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Trends and Levels of HIV/AIDS-Related Stigma and Discriminatory Attitudes: Insights from Botswana AIDS Impact Surveys

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1. Introduction

For a very long time now, people living HIV and AIDS have been stigmatized and discriminated against and these negative attitudes have been observed to deter people from seeking health care services such as participating in voluntary counselling and testing and prevention of mother-to-child transmission (Nyblade and Field, 2002). UNAIDS (2007) argued that in many countries and communities, the stigma associated with HIV and the resulting discrimination can be as devastating as the illness itself: abandonment by spouse and/or family, social ostracism, job and property loss, school expulsion, denial of medical services, lack of care and support, and violence. It found that these consequences, or fear of them, mean that people are less likely to come in for HIV testing, disclose their HIV status to others, adopt HIV preventive behaviour, or access treatment, care and support. If they do, they could lose everything. Previous research (for example, Alonzo and Reynolds, 1995) has found that HIV-related stigma originates from several sources. First, HIV and AIDS are associated with the deviant behaviour that is suspected to have caused the HIV-positive status. Second, that the individual was irresponsible to have contracted HIV. Third, that it is the individual's immoral behaviour that caused HIV and AIDS. Finally, that HIV and AIDS are contagious and threatening to the community.

One of the major challenges for studying HIV/AIDS-related stigma discrimination is how to best measure the concept of "stigma". At the moment, as USAID (2006) rightly stated: "...measures that can both describe an existing environment, and evaluate and compare interventions, are lacking" (p.2). A wide range of questions are used to measure stigma. There is a need to correctly measure stigma for a variety of reasons. USAID (2006) has summarized why there is a need to measure stigma and the reasons are summarized below. One such reason is the fact that anti-stigma interventions that have been designed and implemented need to be evaluated to determine if the intervention is effective or not. Another equally important reason for measuring stigma is to identify effective models and take them to scale. Measurement of stigma allows researchers to test the hypothesis that stigma would decline if antiretroviral drugs were more widely available. These are some of the reasons for developing a tested and validated measure of stigma.

In responding to the HIV/AIDS epidemic, the Government of Botswana embarked on various strategies to fight the disease, including HIV/AIDS-related stigma and discrimination. The National Strategic Framework (NSF) for HIV/AIDS 2003-2009 had as some of its key goals psycho-social and economic impact mitigation and the provision of a strengthened legal and ethical environment. It also had as one of its objectives the minimization of the impact of the epidemic on those infected and/or affected and creation of a supportive, ethical, legal and human rights-based environment conforming to international standards for the implementation of the national response (Republic of Botswana, 2002b). The NSF also identified stigma and denial as creating an environment maintaining the potential for increased infection as well as limiting the ability of people to live positively and responsibly with HIV and AIDS. The provision of voluntary counselling and testing was expected to enable people living with HIV and AIDS to go public with their serostatus.

In reviewing previous efforts before the NSF to address HIV and AIDS in the country, Government observed that important gaps existed. One such gap was that support groups for people living with HIV/AIDS (PLWHA) needed to be expanded in order to increase coverage and further assist in the breakdown of stigma and denial around HIV/AIDS. Another important gap identified was that the legal, ethical and human rights environment required strengthening to enable and support an effective national response (Republic of Botswana, 2002b).

The Government of Botswana has assumed that as voluntary counselling and testing becomes easily accessible and people know their status, it will bring down stigma and discrimination. It is argued that in countries such as Uganda, Cuba and others where HIV status is openly discussed, stigma surrounding HIV and AIDS has been dramatically reduced, if not completely eliminated (Republic of Botswana, 2002b:31)

On the basis of the foregoing, the key objective of this paper is to assess progress made in reducing the prevalence of HIV-related stigma and discriminatory attitudes in Botswana which was and continues to be a key objective in the national response. The purpose of the paper therefore is to estimate the levels and trends of HIV-related stigma in the country using three Botswana AIDS Impact Surveys (BAIS) I, II and III. It is assumed that any reduction in HIV/AIDS-related stigma and discrimination is a result of the anti-stigma interventions that the Government of Botswana has embarked on.

2. Methodology

2.1 Data

Data for this paper were drawn from the Botswana AIDS Impact Surveys (BAIS) conducted in 2001, 2004 and 2008. The main objectives of the BAIS were to provide information to: assess whether programs are operating as intended; assess performance of intervention programs; assess whether people are changing their sexual behavior; establish the proportion of people in need of care due to HIV infection; establish the proportion of people who are at risk of HIV infection; assess the impact of the pandemic at household level; and provide information on issues related to the impact of HIV/AIDS on households and communities (Republic of Botswana, 2002a).

All the three surveys have asked the same questions that can be used to assess the level and trends in HIV/AIDS-related stigma and discriminatory attitudes. In this paper, the following

three questions were used to assess HIV/AIDS-related stigma and discrimination: i) If a member of your family became sick with HIV/AIDS, would you be willing to care for him or her in your household? ii) If a teacher has HIV/AIDS but is not sick, should s/he be allowed to continue teaching in school? iii) If you knew that shopkeeper or food seller had HIV/AIDS, would you buy vegetables from them? These questions were asked in the three surveys in the same way that makes them comparable.

Respondents who did not complete the individual questionnaire were excluded from the present analysis. The analysis was also restricted to those aged 10-64 years.

2.2 Measurement of variables

2.2.1 Response variables

Stigma is often rooted in social attitudes and it is in this context that trends and levels of HIV-related stigma and discrimination are investigated using variables assumed to measure social attitudes. Participants who did not respond in the affirmative to any of the below three questions were considered to harbor discriminatory attitudes towards people living with HIV/AIDS. The following three response variables were used in this study as measures of stigma and discriminatory attitudes towards people with HIV/AIDS:

2.2.1.1 Unwillingness to care for a family member with HIV/AIDS

Respondents were asked: "If a member of your family became sick with HIV/AIDS, would you be willing to care for him or her in your household?" This indicator is a dummy variable that equals one for respondents who said "no" or zero if it was "yes".

2.2.1.2 Should not allow a teacher with HIV/AIDS to teach

Respondents were asked: "If a teacher has HIV/AIDS but is not sick, should s/he be allowed to continue teaching in school?" This binary variable was coded in such a manner that the response "no" equals one or zero if it was "yes".

2.2.1.3. Would not buy vegetables from a shopkeeper with HIV/AIDS

Respondents were asked: "If you knew that a shopkeeper or a food-seller had HIV/AIDS, would you buy vegetables from them?" This variable was a dummy variable that equals one for respondents who stated "no" or zero if it was "yes".

2.2.2 Control variables

Control variables used for this study included age (10-19, 20-29, 30-39, 40-49, 50-59 and 60-64 years), current marital status (married (married plus living together), once married (divorced, separated, widowed) and never married), and the highest level of education attained (no education, primary (non-formal plus primary), secondary and higher).

2.2.3 Statistical analysis

The proportions of the people expressing discriminatory attitudes toward people living with HIV/AIDS were calculated using percentages. Cross tabulations were used to present the proportions of males and females with discriminatory attitudes toward people living with HIV/AIDS. Graphs were used to examine levels and trends in the proportions of people with discriminatory attitudes. Because comparison of percentages between the three surveys

may not be reliable because of differences in the age structures in the three sample populations, direct standardization procedure was used to eliminate the compositional effects or confounding. Standardization involved taking the 2001 population in 10-year age groups from 10 to 64 years as a standard and applying to it the specific proportions expressing discriminatory attitude for the populations being compared. This produced the number of expected population expressing discriminatory attitudes which was compared with the actual number of people expressing discriminatory attitudes in the standard population. The ratio of expected divided by observed gave the standardized proportion. The standardized proportions were used to examine the levels and trends in the population expressing discriminatory attitudes toward people living with HIV/AIDS.

3. Results

The results are presented in the form of tables and figures as shown below. The results indicated that although the percentage of people expressing discriminatory attitudes toward people living HIV/AIDS remains high, it has been declining over the past several years. Figures I to III show trends in the percentage of people expressing discriminatory attitudes toward people living with HIV and AIDS, classified by gender.

Figure I shows that men tended to discriminate a shopkeeper who sells vegetables more than other people living with HIV and AIDS. Men were less discriminating when it came to their family members who were living with HIV and AIDS. However, over time these discriminatory attitudes appear to be declining, which may suggest that anti-stigma and discrimination interventions that the Government of Botswana has embarked on are producing the desired outcomes.

Figure II portrays that females compared to their male counterparts were less discriminating against people living with HIV and AIDS. The percentage of females reporting discriminatory attitudes were much lower than those of their male counterparts. In addition, the speed or pace of the decline in the percentage of females expressing discriminatory attitudes against people living with HIV and AIDS is much faster than those of the males over time. It is also evident from this figure that females were less discriminating when their family members were involved compared to those who were considered distant family-wise.

Figure III simply presents the percentage of both males and females combined who discriminate against people living with HIV and AIDS. This figure shows results very similar to what has already been discussed. Overall, discriminatory attitudes toward people living with HIV and AIDS have declined over time. Family members living with HIV and AIDS were less discriminated against compared to other groups of people.

3.1 Levels and trends in percentage of people who reported that they would not care for a family member sick with HIV and AIDS

From Table 1 and Figure 3, the percentage of the population who reported that they would not care for a family member sick with HIV and AIDS decreased from 11.5 percent in 2001 to 7.6 percent in 2004 and finally to 3.6 percent in 2008. Generally, a higher percentage of males were more likely to portray HIV-related stigma and discriminatory attitudes than their female counterparts (see Figures 1 and 2). For example, in 2001, 13.2 percent of males reported that they would not care for a family member sick with HIV and AIDS compared to 10.1 percent of females. The same pattern emerged in the BAIS 2004 and 2008 results (11.8 percent males versus 4.6 percent females in 2004 and 5.3 percent versus 4.3 percent in 2008).

Socio-demographic differentials showed that the proportion of the population who reported that they would not care for a family member sick with HIV and AIDS decreased as age increased, although slightly higher proportions of people aged 50 and above tended to portray higher levels of HIV-related stigma and discrimination. A similar pattern was observed for both males and females.

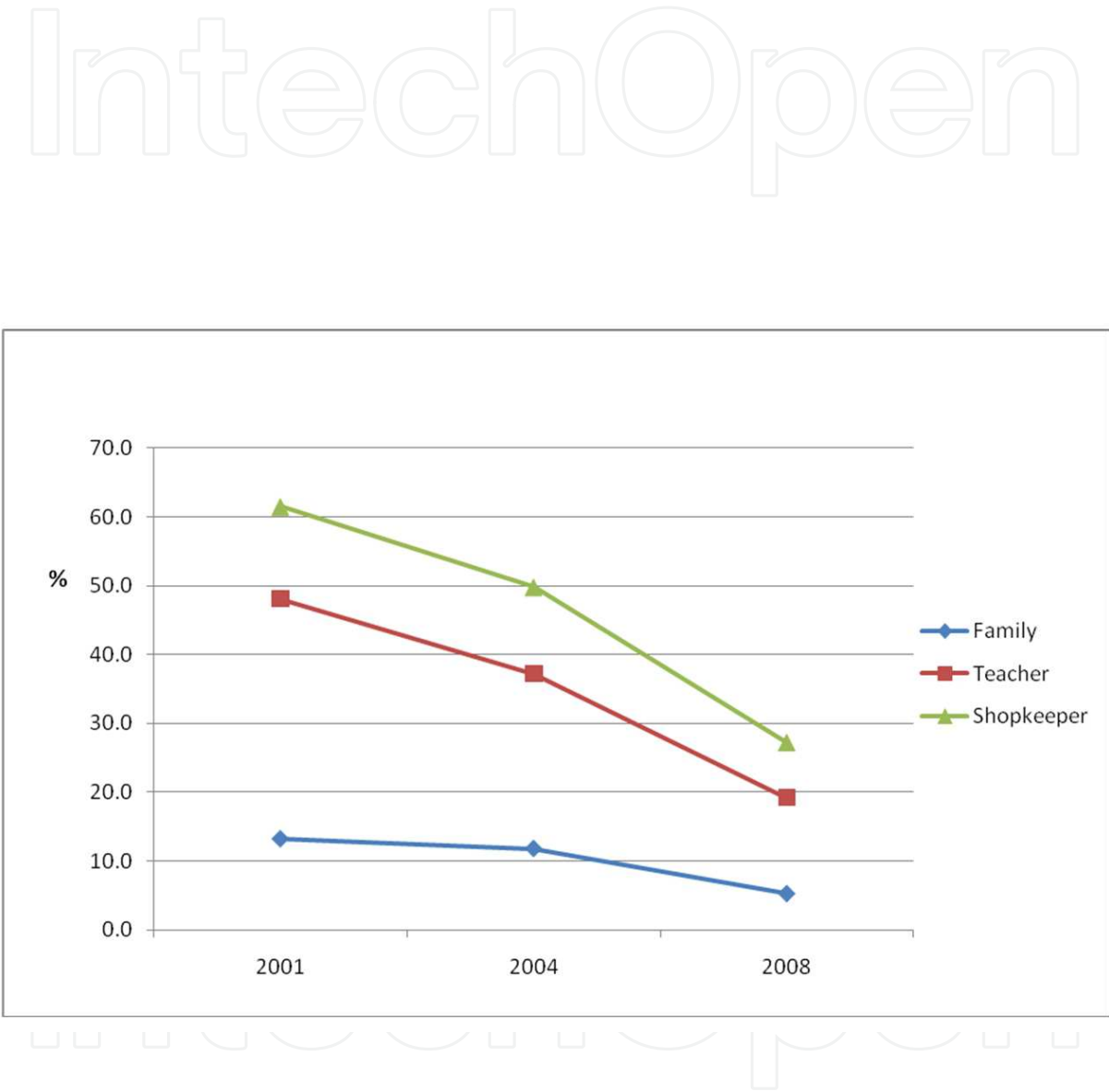


Fig. 1. Levels and trends in the proportion of males who expressed discriminatory attitudes toward people living with HIV and AIDS

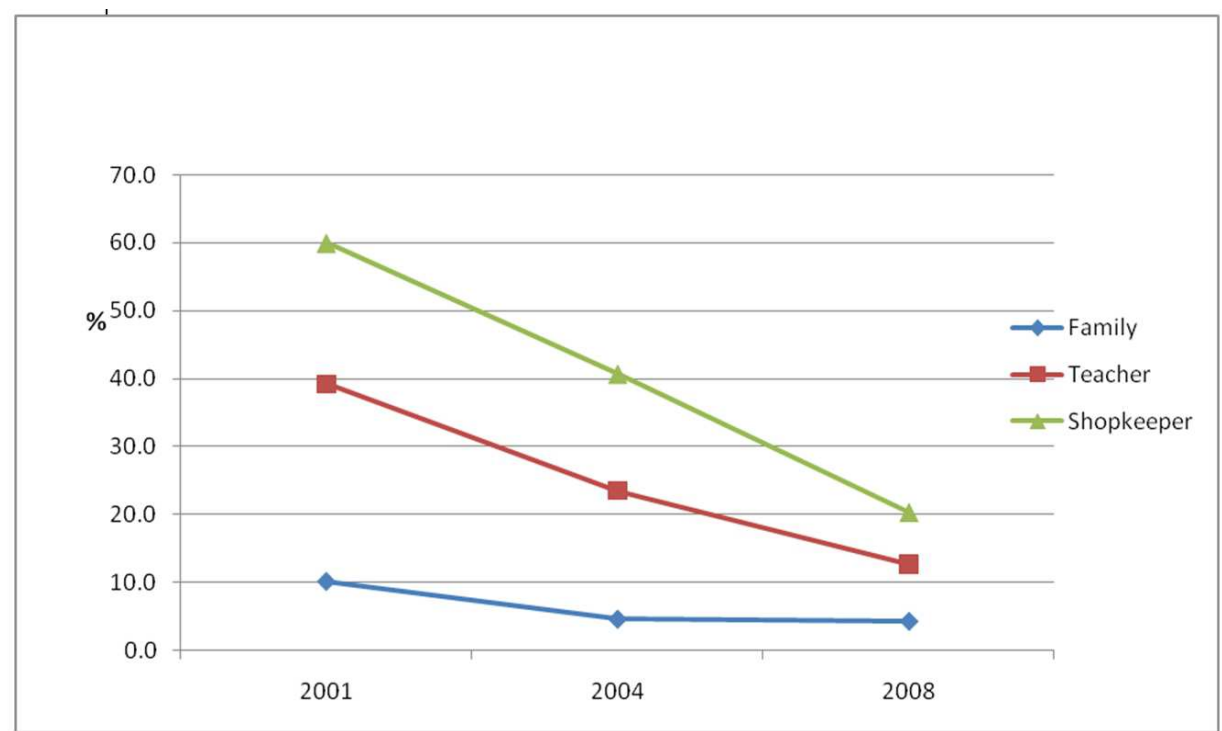


Fig. 2. Levels and trends in the proportion of females who expressed discriminatory attitudes toward people living with HIV and AIDS

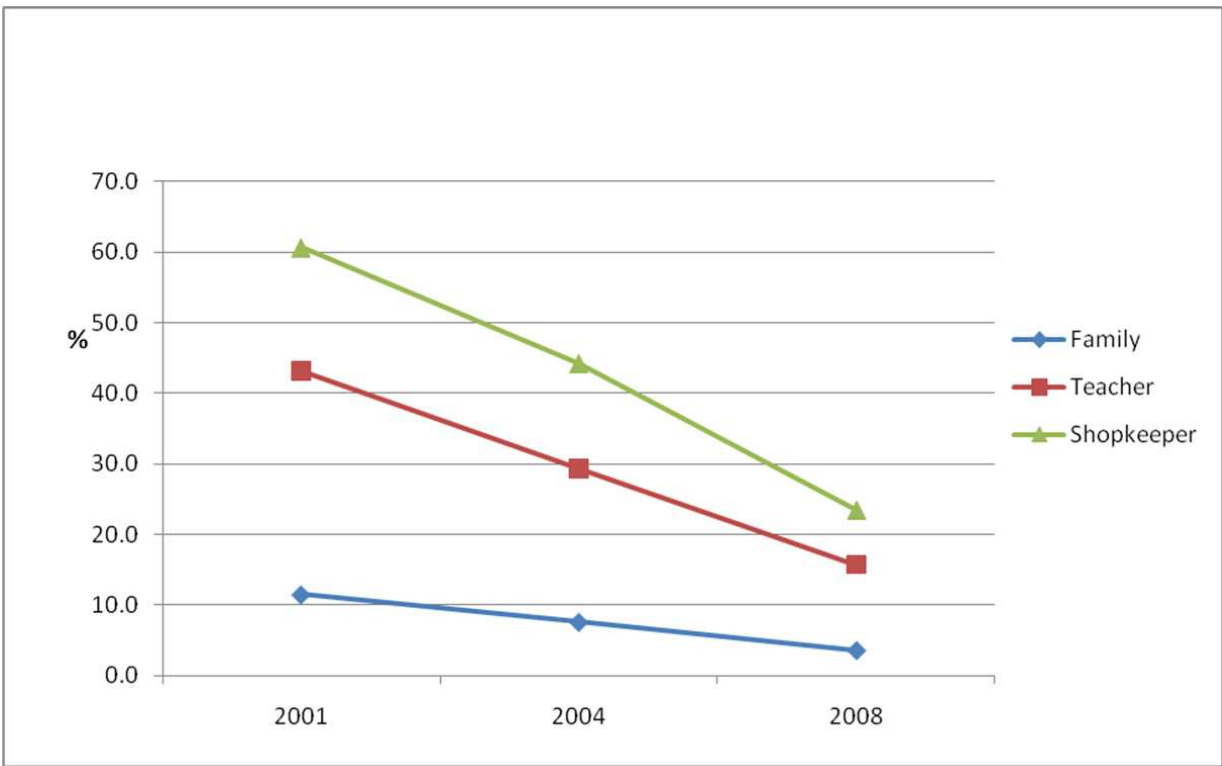


Fig. 3. Levels and trends in the proportion of both males and females who expressed discriminatory attitudes toward people living with HIV and AIDS

Socio-demographic variables	BAIS I			BAIS II			BAIS III		
	Male	Female	Total	Male	Female	Total	Male	Female	Total
Age group									
10-19	22.5	20.5	21.5	19.7	6.3	12.5	8.6	6.7	7.6
20-29	11.0	6.8	8.7	9.0	3.6	5.3	5.1	2.1	3.5
30-39	5.8	2.0	3.5	8.8	3.2	5.6	2.3	1.8	2.0
40-49	5.5	4.3	4.8	2.3	3.3	2.8	1.7	1.5	1.6
50-59	8.1	4.9	6.3	5.8	4.4	5.0	3.4	1.9	2.5
60-64	3.0	5.1	4.2	10.0	7.4	9.0	2.1	5.1	3.8
Education									
No education	7.6	9.8	8.7	13.5	9.1	11.6	5.8	4.7	5.3
Primary	17.9	13.4	15.4	8.9	4.1	6.1	7.7	4.5	5.9
Secondary	12.0	7.9	9.5	9.1	2.9	4.8	3.8	2.3	2.9
Higher	9.1	3.2	6.4	0.9	1.3	1.1	2.5	2.0	2.2
Marital status									
Married	6.0	4.0	4.8	7.7	4.2	5.8	2.1	1.5	1.8
Once married	14.7	5.3	7.6	4.5	2.2	2.6	4.3	2.7	3.1
Never married	16.5	13.4	14.8	10.2	3.8	6.3	6.6	4.3	5.4
Total %	13.5	9.9	11.5	8.7	3.8	5.8	4.9	3.1	3.9
Adjusted Total %	13.2	10.1	11.5	11.8	4.6	7.6	5.3	4.3	3.6

Table 1. Percentage of the population who reported that they would not care for a family member sick with HIV & AIDS, actual and standardized percentages, by survey and sex, Botswana AIDS Impact Surveys (BAIS) I, II & III

Generally, a higher percentage of people with primary education compared to other educational categories tended to report that they would not care for a family member sick with HIV and AIDS compared to those with other educational achievements. People with post-secondary education overall were less likely to report that they would not care for a family member sick with HIV and AIDS. This pattern also emerged regardless of the sex of the respondent.

With regards to marital status, a higher percentage of never married people reported that they would not care for a family member sick with HIV and AIDS compared to people in other marital categories. Married or living together couples were less likely to report that they would not care for a family member sick with HIV and AIDS.

3.2 Levels and trends in percentage of people who reported that a teacher who has HIV and AIDS but not sick should not be allowed to teach

In 2001, 43.2 percent of people stated that a teacher who has HIV or AIDS but not sick should not be allowed to teach compared to 15.7 percent in 2008 (see Table 2).

Again, a higher percentage of males were more likely to portray HIV-related stigma and discriminatory attitudes than their female counterparts (Figures 1 and 2). Overall, 48.1 percent of males indicated that a teacher who has HIV or AIDS but not sick should not be allowed to teach compared to 39.2 percent of females in 2001. These percentages were recorded as 37.2 and 23.5 percent respectively in 2004 and 19.2 and 12.7 percent respectively in 2008.

Socio-demographic variables	BAIS I			BAIS II			BAIS III		
	Male	Female	Total	Male	Female	Total	Male	Female	Total
Age group									
10-19	59.1	48.8	53.7	52.0	26.4	38.6	28.8	20.6	24.6
20-29	40.5	27.9	33.5	27.4	15.4	19.2	11.8	7.3	9.4
30-39	39.8	29.6	33.7	26.9	19.2	22.5	11.6	5.4	8.1
40-49	39.7	43.5	41.8	31.8	24.0	27.6	14.8	9.6	11.8
50-59	52.1	49.5	50.7	29.0	40.7	35.1	22.8	12.8	17.1
60-64	56.8	51.6	53.9	49.8	52.9	51.3	22.7	30.8	27.1
Education									
No education	66.9	65.0	66.0	55.6	46.0	51.6	31.8	25.8	29.0
Primary	63.5	54.2	58.4	41.6	31.3	35.6	31.0	19.0	24.3
Secondary	37.2	26.8	31.0	21.1	12.0	14.8	11.9	7.0	9.3
Higher	6.8	3.6	5.3	2.5	2.1	2.3	4.0	1.8	2.9
Marital status									
Married	38.5	35.7	36.9	25.9	23.2	24.4	13.4	7.8	10.3
Once married	64.8	44.1	49.3	5.3	29.6	25.5	14.2	13.7	13.9
Never married	52.0	40.5	45.9	39.6	16.8	26.1	20.8	13.7	17.1
Total %	52.0	40.5	45.9	31.9	20.7	25.3	18.1	11.5	14.5
Adjusted Total %	48.1	39.2	43.2	37.2	23.5	29.3	19.2	12.7	15.7

Table 2. Percentage of the population who reported that a teacher who has HIV & AIDS but not sick should not be allowed to teach, actual and standardized percentages, by survey and sex, Botswana AIDS Impact Surveys (BAIS) I, II & III

The proportion of the population who reported that a teacher who has HIV or AIDS but not sick should not be allowed to teach that a teacher who has HIV or AIDS but not sick should not be allowed to teach did not vary significantly by age for both males and females. There is no clear trend that can be discerned from the data in terms of age differentials. Generally, a higher percentage of people with no or primary education compared to other educational categories tended to report that a teacher who has HIV or AIDS but not sick

should not be allowed to teach compared to those with higher educational achievement (see Table 2). People with tertiary education were less likely to report that a teacher who has HIV or AIDS but not sick should not be allowed to teach. This pattern also emerged regardless of the sex of the respondent.

With regards to marital status, a higher percentage of never married people reported that a teacher who has HIV or AIDS but not sick should not be allowed to teach compared to people in other marital categories. Married or living together couples were less likely to state that they would not care for a family member sick with HIV and AIDS.

3.3 Levels and trends in percentage of people who reported that they would not buy vegetables from shopkeeper who had HIV and AIDS

Overall, the percentage of people indicating discriminatory attitudes toward a shopkeeper who has HIV or AIDS has been decreasing over time (Figures 1 to 3). About 60.7 percent of people in 2001 compared to 23.5 percent in 2008 indicated that they would not buy vegetables from a shopkeeper who had HIV or AIDS (see Table 3).

The majority of people who stated that they would not buy vegetables from a shopkeeper who had HIV or AIDS were predominantly males.

The percentage of the population that reported that they would not buy vegetables from an HIV positive shopkeeper varied in an unclear direction in terms of ages for both males and females. It would appear that young people generally stated that they would not buy vegetables from a shopkeeper who had HIV or AIDS.

A higher percentage of people with no education and those with primary education compared to other educational categories tended to report that they would not buy vegetables from a shopkeeper who had HIV or AIDS compared to those with higher educational achievement. People with tertiary education were less likely to report that they would not buy vegetables from a shopkeeper who had HIV or AIDS. This pattern also emerged regardless of the sex of the respondent.

With regards to marital status, a higher percentage of never married people reported that they would not buy vegetables from a shopkeeper who had HIV or AIDS compared to those people in other marital categories. Married couples were less likely to state that they would not buy vegetables from a shopkeeper who had HIV or AIDS.

4. Discussion

The purpose of the paper was to estimate the levels and trends of HIV-related stigma in Botswana using three Botswana AIDS Impact Surveys (BAIS) I, II and III. The study shows that HIV/AIDS-related discriminatory attitudes among Botswana are declining. HIV/AIDS-related discrimination is much lower when an HIV infected person is a family member of the respondent. The study results showed that people who were more likely to report that a teacher who has HIV or AIDS but not sick should not be allowed to teach were males, those who had primary education, and the never married. The results showed that people who were more likely to report that a teacher who has HIV or AIDS but not sick should not be allowed to teach were males, those who had primary education, and the never married. The study also showed that people who were more likely to report that they would not buy vegetables from a shopkeeper who had HIV or AIDS were males, those who had no or primary education, and the never married.

It is evident from the results that in the past, most Batswana discriminated against people living with HIV and AIDS. Letamo (2003) found that close to two-thirds of people in 2001 expressed discriminatory attitudes toward people living with HIV and AIDS and the majority of these people were males. This percentage dropped to 44.3% in 2004 and later in 2008 to 23.5%. The reductions in the proportion of people who discriminate against those living with HIV/AIDS are believed to be due to government efforts to reduce stigma and discrimination. The consistent declining trends in discriminatory attitudes towards people living with HIV and AIDS may be suggestive of the fact that the Government of Botswana initiatives in fighting stigma and discrimination associated with HIV and AIDS are starting to produce desired results.

A consistent finding emerging out of the data is that people tend to express accepting attitudes toward people living with HIV and AIDS if they are family members but more discriminating if they are unrelated to them. Like it was earlier stated in Letamo (2003), the more tolerant attitude to care for a family member who is living with HIV/AIDS probably reflect the government intervention of promoting community home-based care programmes. The concept of community home-based care was introduced in 1992 to reduce the relieve public hospitals of the burden of caring for increasing number of AIDS patients. Community home-based care is a programme desired to ensure that family members of people living with HIV and AIDS actively participate in the care of their members. In other words, one can conclude that community home-based care indirectly promotes tolerant attitudes towards people living with HIV and AIDS.

Another emerging observation from the results is that females rather than males have more tolerant attitudes toward people living with HIV and AIDS. The more tolerant attitudes toward people living with HIV and AIDS of females may reflect the current set-up where a disproportionate number of women provide care to all members of the family. Community home-based care is almost exclusively shouldered by women (Population Reference Bureau, n.d.).

5. Conclusions

This study found that although HIV/AIDS-related discrimination has been decreasing over the years, there are still those who harbour these negative attitudes toward people living with HIV and AIDS. Unattended to, these negative attitudes may hamper utilization of various HIV/AIDS care services. It is evident that government efforts or interventions to address HIV/AIDS-related stigma and discrimination are producing desirable outcomes, even though there is room for improvement. Current anti-stigma interventions need to be strengthened in order to uproot HIV/AIDS-related stigma and discrimination completely. It is also important to conduct further studies to understand why people stigmatise and discriminate against those living with HIV or have AIDS.

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also like to express his heartfelt gratitude to Central Statistics Office in the Ministry of Finance and Development Planning for granting him permission to use the BAIS data.

Socio-demographic variables	BAIS I			BAIS II			BAIS III		
	Male	Female	Total	Male	Female	Total	Male	Female	Total
Age group									
10-19	71.4	66.1	68.6	55.2	44.3	49.3	36.9	32.0	34.4
20-29	54.6	52.3	53.3	46.4	34.7	38.4	21.6	13.1	17.0
30-39	54.7	53.4	53.9	46.4	34.3	39.4	17.0	10.2	13.2
40-49	58.3	62.1	60.5	50.2	41.1	45.3	21.9	15.8	18.4
50-59	59.6	71.8	66.5	44.3	54.2	49.9	28.9	20.8	24.1
60-64	61.5	63.4	62.6	43.8	66.0	52.6	37.9	32.5	34.9
Education									
No education	72.6	77.6	75.0	72.8	59.1	66.8	40.4	30.6	35.8
Primary	75.5	70.1	72.6	60.5	50.0	54.4	39.0	26.2	31.9
Secondary	52.1	51.9	52.0	34.6	29.6	31.1	19.6	15.3	17.2
Higher	28.8	27.6	28.3	14.4	10.5	12.7	10.3	6.5	8.4
Marital status									
Married	53.4	58.7	56.5	42.1	39.3	40.6	19.4	13.9	16.3
Once married	66.0	63.9	64.5	22.5	39.0	36.4	25.9	20.3	21.6
Never married	65.2	60.2	62.6	55.7	36.6	44.3	29.6	21.8	25.6
Total %	61.9	59.9	60.8	48.1	38.0	42.1	25.7	18.7	22.0
Adjusted Total %	61.5	60.0	60.7	49.8	40.7	44.3	27.2	20.3	23.5

Table 3. Percentage of the population who reported that they would not buy vegetables from a shopkeeper who had HIV & AIDS, actual and standardized percentages, by survey and sex, Botswana AIDS Impact Surveys (BAIS) I, II & III

7. References

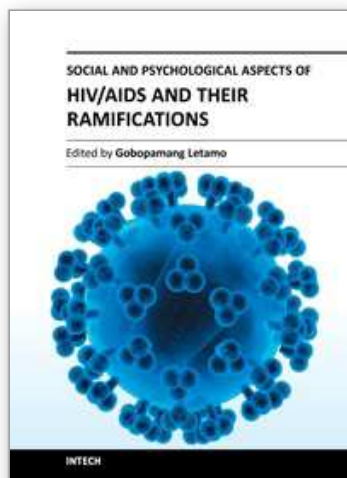
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This book has assembled an array of chapters on the social and psychosocial aspects of HIV/AIDS and their impact on HIV/AIDS and related behaviours. The book addresses key areas of HIV and AIDS, including, but not in any way limited to, care-seeking behaviour, adherence, access, psychosocial needs and support services, discrimination and the impact the epidemic has on various sectors of the economy. The book has seventeen chapters; seven chapters deal with social aspects of HIV/AIDS, four with psychosocial aspects of HIV/AIDS, and the remaining six chapters with the impact of social and psychosocial factors on HIV/AIDS and related behaviours. The book is an essential reading for academics, students and other people interested in the field of HIV and AIDS.

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