

Minimising stigmatisation of HIV/AIDS persons in curbing , the spread of the pandemic in the Sunyani Municipality: The role of relations, friends and other community members.

By

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DECLARATION

I hereby declare that this submission is my own work towards the Master of Science, Development Planning and Management Programme and that, to the best of my knowledge, it contains no material previously published by another person nor material which has been accepted for award of any other degree of any University, except where due acknowledgement has been made in the text.

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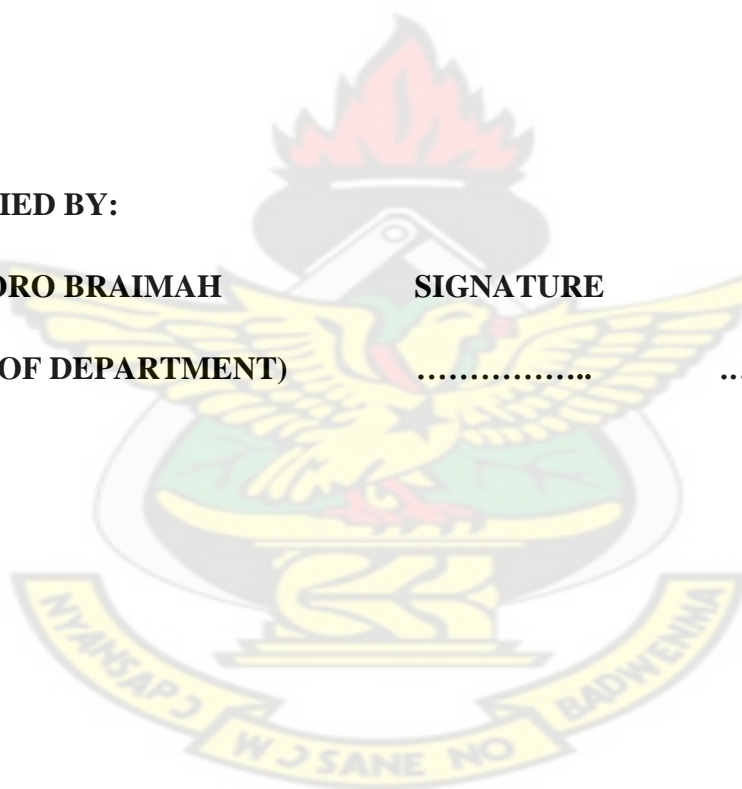
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ABSTRACT

The HIV and AIDS appeared on the world scene in the early 1980s. Since then millions of infected persons have died and are still dying every passing day. Its devastating and destructive impact is felt much in the Sub-Saharan Africa which houses two-thirds of all the infected persons globally (UNAIDS, 2008). Though the introduction of an Antiretroviral Therapy (ART) into the healthcare system is impacting greatly on the health conditions of the HIV infected persons accessing this drug, there is still not a vaccine that can cure the disease completely (Blechner, 1997). The stigma and the choice of derogatory words referring to the HIV/AIDS disease contribute to the spread of the disease (Angleton, 1998).

The objectives of the study were to assess the extent at which HIV/AIDS persons are stigmatised, analyze the type of care and support given by relations, friends and community members to infected persons, assess the effectiveness of the existing HIV/AIDS educational programmes in addressing the dangers of stigmatising HIV/AIDS infected persons and to assess the progress so far made in addressing the spread of the disease in the Sunyani Municipality.

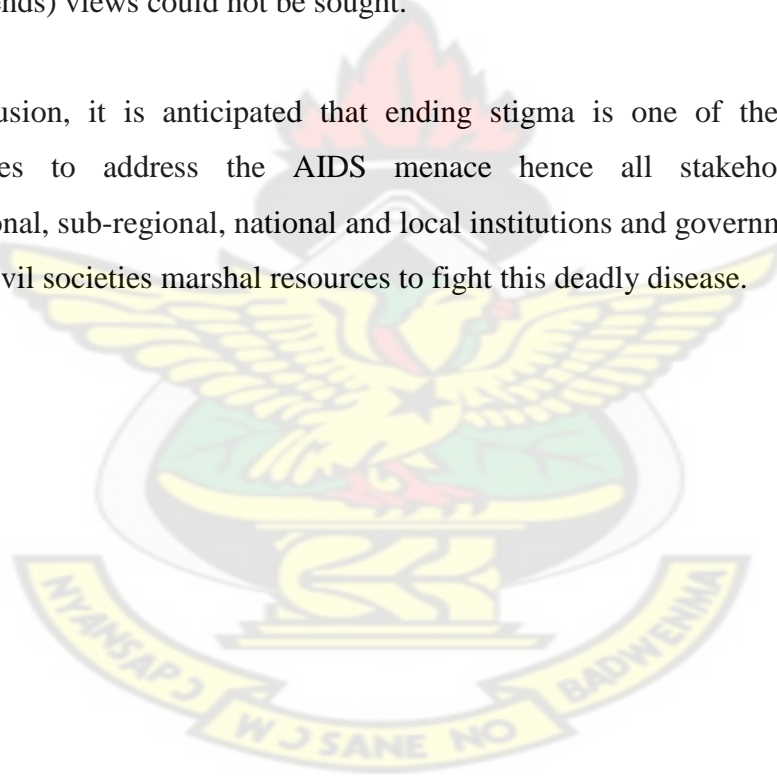
The case study approach was used to collect data with a sample size of two hundred household respondents. The snowball technique was adopted for the study as it is a sensitive domain. Institutional questionnaires were also used to collect information from institutions like the Municipal Health Directorate, the Municipal Assembly, Concern Universal, Planned-Parenthood Association of Ghana and the 6th March Women's Foundation as well as the Seventh Day Adventist Church and the Islamic religious bodies. Interview guide was used to solicit information from the 13 PLHIVs and five known relations.

The survey revealed that stigma is deeply-rooted in the community as 58.5 percent of those interviewed were not willing to disclose their HIV status if tested positive whereas 41.5 percent respondents were willing to disclose their positive HIV status to a spouse and children and other close relations. None would disclose to a friend.

The study revealed that the support needed by the people living with HIV/AIDS included empathy, companionship, love, confidentiality, socialisation, nutritious diets and continuous supply of Antiretroviral Therapy (ART). The educational campaign in addressing the dangers of stigma and its attendant spread of the disease in the study area is woefully inadequate and that much effort needs to be done.

One significant revelation of the study was that the health workers insist on confidentiality as AIDS victims queue with all other patients seeking medical care. The PLHIVs who have disclosed their HIV status to others were happy about the kind of support like financial, companionship and pieces of advice they receive from them. They have not regretted for doing so. Since the PLHIVs have not disclosed to friends, their (friends) views could not be sought.

In conclusion, it is anticipated that ending stigma is one of the most effective approaches to address the AIDS menace hence all stakeholders including international, sub-regional, national and local institutions and governments globally as well as civil societies marshal resources to fight this deadly disease.



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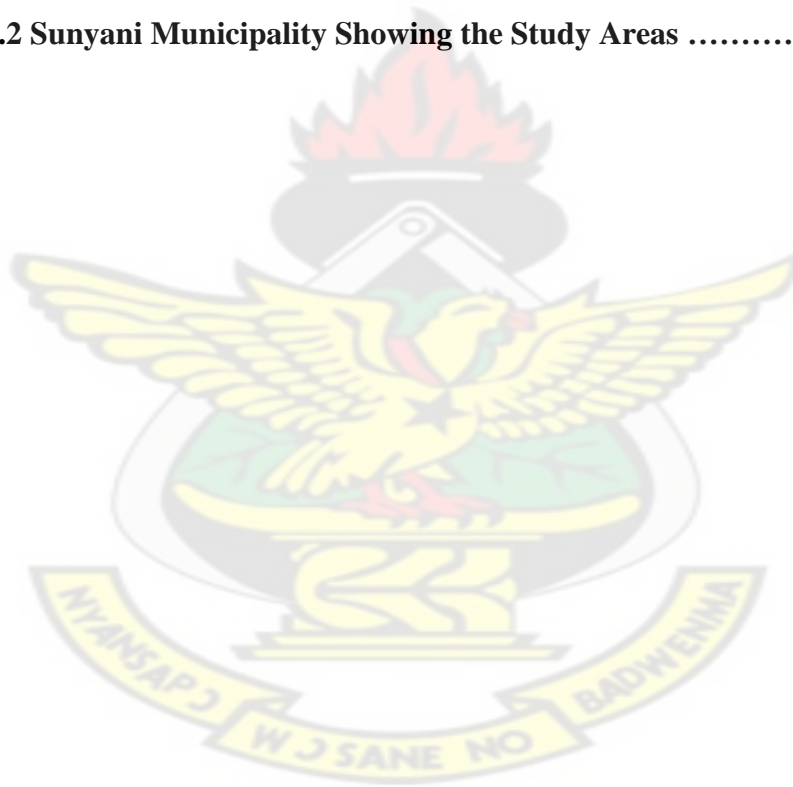
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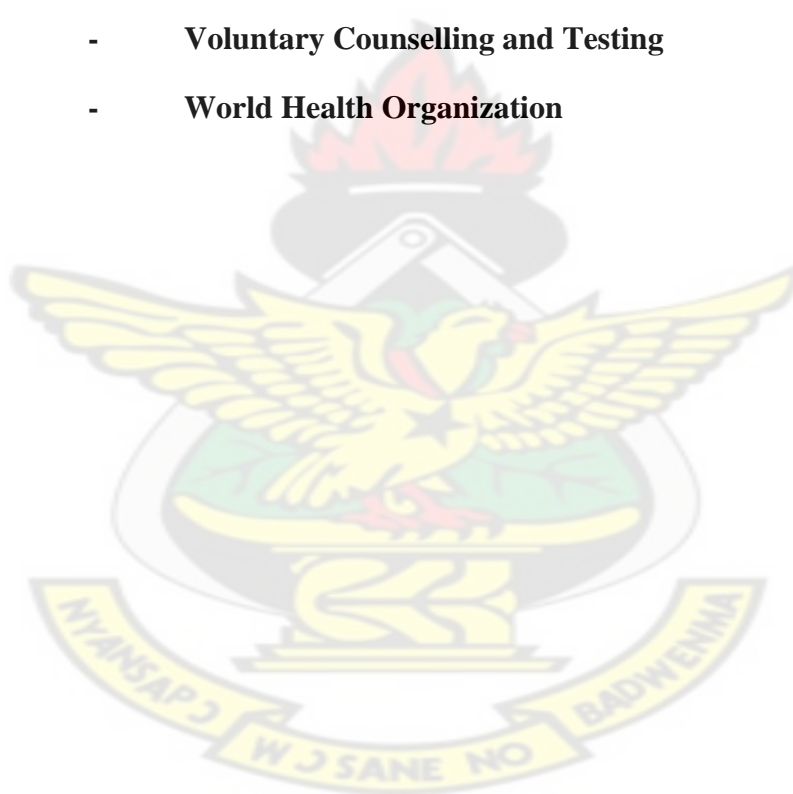
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LIST OF ABBREVIATIONS

ADA	-	American with Disabilities Act
AIDS	-	Acquired Immunodeficiency Syndrome
ARC	-	AIDS-related Conditions
ART	-	Antiretroviral Therapy
CBO	-	Community-Based Organization
CDC	-	Centers for Diseases Control and Prevention
CU	-	Concern Universal
DFID	-	Department for International Development
DRI	-	District Response Initiative
FBO	-	Faith-Based Organization
GoB	-	Government of Botswana
GoG	-	Government of Ghana
HM	-	Health Ministry
HCSUS	-	HIV Cost and Services Utilization Study
HIV	-	Human Immunodeficiency Virus
HOPWA	-	Housing Opportunities for People Living with AIDS
ICRW	-	International Centre for Research on Women
MHD	-	Municipal Health Directorate
MOH	-	Ministry of Health
MPCU	-	Municipal Planning Coordinating Unit
MRS	-	Medical Reception Station
NGO	-	Non-Governmental Organization
NHS	-	National Health Service
PLHIV	-	People Living with Human Immunodeficiency Virus
PPAG	-	Planned Parenthood Association of Ghana

SSA	-	Sub-Saharan Africa
STD	-	Sexually Transmitted Disease
STI	-	Sexually Transmitted Infection
USAID	-	United States Agency for International Development
UK	-	United Kingdom
UNAIDS	-	Joint United Nations Programme on HIV and AIDS
UNGASS	-	United Nations General Assembly Special Session
USA	-	United States of America
USD	-	United States Dollar
VCT	-	Voluntary Counselling and Testing
WHO	-	World Health Organization



CHAPTER ONE

GENERAL INTRODUCTION

1.0 Introduction

The Human Immuno-deficiency Virus/Acquired Immuned Deficiency Syndrome (HIV/AIDS) reared its ugly face on the world scene in the early 1980s. The estimated number of persons living with HIV and AIDS worldwide in 2007 was 33.2 million. The worst affected region in the world is Sub-Saharan Africa with two-thirds (63 percent) of all persons infected with HIV (UNAIDS, 2008).

In every 18 seconds, someone in the world becomes infected with HIV--the virus that causes the AIDS. In Africa around 3,000 new cases of infection occur every day (UNAIDS, 2008). In the year 2007, an estimated 1.7 million adults and children became infected with HIV in Sub Saharan Africa, with 16 million dying with AIDS.

In the mid-1980s, HIV/AIDS was recognized as a major health crisis in Africa. Until then the disease had primarily been restricted to high-risk groups, like homosexual men, in the Western part of the world. Now health officials realised that the disease had spread largely in the heterosexual population of Sub-Saharan Africa. Consequently, in 1987 World Health Organisation (WHO) launched its first global programme on HIV/AIDS (UNAIDS, 2007). Since then health officials, scientists, economists, development workers etc. have conducted a huge number of prevention projects in Sub-Saharan Africa – all with the aim of reducing the number of new infections.

More than 20 years and billions of dollars later, HIV/AIDS is still a huge problem in Sub-Saharan Africa. All those well-meaning efforts have failed to yield results as many more people are being infected every day in the region. It is estimated that 1.7 million people became infected with HIV in Sub-Saharan Africa in 2007, bringing the total number of people living with HIV to 22 million (UNAIDS, 2008). The epidemic seems to have stabilized in many countries, as the prevalence is leveling and in a few countries even falling. But a stabilization of prevalence does not mean the HIV problem is solved. Among other reasons because the levelling takes place at a very high prevalence—in many countries in Southern Africa more than 10 percent of the

adult population is infected. Infection rates are also unequally distributed in the population; especially young women are at high risk. In the age group 15-24 years, girls are about three times as likely to have HIV as boys. HIV/AIDS continues to have a vast impact on life and development in Sub-Saharan Africa (UNAIDS, 2008).

It is estimated that around 12 million children have been orphaned because of HIV/AIDS leading to an excess toll on older family members and increasing the number of child-headed households. HIV/AIDS reduces productivity, increases health costs and causes important knowledge and skills in the adult population (Smith, 2003).

The problems are huge, but at the same time no other disease in history has achieved so much attention and caused such a great mobilization of political, financial and human resources. Some of the major donors are Joint United Nations Programme on HIV/AIDS (UNAIDS), the World Bank, European aid agencies and United States Agency for International Development (UNAIDS), all of which post billions of dollars into prevention and treatment of HIV/AIDS. Globally USD 10 billion was spent on HIV projects in 2007; a number which has increased steadily from USD 1.4 billion in 2000 (UNAIDS 2008). The stigma attached to the disease which is associated with lifestyles and behavior, attitude towards those infected with HIV through isolation is increasingly recognized as single most humiliating challenge to the spread of the disease at all levels hence all efforts must be geared towards the fighting of the pandemic. Stigma relating to HIV and AIDS undermines public health efforts to combat the pandemic (USAID, 2003).

1.1 The Problem Statement

Human Immuno-deficiency Virus/Acquired Immuned Deficiency Syndrome (HIV/AIDS) is spreading at an alarming rate globally putting everyone at risk. It strikes down mostly people in their prime age. As it affects the economically active labour force, it threatens productivity thereby worsening Sub-Saharan African economies in particular and the world at large (WHO, 2001).

HIV/AIDS has dire consequences on the labour force. It increases the dependency ratio as the working class is dying day in and day out. It is again increasing the orphan population in Africa, south of the Sahara as more parents are dying. Infected persons undergo bodily pains and become dependence on drugs for life. Again, they are also greatly stigmatized by civil society thereby worsening their already precarious plight. The pandemic has no cure as of now but infected persons could be put on anti-retroviral drug to lengthen their lives as against the initial days of eminent death with traumatized and damaging bodies. In fact, due to this drug, some of the infected persons look 'healthier' than some non-infected persons and could live far more than twenty years after infection (Smith, 2003). It seems therefore that the pandemic is manageable. However, infected persons feel reluctant to disclose their HIV/AIDS status for fear of being discriminated against. The stigma attached to the disease is so dehumanizing causing a whole lot of disintegration of the family system as members of families as well as the general public separate themselves from their otherwise loved ones (Nyanzi, 2004).

In Ghana, PLHIVs have been ejected from their homes, lost their jobs, and some have been denied the use of community amenities. Some have received verbal abuse and clients have avoided patronage of their goods and services. There are also reports of persons abandoned by family members. Prospective foster parents are avoiding orphans of HIV-positive couples from the orphanages (GoG/MOH, 2006).

In the Sunyani Municipality (where the HIV prevalence rate is 3.0 percent) (GoG/MOH, 2007) and elsewhere, people frown upon an HIV-infected person and those perceived to be harbouring the disease as they disassociate themselves from them. People whose relations die from AIDS-related disease refuse to mention it as it tends to disgrace them. These deaths are therefore attributed to curses caused by the gods which is not helping the fight against the pandemic (Osei-Hwedie, 1994).

Most studies on the prevention of the pandemic are related to the bodily pains an infected person goes through hence the research is seeking to find out how the problem of stigmatisation could be addressed and then possibly unearth some solutions to this problem to make life a little bit bearable to the infected persons themselves and all members of society.

1.2 Research Questions

1. Does HIV-related stigma severely hampers efforts to effectively fight the HIV and AIDS epidemic?
2. What support systems can relations; friends and community members give to assuage the pains of HIV/AIDS infected persons?
3. What effective stigmatisation programmes exist to address the spread of the pandemic?
4. What progress had been made in over-coming stigmatisation of HIV-infected persons to reduce the spread of the pandemic?
5. What recommendations can be made to ameliorate this problem?

1.3 Research Objectives

The broad objective of the research is to assess the effects of stigma on HIV-infected persons and how best it could be minimized in curbing the spread of the epidemic. The specific objectives of the study include:

1. To assess the extent at which HIV/AIDS persons are stigmatized;
2. To analyze the type of care and support given by relations, friends and community members to infected persons;
3. To assess the effectiveness of the existing HIV/AIDS educational programmes in addressing the dangers of stigmatising HIV/AIDS infected persons;
4. To assess the progress so far made in addressing the spread of the disease in the study area; and
5. To give recommendations to inform policy;

1.4 Significance of the Study

It cannot be denied that HIV/AIDS is the most deadly disease at the moment in Ghana in particular and the world at large. Notwithstanding the public education campaigns to sensitise the general public on the devastating effects of the disease, some people either show little interest or regard the campaigns with contempt under the illusion that HIV/AIDS is fading out. People living with HIV/AIDS more often than not are isolated, gossiped about and shunned by non-infected counterparts. This stigma

attached to the disease makes “carriers” concealed their HIV status. This concealment is more likely to result in the spreading of the disease, rather than to its control or eradication (Baiden, 2004). It is therefore necessary to research into this phenomenon to ascertain the validity of this assertion held by the majority of community members against HIV infected persons to help fight this pandemic and also contribute to knowledge.

1.5 Scope of the Study

The study is restricted to the geographical area of the Sunyani Municipality of the Brong-Ahafo Region. The Municipality is attracting all manner of visitors and the rate of infection of HIV persons is increasing at an alarming speed with the HIV prevalence rate at 3.0 percent (GoG/MOH, 2007) as compared to the national prevalence rate of 2.7 percent.

The bio-medical model of HIV/AIDS will be described briefly. However, the emphasis will be on the stigmatization model in order to address the problems associated with it. The research is to assess the people’s perception of HIV and their understanding of the disease’s mode of transmission and their contribution towards finding a lasting solution to the problems associated with it. The study was carried out from the 18th December 2009 to 20th May, 2010.

1.6 Limitation of the Study

A major limitation is that some of the respondents and assembly persons being told about the purpose of the research still thought that it was some government or non-governmental agents carrying out interviews and hence demanded money before answering the questionnaires. While the purpose of the study was explained to them without any monetary gains it might have influenced some of the responses from the selected interviewees.

1.7 Organisation of the Report

The research report is organized into five main chapters. Chapter one gives the general background to the study, the problem statement, research questions and objectives, significance of the study, limitation and scope of study. Chapter two is

basically a review of the literature of concepts and issues on HIV/AIDS, United States policy on HIV/AIDS and that of Ghana. The chapter three presents the research approach and determination of the sample size, sampling technique and data analysis likewise the profile of the study area among others.

In chapter four, the findings of the study as presented and discussed included knowledge about HIV/AIDS, routes of transmission of HIV/AIDS, degree of HIV/AIDS stigma and concealment, the roles of relations and community members towards PLHIVs amongst others. The chapter five contains summarized findings, recommendations and conclusion.



CHAPTER TWO

CONCEPTS AND ISSUES ON HIV/AIDS

2.0 Introduction

This chapter deals with the HIV/AIDS in the global perspective through to the Sub-Saharan region to the Ghanaian level. HIV/AIDS-related stigma and discrimination, its different context, types, effects and the United States policy on HIV/AIDS are all treated in this chapter.

2.1 Concepts of HIV/AIDS

The Acquired Immune Deficiency Syndrome or Acquired Immunodeficiency Syndrome (AIDS) is a disease of the human immune system caused by the human immunodeficiency virus (HIV). The condition progressively reduces the effectiveness of the immune system and leaves the individuals susceptible to opportunistic infections and tumours. HIV is transmitted through direct contact of a mucous membrane or the bloodstream with a bodily fluid containing the HIV, such as blood, semen, vaginal fluid, preseminal fluid and breast milk (Sepkowitz, 2001).

This transmission can involve anal, vaginal, or oral sex, blood transmission, contaminated hypodermic needles, exchange between mother and baby otherwise called vertical transmission during pregnancy, childbirth breastfeeding or other exposure to one of the above bodily fluids. However, sexual intercourse accounts for 78 percent of transmission (Coovadia and Bland, 2007).

Genetic research indicates that HIV originated in west-central Africa during the late nineteenth or early twentieth century (Hooper, 1999). AIDS was first recognized by the United States Center for Disease Control and Prevention in 1981 and its cause, HIV identified in the early 1980s (CDC/MMWR, 2004).

Although treatment for AIDS and HIV can slow the course of the disease, there is currently no vaccine or cure. Antiretroviral treatment reduces both the mortality and the morbidity of HIV infection, but the drugs are expensive and routine access to the antiretroviral medication is not available in all countries. Due to the difficulty in treating HIV infection, preventing infection is a key in controlling the AIDS

pandemic, with health organisations promoting safe sex and needle exchange programmes in attempts to slow the spread of the virus (Blechner, 1997).

AIDS is the most severe acceleration of infection with HIV. HIV is a retrovirus that primarily infects vital organs of the human immune system such as CD4+T, macrophages, and dendritic cells. It directly destroys CD4+ T cells. Once the HIV has killed many CD4+ T cells that are AIDS, which is identified either on the basis of the amount of CD4+ T cells remaining in the blood and or the presence of certain infections (Mehandru et al. 2004).

In the absence of antiretroviral therapy (ART), the median time of progression from HIV to AIDS is nine to 10 years and the median survival time developing AIDS is only 9.2 months. However, the rate of clinical disease progression varies widely between individuals, from two weeks up to 20 years (Sayles, et al. 2003).

2.1.1 Types of HIV

There are two types of HIV. These are HIV-1 and HIV-2. Both are transmitted the same way and are associated with similar opportunistic infections and AIDS. HIV-1 is more common worldwide whilst HIV-2 is predominately found in West Africa, Angola and Mozambique. In Ghana, HIV-1 is more common forming 95 percent of HIV infections whereas HIV-2 constitutes far less than 1 percent. The dual infections of HIV-1 and HIV-2 representing 5 percent of cases (GoG/MOH, 2008).

2.1.2 Differences Between HIV-1 and HIV-2

HIV-2 is less easily transmitted than is HIV-1, and it is less pathogenic, meaning that the period between infection and illness is longer. In some cases, a person may be infected with both HIV-1 and HIV-2. While HIV-2 can be transmitted from an infected mother to her child it appears to be rare (GoG/MOH, 2008).

2.1.3 Natural History of HIV Infection

People infected with HIV usually develop antibodies 4-6 weeks after being infected, but this may take as long as three months for antibodies to develop. This period

between when one is infected with HIV and when the antibody test result is positive is called the window period. When a recently infected person develops antibodies that can be measured using a laboratory test, sero-conversion has occurred. Some people may experience a glandular illness [fever, rash, joint pains, and enlarge lymph nodes] at the time of sero conversion (GoG/MOH, 2008).

Anyone whose blood test results (two tests) show HIV infection is said to be sero-positive. On the other hand, any person whose blood test results do not show HIV infection is presumed to be sero-negative or HIV negative. A person who tests HIV negative but who has engaged in behavior within the past three months that places him or her at risk for HIV should be tested again in three months (GoG/MOH, 2005).

A person who is HIV positive but looks and feels healthy is asymptomatic. None of the physical signs or symptoms that indicate HIV infection is present. Whether they have symptoms or not, people who are HIV-positive or sero-positive can still pass the virus to others. A person who has developed physical symptoms of HIV-infection and reports symptoms related to infection is symptomatic (GoG/MOH, 2008)

2.1.4 Phases of the HIV and AIDS Epidemic

Three phases of the HIV and AIDS epidemic have been identified: the epidemic of HIV; the epidemic of AIDS; and the epidemic of stigma, discrimination, and denial. The third phase is as central to the global AIDS challenge as the disease itself (GoG/MOH, 2005).

2.2 Factors Affecting the Rate of Progression

Many factors affect the rate of progression of HIV. These include factors that influence the body's infected ability to defend against HIV such as the infected person's general immune function. Older people have weaker immune systems, and therefore have a greater risk of rapid disease progression than younger people. Poor access to health care and the existence of coexisting infections such as tuberculosis may also predispose people to faster disease progression (Bozzette, 1999).

The infected person's genetic inheritance plays an important role and some people are resistant to certain strains of HIV. An example is people with homozygous CCR5-32 variation are resistant to infection of certain strains of HIV. HIV is genetically variable and exists as different strains, which cure different rates of clinical disease progression (Campbell, et al. 2005). Sexual transmission occurs with contact between sexual secretions of one person with the rectal, genital or oral mucous membrane of another. Unprotected sexual acts are riskier for the receptive partner than the insertive partner, and the risk of transmitting HIV through unprotected anal intercourse is greater than the risk from vaginal intercourse or oral sex. However, oral sex is not entirely safe, as HIV can be transmitted through both insertive and receptive oral sex. Sexual assault greatly increases the risk of HIV transmission as condoms are rarely employed and physical trauma to the vagina occurs frequently, facilitating the transmission of HIV (Koeing, 2004).

Other sexually transmitted infections (STIs) increase the risk of HIV transmission and infection because they cause the disruption of the normal epithelial barrier by genital ulceration and or micro ulceration of pools of HIV-susceptible or HIV-infected cells (lymphocytes and macrophages) in semen and vaginal secretions. Epidemiological studies from SSA, Europe, and North America suggest that genital ulcers, such as those caused by syphilis and or chancroid increase the risk of becoming infected with HIV by about fourfold. There is also a significant although lesser increase in the risk from STIs such as gonorrhea, chlamydia and trichomoniasis, which cause local accumulations of lymphocytes and macrophages (Benchley, et al. 2006).

2.2.1 Exposure to Blood-borne Pathogens

This transmission route is particularly relevant to intravenous drug users, homophiliacs and recipient of blood transfusions, and blood products. Sharing and reusing syringes contaminated with HIV-infected blood represents a major risk for infection with HIV. Needle-sharing is the cause of one-third of all new HIV infections in North America, China, and Eastern Europe. The risk of being infected with HIV from a single prick with a needle that has been on an HIV-infected person is thought to be about 1 to 50. Post exposure prophylaxis with anti-HIV drugs can further reduce the transmission (Fan, et al. 2005).

This route can also affect people who give and receive tattoos and piercing. Universal precautions are frequently not followed in both SSA and much of Asia because of both shortage of supplies and inadequate training. The WHO estimates that approximately 2.5 percent of all HIV infections in SSA are transmitted through unsafe healthcare injections (WHO/UNAIDS, 2003). Because of this, the United Nations General Assembly has urged the nations of the world to implement precaution to prevent HIV transmission by health workers (WHO/UNAIDS/UNICEF, 2007).

The risk of transmitting HIV to blood transfusion recipients is extremely low in developed countries where improved donor selection and HIV screening is performed. However, according to WHO, the overwhelming majority of the world's population does not have access to safe blood and between 5 percent and 10 percent of the world's HIV infection comes from transfusion of infected blood and blood products.

2.2.2 Perinatal/Vertical Transmission

The transmission of the virus from the mother to the child can occur in the uterus during the last weeks of the pregnancy and at childbirth. In the absence of treatment, the transmission rate between mother and her child during pregnancy, labour and delivery is 25 percent. However, when the mother takes ART and gives birth by caesarean section, the rate of transmission is just 1 percent (Toth, et al .2001). The risk of infection is influenced by the viral load of the mother at birth, with the higher the viral load, the higher the rate. Breastfeeding also increases the risk of transmission by about 4 percent (Coovadia, 2007).

2.3 Symptoms

The symptoms of AIDS are primarily the result of the conditions that do not normally develop in individuals with healthy immune system. Most of these conditions are infection caused by bacteria, virus, fungus and parasites that are normally controlled by the elements of the immune system that AIDS damages (WHO, 1990).

2.3.1 Opportunistic Infections

These are illnesses caused by germs that may not normally cause illness in a healthy person who has a weakened immune system. For example, co-infection with tuberculosis (TB) and oral candidiasis very common in people infected with HIV.

These types of infection are common in people with AIDS and they affect nearly every organ system. PLHIVs also have increased risk of developing various cancers such as Kaposi's sarcoma, cervical cancer and cancers of the immune system known as lymphomas. Additionally people with AIDS often have systematic symptoms of infection like fever, sweats (particularly at night), swollen glands, chills, weakness and weight loss. The specific opportunistic infection that AIDS patients develop depend in part of these infection in the geographical area which the patient's lives (Guss, 1994).

2.3.2 Misconceptions about AIDS

A number of misconceptions have arisen surrounding HIV/AIDS. Three of the most common are that AIDS are spread through casual contacts, that sexual intercourse with virgin will cure AIDS, and that HIV can infect only homosexual men and drug users. Other misconceptions are that any act of anal intercourse between gay men can lead to AIDS infection, and that open discussion of homosexuality and HIV in schools will lead to increased rates of homosexuality (Eagle, 2003).

2.4 Economic Impact of AIDS

HIV/AIDS affects economic growth by reducing the availability of human capital. Without proper nutrition, health care and medication that is available in developed countries, large number of people suffer and die from AIDS-related complications. They will not only be unable to work, but will also require significant medical care. The forecast is that this will probably cause a collapse of economies and societies in countries with a significant AIDS population. In some heavily infected areas, the epidemic has left many orphans cared for by elderly grandparents (Eagle, 2003).

The increased mortality in this region will result in a smaller skilled labour population and labour force. This smaller labour will be predominantly young people with reduced knowledge and work experience leading to reduced productivity. An increase of workers' time off to look after sick family members or for sick leave will also lower productivity. Increased mortality will also weaken the mechanisms that generate human capital and investment in people, through loss of income and the death of parents (Eagle, 2003).

By killing mainly young adults, AIDS seriously weakens the taxable population reducing the resource available for public expenditures such as education and health services not related to AIDS resulting in increasing pressure for the state's finances and slower growth of the economy. This results in a slower growth of the tax base, an effect that will be reinforced if there is growing expenditures in treating the sick (to replace sick workers), sick pay and caring for AIDS orphans. This is especially true if the sharp increase in adult mortality shifts the responsibility and blame from the family to the government in caring for these orphans (Eagle, 2003).

On the level of the household, AIDS results in both loss of income and increased spending on health care by the household. The income effects of this lead to spending reduction as well as substitution effect away from education and towards healthcare and funeral spending. A study in Cote D'Ivoire showed that households with an HIV/AIDS patient spent twice as much on medical expenses as other households (Epstein, 2007).

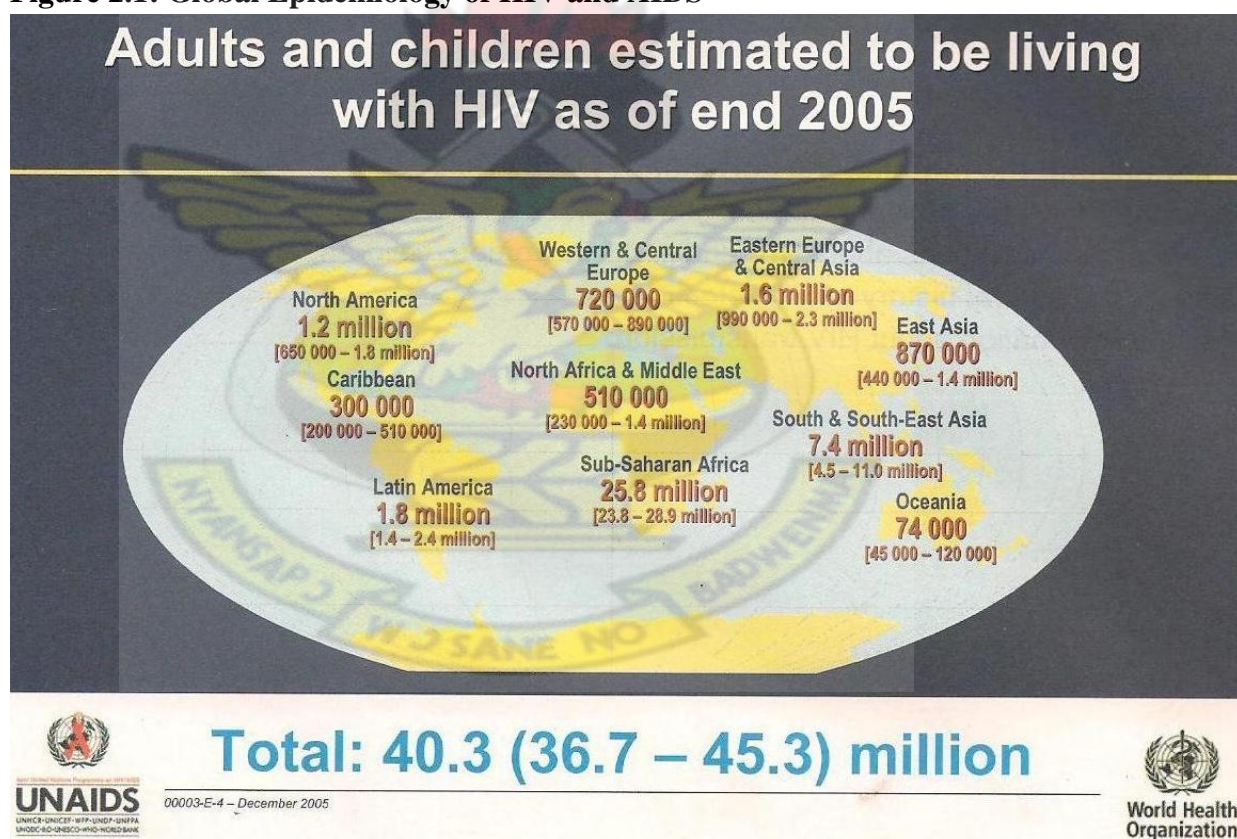
2.5 Models of AIDS

AIDS is classified into two models namely the bio-medical model and the stigmatisation model. The bio-medical model is the problem within the body. The infection of the virus and its attack and the destruction to the white blood cells which leads to severe bodily pains and the stigmatisation model is the problem outside the body and is associated with lifestyles and behavior. The attitude of society members towards those infected with HIV through isolation (Angleton, 1998).

2.6 Global Perspective of HIV/AIDS

UNAIDS estimated that at the end of 2005, 40.3 million people worldwide were living with HIV and AIDS out of which 2.3 million were children younger than 15 years old, 90 percent of children living with HIV and AIDS were from SSA. At the same time, 700,000 children worldwide were newly infected and that 570,000 child deaths were estimated to have occurred from HIV and AIDS during 2005. According to UNAIDS, about 14,000 new infections occurred each day in 2005. Of these more than 95 percent were in low and middle income countries and almost 2000 were children under 15 years of age. About 12,000 were persons aged 15 to 49 years of whom almost 50 percent were women and with about 50 percent between 15 -24 year olds (GoG/MOH, 2006).

Figure 2.1: Global Epidemiology of HIV and AIDS



Source: GoG/MOH, 2006

AIDS is now a pandemic. In 2007 it was estimated that 33.2 million people lived with the disease worldwide and that AIDS killed an estimated 2.1 million people including 330,000 children. In the last decade and half, the pandemic has swept through Sub-

Saharan Africa with increasing destructive force. According to WHO/UNAIDS (2000), the disease has claimed the lives of 14 million men, women and children of Africa, south of the Sahara. Though HIV is a global phenomenon, Sub-Saharan Africa is bearing the blunt of the epidemic. With only 10 percent of the world's population, it accounts for 71 percent of the men, women and children estimated to be living with the disease as of 2004. In the most severely affected African countries, up to 25 percent of the adult population is infected with HIV and most of them are parents with young children. As a result, Africa is also experiencing a catastrophic increasing number of children living in AIDS-affected households or struggling to survive after the death of one or both parents (Hunter and Williamson, 1998).

Hard won gains in the life expectancy and child survival rate are being wiped out in many African countries. In South Africa, the life expectancy at birth which rose from 44 years in the early 1950s to 59 years in the early 1990s is expected to drop back to 45 years between 1995 -2010. In East Africa, child mortality rates were expected to double or even triple by 2005 (Hunter and Williamson, 1998).

In economic terms, Africa, south of the Sahara is losing its labour force. By 1999, 860,000 school children lost their teachers in the region and in the banking sector, 25 percent of staff died (The Northern Advocate, 2001). WHO/USAID in 1999 indicated that the orphan population worldwide was 14.2 million of whom 92 percent with approximately 12.4 million in Sub-Saharan Africa. Dependency ratio therefore weakens as breadwinners forming 25 percent are dying with the rest of 75 percent providing for the aged and the young (inactive group) Women constitute 70 percent of the labour force in agriculture in rural sub-Saharan Africa. With the women and men infection ratio of 6:5, agricultural production is greatly affected with its concomitant consequences on the family in areas of pounding grains, ploughing, planting, fetching water and fuel wood etc. Again, 41 percent of adults infection are women in SSA and as they work three hours more than men on the average, labour force is decreased dramatically (Sepkowitz, 2001).

South Africa has the largest population of HIV patients in the world, followed by Nigeria and India. South and South-East Asia is second worst affected region; in 2007 the region contained an estimated 18 percent of all people living with AIDS and an

estimated 300,000 deaths. India has an estimated 2.5 million infections and an adult prevalence of 0.36 percent (UNAIDS/WHO/UNICEF, 2007). Life expectancy has fallen dramatically in the worst affected countries; for example, in 2006 it was estimated that it has dropped from 65 to 35 years in Botswana (Smith et al, 2005).

In the United States, young African-American women are also usually high risk for HIV infection. This is due in part to a lack of information about AIDS and perception that they are not vulnerable as well as limited access to health-care resources and a high likelihood of sexual contact with at risk male sexual partners (Arya, et al. 2009). There are also geographical disparities in AIDS prevalence in the US, where it most common in rural areas and in the Southern states, particularly in the Appalachian and Mississippi, Delta regions and along the border with Mexico (Arya et al. 2009).

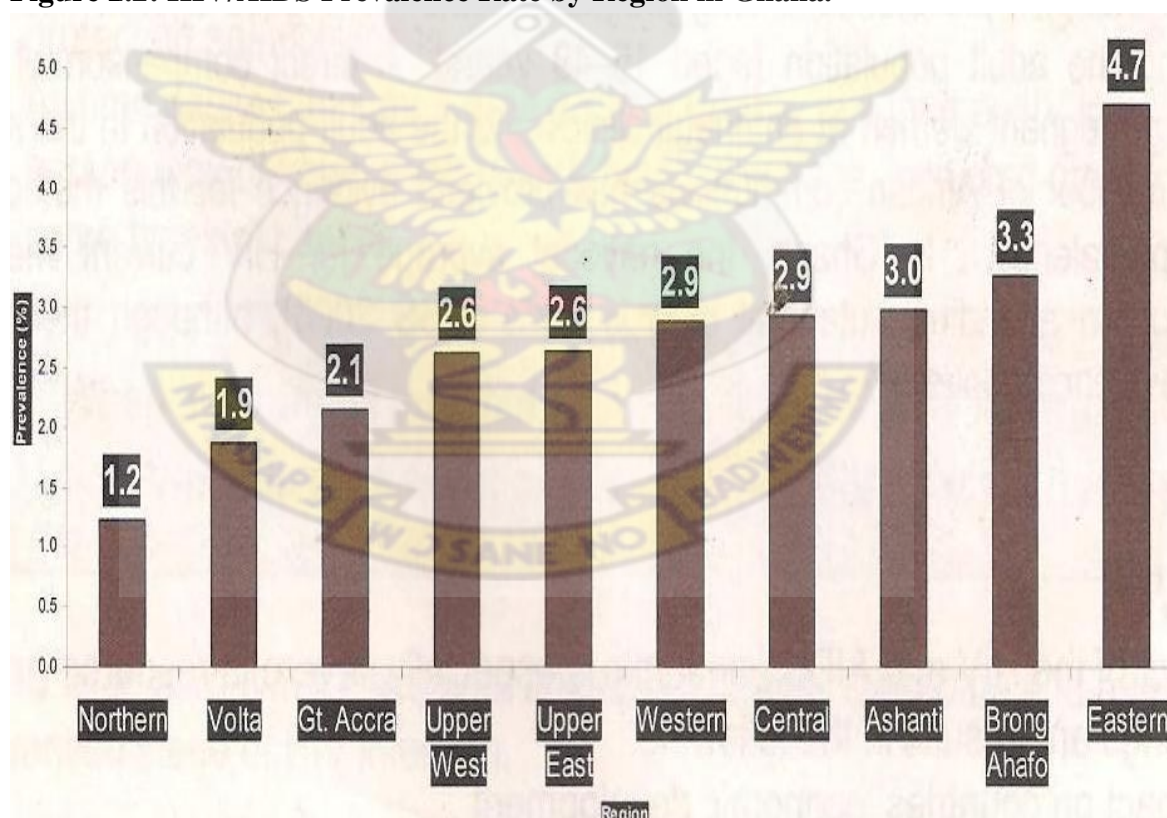
The Republic of Ghana has not been spared the global HIV/AIDS pandemic. The first HIV case in Ghana was diagnosed in 1986. Since then there has been steady increase in HIV prevalence rate in the country. By September 2004, 72,541 cumulative cases had been reported by the Ministry of Health (MOH), a figure believed to represent only 30 percent of cases due to under-reporting (Bentsi, 2003). Projections suggest that over 185,000 people were living with AIDS at the end of 2002. Surveillance data disaggregated by sex, age and region shows a high prevalence among the youth (15-30) years. Indeed, about 90 percent of the AIDS cases are within the reproductive age group of 15-49 years with the peak age group for females being 25-29 years and 30-34 years for males. Furthermore, the orphan population was estimated to be 170,000 (GoG/MOH, 2004)

According to the 2002 sentinel survey, the median HIV prevalence rate increased from 2.3 percent in 2000 to 3.6 percent in 2002 (GoG/MOH, 2003). This shows an increase of almost 50 percent. The national median HIV prevalence which increased in 2006 after declining for two consecutive years has declined to 2.2 percent, a level below that observed in 2002, the lowest in nine years. Prior to 2004 there had been a steady increase from 2.3 percent in 2000 to 3.6 in 2003. The 2008 results represent a 15.4 percent decline in prevalence from 2007 (GoG/MOH, 2007).

In Ghana, although the HIV prevalence is low, HIV is firmly established within the whole society. The HIV and AIDS population in 2007 was estimated at 312,030 people comprising 247,220 adults and 19,631 being children with cumulative death of 147,357 (GoG/MOH, 2007).

In 2008, the estimated adult national HIV prevalence was 1.7 percent, with an estimated 236,151 persons made up of 98,306 males and 137,845 females living with HIV and AIDS. There were 22,541 new infections and 18,082 AIDS deaths. Twenty one thousand children were living with HIV with 10,163 being females. Three thousand nine hundred and seventy eight (3,978) new infections occurred in almost equal proportions by gender. An annual AIDS death amongst children is estimated at 2,241. The urban and rural HIV prevalence is estimated at 2.1 percent and 1.5 percent respectively (GoG/MOH, 2009).

Figure 2.2: HIV/AIDS Prevalence Rate by Region in Ghana.



Source: GoG/MOH 2006

2.7 AIDS-related Stigma and Discrimination

Stigma is a common human reaction to diseases. Throughout history, many diseases have carried considerable stigma, including leprosy, tuberculosis, cancer, mental illness, and many sexually transmitted diseases (STDs). HIV/AIDS is only the latest disease to be stigmatised (UNAIDS, 2006).

HIV and AIDS are not the only greatest health challenges of our time, but they are also the greatest human rights challenges. Those who are aware of their seropositive status shoulder the twin burden of stigma and discrimination. The fear of becoming infected underlies stigma and discrimination, which remain major impediment to the prevention of HIV transmission and providing treatment, care, and support to people who are HIV-positive and their families. HIV and AIDS-related stigma is increasingly recognized as the single most humiliating challenge to the slowing of the spread of the pandemic at the global, continental, national and the community levels (Osei-Hwedie, 1994).

Stigma and discrimination relating to HIV/AIDS (AIDS-stigma) undermines public health efforts to combat the epidemic (USAID, 2003). AIDS stigma negatively affects preventive behaviours such as condom use, HIV test seeking behaviour upon diagnosis, quality care given to HIV-positive patients, and perception and treatment of PLHIVs by communities, families, and partners. One of the most surprising elements of AIDS stigma is its ubiquitous nature even where the epidemic is widespread and affecting so many people, such as Sub-Saharan Africa. Therefore, as many communities note, decreasing AIDS stigma is a vital step in stemming the epidemic (Herek, et al. 2002).

2.7.1 Stigma and Disclosure

Disclosure is the sharing of HIV status with others. Disclosure is advocated for the effective means for fighting the pandemic but it is often difficult and uncommon in practice. Most people believe that disclosure of HIV infection should be encouraged. Yet many people infected with HIV avoid disclosing their HIV status for fear that doing so will subject them to unfair treatment and stigma. However, disclosure can

encourage partner(s) to be tested for HIV to prevent the spread of the disease. It allows individuals to receive support from partner(s), family, and friends (GoG/MOH, 2005). The effects of stigma often extend beyond the infected individuals by association also known as secondary stigma. Secondary stigma is evidence in a statement like, “If I sit near someone with AIDS others will think I have AIDS too.” There are cases where healthcare providers have experienced such stigma because of their work with PLHIVs (GoG/MOH, 2005).

AIDS-related stigma and discrimination refers to prejudice, negative attitudes, abuse and maltreatment directed at people living with HIV and AIDS. They can result in being shunned by family, peers and the wider community; poor treatment in healthcare and education settings; an erosion of rights; psychological damage; and can negatively affect the success of testing and treatment.

AIDS stigma and discrimination exist worldwide, although they manifest themselves differently across countries, communities, religious groups and individuals. They occur alongside other forms of stigma and discrimination, such as racism, homophobia or misogyny and can be directed towards those involved in what are considered socially unacceptable activities such as prostitution or drug use. Stigma not only makes it more difficult for people trying to come to terms with HIV and manage their illness on a personal level, but it also interferes with attempts to fight the AIDS epidemic as a whole. On a national level, the stigma associated with HIV can deter governments from taking fast, effective action against the epidemic, whilst on a personal level it can make individuals reluctant to access HIV testing, treatment and care.

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 to seek treatment if so. It helps make AIDS the silent killer, because people fear the social disgrace of speaking about it, or taking easily available precautions. Stigma is a chief reason why the AIDS epidemic continues to devastate societies around the world (Ban Ki-moon, 2008).

2.8 Society and Culture

AIDS stigma exists around the world in a variety of ways, including ostracism, rejection, discrimination and avoidance of HIV infected people; compulsory HIV testing without prior consent or protection of confidentiality, violence against HIV infected individuals or people who are perceived to be infected with HIV, and the quarantine of HIV infected individuals (UNAIDS, 2006).

Stigma-related violence or the fear of violence prevents many people from seeking HIV testing, returning for their results, or securing treatment, possibly turning what could be a manageable chronic illness into a death sentence perpetuating the spread of HIV (Ogden/Nyblade, 2005). AIDS stigma has been further divided into the following three categories:

- Instrumental AIDS stigma—a reflection of the fear and apprehensions that are likely to be associated with any deadly and transmissible illness (Herek and Capitanio, 1999).
- Symbolic AIDS stigma—the use of HIV/AIDS to express attitudes toward the social groups or lifestyles perceived to be associated with the disease. (Herek and Capitanio, 1999).
- Courtesy AIDS stigma—stigmatisation of people connected to the issue of HIV-AIDS or HIV positive (Synder. et al, 1999).

Often AIDS stigma is expressed in conjunction with one or more other stigmas, particularly those associated with homosexuality, bisexuality, promiscuity, prostitution, and intravenous drug use.

In many developed countries, there is an association between AIDS and homosexuality or bisexuality and this association is correlated with levels of sexual prejudice such as anti-homosexual attitudes (Herek. et al, 2002). There is also a perceived association between AIDS and all male-male sexual behaviour including sex between uninfected men (Herek and Capitanio, 1999).

People in society who are often marginalized like the poor, men who have sex with men, injection drug users, sex workers and others frequently bear the blunt of the HIV and AIDS related-stigmatisation. Infected persons are often assumed to be members of these groups whether indeed they are or not (GoG/MOH, 2005).

2.9 Stigma related to HIV and AIDS

Fear of contracting the disease coupled with negative, value-based assumptions about people who are infected leads to high levels of stigma surrounding HIV and AIDS (UNAIDS, 2008). Factors that contribute to HIV/AIDS-related stigma:

- HIV/AIDS is a life-threatening disease, and therefore people react to it in strong ways.
- HIV infection is associated with behaviours (such as homosexuality, drug addiction, prostitution or promiscuity) that are already stigmatised in many societies.
- Most people become infected with HIV through sex which often carries moral baggage.
- There is a lot of inaccurate information about how HIV is transmitted, creating irrational behaviour and misperceptions of personal risk.
- HIV infection is often thought to be the result of personal irresponsibility.
- Religious or moral beliefs lead some people to believe that being infected with HIV is the result of moral fault (such as promiscuity or 'deviant sex') that deserves to be punished.

The fact that HIV/AIDS is a relatively new disease also contributes to the stigma attached to it. The fear surrounding the emerging epidemic in the 1980s is still fresh in many people's minds. At that time very little was known about the risk of transmission, which made people scared of those infected due to fear of contracting it. From the early days of the AIDS epidemic a series of powerful images were used that reinforced and legitimised stigmatisation.

- HIV/AIDS as punishment (e.g. for immoral behaviour)
- HIV/AIDS as a crime (e.g. in relation to innocent and guilty victims)
- HIV/AIDS as war (e.g. in relation to a virus which must be fought)

- HIV/AIDS as horror (e.g. in which infected people are demonised and feared)
- HIV/AIDS as otherness (in which the disease is an affliction of those set apart)

2.10 Different Contexts of HIV-Related Stigma

HIV/AIDS-related stigma is not a straightforward phenomenon as attitudes towards the epidemic and those affected vary a lot. Even within one country reactions to HIV/AIDS will vary between individuals and groups of people. Religion, gender, sexuality, age and levels of AIDS education can all affect how somebody feels about the disease. AIDS-related stigma is not static. It changes over time as infection levels, knowledge of the disease and treatment availability varies (Odgen and Nyblade, 2005).

In 2003, when launching a major campaign to scale-up treatment in the developing world the World Health Organization (WHO) claimed that HIV/AIDS has become a disease that could be both prevented and treated, attitudes change, and denial, stigma and discrimination would rapidly be reduced (WHO, 2001).

It is difficult to assess the accuracy of this statement as levels of stigma are hard to measure. A number of small-scale studies have however been conducted, with fairly positive results. A study of 1,268 adults in Botswana found that stigmatising attitudes had lessened three years after the national programme providing universal access to treatment was introduced. The study concluded that although improving access to antiretroviral treatment may be a factor in reducing stigma, it does not eliminate stigma altogether and does not lessen the fear of stigma amongst HIV positive people (Sayles, 2008).

The fact that stigma remains in developed countries such as America, where treatment has been widely available for over a decade, also indicates that the relationship between HIV treatment and stigma is not straightforward. An estimated 27 percent of Americans would prefer not to work closely with a woman living with HIV (UNAIDS, 2007).

Stigma may also vary depending on the dominant transmission routes in the country or region. In Sub-Saharan Africa, for example, heterosexual sex is the main route of infection, which means that AIDS-related stigma in this region, is mainly focused on promiscuity and sex work as an African woman in the UK remarked;

"Because it is about sex, in my country they then automatically think you got it because you have been loose...you are not anything better than a prostitute... they don't believe you didn't get it any other way" (Stigma Research, 2004).

This woman's experience reveals the multi-layered nature of stigma. Within her quote she reveals being stigmatised but perhaps unknowingly accepting the stigma against infected sex workers.

In Western countries where injecting drug use and sex between men have been the most common sources of infection; it is these behaviours that are highly stigmatised. Women with HIV or AIDS may be treated very differently from men in some societies where they are economically, culturally and socially disadvantaged. They are sometimes mistakenly perceived to be the main transmitters of sexually transmitted diseases (STDs). Men are more likely than women to be 'excused' for the behaviour that resulted in their infection.

"Even a married woman who has been infected by her husband will be accused by her in-laws... In such a male-dominated society no-one ever accepts that the man is actually the one who did something wrong... It is even harder on women since it is seen as a fair result of their sexual misbehavior." HIV-positive woman in Lebanon (IRIN/PlusNews, 2005).

2.11 The Effects of Stigma

"The epidemic of fear, stigmatization and discrimination has undermined the ability of individuals, families and societies to protect themselves and provide support and reassurance to those affected. This hinders, in no small way, efforts at stemming the epidemic. It complicates decisions about testing, disclosure of status, and ability to

negotiate prevention behaviours, including use of family planning services” (ICRW, 2008).

AIDS-related stigma has had a profound effect on the epidemic’s course. The UNAIDS (2007) cites the fear of stigma and discrimination as the main reason why people are reluctant to be tested, to disclose their HIV status or to take antiretroviral drugs. One study found that participants who reported high levels of stigma were more than four times more likely to report poor access to care. These factors all contribute to the expansion of the epidemic as a reluctance to determine HIV status or to discuss or practise safe sex means that people are more likely to infect others and a higher number of AIDS-related deaths. An unwillingness to take an HIV test means that more people are diagnosed late, when the virus has already progressed to AIDS, making treatment less effective and causing early death (Sayles. et al, 2008).

The widespread fear of stigma is held accountable for the relatively low uptake of prevention of mother-to-child transmission (PMTCT) programmes in countries where treatment is free. In the case of Botswana, for example, despite the fact that the service is available at every antenatal centre in the country, only 26 percent of pregnant women availed themselves of the opportunity to protect their unborn children. Over half refused to take a test, and nearly half of those who tested positive did not go on to accept treatment (GoB/HM, 2004). Research by the International Centre for Research on Women (ICRW, 2008) found the possible consequences of HIV-related stigma to be:

- Loss of income/livelihood,
- Loss of marriage and childbearing options,
- Poor care within the health sector,
- Withdrawal of care giving in the home,
- Loss of hope and feelings of worthlessness,
- Loss of reputation.

Some of these consequences refer to ‘internal stigma’ or ‘self-stigma’. Internal stigma refers to how people living with HIV regard themselves, as well as how they see public perception of people living with HIV. Stigmatising beliefs and actions may be imposed by people living with HIV themselves:

"I am afraid of giving my disease to my family members—especially my youngest brother who is so small. It would be so pitiful if he got the disease. I am aware that I have the disease so I do not touch him—I talk with him only. I don't hold him in my arms now "a woman in Vietnam (ICRW, 2008).

Self-stigma and fear of a negative community reaction can hinder efforts to address the AIDS epidemic by perpetuating the wall of silence and shame surrounding the epidemic. Stigma also exacerbates problems faced by children orphaned by AIDS. AIDS orphans may encounter hostility from their extended families and community, and may be rejected, denied access to schooling and health care, and left to fend for themselves.

Fear of stigmatisation and discrimination acts as significant barrier to people taking part in HIV testing, and, by extension, seeking treatment. This can be a particularly serious issue in the workplace where such discrimination has potential to compromise a person's career or even to lead to their exit- with significant consequences for the individual and their employer. Stigma and discrimination kill, they keep people from getting tested, and from getting care and support if they need it. Ending stigma is one of the most effective things any one can do to stop AIDS (Tedstrom, 2008). In addition, different names calling associated with HIV and AIDS are so abusive that it prevents HIV-infected persons to come out to disclose their HIV status. In some countries, tags like "a walking corpse", "expected to die", "that disease", "the thing", among others are used to describe people living HIV/AIDS (GoG/MOH, 2008).

2.12 Types of HIV/AIDS-Related Stigma and Discrimination

AIDS-related stigma can lead to discrimination such as negative treatment and denied opportunities on the basis of a person's HIV status. This discrimination can occur at all levels of a person's daily life, for example, when they wish to travel, use healthcare facilities or seek employment.

2.12.1 Government

A country's laws, rules and policies regarding HIV can have a significant effect on the lives of people living with the virus. Discriminatory practices can alienate and ostracise people living with HIV, reinforcing the stigma surrounding the disease.

In 2008, UNAIDS reported that 67 percent of countries now have some form of legislation in place to protect people living with HIV from discrimination (UNAIDS, 2007). However, Ban Ki-moon, Secretary-General of the United Nations, believes that 'almost all permit at least some form of discrimination' against HIV/AIDS infected persons.

There are many ways that governments can actively discriminate against people or communities with, or suspected of having HIV/AIDS. Many of these laws have been justified on the grounds that the disease poses a public health risk. Below are some examples of government level stigma and discrimination against people living with HIV/AIDS:

- President Museveni of Uganda supports the national policy of dismissing or not promoting members of the armed forces who test HIV positive (Eagle, 2003).
- The Chinese government advocates compulsory HIV testing for any Chinese citizen who has been living outside of the country for more than a year (China View, 2007).
- The UK legal system can prosecute individuals who pass the virus to somebody else, even if they did so without intent.

2.12.2 Healthcare

In healthcare settings people with HIV can experience stigma and discrimination such as being refused medicines or access to facilities, receiving HIV testing without consent, and a lack of confidentiality. Such responses are often fuelled by ignorance of HIV transmission routes amongst doctors, midwives, nurses and hospital staff. That medical staff should perhaps have a better understanding of HIV makes discrimination in healthcare settings all the more damaging. Lack of confidentiality has been repeatedly mentioned as a particular problem in health care settings. Many

people living with HIV/AIDS do not get to choose how, when and to whom to disclose their HIV status. Studies by the WHO in India, Indonesia, the Philippines and Thailand found that 34 percent of respondents reported breaches of confidentiality by health workers (Stigma Research, 2004).

Doctors in healthcare setting in resource-poor areas with limited or no drugs have reported a frustration with the lack of options for treating people with HIV/AIDS, who were seen as 'doomed' to die (Stigma Research, 2004). This frustration may mean that AIDS patients are not prioritized or are actively discriminated against. Fear of exposure to HIV as a result of lack of protective equipment is another factor fuelling discrimination among doctors and nurses in under-resourced clinics and hospitals.

Stigma and discrimination in healthcare settings are not confined to developing countries. Below an HIV positive woman in London, UK tells of her experience with an National Health Service dentist:

“I have a dental problem and I go to this clinic, and I go there, two maybe three times. So eventually I told them about my condition. They explained that I would have to be the last appointment of the day. I have been to that room, and sat on that chair, and the same doctor examined me as before, but after I told them I was HIV positive. So I went for the last appointment of the day last week, they covered the chair, the light; the doctors were wearing three pairs of gloves (Roome and Hadler, 1991).

A review of research into stigma in health care settings advocated a multi-pronged approach to tackling it, requiring action on the individual, environmental and policy levels. Health care workers need to be made aware of the negative effect that stigma can have on the quality of care patients receive; they should have accurate information about the risk of HIV infection, the misperception of which can lead to stigmatising actions; and they should also be encouraged to not associate HIV with immoral behaviour. Facilities should have sufficient equipment and information so health workers can carry out universal precautions and prevent exposure to HIV. Policies within health care settings can also be effective in reducing stigma. Such programmes would involve participatory methods like role play and group discussion, as well as training on stigma and universal precautions. The involvement of people

living with HIV could lead to a greater understanding of patients' needs and the negative effect of stigma (Human Rights Watch, 2009).

2.12.3 Employment

In the workplace, people living with HIV may suffer stigma from their co-workers and employers, such as social isolation and ridicule, or experience discriminatory practices, such as termination or refusal of employment. Fear of an employer's reaction can cause a person living with HIV anxiety:

"It is always in the back of your mind, if I get a job, should I tell my employer about my HIV status? There is a fear of how they will react to it. It may cost you your job; it may make you so uncomfortable it changes relationships. Yet you would want to be able to explain about why you are absent, and going to the doctors" HIV-positive woman in UK (Stigma Research, 2004).

"Though we do not have a 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'll 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'll not buy it," a Head of Human Resource Development India (WHO/UNAIDS, 2003).

2.12.4 Restrictions on Travel and Stay

Many countries have laws that restrict the entry, stay and residence of people living with HIV. Almost 60 countries, territories and areas have restrictions that specifically apply to HIV or AIDS based on positive status alone. This number does not include those countries where the legislation uses language such as "contagious" or "transmissible diseases" if HIV and AIDS are not mentioned specifically.

UNAIDS (2006) has identified around a dozen restrictions applying to HIV-positive people regarding entry, stay and residence. Six countries including China require a declaration of HIV status which can result in HIV-positive people being denied entry or stay, or the need for discretionary approval. Until 4th January 2010 the United

States restricted all HIV positive people from entering the country, whether they were on holiday or visiting on a longer-term basis (Human Rights Watch, 2010).

Twenty-six countries including Egypt, Russia, China, Korea and the U.S.A. deport foreigners based on their positive status alone. Some countries have policies that could violate confidentiality of status if, for example, a stamp is required on a waiver or passport in order to gain entry or stay. Students living with HIV are barred from applying to study in certain countries including Malaysia, the U.S.A. and Syria.

Deportation of people living with HIV has potentially life threatening consequences if they have been taking antiretroviral drugs. If they are deported to a country that has limited treatment provision, this could lead to drug resistance and death. Alternatively, people living with HIV may face deportation to a country where they would be subject to even further discrimination. As Human Rights Watch has pointed out, this practice could contravene international law (Human Rights Watch, 2009)

Community level stigma and discrimination towards people living with HIV/AIDS is found all over the world. A community's reaction to somebody living with HIV/AIDS can have a huge effect on that person's life. If the reaction is hostile a person may be ostracised and discriminated against and may be forced to leave their home, or change their daily activities such as shopping, socialising or schooling (MMWR, 2006).

"At first relations with the local school were wonderful and Michael thrived there. Only the head teacher and Michael's personal class assistant knew of his illness... Then someone broke the confidentiality and told a parent that Michael had AIDS. That parent, of course, told all the others. This caused such panic and hostility that we were forced to move out of the area. Michael was no longer welcome at the school. Other children were not allowed to play with him - instead they jeered and taunted him cruelly. One day a local mother started screaming at us to keep him away from her children and shouting that he should have been put down at birth. Ignorance about HIV means that people are frightened. And frightened people do not behave rationally. We could well be driven out of our home yet again" a British woman

describing the experience of her foster son in a British school (Human Rights Watch, 2009).

Community-level stigma and discrimination can manifest as ostracism, rejection and verbal and physical abuse. It has even extended to murder. AIDS related murders have been reported in countries as diverse as Brazil, Colombia, Ethiopia, India, South Africa and Thailand. In December 1998, Gugu Dhlamini was stoned and beaten to death by neighbours in her township near Durban, South Africa, after speaking openly on World AIDS Day about her HIV status (Baleta, 2003).

2.12.5 Family

In the majority of developing countries families are the primary caregivers when somebody falls ill. There is clear evidence that families play an important role in providing support and care for people living with HIV and AIDS. However, not all family responses are positive. HIV-infected members of the family can find themselves stigmatised and discriminated against within the home. There is concern that women and non-heterosexual family members are more likely than children and men to be mistreated.

“When I was in hospital, my father came once. Then he shouted that I had AIDS. Everyone could hear. He said: this is AIDS, she’s a victim. With my brother and his wife I wasn’t allowed to eat from the same plates, I got a plastic cup and plates and I had to sleep in the kitchen. I was not even allowed to play with the kids” HIV-positive woman in Zimbabwe (Cunningham, 2005).

A Dutch survey of people living with HIV found that stigma in family settings - in particular avoidance, exaggerated kindness and being told to conceal one's status - was a significant predictor of psychological distress. This was believed to be due to the absence of unconditional love and support, which families are expected to provide (Tedstrom, 2008).

However, since the outbreak of the HIV/AIDS pandemic in the 80s, experience in Malawi and the rest of Africa shows that the family plays a key role in caring for

those infected by HIV as a Malawian man who was domiciled in Lusaka, Zambia indicates. In 2001, Maqunda has a child who died few months after birth from AIDS related conditions (ARC). Later his wife started presenting with ARC and died after visiting several health facilities. Later, he started presenting with ARC and his health deteriorated. He was hospitalized in different health facilities but did not respond positively to medications. Later, he started showing signs of acute depression. He resisted attempt by his friends to access voluntary counselling and testing (VCT) service. Without a family in Lusaka, he was unable to receive the necessary attention to improve his ailing health condition. He returned to Malawi to seek support from his family members. While in Malawi, his brother facilitated an HIV test, which was positive. He was commenced on ART treatment and his condition has improved and now living happily and running a business in Lilongwe (Kuchande, 2004).

2.12.6 Faith-Based Organization

HIV/AIDS continues to be a major obstacle to prevention and care intervention in SSA. Faith-based organizations (FBOs) have shown to both foster HIV stigma as well as mitigate it as 15 male and female Tanzanian church leaders emerged from a participatory workshop to assess their HIV health preventing activities following a series of HIV/AIDS and reproductive health training session.

The participants were allowed to define the root social cause of HIV underlying stigma and revealed the lack of language to talk about HIV/AIDS stigma. However, participants had moved from the position of silence and condemnation to teaching about HIV/AIDS. Ten of the participants actively did some form of HIV education and their own actions have influenced their church membership's attitude towards HIV. However, others faced opposition from even senior pastors. All the same, narrative and HIV work within the church community create opportunity for reflection and compassion needed to combat the disease (Kissioki, 2006).

In Zimbabwe, although the majority of people know about HIV and AIDS, there is still a widespread belief that being HIV-positive is shameful, even “a punishment from God”. The stigma that surrounds infection prevents people from getting tested, seeking treatment and admitting their HIV-positive status to others.

The Anti-Stigma Campaign, which is supported by Department for International Development (DFID), aims to change attitudes towards HIV/AIDS, and so get more people to access HIV-related services. Research has shown that the fear of casual transmission and a lack of empathy are major reasons for the high levels of stigma and discrimination in Zimbabwe. By telling the stories of prominent people who lead productive lives with HIV, the campaign hopes to make role models of those who are willing to share their HIV status in public, helping to overturn prejudices and encouraging others to follow their example.

“I wanted to die fast before my community knew about it” When Pastor Maxwell Kapachawo became ill in 2001, he did not think that the illness was HIV-related. However, the deterioration in his health became so great that he was ordered to leave his Ministry and even his Bishop shunned him. In 2004 Maxwell found out that he was HIV-positive. “Alas that was the end of me. I was bitter and wanted to die fast before even my community knew about it.” For a long time after his diagnosis, Maxwell felt that he could not continue as a pastor. However, a meeting with an old friend, also a pastor, changed his mind. “He told me that my status cannot make me the biggest sinner before God and he was ready to see me back in the ministry of God again. That became my turning point in life; I never thought one day I would again be able to say ‘God is good.’” Soon afterwards, inspired by a workshop for HIV-positive religious leaders, Maxwell spoke to his congregation about his own situation. “About three weeks after disclosing my status in the church, about half the church testified that they had gone for their HIV test. They were happy to know their status because they had seen life in me.”

2.12.7 Living with HIV and Serving the Community

Maxwell now understands the power of community leaders to change attitudes towards HIV and AIDS. The question of “How did you get it?” has hindered a lot of people to get help and support because of the stigma and discrimination within our places of worship. It’s tragic when someone with the HIV virus goes to their pastor for support and it is rejected.

“But if religious leaders were better informed and trained to respond to the needs of people living with HIV, they would know how to respond in a more understanding and supportive way. I have learnt that HIV has given me a better opportunity to serve God.”

Anti-Stigma is telling Maxwell’s story to Zimbabweans to show how being HIV-positive is not shameful, and may still allow a person to live a rewarding and valuable life. By being public about their HIV status, Maxwell and the others like him featured in the campaign should help to increase empathy and acceptance towards those living with HIV and AIDS, and so encourage more people to access HIV-related services. “We must transform the HIV issue into productive ideas, and overcome ignorance. But first we must admit our ignorance and create room for caring, loving and supporting people living with HIV,” concludes Maxwell.

Anti-Stigma was launched in March 2007 as the second part of a campaign to reduce levels of HIV infection in Zimbabwe by tackling issues of stigma and discrimination. The first campaign, launched in May 2005, has been successful in addressing stigma as a barrier to accessing HIV services. Those exposed to the campaign were more likely to know their HIV status (31 percent) than those not exposed (16 percent), and were less likely to see “HIV as a punishment from God” and now “touching an HIV positive person or playing with an HIV positive child” Therefore the most effective response to the HIV and AIDS epidemic are those that seek to prevent the stigma and discrimination associated with HIV and to protect the human rights of people living with HIV and those at risk of infection (DFID/ZIMBABWE, 2008).

2.13 United States Policy on HIV/AIDS

In 2001, at the United Nations General Assembly Special Session (UNGASS) on HIV/AIDS, 189 national governments including the United States of America adopted the Declaration of commitment on HIV/AIDS. The document commits government to improve response to their domestic Aids epidemic and set targets for AIDS related financing policy and programming. The Declaration also stipulated that government conduct periodic reviews to assess the progress on realizing their UNGASS

commitment in recognition of the crucial role civil society plays in response to HIV/AIDS, in the review process (Public Health Watch, 2005).

The United States of America came out with policies to address the spread of the pandemic both within and outside. According to UNGASS Declaration, national governments were to establish time bound national target to achieve the internationally agreed global prevention goal to reduce by 2005 HIV, prevalence among young men and women aged 15-24 in the most affected countries by 25 percent (Holtgrave and Curan, 2006).

It cannot be denied that myths; stigmatization and misconception about HIV remain some of the greatest challenges facing PLHIVs who face a lot of gross disrespect, prominent among which are rejection from their homes, discrimination, stigmatization, and violations of their human rights (National Research Council, 2005).

It therefore became necessary that positive steps were taken to address the perception and attitude held by majority of community members irrespective of being a developed or developing country.

Against this background United States of America embarked on policy objectives to:

- Create an enabling environment to eliminate all forms of discrimination against PLHIVs,
- Scale up prevention against HIV/AIDS removing stigma, fears changing high risk behavior and,
- Engender more compassion and positive attitudes from the society at large and that the realization of human right and fundamental freedom for all is essential to reduce vulnerability to HIV/AIDS and that respect for the rights of PLHIVs drives on effective response to an effective treatment.

2.13.1 Success Stories

The annual HIV transmission rate, an estimate of the percentage of people who pass this infection to others has fallen significantly over the course of the United States

epidemic. In 1983, the rate was 43.9 percent but within two years had being reduced to 25.23 percent due to a legislation passed to end all forms of discrimination against PLHIVs in the health sector. The transmission rate is between 4 percent and 4.34 percent, meaning that approximately 96 people living with HIV/AIDS (PLHIVs) do not transmit the virus to others in a given year (Public Health Watch, 2005).

The knowledge of serostatus with appropriate counseling has become a powerful tool. People who know their HIV status are now highly unlikely to transmit HIV to others. It is estimated that the HIV transmission rate among those who know they are HIV positive is 1.7 percent, compared with 8.8 percent to 10.79 percent for those who are unaware of their status. The federal government provides resources to address the housing, mental health and substance abuse treatment needs of PLHIVs. The Housing Opportunities for People Living with AIDS (HOPWA) funds housing assistance and related support services for low income persons with HIV/AIDS and their families (Anderson, 2004).

2.13.2 Challenges

AIDS reveals and exploits longstanding inequities in the American Society and health care access. The country has failed to come to grips with an interwoven set of social factors including economic inequality, racial and gender disparities, racial discrimination and health care service. The epidemic among African Americans is the clearest example of the harsh disparities that characterize AIDS in the United States of America. No significant progress can be made on the national level outcomes unless policy and programming better meets the needs of this community. African Americans account for 40 percent of cumulative AIDS diagnoses through 2004, though they represent only 12 percent of the United States population. In 2004, African Americans accounted for 50 percent of new HIV/AIDS diagnoses in the area with confidential name base reporting HIV. Between 2000 and 2004, deaths among African-Americans with HIV declined 7 percent compared with 19 percent decline among whites over the period (Kaiser Family Foundation, 2005).

HIV Cost and Services Utilization Study (HCSUS) also found that African-Americans fared poorly with regard to access to health care than whites and were more likely to

report postponing medical care because they lacked transportation, were too sick to go to the doctor, or has other competing needs (CDC/MMWR, 2004).

By 2003, a new law was enacted, strengthened or enforced, as appropriate legislation, regulation and other measures to eliminate all forms of discrimination and stigmatization against and to ensure the full enjoyment of all human rights and fundamental freedom by PLHIVs and members of other vulnerable groups. Though federal law prohibits discrimination against PLHIVs, it is one additional factor inhibiting access to care and treatment (Kaiser Family Foundation, 2005).

In 2003, the American Civil Union released a report documenting civil rights violation against PLHIVs in employment, child custody and visitation medical care and housing (Kaiser Family Foundation, 2005). In a Kaiser study released in June 2004, 28 percent respondents said they would be “somewhat” or “very uncomfortable” working with someone who has HIV or AIDS (Kaiser Family Foundation, 2005). The Americans with Disabilities Act (ADA) widely interpreted as outlawing discrimination against PLHIVs based largely on 1998 Supreme Court ruling. Yet ADA does not specifically mention HIV and so the extent of these protections at the federal level is not entirely clear.

2.14 Ghana’s Response to HIV/AIDS

Ghana paid serious attention by responding early to the HIV and AIDS epidemic. The initial response was coordinated by the Ministry of Health (MOH). It was later realized that the continuous increase of the threat needed strong political commitment and a multi-sectoral approach to stop the spread of the disease. In view of this, a National HIV/AIDS Strategic Framework (NSF) was developed as an important guide to fight the menace at the national, regional, district and community levels (GoG/MLGRD, 2004).

Subsequently, the District Response Initiative (DRI) was introduced to mobilize local capacity for a multi-sectoral response to HIV/AIDS at the district level. This was through a collaborative effort of the Ministry of Manpower and Development (then

Ministry of Employment and Social Welfare), UNAIDS, WHO, German Technical Cooperation (GTZ) and DFID.

The DRI has since 2001 been under the Ministry of Local Government and Rural Development and implemented with the Ghana HIV/AIDS Strategic Framework, which is coordinated by the Ghana AIDS Commission. (GoG/MLRGD, 2004). The objectives of the DRI in Ghana are:

- To attain the goals of National Strategic Framework by decentralization of national response;
- To create a rallying point for HIV/AIDS at the district level;
- To provide a forum for dialogue for local government, the private sector, NGOs, CSOs and communities in HIV/AIDS;
- To ensure the mobilization of human, financial and material resources for HIV/AIDS at the district level and;
- To present a comprehensive implementation strategy for the prevention, care and support priorities of the HIV/AIDS National Strategic Framework.

Due to this the Ministry of Health (MOH) and the Ghana Education Service (GES) came out to incorporate the teaching of AIDS issues in the school curriculum at both the basic and second cycle levels to inculcate in the pupils and students to be abreast with the dangers of the disease (GoG/MLGRD, 2004).

CHAPTER THREE

RESEARCH METHODOLOGY AND PROFILE OF THE STUDY AREA

3.0 Introduction

This chapter deals with the research approach, the study population and the sampling method which was used in the selection of the respondents plus data requirements, forms and collection methods or instrumentation used and how data were analysed. Again it describes on the location and size of the study area, the physical characteristics, natural resources, demographic characteristics, household sizes, migration trend, and health facilities availability among others.

3.1 Research Approach

The case study approach was used in collecting information for the study. The case study was used because it is an empirical enquiry that allows the researcher to investigate and understand the dynamics of the phenomenon being studied. It also focuses on contemporary issues like this topic. It again probes deeply and therefore gives proper meaning to what is being investigated (Amedahe, 2002). The case study is to determine the factors relating to the respondents knowledge base about the disease and how it affects the support and care to PLHIVs.

3.2 Sample Size Determination

The calculation of the sample size was done using the formula:

$$n = \frac{N}{1 + N (\alpha)^2}$$

Where 'n' is the sample size

N is the total number of population (Households)

α is the margin of error (7%)

Thus the sample used for this study was computed using:

$$N = 21,492$$

$$\alpha = 0.07$$

$$\text{Therefore, } n = \underline{\hspace{2cm} 21,492 \hspace{2cm}}$$

$$n = \frac{1 + 21,492 (0.07)^2}{106.3108}$$

$$n = 202$$

Thus, the number of questionnaires to be administered was estimated at 200.

Table 3.1: Household Sampled Respondents for the Study.

Area	Electoral Areas	Electoral Areas Selected	%	Administered Questionnaire	%
Sunyani	13	7	53.8	144	72
Abesim	3	1	33.3	34	17
Atronie	2	1	50.0	22	11
Total	18	9		200	100

Source: Sunyani Municipal Assembly, April 2009.

Based upon the skewed nature of the population, 144 respondents representing 72 percent, 34 respondents representing 33 percent and 22 respondents representing 11 percent questionnaires were administered in the Sunyani Urban, Abesim Town and Atronie Area councils respectively.

3.3 Sampling Technique

The research utilized a combination of both probability and non-probability techniques. As the topic was a sensitive one, the snowball technique was used to solicit for information from infected persons through health personnel who were already aware of their HIV status. These were the people they have confided in and hence could convince them to provide the researcher with the confidential information. Information from the cross-section of the general public was also collected through simple random sampling technique from respondents who were interviewed on their knowledge about the disease, its mode of transmission and how they would relate to an infected person whether he or she was a relative, a friend or a community member. The respondents came from the Sunyani urban, Abesim town and Atronie area councils in the Municipality. Purposive sampling technique was used

to collect information from the health personnel from the Municipal hospital as well as the Seventh Day Adventists Church coordinator in charge of health services as they have a wealth of information on the topic.

Furthermore, stratified sampling was adopted to select the respondents from the 18 electoral areas of the municipality. The electoral areas were stratified into Sunyani Urban Council with 13 electoral areas, Abesim Town Council with three electoral areas and Atronie Area council with two electoral areas. One electoral area from the Abesim and Atronie which have three and two electoral areas and seven electoral areas out of the thirteen in the Sunyani Township respectively were randomly selected.

The nine electoral areas were selected due to the fact that amongst all the electoral areas within the Municipality, they have more HIV/AIDS cases according to the Municipal Health Directorate.

Based on the uneven number of electoral areas, proportional stratification was used to select the number of respondents for the study. Hence, 72 percent representing 144 household respondents, 17 percent representing 34 household respondents and 11 percent representing 20 household respondents from the Sunyani Urban council, Abesim Town council and the Atronie area council respectively were selected to answer the questionnaires.

3.4 Data Collection Methods

Data were derived from both primary and secondary sources. Interviewing, involving the collection of data through direct interaction between the researcher and the individuals from whom information was needed was adopted. The questionnaire is a series of questions that are written down for respondents to answer. Examination of relevant secondary data from publications in the areas of the Ministry of Health, Ghana AIDS Commission, World Health Organization, the internet, books, periodicals, and articles from published and unpublished sources were also used for the study.

Field survey involving the administration of questionnaires was adopted. The questionnaires were administered to the sampled household respondents. The questionnaires were administered by the researcher and other six research assistants. The six research assistants were given a day's training by the researcher on how to administer the questionnaires. In the training, they were given orientation on how to establish rapport with the respondents. They were again briefed on the purpose of the study.

An interview guide was used to interview health personnel, the Municipal Assembly focal person on HIV/AIDS, the three NGOs and two religious bodies. A topic guide or a checklist was used to generate free range of discussions with infected persons themselves and some close relations which here means a parent, a sibling or a spouse and children on individual basis to collect the opinions or views of each person without being influenced by another. Individual in-depth interview was used to interview household respondents. This led to diversity of opinions and clearer understanding of the phenomenon to include topics that come spontaneously which would not have been foreseen to be relevant. Interviewer also had the opportunity to ask for further clarification where necessary.

3.5 The Population of HIV/AIDS Patients

According to Amedahe (2002), the population always comprises the total collection of the elements in which the researcher is interested. The target population for the study was the HIV/AIDS infected persons in the Sunyani Municipality of the Brong-Ahafo Region. The total number of infected persons for 2008 and 2009 were 250. However, those receiving Anti-Retroviral Therapy (ART), the accessible population were only 16 with two defaulters and two deaths. The total number of the 250 was not publicly known. Therefore, it was prudent to reach out to all the 16 known persons within the study period to get varied opinions about the subject matter. However, 13 out of the 16 were able to be contacted and interviewed. Again, the 2 defaulters were to be contacted to solicit for their views on stigmatisation of HIV/AIDS persons by society but since they have re-located, they could not be reached.

Table 3.2 Reported HIV/AIDS Persons, 2008-2009

AGE	>10		10-14		15-19		20-24		25-29		30-34		35-39		40-44		45-49		50+		TOTAL	%
SEX	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F		
2008 # TESTED	1	1	97	102	223	314	265	836	218	968	171	897	146	417	122	300	102	110	63	69	5422	100
# POSITIVE	0	0	0	1	1	3	2	14	6	10	4	37	8	10	2	5	0	1	2	3	109	2.0
% AGE GROUP POSITIVE	0		0.9		3.6		14.6		14.6		37.6		16.5		6.4		0.9		4.5			
2009 # TESTED	3	1	123	139	772	604	377	1108	300	1271	198	961	197	553	147	392	119	141	70	82	7558	100
# POSITIVE	1	0	0	1	3	3	5	18	5	19	6	42	6	15	2	8	0	1	3	3	141	1.8
% AGE GROUP POSITIVE	0.7		0.7		4.2		16.3		17.0		34.0		14.8		7.0		0.7		4.2			

Source: Sunyani Municipal Health Directorate, 2009

Table 3.2 above shows the number of reported cases of HIV/AIDS infected persons for the 2008 and 2009 years. Out of a total number of 12,980 people tested for HIV/AIDS, 250 were positive.

Table 3.3: ART Services, 2009.

INDICATORS	SEX	AGE GROUP										SUB TOTAL	TOTAL	%
		>10	10-14	15-19	20-24	25-29	30-34	35-39	40-44	45-49	50+			
# OF HIV/AIDS CASES ON ART	M	0	0	0	0	4	0	0	1	0	1	6	16	100
	F	0	0	0	3	2	4	1	0	0	0	10		
# OF RX FAILURES	M	0	0	0	0	0	0	0	0	0	0	0	0	0
	F	0	0	0	0	0	0	0	0	0	0	0		
DEFAULTERS	M	0	0	0	0	0	1	0	0	0	0	1	2	12.5
	F	0	0	0	0	1	0	0	0	0	0	1		
# OF EXPOSED BABIES SCREENED @ 18MONTHS												0		100
# OF EXPOSED BABIES POSITIVE @ 18MONTHS												0		23.5
DEATHS	M	0	0	0	0	0	0	1	0	0	0	1	2	12.5
	F	0	0	0	0	0	1	0	0	0	0	1		
HAART FEES COLLECTED												60		

Source: Sunyani Municipal Health Directorate, 2009

Table 3.3 above shows the number of HIV/AIDS infected persons receiving ART from the hospital's service centre. These 16 persons serve as the accessible respondents. Defaulters here mean those HIV-infected persons who were receiving ART but due to the improvement in their health status have since stopped the treatment.

3.6 Mode of Data Analysis

The statistical package for social scientists sixteenth edition was used to generate tables for the analysis of the study.

3.7 Profile of the Study Area (Sunyani Municipal Assembly, 2006-2009)

3.7.1 Location and Size

Sunyani Municipality is one of the 22 administrative districts of the Brong Ahafo Region of the Republic of Ghana. It lies between latitudes $90^{\circ} 28'$ North and $90^{\circ} 55'$ North and longitudes $20^{\circ} 3'$ West and $20^{\circ} 5'$ West and shares boundaries with Sunyani West District to the north, Dormaa Municipality and Berekum Municipality to the west, Asutifi District to the south and Tano North District to the east.

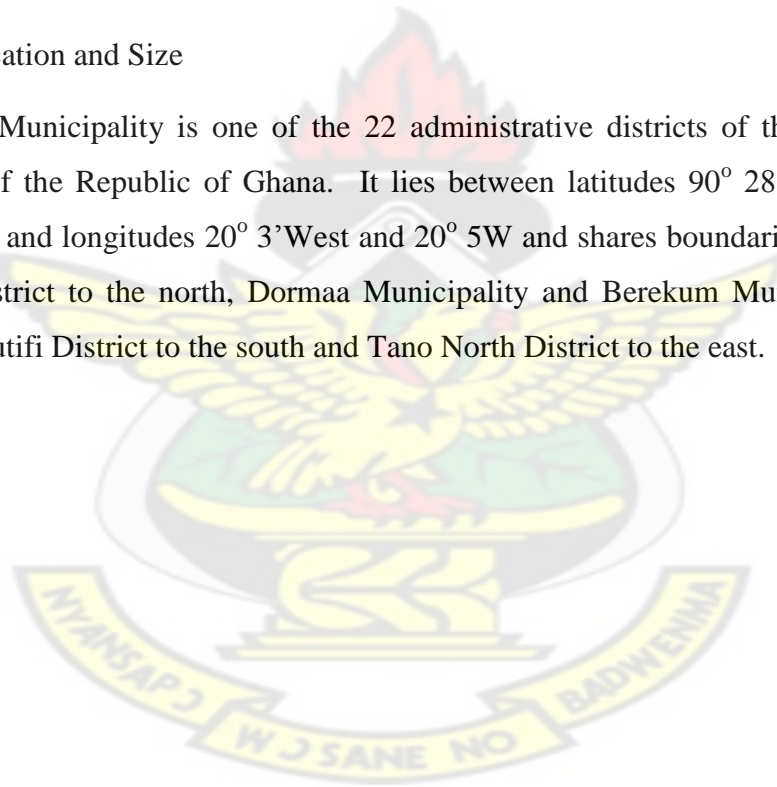
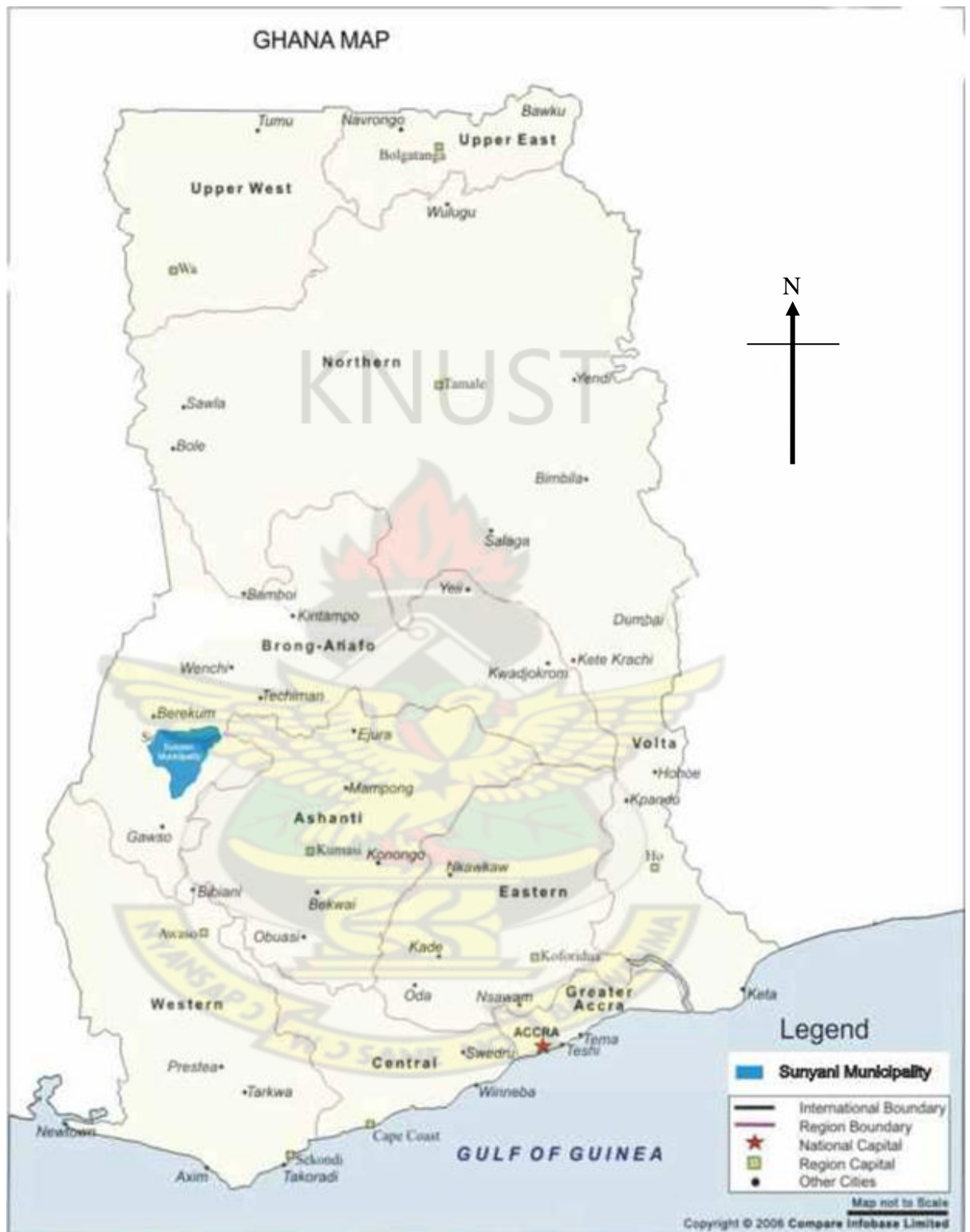
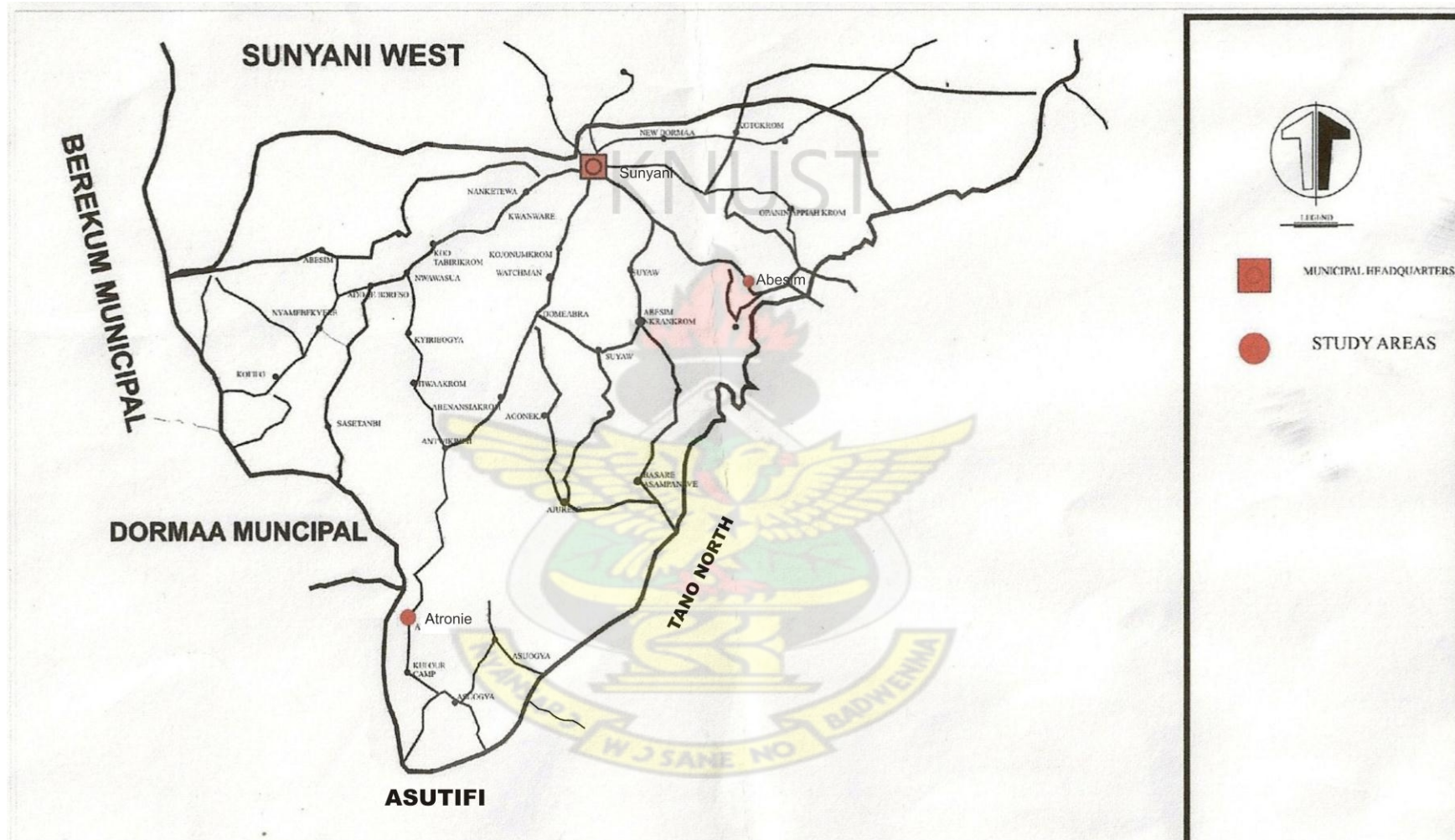


Figure 3.1 Sunyani Municipality in the National Context



Source: Compare InfoBase Limited, 2006.

Figure 3.2 Sunyani Municipality Showing the Study Areas



Source: Sunyani Municipal Assembly, 2010.

The Municipality has a total land area of 829.3 square kilometers. The Municipal capital, Sunyani is the largest settlement in the region in terms of population and area extent and also serves as the regional capital of Brong Ahafo.

3.7.2 Physical characteristics

Sunyani Municipality falls within the middle belt of Ghana with heights ranging between 750 feet (229) meters to 1,235 feet (376 meters) above sea level. The drainage is basically dendritic with several streams and rivers notably Tano, Amoma, Benu and Yaya. Most of the water bodies are seasonal and sometimes dry up in the dry season. This often creates water shortage in the Municipality during this period for both domestic and agricultural use.

3.7.3 Climate and Vegetation

The Municipality falls within the wet semi-equatorial climatic zone characterised by double-maxima rainfalls a year. Major rains start in April and end in July and the minor from September to October. Average rainfall is about 170 cm. The dry season often lasts for five months (between November and mid-March) each year. The abundance of rainfall offers the district a comparative advantage in agricultural production.

Sunyani Municipality falls within the moist-semi deciduous forest vegetation zone. The major vegetation types are grassland, broken forests and forest reserves. Most of the primary forest vegetation can be found in patches around the northwest, east and southern parts of the Municipality. This vegetation zone contains most of the Municipality's valuable timber resources. In recent times however, the forest is depleting so fast into savannah vegetation through human activities such as agriculture, settlement expansion, bushfires and indiscriminate felling of trees.

3.7.4 Demographic Characteristics

The population of the Municipality has been growing steadily since 1970. Between 1970 and 1984 the population of the Municipality grew at the rate of 3.5 percent per year from 60,344 to 98,183. The 2000 population and housing census put the

population of the old Municipality at 179,165 with a growth rate of 3.8 percent per year. The population of the current Municipality is estimated at approximately 112,446 with the same population growth rate of 3.8 percent. There are four major towns within the Municipality namely Sunyani, Abesim, New Dormaa and Atronie with a number of smaller communities scattered within the Municipality.

The steady increase in the Municipality's population may be attributed to in-migration to Sunyani which serves as the Regional and Municipal capital, as well as that of settler farmers into major farming areas.

3.7.5 Spatial Distribution and Density of Population

The distribution of population in the Municipality is generally skewed. The four largest localities of Sunyani, Abesim, New-Dormaa and Atronie hold about 96.3 percent of the municipality's population with only 3.7 percent distributed among the other smaller settlements. Sunyani alone accommodates 72 percent of the district's total population. The concentration of population in the four major settlements has increased demand for utility services such as water, electricity and telephone services. Equally, there is pressure on accommodation. Waste generation has also increased, especially in Sunyani.

3.7.6 Household Size/Characteristics

The 2000 population and housing census indicate that the average household size is less than 5 (4.7) which is almost the same as the region's 5.3 and the national average of 5.1.

Household sizes range between 1-3 and 4-6 members and above 7 members. On the whole, household in the urban areas of the municipality is quite larger than those in the rural areas. A significant aspect is that about 41.7 percent of households with size of seven (7) and above are living in urban areas with only about 7.1 percent in the rural areas. The traditional family structure still exists in the Municipality. Females head more than a third (34.6) of the households in the Municipality. The ages of female-headed households range between 15-39 years.

3.7.7 Ethnicity

By ethnicity, the Municipality is highly homogeneous. The 2000 population and housing census, conducted by the Ghana Statistical Service, indicate that the Akan constitute 73.5 percent. Other tribes like Dagombas make up 13.6 percent, Ewes 3.3 percent, Guan 0.8 percent, Gruma 0.6 percent, Ga-Dangbe 2.2 percent, Grusi 3.5 percent, Mande 1.5 percent, and other tribes 1.0 percent. More than three-fifth of the Akan in the Municipality are Brongs. Asantes and Ahafo are the other two recognizable Akan groups in the Municipality.

Table 3.4 Distribution of Population by Ethnicity

Ethnicity	Percentage
Akans (Bono, Asante, Ahafo)	73.0
Northern Extraction	17.7
Ga-Dangbe	2.2
Ewe	3.3
Mande	1.5
Others	2.3

Source: Sunyani Municipal Assembly, 2006.

3.7.8 Religion

The results of a survey undertaken by the Municipal Planning Coordinating Unit (MPCU) identified Christianity as the largest religious denomination in the municipality. As indicated in Table 3.5 below Christians formed 82.3 percent of the sampled population. Moslems represented about 11.8 percent of the population while Traditional religion accounted for 3.9 percent. About 2 percent of the populations were atheist.

Table 3.5 Distribution of Population by Type of Religion

Religion	Percentage
Christianity	82.3
Islam	11.8
Traditional Religion	3.9
Atheist	2.0
Total	100.0

Source: MPCU Survey 2006.

3.7.9 Migration Trend

The survey shows that the Municipality experiences geographical mobility in and outside the Municipality as shown in table 3.6 below.

Table 3.6 Percentage Distribution of Sample Population of Migrants

Sex	In-migrants	Out-migrants
Male	18.1	45.8
Female	15.3	20.8
Total	33.4	66.6

Source: Household Survey, Sunyani, MPCU 2006.

Males alone account for about 63.9 percent of all movements (both in and out migrants) and their ages range between 8 and 50 years. In both movements, males out-number females. Males form 18.1 per cent of in-migrants and 45.8 percent of out-migrants, whereas females form about 15.3 percent of in-migrants and represent about 20.8 percent of out-migrants. The female migrants are aged between 5 and 40 years. On the part of the female out-migrants the reasons for their movement are that of education for the younger ones and employment and marriage for the older age groups. On the other hand, movement of males outside the Municipality is attributable to education and apprenticeship training for the younger age groups and seeking job opportunities and other economic related reasons for the older people.

Sunyani being the regional as well as the municipal capital, with the availability of the basic infrastructural facilities attracts migrants into the Municipality. The increase in population has also resulted in increase in crime and other social vices like prostitution, robbery among others.

Occupational distribution of the sample population shows clearly that there are limited employment opportunities outside agriculture, which engages about 57.6 per cent of the municipality's labour force and therefore tends to support the evidence from the migration pattern. The migration rate for the district is 0.387. This therefore, means that there is net out-migration. In other words, more people move outside the municipality than those coming into the municipality.

3.7.10 Rural-Urban Split

The district is highly urbanized with the criterion that any settlement with a population of 5,000 or more represents an urban centre. The population is concentrated mostly in the four urban centres. Sunyani alone absorbs about 72 percent of the total urban population, with Abesim, New Dormaa and Atronie sharing the rest. The Municipality's rural population of about 4 percent is distributed among villages and hamlets scattered throughout the Municipality.

It is anticipated that due to the seasonality of farming activities in the Municipality giving rise to under-employment within the district, the assumption is that more people will be attracted to the urban centres in the future in search of non-existing jobs, thereby increasing the urban population. The implication is that:

- Agricultural production will decrease because of the rural-urban migration,
- The unemployment rate in the Municipality will rise and,
- There would be pressure on existing available urban social facilities like water, housing, electricity.

3.7.11 Dependency Ratio

Dependency ratio shows the relative predominance of persons in dependent ages (youth under 15 years and persons 65 years and older) and those in productive ages 15-64 years. The Municipality has a large labour force of about 62.6 percent, but the percentage of the labour force actually working may be low judging from the fact that those between 15-17 years are expected to be in school or are not expected to work according to the laws of Ghana.

This notwithstanding, the dependency ratio is about 1:1.8. This means that every one person within the working age group (15-64) has almost two persons to cater for. These dependants are made up of the 0-14 and 65 and older age groups. This suggests that there is burden on the labour force since fewer people are catering for more dependants within the Municipality.

3.8 Occupational Distribution

3.8.1 Agriculture

Agriculture and related work is the major occupation in the Municipality. Sunyani Municipality has 57.6 percent of its active population engaged in agricultural activities. Though it is the Regional Capital of Brong Ahafo and has about 73.8 percent of its population residing in urban areas, the ease at which land can be acquired for agricultural purposes, the fertility of the soil for cultivation of food crops, coupled with the low industrial base, has inevitably led to a situation where agriculture is the livelihood of many people.

3.8.2 Industry

About 48 percent of the active population is in agriculture, hunting and forestry and less than 2 percent engaged in fishing. The manufacturing sector also employs a significant proportion of the work force (10 percent) in several small-scale businesses such as manufacturing of garments, leather products, metal fabrication and spare parts, carpentry and joinery

Wholesale and retail trade industry employs 13.8 percent of the workforce in Sunyani. It attracts traders from other districts in the region, from the north and south of the country and even from neighboring countries.

The Municipality has a high proportion of the workforce engaged in other industries such as hotels and restaurants, public administration and education.

The proportion of females engaged in wholesale and retail trade, private households which employed persons and personal and social service activities is more than the males. On the other hand, more males than females work in construction, financial, intermediation, public administration, defense and education.

3.8.3 Health

The Sunyani Municipality currently has 27 health facilities. The current facilities include five hospitals, two health centers, two rural clinics, three maternity homes, 12 school/other clinics and 3 quasi-government clinics.

Table 3.7: Sunyani Municipal Distributions of Health Facilities, 2009.

Hospital	Health Centre	Rural Clinic	Maternity Homes	School Clinic/others	Quasi Govt Clinic
Nkwabeng Hospital	Abesim Health Centre	Antwikrom Rural Clinic		Ridge Experimental. School Clinic	Police Clinic
Owusu Memorial. Hospital			Monica Maternity Home	Sunyani Poly. Clinic	Prisons Clinic
SDA Hospital			Florence Maternity Home	Sunyani Senior High School Clinic, Christian Eye Centre	3 RD Infantry Medical Reception Station-Liberation Barracks
Health Lane Hospital				Forestry Sch. Clinic, Emmavic Clinic	
		Atuahenekrom Rural Clinic		St James Clinic, Fofie Memorial Clinic	
Sunyani Municipal Hospital	Methodist Health Centre (Yawsai)		Peace Maternity Home.	Rafchick Clinic, Opoku Clinic, Greenhill Clinic, Kenam Clinic.	

Source: Sunyani Municipal Health Directorate, 2009.

The staff strength currently stands at 122 in the public sector and 29 in the private sector. The staff strength reflects only those in the Sunyani Municipality excluding the Regional Hospital. A major aspect of service delivery is based on an integrated disease surveillance and response. Use is made up of 160 community based surveillance volunteers. In furtherance of the desire to improve the availability of health service, there is currently ongoing construction of CHIPS Compounds at Abesim-Nkrankrom and Wawasua.

Table 3.8: Health Staff Strength of the Municipality

Category of Staff	Personnel Available	
	Public	Private
Doctors	4	7
Medical Assistants	2	
Nurses/Midwives	69	7
Paramedics	30	15
NYEP (Health Extension Workers)	17	--
Total	122	29

Source: Sunyani Municipal Health Directorate, 2009.

3.8.5. HIV/AIDS

The incidence of HIV/AIDS in the Municipality has shown fluctuating trends. The Municipal Health Directorate (MHD) reported 19 cases in 2003, 42 in 2004 and 40 in 2005. Between 2008 and 2009, 250 people were tested positive. To mitigate the relatively increasing trend, the MHD works in close collaboration with Community-Based Organisations and Non-Governmental Organisations (CBOs/NGOs) in the Municipality and the Municipal Assembly to educate the populace on the dangers of HIV/AIDS menace, and the need for civil society to team up with the MHD to control the menace.

3.8.6 Common Diseases

The ten top cases of admission to hospitals in the Municipality are indicated in the Table 3.9. These diseases include Gastro Enteritis, Hypertension, Rheumatism, Intestinal Worms, Diarrhoea, and Malaria among others.

Table 3.9: Top Ten Common Disease Cases

Disease	2004			2007		
	No. of cases	As % of top ten		No. of cases	As % of top ten	
Malaria	50,887	62.2		73,339	51	
Upper Respiratory Tract Infections	6348	7.8		8665	6	
Skin Disease & Ulcers	5095	6.2		7007	4.8	
Home/Occupation Accident	4,178	5.1		5027	3.5	
Intestinal Worms	2,970	3.6		4587	3.2	
Diarrhoea	2,909	3.6		3899	2.7	
Acute Eye Infection	—	—		3877	2.7	
Rheumatism	2341	2.9		3392	2.3	
Hypertension	—	—		2702	1.8	
Gastro Enteritis	2,765	3.4		2124	1.4	
Ten Top Total	81,783			114,619		
All Other Diseases	14,606			28,814	20	
Grand Total	96,389			143,433		

Source: Municipal Health Directorate, 2008.

Malaria still showed dominance among the ten top diseases with URTI featuring prominently in both situations. Absolute figures for 2004 and 2007 however show an increasing incidence of the disease. This can be attributed to increasing population. Further research needs to be conducted to reduce the numbers.

CHAPTER FOUR

ANALYSIS OF DATA

4.0 Introduction

This chapter dilates on the findings and analysis of data gathered from the field. It discusses at the respondents' knowledge about HIV/AIDS, the mode of transmission, the levels of HIV/AIDS stigma held by the public, institutions, people living with HIV/AIDS and their relations, the type of support PLHIVs need and the progress so far made in curbing the spread of the disease in the Municipality.

4.1. Knowledge about HIV/AIDS

The focus of the study is to find out the level of stigmatizing PLHIVs among society members. However, before assessing this phenomenon, the respondents' knowledge about the disease was sought hence the information on the existence of the disease and the mode of transmission of the disease.

Table 4.1: Respondents' Knowledge about HIV/AIDS

Item	Responses	Public n = 200		PLHIVS n = 13		Relations n = 5	
		No	%	No	%	No	%
Existence of HIV/AIDS	Yes	196	98.0	13	100	5	
	No	4	2.0	-	-	-	
HIV can be transmitted through:							
Sex with prostitutes	Yes	200	100.0	13	100	5	100
	No	-	-	-	-	-	-
Sharing lavatories	Yes	20	10.0	-	-	-	-
	No	180	90.0	13	100	5	100
Unprotected sex	Yes	196	98.0	13	100	5	100
	No	4	2.0	-	-	-	-
Coughing/sneezing	Yes	40	20.0	-	-	-	-
	No	160	80.0	13	100	5	100
Hugging PLHIV	Yes	6	3.0	-	-	-	-
	No	194	97.0	13	100	5	100
Sex with several partners	Yes	196	98.0	13	100		100
	No	4	2.0	-	-		-
Dancing with PLHIV	Yes	10	5.0	-	-	-	-
	No	190	95.0	13	100	5	100
Eating with PLHIV	Yes	3	1.5	-	-	-	-
	No	197	98.5	13	100	5	100
Sharing of blades/razor use	Yes	186	88.0	-	-	-	-
	No	24	12.0	13	100	5	100
Prevention of mother to child	Yes	180	90.0	-	-	-	-
	No	20	10.0	13	100	5	100

Source: Author's Field Survey, April 2010.

Table 4.1 presents the respondents knowledge about HIV/AIDS and 98.0 percent of them had knowledge about the existence of the disease whilst 2.0 percent did not. All the thirteen (13) PLHIV and the five known relations were also aware of the existence of the disease. The Table again reveals that majority of the respondents knew very well that HIV could not be transmitted through dancing with infected person (95 percent), sharing lavatories (90.0 percent), hugging infected person (97 percent), coughing and sneezing (80.0 percent). Most of the respondents were also right to indicate that HIV can be transmitted through unprotected sex (98.0 percent), sharing toothbrush (98.0 percent) sex with many partners (98.0 percent) and sex with prostitutes (100 percent). All the 13 PLHIV and the five known relations were able to identify the major routes of the transmission of the disease.

The study revealed that generally, the respondents in the study area have good knowledge about the HIV/AIDS, particularly on the mode of transmission. This result is consistent with that of some previous studies in Ghana (USAID, 2003).

4.1.2 Difference between HIV and AIDS

This part talks about the respondents' understanding of the disease which could help prevent stigmatizing PLHIV.

Table 4.2: Difference between HIV and AIDS

Issue	Public n = 200		PLHIVs n = 13		Relations n = 5	
	No	%	No	%	No	%
HIV is first phase followed by AIDS	182	91.0	13	100	5	100
Unknown	18	9.0	-	-	-	-
Total	200	100.0	13	100	5	100

Source: Author's Field Survey, April 2010.

From the responses, it was revealed that 91.0 percent knew the difference between HIV and AIDS. This majority was able to tell that the HIV is the first phase of the disease which develops into a full blown AIDS when unchecked. Only 9 percent was unable to differentiate between the two. The 13 PLHIV and the five known relations

interviewed were also able to differentiate between them collaborating DFID/Zimbabwe's (2008) report.

4.1.3 Awareness Creation of HIV/AIDS by the Public

This section wanted to find out the sources of awareness about the disease. Various ways are used to create awareness of which these were identified.

Table 4.3: Awareness Creation of Respondents

Item	Frequency	Percentage
Parents	61	30.5
Siblings	50	25.0
Television	39	19.5
Radio	10	5.0
Newspaper	12	6.0
Friends	10	5.0
Schools	18	9.0
Total	200	100.0

Source: Author's Field Survey, April 2010.

From Table 4.3 it is observed that 30.5 percent of the respondents were made aware of the existence of the disease through their parents, 25.0 percent through siblings. Television recorded 19.5 percent, schools 9.0 percent with radio and friends taking 5.0 percent each. The study revealed that families are playing significant roles in the information disseminating process of the awareness and prevention of the pandemic in the Municipality. The NGOs and other partners could take advantage of this by engaging them in workshops and seminars to give them much more insight of the dynamics of the disease.

4.1.4 Major Routes of Transmission of HIV/AIDS amongst PLHIVs.

There are several routes of transmitting the HIV/AIDS but amongst the PLHIVs the study revealed the routes below.

Table 4.4: Routes of Transmission of HIV/AIDS to PLHIVs

Item	Sexual Intercourse	Sharp implement	Unknown	Total
PLHIVS	11	1	1	13
Percentage	84.6	7.7	7.7	100

Source: Author's Field Survey, April 2010.

Table 4.4 indicates that 84.6 percent of the PLHIVs contracted the disease through sexual intercourse whiles 7.7 percent each through sharp implement and an unknown source. Eighty four percent of the PLHIVs contracted the disease through sexual intercourse confirming (Bentsi, 2003) study in Ghana which accounts for 75 percent of the spread of the disease likewise (Coovadia and Bland, 2007) study of 78 percent of transmission.

4.2 Degree of HIV/AIDS Stigma

This section discusses the level of stigma of HIV and AIDS amongst society members which is the main focus of the study. The responses included that of the general public, institutions, the people living with HIV/AIDS themselves and their relations.

Table 4.5: Levels of HIV/AIDS Stigma in Society

Respondents	Frequency	Yes	%	NO	%
PLHIVS	13	13	100	-	-
Relations	5	5	100	-	-
NGO's	3	3	100	-	-
Municipal assembly	1	1	100	-	-
Municipal health	1	1	100	-	-
Religious Bodies	2	2	100	-	-
The public	200	187	93.5	13	6.5
Total	225	212	—	13	6.5

Source: Author's Field Survey, April 2010.

All the 13 PLHIVS agreed that HIV/AIDS infected persons are stigmatized as well as the five known relations of people living with HIV/AIDS. The three NGO's interviewed also attested to this. The Municipal focal person on HIV/AIDS, the healthcare provider and the two religious bodies agreed that PLHIVs are stigmatized.

Among all the respondents interviewed, 93.5 percent admitted that PLHIVs are stigmatized by society members whilst 6.5 percent thought otherwise. This is an indication that stigmatization of HIV persons is deeply-rooted among the public as the respondents indicated which was collaborated by the PLHIVs themselves, their relations and all the institutions interviewed alike confirming the fact that though HIV prevalence is low in Ghana, HIV is firmly established within the whole society with its attendance consequences of stigma and discrimination (GoG/MOH, 2007).

This study, together with others, (Ban Ki-moon, 2008) and (ICRW, 2008) had made stigma the single most important barrier to public action as people fear the social disgrace of speaking about it and that stigma has become the chief reason why the AIDS epidemic continues to devastate societies around the world. The respondents' reaction to disclosure of a friend's HIV-positive status was indicative that stigma is really imbedded in society.

4.2.1 Stigma and Concealment

The stigmatization of people living with HIV/AIDS amounts to the concealment of one's HIV-positive status. The fear of social disgrace makes them go underground as depicts by Table 4.6 below.

Table 4.6: Stigma and Concealment

Respondents	Frequency	Yes	%	No	%
PLHIVS	13	13	100	-	-
Relations	5	5	100	-	-
NGO's	3	3	100	-	-
Municipal Assembly	1	1	100	-	-
Municipal Health	1	1	100	-	-
Religious bodies	2	2	100	-	-
The public	200	180	90	20	10
Total	225	205		20	10

Source: Author's Field Survey, April 2010.

The information from Table 4.6 shows that 90.0 percent of the public respondents admitted that stigmatizing people living with HIV/AIDS leads to concealment whilst 10 percent did not agreed to that. The non-governmental organizations, the Municipal Assembly, the health directorate and the religious bodies as well as the PLHIVs themselves and the known relations all agreed to this assertion.

Though, disclosure is advocated as an effective means of fighting the pandemic, it remains uncommon in practice as majority of the household respondents, the institutions and PLHIVs themselves agreed to this assertion. In fact, out of the 13 people living with HIV/AIDS, eight of them have not had the courage to disclose their HIV status. The five who have been able to disclose had done so to a sibling, grandparent, parent or spouse and children but not to a friend confirming that of Cunningham's (2005) study which stated that families in developing countries are primary care-givers when somebody falls ill.

Those PLHIVs who have informed relations are happy with the kind of support like financial, companionship and the pieces of advice they receive from them. They have not regretted informing them especially in respecting the confidentiality of their HIV status. Apart from those they had informed no other person had ever heard of their HIV-positive status.

Moreover, it was revealed that as many as 53.5 percent of the respondents would not disclose their HIV-positive status if tested positive with 46.5 percent willing to do so. Again, a whopping majority of 90.0 percent of the respondents claimed that PLHIVs are highly stigmatised whilst 10.0 percent thought they are treated well. The main reasons why the public isolate PLHIVs, whose status are known is the fact that those infected led an immoral life styles whereas others also harbour the fear of uncertainty about the disease that they might be infected with the virus when they go closer to them. UNAIDS, (2008) study also revealed that the fear of contracting the disease, coupled with negative, value-based assumptions about people who are infected leads to the high level of stigma surrounding HIV and AIDS.

4.2.2 Concealment and Spread of the Disease

Concealment has been found to be a major contributory factor to the spread of the HIV/AIDS disease (Ban Ki-moon, 2008). The respondents' attestation to this fact was therefore sought.

Table 4.7: Concealment and Spread of the Disease

Item	Frequency	Yes	%	No	%
PLHIVS	13	13	100	-	-
Relations	5	5	100	-	-
NGO's	3	3	100	-	-
Municipal assembly	1	1	100	-	-
Municipal health	1	1	100	-	-
Religious bodies	2	2	100	-	-
The public	200	177	88.5	23	11.5
Total	225	202	-	23	11.5

Source: Author's Field Survey, April 2010.

Table 4.7 also shows that 88.5 percent of the public respondents interviewed concluded that concealment leads to the spread of the disease but 11.5 stated otherwise. The institutions, together with the people living with HIV/AIDS and their relations also attested to this fact. Ninety percent of the household respondents, the PLHIVs, the institutions and the relations of PLHIVs admitted that concealment of one's HIV-positive status could increase the spread of the disease. This collaborates that of (Baiden, 2004) study in Ghana.

The study undertaken in the Sunyani Municipality revealed that the PLHIVs have not disclosed their HIV serostatus to either their employers or customers for fear of losing their income or livelihood as (ICRW, 2008) research had earlier on revealed. Stigma research (2004) also indicated that termination or refusal of employment contributes to concealment of one's HIV positive status. UNAIDS (2008), also reported a head of Human Resource Development in India as saying that he would not recruit a person with HIV as he would be buying a problem for the company.

4.2.3 Isolation of PLHIVS

People have different perceptions of the disease and hence would not like to associate themselves with PLHIVS. It was therefore necessary to look into this phenomenon in order to confirm it or otherwise.

Table 4.8: Reasons for Isolating PLHIVS

Issue	Frequency	Percentage
Fear of casual contact with disease	149	74.5
Wrong perception of the disease	15	7.5
Immoral life styles	32	16.0
Do not believe in the existence of the disease	4	2.0
Total	200	100.0

Source: Author's Field Survey, April 2010.

From the table above, it is seen that the fear of contracting the disease from infected persons drives them away from the PLHIVs as 74.5 percent of the respondents indicated denying them the kind of empathy they need. Sixteen percent of the respondents thought those infected lived immoral life styles hence isolating them as indicated by (UNAIDS, 2008) where HIV infection is associated with behaviours like prostitution or promiscuity which carries moral baggage whilst 7.5 percent thought of wrong perception of the disease with 2.0 percent not believing in the existence of the disease.

4.2.4 Individuals Reaction to Disclosure

Disclosure is difficult among PLHIVs as well as the public even though it is considered as a sure way of fighting the epidemic (Sayles et al. 2008). This section tries to ascertain the willingness of the respondents to disclose their HIV/AIDS status when tested positive.

Table 4.9: Individuals' Reaction to Disclosure

Issue	Frequency	Percentage
Preparedness to disclose HIV status	83	41.5
Unwillingness to disclose	117	58.5
Prepare to disclose	n – 83	
Spouse and children	63	75.9
Other relations	17	24.1
Friends	0	0.0

Source: Author's Field Survey, April 2010.

Table 4.9 indicates that 41.5 percent of the respondents were prepared to disclose their HIV status to others when tested positive whereas 58.5 percent would not do so. Out of the 83 respondents willing to disclose their HIV positive status, 63 of them (75.9 percent) would do so to a spouse and children and 24.1 percent respondents would do so to other relations. None would disclose to a friend. This contradicts (Tedstrom, 2008) work in the Netherlands where one is told to conceal one's status which is a predictor of psychological distress of the person concerned.

4.2.5 The Sort of Treatment Meted to PLHIVs

All manner of treatments are meted out to PLHIVs by members of society that served as a strong barrier for fighting the disease at all levels. The study sought to find out some of these treatments.

Table 4.10: How Society Treats PLHIVs

Respondents	Type of treatment
PLHIVS	Rejection, insulting words etc.
Relatives	Not willing to talk to them, gossiping etc
NGO's	Given all manner of names e.g. "the victim", "walking corpse", "that thing", "expected to die"
Municipal Assembly	Verbally attacked in public with insulting words
Municipal Health	Vilified and condemned
Religious Bodies	Highly stigmatized, seen as immoral persons, demonised
The public	Not willing to go near them

Source: Author's Field Survey, April 2010.

The responses from the respondents indicated that people living with HIV/AIDS are not treated very well in society. Calling them names like “walking corpse”, “that disease”, “the thing”, “expected to die” among others are all abusive and disheartening for one to bear. The Municipal focal person on HIV/AIDS admitted that he has had an experience where a PLHIV had been verbally assaulted in public. The assembly’s major challenge is that of concealment which is being addressed through public education.

The two religious bodies interviewed also admitted that stigmatizing PLHIVs is heavily imbedded in society. The Seventh Day Adventist church had two HIV-infected persons whose identities have not been disclosed to the congregation for personal reasons. The Islamic sect had not reported any case of a member with HIV/AIDS. Both bodies collaborate with healthcare providers to talk to their memberships about the destructive nature of the epidemic. The Adventist church incorporates the teaching of the pandemic on every Sabbath morning divine service. According to the two religious bodies, the public associate the disease to immorality as they have still not understood the way and manner the disease is spread. They agreed that known PLHIVs must be permitted to mix up with the congregation during divine services.

4.2.6 PLHIVs Unwillingness to Disclose HIV Status

People living with HIV/AIDS feel reluctant to disclose their HIV status to either their employers or customers for fear of being sacked or lose customers as has happened to some PLHIVS before. This section deals with this issue.

Table 4.11: Disclosure to Employers/Customers

Item	No	Employers	Customers	Reason
PLHIV	13	-	-	Fear of loosing jobs/customers
Household Respondents	Frequency	Percentage		
Lost of Customers	Yes 61 No 139	30.5 69.5		
Lost of jobs	Yes 65.5 No 34.5			

Source: Author’s Field Survey, April 2010

Table 4.11 reveals that all the thirteen (13) people living with HIV/AIDS have not disclosed their identity to either their employers if employed and to customers when self-employed. The public responses also revealed that they have heard or seen persons living with HIV/AIDS who have lost their customers (30.5 percent) whilst the majority of 69.5 percent had not experienced such a thing before. On the part of those who have been sacked from their jobs, 65.5 percent answered in the affirmative but 34.5 stated otherwise. This agrees with a (Stigma Research, 2004) report where a woman was quoted as saying, “It may cost you your job, it may make you so uncomfortable and changes relationship, you would have to explain about why you are absent and going to the doctor.” Also an estimated 27 percent of Americans would prefer not to work closely with a woman living with HIV (UNAIDS, 2007).

4.2.7 Ejection of PLHIVS

Several reports from Ghana and elsewhere indicated that there have been some instances where PLHIVs have been ejected from their homes or abandoned by relations (GoG/MOH, 2008).

Table 4.12: Types of Treatment to PLHIVs

Issues	Responses	Frequency N-200	Percentage
Abandon by relations	Yes	103	51.5
	No	97	48.5
Thrown out of matrimonial home.	Yes	97	48.5
	No	103	51.5

Source: Author’s Field Survey, April 2010.

The survey revealed that 51.5 percent of the respondents indicated that some PLHIVs have actually been abandoned by family members whilst 48.5 had not encountered such a situation. On the question of PLHIVs thrown out from their matrimonial homes, 48.5 percent said they had witnessed such occurrences (Table 4.12) which confirms (Cunningham, 2005) report. “When I was in hospital, my father came once. Then he shouted that I had AIDS. Everyone could hear. He said: this is AIDS, she’s a

victim. With my brother and his wife I wasn't allowed to eat from the same plates, I got a plastic cup and plates and I had to sleep in the kitchen. I was not even allowed to play with the kids," HIV-positive woman in Zimbabwe. However, 51.5 percent said they had not witnessed such incidence.

Table 4.13: Plight of PLHIVs Abandoned and Thrown out From Home

Issues	Responses	Frequency
Relocated	65	32.5
Had since died	51	25.5
AIDS Campaigners	9	4.5
Hospitalised	20	10.0
Miserable	45	22.5
Missing system	10	5.0
Total	200	100.0

Source: Author's Field Survey, April 2010.

The table 4.13 shows that 32.5 percent of PLHIVs have been relocated to somewhere else as happened to a British woman whose foster son's HIV status was made known publicly as stated by the (Human Rights Watch, 2009). Again, 25.5 percent had since died, 22.5 percent are living miserable lives with 10.0 percent hospitalised as of now whilst 4.5 percent of them have become HIV/AIDS campaigners with 5.0 percent missing items.

4.3 Care and Support to PLHIVs

Table 4.13 below discusses who should take care of PLHIVs as well as who should be responsible for the cost of treatment. The respondents came out with these statistics.

Table 4.14: Care and Support to PLHIVs

Item	Body	Frequency	Percent
Who should take care of PLHIVs	Self	19	9.5
	Relative	136	68.0
	Government	25	12.5
	NGOs	8	4.0
	Friends	5	2.5
	Others	7	3.5
Total		200	100.0
Who should pay for the cost of treatment for PLHIVs	Self	16	8.0
	Relative	44	22.0
	Government	109	54.5
	NGOs	15	7.5
	Friends	13	6.5
	Others	3	1.5
Total		200	100.0

Source: Author's Field Survey, April 2010.

Table 4.14 indicates that 68.0 percent of those interviewed were of the view that family members should be responsible to take care of PLHIVs which confirms Kuchande, (2004) study in Malawi. ‘Without a family in Lusaka, he was unable to receive the necessary attention to improve his ailing health condition. He returned to Malawi to seek support from his family members. While in Malawi, his brother facilitated an HIV test, which was positive. He was commenced on ART treatment and his condition has improved and now living happily and running a business in Lilongwe.’ This however contradicts Tedstrom, (2008) study conducted in Holland where stigma in the family settings leads to avoidance and its attendant psychological distress which is believed to be due to the absence of unconditional love and support which families are expected to provide.

About 13 percent wanted the government to shoulder this responsibility whilst 9.5 percent answered that PLHIVs themselves should do so whereas 4.0 percent and 2.5 percent would want NGOs and all stakeholders to take up this responsibility. On who should take the cost of treating PLHIVs, 54.5 percent of the respondents said the government should do so whilst 22.0 percent wanted the family to take this responsibility. Eight percent agreed that PLHIVs should pay for their own treatment, NGOs taking 7.5 percent, others with 1.5 percent. Though PLHIVs have not disclosed

their HIV positive status to friends, 6.5 of the respondents believed that friends could shoulder this responsibility.

4.3.1 Kinds of Support to PLHIVs

Support to PLHIV by relations, friends as well as the general public and institutions would go a long way in soothing the pains and agony of PLHIVs. This part of the study reveals the support PLHIVs needed.

Table 4.15: Institutional Support to PLHIVs

Institution	No. of registered PLHIVs	Support to PLHIVs
Municipal Assembly	56	Supplementary feed, payment of NHIS premium
Municipal Health Directorate	16	PMTC, and VCT, services, Educational campaign, Provision of ART
Concern Universal	50	Entrepreneurial Skills
Planned–Parenthood Association of Ghana	---	---
6 th March Women’s Foundation	---	---
Seventh-Day Adventist	---	---
Islamic Sect	---	---

Source: Author’s Field Survey, April 2010.

Table 4.15 shows the type of support these institutions are offering to PLHIVs in the Municipality. Four out of the seven institutions have not registered any PLHIV hence are not providing any support. The Municipal Health Directorate, the Municipal Assembly and Concern Universal have altogether registered 122 PLHIVs providing them with various types of support. It is therefore anticipated that many people would avail themselves to take advantage of these supports to go for voluntary counseling and testing so that the fight against the epidemic could be won.

It came out that health workers faced a lot of challenges which includes difficult conduct of clients during counseling sessions and convincing them to roll onto the antiretroviral therapy (ART). They could also be pricked when injecting a PLHIV.

Table 4.16: Kind of support to PLHIVs

Respondents	Types of support
PLHIVs	Companionship, Care, Love, Empathy.
Relative	Socialization, Compassion, Counselling.
NGOs	Compassion, Financial provision of ART sustainable basis.
Municipal Assembly	Love, Compassion and good company.
Health Directorate	Nutritious food, Financial etc.
Public	Associating with PLHIVs, moral, good shelter, financial
Religious Bodies	Kindness, love, moral, monetary etc

Source: Author's Survey, April 2010.

Table 4.16 shows the type of support needed to be extended to people living with HIV/AIDS. PLHIVs themselves wanted society members to show care, love, empathy and companionship to make them feel at home. The other respondents also indicated that there is the need to show love and care to PLHIVs.

A variety of support was advocated by the community respondents to be provided to PLHIVs. It is noteworthy that the PLHIVs shoulder stigma and its twin sister of the disease itself. About 9.5 percent of the respondents advocated that PLHIVs should cater for themselves while 68.0 percent of the respondents expressed concern that families should take care of PLHIVs whereas 12.5 percent of the respondents indicated that the state should shoulder the payment for the treatment. As the survey revealed, friends, NGOs and indeed all stakeholders (10 percent) have a crucial role to play to relieve them of this burden.

4.4 Educational Campaign on HIV/AIDS Stigma

Education has being identified as an essential means for combating the spread of the disease. Table 4.17 shows the level of educational campaign going on in the Municipality.

Table 4.17 Educational Campaign on HIV/AIDS Stigma

Item	PLHIVs		Relations		NGOs		Public		Religious Bodies		Municipal Assembly		Municipal Health	
	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%
Not Heard	10	76.9	4	80	-	-	32	60	-	-	-	-	-	-
Heard	3	23.1	1	20	3	100	168	40	2	100	1	100	1	100
Total	13	100	5	100	3	100	200	100	2	100	1	100	1	100
Degree of Educational Campaign														
Enough	-	-	-	-	1	33.3	44	22.0	-	-	1	100	-	-
Not Enough	13	100	5	100	2	66.7	156	78.0	2	100	-	-	1	100
TOTAL	13	100	5	100	3	100	200	100	2	100	1	100	1	100

Source: Author's Field Survey, April 2010.

The level of the educational campaign going on in the study area revealed that indeed there is a programme of that sort as 84.0 percent of the respondents indicated with 26.0 percent thinking otherwise (Table 4.17). All the other bodies and individuals interviewed collaborated this assertion. However, 78.0 percent of the community respondents answered that the on-going campaign was woefully inadequate whereas 22.0 percent thought the campaign was adequate. Two of the NGOs (66.7 percent) engaged in HIV/AIDS programmes were of the opinion that the campaign was not adequate whilst the other one (33.3 percent) thought it was adequate.

The PLHIVs themselves and the known relations also affirmed the previous thinking. Apart from the Municipal Assembly, the other institutions like the Municipal Health Directorate and the Religious bodies were of the view that although there was an on-going educational campaign much needed to be done. The Metropolitan, Municipal and the District assemblies should intensify education through seminars and workshops as contained in the District Response Initiative (DRI) in schools and in churches and mosques to help reduce the spread of the disease. This could be successfully done at the expense of other equally important interventions.

4.4.1 Intensifying Stigma Campaign

The respondents interviewed came out with these modes of campaigning to combat the disease (Table 4.18).

Table 4.18: Intensification of Educational Campaign

Mode	Frequency	Percent
Television	58	28.0
Radio	114	57.0
Mobile vans	10	5.0
Public/Social Gatherings	18	9.0
Total	200	100.0

Source: Author's Field survey, April 2010.

From Table 4.18 the respondents identified some mode of intensifying the educational campaign. About 57.0 percent of those interviewed showed that the campaign should be more on the radio due to its visibility throughout the length and breadth of the country followed by (28.0 percent) television, 5.0 percent agreed on mobile vans whereas 9.0 percent thought that the programme should be done at both social and public gatherings. Anti-Stigma campaign in Zimbabwe reduced the HIV infection when it tackled the issue of stigma and discrimination as those exposed to the campaign were likely to know their HIV status than those who were not hence the need to tackle the education from all corners.

4.4.2. Antiretroviral Therapy (ART)

The awareness of ART could also help in fighting the disease as newly HIV infected persons could avail themselves to it.

Table 4.19: Knowledge of ART

Item	PLHIVs		Percent		NGOs		Public		Municipal Assembly		Religious Bodies	
	No	%	No	%	No	%	No	%	No	%	No	%
Known	13	100	5	100	3	100	198	99.0	1	100	2	100
Unknown	-	-	-	-	-	-	2	10.0	-	-	-	-
Total	13	100	5	100	3	100	200	100.0	2	100	2	100

Source: Author's Field Survey, April 2010.

Table 4.19 shows that all the 13 people living with HIV/AIDS were aware of the existence of an antiretroviral therapy which is used to prevent the multiplication of the virus that kills the white blood cells. All the PLHIVs interviewed are receiving the antiretroviral therapy. Whilst some of them pay five Ghana cedis (GHc5.00) for the drug, about 70 percent of them receive it for free due to their levels of poverty. The five known relatives were also aware of this drug. Ninety nine percent of the community respondents knew the presence of the drug whilst only 1.0 percent did not. All the institutions were also aware of this drug. All the respondents knew the existence of the antiretroviral drugs which prevents the multiplication of the virus in an infected person so that the disease could not move into AIDS epidemic phase. All the 13 PLHIVS knew as well as those they have informed of their HIV-status. The relations attested to the fact that indeed, the ART has brought significant improvement in their lives which also confirms Smith, (2003) revelations that due to the drug some of the infected persons look “healthier” than even non-infected persons in a study conducted in South Africa.

4.5. Government Policy on HIV/AIDS Stigma

Table 4.20 shows the respondents’ knowledge about the role the state is playing to address the effects of the epidemic.

Table 4.20: Knowledge of Government Policy on HIV/AIDS Stigma

Item	PLHIVs		Relations		NGOs		Municipal Assembly		Public		Religious Bodies		Health Workers	
	No	%	No	%	No	%	No	%	No	%	No	%	No	%
Known	-	-	-	-	1	33.3	1	100	49	24.5	-	-	-	-
Unknown	13	100	5	100	2	67.7	-	-	151	75.5	2	100	5	100
Total	13	100	5	100	3	100	1	100	200	100	2	100	5	100

Source: Author’s Field Survey, April 2010.

From Table 4.20, 75.5 percent were not aware of any government policy in place as of now, 24.5 percent knew an on-going policy, 33.3 percent (1) of the NGOs knew of a policy whereas the other two (66.7) percent knew nothing of a sort. The Municipal Assembly also knew of an existing policy as regards the Municipal Health Directorate. Surprisingly, the PLHIVS and the five relatives were not aware of any

existing government policy on HIV and AIDS stigma. The five health workers especially those in charge of the ART delivery centre were also aware of some policies in place.

4.5.1 Types of Policy

Those who expressed the existence of a policy on HIV/AIDS stigma came out with the following.

Table 4.21: Types of Policy in Place

Institution/Public	Policy
Municipal Assembly	Incorporates HIV/AIDS issues in Assembly's programmes
NGOs	Disclosure of status by health official to anybody is prohibited
Public	School curriculum, PMTCT, ART availability.

Source: Author's Field Survey, April 2010.

The institutions and the general public brought to the fore the existence of a policy on HIV/AIDS and came out with the policy or policies stated above.

The government policy on HIV/AIDS-related stigma was unknown by the majority of those interviewed. The 24.5 percent of respondents who knew the existence of government policy mentioned the prevention of Mother-to-Child Transmission (PMTCT) and Antiretroviral Therapy (ART) delivery services and the school curriculum. The only NGO aware of a policy mentioned the disclosure of one's HIV-status by health officials to anybody which is strictly prohibited except with the permission of the individual concerned. One revelation from the study was that the healthcare providers within the Municipality insist on maintaining confidentiality of one's HIV serostatus. Accordingly, the PLHIVs do not know each other and had not encountered any breaches of their confidentiality as they queue with all other patients attending hospital for medical care. The PLHIVs also attest to this which is a contradiction to a study conducted by (UNAIDS, 2008) in India, Indonesia, the Philippines and Thailand where respondents reported breaches of confidentiality by healthcare workers. The Municipal Assembly is mandated to incorporate HIV/AIDS issues in their programmes undertaken by the institution.

4.6. Progress Made

This table 4.21 illustrates the modest progress chalked in the area of addressing the impact of the epidemic in the Sunyani Municipality.

Table 4.22: The Progress Made in Curbing the Disease.

Institution	Progress	Mode
Municipal Assembly	Adequate	Educate the PLHIVs to live responsible sexual life, Incorporate HIV/AIDs issues in Assembly programmes
NGOs	Not Adequate	Talk shows, Educational campaign on radio
Health Directorate	Adequate	Public Health Education, PMTCT, voluntary counselling and Testing
Religious Bodies	Not Adequate	Sermons, social gatherings talks on HIV/AIDs issues

Source: Author's Field Survey, April 2010.

Table 4.22 illustrates the progress made in curbing the spread of the pandemic. From the study, 60.0 percent of the community respondents have not heard of any on-going education in the study area addressing the spread of the disease indicating that not much has been achieved in addressing the menace. The NGOs admitted that not much has been done whereas the Municipal Focal person on HIV/AIDs and the Municipal Health Directorate maintained that they had chalked some form of successes.

The Municipal Health Directorate indicated that through the Public Health Education section, and through the PMTCT and sustainable availability of the ART, much has been achieved. The Municipal Assembly holds monthly meetings with PLHIVs who have registered with the assembly where the PLHIVs are educated to lead a responsible sexual lifestyle so that they do not spread the disease and at the same time, (though not known publicly) to be AIDS ambassadors to educate their friends and relations about the dangers of the disease and its humiliating stigma attached to it. However, the two institutions agreed that much is needed to be done to prevent people from being infected day in and day out. Although the two religious bodies educate their members about the disease, they admitted that the campaign needs to be given a wider recognition through social and public gatherings.

4.7 The Way Forward

The respondents came out with some recommendations to help reduce the problem of stigmatizing the PLHIVs

Table 4.23: Recommendations Made by the Respondents.

Item	PLHIVs		Relations		NGOs		Health Directorate		Municipal Assembly		Public		Religious Bodies	
	No.	%	No	%	No	%	No	%	No	%	No.	%	No	%
Education	13	100	5	100	3	100	5	100	1	100	200	100	2	100
Total	13	100	5	100	3	100	5	100	1	100	200	100	2	100
Television	3	23.1	1	20	-	-	-	-	-	-	58	29.0	-	-
Radio	8	61.5	4	80	3	100	5	100	1	100	114	57.0	2	100
Mobile Van	-	-	-	-	-	-	-	-	-	-	10	5.0	-	-
Legislation	2	15.4	-	-	-	-	-	-	-	-	18	9.0	-	-
Total	13	100	5	100	3	100	1	100	1	100	200	100	2	100

Source: Author's Field Survey April 2010.

On the way forward, all the respondents be it PLHIVs themselves, relations, the public as well as all the institutions agreed that education could be an effective means of addressing the menace. It was revealed that 23.1 percent of the PLHIVs wanted the educational campaign done through the television with the majority of 61.5 percent agitating for radio programmes whilst 15.4 percent called for legislation, 20.0 percent of the relatives asked for television programmes whereas 80.0 percent wanted it done through the radio. All the institutions would also like the radio to do the campaign. Among the community respondents 57.0 percent once again is calling for the radio to disseminate the information while 9.0 percent wanted a legislation to be passed to address the problem. Legislation, though necessary for PLHIVs to fight for their rights, could not contain the spread of the epidemic.

CHAPTER FIVE

SUMMARY OF FINDINGS, RECOMMENDATIONS AND CONCLUSION

5.0 Introduction

This concluding chapter presents a summary of issues and challenges from the analysis of data and information from the field discussed in the previous chapter. It makes recommendations on how best the challenges contained in the findings presented could be tackled in order to minimize the fear of stigma and to curb the acceleration at which the epidemic is moving. The chapter again contains the general conclusion.

5.1 Summary of the Findings

There were 16 HIV-infected persons receiving the antiretroviral therapy from the Sunyani Municipal Hospital Delivery Service Centre as at the end of the year 2009. Out of this number, 13 were contacted for their varied opinions. Eleven of them contracted the disease through sexual intercourse, the main route of transmission of the disease. Among the 13 PLHIVs interviewed, five have been able to disclose their HIV status to a sibling, parent, grandparent, a spouse and children. None had informed any friend. Apart from those they had informed no other person had ever heard of their HIV-positive status. Those PLHIVs who have informed relations are happy with the kind of support like financial, companionship and the pieces of advice they receive from them. They have not regretted informing them especially in respecting the confidentiality of their HIV status.

The remaining eight PLHIVs have not been able to disclose their HIV status for fear that doing so would subject them to unfair treatment and stigma. All the HIV infected persons were of the view that they are stigmatized which leads to concealment with the possibility of spreading of the virus. From the analysis, it was established that stigmatization is deeply-rooted among the people especially when the victim's HIV positive status had been made known to the general public. The PLHIVs have neither disclosed their status to their employers nor to their clients. The people living with HIV/AIDS wanted the general public to live responsible sexual life as the stigma attached to the disease is too humiliating for anyone to bear. All the PLHIVs

interviewed are receiving the antiretroviral therapy. Whilst some of them pay five Ghana cedis (GHc5.00) for the drug, about 70 percent of them receive it for free due to their levels of poverty. On who should take care of PLHIVs, they agreed that family members should take responsibility whilst the state should shoulder the responsibility of the cost of the treatment.

5.1.1 Relations Responses

All the five relations of the PLHIVs knew almost all the modes of transmission of the virus like sex with prostitutes, multiple sex partners, razor-use sharing of needle or syringe, blood contamination, mother-to-child transmission and breastfeeding. They testified that the health conditions of their relations have seen some remarkable improvement than before confirming Smith (2003) assertion that some of the HIV infected persons receiving ART look “healthier” than even non-infected persons in a study conducted in South Africa.

5.1.2 NGOs

Concern Universal (CU), Planned-Parenthood Association of Ghana (PPAG) and the 6th March Women’s Foundation (MWF) the Non-Governmental Organizations operating in the Municipality were also of the view that PLHIVs are stigmatized in society. Whilst CU buys air time on a local frequency modulation (FM) radio station to educate the public as and when the need arises, PPAG organizes talk shows from time to time to address the menace of the disease. They also collaborate with the health workers to embark on educational campaigns. MWF had not been able to engage in any HIV/AIDS related campaign due to lack of funding.

5.1.3 Challenges Facing Health Workers

It came out that health workers faced a lot of challenges which includes difficult conduct of clients during counseling sessions and convincing them to roll onto the antiretroviral therapy (ART). They could also be pricked by the syringe when injecting a “stubborn” PLHIV. The confidentiality of one’s HIV status is kept intact as the PLHIVs join the queue with all other patients seeking medical care at the hospital. The PLHIVs themselves do not know each other as they have not formed

any association like elsewhere. Antiretroviral therapy awareness among the PLHIVs and their relations is very high likewise the general public as 99.0 percent of all the community respondents answered the question in the affirmative.

5.1.4 Municipal Assembly and Religious Bodies

The Municipal Assembly had so far registered 56 people living with HIV/AIDS all of them receiving ART. The assembly gives supplementary feed and contributes to the payment of the National Health Insurance premium of the PLHIVs who have registered with the assembly. The Municipal focal person on HIV/AIDS admitted that he has had an experience where a PLHIV had been verbally assaulted in public. The assembly's major challenge is that of concealment which is being addressed through public education.

The two religious bodies interviewed also admitted that stigmatizing PLHIVs is heavily imbedded in society. The Seventh Day Adventist church had two HIV-infected persons whose identities have not been disclosed to the congregation for personal reasons. The Islamic sect had not reported any case of a member with HIV/AIDS. Both bodies collaborate with healthcare providers to talk to their memberships about the destructive nature of the epidemic. The Adventists incorporate the teaching of the pandemic on every Sabbath morning divine service. According to the two bodies, the public associate the disease to immorality as they have still not understood the way and manner the disease is spread. They agreed that known PLHIVs must be permitted to mix up with the congregation during divine services.

5.1.5 Types of Support PLHIVs Need

A variety of support to PLHIVs has been brought to fore by the study. PLHIVs needed compassion, companionship, empathy among several others from the general public to assuage the pains and agony they undergo through every now and then. Isolation, gossip, verbal abuse, vilification and criminalizing the PLHIVs indeed contribute immensely to concealment which also serves as a fertile ground for the rapid spread of the pandemic.

5.1.6 Campaign against Stigma

According to the respondents, there was an on-going educational campaign addressing the spread of the disease. However, the campaign is concentrated on the bio-medical model neglecting the stigmatization aspect of the disease which also serves as a great threat to the spread of the epidemic. The people living with HIV/AIDS admitted that there was no educational campaign that seeks to address the dangers of stigmatizing them and that a lot needs to be done to that effect. All the respondents agreed that the educational campaign should be intensified to drum home the message to the general public to show concern to the people living with HIV/AIDS.

It was revealed that there is a mistaken belief of HIV and AIDS related issues as 74.5 percent of the public respondents thought that casual contact with an HIV-infected person could result in contracting the disease and therefore called for effective educational campaign to inform the public about the modes through which the disease is spread to allay their fears.

5.1.7 Policy in Place and Progress Made

Majority of the respondents never knew the existence of any government policy on the disease. One of the NGOs admitted knowing the policy on the insistence on the confidentiality of one's HIV status by health workers. The 24.5 percent of the community respondents who knew the existence of a government policy mentioned the prevention of mother-to-child transmission, the provision of antiretroviral therapy and HIV/AIDS issues in the school curriculum.

Minimal progress had been made in curbing the spread of the disease due to the heavy presence of stigma in the study area. Most of the respondents felt reluctant to disclose their HIV/AIDS status if tested positive. Those who were willing to disclose their HIV-positive status would like to do so to a close relation. The institutions' effort in addressing the epidemic is generally geared towards the bio-medical aspect of the disease at the expense of the stigmatisation model.

5.2 Recommendations

In view of the findings presented in the text some recommendations have been made to help surmount the challenges the pandemic has brought to bear on mankind.

5.2.1 Intensification of Educational Campaign

Firstly, there is the need to intensify the educational campaign as there is a widespread belief that a casual contact with an HIV-infected person leads to the transmission of the virus creating irrational behaviour and misperception of personal risk. It is therefore incumbent upon the Ghana AIDS Commission and its partner agency, the National AIDS Campaign Programme, the Metropolitan, Municipal and the District Assemblies to provide HIV/AIDS education and training to all members of the community especially key opinion leaders like traditional rulers, assembly persons, leaders of religions bodies, teachers, health professionals among others to increase their knowledge based on HIV/AIDS and issues concerning PLHIVs.

These opinion leaders could also communicate to community members at all social and public gatherings to desist from stigmatizing PLHIVs which is not only inappropriate but also an affront to their fundamental human rights as they could still contribute their quota to the developmental needs of society.

As more awareness is created by community members on HIV/AIDS issues, it could strengthen social support from them to infected partners, extended family members and friends as families and friends could help remind those infected with HIV/AIDS to take their medicines and attend ART services on regular and consistent basis.

As the study revealed, it is expected that the radio could assist in the efforts by all stakeholders especially the Ghana AIDS Commission to ensure that victims of AIDS are not stigmatized, vilified, isolated or discriminated. If the radio stations scattered throughout the country could devote a five-minute free air-time to health professionals and PLHIVs to discuss the bio-medical and the stigmatization models of the pandemic, it would go a long way in addressing this menace. The television stations could also incorporate into their programmes documentaries and drama on the dangers of the disease to the watching public to learn some useful lessons from them.

5.2.2 Anti-stigma Campaign Involving PLHIVs

The inclusion of Pastor Maxwell Kapachawo, of Zimbabwe, a PLHIV himself, in an anti-stigma campaign stimulated his church members to test for their HIV status hence in organizing, developing and delivering HIV education, prevention and support programmes, community members should include PLHIVs.

Encouraging greater involvement and participation of PLHIVs in all activities at all levels could empower them and also help the community to realize that PLHIVs are not the cause of the HIV and AIDS problem but are part of the solutions. Promoting the active involvement of PLHIVs in national and local activities would foster positive perceptions of people living with HIV. Their involvement in PMTCT and ART services as mentors would help to educate, counsel and support others who are HIV infected. They could share personal experiences to encourage others for disclosure and treatment. The more they come out, the more the public would appreciate their efforts and hence erase the wrong perception about the disease so as to decrease the momentum the disease has gathered as of now. The NGOs/CBOs and other institutions engaging in HIV/AIDS activities should take this challenge.

5.2.3 Behaviour Change

Behaviour change intervention programmes should be instituted in all workplaces and at homes to create much awareness for all categories of workers and family members to adopt responsible sexual life. The intervention process should include advocacy and sensitization sessions, development and production of publicity materials such as HIV curriculum for schools, condom use promotion and peer education programmes to create the much needed awareness as out of the 13 PLHIVs interviewed, 11 contracted the disease through sexual intercourse, the main route of transmission.

This programme could inculcate in the people the need for voluntary counseling and testing (VCT), a process an individual undergoes to enable one to make informed choices about being tested for HIV/AIDS. The process aims at helping people understand their situation more clearly and to make choices that fit their values,

feelings and needs and also promotes behavioural changes, for example the change from “unsafe sexual practices” to “safer sexual practices” which could help to prevent the transmission of the disease.

5.2.4 Counselling and Education of PLHIVs

As most of the PLHIVs have not disclosed their status, counselling and education for PLHIVs can be used to address HIV-related stigma as counsellors can encourage, empower and support PLHIVs to disclose their HIV status to family and eventually to friends. As more people disclose their HIV status, PLHIVs become more visible which would encourage community acceptance of PLHIVs.

More counsellors should be trained by the Ghana AIDS Commission and its partner agencies to make them available to increase access for PLHIVs. Consideration should also be given to the establishment of decentralized testing and counselling centres with adequate logistical support. Free access for testing for especially survival spouses and children of PLHIVs should be provided at these centres.

5.2.5 Training Programmes for PLHIVs

There should be the development and implementation of training programmes for PLHIVs to help them advocate for their rights and take active role on their own healthcare. By participating in interventions like HIV prevention and care education as volunteers, advisors, and mentors could enable PLHIVs to demonstrate their ability to remain productive members of the community which normalizes the experience of living with HIV infection.

As the study revealed, there is no association for the PLHIVs hence counselors could suggest to PLHIVs to form a strong and formidable association at all levels to serve as a mouth piece to challenge stigma and discrimination.

5.2.6 Promotion of Disclosure

Concealment serves as one of the pillars that facilitate the spread of the disease. It would therefore be necessary on the part of society to commend an HIV infected

person who discloses his/her status instead of despising him/her. It takes a bold and courageous person to disclose his HIV status as he/she is aware of the consequences ahead of him or her. Therefore to encourage more disclosures, society must be made HIV-friendly where HIV infected persons should not be condemned, blamed, criminalized and disassociated from. Decreasing HIV/AIDS stigma is one vital step in stemming the epidemic hence all and sundry should try as much as possible to end it.

5.2.7 Encourage Peer Support

PLHIVs should be encouraged by counselors to pair with another person either an HIV positive or negative who can provide friendship, companionship, advice or mentoring to each other. This kind of support would diffuse people's minds associated with PLHIVs the stigma from the disease.

5.2.8 Dealing with Misconception of HIV/AIDS

There are a lot of misconceptions about the epidemic. Notwithstanding the fact that many people know about the HIV/AIDS, there is still a widespread belief that being HIV-positive is shameful and even "a punishment from God," and again casual contact with an infected person could lead to the transfer of the virus. The wrong perception exhibited by the respondents need to be explained in its proper context to erase it from the minds of the general public irrespective of one's background. The government, NGOs, development partners, international agencies, faith-based organizations among others should all put resources together in addressing this menace. If at all social or public gatherings time is devoted to give those assembled better understanding of the problem of this deadly disease, it may help to address the devastating nature of the pandemic.

5.2.9 Role of Religious Bodies

The religious bodies could also play significant roles in addressing the twin problem of the bio-medical and the stigmatisation models of HIV/AIDS by constantly educating their members. As they preach morally upright lives to their members they should also not forget that there are miscreants within their memberships. Therefore through their sermons, bible or koran studies, crusades and conferences they should

talk about HIV/AIDS issues to drum home the message of inculcating the habit of going for HIV test as early detection will help those infected to be put on the Antiretroviral Therapy (ART) on time to save their lives. At the same time, they should be educating them to show empathy, love, and companionship among others to those unfortunate ones who have been infected with the disease rather than condemning them.

5.3 Conclusion

The study revealed that the HIV/AIDS epidemic has not spared the people in the Sunyani Municipality. The current prevalence rate of the Municipality's 3.0 percent is lower than the Brong Ahafo Region rate of 3.3 percent but higher than the national rate of 2.7 percent. The respondents were aware of the pandemic and its modes of transmission yet stigmatised known PLHIVs. Those interviewed still have misconception about the disease as there was a widespread belief that the disease could be contracted through casual contact with an HIV infected person which is not true. This misconception contributes to the spread of the disease as those who have been diagnosed HIV/AIDS positive conceal it as eight out of the 13 people living with HIV/AIDS have not disclosed their status to anyone. Again, 58.5 percent of the community respondents were not willing to disclose their status when tested HIV positive.

The 83 respondents (41.5) percent were prepared to disclose their HIV positive status to their spouse and children, a parent, a grandparent or a sibling which could be tapped by the operators like the NGOs/CBOs to sensitise the public to embrace infected persons for them to feel at home to avoid "self-stigmatising" themselves which may lead to relocation of the victim.

Their use of derogatory words like "expected to die", "walking corpse", and "the victim" to describe PLHIVs by community members need to be taken a second look at. Verbal assault against PLHIVs would make the fight against the disease a herculean task instead of addressing it. The fear of losing one's job or customers also leads to concealment as coming public could cost one's livelihood. Again the victim may decide to go "underground" to spread the pandemic to put everyone at risk.

Sexual intercourse still remains the major mode of transmission of all HIV cases. It is therefore incumbent upon all and sundry especially those in the sexually active age groups to be conversant with all HIV/AIDS related issues so that they do not live “a loose life” which may cost them in the very near future. The youth which is the backbone of the country should try to “preserve” themselves by changing their sexual habits as such.

The other possible areas of the HIV pandemic that needs further studies is to research into why in spite of the numerous campaign on VCT, the patronage is still low in the Municipality. Secondly, a further study could be conducted to find out the reasons why so many of those diagnosed to be HIV positive only 16 are receiving the ART services even though they need the service. This is so because in 2008 and 2009 out of a total of 12, 980 people who were tested, 250 were positive. This wide disparity poses a great threat to the fight against the pandemic in the Municipality.

One major implication of the disease is that as more people are infected, the human resource base could also suffer thereby decreasing productivity. More resources which could have otherwise been used to better the lot of the general public would be diverted to the cure and the prevention of the disease. The District Response Initiative (DRI) could also be affected as they may not get adequate financial support to work with due to the budgetary constraints of the various District, Municipal and Metropolitan Assemblies.

REFERENCES

Amedahe F.K (2002), Fundamentals of Educational Research Methods, Mimeograph, University of Cape Coast, Cape Coast.

Anderson R.M, Cunningham, W.E: Katz M.A (2004).“The impacts of competing subsistence needs and barriers on access to medical care to persons with Human Immunodeficiency Virus receiving care in the United States of America. Med Care 1999 (PubMed).

Angleton, P. (1998) (Eds.) AIDS: Rights, risks and reason. London, Palmer Press.

Arya, M. Behforouz, H.L. Viswanath, K. (2009). “African-American Women and HIV/AIDS: A National calls for Targeted Health Communication Strategies to Address a Disparity.” The AIDS Reader,19 (2).

Author’s Field Survey 2010

Baiden, K.B (2004) Reducing stigmatisation and Discrimination, Ghana Today Magazine July, 2004

Baleta A (2003). “South Africa’s AIDS activists accuse government of murder.” Lancet Publishing House New York, 361 99363

Ban Ki-moon (2008), United Nations General Assembly Special Session on HIV/AIDS, United Nations Publication.

Bentsi, C (2003) Adolescents and HIV, Daily Graphic 4-12-2003

Blechner, M.J (1997). Hope and mortality: psychodynamic approaches to AIDS and HIV. Hillsdale, NJ: Analytic Press.

Bozzette, G.A. (1999) “Expenditures for the care of HIV-infected patients in the highly active Antiretroviral Therapy” New England Journal of Medicine.

Brenchley J.M, Schacker T.W, Ruff L.E, Price D.A, Taylor J.H, Beilman G.J, Nguyen P.L, Khoruts A, Larson M, Haase A.T and Douek D.C (S, 2006). "CD4+ T cell depletion during all stages of HIV disease occurs predominantly in the gastrointestinal tract". J. Exp. Med.

Campbell G.R; Pasquier E and Watkins J (2005) "The glutamine-rich region of the HIV-1 Tat protein is involved in T-cell apoptosis" J. Biol. Chem. PMID 15331610

CDC/MMWR (2004), Trends in HIV/ AIDS Diagnosis; 33 States, 2001-2004. CDC, HIV/AIDS Surveillance Report.

China View Magazine (2007), Compulsory testing for HIV among re-entry migrants and migrants in China.

Compare Infobase Limited (2006) Accra

Coovadia H (2004), "Antiretroviral agents—how best to protect infants from HIV and save their mothers from AIDS". N. Engl. J. Med.

Coovadia H.M and Bland R.M (2007), "Preserving breastfeeding practice through the HIV pandemic". Trop. Med. Int. Health.

Cunningham, W (2005) Journal of Health Care for the Poor and underserved. John Hopkins University Press, 2005.

DFID/Zimbabwe (2008) "Fighting stigma of HIV/AIDS: The Pastor's story" <http://www.dfid.gov.uk/case studies>. Retrieved 3/4/10

Eagle, E (2003) HIV/AIDS: Socio-Psychological Insights, University of South Africa, Pretoria.

Epstein H, (2007) The invisible cure: Africa, the West, and the fight against AIDS. New York, Farar Straus and Giroux ISBN 0-374-28152-1.

Fan H, Conner R.F and Villarreal L.P (2005) AIDS, Science and Society (4th Ed.) Boston, MA: Jones Bartlett Publishers.

GoB/MOH (2004) Government of Botswana/Ministry of Health Annual Report.

Government of Ghana/Ministry of Health (2003) HIV Sentinel Survey Report
Design Press Limited, Accra.

Government of Ghana/Ministry of Health (2004) HIV Sentinel Survey Report
Design Press Limited, Accra.

Government of Ghana/Ministry of Health (2005) HIV Sentinel Survey Report
Design Press Limited, Accra.

Government of Ghana/Ministry of Health (2006) HIV Sentinel Survey Report
Design Press Limited, Accra.

Government of Ghana/Ministry of Health (2007) HIV Sentinel Survey Report
Design Press Limited, Accra.

Government of Ghana/Ministry of Health (2008) HIV Sentinel Survey Report
Design Press Limited, Accra.

Government of Ghana/Ministry of Health (2009) HIV Sentinel Survey Report
Design Press Limited, Accra.

Government of Ghana/Ministry of Local Government and Rural Development (2004)
Handbook for preparing District HIV/AIDS Strategic Plans, Express Publishing,
Accra.

Guss D.A (1994). "The acquired immune deficiency syndrome: an overview for the
emergency physician, Part 2". J. Emerg. Med.

Herek G.M and Capitanio J.P (1999), “AIDS stigma and sexual prejudice.” American Behavioral Scientists

Herek G.M; Capitanio J.P and Widaman K.F (2002), “HIV-related stigma and knowledge in the United States: prevalence and trends 1991-1999.” AM J. Public Health 92 (3).

Holtgrave, D and Curran, J (2006) What works, what Remains to be done in HIV prevention in the United States. Annual Review of Public Health

Hooper E (1999), The River: A Journey to the source of HIV and AIDS (Ist. Edition) Boston, MA, Little Brown and Company

http://dataunaids.org/Report/2007/20070925_advocacy_gme2_en.pdf. Retrieved 23/03/10

Human Rights Watch (2009) The United States of America Annual Report

Human Rights Watch (2010) The United States of America monthly report for March

Hunter, S. and Williamson, J (1998) “Children on the Brinks: Strategies to support children isolated by HIV/AIDS”. USAIDS

International Centre for Research on Women (2008) second quarter report. Preliminary report, Unpublished.

International Centre for Research on Women (2009) annual report. Preliminary report, Unpublished.

IRIN/PlusNews (2005) The socio-economic impacts on Orphans of HIV/AIDS couples.

Kaiser Family Foundation (2004) Kaiser Health Pool Report Iniquities in the American Society and health care access.

Kaiser Family Foundation (2005) Kaiser Public Opinion Spotlight Discrimination as a factor inhibiting access to care and treatment

Kissioki, S (2006) "Church leaders confront HIV/AIDS and stigma." Journal of Community and Applied Social Psychology Volume 16 Issue 6 2006

Koeing M.A; Zablotska; Lutala I; Nsulugoda F; Wagman J; Gray R.(2004) "Coerced first intercourse and reproductive health among adolescent women in rural Rakai, Uganda. International Plan Perspective WHO, Geneva

Kuchande, L (2004) International conference on AIDS abstract no. D12349. Lancet Publishing House, New York

Mehandru S, Poles M.A, Tenner-Racz K, Horowitz A, Hurley A, Hogan C, Boden D, Racz P, Markowitz M (2004). "Primary HIV-1 infection is associated with preferential depletion of CD4+ T lymphocytes from effectors sites in the gastrointestinal tract". J. Exp. Med. 2006.

National Research Council (2005) "The Social Impact of Aids in the US." Washington DC, National Academy Press

Nyanzi S (2004) "Better a dead child than a dry womb." Reproduction and HIV/AIDS in Sub- Saharan Health Policy Unit of London School of Hygiene and Tropical Medicine

Ocansey F (2008) Gender differences in adolescent students knowledge, attitudes and practices on HIV/ AIDS in Ghana, Gender and Behaviour, Volume 4 No.1,(2006) Ife Centre for Psychological Studies, Ile Ife, Nigeria. .

Ogden J and Nyblade (2005) "Common as its core: HIV-related stigma across contexts" N. Engl. J. Med.

Osei-Hwedie, K. (1994) AIDS, the individual, family and community: Psychosocial issues, Journal of Social Development in Africa.

Public Health Watch (2005) Quarterly Newsletter, Washington D.C

Roome A.J and Hadler J (1991) AIDS knowledge, attitude and behaviour in Connecticut, An overview of 1986-89 surveys, Connecticut

Sayles, J.N; Hays, R.D; Sarkisten. C.A; Mahajan A.P.(2008) Development and Psychometric assessment of a multidimensional measures of internalized HIV stigma in a sample of HIV-positive adults. AIDS Behav. 2008 (PubMed)

Sepkowitz, R (2001) "AIDS-the first 20 years." New England Journal of Medicine.321-330.

Smith D.K; Grohskopf L.A; Black R.J. (2005) "Antiretroviral Post-exposure Prophylaxis. After Sexual, Injection drug use or other Non-occupational Exposure to HIV in the US N. Engl. J. Med.

Smith, C, (2003) Micro-level Insights: HIV/AIDS and the individual, familial and community contexts . Pretoria, University of South Africa.

Stigma Research Program (2004) Magazine: Fighting stigma to reduce HIV infection.

Stigma Research Program (2004) Magazine: Maintaining Confidentiality of one's HIV positive status by Healthcare providers

Sunyani Municipal Assembly (2006) Medium Term Development Plan 2006-2009

Sunyani Municipal Assembly (2009) Medium Term Development Plan 2006-2009

Sunyani Municipal Assembly (2010) Medium Term Development Plan 2006-2009

Sunyani Municipal Coordinating Unit (MPCU) survey (2007) Medium Term Development Plan 2006-2009

Sunyani Municipal Health Directorate (2008) Medium Term Development Plan 2006-2009

Sunyani Municipal Health Directorate (2008) Medium Term Development Plan 2006-2009

Synder M; Omoto A.M; Crain A.L (1999) "Punished for their good deeds: Stigmatisation for AIDS volunteers." American Behavioral Scientists

Tedstrom, J (2008) "Stigma as a barrier to participation in HIV testing", Maplecrafter/UN Global Compact

MMWR (2006) The global HIV/AIDS pandemic Morbidity and Mortality Weekly Report

The Northern Advocate Magazine (2001) UNICEF' Report "Sub-Saharan Africa's Labour in Danger",

Toth, F.D; Bacsi A; Back Z; Szabi J (2001) "Vertical transmission of HIV-Issue Acta Microbiol Immuno Hung PMID 3225742

UNAIDS (2006) "The impact of AIDS on people and societies." 2006 Report on global AIDS epidemic.

UNAIDS (2007) "Financial Resources Required to Achieve, Universal Access to HIV Prevention, Treatment, Care and Support" (PDF). UNAIDS

UNAIDS (2008), Annual Report- Making the money work (PDF). UNAIDS

USAID (2003) Success stories of HIV/AIDS. Religious Leaders support Ghana's HIV/AIDS campaign against stigma. Washington D.C.,1300 Pennsylvania Avenue

WHO (2001) "Blood safety....for too few" <http://www.who.int/inf-pr-2000/en/pr2000-25.html> Retrieved 2010-03-10

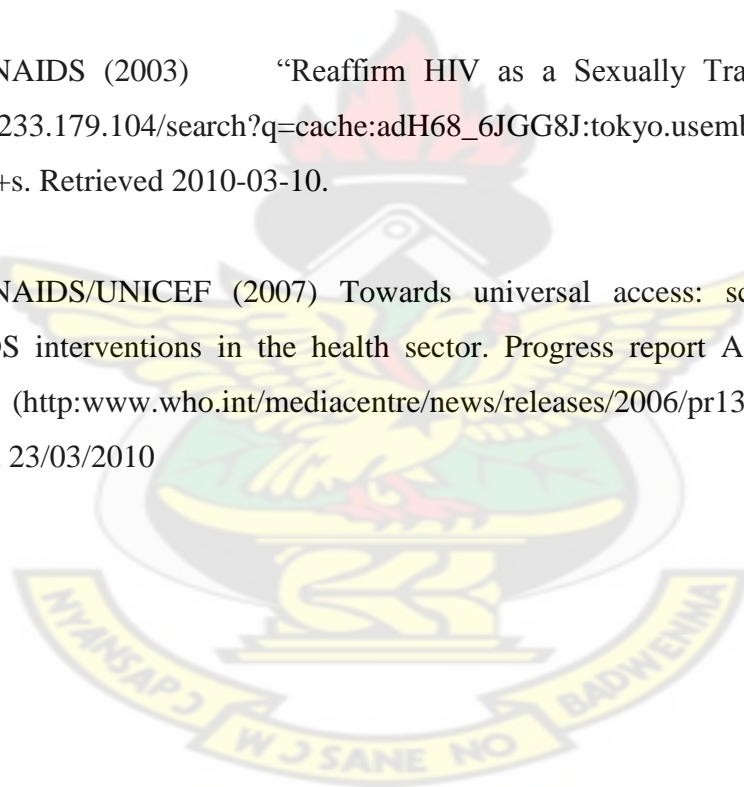
WHO/UNAIDS (2000) Report on the Global HIV/AIDS Epidemic Scale up treatment of HIV/AIDS in Developing countries

WHO (1990) "Interim proposal for WHO staging system for HIV infection and disease." WHO Weekly Epidemiology.

WHO/UNAIDS (2003) Nutrient Requirement for people living with HIV/AIDS Report of a Technical Consultation, Geneva

WHO/UNAIDS (2003) "Reaffirm HIV as a Sexually Transmitted Disease" http://64.233.179.104/search?q=cache:adH68_6JGG8J:tokyo.usembassy.gov/20030317a3.html+s. Retrieved 2010-03-10.

WHO/UNAIDS/UNICEF (2007) Towards universal access: scaling up priority HIV/AIDS interventions in the health sector. Progress report April 2007 Geneva, WHO (<http://www.who.int/mediacentre/news/releases/2006/pr13/en/index.html>). Accessed 23/03/2010



APPENDICES

Appendix 1

HOUSEHOLD QUESTIONNAIRE

Knowledge about HIV/AIDS

- 1a. Do you know the existence of HIV/AIDS? Yes ☐ No ☐
- b. If yes, through what means? Tick the ones you know. (a) parents (b) siblings (c) T.V (d) radio (e) newspapers (f) friends (g) others (specify)
2. What is the difference between HIV and AIDS?
3. How does one acquire the virus that causes HIV? Please tick the appropriate places. Through
- (a) unprotected sex with infected person (b) sharing toothbrush with infected person (c) dancing with infected person (d) kissing infected person (e) sleeping on the same bed with infected person (f) eating with an infected person (g) hugging an infected person (h) sharing the same toilet (i) coughing and sneezing from an infected person.

Perceptivity of stigma in society

- 4 (a). Are HIV-infected persons stigmatised, scorned, gossiped or socially isolated? Yes ☐ No ☐
- (b) If yes, what are some of the reasons given?
-
-
-
- (c) Are the reasons valid? Please give reasons
-
-
5. Can stigma associated with HIV/AIDS prevents infected persons from disclosing their HIV status? Yes ☐ No ☐
- 6.. Can concealment lead to the spread of the disease? Yes ☐ No ☐
7. In case a friend informs you that she or he is HIV-infected person what shall be your reaction? Positive ☐ Negative ☐
8. (a). In case you are diagnosed HIV positive would you inform someone? Yes ☐ No ☐
- (b). If yes, who would you disclose to? Relative ☐ Friend ☐ Spouse and children ☐ Other (please, specify)
9. How does society treat HIV-infected persons?

.....
.....
10. How would you like society members to treat you in case you are HIV positive?
.....
.....

11. Would you treat an HIV infected person the same way? Yes [] No []
.....

Support to PLHIVs

12. Should people living with HIV/AIDS (PLHIVs) live freely in society? Yes []
NO []

Give reasons

13. Should society condemn HIV-infected persons for living immoral or, reckless life? Yes [] No []

14. Would you be willing to take care of a PLHIV? Yes [] No []

15. If a PLHIV is a relative are you willing to look after him/her? Yes []

No []

16. Who should take care of a person living with HIV/AIDS (PLHIVs) Self []
Relative [], Friend [], Government [], NGO [], Other (specify)

17. Who should pay for the cost and treatment of PLHIVs? Self [] Relative
[] Friend [], Government [], NGO [], other (specify)

18. (a) Should relatives and friends support PLHIVs? Yes [] No []

(b) If yes, what kind of support should they give to them?
.....
.....

(c) If no, why?
.....
.....

19. Have you ever seen or heard about PLHIVs isolated or abandoned by a relative or a friend? Yes [] No []

20. Have you ever seen or heard about an HIV positive person thrown out of his or her matrimonial home? Yes [] No []

(b) If yes, what is the present plight of Him/her?.....

.....

.....

Educational campaign on stigma

21 (a). Is there any educational campaign addressing the dangers of stigmatisation of HIV infected persons?

Yes [] No []

(b) If yes, mention some of them?

.....

.....

22. Through what means do you get the campaign message? Radio []

Television [] Institutions [] other (specify)

.....

23. (a). Is the educational campaign enough? Yes [] No []

(b) If no, what should be done?

.....

24. Are you aware of a drug (antiretroviral therapy (ART) that reduces the multiplication of the HIV virus? Yes [] No []

25. What advice would you give to HIV positive persons due to the presence of this drug?

.....

Government Policy on HIV/AIDS stigma

26. (a) Are there any government policies of HIV/AIDS on stigmatization? Yes []

No []

(b) If yes, what some of them?

.....

27. (a) If there is any policy on HIV/AIDS stigma, is it effective? Yes []

No []

(b) If no, what should be done by the government?

.....

28. Have you ever seen or heard of an HIV-infected person thrown out of his/her job?

Yes []

No []

29. If yes, what does he/she do for a living?

30. If the person was self-employed, has he/she lost his/her clients/customers/buyers?

Yes [] No []

31. What can be done to find a lasting solution to the problem of stigmatising HIV/AIDS infected persons?

THANK YOU FOR YOUR QUALITY TIME SPENT ON ANSWERING THESE QUESTIONS

KNUST



Appendix 2

Interview Guide for NGOs

Job Title of interviewee

Name of Organisation

1. When and where was the organization established?.....

2. Where is your headquarters?.....

3 What are your objectives?.....

.....
.....
.....

4. (a) Is the organization affiliated to other NGOs in or outside Ghana? Yes [☐]

No [☐]

(b) If yes, please name them.....

5. What is your source of income? External [☐] Internal [☐] Both [☐]

6. When did your organization start operating in the Municipality?

.....

Involvement on HIV/AIDS issues

7. Do you engage in HIV/AIDS programmes? Yes [☐] No [☐]

(b) If yes, what types of programmes do you engage in?

.....

8. Do you collaborate with healthcare providers? Yes [☐] No [☐]

(b) If yes, what role do you actually play?

.....

.....

9. Does your organization deal directly with HIV-infected persons? Yes [☐]

No [☐]

(b) If yes, how many are benefitting from your support?

.....

10. What kind of support do you offer to them?

.....

11. Had any of them told your outfit that he/she has been stigmatised before?

Yes [☐] No [☐]

(b) If yes, by whom? Relations [] Friends [] Others (specify)

.....

Stigmatization of PLHIVs

12. Would you agree that HIV/AIDS infected persons are stigmatised? Yes []

No []

(b) If yes, by whom? Relative [] Friend [] Other (specify)

.....

13. Have you encountered a PLHIV who has been verbally stigmatized before?

Yes [] No []

14. Can stigmatisation lead to the concealment or undisclosed of one's HIV-status?

Yes [] No []

15. Can concealment lead to the spread of the disease? Yes [] No []

16. Have you ever heard of any HIV-infected person being denied services by a healthcare provider? Yes [] No []

Measures to address the problem

17. What measures need to be taken to address the dangers of stigmatising HIV-infected persons?

.....

.....

.....

18. Do you have any collaboration with the FM stations in the Municipality to educate the general public to open up to HIV-infected persons so that together we fight the pandemic? Yes [] No []

(b) If yes, in what way(s)?

.....

.....

(c) If no, why are you not using them to propagate the message?

.....

.....

Support to PLHIVs

19. Who should take care of person living with HIV/AIDS (PLHIVs)? Self []

Relative [] Government [] NGO [] Other (specify)

.....

20. Who should pay for the cost and treatment of PLHIVs? Self ☐ Relative ☐

Government ☐ NGO ☐ Other

(specify.....

21. Should PLHIVs live freely in the community? Yes ☐ No ☐

22. Should premarital HIV/AIDS test be made compulsory? Yes ☐ No ☐

Progress made

23. What progress has been made in addressing the dangers of stigma attached to HIV/AIDS persons?

.....
.....

24. (a) Is it enough? Yes ☐ No ☐

(b) If no, what should be done?

.....
.....

25. (a) Are there any government policies on HIV/AIDS on stigmatisation?

Yes ☐ No ☐

(b) If yes, mention some of them

.....
.....

(c) If no, what do you think should be done?

.....

26. (a) If there is any policy on HIV/AIDS on stigmatising infected persons, is it effective? Yes ☐ No ☐

(b) If yes, what could be done to intensify it?

.....

27. (a) Has your outfit heard about any travelling restrictions imposed on an HIV/AIDS person? Yes ☐ No ☐

(b) If yes, how many reports have you received from infected persons themselves?

.....

28. (a) Have you got any information on HIV/AIDS infected person stopped schooling due to stigma? Yes ☐ No ☐

(b) If yes, what is your outfit doing about this person's education?.....

.....

29. Has any relation of an HIV/AIDS infected person stigmatised by pupils, school authorities, or individuals? Yes [] No []

30. (a) Does one's HIV positive status affect productivity at the workplace? Yes [] No []

(b) If yes, how?

31. Do HIV/AIDS infected persons have access to antiretroviral therapy on sustainable basis? Yes [] No []

If yes, how much do they pay for this service per visit?

32. What kind of support should society members provide to HIV-infected persons?
.....



Appendix 3

Interview Guide for Healthcare Providers

1. Since when did you established the HIV care centre?
.....
2. How many HIV-infected persons have visited you centre since then?
.....
3. Are all of them receiving antiretroviral therapy? Yes [] No []
(a) If no, why?
.....
4. How many of the infected persons are receiving antiretroviral therapy?
.....
5. Do individuals come to your centre for counselling and testing? Yes []
No []
6. If yes, how many people on the average visit your centre every month?
.....
7. How many are tested HIV-positive on the average in a month?
.....
8. How do you go about your counselling and testing?
.....
.....
9. If someone is tested HIV-positive how do you feel when breaking the sad news to him/her.....
10. How do such people react to the news?
.....
What do you do afterwards?.....
.....
11. Are they willing to disclose their HIV status to others? Yes [] No []
12. Is disclosure an effective means for fighting the pandemic? Yes [] No []
13. Can disclosure allow HIV-infected person receive support from partners? Yes [] No []
14. Why is it uncommon and difficult in practice?
.....
15. Do you think that society members stigmatised HIV-infected persons?
Yes [] No []

16. Does that contribute to the spread of the disease? Yes [] No []
17. If yes, what can be done to deal with the issue?
-
18. Have you encountered any HIV-infected person who has been verbally stigmatised? Yes [] No []
19. How deep-rooted is stigmatisation amongst community members towards HIV/AIDS persons?
20. Does your outfit have any HIV related stigmatisation campaign? Yes [] No []
21. Can the media play any role in curbing the spread of HIV/AIDS transmission? Yes [] No []
22. Have your outfit approached any FM station in the Municipality for a free air-time to educate the public on the prevention and treatment of HIV/AIDS? Yes [] No []
23. If yes, for how many months?
24. If no, why haven't your outfit done so?
25. What progress has been made by your outfit in addressing the dangers attached to HIV/AIDS persons?.....
26. (a) Is it enough? Yes [] No []
- (b) If no, what should be done?
27. How does HIV-infected person see himself/herself?
28. Has any HIV-infected person told you that he/she has ever thought of committing suicide? Yes [] No []
29. What are some of the psychological make-up of HIV/AIDS infected persons?
-
-
- (a) Do you give medical care to HIV/AIDS infected persons? Yes [] No []
- (b) If yes, what type of medical care do you give to them?
30. How much does it cost an HIV-infected for this medical care?
-

31. Who should pay for the cost of treatment of HIV-infected persons? Self ☐ Relative ☐ Government ☐ NGO ☐ Other please, specify
32. Have you refused an HIV-infected person medicines or access to health care facilities? Yes ☐ No ☐
33. Have you ever conducted HIV-testing without the consent of the individual involved? Yes ☐ No ☐
34. Is there any lack of confidentiality of one's HIV status by your outfit? Yes ☐ No ☐
35. What could be done to encourage more people to test for their HIV status?
.....
.....
36. (a) Are there any government policies on HIV/AIDS stigmatisation? Yes ☐ No ☐
- (b) If yes, are they effective in controlling the spread of the pandemic? Yes ☐ No ☐
37. What are some of the challenges your outfit encounter in face of this disease?
.....
.....
38. How can these challenges be addressed?
.....
.....

Appendix 4

QUESTIONNAIRE FOR RELIGIOUS BODIES

- 1 Name of religious body.....
- 2 Do you engage in HIV/AIDS programmes? Yes [] No []
- 3 (a) Do you organize workshop for your leaders on how HIV/AIDS programmes could be integrated into your worship? Yes [] No []
(b) If yes, how do you do it?.....
(C) If no, why?.....
- 4 (a) Do you have HIV/AIDS persons among your membership? Yes [] No []
(b) If yes, how do you treat them.....
5. (a) Does your outfit deal directly with HIV/AIDS infected person? Yes []
No []
(b) If yes, what do you do with them?.....
6. (a) Do you collaborate with healthcare workers? Yes [] No []
(b) If yes, in what ways?
.....
7. How many HIV/AIDS infected persons among your membership do you know?
.....
8. (a) Are their HIV- positive status known by the non-infected members?
Yes [] No []
(b) If yes, how do they treat the infected person?.....
9. If their HIV-positive status is not known by the members, why is it so?
.....
10. (a) Would you agree that HIV/AIDS persons are stigmatized? Yes [] No []
(b) If yes, why is it so?
11. Does your organization have any policy of HIV/AIDS on stigmatizing HIV/AIDS person? Yes [] No []
12. Who should take care of persons living with HIV/AIDS (PLHIVs)?
Self [] Relative [] Government [] NGO [] Friends [] Others ,
(Please Specify)
.....
13. (a) Do you educate your members on the dangers of stigmatization of HIV/AIDS person? Yes [] No []

(b) If yes, are the members willing to show compassion and empathy to the HIV-infected persons? Yes [] No []

14. How do they do this?.....

15. Should people living with HIV/AIDS live freely in the community?

Yes [] No []

16. Should people living with HIV/AIDS be mixed up with members during worship?

Yes [] No []

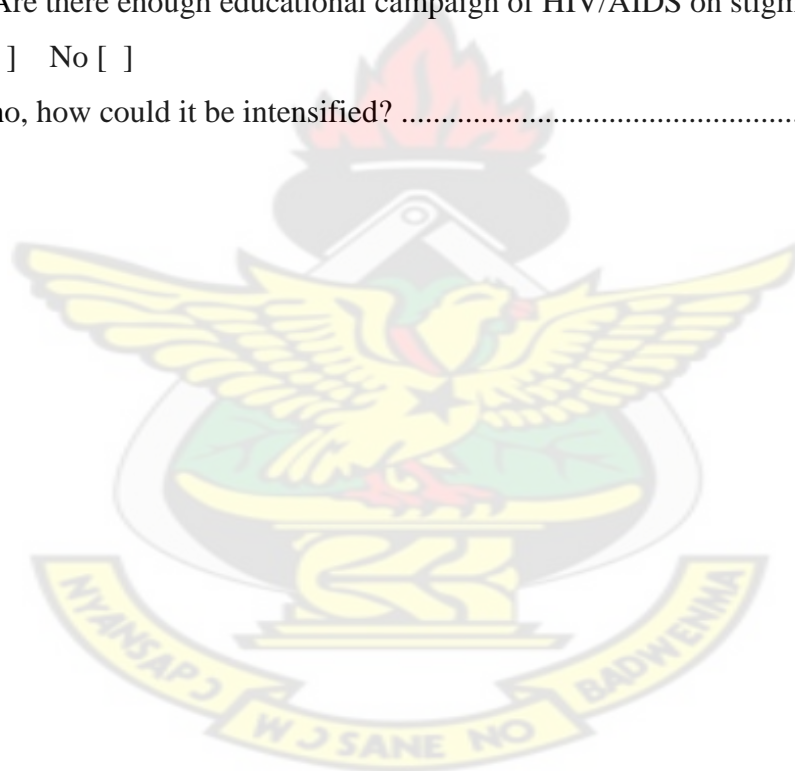
17. What kind of support do you think HIV/AIDS persons need from members of society?.....

18. What educational campaign could be put in place to encourage more people to embark on voluntary counseling and testing (VCT)?.....

19. (a) Are there enough educational campaign of HIV/AIDS on stigmatization

Yes [] No []

(b) If no, how could it be intensified?



Appendix 5

INTERVIEW GUIDE FOR MUNICIPAL ASSEMBLY

Job title of Interviewee.....

1. Since when did you incorporate HIV/AIDS issues in your programmes?.....

2. What HIV/AIDS programmes do you embark upon?

3. How many HIV – infected persons are in Municipality?

a) Are all of them receiving antiretroviral therapy (ART)? Yes [] No []

b) If yes, how many are they?

4. Do you give directly with HIV-infected person? Yes [] No []

a) Do you give any support to them? Yes [] No []

b) If yes, what kind of support do you give to them?

6. (a) Are you satisfied with the kind of support you give to them? Yes [] No []

(b) If no, why can't you increase the support?
.....

7. (a) Are HIV-infected persons stigmatized by community members Yes [] No []

b) If yes, does stigma lead to the concealment of one's HIV positive status?

Yes [] No []

8. What are some of the possible implications?
.....

9. Is disclosure an effective means for fighting the pandemic Yes [] No []

a) Can disclosure allow HIV –infected person receive support from partners?

Yes [] No []

b) If yes, why is it uncommon?

10. Have you encountered any HIV –infected person who has been verbally stigmatized? Yes [] No []

How deep-rooted is stigmatization among community members towards HIV/AIDS person?

11. (a) Does your outfit has any HIV –related stigmatization campaign Yes []

No []

b) If yes, is it effective? Yes [] No []

c) If no, what do you think can be done to intensify it?
.....

12. What progress has been made by your outfit in addressing the dangers attach to HIV/AIDS persons in the Municipality?

13. How does HIV –infected person see himself/herself?

.....

14. Who should pay for the cost of treatment of HIV –infected person?

Self [] Relative [] Government [] NGO [] others (Specify)

.....

15. (a) Are there any government policies of HIV/AIDS on stigmatization?

Yes [] No []

b) If yes, are they effective in controlling the spread of the pandemic?

Yes [] No []

16. What are some of the challenges you encounter in the face of the deadly disease?

.....

How can these challenges be addressed?



Appendix 6

INTERVIEW GUIDE FOR RELATIONS/FRIENDS OF PLHIVS

Knowledge about HIV/AIDS

1. What is the most serious disease facing the world today?

Malaria [] Typhoid [] TB [] AIDS [] other (specify)

2. HIV carrier looks healthy without symptoms? Yes [] No []

3. HIV can be transmitted through

Mosquito bite Yes [] No []

Touching the body Yes [] No []

Coughing or sneezing Yes [] No []

Sharing toilet seats Yes [] No []

Razors Yes [] No []

Toothbrush Yes [] No []

Sharing public places Yes [] No []

Sharing needle or syringe Yes [] No []

Intravenous drugs use Yes [] No []

Sex with prostitutes Yes [] No []

Sex with many partners Yes [] No []

Sharing other clothes Yes [] No []

Blood donation Yes [] No []

Mother-to-fetus Yes [] No []

Breastfeeding Yes [] No []

Body fluid (sweat) Yes [] No []

4. Does AIDS have no curative vaccine? Yes [] No []

5. Does AIDS have curative treatment? Yes [] No []

6. When did you get to know that your friend/relation was HIV-positive?

7. Who informed you? Herself/Himself [] Friend [] other specify

8. How did you feel when you first heard of it?

9. Why did you tell him/her?

10. Since then, what has been your relationship towards him/her

Positive [] very positive [] negative [] very negative []

11. Give reasons(s) for each of the option chosen?

12. Have you been offering some support to him/her Yes [] No []

13. If yes, what kind of support is it?

14. If no why you are not prepared to do so?
15. Has she/he ever complained to you about how you treat him/her? Yes [] No []
16. Have you expressed any ill-feeling about him/her? Yes [] No []
17. If yes, what led to that?
18. Who should take care of PLHIVs? Self [] Friend [] Government [] other specify
19. Who should take care and treatment of PLHIVs?
Self [] Friend [] Government [] other
20. Are HIV persons stigmatized by society? Yes [] No []
- 21.(a) Has someone stigmatized your friend/relative before in your presence
Yes [] No []
- (b) If yes, what your reaction?
22. How do you want the public to treat PLHIVs?
23. Has she/he told you that she/he has been stigmatized by someone before?
Yes [] No []
24. Has your friend/relative ever thought of committing suicide? Yes [] No []
25. Have you taken HIV/AIDS test? Yes [] No []
26. (a) Is your friend/relative been receiving ART? Yes [] No []
- (b) If yes, how is her/his condition compared to the past?
.....
27. Do you constantly remind him/her of taking the ART? Yes [] No []
28. Who collects the ART on her/his behalf? Self [] Relative [] Friend []
Other (specify)
29. Who pays for the ART?
.....

Appendix 7

INTERVIEW GUIDE FOR HIV-INFECTED PERSONS

1. When were you tested HIV-positive.....
2. Before then, were you aware of the existence of HIV/AIDS?
Yes [] No []
3. Through what means were you infected?
Sexual intercourse [] Sharp instrument [] blood transfusion []
Other (specify)
4. Since you were tested positive have you informed anybody? Yes [] No []
 - a) If yes who is this person?
.....
 - b) And why did you do so?.....
 - c) If no, why have you not done so?.....
5. If you had informed anyone, what was his/her reaction? Positive [] Negative []
6. Has the relationship between you and the person changed? Yes [] No []
7. Have you been stigmatized before? Yes [] No []
8. Have you been regretted informing someone?
9. Have you been receiving any support from those you have informed?
Yes [] No []
 - a) If yes, what kind of support do they give to you?
 - b) If no, why are they behaving in that manner?
10. If they are supporting you do need more help than they are presently giving to you?
Yes [] No []
 - a) If yes, what kind of additional support?
Elaborate.....
11. Apart from those you have informed, are you aware that other people might have
Heard of it? Yes [] No []
 - a) If yes, do you suspect anyone for disclosing it? Yes [] No []
12. Who in your opinion did that?
13. How do you relate to this person.....
14. Are you aware of the types of service available to HIV-positive person?
Yes [] No []
 - (b) If yes, what kind of service?

15. Where do you get this service?
16. Have you been reporting your status to healthcare provider? Yes ☐ No ☐
17. Are you on ART? Yes ☐ No ☐
18. Do you pay for the ART? Yes ☐ No ☐
19. Have you ever been ridiculed by a healthcare provider? Yes ☐ No ☐
20. What effect is stigmatization having on you?
.....
21. In your candid opinion, what can be done to do away with this stigmatization?
.....
22. Can this stimulate HIV positive status increase the spread of the disease?
Yes ☐ No ☐
23. Can Concealment of one's HIV positive status increase the spread of the disease?
Yes ☐ No ☐
24. Is there any on-going programme to educate the public on the dangers of stigmatization? Yes ☐ No ☐
25. (a) If yes, is it effective?
.....
(b) If no, what should be done?
.....
26. Were you working before the infection? Yes ☐ No ☐
27. Are your client's employers aware of your HIV status? Yes ☐ No ☐
(a) If yes, have they stopped patronizing your goods/services or sacked?
Yes ☐ No ☐
28. Who should take care of PLHIVs? Self ☐ Family ☐ Government ☐
Other (specify).....
29. Who should take care of PLHIVs? Self ☐ Family ☐ Government ☐
Other (specify).....
30. What type of behavior do you want the general public to exhibit in the face of this disease?
31. What message do you have for the public on how to treat HIV-infected person?