THE SOCIO-DEMOGRAPHIC EFFECTS OF HIV/AIDS ON WOMEN IN ACHOLI SUB REGION

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DECLARATION

I **Alice Kipwola Opio** hereby declare that this piece of work (***The Socio-Demographic Effects Of HIV/AIDS On Women In Acholi Sub Region***) is original and has not been submitted for the award of any degree in any University or Institution before.

Signed .....

Alice Kipwola Opio

Date 19/2010

APPROVAL

This research work has been under my supervision and it is now ready for submission.

Signed ..... Date .....

LAAKI SAMSON

DEDICATION

I dedicate this piece of work to my love Mr. Okot James Bonn, my sisters; Anenocan Christine, my father and mother and the family of my dear friend Helmut Okello of Austria who assisted me financially during the cause of my studies may Almighty God bless you abundantly.

May God bless you all!

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May God Bless You All

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ACRONYMS

AIDS	Acquired Immune Deficiency Syndrome
HIV	Human Immunodeficiency Virus
IEC	Information, Education and Communication
MDG	Millennium Development Goals
MoH	Ministry of Health
TBAs	Traditional Birth Attendants
UBOS	Uganda Bureau of Statistics
UDHS	Uganda Demographic and Health Survey
UNDP	United Nations Development Programme
UNFPA	United Nations Population Fund
UAC	Uganda AIDS Commission
PHA	People Living with HIV/AIDS
WHO	World Health Organisation
UNAIDS	United Nations AIDS
WHA	Women Living with HIV/AIDS

ABSTRACT

This study investigated the socio demographic effects of HIV/AIDS on women living with HIV/AIDS in Acholi Sub region, northern Uganda. The specific objective was to explore the socio-demographic burdens of HIV/AIDS on women and to examine gender roles that render women vulnerable to HIV/AIDS, then find out coping strategies of women affected and Infected with HIV/AIDS in the community in order to come up with a helpful generalization for people affected by and infected with HIV/AIDS in Acholi sub region.

The study utilized primary data, collected from a sample of 100 women from Acholi Sub region both Affected and Infected with HIV/AIDS targeting 6 sub counties estimated to be having high HIV prevalence rate hence forth representing the whole of northern region. Data was collected using a semi-structured questionnaire and analyzed in SPSS program.

It was found out that HIV/AIDS has had a significant impact on Women in Acholi Sub region but differ according to residence, marital status, employment status and the number of children ever born. In this regard this is an important study in promoting gender roles in the fight against HIV impacts. The study recommended that women living with HIV/AIDS be trained and provided with Income generating Activities coupled with a number of follow ups for progress.

CHAPTER ONE: INTRODUCTION

1.1 Background to the study

HIV/AIDS is now the leading killer of adults and youths in Sub-Saharan Africa, where over 25.8 million people are reportedly infected with the virus (1:10 adults). According to the UNAIDS report 1999, over 90% of the world's 11 million children orphaned by AIDS live in Africa. In fact two-thirds (95%) of the world's HIV positive population is found in Sub Saharan Africa, which accommodates a tenth of the world's population(World Vision, 2005).

Uganda was one of the first sub-Saharan African countries to be affected by HIV/AIDS. The first reported cases were identified in south central Uganda in 1982. There after the country experience an unparallel exponential increase in HIV transmission over one million people are estimated to have died from HIV/AIDs related causes over the past two decades. In addition, nearly one million adults and over 100,000 children are currently living with HIV and AIDs (MoH, 2003a)

HIV/AIDS is a major contributor to both poverty and the loss of a caring family over half of Uganda's orphans and widows are estimated to have lost husbands/ one or more parent's due to HIV/ AIDS. Vulnerability caused by HIV/ AIDS is often a gradual process involving the progressive loss of capacity (income, parenting capacity) by parents before death as they fall ill. Children/ women themselves may become the primary care givers to the spouse and or of their parents (Witter, S, 2002, Ibid, P66).

The impact of the HIV/AIDS put families under serious psycho-social and economic pressure and is reducing the network of care and protection surrounding women. With increasing poverty and decreasing social support, women are at increasing risks of social and economic deprivation and all that follows such as loss of support from relatives grabbing of property, child-labor and, for some, criminal (MoGLSD/ IL. 2004a, Ibid, P66).

Gender, the social construction of differential roles, status, privileges, duties and obligations between males and females, permeates all aspects of life, including the family, influencing the social and economic situations of males and females expectations of appropriate behavior, the ability in diversity to find solutions to the challenges facing them and the strategies that they adopt, as gender discrimination starts from childhood (UBOS, 2001, Ibid, P103)

In Uganda, there is marked gender inequality in control over resources and decision-making power. Within the family, women are poorer than men, women are over burdened in that they have primary responsibility for domestic duties play the major role in agriculture production and have a disproportionate responsibility for meeting the family needs (for example, they are generally responsible for providing food for the entire family). (MOFPED- Uganda participatory Poverty Assessment Process (UPPAP), 2002, P25 – 26).

Inevitably, this is reproduced in the differential expected contributions of girls and boys to the households; girls spend three to five times on domestic tasks than boys. Within the

households, decisions over the allocation of scarce resources tend to privilege boys and as a result, girls tend to drop out of school earlier. Meanwhile, men control virtually all households resources, women lack control over land and the crops that result from their Labour (which facilitate asset – grabbing by a man's family when he dies, leaving widows and orphan's destitute) (MOFPED, 2002, Ibid , P32 – 34). Approximately 26% of Ugandan Households are female-headed households and approximately 20% of the population lives in a female-headed household. Most females heading households are widowed or divorced (indicating that female headship is generally a result of descriptive life changes for women and is indicative of instability in household's structures and composition) (World Bank, 2002, Ibid, P3).

Inequality based on gender differentials is reflected in not only the division of labor within the home and the community, but also in values and practices such as payment of bride price, early marriage, and girl –child pregnancies both in and outside marriage. In conflict situation, girls are exposed to greater risks of sexual violence and abuse that exposes them to STI's (UNICEF, 2005).

It is estimated that 6.4% or over 800,000 adults are infected with HIV in Uganda in 2005. Women are more affected by HIV than men, particularly in urban areas and in younger age groups. A large number of children and youths have also been infected by the pandemic. Sero-survey data on HIV prevalence among children aged zero- 4 years indicates a rate of 0.7% for both girls and boys. It is estimated that 100,000 children under the age of 15 in Uganda are living with HIV/ AIDS (Opio, Alex, 2005)

HIV/ AIDS is both a result and a contributing factors to violations of women's rights once infected, HIV positive women often face stigmatization, discrimination, domestic, violence, abandonment and loss of inheritance rights (when husbands and fathers die). Although awareness of the modes of transmission of HIV /AIDS is almost universal to day in Uganda the pandemic has continually been characterized by fear and denial ,in turn ,leading to discrimination ,abuse and violence against women living with HIV/AIDS as well as against their families .women are more likely to be exposed to HIV infection due to social and cultural norms that support early marriage and child bearing /polygamy and extra martial partners for men ,cross generational sex ,domestic violence and dependence of women that prevents them from negotiating safer sex (UNICEF,2005).

The gender distribution trend of new clients registering with TASO-Gulu in 2006 was 65% females and 35% male in 2005 was 66% female and 34% male .This trend is in line with the internationally known health seeking behavior of women visa vie men in developing countries, however TASO is trying various ways of encouraging males to be come serious about their status, hence the study will find out the effects of HIV/AIDS on women as they carry higher burdens compared to men.

1.2 Problem statement.

The country has been at the fore front of the struggle, boldly experimenting with openness and a commended well-organized multi-sectoral approach. Substantial donor funding over the past two decades has allowed the development of myriad of government and NGO sponsored interventions including prevention information, education and communications (IEC); behavior change communication (BCC); clinical services, Sexual

and Reproductive health, adolescent health, antenatal care, family planning, condom distribution and HIV counseling and testing (HCT); prevention of mother-to-child transmission (PMTCT); antiretroviral therapy (ART); and palliative care; support for orphans and vulnerable children; and related activities. Most recently, there is free ART countrywide for those in need.

Despite Uganda's notable achievements, there are many urgent challenges ahead. The gender discrimination has denied women access to and getting treatment nationwide; decreased coverage of services for adolescent and women of reproductive age in rural areas; and less access to health care for populations in the conflict districts, especially those living in internally displaced people's camps in Northern Uganda has laid high burden on women as care givers for sick people at home.. In addition, the HIV/ AIDS pandemic in Uganda has led to abuse of women by the fact that the human rights of women and vulnerable girl-child have not yet been adequately recognized, of particular concern are women living in acute poverty, single mothers' households, and abandoned by their husband as a result of HIV/AIDS that has made women to be left alone to look after their children. Thus the study will find out the impact of HIV/AIDS on women in Acholi sub-region.

1.3 Purpose of the study

1.3.1 General Objectives

- To find out the socio-demographic impacts of HIV/AIDS on women.

1.3.2 Specific Objectives

- To find out socio-demographic burdens of HIV/AIDS on young girls and women.
- To examine gender roles that render women vulnerable HIV/AIDS.
- To identify strategies of women with the impact of HIV/AIDS in the community.

1.3.3 Research Questions

- What are the socio-demographic impacts of HIV/AIDS on young girls and women?
- What are gender roles that render women vulnerable to HIV/AIDS?
- How do the young girls and women cope with the burden of HIV/AIDS in the family and community?

1.4 The scope of the study

HIV/AIDS is a dynamic phenomenon that needs a holistic approach in addressing its impact. The study was conducted in Acholi sub-region. The place was selected because its host people from different background and cultures that might have made the impacts of HIV/AIDS felt differently hence making women much more prone to its effects.

The study had women aged 16-65 as its main respondents and stakeholders supporting women deals with the impact of AIDS. The study took a period from Jan 2008 to September 2007 covering a total study population of 100 respondents.

1.5 Significance of the study

The study will help to break community fabric that had affected negatively, create awareness on issues that affect women in line with HIV/AIDS, provide information on the danger of HIV/AIDS that will help to reduce its prevalence among women.

The findings from the study shall help to identify the existing gaps in service provision, factual information on how AIDS has affected women in the community.

It will provide a chance for both the infected and affected women to open up and disclose their HIV status, share their experiences, expectations, how they have been coping with their situation and how the testimonies can be used as a lesson to reduce HIV prevalence with practising positive living.

CHAPTER TWO: LITERATURE REVIEW

This chapter will review the current HIV/AIDS situation in Uganda with regards to women as vulnerable people in society, gender inequalities, violence against women, health situation as well as responses and coping strategies with the effects of HIV/AIDS

2.1 Vulnerability and HIV/AIDS in women

Under the third Millennium Development Goal, it states that promote gender and empower women but this has not yet been achieved. Vulnerability to abuse has affected women throughout their lives. The threat is more severe for girls and women who live in societies where women's rights mean practically nothing. Mothers who do not know their own rights have little protection to offer their daughters, much less themselves from male relatives and other authority figures. The frequency of rape and violent attacks against women in developing world is alarming. Up to 45% of Ethiopian women say that they have been assaulted in their families. In 1998, 48% of Pakistani women admitted being abused by an intimate partner within the past years.

The majority of women are vulnerable due to unequal access to opportunities like education, employment, income, ownership of property as well as the negative socio-cultural attitudes regarding the equal status of women.

The 1995 Uganda Constitution gives liberty to women to own land and be entitled to inherit land from parents or their husbands but today women have limited access to and control of land; with women holding only 7% of registered land titles in Uganda. This gender inequality in access to and control of productive assets and resources acts as a break to women's economic participation and limits economic growth. It is therefore

important for Uganda to unleash the full productive potentials of female economic actors if it is to achieve high and sustained rates of pro-poor growth.

According to the 1995 Constitution, women should have equal rights just as the men but women's productivity is affected by gender discrimination and most of all gender-based violence. Violence on women affects their physical, psychological and social well-being and ultimately their economic productivity. This kind of discrimination has kept women lagging behind men yet they contribute a lot to the economic development of our country. Millions of women are victims of discrimination. Others suffer from the impact on sexual violence, which exposes them to various forms of sexually transmitted diseases (STDs). Extreme poverty and deep biases against women creates a remorseless cycle of discrimination that keeps girls in developing countries from living up to their full potential. It also leaves them vulnerable to severe physical and emotional abuse. These "servants of the household" come to accept that life will never be any different.

2.2 Gender inequalities and HIV/AIDS among women

According to the Ministry of Gender, Labor and Social Development; the care and protection of women in adversity and need to reduce vulnerability due to conditions they face has become a central theme. A girl loses her childhood as she takes the adult responsibilities at a tender age, these causes harsh realities of life. Housework in developing countries consists of continuous, difficult physical labor. A girl is likely to work before daybreak until the light drains away. She walks barefoot long distances several times a day carrying heavy buckets of water, most likely polluted, just to keep her family alive. She cleans, grinds corn, gathers fire woods, attends to the fields, bathes her

younger siblings, and prepares meals until she sits down to her own after all the men in the family have eaten. Most families cannot afford modern appliances. so her tasks must be done by hand—crushing corn into meal with heavy rocks, scrubbing laundry against rough stones, kneading bread and cooking gruel over a blistering open fire. There is no time left in the day to learn to read and write or to play with friends.

The effect of physical and emotional abuse may result in low self-esteem. Shocks and denials are experienced immediately after trauma hence discouraging a woman's economic participation, therefore hindering her economic development, and making her more dependant on a man for survival.

According to Hausmann et al. (2006), who presents an index of gender inequality in four areas – economic and political participation, and access to health and education inputs – no country has managed to eliminate the gender gap. Wherever one goes, females find it more difficult than males to gain access to the labors market, political power, health and education. Gender discrimination is widespread and appears in many guises, being associated with a given country's social, cultural, and economic characteristics, both as a consequence and a cause.

Though gender discrimination tends to decrease over time, the differences across countries are quite substantial, and progress is slow and subject to setbacks. Unwarranted discrimination is first of all an ethical and political issue.

According to Klasen (1999)) the issue of ''gender wage-gap" discourages female labor force participation, with a direct negative effect on output. The lower rate of participation

of females is a universal empirical phenomenon. We believe this lower participation is likely to increase fertility and discourage investment in the education of the off springs, particularly girls. Discrimination is economically inefficient since it prevents the equalization of marginal rates of substitution in production. This inefficiency shows up directly in terms of lower wages for women, but it also lowers an economy's total output. It results in millions of individual tragedies, which add up to lost potential for entire countries. Studies show there is a direct link between a country's attitude towards women and its progress socially and economically. The status of women is central to the health of a society. If one part suffers, so does the whole. Tragically, female children are defenseless against the trauma of gender discrimination.

According to Rukia Isanga, women must be given physical safety. The women have no protection against horrifying experiences involving the future, sexual and physical abuse. They are weak without a defender, loss of physical health due to illness contracted during sexual abuse. No one can raise bride price. Girls end up being unable to produce since they go through a lot of trauma, which ends up destabilizing their reproductive health.

If a woman exhibits intelligence, she is taken for a crafty person; if she dares to express her views, she is labeled "long tongued;" if she happens to be gutsy and vigorous, she is dubbed "masculine;" if she is not hard working, she is considered to be not only lazy but lacking cooking and house keeping skills as well. Women are as a whole viewed as a personification of weakness and as treacherous beings that do their duties when they are whipped or beaten.

2.3 Violence against women and HIV/AIDS

According to WHO, World Report on Violence and Health, gender-based violence, or violence against women (VAW), is a major public health and human rights problem throughout the world. Violence against women has profound implications for health but is often ignored. The WHO's report notes, "one of the most common forms of violence against women is that performed by a husband or male partner." This type of violence is frequently invisible since it happens behind closed doors, and effectively, when legal systems and cultural norms do not treat as a crime, but rather as a "private" family matter, or a normal part of life.

According to the HURIFO, violence against women is an obstacle to the achievement of the objectives of equality, development and peace. Violence against women both violates and impairs or nullifies the enjoyment by women of their human rights and fundamental freedoms. The long-standing failure to protect and promote those rights and freedoms in the case of violence against women is a matter of concern to all states and should be addressed.

2.3 Women's health situation with HIV/AIDS

According to the latest (2007) WHO and UNAIDS global AIDS estimates, worldwide, approximately as many women as men are living with HIV and in sub-Saharan Africa, women constitute 61% of people living with HIV. Gender inequalities as well as biological factors make women and girls especially vulnerable to HIV and to the impact of AIDS.

Millions of women do not enjoy access to educational opportunities and lack economic security and equal protection under law, which further contributes to their vulnerability to HIV. HIV/AIDS programmes that include comprehensive AIDS education and clear prevention messages promote condoms, provide needle exchange for injecting drug users and prompt treatment for sexually transmitted infections can help women and girls protect themselves from HIV. However, many of these programmes and services are not easily accessible, in part because they do not invest in the specific needs of women and girls, and fail to address the underlying gender inequalities that pose a barrier to their access.

According to the World Conference on Education for All, discrimination in girls' access to education still persists in many areas, owing to customary attitudes, early marriages and pregnancies, inadequate and gender-biased teaching and educational materials, sexual harassment and lack of adequate and physically and otherwise accessible schooling facilities. Girls undertake heavy domestic work at a very early age. Girls and young women are expected to manage both educational and domestic responsibilities, often resulting in poor scholastic performance and early dropout from the educational system. This will have lasting consequences for all aspects of women's lives.

According to HURIFO, there are many crimes against women that still occur in the community. Such crimes include rape and defilement, domestic violence and child neglect. Gender discrimination in the community is still an issue due to stereotyping especially at the family level. In some families, you can still find women still marginalized, girls not offered equal opportunities to education and generally still restricted to several activities. A number of men in the community still reject and are still

against the rights of women. The contribution of women to the family, community and nation is crucial and need more support.

Mortality problems relating to malaria, malnutrition, anemia, tuberculosis, maternal ailments and STDs like AIDS affect greater percentage of women. Worldwide, AIDS is a health, social, economic and political issue. According to the WHO, the number of new HIV infections among women in most African countries outnumbers men by 6 to 5 and more than five to six million women of childbearing age have been affected. One out of every three pregnant women attending antenatal clinics in some major African urban centers is infected. Young women are being most seriously deliberate by the impact of AIDS pandemic. Women with serious repercussions on the elderly women who are left to care for orphans when they are least capable mostly feel the economic and social consequences of AIDS. Besides AIDS, Africa continues to experience high mortality rates caused by other diseases such as malaria, sickle cell, anemia, tuberculosis and ailments related to malnutrition.

According to Ms Rufina Akepa Acago, the acting Commissioner; childcare and protection- Department in the Ministry of Gender, Labor and Social Development, the girl child is highly vulnerable. The girl child is often subjected to sexual and physical abuses. They are exposed to exploitation, early pregnancy, HIV/AIDS and other sexually transmitted infections. They also face complete rejection from their families at home and the community simply because they are looked at as burdens to the society.

According to women and child development minister of India, Renuka Chowdhury, most people prefer sons who are typically regarded as breadwinners, while girls are seen as burdens because of the matrimonial dowry demanded by a groom's family and the fact

that their earnings go to their husband's families. For a girl, there is only suffering in life. Even well off people who can afford a dowry often, prefer boys because girls are seen to bring financial benefits to their in-laws –not to their parents. Social activists say abortions of female fetus are more common because the women fear giving births to girls as society under looks them. Sex-selective abortions are even more common than infanticides in India. They are growing ever more frequent as technology makes it simple and cheap to determine a fetus' gender. In Jaipur, a Western Indian city of 2 million people, 3,500 sex-determined abortions are carried out every year. The gender ratio across India has dropped to an unnatural low of 927 females to 1,000 males due to infanticide and sex-based abortions.

Economic decline, recession and resultant economic restructuring in the face of external debt have led governments to focus on the more pressing and immediate problems often to the neglect of longer term issues that have direct bearing on the advancement of women. At the same time, pre-existing conditions of inequality between men and women, inter alias, in health and nutrition, levels of literacy and training, access to education and economic opportunity and in participation in decision-making, have sometimes been exacerbated both by the crisis and by the policies adopted to cope with them. Such policies have already compounded further disadvantaged situations of the women because they do not take account of their specific roles and concerns.

According to the report issued by the Ministry of Gender, Labor and Social Development, female genital mutilation (FGM) is discriminatory and is meant for the selfish interests of men. It is meant to facilitate the control by men over women. It presupposes that a woman is the property of the man and therefore harmful operations

can be performed on her to enable the man have unhindered control over her. This removes the accepted human right principals that men and women are equal in dignity of the person. FGM cannot be supported based on promoting a cultural right. What is harmful and dangerous to life of an individual cannot be said to be a right. FGM is a violation of human right and must therefore be progressively fought. FGM is usually performed on girls between the ages of 11-13.

According to Aliro Omara's study on FGM, circumcision as an initiation process can therefore lead to a girl leaving education and getting married at a tender age with the attendant health and emotional problems she is likely to undergo. They are too young to understand the implication of what they are being subjected to. Once mutilated, the girl-child is considered initiated into womanhood and is therefore vulnerable to early marriage and sexual relations to the detriment of her development and health. The reasons advanced for FGM is not strong enough to justify the risks it exposes women to. It is not carried to subject women to such risks merely because the community is practicing its tradition.

According to the statistical abstract 2000, men earn 83% of bachelors' degrees in the masculine field of engineering, while women are awarded 88% of bachelors' degrees in the feminine field of library science. Because gender socialization gives men and women different orientations to life, they enter college with gender- linked aspirations. Most employed wives face greater role conflict than do their husbands. They are most likely to be caretakers of the marriage, to nurture it through the hard times. They also spend more time in maintaining family ties. Most wives, even though employed full time, also spend more time taking care of the children and doing housework.

Forced prostitution to support their families often fills their burden deeply. "When I was at work, 50 percent of me hated what I was doing," said one 14-year-old girl, who felt conflicted about being taken out of a brothel in Chiang Mai, Thailand. "But the other 50 percent wanted to stay so that I could earn money for my parents. My father cannot work. He is very old and I must support the family. It is my job."

It is estimated that 1 million children around the world are involved in the sex trade; a third of all sex workers in Southeast Asia are between the ages of 12 and 17.

According to the report carried out by the Ministry of Gender, Labor and Social Development; in the rural areas, many women have little say when it comes to selecting a partner and deciding the number of children to have. The husband always has the only word over her and male preference pervades all aspects of social life. Phrases such as "more sons, more wealth" and "May you have more sons" or "it is fate to be born a girl" contribute to the low self-esteem among women. Son parents still give preference to sons and educating a girl is considered unnecessary since girls usually leave the family after marriage.

2.4 Effects/impacts of HIV/AIDS

2.4.1 Current deaths rates; number of orphans; economic and social results

HIV/AIDS has left the worst repercussions on the population of Uganda since it was recognized in the early 80s. According to the AIDS surveillance report of June 2000, 838,000 people have been reported dead due to HIV/AIDS. Of these 754,200 were adults, 411,382 women, and 342,818 men and were 83,800 children (AIDS surveillance report, 2000). The same report reveals that 1,438,000 people are currently living with HIV/AIDS, 761,300 women and 143,800 children less than 12 years. It was estimated

that in 1999, new cases would be 112,000 people of who 11.200 will be children and 54,982 will be women.

2.4.2 HIV/AIDS and the Children

The cruelest effect of HIV/AIDS is the millions of children who have been orphaned by the disease.

- The cumulative global AIDS orphans are currently 13.2 million accounting for 7% 11% of children in many African countries. At least 90-95% of all AIDS orphans are in the African continent.
- Of the 10.4 million orphans who are alive and under 15 years of age, Africa account for 9.4 million (UNICEF/UNAIDS). This is a rapidly growing trend, which will continue to stretch the extended families and communities.
- Uganda: the country contained 1.7 million orphans in 1999, making it the world's leader (UNAIDS 1999:2) 10% of the children in Masaka region are orphans (Barnett and Whiteside: 11Orphans. These children are at a greater risk of illness, abuse and sexual exploitation. In addition they have to struggle with the stigma and discrimination, which may deprive them of basic social services and education (UNAIDS 2000). A Generation of children who have not known parenthood is emerging. This is made more complicated with illiteracy, lack of employment, low incomes, lack of basic needs leading to social strife, increasing infant/child mortality. Traditional support systems are failing to cope with the increasing number of orphans; some of the children are taking up roles of parents at tender ages. Furthermore, a good number are experiencing various forms of exploitation, physical and sexual abuses, child labor, prostitution, defilement and others have taken on the

life of living on the streets. All these have implications to World Vision as the major focus of development lies in improving the welfare and quality of life for children.

2.4.3 Economic and Social results

HIV/AIDS is erasing the potential gains in life expectancy, and will cause a reverse of

- The social progress and most of the development gains attained in the past years. This will have implications on the management of natural resources and sustaining the flow of trade.
- It is estimated that in high HIV prevalence countries with prevalence of 10% or more, 17 years of potential gains will be erased. This implies that instead of reaching, 64 years by 2010-2015, life expectancy will regress to an average of 47 years. Uganda's current life expectancy in now 42 years.
- The labor force will also shrink by 10% to 22% (International Labor Organization ILO). Both domestic savings and investments will be reduced. Life insurance companies and disability insurance will soon have little money to invest. Foreign Direct investment will diminish as well especially in agriculture commodity markets. This declining productivity is due to the death of skilled workers who die during their prime. Most of these are workers in companies, thus replacements and retraining of new personnel is mandatory for the continuing production and economic progress.
- In Uganda, poverty among households is forcing people to migrate away from their families to find employment or into high-risk activities such as commercial sex for economic survival. This is also causing social disruption in the communities.

- Studies in Uganda have shown that the chance of orphans continuing with education after the parents death is halved and those who go to school spend less time there than they did formerly.
- Other studies have also shown that orphans face an increased risk of stunting and malnourishment.
- The illness and deaths of so many Ugandans due to HIV/AIDS is affecting the national productivity and earnings. The labor productivity is dropping, and benefits of education and skills training are being lost. The savings, which would have been used for investments, are spent on health care, funerals and related social costs. At the district level, authorities are experiencing graduated tax defaulter rate of varying degrees.
- In most districts, up to more than 70% of their local resources are raised from graduated tax collection which contributes 24% of the total revenue.
- According to the Ministry of Local Government (MOLG 1998) report on analysis of district and urban council budgets, only three districts realized over 75% of graduated tax collection while nine districts had a rate between 60-75% collected. Seven districts realized 50-60% and the rest collected less then 50%.

There is no doubt that HIV/AIDS is among the major factors that account for the high defaulter rates in many of the districts. This reduction in graduated tax collections will affect the capacity of districts to provide the required services to the population.

2.4.4 Future Trends

- A declining labor force is envisaged in the future and as a result tax collections will continue to decline tremendously.
- There will also be increasing numbers of poor households because of deaths of the breadwinners and also the over stretched extended families, which will have a bigger burden in raising number of orphaned children. Increase in child headed households will increase their vulnerability.
- Low productivity leading to poor food security and increasing rates of malnutrition and lowered immunity.
- Inability of households to afford social services, affected families will spend more time caring for the sick which in turn will affect the family's labor force and productivity.

2.4 Copying strategies with the impact of HIV/AIDS

Girls' education is the greatest strategy that brings comprehensive change for a society. As women get the opportunity to go to school and obtain higher-level jobs, they gain status in their communities. Status translates into the power to influence their families and societies. Even bigger changes become possible as girls' education becomes the cultural norm. Women cannot defend themselves against physical and sexual abuse until they have the authority to speak against it without fear. Knowledge gives that authority. Women who have been educated are half as likely to undergo harmful cultural practices such as female genital mutilation (FGM) and four times as likely to protect their daughters from it. The Global Campaign for Education also states that primary education

defends women against HIV/AIDS infection—disproportionately high for women in developing countries—by giving "the most marginalized groups in society—notably young women—the status and confidence needed to act on information and refuse unsafe sex." Therefore, education is the sole healer of gender discrimination on the women and society as a whole.

Condom promotion has been part of the HIV prevention efforts in Uganda since 1986. In 1991, as part of the Abstain, Be faithful or use Condom (ABC) strategy, a national policy was adopted to support 'quit promotion and responsible use of condoms and appropriate education in recognition that individuals may need to choose different prevention strategies at various periods in their lives as circumstances change 449 condoms are distributed by the government health centres, social marketing organizations, and private –for –profits outlets (UNICEF, 2005).

2.4.1 Prevention: Behavioral change interventions

Behavioral change interventions have been the foundation of Uganda's Strategy for the prevention of HIV infection. Behavioral change approaches have been well documented and include IEC, BCC, life skills, peer education, various adolescent in and out-of-school approaches, support groups and community interventions, among others. The approaches have been multi-sectoral and emphasized a broad-based social, economic and public health approach to serve all segments of society. In the late 1980's media campaigns focused on "Zero grazing" message which encouraged men and women to restrict themselves to one sex partner(s) within the household. This was followed by "love carefully" messages aimed at protection and concern for oneself and others. Programmes for adolescents focused upon delaying sexual debut and marriage, life skills, sexual and

reproductive health knowledge, and rights to services including condoms. The approach was inclusive of organizations with various religious beliefs. Most recently, there has been a renewal of interest among faith-based organizations who believe abstinence and the Uganda AIDS Commission drafted faithfulness Policy and Strategy on Prevention of transmission of HIV. The goals and objectives of this policy include promotion of abstinence among adolescents, those unmarried (including widows and widowers) and mutual faithfulness in marital relationships (UAC, 2004c. Uganda National Abstinence and Being Faithful Policy and Strategy on Prevention of Transmission of HIV; Draft Policy and Strategy. (UNICEF, 2005).

There have clearly been successes in behavioral change although not as much as one might hope for this late in the pandemic. In addition, as mentioned previously, there is evidence of plateau in prevalence and maybe even an increase in incidence among some "pockets" of the population. This suggests a degree of caution in interpreting past successes as evidence of sustained trends. Nonetheless, however, recent data suggests the following. The number of males reporting three or more sex partners

Fell from 15%to 3% between 1989 to 1995 446 among females ,a decline from 23% in 1989 to 9% in 1995 has been observed .447 twenty –seven percent of young women aged 15-24 abstained from sex in 1989 compared with 35% by 2000 .these increases were greatest among urban women and with secondary education. Among men aged 15-24,47% reported abstaining from sex in 1996 and 53% reported the same case in 2000.contrary to the finding for females, male abstinence was found to be highest among rural populations .448 in conclusion, it appears that innovative new strategies and

approaches will be needed to effectively deal with prevention and behavioral change issues for each generation.

From the early days of the pandemic in the late 1980s, Uganda took aggressive action to disseminate HIV/AIDS information across the country. In 1986, Uganda embarked on a strategy of health education in HIV/ AIDS. The goals of the programme were to inform people about modes of HIV transmission and risk reduction. IEC activities (including mass media, materials development, special campaigns and trainings seminars, etc) have been widely supported by both government and donor-funded Programmes.

In order to reach young people, the School Health Education Programme was established in 1987. More recently, the Presidential Initiative on AIDS strategy for communication to Youth (PIASCY) was launched in schools (2003) to complement formal health education and life skills Programmes. PIASCY objectives include increasing HIV/ AIDS education for school children, Youth, and further developing the capacity of parents, teachers and health service providers to engage in constructive communication with young people. At secondary level, 15% of teachers have been trained and life skills education is offered at 66% (about 1400) of secondary schools. Another 171 tertiary institutions (in 34 districts) have teachers trained in life skills education. In the near future all government departments and schools will have counseling section.

Currently, awareness of HIV and AIDS is virtually universal, as nearly every household has lost relative or family members to the disease (UBOS et al, 2001. Uganda Demographic and Health Survey 2000 – 2001). Most men (95%) and women (87%)

know that HIV can be prevented, yet practical behavioral change strategies to reduce the risk of transmission are far less known. .Knowledge of condom as a preventive measure increased between 1995 and 2000 from 21%to 54% among women and from 32% to72 percentage among men. Having only one sexual partner as away to avoid AIDS was mention by 49% of women and 43% of men, while abstaining from sexual relations was mentioned by 50% of women and 65% of men UBOS et al, 2001. Ibid). Knowledge of at least two method of prevention (condom use and limiting sexual partners) was reported by 75% of rural women 89% of rural men. Among urban populations knowledge is much higher and varies from 92% for women and 95% for men. Knowledge was generally highest among men and women in their twenties and thirties and lowest among those aged 15 – 19. It is important to note that approximately 15% of women aged 15- 19 and 40- 49 had not heard of AIDS or did not know of any way to prevent the disease. Among men, this figure was 8% for those aged 15 -19 and 11% for those aged 50 -54. Most men and women (about 93%) know that AIDS can be transmitted from mother to child. Approximately 53% of men and 58% of women are aware that HIV can be transmitted during pregnancy. 69% of men and women are aware that it can be transmitted during delivery. However, less than half (46% of women and 43% of men) know that the virus can be transmitted during breastfeeding (UBOS et al, 2001 Ibid.)

CHAPTER THREE: METHODOLOGY

3.1 Introduction

This section gives an account of data source, sample size and methods used in the execution of the study. The research employed a quantitative method of data collection which was relevant to extract primary information about the impact of HIV/AIDS on women.

3.2 Source of data

The study utilized primary data, collected from a sample of 100 women from Acholi Sub region both Affected and Infected with HIV/AIDS targeting 6 sub counties estimated to be having high HIV prevalence rate hence forth representing the whole of northern region. Data was collected using a semi-structured questionnaire and analyzed in SPSS program.

3.3 Data collection procedure

Data collection was done simultaneously in all the six sub counties. The quantitative data was collected through the use of an individual questionnaire to the selected women both affected and infected with HIV/AIDS as the target respondents.

3.4 Sample design and Study area

The sample selection of study individuals employed the random sampling method where by 100 respondents were selected from the 6 sub counties from Acholi sub region. The research collected current data from the respondents in six sub counties and information about the women infected and affected by HIV/AIDS and their households. Among the main issues collected and analyzed in this study were the Individual and relevant household demographic and socio economic profile was used as the dependent variable in the study.

3.5 Data analysis

Data was analyzed in Statistical Package for Social Scientists (SPSS) program and the analytical tools for this study were mainly the chi-square tests and analysis. Chi-square test used to test a hypothesis whether there was a significant impact of HIV/AIDS on Women.

3.6 Ethnical considerations

An introductory letter that guaranteed a permission to do the fieldwork was got from the department Institute of open and distance learning. The letter was taken to the six sub-county headquarters which allowed the research to be conducted. Consent to participate in the study were sought first and obtained from every respondent who participated in the interviews.

The names of participant in the study were not documented for confidentiality purposes and no photography was done.

Confidentially was observed at all times in respect to the respondents' views and experiences shared. Given the sensitivity of the topic, there were cases of emotional break down of some respondents during the interviews, in such cases, enough time and care were given to the respondents to cool down before continuation with the interview and feeling of empathy was applied where necessary.

CHAPTER FOUR: PRESENTATION OF FINDINGS

4.1 Introduction

This chapter presents analysis of the relationship between demographic and socio-economic characteristics of the study population. It presents results from both univariate analysis of the background characteristics of respondents on dependent variables associated with socio-economic impact of HIV on women affected and infected HIV in northern Uganda.

4.2 Socio-demographic characteristics of respondents

Social, cultural and demographic factors strongly influence decision-making for any kind of behavior and can determine how individuals perceive the issues to deal with their lives (Population Reference Bureau, 2002). In the attempt to examine the contraceptive behaviors, the socio-demographic characteristics of people living with HIV/AIDS are presented. Frequencies were made to establish the distribution of these factors about the impact of HIV on women. This chapter presents the distribution of the background characteristics. The sample consisted of 100 women affected and infected with HIV/AIDS who were interviewed during the research in Acholi Sub Region summarized in Table 4.0

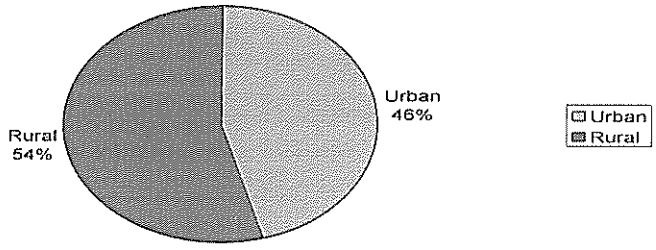
Table 4.0; Distribution of respondents by Sample Sub county and District

Sub county/ District	Frequency	Percent
Paicho s/c Gulu	16	16.0
Bobi s/c Gulu	18	18.0
Lapul s/c Pader	18	18.0
Amuru s/c Amuru	19	19.0
Palabek Kal s/c Lamwo	17	17.0
Orom s/c Kitgum	12	12.0
Total	**100**	**100.0**

4.2.1. Residence

According to Thackway et al 1997, it was argued out that people of different locations, have different perceptions on certain issues especially the health seeking behavior. In this case, women who live in the urban areas are more likely to be exposed to health services and awareness than those who reside in the rural areas, according to this study, out of the 100 respondents, majority were from rural areas and they accounted for 54.5 percent while the remaining 45.5 percent were from urban areas reference made to Table 4.1.

Figure 2: Sample of women interviewed by the type of residence



4.2.2. Age

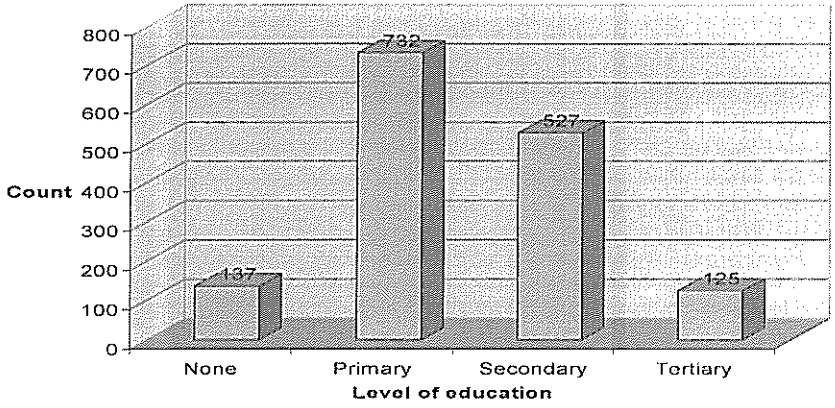
Out of the 100 respondents, which the study encompassed, majority that is to say 40.3 percent lay in the age bracket of 25–34, the least number was above 45 year which constituted only 18.5 percent. The other age brackets were 15-24 accounting for 19.4 percent and 35-44 accounting for 21.8 percent.

4.2.3. Education

Although women's knowledge of contraceptive options is generally incomplete, awareness of at least one method is fairly high. This is true even in regions characterized by low levels of contraception, such as sub-Saharan Africa. Yet while contraceptive

awareness is fairly uniform among women having different levels of education, the difference in contraceptive use as a factor of education is remarkably large. For instance, in five of the sub-Saharan African countries examined Burundi, Liberia, Mali, Senegal and Uganda the percentage of married women using contraception is four times higher among women with 10 or more years of education than among women having no formal schooling. Better-educated women have much higher rates of contraceptive use. They are also more likely to use effective methods and to rely on contraception at earlier stages of family formation (Valerie 2004).

Figure 3: Sample of the Respondents by their level of education



Majority of the respondents had primary education; they constituted 48.2 percent followed by 34.7 percent who had secondary education, those who had never had any formal education accounted for 9 percent while only 8.2 percent were the only one who had at least tertiary education. In this case, it is urged that the level of education indicates the level and degree of awareness, and this has a significant impact on the behaviors of women, especially those having HIV/AIDS.

4.2.4 Marital Status

Marriage exposes women to sexual relations, individual women are likely to respond to HIV/AIDS epidemic by delaying their first sexual intercourse, and for those already

sexually active reduce premarital sexual relations due to fear of infection. There is also a possibility of girls postponing their marriage or deciding not to marry at all. Those women married may decide to separate with unfaithful spouses to avoid infection. Due to increased death of partners, more women become widows, which reduce their reproductive lifetime. The widows and divorced women may find it more difficult than before to remarry for lack of suitors who fear possible HIV infection.

According to this study, four categories were generated for marital status, 81.5 percent of the respondents were married, while the least number of women interviewed fall into the category of divorced/ separated, this accounted for only 4.5 percent, the other categories were never married and widowed accounting for 8.5 and 5.5 percentages respectively as indicated in Table 4.1.

4.2.5 Main source of livelihood

The mother's occupation determines her behavior. In this case, it was found out from the study that 33.1 percent were practicing farming as their main source of livelihood, 31 percent of the respondents earned their livelihood from trading while 6.4 percent from doing casual labour, 10 percent were in public service, 19.5 percent entirely depended on the social support from NGOs as illustrated in Table 4.1.

Table 4. 1: Percentage distribution of the respondents by background characteristics

Category	Frequency	Percentage
Location/Residence		
Urban	45	45.5
Rural	54	54.5
Total	**100**	**100**
Age of the Respondent		
15-24	19	19.4
25-34	40	40.3
35-44	21	21.8
45+	18	18.5
Total	**100**	**100**
Highest Level of Education		
None	9	9.0
Primary	42	48.2
Secondary	34	34.7
Tertiary	8	8.2
Total	**100**	**100**
Marital Status		
Never Married	8	8.5
Married	81	81.5
Separated/Divorced	4	4.5
Widowed	5	5.5
Total	**100**	**100**
Main Source of Livelihood		
Farming	33	33.1
Trading	31	31.0
Civil service	10	10.0
Casual labour	7	6.4
Social support from NGOs	19	19.5
Total	**100**	**100**

4.2.6 Ever been pregnant

Women who have ever been pregnant are more likely to differ from those who have never been pregnant when it comes to contraceptive use. In this case, as presented in Table 4.2, the study involved 87.4 percent of women who had ever been pregnant, and only 12.6 percent of the respondents had never been pregnant.

4.2.7 Age at first pregnancy

When women who had ever been pregnant were asked a subsequent question about their age at first pregnancy, it was found out that, 14.5 percent first became pregnant before their 15th birth day, 30.8 percent became pregnant at the age of 16 and 17 years, 38 percent of the women who were interviewed first became pregnant at the age of 18 and or 19 years and they were the majority. Only 14.7 percent had their first pregnancy after the age of 20 signifying that there was high rate of teenage pregnancy.

4.2.8. Children ever born

The parity of the woman and the number of children she has ever produced makes her behavior different especially about the desired fertility, which interns affect the use of contraceptives. In this case, as presented by Table 4.2, out of the women who were asked interviewed, majority that is 39.8 percent had one to two children, followed by 35 percent having three to four children, 16.4 percent had had five or six children, while a minimum number of women culminating to only 8.8 percent had had 7 children and more.

Table 4.2; Percentage distribution of the respondents by intermediate variables

Category	Frequency	Percentage
Ever been Pregnant		
Yes	87	87.4
No	13	12.6
Total	**100**	**100**
Age at First Pregnancy		
<=15	15	18.6
16-17	25	30.8
18-19	23	28.0
20+	15	14.7
Total	**87**	**100**
Children Ever Born		
1 - 2 children	30	39.8
3 - 4 children	28	35.0
5 - 6 children	13	16.4
7 and more	5	8.8
Total	**87**	**100**

Impact of HIV Infection on Households in Acholi Sub Region Described

The study assessed the burdens of HIV on households and their leaders in Acholi sub region. The researchers, working, examined "HIV prevalence, and mortality among adult heads and non-heads of households" in a "community study of 100 adult women aged 15-49, residing in 100 households in 6 Sub counties" in the Acholi Sub region

The findings indicated there were 56 heads and 44 non-heads of households. "Interviews were then used to determine socio-demographic/behavioral characteristics," the researchers explained. "HIV prevalence was diagnosed by 5 districts within northern region," HIV infection in household heads and non-heads were high in relation to mortality was also assessed."

Results revealed that "HIV prevalence was 16.9 percent in the population, and 21.5 percent of households had at least one HIV-infected person "HIV prevalence was higher among heads than non-heads of households (21.5 percent and 13.3 percent, respectively" According to the study, "Most household heads were males (70.5 percent), and HIV prevalence was 17.8 percent among male heads compared to 6.6 percent in male non-heads of households." "Women heading households were predominantly widowed, separated, or divorced (64.4 percent). HIV prevalence was 30.5 percent among female heads, compared to 15.6 percent in female non-household heads" Published data indicated, "Age-adjusted mortality was significantly lower among male household heads than non-heads, both for the HIV-positive and HIV-negative men. Among women, HIV-negative female household heads had significantly higher mortality than HIV-uninfected female non-heads." "HIV disproportionately affected heads of households, particularly males," concluded the researcher. "Mortality due to AIDS is likely to increase the proportion of female-headed households, and adversely affect the welfare of domestic units."

CHAPTER FIVE:

SUMMARY, CONCLUSION AND RECCOMENDATION

Perfect knowledge of HIV/AIDS has become the burning issue of the day. The correct knowledge of HIV/AIDS in sub-Saharan Africa has long been a topic of interest to population research because of its apparent direct relationship with lack of health facilities and indirectly with the poverty.

The results of the study showed wide differences in specific knowledge about HIV/AIDS between rural and urban areas. To reduce the risk of HIV/AIDS spreading in the future to the general population, there is a strong need to provide full and specific knowledge to the general public, especially the rural population. The results showed that the wide urban-rural gaps in knowledge about HIV/AIDS diminished, when socio-demographic factors, especially education, occupation and media exposure, were taken into account.

The study shows that residence, sex, age, marital status, education, occupation and media exposure of respondents and prevention is the major factor/ contributors of HIV/AIDS. Media exposure has a statistically significant positive influence on correct knowledge of AIDS transmission and prevention, net of educational and occupational effects. This indicates that diffusion of knowledge on AIDS prevention could be successful with effective and efficient mass media coverage, given the existing infrastructure for long-term structural improvement in socio-demographic status of women.

Sound health education programmes through televisions, radios, newspapers and magazines should be made more accessible to the people with little education in rural areas. This indicates that various socio-economic and demographic factors have played a crucial role in influencing HIV/AIDS of Acholi Sub region in Northern Uganda. Though, it is difficult in poor setting Uganda, the regarding authority should take proper steps in improving the situation of education in rural areas as well as throughout the country. However, there is a real need for sufficient funding resources and manpower to advocate and implement the campaigns and needs for more in depth studies on this regard. Thus, necessary action is called for to reduce future level of HIV/AIDS in the country in order to achieve better living conditions in future.

Stigma enables people to believe they are not at risk for HIV. People who express stigmatizing attitudes about HIV often have retained misinformation about the transmission of HIV. While blatant stigma towards people living with HIV has declined in recent years, stigma still impacts HIV prevention efforts.

Recent surveys have demonstrated that people still believe that HIV can be transmitted by casual contact. 40% of people surveyed believed that sharing a drinking glass with a person living with HIV could put them at risk for HIV infection. 25-30% of people surveyed would be uncomfortable sending their children to school with children living with AIDS. Almost 20% of people surveyed believe that people, who were exposed to AIDS through sex or drug use, got what they deserved.

Stigma can be expressed at the instrumental and symbolic levels. Instrumental stigma is expressed through an individual's concern about his or her risks of contracting HIV through casual contact with people living with HIV/AIDS. Symbolic stigma is a vehicle for expressing religious, political, or other attitudes and values through one's perception of people living with HIV/AIDS. Stigma is closely associated with homophobia.

It is important to highlight the role of stigma in HIV prevention. Stigma is an important component of both individual and community-level responses to HIV prevention messages. An exploration of stigma and its effects should encourage the development of more effective HIV prevention messages. HIV prevention messages must counteract the phenomenon in which people disassociate their own personal behaviors with the risk of contracting HIV. The impact of stigma on women and communities of color has not been fully explored and requires additional researches.

The following list of recommendations is a summary of *Stigma: Breaking through the Misinformation*, a forum convened on January 26, 2001, by AIDS Action in cooperation with the Centers for Disease Control and Prevention.

Develop a Greater Understanding of Stigma and Its Relationship to Homophobia

People who are homophobic are more likely to express stigma towards people living with HIV/AIDS. Stigma can also be closely related to racism, classism, ageism, and gender-based prejudices. Confronting homophobia is a critical step in addressing and reducing stigma.

Work within a Cultural Framework to Address Stigma

All cultures have value systems that may conflict with some components of HIV prevention. HIV prevention is by its very nature explicit about sexual activity and drug use. Stigma needs to be addressed at the community level in order to minimize its impacts on HIV prevention services. Rather than rejecting cultural values, HIV prevention providers should focus on the expression of those attitudes and encourage positive, culturally-appropriate messages about HIV prevention. For example, HIV prevention providers can encourage those voices within the community that are striving to create positive, non-stigmatizing messages. Or facilitate collaboration between communities that are seeking to mobilize a non-stigmatized response to the AIDS epidemic. While it is critical to challenge cultural norms that encourage stigma, wholesale rejection of cultural norms is not likely to be a successful strategy.

Meet People in Their Communities to Provide HIV Prevention Services

HIV prevention providers have found that it is critical to locate HIV prevention programs within the targeted communities, rather than offering services at a remote location. In order to identify participants for HIV prevention programs, one AIDS service organization has successfully conducted outreach in collaboration with local Parent-Teacher Associations and tenant associations. Once the target population has been identified, it is important that individuals who the community can relate to deliver the HIV prevention messages. Only then can providers begin to address the diverse needs of their targeted population. Questions and concerns regarding HIV may be significantly

less important to the community members than meeting their basic needs or exploring other issues.

Providing HIV prevention services within the community that meet the community's needs are particularly relevant to conducting HIV prevention with youth. Sex education in schools is an ideal time to discuss HIV prevention and education. In September 2000, a Kaiser Family Foundation study found that a majority of parents want their children to receive comprehensive sex education, including HIV prevention, in school from trained educators who are comfortable conducting age-appropriate discussions about sexual and risk-taking behaviors. Community-based organizations can provide HIV prevention education and outreach to youth as well as assistance to parents who are seeking guidance in exploring these sensitive issues with their children.

Successful HIV Prevention Outreach May Not Even Mention AIDS

HIV prevention providers have found that HIV prevention is not the highest priority in the lives of the people they serve. It is important to meet the needs of the targeted population first. In various communities, from youth to African-American and Latina women, prevention providers have found that providing a safe space in the community for a discussion of meaningful issues can engender trust between HIV prevention providers and the community. After gaining that trust, HIV prevention providers can begin to discuss HIV transmission. HIV testing may be the last component of HIV prevention programs.

Normalize HIV Testing

There are various immunizations and screenings that are provided to individuals at their physician's offices. Why isn't HIV testing one of those screens? While there are significant issues with insurance coverage of HIV testing and confidentiality of test results, the normalization of HIV testing could increase the number of individuals living with HIV who know their status.

Target Prevention Messages at People Who Are HIV+ and HIV-

Diverse communities are responsive to very different HIV prevention messages. In order to reach different communities at risk for HIV, it is critical that a variety of HIV prevention messages are available. HIV prevention messages are most effective when they are ongoing and consistent, although they should vary in venue and presentation. Stigma also impacts people living with HIV/AIDS and may prevent them from seeking prevention services. The development of prevention messages for people living with HIV/AIDS must acknowledge AIDS stigma and promote non-stigmatizing images of people living with HIV/AIDS.

Increase Cultural and Media Exposure of People Living with HIV/AIDS

Exposure to the personal experiences of people living with HIV and AIDS can have a profound impact on individual and community perceptions of HIV/AIDS. Similarly, media representation of people living with HIV/AIDS increases cultural exposure to AIDS and may reduce some of the stigma surrounding the disease. Both national and

local media can provide opportunities for people living with HIV/AIDS to share their life experiences with a broader audience.

Increase Coordination between Community-Based Organizations, Funders and HIV Prevention Providers

All of the recommendations discussed above are components of successful HIV prevention strategies that reduce stigma and reach communities in need. In order to combat stigma, it is important for all of the interested parties to work together to promote a greater understanding of, and exposure to, HIV/AIDS. While stigma is a product of broader social problems such as homophobia, illness, and ignorance, it is imperative to address stigma in HIV prevention immediately in order to limit the number of new HIV infections in this country.

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APPENDIX 1:

Selected questions from the Research tool / Questionnaire

Section A: Informed Consent

Good morning/ Good afternoon? My name is Kipwola Alice Opio, a student of Kampala International University pursuing degree in Bachelor of Guidance and Counselling. I am carrying out a study on the effects of HIV/AIDS on women in Acholi Sub region. As part of the requirements for my course, I am required to conduct a study that could also be useful to the University and this community, as it will generate useful information. Be free because there no wrong answer and I pledge that the information given to me will be kept confidentially.

Would you like to participate in this interview?

1. Yes (Continue with the interview)
2. No (Terminate the interview and look for another respondent)

Section B: General individual information

No	Question	Responses (*Tick and fill in where appropriate*)
Q.1	How old are you? (age in completed years)	1. 15-29 2. 30-49 3. 50+s
Q.2	Have you ever been married?	1. Yes..... 2. No.....
Q.3	What was your age at the time of first marriage?	.....
Q.4	What is your current marital status?	1. Never married ..... 2. Married ..... 3. Divorced/Separated ..... 4. Widowed .....
Q.5	Location of the usual residence	1. Urban.....

		2. Rural.....
Q.6	How long have you lived in this residence continuously?(*Enter 00 if less than one year*)	1. Less than 1 year..... 2. 1-5 years..... 3. 6-10 years..... 4. More than 10 years.....
Q.7	Did you attend any educational institution?	1. Yes ..... 2. No (skip to Q.9).....
Q.8	What is the highest level of education achieved?	1. None ..... 2. Primary..... 3. Secondary..... 4. Tertiary.....

Section C: Household Characteristics and source of income		
Q.9	What is your main source of livelihood?	1. Farming..... 2. Trading..... 3. Civil service..... 4. Casual labour..... 5. Social support from NGOs..
Q.10	Were you engaged in any economic (Income generating) activity during the last month? *(Work without pay in family business is also classified as engagement in economic activity)*	1. Yes ..... 2. No.....
Q11	How many people dwell in your household?	1. Only me 2. Me and my husband 3. Me, my husband and children
Q12	Who supports you in case you get any problem related to HIV?	1. Health worker..... 2. Husband..... 3. Friends..... 4. Relatives.....
Q13	What psychosocial problems you are experiencing in this community	1. Violence from husbands 2. Lack of children school fees 3. Lack of food 4. Others specify
Q14	How are you coping with the situation?	5. Through Counseling 6. Support/peer groups 7. Get help from NGOs 8. Get help from the Government
Q15	What kind of support given to you by the family, community and any other stakeholders?	1. Counseling 2. Food supplement 3. Treatment 4. School fees 5. Other specify--------

Section D: Fertility & HIV/AIDS		
Q.16	Have you ever been pregnant?	1. Yes..... 2. No .....
Q.17	How many children have you ever produced all together?	1. Number of Females..... 2. Number of Males.....
Q.18	Are you pregnant?	1.Yes..... 2.No ..... 3.Do no know .....
Q.19	Do you relate well with other community members	1. Yes ..... 2. No .....
Q.20	Do you think that there are factors that render women vulnerable to HIV/AIDS	1. Yes..... 2. No.....

THANK YOU FOR YOUR TIME