

HIV/AIDS related discrimination among females aged 15-24 in Lesotho

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Abstract

In many developing countries, stigma and discrimination together pose most significant challenges towards stemming the spread of HIV/AIDS. Although Lesotho has one of the highest HIV/AIDS prevalence in the world, there is little or no research about how people living with HIV/AIDS or are suspected of living with HIV/AIDS are perceived and treated. The paper utilised data from the Lesotho 2000 End Decade Multiple Indicator Cluster Survey and the 2004 Lesotho Demographic and Health Survey to address the three fold primary objective of the paper. The paper first compared attitudes of females aged 15-24 towards people who are HIV positive or are suspected of being HIV positive between 2000 and 2004. Secondly it assessed whether knowledge about transmission of and protection against HIV/AIDS has improved overtime. Lastly it examined the factors that are associated with HIV/AIDS-related discrimination. Using both descriptive and multivariate logistic regression to analyse the data, the findings of the paper indicate that HIV/AIDS-related discrimination declined by 12 percent overtime, knowledge about means of transmission of and protection against HIV/AIDS increased by 20 percent, while knowledge of means of transmission and protection against HIV/AIDS translated into reduced levels of HIV/AIDS-related discrimination. Multivariate analysis confirmed that HIV/AIDS-related discrimination had declined between 2000 and 2004 while education was identified as one of the most important factors associated with HIV/AIDS-related discrimination. The conclusion of the paper is that efforts to educate the public about HIV/AIDS are transforming the attitudes of the general population towards people who are HIV positive or are suspected of being HIV positive.

Introduction

AIDS stigma and discrimination continue to affect those living with and affected by HIV especially in Southern Africa where the burden of AIDS is significant. Many health care workers in this region have come to the conclusion that unless stigma is conquered, the illness will not be defeated (University of California San Francisco (UCSF) n.d). UN Secretary-General Ban Ki Moon says:

Stigma remains the single most important barrier to public action. It is a main reason why too many people are afraid to see a doctor to determine whether they have the disease, or to seek treatment if so. It helps make AIDS the silent killer, because people fear the social disgrace of speaking about it, or taking easily available precautions. Stigma is a chief reason why the AIDS epidemic continues to devastate societies around the world (AVERT, 2009:1)

According to UNAIDS (2008a), at the level of 23 percent, Lesotho has the third highest adult HIV prevalence in the world. UNAIDS (2008a:7) estimated that at the end of 2007 there were 270,273 people living with HIV in Lesotho as well as 62 new HIV infections and about 50 deaths due to AIDS each day. In addition females continue to be more infected than their male counterparts. According to the sentinel surveillance conducted in 2007 there is no major difference in HIV prevalence among women attending antenatal care (ANC) clinics while a slight downward trend in the HIV prevalence among the 15 to 24 year old people was observed. UNAIDS further estimated that 81,270 people were in need of ART at the end of 2007.

Lesotho declared the HIV/AIDS epidemic a crisis in 2000. Since then Lesotho has aggressively put in place a number of programmes aimed at arresting the pandemic situation. First, Lesotho AIDS Programme Coordinating Authority (LAPCA) was established within the office of the Prime Minister in 2001 to coordinate and oversee national efforts to address the HIV epidemic. In 2005 a more autonomous body, the National AIDS Commission (NAC) replaced LAPCA. The national HIV/AIDS policy was adopted in 2006. Basotho are encouraged to know

their status while ministries commit 2 percent of their annual budgets towards mitigating against HIV/AIDS pandemic. What still remains to be answered is whether all these efforts have translated into more knowledge about how HIV/AIDS are transmitted and how people can protect themselves against HIV/AIDS.

Government efforts notwithstanding, HIV/AIDS continue to be a problem among Basotho (UNAIDS, 2008a). HIV/AIDS are leading causes of death among both males and females and second leading cause of death among children after pneumonia (Ministry of Health and Social Welfare, 2008). HIV/AIDS is also the second leading cause of admission among males and females after injury and other trauma and abortion respectively for males and female. Among children HIV/AIDS is the third cause of admission after pneumonia and diarrhoea and gastroenteritis (Ministry of Health and Social Welfare, 2008). If the government of Lesotho is to meet the set MDG target of halting and reversing the spread of HIV/AIDS by 2015 and other international commitments the issues surrounding AIDS stigma should be known and effectively dealt with. Otherwise the set programmes at different levels are liable to failure. Obviously Lesotho needs to perfect its strategies in the fight against the pandemic and empirical research is one such tool, hence the present paper.

Studies such as "Perceived HIV/AIDS Stigma: A Multinational Study n.d." carried out by UCSF have shown that stigma negatively impacts on prevention, on accessing treatment, and on care programmes. Decreasing stigma is therefore an important goal in HIV/AIDS programmes. Stigma not only makes it more difficult for people trying to come to terms with and manage their illness on a personal level, but it also interferes with attempts to fight the AIDS epidemic as a whole. Regardless of how well disclosure experiences have gone in the past, many people with HIV fear that they risk a stigmatizing response with each disclosure. This potential of stigmatization might also make people less willing to be tested for HIV, which in turn might interfere with prevention and early treatment efforts (Berger, Ferrans, and Lashley, 2001;

Holzemer and Uys, 2004 cited in Hlabana 2007). On a national level, the stigma associated with HIV can deter governments from taking fast, effective action against the epidemic, whilst on a personal level it can make individuals reluctant to access HIV testing, treatment and care (AVERT, 2009). Furthermore, for people to participate in the “Know Your Status” campaign, HIV/AIDS-related discrimination should be non-existent. Moreover, as long as some sections of the population within communities are unfairly treated and or discriminated against due to their actual or suspected HIV/AIDS status as suggested by past research findings (Letamo, 2004), more people will suffer silently instead of taking advantage of anti-retroviral treatment.

The fact that Lesotho in 2006 amended the Labour Code to prevent employers to discriminate against people living with HIV or suspected of being HIV positive, suggests that there is HIV/AIDS-related discrimination among Basotho. Furthermore, national surveys such as the 2004 Lesotho Demographic and Health Survey (LDHS) to a large extent indicate some level of HIV discrimination. Moreover, research elsewhere has documented that some sections of the population within communities are unfairly treated and or discriminated against due to their actual or suspected HIV/AIDS status (Letamo, 2004).

Objectives and Justification

The two surveys of 2000 and 2004; present an opportunity for one to assess the extent to which government efforts in the fight against the pandemic are bearing fruit.

Although information that could be used to investigate discrimination towards people living with HIV or suspected of being HIV positive was collected in the past, a few quantitative studies such as the 2004 LDHS have investigated factors associated with HIV/AIDS related discrimination among Basotho. With the view of filling this gap in the body of knowledge, the primary objective of this paper is three fold. First, it measures and compares attitudes of females aged 15-24 towards people who are HIV positive or are suspected of being

HIV positive between 2000 and 2004 in Lesotho. The comparison is meant to establish whether efforts to educate the public about HIV/AIDS are contributing towards lowering levels of HIV/AIDS related discrimination. The main thrust is to establish if knowledge about protection against or transmission of HIV/AIDS is associated with low levels of HIV/AIDS-related discrimination. This is important in the fight against the HIV/AIDS pandemic given that Lesotho has the third highest level of HIV prevalence in the world. Second, the paper assesses whether there is evidence that knowledge about means of transmission and protection against the pandemic have improved. Third, the paper examines the factors that are associated with HIV/AIDS-related discrimination. The results of the paper can go a long way in helping policy and decision makers to perfect their strategies in the fight against the pandemic.

Methods

Sources of data

Data from Lesotho 2000 End Decade Multiple Indicator Cluster Survey and Lesotho 2004 Demographic and Health Survey are used for the analysis in the paper. Both studies were nationally representative with a combined sample size of 3191 respondents (1762 respondents for 2000 survey and 1429 respondents for 2004 survey). Details of the sampling methodology for the two studies can be found in 2000 survey report (Bureau of Statistics, n. d) and 2004 survey report (Ministry of Health and Social Welfare (MOHSW, Lesotho), Bureau of Statistics (BOS), and ORC Macro., 2005). Both surveys solicited information from male and female respondents. However, the 2004 DHS file that the authors have access to has only female respondents. For comparisons reasons, the male respondents were left out from the 2000 survey sample.

Variables

Two questions are used to measure discrimination or stigma. The first question was whether the respondent can buy from a vendor who is HIV positive. The second question was whether an HIV positive teacher should be allowed to continue teaching.

The first question was identical in both surveys. The second question was not identical in the two surveys. In the 2000 survey, respondents were asked whether a HIV positive teacher should be allowed to teach while in the 2004 survey the question was asked separately for a male teacher and a female teacher. The difference in the way the question was asked is not viewed as something that can pose a problem for the intended analysis. Using these two questions, a respondent is classified as discriminatory if the response to one or both questions is negative. That is the respondent would not buy from a vendor who is HIV positive or an HIV positive teacher should not be allowed to continue to teach. Respondents who did not know whether they would buy from an HIV positive vendor or whether an HIV positive teacher should continue with teaching were excluded from the analysis. Additional questions such as willingness to care for a family member who is ill with HIV/AIDS or whether or not it should remain a secret if a family member got infected with HIV/AIDS were included in the 2004 Demographic and Health Survey which are normally used to estimate the level of HIV/AIDS-related discrimination but had not been used in the present paper since they were not included in the 2000 survey.

Several questions were used to measure knowledge of how HIV/AIDS can be transmitted as well as how individuals can protect themselves against the disease. The question of transmission of HIV from mother to child during pregnancy was asked differently in the two surveys. During the 2000 survey, respondents were asked whether the AIDS virus can be transmitted from mother to child during pregnancy while during 2004 respondents were asked whether medicine exists for prevention of mother to child transmission during pregnancy. Notwithstanding the differences in the way the question was asked between the two surveys, the authors felt that the differences would not bias the results. Transmission of HIV/AIDS through witchcraft and protection offered by abstaining from sex are the two questions that were asked in the two surveys and have been used to measure knowledge about transmission of and protection against HIV. Respondents were also asked whether a healthy looking person can be HIV

positive and the question was in both surveys. This question was also used to measure knowledge about HIV/AIDS. Protection through having one uninfected partner or use of a condom during sexual intercourse was asked in both surveys and the information is used to measure knowledge of HIV/AIDS. Transmission of the HIV virus through mosquito bites was yet another piece of information used to measure HIV/AIDS knowledge.

Access to mass media is another variable used in the paper. During the 2000 survey respondent can be classified as whether they were residing in a household which owns a working TV or radio or both. During the 2004 survey, the enquiry went further than presence of a working TV and or radio and asked respondents for the frequency of watching TV and listening to the radio. To ensure comparability of the results between the two surveys, presence of a working TV and or radio is used as a measure of access to mass media. During the 2004 survey respondents were also asked for their frequency of reading newspapers as another measure of access to mass media. Since frequency of reading papers was not in the 2000 survey, this information is not used in the present paper.

Methods of analysis

Both bivariate and logistic regression methods were used. At the bivariate level, prevalence of discrimination was compared between the two surveys using socio-demographic information as well as knowledge of HIV/AIDS as control variables. Prevalence differences were tested for statistical significance. Logistic regression was used to evaluate the effect of predictor variables on the probability of expressing discriminatory attitudes towards people who are HIV positive or are believed to be HIV positive. Three separate models were used for 2000 survey data, 2004 survey data and for both data sets combined.

Results

Characteristics of the paper population

Table 1 presents characteristics of the paper population. For the whole sample few respondents had no formal education while

at least half had primary education. The majority of the respondents were residing in the rural areas and according to ecological zone the lowlands had the largest share of the population followed by mountains and then foothills. Senqu River valley had the smallest population residing within it. For 2000, the population is equally distributed between age groups 15-19 and 20-24 while in 2004 only less than 20 percent of respondents were aged 15-19. As regards marital status, in 2000 the never married were the majority followed by those currently married and previously married were the least. The opposite was the case in 2004 where the currently married were the majority followed by those who were never married. There were also ecological zone distribution differences between 2000 and 2004.

Table 1: Characteristics of the Paper population.

Characteristic		2000		2004	
		%	N	%	N
Education	No education	1.8	32	0.5	13
	Primary	48.6	886	54.8	606
	Secondary or better	49.6	869	44.6	794
Rural	Maseru Urban	14.6	261	10.9	70
Urban	Other urban	13.3	237	10.8	301
Residence	Rural	72.1	1289	78.3	1042
Ecological Zone	Foothill	10.9	195	10.5	637
	Mountain	19.1	341	20.7	193
	Senqu River Valley	4.0	72	7.2	420
	Lowland	66.0	1179	61.6	163
Age	15-19	44.5	796	54.8	781
	20-24	55.5	991	45.2	632
Marital Status	Never Married	56.8	1015	64.4	898
	Married	39.5	712	31.9	469
	Previously Married	3.4	60	3.7	46

Knowledge about means of protection and transmission

Generally speaking, knowledge about means of HIV transmission has improved overtime. On the average, the proportion of respondents reporting that HIV can be transmitted through witchcraft decreased by 5 percentage

points between 2000 and 2004 and the decline is statistically significant. Across all the socio-demographic variables there is a statistically significant decline in the proportion of respondents reporting that HIV can be transmitted through witchcraft (see Table 2). The highest decline of 16 percent was recorded among residents of the Senqu River Valley, while in the majority of cases the decline is between 5 and 10 percent.

Table 2: Respondents (%) who reported that AIDS can be transmitted through witchcraft by selected socio-demographic variables

Variable		2000	2004	Difference ⁺
Educational Attainment	no education	4	0	4
	Secondary or better	9	3	6**
	Primary	11	6	5*
Rural-Urban Residence	Other Urban	9	3	6*
	Maseru Urban	13	4	9
	Rural	9	5	4**
Region	Foothill	12	4	8**
	Mountain	9	4	5
	Senqu River Valley	19	3	16**
	Lowland	9	5	4**
Respondent listens to a Radio	No	12	5	7*
	Yes	9	5	4**
Respondent watches TV	Yes	9	5	4
	No	10	6	4**
Age	15-19	12	5	7**
	20-24	9	5	4**
Marital status	Previously Married	12	4	8
	Never Married	10	3	7**
	Married	9	6	3*
Total		10	5	5**

Notes: ** denotes that differences in discrimination between 2000 and 2004 are significant at 1% while * denotes that differences are significant at 5%. + The difference is calculated by subtracting 2004 figure from 2000 figure.

Knowledge about protection against HIV/AIDS offered by abstinence has also improved between 2000 and 2004. The proportion of respondents reporting that abstinence offers protection against HIV/AIDS increased by 20 percentage points on the average between 2000 and 2004 and the increase is

statistically significant. For all the socio-demographic variables, the increase in the proportion of respondents reporting that abstinence offers protection against HIV/AIDS is statistically significant suggesting more knowledge among Basotho female adolescents (see Table 3).

Table 3: Respondents (%) who reported that abstinence offers protection against AIDS by selected socio-demographic variables

Variable		2000	2004	Difference
Educational Attainment	no education	61	88	27
	Secondary or better	64	89	25**
	Primary	63	81	18**
Rural urban Residence	Other Urban	60	88	28**
	Maseru Urban	70	90	20**
	Rural	63	83	20**
Ecological Zone	Foothill	61	83	22**
	Mountain	60	79	19**
	Senqu River Valley	69	85	16**
	Lowland	65	86	21**
Respondent listens to a Radio	No	58	84	26**
	Yes	65	84	19**
Respondent watches TV	yes	65	83	18**
	No	63	84	21**
Age	15-19	66	82	16**
	20-24	61	86	25**
Marital status	Previously Married	57	89	32**
	Never Married	66	85	19**
	Married	60	82	22**
Total		63	83	20**

Notes: ** denotes that differences in discrimination between 2000 and 2004 are significant at 1% while * denotes that differences are significant at 5%. + The difference is calculated by subtracting 2000 figure from 2004 figure.

Discrimination Prevalence

Generally speaking, discrimination prevalence has declined between 2000 and 2004 and the decline ranges from less than 10 percentage points to more 20 percentage points. Respondents with secondary education or better, residents of Maseru urban and respondents aged 20-24 recorded the highest decline of between 19 and 38 percentage points compared with respondents residing in other urban, those residing in lowlands, those aged 15-19, those who are never married and those residing in a household with a working radio or TV with a decline of between 10 and 15 percentage points. Respondents with primary education, those residing in rural areas or mountain zone, those who were currently married and those residing in households without a working radio or TV recorded a decline of less than 10 percentage points. There were marginal

differences in decline among respondents residing in both foothills and Senqu River Valley, respondents without education and those reported as previously married (see Table 4).

Table 4: Discrimination Prevalence and Reduction in Prevalence: Lesotho 2000 and 2004

Variable		2000	2004	Difference
Education:	No education	79	94	-15
	Primary	74	70	4**
	Secondary	60	41	19**
Rural urban Residence	Other Urban	63	48	15**
	Maseru Urban	57	29	28*
	Rural	70	63	7**
Ecological zone	Foothills	68	64	4
	Mountains	71	73	-2*
	Senqu River Valley	58	57	1
	Lowlands	66	51	15**
Age	15-19	69	58	11**
	20-24	65	27	38**
Marital status	Never married	64	53	11**
	Married	70	68	2**
	Previously married	72	46	26
Respondent listens to a Radio?	No	70	67	3**
	Yes	66	51	15**
Respondent watches TV?	No	69	60	9**
	Yes	57	44	13**
Total		67	57	10**

Notes: ** denotes that differences in discrimination between 2000 and 2004 are significant at 1% while * denotes that differences are significant at 5%.

+ The difference is calculated by subtracting 2004 figure from 2000 figure.

Discrimination and Knowledge of HIV Transmission and Protection

Having compared HIV/AIDS-related discrimination among respondents by their different background characteristics, the second question is whether knowledge about either transmission or protection against HIV/AIDS makes a difference when it comes to discrimination. Table 5 presents

HIV/AIDS discrimination prevalence by means of protection against HIV/AIDS or transmission of HIV/AIDS. The figures in Table 5 do suggest that knowledge of means of either protection or transmission is associated with lower levels of HIV/AIDS-related discrimination. It is also apparent from Table 5 that there was a decline in the prevalence of discrimination between 2000 and 2004 among respondents who knew about protection against and transmission of HIV/AIDS.

Table 5: HIV/AIDS-related discrimination by means of protection against HIV/AIDS or transmission of HIV/AIDS.

Means of Transmission or protection		2000	2004	Difference
Can HIV be transmitted through witchcraft?	Do not know	86	64	22**
	Yes	62	73	-11
	No	67	56	11**
Can HIV virus be transmitted from mother to child during pregnancy?	Do not know	83	63	20**
	Yes	70	50	20**
	No	66	68	-2
Can HIV virus be transmitted through mosquito bites?	Do not know	80	74	8**
	Yes	75	68	7*
	No	66	46	20**
Can abstinence offer protection against HIV?	Do not know	83	71	12
	Yes	65	57	8**
	No	69	58	11**
Can having one uninfected partner protect one against the HIV virus?	Do not know	77	79	-2
	Yes	70	56	14
	No	72	64	8
Can correct use of a condom during sex protect one against HIV virus?	Do not know	81	81	0
	Yes	71	55	16
	No	71	63	8
Is it possible for a healthy looking person to have the AIDS virus?	Do not know	82	75	7
	Yes	66	51	15
	No	80	83	3

Notes:** denotes that differences in discrimination between 2000 and 2004 are significant at 1% while * denotes that differences are significant at 5%.

+ The difference is calculated by subtracting 2004 figure from 2000 figure.

Multivariate Analysis of HIV-related Discriminating Attitudes of respondents Toward HIV/AIDS Patients

Table 6 presents the relative odds of respondents expressing discriminatory attitudes towards people living or suspected of living with HIV/AIDS for the two samples separately and for the two samples combined. Respondents who did not know if HIV can be transmitted through witchcraft were more likely to report discriminatory attitudes towards HIV positive people while there was no difference between those who knew that HIV cannot be transmitted through witchcraft and those with the misconception that HIV cannot be transmitted through witchcraft and this was the case for 2000 sample only. Protection offered by abstinence was found significant for the 2000 sample and for the two samples combined. The same was the case with rural urban residence and availability of a working TV in the household. Respondents with secondary education or better were found to be less likely to discriminate against HIV positive individuals for the three models while ecological zone was only significant for the combined sample. District was found significant for both samples separately while age was important only in 2000 while radio was important in 2004 only.

Table 6: Odds ratios that respondents would not buy from a vendor if the vendor is HIV positive

	2000		2004		2000-2004	
	B	Exp(B)	B	Exp(B)	B	Exp(B)
Can HIV be transmitted through witchcraft?						
Do not know	0.920*	2.510	NA	NA	NA	NA
Yes	-0.233	0.792	NA	NA	NA	NA
No (RC)	-	-	NA	NA	NA	NA
Can abstinence offers protection against HIV?						
Do not know	0.825**	2.281	NA	NA	0.736**	2.089
No	0.244*	1.276	NA	NA	0.131	1.140
Yes (RC)	-	-	NA	NA	-	-
Education						
No education	0.436	1.546	-0.083	0.920	0.162	1.176
Secondary or better	-0.555**	0.574	-1.013**	0.363	-0.753**	0.471
Primary (RC)	-	-	-	-	-	-
Rural urban residence						
Other Urban	-0.154	0.857	NA	NA	-0.276*	0.759
Maseru Urban	-0.579*	0.561	NA	NA	-0.354*	0.702
Rural (RC)	-	-	NA	NA	-	-
District						
Butha-Buthe	-0.873**	0.418	0.346	1.414	NA	NA

Leribe	0.082	1.086	-0.094	0.911	NA	NA
Berea	-0.249	0.780	0.168	1.183	NA	NA
Mafeteng	0.042	1.043	0.124	1.132	NA	NA
Mohale's Hoek	-0.762**	0.467	0.657**	1.928	NA	NA
Quthing	-0.369	0.692	-0.194	0.824	NA	NA
Qacha's Nek	-0.936**	0.392	0.614*	1.848	NA	NA
Mokhotlong	-0.140	0.870	0.602*	1.826	NA	NA
Thaba-Tseka	-0.652*	0.521	0.470#	1.599	NA	NA
Maseru (RC)	-	-	-	-	NA	NA
Respondent watches TV?						
Yes	-0.428**	0.652	NA	NA	-0.254*	0.776
No (RC)	-	-	NA	NA	-	-
Respondent listens to the radio?						
No	NA	NA	0.352**	1.422	NA	NA
Yes (RC)	NA	NA	-	-	NA	NA
Age						
15-19	0.222*	1.248	NA	NA	NA	NA
20-24 (RC)	-	-	NA	NA	NA	NA
Year of the Survey						
2000	NA	NA	NA	NA	0.702**	2.018
2004	NA	NA	NA	NA	-	-
Ecological Zone						
Foothills	NA	NA	NA	NA	-0.028	0.972
Mountains	NA	NA	NA	NA	0.172#	1.188
Senqu River Valley	NA	NA	NA	NA	-0.294#	0.745
Lowlands (RC)						
Constant		1.228**	0.116	0.457**		

Notes: ** denotes that $p < 0.01$, * $p < 0.05$ and # $p < 0.1$

Discussion

Knowledge about misconceptions that HIV can be transmitted through witchcraft and that abstinence can protect one against HIV/AIDS has significantly improved between 2000 and 2004. The proportion of respondents reporting that HIV can be transmitted through witchcraft has generally declined on a statistically significant level except for few isolated cases such as among uneducated individuals, urban Maseru residents, respondents residing in the mountain region and previously married individuals. On the other hand, the proportion of respondents reporting that abstinence can protect someone against HIV/AIDS has also increased significantly.

As to whether increased knowledge about means of transmission and protection against HIV/AIDS translated into declines in levels of HIV/AIDS-related discrimination, results of the present paper suggest that knowledge translated into reduced levels of HIV/AIDS-related discrimination. There has

been a decline in the level of HIV/AIDS related discrimination between 2000 and 2004 in Lesotho. Generally speaking, the decline is statistically meaningful with the exception of one or two isolated cases. The decline was highest among respondents with secondary education or better, respondents residing in the lowlands and urban Maseru as well as never married respondents with a decline of at least 20 percent. Listening to the radio and watching TV also had a high decline of 18 percent. Comparison of HIV/AIDS related discrimination by knowledge of both means of transmission of and protection against HIV/AIDS between the two survey showed that respondents with the misconceptions about either protection or transmission reported slightly higher but not significant prevalence in 2004 while those who had the knowledge and those who did not have the knowledge reported lower levels of prevalence of HIV/AIDS related discrimination which were statistically significant.

This indicates that AIDS-related stigma is not static. It can change over time as infection levels, knowledge of the disease and treatment availability vary. In fact, WHO in 2003 at a launch of the major campaign to scale up treatment in the developing world, declared that as HIV/AIDS becomes a preventable and treatable disease, attitudes will change and stigma and discrimination will be reduced rapidly (UNAIDS & WHO, 2003). Some small-scale studies have confirmed this statement. In Botswana it was found that stigmatising attitudes had lessened three years after the national programme providing universal access to antiretroviral treatment was introduced (AVERT, 2009). The paper concluded that although antiretroviral therapy access may be a factor in reducing stigma, it does not eliminate stigma altogether and does not lessen the fear of stigma amongst HIV positive people. However, stigma still remains in developed countries such as America, where treatment has been widely available for over a decade, indicating that the relationship between HIV treatment and stigma is not straightforward. An estimated 27 percent of Americans would prefer not to work closely with a woman living with HIV (UNAIDS, 2008b).

Among the socio-demographic factors, education, rural urban residence, district of residence and whether respondents were watching TV or listening to the radio were identified as factors associated with HIV/AIDS related discrimination. Among knowledge about transmission and protection variables the results suggest that programmes targeting HIV stigma and discrimination are to be effective they need to be designed appropriately for the different settings as attitudes towards the epidemic and those affected vary massively. Even within one country reactions to HIV/AIDS will vary between different groups of people and individuals.

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