BackGround
REPORT

Partnership in Improving Reproductive Health

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Stigma Towards People with the AIDS Virus - A Case Study in Ethiopia*

Abstract

This paper demonstrates the importance of addressing AIDS-related stigma as a component of HIV/AIDS prevention. We argue that educational efforts have been partially handicapped because they have primarily focused on elevating risk perception by emphasizing how AIDS is fatal and contagious. This emphasis contributes to stigmatizing behavior by generating irrational fears directed at AIDS victims. Given the synergy between AIDS-related stigma and the spread of the disease, educational campaigns should be modified to reduce stigma in conjunction with providing basic knowledge about the disease.

Background

Although many regard the 20th century as an epoch of major developments in science and technology, science has not yet triumphed over HIV/AIDS. Development of either a preventive vaccine or a curative drug is still remote. From a preventive point of view, promoting communication and disseminating knowledge about the HIV/AIDS virus, and encouraging social support to AIDS patients, are important actions for halting the further spread of HIV infection.

The high death toll of AIDS and the consequent social and economic costs of the disease are increasing every day. By the end of 1999, a total of 18.8 million people around the world died of AIDS, 34.3 million people were estimated to be living with HIV, and 13.2 million children were orphaned because of AIDS.[1] The burden of HIV/AIDS is heaviest in sub-Sahara Africa. Constituting only one-tenth of the world's population, sub-Sahara Africa alone hosted more than 70 percent (24.5 million) of the people with HIV. The prevalence of HIV infection among adults in the sub-regions of Africa varies substantially [from 35.8% in Botswana and 25% in Swaziland and Zimbabwe in southern Africa, to 1.4% in Niger and 1.8% in Senegal in western Africa]; the prevalence of HIV in Ethiopia is 10.6 percent. With its relatively large population (65 million) Ethiopia hosts the third largest number of HIV/AIDS victims in the world.[2]

The rapid spread of HIV is a matter of much concern in sub-Sahara Africa in general, and in Ethiopia in particular. The first HIV case in Ethiopia was identified in 1986. By the end of 1999, the estimated number of HIV cases had risen to three million. In an effort to slow the spread of HIV infection, governmental and non-governmental organizations have launched educational efforts to increase HIV awareness and knowledge. However, two decades after the disease emerged, negative attitudes and general neglect are widespread reactions to HIV/AIDS victims. Policy advocates question what messages

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messages are being disseminated, and how effective those messages are in increasing public awareness and knowledge of HIV/AIDS and ultimately in stopping the spread of HIV.

In general, the AIDS education messages being disseminated in Ethiopia emphasize that HIV/AIDS is contagious and fatal, and identify the modes of HIV transmission and the means of prevention. To date little to no emphasis has been given to caring for HIV positive people. Because AIDS is presented in the educational campaigns as a disease that is primarily transmitted by risky behaviors, fear is a common response to news of HIV/AIDS. For example, the idea that HIV can be acquired through casual contact is still common and may become even more entrenched with the spread of fear regarding HIV/AIDS. Moreover, educational programs have not been able to reduce the stigma (intense negative reactions) attached to HIV/AIDS victims. As long as negative attitudes toward people with HIV/AIDS continue to prevail, people who do not know their HIV status may be reluctant to have their blood screened. People who are HIV positive but do not know their status may become a source of transmission for the disease. Moreover, those who know they are HIV positive may be unwilling to disclose their status to others or to change their sexual behavior out of fear that they may unwittingly reveal their HIV positive status to others. Appropriate measures should be taken to reduce the stigma attached to HIV/AIDS in order to effectively promote preventive activities. For example, the final report of the 2001 African Development Forum (ADF) clearly stated that stigma should be dealt with in an effective and appropriate manner to increase the success of preventive efforts.[4]

This paper examines the relationship between knowledge about modes of HIV transmission and stigmatization of people with AIDS. We measure knowledge using a 14 point scale, and we define stigma as having negative reactions (hate or avoidance) toward people with HIV. Because recent educational activities have focused primarily on increasing awareness of modes of transmission and as a result have generated fear regarding HIV/AIDS, we hypothesize that increased knowledge of HIV/AIDS is actually associated with a greater likelihood of stigmatizing AIDS victims.

Data Source and Analysis

This paper uses data from the 2000 Amhara Reproductive Health Survey, which was conducted in three zones in the Amhara region - Debub Wello, Oromia, and Semen Shewa. The survey interviewed 4,710 women aged 15-49. The analysis uses data for 3,714 women who reported they were aware of HIV/AIDS. We use logistic regression models to identify factors that are associated with the stigmatization of HIV/AIDS victims.

Distribution of Respondents

Table 1 presents the distribution of the variables that we use in our analysis. We define stigma as a 0-1 dummy variable that equals one if the respondent answered yes to the question "Would you hate or avoid someone very close to you if s/he told you that s/he has AIDS?" Close to 29 percent of respondents said yes to this question. To measure knowledge, we used the responses from 14 questions on modes of HIV transmission, methods of HIV protection, and myths and misconceptions related to HIV/AIDS. We assigned each accurate response one point and summed the responses to produce a composite knowledge score that ranges from 0-14. The mean knowledge score is 4.1 and the standard deviation is 4.7. The distribution of responses to individual questions indicate that women in general are poorly informed about HIV/AIDS (full results not shown here). Close to 45 percent of the respondents said they had heard of HIV/AIDS but did not know anything about the modes of transmission. Many women also had misconceptions about HIV transmission. For instance, 25 percent of the respondents believed that mosquitoes can transmit the virus and 74 percent believed a healthy-looking person cannot have the virus.

Table 1. Distribution of Variables Used in Analysis of HIV/AIDS Stigma, Ethiopia 2000 Amhara Reproductive Health Survey.

Variable Labels	%
Outcome	
Stigma	28.8
HIV/AIDS knowledge variables	
Knowledge Score *(MEAN)*	4.1
Knows someone with HIV/AIDS	7.8
Responsibility for acquiring HIV/AIDS	
Own fault	10.8
Lacked parental control	13.4
Lacked advice	19.6
Source of information about HIV/AIDS	
Radio/TV	15.7
Leaflet/brochure	30.6
Intimates	70.0
Social gathering	35.0
Youth club/school/college	10.9
Health worker/CBD agent	13.5
Fear HIV/AIDS	56.1
Socio-demographic control variables	
Age group	
15-29	47.2
30-39	27.7
40-49	25.0
Religion	
Muslim	
Christian	
Education	
Illiterate	74.4
Primary	21.1
Secondary and above	4.5
Work status	
Not economically active	
Working at home	28.2
Working out of home	11.2
Place of residence	
Urban	23.1
Rural	76.9
Zone of residence	
Oromia	20.2
Debub Wello	41.8
Semen Shewa	38.0
Number of observations	**3,714**

About eight percent of the respondents said they know someone with HIV/AIDS. When asked where the blame should be placed for acquiring HIV/AIDS, 11 percent thought it was the victim's fault, 13 percent thought it was due to a lack of parental control, and 20 percent felt it was due to a lack of good advice. The single most important source of information about HIV/AIDS was intimates such as friends, relatives, or a spouse, followed by social gatherings (35.0%) and leaflets or brochures (30.6%). Radio and TV announcements, youth or school clubs, and health workers were only mentioned by roughly 10 to 16 percent of the respondents. Finally, slightly over one-half (56.1%) of the respondents said they would be fearful of someone with HIV/AIDS.

Regression Analysis

An initial assessment of the data showed that knowledge about HIV/AIDS is associated with stigma in a surprising way: an increase in knowledge leads to an increase in stigma towards persons having HIV/AIDS. Since this association could be due to factors that mediate between these two variables, we carried out a multivariate analysis to examine the effects of all variables simultaneously. We estimated models with and without the effect of *fear of HIV/AIDS* to determine whether knowledge had an effect on stigma independent of fear.

Table 2 presents the results of the logistics regressions. When we exclude fear from the model (Model I), knowledge about HIV/AIDS is significantly associated with a greater likelihood of stigmatizing someone with AIDS. This result is consistent with our hypothesis: greater knowledge of HIV/AIDS, as it is measured in Ethiopia, increases the chances that someone stigmatizes others with HIV/AIDS. Believing that having HIV/AIDS is one's own fault or is due to a lack of parental control (i.e., the victims were deviant or unable to be controlled by their parents) is also associated with significantly greater likelihood of stigmatizing someone with AIDS. On the other hand, respondents who think that people get infected with HIV because they lack advice or knowledge about how to protect themselves are less likely to stigmatize HIV/AIDS victims. Therefore, while knowledge of HIV/AIDS is associated with stigmatizing AIDS victims, those who are more sympathetic to HIV/AIDS victims feel that good advice and knowledge

would have helped the victim avoid contracting HIV in the first place. Sources of information also have significant impact on stigma. Women who obtain their information about HIV/AIDS through leaflets/brochures or social gatherings are more likely to stigmatize victims, whereas women who obtain their information through radio/TV or from intimate friends or family members are less likely to stigmatize victims.

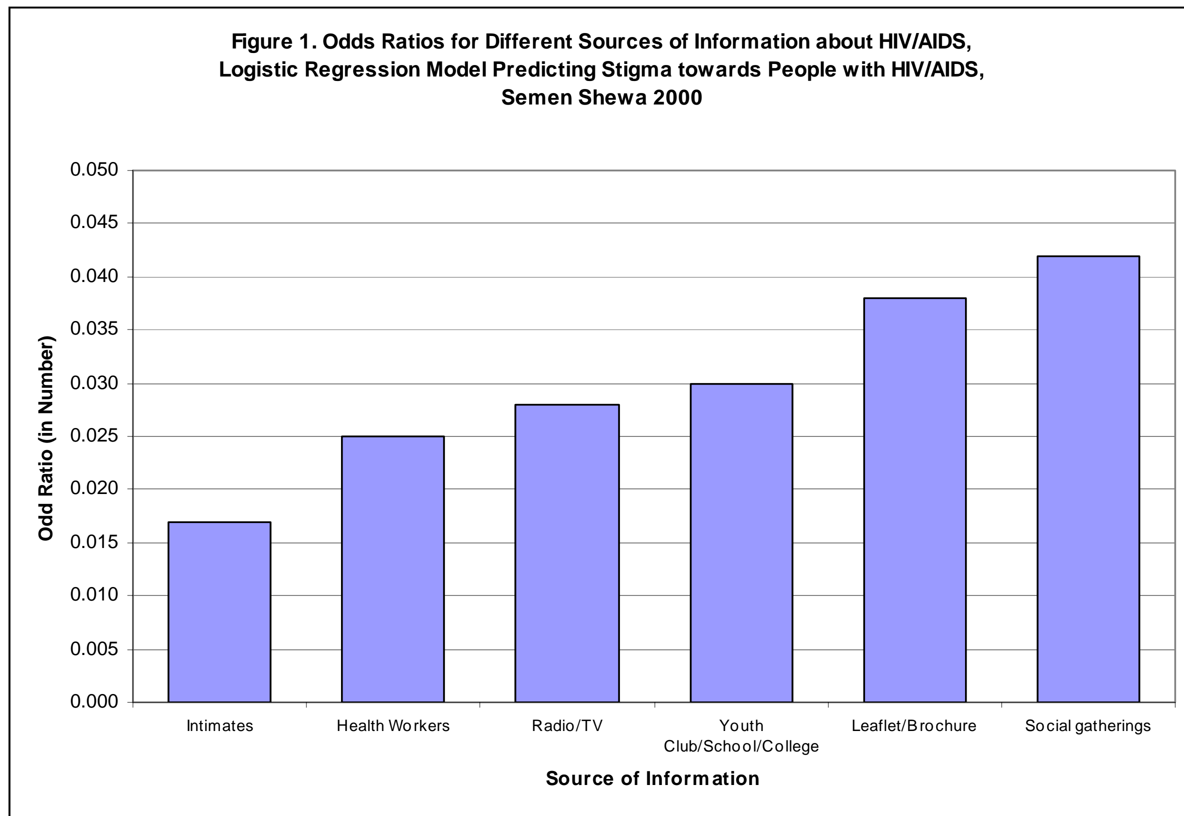
With respect to background characteristics, Christians are less likely to stigmatize HIV/AIDS victims than Muslims, as are women with primary or secondary education compared to women with no education. Women who work at home are also less likely to stigmatize AIDS victims compared to women who do not work, although women who work outside of the home are not different from women who do not work in terms of their reaction to people with AIDS. Urban residents are also less likely to stigmatize HIV/AIDS victims.

Once we include *fear of HIV/AIDS* as a predictor variable (Model II), knowledge of HIV/AIDS is no longer significant in predicting stigma towards AIDS victims. However, fear is an extremely powerful predictor, and in fact fear of HIV/AIDS is very strongly correlated with stigmatizing HIV/AIDS victims. Women who fear HIV/AIDS are sixty times more likely to stigmatize AIDS victims than women who do not fear HIV/AIDS. The effects of the other variables in the model are relatively unaffected by the inclusion of *fear* in the model, including sources of information. For instance, after we control for the effect of fear, there remains significant variation in the effects of different sources of information on the likelihood of stigmatizing HIV/AIDS victims (see Figure 1).

Table 2.
Odds Ratios from Logistic Regression Models Predicting Stigma toward Persons with HIV/AIDS, Ethiopia, 2000 Amhara Reproductive Health Survey.

Variable Labels	MODEL I	MODEL II
HIV/AIDS knowledge variables		
HIV/AIDS Knowledge score	1.28**	1.02
Knows someone with HIV/AIDS	1.04	1.00
Responsibility for acquiring HIV/AIDS		
Own fault	3.08**	2.69**
Lacked parental control	5.77**	4.35**
Lacked advice	0.73*	0.56**
Source of information about HIV/AIDS		
Radio/TV	0.58**	0.60**
Leaflet/brochure	1.26*	1.12
Intimates	0.57**	0.66**
Social gathering	1.41**	1.41**
Youth club/school/college	1.04	0.99
Health worker/CBD agent	0.84	0.83
Fear HIV/AIDS		59.74**
Socio-demographic control variables		
Age group (reference=40-49 years)		
15-29	1.14	1.15
30-39	1.17	1.15
Religion (reference=Muslim)		
Christian	0.57**	0.64*
Education (reference=Illiterate)		
Primary	0.73*	0.74*
Secondary and above	0.42**	0.48**
Work status (reference=not economically active)		
Working at home	0.64**	0.59**
Working out of home	1.10	1.05
Place of residence (reference=rural)		
Urban	0.77*	0.78*
Zone of residence (reference=Semen Shewa)		
Oromia	0.45**	0.87
Debub Wello	0.49**	0.67*
Degrees of Freedom	21	22
Likelihood Ratio Chi-square	1301.6**	1700.7**
Number of observations	3,714	3,714

*p<0.05, **p<0.005



Policy Implications

Our analysis demonstrates that knowledge about HIV/AIDS in Ethiopia is associated with a greater likelihood of stigma toward AIDS victims. To date, the only intervention in Ethiopia to halt the spread of HIV/AIDS is AIDS-related education including the promotion of safe sexual behavior. The central messages of the sexual education programs have been "abstain," "be faithful," and "use condoms." These messages mainly focus on how to raise awareness of the risks of contracting HIV by alerting the population about the dangers of the disease. The downside of the educational messages is that they have generated and reinforced fear of HIV/AIDS, which in turn has led to stigma towards AIDS victims. So far, the education campaigns have not addressed the issue of stigma, which is believed to be an important component of successful preventive campaigns.[5] Given that stigma is an obstacle to effective preventive efforts, education programs to date are partially handicapped. In order for preventive efforts to succeed, we need to modify education campaigns. In conjunction with raising risk awareness, education campaigns need to address the issue of stigma.

This study also has implications for how information regarding HIV/AIDS should be disseminated. The majority of the population acquires their knowledge about HIV/AIDS through informal contacts. Those who receive information from intimates are less likely to stigmatize AIDS victims, whereas those who receive their information from social gatherings are more likely to stigmatize AIDS victims. Information disseminated through youth clubs, schools, and colleges does not appear to promote nor discourage stigmatization. Because AIDS is differentially viewed from moral, cultural, and political perspectives, AIDS information can be ambiguous or misleading depending upon who disseminates the information. The challenge is to ensure that the information disseminated is accurate and non-stigmatizing.

Given that information is commonly and quickly transmitted at social gatherings, we should exploit the full potential of social gatherings for disseminating accurate and non-stigmatizing HIV/AIDS information. This mechanism has the important advantage of being highly cost effective.

Recommendations

- The overall level of knowledge about HIV/AIDS is low; therefore, in order to raise knowledge levels, comprehensive education campaigns providing basic knowledge about infection and protection should be continued.
- Education promotion should recognize that stigma is a component of prevention activities, and hence appropriately tailored non-stigmatizing messages should be included in all educational materials.
- Since information is commonly and quickly disseminated at social gatherings, educational programs should take full advantage of social gatherings as a medium for disseminating *accurate* information. Working through this mechanism has the significant advantage of being cost effective.

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The Partnership in Improving Reproductive Health Background Reports present findings from work in progress on the dimensions and determinants of fertility and reproductive health in Ethiopia. This work is being conducted by faculty and advanced graduate students at the following institutions:

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