ANALYSING THE EFFECTS OF DISCRIMINATION OF PEOPLE LIVING WITH HIV/AIDS IN TORORO DISTRICT

(CASE STUDY: TORORO MUNICIPAL COUNCIL)

BY

ASWAT HELLN

BSW/5835/41/DU

A DISSERTATION SUBMITTED TO THE FACULTY OF SOCIAL SCIENCES IN PARTIAL FULFILMENT AS THE REQUIREMENT FOR THE AWARD OF BACHELORS' DEGREE IN SOCIAL WORK AND SOCIAL ADMINISTRATION OF KAMPALA INTERNATIONAL UNIVERSITY

SEPTEMBER 2008

DECLARATION

I, the undersigned do declare that this Dissertation is entirely my own tireless efforts work and has never been submitted to any University or any other Institution of higher learning in Uganda, East Africa and the rest of the world over.

Signed
30th/09/08
M'S ASWAT HELLEN
BSW/5835/41/DU
30th/09/08
DATE

APRROVAL

This Dissertation is presented by Aswat Hellen and it has been under close supervision by Mr. Tumukunde Aloysius, and it is now recommended for consideration

Signed .....

MR.TUMUKUNDE ALOYSIUS

.....13/10/2008.....

DATE

DEDICATION

I dedicate this piece of work to my beloved children, Ochieng Allan, Lapa Walter, Kide Aswat Linda, David Emojong Akou and Donald Raymond Olupot.

Not to forget my parents Ann Emojong and Micheal Emojong and all my brothers and sisters who have been a very big encouragement to me.

Very special and Sincere thanks go to my classmates, Angela, Richard, Raymond, Moses, Robert, Harriet, Judith, Moses, Jacky to mention but few. You were a very big motivate during my class time at campus who supported me academically and morally throughout my study time of three years.

ACKNOWLEDGEMENT

I would like to take this as a real golden chance to express to Tororo Municipal Council Community, at the outset my deepest gratitude to all of you for enabling me to carry out this research study. Special thanks go to them for allowing me to access information from their sources and for allowing me conduct the research with their location.

Not to forget the officials at the Tororo District offices. The AIDS Support Organization (TASO) for allowing me accesses their library which contributes a great deal to my literature review.

I am heavily indebted to the respondents most of whom are living with HIV/AIDS for their kindness and willingness in providing me with the necessary information to feed into the study and above all for sparing me their precious time during the study. The experiences they shared is of high value and will help many more people in future.

Most important of all I would like to thank the staff and Management of Kampala Internationals University (KIU) for giving me a chance to experience a field study exercise. To the lecturers in general for providing me with a good a academic environment and knowledge without which I would not have been able to complete my study.

Best regards to all the lecturers of the faculty of Social Sciences and Law and specifically Mr. Tumukunde Aloysius for his tireless efforts, patience, and tolerance in guiding me to accomplish this research study and the course as a whole

Not to forget my parents, children and close family relatives for being very supportive and always identifying my potentials by encouraging me at all times.

TABLE OF CONTENTS.

CHAPTER FOUR: DATA PRESENTATION, INTERPRETATION, ANALYSIS AND DISCUSSIONS OF RESEARCH FINDINGS

4.8 DISCUSSION OF RESULTS

LIST OF ACRONYMS

AIDS	**Acquired Immune Deficiency Syndrome**
ASOs	**AIDS Service Organizations**
ARVs	**Anti-Retroviral**
CDC	**Centers for Disease Control and prevention**
CD4	
DNA	**Deoxyribonucleic Acid**
FAO	**Food and Agricultural Organization**
HIV	**Human Immume-Defeciency Virus**
M.O.H.	**Ministry of Health**
NGOs	**Non-Governmental Organizations**
PLHAs	**People Living with Human Immune-Deficiency Virus/ Acquired Immune Deficiency Syndrome**
PTC	**Pots Test Club**
RNA	**Ribonucleic Acid**
SSSA	**Southern Sub-Saharan Africa**
TASO	**The AIDS Support Organization**
TMC	**Tororo Municipal Council**
UCC	**Uganda College Of Commerce**
UNAIDS	**United Nations AIDS International Development Service**
UNIFEM	
USA	**United States of America**
WHO	**World Health Organization**

LIST OF TABLES

CHAPTER ONE

INTRODUCTION

1.0 Background of the study

The Human Immunodeficiency Virus (HIV) is a retrovirus belonging to the family of lent viruses. Retroviruses have the ability to use their Ribonucleic Acid (RNA) which carries the genetic message from Deoxyribonucleic Acid (DNA) to make viral DNA and are unknown for their long incubation periods. Like other retroviruses, HIV infects the human body, has along incubation period (clinical latency), and ultimately causes the signs and symptoms of AIDS. It is an extremely small organism which is a parasite and mostly found in blood, semen and virginal secretion. HIV causes severe damage to the immune system and eventually destroys it. It accomplishes this by utilizing the DNA of CD4+ to replicate itself. In the process the virus destroys the CD4+ rendering the human body immunity defenseless and therefore vulnerable to any infections. It is therefore fatal in nature. The resulting condition of this is AIDS which is an abbreviation for "Acquired Immune Deficiency Syndrome" Acquired is something one gets, immune refers to the resistance against infections, deficiency is lack of and in this context of protection, a syndrome is a collection of signs and symptoms.
Recent estimates indicate that 42 million people were living with HIV/AIDS (Human2.) Immunodeficiency Virus/ Acquired Immune Deficiency Syndrome) by the end of 2002 world wide. The total of AIDS deaths in 2002 was 3.1 million. No country or region is immune or shielded from the pandemic, though the prevalence rates vary (Joint United Nations Programme on HIV/AIDS [UNAIDS], 2002).

Sub Saharan Africa (SSA) is the worst affected region, where 29.4 million people are living with HIV/AIDS (UNAIDS, 2002). 10 million out of these are young people between the ages of 15-24, while 3 million are children under the age of 15 (UNAIDS, 2002. Overall about twice as many young
women as men, aged 15-24, are infected in some SSA countries (UNAIDS, 2002). Teenage girls are 5 times more likely to be infected than boys, as girls often become infected by older men (United Nations Development Fund for Women [UNIFEM], 2003).

Approximately 3.5 million people in SSA became infected with HIV in 2002. In some countries the prevalence amongst the adult population, aged 15-49, has risen higher than expected, exceeding 30% of the population (UNAIDS, 2002a). The number of HIV/AIDS deaths in Sub Saharan Africa during 2002, is estimated to 2.4 million (UNAIDS, 2002). Due to insufficient HIV prevention, treatment, care and support, death stalks the continent and the numbers of deaths are believed to continue rising (UNAIDS, 2002b). Patel et al. (2002) put it quite eloquently: "The human costs are, like the distances between stars, impossible for a human being to properly appreciate."

People can live with HIV/AIDS for many years, but stigma and discrimination reduces the life-quality of PLWHA (France, 2001). Stigma and discrimination can prevent people from attending testing for HIV, acknowledging and disclosing their HIV-status, suggesting safe sex, and seeking treatment, care and support (Muyinda et al., 2002). This

therefore pauses a threat of further spread of this deadly infection. My personal interaction with many people still wonder how the community will look at them in case they learnt that they are infected with HIV and therefore living with it.
It's upon this background that this study will investigate the status of effects of discrimination of people living with HIV/AIDS in Tororo Municipal Council located in Tororo District, Uganda.

1.1 Statement of the problem

Research in the last decade has increased the understanding of many psychological and social aspects of HIV/AIDS (King, 2002). However, most of the international HIV/AIDS research resources have been put into sophisticated medical research. Such research is important but has seemingly excluded attempts to confront the many non medical impacts of HIV/AIDS (Barnett & Blaikie, 1992). Parker and Aggleton (2003) point to how social science research and campaigns mainly have focused on prevention and information, and less on care and support for PLWHA. Documented attempts of challenging HIV/AIDS-related discrimination remain relatively rare. Research is urgently needed to identify and exemplify the most effective ways of dealing with this discrimination across a range of contexts hence the need for this study.

1.2 Objectives of the study

The study was guided by two sets of objectives as shown below.

1.1.2 General objective of the study

The overall objective of this study was to analyze whether people living with HIV/AIDS in Tororo Municipal Council (TMC) in Tororo District -Uganda were subject to effects of discrimination and if so, what influence did it have on their possibilities to enjoy their human right to health and adopt health seeking behaviours.

1.2.2 Specific objectives

- To determine if the people living with HIV/AIDS (PLWHIV/AIDS) in Tororo Municipal Council in Tororo District - Uganda were discriminated in their closest social context
- To identify the sources of discrimination, the ways in which HIV/AIDS related discrimination manifests itself.
- Determine what could be the ways in which People living with Human Immunodeficiency Virus are in Tororo Municipal Council are subject to discrimination.
- Determine how discrimination affected their possibilities to maintain a good health.

1.3 Research Questions

- Are people living with HIV/AIDS in Tororo Municipal Council in Tororo District discriminated in their closest social context?
- In what way are people living with HIV/AIDS in Tororo Municipal Council in Tororo District subject to discrimination?
- How does discrimination affect their possibilities to maintain a good health and adopt health seeking behavoiurs?

1.4 SCOPE OF THE STUDY

Basically the Research was conducted in Tororo District- Tororo Municipal Council as the case study, and the results got represent other districts.
people living with HIV/AIDS

1.5 Significance of the study

This study will be of great importance both at the macro and micro level;

At the macro level, informed decisions in policy formulations and in the building of the institutions aimed at HIV/AIDS counseling as a management tool for the fight against stigma and discrimination will be considered by the policy makers.

At the micro level, the local community leaders and a number of NGOs responsible for the fight against stigma and discrimination may adopt the recommendations put forth, and use the findings to address issues in the report.

The research will help researchers and academicians to increase on the available literature for further studies.

At personal level, the research will empower me with the skills and experiences of and above all understanding the effects of discrimination to people infected by HIV and identify strategies to support the.

CHAPTER TWO

LITERATURE REVIEW

2.0 Introduction

This chapter reviews literature as an account of the knowledge and ideas that have been established by accredited scholars and experts in the field of study. It is guided by the objectives of the study outlined in chapter one

2.1 History of HIV/AIDS in Uganda

Uganda is often sited as the success story in sub-Saharan Africa in its efforts to reduce HIV prevalence levels. Uganda has braved a severe devastating epidemic of HIV infection and AIDS disease for almost a quarter a century.

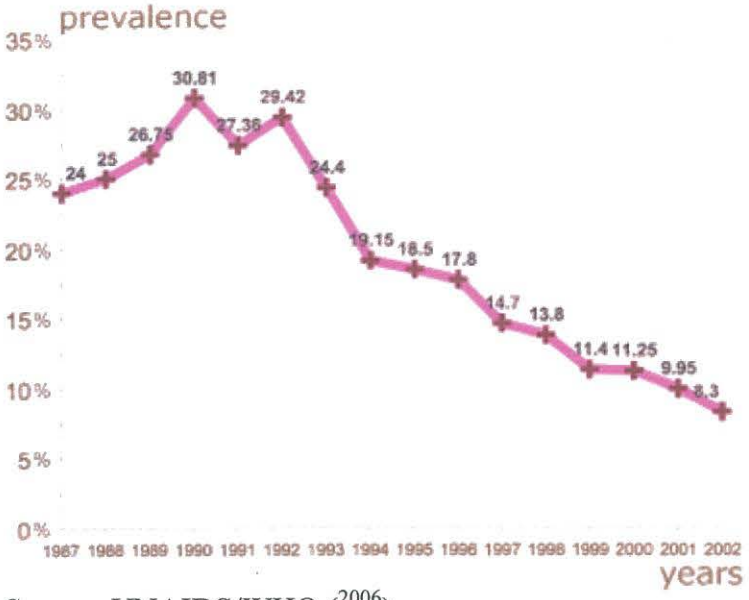
In Uganda this epidemic was first discovered in the shores of Lake Victoria in Rakai District in the early 1980s the initial epicenter of the illness. Thereafter HIV spread quickly initially in major urban areas and along the highway and by 1986 HIV was reported in all districts in Uganda ,Tororo inclusive and therefore Tororo Municipal council a major urban area resulting in what is classified as a generalized epidemic.

HIV infection continued to spread relentlessly through out the 1980s to date and gave rise to a wave of AIDS as more people succumbed to the opportunistic infections arising from their suppressed immune systems. The persistent ill health and the sexual transmission which was by then the only known mode of transmission created fear which eventually resulted to stigma and discrimination of the people who were and are infected with HIV. Like in many countries in Sub-Saharan Africa HIV is predominantly spread through hetero sexual contact.

The impact of the disease has been mainly felt through the escalating morbidity and mortality that disproportionably affects women, men during the prime of their reproductive life. The consequences of the epidemic sprang across all spheres of life (individuals and communities nationwide and of course Tororo District.

The HIV epidemic has also had a far reaching social consequence, by depriving families and communities of their most productive population. It has caused untold suffering to individuals and communities both physically and psychologically. According to the recent TASO Tororo 2007 reports more than one thousand families have lost their dear ones to HIV and more than 500 people are living with HIV/AIDS in TMC.This number refers to those individuals and families who have sought support and care from the organization.

It has therefore been very challenging to effectively implement on HIV/AIDS preventive programmes. The incidence rates are stagnant or rising. There are a number of factors that have impacted negatively on the fight against HIV/AIDS in Uganda and in Tororo Municipal Council. This lends credence to the fact that there is a significant number of



Source: UNAIDS/WHO ([2006])

AIDS in Uganda was initially known as 'slim' due to the physical wasting it caused. HIV was already spreading in Uganda on the shores of Lake Victoria in the late 1970s. It is from here that some theories suggest HIV spread to the rest of the world. If this is true then Uganda's HIV epidemic might be said to have had something of a 'head start' on other national epidemics. World Bank (2007)

In 1982 the first AIDS case in Uganda was diagnosed. Between 1982 and 1986 there was little understanding of what AIDS was. During this period the epidemic was largely addressed at local levels with communities caring for those infected and affected. (www.aidsuganda.org)

2.2 Discrimination

To understand discrimination it is a good idea to first understand what stigma is. A dictionary meaning of stigma is" a disgrace or reproach attached to someone". Stigma can be defined as an act of identifying, labeling or attributing undesirable qualities targeted towards those who are perceived as being shamefully different and deviant from the social ideal" and as an attribute that is significantly discrediting used to set the affected persons or groups apart from the normalized social order. This is very appropriate to the way that people with HIV may sometimes be perceived.

Discrimination signifies an unequal treatment of a person or group. It can also be defined as "an action or treatment based on the stigma and directed towards the stigmatized" and as sanction, harassment, scapegoating and violence based on infection or association with HIV/AIDS". In a nut shell Stigma is the "attitude" and discrimination is the "act" There is positive, neutral or negative discrimination, although the term is often associated with negative treatment of someone. It is necessary to look at the norms that are accepted in a specific society, to be able to establish that someone has been discriminated. There is

both individual and institutional discrimination. Institutional discrimination are when rules, practices and regulations in a social system leads to that people or groups are getting treated different; some are getting discriminated. National legislation and international law are supposed to protect everyone from unfair treatment (Banton and Michael, 1994).

One definition of discrimination is that someone is being treated different because of their belonging of a specific group. If this different treatment should be classified as discrimination the difference cannot be morally justified. The cause (for example sex, age or ethnicity) of the difference in treatment has to be known in order to state if it is discrimination. Some distinction in treatment is morally justified and lawful (such as student discounts). A different treatment is very common in social life, as an example; children are not treated in the same way as their parents by their relatives and amongst each other.

2.3: Why people living with HIV/AIDS are discriminated against

People living with HIV/AIDS are stigmatized and discriminated against for many reasons:

- **Nature of the infection**
  HIV is a slow, incurable, disease that eventually results in severe illness and death. It is a serious illness and even now many people think it is invariably fatal.

- **Attitudes**
  Many people regard HIV as an automatic death sentence.

- **Mode of transmission**
  The public often poorly understands how HIV is transmitted, and people are often irrationally afraid of acquiring HIV from people already infected with it because it is perceived to sexually transmitted only.

- **Cultural Beliefs**
  HIV transmission is often associated with violations of social morals regarding proper sexual relations, so people with HIV are associated with having done something "bad". For example in some cultures in Tororo District people believe that a woman becomes infected with HIV because she violates the mourning period after her husbands death. Ref: (HIV Curriculum for the Health Professionals by Baylor College of Medicine Houston, Texas, USA). The sexual mode of transmission subject PLWHIV/AIDS to moral judgment.

- **Religious Beliefs**
  HIV is simply interpreted by some people as a punishment or a fulfillment or scriptural warnings.

- **Vulnerability**
  Many PLWHIV/AIDS for example children, women, the poor and other minority groups have no voice and protection (defenseless) and as a result they are discriminated because of their status.

Discrimination is one possible cause of inequality; only if other possibilities have been eliminated can it be identified as the main cause. Discrimination is an individual action, but since several members of one group can be discriminated, it can also be a social phenomenon. It can be hard to identify the motive for discrimination. Some might discriminate another person without the intention of doing so, while others know very well the motives of why they are treating people different. It is important to separate discrimination as an action, and prejudices as an attitude. Prejudices can lead to discrimination but it does not always do that. In finding the cause for discrimination it is vital to study the legal system and the culture where the discrimination appears. Discrimination is rarely an isolated act but part of a larger system; a behavioral pattern that suppresses for example women, blacks or handicapped (Banton, 1994).

Discrimination functions like a superlative power; it makes difference amongst the undifferentiated. Discrimination separates the society and small social groups such as the family and neighborhood into different units. It separates men from women and healthy from unhealthy into a society that is split up into different parts. The world is a differentiated place and it is very hard to avoid this separation amongst people. Human rights aim to condemn discrimination, it is very hard to abolish a differentiated world, even with the assets of human rights, but it is possible to avoid a denial of peoples' basic rights. There has to be an establishment of boundaries between people in order to discriminate others. The boundaries create different groups in societies; human rights instruments have to demand that all these groups will be treated with equal respect. This difference amongst people is tolerated to a certain degree, if the distinction is too profound it is more likely that people stop being tolerant (Hastrup and Ulrich, 2002).

2.3.1 Implications of discrimination

The extensive nature of the stigma and discrimination against people with AIDS is well established. This has significant impacts on those immediately infected and affected, but also has a number of implications for the epidemic and broader society. Stigma and discrimination relating to HIV/AIDS undermines public efforts to combat the epidemic (Malcolm et all 1998, UNAIDS 2000a, 2000b). According to me as an HIV/AIDS Counsellor since 1992 this undermines all round efforts right from the individual to the family, community and the nation at large combat the epidemic. AIDS stigma and discrimination negatively affects preventive behaviuors such as abstinence, condom use, HIV testing seeking behaviours, care seeking behaviours upon diagnosis, quality of care given to the HIV positive patient and perception and treatment of PLWHIVAIDS by communities, families, and partners. People at risk of HIV can be so fearful of any association with it that they deny any possibility that they could be at risk. It is known that a big percentage of all HIV in Tororo Municipality is undiagnosed and many people will have lived with the virus for very many years before they are diagnosed. (Michael Carter HIV Stigma and you pgs 7 to 10. Finding out that one is HIV positive may also

cause one to think differently about him/herself and even possibly for a new self stigmatizing identity z someone who is blameworthy, sick, and unproductive and a potential health risk to others. Its important to remember that HIV is just an infection. It isn't a moral judgment or punishment given to you because of who you are or what you did. It's just a virus that has evolved to be transmitted in particular ways. Its is really important to forgive oneself for contracting HIV and to accept that one is living with the infection. For some if not most people this can be a long and emotionally a painful process and it is likely to involve confronting some deep-seated negative feelings that one has about who and what one is. It can be unnerving or unsettling process experience as mentioned by one of the clients who registered in TASO in December, 2007.

"*I always felt like I have made the worst mistake on earth, why has this happened to me and I wish I never married at all may be I would be an HIV/AIDS widow having lost my husband in 1999. My God guide me to challenge these negative feeling and instead help me to like myself and therefore seek for support always" Counsellor, I used to I isolate myself until I realized I was getting no where especially after seeing my fellow AIDS patients health conditions improving every year"*
(File Quotation from PLWHIV/AIDS)

At one burial in Agururu B village on the 17th/May/2008. Alonsia had this to say, "You *see me like this I used to hide myself inside the house because I thought that every one was talking about me. When I hear them making jokes and laughing, I would definitely know that they are talking about me and it would pinch my heart deep .Abu eong kakotin alemun awuno amiedakin tetere ebwarari eong akisro nuka akwap ana.* Meaning, "*I had felt like getting a rope and hanging myself so that I rest from these earthly problems"*
(File Quotation from PLWHIV/AIDS)

These are the minority of experience s shared by PLWHIVAIDS meaning that there are a lot more people going through this self stigma and discrimination and therefore need to be helped if HIV has to be managed and combated in Tororo Municipal Council.
One of the most surprising elements of AIDS stigma and discrimination is its ubiquitous nature even where the epidemic is widespread and affecting so many people. Given these situations it is critical that interventions that effectively reduce AIDS stigma and discrimination be identified and implemented.
Hence these insidious impacts must be acknowledged, if the work to eradicate stigma is to be taken seriously.

2.3.2 Making the epidemic invisible

A prime impact of discrimination is that it pushes the epidemic underground, forcing people who have contracted HIV, and anything else associated with the disease, into hiding. An acknowledgement of HIV becomes difficult if not impossible. Likewise any association with the disease or people with HIV can be a basis for that person being excluded from their community, so is denied. The disease itself then remains hidden so its perceived threat is reduced. It also makes the disease someone else's problem. The stigmatizing beliefs then facilitate the use by individuals and communities of denial and distancing as defensive processes against the epidemic, again reducing the need to adapt

(Skinner, 2001). Distancing or creating barriers between those infected and the rest of the population consumes considerable energy that could be more profitably used, and robs the intervention of some of the best advocates for behaviour change, namely those who are directly affected.

What is more, one will also have to interact with others HIV- positive people. Although some people in TMC find this very empowering, others who are the majority find very unsettling and actually very disturbing to the mind and general health condition. (HIV and you Michael carter page 10)

Thus the epidemic disappears, or at least has few public faces, leaving the space open for scapegoating of any person or group associated with the disease. These scapegoating processes can be dangerous, as they pin the blame on a small section of the population, leaving the rest with the mistaken belief that they are safe (Douglas, 1995; van der Vliet, 1996).
A greater problem arises when those with the power to construct interventions use discrimination as a basis for not implementing such programmes. For communities as a whole, or for those responsible for structuring interventions, blaming infected people can be a substitute for tackling the problem itself. So even when interventions are developed from this basis, they are constructed in such a way as to discriminate against those in affected groups and to reinforce a false sense of safety in the majority of the population.
Sometimes on individual basis one may be concerned about seeing or recalling people who are ill or have died painfully of HIV/ AIDS might cause someone to think about the way that might cause them to think about the way the virus might affect their own health condition and general life in future. There are a lot more people in TMC who are aware about this and therefore need a lot of help with dealing with self stigma and discrimination. On the other hand it could be that experiencing other people worth HIV leads one to think about their own preconceptions about the 'type' of people who have HIV and about how similar, or how different one is to these people. In this.
There are other ways in which self stigma and discrimination can operate. For example, if you feel that you are so different from other people, you might avoid socializing and end up isolated, without understanding and support. This is not good for the health of PLWHIV/AIDS. Sometimes PLWHIV/AIDS think of themselves as being ill even though HIV isn't the real cause of the ill health problems and some even go a far as leaving work.
Sometime PLWHIV/AIDS experience side effects that can be stigmatizing and discriminating such as the body fat changes (lipodystrophy) caused by some ARV or other side effects, such as cardiovascular which involve a whole new set of long term health problems.

2.3.3 Limiting access to treatment

Discrimination has significant impacts on diagnosis and treatment. For the individual it can delay diagnosis and therefore also delay entry into treatment and adoption of a healthy lifestyle. There is no motivation to be tested, as the person sees no benefit when the diagnosis of HV is seen as equivalent to death, and they are likely to experience discrimination (Abdool Karim, Tarantola, Sy & Moodie, 1992). In certain contexts

research respondents have been shown to be more fearful of the discrimination resulting from stigma than of the disease itself, so even with treatment, stigma may be a block to access (Lie & Biswalo, 1994).This has already been shown to be a problem in the case of PMTCT, where women have expressed fear of being tested as I have observed in the main Tororo District Hospital in Tororo Municipal Council. In the same way the use of formula feeding rather than breastfeeding can become a problem. Many women feel restricted from being able to breastfeed for fear of family observation and questions.

Even for those who are aware of their status, discrimination can limit access to care and treatment (Grange, Story & Zumla, 2001; Rehm & Franck, 2000). Many are not able to acknowledge even to their families that they are infected, so are denied that level of care (Wiener, Battles, Heilman, Sigelman & Pizzo, 1996; Yoshika & Schustack, 2001). If some level of general acceptance and support can be obtained for the person who is HIV-positive, this can facilitate better results (Aranda-Naranjo & Davis, 2000). The benefits of testing need to be openly acknowledged.
Even minor modifications of behaviour can improve life (Department of Health, 2001; Feinberg & Maenza, 2000), and the introduction of ARVs can considerably extend a person's life, even in resource-poor settings (Cheever, 2000).

2.3.3 Impact on identity and coping of the person with HIV

Stigma impacts on the PLWH them, as it is internalized into their self-perception and sense of identity, impacting on the person's perceptions and how they interact in the world. Research has found that people with HIV feel isolated, guilty, dirty and full of shame, which is then often incorporated into identity (Kalichman, 2004). General participation in the activities of life is therefore restricted by stigmatization (Sowell, Seals, Moneyham, Demi, Cohen & Brake, 1997). Isaacs (1993) found that among gay men the rejection experienced by the person who was HIV-positive fed into their sense of self, causing them to feel compromised and to blame for their situation. Similar results were found with a sample of HIV positive women (Strebel, 1993).When this stigma is internalized it might influence the ways affected individuals look at themselves and how they interact with others, including health care providers (Lee, Kochman & Sikkema, 2002).This again impacts on a person with AIDS coming to terms with their illness.
On a more personal level discrimination related to HIV can sometimes fundamentally undermine ones sense of oneself.

2.3.4 Disclosure, support and protection of those close to the infected person

In all relationships discrimination counteracts trust. This often leaves those infected alone and distanced from the rest of their communities, colleagues and even family. The fear of discrimination has been shown to create problems for disclosure, since disclosure has the common reaction of rejection, leaving the person living with HIV alone (Maman, Mbwambo, Hogan, Kilonza, Sweat & Weiss, 2001). This also increases the risk of infection for the sexual partner of the HIV-positive person. Studies focusing on disclosure have also begun to explore the processes of dealing with negative reactions and the empowerment of the person who is disclosing their status (Maman, Mbwambo, Hogan, *et al.*, 2001). Social contacts and family members may also resist being informed,

as they too may become vulnerable to exclusion, by being associated with a person with HIV. This in turn can lead to breakdown in the social commitments to care as these is a fear of asking for care and a fear of offering care, both regarding the fear of disease and of association.

2.3.5 Impact on behaviour change

Discrimination and stigma have implications for the implementation of prevention efforts and have reduced the possible impact of these interventions (Grundlingh, 1999). Certain behaviours such as the use of condoms have become signifiers of the epidemic, leading to the possible rejection of those who initiate their use (Link & Phelan, 2002).Thus many youth in Uganda are scared to use condoms due to the felt implications (Leclerc-Madlala, 1997). Even the option of being faithful can be stigmatised. In a community where multiple partners are seen as an indicator of success or manhood, a person who has one partner may be marginalised.

The intersection of these different points of discrimination can become a vicious circle of stigma with sex workers, gay men, the poor, black women etc. being seen as responsible for HIV/AIDS. However these are also the groups most vulnerable to infection, so they are more likely to contract the disease and thus increase the stigma again (Parker, Aggleton, Attawell, *et al.*, 2002). Stigmatisation of 'at risk groups' or other stigmatisation based on race, gender, class, occupation or sexual preference also puts people at greater risk of infection (Zierler & Krieger, 1997). There is pressure to deny being part of these groups in order to reduce the felt stigma, including refusing to user safer sexual practices that act as markers for HIV (Leclerc-Madlala, 1997). People who can define themselves outside of these groups are also able to reject the need for safer sexual practices (Crewe, 1992; Ross & Levine, 2002).

3.5 Data collection methods

3.5.1 Research questionnaires

A questionnaire structured to give information by way of content and purpose was the main instrument of data collection. A 3-point Likert Scale (1-disadgee, 2-agree and 3-strongly agree) was used for the questionnaire. All questions were close ended to increase the response rate of the respondents.

After the necessary introductions and outlining the objectives of the study to the authority in the areas of the study, the researcher was granted permission to carryout this research in the places of interest for the study. Which the assistance of two (2) trained researcher assistants, questionnaires were administered to the selected respondents

3.6 Data analysis and interpretation

3.6.1 Data analysis tools

Data from each questionnaire were categorized and edited for accuracy and completeness of information. This was to ensure that all questions were answered. All the questions were pre coiled. After this process, the statistical packages for social science (SPSS 12.0 version) computer programme were used to produce frequencies and percentages.

3.6.2 Data interpretation

Analyzed data from the questionnaires were presented in chapter four (4) in form of tables showing frequency counts and percentages. This information was further triangulated with information from secondary sources for meaningful interpretation and discussion.

CHAPTER FOUR
DATA PRESENTATION, INTEPRETATION, ANALYSIS AND DISCUSSION OF THE RESEARCH FINDINDS

4.0 Introduction

The analysis presented in this chapter is done on data generated from the field regarding the effects of discrimination of people living with HIV/AIDS in Tororo Municipality, Tororo District.

Research findings are presented in tables and in form of frequency counts and percentages.

4.0 Respondents composition

As a researcher, I identified some characteristics from respondents such as sex, age, religion, marital status, occupation and educational level. The data collected was therefore presented, interpreted, discussed and analyzed in reference to those specific aspects mentioned above.

4.2.1 Sex of respondents investigated by percentage.

Table 1: Showing Percentage of respondents by sex

Sex	Questionnaires distributed	Number of respondents interviewed	Sub-Total	Percentages
Male	150	145	145	48.3
Female	150	148	148	49.3
Total	**300**	**293**	**293**	**97.6**

Source: Primary data

A total number of 150 questionnaires were distributed to male respondents and 150 to female respondents. 145 male respondents together with 148 female respondents were interviewed. The total number of responds was therefore 293

So a total number of 145 male respondents formed part of the sample accounting for48.3%. Female respondents accounted for 48.3% that is 97.6 as shown by table 1

4.3.1 Age groups of respondents by percentage.

Table 2: Showing percentages of respondents by age group.

Age	Sex		Sub-Total	Percentages
	Males	**Females**		
15-25	42	27	69	23.5
26-35	50	43	93	31.7
36-45	34	30	64	21.8
46-55	10	22	32	10.9
56-65	06	18	24	8.1
Above 66	04	08	12	4
Total	**145**	**148**	**293**	**100**

Source: Primary Data

Table 2 above indicated research study results of respondents by age group.
Majority of the respondents (93%), fall under age group (26 to 35), and accounting to (31.7%) of the total population of (300) investigated. On the other hand the least proportion of the respondents fall under age group (66) and above accounting for {4%), of the total sample investigated.

4.4.1 Respondents occupation by percentage

Table 3: Showing proportion of respondents by occupation

Occupation	Sex		Sub-Total	Percentages
	Males	Females		
Peasant farmers	86	100	186	63.4
Self employed	20	15	25	8.5
Medical	08	06	14	4.7
Counseling	02	04	06	2.0
Students	15	12	27	9.2
Teaching	02	03	05	1.7
Armed forces	02	01	03	1.0
Brewers	07	00	07	2.3
Total	**145**	**148**	**293**	**100**

Source: Primary Data.

The findings of the research study indicate that the largest proportion of respondents, were peasant farmers and accounted for (63.4 %). Students came second at (9.2 %), while armed forced formed the least proportion of the sample accounting for {1.0 %), as shown above.

4.5.1 Educational level by percentages

The research study findings indicate that most of the respondents interviewed attained education at different levels though most of them did not go beyond primary seven.

Table 4: Showing Educational level

Educational level	Sex		Sub-Total	Percentages
	Males	Female		
No School	20	31	51	17.4
Primary	76	88	164	55.9
"O" Level	28	16	39	13.3
"A" Level	10	06	16	5.4
Diploma	06	04	10	3.4
Graduate	05	03	08	2.7
Post Graduate	0	0	00	00
total	**145**	**148**	**293**	**100**

Source: Primary Data

The results in the table above indicate that {55.9%} had primary level, represented by 76 males and 88 females and this was the largest accounting for (55.9%) of the total respondents. Those with post graduate level were the least accounting for 0 % of the total sample of the population studied were, 145males and 148 females.

4.6.1 Marital status of respondents by percentage

Table 5: Showing Marital Status by percentage

Marital Status	Sex		Sub-Total	Percentages
	Males	Females		
Legally married	25	22	47	16
Co-habiting	51	41	91	31.0
Widowed	33	58	91	31.0
Single	20	12	36	12.2
Separated	15	08	23	7.8
Divorced	01	05	06	2.0
Total	**145**	**148**	**293**	**100**

Source: Primary Data

The researcher's findings about martial status indicated that majority of the respondents were in co-habitation marriage totaling to 91 and widowed 91 which accounted for 31% each while the second are legally married totaling to 47 which accounted to 16%. 36 respondents were single accounting for 12.2% while 23 respondents are separated accounting for 7.8%. The least was divorced accounting 2%

4.7.1 HIV sero-status of respondents by percentage

Table 6: Showing HIV Sero-Status by percentage.

Research findings indicate that more than half of the respondents are HIV positive and therefore living with HIV

	Sex		Sub-Total	Percentages
	Males	Females		
HIV Positive	81	106	187	63.8
HIV Negative	45	36	76	25.9
Unknown	19	06	24	10.2
Total	**145**	**148**	**293**	**100**

Source: Primary data

The research findings in the table above indicate that majority of the respondents that is 81 males and 106 females totaling to 187 were HIV positive and therefore living with the virus. This accounted for63.8% and are registered in an AIDS service organization like TASO, CDC, Plan Uganda, and Community Vision. While the HIV negative were 45 males and 36 females totaling to 76 accounted for 25.9%. The

respondents who don't know their HIV status were .19 males and 6 females totaling to 24 accounted for 10.2% of the total respondents.

4.8 DISCUSSION OF RESULTS

4.1.8 Why does HIV discrimination of PLWHIA/AIDS occur in Tororo municipal council?

To understand the ways in which HIV/AIDS related discrimination appear and the contexts in which they occur, I found out that there were pre-existing stigma and discrimination associated with several major societal aspects like sexuality, gender, race, religion and above all poverty. HIV/AIDS- related stigma and discrimination also interact with the pre-existing fears about contagion and disease. For example, early AIDS metaphors (imaginative or descriptions) as death, as horrors, as punishment, as guilt, as shame, and others have exacerbated these fears, reinforcing and legitimizing stigmatization and discrimination.

Table 7: Shows Pre-existing societal aspects of HIV discrimination

Pre-existing aspect	**Sex**		**Sub-Total**	**Percentages**
	Males	**Females**		
Sexuality	50	55	105	35.8
gender	30	35	65	22.1
Race	13	08	21	7.2
Religion	17	10	27	9.2
Poverty	35	40	75	25.5
Total	**145**	**148**	**293**	**100%**

Source: Primary data

The research finding in the tabled 7 indicated that the majority of the respondents had pre-existing societal aspects of HIV in relation to sexuality. The total was 105 which accounted for 35.8% of the total respondents. This qualifies the findings in literature review under the section of sexuality and the researcher concurs with this because it has been mentioned every where. The second was gender which is 65 and accounted for 22.1 %

4.2.8 Sexuality

Sexuality in this context refers to any issues related to having sex with either a man or woman. According to the research findings on the table 7 above

HIV/AIDS related discrimination are mostly related to sexual stigma accounting for 38.5%. This is because HIV is mainly sexually transmitted and in most areas of the world, the epidemic initially affected population whose sexual practices or identities are different from the norm. HIV/AIDS related discrimination has therefore appropriated and reinforced pre-existing sexual stigma and discrimination with sexually transmitted diseases, promiscuity, prostitution, and sexual deviance" The believe that the

promiscuous, and the prostitutes are the only group at high risk of contracting HIV is still very common in Tororo Municipal Council. Promiscuous sexual behavior by some women who were mentioned by some community members is also during the interviews commonly believed to be responsible for the heterosexual epidemic, regardless of the epidemiological reality. In Tororo Municipal Council which is located 10 kilometers away from the Kenya – Uganda bordering town of Malaba HIV positive women and men are still widely perceived to be sexually promiscuous and therefore the one who are continuing the spread HIV within the municipality.
Two of the male respondents had this to say
"I lived in Malaba for seven years before l moved to Tororo and l am sure it is those prostitutes for example (name with held)…… who have infected many people in Malaba and Tororo town"(Respondent Agururu A Zone)

Another said,
"My fate of getting HIV was through that woman prostitute. She is called (name with held……) who owns the other bar name with held……) was the best prostitute in this district. I wish didn't involve myself. I believe l would never have got infected with this terrible disease, if l didn't meet her as a woman" "(Respondent Water village Zone-TMC)

4.3.8Gender

Gender in this research context refers to an individuals being a man or a woman.
HIV/AIDS related discrimination are also linked to gender-related stigma and discrimination. My findings as indicated on table 7 reveal that the impact of HIV/AIDS-related discrimination on women reinforced pre-existing economic, educational, cultural, and social disadvantages and unequal access to information and services. This accounts for 22.1% of societal aspect of stigma and discrimination.
In setting where there man and woman (heterosexual) transmission is significant, the spread of HIV infection has been associated with female sexual behavior that is not consistent to sexual norms. For example female sexual workers are often identified as "Vectors' of infection who put their clients at risk.
As l was conducting an interview, a lady passed in front of us and the respondent said,
"You see that woman passing, she is a carrier of AIDS she has killed so many people and she has refused to die herself. Right now the whole town knows that she is having a love affair with" name with held……) and l am very sure that very many people sleep with her everyday. "(Respondent)Amagoro A zone)

Equally in many setting like husband and wife, men are blamed for heterosexual transmission, because of assumptions about male sexual behavior, such as men's preference or need for multiple sexual partners.
Four female respondents told me that,

" if l did not marry this man, l wouldn't have got this deadly disease because l discovered when it was too late that his two wives had died of AIDS, l even saw the

graves at home but didn't bother much. These men are killing us the women because for us we don't move out to sleep with other men." "(Respondent- Police barracks TMC)

"For me this is my first husband and the first one for me to sleep (have sex) and l have landed into his deadly disease straight away. All my sisters died of AIDS and it is only me left to look after our mother and the many orphans under her care" I don't know why this men can never have one wife or woman, they have killed very many people that is young men and even school girls." "(Respondent- Railway quarters TMC)

4.4.8 Race and ethnicity

In this research context, race and ethnicity refers to a group of people with the same origins, cultural behaviours and practices. The Iteso, adholas, samias, bamasaba, baganda. Racial and ethnic discrimination also interact with HIV/AIDS-related discrimination and the epidemic has been characterized both by racist assumptions about, "African sexuality" and by perception in the developing world of the West's "immoral behavior. Indications from 7.2% of respondents have that. "Racial And ethnic discrimination contribute to the marginalization of minority population groups, increasing their vulnerability to HIV/AIDS, which in turn exacerbate discrimination. For example the saying that it is the adholas who are most infected with HIV than other tribes.

One female respondent had this to say"*These bazungu think that the virus came from Africa. And yet we in Tororo know that it is the baganda who have most HIV because it was discovered in Masaka more than twenty years ago"(Respondent Kasoli B Zone – TMC)*

Some discrimination has been motioned by the interviewees on the grounds of what tribe you are and where you come from. TMC is a typical urban area with the Iteso and Adholas as the dominant tribes though they are many other tribes like the neighbouring Bagisu, Banyole, Bagwere, Basamia. Medical workers seem to discriminate some patients because of their origins.

Even in AIDS service organization like TASO some tribes are being discriminated against. One interviewee had this to say.

"I *had been in the TASO Tororo Drama club for over four years but what l experienced there was only stress. Our leader used to favour members of her tribe for every outreach so that they could benefit from the allowances. Even when there are elections she always wanted people of her tribe to win and yet this is an AIDS service organization and HIV doesn't not select or discriminate who to infect……"*
(respondent Hospital village TMC)

"I know l got this disease because l was poor and the man who married me was rich and able o take care of me with children"
"These people with AIDS got it because there were either very rich men or women or very poor men or women" "(Respondent Nyangole Zone TMC)

"My own son died of AIDS because he became very rich when he was still very young and therefore decided to have so many women, but he never lived for long, that grave(while pointing at it) you see there is his. He never bothered about us the parents, his only interest was women and you can see how he ended up, living mw with all these orphans you see running around the compound" "(Respondent Bison B Maguria)

4.5.8 Fear of contagion and disease

It can not go without mention that HIV/AIDS is a life threatening illness that people are afraid of contracting. The various metaphors associated with AIDS have also contributed a lot to perception of HIV/AIDS as a disease that affects "others", especially those who are already been stigmatized or discriminated against because of their sexual behaviour, gender, race, or socioeconomic status, and have enabled some people to deny that they personally could be at risk or affected.

One respondent said,

"I don't think that l have AIDS and l don't think that any of my family members have it because we are not reckless people in our family. My son is a doctor and he teaches us a lot of things about this disease". "(Respondent Kasoli B Zone)

According to my findings, there are people up to now who feel and think that HIV and AIDS is a disease for others. I have discovered that HIV/AIDS related discrimination is, therefore a result of interaction between diverse pre-existing sources of discrimination and fear of contagion and disease. The pre-existing sources such as those related to gender, sexuality, and class, often overlap and reinforce one another. This interaction has therefore contributed to the deep-rooted nature of HIV/AIDS –related discrimination, limiting our ability to develop effective community and national responses.

4.9 HOW is HIV DISCRIMINATION MANIFESTED?

According to the researchers findings, HIV/AIDS related stigma and discrimination take different forms and are manifested at different levels that is to say individual, family, community, and societal, in different contexts.

Table 8: Showing Levels of HIV discrimination by percentage

Level	Sex		Sub-Total	Percentages
	Males	**Females**		
Personal	33	30	63	21.5
Family	30	25	45	15.3
Community	38	35	73	24.9
Societal	54	58	112	38.2
Total	**145**	**148**	**293**	**100**

Source: Primary data

Research findings from the above table indicate that discrimination occurs or manifests most at societal level accounting for 38.2%, 24.9% of the respondents 'experienced HIV discrimination and its effects at community level. While 21.5% of the respondents

indicated that they suffered from effects of HIV discrimination at individual level. According to table 8 above 15.3% of respondents discrimination and its effects at family level.

4.1.9 Health care system

Tororo Municipal Council is blessed with two three hospitals that is the main District Referral Hospital situated near the stadium and St. Anthony's private catholic founded hospital located behind the adjacent Rock.

Medical services and care is offered in many other health units and clinics like The Divine Mercy ,TMC clinic and over 15 small private clinics being run and managed by Doctors and Medical who are employed in the main Government Hospital and others working else where in the country and originate from Tororo. The findings reveal that all the private clinics have monetary links and therefore limit access to care for most of the interviewees who are Living with HIV/AIDS as most of them are economically unsound and would therefore seek for free medical treatment. Financial and economic positions of most PLWHIV/AIDS set a level of decision on where to seek health care from. To me as a researcher this is an element of discrimination.

Other Health care services for PLWHIV/AIDS are basically provided by Non Governmental Organizations (NGO) which are AIDS service organizations like The AIDS Support Organization (TASO), Center for Disease Control and prevention (CDC), and Plan Uganda whose major focus is on providing health care, emotional and material support to PLWHIV/AIDS. The services here are adequate because each client has a Registration Number and a file a opposed to the Government Hospital where one has to walk with a book and in case it is lost he/she has to buy one and the previous records cannot be easily traced.

The findings indicate that there have been many cases and reports of discrimination occurring in the health care settings. For example testing without consent, breach of confidentiality, and denial of treatment and care

However, despite this, many interviewees still have faith in the public care system. They believe that the services in the main district Government Hospital are fairly good and they are treated fairly well.

"Since the hospital has been expanded and newly constructed there is enough room and space to move around as compared to the former small and crowded place where there not even enough seats for all the patients. This was creating some fear to some people to sit with people living with HIV/AIDS (PLWHIV/AIDS especially if they had Tuberculosis TB" " ***(Respondent Morukatipe Road TMC)***

However, despite this, many respondents still have faith in the public care system. They believe that the services in the main district Government Hospital are fairly good and they are treated fairly well.

Four respondents replied that they seek health care and support from traditional healers for cultural reasons especially for the women who still want to have children and believe they have been bewitched.

"My wife has HIV and has never had a child. I want her to have at least two children so that our home does not die of like that. It is very worrying and painful not to have a child in life even if one is lame or blind" ***"(Respondent Naluwerere TMC)***

However, the government hospitals and other smaller health units like in Bison, Kasoli on Morukatipe Road give people who cannot afford private health care access to treatment they would otherwise not be denied. However, there was much consensus that awareness among medical health staff, in the public and private hospitals and health units including Doctors, nurses, attendants and minor staff had discriminate against PLWIHIV.AIDS and their families. Hence discrimination of PLWHIV/AIDS does occur in the health care units up to date

Comments like

" you are a TASO client, you are a CDC Client you have enough drugs there why have you come to disturb other people here. Your drugs are there". ***"(Respondent admitted Hospital ward)***

Still future in some vocabulary of some medical staff and personnel and some of the respondents feel that this is fair because it seems it is only other people who don't have HIV, who are supposed to benefit from the medical services in the government hospitals. This is because they are aware most of the NGOs operate on contract basis and when the contracts are over they will have to fall back on the existing Government health units.

"These comments and attitudes are very unfair to us and they show us that we are not fully accepted yet in such places. Supposing these NGOs were not there what would be happening to us now. I don't know who will ever change this situations in our big hospitals" "(Respondent admitted in the hospital ward)

Table 10: showing discrimination in Health care system

Manifestation	**Sex**		**Sub-Total**	**Percentages**
	Males	**Females**		
Testing without consent	55	45	100	34.2
Breach of confidentiality	50	65	115	39.2
Denial of treatment and care	40	38	78	26.6
Total	**145**	**148**	**293**	**100**

Source: Primary data

According to the findings of the above table of respondents revealed that breach of confidentiality and testing without consent have contributed a lot to HIV discrimination accounting for 39.2% and 34.2 respectively. Denial of treatment and care in the health system is one other aspect of discrimination accounting for 26.6%

4.2.9 Breach of Confidentiality

Breach of confidentiality is one of the major unprofessional aspects of any service provider which has contributed a lot to discrimination in all aspects of life to people living with HIV/AIDS in Tororo Municipal Council.

Breach of confidentiality refers to the failure of any professional worker or service provider to maintain responsibility and professional duty to keep any interaction or information she/he knows about anything or any person to him/herself. Hence letting out information without the consent of the person concerned.

Trust is an essential cornerstone in the helping process, and central to the development of and maintenance of trust from the persons in need of help. The obligation of care providers or helpers to maintain confidentiality in their working relationships with their clients and even colleagues is not absolute. However, they need to be aware of both the ethical and legal guideline that applies to their professions. Professional ethical standards mandate this behaviour except when the care provider commitment to up hold client confidence must be set aside due to special compelling circumstances or legal mandate. (Arthur & Swanson 1993. p.3)

Breach of confidentiality has adverse effects on the physical, emotional, psychological, social and mental states of people living with HIV/AIDS all over the world and not only in Tororo Municipal council. Most of which can lead to severe acts of discrimination which have a lasting negative effects. This leads to embarrassment, mistrust for the care providers and discouragement from seeking health care and services.

According to the respondents, there were several cases in which confidentiality regarding PLWHIV/AIDS was or is not respected and therefore breached. Some medical workers, and other care providers continue to shout about the issue of clients being HIV positive.

"One *day l had taken my boss's child for treatment in the hospital. While I was sitting carrying the child my boss was standing waiting to talk to a nurse.One of the nurses shouted whose child is that, so you can also be a baby seater" my boss asked her "why", she is a good lady who takes care of my children and house very well". And the nurse said you don't know these TASO patients? My boss got very shocked and immediately grabbed her baby from my hands and asked me never to step in her home again. I lost my job because of the nurse who should have thought twice before making such a comment.....The respondent was silent and crying.* I gave her time to go through that emotion..... She then continued and said

"and yet l had worked for that lady for three years and l was educating my only son in senior with that salary l was getting. This was very unfortunate and l have never got another job from then. My son has dropped out of school and rides his uncles boda boda bicycle I really felt so bad and yet l was such a hard working lady. Why cannot these people learn to keep secrets because this was a secret between me and my boss" ***"(Respondent Amgoror A Zone)***

Another respondent had the following experience

"I was one day looking for a job and one of the staff working in an NGO asked me to help her with house work. But before that she told me to go for an HIV test and even took me there herself. I was tested and found HIV positive. She told me that she could not employ me with my AIDS; She said you go to TASO and get help. I felt very embarrassed and hopeless" She continued to spread the story everywhere and Tororo being a small town the news spread like wind and I am now seated at home very helpless" why don't these people choose what they say and who they tell what" ***(PLWHIV, Maguria A)***

Four of the respondents teaching in different schools within the Tororo Municipality said they were denied promotion as class teachers within the school just because some one leaked information that they were HIV positive to the school administration. They said it is very unfair and yet they all feel that they are even better teachers than those who claim that they don't have HIV in their bodies. This has in turn caused them to relax in their work and in the long run have far reaching negative effects on the academic performance of the children. Even the pupils/student seem selective on who should actually teach them. This is a clear act of discrimination which needs to be dealt with.

"it is up to those who decide to spread romours about my being HIV positive, what is important? Is it my being HIV or the knowledge and skills that I impart into the children. I feel I am capable of producing good and potential resourceful people through my teaching" " ***(Respondent teacher one of the Primary schools TMC)***

One female respondent had this to say

"The way I hate that man and each time I go to the hospital, I don't even like to look at him and I don't want him to deal with any of my health problems. I wish he could be transferred to another hospital because it is not only me who as been treated like that" He shouts when asking you about you sickness and by the time you come out everyone will have known that you have a disease of sex" (PLWHIV Kasoli TMC)

Another case which implicates breach of confidentiality occurred at a private hospital. The patient said she had been tested there for HIV because the brother-in-law was employed by the hospital. When the HIV test results returned positive, prior to informing the patient, the medical personnel had passed the result on to the patients brother-in-law.

Furthermore, the test result had been leaked by the hospital lab, and as a result, the entire hospital staff learnt about it. The patient stated that the immediate family was only notified after everyone in the hospital had already known. None medical staff such as cleaners, drivers also learnt of the result. One of the cleaners comes from the same village with the patient and therefore, spread the news like a hot cake. This led to various acts of discrimination. Even the child at school was informed in such a way and this led to the child having no friends.

"Some attendants even go as far as bringing visitors from other wards and show them to us the PLWHIV/AIDS as if we are exhibits; hence it is clear that they discuss these cases in other wards in order to appear important. In one instance the father of one the PLWHIV/AIDS was so upset when this happened that he instead said his son was suffering from TB but the attendant loudly urged with him in front of the visitors and said it was AIDS. ***(PLWHIV, Hospital ward)***

4.3.9 Denial of treatment and care

There are several cases where PLWHIV/AIDS have been denied treatment for the mere reason that treatment and management of HIV/AIDS is an issue of NGOs like TASO or CDC. The service provider had this to say.

"Here we treat other cases only, you will benefit more if you go to TASO because those people are qualified to deal with your situations" (PLWHIV Hospital ward)

This is very discriminating and discouraging because the panadol or any other drugs in TASO are not different from those in other health units. There are cases were by the drugs in the ward are regarded as drugs for other people not for PLWHIV/AIDS. The statement is always that

"Your drugs are in TASO or CDC why don't you go there"
To me this is even how many drugs find their way to the private clinics of some medical personnel who have opened them.

One of the respondents had this to say,

"we were three of us admitted in the government hospital at almost the same time with different health problem. For my case I had diahorea and vomiting and high fever. Incidentally, we are all registered in TASO and CDC. But when the hospital fluids were over and therefore out of stock the nurse on duty at that time said" let me give these drug and fluids to other people because for you, you will get yours from your CDC clinic". I felt this was very unfortunate and very discriminating. It was a Sunday morning and CDC and TASO offices do not operate during the weekends. Are not supposed to receive full services from the government hospital just because we are HIV positive. (PLWHIV, Senior quarters TMC)

c) Unprofessional/Unkind Treatment by medical Staff.
Professionally, Health care providers are required to treat individuals as they come and where possible first come first serve. Except in cases where there is an emergency. But sometimes they act unprofessionally when they see a PLWHIV/AIDS who is registered in one of the AIDS service organizations.

"What irritates me most is the negligence by the ward in-charges and other staff just because I as a patient is registered with TASO or from CDC. The CDC staffs have to come in and inject us. Even if the hospital has the drugs, they will say go to your doctors and

wait for your nurses because they are almost coming. My work is to deal with the rest of the patients" (PLWHIV, Juba zone)

There is need for more and continuous sensitization of Health and medical staff about HIV/AIDS so that they continuously take proper precautions and treat patients in a non-discriminatory way. It is very important they put this into practice at all times during their work. This will facilitate accurate information giving leading to dispelling of fear and misconceptions about how to live and manage HIV/AIDS. There is clear evidence that there are people who still fear and therefore don't want to be associated with HIV/AIDS. In the main District Government Hospital many medical personnel have a very big gap in the way they communicate to patients. It is worse if she/he is known HIV positive personnel. This is suggestive that they still think that HIV is for other people.

4.4.9 Family context

The family is the main source of support and care for PLWHIV/AIDS every where in the world and in Tororo municipal council and in most developing countries.. However, negative family responses have been reported by many respondents as being common. Some infected individuals often experience discrimination in the home and the women are often treated more badly than the men or children. Such reported negative community and family responses to people infected with HIV include blame, rejection, and loss of respect. In several cases during the interviews, HIV/AIDS related discrimination has been extended to families, neighbours and friends of PLWHIV/AIDS. This secondary stigmatization and discrimination has played an important role in creating and reinforcing social isolation of those affected by the epidemic, such as the children and PLWHIV/AIDS.

At family level some respondents still continue to experience discrimination for the mere fact that they are living with HIV.

Table 11: Discrimination at family level context by percentage

Manifestation	**Sex**		**Sub-Total**	**Percentages**
	Males	**Females**		
Isolation Negligence loneliness	45	38	83	28.3
Depression and rejection	40	45	85	29.0
Deterioration of health condition	35	35	70	23.8
Separation/ divorce	25	130	55	18.7
Total	**145**	**148**	**293**	**100**

Source: Primary data

One respondent narrated his own situation in his family at home.

He said;

"From the day my wife and children learnt that I have AIDS, they prefer to leave me out in most family decision making things just because they feel that I must have got the HIV from some prostitutes. They give me food and any other care and support in the

family life but I am no longer the decision maker in the family even when I have good ideas, they feel other relatives' decisions work better than mine in my own family. This hurts me a lot because I feel left out in my own family totally" (PLWHIV, Bison A zone TMC)

Another female respondent shared her experience with me and had this to say.
"my husband rarely shares a bed with me because I am HIV positive and he is HIV negative even when our counselors encourages us to use condoms. He actually decided to buy his own bed and he doesn't want me to go back to my parent's home. I feel so lonely and I really wonders why he isolates me very painfully like that" (PLWHIV, Western Division)

The client feels isolated and therefore discriminated with her own family and home.
"At home my children have been denied school fees by my husband just because me the mother has HIV. The children of my co-wives are all going to school. It is not my children's fault that I have AIDS. God should help me and my children out of this situation" I feel my children are left out within their own family and this is not fair even in the eyes of God the almighty". (PLWHIV Rubongi army barracks TMC)

4.5.9 Individual Context.

In individuals, the research found out that the way in which HIV/AIDS manifests depends on the family and social support and the degree to which people are able to be open about such issues as their sexuality as well as their sero-status. Some individuals up to now still isolate themselves to an extent that they no longer feel part of civil society and are unable to gain access to the services and support they need. They actually experience loss reaction of denial for a very long time. This is called internalized stigma and discrimination. In extreme cases this has led to suicidal tendencies or premature death through suicide. Other have practice passive suicide.

One lady said,
" *My daughter was working in the bank in Kampala, she fell sick and was brought home. We decided to tell her to take an AIDS test. When she was tested and told the results her health condition became even worse. She cannot believe in what is happening in her life" I have encouraged her to go and register with TASO or CDC so that she can start receiving these new drugs but she has refused. When she is much better, she even refuses to eat food and can lock herself in her room for the whole day. When her friends and cousin brothers and sisters come to see, she whispers to me to tell them that I am asleep. My biggest worry is that she will either die or kill herself inside her room. She is not co-operative, so I don't know how to help her. I worry a lot and my pressure rises at any time. May be I might even die before" (Family care taker Kyamwenula Zone TMC)"*

Even when NGOS like TASO and laws exist to protect to protect PLWHIV/AIDS rights and confidentiality, few individuals are willing to litigate for fear that this will result in disclosure of their identity and HIV status. Given widespread negative community and family responses, many people choose not to know or reveal their sero-status.

I have also found out during the data collection that individuals who are marginalized may be fearful of negative or hostile reactions from others, regardless of their sero-status. Even when the family response is positive, fear of stigmatization and discrimination by the community may mean that an individual's sero-status is not revealed outside the home.

One respondent had this to say,
"I was killing my own self with worries. I had two women who were both hardworking and with six and eight children respectively. My question is how would I learnt that I had AIDS. I was too sick for anyone to react and in me I felt the job of tell them that I have AIDS? I just knew they would both run a way. It took me four years to tell anybody that I had AIDS. It is not until I fell very sick that I was taken to the hospital and other fellow clients from TASO came to see me in the ward. That is how my family members telling out that I have AIDS had be done for me. Personal fear and suspicion can make one isolate him or him/herself. I am very sure there are many more people out there whoa re suffering silently and need to be helped". (PLWHIV, Amagoro B zone"

4.6.9 Effects of HIV discrimination at institutional level

Table 12: Showing Effects of HIV Discrimination at Institutional level by percentage

Effect	No of respondents		Sub-Total	Percentages
	Sex			
	Males	Females		
Exclusion from school activities and responsibilities	8	10	18	52
Isolated from friends	10	16	26	36
Poor academic performance	5	11	16	32
Total	**23**	**32**	**50**	**100**

Source: Primary data

According to findings indicated on table 12 above, exclusion of PLHAs from non-academic school activities and responsibilities is the most common occurrence of discrimination accounting for 52%. Some respondents, (38%) revealed that they were isolated by friends, colleagues and schoolmates as a result of their positive HIV status. while to diminished interest and low morale 32% of respondents indicated they were performing poorly academically

Tororo Municipal Council is blessed with very many big secondary schools, like Tororo College, TOPA, Manjasi High, Rock High school among many others. Colleges like Uganda College of Commerce, Districts Farm Institute and many primary schools. Discrimination in institutions like schools and colleges does occur up to date.

Children and teachers living HIV/AIDS or associated with HIV through the family have been discriminated against in educational setting in Tororo Municipal Council. For example exclusion from school responsibilities and activities.

One other respondent a school boy in one of the big secondary schools in Tororo narrated his experience.

"*I couldn't be elected as the Head Prefect of the school just because l am known to be living with HIV by most students in the school. My counselor encouraged me to be open about my HIV sero status in order to get support in may life. Most of the students in school felt that this post is better held by a student who is not living with HIV or has no AIDS. They preferred the boy who has no AIDS to head them and interesting enough, he stealthily comes to me for advice occasionally and even tells me not tell other students that those good ideas are me.* ***(PLWHAs,* Secondary student)**

The researcher identifies this as institutional discrimination on the grounds of being HIV positive. This means that other students or people in institutions have no confidence in their colleagues for the mere fact that they are HIV positive even if they are very resourceful.

I personally wonder what will happen if they discover that even the one elected and in whom they have confidence has HIV. There is need for them to identity us as big human resources to them other than discriminating us. Being HIV positive does not mean not being responsible.

However, from the interviews, it seems less concern has been shown for young people who are perceived to be responsible for their HIV infection and who are already discriminated against because they are sexually active. Above all the population of the school is so high that it is almost unmanageable administratively.

4.7.9 Religious Institutions

In some contexts, HIV/AIDS- related discrimination has been reinforced in religious institutions by Religious leaders of believers themselves or organizations, which have used their power to maintain the status quo rather than to challenge negative attitudes towards marginalized groups and PLWHIV/AIDS

I actually had very many cases of experienced discrimination and l managed to cite a few out of the many. My prior feeling was that in church every one is regarded as a child of God.

Another lady had this to say.

" *I was the Treasurer of our Church group until recently when my wife who l had separated with, many years ago was brought home dead by her relatives. The cause of the death was said to be AIDS. To my surprise my church decided to relieve me of my responsibilities as a treasurer and gave it to some one else who they thought didn't have AIDS. I always prayed to god to give me the strength and courage to go through such a difficult time and even cope with it without malicing anyone".* ***(PLWHIV, one of the Pentecostal churches TMC)***

Also in some preaching in some churches in Tororo Municipal Council it has been reported by some respondents that some religious doctrines, moral and ethical positions regarding sexual behaviour, sexism, and homophobia, and denial of the realities of HIV/AIDS have contributed a lot to the creation and the perception that those infected have sinned and deserve their "punishment" increasing discrimination related to HIV.

Preaching like as reported by an respondent.

"If you have sex before you get married or have it with another person's wife or husband, that is a very big sin and if you get HIV or any other disease through that action of yours then god will punish you for that. You will pay for it as God the almighty wishes. Many people have god this deadly disease because of being reckless and accepting the weak actions of Satan. Remember that God will forgive you through punishment" ***(a quotations of one of the preaching from a church)***

The respondent confessed having left that church and has never gone back there again. He said that one reason why he got saved is to seek for forgiveness for his HIV situation but if those are the feelings of the pastor then he is lost in his spiritual life.

"*I have been saved as a born again for several years since 1996 when Jesus called me to his life. I got saved after my husband died of HIV and after I also tested and found out that I have HIV. I accepted Jesus because I thought and believed that he would heal me of this deadly disease. I gave my testimony but after several years I still tested HIV Positive. When I told my pastor, he told me that my faith is not strong that is why I am still testing HIV positive. He said there is nothing impossible with Jesus. From then I was relieved of the active roles in church for the fact that my faith might not be strong enough" How can the church isolate me like this". (PLWHIV, born again savdee)*

4.8.9 Employment and other Work places

The majority of the people interviewed during the study are unemployed, and a few are self-employed as most of the have hardly reached Primary seven. Several cases involving discrimination in the workplace were highlighted. In the cases, the PLWHIVAIDS had to leave their employment.

Such discriminatory practices like pre-employment screening, denial of employment to individuals who test HIV positive, termination of employment of PLWHIV/AIDS , and discrimination of PLWHIV/AIDS who are open about the sero-status is common.

Table13: Discrimination in employment and other workplaces by percentage

Effect	**Sex**		**Sub-Total**	**Percentages**
	Males	**Females**		
Loss of employment	11	9	20	6.8
No promotion	02	01	03	1.0
Mistrusted	10	12	22	7.5
Uncertainty	10	07	17	5.8
Low productivity/poor performance	10	08	18	6.1
Unemployment	108	113	221	5.4
Total	**145**	**148**	**193**	**100%**

Source: Primary data

a) Loss of Employment

One respondent narrated several cases where he had been asked to leave his job because of being HIV positive status. He had started working in a restaurant as a waiter with his cousin brother when someone leaked his HIV status to his cousin brother. His cousin did not waste any time and asked him to leave immediately for fear that people would fear to come and receive services from the restaurant because of that.

He said,

" *I was very shocked when my cousin brother called me and asked me to leave immediately. On inquiring what I had done wrong, he said I will tell my aunt when I come to visit you at home. Later in the day the neighbour told me that I had been sucked because his cousin was told that he has AIDS and people will fear to come and eat food in the restaurant. He doesn't want his restaurant to collapse. That was a terrible blow in my life. My question was, Up to today people still misunderstand the issue of having HIV? I did not argue with him so I went a way straight home and wondering what to do next".* ***(Respondent Tororo Central Zone)***

He said his second job was at one of the supper markets being managed by Asians. He thought he was lucky this time that no body associates themselves so much with the Asians. But after six months, the management of the supper market heard about his being HIV positive and also told him to leave immediately.

"This time I thought that I had stolen something because the Asian was very rude and threatened to take me to Police. He said Do you want my business to fail because of your sickness get out of my shop now". ***(PLWHIV, Osukuru Corner)***

Unfortunately he never even allowed him to receive his accrued unpaid salaries, not even to pick his small hand bag from the shop he had to leave.

"I went back home and started concentrating on my garden work and up to now that is how I earn my leaving with my small family. So people with HIV are still feared even in the business world to an extent where by one wouldn't allow his/her business to fail because an HIV positive person working for Him/her" ***(PLWHIV, Muaguria A. TMC)"***

In one of the big Hotels in the town one of the respondents was employed there and she said that one of her colleagues where not happy about the good work she was doing which proved better than theirs. She had whispered to some of them she had tested her blood for HIV and was therefore registered with TASO. So they malice her by informing the management about her HIV status. She was told to leave because the Hotel couldn't loose very important visitors and customers just because of one person.

"What made my friends jealousy and therefore malice me is because I am a holder of a Diploma in Hotel and Institutional catering and yet most of them just have local certificates" ***(PLWHIV, Masaba Road TMC)"***

Another respondent said,

"I *work with the Prison Department as a wardress in the Uganda Government Prison Farm Tororo. I live in Tororo town with my husband who is a business man. I have*

been denied promotion of any kind just because of my HIV positive status and yet l work very tirelessly while on duty on a daily basis. Even the inmates themselves now have a minimizing attitude towards me. This is because people still feel that l am not fit for the job and then l can die any time and yet l know of other people who are also HIV positive and have hidden their HIV positive status but they have been promoted. I feel that this is very unfair and yet l am more hard working than other officers who claim that they done have HIV". ***(PLWHIV, Nagongera Road TMC)"***

In another case a husband was employed to deliver bread to retail sellers. He lost his job when his employee found out that he was HIV positive.

In yet another case, the respondent was employed by one company and had taken some days off as a result of his deteriorating health condition. When questioned by his boss, he decided to disclose his HIV positive status to him thinking the boss would be understanding and might be very considerate to him. The boss told him that the company might not feel comfortable working with an HIV positive person and might decide to leave. As a result, the respondent felt pressured to resign from his employment.

"I am sure that all these bosses do not have HIV?"

The researcher concurs with this experience and indicated in the literature review section of loss of employment

4.9.9 HIV/AIDS Programmes

HIV/AIDS policies and programmes may inadvertently contribute to HIV discrimination by differentiating between, "the general public" and "the high risk population" prioritizing actions to prevent HIV spreading to the former from the latter. For example having AIDS service organizations for particularly and preferably for PLWHIV/AIDS only has an element of discrimination. That is why there are several reports from the respondents that they are being referred to as TASO or CDC. This makes them completely different from the rest of the population.

"*You TASO people are lucky you have your food and drugs and l think TASO should even pay your children's school fees, get them jobs and burry them when ever they die."* ***(Quotation from Eastern division)***

In this case does TASO have the capacity to offer all those servicesto all its clients?
*"Madam have you come to see your TASO, people? They have gone for their TASO meeting in Mukujju may be you can follow him there. He left in the morning"****(care provider of a PLWHIV,)"***

Here there is a tendency to disassociate the person from being part of the family.
This approach is often justified in terms of avoiding discrimination of "high risk population" since targeting such populations is believed to reinforce the association of HIV/AIDS within marginalized groups.

CHAPTER FIVE

SUMMARY, RECOMMENDATIONS, CONCLUSION AND AREAS OF FURTHER RESERCH

5.0 Introduction

Basically this chapter presents the summary results, conclusions and recommendations of the findings and areas of further research

5.1 Summary

The researcher found out that the female respondents were more willing to answer the questions that 293 respondents were willing to answer accounted for 92.6%.

The majority age group of the respondents was 26 to 35 which accounted for 31.7% and the least being above 66 years accounting for 4% of the respondents.
Considering level of education during the research most of the respondents have only completed different levels of primary totaling to 164 which accounted for 55.9% and the least were post graduates who were 0.

The researcher also found out most of the respondents are wither co-habiting or widowed that 91 for all and 31%.

According to the findings 63.8% of the respondents are living with HIV and 76 which is 25.9% are negative meaning they may not be having the virus or at the HIV window period.

There are several pre-existing societal aspects regarding HIV which Discrimination which include sexuality 105 respondents accounting for 35.8%, gender 65 accounting for 22.1%, race and ethnicity 21 accounting for 7.2%, religion 27 accounting for 9.2%, and poverty 75 which accounts for 25.2%which are the key issues leading to HIV discrimination.

The above therefore lead to acts of discrimination at individual 63 accounting for 21.5%, family 45 accounting to 15.3%, Community level 73 accounting for 24.9%, and at societal level 112 accounting for 38.2%.

Summarily effects of HIV discrimination include isolation, negligence 83 which is 28.3%, , depression and rejection 85 which is 29%, deteriorating health condition 70 which is 23.8%, separation and divorce55 which is 18.7%, exclusion from school activities 18 which is 52%, poor academic performance 16 which is 32%, loss of employment 20 accounting for 6.8%, no promotion 01 which is 1%, mistrust 22 which is 7.5%, uncertainty17- 5.8%, emotional and psychological torture, low productivity18- 6.1%, unemployment 221 which is 64%. Suicidal tendencies among others as shown in tables 11, 12, and 13.

guidance to local and national policymaking bodies on means of actively involving people living with HIV/AIDS at various levels. More emphasis should be put on HIV mainstreaming

The Central Government and other institution like health centers and NGOs should never take HIV for granted by thinking that people no longer fear to test and therefore they can relax

Advertising agencies should raise awareness among professional involved in advertising on HIV/AIDS and provide training on modalities of sensitive advertising preferably in appositive way. This would ensure sensitized advertising which respects the privacy of people living with HIV/AIDS.

Religious leaders should take an active role in promoting awareness about and working to reduce discrimination related to HIV/AIDS. Programmes should be initiated at the national, regional and local levels.

The Judiciary, Police, Bar Associations, Accredited Advertising Agencies' Associations and others should implement programmes to sensitize their members on HIV/AIDS issues and not relax at any one moment.

More programmes aimed at raising awareness and educating the public on HIV/AIDS must be conducted. These should be more long term and should involve follow up work.

Providing medical, legal and other assistance to people living with HIV/AIDS and their families by the Government and Non-Governmental organizations.

NGOs, Community members, caretakers of HIV/AIDS patients plus all citizens in general should take up the responsibility of reducing discrimination of People Living with HIV/AIDS

NGOs International and National should direct more resources or care and support projects (interventions).

Participatory/Community based approaches could be used in designing HIV/AIDS programmes for sustainability purposes.

5.4 Areas for further research

There is need to establish if the policies and programmes currently in use are yielding any positive results. This is because the problem of discrimination is still persistent in most sectors.

HIV/AIDS is the underlying cause of discrimination and all the efforts associated to it. The HIV infection rate is stagnant and in some age groups its increasing in spite of all the resources put in HIV/AIDS programmes. There is therefore need to study this

Discordance as a destabilizing condition.
Is it understood?
What are the effects at family level?
Is it a source of false confidence?

REFERENCES

Abdool Karim, Q.,Tarantola, D., Sy, E. & Moodie, R. (1992). Government responses to HIV/AIDS in Africa:What have we learned. AIDS, 11(suppl. B), S143-S149.

Amnesty International 2004: Amnesty International and the fight against HIV/AIDS. Questions and answers.

http://web.amnesty.org/library/print/ENGACT750052004 (2008-03-10)

Aranda-Naranjo, B. & Davis, R. (2000). Psychosocial and cultural considerations. In J. Anderson (Ed.), A guide to the clinical care of women with HIV (pp. 269-282).

Banton, Michael (1994): Discrimination. Open University Press

Building Social Capital in Uganda: The role of NGOs in Mitigating HIV/AIDS challenges. ISHTIAQ JAMIL AND ROBERTS MURISA 11-14-

(Banton and Michael, 1994).

JULY 2004.

Cheever, L. (2000). Adherence to HIV therapies. In J. Anderson (Ed.), A guide to the clinical care of women with HIV (pp. 139-148).Washington: US Department of Health and Social Services.

Crewe, M. (1992). AIDS in South Africa: The myth and the reality. London: Penguin

Daphne Topouzis, Ph.D Consultant .Uganda - The socio-economic impact of HIV/AIDS on rural families with an emphasis on youth

Douglas, M. (1995). Risk and blame: Essays in cultural theory. London: Routledge.

FAO - Food and Agriculture Organization of the United Nations February 1994, Rome TCP/UGA/2256

Feinberg, J. & Maenza, J. (2000). Primary medical care. In J. Anderson (Ed.) A guide to the clinical care of women with HIV (pp. 79 138).Washington: US Department of Health and Social Services

Grange, J., Story, A. & Zumla, A. (2001) Tuberculosis in disadvantaged groups. Current Opinion in Pulmonary Medicine, 7(3), 160-164.

Grundlingh, L. (1999). HIV/AIDS in South Africa: A case of failed responses because of stigmatization, discrimination and morality, 1983-1994. New Contree, 46, 55-81.

Hastrup, Kirsten and Ulrich, George (eds) (2002): Discrimination and Toleration. New Perspectives. Kluwer Law International.

Kalichman, S. (2004). AIDS stigmas as barriers to HIV prevention, diagnosis and care. Paper presented at 2nd African Conference on Social Aspects of HIV/AIDS Research Alliance, 9-14 May, Cape Town.

(King, 2002).

Leclerc-Madlala, S. (2002).Youth, HIV/AIDS, youth and the importance of sexual culture and context. Social Dynamics, 28 (1), 20-41.

Link, B. & Phelan, J. (2002). On stigma and its public health implications. Available at http://www.stigmaconference.nih.gov/LinkPaper.htm.

Maman, S., Mbwambo, J., Hogan, M., Kilonza, G., Sweat, M. & Weiss, E. (2001). HIV and partner violence: Implications for HIV Voluntary Counselling and Testing Programmes in Dar – es- Salaam, Tanzania. New York: Population Council.

Ref: (HIV Curriculum for the Health Professionals by Baylor College of Medicine Houston, Texas, USA)

Ross, F. & Levine, S. (2002). Perceptions of and attitudes to HIV/AIDS among young adults at UCT. CSSR Working Paper, No. 11, Cape Town.

Zierler, S. & Krieger, N. (1997). Reframing women's risk: Social inequalities and HIV infection. Annual Review of Public Health, 18, 401-436.

Parker, R., Aggleton, P., Attawell, K., Pulerwits, J. & Brown. (2002). HIV/AIDS related stigma and discrimination: A conceptual framework and an agenda for action. Washington: Horizons Report, Horizons Project.

Lee, R., Kochman, A. & Sikkema, K. (2002). Internalized stigma among people living with HIV-AIDS. Aids and Behaviour, 6 (4), 309-319.

Strebel, A. (1993).Women and AIDS:A study of issues in the prevention of HIV infection. Unpublished PhD thesis, University of Cape Town.

Sowell, R., Seals, B., Moneyham, L., Demi, A., Cohen, L. & Brake, S. (1997). Quality of life in HIV infected women in the south eastern United States. AIDS Care, 9(5), 501-512.

Wiener, L., Battles, H., Heilman, N., Sigelman, C. & Pizzo, P. (1996). Factors associated with disclosure of diagnosis to children with HIV/AIDS. Pediatric AIDS and HIV Infection, 7(5), 310-324

van der Vliet,V. (1996). The politics of AIDS. London: Bowerdean

Skinner, D. (2001). How do the youth in two communities make decisions about using condoms? CSSR Working Paper No. 2, University of Cape Town.

The AIDS Support Organization Annual Report 2007

UNAIDS 2005: Fighting HIV-related intolerance: Exposing the links between racism, stigma and discrimination.

http://www.unaids.org/html/pub/publications/ircpub03/ bpracism_en_doc.htm (2008-03-10)

UNAIDS/WHO 2006 Report on the global AIDS epidemic(2008-03-10)

World Bank (2007): Uganda: The Sexually Transmitted Infections Project

www.aidsuganda.org

APPENDIX I

KAMPALA
INTERNATIONAL
UNIVERSITY

Ggaba Road, Kansanga * PO BOX 20000 Kampala, Uganda
Tel: +256 (0) 41 - 266 813 * Fax: +256 (0) 41 - 501 974
E-mail: admin@kiu.ac.ug * Website: http://www.kiu.ac.ug

FACULTY OF SOCIAL SCIENCES

Date: 10TH/JUNE/2008

To....DISTRICT DIRECTOR OF HEALTH SERVICES

.....TORORO DISTRICT.....

.....UGANDA.....

This is to introduce to you .....ASWAT HELLEN..... who is a bonafide student of Kampala International University. He/she is working on a research project for a dissertation, which is a partial requirement for the award of a degree. I here by request you, in the name of the University, to accord him/her all the necessary assistance he/she may require for this work.

I have the pleasure of thanking you in advance for your cooperation!

Yours sincerely,

Ms. Sidonia Angom
Associate Dean

RESEARCH QUESTIONNAIRE: FOR PEOPLE LIVING WITH HIV/AIDS

Dear respondent,
My names are Aswat Hellen a student of Kampala International University carrying out an academic research on the topic "to examine whether people living with HIV/AIDS in Tororo Municipal Council in Tororo District are subject to discrimination and if so, what influence does it have on their possibilities to enjoy their human right to health." You have been randomly selected to participate in the study and you are therefore kindly requested to provide an appropriate answer by either ticking the best option or give explanation where applicable. The answers provided will only be used for academic purposes and will be treated with utmost confidentiality. Remember that every answer that you give is correct.
Please answer questions that apply to you only, if you feel it doesn't apply to you go to the next. Do not write your name anywhere on this paper. Also feel free not to answer any questions that you don't feel are uncomfortable to you.
NB: - Please seek for clarification if you don't understand any question.

(I) Personal Data

1.) Sex:
Male ☐ Female ☐

3.) Age: *(Tick what applies to you)*

1. 15 – 25 yrs ☐ 4. 46 – 55 yrs ☐
2. 26 – 35 yrs ☐ 5. 56 – 65 yrs ☐
3. 36 – 45 yrs ☐ 6. 66 yrs and above ☐

4.) **Marital Status** *(Tick what applies to you)*

1. Single ☐ 2. Married ☐ 3. Divorced ☐
4. Widowed ☐ 5. Other____ ☐

5.] **Occupation** *(circle what applies)*

1. Peasant farmers 4.Self employed 7.Medical
2. Counseling 5.Teaching 8.Student
3. Armed Farces 6.Brewers

6. Educational Level *(circle what you do).*

1. No schooling 2. Primary 3. "O" level
4. "A" Level 5. Diploma 6. Graduate
7. Post Graduate

(III) Privacy

1.) Many people do go to test their blood for the virus that causes AIDS. Have you ever gone for and HIV test?
Yes { } No { }
If yes, what was the result?
Positive Negative

2) Have you ever told anyone about your HIV results

Yes { } No { }

If yes how many people know about your HIV test results?

.....

3.) People are sometimes treated in different ways when they tell others about their HIV test results. How were you treated when those people you mentioned above learnt about your HIV test results?.....

.....

.....

.....

.....

4.) How has that treatment changes your life?

.....

.....

.....

5.) When you received your HIV test results, how did you feel about the

6.) People who go for HIV tests may think of doing something about their test results. Tell me what steps did you take after receiving your HIV test results?

.....

.....

.....

7.) Who informed you of the result?

.....

.....

8.) How were you informed?

.....

.....

.....

9.) Was anyone told of your results before you were informed?

.....

.....

.....

10.) If Yes, who? .....

a) How was that person informed and by who?

.....

.....

.....

b) There is a way many people who take HIV test may feel after their results are told to some one. Tell me how did you feel about your results being told to someone else?

.....

.....

.....

.....

c) How did that affect your life and relationship with your family and any other people?

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

(IV) Health Care

1.) Where do you to get treatment whenever you are sick?.....
.....

	V. GOOD	GOOD	UNHELPFUL	NO COMMENT
1b) How is the status of the Healthcare System?				

Has any hospital or health unit refused to treat you as a result of your HIV status?

Yes { } No { }

2.) Have there been delays in treatment/providing medicine as a result of your HIV positive?

Yes { } No { }

3.) Have you had to pay extra for health care services as a result of your HIV positive?

Yes { } No { }

4} Has your family or people associated with you ever been refused treatment by a health care worker or hospital as a result of your HIV status?

Yes { } No { }

5} Have you ever been charged or brought to court on an offence or act related to your status?

Yes { } No { }

If yes, how did you feel?.....
.....
.....

6.) Has your family or people associated with you ever experienced delays in treatment/care as a result of your HIV status?
.....
.....
.....

7.) Has your family or people associated with you ever had to pay extra as a result of your HIV status?
.....

.....
.....

8.) Has anyone advised you not to seek health care services? Give details.

.....

9.) Have you ever been denied or lost insurance or benefits as a result of HIV your status or for taking a HIV test?

Yes { } No { }

10.) Has your family or people associated with ever been denied insurance or benefits as a result of your HIV status?.

Yes { } No { }

(V) Social Life

1.) Have you/family member ever been, as a result of your/family member's HIV status,	YOU		FAMILY MEMBER	
	YES	NO	YES	NO
Threatened				
Assaulted				
Ridiculed				
Insulted				
Harassed				

2.) Have you ever undergone any medical or health procedures without your consent?	YES	NO
Abortion		
Sterilization		
Other (specify)		

3.) Have you ever had to disclose your HIV status when applying for a visa, leaving or entering a country?

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

4.) Have you/family member ever been, as a result of your/family member's HIV status,	YOU		FAMILY MEMBER	
	YES	NO	YES	NO
Detained				
Quarantined				
Isolated				
Segregated				

5.) Have you ever been charged or brought to court on an offence or act related to your?
.....

6.) Have you/family member ever been, as a result of your/family member's HIV status, excluded from joining any	YOU		FAMILY MEMBER/FRIENDS	
	YES	NO	YES	NO
Organization				
Club				
Society				
Meeting				
Gathering				

8.) Have community leaders in your area been in HIV/AIDS work? Education, awareness raising, advocacy vs. increasing stigma and discrimination e.tc.)
Yes { } No { }

9.) Have they been effective? Give details.
Yes { } No { }

10.) Have actions (related to HIV/AIDS) by religious institutions and religious leaders directly affected you, your family or anyone closely associated with you?
.....

(VII) Employment

1.) Does anyone at your workplace know of your status?

Yes { } No { }

If Yes, who? .....

4.) Has their relationship with you changed since finding out your status?

Yes { } No { }

If yes, how?

.....

.....

5.) Have you/family member ever experienced any discrimination at work as a result of your/family member's HIV status?	YOU		FAMILY MEMBER	
	YES	NO	YES	NO

6.) Have you/family member ever been terminated from work as a result of your/family member's HIV status?	YOU		FAMILY MEMBER	
	YES	NO	YES	NO

8.) Have you/family member ever been harassed at work as a result of your/family member's HIV status?	YOU		FAMILY MEMBER	
	YES	NO	YES	NO

9.) Has your work changed as a result of your HIV status?

.....

Yes { } No { }

10.) Have you/family member ever been offered early retirement as a result of Your/family member's HIV status?	YOU		FAMILY MEMBER	
	YES	NO	YES	NO

Do you have any questions to ask or any other concern?.....

.....

Thank you very much for giving me your time to cover these Questions.