SOCIO DEMOGRAPHIC FACTORS CONTRIBUTING TO STIGMA AMONG HIV/AIDS PATIENTS RECEIVING MEDICAL TREATMENT FROM KAKUUTO HEALTH CENTRE IV

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A DISSERTATION SUBMITTED TO THE SCHOOL OF SOCIAL SCIENCES AS A PARTIAL FULFILLMENT FOR THE AWARD OF A DEGREE OF BACHELOR OF SOCIAL WORK AND SOCIAL ADMINISTRATION OF UGANDA CHRISTIAN UNIVERSITY

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UGANDA CHRISTIAN UNIVERSITY

A Centre of Excellence in the Heart of Africa

DEDICATION

I dedicate this research to my family and friends. A special feeling of gratitude to my beloved momma Nakabazzi Resty and sponsor Mrs. Victoria Fraser who have sacrificed their own happiness and comfort to support me without fail, financially, economically and spiritually.

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I am highly grateful to the Almighty God for His loving kindness to me throughout my entire academic journey.

My sincere gratitude goes to the Uganda Christian University for skilling me to pursue a Bachelor's degree in Social work and social administration. all lecturers who have provided us with academic support and knowledge always.

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My thanks also go to the staff at Kakuuto Health Centre IV for allowing me to conduct my research in their ART clinic.

Lastly, and most importantly, my deepest appreciation is for my family and friends for their financial, emotional and mental support.

DECLARATION BY STUDENT

DECLARATION BY THE STUDENT

I NAGGIRINYA FAVOUR declare that this dissertation, titled Socio-demographic factors contributing to stigma among HIV/AIDS patients receiving medical treatment from Kakuuto Health Centre IV is my original work and has not been submitted anywhere else for academic grading.

I therefore declare that I have adhered to the ethical guidelines and principles of academic integrity throughout the research and writing process. I have properly cited and referenced all the sources of information, ideas and data used in the dissertation.

I do understand that plagiarism, academic malpractices of information are serious offenses and can have severe consequences. Therefore, I decided that I have conducted my research with the highest level of integrity.

Signature.....

Date...12/09/2024.....

APPROVAL BY THE RESEARCH SUPERVISOR

APPROVAL BY THE RESEARCH SUPERVISOR

This is to certify that Naggirinya Favour who is a third-year student at Uganda Christian University pursuing a Bachelor's degree in Social work and social administration has been under my guidance and supervision and her dissertation is ready for submission.

Supervisor

Mr. Wareeba Stanley

signature.....Date.....13th September 2024.

LIST OF ACRONYMS

AIDS Acquired Immunodeficiency Syndrome

ARVS Anti-retroviral Treatment

HIV Human Immunodeficiency Virus

PLWHA People Living With HIV/AIDS

UNAIDS United Nations Programme on HIV/AIDS

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ABSTRACT

In Uganda, even with established policies aimed at guiding the national response, stigma and discrimination continue to obstruct access to and use of HIV and AIDS services, impeding progress towards the goal of achieving zero discrimination. This study aimed to evaluate the social demographic factors contributing to stigma among HIV/AIDS clients receiving medical treatment from Kakuuto Health Centre IV, employing an explanatory study. Purposive and convenient sampling methods were employed to recruit 230 participants for the study.

The findings revealed that 74% of respondents believed that financial status could impact the stigmatization process, 87% felt that low education levels fostered HIV/AIDS-related stigma, and 74% viewed cultural beliefs that individuals with HIV/AIDS bring shame to their clan and community as contributing to stigma. The researcher concluded that socio-economic factors such as financial status, pre-employment screening, and the absence of clear workplace policies regarding the care of HIV/AIDS-infected individuals were influential in perpetuating stigma. Additionally, socio-demographic factors like low education levels, gender, age, nationality and religion contributed to HIV stigma.

CHAPTER ONE

1.0 **INTRODUCTION**

This research is an exploratory study aimed at examining the socio-demographic factors that contribute to stigma among HIV clients currently receiving ART treatment at Kakuuto Health Centre IV in Kyotera district. The study will utilize both qualitative and quantitative approaches. Despite ongoing efforts to disseminate information, raise awareness, and conduct campaigns about HIV, stigma continues to be a major barrier to both seeking and maintaining care among HIV patients.

Stigma is characterized as a trait that significantly devalues a person in the eyes of others, leading to negative perceptions based on certain attributes (Abadia et al., UNAIDS, 2002). A stigmatized individual is often regarded as having a tarnished identity that deviates from social standards and is subject to disapproval (Goffman, 1963, qtd in UNAIDS, 2002).

HIV-related stigma manifests in several ways, including enacted stigma, which involves discriminatory behaviors such as prejudice directed at individuals due to their HIV status (Earnshaw, 2013; Catona, 2016). Anticipated stigma refers to the expectation of future stigma experiences (Earnshaw, 2013), while internalized stigma pertains to an individual's recognition, acceptance, and application of stigma upon themselves (Munoz and Phillips, 2011). The WHO defines social stigma in health as a negative association between certain characteristics of individuals or groups and a specific disease.

The study identifies several socio-demographic factors that contribute to stigma, including low educational attainment, religious beliefs, gender differences, ethnicity, and marital status.

1.1 **BACKGROUND**

The United Nations Program on HIV/AIDS (UNAIDS) has created a worldwide strategy aimed at eradicating HIV/AIDS, which outlines goals for countries to enhance testing and treatment access for HIV (UNAIDS, 2017). The strategy specifies that by 2020, 90% of individuals living with HIV should know their status, 90% of those aware should be receiving antiretroviral therapy, and 90%

of those on treatment should achieve viral suppression (UNAIDS, 2017). However, reaching these 90-90-90 objectives requires an understanding of the challenges faced in accessing HIV testing and treatment services. Research consistently points to significant stigma and discrimination against people living with HIV as major obstacles (Ekstrand et al., 2018; Hargreaves et al., 2018). Both external stigma, resulting from real discrimination, and internalized stigma, characterized by feelings of shame or anticipated discrimination, deter individuals from revealing their status and seeking medical help (Mbonu et al., 2009).

Stigma is the primary hurdle for many HIV patients in accessing care and treatment, perpetuating the impact of HIV on communities globally (Akande, 2009; Alemu et al., 2013; Jain et al., 2013; Muloongo et al., 2014). In sub-Saharan Africa, HIV stigma manifests in various forms, including physical, moral, and social stigma (Ogunmefun et al., 2011). Shisana and Simbaya (2012) observed that in Cape Town, South Africa, physical stigma was evident with 18% of people unwilling to share a room with individuals living with HIV, 26% refusing to eat with them, and 6% not wanting to communicate with known AIDS patients.

Social exclusion is also widespread; a study by Ebersohn and Ferreira (2011) in Western Uganda found that 16% reported exclusion from social events, 7% from religious gatherings, and 10% from family activities, with 68% attributing their social exclusion to their HIV status. Gossiping emerged as the most common form of stigma, affecting 60% of respondents. Factors such as socioeconomic status, age, and gender influence how individuals experience stigma. While poorer individuals are often blamed less for their infection compared to wealthier individuals, they frequently confront greater stigma due to limited resources to conceal their HIV-positive status.

1.2 **STATEMENT OF THE PROBLEM**

In recent years, the use of anti-retroviral drugs (ARVs) has significantly improved survival rates and health for people living with HIV, transforming the condition from a life-threatening diagnosis to a manageable chronic illness (Deeks, Lewin & Havlis, 2013). However, many countries still face difficulties in providing adequate care for individuals with HIV (Mugglin et al., 2012). HIV-related stigma is prevalent worldwide, affecting more than 70% of those living with the virus, largely due to the illness's association with high mortality rates (Bogart et al., 2010).

In Africa, HIV is often linked to behaviors deemed immoral and is commonly perceived to be prevalent among specific groups, such as sex workers. Consequently, 83% of HIV-positive individuals are believed to have contracted the virus through sexual promiscuity and are stigmatized, leading to social exclusion from the wider community (Ngozi, 2009).

In Uganda, despite policies aimed at guiding the national response, stigma and discrimination remain significant obstacles to HIV treatment, prevention, care, and the goal of eliminating discrimination altogether (Bwambale et al., 2008). In 2005, Uganda launched an expert client initiative within government-funded healthcare facilities, involving individuals living with HIV who are stable on ARV treatment. These expert clients use their experiences to support fellow patients in achieving better treatment outcomes (Ahmed et al., 2022). Additionally, peer support groups exist in other contexts (Fauk et al., 2019). These experts and peers collaborate with healthcare workers to combat stigma and discrimination towards people living with HIV. However, resource shortages often necessitate task shifting to expert clients, who are not adequately supported with resources.

People living with HIV deserve fair and equal treatment in all sectors of life like employment, social interactions like the other people who are HIV negative. Stigmatization of HIV has negative impacts on the social, emotional, mental and psychological life of people living with HIV for example non adherence, social exclusion, isolation and marital conflicts. The ministry of health and TASO needs to provide sufficient resources to fight against stigma and discrimination. The available laws and policies against stigma are weak and some aren't known by the masses. Therefore, the ministry of health needs to revise the laws and sensitize the nation about the causes and effects of stigma. The ministry also needs to implement the laws starting with health workers then the masses.

1.3 **OBJECTIVES**

1.3.1 GENERAL OBJECTIVE

The primary aim of this study is to investigate the impact of socio-demographic factors on stigma experienced by HIV patients undergoing ART treatment at Kakuuto Health Center IV in Kyotera district.

1.3.1 **SPECIFIC OBJECTIVES**

The specific goals of this study are to:

1. Examine the social demographic factors that play a role in stigma for HIV clients undergoing ART treatment at Kakuuto Health Centre IV in Kyotera.

2. Examine how socio-demographic factors influence stigma among HIV clients receiving ART at Kakuuto.

3. Examine the connection between socio-demographic factors and stigma in HIV clients undergoing ART treatment at Kakuuto Health Centre IV.

1.4 **RESEARCH QUESTIONS**

1. What social demographic elements play a role in the stigma experienced by HIV patients undergoing ART at Kakuuto Health Centre IV?

2. In what ways do socio-demographic factors influence the stigma faced by HIV patients receiving ART at Kakuuto?

3. How are socio-demographic factors related to the stigma encountered by HIV clients undergoing ART treatment at Kakuuto Health Centre IV?

1.5 **SCOPE OF THE STUDY**

1.5.1 GEOGRAPHICAL SCOPE

The study will concentrate on Kakuuto Health Centre IV in Kyotera district because stigma can be best understood from there.

1.5.2 CONTENT SCOPE

HIV related stigma will be looked at in different types or manifestations like social and internalized stigma while the factors will be social demographic.

1.5.3 TIME SCOPE

Data in the study will be collected during the months of February to April 2024 because it is enough time to collect and process the data.

1.6 JUSTIFICATION

There is a lack of adequate research examining the factors that lead to stigma among individuals with HIV. This study aims to fill those gaps in the literature by detailing and emphasizing these contributing factors. Many people may not realize that their biases and stereotypes are responsible for the various forms of stigma—enacted, internalized, anticipated, and perceived—that HIV patients experience. The findings of this study could serve as an important resource for developing effective interventions against stigma and discrimination. It is hoped that this research will promote empathetic and equitable interactions with HIV patients, regardless of their HIV status.

1.7 SIGNIFICANCE

The results of this study are expected to assist the Ministry of Health, Uganda Cares, and TASO in formulating policies related to stigma and discrimination, as well as planning health education initiatives aimed at reducing stigma.

Additionally, the study will serve as a reference for other researchers and scholars interested in exploring the factors that contribute to stigma and discrimination.

It aims to encourage the community members of Kyotera to view individuals living with HIV as integral members of the community, deserving of normal interactions and equal treatment.

1.8 LIMITATIONS

The reasons behind stigma may be influenced by bias, as they often revolve around hypothetical situations, which could impact the outcomes. Additionally, time constraints present another challenge, as there isn’t enough time to gather, analyze, and share the data effectively.

1.9 CONCEPTUAL FRAMEWORK

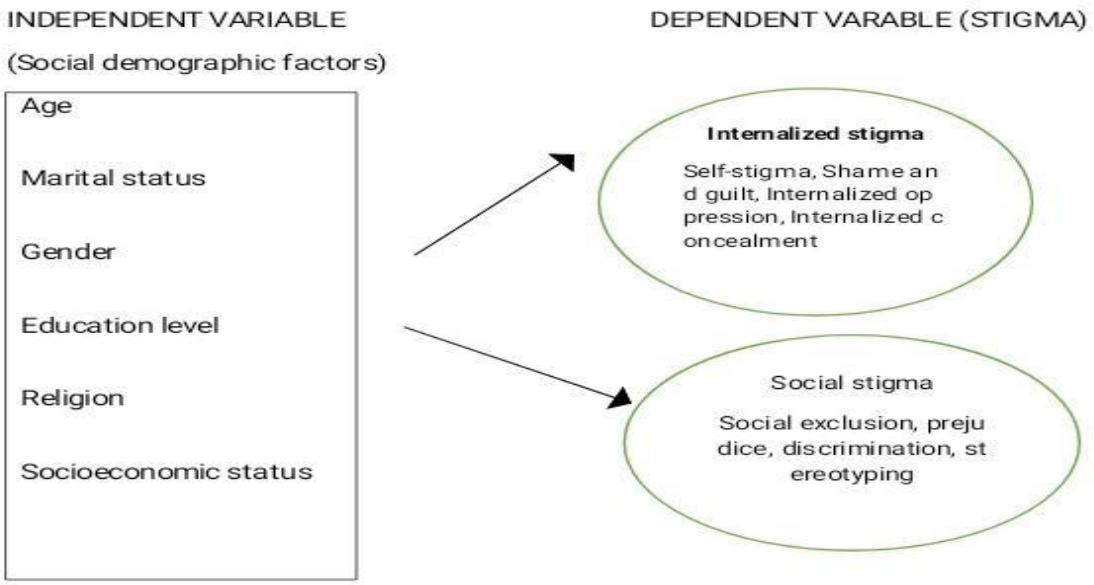


Figure 1 presents a conceptual framework addressing the socio-demographic factors that contribute to stigma associated with HIV/AIDS.

This framework aids in understanding how these socio-demographic elements lead to various forms of stigma. It posits that these factors are linked to two distinct types of stigma outlined in the health stigma and discrimination framework: social stigma and internal stigma (Turan et al., 2017; Stangl et al., 2019).

The study aims to explore the health stigma and discrimination framework (Turan et al., 2017; Katz et al., 2013), which suggests a connection between types of HIV stigma and the socio-demographic factors influencing them. It is hypothesized that these socio-demographic factors contribute to both social and internalized stigma, as illustrated in Figure 1 (Rao, 2019).

The hypothesis indicates that factors such as insufficient education about stigma and religious beliefs that promote the idea of its retribution lead individuals to view all HIV patients as immoral, believing they contracted the virus through promiscuity. This misperception further fosters both social and internalized stigma, resulting in the social and physical isolation of those living with HIV (Reddy & Frantz, 2011; Mall et al., 2013).

1.10 **SUMMARY OF THE CHAPTER**

This chapter consists of ten sections that utilize the Conceptual Framework to explain the factors influencing various forms of stigma among HIV patients undergoing ART at Kakuuto Health Centre IV. The insufficient research on stigma-related factors was the primary impetus for this study. The findings suggest that socio-demographic factors play a role in both internalized and social stigma. There is a pressing need for HIV-related stigma and discrimination policies to help alleviate stigma and discrimination faced by individuals living with HIV.

The outcomes of this study can inform the development of future interventions aimed at reducing HIV-related stigma among patients. Subsequent research should compare these findings with earlier studies to identify any differences. Further investigation is essential for a deeper understanding of the issue. The next chapter will present a literature review focusing on existing research related to the factors contributing to the two distinct types of stigma.

CHAPTER TWO

LITERATURE REVIEW

2.0 INTRODUCTION

This chapter examines existing research on HIV-related stigma and discrimination pertinent to the study. The information was gathered from various sources, including the internet, magazines, newspapers, and academic journals. It begins with social psychology as the theoretical framework and concludes by identifying the socio-demographic factors that influence stigma among HIV clients.

2.1 SOCIAL PSYCHOLOGY AS A THEORETICAL FRAMEWORK.

Fan et al. (2004) highlight cognitive theories that aid in understanding the human and societal aspects of HIV/AIDS. Social psychologists define stigma as an attitude comprising emotional, cognitive, and behavioral traits. This attitude is difficult to change because it serves as a cognitive framework that organizes information about particular concepts, events, and situations (Wyer and Srull, 1994).

From a cognitive and emotional standpoint, stigma towards HIV/AIDS manifests as anger and negative sentiments towards individuals living with the virus. Many believe that those affected by HIV/AIDS deserve neglect due to the disease's incurability. This includes misconceptions regarding how HIV/AIDS spreads, fears surrounding physical contact with infected individuals, and negative attitudes towards communities with high infection rates, such as homosexuals, sex workers, and drug users (Herek and Capitanio, 1998).

The stigma associated with HIV/AIDS is closely linked to its sexually transmitted nature and the visible physical symptoms that emerge as the disease progresses. Such stigmas lead people to view AIDS as a consequence of immoral behavior, such as promiscuity and anal sex. By labeling these actions as deviant compared to their own sexual conduct, individuals seek a sense of security. Stigmatization often emerges as a reaction when individuals feel threatened. Byong-Hee (2005) noted that to mitigate this threat, people isolate those they perceive as different, regaining a sense of health (Klizman, 1997) and reducing their interactions to conceal their own illnesses (Green and Serovich, 1996).

Research by Lee et al. (2002) has significantly advanced the understanding of the social and psychological dynamics of stigma and the lives of those affected. The social psychological and cognitive perspectives aim to elucidate the reasons behind social behaviors and individual thoughts—encompassing actions, emotions, beliefs, memories, and perceptions about others. HIV stigma is conceptualized in various ways, including emotional responses to individuals with HIV, attribution of blame and guilt to them, and support for differing public policies related to AIDS.

Green (1995) emphasized that neglecting the needs of individuals with HIV can cause psychological, physical, and emotional harm. Ignoring stigma may deter individuals from seeking voluntary counseling, HIV testing, and adequate medical care. Carrying condoms may be stigmatized by those who interpret it as a sign of loose morals. To address this societal issue, it is crucial to understand HIV, its modes of transmission, and the array of diseases it can cause. AIDS stigma often manifests as anger and other negative feelings toward those living with the virus.

2.2 SOCIO-DEMOGRAPHIC FACTORS CONTRIBUTING TO STIGMA AMONG HIV CLIENTS.

Several factors have heightened the prevalence of HIV/AIDS-related stigma. Reddy and Frantz (2011), in their study in India, observed that even with a high secondary education rate (80%), many individuals remained uninformed about HIV transmission, perpetuating stigma among those living with the virus. Moreover, studies by Potgieter et al. (2012) and Parry et al. (2009) in South Africa found that although some individuals had received education on HIV transmission, 56% still believed that HIV patients contracted the virus solely through unprotected sex—this perception being particularly prevalent among the educated demographic. Researchers noted that this misbelief exacerbates HIV-related stigma, as many individuals acquired the illness through non-sexual means.

Recent UNAIDS-supported studies indicate that HIV-positive women often face different treatment compared to men (Herek, 2009). While men may be excused for behaviors leading to infection, women often are not. In India, for instance, husbands who infect their wives may abandon them. Reports indicate that rejection by wider family members is common (Minrie et al.,

2008). In various African countries, women whose husbands have died from AIDS-related infections may face blame for the death, leading to eviction from their homes by surviving relatives (Mall et al., 2013). Out of fear of such repercussions, some women may choose to remain unaware of their HIV status or keep it secret (Holzemer et al., 2007). Gender-based power dynamics result in women being more readily blamed for infringing sexual norms, and the consequences of HIV infection, stigma, and care burdens tend to be greater for women than for men (Mall et al., 2013).

While Krakauer and Newbery (2007) acknowledge that religious institutions like churches have played a role in raising awareness about HIV, they have also faced criticism for perpetuating moral stigma associated with the virus. Some churches view individuals living with HIV as those who have strayed from divine teachings, seeing their condition as a result of self-destructive behavior and moral failure (Campbell et al., 2011).

In Uganda, although physical stigma remains a significant concern, Allanise et al. (2010) noted that the perception of immorality associated with individuals living with HIV exacerbates the stigma, as they are often seen as promiscuous, disloyal to partners, and punished by God for their behavior. This moral stigma is closely linked to the physical stigma experienced by these individuals.

Young people are frequently blamed for spreading HIV through what is viewed as risky sexual behavior (Attawell et al., 2008).

CHAPTER THREE

METHODOLOGY

3.0 **INTRODUCTION**

This chapter outlines the research methodology, detailing the specific procedure followed in the study. It explains the research method utilized for gathering data. Data will be collected from Kakuuto Health Centre IV through a questionnaire consisting of quantitative questions. The discussion will focus on the research approach, design framework, study population and sampling techniques, methods and tools for data collection, validity and quality control, as well as data management and analysis.

3.2 **RESEARCH APPROACH**

The research will adopt a mixed methods approach that integrates qualitative and quantitative techniques. It will utilize a Sequential Explanatory Design to clarify and interpret the research process. Quantitative data will be gathered through semi-structured questionnaires distributed online, which respondents will complete. Similarities in their answers will be analyzed statistically (Rahman, S, 2016).

Qualitative data will be obtained through interviews and focus group discussions aimed at understanding how socio-demographic factors contribute to stigma among individuals living with HIV. The focus groups will include 25 HIV patients currently undergoing ART at Kakuuto Health Centre IV and an additional group of 5 nurses from the same facility. Both groups will answer the same questions regarding the socio-demographic factors influencing stigma. All participants will sign a consent form before taking part in the focus groups (Saunders, Lewis, and Thornhill, p. 39).

3.3 **RESEARCH DESIGN**

This study will employ a mixed methods research design to investigate the factors that contribute to stigma among HIV patients. Qualitative data will be collected through interviews and focus group discussions, while quantitative data will be gathered using semi-structured questionnaires.

A cross-sectional survey design will be implemented, utilizing a venue intercept approach that recruits participants, including nurses and HIV patients. This survey design will involve analyzing data to address each research question, compiling information, summarizing findings, and presenting and interpreting data for classification purposes (Bryman, 2008).

3.4 **RESEARCH AREA**

The research will be conducted at Kakuuto Health Centre IV between February and April 2024. Kakuuto Health Centre IV will be chosen because it has the most targeted respondents with high levels of stigma and this means stigma can be best understood from there.

3.5 **STUDY POPULATION AND SAMPLING**

3.5.1 STUDY POPULATION (TARGET POPULATION)

The 360 adults aged 18-70 years included HIV patients and their relatives, nurses, government officials, social workers, and policy makers. From the 360 adults, the researcher chose 305 respondents as the study sample.

3.5.2 SAMPLE SIZE AND SAMPLE DISTRIBUTION

Sample size will be determined using Yamane's formula to estimate the 305 respondents

n=N(1+N(e)

n= Sample population

N= Study population

e= Margin of error

Calculating using the formula

=360/1+360(0.05)

=360/1.18

=305

Sample size is 305 respondents

SAMPLE DISTRIBUTION

Convenient sampling and purposive sampling methods will be utilized for this study. Convenient sampling relied on individuals' willingness and interest to participate after being contacted by the Linkage Officer (Chimoyi et al., 2015). The eligibility of participants was based on factors such as age, gender, marital status, race, and ethnicity. This approach will help gather insights and knowledge regarding stigma among HIV patients.

On the other hand, purposive sampling will focus on selecting specific groups of participants, including HIV patients and their relatives, social workers, nurses, policymakers, and government officials. These individuals were chosen for their expertise and understanding of issues related to HIV stigma.

3.6 **DATA COLLECTION METHODS AND INSTRUMENTS/ TOOLS**

3.6.1 DATA COLLECTION METHODS

Quantitative data will be gathered via semi-structured questionnaires available online. The closed-ended questions will collect information on socio-demographic factors, and the questionnaire will be created in both Luganda and English, making it convenient for government officials who have busy schedules during working hours.

In addition, qualitative data will be obtained through interviews and focus group discussions. The interviews will feature a combination of open and closed-ended questions to extract valuable information. This method is particularly beneficial as some respondents may lack literacy skills. Focus groups will include nurses, stigmatized HIV patients, and lawmakers. Participants will be asked a mix of structured, semi-structured, and unstructured questions to understand their views, beliefs, and insights regarding the socio-demographic factors that contribute to stigma.

3.6.2 **DATA COLLECTION INSTRUMENTS/ TOOLS**

Surveys will be employed to collect information. The survey consists of two parts: the first portion gathers data on the respondents, while the second focuses on social demographic factors.

3.7 **QUALITY CONTROL**

3.7.1 VALIDITY

The research will employ content validity to assess how accurate and meaningful the data collected from the research tools will be.

3.7.2 **RELIABILITY**

The reliability of the data collection tools will be assessed using the test-retest method, which involves administering the same instrument to 10% of the target population. To evaluate internal consistency, Cronbach's alpha will be calculated during the scale's development, including for the factors and the HIV-related stigma scale. Univariate log-binomial regression analyses will identify factors contributing to HIV-related stigma, while multivariate robust Poisson regression analyses will employ individual-level predictors with $p < 0.01$ from the univariate analyses. Factors with $p < 0.05$ in the univariate analysis will be deemed associated with stigma.

3.9 DATA MANAGEMENT AND ANALYSIS

The results will be examined through both quantitative and qualitative methods. Qualitative data will undergo descriptive statistical analysis, which includes calculating the mean, standard deviation, and median. The Standard Package for Social Sciences (SPSS) will facilitate this analysis. Descriptive statistics will be used to investigate the relationships between variables, and the findings will be visually represented using graphs, pie charts, and tables. Descriptive analysis will focus on assessing variability and central tendency.

For quantitative data, both descriptive and inferential statistics will be applied. Descriptive statistics will summarize the data, while inferential statistics, such as univariate analysis, will be utilized to explore the relationships between variables. Data management will involve organizing, analyzing, coding, categorizing, and ultimately interpreting the data.

3.10 **SUMMARY**

The research investigates the elements that lead to stigma among individuals living with HIV. It employs a mixed-methods approach, utilizing interviews and semi-structured questionnaires to gather both qualitative and quantitative data. Participants are selected through purposive and convenient sampling based on their expertise, interest, and willingness to take part. The study conducts univariate and multivariate analyses to examine the relationships between the variables, along with inferential and descriptive statistics to analyze the collected data.

CHAPTER FOUR

DATA ANALYSIS, INTERPRETATION AND REPRESENTATION

4.0 INTRODUCTION

Ihis chapter focuses on the analysis, interpretation, and presentation of data gathered from fieldwork. The study involved 305 participants, achieving a response rate of 80%. Out of these, 55 individuals discontinued the research before answering all the questions, and 20 chose not to participate. Consequently, 230 respondents completed the questionnaires, interviews, and focus group discussions. Of these, more than half, specifically 125 (54.3%), were female, while 105 were male. The largest age group represented was 20-29, comprising 27.0% of the respondents, which also reflected the average age range. Ethnically, the majority identified as Baganda, accounting for 80 participants (34.8%), and 120 (34.8%) were married. Among the participants, 90 (39.1%) had no formal education, and 110 (47.8%) were engaged in farming as their occupation. In terms of religion, 80 participants (34.8%) identified as Catholics. Additionally, 200 participants (86.9%) lived in rural areas, and 90 (39.1%) resided in nuclear family structures, as indicated in Table 1 below.

4.1 BIO DEMOGRAPHIC DATA OF THE RESPONDENTS N=230

Characteristic	**Frequency**	**Percentage (%)**
Age		
10-19	38	16.5
20-29	62	27.0
30-39	54	23.5
40-49	36	15.7
50-59	24	10.4
60+	16	7.0
Sex		
Male	125	54.3
Female	105	45.7
Marital status		
Married	120	52.2

Single	80	34.8
Divorced/ separated	20	8.7
Widowed	10	4.3
Religion		
Protestant	60	26.1
Muslim	50	21.7
Catholic	80	34.8
Traditional	10	4.3
Pagan	30	13.0
Ethnicity		
Baganda	80	34.8
Basoga	50	21.7
Bakiga	40	17.4
Banyarwanda	30	13.0
Bahaya	30	13.0
Education status		
No formal education	90	39.1
Primary	30	13.0
Secondary	40	17.4
Tertiary	50	21.7
University	20	8.7
Occupation		
Self employed	110	47.8
Unemployed	70	30.4
Employed	50	21.7
Living arrangement		
Family (extended)	100	43.5
Alone	40	17.4
Husband and wife (nuclear)	90	39.1
Residence		

Urban	30	
Rural	200	

Source: Primary data from the field 2024

4.2 ADMINISTRATION OF THE QUESTIONNAIRES

The questionnaires were conducted in person, either at the participant's home or at another appropriate location, such as a healthcare center. Participants received assistance in filling out the questionnaires, which included reading the questions aloud, rephrasing them for better understanding, and clarifying the response format. They were urged to take their time when answering, and those who were not proficient in English or Luganda were provided with interpreters.

4.3 INTERNALIZED STIGMA ATTITUDES TOWARDS INDIVIDUAL ITEMS N= 230

Attitude	**Strongly agree**	**agree**	**disagree**	**Strongly disagree**
People look down on me	60 26.1%	70 30.4%	30 13%	70 30.4%
People make fun of me	55 23.9%	65 28.3%	35 15.2%	75 32.6%
People make me feel embarrassed	50 21.7%	60 26.1%	40 17.4%	80 34.8%
I worry that people may look down on me	65 28.3%	70 30.4%	30 13%	80 34.8%
I keep away from people because they are not nice	70 30.4%	75 32.6%	35 15.2%	50 21.7%
People look at me in a funny way	65 28.3%	70 30.4%	35 15.2%	60 26.1%
The way people talk to me makes me angry	60 26.1%	65 28.3%	40 17.4%	65 28.3%

Source: Primary data from the field 2024

4.4 PUBLIC STIGMA RESPONSES TOWARDS INDIVIDUAL ITEMS BY PLWHA N=230

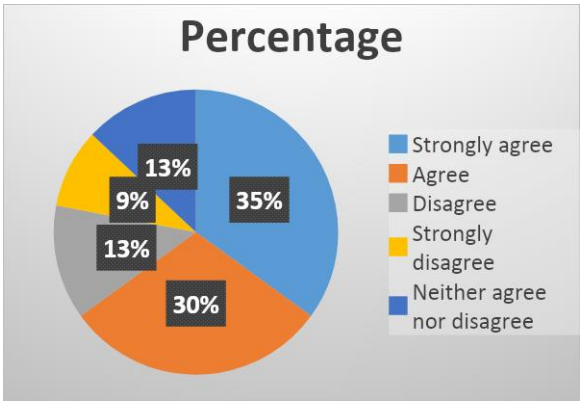
Attitude	**Strongly agree**	**Agree**	**Disagree**	**Strongly Disagree**
People's attitudes about HIV make me feel worse	50 21.7%	70 30.4%	60 26.1%	50 21.7%
Telling someone I have HIV is risky	70 30.4%	60 26.1%	50 21.7%	50 21.7%
People I care about stopped calling me after learning that I have HIV	80 34.8	90 39.1%	30 13.3%	30 13.3%
I work hard to keep my HIV status a secret	90 39.1	70 30.4%	50 21.7%	40 17.4%
I'm very careful who I tell I have HIV	100 43.5	90 39.1%	30 13.0%	10 4.3%
I feel I'm not good as others because I have HIV	50 21.7%	80 34.8%	40 17.4%	60 26.1%
Some people avoid me because I have HIV	80 34.8%	70 34.8%	40 17.4%	40 17.4%
People are uncomfortable around me because I have HIV	90 39.1%	80 34.8%	40 17.4%	20 8.7%
I have lost friends because I have HIV	80 34.8%	50 21.7%	60 17.4%	40 17.4%
I feel guilty because I have HIV	90 39.1%	70 30.4%	40 17.4	30 13.3%
Most people believe having HIV is being dirty	70 30.4%	40 17.4%	70 30.4%	50 21.7%

Source: Primary data from the field

4.5 **DATA REPRESENTATION**

4.5.1 Shows whether low education level contributes to HIV stigma n=230

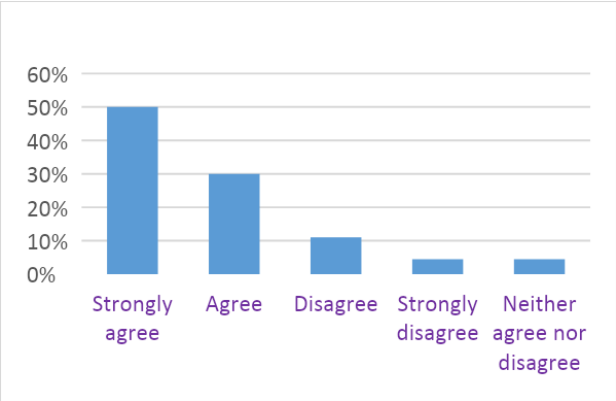
Response	Frequency	Percentage
Strongly agree	80	35%
Agree	69	30%
Disagree	30	13%
Strongly disagree	21	9%
Neither agree nor disagree	30	13%



Interpretation: 65% agree that low education levels contribute to stigma which is a clear majority of the respondents, 26% disagree and 9% neither agree or disagree

4.5.2 Shows whether age contributes to HIV stigma n=230

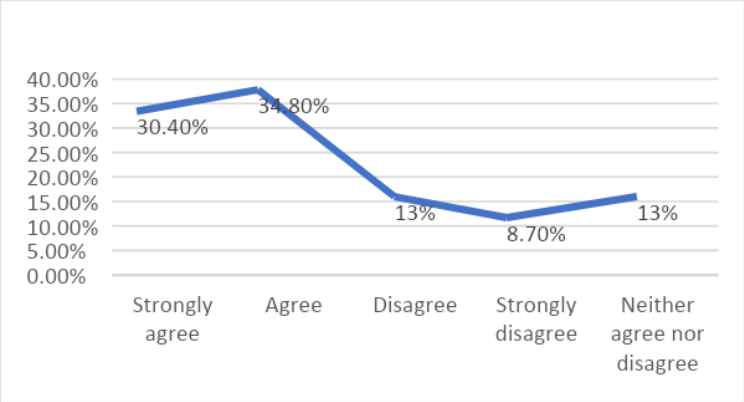
Response	Frequency	Percentage
Strongly agree	115	50%
Agree	69	30%
Disagree	25	11%
Strongly disagree	10	4.5%
Neither agree nor disagree	10	4.5%



Most of the respondents (80%) agree that age contributes to stigma, 15.5% disagree and 4.5% neither disagree nor agree

4.5.3 Shows whether gender contributes to HIV stigma n=230

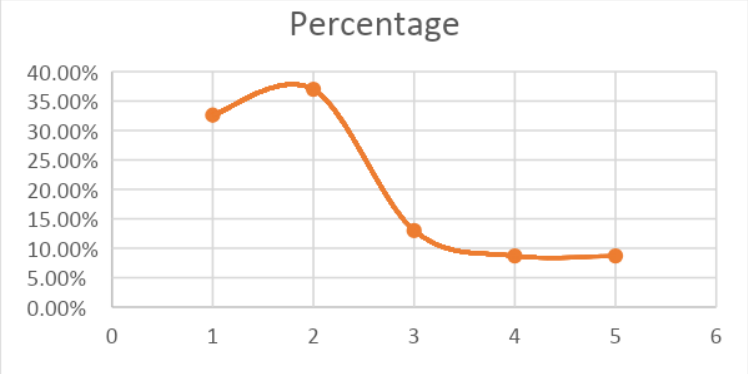
Response	Frequency	Percentage
Strongly agree	70	30.4%
Agree	80	34.8%
Disagree	30	13%
Strongly disagree	20	8.7%
Neither agree nor disagree	30	13%



A clear majority of the respondents (65.5%) agree that gender/sex contributed to stigma, 21.7% disagree and 13% neither agree nor disagree

4.5.4 Shows whether marital status contributes to HIV stigma n=230

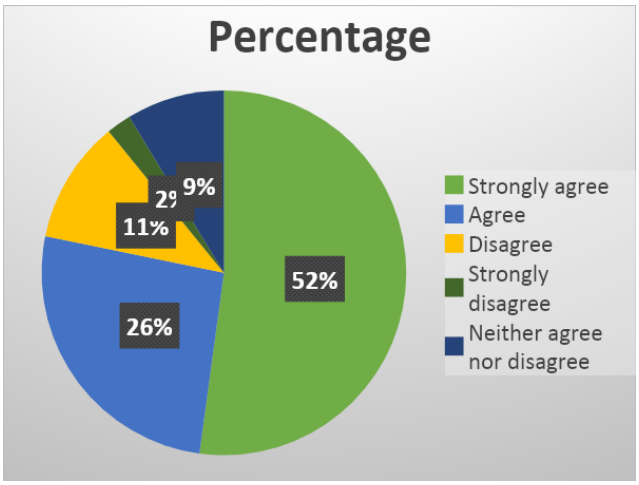
Response	Frequency	Percentage
Strongly agree	75	32.6%
Agree	80	37%
Disagree	30	13%
Strongly disagree	20	8.7%
Neither agree nor disagree	20	8.7%



A clear majority of the respondents (69.6%) agree that marital status contributes to 21.7% disagree and 8.7% neither agree nor disagree

4.5.5 Shows whether religion contributes to HIV stigma n=230

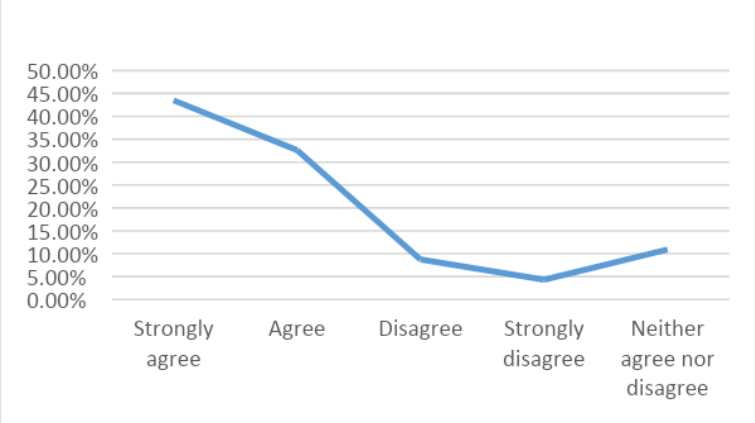
Response	Frequency	Percentage
Strongly agree	120	52.2%
Agree	70	26.1%
Disagree	25	10.9%
Strongly disagree	5	2.2%
Neither agree nor disagree	20	8.7%



Most of the respondents, (78.3%) agree that religion contributes to stigma, 13.1 disagree and 8.7 neither agree nor disagree

4.5.6 Shows whether socio-economic status contributes to HIV stigma n=230

Response	Frequency	Percentage
Strongly agree	100	43.5%
Agree	75	32.6%
Disagree	20	8.7%
Strongly disagree	10	4.3%
Neither agree nor disagree	25	10.9%



Most of the respondents 76.1% agree that socio-economic status contributes to stigma, 13% disagree and 10.9% neither disagree nor disagree.

4.6 ETHICAL CONSIDERATIONS

The present study was carried out in accordance with the Declaration of Helsinki regarding research involving human participants. A letter of introduction was secured from the School of Social Sciences at Uganda Christian University Mukono campus to authorize the researcher to conduct the study. Approval was also granted by the management of Kakuuto Health Centre IV. Participants were informed about the study, including its procedures, potential risks, and benefits. Written informed consent was voluntarily obtained from all participants prior to the study, which was entirely voluntary and ensured the confidentiality of the information collected. The anonymity of participants was preserved, and the research was conducted in adherence to professional ethical standards, ensuring that the scientific integrity of the study was maintained.

4.7 SUMMARY OF THE QUANTITATIVE AND QUALITATIVE ANALYSIS

The research highlighted that much of the observed stigmatizing language and actions primarily revolved around themes of abuse, blame, judgment, and avoidance. Many individuals believe that HIV is contracted as a result of one's poor choices. This chapter details an analysis of the data gathered from a questionnaire, employing both quantitative and qualitative methods. Key findings indicated that people with HIV/AIDS are often shunned by others due to fears of casual transmission. Additionally, some respondents noted that individuals with HIV frequently face rejection from their families, partners, friends, and colleagues. Furthermore, some individuals living with HIV have encountered verbal abuse, being viewed as a threat to the community. Stigma, both public and internalized, was found to be influenced by factors such as age, gender, education level, marital status, religion, nationality, race, and ethnicity.

CHAPTER FIVE

FINDINGS AND CONCLUSION AND RECOMMENDATIONS

5.0 INTRODUCTION.

This chapter focuses on interpreting and discussing the findings from the field to address the research questions, draw conclusions, and offer recommendations regarding the social demographic factors that contribute to stigma among HIV clients receiving ART treatment at Kakuuto Health Centre IV. In the 21st century, many individuals still believe they are not at risk for HIV/AIDS due to stigma, despite efforts from the government, the Ministry of Health, and non-governmental organizations to raise awareness. Those who stigmatize individuals living with HIV often misunderstand how the virus is transmitted. Responses from participants indicate that stigmatizing attitudes towards individuals with HIV/AIDS remain prevalent. Moreover, language plays a significant role in reflecting either stigmatizing attitudes or support for those living with HIV/AIDS.

5.1 There is a high level of stigma associated with HIV/AIDS in Kakuuto.

The study revealed that the public stigma scores were notably higher than the internalized stigma scores among participants. When reflecting on their personal attitudes, 30.4% believed that people with HIV/AIDS were to blame for their condition, 39.1% felt those with HIV should be ashamed, and 18% thought that people with HIV/AIDS should be socially isolated. Despite many participants having considerable knowledge about the illness, some expressed apprehension and a desire to avoid individuals with HIV/AIDS. Additionally, 73% felt that if a family member had HIV, the community would keep it a secret, while 68% believed the community was uncomfortable around people with HIV and thought they should feel ashamed. Furthermore, 47% thought others in the community looked down on individuals with HIV. These results support the hypothesis of perceived stigma surrounding HIV/AIDS in the Kakuuto and Kyotera districts.

The findings indicated that internalized stigma associated with HIV/AIDS was lower than the community stigma, reflecting a broader perception of collective stigma that was negative, blame-oriented, and restrictive regarding interactions with those affected by HIV/AIDS. Herek and

Capitanio note that attitudes toward people with HIV/AIDS are shaped by emotional reactions, blame, and avoidance of contact. All participants exhibited shared views of strong stigma within their communities, illustrating a public stigma that fosters blame and discomfort regarding individuals with HIV/AIDS. The internalized stigma experienced by those living with HIV/AIDS—stemming from their negative self-perceptions—can lead to significant psychological consequences, including depression and low self-esteem.

Green's (1995) research in Scotland echoed these findings, highlighting a distinct gap between internalized and public stigma perceptions. While comparisons across different countries may be complicated by diverse sampling methods and cultural contexts, interesting parallels can be observed. When comparing the responses from Ugandan participants with those from studies by Herek, Capitanio, and Widaman (2002) in the United States, similarities in stigmatizing attitudes emerged. For example, in the U.S. study, 20% expressed fear toward those with HIV/AIDS, while 17% of Ugandan respondents did. Moreover, a higher percentage in Uganda (31%) felt individuals living with HIV/AIDS deserved their condition compared to 25% in the U.S. The study also revealed a relationship between the level of stigma and factors such as sex, age, educational background, marital status, religion, nationality, race, and ethnicity.

In Kakuuto, male participants exhibited stronger stigmatizing attitudes than females. Factors such as low socioeconomic status and economic reliance on men further exacerbate stigmatization against women, limiting their autonomy in sexual decision-making and increasing their vulnerability to coercive situations. Consistent with international studies (Crawford, 1996; Herek & Capitanio, 1993), females demonstrated significantly less stigma towards individuals with HIV/AIDS, potentially because men tend to attribute HIV risk to women's behavior, while women often trust their partners, believing they are not at risk (Caldwell, Orubuloye & Caldwell, 1999).

Individuals over 50 were identified as the most stigmatizing age group. Changing these entrenched views is challenging as they often form cognitive frameworks about HIV/AIDS. Green (1995) also noted that older adults, less exposed to HIV, tended to have less knowledge about it, correlating with negative attitudes. Single respondents exhibited higher stigmatization as well. Those who do not know anyone with HIV/AIDS had significantly higher stigma levels, as many people avoid

discussions about the condition. A notable difference in internalized stigma was also found between respondents who knew someone living with HIV and those who did not. This distancing and discomfort contribute to discrimination and negative mental health outcomes.

Religious beliefs further exacerbate stigma, as the notion that HIV is primarily transmitted through sexual intercourse leads to the perspective that individuals contract HIV due to "immoral" behavior. There is a common assumption that those with HIV have engaged in unacceptable conduct, marking them as deviant for not conforming to societal and religious norms (Banteyerga et al., 2003). This association between HIV and immorality is reflected in the 73.9% of respondents who believe that people living with HIV/AIDS are promiscuous, a viewpoint likely influenced by religious teachings. This culture of blame allows institutions, such as the Church, to absolve themselves of the responsibility of caring for those affected.

5.3 SOCIAL DEMOGRAPHIC FACTORS INFLUENCING STIGMA RELATED TO HIV/AIDS

The socio-demographic factors identified as contributing to HIV/AIDS stigma include levels of education, gender, age, religion, socioeconomic status, nationality, race, and ethnicity. A significant number of respondents (65.2%) believe that low educational attainment fosters stigma associated with HIV/AIDS. Education plays a key role in fostering positive behavioral changes; those with higher educational levels are typically better equipped to understand the complexities surrounding the disease and are less likely to subscribe to traditional beliefs that associate HIV/AIDS with divine punishment, resulting in lower stigma levels among the educated as opposed to the uneducated, though exceptions may occur. These observations align with Reddy and Frantz (2011), who noted that even among individuals with secondary education in India, there existed a lack of understanding regarding the transmission of the virus, which perpetuated stigma among people living with HIV/AIDS (PLWHA). Furthermore, Potgieter et al. (2012) and Parry et al. (2009) found, in their South African studies, that despite education concerning HIV transmission (56%), many still wrongly attributed the infection solely to unprotected sexual activity, particularly among educated individuals.

The majority of respondents (65.2%) felt that women infected with HIV should be isolated in their communities, while men should be tolerated, with only 13% remaining neutral. This reflects prevalent gender-based stigma in certain communities, which often view women as the primary spreaders of HIV, despite equal risks for both genders. This finding is consistent with Herek (2009), who documented the different treatment of HIV-positive women compared to men in developing countries, where men are often excused for their circumstances while women face blame. Similarly, Mall et al. (2013) highlighted instances in some African countries where women were held responsible for their husbands' deaths from AIDS-related illnesses, even facing eviction. The results also support the assertion that although both genders face stigma for violating sexual norms, the prevailing gender power dynamics lead to women facing greater accountability, resulting in harsher consequences regarding stigma, disclosure, and care responsibilities.

Additionally, a considerable portion of respondents (77.8%) agreed that HIV-positive youth should be barred from associating with other members of their communities, with only 5% taking a neutral stance. Young people are often viewed unfavorably by society due to their association with various crimes, including sexual violence, thus influencing the belief that they should be shunned. This viewpoint aligns with Attawell et al. (2008), who noted that youth are frequently blamed for the spread of HIV attributed to perceived risky sexual behaviors.

A considerable number of respondents (76.1%) agreed that socio-economic status plays a role in perpetuating stigma, while only 10.9% remained neutral. Socioeconomic status affects individuals' living conditions and their capacity to gain respect in their communities. Those with greater economic resources can better conceal their HIV status and manage healthcare costs compared to those from lower socioeconomic backgrounds. This finding is supported by Van et al. (2009), who noted that higher socio-economic status could enable families to "conceal" HIV-affected members, thus avoiding overt stigma.

Additionally, 70% of participants believed that pre-employment screening tests could contribute to HIV/AIDS stigma. While such screenings can help organizations address employee healthcare needs, they may also lead employers to deny employment to people living with HIV/AIDS. This concern echoes Cao et al. (2008), who detailed how pre-employment screenings could lead to discrimination against HIV-positive individuals in countries with accessible testing resources.

Moreover, respondents acknowledged that challenges in securing employment contribute to stigma, with this relationship forming a vicious cycle, as stigma can hinder job opportunities while unemployment exacerbates the stigma faced by those living with HIV/AIDS. This cycle is highlighted by Visser et al. (2008), who addressed the lack of effective workplace policies regarding HIV/AIDS, resulting in widespread denial of the issue among employers. Finally, the respondents expressed strong agreement that the absence of clear workplace guidelines for treating HIV-positive individuals contributes to stigmatizing behavior, while only 2% disagreed. Without protective policies in place, HIV-positive individuals might suffer discrimination from both peers and employers, often leading them to conceal their status to avoid stigma. This finding aligns with Gilbert and Walker (2009), who stressed the importance of transparency and policies in combating the stigma associated with HIV/AIDS, which often leads individuals to hide their status, contributing to the epidemic's invisibility and increasing challenges for affected individuals.

5.4 RECOMMENDATIONS

At the community level, it is essential to shift away from the belief that being HIV positive or having a friend or family member with HIV/AIDS is something to be ashamed of. This study emphasizes the need for a change in attitudes that blame individuals living with HIV/AIDS for their condition, as such blame leads to discrimination and stigma, fosters misunderstandings about the illness, and complicates efforts to provide necessary support.

The research highlights that when people personally interact with those living with HIV/AIDS, they often demonstrate greater understanding. To mitigate the impact of stigma, community-level interventions must be addressed. Rather than denouncing cultural values, providers of HIV/AIDS programs should focus on reshaping attitudes and promoting positive and culturally sensitive messages. While individuals and organizations can implement interventions, it is preferable for the government to lead these efforts using a comprehensive approach to reduce stigma.

The study cautions against explaining all behaviors of people living with HIV/AIDS solely in the context of HIV-related stigma. It is crucial for individuals to reflect on their thoughts and feelings about AIDS, especially regarding public stigma. HIV/AIDS is commonly linked with fear, stigma, and prejudice, compounded by widespread myths and misunderstandings. Failing to

confront personal feelings about HIV can lead to differential treatment of those perceived as HIV positive or at risk.

Indicators of stigma such as suspicion, blame, fear, prejudice, and judgment observed in these communities play a role in perpetuating HIV/AIDS stigma. There is a pressing need for community-level interventions to combat stigma. While some AIDS prevention programs address stigma, many initiatives lack sufficient evaluation and documentation. Therefore, comprehensive community-targeted efforts are necessary to change perceptions about HIV/AIDS. Individual-level education is also vital for fostering realistic risk perceptions and enhancing self-efficacy to decrease stigma and negative attitudes toward those living with HIV/AIDS, thereby altering the community response to the epidemic.

Even though the findings align with international research, further studies of this nature are needed in Uganda to substantiate these results, as the data currently covers only one county. There is also a need for additional research to be conducted with larger, more representative populations to deepen the understanding of HIV/AIDS stigma within communities.

5.5 POSSIBLE IMPLICATIONS OF THE STUDY:

The findings of this study may assist individuals living with HIV/AIDS in realizing that their fears and perceptions of community stigma might be exaggerated. The research suggests that community-based interventions could be created to alleviate fears surrounding HIV/AIDS and the prevalent moral judgments associated with it. It distinguishes between two types of stigma, revealing that community social stigma is greater than internalized stigma. This indicates that participants perceive the stigma associated with HIV/AIDS to be significantly lower for themselves than what they believe others in the community think. There is a prevailing collective stigma that is negative, blaming, and restrictive towards interactions with those living with HIV/AIDS. All areas of the study reflect a shared understanding of the strong stigmatizing attitudes within the community, highlighting the need for awareness regarding their own biases and how these affect their behavior.

On an individual level, the exposure to HIV/AIDS significantly impacts attitudes towards those affected. Encouraging people with HIV to openly share their status with family and friends can foster personal interactions, which may lead to a reduction In blame, judgment, and personal stigma.

To combat stigmatizing behavior within the community and change perceptions, a collective effort from all sectors—including government, community and church leaders, schools, and media—is necessary to support and care for those living with HIV. The entire community needs to participate in the fight against HIV/AIDS, focusing on positive beliefs and values that can be incorporated into intervention programs. Community and church leaders should actively partake in creating these initiatives.

The study indicates that many respondents perceive discrimination and prejudice against individuals in the community, which underscores the need for laws to protect those living with HIV/AIDS from stigma and discrimination. Increased involvement of people with HIV/AIDS in the creation and execution of intervention programs is necessary to diminish stigma. Men should be encouraged to spearhead these initiatives within communities, as their active participation is crucial due to their positions of influence. Both men and women should work to challenge societal norms that place men at risk, such as the expectation that they should inherently possess extensive knowledge and experience with sexual health, which influences HIV/AIDS stigma. Collaborative efforts among village leaders, male religious figures, and businesspeople in educational outreach, community care, and faith-based organizations are essential. Programs aimed at changing attitudes and behaviors that contribute to stigma must be systematically designed and implemented.

5.6 CONCLUSION

The findings of this study reveal that significant work remains to address the stigma surrounding HIV and AIDS in Kakuuto and across Uganda. There appears to be a disconnect between the limited research available on the nature of stigma and actionable solutions for communities. Despite awareness campaigns conducted through various media, many individuals continue to hold negative views of people living with HIV/AIDS.

By understanding stigma as a reaction rooted in fear and blame rather than ignorance, we can better comprehend the stigmatization process without attributing it solely to individual perspectives.

Many individuals cast blame on those with HIV/AIDS, perceiving them as deserving of their situation due to the disease's association with socially unacceptable behaviors. Consequently, HIV/AIDS is often seen as a "bad disease" linked to high-risk activities like promiscuity and drug use, prompting people to distance themselves from it.

Having personal knowledge of someone living with HIV/AIDS significantly influences both individual and community perceptions. HIV/AIDS is heavily stigmatized, leading to discrimination, blame, and judgment. The overall conclusion from this research is that a high level of stigma regarding HIV/AIDS exists at the community level in Kakuuto. On a personal level, respondents expressed negative attitudes towards individuals living with the virus. Many who hold such stigmatizing views are misinformed about HIV transmission, with some incorrectly believing it can be spread through casual contact. Notably, 22% of surveyed individuals would feel uncomfortable sending their child to school with those living with AIDS, and nearly 42% believe that people who are exposed to AIDS through sexual activity deserve their fate.

There are significant limitations to this research that warrant mentioning:

First, the sampling method was not entirely random; it was chosen based on practical concerns such as the safety of field workers and the need for a representative group.

Second, while the goal was to interview 305 individuals (20 from each sub-county), some participants withdrew for various known and unknown reasons.

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APPENDIX I: INFORMED CONSENT

Good morning/afternoon/evening?

My name is **Naggirinya Favour** a student of Uganda Christian University Mukono Campus School of Social Sciences. I am here to conduct research **on social demographic factors contributing to stigma among HIV/AIDS clients receiving medical treatment from Kakuuto Health centre IV** as a partial fulfilment of the requirements for the award of Bachelor's degree in social work. You have been randomly selected to participate in this study. Please be assured that all information gathered will remain confidential and I will not record your name or any identifiable details about you. Participation is entirely voluntary, and you will not face any consequences if you choose not to take part. You are also not obliged to answer any questions that you prefer to skip and can withdraw from the interview at any time. The success of this study relies heavily on your candid responses. If you choose to participate, the interview will take approximately one hour. Do you agree to take part in the study? Do you have any questions or need any clarification before we begin?

Signature of the respondent …….

Date: _____/_____/_____

APPENDIX 11: BIODEMOGRAPHIC DATA.

BIODEMOGRAPHIC PARAMETER		**RESPONSE(TICK)**
Age(years)	10-19	
	20-29	
	30-39	
	40-49	
	50-59	
	60+	
Sex	Male	
	Female	
Tribe	Baganda	
	Basoga	
	Others (Specify)	
Employment status	Un employed	
	Self employed	
	Employed	
Marital status	Married	
	Single	
	Cohabiting	
	Divorced	
	Widowed	
Education level	No formal education	
	Primary	
	Secondary	
	Tertiary	

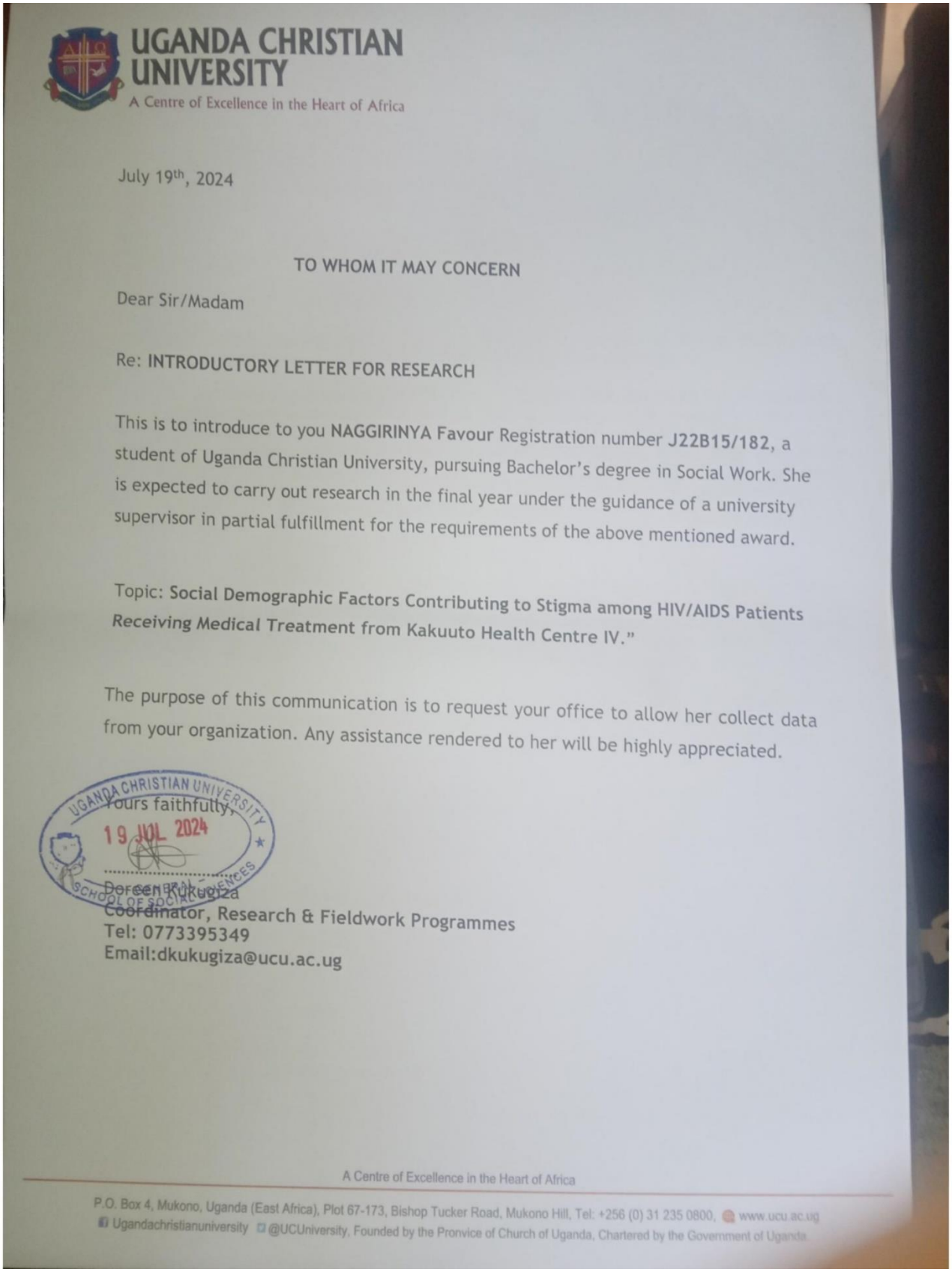
APPENDIX III: SOCIO-DEMOGRAPHIC FACTORS CONTRIBUTING TO HIV/AIDS

Socio-demographic factors	**Strong agree**	**Agree**	**Neither agree nor disagree**	**Strongly disagree**	**Disagree**
Lack of proper education may promote HIV/AIDS related stigma					
HIV infected women should be isolated from the community while men should be tolerated					
Religious teachings about moral purity may contribute to HIV/AIDS stigma					
HIV infected youth should not be allowed to associate with other members of the community					
Laws such as compulsory testing of individuals before marriage can contribute to HIV/AIDS stigma					

Socio economic factors	Strongly agree	Agree	Neither agree nor disagree	Strongly disagree	Disagree
Financial status can influence stigmatizing process					
Pre-employment screening tests can contribute to HIV/AIDS stigma					

High health care charges for HIV/AIDS clients in private hospitals can contribute to HIV/AIDS related stigma					
Difficulty in obtaining jobs or employment may contribute to stigma among HIV/AIDS infected persons					
Lack of clear work place policies regarding care of HIV/AIDS infected individuals may contribute stigmatizing behavior towards these persons					

APPENDIX IV: INTRODUCTORY LETTER



UGANDA CHRISTIAN UNIVERSITY
A Centre of Excellence in the Heart of Africa

July 19th, 2024

TO WHOM IT MAY CONCERN

Dear Sir/Madam

Re: INTRODUCTORY LETTER FOR RESEARCH

This is to introduce to you **NAGGIRINYA Favour** Registration number **J22B15/182**, a student of Uganda Christian University, pursuing Bachelor's degree in Social Work. She is expected to carry out research in the final year under the guidance of a university supervisor in partial fulfillment for the requirements of the above mentioned award.

Topic: **Social Demographic Factors Contributing to Stigma among HIV/AIDS Patients *Receiving Medical Treatment* from Kakuuto Health Centre IV."**

The purpose of this communication is to request your office to allow her collect data from your organization. Any assistance rendered to her will be highly appreciated.

UGANDA CHRISTIAN UNIVERSITY
19 JUL 2024
SCHOOL OF SOCIAL SCIENCES

Yours faithfully,

Dorcen Kukugiza
Coordinator, Research & Fieldwork Programmes
Tel: 0773395349
Email:dkukugiza@ucu.ac.ug

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