-experimental design;
- The sample is structured, pre-determined and the sampling could follow a non-probability method.

Quantitative design was also useful because it provides more insight about the nature of a phenomenon which helped in exploring ways that can be used in reducing the stigmatization of HIV-positive clients at the clinics in Leribe.

Quantitative research design encompasses both experimental and non-experimental studies, but this study focused on non-experimental studies.

3.6.1 STUDY POPULATION

The study population includes the entire group of persons, objects or events which meet the criteria that are of interest to the researcher. Usually populations are too large, unwieldy and spread out to study directly as a whole, making it uneconomical and impractical. Researchers therefore, rather work with samples which forms a representative group of the study population (Brink 2001; Katzenellenbogen, et al, 1997; Mouton, 2001). In this study, the population includes the HIV positive clients who enrolled for ARV in the government clinics in Leribe District.

The total number of persons enrolled on care for both opportunistic infections and anti-retroviral treatment in Leribe district as at the period of data collection of this study is 42924. This includes the private PHC's, the Christian Health Association of Lesotho (CHAL) and the Government PHC's. The total number of persons ever enrolled on only antiretroviral treatment (ART) in Leribe district is 12980 (Bosiu, 2009: 5-11)

There are 23 government PHC's in Leribe District, 9 of which offer ARV to people living with HIV. These include:

1. Clinic A: 252 HIV patients.
2. Clinic B: 18 HIV patients.
3. Clinic C: 9 HIV patients
4. Clinic D: 301 HIV patients.
5. Clinic E: 530 HIV patients.
6. Clinic F: 442 HIV patients.

7. Clinic G: 94 HIV patients.
8. Clinic H: 182 HIV patients.
9. Clinic I: 3372 HIV patients (Bosiu, 2009:5:12).

The total number of HIV patients who were on ARV in these nine PHC (Clinics) at the time of this study was 5200, and this formed the study population.

3.6.2 SAMPLE

A sample is a part or portion that can be the representation of the whole population. It can be a fraction of the whole which consists of a selected group of element that can be used to collect the most basic information from individuals, events, groups, blood and documents. A representative sample guarantees the generalization of the sample result to the entire population (Brink, 2001; Gordis, 2000:204; Katzenellenbogen, Joubert, Abdool, 1997:74; Burns, et al, 2001).

The sample size was 520 HIV-positive clients who had enrolled for ARV in the nine government clinics in Leribe District which offer ARV to people living with HIV and AIDS.

3.6.3 SAMPLING TECHNIQUE

Sampling is the process of selecting a sample, choosing the objects, individuals and events from which data are gathered. It is usually important to define both the population and the sample in a study. Since it is most times difficult to access the whole population there is need to define an accessible population for a study using distinguishing descriptors (Katzenellenbogen, et al; 1997; Burns & grove, 2001). We have two major types of sampling probability and non probability sampling. Non probability sampling simply means non-randomized. In other words, it does not give every object the chance of being selected while probability sampling is a randomized method which gives everybody the chance of being selected. In this study the researcher has used systematic convenience sampling where every second HIV patient who attended the government clinic for ARV on the day of the research was included.

The inclusion criteria were:

- Patients (who are 15 years and above);

- Status of being HIV positive known to patient;
- Already on ARV treatment and
- Registered at the government primary health care in the Leribe district for ARV.

The researcher visited each of the study clinics twice except for the one at Maryland which was visited once and Tsepong which was visited for a whole week. The number of visits here was determined by the number of HIV clients in a primary health care. The public health nurse in Leribe District phoned and set appointments to synchronise with the specified days when their HIV positive clients attend the clinics.

A total number of 520 respondents were sampled from the population of 5200. This should be a good representative of the study population. Systematic convenience method was adopted. The researcher selected one in two patients that came into the clinic for ARV, until the defined sample size of 520 HIV –positive clients from all the registered HIV –positive patients in the nine government primary health-care centers in Leribe district was arrived at. These clients must have known their HIV status for at least six months and must have been enrolled for ARV in one of the nine government PHCs mentioned above.

The following include the break down of the number of patients the researcher selected from each of the nine government clinics which offer ARV in Leribe District:

Table 3.1: Number of patients per chosen clinic

Clinic	Population enrolled for ARV	Study sample
Clinic A	252	25
Clinic B	18	2
Clinic C	9	1
Clinic D	301	30
Clinic: E	530	53

Clinic: F	442	44
Clinic: G	94	10
Clinic: H	182	18
Clinic: I	3372	337
Number of clients	N=5200	S=520

3.6.4 DEVELOPMENT AND TESTING OF THE DATA COLLECTION INSTRUMENT

The questionnaire was developed through the information in the literature which gave the researcher an insight on the salient areas which were relevant in achieving the objectives of the study. (Refer to Annexure A). The instrument was developed using both close- ended and open- ended questions. This is because it enables the respondents to respond directly to the research questions as well as give information of their experience which may not have been included in the literature. In this study, the researcher and her supervisors decided to construct many questions in different formats meaning that some questions were re-cast to accommodate the various types and levels of stigmatization of HIV positive clients at the clinics; this was to check for consistency of the responses. The question number 4, 5, 6, 7, and 8 are all framed in different formats to elicit information on the type and level of stigmatization of HIV clients. And the responses of these clients in all the questions show consistency in the results.

The instrument was tested using similar population which was not included in the study

3.6.5 DATA COLLECTION INSTRUMENT

The literacy rate of clients in the Leribe District is low. A questionnaire to serve as structured interview guide was therefore designed to obtain the necessary data. This questionnaire was translated into the local vernacular to enhance the consistency of questions and in so doing to enhance the validity and reliability of the study. The translation was done by language experts; the English version of the questionnaire was translated to

Sesotho then Sesotho version was also translated back into English by another language expert to enhance the reliability of questions. (Refer to Annexure 6 and 7).

In cases where clients could read and write, they were requested to complete the questionnaire while the researcher was on the hand to clarify any uncertainties and /or misunderstanding.

The questions covered the following broad topics which were identified during the literature study:

- Biographical data
- Knowledge of HIV status
- Choice of a specific clinic to receive ARV treatment
- Residential location in terms of the specific clinic
- Duration since commencement of treatment
- Whether stigmatization is or was experienced during the period of treatment
- Type of stigmatization
- Intensity of stigmatization
- Source of stigmatization
- Suggestions to reduce stigmatization

The researcher helped to complete the questionnaire for the few who could not. The researcher orally interviewed the Health workers to be able to compare the consistency of the respondent's information. This was possible because, in each of the clinics the researcher was given a health worker who introduced the researcher to the HIV clients and this was mainly at the section where the clients receive their ARV. Therefore the researcher deemed it necessary to interview each health worker (on whether they treat HIV patients separately from other patients or not? Whether they indicate patient's HIV status in the patients's hospital card or not? Whether the HIV positive patients who visit their clinic for ARV mainly come from the nearby communities or far places? Whether they wear gloves when treating all patients or only HIV patients?) who introduced her to the clients in each of the nine clinics and this was done after the collection of data from the respondents for each clinic.

3.7 DATA COLLECTION

The data necessary to meet the objectives of this study were obtained from the HIV positive clients attending primary health care in the Leribe District. This is a quantitative research; therefore the data collection method used must comply with the characteristics of a quantitative research. Interviews and questionnaires were used to elicit information from the study participants. Respondents' names and the clinic names were not written in the questionnaire for ethical reasons.

The instruments were constructed using both close-ended structured questions and open ended questions. The researcher filled in the questionnaire as she interviewed the respondents in the cases where the participants were not able to read and write. In cases like this, interview and the filling in of the questionnaire were done face to face by the researcher and the respondents to avoid information bias where the questionnaire may be completed for HIV positive clients or a situation where PLWA will be advised on what to fill in, which would surely affect the reliability and validity of the study. The completed questionnaires were collected from the respondents by the researcher the same day to minimize data loss and bias.

The researcher did not use any research assistants in conducting the interviews. While visiting the clinics for sampling and interviewing purposes, the researcher observed clinic activities and organization in a non-participatory manner and informal discussions with staff members served as validation for findings and conclusions. The aim was to establish the type and level of stigmatization of HIV positive clients at the clinics in Leribe District and how to reduce this problem.

3.8 DATA ANALYSIS

Data were analyzed using the statistical package (STATA version 9) software. Quantitative data were presented in percentages as well as in a graphic form such as bar chart and pie chart and tables. After the collection of data, the researcher and the statistician keyed in those data in a spreadsheet which the statistician subsequently transferrerd into the (STATA version 9) software which analyzed the data. The statistician was very helpful in the analysis stage.

3.9 INTERNAL AND EXTERNAL VALIDITY AND RELIABILITY.

Validity refers to the truth interpreted as the extent to which an account accurately represents the social phenomena to which it refers (Hammersley, 1990). While, reliability refers to the extent or consistency to which research instrument measures what it opted to measure. External validity of a study or generalizability relates to the extent to which a study results can be generalized to the entire population, which requires randomization of the study sample. The issue of reliability refers to the extent to which the question or result is reliable or repeatable. For example, if a questionnaire used in this study is to be used in another district with similar samples will the result be consistent with the findings of this study? If it does it means the questionnaire is reliable (Gordis, 2000:120; Katzellenbogen, et al, 1997:74-80; Mouton, 2001:108).

A pre-test of the questionnaire was conducted on PLWAs that were not included in the study sample and no problems were identified from the instrument. This enhanced the validity and reliability of the instrument. The researcher conducted the pre-test of the instrument at the Botha – Bothe District Government clinic with similar patients. Only 20 HIV positive clients who were enrolled for ARV in the Botha- Bothe District government clinics where used to pre-test the instrument since this District is about 50km from the main study area.

The questions were translated into the respondents' local language using a language expert. Then a different person translated the same questionnaire from Sesotho (local language) to English to ensure the reliability of the questionnaire. The use of systematic random sampling which gives every HIV positive client enrolled for ARV in the nine government clinics the chance of being selected for the study and the use of a large sample size which is a representative of the study population also ensured validity and reliability in the area of generalizability.

The researcher repeated items in different formats in the questionnaire to be able to check for consistency, thereby ensuring validity and reliability of the study findings.

The fact that the researcher did the data collection herself also ensured consistency.

3.10 ETHICAL CONSIDERATIONS

Research ethics is doing what is right and good during research; it is the application of general ethical principles to the realm of research (Burns, et al, 2005). Ethics should be upheld in every research for human, humane and humanistic reasons, for legal reasons, credibility/trustworthiness or reliability/validity of data and to demonstrate the researcher's authenticity (Burns et al 2005; Nelleke, 2003:28). In research, ethical guidelines are set to direct the researchers in order to ensure a high standard (Polit, et al, 2001:90). In research, the researcher's paramount responsibility is to the respondents. When there is conflict of interest, the researchers must do everything in their power to protect the physical, social, and psychological welfare of the respondents. The honour, dignity and privacy of those studied must be preserved. Where research involves the acquisition of material and information transferred on the assumption of trust between persons, it is axiomatic that the rights, interests, and sensitivity of those studied be safeguarded.

3.10.1 Ethical principles:

This study maintained a high level of ethical principles which include:

- **Principle of beneficence** (free from harm). This research kept to the ethical principle of beneficence by not posing any physical or emotional harm to the respondents. There were no willful questions to the respondents; there were no probing questions to the clients. The questionnaire was structured and consisted of both open-ended and close-ended questions.
- **Principle of respect for the human being** (self-determination, transparency, informed consent, autonomy, dignity). This principle requires that the researcher accord due respect to study respondents by granting them informed consent before the commencement of the study. The research proposal was submitted and approved by the supervisor for the Department of Health studies at the University Of South Africa (UNISA) before other steps were taken. Since the study involved human subjects (HIV positive clients who are on ARV) the researcher adhered to a strong ethical code of conduct by obtaining a clearance or permission to carry out the study from the Director General Ministry of Health and Social welfare, the Ethical committee Ministry of Health

Maseru Lesotho and from the participants before the actual commencement of the study.

The researcher explained to the participants their rights of voluntary participation; the researcher maintained high standard of informed consent in this study (Refer to Annexure A, B, &C).

- **Principle of justice** (fair selection and treatment, privacy, anonymity, confidentiality, exploitation). This principle stresses that the source of data must be protected by keeping informants nameless and this is exactly what has happened in this study.

This study ensured privacy, anonymity and confidentiality by organizing a consulting room where the participants were interviewed and completed the questionnaire privately under the supervision of the researcher.

Confidentiality was also ensured by constructing the questionnaire in such a way that the respondents were not made to write their names and phone numbers since the administration of the questionnaire and collection was done face to face.

To ensure confidentiality, cameras and recorders were not used to collect data from the participants.

During the administration of the questionnaire, cell phones of the researcher were switched off to maintain confidentiality and avoid disturbances. (See Annexure D for more clarifications).

3.11 CONCLUSION

In this chapter, the researcher has discussed the research design and methods used in this investigation. The study population included all the HIV positive clients (5200) who enrolled for ARV in the nine government clinics in the Leribe District which offer ARV. The researcher randomly selected 520 study samples which is 10% of the population. The questionnaire was used to elicit information from the respondents. The researcher maintained high ethical code of conduct by getting permission to carry out the study from both the Ministry of Health and Social Welfare Lesotho and a written and signed consent from the study participants. The researcher maintained a high level of confidentiality throughout the study by not writing the names and phone numbers of the respondents, and there was no video record of the clients.

CHAPTER 4: ANALYSIS, PRESENTATION AND DESCRIPTION OF THE RESEARCH FINDINGS

4.1 INTRODUCTION

In this chapter, the researcher has discussed the results of the investigation into the stigmatization of HIV-positive clients at clinics in the Leribe District of Lesotho. The measures that will help in reducing the type and level of stigma experienced by people living with HIV/Aids have also been discussed. This study was carried out in nine government clinics in Leribe district of Lesotho who offer ARV to the people living with HIV and AIDs. Five hundred and twenty respondents were included in the study population.

4.2 DATA MANAGEMENT AND ANALYSIS

Data was collected from people living with HIV and AIDS that enrolled for ARV in the nine (9) government clinics which offer ARV in Leribe district. Structured questionnaire and informal interview were administered to the health workers. The completed questionnaires were collected directly after completion to in minimize losses. A sample of 520 HIV positive clients who enrolled for ARV which was 10% of the study population (5200) was interviewed on the type and level of stigma they experience when visiting the clinics. Data analysis was done by a statistician using statistical package (STATA version 9) software, and the analysis are presented in percentages, tables, pie charts, bar charts and histogram in this dissertation.

4.3 RESEARCH FINDINGS

4.3.1 Profile of respondents

The respondents of this study were HIV positive clients who enrolled for ARV in the government clinics that offer ARV in Leribe district of Lesotho.

- **Gender distribution:** The number of females in the study was 397 (76.35%) while males were 123 (23.65%) The number of females who have enrolled for ARV is higher

than the number of males. One health care worker in Leribe who was interviewed during the study reported that the males often turn down invitations even when invited through their wives who are already on ARV treatment. This was corroborated by oral reports by some of the clients. The high number of females 397(76%) as against the number of males 123 (23.65%) in this study shows that females are more open to disclose their status and seek medical care than their male counterparts thus confirming studies that in South Africa men internalize stigma to a great extent than women (Macquarrie, Nyblade, Philip, Kwesigabo & Mbwambo 2006; Simbayi, Kalichman, Strebel, Cloete, Henda and Mqeketo 2007). While studies carried out in US revealed that HIV positive women are less likely to seek health care than their male counterparts (Macquarrie, Eckhaus & Nyblade 2009:8) Therefore the findings of this study has confirmed the above study of different patterns of reaction to stigma by gender.

- **Marital status:** The study result shows that 43.46% of HIV positive clients who enrolled for ARV in Leribe Districts are married, 18.85% has never married, 14.62% are divorced and 22.88% are widowed.

Table 4.1: Marital status of the study respondents

Marital status	% Response (N = 520)	Mean	Standard Deviation
Married	43.46 (226)	2.58	9.32
Never married	18.85 (99)		
Divorced	14.62 (76)		
Widowed	22.88 (119)		

This indicates that the rate of divorce due to spouse HIV status is high (14.62%) in Leribe district and it is affecting the rate of health seeking behavior of the high risk group. This result also indicates that the rate of widowhood (22.88%) due to HIV and AIDs in Leribe is as well very high (Refer to question: Are you married, never married, divorced or widowed?).

- **Age distribution of the study respondents:** This study has shown that HIV and AIDS is prevalent in all age groups, the results of this study indicates that 1.54% of people living with HIV and AIDS who are on ARV in Leribe District are under 15years, 11.35% are between 15-24years, 22.50% are between 25-34years, 29.04% are between 35-44, 17.88% are between 45-54, 13.08% are between 55-64 and 4.62% are over 65years. Majority of HIV positive clients who have enrolled for ARV in Leribe district are between the ages of 35 and 44. This implies that HIV infection has affected mostly people within the reproductive age, which automatically has reduced the population, reduced economic productivity, and eroded cultural values.

Table 4.2: Age distribution of the study respondents

Age	% Response (N = 520)	Mean	Standard Deviation
Under 15 years	1.54 (8)	4.08	1.39
15-24 years	11.37 (59)		
25-34 years	22.35 (117)		
35-44 years	29.09 (151)		
45-54 years	17.92 (93)		
55-64 years	13.10 (68)		
65+ years	4.62 (24)		

It is important to note elderly that people are not exempted from contracting the HIV infection because people tend to think that HIV infection is for the young people, injection drug users and prostitutes only. During the data collection stage of this study, the researcher discovered a 74 year old woman and 83 year old man who are on ARV respectively, though they were not able to say exactly when they contracted the infection, even though both patients are widowed. The results of this study show that 4.62% of people who are enrolled for ARV in the primary Health care in Leribe are over 65 years of age which means that HIV infection can be contracted at all age groups.

- **Place of residence:** HIV positive clients visit the government clinics in Leribe for ARV from far and wide. The study focused on three areas of residence which include: clients who live within 20 km radius from the clinic which they attend in Leribe, clients who also live in Leribe but more than 20km from the clinic and the clients who live in other Districts outside Leribe district.

Table 4.3: Place of residence of the study respondents

Place of residence	% Response (N = 520)	Mean	Standard Deviation
Live in Leribe district but more than 20km from this clinic	49.13 (256)	1.76	0.83
Live within 20km from this clinic in Leribe	25.82 (134)		
Live in another district	25.05 (130)		

According to the results of the study, only 25.77% (134) of HIV positive clients come within 20 km to clinics for ARV in Leribe District. The rest come to from very far places in the bid to avoid being stigmatized as the respondents indicated. The results of the study has indicated that 49.05% of HIV positive people travel very far from their home to get ARV either because they are hiding away from their families, friends, neighbors and members of their communities (Refer to question: place of residence). It is important to note that 49.23% (256) of the respondents go to clinics situated more than 20km from where they live for ARV whereas they know other clinics which are closer to them which also offer Anti-retroviral treatment (Refer to table 3). The implication is that stigmatization and discrimination of people living with HIV/AIDS has led people into hiding their HIV status which in turn has continued to increase the incidence (new cases) of the infection. This study results have shown that 25% (130) of HIV positive clients who attend ART clinics in Leribe District come from other districts outside Leribe (Refer table 3 above for evidence).

Many travel monthly as far as 50km to the remote clinics in Leribe district of Lesotho for ARV. This is not because they do not know any other clinic which offer ARV but because they do not want to disclose their status to their spouses, relatives, families and friends because of the type and level of stigmatization associated with HIV infection (Refer to the question: why do you prefer coming to this clinic for antiretroviral treatment?).

“I discovered my HIV positive status in Gauteng and decided to come home, my husband was still working in Gauteng but now he is dead. Each time I am coming to this clinic from my home, it takes me two days because it is very far and not motorable but I prefer it to other clinic by the road, I don't want my friends and neighbors to know my status, each time I'm not well, I tell my friends that I am having high blood pressure” (A woman age 54 reported on the 21st September, 2009 at a clinic in Leribe when the researcher interviewed her).

4.3.2 HIV status:

- **Duration of being HIV positive:** The result of this study has shown that 53.08% (276) of the respondents have known their HIV status longer than three years before this study was carried out, 30.96% (161) said they have known their HIV status for the last three years, 13.46% (70) have known their status within the last one to 11 months, while 2.50% have just known their status in the last month. This implies that there is need to reduce the stigmatization of HIV clients so as to increase the willingness to HIV testing which will surely improve care seeking behavior and reduce the rate of new cases, improve the life of HIV clients, and prevent early deaths.

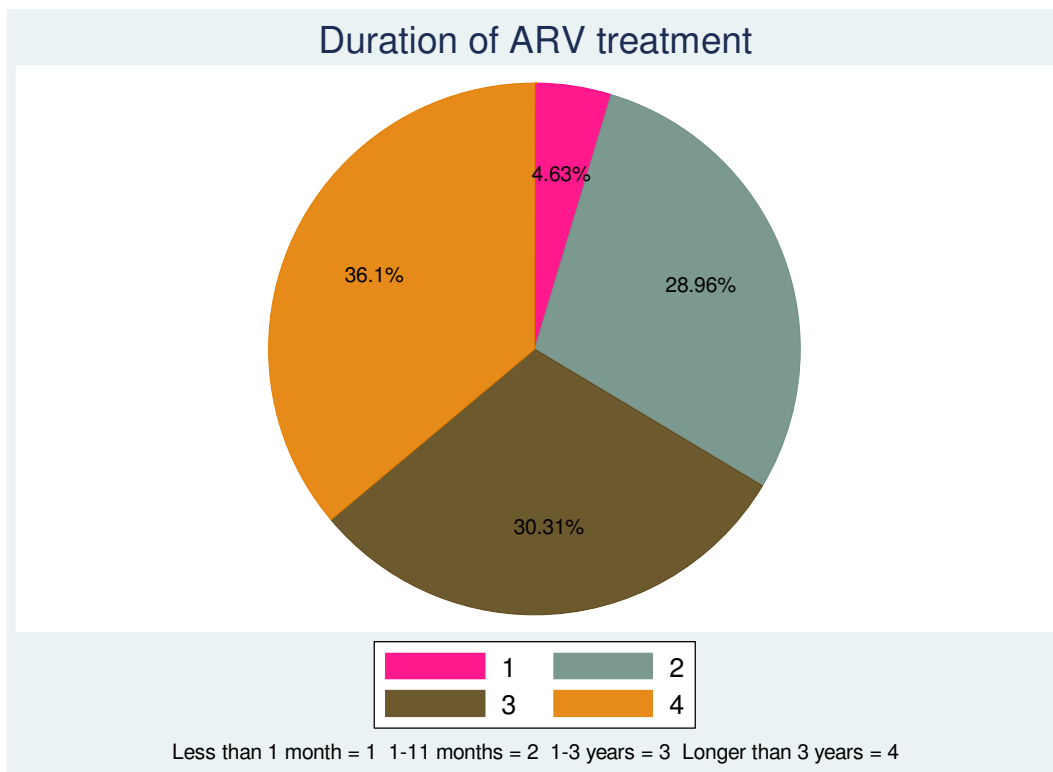
4.3.3 ARV Treatment:

- **Duration of ARV treatment:** The result of this study has shown that 41.43% (215) of the clients studied have only been attending this clinic for ARV in the last 1-11 months, 7.32% (38) have been attending clinics in Leribe for ARV in the last month, 25.63% have been attending clinic for ARV between one to three years, only 25.63% have been attending this primary health care for ARV longer than three years. This still proves that HIV positive clients are always migrating from one clinic to another for ARV, and this is because of trying to hide from relatives and friends who may stigmatize against these

clients as well as health workers who call them names (Refer to question: Have you been attending this PHC before you were treated with ARVs?).

The pie chart below is showing that 4.63% of the study sample have only started using ARV in less than 1 month ago, 28.96% are between 1-11 months on ARV, 30.31% are between 1- 3years on ARV while 36.1% have been using ARV longer than 3years now. This result shows that antiretroviral regimen is greatly sustaining the life of people infected with HIV. It also shows that people are enrolling for ARV every day which calls for the need to make antiretroviral available at the clinics.

Figure 1: Duration of ARV use



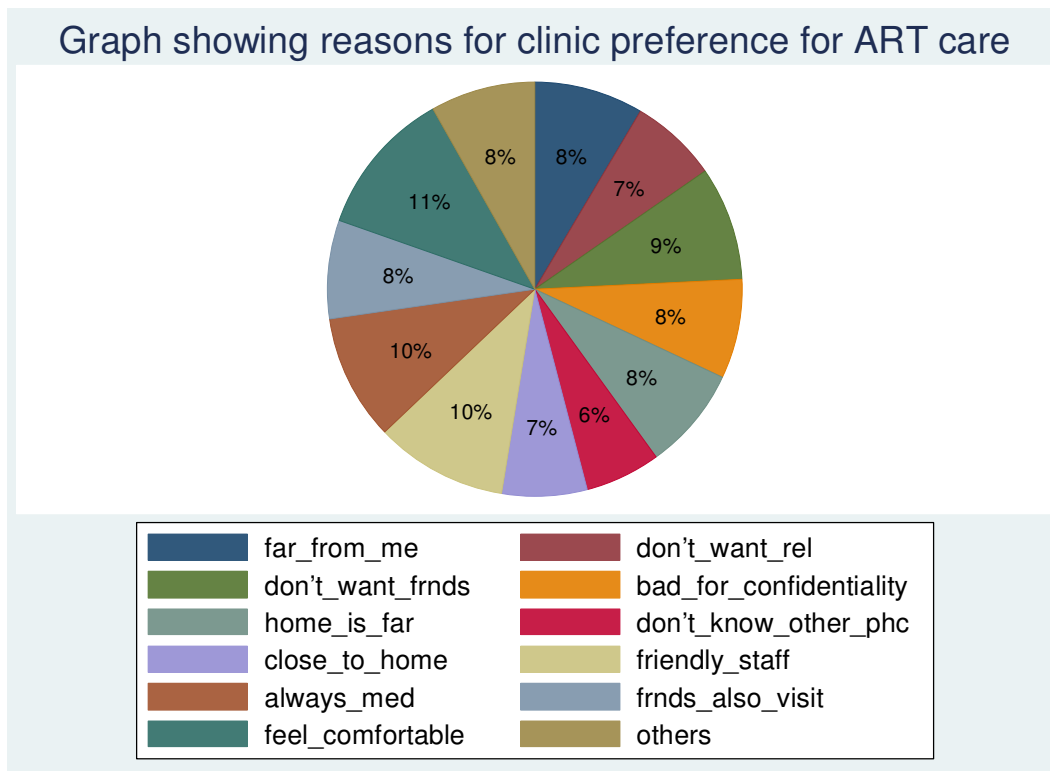
- Reasons for clinic preference:** The analysis of this study has revealed that 58.56%(301) of the clients who have enrolled for ARV in Leribe District totally agreed that the clinic they were attending for ARV is far from them, 37.57% (195) totally agreed that they do not want their relatives to know their HIV status. While 16.76 % (308) and 42.56% (259) sometimes agreed and totally agreed respectively that they do not want their friends to know their HIV status.

It has also indicated that 28.96% (172) and 21.04% (109) sometimes agreed and totally agreed respectively that it is bad to go to primary health care nearer home since they cannot guarantee their privacy. This implies that there is lack of confidentiality of information concerning HIV positive clients at the clinics. However, 33.20% (172) of the clients agreed that there is some level of confidentiality in some clinics in Leribe district.

The result of this study is consistent with results of investigations carried out by UNAIDS (2009) in India, Thailand, Nigeria and Ghana which proves that stigmatization and discrimination of people living with HIV and AIDS has led to poor health seeking behavior, unwillingness to disclose HIV status to relatives and friends, and this has hampered most efforts of the public health to combat the infection. The study further indicates that people living with HIV/AIDS prefer visiting clinics that are far from them so that their relatives, friends, and community members will not know their HIV status, and the result of this dodgy behaviour is increase of new cases due to the fact that their sexual partners will be unaware of their status. HIV positive patients prefer visiting the clinics where they receive great care and medication; this simply means that clients prefer clinics where they always get ARV because many clinics often face the problem of ARV shortage. When the researcher was collecting data for this study, there was a clinic which had more than 300 HIV clients enrolled for ARV but not even one client showed up in that clinic yet it was the only day that the clinic offers ARV to the clients for the week. When the researcher asked why, the health worker responded that the clinic had not received any medication for the past three weeks and that was why the patients had gone to other clinics where they could get treatment. 50.88% of the HIV infected people who travel to far places for ARV do know the clinics near their homes which offer ARV services but decided to go far away to prevent stigmatization and discrimination from within their domain.

A large percentage (42.58%) of the HIV clients prefer visiting the clinics where they will not see their friends just to avoid being stigmatized and most of these patients keep migrating once they notice that people have known their HIV status in a particular zone.

Figure 2: Reasons why HIV positive clients prefer certain clinics for ARV



The people living with HIV/AIDS jump from one clinic to the other for ARV in the bid to hide or run away from the sites of their friends and relatives to avoid stigmatization, (Refer to the question: why do you prefer coming to this clinic for antiretroviral treatment?; See figure 2 above.) This stigmatization of HIV clients has led HIV positive persons into not staying in the clinics where they tested positive, or a clinic near their home. And this is a very serious problem, because it consequently means that the clients will definitely not disclose their status to their partners hence will continue to infect others. Therefore urgent measures to deal with the stigmatization of HIV positive clients in the clinics are needed.

- Period of attending a specific clinic:** This study has revealed that 45.16% (233) of the study sample declared that they had not been attending this clinic before they were treated with ARV while 54.84% (283) revealed that they have been attending this primary health care before they were treated with ARV. This suggests that 45.16% of the HIV clients tested HIV positive in a different clinic from the one they have enrolled for ARV at the time of the study which may be as a result of poor confidentiality level among the health worker in these clinics. Poor confidentiality at the clinics can lead to the stigmatization of the HIV clients and the movement of clients from nearby to very far

clinics. Therefore, the health systems and the health care providers should adhere to all strategies in terms of policies and legislations concerning the confidentiality of HIV positive clients as this will help to halt client's movements.

- Those who responded 'yes' to question 3.3 of the study questionnaire (those who said that they have been attending this clinic before being tested with HIV infection), 4.45% have attended this clinic in less than 1 month, 15.07% between 1 to 11 months, 25.68% between 1 to 3 years and 54.79% have been attending the clinic they were at the time of this study. Majority of clients who enrolled for ARV in the clinics where they tested HIV positive are widows and those who are above 65 years. This means that most young clients who enrolled for ARV in the clinics in Leribe come from clinics other than where they tested positive because 8.9% of the HIV patients do not want their relatives to know their status. So HIV and AIDS awareness should be promoted through Media and other channels of information to reduce stigma.

4.3.4 STIGMA

- **Types of stigma:** 83.85% of the respondents who participated in this study revealed that they have experienced different types of stigma in these clinics, while 16.15% responded that they have not been stigmatized in this clinic. This finding is in line with the two studies carried out in the United States, one of housing project clients and the other of ART clients which reported that 40% of their respondents had experienced discrimination in the health care centre (Sohler and Cunningham 2007). This means that the stigmatization and discrimination of HIV positive clients at the clinics needs urgent attention.

Table 4.4: Stigma experienced due to HIV positive status (Have you experienced stigma due to your HIV positive status?)

yes_or_noc1 inicep	Freq.	Percent	Cum.
0	83	16.15	16.15
1	431	83.85	100.00
Total	514	100.00	

Key: 0-No; 1-yes.

Table 4.5: Major types of stigmatization of HIV positive clients at the clinics which makes the clients feel very bad.

Type of Stigma	Number of Responses(N=520)	Percentage Response (%)
Discrimination	259	21.30
Isolation	236	19.41
Separate treatment rooms, consulting rooms and wards	182	14.97
Labeling	119	9.79
Separation	119	9.79
Wearing of gloves and mufflers when giving injections	90	7.4
Gossips	55	4.52
Name calling	33	2.71
Blame for contracting HIV	27	2.22
Violence	26	2.14
Denial of treatment	20	1.64
Loss of respect	20	1.64
Lack of confidentiality	13	1.07
Lots of insult	8	0.66
Revealing test result to relatives without consent	6	0.49
Been tested	3	0.25

without consent		
Total	1,216	100

1. **Discrimination:** As one can see from table 4.5, 20.30% of the respondents reported that they have been discriminated against by the clinic staff due to their HIV positive status. This study has shown that the major frustrations of people living with HIV/AIDs include discrimination and separation of HIV patients from other patients. Most respondents reported that what made them feel discriminated was being made to queue separately at the gate on arrival for their ARV regimen by the security staff at the clinic. Most hospitals in the countries in sub Sahara Africa where the burden of HIV/AIDS is on the increase have specific (designated) areas where the people living with HIV can access services and this practice of discrimination is regarded as stigma (Herek, 1990). In a United States study of 28 urban areas and 24 rural counties, 40% of the ART clients revealed being discriminated against at the health settings due to their HIV positive status (Thrasher, Earp, Golin and Zimmer. 2008). Studies in different areas of India reported health services as the predominant setting in which discrimination occurs; such as refusal of medical care and delivery of ARV in a specific area (Marfatia, Sharma and Modi. 2007).
2. **Isolation:** 19.41% reported that they have been isolated in this primary health care due to their HIV status. Many clinics in Leribe district isolate people living with HIV/ AIDS for treatment by designating a specific building/ward where they are treated by designated doctors, nurses, counselors and lay counselors. The respondents reported that the practice particularly exposed them to ridicule and finger-pointing. These types of negative experiences of the PLWA discourage many patients from seeking treatment leading to many untimely deaths. A study conducted in Ethiopia in 2005 by Miz-Hasab Research center on perceived stigmatization and discrimination by health care providers towards HIV patients, the health care providers strongly argued in favor of isolating HIV positive patients on separate wards and/or in separate facilities.
3. **Consulting and treating HIV positive patients in different rooms and wards from other patients:** 14.97% of the respondents revealed that they have been consulted and treated separately from other patients in the clinic due to their HIV status; this affects the rate at which people decide to go for tests, disclose their

status and seek care. The level of separation, isolation and discrimination of people living with HIV/Aids are recorded more at the clinics in Leribe than at homes. Some clinics in Leribe have specific days when they consult and give ARV to HIV positive individuals and the entire community is aware of these days. This makes HIV patients very uncomfortable to go to the clinics near their homes for ARV because everybody will know their status and will start to stigmatize them. A high percentage of the respondents of this study disclosed that they travel from very far distances to go to clinics on the belief that their relatives and friends will not know their HIV status if they go far. This study discovered that the HIV positive clients travel as far as 150km passing several clinics before the one where they receive ARV.

4. **Labeling of hospital cards:** 9.79% reported that their cards have been labeled 'HIV positive' at the clinic. The result of this study has shown that majority of primary health care workers label the hospital cards of HIV/ AIDS patient's inappropriately. This leads the patients into tearing their hospital cards which is making the job of the workers more difficult and also hampering the proper treatment of the patients. Additionally, a similar study carried out in Ethiopia in 2005 by Miz-Hasab Research center revealed that health care providers in all the 12 facilities reported writing 'RVI' (retroviral infection) in patients medical records as a reminder to take precautions when attending to patients with HIV infection. However in one clinic in Leribe District, the staff code patients' hospital cards with numbers which they use to open files for them containing all the information about their HIV positive status. This clinic does not also treat HIV patients separately from other patients. ARV regimens are kept in all the consulting rooms so that when a patient with HIV comes in to consult, he/she will be given ARV if he/she has enrolled for it. This is a clear contrast to other clinics in the district with separate consulting rooms, treatment rooms, and pharmacy for people living with HIV and AIDS which does not ensure confidentiality.
5. **Separation:** 9.79% (119) reported that they have experienced separation in the clinic because of their HIV positive status. (Refer to number: 3 above).
6. **Wearing of gloves and mufflers** 7.40% of the respondents reported that the health care workers indiscriminately wear gloves when giving them treatments although many PLWA did not have any problem with that believing that they have to protect themselves in as much as they are taking care of the patients. Many studies have revealed that health workers wear gloves and mufflers when giving treatment to

PLWA. This study also reported the indiscriminate wearing of gloves among health workers when treating HIV patients as very low in percentage. The wearing of gloves and mufflers at all times while on duty by health workers as a standard practice is highly recommended. This will not only forestall stigmatization, but also protect them. People living with HIV and Aids prefer going to clinics where their friends and relatives will not see them, where the staff gives them great care, where medication is always available, where they feel comfortable, and at distant clinics.

- 7 **Gossips:** 4.52% (55) of the respondents reported being gossiped against by the clinic workers based on their HIV infection. The result of this study has shown that health care providers also gossip about people living with HIV and Aids. A multi-country qualitative study conducted in Lesotho, Malawi, South Africa, Swaziland and Tanzania recorded "extensive" verbal and physical abuse and neglect by nurses in health service centres (Dlamini, Kohi, Uys, Phetlhu, Chirwa, Naidoo, Holzemer, Greeff and Makoe. 2007). But the findings of this study revealed that PLWA in Leribe District experience more gossip from their families and friends than they do at the clinics. Gossip is also one of the reasons why PLWA travel very far away from the clinics in their neighbourhood in search of ARV.
- 8 **Name calling:** 2.71% have reported that the staff of this clinic had called them names due to their HIV status.
- 9 **Blame for contracting HIV infection:** 2.22% of the respondents reported that the health care providers of this clinic had blamed them for contracting HIV infection. The study respondents admitted that they have experienced this type of insult where the health care givers abuse them saying that HIV is a pay back for their immoral behaviour. But some respondents reported that they have been blamed for their HIV infection at home than at the clinic. In Puerto Rico, a study conducted on attitudes among women found that there was significantly less sympathy for people living with HIV who were drug users somewhat more homosexuals who are HIV positive. But children and heterosexual women with HIV received the most sympathy (Norman, Abreu, Candelaria and Sala 2009).
- 10 **Violence:** 2.14% of the respondents reported having experienced violence at the clinic by the non clinical workers. For instance, a client reported been pushed down from the chair by a cleaner at the clinic.

11 Denial of treatment: 1.64% reported being denied medical treatment by the health care

Providers while their relatives and friends have denied them respects, trust and rights.

12 Loss of respect: 1.64% reported that they have lost their respect at home, workplace and clinic since they tested HIV positive.

13 Lack of confidentiality: Only 1.07% of the study respondents felt lack of confidentiality among the clinic nurses.

14 Lots of insults: The respondents (0.66%) experienced insults from the health care workers due to their situation as HIV positive patients.

15 Revealing test results to relatives without the consent of the Patient: This was experienced by 0.49% of the respondents from both the nurses, laboratory attendants and the doctors. The percentage response in this type of stigma is low in Leribe District based on the findings of this study; compared to a study conducted in India which revealed that 94% of doctors inform the HIV patient's partners and relatives of their HIV test result without their consent.

16 Being tested without client's consent: 0.25% of the study respondents said that they were tested without their consent by the clinic care givers due to the fact that they suspected the clients situation based on the manifestations of some signs and symptoms. But this is a violation of the UNAIDS/WHO policy on voluntary counseling and testing.

Types of stigma experienced by HIV positive clients include: Physical stigma, social stigma, verbal stigma, and institutionalized stigma. These types of stigma include avoidance and isolation, rejection, violence, loss of identity, loss of role, loss of respect, blaming, pointing fingers, insulting, charting and labeling, name calling, gossips, rumors, verbal harassment, disclosing of ones HIV status without his/her consent, indiscriminate wearing of gloves when attending to PLWA, refusal of admission and treatment, burning of linen used PLWA, and referrals for testing (Igor, 2005; Ogden & Nyblade, 2005:7-10).

"I am the only girl, my parents have passed away everyday my brothers are beating me at home telling me that they will help HIV to kill me, when I come to the clinic, the nurses call me flying hairs because whenever they check my weight it is less and my hair is very light"

(A lady aged 26 reported in this study, when the researcher was interviewing the respondents at Leribe on the 16th September, 2009).

In this study, 97.04% of the study respondents confirmed that they have experienced different types of stigma as a result of their HIV positive status. 88.72% (131) of the respondents in this section (Refer to question 8 in the questionnaire), reported that they have been separated at the clinic by the clinic staff, While 5.26% of the respondents reported being separated from their family. On the issue of rejection, 70.15% of the respondents pointed out that they have been rejected while 38.46% were rejected by their family members at home, 30.77% were rejected by their friends, 2.56% were rejected by the clinic staff and 3.42% were rejected in their communities by their neighbors and community members.

HIV/AIDS patients have experienced disassociation from different people due to their infection, 66.67% of this study respondents expressed that they have been disassociated; 1.40% reported being disassociated at home by family members, 36.36% reported being disassociated at work by friends, 0.83% expressed disassociation at the clinic by the clinic staff while 2.48% had experienced disassociation from their community by friends and community members.

The figure 3 of this study (refer to page 72) shows that 67.88% of the respondents have experienced discrimination due to their HIV status, 47.01% have experienced discrimination at the clinic by the clinic staff, 23.08% have experienced discrimination at home from family members, 22.41% experienced discrimination from friends and 8.62% experienced discrimination at their communities by the community members.

From figure 3 in page 72, one can deduce that experiences of denial of treatment is not much at the clinics as this graph is only showing the percentage responses of stigma at the clinics. Only 3.28% of the respondents complained of denial of treatment at the clinics in Leribe (Refer to figure 3 for evidence).

Studies carried out in Ghana, Nigeria and other places of the world highly revealed that health workers reveal HIV status of patients to relatives, partners, and friends without the consent of the patient, (UNAIDS 2009) but in this study only 6.52% (refer to graph in page 72) of the respondents have reported that their status was revealed to people without their

consent, 93.48% said that their status was not revealed without their consent. Among the percentage of respondents who acknowledged that their status was revealed without their consent, only 3.57% was revealed by the health workers at the clinic.

Some families disown their children, wife, husband and other relatives due to their HIV status, 45 year old man in Leribe killed himself on the 23rd September 2009 because his wife and children disowned him due to his HIV positive status (reported by one of the clients). This study has revealed that 15.94% of people enrolled for ARV in Leribe government clinics have been disowned by their families, and 1.69% by their friends.

Stigmatization of people living with HIV/Aids in the primary health care (PHC) has negative effects on the prevention and control of HIV/AIDs. It has led to negative behaviors such as refusal of HIV testing, condom use, care-seeking upon diagnosis, and in disclosing one's HIV status which has caused multiple increases of new cases of HIV and early deaths It has affected the quality of care given to people living with HIV and AIDS in the health settings (HIV & AIDS stigma and discrimination. From: <http://www.avert.org/aidsstigma.htm> 25th April, 2008; HIV & AIDS stigma and discrimination. From: <http://www.avert.org/aidsstigma.htm> 9th June, 2009).

The histogram (refer to page 72) below shows the percentage responses of the type of stigma experienced by people living with HIV and Aids who visit the PHC in Leribe district. This study result has revealed that 16.91% of the respondents have been blamed for their HIV positive status, majority of these people have experienced this blame at home from their family members while 1.79% have experienced blame for their situation at the clinic by health workers.

A study carried out in Ethiopia, Tanzania, Vietnam and Zambia by Ogden & Nybade reveals that prostitution and injection drug use are widely referred to as social evils (Asiedu, 1998:11), therefore these behaviours are already stigmatized. The fact that HIV can be transmitted sexually has led people into associating HIV infection with socially improper sex behaviors and this leads to high level of blame placed on people living with HIV infection on the grounds that they got infected due to their immoral behaviour. This association between HIV infection, multiple sex partners, sex work, injection drug use and social evil affects both

people who engage in such behaviors and those who do not, though at different levels. Men, unmarried women, sex workers and injection drug users experience high level of stigma which is referred to as presumed "guilt". This study has proven that 57.97% of people living with HIV/AIDs who have enrolled for ARV at the government clinics in Leribe have experienced that people gossip about them due to their HIV infection. Those who reported their experiences on gossips at the clinic by the clinic staff were 56.76%, while only 3.60% and 7.21% experienced theirs at home by family members and community members respectively.

In this study, 36.23% of the study sample reported that they have no care and support, and among these 33.72% do not have care and support from their families at home, 20.93% do not have care and support from the clinic by the clinic staff, while 17.05% do not get care or support from their friends.

Children, Married women who contracted HIV from their husbands and health workers who contracted HIV as a result of their work, the police and road traffic workers who contracted HIV while on duty experience lower level of stigma which is referred to as presumed "innocence" (Asiedu, 1998:12-13, International Center for Research on Women, 2005:23). "Since Mr Tsoeu Habofanoe of Likhakeng in Leribe district revealed his HIV positive status his house has been set on fire twice" (weekly mail, volume 03 no.4 page 5, 02-08 September 2009). 33.33% of this study sample indicates that they have experienced violence as a result of their HIV status. Of those 35.44% have experienced violence at home by the relatives and family members, 21.25% by friends and 15.00% have experienced violence from the clinic staff.

"My father refused to offer me any care, he never asked if I will eat or go to the hospital and my only brother joined him in that way. They dealt with me, today they are both dead, but I am still alive I thank God for ARV (A man aged 24 reported at Leribe on the 18th of September 2009 when the researcher interviewed him.)

Figure 3: Types of stigma (negative experiences) experienced by HIV positive clients

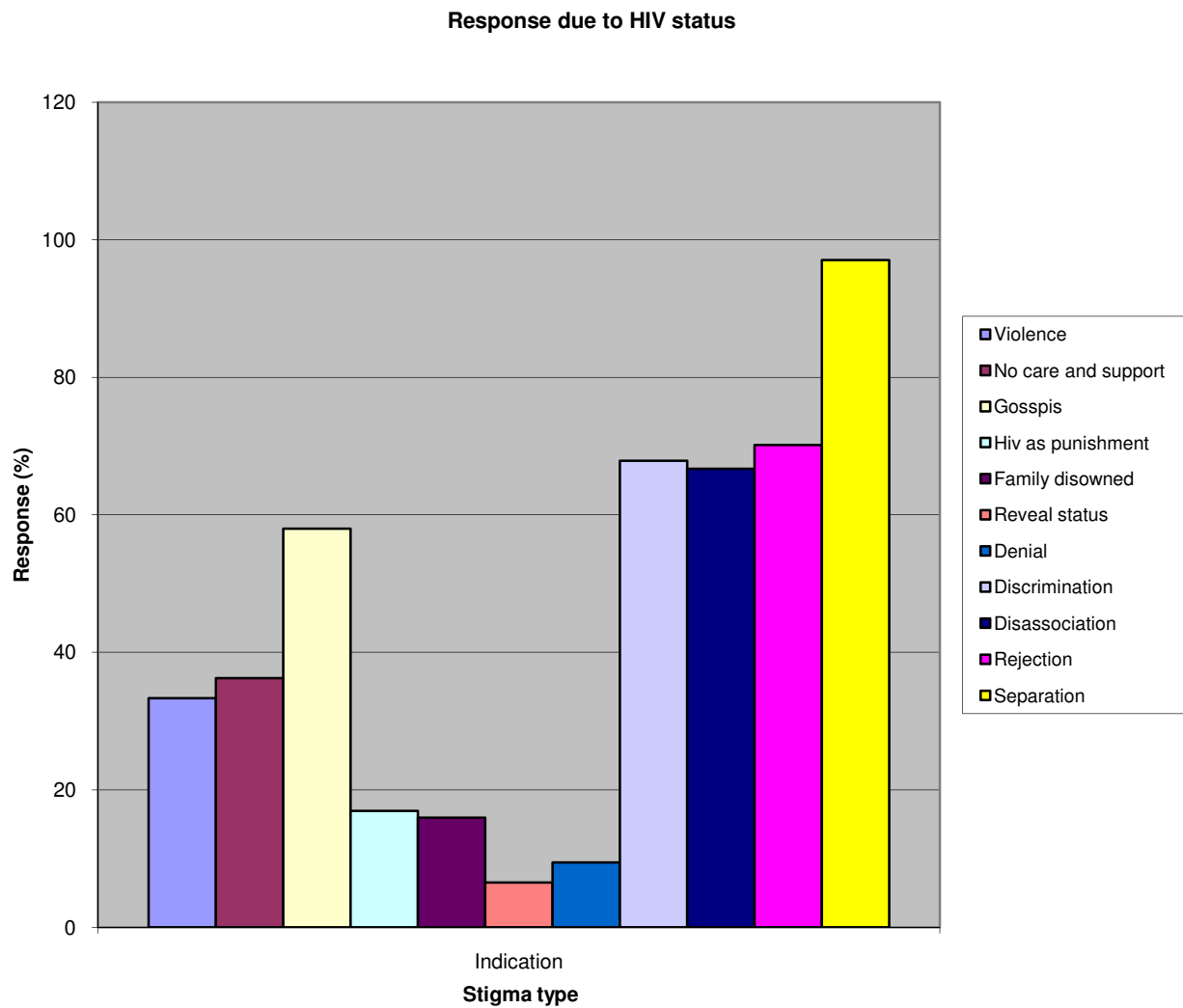
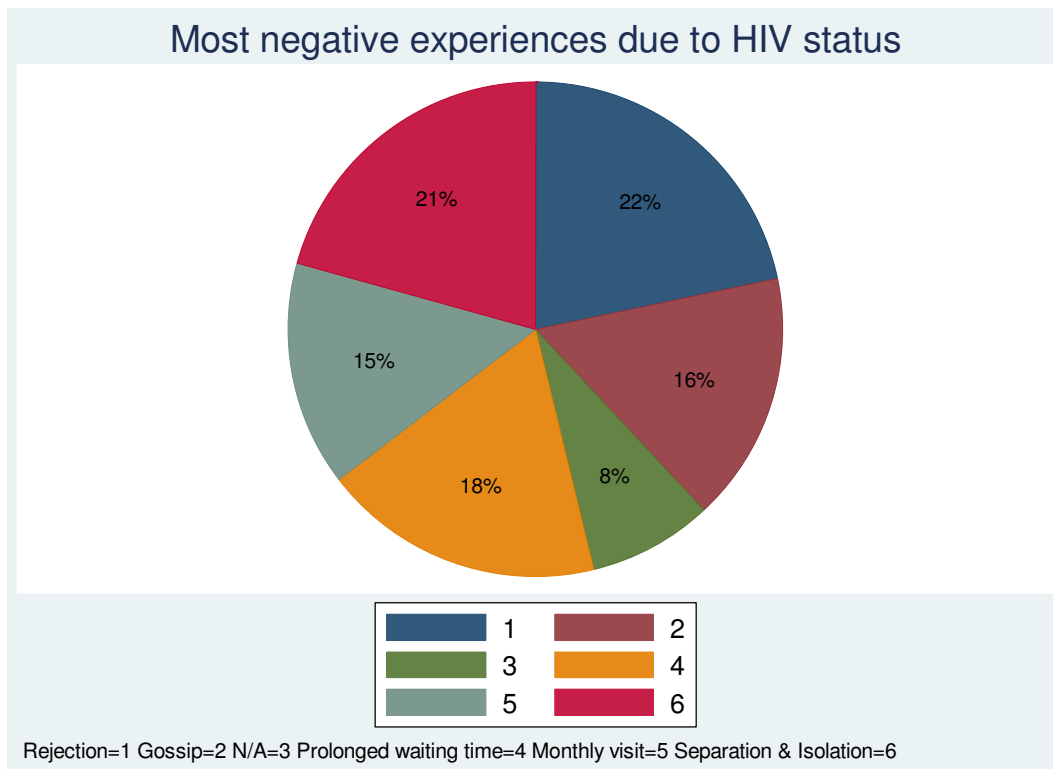


Figure 4: Most negative experiences of HIV positive clients at the clinic.



Figures 3 and 4 have both revealed information on the negative experiences of the HIV positive clients at the clinics in Leribe. These figures have shown consistency in the responses of the study sample. However, figure 4 revealed that HIV positive clients are also experiencing prolonged waiting time at the clinics when they visit for ARV. It expressed that HIV positive clients regard monthly visits at clinic for ARV as stigma, therefore requesting that care givers must provide them with 3 monthly regimens to reduce their frequent visit to the clinic.

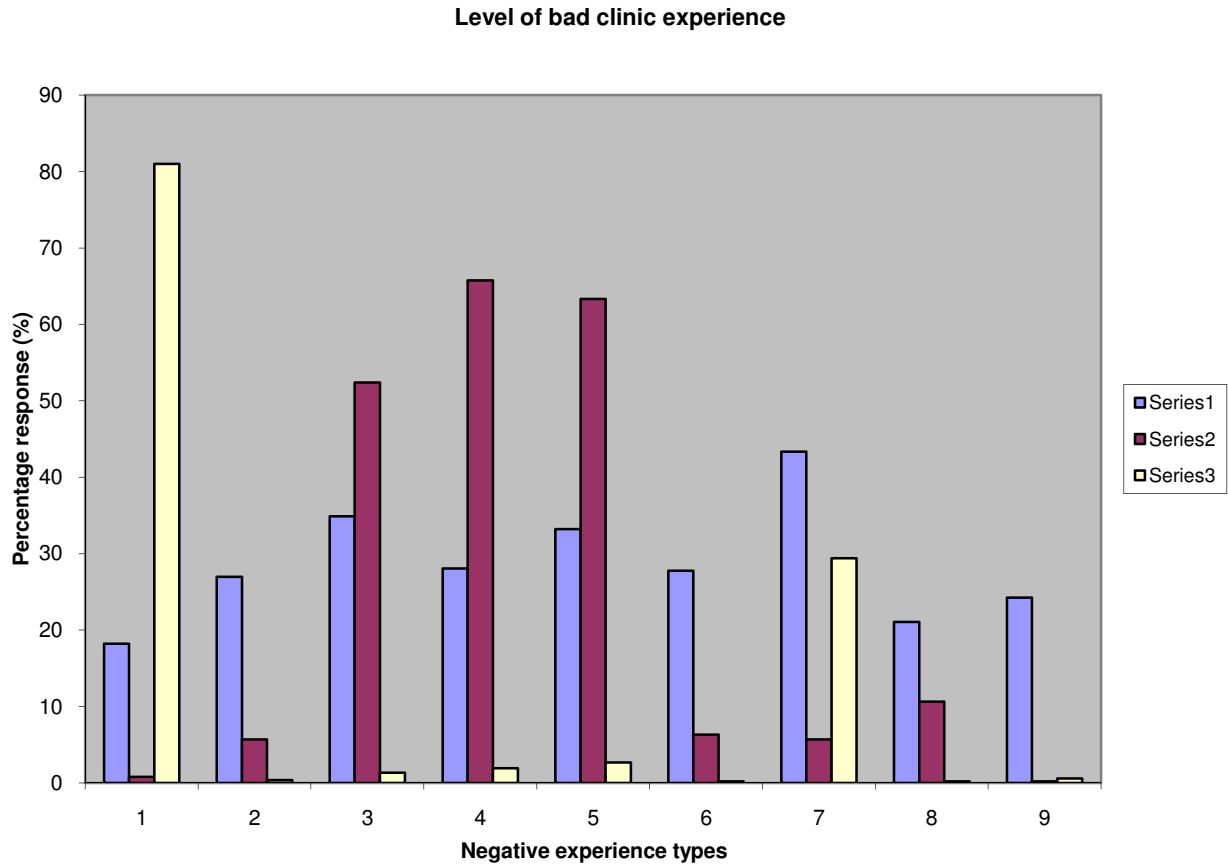
Based on the findings so far, this study has explored different types of stigma experienced by HIV positive clients at the clinics in Leribe district. The researcher therefore concludes that people living with HIV and AIDS suffer stigmatization at the clinics.

- **Intensity / Level of stigma:** People living with HIV and AIDS face different types of stigma depending on the stage of their disease and how they have contracted it. For instance, HIV positive clients experience high level of stigma especially when they start experiencing physical deformities such as growing lean and having rashes all over the

body as a result of the disease progression which takes some time to happen, although HIV positive patients start experiencing stigma from the time they disclose their status or the moment it is known to people. Figure 5 below shows level (intensity) of stigmatization felt by PLWA when they visit the clinics for ARV in Leribe Districts.

- The study result presented graphically has shown that consulting and treating HIV patients separately from other patients at the clinic had the highest intensity of stigmatization on HIV positive clients. This indicates that it makes the HIV infected patients feel very bad.
- In the graph below, labeling of hospital cards of HIV patients ranked number two, it has also shown that the patients concerned felt very bad about it, leading them into tearing their hospital cards, making it difficult to access their treatment history.
- Isolation of PLWA ranks number three in the graph also indicating that HIV patients feel very bad being isolated at the clinic when they visit for ARV. This feeling of isolation often results in the non follow-up or non adherence to treatments.
- Wearing of gloves and mufflers have been recorded (7.4%) in this study as a form of discrimination experienced by people living with HIV/Aids, but (figure 5 which is showing levels of stigmatization) had shown that the respondents did not feel very bad about it. On the denial of treatment in the clinic, majority of the respondents responded “can’t explain” which invariably indicated that this type of negative experience is not very significant at the clinics in Leribe district.
- Other negative experiences such as blame for HIV infection, revealing of HIV status without consent and carrying out of HIV test without patients’ consent have shown low level in the graph. This means that HIV patients do not feel as bad as they do concerning isolation, separation and labeling. Many participants of this study did not respond to the marking of the admission bed as (HIV+) because they said that they had not been admitted since they started using ARV.

Figure 5: Levels of stigmatization experienced by HIV positive clients



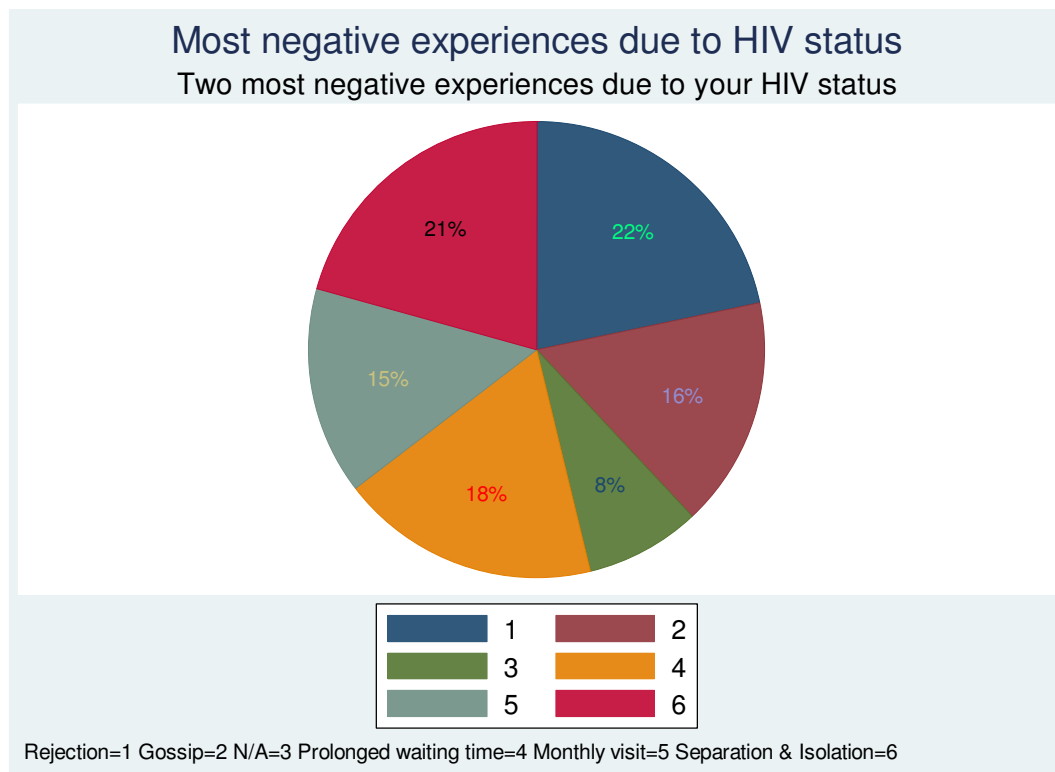
Legend Interpretation

Series 1 = BAD	Series 2 = VERY BAD	Series 3 = CAN'T EXPLAIN
1 = Denial of treatment	2 = Blame for HIV infection	3 = Isolation
4 = Separate consultation and treatment	5 = Labeling of hospital cards	6 = Marking admission beds
7 = Indiscriminate glove wearing	8 = Reveal status without consent	9 = Testing without consent

The results of this study reveal that 22% of the respondents experience rejection, 21% experience separation and isolation, 18% complain of the prolonged waiting time at the clinics for ARV, 16% experience gossips while 15% show bitterness on the monthly visit to the primary Health care for antiretroviral (ARV) treatment. These respondents complain that they waste a lot of energy and money on transport on monthly bases because they live far

from the clinics. A large number reported going to the clinic and not getting ARV due to shortage or poor supplies of their ARV regimen. In some cases, the staff shared a bottle of regimen for two people meaning that they would take it for only two weeks and go back to the clinic for another medication. Sometimes patients hunt for ARV with their own transport. The patients contribute money so that the staff could get transport to other clinics and get medication since they couldn't stay without ARV. This non-regular supply of ARV regimen obviously aggravates the feeling of discrimination and stigmatization by these PLWAs (83.85%) "Otherwise, why is it that medication for other treatments are available but ARV?" Some of them had asked during the interview.

Figure 6: Ranking of stigmatization of HIV positive clients.



Sources of stigma: Health care providers, Families and Friends.

- Health care providers:** Primary Health care settings are where people living with HIV and AIDS often discover their status. It is where HIV patients have the potential to get or gather information on how to care for themselves and prevent transmission to other people, as well as get quality treatment and care. But sometimes the reverse is the

case; patients significantly have negative experiences at these clinics. This study has indicated that 17.65% of the clinic staffs are not friendly with the HIV positive patients. More than fifteen percent (15.29%) of the study population revealed that the clinic staff rejected and separated them from other patients, 13.53% experienced isolation at the clinics in Leribe, 3.53% complained of being gossiped about by the clinic staff. As a matter of fact 28.43% of the respondents of this study lamented on the rate at which the staff of this clinic waste the time of the patients when they come for ARV. The respondents raised concern on why health providers do not show concern to attend to HIV patients? 21.57% revealed their bad experiences on the shortage of drugs (ARV) at the government clinics in Leribe District.

The excessive and unnecessary precautions by health care providers when treating or caring for HIV patients, for instance the misinterpretation of universal precautions and the inappropriate use of gloves when transporting HIV patients from one location to the other and when giving them injections, placing them in separate wards, rooms and sometimes in a designated building is in itself stigmatization and discrimination of HIV positive clients. Approximately one quarter of the respondents reported that they had always been advised by the health care providers not to get married and not to get pregnant due to their HIV status. The percentage experiences of people living with HIV/AIDS concerning blame for HIV infection, denial of treatment, testing without consent, revealing status without consent and violence are less than 9.5% each which shows low level of stigma in these issues at the health centers in Leribe districts.

- **Health care systems** are major sources of stigmatization and discrimination of people living with HIV and AIDS, This study has shown that 55.11%(286) of the HIV positive people who have enrolled for ARV in the Leribe government clinics feel isolated due to their HIV positive status while 44.89% (233) do not. Based on this result, one can see that isolation is among the types of stigma experienced by the HIV clients at the clinics in Leribe.

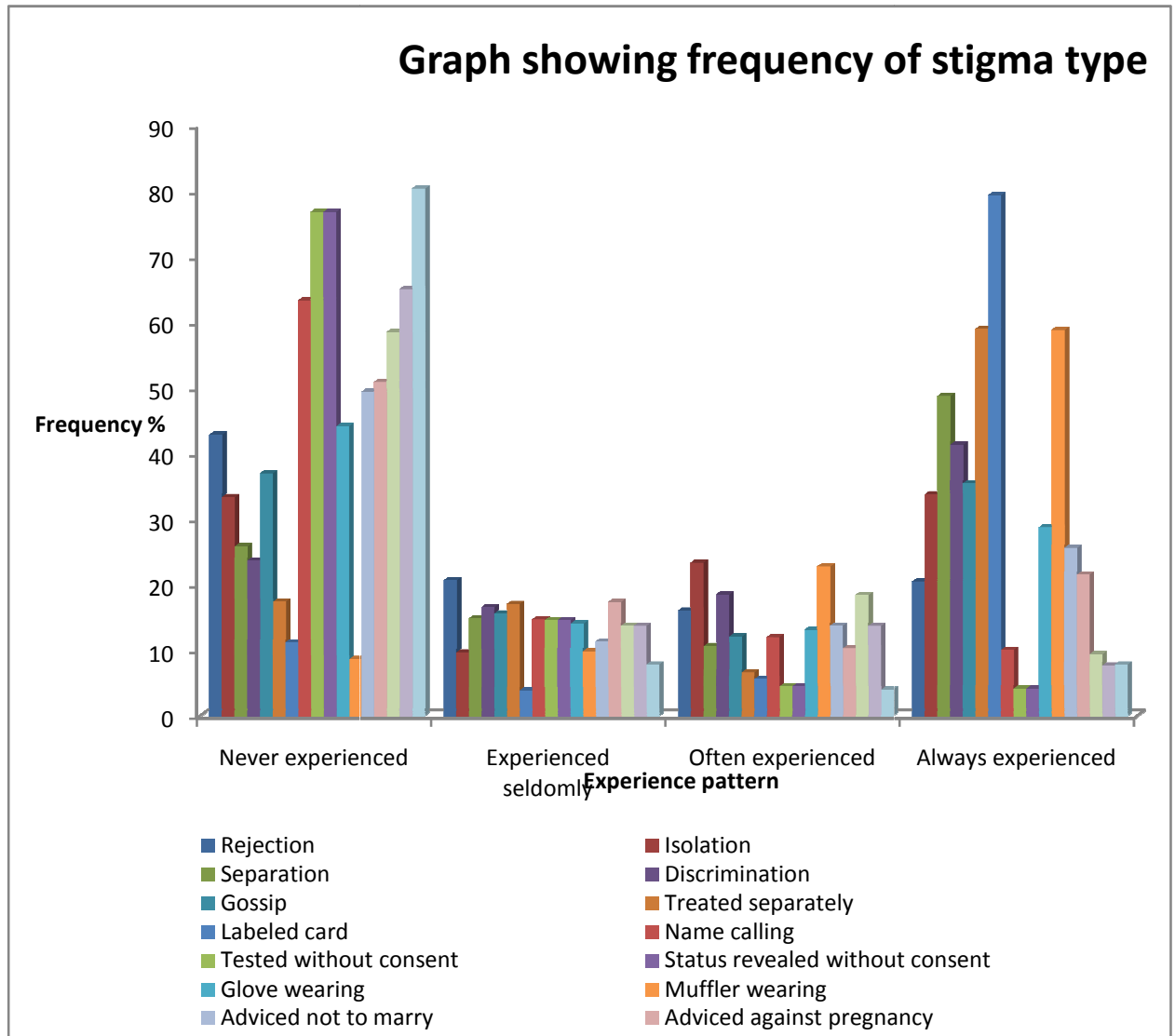
Majority of the primary health care in Leribe designated places and days in the week when they treat HIV patients. The level of stigma experienced by HIV positive clients is fueled by the nature and process of service delivery at the clinics in Leribe district. For instance:

1. The labeling of patients' clinic card
2. The queuing of HIV patients at the gate by the security men when they visit for ARV
3. The whole idea of separating HIV positive patients from other patients
4. Isolating patients in designated areas (HIV clinics)
5. Not ensuring that ARV is available in all the clinics
6. Designating specific days to attend to HIV patients
7. And many others.

Eight out of the nine government clinics in Leribe district clearly distinguish between venues and times dedicated to HIV and HIV treatment. Clients who therefore publicly have to use these services can be identified by other clients. The rights of clients to confidentiality are therefore compromised and this has led to stigmatization. This study has revealed that 81.01% (418) of people who have enrolled for ARV in the government clinics in Leribe district experienced that the staff in these clinics treated them differently in terms of consulting rooms, treatments rooms, from HIV negative.

“What I hate most is the way the security people queue us separately from other patients at the gate whenever we come for ARV, they will say HIV patients this way, non HIV patients this way, later they will tell non HIV patients to go to the OPD while we go to HIV clinic section” (A woman aged 35 who is HIV positive reported during the data collection of this study at Leribe clinic on the 15th September 2009)

Figure 7: Frequency of stigmatization of HIV positive clients at the clinics in Leribe District.



The analysis of this study has shown that the respondents ranked labeling of hospital cards (HIV+) as the most (79.38%) negative experiences they have had at the PHC. It can also be observed that 58.99% of the respondents have experienced being treated separately from other normal out-patients in the clinics in Leribe. This shows that there is high level of separation of HIV infected individuals from non infected ones at the primary Health care in Leribe District. The graph has also shown that there is high level of discrimination of people living with HIV/AIDS at the primary health care, revealing that there is very high level of separation, discrimination, isolation, and labeling of hospital cards of people living with HIV and AIDS in the clinics in Leribe district. These statistics are evidence that health care systems are sources of stigma; howbeit inadvertently. The method of service delivery to HIV positive clients has increased the problem of the infection.

The level or degree of stigmatization of HIV positive clients at the clinic varies, depending on how one has contracted the infection and the attitude of Health workers who attend to these clients at the clinic (Asiedu, 1998:10).

The level of gossip experienced by the HIV positive clients at the clinic is high because if one adds up the percentage of responses 'often' experienced and 'always' experienced together, one will be able to see that PLWA experience high level of gossip at the primary health care clinics.

The people living with HIV and AIDS who visit the Primary health care in Leribe reported that they experienced the highest level of stigma in the areas of isolation, separation, labeling, and discrimination, result has also shown that they experience high level of gossips at the clinics while they experience low level of stigma in the areas of blame for HIV infection, denial of treatment, HIV testing without consent, revealing of HIV status without consent, rejection, violence, advise not to marry due to HIV status and advise not to get pregnant due to HIV status. The graphs above have presented different types and levels of stigmatization of HIV positive clients in the clinics in Leribe District.

- **Families and friends:**

In this study, 53.10% of the respondents reported that their friends, relatives and health care providers had gossiped against them due to their HIV positive status, while 46.90% said that people had not gossiped against them. This statistics has equally shown that HIV positive clients experience gossips more from their friends and families than from health workers.

Stigma is a common reaction to disease. Many diseases have carried some degree of stigma in the history such as Tuberculosis, cancer, Leprosy, Mental illness, many STD's, now HIV/Aids are among the most stigmatized diseases in the world (Brown, et al., 2001:12-14). The results of this study have revealed that 58.95% of the family members of the respondents reacted negatively to their HIV positive status, While 41.05% reacted positively in the sense that they still offered them some level of support.

According to the findings of this study, 29.63% of the respondents have been rejected by their families and friends due to their HIV positive status while 70.37% have not been rejected by either families or friends, this is because majority of this group have not disclosed their status to their so called families and friends (Refer to question 4) They have succeeded in going to the clinics far from their relatives and friends.

Majority of HIV positive people who have disclosed their status to their families and friends do not receive enough security and support from them. 52.13% of the respondents of this study revealed that their families and friends have refused to give them enough support due to their HIV status While 47.87% have received support from their families and friends.

Some families and friends do totally reject people living with HIV and Aids, but in this study 89.32% of the respondents are still staying with their family members though they had not received enough support. While 10.68% have been totally rejected and separated from their family members due to their status. 39.07% of the respondents who are still staying with their family members stated that their families had not treated them well, while 60.93% expressed being tolerated by their families. The high intensity of negative treatment or experience of people living with HIV and AIDS has led to a high incidence of HIV infection and many deaths.

Disassociation has been experienced by HIV positive clients, from husbands, wives, friends, health workers, community members, and neighbours due to HIV+ status. This study has revealed that 63.02% of people who had enrolled for ARV in the government clinics in Leribe district were no longer intact with their friends, because 53.71% of their friends were no longer associating with them due to their HIV infection. This ugly experience has led to the feeling of isolation of people living with HIV infection in their families, as this study has reported that 47.90% respondents feel isolated in their families, although 36.98% claim that they are still intact with their friends and 47.96% said that they had not felt isolated. In this study, 69.12% of the respondents believe that people had gossiped or talked about them at their back concerning their HIV status. 61.89% believed

that their friends gossiped about them most, 29.97% reported that their family members talked or gossiped about them most, and 7.17% insisted that the health care staff were the people who had gossiped or talked about them. Only 30.88% of the sample felt that people had not talked behind their back about their status and 0.98% of the sample did not respond to this question (Refer to question 4 in the questionnaire). It can be observed that the higher the intensity of stigmatization of HIV positive clients, the more reclusive, denial and refusal to co-operate with the campaigns to manage the HIV by the clients such as testing, disclosure of HIV status, use of condom, and adherence to treatment. This is a dangerous road to go in the fight against AIDS and for public health.

Based on these findings, this study has explored and described the levels of the stigmatization of HIV positive clients in Leribe district. Hence the research has achieved its second objective.

4.3.5 STRATEGIES SUGGESTED BY THE RESPONDENTS ON HOW TO REDUCE THE STIGMATIZATION OF HIV POSITIVE CLIENTS

The respondents were asked what they see that will be helpful to reduce the type and level of negative experiences at clinics which they attend for ARV. (Refer to question 9.1), and the summary of their responses include: more drugs, better staff attitudes to the patients, better time management, lengthy appointments, non separation of HIV positive patients from other patients, more staffing, better education of PLWA on how to care for themselves and prevent multiple infection, improve confidentiality, improve quality of counseling and better education and training for health workers on the care and relationship with HIV positive people.

Table 4.6: Suggestions on how to reduce HIV related stigma at the clinics.

Category	Respondent's suggestions
Counselling	<ul style="list-style-type: none"> • 10 (3.94%) suggested that quality counseling will reduce both the type and level of stigma experienced by HIV positive clients at the clinics and
	<ul style="list-style-type: none"> • 13 (5.12%) suggested that there should be improvement on confidentiality to reduce negative experiences of the PLWA at the PHC, • 12 (4.72%) finally suggested that educating health workers on the care and relationship with HIV infected patients will greatly reduce the stigmatization of HIV positive clients
Health systems	<ul style="list-style-type: none"> • 39 (15.35%) reported that they needed more drug to reduce their frequent visit to the clinic which exposes them to stigmatization and discrimination, • 47 (18.50%) suggested that the health workers should stop separating HIV positive patients from others for this alone will reduce the type and level of negative experiences they are facing in the clinic, • 23 (9.06%) suggested that educating people living with HIV/AIDs on how to take care of themselves will help to reduce the rate of stigma they experience because if they are able to manage themselves well, they will look good and people will stop calling them names. • 10 (3.94%) pointed out that more staffing will help to reduce their waiting time as people living with HIV infection has continued to increase.

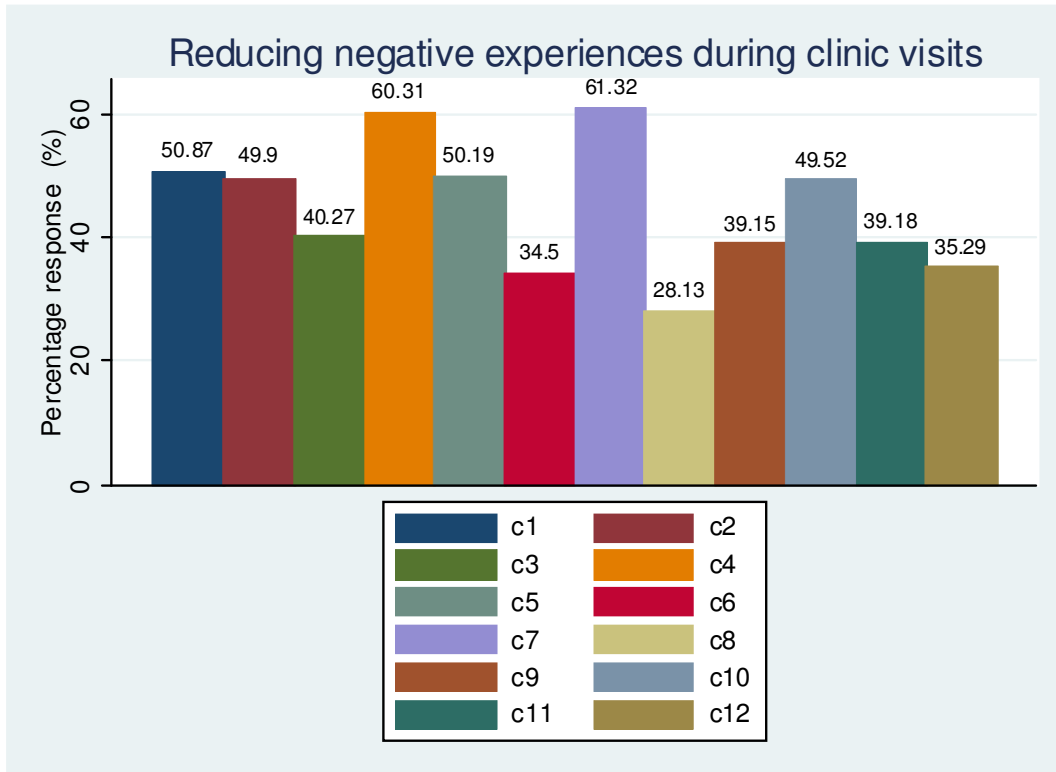
Health care providers	<ul style="list-style-type: none"> • 25 (9.84%) suggested that better staff attitudes will help to reduce the type and level of stigma experienced by the PLWA, • 48 (18.90%) expressed that better time management by the staff of the clinic will in no small measure reduce their suffering, • 27 (10.63%) stressed that lengthy appointments will help to reduce both the type and level of stigma they experience at the clinic and the time, energy and money they spend on transport every month and sometimes twice a month just to go and collect ARV. They suggested that they get the regimen that they can use for three months before they visit the clinic again for ARV,
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A study in San Francisco shows that with an increased, though improved information, education and communication (IEC), counseling services and government enacted policies, stigmatization and discrimination will likely reduce and this will positively affect the prevention and control of the HIV/AIDS pandemic especially in developing countries (Sseruwagi, et al, 1998). The health care workers should improve on confidentiality, improve their public posture and stop camouflaging services in order to alleviate the stigma experienced by PLWA within the primary health care facilities (Jackson, et al, 2006).

The study respondents were given options to tick any five most appropriate means of reducing negative experiences that they face at the clinic and their responses are demonstrated by the figure below. As one can see, 61.32% of the respondents suggested that educating PLWAs on how to protect themselves from multiple infection will to a large extent reduce the negative experiences of the PLWAs at the clinic. This option is followed by the provision of quality counselling to people living with HIV infection (60.31%) in terms of priority; from the most suggested to the least, educating health care providers on HIV/Aids, giving care and treatment to the PLWA was also suggested to be very important in reducing negative experiences of the PLWAs at the clinic as it ranked 50.87%. 50.19% of

the study sample suggested that improvement in the confidentiality of patients' health information will grossly reduce negative experiences of people living with the disease in question. 49.52% of the study population expressed that the clinic staff should stop treating HIV positive patients differently so as to reduce the stigmatization and discrimination that the infected and affected patients are suffering from. 49.9% of the respondents suggested that provision of guidelines on precautionary measure for providers and PLWAs will reduce stigma experienced by the PLWAs. 40.27%, 39.18%, 39.15%, 35.29%, 34.5% and 28.13% respectively of the study sample suggested that introduction of punitive measures for strong stigma, reduction of indiscriminate wearing of gloves when attending to patients, increase of the level of contacts with HIV patients, establishment of good relationship with patients and the use of positive images of HIV patients instead of negative images will reduce the stigmatization of HIV positive clients at the clinics in Leribe District.

Figure 8: Measures that will be helpful to reduce the stigmatization of HIV positive clients at the clinics.



Legend Interpretation

C1= Education of health care providers	C2 = Provision of guidelines
C3 = Introduction of punitive measures	C4 = Provision of quality counseling
C5 = Improvement of confidentiality	C6 = Establishment of good relationships
C7 = Education of PLWAs	C8 = Use of positive images
C9 = Increase in contact level with patients	C10 = Stopping of separate treatment
C11 = Reduction of indiscriminate glove wearing	C12 = Reduction of labeling

Health care providers can alleviate or reduce the level of stigma experienced by PLWA when they visit the health care centers by establishing warm and cordial relationships with their clients (people living with HIV and Aids), although this may take time it will build trust

which will obviously encourage patients to visit for care. Stigma related to HIV/Aids can be reduced through appropriate provision of services by competent culturally acceptable health workers in the health facilities (Jackson, et al, 2006; Nyblade, 2006).

Through regular support and refresher training, health care providers can be equipped with proper knowledge which will enhance the education of clients on how to protect themselves from multiple infections and how to manage their situations and reduce self stigmatization and all types and levels of stigmatization and discrimination of HIV positive clients at the clinics in Leribe District and everywhere in the world. Based on these, the researcher concludes that this study has described strategies that can be used to reduce the stigmatization of HIV positive clients in a primary health care context.

4.4 OVERVEIW OF THE RESEARCH FINDINGS

4.4.1 The research findings have highlighted the different types and levels of stigmatization of HIV positive clients at the clinics in the Leribe District.

It also highlights reasons why HIV patients prefer one clinic to another.

The study results revealed that HIV infected and affected people experience the highest level of stigma at clinics in the form of isolation, separation, labeling and discrimination. They also experienced a high level of gossip, but low level of stigma in the areas of blame, name calling, revealing of HIV status without consent, testing for HIV without consent, rejection and others in the clinics in Leribe district.

Violence: People living with HIV and Aids are experiencing violence at their homes, from their friends and also at the clinics from the health care providers, (verbal) this type of negative experience keeps people from disclosing their HIV status.

Poor/no care and support: The study results show that a good number of people living with HIV and AIDs do not receive care and support from their families, friends and health care givers and this is making them feel 'very bad' and sometimes causes them to take their lives.

Disowned Because of HIV positive status: A number of people living with HIV and Aids who have enrolled for ARV in the Government clinics in Leribe expressed that they have either been rejected or disowned by their husband, wife, father, mother, brother, friend, or

clinic staff. According to the responses the clinic staffs have ranked very low in disowning the PLWA.

Reveal HIV status without patients' consent: The study revealed that some clinic staff reveals their HIV status without their consent. (Refer to table 5 and figure7 of chapter 4). At the same time, it has proven that the clinic staff in Leribe still maintains some level of confidentiality. This is because the percentage response on this particular issue and the issue of **Denial of medical services** is low compared to studies carried out in other countries of the world such as Ghana and Nigeria just to mention a few(UNAIDS,2009).

Disassociation: Results of this study have shown that PLWA experience disassociation as a result of their HIV status. PLWA have experienced disassociation from families, friends' community members and clinic staff.

People living with HIV infection who have disclosed their status and have also enrolled for ARV sometimes do not adhere to the medication because of the antiretroviral (ARV) shortage at the clinics in Leribe thereby endangering their lives. Some clinics like Clinic H require more supply of ARV because they are very far from the major roads. The road to Clinic H is very bad and when it rains, nobody will be able to cross the river because the bridge is incomplete and water overflows, making the zone a death trap.

Study suggestions: The respondents of this study suggested that HIV patients should be given three months regimen, that is, the dose of ARV which will last for three months so that they will not be visiting the clinic too often, but when the researcher interviewed a nurse concerning this issue, the nurse responded that the ARV supplies for three months will not be available in that quantity. Moreover the patients do not adhere to their medication schedule and that is why they must visit the clinic monthly to enable staff to identify non-compliance early. The system policy makers should look into this so as to know how to mitigate the patients' suffering.

The results show that there is need to train, re-train and engage more health workers so that HIV patients do not spend the whole day at the clinic waiting for ARV coupled with the fact that they travel from far away places to the clinic where they think they feel comfortable to attend.

The study also suggests the need to improve the quality of counseling given to PLWA as this will help them to tear away the cloth of fear of stigma and be able to disclose their status to their partners.

The majority of the study participants suggested that educating PLWA on how to protect themselves from multiple infections is a very brilliant idea that should be carried out without wasting time. This suggestion is of the highest frequency of all the respondents' suggestions.

There should be improvement in the confidentiality of patients' information, health workers' attitudes and relationship with the HIV patients, level of contact with the patients and the use of positive images of HIV patients instead of negative images.

It is suggested that health care workers should wear gloves and mufflers as part of their dress code when treating all the patients and not only HIV patients. This will help to reduce the rate at which the health workers contract infections, go on sick leave and also reduce the rate of death of health workers as well as the rate at which people point fingers at them concerning stigmatization and discrimination of people living with HIV and AIDS.

Other clinics in Leribe should borrow a leaf from Matalameng Health centre on how to treat people living with HIV and Aids in terms of not treating HIV patients separately, not having separate pharmacy for HIV patients and not labeling their patients' cards. This guarantees some level of confidentiality.

Finally, the results of this study suggest that there should be provision of guidelines on precautionary measures for providers and PLWA as well as the implementation of punitive measures errant care- givers to stem stigma.

4.5 CONCLUSION

The fact that 83.85% of the study respondents complained that they have been stigmatized in the clinics in Leribe district when they visit for ARV, calls for urgent attention to handle this situation. The researcher therefore concludes that HIV positive clients experience stigma when they visit the clinics for ARV in the Leribe District.

The findings of this study have shown different types and levels of stigmatization of HIV positive clients at the clinics in the Leribe District. these include: Separate consulting and treatment rooms, isolation, discrimination, labeling of hospital cards, gossips, violence, rejection, low care and support, blame for HIV infection, indiscriminate wearing of gloves , revealing of patients HIV status without consent, carrying out HIV test without patients consent and disassociation. All these negative experiences have led HIV positive clients into refusal of disclose their HIV status, travelling long distances for ARV in the bid to hide or avoid stigmatization and discrimination. It has as well caused many deaths since high

risk group refuse to test and get treatment. Based on these findings, the researcher concludes that HIV positive clients experience different types of stigma at different levels at the clinics in the Leribe District of Lesotho.

The researcher concludes that, the several suggestions made by the study respondents on the strategies that can be used to reduce the type and level of stigmatization of HIV positive clients are appropriate and should be used timeously to combat this ugly situation. These strategies include: educating PLWA on how to protect themselves from multiple infection and the prevention of transmission, Lengthy appointment to the clinic (by giving patients 3months regimen of ARV), stop separating HIV patients from others, making ARV available, better time management by the clinic staff, better clinic staff attitude, more clinic staff, improvement in confidentiality, quality counseling, education and training of health workers on the care and relationship with the HIV patients, and avoidance in labeling the HIV patients' hospital cards.

This study has explored and described different types and levels of stigmatization of HIV positive clients at the clinics in Leribe. It has also described several ways that can be used to reduce the stigmatization of HIV positive clients at the clinics in the Leribe District.

Studies carried out in Nigeria, Ghana, Ethiopia, Vietnam and some other places (as one can see in the literature review) recorded that people living with HIV infection experience high level of denial of treatment, rejection, HIV testing without clients' consent, revealing of HIV status without clients' consent and violence at the clinics by the staff,

CHAPTER 5: CONCLUSIONS AND RECOMMENDATIONS

5.1 INTRODUCTION

In this chapter, the following aspects are discussed: research design, methods and interpretation of the study results. The conclusions and recommendations Contributions and the limitations of the study are also presented and discussed.

5.2. AIM AND OBJECTIVES

The aim of the study was to explore the type and level of stigmatization of HIV positive clients within the context of primary health care services. The study objectives were

- To explore and describe the type of stigma related to HIV and AIDS as experienced by HIV positive clients attending primary health care clinics in the Leribe district.
- To explore and describe the level of stigmatization as experienced by HIV positive clients attending primary health care clinics in the Leribe district.
- To describe strategies/ways that health care workers in a primary health care context can play to reduce the stigmatization of HIV positive clients.

5.3 RESEARCH DESIGN AND METHOD

Quantitative research design was used in this study because it is appropriate to explore the type and level of stigmatization of HIV positive clients who visit the primary health care in Leribe district. Questionnaire and oral interview were used to elicit information on the useful ways of reducing the stigmatization and discrimination of HIV positive clients at the clinics in Leribe.

The study population included 5200 HIV positive patients who had enrolled for ARV in the government clinics in Leribe district .The researcher selected a sample of 520 HIV positive clients using systematic convenience sampling method. The researcher interviewed at least one staff from each of the study clinics after data collection from those clinics since the researcher was always assisted by one clinic staff from these clinics. This oral informal interview was used to check the consistency of the client's responses.

Data was collected using questionnaire and informal interview (Refer to chapter 3). The completed questionnaire was collected the same day by the researcher to minimize loss as well as bias.

A pre-test of the questionnaire was done in Botha Bothe district which is a different district from the study area but with similar sample which included people living with HIV/AIDS who have enrolled for ARV at the government clinics. This was done to ensure the validity and reliability of the instrument (questionnaire). The questions were translated from English language to Sesotho which is the local language of the respondents by a local Sesotho teacher who holds a master's degree in sesotho and quite fluent in English Language too. The Sesotho version of the questionnaire was then translated back to English language to ensure reliability by another language expert. The researcher repeated items in different formats in the questionnaire to be able to study the consistency of the responses of the study samples and this ensured the validity and the reliability of the study findings.

Since the study involved human subjects (HIV positive clients who are on ARV), the researcher adhered to a strong ethical code of conduct by obtaining a clearance from the Ministry of Health and Social welfare Lesotho (see annexure C) which was given to the District Medical Officer Leribe and the matron as protocol demanded. The researcher as well sought the consent and explained to the participants their rights of voluntary participation before the actual commencement of the study. The study ensured privacy, anonymity and confidentiality by arranging a room where the respondents were interviewed and completed the questionnaires. High level of confidentiality was maintained in this study right from the construction of the questionnaire, there was no provision for the HIV positive clients to write their names or phone numbers, interview and the completion of the questionnaire was done face to face, camera and recorder were not used in data collection and researcher's cell phone was switched off during the interview and completion of the questionnaire to maintain confidentiality.

This research work took two academic years; (2008-2009) the research proposal was approved in 2009; it took approximately two weeks to process the permission to carry out the study by the Ministry of Health. The study sample was drawn within one week, the pre-test of the questionnaire was done in one day, and the actual collection of the data was

done in a whole two stressful weeks, followed by one month of data analysis and another month of presentation, interpretation and all the scientific writings.

5.4 SUMMARY AND THE INTERPRETATION OF THE RESEARCH FINDINGS

The study result has shown that HIV infection has affected both male (23.65%) and female (76.35%) of all age groups, married, never married, divorced and widowed (refer to tables 4.1 and 4.2). HIV /AIDS is a threat to the welfare and well-being of people throughout the world (Fredrikson and Kanatus 2008). Based on the result of this study, the number of females who have enrolled for ARV in the government clinics in Leribe out numbered the males suggesting that the females are more open in disclosing their status and seeking for medical treatment than the males. The number of widows who participated is high (22.88%) and is likely to increase, many HIV infected people who visit the clinics in Leribe are married (43.46%) and this is why there is low level of stigmatization on the issue of blame for HIV infection at the clinics. The level of divorce due to HIV/AIDS is a bit low among married HIV positive clients who have enrolled for ARV in the clinics in Leribe.

HIV positive clients (83.85%) who visit the government clinics in Leribe for ARV experience the following types of stigma which are presented chronologically: labeling of hospital cards, consulting and treating separately from other patients, discrimination, isolation, gossiping, wearing of gloves and mufflers when attending to patients by the staff, blame for HIV infection, advice not to get pregnant, rejection and violence (refer to table 4.4). This result, is in line with the result of the study of 1000 physicians, nurses and midwives conducted in Nigeria in 2002 which reported that one out of 10 doctors accepted having refused to care for an HIV/AIDS client or had denied HIV/AIDS persons admission to the hospital. The result of this study is not far from similar studies carried out in other countries of the world such as a study conducted in Ethiopia which explored the attitudes and behaviors of physicians and nurses toward people living with HIV/Aids, which revealed that 85% of physicians and 83% of nurses stigmatized against PLWA due to fear of contagion (USAID & INTRA HEALTH 2007).

5.4.1 Objective 1: To explore and describe the types of stigma related to HIV/AIDS as experienced by HIV positive clients attending clinics in Leribe District.

The research findings highlight the different types and levels of negative experiences of the people living with HIV/AIDS at the primary Health care context (refer to table 4.5 and figure 3 in chapter 4 for statistics). It also highlights reasons why HIV patients prefer one clinic to another.

Majority of the clinics in Leribe have specific days when they consult and give ARV to HIV positive clients and the entire community is aware of these days. This makes HIV patients very uncomfortable to go to the clinics near their homes for ARV because every body will know their status and will start to stigmatize them. High percentage of the respondents of this study admitted that they travel from very far distances (refer to figure 1 in page 61) to go to clinics for the reasons that their relatives and friends will not know their HIV status if they go far. This study discovered that the HIV positive clients travel as far as 50km to Leribe for ARV by-passing several clinics before the one they are attending. People living with HIV and Aids prefer going to clinics where their friends will not see them, where the staff gives them care, where medication is mostly always available, where they feel comfortable, and where the clinic is not close to their home. (Refer to figure 2 in chapter four for evidence).

The findings of this study revealed that 83.85% of the respondents (HIV positive clients) have experienced stigma at the clinics in the Leribe District. The types of stigma experienced by HIV positive clients include: Discrimination, isolation, separation, labeling, wearing of gloves and mufflers only when attending to HIV clients, gossips, name calling, blame for contracting HIV, violence, loss of respect, denial of treatment, lots of insults, revealing test result to relatives without consent and being tested without consent. Based on the above findings, the researcher concludes that HIV positive clients experience different types of stigma at the clinics in Leribe district when they visit for ARV, therefore the first objective of this study has been achieved.

5.4.2 Objective 2: To explore and describe the level of stigmatization of HIV positive clients at the clinics in Leribe District.

The study respondents revealed that they experience the highest level of stigmatization in the areas of isolation, separation, labeling and discrimination. The HIV positive clients also

experience high level of gossip, but low level of stigmatization in the areas of blame, name calling, revealing of HIV status without consent, testing for HIV with out consent, rejection, disassociation and others in the clinics in Leribe district as refelected in figure 5 &7 in chapter 4.

The level of rejection, blame for infection, and advice not to marry are low among the HIV positive clients in Leribe which may be because there is high percentage of married, and widowed than never married and divorced.

Separation, discrimination, isolation and labeling have been experienced by HIV positive clients at the highest level at the clinics in Leribe District (refer to figure 5, 6 and 7). According to the result of the study, there is still some level of confidentiality and care for the HIV positive clients in Leribe District unlike other places of the world based on study results. The respondents reported that the denial of treatment, revealing of HIV status, testing clients for HIV without their consents and lots of insults have been experienced though in a low level.as reflected in figure 5. This study has reported the indiscriminate wearing of gloves among health workers when treating HIV positive patients in a very low percentage (refer to figure 5 in page 75). This is because, the respondents expressed that in as much as the health workers are caring for them they should as well protect themselves from the infection by wearing gloves and mufflers.

Consulting and treating HIV positive patients separately from other patients: The respondents who participated in this study revealed that majority of the health care givers at the primary health care centers consult and treat HIV patients separately, and as a result, this affects the rate at which people decide to go for tests, disclose their status and seek care. This is costing the PLWA and the nation the much needed manpower resources and lives. The level of separation, isolation and discrimination of people living with HIV/Aids are recorded more at the clinics in Leribe than at homes. The respondents reported that they are queued separately at the gate, consulted and treated separately by separate doctors, nurses and pharmacist in a different building.

The nurses are very slow to attend to HIV patients making them to stay at the clinic the whole day for ARV collection, health workers reveal patients HIV status without client's consent. Health care workers highly gossip against HIV positive patients but clients experience low level of blame for their HIV infection from the clinic staff (refer to table 4.5 and figure 7).

The researcher therefore suggests that the health workers can make the wearing of gloves and mufflers part of their dressing code; just as doctors wear apron and stetoscope to treat

all patients as this will help to ensure their safety and reduce the idea of stigmatization of HIV positive clients.

Based on the findings of this study, the researcher concludes that HIV positive clients experience different levels of stigma in the clinics in Leribe District. Thus, the second objective of this study has been achieved.

5.4.3 Objective 3: To describe ways and strategies that health workers in a primary health care context can use to reduce the stigmatization of HIV positive clients

Majority of the study respondents suggested that educating PLWA on how to protect themselves from multiple infections is a very brilliant idea (refer to figure 8 and table 4.6) that should be carried out without wasting time as this will help in the prevention of new cases as well as control of HIV and AIDS. This can be carried out through workshops, seminars and community-level campaigns.

The respondents of this study have suggested several strategies that can be used to reduce the stigmatization of HIV positive clients at the clinics. The figure 8 of chapter 4 of this study has shown all the strategies.

The study participants expressed the need for improvement in the confidentiality of clients' information, health workers' attitudes as well as the care giver-client relationship and level of contacts with the PLWA. Based on the study findings, the researcher concluded that health workers in the primary health care can play many roles to reduce the stigmatization of HIV positive clients at the clinics in Leribe District.

Sumarily, the findings of this study revealed that HIV positive clients experience different types and levels of stigma when they visit clinics in Leribe District (refer to tables 4.4 and 4.5, as well as figures 3, 4, and 5 in chapter 4).

Figure 8 of chapter 4 has demonstrated the findings of this study concerning the strategies to reduce the stigmatization of HIV positive clients at the clinic.

The study conclusions are:

- Based on the findings of this study, the researcher concludes that HIV positive clients experience different types of stigma at the clinics in Leribe district. Therefore, objective 1 of this study has been achieved.

- The researcher concludes based on the findings that HIV positive clients experience different levels of stigma at clinics in the Leribe District. The levels range from highest, high, and low. The types of stigma that are experienced at highest level in the clinics in Leribe include: separation, labeling, isolation and discrimination. Gossip is experienced at the high level while blame, name calling, testing for HIV without patients consent, revealing HIV status without patients consent are experienced at the low level. Therefore objective 2 has been achieved.
- Based on the findings of this study, the researcher concludes that there are many strategies that can be used to reduce the stigmatization of HIV positive clients at the clinics in Leribe district. Based on the findings, the researcher has achieved all the objectives of this study, glory to God.

Summary of the study recommendations include:

- The researcher recommends that HIV positive clients should be given quality counseling, and there should be improvement in the confidentiality of client's health information
- The study recommends that wearing of gloves by the clinic staff should be made a dressing code instead of wearing it only when treating HIV positive clients.
- It further recommends that the clinic staff should reduce the level of separation, labeling, isolation and discrimination of HIV positive clients at the clinics
- The government, public Health, policy makers and planners should utilize the findings of this study in the areas of improving the policies governing primary health so as to reduce the stigmatization of HIV positive clients. They should educate both the clients and the health workers on the how to care for people living with HIV infection
- The Ministry of Health should prepare a chart highlighting all stigma types and their effects on the clients and public health. This should be pasted on all the bulletin boards, consulting rooms and wards of all the clinics to serve as a warning signal and reminder for health workers to reduce stigma.

5.5 CONCLUSIONS

The findings revealed that the most common types of stigmatization of the HIV positive clients visiting the Government clinics in Leribe District included separation, isolation, labeling and discrimination. Recommendations to reduce the stigma within a community

based primary health care facility have been suggested by the respondents. These include the integration of HIV-related activities into the “normal” and everyday activities of a clinic, the attitudes and knowledge of nursing staff and the consistent availability of ARV treatment.

The result of this study has described the types of stigmatization of HIV positive clients who visit the primary health care in Leribe District, which include: Separate consulting and treatment rooms, isolation, discrimination, labeling of hospital cards, gossips, violence, rejection, low care and support, blame for HIV infection, indiscriminate wearing of gloves and muffling, revealing of patients HIV status without consent, carrying out HIV test without patients consent and disassociation. All these negative experiences have led the HIV positive clients into refusal to disclose their HIV status, travelling from one district to the other for ARV in the bid to hide or avoid stigmatization and discrimination. It has as well caused many deaths since high risk group refuse to test and get treatment. Based on the findings of this study, the researcher concludes that HIV positive clients experience different types and levels of stigma at the clinics in the Leribe District. Consequently, the researcher has achieved the objectives of the study. Such as explore and describe the types of stigma related to HIV/AIDS as experienced by HIV positive clients attending clinics in Leribe District and to explore and describe the level of stigmatization of HIV positive clients at the clinics in Leribe District.

The study respondents have made several suggestions which can be used to reduce the stigmatization of the HIV positive clients at the clinics such as educating PLWAs on how to protect themselves from multiple infection and the prevention of transmission, Lengthy appointment to the clinic (by giving patients 3 months regimen of ARV), stop separating HIV patients from others, making ARV available, better time management by the clinic staff, better clinic staff attitude, more clinic staff, improve confidentiality, quality counseling, educate health workers on the care and relationship with the HIV patients, and reduce the rate of labeling the HIV patient’s hospital cards. Strategies to reduce the stigmatization of HIV positive clients at the clinics have been recorded in the findings of this study. Based on these findings, the researcher therefore concludes several strategies are available to reduce the stigmatization of HIV positive clients at the clinics in the Leribe district. It therefore, proves that the final objective of this study has also been achieved.

5.6 RECOMMENDATIONS:

Recommendations to reduce the stigma within a community- based primary health care facility were suggested by the respondents. These include the integration of HIV-related activities into the “normal” and everyday activities of a clinic, the attitudes and knowledge of nursing staff and the consistent availability of ARV treatment. The study recommends that coded text messages can be developed and used between health care workers and their HIV clients to determine the state of health and quantity of ARV remaining so that the health worker can deliver the ARV to the clients to save them transport and reduce the level of exposure instead of giving the patients three-month regimen as they are requesting because this can lead to wastage, abuse and non-adherence. Government can assist by hiring and training more health care workers and supplying the clinics with more vehicles for this purpose.

Furthermore, The government, Public Health, policy makers and planners should utilize the findings of this study in the areas of improving the policies governing primary health care so as to reduce the stigmatization of HIV positive clients.

The Ministry Health should prepare a chart highlighting all stigma types and their effects on the clients and public health. This should be distributed and pasted on all the bulletin boards, consulting rooms and wards of all the clinics to serve as a warning signal as well as reminder to health care –givers to reduce stigma.

Based on the findings of this study, the researcher recommends the training and staffing of more health workers so that HIV patients do not spend the whole day at the clinic waiting for ARV coupled with the fact that they travel from far away places to the clinic where they think they feel comfortable to attend.

The researcher recommends that HIV positive clients should be given quality counselling, and there should be improvement in the confidentiality of clients’ health information. This will help the clients tear away the cloth of fear of stigma and be able to disclose their status to their partners.

It is further recommended that the clinic staff should reduce the level of separation, labeling, isolation and discrimination of HIV positive clients at the clinics by intergrating them into the normal, everyday health service delivery system. They receive their ARV regimen as every normal drug is administered.

The researcher recommends that there should be improvement in the attitudes and relationship of the Health workers and HIV positive clients, level of contact with the patients and the use of positive images of HIV patients instead of negative images.

It is equally recommended that health care workers should wear gloves and muffler as part of their dress code when treating all the patients and not only HIV patients. This will help to reduce the rate at which the health workers contract infections, go on sick leave and also reduce the rate of death of health workers as well as the rate at which people point fingers at them concerning stigmatization and discrimination of people living with HIV and AIDS.

The researcher recommends that other clinics in Leribe should borrow a leaf from Matalameng Health centre on how to treat people living with HIV and Aids in terms of not treating HIV patients separately, not having separate pharmacy for HIV patients, not labeling their hospital cards. This guarantees some level of confidentiality.

Furthermore, HIV positive clients should be educated on how to protect themselves from multiple infections through workshops, community level campaigns and enriched counselling, because this will help in both the reduction of infections and the management of the infected individuals.

The government and all concerned should make ARV always available at all the clinics in Leribe district since patients depend on ARV for life and need to adhere to the treatment. ARV has greatly improved the life of people living with HIV infection but as the demand increases there is need for more supply to prevent early deaths.

The study recommends that further to the provision of guidelines on precautionary measures for care- providers, punitive measures should be introduced to discipline offenders to serve as a deterrent to others.

The government, public health, policy makers and planners should utilize the findings of this research to amend and improve their policies and programs concerning the fight against HIV infection.

HIV positive clients who have disclosed their status and have also enrolled for ARV some times do not adhere to the medication because of the antiretroviral (ARV) shortage at the clinics in Leribe thereby endangering their lives. This requires urgent attention.

5.7 CONTRIBUTIONS OF THE STUDY

This study has contributed to the knowledge of the type and level of stigmatization of HIV positive clients who visit the primary health care. Different studies have revealed different types of HIV related stigma but this study has shown both types and levels of stigmatization and discrimination of HIV positive clients at the clinics.

The findings of this study will go a long way in guiding the, government, policy makers, public health administrators and planners in making policies that will help to reduce the stigmatization of HIV positive clients at the clinics (primary Health Care).

1. It will create awareness to the health policy makers on the needs, and desires of the HIV positive clients, so that adequate plans can be made to address these concerns.
2. Based on the results and the recommendations of this study, the policy makers can face the challenge of making a policy that all health workers should wear gloves as part of their dressing code when attending to all patients at the clinic (instead of wearing gloves only when attending to the HIV patients). Since a policy like this will reduce the rate at which the health care givers are contracting infections which results to frequent sick leaves and early deaths of health workers. It will as well reduce the negative feelings of people with HIV infection on the issue of glove wearing by the health workers.
3. Results of this study have shown that there is great need to make ARV available in all the clinics, because many clinics are not offering ARV and the ones that are offering ARV are facing shortage of medication, which is affecting patients' adherence to the medication which in turn cost people their lives. Therefore this study is an eye opener to the government in the sense that it has helped to discover areas of people's need.
4. People travel to far distance in search of ARV, while others travel to very far places due to the fact that they do not want their relatives and friends to know their HIV status which is not in any way helping in the prevention and control of HIV pandemic, this study has reported strategies that can play role in the reduction of the stigmatization of HIV positive clients , hence the global fight of HIV and AIDS will never be won until the stigma experienced by people living with HIV/AIDs are drastically reduced at the primary health care context.
5. This study has recommended many ways that can be employed to reduce the type and level of stigma experienced by the PLWA when they visit the primary health care which include: training and staffing more health workers, educating PLWAs on how to protect

themselves from multiple infections, provision of quality counseling to the PLWAs, educating health care providers on HIV/AIDS, care and treatment of people living with HIV infection, improvement of confidentiality of patients' information and many others.

6. This study has recorded 4.6% of people on ARV who are over 65 years such as 74 year and 83 year old people on ARV), therefore further studies are required to find out the age at which such people contracted HIV as well as the mode at which they contracted (transmission) HIV infection to enable policy makers to plan adequately for people of their age bracket.
7. Further studies should be carried out to explore reasons why the primary health care givers prefer specific days to attend to HIV patients.

5.8 LIMITATIONS TO THE STUDY

Quantitative research design was used in this study which has its strengths and weaknesses as other designs. The data were collected only from the government clinics which offer ARV to people living with HIV and AIDS in Leribe District. The private and non governmental primary health care providers were not included in the study sample .Based on this; the findings of the study may not be generalized to the entire country's health care system because the study could not explore the type of stigmatization of HIV positive clients at the private and non governmental clinics in Leribe District.

However this study had a large sample size which is a representative of the study population and suggest that the findings can be generalized, study participants do not necessarily represent different cultural groups of Lesotho which may have contributed to the low level of stigmatization of HIV infected patients in such areas as denial of treatment, rejection, violence, exposure of HIV status without patients consent, testing for HIV without consent, advise not to marry due to HIV status and advise not get pregnant due to HIV status which other studies carried out in other countries have recorded as high.

The fact that most of the clinics in the study area had different specific days in a week when they attend and offer ARV to the HIV clients gave the researcher a great problem of visiting the clinics severally which increased the cost of the study.

In as much as the questionnaire was translated to the local language of the respondents, the researcher still did not find it very easy relating with the study participants and she employed a local person who helped her in introducing her to the study sample and telling

the participants their rights to voluntary participation and the essence of the study when the researcher must have spoken in English language. Language problem may have introduced information bias to the study.

5.9 CONCLUDING REMARKS

The distancing of HIV positive persons and the designation of specific areas for the preferred service provision for people living with HIV infection in the primary health care centre (clinics) and hospitals which the entire public is aware of, is affecting the number of people going for both testing and treatment. The stigmatization of HIV positive clients has become a stumbling block on the prevention and control of HIV pandemic as it has led to negative behaviours of refusing HIV testing, disclosing ones status, condom use, and care - seeking upon diagnosis which has caused multiple increase of new cases of HIV and early deaths.

The government and public health efforts to combat HIV and AIDS will continue to be frustrated until the stigmatization and discrimination of HIV positive clients is reduced to the bare minimum at the grassroot level (PHC). It is also very important that the government plan and carry out regular community based campaign with which they educate the general public on matters concerning HIV and Aids.

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**Annexure 3: Consent: Request to the Ministry
University of South Africa (UNISA),
Department of Health studies,
In fulfillment of the masters of public Health,
Researcher: Mrs. Ekeji. N. I.
Supervisor: Prof. S.P.Human,
Assistant supervisor: Dr B. I. Dolamo,
19th August, 2009.**

**The Director General,
Ministry of Health and Social Welfare,
Maseru, Lesotho.
Dear Madam,**

A letter for consent to carry out a research in the nine Government primary health care centers in Leribe district who are offering ART services.

To fulfill the requirements for the degree Master in Public Health which I follow at the University of South Africa, I also have to complete a research project for which I kindly request your permission.

Topic: Stigma experienced by PLWA visiting the PHC in L District.

This study will explore the types and levels of stigma experienced by people living with HIV and AIDS as well as explore ways that the health workers in the primary health care context can help to alleviate stigma experienced by people infected with HIV.

The proposal as approved by the ethics and research committee of UNISA is attached for your information.

Please note that the highest level of ethical rigor and confidentiality will be maintained throughout the study, especially because of the sensitivity around HIV and Aids. Respondents will participate on a voluntary basis and no information will be linked to any name or to a name of the clinic.

I am of the opinion that the outcomes of the study will be of value to both staff and people living with HIV and Aids.

My request is to kindly allow me the following:

- **Access to the nine clinics to enable me access to the study population, namely clients who visit these clinics for ARV treatment**
- **A room in or near the clinic where a confidential interview with a client can be conducted**

Your positive response will be highly appreciated.

My contact details are:

uzomaekeji@yahoo.co.uk

Cell phone numbers: 0735152052 /+266 63119261.

With kind regards

Mrs. Ekeji N.I.

Student number: 34940820.

**Annexure 4: LETTER OF APPROVAL TO CARRYOUT THE STUDY, FROM THE
MINISTRY OF HEALTH AND SOCIAL WELFARE LESOTHO**



Ministry of Health and
Social Welfare
P.O. Box 514
Maseru 100

03 September, 2009

Mrs Ekeji N. I
University of South Africa (UNISA)
Department Health Studies

Dear Mrs Ekeji

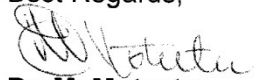
Re: Stigma Experience by PLWA Visiting the PHC in Leribe District.

Reference is made to your letter requesting ethical approval of the above mentioned study.

The Ministry of Health and Social Welfare Research and Ethics Committee having reviewed your protocol hereby authorizes you to conduct this study among the specified population. The study is authorized with the understanding that the protocol will be followed as stated. Departure from the stipulated protocol will constitute a breach of the permission.

We are looking forward to have a progress report and final report at the end of your study.

Best Regards,



Dr. M. Moteetee
Chairperson Research and Ethics Committee
Director General
Health Services

Annexure 5: Consent: Request to the study respondents requesting them to participate in my study.

University of South Africa (UNISA),
 Department of Health studies,
 In fulfillment of the masters of public Health,
 Researcher: Mrs. Ekeji. N. I.
 Supervisor: Prof. S.P.Human,
 Co-supervisor: Dr B. I. Dolamo,
 28th July, 2009.

Dear Sir/Madam/Miss,

A letter requesting for your consent to participate in my study.

I am a post graduate student of the University of South Africa (UNISA) and to complete my degree I also need to complete a research project.

If you agree to participate in a confidential interview with me on the types and levels of stigma experienced by people living with HIV and Aids, you will assist us to understand better how and why you may experience stigma and enable us to determine areas where stigma can be addressed in clinics such as the one you use to get your medication.

Your participation is totally voluntary. All information is confidential and will remain confidential. You are free to withdraw from the interview at any stage and if the interview is causing any psychological uneasiness or trauma, I have the services of a counselor available for you to use free of charge.

If you sign this consent form, it means that

- you experienced no pressure from me or anybody else to participate, but you do so voluntarily
 - you understand the reason for the research
 - you understand the topic of the research
 - you understand the process of research
 - you understand that you may withdraw at any stage
 - you understand that no information will be linked to your name and will remain confidential
- You can contact me at any time at the following number: 0735152052 /+266 63119261.

Thanks for your anticipated co operation.

Mrs. Ekeji N.I.

Signature of participant

Date:

Annexure 6: Questionnaire: English version.

**University of South Africa
Department of Health Studies**

**Research TITLE: STIGMA EXPERIENCED BY PLWA VISITING THE PHC IN L
DISTRICT.**

**The aim of the study is to explore the type and level of stigma experienced by
PLWA who visit the PHC in Leribe district.**

Researcher: Mrs. N.I. Ekeji

Supervisor: Prof. S.P. Human

Assistant supervisor: Dr BL Dolamo

**The questionnaire will be filled in or completed by the researcher as she orally
interviews the respondents, this is because some respondents may not be able to
read and write. But the study participants who can read and write can complete the
questionnaire as the researcher interviews them.**

1. Biographical data

1.1 Please complete your biographical data below.

Gender: Are you male or female?

	Tick when applicable.
Male	
Female	

Marital Status: Are you married, never married, divorced or widowed?

	Tick where applicable
Married	
Never Married	
Divorced	
Widowed	

Place of resident: Are you living in Leribe, if yes are you living within 20klm from this clinic? Or you live in another district.

	Tick where applicable
Live in Leribe district	
Live within 20klm from the environment of this clinic Leribe	
Live in another district	

Age: What is your age on your last birthday?

	Tick where applicable
Under 15years	
15-24 years	
25-34 years	
35-44 years	
45-54years	
55-64years	
65years and above	

2.1 Why do you prefer coming to this clinic for antiretroviral treatment?

Reasons	1 I total ly disag ree agree	2 I someti mes disagr ee with this statem ent	3 I do not know	4 I sometime s agree with this statement	5 I totally agree with this statem ent
It is far from me,					
Does n't want relati ves to know HIV statu s					
Does n't want friend s to know					

HIV statu s					
It's bad to go to PHC near home since there is no confi denti ality					
My home is far from here					
Do not know any other PHC which offer ARV					
It is close to my					

home					
The staff is friendly and helpful					
There is always medication available at this clinic					
My friends also visit this clinic					
I feel comfortable to visit this clinic					

Any other reason? Please write it down					

3.1 HIV Status

3.1 How long have you known that you are HIV positive?

Duration	Tick when applicable
Less than 1 month	
1 month to 11 months	
1 year to 3 years	
Longer than 3 years	

3.2 How long have you been attending this PHC for your ARV treatment?

Duration	Tick when applicable
Less than 1 month	
1 month to 11 months	
1 year to 3 years	
Longer than 3 years	

3.2 Have you been attending this PHC before you were treated with ARV's?

Yes

No

3.3 If yes, for how long have you been attending this clinic?

Duration	Tick when applicable
1. Less than 1 month	

2. 1 month to 11 months	
3. 1 year to 3 years	
4. Longer than 3 years	

3.4 How long have you been using ARV treatment?

Duration	Tick when application
Less than 1 month	
1 month to 11 months	
1 year to 3 years	
Longer than 3 years	

4.1. Type of negative experiences felt by the respondent.

4.1 Do you experience that people sometimes gossip against you? Yes/No

4.2 Do you experience that the staff in this clinic treat you differently from people who are HIV negative? Yes/No

4.3 Do you feel isolated and alone because you are HIV positive? Yes/No

5.1. Frequency of the type of stigma (negative experiences).

Type of stigma	1. Never experienced this type of stigma	2. Experienced this type of stigma in isolated incidents-seldomly	3. Often experience this type of stigma regularly but not always	4. Always experience this type of stigma
Have you been rejected? If yes, by who? Rejection				
Have you been isolated? If yes where? And by who/ Isolation				
Have you experienced Separation? Where? And by who?				

<p>Have you been discriminated against? Where? And by who?</p>				
<p>Has anyone Gossiped about you due to your HIV status?</p>				
<p>Have you been Treated separately from HIV-negative patients in the PHC?</p>				
<p>Has your Hospital card been labeled HIV positive?</p>				
<p>Have you experienced any Name calling due to your HIV status?</p>				

<p>Have you Been tested for HIV without your consent? if yes where?</p>				
<p>Has any one revealed your HIV status without your consent? If yes who and where?</p>				
<p>Are Health providers wearing gloves when giving you injections?</p>				
<p>Are health providers Wearing muffling when providing care to you?</p>				
<p>Have you been advised not</p>				

<p>to marry because you are HIV positive? If yes by who and where?</p>				
<p>Have you been advised not to get pregnancy because you are HIV positive? If yes by who and where?</p>				
<p>Have you been Blamed for contracting HIV? If yes by whom? And where?</p>				
<p>Have you been Denied treatment in the PHC? If yes by whom?</p>				
<p>Have you experienced</p>				

any form of violence as a result of your HIV positive status? if yes from who?				
--	--	--	--	--

6. Ranking of type of stigma (Level of stigma).

5. 6.1. State the two most negative experiences that you have had due to your HIV status.

1.

2.

6.2 Have you experienced any of the following as a result of your HIV status in this clinic? Yes/No. if yes tick the three that made you feels very bad.

Type of stigma	Ranking order
Denial of treatment	
Isolation	
Rejection	
Labeling	
Name calling	
Blame for contracting HIV	

Separate treatment rooms, consulting rooms and word	
Lack of confidentiality	
Discrimination	
Violence	
Gossips	
Loss of respect	
Lots of insult	
Been tested without consent	
Revealing test result to relatives without consent	
Wearing of gloves and muffling when giving injection	

6.3 List practices that make you feel bad when you visit this clinic for ARV:

- 1.....
- 2.....
- 3.....
- 4.....
- 5.....

6.4 Have you experienced these practices from this clinic? Yes/No. If yes how bad have you felt?

Type of negative experiences	Yes	No	Bad	Very bad	Can't explain

Denial of treatment in this clinic					
Blame for HIV infection					
Isolation from HIV - patients					
Consulting and treating separately from HIV- patients					
Labeling of hospital cards as (HIV +)					
Marking of admission beds as(HIV +)					
In discriminate wearing of gloves when giving injections					
Revealing of HIV status without your consent					
Carrying out of HIV test without your consent					

6 Reactions from families and friends.

7.1. What are the reactions of your family members regarding your HIV positive status?

Positive OR Negative

7.2 Have you been rejected by family and friends due to your HIV status? Yes/No

7.3 Do you receive enough support from your family and friends? Yes/No

7.4 Are you still staying with your family members? Yes/No

7.5 Are they treating you well? Yes/No

7.6 Are your friends still associating with you as before your HIV positive status? Yes/no

7.7 Do you feel isolated in your family? Yes/No

7.8 Are you still intact with your friends? Yes/No

7.9 Do you feel that people are talking about you behind you? Yes/No

7.10 If yes who are those talking about you most? Friends, Family members, OR Health care givers?

6. Have you experienced any of the following due to your HIV status?

Stigma	Yes	No	Where	By whom
Violence;				
No care and support				
Gossips				
HIV is a punishment for your immoral behavior				

Family disowned you				
Reveals HIV status without consent				
Denial of medical services				
Discrimination				
Disassociation				
Rejection				
Separation from non HIV positive patients				

9. Measures that can be used to reduced the type and level of stigma experienced by people living with HIV/AIDS at the primary Health care context.

9.1 What do you see that will be helpful to reduce the negative treatment that you are experiencing in this clinic?

1.
2.
3.
4.
5.
6.
7.
8.
9.
10.

9.2. Tick any five of the following which you feel will be most appropriate to reduce the negative experiences of PLWA at the clinic.

Way forward	Tick
Educating health care providers on HIV/AIDS, giving care and treatment to PLWA	
Provide guidelines on precautionary measures for providers and PLWA	
Introducing punitive measures for stem stigma	
Provision of quality counseling to people living with HIV infection	
Improvement in the confidentiality of patients information	
Establishment of good relationship with patients, example greetings, good rapport	
Educating PLWAs on how to protect themselves from multiple infections	
Using positive images of HIV patients instead of negative images	
Increase the level of contacts with HIV patients' example visitation.	

Stop treating HIV patients separately	
Reduce indiscriminate wearing of gloves when attending to HIV patients	
Reduce the rate of labeling people with HIV infection	

Annexure 7: Questionnaire: Setsotho version.

University of South Africa

Department of Health Studies

Sehlooho sa Phuputso: SEKHOBOTHO SEO BATHO BA PHELANG LE AIDS BA E TELANG LEFAPHENG LA BOPHELO (TLILINIKING) LA SETEREKE SA LERIBE BA BANG LE SONA

Sepheo sa thuto ena ke ho fuputsa mekhoha le maemo a sekhobotso seo batho ba phelang le Aids lefapheng la bophelo seterekeng sa Leribe ba bang le sona.

Mofuputsi: Mrs N.I. Ekeji

Motataisi: Prof. S.P. Human

Mothusi oa Motataisi: Dr. B.L. Dolamo

Lipotso tsena li tla tlatsa le ho phetheloa ke mofuputsi ha a buisana le baarabi, hona ke hobane babang ba baarabi ba kanna ba sitoa ho bala le ho ngola. Empa baarabi ba ka tsebang ho bala le ho ngola ba ka tlatsa lipotso nakong eo mofuputsi a ntseng a buisana le bona.

LITABA TSE AMANG MOARABI

Ka kopo tlatsa litaba tse u amang

Botona / Bots'ehali: Na u motona kapa u mots'ehali?

	Ts'oea moo ho lokelehang.
Botona	
Bots'ehali	

BOEMO BALENYALO: Na u nyetse / u nyetsoe, ha u kaba oa nyala / nyaloa, u hlalile / u hlaliloe kappa u shoetsoe ke molekane?

	Ts'oea moo ho lokelehang
U nyetse / nyetsoe	
Ha u ka ba nyala / nyaloa	
U hlalile / hlaliloe	
U shoetsoe ke molekane	

Sebaka sa bolulo: Na u phela Leribe, haeba ho joalo na u phela likilomitara ts 20 ho tloha Tlilining? Kapa u phela seterekeng se seng?

	Ts'oea moo ho lokelehang
U phela seterekeng sa Leribe	
U phela likilomitara tse 20 ho tloha tikolohong ea Tlilini ea Leribe	
U phela seterekeng se seng	

Lilemo: U lilemo li kae ho tloha letsatsing la hao la ho qetela la tlhaho?

	Ts'oea moo ho lokelehang
Ka tlase ho lilemo tse 15	
Lilemo tse 15-24	
Lilemo tse 25-34	
Lilemo tse 35-44	
Lilemo tse 45-54	
Lilemo tse 55-64	
Lilemo tse 65 ho ea holimo	

2.1 Ke hobane'ng ha u khetha ho ea Tlilining ee bakeng sa lipilisi tsa A

Mabaka	1 Ke hana kanne te Ke lumel a kanne te	2 Ka nako 'ngoe ke hana na le taba ena	3 Ha ke tse be	4 Ka nako 'ngoe ke lumella na le taba ena	5 Ke lumella na ka nnete le taba ena
1. E hole le 'na					
2. Ha ke batle baaman i / baheso ba tsebe ka boemo ba ka ba HIV					
3. Ha ke batle metsoall e e tsebe ka boemo ba ka ba HIV.					
4. Ho					

<p>hobe ho ea Tlilinkin g e haufi le hae hoba ha ho na lekunutu</p>					
<p>5. Haeso ho hole le Tlilinki</p>					
<p>6. Ha ke tsebe Tlilinki e 'ngoe e fanang ka lipilisi tsa ARV.</p>					
<p>7. E haufi le haeso</p>					
<p>8. Basebet si ban a le setsoall e ebile baa</p>					

thusa					
9. Lipilisi li fumane ha kamehla Tlilini kin g ena					
10. Metsoall e eaka le eona e etela Tlilini kin g ena					
11. Ke utloa ke khotsofa lla ho etela Tlilini kin g ena					
12. Lebaka le leng e ka ba lefe? Ke kopa u le ngole.					

3.1 Boemo ba HIV

2.1 ke nako e kae u tsebile hore u ts'oeroe ke lefu la HIV

Nako	Ts'oea moo ho lokelang
Ka tlaase ho khoeli e le 'ngoe	
Khoeli e le 'ngoe ho isa likhoeling tse 11	
Selemo se le seng ho isa lilemong tse 3	
Ho feta lilemo tse 3	

3.2 Ke nako e kae u tsamaea Tlilinking ee bakeng sa lipilisi tsa hao tsa ARV?

Nako	Ts'oea moo ho lokelang
Ka tlaase ho khoeli e le 'ngoe	
Khoeli e le 'ngoe ho isa likhoeling tse 11	
Selemo se le seng ho isa lilemong tse 3	
Ho feta lilemo tse 3	

3.2 Na u ne u se ntse u tsamaea Tlilinking ee pele u okoa ka lipilisi tsa ARV?

E

Che

3.3 Haeba ure E, ke nako e kae u tsamaileng Tlilinking ee?

Nako	Ts'oea moo ho lokelang
Ka tlaase ho khoeli e le 'ngoe	
Khoeli e le 'ngoe ho isa likhoeling tse 11	

Selemo se le seng ho isa lilemong tse 3	
Ho feta lilemo tse 3	

3.4 Ke nako e kae u sebelisa lipilisi tsa ARV?

Nako	Ts'oea moo ho lokelang
Ka tlaase ho khoeli e le 'ngoe	
Khoeli e le 'ngoe ho isa likhoeling tse 11	
Selemo se le seng ho isa lilemong tse 3	
Ho feta lilemo tse 3	

4.1 Mokhoa oa tsela ea tthekefetso / khoboso e utluoang ke moarabi. Na ho na le boemo boo batho ba u sebang? E/Che

4.2 Na basebetsi ba Tiilini ba u sebeletsa ka tsela e fapaneng le batho ba se nang ts'oaetso ea HIV? E/Che

4.3 Na u utloa u khetholloa ebile u sa amohelehe hoba u na le ts'oaetso ea AIDS? E/Che

5.1 Makhetho a mekhoe / tsela ea khoboso (Tthekefetso / Khoboso)

	1.	2.	3.	4.
Tsela ea Khuboso	Ha ke e s'o hobos oe ka	Ke ka seoelo ke ileng ka	Ke ka makhethlonya na ke ileng ka hobosoa	Ke ha ngata ke hobosoa ng ka

	tsela ena	hobots oa	empa ha se hangata	tsela ena.
Na u kile ua nenoa / nyatsoa? Haeba ho joalo, ke mang?				
Na u kile ua behelloa moo u leng mong? Kae? Ke mang?				
Na u kile ua arohanngo a le batho ba bang? Kae? Ke mang?				
Na u kile ua khetholloa ? Kae? Ke mang?				
Na ho na le motho ea seng a kile a tseba ka				

boemo ba hao ba HIV?				
Na u kile oa arohangoa le bakuli ba se nang ts'oaetso ea HIV Tiiliniking?				
Na karete ea hao ea Sepetlele e totobalitse hore o na le ts'oaetso ea HIV?				
Na u kile ua rehoa mabitso – bitso ho latela boemo ba hao ba HIV?				
Na liteko tsa HIV li kile tsa etsoa ntle				

<p>le tumellano ea hao? Haeba ho joalo, kae?</p>				
<p>Na ho na le motho ea kileng a phatlalatsa boemo ba hao ba HIV kante ho tumello ea hao? Haeba ho joalo, ke mang? Kae?</p>				
<p>Na baoki Lefapheng la Bophelo ba its'ireletsa ka se'khafo ha ba u entsa?</p>				
<p>Na u kile ua eletsoa hore u se ke ua nyala/nyal oa hobane</p>				

<p>u na le ts'oaetso ea HIV? Haeba ho joalo, ke mang? Kae?</p>				
<p>Na u kile ua eletsoa ho se ime (hosebe le bana) hobane u na le ts'oaetso ea HIV? Haeba ho joalo, ke mang? Kae?</p>				
<p>Na u kile ua ts'oaouoa phoso ka hore u na le ts'oaetso ea HIV? Haeba ho joalo, ke mang? Kae?</p>				
<p>Na u kile</p>				

<p>ua haneloa ka lithuso tsa bolo Tiiliniking? Haeba ho joalo, ke mang?</p>				
<p>Na u kile ua loant'soa ka lebaka la boemo ba hao ba HIV? Haeba ho joalo, ke mang?</p>				

6. Tlhophiso ea mokhoa / tsela ea khoboso/Tlhekefetso

6.1 Bolela litsela tse peli tsa khoboso/tlhekefetso e mpe tseo u kileng ua li etsetsoa ka lebaka la boemo ba hao ba HIV.

.....

.....

6.2 Na u kile ua phumana u hlaheloa ke e 'ngoe ea tsee ka lebaka la boemo ba hao ba HIV Tiiliniking ee? E/Che. Haeba ho joalo, ts'oea tse tharo tse ileng tsa u utloisa bohloko haholo.

Mokhoa oa khoboso	Tlhophiso ea Boemo
Ho haneloa ka lipilisi	
Karohano	
Ho nenoa	
Ho tlontlolloa / pepesoa	
Ho bitsoa mabitso-bitso	
Ho ts'oauoa phoso ka ho ba HIV	
Likamore tse ikhethang ka kokelo/likamore tse ikhethang tsa puisano le ngaka le tsa ho robala	
Ho hlaka lekunutu	
Khethollo	
Lintoa/Tlhekefetso/Ho hloka botsitso	
Lits'ebo	
Ho hlokeloa tlhompho	
Mahlapa a mangata	
Ho etsoa liteko ntle ho tumello	
Phatlalatso ea liteko ho baamani ntle tumello	
Ho roala liatlana le ho ho entoa	

6.3 kolokisa liketsahalo tse u utloisang bohloko/khents'ang ha u etetse Tiilining ena u il'o la li ARV:

1.....

2.....

3.....

4.....

5.....

6.4 Na liketsahalo tsee li ile tsa etsahala ho uena Tliniking ee? E/Che. Haeba ho joalo, u ile ua utloa bohloko / kkena hakae?

Tsela/Mokhoa a Tlhekefetso	E	Che	Hampe	Hampe haholo	Ka sitoa ho hlalosa
Ho haneloa ka lits'ebeletso Tlilining					
Ho ts'oauoa phoso ka ho ba le ts'oaetso ea HIV					
Ho khetheloa thoko le ho bakuli ba bang ba HIV					
Ho buisana le ho o kelo thoko le bakuli ba bang ba HIV					

Ho ngoloa hoa bukana / karete ea hao ho totobatsa u le HIV					
Ho nts'ouoa ha bethe ea hao ea sepetlele hore u na le HIV					
Ho roaloa liatlana ka bohlasoa nakong eo u entoang					
Ho phatlalatsa boemo ba hao ba HIV ntle le tumello ea hao					
Ho etsa liteko tsa HIV ntle le tumello ea hao					

7. Liketso/Likhato tsa ba Malapa le Metsoalle

7.1 Liketso/Likhato tsa litho tsa lelapa la hao malebana le boemo ba hao ba HIV ke life?

LINTLE KAPA LI MPE

7.2 Na u kile ua nenoa/nyatsoa ke ba lelapa kapa metsoalle kalebaka la boemo ba hao ba HIV? E / Che

7.3 Na u fumana ts'ehetso e lekaneng ho ba lelapa le ho metsoalle?

7.4 Na u ntse u lula le litho tsa hao tsa lelapa? E /Che

7.5 Na ba u phelisa hantle? E / Che

7.6 Na metsoalle ea hao e ntse e ikamahanya le uena joaloka pele u ba le ts'oaetso ea HIV? E / Che

7.7 Na u utloa u khetholloa ka lapeng la hao? E / Che

7.8 Na sekhotso sa hao se ntse se tiile le metsoalle ea hao? E / Che

7.9 Na u nahana hore batho baa u seba / ba bua ka uena? E / Che

7.10 Haeba ho joalo, ke bo-mang haholo ba buang ka uena? Metsoalle, Litho tsa lelapa kapa Baoki / Bathusi ba Bophelo?

8. Na ho kile hoa etsahala ho uena tse latelang ka lebaka la boemo ba hao ba HIV?

KHOBOSO	EE	CHE	KAE	KE MANG	
Ntoa, Tlhekefetso/ho hloka botsitso					
ho hloka tlhokomelo le tshehetso					
litshebo					

HIV ke khalemo ea boitshoaro ba hao bo bobe					
lelapa le ea u furalla					
phatlalatsa boemo ba hao ba HIV ntle le tumello					
ho haneloa ka moriana					
khethollo					
ho se amohelehe					
ho nenoa kapa ho nyatsoa					
ho khetheloa thoko ho bakuli ba bang ba senang HIV					

9. Mekhoa e ka sebelisoang ho fokotsa mefuta le boemo ba khoboso/tlhekefetso bathong ba phelang le tshoatso e HIV/AIDS Tlilining.

9.1 ke eng eo u bonang eka e ka thusa ho fokotsa tlhekefetso e tsoang ho uena tlilining?

1.
2.
3.
4.
5.
6.
7.
8.
9.

10.....

9.2 Tshoaea tse hlano tsa tse latelang tseo u hopolang hore li nepahetse haholo ho fokotsa tlhekefetso ho batho ba phelang le AIDS tliliniking.

Tsoela pele	Tšoaea
ho rupela baoki ka HIV/AIDS, ho fana ka tlhokomelo le ho oka batho ba phelang le AIDS	
Ho fana ka tataiso mekhoa ea boitlhokomelo ho baoki le batho ba phelang le AIDS	
ho kenngoe tšebetsong mekhoa ea khalemo boitshoarong bo khothaletsang tlhekefetso	
ho fana ka tlhabollo ea bohlokoa/ea popota ho batho ba phelang le tšoetso ea HIV	
Ho ntlafatsoe lekunutu litabeng tsa mokuli oa HIV	
ho thehoe likamano tse ntle, le bakuli, mohlala : ho lumelisana, ho utloisisana	
ho rupela batho ba phelang le AIDS, ho itlhokomela mafung a mefuta-futa	
tsebeliso ea mehlala ea batho ba HIV ba ikamohetseng hantle eseng ba sa ikamohelang hantle	
ho eketsoa manane a likopano le bakuli ba HIV, mohlala: ho ba etela	
ho khaotsoe ho khethela bakuli	

ba HIV ka thoko	
ho fokotsoe bohlasoa ba ho roala liatlana ha ho sebetsanoa le batho ba nang le tšoaetso ea HIV.	
ho fokotsoe sekhahla sa ho beha ba kuli ba HIV pepeneneng	