STIGMA, DISCRIMINATION EXPERIENCE, AND COPING MECHANISM: A CASE STUDY OF PEOPLE LIVING WITH HIV/AIDS IN URBAN AND RURAL CAMBODIA.

By

MATH SRALES

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ORIGINALITY DECLARATION

I, MATH Srales, would like to announce that this thesis is personally written by me. So far, this thesis has not been submitted for the purpose of another degree at other universities or academic institutions.

All the relevant information and data that were searched from unpublished and published sources have been cited and recognized properly.

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LIST OF ACRONYMS AND ABBREVIATIONS

AIDS	Acquired Immune Deficiency Syndrome
ANC	Antenatal Care
ART	Antiretroviral therapy
ARV	Antiretroviral
CACHA	Cambodia Alliance for Combating HIV and AIDS
CAS	Cambodia Center for Advanced Study
CCW	Cambodia Community for Women Living with HIV and AIDS
CDHS	Cambodia Demographic and Health Survey
CMDG	Cambodian Millennium Development Goals
CPN+	Cambodian People Living with HIV/AIDS Network
CSES	Cambodia Socio Economic Survey
CSO	Civil Society Organizations
HACC	HIV/AIDS Coordinating Committee
HDI	Human Development Index
HDI	Human Development Index
HSS	HIV Sentinel Survey
IDUs	Injecting drug users
KHANA	Khmer HIV/AIDS NGO Alliance
MARPs	Most at risk populations
MDGs	Cambodia Millennium Development Goals
MoP	Ministry of Planning
MSM	Men who have sex with men

NAA	National AIDS Authority
NASA	National AIDS Spending Assessments
NCHADS	National Center HIV/AIDS, Dermatology and STD
NGOs	Non Government Organizations
NIPH	National Institute of Public Health
NIS	National Institute of statistic
NSP	National Strategic Plan
OI	Opportunistic infections
PASW	Predictive Analytics Software
PEPFAR	U.S President's Emergency Plan for AIDS Relief
PLHIV	People living with HIV/AIDS
PMTCT	Preventing Mother to Child Transmission
S&D	Stigma and Discrimination
SI	Sanigest International
SPSS	Package for the Social Sciences
SRH	Sexual Reproductive Health
STD	Sexual Transmitting Disease
TB	Tuberculosis
TNP+	Thailand Network of People Living with HIV and AIDS
UA	Universal Access
UNAIDS	the Joint United Nations Program on HIV/AIDS
UNDP	United Nation Development Program
UNDP	United Nation Development Program

VCCT	Voluntary, Counseling, Confidentiality and Testing service
VOA	Voice of America
WAI	Weight Average Index
WHO	World Health Organization
WVI	World Vision International

ABSTRACT

Cambodia has recently succeeded in decreasing the prevalence of HIV, but the consequences of the disease remained a serious obstacle with negative impacts for the country's development. HIV/AIDS related social stigma and discrimination are considered as one of the main social issue which interferes with the government's strategic development plan because people living with HIV/AIDS (PLHIVs) are unable to access of essential social public and private services. Therefore, this study examines stigma, discrimination experiences and coping mechanisms among PLHIVs in urban and rural areas of Cambodia.

This research is a cross sectional and descriptive study conducted in Kampong Tralach disctrict and Kean Svaiy district, which are located rural and urban areas respectively. Due to complexity to recruit respondents, a mixed sampling design (systematic sampling and simple random sampling) was employed. Respondents from 100 households were randomly selected, and three key informants were also purposively selected. Furthermore, data collection method was taken from two main sources; firstly, the primary data included household and key informant interviews, standardized questionnaires, and field observation in a field trip survey. Secondly, secondary data consisting of books, journals, reports, and website were identified from relevant institutions. Using the data collected above, SPSS, V.18, was used to analyze the quantitative data [descriptive analysis, chi-square test, and weight average index (WAI)]. The qualitative data was analyzed using content analysis by classifying and grouping responses from the respondents.

In this study, it was found that HIV/AIDS related stigma and discrimination still existed in the Cambodian society. 76 PLHIVs of 100 sample households were found to be demonstratively discriminated in the community. Of which 47 PLHIVs experienced it at their workplace, 18 within household members of the family, and 13 were being discriminated against in health care centers. However, in relation to internalized stigma, 42 PLHIVs felt strong concern about losing friends; 37 PLHIVs preferred to hide their HIV status, and 39 respondents were concerned that people would be afraid of them. Regarding the coping mechanism, 55 respondents opted to meet with NGOs staff at all time, while 41 PLHIVs rarely asked help from local authority. Interestingly, result of the hypothesis testing showed that rural PLHIVs experienced higher discrimination from health care service providers than urban PLHIVs. (X^2= 0.4332, DF = 1, P - value= 0.037). Also, discrimination against urban and rural PLHIVs in the community was associated with poverty status (X^2= 5.03, DF = 1, P - value= 0.025).

In conclusion, due to the lack of HIV awareness, misunderstanding, fear, individualism, capitalism, and political influence, and others, HIV/AIDS related stigma and discrimination occurs in all levels of Cambodian society. Hence, recommendations are suggested to increase HIV awareness through strengthening of the existing educational and training programs. Moreover, advocacy for the strengthening of the community at the grassroots level to the national level and social empowerment and existing national network should be increased and enhanced in capacity and function. Meanwhile, policies and laws regarding discrimination should be set up and implemented effectively in all sectors of society.

Keywords: Stigma, Discrimination, Coping mechanisms, HIV, Cambodia

CHAPTER I

INTRODUCTION

This chapter includes the background of this study, a statement of the research problems, research objectives, research questions, hypothesis and significance of the research, and scope, limitations and difficulties encountered in the research.

1.1 Background of the study

As of 2011 Cambodia has a population of more than 13 million [National Institute of statistic (NIS) & Ministry of Planning (MoP), 2008] and a total land surface area of 181 035 square kilometers. Cambodia located in the mainland Southeast Asia and shares international borders with Thailand to the northwest, Laos to the northeast and Vietnam to the southeast and east, and the gulf of Thailand to the southwest [NIS & MoP, 2006]. The country was devastated by a massive chronic civil war for more than two decades – from 1970s until 1990s. Because of the civil war, Cambodia has been categorized as one of the poorest nations in Asia due to the immense gap of living condition between the rich and the poor, especially in rural and urban areas. According to the NIS & MIP (2007), 30.1 % of the population live below the national poverty line (one dollar) and earn only $ 0.60 dollar per day [United Nation Development Program (UNDP), 2009]. Accordingly, 76% of Cambodian population lives on subsistence agriculture which includes farming and fishing. Also, 84% of the population lives in rural areas while 16 % reside in urban areas [NIS & MoP, 2006]. Based on the 2010 UNDP generated Human Development Index (HDI)

Cambodia is ranked 124th out of 169 countries; with a composite index of 0.494[1] which is slightly higher than few African countries in Sub-Saharan, but much lower than other countries in Asia such as Thailand, Malaysia, Indonesia, and so on. Having been still listed as a third-world country with the least economic growth and solely depended on foreign aid, Cambodia has been dealing with issues such as extreme poverty and hunger, illiteracy, gender inequality and disempowered women, infant mortality, maternal mortality, communicable diseases (HIV/AIDS, Malaria, and Tuberculosis), environmental degradation, land mine and a myriad of other problems associated with war and poverty.

HIV/AIDS is one of the prime priority issues that has been included in National Strategic Development Plan Update 2009 – 2013 (NSDP), and is vitally important for Cambodia's Millennium Development Goals (MDGs). Since HIV was initially detected in a man who donated blood in 1991 and after an epidemic nationwide, the Royal Government of Cambodia has declared that HIV is not only a health issue but also a social issue that impedes economic growth and human resources development. According to [U.S President's Emergency Plan for AIDS Relief (PEPFAR), 2008] & [Tia et al., 2008] & [National AIDS Authority (NAA), 2010], HIV/AIDS in Cambodia is mainly spread through heterosexual intercourse through sex workers and entertainment workers since people expose themselves to high risk behavior in seeking sexual relationship with multiple partners. A study by [National Institute of Public Health (NIPH) & National Institute of Statistic (NIS), 2006] indicated that 9.5% of male adults have multiple sexual partners

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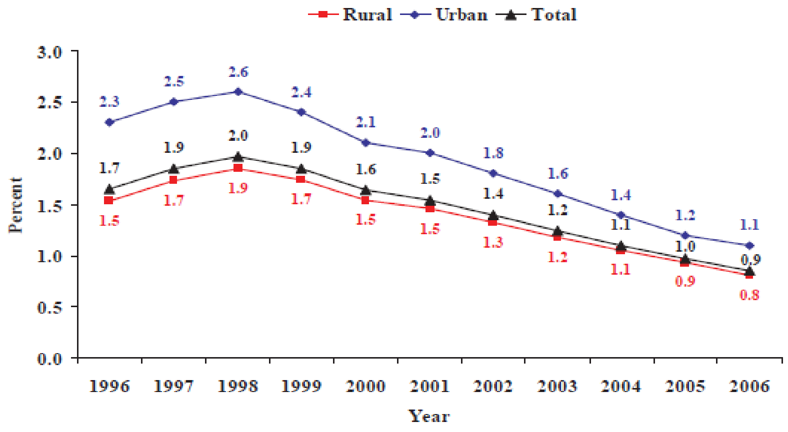
[1] Those countries having point over 0.8% are categorized as developed country.

while 17.1% of young females and 7.4% of young males aged between 15 and 24 have had sexual intercourse before the age of 18.

Due to the highest prevalence rate of 2% in 1998, HIV/AIDS in Cambodia, compared to other countries in Southeast Asia, was recognized as the most widespread disease but later lessened to 1.5% in 2001, 1.1% in 2004, and 0.9% in 2006; besides, HIV/AIDS diminished to 0.8% in rural areas and 1.1% in urban areas. This view has been supported in the work of [National Center for HIV/AIDS, Dermatology, and Sexual Transmitted Diseases (NCHADS), 2006].

Figure 10. Estimated HIV prevalence among adults aged 15-49 years by urban or rural residence in Cambodia, 1996-2006*

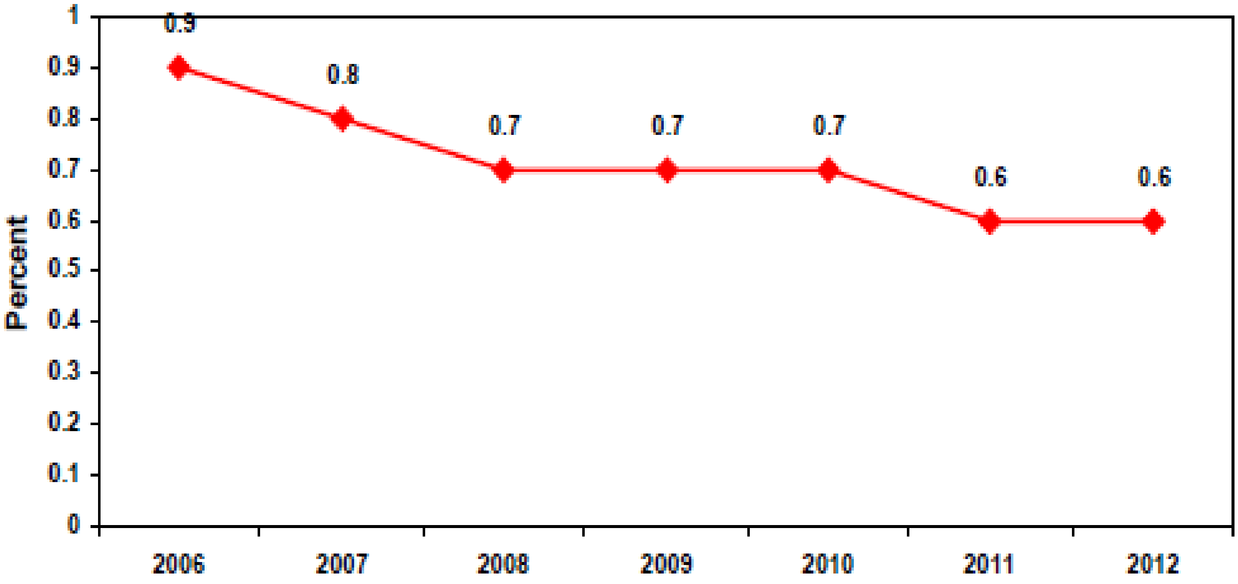


QC-adjusted, weighted, and EPP-smoothed

Source: NCHADS 2006

However, the most up-to-date data, according to [NCHADS, 2007] cited in [NSDP, 2010] and [NAA, 2010], using Asian epidemic model for prediction has publicized that HIV prevalence rate among adult population aged between 15 and 49 has been stabilized to 0.7% in the following years of 2008, 2009 and 2010; it is also expected that

HIV prevalence rate will continue decreasing to 0.6% by 2012. Besides, at the end of 2010, the total people living with HIV (PLHIVs), aged 15 – 49 years old, were 56, 200, among which there were 26, 700 men and 29, 500 women; also, the new HIV infected cases were 630 people. 360 and 270 of PLHIVs were men and women. However, people who died of AIDS suddenly increased to 1210 in 2010, and the number of PLHIV needing antiretroviral therapy (ART) remarkably increased from 33, 500 in 2009 to 34700 in 2010.



NCHADS 2007

Recently, if national policy and stakeholder involvements in implementation program against HIV/AIDS do not effectively respond to the needs, problems, and interventions among most – at- risk- populations (MARPs), there are concerns about new outbreak of HIV infection that might occur among marginalized populations. [Tia et al., 2008] and [NAA, 2009] have both shown that HIV infection might have an outbreak again among (MARPs) including men having sex with men (MSM), female sex workers, their clients and other sexual partners, and injecting drug users (IDUs) . Since the Royal Government of Cambodia, according to [Sopheng, 2008] & [Soy, 2010], issued a crackdown on closing brothels, most of sex workers transform themselves into indirect sex worker working irregularly at beer garden, karaoke, or hidden place where the public health workers could not control the movement of sex worker . An article by [KC Team, 2009] shows that after prostitutes were aggressively forced to leave their brothel, civil society and stakeholders have expressed their concern about the threat of HIV epidemic as a second wave of HIV infection. However, the policy implementation has been limited.

Furthermore, injecting drug user has noticeably increased and expanded among young people (aged 18 – 25) even though it is reported that the numbers of drug use have gradually declined. According to [Medical News Today, 2008], in the capital of Phnom Penh in 2006, 14% of injecting drug users were HIV positive, and it grew to 35.1% in 2007. Similarly, according to [NAA, 2008], the overall numbers of illicit drug users were about 46,300 in 2007. More than 23,150 (50%) of drug users were using Amphetamine Type Stimulants (ATS) and 2,900 (6.3%) of them using heroin while injecting drug users were estimated at about 2,025 (range: 1,250-7,500).

Meanwhile, men who have sex with men (MSM) were also considered as marginalized groups who raise HIV prevalence rate with regard to their risky behavior. A study by [Kha & Chris, 2004] noted that the risky factors among men having sex with men (MSM) were ignorance of HIV transmission and unprotected sex with multiple partners while the use of condom was only 13.3 %. Also, discrimination has compelled them to hide from the people and caused them to receive health services late.

However, with the anticipation of achieving Cambodia Millennium Development Goals by 2015, Royal Government of Cambodia has recently succeeded in combating against HIV since the prevalence rate has been dramatically declining over time, albeit some warnings related to new outbreaks have been raised by health policy makers and health policy implementers. Hence, government, civil society, international organization, donor, and other stakeholders have been powerfully collaborating to mobilize resources and to strengthen prevention and care and treatment program in order to ensure the achievement of fighting against HIV/AIDS. According to [NAA, 2009], the budgets allocation for HIV/AIDS program in 2008 were divided into 39% for prevention program and 29% for care and treatment program while those budgets were advocated by foreign aid. Likewise, Mr. Tony Lisle, country coordinator of the Joint United Nations Program on HIV/AIDS (UNAIDS) in Cambodia, [UNAIDS, 2010], aired a similar view of collaborating and cooperating among key development partners and stakeholders in order to combat HIV and to free issues or consequences made by HIV while continuing to stress on the following:

> *"We must now work together to ensure we continue reaching key people at risk and those affected by HIV through initiatives grounded in human rights. For Cambodia to stay ahead of its epidemic, we have to build further on the achievements made."*

1.2 Statement of the problem

Although Royal government of Cambodia has effectively responded to the HIV epidemic, the consequences of HIV/AIDS have remained serious obstacles and negative impacts hindering the country development, especially PLHIVs. Due to living with this chronic disease, PLHIVs have been facing vast barriers in daily life that has been shown in the form of lack of income, the erosion of family, community cohesion, impoverishment of households, planting land, poor health condition, inadequate treatment, care and support, stigma and discrimination, and others inaccessible social services. In fact, HIV/AIDS related S&D is one of the main challenges to interfere with PLHIVs in accessing a wide range of important services and social involvements and has still been noticed as a crucial social issue occurring mainly in urban and rural Cambodia. Generally, it was realized that PLHIVs were seriously discriminated by not only the public but also family members, community people, health care service providers, and their colleagues. As a result, their quality of life become deteriorated and complicated on a daily basis.

According to [Cambodian Civil Society Organizations (CCSO), 2011] [2] & [UNAIDS, 2010], HIV/AIDS related S&D remains high in Cambodia society, and it is also an obstacle in country development. HIV/AIDS related S&D occurs frequently in rural areas rather than urban areas; furthermore, an observation proved that woman are more likely to be discriminated than men, and they fear of disclosure of their HIV status [Tia et al., 2008]. In addition, HIV/AIDS related S&D affects their individual socioeconomic status so that PLHIVs have to confront their livelihood. Since their income is somewhat

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[2] Key messages on HIV/AIDS in Asia Pacific regional consultation on Universal Access to HIV prevention, treatment, care and support: getting to zero, Bangkok, Thailand, 30th&31st March 2011

low, and agricultural land was sold in order to afford their medical care and treatment; they do not have enough capital to invest in any small businesses. A study by [Sok et al, 2009] indicated that the main factors influencing PLHIV's socio-economic condition were being stigmatized, discriminated and isolated.

Furthermore, the perspective and attitude of the community against PLHIVs has shown that PLHIV were remarkably discriminated in the form of limited accessibilities of employments, housing, expression freedom, community involvements and other events. According to [Sok et al, 2009], people behave badly toward PLHIVs, and that behavior force them to live with hopelessness, uncertainty, and isolation. Moreover, discrimination not only happens toward individual PLHIVs but also involves with subordinates like family members. A report by [Khmer HIV/AIDS NGO Alliance (Khana), 2008] & Research carried out by [Sanigest International (SI) & Cambodia Center for Advanced Study (CAS), 2010] similarly indicated that PLHIVs family members are strongly discriminated and isolated, especially when the head of family or husband dies, people will oppose to attend funeral ceremony although there are Home Based Care team working to reduce the discrimination in the community; the lack of understanding and the fear of HIV still creates a barrier and gap between PLHIVs family members and neighbors. Likewise, a study by [KHANA, 2010] indicated that less than 10% of PLHIV are excluded from social gathering and religious ceremonies. Due to misconception and misunderstanding about HIV/AIDS, people dared not to buy PLHIV's products as they were afraid of HIV infection, or people think that they are disgusting so that they are not willing to talk to PLHIVs, but continue gossiping [Voice of America (VoA), 2007]. Interestingly, a study by [Deng, 2010] among beer girl promoters indicated that one – third of beer girl promoters would not buy food sold by PLHIVs while 13% of them did not allow their children to study with female teachers with HIV; therefore, 7% of them claimed that their relatives having HIV could not stay at their home.

Because of unacceptability and disharmony by the community, it was deemed that internal stigma including fear, self recrimination, depression, and soreness, fuels a general sense of despair and suicidal thoughts, is pervasive and has negative impacts against the quality of life of PLHIVs. Research carried out by [SI & CAS, 2010] showed that 65% of PLHIVs experienced low self esteem while PLHIV (16%) felt suicidal in the 12 months prior to the survey. Also, 46% of PLHIVs blamed themselves because of the disease, and 49% felt guilty.

In addition, health care service providers in hospital and health center act in an unfriendly and negative attitude or way that have been identified as main barriers in providing prevention, care and treatment services to PLHIVs and MARPs. According to [Voice of America (VoA), 2007], HIV/AIDS related S&D is still happening even in the community, at health care center or at national level. Even though hospital in Cambodia, according to [Independent Catholic News, 2009], had no policy to oppose the negative behavior of health care service providers when providing health care to PLHIVs, some general practitioners discriminated PLHIVs who seek for health care services. Similarly, a study by [KHANA, 2010] indicated that PLHIVs (7.6%) were denied family planning service while 8.4% of them were rejected sexual reproductive health services.

On the other hand, Royal government of Cambodia has not well implemented the impact mitigation program against the stigma and discrimination mechanism to serve the needs of PLHIVs even though it is one of the main priorities that has just been revised in National Strategic Plan III 2011-2015 (NSPIII). According to [CCSO, 2008][3], HIV/AIDS related S&D is a key barrier in reaching Universal Access (UA[4]) targets for all communities while the national policies are still conflict and contradictory to relevant stakeholders in implementing multi-response against HIV/AIDS. Moreover, [Tia et al., 2008] claimed that when dealing with issues of HIV/AIDS related S&D and overcoming taboos against the public discussion of sex and sexuality, the role of leaders cannot be underestimated. In addition, National AIDS Authority, [NAA, 2009], revealed that National AIDS Spending Assessments (NASA) was about US$ 50 million for HIV/AIDS response per year while most of the spending was for prevention and care and treatment rather than for impact mitigation (Less than 1%). In fact, HIV/AIDS related S&D is one of the main priority issues among the problems of prevention, care and treatment, and support, which still continues and happens among PLHIVs.

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[3] Cambodia Civil Society Statement during the High-Level Meeting on AIDS, New York, 10- 11June 2008

[4] All people should be able to have access to information and services including equitable, accessible, affordable, comprehensive, and sustainable.

1.3 Research objective

The overall objective of the study is to examine the stigma and discrimination experiences of people living with HIV/AIDS in both urban and rural Cambodia, and the way in which they cope with it.

Thus, the specific objectives are listed as the following:

- To describe the demographics and health characteristics of people living with HIV/AIDS;
- To examine discrimination experiences in family context, community context, health care context and work place context;
- To assess self feeling of stigma among people living with HIV/AIDS;
- To explore the availability of social support and health support;
- To identify the way in which PLHIV deal effectively with stigma and discrimination;

1.4 Research questions

According to the statement of the problems, the essential research questions were developed as the following:

- What is the degree of stigma and discrimination among people living with HIV/AIDS?
- How do people living with HIV/AIDS stigmatize themselves?
- What kind of stigma and discrimination experiences do PLHIVs have?
- What kind of social supports and health supports do PLHIVs need?
- How do PLHIVs deal with stigma and discrimination?

1.5 Hypothesis of the research

The assumptions of the research were determined as the following:

1. PLHIVs living in urban areas are less likely to be discriminated than PLHIVs who live in rural areas.
2. Rural PLHIVs face higher discrimination by health care service providers than urban PLHIVs.
3. Urban PLHIVs face less discrimination at workplace than those living in rural areas.
4. PLHIVs living in rural and urban areas face the similar discrimination from their family members.
5. Discrimination against urban and rural PLHIVs in the community affects their job status.
6. Discrimination against urban and rural PLHIVs in the community associates with poverty status.
7. Discrimination against urban and rural PLHIVs at workplace associates with gender.
8. Discrimination against urban and rural PLHIVs at health care center associates with access to ARV medicine.
9. Rural PLHIVs are more likely to be afraid of losing friends than urban PLHIVs if they were known to have HIV positive.
10. Rural PLHIVs feel more concerned than urban PLHIVs over losing good relationship with others if people found them disgusting.
11. Rural PLHIVs feel more concerned than urban PLHIVs when people keep telling their HIV status to others.

1.6 Significance of the research

According to [NAA, 2010], impact mitigation against HIV/AIDS related S&D has been enacted in National Strategic Plan III 2010 (NSP III) in order to reduce the burden of HIV/AIDS consequence toward PLHIV since there were several reports stating that HIV/AIDS related S&D still commonly occur in Cambodian society. It was found that HIV/AIDS related S&D is a main challenge for PLHIVs to access social services and economic development.

Hitherto, there have been only a few specific studies about HIV/AIDS related S&D experiences amongst PLHIVs; the majorities of studies, according to Mean et al [2007], have focused on three main different areas that included prevention (knowledge, attitude, and practice) (144 surveys),care and treatment (73 surveys),and social economic impact (34 surveys). It was observed that those studies were only reports, journals, or publications that had been done for program evaluation or institute's report while the detailed studies of HIV/AIDS related S&D are seldom conducted by government, civil societies or stakeholders.

Because of the lack of explicit researches in this division, this study would look into the actual situation of stigma and discrimination experiences and coping mechanisms among PLHIVs in the family environment, community environment, workplace environment, and health care environment that include socio - demographics, health characteristics, social support, health support, general problems, and suggestions for people living with HIV/AIDS.

Therefore, the result of this study would be vitally important for government, civil societies, and other stakeholders, particularly for local authority and development partners that have been intervening HIV/AIDS program in the two locations. Moreover, the outcome from the study provides an understanding of the needs of PLHIVs so that decision makers can use of the data to fill research gaps in the previous studies; also, this research provides suggestions for policy reform and strategic development planning for improved legal framework useful to achieving the Cambodian Millennium Development Goals (CMDGs) by 2015 and the Universal Access Target indicators of United Nations program.

1.7 Scope, Limitations, and difficulties of the research

Since this research was a cross sectional study, the scope of the research was primarily focused on stigma, discrimination, and coping mechanisms among PLHIVs. The interviews were conducted in rural areas (Kampong Tralach District) and in urban areas (Kean Svay District) in order to compare and contrast the different level of HIV/AIDS related S&D among both urban and rural residents. As a result, 50 household respondents in rural areas and another 50 household respondents in urban areas were randomly selected for interview using a questionnaire that included open-ended and closed questions.

Due to the time limitation and financial support, this study does not cover a large sample size; furthermore, the results of this research could also not represent the whole country circumstances as the sample size was too small, and the findings would be biased in terms of the different social context, situation, livelihood, and location of the respondents. Furthermore, before starting field survey, the research was based on convenient sampling, with study areas predetermined. Therefore other areas did not have the same chance for random selection. As a consequence, the results of these findings are only relevant to the specific locations and issues to those areas. .

Although the field work was completed, the researcher faced several constraints and difficulties during the data collection phase of the research because the knowledge of respondents was low. And much time was needed for the interviewees to understand the questions being asked. Also, the questionnaires which were translated into Khmer version were not well adjusted to the local community languages because of this the researcher had to reiterate the explanation, which made the time need for each interview longer and less comprehensive as the research had initially hoped. Next, due to rainy season, the month of planting rice and heavy rain, we, sometimes, could not carry out the field survey. The roads were muddy and in bad condition, which made it impossible for travelling even by motorcycle, but sometimes the researcher had to cross muddy road in order to reach households' respondents. Because it was the rainy season some PLHIVs were at the paddy rice field, so interviews could not be done. In addition, the geographic location of the target people is very distant and households' respondents settle in remote areas far away from the main road and scatter along the vast paddy rice fields. Despite these hindrances, every effort was made to deal with all above issues in order to complete the field research.

1.8 Organization of the thesis

The overall structures of this thesis were purposively divided into five main chapters:

Chapter 1 describes the general overview of introduction part including the background of the study, statement of the problem, research objectives, research questions, hypothesis of the research, significance of the research, scope, limitations and difficulties of the research and conceptual framework.

Chapter 2 focuses on the existing and supporting literature on HIV/AIDS that relates to stigma and discrimination experiences, by highlighting and analyzing previous supporting literature in relation to the areas of this study. First, it seeks to explain the general overview of HIV/AIDS related S&D in order to clearly distinguish the definition between S&D. This chapter will also demonstrate the sources of HIV/AIDS in relation to S&D and under the context of individual, family, community, health care, and job employment. Even more, the previous studies were also identified and analyzed not only in Cambodia but also in Southeast Asian Countries and others in order to analyze, to interpret and to discuss the situation and to find the factors causing HIV/AIDS related S&D; that is taken as a benchmark in comparison to the results and the findings of this research. Finally, Chapter 2 offers a conceptual framework, based on the result of literature reviews, had been designed and interpreted.

Chapter 3 focuses on research design, procedure, and the methodology applied in data construction/collection and data analysis in a comprehensive manner. The first section explains the types of research, research design and the selection criteria of the study site. The next section discusses sampling design including the sampling methods, procedures, and sample size. The last section of this chapter explains the types of data collection used including primary data, using structured interviews, key formant interviews, field survey, observations, and secondary data from existing previous research. The last section also discusses the techniques of data processing, the data analysis procedure and the statistical tools for quantitative as well as the methods of qualitative analysis done by categorizing the answers provided by respondents.

Chapter 4 discusses the results of the study on the issues of stigma, discrimination experience and coping mechanism amongst PLHIVs living in both urban and rural Cambodia. This chapter is divided into eight sub-sections: 1) demographic and socioeconomic characteristics of respondents, 2) respondents' current health condition, 3) discrimination experience, 4) stigmatization experience, 5) Coping mechanism experience 6) Social and health support, 7) hypothesis results, and finally a 8) chapter summary. The findings from key informants' interviews were also included into relevant sections since that information supports the finding from PLHIVs' side.

Chapter 5 offers policy implications, and provides conclusions and recommendations for further research. This section also compares the results of the findings with the objectives, hypothesis, and research questions. Then, it compares the results of this research with the previous studies and key informants' findings.

CHAPTER II

LITERATURE REVIEW

This chapter focuses on literature the Stigma and Discrimination (S&D) experiences of those living with HIV/AIDS. First, I provide the general overview of S&D by defining stigma and discrimination. This chapter also describes the sources of HIV/AIDS related S&D in the context of the individuals themselves and their families, communities and how each relates to health care, and employment. Furthermore, previous studies on S&D also identified, analyzed, and discussed the situations and the factors causing S&D not only in Cambodia but also in other Asian countries. These studies were selected to create benchmarks to which the results and findings of this research can be compared. Finally, this literature review provides a conceptual framework of this study.

2.1 General Overview of stigma and discrimination

When talking about HIV/AIDS, many people become concerned with their own sexual history often panicking or appearing nervous out of a fear of becoming infected with viruses and ailments. They might get depressed and fear of death [Patton, 1985]. However, HIV/AIDS related S&D has many more problems in addition to those mentioned above. According to UNAIDS [2000] & Malcolm et al[1998], the issue of S&D was undermined by public health efforts since there was not enough effort against stemming the spread of the disease. Add to this, S&D were shown in the form of inequality of human dignity when people were treated with prejudice against marginalized groups including homo and bisexuals, drug users, sex workers, prostitutions, and so on. According to Goldin, [1994], the risky behavior of seeking unprotected sex was associated with immoral or deviant manner which led to S&D. In reality, HIV/AIDS related S&D has been shown to be a major challenge among PLHIVs to access social services health care treatment, and social support.

According to Piot,[2000], the former executive director of UNAIDS, S&D has interfered with PLHIVs' ability to take part in social development at the community, national, and regional levels. Similarly, the former director of the WHO global program on AIDS Mann [1987] claimed that the HIV/AIDS epidemic could be classified into three stages: the stage of HIV epidemic, AIDS epidemic, and the epidemic of stigma, discrimination, and denial. Indeed, the last phase was considered as central to the global AIDS challenge as the disease itself. Somerville and Orkin, [1989] expressed a similar view that not only there is intense concern over the HIV pandemic itself, but there was also worried about the S&D consequences which was also dubbed as a second phase of the AIDS epidemic. Also, due to a misconception about the disease, Alonzo, Angelo, & Nancy [1995] pointed out that historically people reacted to the fear of embarrassing, incapacitating, and fatal diseases by discriminating against infected people. Simultaneously, [CCSO [2011]] mentioned that S&D is perpetuated by lack of awareness and understanding about PLHIVs and MARPs issues among the general population and among social and political leaders in particular.

In 1994, Goldin felt that the effectiveness of HIV/AIDS strategies against prevention and treatment programs, cultural ,and social stigma should be included in the greater fight against the disease. According to Aggleton [2000] & the Center for research on Women [2002], discrimination against PLHIV was unjust and inhibit public health program effectiveness.

2.2 Definition stigma and discrimination

2.2.1 Stigma

There are many definitions related to stigma. According to Jonna, [1999], stigma was defined as “tangible or intangible characteristic distinguished by negative emotions”. For Gilmore & Somerville [1994], stigma is process by which caused a people or group to be isolated from social gatherings and detached from general population [Gilmore & Somerville, 1994]. Furthermore, Goffman [1963] claimed that:

> *Stigma is a concept of disgrace that people attributed as an undesired difference which is an obstacle for a person or individuals to display certain traits.*

Similarly, according to the Population Council [2008], stigma is a label given to infected people who have to live apart from society and need to escape from the reaction of others. Other researchers have separately classified the definitions of stigma into “felt or perceived stigma” and “enacted stigma” [Malcolm et al., 1998] & [Scrambler, 1998] & [Jacoby, 1994]. Felt stigma refers to the association between internal feeling of undesirable attribute of scare against social attitudes and surrounding environment where infected people dwell. By comparison, enacted stigma was defined as the authentic experience of discrimination. Moreover, [Gilmore & Somerville, 1994] expressed a similar view that the characteristics of stigma are associated with individual features leading to discrimination, which results in limitations, prohibitions, and negative distinction.

2.2.2 Discrimination

There are various definitions raised about discrimination. According to [Population Council, 2008], discrimination was shown as a negative action amongst general people against marginalized groups. Also, [Jonna, 1999] expressed a similar views that:

> *Discrimination was the process of social dissatisfaction of HIV infected people who were displayed in the form of limited knowledge, behavior, belief, and fear from community members.*

Besides, it was further described as dominance and oppression against a particular group for the purpose of power and privilege [Marshall, 1998]. In addition, [Bunting, 1996] also drew attention to the fact that the components of discrimination consisted of pessimistic practice and treatment that were directly transformed to stigma.

According to [Goffman, 1963], stigma and discrimination have a similar meaning, and it is hard to distinguish definition and function.

2.3 Sources of HIV/AIDS-related to stigma and discrimination

In order to find out the sources of HIV/AIDS related S&D against PLHIVs, Aggleton, [2000] showed that as the HIV/AIDS pandemic has spread around the world, there are misconceptions about the disease. It was assumed that HIV/AIDS was associated not only with death, but also horror, punishment, guilt, shame, and so forth. Furthermore, due to these stereotypes, people infected with HIV were likely to hide their status from others. However, De [Bruyn, 1999] pointed out that there were five factors causing HIV/AIDS related S&D;

- HIV/AIDS was considered a life threatening disease
- Due to their limited knowledge, people were still afraid of contracting HIV/AIDS
- Due to their risky behavior, MARPs including MSM, IDU, SW were already discriminated against by society
- PLHIVs were seen as having contracted the disease as their own responsibility
- Infected people were considered to have deserved punishment of the disease because they are seen as having disobeyed the rules of religious belief and morality

2.4 Context of HIV/AIDS-related stigma and discrimination

The manifestation of HIV/AIDS related S&D has been seen in contexts ranging from the infected individual themselves, their families, the local community, their work place environment, and in the health care system.

2.4.1 Individual Context

Not only does discrimination occur but infected people also face internal stigma or negative internal feelings. PLHIVs were attributed to have stigma in either family or community when their HIV status disclosure was unaccepted by societies. According to Daniel & Parker [1993], when people are afraid of HIV infection, it leads to discrimination that caused PLHIVs to feel isolated, hopeless, ignored, and suffers. Due to this continuing process of internal feeling, infected people were unable to access any kind of social support or public services they need. In some cases, some infected people decided to commit suicide to end these issues [Gilmore & Somerville, 1994]. Others who learnt about this internal stigma decided to hide their HIV status in order to prevent themselves from the reactions and fear from others [Public Media Center, 1995].

2.4.2 Family context

Generally, in developing countries, there have been similar reports about the role of family members in caring of PLHIVs as they played a fundamentally important role in providing basic needs and care to sick members. According to [Work Bank, 1997] & [Warwick et al, 1998], the main function of family members is to care PLHIVs for either emotional or physical support. Nonetheless, it was not for all family members since some infected or affected people reported that they were unequally treated within the home stays. Once again, [Bharat & Aggleton, 1999] drew attention to the fact that women and homosexual family members were more likely to face discrimination than men and children.

Also, PLHIVs were more likely to be refused not only due to their HIV status but also their negative action such as promiscuity, drug user, and homosexuality. This view was supported in the work of Misra [1999] & Mpundu, [1999]. However, HIV/AIDS related S&D in the family environment is seen to have spread to their neighbor, friends, and others.

2.4.3 Community context

Due to the lack of knowledge, misconception, and fear of HIV/AIDS disease, PLHIVs faced S&D while the society including cultural belief against HIV/AIDS disease accused infected people of bringing the HIV virus into their community. [Warwick et al, 1998], those who were infected by HIV virus were believed to be immoral people and were judged as deviant. This type of conceptualization would, therefore, manifest the way, which community people reacted against S&D. At the same time, it has been commonly observed that S&D in either family or community is frequently illustrated in the form of guilt, blame, punishment, gossip, and others. Nardi & Bolton [1991] notes that S&D sometimes manifested in violence just as it was pointed out that sex workers and street children were also abused [Public Media Center, 1995].

2.4.4 Job Employment and Workplace context

Discrimination against PLHIVs in the workplaces has limited the ability of infected people to earn an income in order to support them. According to Gostin & Lazzarini [1997], and Omangi[1997], S&D in the workplaces took the form of denied employment, pre-employment HIV testing, dismissal from jobs, and job harassment. Sometimes it was reported that some colleagues resist working with or sitting near PLHIVs. Hughes [1988] concluded that in developing countries, few companies set up a policy to fight against HIV/AIDS related S&D and that there was little attention given to infected people at their workplaces.

2.4.5 Health Care Context

HIV/AIDS related stigma and discrimination also occurs in the health care system when infected people seek health care support and treatment. According to Masini & Mwampeta[1993] and Ogola [1990] found that PLHIVs were ignored and turned away while hospitalized. Herek & Capitano [1993] & Herek et al. [1998] stated that stigma occurs due to a lack of knowledge and unawareness of how HIV/AIDS is transmitted. S&D led to fear because of the diseases, which in turn leads to a generally weakened health care system. This view is supported in the work of Tesch, Simpson & Kirby [1990] and Masini & Mwampeta [1993] as well.

2.5 Result of Previous Studies about HIV/AID related stigma and discrimination

In Cambodia, there were many studies about HIV/AIDS related to knowledge, attitude, and practice (KAP), but researchers had rarely investigated a survey on specific topic of HIV/AIDS related S&D. Conversely, there were some annual or programs evaluation reports done by NGOs, Government or other institutions pertaining to the issue of HIV/AIDS related S&D. Thus, it is recommended to review previous papers or similar research context whether in Cambodia or other countries.

2.5.1 Cambodia

A study done by KHANA in 2010 found that that 10% of PLHIV respondents had been excluded from social gatherings, religious events, and family activities. Moreover, it found that 25% of PLHIVs said they had been harassed, threatened, and verbally abused while about 10% had been physically threatened (7% of men and women 13% of women). Also, 7% of respondents were had been denied sexual relationship while 5% of those said that their spouses or family members discriminated against them. Surprisingly, 13% of infected people experienced discrimination from other PLHIVs.

In a similar manner, due to their HIV status, 12% of respondents were forced to move out from their residences while 51% lost their jobs due to their status. Likewise, the survey found that 9.2% of men had been refused employment compared to 14.3%, of women. Also7.6 % of respondents had been refused to access family planning services while 8.4% of them had also been denied access to sexual reproductive health. Painfully, 9% of respondents said that their children were dismissed or suspended from schools.

Fellow researchers showed that 74% of respondents (73% of men versus 75% of women felt guilty while 63% felt ashamed (61% of men versus 63% of women). PLHIVs reported that 54% of infected people blamed themselves after learning that they had HIV; among those respondents, the percentage of men was higher than that of women (65% versus 50%). It was noticed that 48% of PLHIVs had low esteem (men: 41% versus women 51%); 21% of infected people blamed others (9% of men against 26% of women), and sadly, 16% of PLHIVs felt suicidal (men: 6% opposed to women: 20%).

Fortunately, the majority of infected people (91%) could identify organizations for help, and only 37% sought help from helpful services (41% of men versus 36% of women). Interestingly 7% of PLHIVs were involved in policy development while the percentage of men (10%) was higher than that of women (6%), and, 42% of respondents said that civil society organization played a very important role in addressing S&D issues while 37% said that they are supportive to other PLHIVs.

Another study conducted done by SI & CAS [2010] about the socio- economic impact of PLHIVs at the household level[5] indicated that because of their HIV status, 47% of infected people felt ashamed including 42% of men versus 49 % of women while 49% felt guilty (Men: 65% versus Women: 43%). Plus, 46% of PLHIV felt self recrimination (Men: 58% opposed Women: 40%), yet 21% of infected people blamed others with 28% of women compared to 9% of men. 65% of PLHIVs faced low self esteem (Women: 66% against Men: 61 %) while sixteen percent of infected people felt suicidal, which showed that women were higher than men (19% versus 10%).

More importantly, it was found that due to their HIV status, 13 % of infected people including their family members felt they were treated differently treated by community members as it was manifested in the form of verbal abuse, isolation, negligence, and not allowing their children to play with others whereas 23% of women reported that they experienced verbal abuse while 7% of them said that they were physically threatened.

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[5] Even though this study was only focused on socio economic impact, there were some components of questions related to S&D that is useful for researcher to draw for literature review.

2.5.2 China

A study by Marie Stopes [2009] related to the stigma index in China found that more than half of respondents (62.1%) experienced feeling of embarrassment while 43.2 % felt guilty, and 74.5% of respondents said that they blamed themselves. Also, 75.4% had low self-esteem, and more than half of women compared to men (over 40%) felt suicidal. Self-stigma also prevented infected people from taking action or seeking social services. To illustrate this point, PLHIVs between the ages 15 to 50 had decided not to have children (60.8%) while 34.7 % of respondents said that they had stopped working, and more than 55 % decided to avoid social gatherings altogether. At the same time, 55.4% of those reported that they decided to isolate from family while 58.1 % of those decided to isolate from friends.

Moreover, 12.1% of PLHIVs said that the staff at medical care centers refused them cares even though they were permitted to receive medical services. This showed that discrimination from health care providers led to interference in the efforts of HIV prevention and treatment programs, so it is the main reason to discourage people to access HIV testing or treatment. Here again, 1.3% (24 people) was refused to access ARV while 1.7% (32 respondents) was denied from accessing family planning services. 1.5 % refused from sexual reproductive health services, and 16.6% of people were suggested not to have children.

The reports also stated that 14.8% (277 respondents) of total population (1877) were refused job employment (Men: 16.3% versus Women: 13%) while 16.8 % (305 people) changed their jobs, and 3.8% (70 respondents) had been refused any promotion. There were

740 people who lost incomes after knowing their HIV status, and 22.4 % was discriminated from employers or colleagues. Another issue is that 9.1% of PLHIV’s children were forced to leave schools while 36.2% of them were very much discriminated by teachers. Meanwhile, 134 respondents (7.1%) could not find accommodation.

It was found that the percentage of women who suffered discrimination through gossip was higher than that of men (47% versus 34%) while 17.8% of women compared to 12.3% of men had been verbally insulted. Also, 7.4% of women were thrown out of social events compared to 5.8% of men (5.8%), and 6.4% of women were physically threatened compared to men (3.1 %). It was further found that the percentage of women excluded from family life was higher than men (5.8% compared to 4.4%).

2.5.3 Thailand

A study by the Thailand Network of People Living with HIV and AIDS (TNP+), [2009] created a stigma index for Thailand that is a trending issue in implementing HIV/AIDS prevention and treatment programs. Among 233 PLHIVs, 34.3% indicating that they were prohibited from community activities. Due to their HIV status, 32.2% of them had lost their jobs while S&D in schools remains a significant problem.

Another study by Pranee & Niphattra and Niyada [2009] among women living with HIV and AIDS in central Thailand showed that HIV/AIDS program were actively implementing nationwide, but HIV/AIDS related S&D could not reduced since PLHIVs (particular women) would keep their HIV/AIDS status hidden due to fear of societal discrimination. The same source also pointed out that women were more likely to be stigmatized than men since the society perceived women who contracted HIV/AIDS to be "Pu Ying Mai Dee" meaning bad women who have multiple sexual partners.

> *As women can have only one husband, if we contracted HIV, people assumed that we had many partners. They did not believe that we were infected by our husbands (A Thai female PLHIV).*

Due to insufficient knowledge and cultural believes, Thai people reckoned that PLHIVs die quickly before they transmitted the disease to others. Owing to this, PLHIVs were being isolated. Luckily, It was reported that rural people were more likely to be helpful than urban people for PLHIVs as those living northern part of Thailand assisted PLHIVs in the form of emotional, physical and financial support; in contrast, urban people around Bangkok areas seemed to discriminate against people as socially abnormal including PLHIVs.

Another issue is that women were forced to leave their jobs when becoming infected with the AIDS virus since their employers were afraid of them spreading the disease to customers, and they could not apply to other jobs in Bangkok so that they moved to other areas where people would not know of their illness. Some cases reported that they were negatively treated by health care providers as some nurses expressed bad attitude towards PLHIVs while society recognized that these women are the sufferers of HIV infection. Women were also experiencing discrimination from their family members as they pointed out that in spite of educated people, they were still afraid of us.

2.5.4 Vietnam

A study by ANP+ & Policy Project [2005] indicated that not only PLHIVs were discriminated at health care centers by doctor's attitudes and service delaying but also there were complaints against hospital leaders and physicians who did not practice effectively their roles in charge of medical treatment, care and support. In addition, the pregnant PLHIVs were forced to pay medical charges when they sought for antenatal care. Abominably, doctors avoided contacting them while some people were tested for HIV without consent. As a result, PLHIVs were concerned about their HIV status as they were afraid of discrimination. Other report stated that infected family members including sons and daughters were also refused social services.

Pertaining to job employment, people had to disclose their health status whether they had HIV or not. Generally, due to fear of infection, PLHIVs were transferred from higher positions to lower positions; otherwise, they were asked to terminate their jobs after contracting HIV. Also, PLHIVs reported that they also experienced discrimination from family members and friends as they stressed that the more symptoms got worse, the more discrimination they face. However, it was pointed out that the behavior of community people still acted negatively.

2.6 Conceptual Framework

After reviewing theories and previous studies, conceptual framework was designed, so the diagram below not only describes the causes of stigma and discrimination but also demonstrates the overall consequences and options of PLHIV. Furthermore, it also supports all the issues mentioned in the research problems. Figure 2.1 illustrates that when S&D happen, PLHIVs face two main factors, which is health condition and economy status including income and expenditure, which these two factors were interactive each other. Having been infected by HIV, PLHIVs could not afford their livelihood that is difficult to make ends meet as daily expenses and incomes were imbalanced. Also, they lost their jobs they lived in hunger and in debt. SI & CAS [2010] claimed that having known their HIV diagnosis, PLHIVs (27%) discontinued earning incomes while others remained employed and earned less than half of their previous incomes compared to their incomes before diagnosis. The same study further reported that 65% of PLHIVs were asking for loans compared to 53% of non- PLHIV. Since health status is linked to economic earning potential and vice versa, PLHIVs become sicker because they do not seek health care services due to their limited income potential. As such a spiral of poor health and weakened economic sadly occurs.

Because of HIV status or another sometimes serious disease appearing, people who have limited knowledge or misconceptions about HIV are afraid of infection as they hesitantly assumed that PLHIVs could infect HIV if they lived nearby. Owing to this negative concept, people started discriminating against PLHIVs by showing their bad behavior, gossiping, class separation, verbal abuse, denying them food, excluding them from community events, and so on. This supported the work of Marie Stopes [2009]. The cultural belief and individual behavior, according to Tesch & Simpson & Kirby, [1990] and Masini & Mwampeta [1993], were considered as the main issues in causing S&D.

Generally, it was observed that S&D occurred in family households, communities, health care centers, and in the workplaces where some reports had been raised. Moreover, while PLHIVs received discrimination, they felt isolated; besides, stigmatization coincidentally occurred and led to mental health problems.

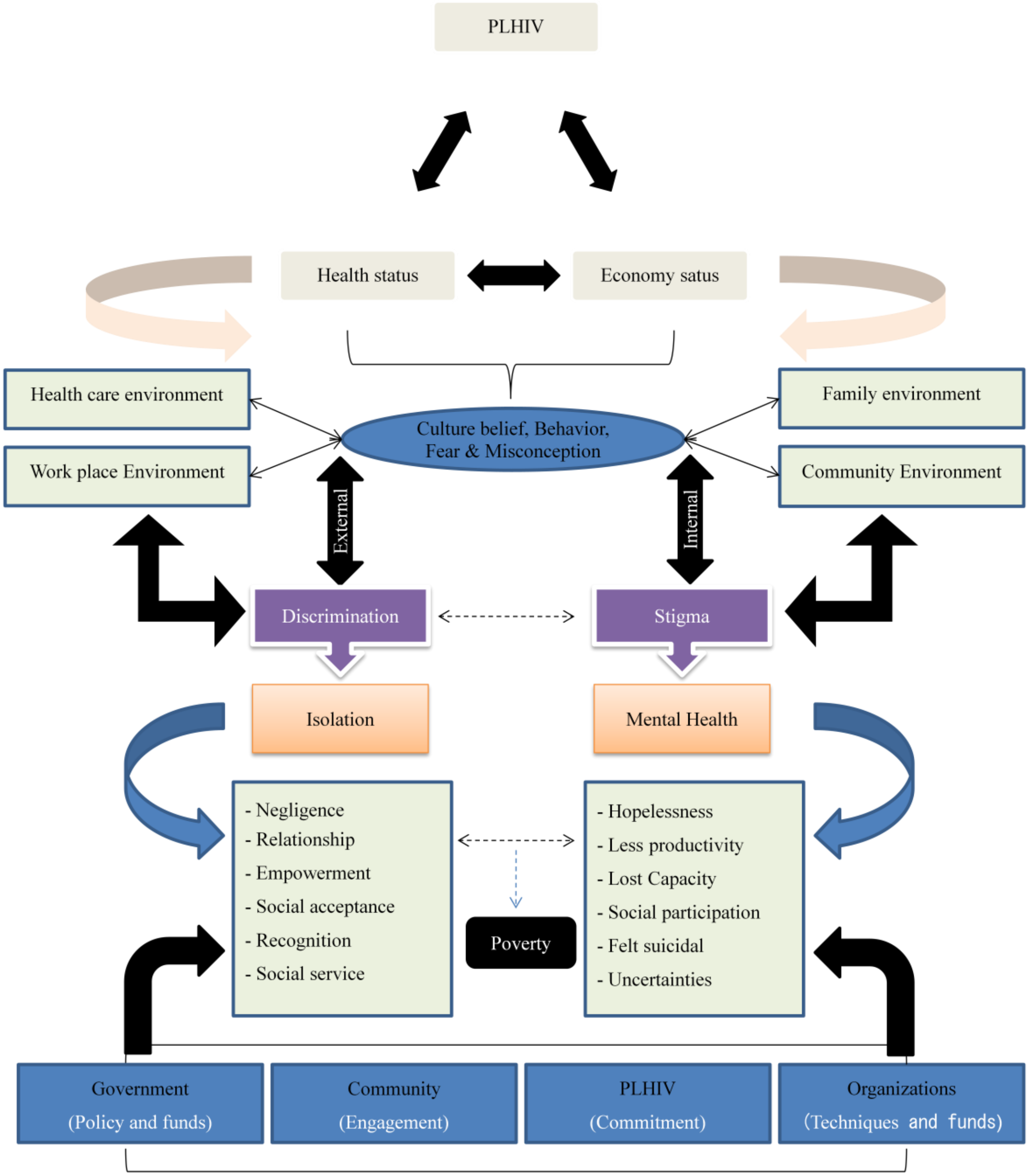
In fact, PLHIVs face negative consequences whether physically or emotionally that hinders their quality of life. As discrimination caused isolation, it gave negative results in the form of negligence, limited personal relationships, disempowerment, minimized social acceptance, low social status recognition, exclusion from social services, and so forth. Besides, stigma caused mental health problem, so it was shown in the form of hopelessness, productivity loss, limited social participation, suicidal, uncertainty, and so on. Ultimately, these consequences including stigma and discrimination lead to poverty that has been occurring not only for PLHIVs but also general public. A study by Lor [2009] indicated that the correlation coefficient between occupation and dysfunctional ability was 0.67 (R-squared = 0.4553) illustrating a moderate significance of mental health as a main cause of poverty.

Anyhow, in order to solve S&D problem, it was recommended that all stakeholders involved from the grass root level to national level must collaborate with each other. For example, besides HIV prevention, care, treatment, and supporting programs, the government plays a fundamental role in enacting policies, national strategic plans, monitoring, evaluating, resource mobilization, advocacy, coordination, and so on. In order to reduce impact mitigation against PLHIVs, government also functions as a fund provider to hospitals and health centers or to local authorities to organize HIV/AIDS awareness campaigns in the communities. Moreover, Organizations including local civil society organizations and international organizations were reckoned by their efforts in implementing HIV/AIDS program through outreach education, mass media, educational campaigns, advocacy, coordination, and information sharing. International organizations in particular not only act as donors but also implement HIV/AIDS program including providing technical support to either local governments or civil society organizations.

From the efforts of government and organizations, which pushed for community people to change their behavior, attitude, and misconception about HIV/AIDS through various multi-responses including HIV/AIDS training, HIV/AIDS campaigns, HIV/AIDS promotions, community people were considered as catalysis to facilitate daily livelihood between PLHIVs and non - PLHIVs, so when they clearly understand HIV/AIDS, they will be encouraged to participate in the promotion of HIV awareness, HIV/AIDS related human rights issues and other social advocacy. On the other hand, in order to reduce S&D, PLHIVs must be willing and commit to solve the problems they have been facing so far. In order to avoid jeopardy whether emotional feeling or physical appearance, PLHIVs must seek help from local authorities, community leaders, NGOs staff, self-help groups, families, friends to whom PLHIVs feel confident with

To sum up, S&D against PLHIVs still exist whether in urban or rural areas since general public as well as social and political leaders have limited awareness of HIV/AIDS, which causes those people to mistreat PLHIVs and change their personal behavior. As S&D still continues, it will affect PLHIV’s daily life and health conditions. In general, the consequences of S&D are shown in the form of isolation and mental health problems, and these two factors are associated with poverty. In order to cope with the issues above, PLHIVs, their communities, government, and organizations must closely work together with technical support, funding, participation, and awareness promotion.

Figure 2.1: Conceptual Framework



Source: Author

CHAPTER III

RESEARCH DESIGN AND METHODOLOGY

This chapter focuses on the research design, procedure, and methodology that are applied in data construction, collection and data analysis. The first section of this chapter explains the types of research, research design and the criteria for selection of the study site. The second section discusses the sampling design, methods, procedures and sample size; and the last section of this chapter explains the data collection sources. The primary data for this research consists of structured questionnaires interview, standard questionnaires training, household interview, key formant interview, and field observation. The secondary data was obtained from existing research. Furthermore, this paper elaborates the technique and method of data processing and the procedure of data analyzing using statistical tools for quantitative analysis that include descriptive and analytical analysis, while qualitative analysis was employed by categorizing the responses from the study participants.

3.1 Types of Research

This research is a cross sectional study that employs method of descriptive and analytical design. Standardized interview techniques were used for all the respondents. This research mainly focuses on a quantitative approach; meanwhile, it is also enhanced by some qualitative information that was gathered.

3.2. Research Design

Based on the overall objectives of the study, the research design made use of questionnaire guidelines for collecting the necessary data on the general aspect of stigma and discrimination experience and their coping mechanisms among PLHIVs living in urban and rural areas of Cambodia. This study also tried to identify correlations related to the stigma and discrimination experiences among PLHIVs, and the way they deal with the issues. As such, the criteria are differentiated as shown below.

Subject: People Living With HIV/AIDS (PLHIV)

Inclusion Criteria	**Exclusion Criteria**
• PLHIV	• AIDS patients
• Age 15 – 49	• Hospitalization
• Both gender	• Children affected by HIV/AIDS
• Rural and urban areas	• Family affected by HIV/AIDS

This research design gives details the situation and circumstances of stigma and discrimination experiences. It also seeks to demonstrate the various ways that PLHIVs have dealt with the issues. Moreover, In order to gather significant information, the research design categorizes the components of discrimination experiences into the following types of social context such as family, community, workplace, and health care center. Also, self stigmatization (self feeling) was also included.

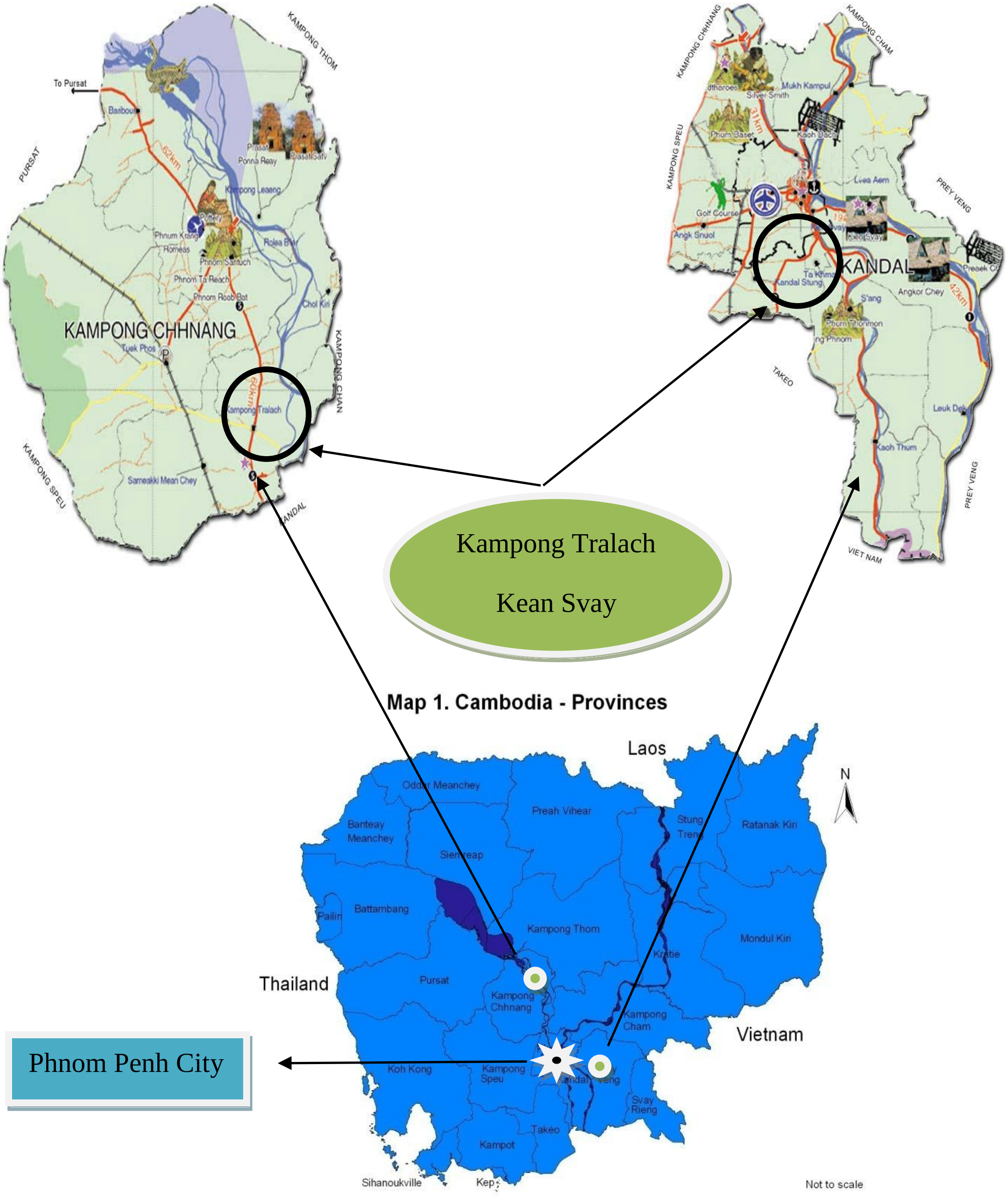
Moreover, the more general information including demographics, socio-economics, health characteristics, social support systems, health support, general problems, and suggestions were summed in order to find correlations that lead to stigma and discrimination experiences amongst PLHIVs.

3.3 Selection Criteria of the Study Site

It is significantly important to make selection of the study convenient before starting the field survey. Based on consultations with NGOs staff, political authority, other researchers and stakeholders, the criteria in determining the study areas was proposed. Those criteria were such as availability, accessibility, affordability, and acceptability.

Firstly, researcher had to make sure that the selected locations are available for the study. The location needed to be sufficiently urban or rural areas and have enough PLHIVs to have a reasonable sample size. Secondly, researcher had to think about accessibility of community people, local leader, and PLHIVs. Thirdly, it was important to know whether PLHIVs can afford to spend enough time with the field interviewer while they were working in their farms or while they were running small businesses. Finally, after compiling, collecting, and analyzing the information, the researcher concluded whether the field work should be in rural and urban areas or not. Based on the estimated cost of conducting the research, the accessibility of PLHIVs, and some challenges such as transportation, communication, time constrain, and others, the researcher was satisfied with the sites selected.

According to the availability, accessibility, affordability and acceptability of the above criteria, Kompong Tralach and Kean Svay, the districts located in rural Kampong Chhnang and urban Kandal province respectively, were selected as the study areas.



Source: Cambodian Population Census, 2008

Figure 3.1: Map of Cambodia – Provinces showing study areas in Kampong Chhnang and Kandal province

3.4 Sample Size

3.4.1 People Living With HIV/AIDS (PLHIV)

In order to gain an appropriate understanding, it was decided that 100 total respondents was needed for this study. Because the research was conducted in both urban and rural areas, the one hundred person sample size was divided into 50 respondents for each study areas.

3.4.2 Key informant

Since many the stakeholders from government and NGOs have not only involved in HIV/AIDS program formulation for many years, but also dealt with many issues of PLHIVs, and because the analysis of the stakeholders was also included in this study, it was decided that three key informants were essential for the conduct of this research. Key stakeholders were identified as those people who have experienced in policy formulation, strategic planning, coordination and social advocacy that could provide comprehensive information about the general overview of PLHIVs' livelihood and problems, especially for stigma and discrimination issue. Regarding the three key informants, one representative from government, the National AIDS Authority (NAA), and two representatives from civil society organizations, HIV/AIDS Coordinating Committee (HACC) and the Cambodia Alliance for Combating HIV and AIDS (CACHA) were purposively selected for more intensive interviews.

3.5 Sampling Design

3.5.1 Mixed Sampling design for Methods and Procedures

Since the study site and sample size had been purposively determined, the sampling used includes both systematic sampling and simple random sampling. As this study conducted in two study areas, the sampling procedure for both urban and rural areas used the same methods. The target sample was systematically chosen from a sample frame made up of a list of NGOs. Of the many possible NGOs, World Vision International (WVI) and Cambodia Community for Women Living with HIV and AIDS (CCW) were chosen.

To choose the PLHIVs that would be interview from a total number of 169 PLHIVs in Kean Svay District and 98 PLHIVs in Kampong Tralach District, the sampling frame, according to systematic sampling method, was first divided into a number of intervals.

To clarify, the width of the interval is from the total population divided by selected sample size. For example, the interval of 169 PLHIVs is 3 and 98 PLHIVs is 2. A simple random sampling technique was then used to select the sample under probability sampling design as one element, and the first selection was randomly chosen as representative, so the next selection was followed by the order components of the first interval selection. For instance, the first element selection among the 169 and 98 that intervals were respectively separated as 3 and 2 was similarly 2. Thus, the rest of the subsequent elements from other intervals must select every second element of the population (See annex).

Because of this sampling process, 50 respondents in urban areas and other 50 respondents in rural areas were systematically selected before field survey had been conducted at household level. This procedure, according to Kumar [1996], has been used for random selection, so the fundamental base for the primary interval and the succeeding intervals are dependent on the first option which is categorized as mixed sampling. (See below sampling procedure).

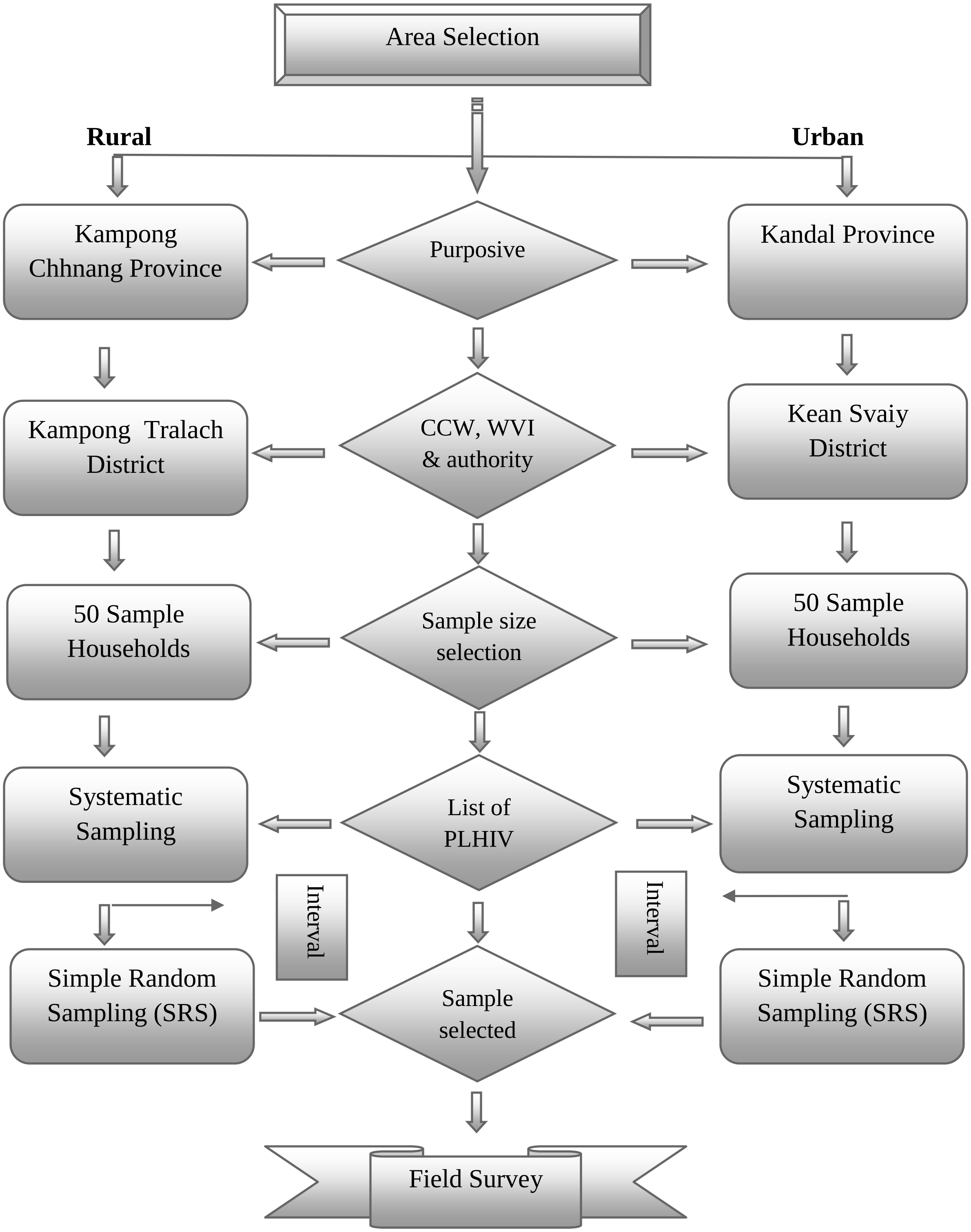


Figure 3.2: The procedure taken for selecting a systematic sample

3.6 Data Collection Sources and Methods

The following section describes how the research collected the primary and secondary data needed for the research.

3.6.1 Primary data

Primary data collected from fieldwork respondents living in both urban and rural areas. Standardized questionnaires, questionnaire training, household interview, key informant interview, and field observation were used to gather primary data during the field research period. With the above techniques, the researcher had opportunities not only to collect data but also to investigate directly and deeply examine the situation and circumstances facing of respondents through direct observation.

- **Standardized questionnaire**

In order to conduct the interviews, standardized questionnaires were developed as guideline tools to get information and data from the survey of household respondents. According to Martin Brett [2007], questionnaires are one of the most useful tools in collecting primary data since it facilitates natural communication between interviewers and respondents; therefore, researcher can make conclusion based on the raw data provided. The overall structures of these questionnaires examine the general situation of stigma, discrimination experience, and coping mechanisms among PLHIVs. Moreover, the questionnaires were also designed based on not only stigma and discrimination experience but also the current situation issues related to PLHIVs livelihood in urban and rural areas of Cambodia.

These questionnaires[6] were originally designed and adapted from previously used and field tested USAID in English version's comprising either closed-end or open-ended questions. Then, they were translated into Khmer, Cambodia major language for field interviews. Indeed, these questionnaires included eight sections consisting of 46 questions. The initial section describes about general basic information; for example, demographic and socio-economic circumstance. The second section mentions health characteristic condition. The third section centers on discrimination experiences in the community environment, family environment, health care environment, and work place environment. The fourth section points out self stigma (internalized stigma); the fifth section relates to disclosure; and the sixth section asks about social and health support. The seventh section asks about coping mechanisms, whereas the last section focuses on general problems and suggestions.

Before carrying out the field survey, the researcher also consulted with the NAA staff about the questionnaires in order to check technical terms and translation verification. Then, 10 sets of questionnaires were piloted with PLHIVs in order to make sure that they were accurately designed in a proper social context. Also, this pilot test gave for the researchers a chance to find out the weak points of the questionnaires and comments on the

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[6] Please see the appendix for full questionnaires survey

questions from the PLHIVs themselves in order that the questionnaires for the greater study to be correctly re-checked and re-edited.

- **Interviewer training**

After standardized questionnaires were adjusted as closely as possible to the situation of Cambodian PLHIVs, the researcher picked three university students to assist him in conducting the field interview; furthermore, pre-field survey training was also provided for a half day. The overall purpose of the training was to guide them how to make interview properly and to clearly explain them about the questions. Moreover, the researcher also trained them in the necessary communication skills including self introductions, encouragement, participation, ethical manners. Also, the researcher offered trainings on interview techniques and skills as it was vitally important to build trust and good rapport with respondents in order to receive meaningful answers. Finally, a rehearsal field interview was performed in order to check the trainees' ability to make sure that the interviewer was up for the task.

- **Household respondents Interview**

According to Kumar [1996] interviews require that there is interaction between two persons and that for specific purpose. Furthermore, [Martin Brett, 2007] has expressed a similar view on the purposes of the research interview which is to enhance the environment of interview process and environment so that the respondents are willing or satisfied to respond and express their opinion freely. Therefore, before conducting field survey, the researcher contacted known stakeholders in including hospitals and local authorities to obtain permission in the proposed study areas. This was possible because supporting documents such as the request letter for conducting survey from Professor Gotbhi Nader, at the Ritsumeikan Asia Pacific University and letters of permission from other authorities along with our questionnaires in both English and Khmer version (see annex). Thus, researcher was authorized to conduct the field survey.

From September 3rd, 2010 to September 17th, the researcher contacted staff at WVI and the deputy director of Kampong Tralach Referral Hospital to collaborate on fieldwork. Also, the assistance from the three university students and one PLHIV team leader was obtained so that the interviews could be conducted in the rural areas. In the same way, from September 22nd, 2010 until October 7th, 2010, after the researcher contacted a director of CCW to ask for permission, collaboration, support and the assistance from the three university students and one staff from CCW, other 50 respondents were also interviewed. In both the rural and urban areas, each interview took approximately 30 to 40 minutes per respondent.

- **Key informants**

Data was not only collected from PLHIVs themselves but also from key informants to get more information from policy maker's perspective. According to the Access Project [1999], "key informant" refers to any person who has a particular knowledge in the issues important to the research and can provide good recommendations for the problem being researched. The key informants were asked about the general problems related to stigma and discrimination of PLHIVs in the family, community, health care center, and workplace. Also, they were asked about the social and health services, coping mechanism and also about different institution's strategy against stigma and discrimination, the main obstacles to achieving this strategy, and suggestions for how to improve the current situation. Similar to the individual interviews with PLHIVs, the interview process took 30 minutes per respondent and was conducted at their designated institution.

- **Filed observation**

Direct Field observation was also a research technique to verify that the interviews accurately reflected the current situation and circumstances for PLHIVs. According to Kumar [1996], systematic and selective observation based on decision – making is a survey tool of inspection and the subject matter of an interaction or phenomenon amongst target people.

Observation can be classified into two types: participant observation and non-participant. The researcher was a non-participant observer and passive observer. Furthermore, the researcher refrained from engaging in the HIV/AIDS group, but keep watched and listened to the activity or reaction of respondents to help him draw conclusions to the interactions as a whole. This was very helpful to verify data collection accurately and efficiently since the researcher could observe the body language in how respondents answered questions, Furthermore, the researcher could also observe the way they expressed their opinions, physical reaction to the questions being asked regarding the discrimination they faced or didn't face. However, field observation was also done to evaluate the environment around the both the PLHIVs and the other stakeholders including the location, living conditions, household facilities, community gathering, and so on.

3.6.2 Secondary data

Secondary data was collected from a variety of sources including books, journal articles, previous research, previous thesis, reports and websites from the following institutions:

- **UN Sources** — Joint United Nations Program on HIV/AIDS (UNAIDS), World Health Organization (WHO), United Nations Development Program (UNDP) etc.
- **Civil Society Organization sources** — HIV/AIDS coordinating committee, (HACC), Khmer HIV/AIDS NGOs Alliance, (KHANA), Cambodian People Living with HIV/AID Network (CPN+), and others.
- **Cambodian Government sources** — Ministry of Health (MoH), National AIDS Authority (NAA), National Center for HIV/AIDS, Dermatology and STD (NCHADS), Ministry of planning (MoP), National Institute of statistics (NIS)
- **Academic online journal aggregators** — JSTOR and PROQUEST

3.7 Data Processing

3.7.1 Data field editing

After completing the field survey, the questionnaires were immediately and carefully checked in order to make sure that given information had been responded to properly. If there were errors or unanswered questions, they were edited using inference technique, according to the procedure outlined by Kumar [1996].

3.7.2 Data coding and measurement

The questionnaires had closed ended quantitative questions which included dichotomous, categorical, ordinal, and continuous variables. Also, open ended questions called qualitative questions were asked and coded for classification. For example, dichotomous variables which resulted in two response options are assigned in nominal measurement and were coded as “Male = 1” and “Female = 2”. Category[7] variables, nominal measurement, normally have more than two divergent unordered response options coding a numerical value to each category as “1 = Married”, “2 = Single”, “3 = Widow”, and “4 = Divorce”. Also, ordinal variables which are ordinal measurement have more than two possible order responses. For example, “1 = Very good”, “2 = Good”, “3 = Normal”, “4 = Bad”, “5 = Very bad”. Continuous variable answers on a scale of measurement. For open-ended qualitative questions, the researcher read all of the responses and categorized them as stipulated by Kumar [1996] and Bowling, [1997].

3.7.3 Data Entry

Data entry was first prepared in Microsoft Excel 2007 once compiled it as was then transferred to Predictive Analytics Software (PASW) statistic version 18, which is known as Statistical Package for the Social Sciences (SPSS), which is commonly employed software to analyze statistics.

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[7] Categorical variable including multiple choice give two unordered options in answering (One answer and multiple answer) as it is set by researcher.

3.7.4 Data Cleaning

After data had been input, cleaned and checked several times, some common errors was eradicated during data collection, coding and data input. In fact, missing values, skips, range, and inconsistency were checked and cleaned.

3.8 Data Analysis

Because the questionnaires included both closed end and open ended questions, quantitative and qualitative procedures were needed. For the quantitative analysis, we used the SPSS statistic software version 18, to analyze frequency distribution (descriptive analysis) and hypothesis setting (Chi – Square test and Weight Average Index (WAI)). For qualitative analysis using content analysis, the information was classified based on the respondent’s answer.

3.8.1 Quantitative Analysis

a) Descriptive analysis

To describe frequency distribution the central tendency that measure the location and measures of variability of the distance or dispersion of the typical value of a data set were applied in descriptive statistic [Osborn, 2006]. Measures of central tendency deal with the mean, mode, median, maximum, minimum, percentage, frequency, cross tabulation are commonly used in analyzing in demographic and socio - economic data. Measures of variability including standard deviation, grouping data…etc were also used in order to effectively communicate the patterns in the data collected, the appropriate graphic displays of data including tables, charts, and graphs as is supported in the works of [Osborn, 2006; Kumar, 1996]

b) Analytical statistics

In order to test whether statistic and hypothesis is true or not, it is necessary to perform a Chi - Square and Weight Average Index (WAI) test because each variable has different level of measurements.

- **Chi – square test**

To analyze the hypothesis of nominal data, Chi –Square test (also known as a nonparametric test) is used to deal with contingency tables (two by two) which displays frequency data in a simple form [Osborn, 2006]. Chi – Square table results shown the value of Pearson Chi - Square, degree of freedom, level of significant at 0.05, P value, and phi coefficient. Indeed, Chi – Square test are essential in illustrating the patterns between discrimination at the community, health care center, workplace and family and geographic location of respondents. It also shows the relationship between discrimination experience at work place and current job status as well as gender and the association between discrimination in the community and poverty status.

- **Weighted Average Index (WAI)**

Weight Average Index (WAI) techniques based on [Sok, 2010] was used to analyze series responses on Likert scale questions from both PLHIVs and key informants, and it has been classified into five opinions ranging from very poor to very good. This Weight Average Index (WAI) shows the result of comparisons between urban PLHIVs and rural PLHIVs on the subject of subjective stigma. For example, it measures the degree of concern of PLHIVs over losing friends, ending relationships, and disclosing their HIV/AIDS status. Therefore, the below table shows the ranging groups weight average index (WAI).

Very Poor	Poor	Moderate	Good	Very Good
0.00-0.20	0.21-0.40	0.41-0.60	0.61-0.80	0.81-1.00

3.8.2 Qualitative Analysis

A qualitative analysis was used to understand respondents' behavior, perception, and reasons regarding S&D. Not only PLHIVs were interviewed but also key informants or stakeholders from civil society and government were interviewed by using open ended questions. To get results from qualitative interview, group data were basically applied in order to search for resemblance and distinction of responses [Priscilla R& Elizabeth T& Elizabeth E, 2005] and [Martin Brett, 2007]. PLHIVs were asked about livelihood problems and needs. For stakeholder analysis side, it captures patterns over perception, behavior and PLHIVs experience related to stigma and discrimination.

3.9. Chapter Summary

This chapter explained about the procedure of research design and its methodology including study locations, sample size determination, sampling procedure, primary data collection (standardized questionnaires, interviewers training, household interview, key informant interview, and observation) and secondary data (books, journals, reports, website and others). Therefore, the results of the statistical analysis described in this chapter are presented in the next chapter.

CHAPTER IV

RESEACH FINDING AND RESULTS

This chapter clearly illustrates and elaborates the results of the study on the issues of stigma, discrimination experience and coping mechanism amongst PLHIVs living in urban and rural Cambodia. This chapter is classified into eight sections: 1) demographic and socioeconomic characteristics of respondents, 2) respondents' current health condition, 3) discrimination experience, 4) stigmatization experience, 5) Coping mechanism experience 6) Social and health support, 7) hypothesis result, and 8) chapter summary.

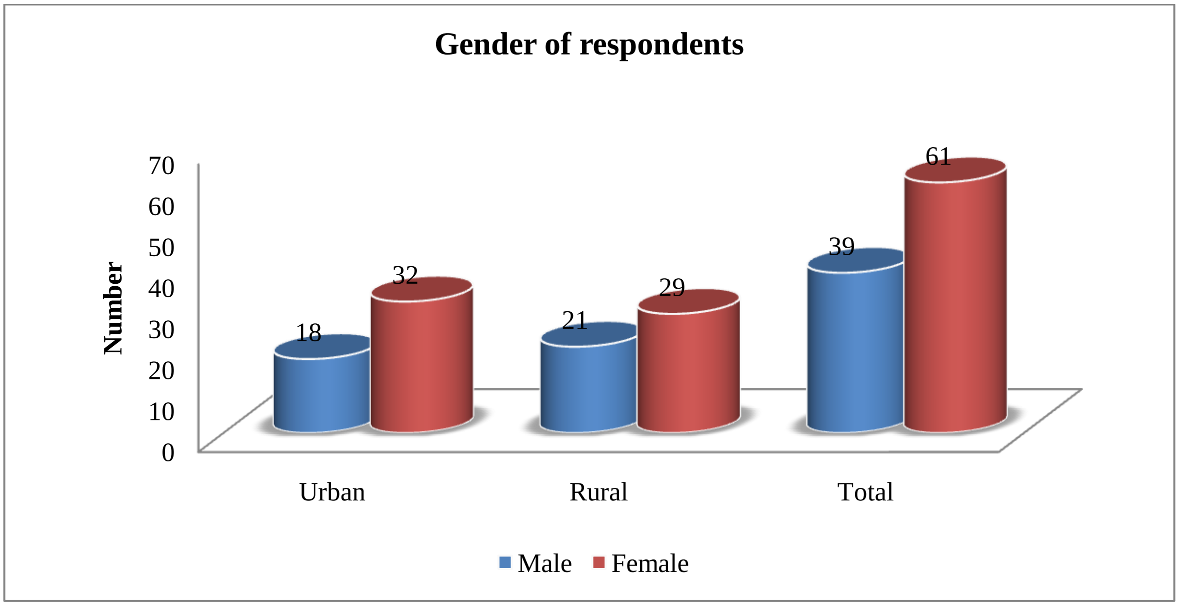
4.1 Basic Profile of Respondents' Demographic and Socioeconomic status

All basic information related to characteristics of demographic and socioeconomic status of research respondents was divided into urban and rural areas. The data were shown in a form of figures and tables which are understandable to differentiate each variable in the result

4.1.1 Gender of research respondents

The figure 4.1 shows that the survey of 100 household respondents was stratified into 50 respondents in urban and rural areas respectively. This figure indicates that the majority of research respondents, 61 PLHIVs, were women while 39 PLHIVs were men. However, the number of women (32 PLHIVs) and men (18 PLHIVs) in urban areas was almost equal to the number of women (29 PLHIVs) and men (21 PLHIVs) in rural areas (see Figure 4.1).

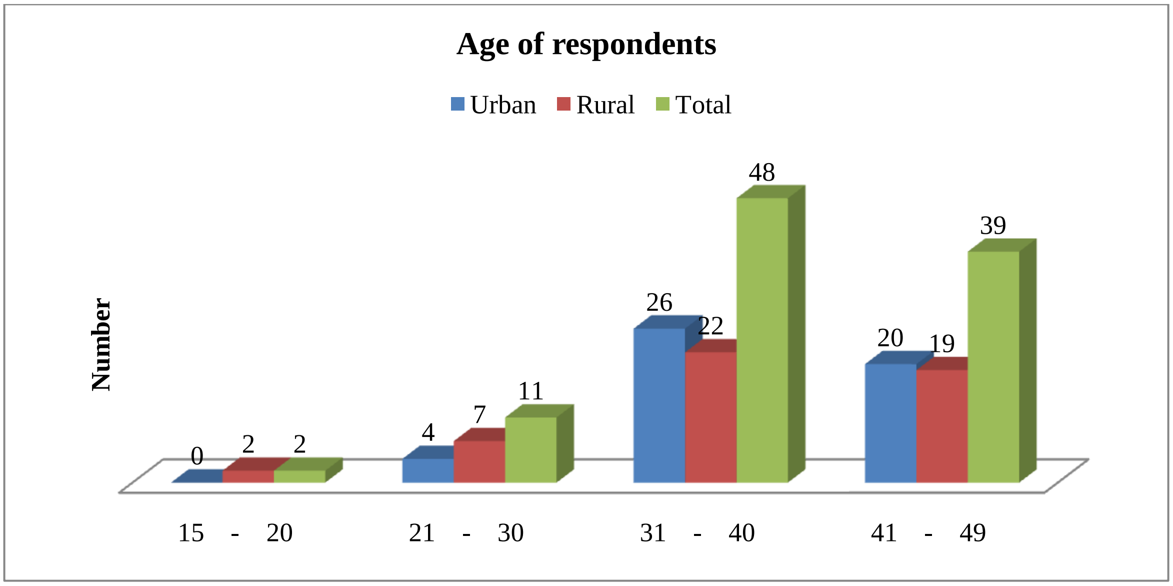
Figure 4.1: Distribution research respondents by gender and locations



4.1.2 Age of research respondents

The figure 4.2 illustrates that the number of the respondents (48 PLHIVs) ranked high for the age group (31 – 40); it shows that 26 PLHIVs are in urban areas and 22 PLHIVs in rural areas, and the following age group (41 – 49) accounted for 39 PLHIVs including 20 urban PLHIVs and 19 rural PLHIVs. The next age group (21 – 30) consisted of 11 PLHIVs which included 7 rural PLHIVs and 4 urban PLHIVs. The last age group (15 – 20) had only two rural PLHIVs (see Figure 4.2).

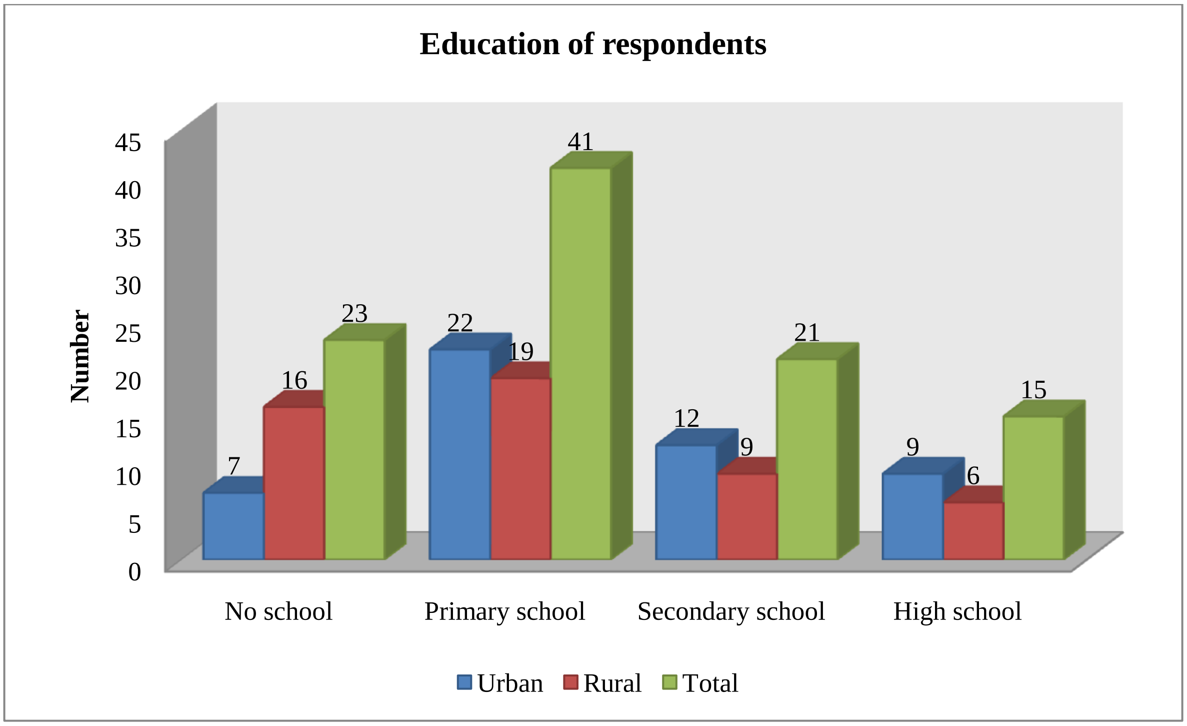
Figure 4.2: Distribution research respondents by age groups and locations



4.1.3 Educational background of research respondents

The below figure 4.3 illustrates that 41 survey respondents consisting of 22 urban PLHIVs and 19 rural PLHIVs completed their education in primary school while 23 research respondents have never attended school. It indicates that the number of illiterate rural PLHIVs was more than double to that of urban PLHIVs (16 rural PLHIVs versus 7 urban PLHIVs); similarly, the number of rural PLHIVs studying at secondary school was much lower than that of urban PLHIVs (12 urban respondents compared to 9 rural respondents). Likewise, the number of urban PLHIVs learning at high school was also little higher than that of rural PLHIVs (9 urban respondents versus 6 rural respondents). Therefore, it is clear that rural PLHIVs had lower educational achievement than urban PLHIVs as a whole (see Figure 4.3).

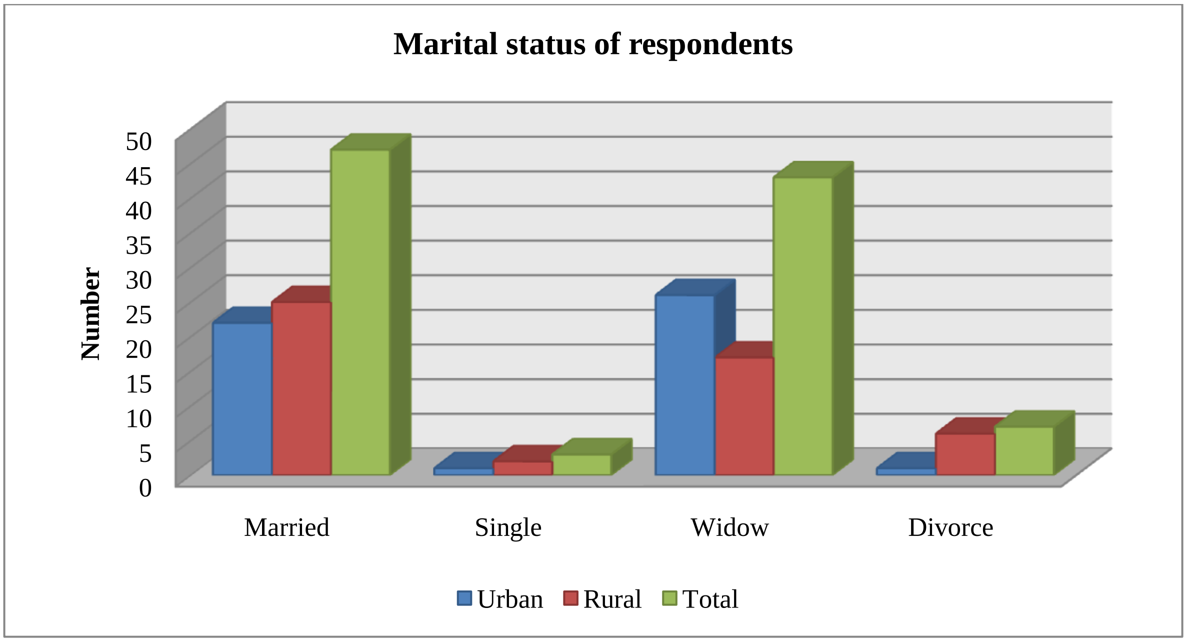
Figure 4.3: Distribution research respondents by educational background and locations



4.1.4 Marital status of research respondents

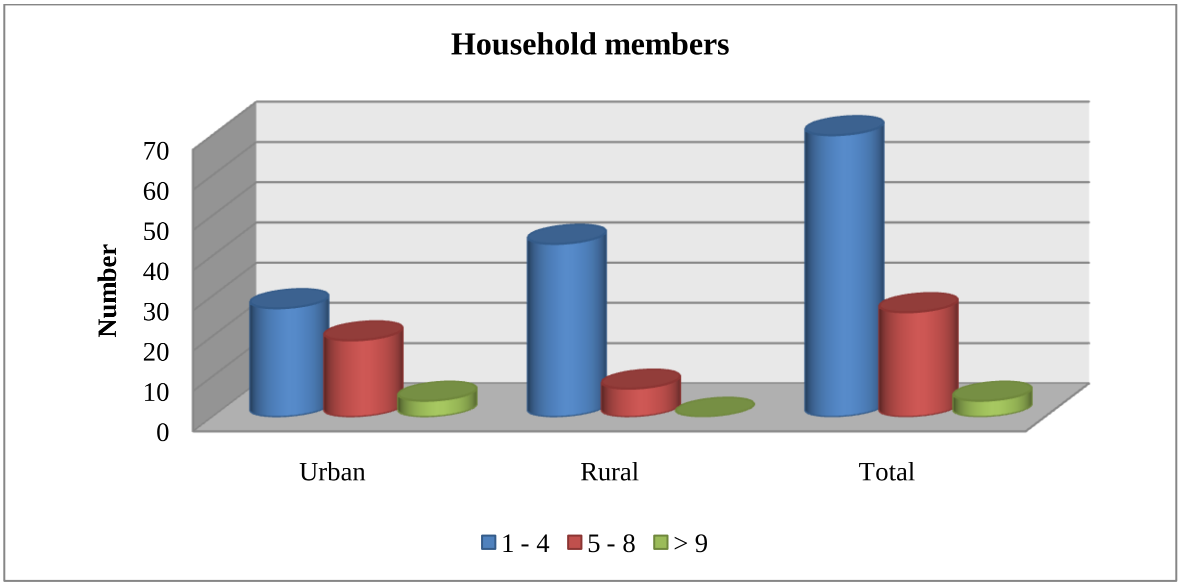
The figure 4.4 reveals that the majority of the household respondents (47 PLHIVs out of 100 survey respondents) were married; 25 PLHIVs were in rural areas, and 22 PLHIVs in urban areas, whereas 43 PLHIVs were widow. The number of urban PLHIVs was higher than the number of rural PLHIVs (26 urban PLHIVs versus 17 rural PLHIVs). However, 7 survey respondents divorced (1 urban respondent and 6 rural respondents). The remaining marital status such as singles accounted for 3 PLHIVs (1 urban respondent versus 2 rural respondents) (see Figure 4.4).

Figure 4.4: Distribution research respondents by marital status and locations



4.1.5 Household members of research respondents

Figure 4.5: Distribution research respondents by household members and locations



This figure 4.5 indicates that most of the PLHIVs (70 PLHIVs) have household from 1 to 4 members in the range group; 43 PLHIVs were in rural areas and 27 PLHIVs in urban areas. Also, PLHIVs reported that they have 5 to 8 family members in the range group, which accounted for 26 PLHIVs (19 urban PLHIVs versus 7 PLHIVs). However, the range group which has more than 9 family members was the smallest one, only 4 urban PLHIVs (see Figure 4.5).

4.1.6 Socioeconomic status of research respondents

The below table 4.1 reveals that socioeconomic status of respondents was more likely to be different in term of income and expenditure between rural PLHIV and urban PLHIV. In average, PLHIVs earn income only $ 0.40 USD per day. Urban PLHIVs earn about $ 0.43USD while rural PLHIVs get around $ 0.36 USD per day. Furthermore, the total amount of annual income of survey respondents was $ 146 USD, which accounted for $ 160.3 USD in urban areas and $ 131.7 USD in rural areas. In comparison, PLHIV spends $ 0.45 USD per day in average, which $ 0.54 USD for urban PLHIVs and $ 0.36 USD for rural PLHIVs. As can be seen from the table 4.1, there was a rise in annual expenditure ($ 166.1 USD). Urban PLHIV spent at least $ 199.4 USD while rural PLHIV expensed $ 132.9 USD. Indeed, the overall income (daily and annual income) and expenditure (daily and annual expense) were imbalance for both groups. Therefore, table 4.1 indicates that the rural PLHIVs' income and expenditure were lower than urban PLHIVs. Also, I can see that the annual gap of income and expenditure between urban PLHIV and rural PLHIV was about $ 20.13 USD. However, both groups earned less than $ 1 USD per day and expensed over their income; thus, it is significant for the data of national socioeconomic survey in 2007 indicating that 30.1 % of Cambodian people lived under national poverty line and earned only $ 0.60 USD per day [NIS & MoP, 2007] (see Figure 4.1).

Table 4.1: Socioeconomic status of research respondents by locations

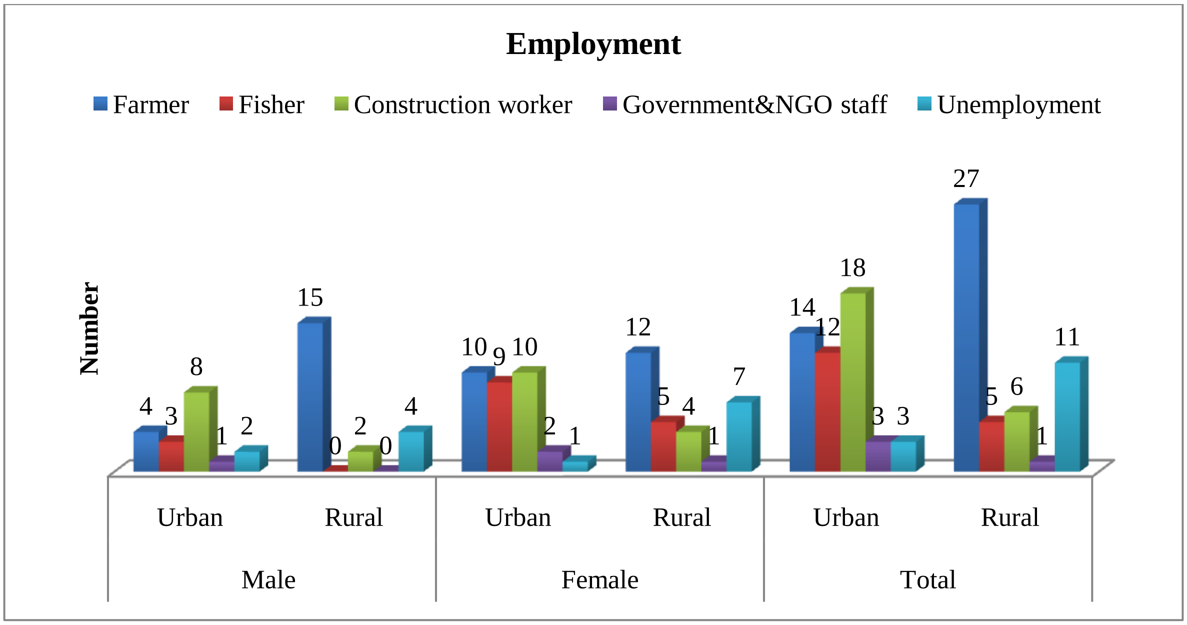
Socioeconomic status	Urban	Rural	Total (Average)
Daily income	$0.43	$0.36	$0.40
Annual income	$160.30	$131.75	$146.03
Daily expenditure	$0.54	$0.36	$0.45
Annual expenditure	$199.41	132.91	$166.16

4.1.7 Occupations of research respondents

The figure 4.6 illustrates that the occupations of respondents in urban and rural areas were divided by gender (male and female). Of all research respondents, 41 PLHIVs worked as farmers; however, the highest number of farmers was in rural areas (27 PLHIVs) compared to urban areas (14 PLHIVs). Moreover, in rural areas, the number of men was higher than women, and it consisted of 15 men and 12 men respectively, whereas the number of men in urban areas was slightly fewer than that of women (4 men versus 10 women).

The second occupation was construction worker which accounted for 24 PLHIVs; the number of urban PLHIVs (18 PLHIVs) was higher than the number of rural PLHIVs (6 PLHIVs); nonetheless, the number of urban men (8 men) and rural men (2 men) was respectively slightly lower than the number of urban women (10 women) and rural women (4 women). The third job was fisher, which accounted for 17 PLHIVs (12 urban PLHIVs versus 5 urban PLHIVs). This shows that women including urban and rural areas were higher than men (14 women versus 3 men). Also, there were few numbers of urban and rural PLHIV (4 PLHIVs) who worked in government or non- government organization. However, 14 PLHIVs (3 urban PLHIVs and 11 rural PLHIVs) were unemployment, and the total number of women who were unemployment was little higher than the number of men (8 women versus 6 men) (see Figure 4.6).

Figure 4.6: Distribution occupations of PLHIV by gender and locations

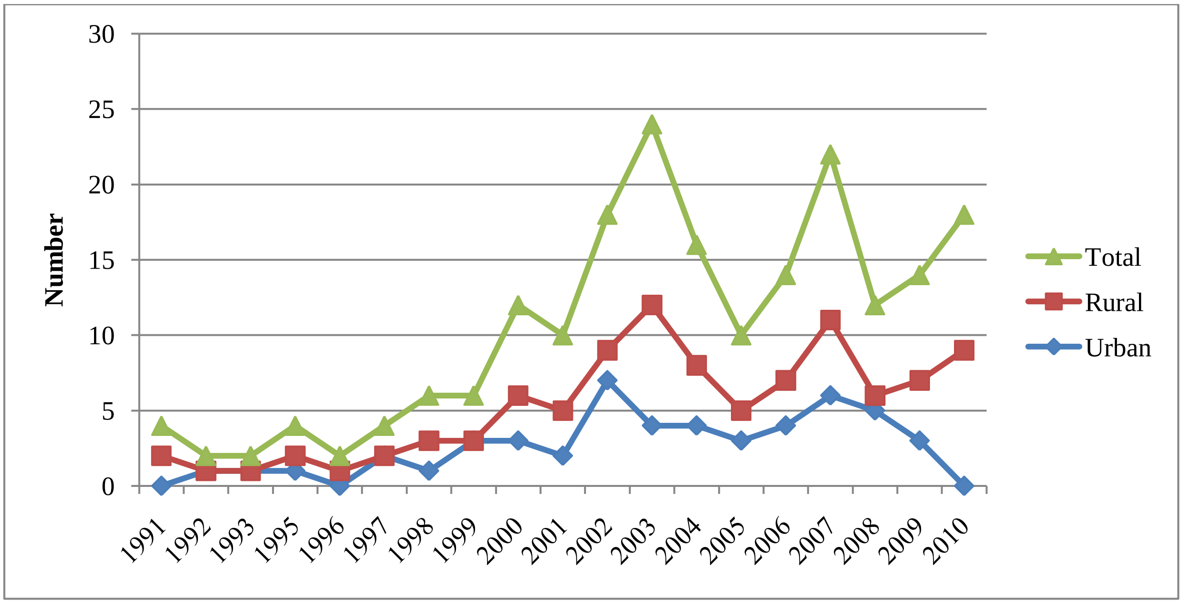


4.2 Respondents' current health condition

4.2.1 Year of HIV infection by gender locations

The below line graph shows figures for the year of having HIV infection between 1991 and 2010. It is clear from the graph that the year of having HIV infection fluctuated tremendously during the time. At the beginning of the period, there were only two PLHIVs in rural areas, and it was a little fluctuation between one person and two persons from 1992 to 1997. A year later the figure had risen slightly to 3 PLHIVs in rural areas and then remained stable until 1999. From this year, the number rose rapidly as it had stood at six people in the year of 2000 .There were equally divided into 3 PLHIVs in urban and rural areas, but by 2001, there was a slightly steady downward trend, and the number had fallen to 5 PLHIVs (2 urban PLHIVs and 3 rural PLHIVs). However, in the year of 2002, it had risen sharply again before reaching a peak of 12 PLHIVs (4 urban PLHIVs and 8 rural PLHIVs) in 2003. Then, it gradually decreased again from 8 PLHIVs in 2004 and 5 PLHIVs in 2005, but there was a small increase in 2006 with the number of 7 PLHIVs (4 urban PLHIVs and 3 rural PLHIVs). Still, it increased quickly in 2007, and the numbers were at 11 PLHIVs (6 urban and 5 rural PLHIVs) after decreasing to six PLHIVs in 2008. Finally, from 2009 onward, however, there was a marked upward trend in the number of PLHIV as the figure shot up from 7 PLHIVs (3 urban PLHIVs and 4 rural PLHIVs) to only 9 rural PLHIVs (see Figure 4.7).

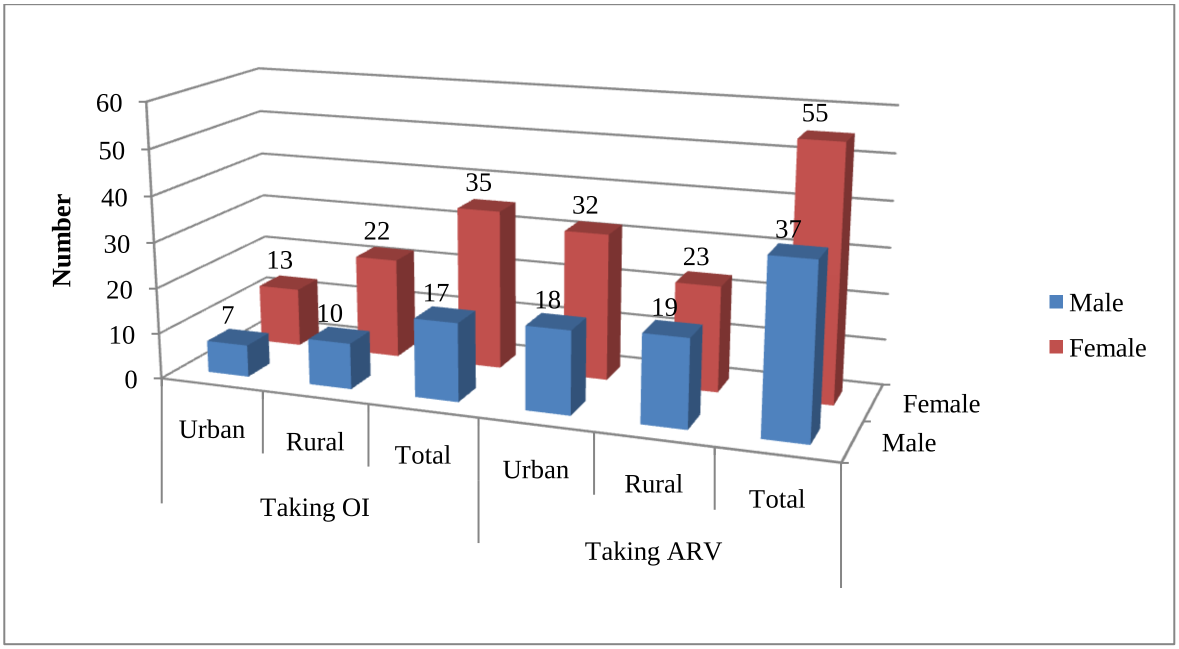
Figure 4.7: Distribution year of HIV infection by gender and locations



4.2.2 Medication of OIs and Utilization of ARV divided by gender and locations

The figure 4.8 describes the medication of opportunistic infections (OI) and utilization of antiretroviral therapy (ARV), which divided by gender and locations. In fact, health is very necessary not only for general people but also for PLHIVs who take care of their health through medication of OI, ARV, fertile food consumption, exercise, daily hygiene, and so on. Furthermore, PLHIV must follow up their health status regularly at the health care center or hospital since the accessibility of OI and ARV amongst PLHIV is free of charge in rural and urban areas. The use of medication for OI determined by urban and rural household survey respondents was significantly different, not explained by stage of disease. Thus, the figure 4.8 illustrates that more than half of all survey respondents, 52 PLHIVs, takes OI, which accounted for 32 rural PLHIVs and 20 urban PLHIVs respectively. Moreover, the total number of women taking OI was much higher than that of men (35 women versus 17 men). This shows that women were more likely to be unhealthier than men while there was a marked upward figure for female PLHIV (see Figure 4.8). In addition, the larger proportion of ARV utilization was very significantly different as the number of women was 55 respondents compared to 37 respondents of men. Also, the figure of PLHIVs living in urban and in rural areas was not similar since the greater numbers of ARV were at urban areas (50 PLHIVs), while forty two PLHIVs were at rural areas. However, the number of urban men (18 men) who take ARV was almost equal to the number of rural men (19 men). Furthermore, the number of women who take ARV was higher than the number of men (32 women versus 23 men) (see Figure 4.8).

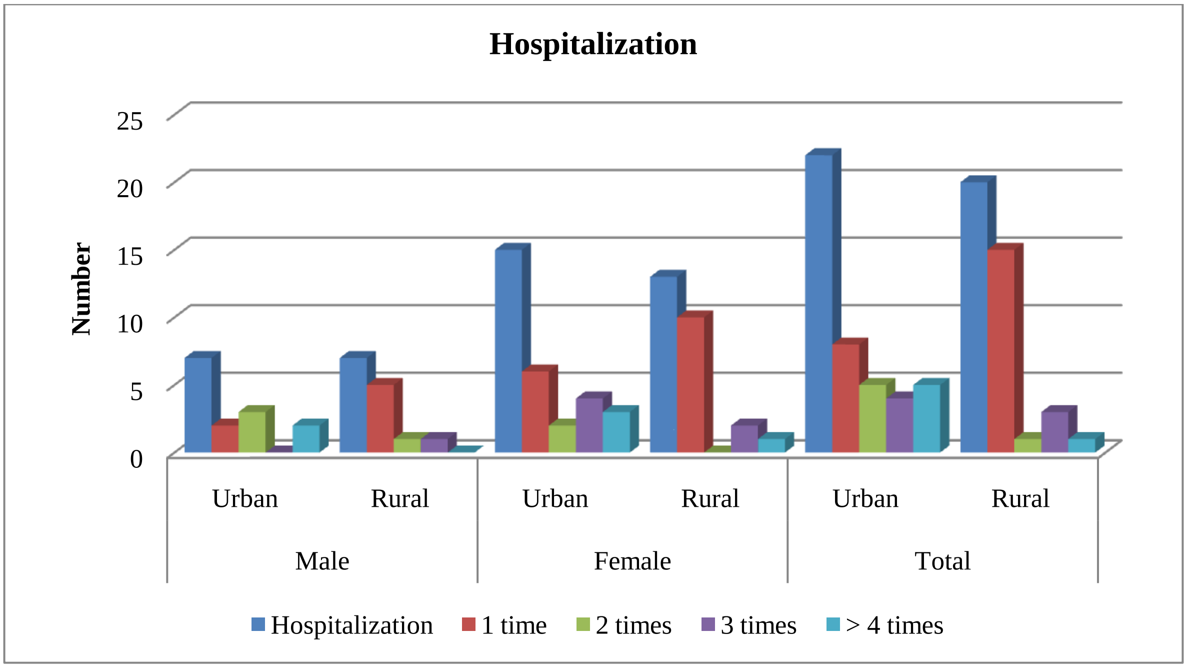
Figure 4.8: Medication of OI and Utilization of ARV by gender and locations



4.2.3 Hospitalization by gender and locations

The figure 4.9 illustrates the experience of hospitalization related to gender and locations. As can be seen from the below figure, the number of urban PLHIVs (22 respondents) was little higher than the number of rural PLHIVs (20 respondents), and the total number of men was half of the number of women in both urban and rural areas (28 women versus 14 men). Furthermore, this study indicates that the total number of PLHIVs who experienced hospitalization for one time was the highest number (23 PLHIVs) compared to others; however, the number of urban PLHIVs was lower than the number of rural PLHIV (8 urban PLHIVs versus 15 rural PLHIVs). Moreover, there were seven PLHIVs who experienced hospitalization for three times. This includes 4 urban PLHIVs and 3 rural PLHIVs. Having said this, similar number of hospitalization for two times and over four times shared the same figure (6 PLHIVs). It is clear that the majority of women experienced hospitalization while men were less likely to be hospitalized; also, this study shows that the number of hospitalization of women was higher than that of men as a whole (see Figure 4.9).

Figure 4.9: Distribution of hospitalization by gender and locations

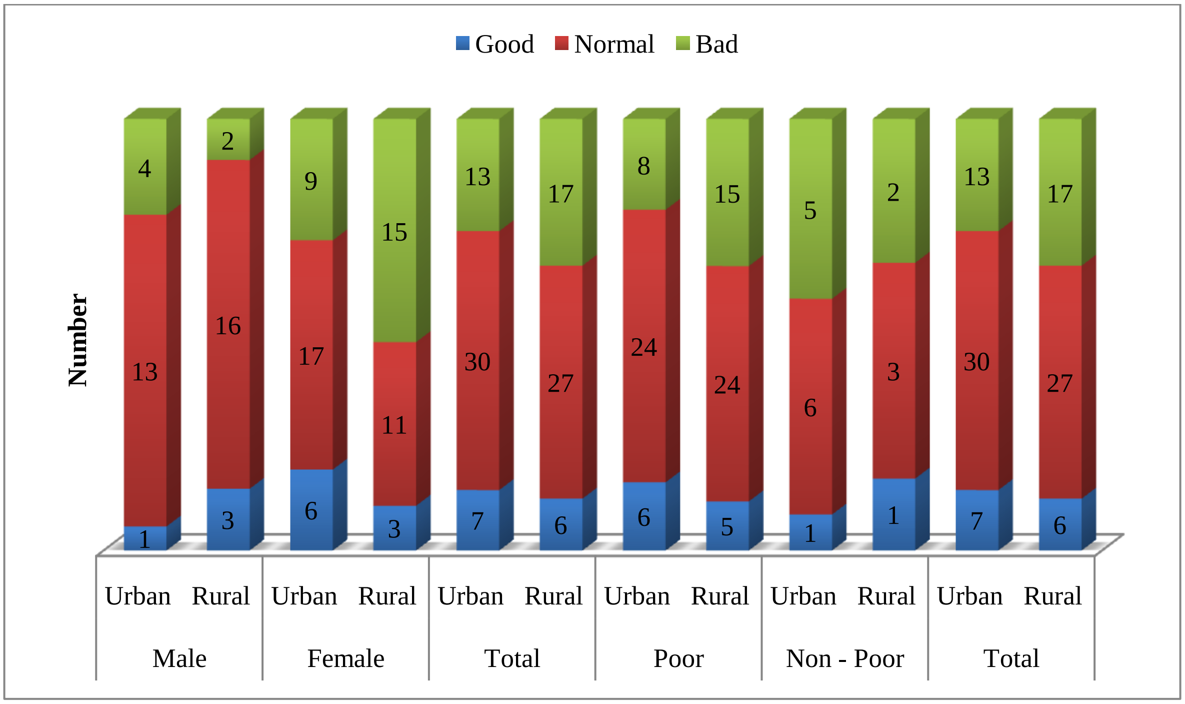


4.2.4 Current health condition by gender, living status, and locations

In spite of OI medication and ARV utilization, the figure 4.10 illustrates the level of current health condition among all subjects that related to gender, living status, and locations. In this study, 57 PLHIVs (30 urban PLHIVs versus 27 rural PLHIVs) reported that their health status was normal while 30 PLHIVs (17 rural PLHIVs and 13 urban PLHIVs) said that they were in bad health condition. In contrast, 13 PLHIVs (7 urban PLHIVs versus 6 rural PLHIVs) answered that their health was good. Interestingly, the number of women who were in normal health was almost equal to the number of men (28 women versus 29 men); the number of women who were in bad health was much higher than that of men (24 women versus 6 men). Moreover, the number of men who were in good health was lower than the number of women (04 men versus 09 women).

On the other hand, forty eight poor PLHIVs (24 urban respondents and 24 rural respondents) were in normal health condition; 9 non - poor PLHIVs including 6 urban PLHIVs and 3 rural PLHIVs were also in normal health condition. Moreover, 30 PLHIVs (23 poor PLHIVs versus 7 non – poor PLHIVs) were in bad health condition, however, 13 PLHIVs (11 poor PLHIVs versus 2 non - poor PLHIVs) were in good health condition (see Figure 4.10).

Figure 4.10: Current health condition by gender, living status and locations



4.3 Discrimination experience of household survey respondents

4.3.1 Discrimination experience in the community, family, health care center, and workplace by gender and locations

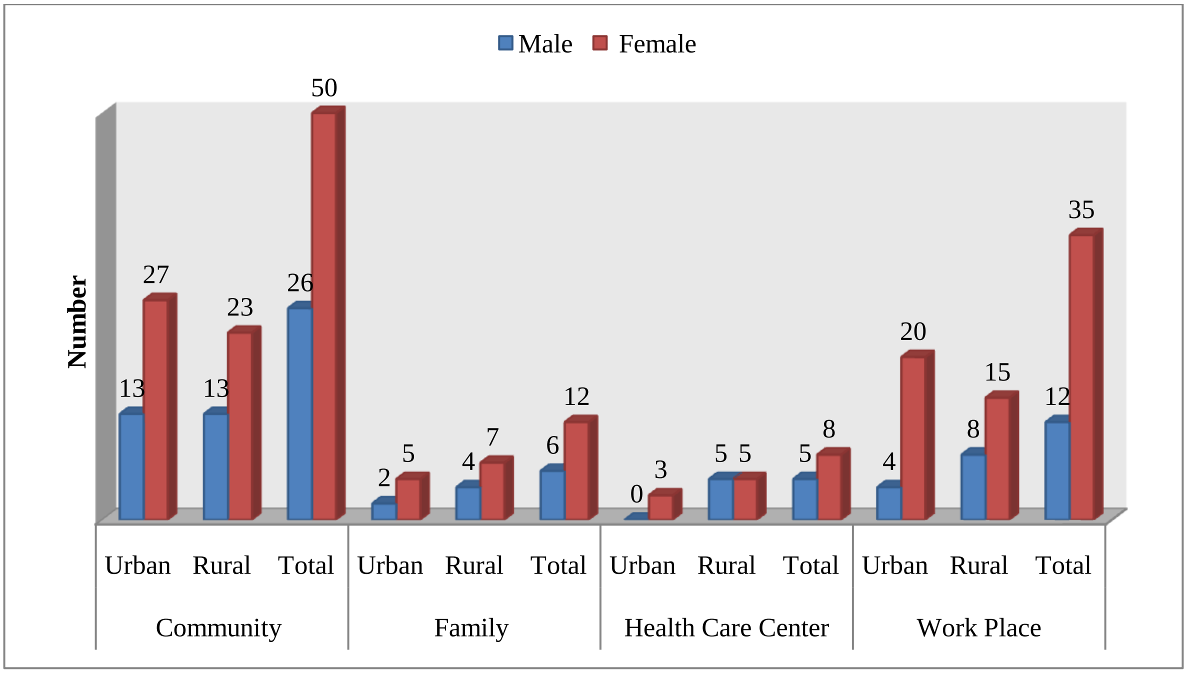
In this study, PLHIVs were asked about discrimination experience in the community, family, health care center, and workplace. The figure 4.11 clearly illustrates that the majority of research respondents, 76 PLHIVs out of 100 survey household respondents, faced discrimination in the community. The number of women doubled than that of men (50 female PLHIVs versus 26 male PLHIVs). Interestingly, the number of men who were discriminated in the community in both urban and rural areas was equal (13 urban men versus 13 rural men). However, the number of urban women was little higher than that of rural women (27 urban women versus 23 rural women) (see Figure 4.11).

Furthermore, PLHIVs working as sellers, construction workers, farmers, factory workers…and so on experienced discrimination at their workplaces. The figure 4.11 indicates that female PLHIVs faced higher discrimination than male PLHIVs (35 women versus 12 men). However, the number of urban PLHIVs who were discriminated at the workplaces was almost equal to the number of rural PLHIVs (23 urban PLHIVs versus 24 rural PLHIVs). Interestingly, the number of rural women was less than that of urban women (15 rural women versus 20 urban women) (see Figure 4.11).

In addition, discrimination against PLHIVs also occurred in the family as figure 4.11 indicates that eighteen PLHIVs (12 women versus 6 men) were discriminated in their family. However, the number of rural PLHIVs was little higher than the number of urban PLHIV (11 rural PLHIVs versus 7 urban PLHIVs) (see Figure 4.11).

Likewise, the lowest number of discrimination against PLHIV among all subjects was at the health care center. 13 research respondents including 8 women and 5 men reported they were discriminated by health care service providers. Also, the number of rural PLHIVs was three times higher than that of urban PLHIVs (10 rural PLHIVs versus 3 urban PLHIVs). Having said this, similar number of men and women who were discriminated at the health care center in rural areas was the same (5 PLHIVs); however, urban men has never faced discrimination at the health care center except women (3PLHIVs) (Figure4.11).

Figure 4.11: Distribution of discrimination experience in the community, family, health care center and workplace by gender and locations



4.3.2 The various ways of discrimination experience in the community by locations

As can be seen from the figure 4.11, it shows that 76 PLHIVs were discriminated in the community. However, the figure 4.12 clearly illustrates that there were various forms of discrimination happening in the community. In this case, from my designed multiple choices questions, PLHIVs who said that they were discriminated by the community members could possibly give answers more than two. Therefore, the majority of survey household respondents (63 PLHIVs) was worst treated by community people. This shows in the form of bad behavior (35 rural PLHIVs versus 28 urban PLHIVs). Sixty PLHIVs were verbally abused (33 rural PLHIVs versus 27 urban PLHIVs). Similarly, during interviewing with key informants, they also expressed the same idea and reasons to prove that PLHIVs were discriminated by community members. As it shows that:

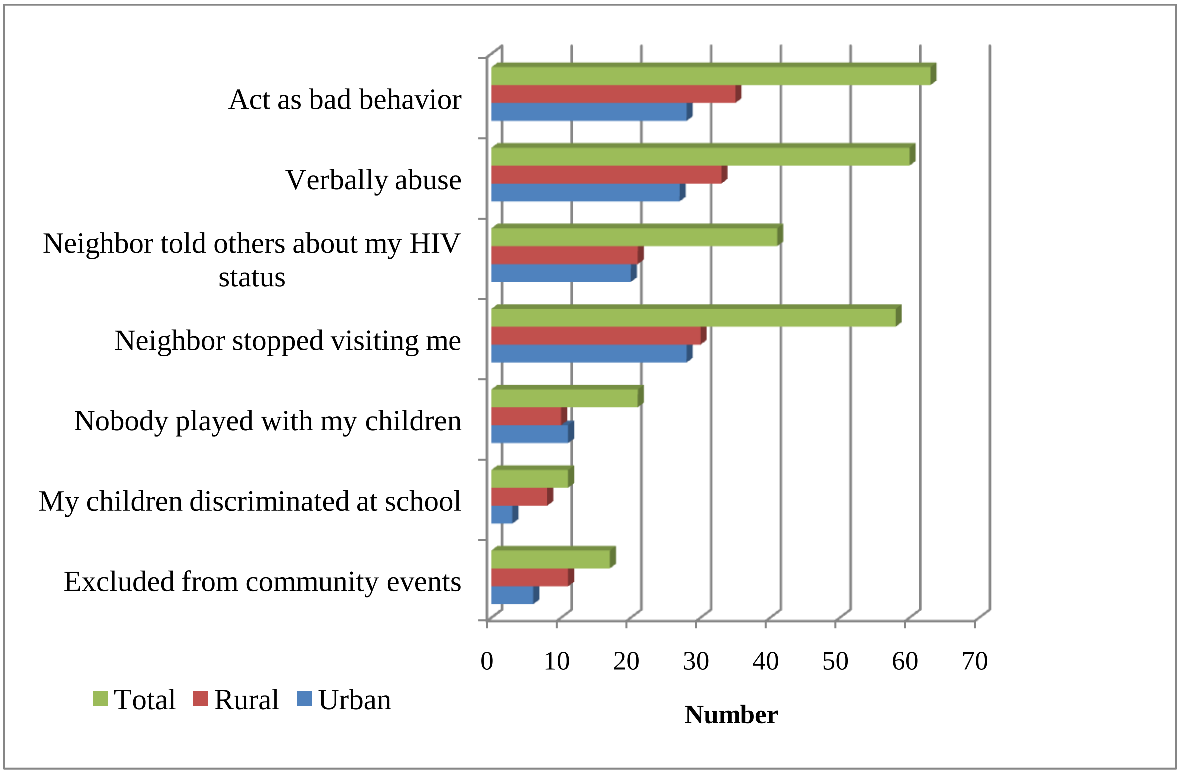
> *Discrimination against PLHIVs in the community was remarkably happening in the form of tangible and intangible manner since community people behaved unfriendly through action and invisible matter through attitude and feeling (Government and NGOs staff).*

Also, 58 survey household respondents reported that their neighbors stopped visiting them after knowing that they had already been infected with HIV. The number of rural PLHIVs was little higher than that of urban PLHIVs (30 rural PLHIVs versus 28 urban PLHIVs). Interestingly, the number of urban PLHIVs whose HIV status was disclosed by their neighbors was almost equal to the number of rural PLHIVs (20 urban

PLHIVs versus 21 rural PLHIVs). Similarly, 21 PLHIVs said that there was no one playing with their children (11 urban PLHIVs versus 10 rural PLHIVs), whereas seventeen PLHIVs reported that they were excluded from community events (11 rural PLHIVs versus 6 urban PLHIVs). Interestingly, eleven PLHIVs reported that their children were also discriminated by their friends or others who know their parents' HIV status, especially rural children (11 rural PLHIVs versus 3 urban PLHIVs) (see Figure 4.12). This result was similar to the view of key informants who expressed that:

> *not only were PLHIVs opposed to provide loan but their children were also prohibited from playing with others as community people still had misconception about HIV/AIDS, they were afraid of HIV infection*
>
> *(NGOs staff).*

Figure 4.12: The various ways of discrimination experience in the community by locations (Multiple responses)

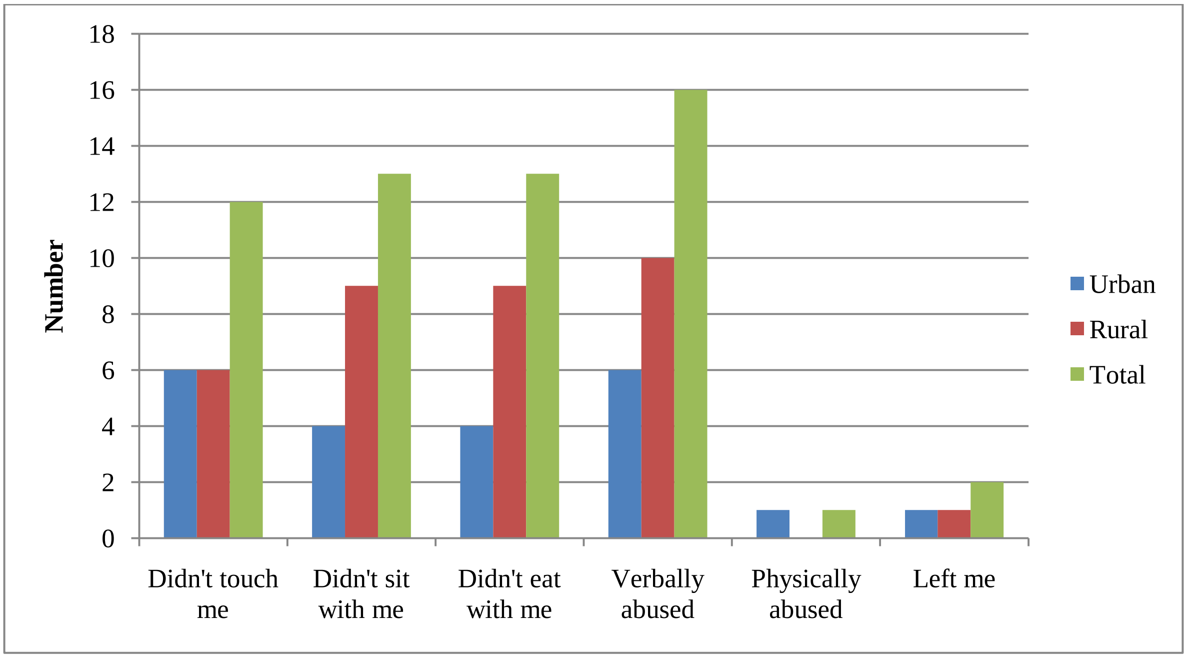


4.3.3 The various ways of discrimination experience in the family by locations

As can be seen from the figure 4.11, it indicates that 18 PLHIVs were discriminated by their family members. However, the figure 4.13 clearly reveals the variety of discrimination forms such as no touching PLHIVs, no sitting with PLHIVs, no eating with PLHIVs, verbal abuse, and leaving PLHIVs alone. Moreover, since the questions were designed in a form of multiple choices, research respondents answered as much as they could. In this study, 16 PLHIVs were frequently verbally abused (10 rural PLHIVs versus 6 urban PLHIVs); however, discrimination which by not being allowed to eat and to share seat together was the same number (13 PLHIVs including 9 rural PLHIVs and 4 urban PLHIVs). Furthermore, twelve PLHIVs said that there was no one touching them (6 urban PLHIVs versus 6 rural PLHIVs). Interestingly, it shows that 2 PLHIVs including 1 rural PLHIVs versus 1 urban PLIHVs were left alone. However, the number of PLHIVs who was physically abused was the smallest one, only one urban PLHIV (see Figure 4.13). Furthermore, during field survey at household level, researcher examined the reaction of respondents through facial expression, attitude, and statement as well as household location. Therefore, it shows that;

> *Being afraid of getting HIV infection, some family members asked PLHIVs to live separately from them. Some PLHIVs do not have enough facilities to support their daily living. Also, they live in unhealthy condition and no hygiene (Field observation).*

Figure 4.13: The various ways of discrimination experience in the family by locations (Multiple responses)



4.3.4 The various ways of discrimination experience at the health care center by locations

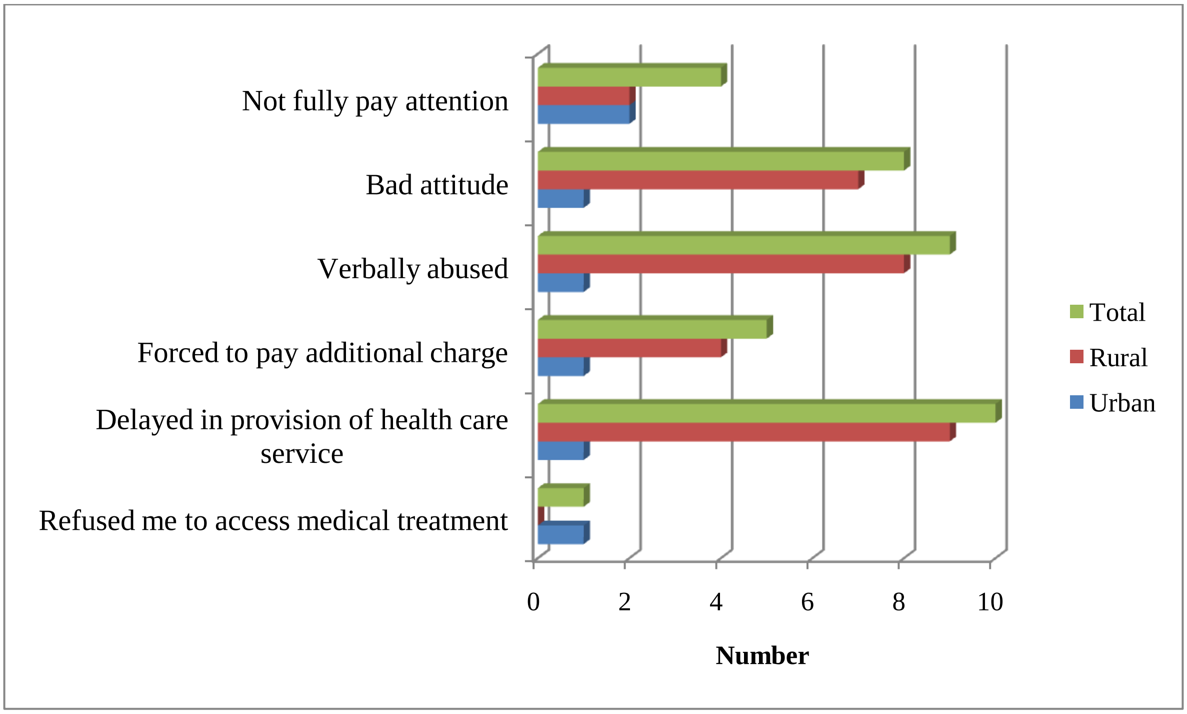
The previous figure 4.11 demonstrates that thirteen PLHIVs were discriminated at health care center. However, the following figure 4.14 evidently describes how discrimination happened to PLHIVs while they were accessing to medical care services. As questions were multiple choices, research respondents answered as much as they could. In this study, it illustrates that 10 PLHIVs (9 rural respondents versus 1 urban respondent) were discriminated by health care service providers as it shows in the form of delaying health care service provision. Furthermore, there were 9 research respondents who were verbally abused by health care service providers. Interestingly, the number of rural PLHIVs was much higher than that of urban PLHIVs (08 rural PLHIVs versus 1 urban PLHIV).

Similarly, eight of survey respondents said that they used to be treated badly by health care service providers. These included 7 rural PLHIVs and 1 urban PLHIV. In addition, key informant reported that;

> *Health care service providers were more likely to pay less attention to PLHIVs while they were seeking health care services; they had been ignored (NGOs staff).*

Interestingly, although medical care service is free of charge for PLHIVs, there were some cases forcing PLHIVs to pay additional charge. For example, five respondents including four rural PLHIVs and one urban PLHIV reported the above issue. Also, four PLHIVs reported that they were not fully paid attention; thus, there were similar numbers of urban PLHIVs and rural PLHIVs who met this problem (2 urban respondents versus 2 rural respondents). Moreover, there was a case of refusing PLHIV to access medical treatment; nonetheless, there was a rare case, and the number of respondents was only one person who lived in urban areas (see Figure 4.14).

Figure 4.14: The various ways of discrimination experience at the health care center by locations (Multiple responses)



4.3.5 The various ways of discrimination experience in the workplace by locations

The Figure 4.11 illustrates that 47 PLHIVs selling food, working at construction site, working at factory, fishing, farming, and doing other job were discriminated at their workplace However, Figure 4.15 clearly indicates the various kinds of discrimination in the workplace and supports the result of figure 4.11. In this study, there were two high similar components of discrimination at the workplace. These show in the form of harassment (32 PLHIVs) and rejecting to buy PLHIVs' products (32 PLHIVs), but the number of rural and urban research respondents shared different number. The figure 4.15 shows that the number of rural PLHIVs who got harassment was little higher than that of urban PLHIV (17 rural PLHIVs versus 15urban PLHIVs).

Moreover, there were 32 PLHIVs whose products or foods were not consumed by the public. Therefore, the number of rural PLHIVs was lower than that of urban (13 rural PLHIVs versus urban 19 PLHIVs). Likewise, twenty two PLHIVs reported that their colleagues behave badly towards them (12 rural PLHIVs versus 10 urban PLHIVs). It further indicates that eight research respondents were discriminated by employers; hence, the number of rural PLHIVs were little higher than that of urban people (05 rural PLHIVs versus 3 urban). Still, PLHIVs were also dismissed from the workplace which accounted for only four PLHIVs. Three and one of which were rural PLHIVs and urban PLHIV (see Figure 4.15).

Similarly, key informants expressed that discrimination against PLHIVs at workplace was still a sensitive issue as some company employers or factory employers seem to be reluctant to accept PLHIVs. Even more, people were not more likely to harmonize well with PLHIV even though they had the same job in the community such as seller, construction worker, factory worker, farmer, and others. Therefore, it shows that:

> *Based on my observation and monitoring the case, when people wanted to work abroad, they were required to do HIV testing. If some people were identified as HIV positive, company agency would not recruit them (government staff).*

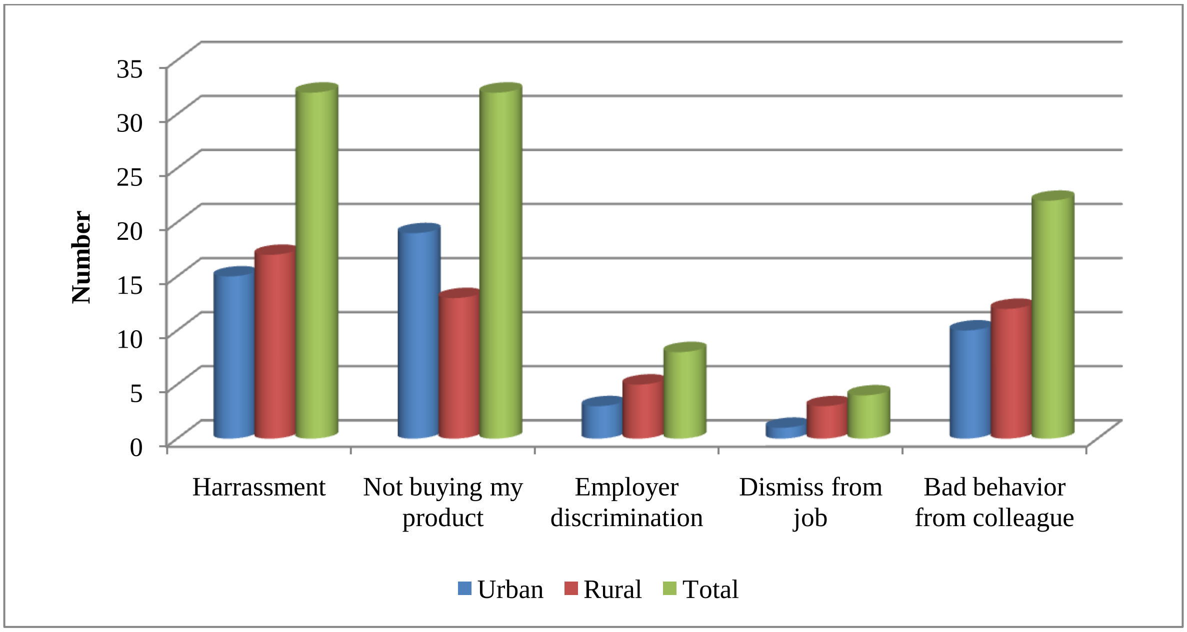
In addition, key informant interviewee continuously pointed out that;

> *PLHIVs selling foods and other products had few clients compared to non- PLHIV if their HIV status was widely known; furthermore, their communication was not extensively good with others (government staff)*

During field household survey, I found that if PLHIVs sell products made by them there will be fewer customers since people are still afraid of HIV infection, and they think that PLHIVs are disgusting.

> *After getting HIV infection, I want my wife to have a job as porridge seller in order to sustain our living condition since I could earn a little income. Later, my wife and I decide not to run that small business because people in the village are still scared of us (rural PLHIVs).*

Figure 4.15: The various ways of discrimination experience in the workplace by locations (Multiple responses)



4.4 Stigmatization experience

4.4.1 Subjective feeling of various stigma experiences by gender and locations

The figure 4.16 illustrates that twenty eight women and fourteen men expressed that it was strongly true statement that they felt concerned about losing friends; similarly, twenty three women against fifteen men agreed that it was true if they told them the truth they would lose friends. However, seven research respondents (4 men versus 3 women) felt normal while eight research respondents (5 women versus 3 men) said that they did not concern over losing friends (false statement) (see Figure 4.16).

Regarding hidden HIV status, there were 36 research respondents (24 urban PLHIVs versus 12 rural PLHIVs) who reported that it was strongly true that they felt concerned over hiding their HIV status from others. Interestingly, there was almost similar figure between urban and rural PLHIVs who marked as true, with 18 urban PLHIVs compared to 19 rural PLHIVs. However, the number of female PLHIVs who said that it was false statement was little higher than male PLHIVs (6 women versus 4 men); furthermore, the number of women who answered normal statement was also higher than the number of men (4 women versus 1 man) (see Figure 4.16).

Moreover, during field interview, I observed that PLHIVs expressed their concern related to their HIV status as they wanted to avoid any difficulty with their business.

> *Because my house was nearby factory, people hired my house yard to park their truck, van, motor taxi. Because of this job, my family lived in a good condition, so if people knew that I had HIV positive, I am afraid that they would stop parking their vehicles (male PLHIV).*

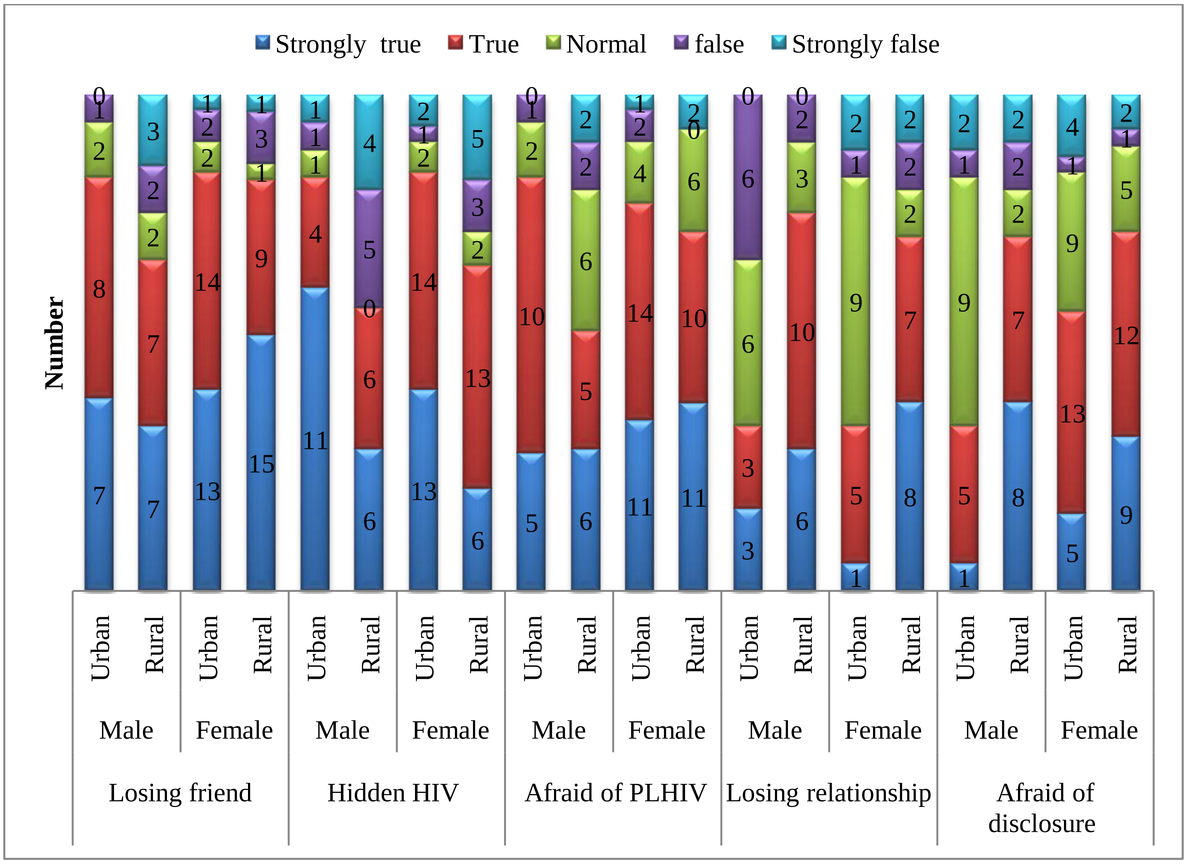
Concerning to their fear caused by the public, there were 33 PLHIVs (11 men versus 22 women) who felt concerned that the public would behave as if they were afraid of them (strongly true statement). Similarly, women were more likely than men to agree to the true statement (24 women versus 15 men). However, there were only 5 PLHIVs (3 men versus 2 women) reporting that it was a false statement, whereas 18 research respondents (10 women versus 8 men) answered that they felt normal (see Figure 4.16)

About feeling afraid of losing relationship with others, there was almost equal number of male (13) and female (12) who reported that their relationship with others would come to a halt if others feel disgusted at them (true statement). Furthermore, the number of men who said that it was false statement was much higher than the number of women (8 men versus 3 women). On the other hand, the number of urban PLHIV who rated average level was much higher than that of rural PLHIV, with 15 urban respondents compared to 5 rural respondents (see Figure 4.16)

Furthermore, with regard to the concern about disclosure of HIV status by others, thirty seven PLHIVs (25 men and 12 women) expressed that it was true. However, 10 research participants (4 men and 6 women) reported that they did not feel concern about disclosure of their HIV status by others. Furthermore, the number of women who answered normal statement was higher than that of men (14 women versus 11 men) (see Figure 4.16). Similarly, key informants expressed that:

> *PLHIVs seemed not to disclosure their HIV positive status to friends, community people, family members or others (NGOs staff).*

Figure 4.16: Distribution of subjective feeling of various stigma experiences by gender and locations



4.5 Coping mechanism experiences

4.5.1 Various means of coping mechanism against stigma and discrimination by gender and locations

The figure 4.17 clearly demonstrates about coping mechanism that PLHIVs had experience in dealing with the issue of stigma and discrimination. In this study, 39 household survey respondents often sought for help from their community. The number of urban PLHIVs was much higher than that of rural PLHIVs (28 urban PLHIVs versus

11 rural PLHIVs). Furthermore, 27 PLHIVs reported that they sometimes sought for help from community. However, the number of female PLHIVs was more likely to be higher than that of male PLHIVs (16 women 11 men). Interestingly, only fifteen PLHIVs rarely sought for help from community (7 men versus 8 women) (see Figure 4.17).

About seeking for help from family members, the Figure 4.17 indicates that the highest number of PLHIVs (64) who is rated as all the time. In fact, the number of women was much higher than that of men (40 women versus 24 men). Also, twenty nine PLHIVs reported that they often sought help from family members, and the number of men was almost equal to the number of women (14 men versus 15 women) (see Figure 4.17).

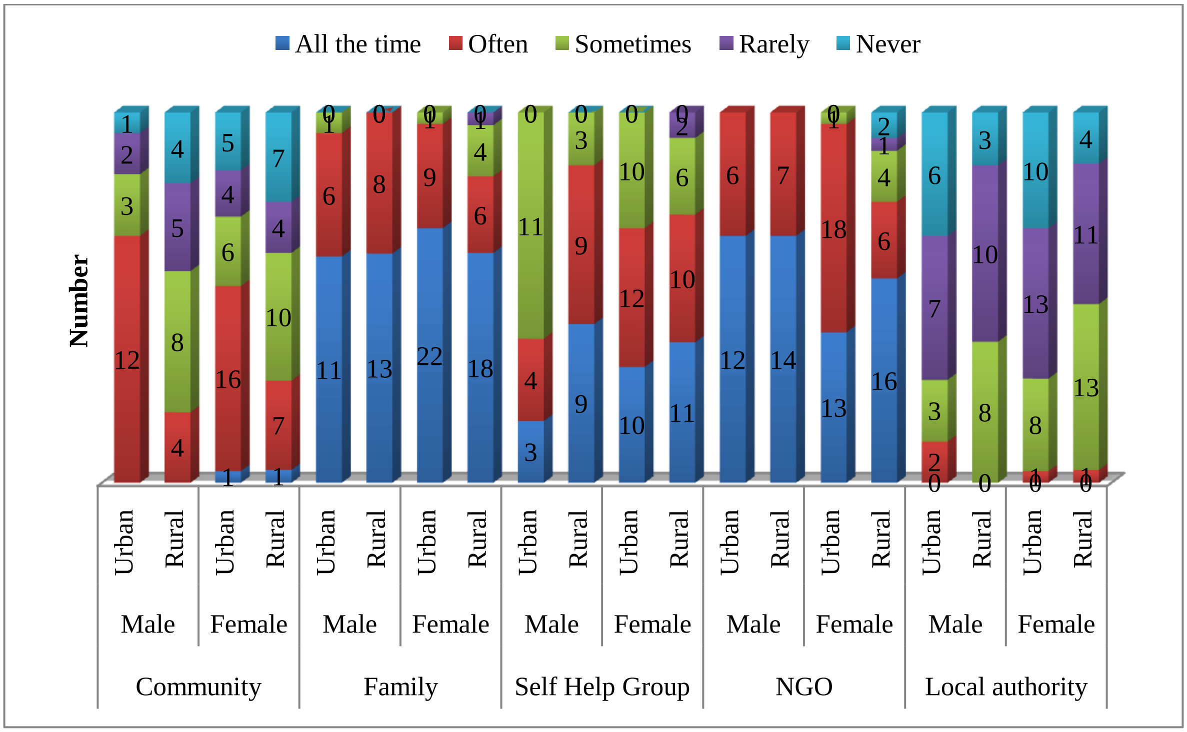
However, on the subject of seeking help from self help group, 33 PLHIVs (rural 20 PLHIVs versus urban 13 PLHIVs) solved the problem with self help group, all the time, whereas 35 PLHIVs often solve the problem with the group. Among those research respondents, the number of urban PLHIVs was less than that of rural PLHIVs (16 PLHIVs opposed to 19 PLHIVs). Furthermore, there were thirty PLHIVs who sometimes sought help from self help group. Interestingly, the number of urban PLHIVs doubled than that of rural PLHIVs (21 urban respondents against 9 rural respondents) (see Figure 4.17).

Regarding seeking help from NGOs, the majority of PLHIVs (55 survey respondents) said that when they had some issues, in particular stigma and discrimination, they, all the time, sought assisting from NGOs staff. In this study, the number of rural PLHIVs was upper than that of urban PLHIVs (30 rural PLHIVs versus 25 urban PLHIVs). Besides, thirty seven of PLHIVs consisting of 24 women and 13 men often sought help from NGOs staff (see Figure 4.17). However, key informants indicate that:

> *Some PLHIVs seemed not to ask help frequently from NGOs as they found that NGOs staffs had a lot of work to do and could not help them immediately when they were seeking support (NGOs staff).*

Finally, in seeking help from local authority, thirty two research respondents said that they sometimes asked for help from local authority. Therefore, the number of men was much lower than the number of women (11 men versus 21 women). In contrast, forty one PLHIVs (20 urban PLHIVs versus 21 rural PLHIVs) reported that they rarely requested support from local authority (see Figure 4.17).

Figure 4.17: Distribution of various means of coping mechanism against with stigma and discrimination by gender and locations



4.6 Social and health support

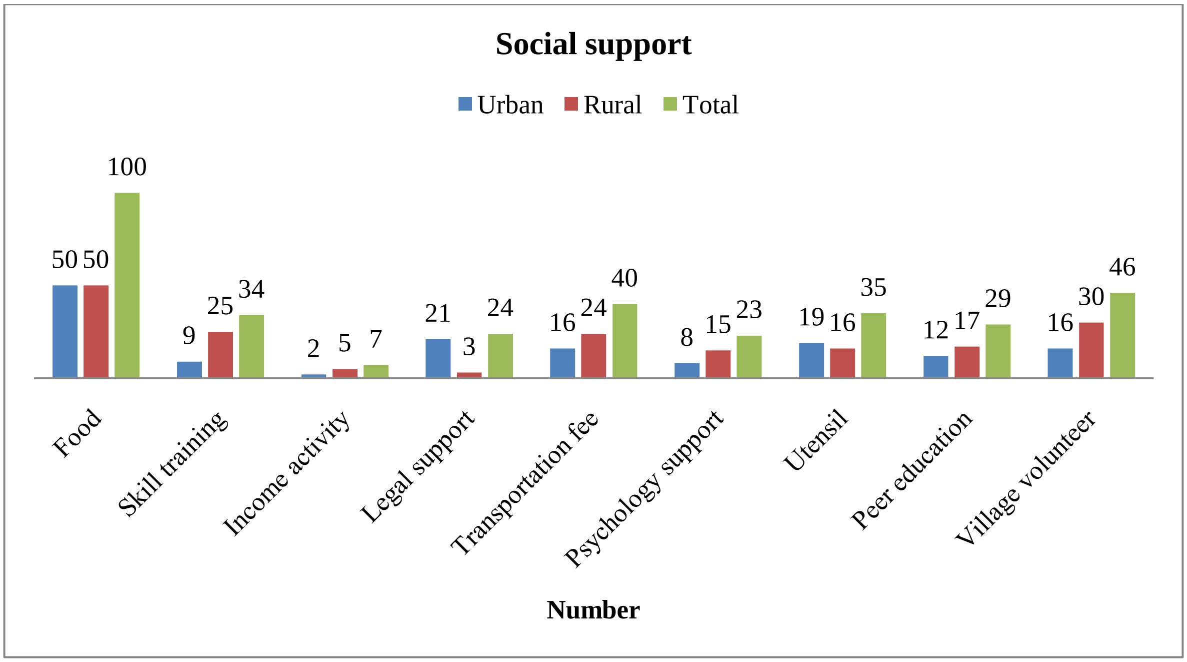
4.6.1 Social support of respondents by locations

PLHIVs faced countless problems not only stigma and discrimination but also daily livelihood. Due to their health condition, the majority of their property was sold for treatment and medical care; besides, their income was very limited. Thus, the figure 4.18 clearly indicates social support provided by NGOs and government. In this study, the highest number among all subjects was food support as 100 PLHIVs received monthly rice support from NGOs. Also, forty six respondents (16 urban PLHIVs versus 30 rural PLHIVs) received support from village volunteer; forty PLHIVs (24 rural PLHIVs versus

16 urban PLHIVs) received transportation fee for accessing medical care services. In fact, the rest of social supports were skill training, income generating activity, legal support, psychology, utensil, and peer education training (see Figure 4.18). However, key informant has drawn attention to the fact that social support is only for temporary period that cannot help PLHIVs to overcome against their deteriorated livelihood.

> *There are a limited number of affected children being supported to go to school, and some of those have dropped out school due to poverty*
>
> *(NGOs staff).*

Figure 4.18: Distribution of social support of research respondents by locations

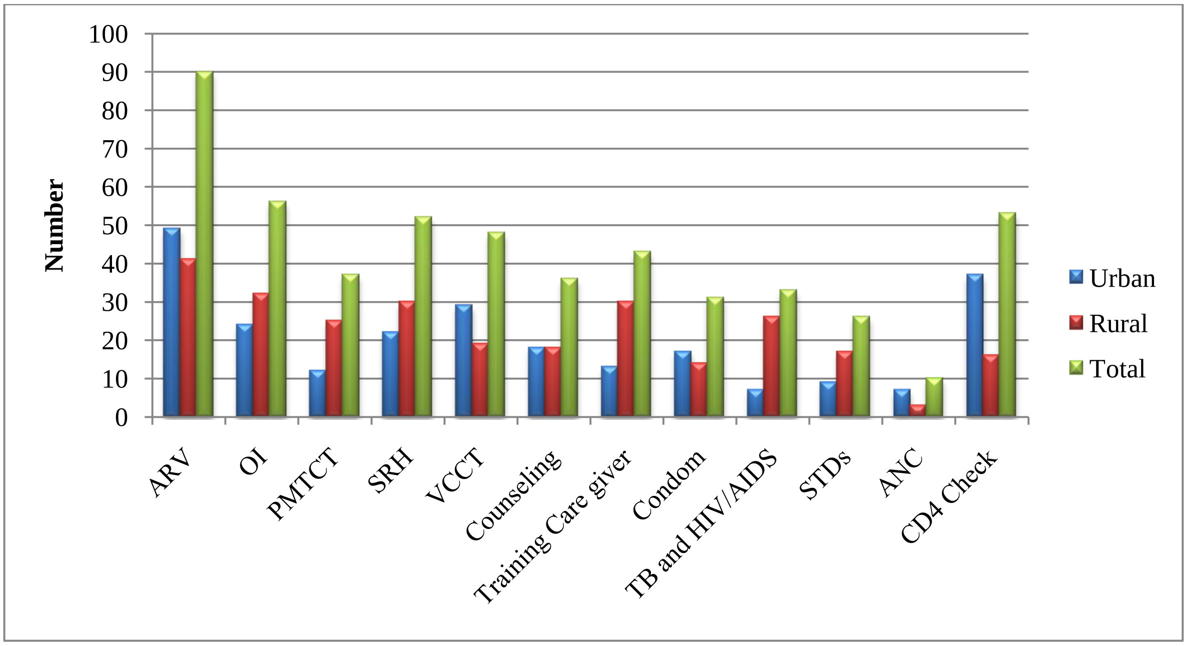


4.6.2 Health support of research respondents by locations

Beside the social support, health support which is quiet vitally important for PLHIVs was involved in this survey. Figure 4.19 generally indicates that the majority of PLHIVs (49 urban PLHIVs versus 41 rural PLHIVs) were provided ARV for free of charge. Moreover, there were 56 research respondents receiving OI. Among those numbers, the number of urban PLHIVs was lower than that of rural PLHIVs (24 urban PLHIVs versus 32 rural PLHIVs). Interestingly, the number of PLHIVs who received sexual reproductive health service support (SRH) and those who received CD4 check was almost equal (52 PLHIVs against 53 PLHIVs). Also, forty eight research respondents sought for Voluntary, Counseling, Confidentiality and Testing services (VCCT). This indicates that the number of urban PLHIVs was more likely higher than that of rural PLHIVs (29 urban PLHIVs versus 19 rural PLHIVs). However, there were many different types of health supports such as preventing mother to child transmission (PMTCT), counseling, Training care giver, condom distribution, sexual transmitted diseases (STDs), Tuberculosis (TB) and HIV/AIDS, and antenatal care (ANC) (see Figure 4.19). However, key informant shows that:

> *Even though ARV is free for PLHIVs, they faced of transportation fee as the health care center was very far; besides, type of ARV line 2 or 3 was not widely available for those PLHIVs who were in the serious stage. More importantly, some PLHIVs were required to pay for consultation if they were asked for general health check up (NGOs staff).*

Figure 4.19 Distribution of Health supports of research respondents by locations



4.7 Hypothesis Results

4.7.1 PLHIVs living in urban areas are less likely to be discriminated than PLHIVs who live in rural areas.

As the hypothesis is clearly stated that discrimination against urban PLHIVs are more likely to be less than those PLHIVs who live in rural areas, the table 4.2, which was given result from the chi – square statistic analysis, clearly illustrates that the majority of research respondents, seventy six PLHIVs consisting of 40 urban PLHIVs and 36 rural PLHIVs, were discriminated by community members. However, there were 24 PLHIVs who had never been discriminated from community members. These consisted of 14 rural PLHIVs and 10 urban PLHIVs. As can be seen from the figures about discrimination in the community, there is no much difference between discrimination against PLHIVs in urban and rural areas. Based on these figures, Statistical analysis, the chi-square test, is highly recommended to apply in order to check whether there is any statistically significant relationship between discrimination against PLHIVs in urban areas and rural areas or not. In this analysis, the result of the chi – square test from SPSS version 18 indicated that there is no statistical significance that discrimination against urban PLHIVs was lower than those PLHIVs who live in rural areas. Discrimination in the community between urban and rural PLHIVs is not different (X^2= 0.877, DF = 1, P - value= 0.349, phi coefficient[8] = 0.094) (see Table 4.2).

Table 4.2: PLHIVs living in urban areas is less likely to be discriminated than PLHIVs who lives in rural areas.

Variable	Location		Chi- Square	DF	P Value	Phi
Community	Urban	Rural				
Discrimination	40	36				
Non- discrimination	10	14	0.877	1	0.349*	0.094
Total	50	50				

* Chi-square is significant at the 0.05 level (2-sided)

---

[8] The range of phi coefficient limitation is 0 to 1. As a general rule of thumb, a value less than 0.30 may be interpreted as a trivial association (Carole. Osborn , 2006,p. 260)

4.7.2 Rural PLHIVs faced higher discrimination from health care service providers than urban PLHIVs

The table 4.3 clearly demonstrates that there were thirteen PLHIVs who were discriminated by health care service providers. Among those household survey respondents, there were 10 rural PLHIVs and 3 urban PLHIVs. However, the majority of research respondents, 87 PLHIVs of the whole 100 samples, have never been discriminated by health care service providers. These show that there were 47 urban PLHIVs and 40 rural PLHIVs. As hypothesis is stated that rural PLHIVs faced higher discrimination by health care service providers than urban PLHIVs, it requires testing statistic since the number of rural PLHIVs and urban PLHIVs was not a big difference (10 rural PLHIVs versus 3 urban PLHIVs). Moreover, I am not sure whether there is any association between rural PLHIVs and urban PLHIVs with discrimination at health care center or not. Therefore, after testing statistical analysis through SPSS version 18, I can see that there is statistically significant that rural PLHIVs were discriminated from health care service providers than urban PLHIVs (X^2= 0.4332, DF = 1, P - value= 0.037, phi coefficient = 0.208) (see Table 4.3).

Table 4.3: Rural PLHIVs face higher discrimination from health care service providers than urban PLHIVs

Variable	Location		Chi- Square	DF	P Value	Phi
Health care center	Urban	Rural				
Discrimination	3	10				
Non- discrimination	47	40	4.332	1	0.037*	0.208
Total	50	50				

* Chi-square is significant at the 0.05 level (2-sided)

4.7.3 Urban PLHIVs face less discrimination at the workplaces than those living in rural areas.

Small business sellers, construction workers, factory workers, farmers, and others experienced discrimination at their workplaces, so it means that discrimination happened not only at the community and at the health care center but also at the workplaces. . The table 4.4 illustrates that almost half of respondents, 47 PLHIVs amongst 100 household survey respondents, were discriminated at the workplaces by the public, colleagues, employers, and customers. Interestingly, the number of rural PLHIVs was almost equal to the number of urban PLHIVs (23 rural PLHIVs versus 24 urban PLHIVs). However, more than half of survey respondents, fifty three PLHIVs who consisted of 26 urban PLHIVs and 27 rural PLHIVs, said that they have never had discrimination at the workplaces. In fact, the hypothesis is stated that urban PLHIVs faced less discrimination at the workplaces than rural PLHIVs; nonetheless, the number of rural and urban PLHIVs was almost the same (23 rural PLHIVs versus 24 urban PLHIVs). Therefore, it is hard for me to make sure whether or not there is any association between rural PLHIVs and urban PLHIVs over discrimination at the workplaces. To solve this problem, SPSS version 18, statistical analysis software, is recommended to use for the chi – square test. In this testing result, I can see that there is no statistically significant to prove that urban PLHIVs faced less discrimination at the workplaces than those who lived in rural areas (X^2= 0.04, DF = 1, P - value= 0.841, phi coefficient = 0.02) (see Table 4.4).

Table 4.4: Urban PLHIVs face less discrimination at the workplace than those living in rural areas.

Variable	Location		Chi- Square	DF	P Value	Phi
Workplace	Urban	Rural				
Discrimination	24	23				
Non- discrimination	26	27	0.04	1	0.841*	0.02
Total	50	50				

* Chi-square is significant at the 0.05 level (2-sided)

4.7.4 PLHIVs living in rural and urban areas face the similar discrimination from their family members.

The table 4.5 indicates that among 100 research respondents, there were only eighteen PLHIVs who were discriminated by their family members. These show that there were 7 urban PLHIVs and 11 rural PLHIVs. Whereas the majority of household survey respondents, 82 PLHIVs, had never been discriminated by their family members, amongst those research respondents, there were forty three urban PLHIVs and thirty nine rural PLHIVs. However, the hypothesis is stated that PLHIVs living in both rural and urban areas faces the similar discrimination from their family members. As can be seen from the table 4.5, the number of PLHIVs who were discriminated from their family members in urban and rural areas was not big difference. Therefore, it is a little bit difficult to ensure whether or not there is any association between rural PLHIVs and urban PLHIVs over discrimination by their family members. However, after running the chi- square test, I found that discrimination against urban and rural PLHIVs in the family environment is not different (X^2= 1.084, DF = 1, P - value= 0.298, phi coefficient = 0.104) (see Table 4.5).

Table 4.5: PLHIVs living in both rural and urban areas face similar discrimination from their family members.

Variable	Location		Chi- Square	DF	P Value	Phi
Family	Urban	Rural				
Discrimination	7	11				
Non- discrimination	43	39	1.084	1	0.298*	0.104
Total	50	50				

* Chi-square is significant at the 0.05 level (2-sided)

4.7.5 Discrimination against urban and rural PLHIVs in the community affects their job status

The below Table 4.6 indicates that 76 PLHIVs out of 100 household survey respondents, were discriminated in the community. It further showed that 66 PLHIVs out of 76 research participants were employed while 10 PLHIVs were unemployed. However, 20 PLHIVs who had never been discriminated in the community were employed, whereas 4 PLHIVs were unemployed. Since the hypothesis stated that discrimination against urban and rural PLHIVs in the community affects their job status, the table 4.6 illustrates that there is much different between employed PLHIVs who were discriminated in the community and unemployed PLHIVs. However, statistic analysis, the chi-square test, was used in order to find out whether there is any statistical significance association between discrimination against urban and rural PLHIVs in the community and job status or not. After running

SPSS, the result shows that there is no statistical significance to prove that discrimination in the community against urban and rural PLHIVs is associated with job status (X^2= 0.187, DF = 1, P - value= 0.666, phi coefficient = 0.043) (see Table 4.6).

Table 4.6: Discrimination against urban and rural PLHIVs in the community affects their job status

Variable	Community discrimination		Chi- Square	DF	P Value	Phi
Job status	Yes	No				
Employment	66	20				
Unemployment	10	4	0.187	1	0.666*	0.043
Total	76	24				

* Chi-square is significant at the 0.05 level (2-sided)

4.7.6 Discrimination against urban and rural PLHIVs in the community associates with poverty status

The table 4.7 reveals that the majority of survey respondents, seventy six PLHIVs out of the entire 100 household survey respondents, were discriminated from general people in the community. Among those PLHIVs, the majority of respondents, 66 PLHIVs, were poor PLHIVs while 10 respondents were non - poor PLHIVs. However, there were twenty four PLHIVs who had never been discriminated by the community people. These show that there were 16 poor PLHIVs and 8 non - poor PLHIVs. In fact, hypothesis mentioned that discrimination against urban and rural PLHIVs in the community associates with poverty status, Based on table 4.7, I can see that there is a big difference between discrimination against urban and rural PLHIVs; however, I had to check with the chi – square test in order to make sure whether or not there is any association between discrimination against both urban and rural PLHIVs and poverty status. Therefore, I found that there were evidence suggesting that discrimination against urban and rural PLHIVs in the community is statistically significantly associated with poverty status (X^2= 5.03, DF = 1, P - value= 0.025, phi coefficient = 0.224) (see Table 4.7).

Table 4.7: Discrimination against urban and rural PLHIVs in the community associates with poverty status

Variable	Living status		Chi- Square	DF	P Value	Phi
Community	Poor	Non-Poor				
Discrimination	66	10				
Non- discrimination	16	8	5.03	1	0.025*	0.224
Total	82	18				

* Chi-square is significant at the 0.05 level (2-sided)

4.7.7 Discrimination against urban and rural PLHIVs at the workplace associates with gender

PLHIVs earn income through various ways to support their family. For example, they work as construction workers, small business sellers, farmers, factory workers, and others. In this study, the table 4.8 demonstrates that forty seven PLHIVs who were discriminated at the workplaces. These consisted of 35 women and 12 men. In contrast, more than half of PLHIVs, fifty three of household survey respondents, had never been discriminated at their workplaces. These show that there were 27 men and 26 women. However, the hypothesis stated that discrimination against urban and rural PLHIVs at the workplace associates with gender. As can be seen from the table 4.8, the number of women who were discriminated at the workplace was much higher than that of men (35 women and 12 men). However, I have to run statistic analysis in order to make sure that whether or not there is any association between discrimination against both urban and rural PLHIVs at the workplace and gender. Therefore, the table 4.8 provides the result of the chi – square test, and it indicates that there is statistically significant that discrimination against urban PLHIVs and rural PLHIVs at the workplace is associated with gender (X^2= 6.761, DF = 1, P - value= 0.009, phi coefficient = 0.26) (see Table 4.8)

Table 4.8: Discrimination against urban and rural PLHIVs at the workplace associates with gender

Variable	Gender		Chi- Square	DF	P Value	Phi
Workplace	Male	Female				
Discrimination	12	35	6.761	1	0.009*	0.26
Non- discrimination	27	26				
Total	39	61				

* Chi-square is significant at the 0.05 level (2-sided)

4.7.8 Discrimination against urban and rural PLHIVs at the health care center associates with accessing to ARV medicine

The table 4.9 visibly demonstrates that there were only thirteen PLHIVs who were discriminated by health care service providers. Among those research respondents, eleven PLHIVs use ARV medicine while other two PLHIVs do not use ARV medicine. Nevertheless, the majority of respondents, 87 PLHIVs out of 100 household survey respondents, had never been discriminated at the health care center. Among those numbers, there were 81 ARV users and 6 non - ARV users. However, the hypothesis stated that discrimination against urban and rural PLHIVs at the health care center associates with accessing to ARV medicine. As I can see from the table 4.9, there is little difference between ARV users (11 PLHIVs) and ARV non - users (2 PLHIVs). However, I had to check with the chi - square test in order to make sure whether or not there is any association between discrimination at the health care center and ARV usage. Based on the table 4.9, the chi – square test result reveals that discrimination against urban and rural PLHIVs at the health care center is not associated with accessing to ARV medicine (X^2= 1.107, DF = 1, P - value= 0.293, phi coefficient = 0.105) (see Table 4.9).

Table 4.9: Discrimination against urban and rural PLHIVs at the health care center associates with accessing to ARV medicine

Variable	ARV medicine		Chi- Square	DF	P Value	Phi
Health care center	Usage	No usage				
Discrimination	11	2				
Non- discrimination	81	6	1.107	1	0.293*	0.105
Total	92	8				

* Chi-square is significant at the 0.05 level (2-sided)

4.7.9 The comparison of subjective stigma between urban PLHIVs and rural PLHIVs

PLHIVs face not only discrimination by general people but also stigmatization from their selves. PLHIVs had to struggle against their internal feeling that caused them to live in hopelessness, depression, disgrace or shame. Therefore, the table 4.10 clearly shows that there were different types of stigma among PLHIVs in urban and rural areas. However, the first hypothesis suggested that rural PLHIVs are more likely to be afraid of losing friends than urban PLHIVs if they are known to get HIV positive. In this study, urban PLHIVs, based on table 4.10, said that it is really true that they concerned over losing friends (0.82), and rural PLHIVs said that it is true that they were more likely to be concerned about losing friends (0.78). However, the hypothesis stated that rural PLHIVs are more likely to be afraid of losing friends than urban PLHIVs. I need to do T – test of statistic analysis, since there was not much difference between urban PLHIVs and rural PLHIVs. After running T-test, it indicates that the P - value (0.37) is greater than the P - critical value level (0.05). In conclusion, it is not true that rural PLHIVs were more likely to be afraid of losing friends than urban PLHIVs if they were known to have HIV positive (see Table 4.10)

Another hypothesis stated that rural PLHIVs feels more concerned than urban PLHIVs over losing good relationship with others if people feel disgusted with them. Table 4.10 indicates that both urban and rural PLHIVs had the same feeling of anxiety for the communication network. In this study, the weight average index of urban PLHIVs (0.61) and rural PLHIVs (0.77) that concerned over losing good relationship with other people is in true level. However, in order to test hypothesis, I need to check T- test as the number of the weight average index of both urban and rural research respondents is not a big difference, and it is hard to ensure whether it is significant or not. After running statistic analysis, it shows that the P - value of T - test (0.00) is much lower than P - critical value level (0.05); therefore, it concluded that rural PLHIVs are more concerned about relationship with other people than urban PLHIVs (see Table 4.10)

The final hypothesis mentioned that PLHIVs feels more concerned about disclosure than urban PLHIVs. The table 4.10 indicates that weight average index of urban PLHIVs (0.66) and rural PLHIVs (0.76) who felt more concerned that people will tell their HIV status to the others is in the same true level. However, these numbers, urban PLHIVs (0.66) and rural PLHIVs (0.76), are not much difference; therefore, T – test of statistic analysis is used to analyze whether it is significant or not. The result of T - test indicates that the P - value is 0.028, which is slightly lower than P - value critical level (0.05). Therefore, there is sufficient evidence to prove that rural PLHIVs felt more concerned than urban PLHIVs about that people will tell their HIV status to the others (see Table 4.10).

Table 4.10: The comparison of subjective stigma between urban PLHIV and rural PLHIV

Self feeling Stigma	Urban		Rural		T - Test
	WAI	OA	WAI	OA	P Value
I felt concerned that I would lose friend if I told people that I had HIV	0.82	ST	0.78	T	0.37
I used to think that I stopped being good relation with others if people were disgusting to me.	0.61	T	0.77	T	0.000
I felt concerned that those knowing I have HIV would tell others.	0.66	T	0.76	T	0.028

Source: Field Survey, September 2010

Note: WAI = Weight Average Index, OA = Overall Assessment, ST = Strongly True, T = True, M = Moderate, F = Fall, SF = Strongly False

Strongly False	FALSE	Moderate	TRUE	Strongly True
0.00-0.20	0.21-0.40	0.41-0.60	0.61-0.80	0.81-1.00

4.8 Chapter Summary

In overall, the most important result and data of chapter VI mainly focused on stigma, discrimination and coping mechanism. As shown in the above result, the majority of household survey respondents faced the issue of discrimination by their community, health care service providers, workplace workers, and family members. Also, they faced the issue of internal feeling (stigma) that caused them to be depressed, concerned, shame hopeless, isolated, and hiding. Moreover, seeking for coping mechanism is almost limited among PLHIVs.

PLHIVs were mostly discriminated by community people as the previous figure 4.11 clearly illustrates that 76 PLHIVs among 100 household survey respondents confronted discrimination in the community. Moreover, forty seven PLHIVs reported that they were discriminated at the workplace; the number of women was more likely to be much higher than that of men (35 women versus 12 men). Furthermore, eighteen PLHIVs who consisted of 12 women and 6 men reported that they were discriminated in the family. More importantly, there were thirteen PLHIVs who were also discriminated at the health care center. Among those research respondents, the number of women was higher than that of men (8 women versus 5 men).

Regarding stigma (internal feeling), the previous figure 4.16 illustrates that twenty eight women compared with fourteen men were strongly concerned that they would lose friends. Similarly, twenty three women against fifteen men said that it was true. Also, thirty six PLHIVs felt concern to hide their HIV status from others, and 37 PLHIVs expressed a similar feeling. Furthermore, thirty nine PLHIVs concerned that general people would be afraid of them (24 women versus 15 men) while twenty five PLHIVs said that people will stop interacting with them if people feel disgusted with them. Moreover, thirty seven PLHIVs including 25 men and 12 women concerned about their HIV status disclosed by others, and 10 PLHIVs did not feel concern (4 men and 6 women).

In addition, the figure 4.17 shows that PLHIVs sought help from different sources such as community people, family members, self help groups, organization, and local authority. As it reported that 39 PLHIVs often sought help from their community, 64 PLHIVs, all the times, asked help from their family members. However, thirty three PLHIV including (20 rural PLHIVs versus 13 urban PLHIVs) solved the problem with self help groups, all the time. Moreover, fifty five PLHIVs said that when they had some issues, in particular stigma and discrimination, they, all the time, sought assisting from NGOs staff. However, thirty two people sometimes asked for help from local authority (21 women versus 11 men).

Finally, in relation to hypothesis result, it shows that discrimination in the community against urban PLHIVs and rural PLHIVs is not different, and there is no evidence to suggest that discrimination against urban PLHIVs was lower than those PLHIVs living in rural areas. However, there is statistically significant that rural PLHIVs were discriminated by health care service providers than urban PLHIVs. Also, it further proved that there is not statistically significant that urban PLHIVs faced less discrimination at the workplace than those who lived in rural areas, and discrimination against urban and rural PLHIVs from the family members is not significantly different. Another hypothesis demonstrates that discrimination in the community against urban and rural PLHIVs is not affected their current job status. Also, it illustrates that discrimination against urban and rural PLHIVs in the community is not only associated with poverty status but also associated with gender of the research respondents, but discrimination against PLHIVs at health care center is not associated with accessing ARV medicine. However, regarding subjective feeling of stigma, rural PLHIVs did not feel concerned about losing friends compared with urban PLHIVs, but rural PLHIVs felt more concerned than urban PLHIVs about relationship with other people and their HIV status.

Table 4.11 summary hypothesis of discrimination at the community, health care center, workplace, and family by locations

Variable	Location		Chi- Square	DF	P Value	Phi
Discrimination	Urban	Rural				
At the community	40	36	0.877	1	0.349*	0.094
At the health care center	3	10	4.332	1	0.037*	0.208
At the workplace	24	23	0.04	1	0.841*	0.02
In the family	7	11	1.084	1	0.298*	0.104

* Chi-square is significant at the 0.05 level (2-sided)

Table 4.12 summary hypothesis of discrimination at the community, health care center, and workplace by poverty status, gender, current occupations, and accessing ARV medicine

Discrimination	Variable		χ^2	DF	P Value	Phi
At the community	Poor	Non-Poor	5.03	1	0.025*	0.224
	66	10				
At the community	Job	No Job	0.187	1	0.666*	0.043
	66	10				
At the workplace	Male	Female	6.761	1	0.009*	0.26
	12	35				
At the health care center	ARV	No ARV	1.107	1	0.293*	0.105
	11	2				

* Chi-square is significant at the 0.05 level (2-sided);

Table 4.13 summary of coping mechanisms against stigma and discrimination

Number

Sources of support	All the time	Often	Sometimes	Rarely	Never
Community	2	39	27	15	17
Family	64	29	6	1	0
Self Help Group	33	35	30	2	0
NGOs	55	37	5	1	2
Local authority	0	4	32	41	23

Table 4.14 summary of subjective stigma among PLHIV

Number

Variable	Strongly true	True	Normal	False	Strongly false
Concerned over Losing friend.	42	38	7	8	5
Wanted to hide HIV status.	36	37	5	10	12
Concerned over people fear of them.	33	39	18	5	5
Stop being good relations with others.	18	25	20	11	4
Concerned over people telling others about their HIV status.	23	37	25	5	10

CHAPTER V

DISCUSSION, CONCLUSION, POLICY IMPLICATIONS AND SUGGESTION FOR FURTHUR RESEARCH

This chapter has been divided into four parts. The first part discussed and compared the results of the study including discrimination in the community, family, health care center, and workplace with previous studies. The second part focuses on conclusion which centered on the overview of the overall findings in line with the main objective of this research. The third part which is about policy implication is developed in accordance with relevant document review, suggestion from key informant interview, and relevant stakeholders. And lastly, recommendation for further research about HIV/AIDS related S&D is suggested and proposed in order to generalize the study results.

5.1 Discussion

5.1.1 Discrimination in the community

In this study, out of 100 research respondents, 76 PLHIVs reported that they had been discriminated in the community. However, an analysis of multiple answers indicates that 63 household survey respondents (25 rural PLHIVs versus 28 urban PLHIVs) frequently faced discrimination in the community. This shows in the form of bad behavior, and 60 research respondents (33 rural PLHIVs versus 27 urban PLHIVs) were verbally abused.

These results were similar to the findings of [KHANA, 2010] indicating that 25% of PLHIVs said that they had been verbally insulted while about 10% had been physically threatened. Another study, [SI & CAS, 2010], has similarly shown that 13 % of HIV infected people including their family members were differently treated by community members with various forms such as verbal violence, isolation, negligence, and prohibition to allow their children to play with others. Furthermore, 23% of women reported that they experienced verbal abuse while 7% of them said that they were physically intimidated. Similarly, a study by [Marie Stopes, 2009] in China found that 17.8% of women and 12.3% of men had been verbally insulted respectively, and 6.4% of women were physically abused compared to men (3.1 %).

The researcher's study showed that 58 survey respondents said that their neighbors stopped visiting them while 41 PLHIVs said that their HIV status was disclosed to others; furthermore, 21 PLHIVs said that nobody wanted to play with their children. Interestingly, 17 PLHIVs reported that they were excluded from social gathering, community activities, or other events.

A similar study by [Marie Stopes, 2009] indicated that 7.4% of women were rejected from social events compared to men (5.8%). Moreover, research carried out by [KHANA, 2010] claimed that 10% of respondents were excluded from community events, religious ceremony, and family activities.

The findings of my study and previous studies have shown that discrimination against PLHIVs in the community still existed. Furthermore, it is likely that the fear of HIV infection due to misconception or limited knowledge about HIV/AIDS still persist in human concept, which led directly or indirectly to pessimistic practice and treatment among general people ([Bunting, 1996] & [Jonna, 1999] & [Lyttleton, 2000]). Although there are promotions on HIV/AIDS awareness through mass media (television, radio, and others), outreach education program, campaign, printed materials, and others, elimination of discrimination at the community level was not successfully achieved owing to human personal behavior.

5.1.2 PLHIVs living in urban areas are less likely to be discriminated than PLHIVs living in rural areas.

As the hypothesis is clearly stated that discrimination against urban PLHIVs is more likely to be less than those PLHIVs who live in rural areas, the table 4.2, which was given result from the chi – square statistic analysis, clearly illustrates that the majority of research respondents, seventy six PLHIVs who consisted of 40 urban PLHIVs and 36 rural PLHIVs, were discriminated by community members. However, there were 24 PLHIVs who had never been discriminated from community members. These consisted of 14 rural PLHIVs and 10 urban PLHIVs. As can be seen from the figures about discrimination in the community, there is not much difference between discrimination against PLHIVs in urban and rural areas. Based on these figures, Statistical analysis, the chi-square test, is strongly recommended to apply in order to prove whether there is any statistically significant relationship between discrimination against PLHIVs in urban and rural areas or not. In this analysis, the result of the chi – square test from SPSS version 18 indicated that there is no statistical significance showing that discrimination against urban PLHIVs were lower than those PLHIVs who live in rural areas; discrimination in the community between urban and rural PLHIVs is not different (X^2= 0.877, DF = 1, P - value= 0.349, phi coefficient = 0.094) (see Table 4.2).

However, this result was not consistent or relevant to other studies. For example, a study by [Tia et al., 2008] indicated that S&D mostly happened in rural areas compared to urban areas; furthermore, [Pranee & Niphattra & Niyada, 2009] who conducted research in central Thailand have found a similar finding. That is, they showed that PLHIVs were sociably accepted by rural people rather than urban people, and they received a lot of positive supports such as emotional, financial, and physical assistance. Nevertheless, urban people showed discrimination against PLHIVs. Similarly, key formant interviews found that urban PLHIVs were more likely to face more discrimination than rural PLHIVs since people living in urban areas were not so friendly, and their living condition as well as lifestyle was different; thus, they did not care for anyone even their neighbors.

Due to this contrast result, it could be concluded that the finding from researcher side only represented the selected study areas, and it could not generalize nationwide country since the sample size was small, and the number of research respondents who were discriminated in urban and rural areas was not much different. Furthermore, the study areas were purposively chosen in which they might be bias or error or PLHIVs in the location where the study had been conducted might not experience discrimination frequently. Besides, systematic sampling would randomly select those who had never been discriminated so that the results were more likely to be a small difference. Moreover, it can be assumed that discrimination situation was more likely to be changeable according to year and time so that results would not be consistent with the previous study and recent findings.

5.1.3 Discrimination in the family

The study of the author showed that16 PLHIVs (10 rural PLHIVs versus 6 urban PLHIVs) were verbally abused. Furthermore, 13 PLHIVs (9 rural PLHIVs against 4 urban PLHIVs) reported that their family members did not allow them to have meals together, and they were rejected to seat nearby.

A relevant study conducted by [Pranee & Niphattra & Niyada, 2009] indicated that even though family members have been educated, they did not touch PLHIVs and exchange some stuff. Moreover, some PLHIVs were asked to eat separately, and their children were being forbidden to touch. Likewise, a research carried out by [ANP+ & Policy Project, 2005] in Vietnam showed that PLHIVs were discriminated by their family members due to the condition of illness; the more disease’s symptoms appeared; the more discrimination they faced. PLHIVs were considered to be less contacted with family members and friends as well. Furthermore, the same study, [ANP+ & Policy Project, 2005], conducting in China, Yunnan province found that of twenty respondents, four PLHIVs did not disclose their HIV status to family members, and one person was excluded by his mother while the majority of them were fearfully rejected and excluded from family members and social network. It further found that the percentage of women who excluded from family member was higher than the percentage of men (5.8% compared to 4.4%) [Marie Stopes, 2009].

However, a study in Laos was differently shown that household survey respondents had never been excluded by their family members; nonetheless, they were being concerned, cared for, and encouraged either emotional or physical support. Moreover, PLHIVs were asked to have less involvement in house work or heavy jobs in order to maintain their health. Another study in Thailand similarly demonstrated that not only some PLHIVs received solid support but also they were advised to take care of their health. These two studies have been supported in the work of [ANP+ & Policy Project, 2005]. Moreover, a study by [Gobopamang, 2001] showed that people in Botswana expressed that they would look after family members who contracted HIV even though it was a risky action.

It is clear that my research findings were more likely to be consistent with some previous research findings, which showed that PLHIVs were discriminated by various forms from their family members. However, there was a negative finding that contrasted with the result of researcher; nevertheless, it was found that there was a few case reporting that they had never experienced discrimination by their family since their livelihood was in better condition. Therefore, [Work Bank, 1997]& [Warwick et al, 1998] claimed that family members played a very important role in looking after PLHIVs in both emotional and physical support, but PLHIVs were also ignored and treated badly by their family members.

5.1.4 Discrimination at the health care center

The research findings of the author demonstrated that discrimination against PLHIVs in the health care centers still exists. 10 PLHIVs reported that their HIV status was delayed in health care services provision; nine PLHIVs were verbally abused; eight of household survey respondents said that they were treated with poor attitude of health care service providers. Interestingly, five respondents consisting of four rural PLHIVs and one urban PLHIV reported that they were forced to pay additional charge even though the available medicine is free of charge. Moreover, four PLHIVs were not fully paid attention while one PLHIV reported that s/he was rejected to access medical treatment.

Likewise, a study by [KHANA, 2010] indicated that 7.6% of PLHIVs were refused to access family planning services; 8.4% of respondents were rejected from accessing sexual reproductive health. Furthermore, a research carried out by [Marie Stopes, 2009] in China showed that 12.1% of PLHIVs were refused by staff at health care center; 24 (1.3%) PLHIVs were denied access to ARV; 32 (17%) survey household respondents were rejected from accessing family planning services, and 1.5% of people were prohibited to obtain sexual reproductive health services. Furthermore, [ANP+ & Policy Project, 2005] reported that in Vietnam, PLHIVs complained that doctors behaved inappropriate manner, and PLHIVs were avoided to ask for any further information about medication; besides, medical care services provision for PLHIVs was also delayed. Moreover, that study pointed out that pregnant PLHIVs were also forced to pay medical charge when they sought for antenatal care. Similarly, another study by [Pranee & Niphattra & Niyada, 2009] released a similar finding, which found that PLHIVs in Thailand received unfriendly treatment by health care service providers, in particular nurses, by considering PLHIVs as deviant or promiscuity, especially women were considered as the carriers of HIV infection.

All in all, discrimination against PLHIVs at health care center is an obstacle for public health intervention program. The recent finding of the author and the previous studies showed a similar discrimination in health care centers either in Cambodia or other countries that health care providers have not completely changed their concept, attitude and behavior against PLHIVs. Hence, discrimination from health care providers led to interfering in the efforts of HIV prevention and treatment program. Furthermore, it is the root cause of discouraging people to access HIV testing or treatment.

5.1.5 Discrimination at the workplace

The survey findings of author illustrates that forty seven PLHIVs working as food seller, company staff, construction worker, fisher and farmer experienced discrimination at their workplace. However, 32 PLHIVs were denied to buy food, and they also faced harassment; 22 PLHIVs experienced bad behavior of colleagues. Moreover, eight PLHIVs were discriminated from employers, and four household survey respondents were dismissed from working place.

This finding (author) is relevant to [KHANA, 2010], which showed that 51% of household survey respondents lost their job; it further reported that the 14.3% of women compared to men (9.2%) were denied to get jobs. Another study by [Marie Stopes, 2009] in China found that 277 (14.8%) of PLHIVs, out of the total 1877 sample population, were denied to get employment. 305 (16.8%) of PLHIVs were asked for job transformation, and 70 (3.8%) of respondents had been denied to promote to better position. Likewise, a study by [Pranee & Niphattra & Niyada, 2009] in Thailand pointed out that PLHIVs, especially women, was forced to quit their jobs since their employers were scared of HIV contamination to customers. Therefore, PLHIVs could not find job nearby their residences. They then moved to other provinces where their HIV status was not publicly disclosed.

Moreover, [TNP+, 2009] found that 32.2% of PLHIVs in Thailand lost job after their HIV status get known to others. Similarly, a research carried out in Vietnam by [ANP+ & Policy Project, 2005] indicated that when PLHIVs applied for job, it required disclosing their health status, and they would not be recruited their HIV status; otherwise, PLHIVs were removed from higher position to lowest position. It further showed that PLHIVs were terminated from employment before ending contract. Furthermore, a study by [Gobopamang, 2001] also indicated that 68.6% of people in Botswana would not buy vegetables, foods, and others from PLHIVs.

From my research findings and some previous studies, it can be concluded that discrimination against PLHIVs was pervasive in the workplace with various forms such as harassment, dismiss ion from job, employer dissatisfaction, and refusing to buy products and bad attitude from colleagues. It is further shown that discrimination still happens in the working place that can affect their income. For example, people still refuse to buy PLHIVs' products, and PLHIVs have to disclose their health status when applying for jobs. Moreover, HIV policy has not well implemented by recruiting agency and others [Hughes, 1988]. Therefore, due to low income, PLHIVs had to challenge their daily expenditure, and they were unable to pay for transportation fee for accessing health care service; also, they could not afford for medical consultation, medical checkup, hospitalization, and others. It further inferred that because of fear of losing job, PLHIVs would hide their HIV status.

5.2 Conclusion

In order to draw conclusion, it is recommended to review the summary of the research findings in chapter four; also, this section provides fundamental overview of the main summary data in conjunction with major objectives in chapter one. Therefore, the comparison between findings and objectives were as the following:

The first main objective was to examine discrimination experiences in the family, community, health care center and workplace. As a result, 76 PLHIVs were discriminated in the community; 47 PLHIVs were discriminated at the workplace, and 18 household survey respondents faced discrimination in their family. Furthermore, 13 PLHIVs were reported that they were discriminated at health care centers. There were various forms of manifestations of discrimination that had been identified in this study; those were categorized as the following:

Discrimination in the community

1. Act as bad behavior (63 PLHIVs)
2. Verbally abused (60 PLHIVs)
3. Neighbors stopped visiting PLHIVs (58 PLHIVs)
4. Neighbor told others about PLHIVs’ status (41 PLHIVs)
5. Nobody played with their children (21 PLHIVs)
6. Exclusion from community events, gathering, and others (17 PLHIVs)
7. PLHIVs’ children were discriminated at school (14 PLHIVs)

Discrimination in the family

1. Verbally abused (16 PLHIVs)
2. Prohibit to have meal together (13 PLHIVs)
3. Not allowing to share seat together (13 PLHIVs)
4. Prohibit to touch PLHIVs (12 PLHIVs)
5. Left alone (2 PLHIVs)
6. Physically abused (1 PLHIV)

Discrimination at the health care center

1. Health care service delay (10 PLHIVs)
2. Verbal abuse (9 PLHIVs)
3. Bad attitude (8 PLHIVs)
4. Force to pay additional charge (5 PLHIVs)
5. No paying attention (4 PLHIVs)
6. Refused to access medical treatment (1 PLHIV)

Discrimination at the workplace

1. Harassment (32 PLHIVs)
2. No buying product (32 PLHIVs)
3. Bad behavior from colleagues (22 PLHIVs)
4. Employer discrimination (8 PLHIVs)
5. Dismissed from workplace (4 PLHIVs)

Based on the first objective, it was shown that the results of this research was consistent with other previous studies which had been shown that discrimination is a social issue, which banned PLHIVs to access a wide range social services, social development, public participation, and other activities.

The second objective was to assess self feeling of stigma among people living with HIV/AIDS. As a result, 42 PLHIVs concerned that they would lose friends; 36 research respondents concerned about hiding their HIV status, and 39 survey respondents felt that people might be afraid of them. Besides, 25 household survey respondents concerned that they would lose good relationship with others while 37 PLHIVs concerned about disclosure of their HIV status. In fact, this result responded to the previous literature review that had been raised by some researchers about internal stigma that caused PLHIVs to be hopeless, depressed, isolated, uncertain, and etc.

The third objective was to identify the way in which PLHIVs deal effectively with stigma and discrimination. 39 PLHIVs often asked help from community; 64 PLHIVs sought help from family members all the time, and 35 household survey respondents often asked help from self help group. Furthermore, 55 respondents, all the time, went to meet NGOs staff while 41 PLHIVs rarely asked help from local authority. These results were also relevant to previous research that focused on the sources of seeking help when stigma and discrimination occurred.

The fourth objective was to explore the availability of social support and health support for PLHIVs. Generally, it was found that PLHIVs had been provided various types of social supports such as receiving rice, skill training, income generation, legal support, transportation fee, psychology, utensil, peer education, and self help group support. Furthermore, they also received health supports such as ARV, OI, PMTCT, SRH, VCCT, counseling, training care giver, CD4 check, ANC, and others. However, these social and health supports did not respond effectively to the need of PLHIVs, but they could reduce some burdens in their daily life since there is limitation of resources and financial supports from development partners. In reality, these results have also shown the similar findings of the previous studies in which they reflected the various needs of social and health supports that they, PLHIVs, could not afford.

Finally, the results of the hypothesis have statistically shown that discrimination against urban and rural PLHIVs either in the community or at workplace was not different; however, rural PLHIVs were highly discriminated by health care service providers compared to urban PLHIVs while discrimination in the family was found not to be different in these two groups. Discrimination in the community was also associated with poverty status, but it did not associate with occupation status. However, discrimination in the previous workplace was associated with gender while discrimination in the health care center did not correlate with ARV usage. In relation to stigma experience, the result showed that urban PLHIVs felt more concerned of losing friends than rural PLHIVs; however, rural PLHIVs not only concerned about friendship with other people but also worried about disclosure of their HIV status compared to urban PLHIVs. Therefore, it is clear that the hypothesis results provided statistically significant factors that were associated with HIV/AIDS related S&D, and those results were mostly found to be similar with previous studies. However, it was also confirmed that some findings were not relevant to other research due to the social context, situation, location, tradition, culture, belief and others.

5.3 Policy implications

HIV/AIDS related S&D is one of the main priority social issues for country development that have been recognized as an obstacle to hinder PLHIVs to access any types of essential social services, social involvement, social development, income generation, and others. Due to the negative impact of HIV/AIDS related S&D, the following recommendations have been developed by researcher in order to propose policy maker, programmer, implementer, and other stakeholders.

- **To increased HIV awareness through strengthening of training and education program**

Because education and training are the indispensable approaches that not only increase the knowledge of either general people or educated people but also encourage people to change their behavior, misconception, belief, fear and others. Training and education should be strengthened and scaled up at all level through various mechanisms in collaboration with policy makers, local authorities, NGO, stakeholders, and others.

That is, at community level, it should broaden existing outreach education program, public awareness campaign, public forum, distributing information, education, and communication (IEC) materials (poster, leaflet, booklets, and others). Moreover, radio and television should increase the number of HIV education program and broadcast at the right time in which most people are free from individual business. This approach is not only to change individual behavior but also to create positive transfers in collective practice and thinking.

However, education should also be provided to PLHIVs in order to increase their understanding about PLHIVs' rights when accessing any kinds of public services. Moreover, psychological support and health care education should be strongly recommended so that PLHIVs would overcome the feeling of stigmatization and fear of others.

At health care level, with the technical assistance from experts, government in collaboration with NGOs should continuously provide additional training either HIV/AIDS knowledge or clinical skill to all relevant medical professionals and staffs in order to eliminate the fear of HIV infection and misconception during job performance. Moreover, the ethical morality of health care service providers should be improved, and their duties and responsibilities should be revised and updated. Also, those health care practitioners should receive extra training about client rights and health care services policy.

At workplace level, not only general people, staff, employer but also political leader should be continuously provided with HIV education in order to reduce prejudice and fear against PLHIVs. Moreover, those who serve high position either government, civil society organization, or private sector should perform good model of no discrimination policy in order to promote sympathy and empathy toward PLHIVs.

- **To strengthening the advocacy**

Since there are still violations related to stigma and discrimination happening against PLHIVs, advocacy which is vitally important mechanism to provide the opportunity for a safe space to discuss and to speak out the issues to policy makers, decision makers, and other stakeholders through round table discussion, campaign, public forum, mass media, and others should be continuously strengthened from grass-root levels to national level. Therefore, because of maintaining advocacy and community mobilization at the community and national level, HIV/AIDS related S&D will not only dramatically decline but also reduced the impact of HIV/AIDS.

- **To join hand to strengthen network extension and social empowerment**

As national network, for example peer educator, self help group, and other support groups, has limited function in dealing with the issues; both government and organization should continuously support and increase the number of networks and reinforce the capacity of current networks; furthermore, the existing structure of PLHIVs network should be reformed so that it provides a safe space for PLHIVs members to exchange their experiences, to discuss the issues openly, and to learn about their rights. Moreover, based on patient legal rights and rights to access medical care and treatment without discrimination, PLHIVs should be given the empowerment to participate in social and community activities to address HIV/AIDS related S&D. Also, PLHIVs should be empowered to report any violations of rights and instances of discrimination that happened against their daily life.

- **To set up legal support services and referral systems**

A set of comprehensive frameworks of referral mechanism including provision of adequate legal support and protection for PLHIVs, MARPs, and other marginalized groups from any forms of stigma and discrimination should be developed and implemented efficiently and effectively. This referral mechanism should be cooperated with MARPs community partnership initiative (MCPI), which is under the coordination of National

AIDS Authority (NAA). Moreover, Because of this forming partnership with MCPI, when there is any meeting which is coordinated by local health services, chief of community, human rights organization, and legal and law enforcement authority, PLHIVs and MARPs networks should be invited to take part in order to show the equity and equality between general people and PLHIVs.

- **To adapt policy and reinforcement**

In order to protect and help PLHIVs from HIV/AIDS related S&D, HIV policy should be set up and implemented by all private sectors, NGOs, government, and other stakeholders. Moreover, HIV/AIDS law should be not only disseminated nationwide but also reinforced the implementation by all relevant stakeholders. However, PLHIVs should involve in national policy and guideline discussion, development and advocacy about rights accessing to care, social services and others

5.4 Suggestion for future for further research

This study focuses on stigma, discrimination experience and coping mechanism among people living with HIV/AIDS. As this study was only conducted for academic purpose, it could not capture detailed information of the research and any issues due to scope, sample size, research contents, and others. Therefore, it is recommended to propose future studies as the following areas:

Since this study was only conducted with PLHIVs. Hence, the research results were more likely to be bias as it reflected only the experience and perspective from PLHIVs' side. As a result, the majority of PLHIVs (76 PLHIVs) were discriminated from community people, and the way in which PLHIVs were discriminated was seen in the form of bad behavior, verbal abuse, none of visit from neighbors, disclosure of their HIV status by neighbors, their children disgusted, exclusion from community, and others. Therefore, it recommends conducting further studies on perspective from community people side; the proposed study will capture the overall areas of knowledge, attitude and practice in order to find out whether the result is consistent with findings from PLHIVs.

Moreover, the results of this study illustrated that PLHIVs were discriminated from health care service providers in the forms of verbal abuse, bad attitude, health care service delaying, not paying attention, refusing medical treatment, and forcing to pay additional charge. The suggested study should conduct at health care centers in order to find out the perspective, behavior, and attitudes from health care service providers. Therefore, the proposed study will reflect the similar or different results between health care service providers and PLHIVs.

A further study should be conducted at working place in order to find out the perspective, attitude, and reaction from employers and colleagues who worked with PLHIVs. Also, this proposed study will search for any relevant policies or laws that can protect PLHIVs from being discriminated with various forms namely harassment, dismissing, no products consumption from others, bad behavior from colleagues, and others.

Lastly, because this study has limited scope to focus on any solutions to stigma and discrimination for PLHIVs, further studies should focus more on solutions to stigma and discrimination.

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APPENDIX 1: PLHIV Questionnaires Survey Form

No________________

Shape your world
APU
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Asia Pacific University

Questionnaires Survey Form

"Stigma, discrimination experience, and coping mechanism: A case study of people living with HIV/AIDS in urban and in rural Cambodia"

By

MATH Srales

Public Health Management (PHM)
School of Health, Environment, and Life Science
Ritsumeikan Asia Pacific University (APU),Japan

1. Detail of Interviewer

Name: ______________________ Date:_________________________

Completion Information

☐ Yes

☐ No

Name: ______________________ Signature: ______________________

Areas ☐ 1- Rural ☐ 2- Urban

I. General Information

1.1. Demographic information

1. Gender ☐ 1- Male ☐ 2- Female
2. Age: ______________________ Years
3. Length of stay: ______________________Years
4. Education: ______________________
5. Status ☐ 1- Poor Households ☐ 2- Non- Poor Households
6. Marital status
   ☐ 1- Married ☐ 2- Single ☐ 3- Widow ☐ 4- Widower
   ☐ 5- Divorce ☐ 6- Separated ☐ 7- living together ☐ 8- other………..
7. Household members:______________________ People
8. Land ownership: ______________________ Meters
9. What is your past employment before you know your HIV status?
   ☐ 1- Farmer ☐ 2- Cropping grower ☐ 3- Fisher ☐ 4- Seller ☐ 5- Livestock
   ☐ 6- Tailor ☐ 7- Factory worker ☐ 8- Construction worker ☐ 9- NGOs staff
   ☐ 10- Gov't staff ☐ 11- Housewife ☐ 12- Unemployment ☐ 13- other……
10. What is your current employment?
   ☐ 1- Farmer ☐ 2- Cropping grower ☐ 3- Fisher ☐ 4- Seller ☐ 5- Livestock
   ☐ 6- Tailor ☐ 7- Factory worker ☐ 8- Construction worker ☐ 9- NGOs staff
   ☐ 10- Gov't staff ☐ 11- Housewife ☐ 12- Unemployment ☐ 13- other……

1.2.The economic information

11. What is your type of income?

   ☐ 1- Daily ☐ 2- Monthly ☐ 3- Yearly

12. Income by types of jobs

Daily income (Answer 1)	**Amount**	**Remarks**
Selling		
Labor/workers		
Others________________		
Monthly income (Answer 2)	**Amount**	**Remarks**
Public/Private services		

Others________________		
Yearly income (Answer 3)	**Amount**	**Remarks**
Rice Cultivation		
Livestock		
Cropping		
Fruit		
Remittance		
Others________________		

Total Income	**Amount**	**Remarks**
(Answer 1+2+3)		

13. Expenditure information

Expenditure	**Amount**	**Remarks**
Daily food		
Education		
Health		
Others________________		

14. If your income is less than your expenditure, please tell me the reason. How can you survive?
…………………………………………………………………………………………
…………………………………………………………………………………………
………………

II. HEALTH CHARACTERISTICS

15. When did you know your HIV status?
………………………………………
16. What was your first CD4 count?
………………………………………
17. What is your current CD4 count?
………………………………………
18. Are you currently using OIs?
☐ 1- Yes ☐ 2- No
19. Are you currently using antiretroviral medications (ARV)?
☐ 1- Yes ☐ 2- No
20. Have you ever had hospitalization because of serious illness?
☐ 1- Yes ☐ 2- No

21. If yes, how many times of hospitalization?
…………………………………………..

22. Now, how is your overall health condition? (Only one answer)

1	2	3	4	5
Very poor	Poor	Average	Good	Very good

III. DISCRIMINATION

23. Have you ever been discriminated by community people?
☐ 1- Yes
☐ 2- No (if no skip to 25)

24. If yes, in what ways have you felt discriminated against (treated badly) by your community? (Multiple answers)
☐ 1- Excluded from community events (religious rites, social gathering and so on)
☐ 2- My children were discriminated against in school.
☐ 3- Nobody played with my children.
☐ 4- Neighbors stopped visiting my house.
☐ 5- Neighbors told others about my HIV status.
☐ 6- Reject to provide job in the community
☐ 7- Not buying whatever I am selling.
☐ 8- Verbally insulted
☐ 9- Act as bad attitude
☐ 10- Other………………

25. Have you ever been discriminated by your family members?
☐ 1-Yes
☐ 2- No (if no skip to 27)

26. If yes, in what ways have you felt discriminated against (treated badly) by your family members? (Multiple answers)
☐ 1- Don't touch me
☐ 2- Don't sit with me
☐ 3- Don't eat with me
☐ 4- Verbally abuse me
☐ 5- Physically abuse me
☐ 6- Deserted me
☐ 7- Other……

27. How is your current relationship with your family member? (Only one answer)

1	2	3	4	5
Very poor	Poor	Average	Good	Very good

28. How is your current relationship with your friends? (Only one answer)

1	2	3	4	5
Very poor	Poor	Average	Good	Very good

29. Have you ever been discriminated by health services providers such as doctor, nurse, staff and others?

☐ 1- Yes ☐ 2- No (if no skip to 32)

30. If yes, in what ways have you felt discriminated against (treated badly) by health care providers such as doctor, nurse, staff and others? (Multiple answers)
☐ 1-Refused me to access in medical treatment or care
☐ 2-Given poorer quality health services
☐ 3- Stopped me to access health care services
☐ 4- Delayed in the provision of health services/treatment
☐ 5- Forced to pay additional charges for medical service
☐ 6- Verbally abuse me
☐ 7- Treat me in bad behavior and attitude
☐ 8- Not fully pays attention to me
☐ 9- Provide expired medicine
☐ 10- Other………………

31. Why are you being discriminated by health care service providers?
☐ 1- HIV Status ☐ 2- Poverty Status

32. Has your work ever exposed to discriminate?
☐ 1- Yes ☐ 2- No (if no skip to 34)

33. If yes, in what ways have you felt discriminated at your work environment? (Multiple answers)
☐ 1- Experience in job harassment and discomfort
☐ 2- Customers refuse to buy products or goods
☐ 3- Discriminated from employers
☐ 4- Dismissed me
☐ 5- Treated differently to colleagues
☐ 6- Other……………

34. Currently, how do you think about the discrimination situation against PLHIVs?

From	Very low	Low	Average	High	Very high	Reason
A/.Community						
B/. Health Care service						
C/. Work place						

VI. SELF FEELING (INTERNALIZED) STIGMA

Please tell me if these experiences, feelings and opinions are true or false for you:

35. Please rate the following items.	Strongly true	True	Average	False	Strongly false
a) I would lose friends if I told them I had HIV	5	4	3	2	1
b) Because of stigma and discrimination problem , I hide my HIV status from others	5	4	3	2	1
c) If people found out that I have HIV, they would behave as if they were afraid of me	5	4	3	2	1
d) I would stop being good relation with other people if they would act inappropriate behavior to me because of my HIV status	5	4	3	2	1
e) I am worried thinking that those who know I have HIV will tell that to other	5	4	3	2	1

V. DISCLOSURE

36. Have you told about your HIV status to others?
☐ 1- Yes ☐ 2- No (if no skip to 41)

37. If yes, whom did you tell first? (one answer)
☐ 1- Spouse ☐ 2- Partner ☐ 3- Family member ☐ 4- Relative ☐ 5- Friend
☐ 6- Next door ☐ 7- Religious leader ☐ 8- Community leader ☐ 9- others…………

38. How often did you feel pressure from other individuals living with HIV or from groups/networks of people living with HIV to disclosure your HIV status?
☐ 1- Often ☐ 2- A few times ☐ 3- Once ☐ 4- Never

39. How often did you feel pressure from other individuals not living with HIV(e.g. family members, social worker, non-governmental organization employees) to disclosure your HIV status?
☐ 1- Often ☐ 2- A few times ☐ 3- Once ☐ 4- Never

40. Did you find the disclosure of your HIV status an empowering experience?
☐ 1- Yes ☐ 2- No

VI.SOCIAL AND HEALTH SUPPORT

41. What types of social supports have you received?
☐ 1- Monthly food
☐ 2- Monthly stipend
☐ 3- Skill building
☐ 4- IGAs
☐ 5- Legal support
☐ 6- Transportation fee
☐ 7- Literacy class
☐ 8- Shelter
☐ 9- Psychology
☐ 10- Materials (utensil)
☐ 11- Peer education
☐ 12- SHGs
☐ 13- Other ______________________

42. What types of health supports have you received?
☐ 1- ARV
☐ 2- OIs
☐ 3- PMTCT
☐ 4- Reproductive Health
☐ 5- VCCT
☐ 6- Counseling
☐ 7- Medical Kits
☐ 8- Training care giver
☐ 9- Providing care giver
☐ 10- Free condom
☐ 11- TB and HIV
☐ 12- STDs
☐ 13- Palliative Care
☐ 14- ANC
☐ 15- CD4 check
☐ 16- Other ______________________

VII. COPING RESPONSE

43. Please answer the following statement through scale up (Never, Rarely, Sometimes, Often, All the time)

Please rate the following items	All the time	Often	Sometimes	Rarely	Never
a).Community support	1	2	3	4	5
b).Support from empower	1	2	3	4	5
c).Family support	1	2	3	4	5
d).Support from SHGs	1	2	3	4	5
e).Support from NGOs	1	2	3	4	5
f).Commune development plan	1	2	3	4	5
g).Stand by myself	1	2	3	4	5
h).Health program support	1	2	3	4	5
i).IGA program support	1	2	3	4	5
j).Loan provision	1	2	3	4	5
k).Skill building	1	2	3	4	5
l).Community participation	1	2	3	4	5
m).Community empowerment	1	2	3	4	5
n).Community ownership	1	2	3	4	5

III. Problems and Suggestions

44. Beside stigma and discrimination, do you have any problems? What kinds of problems do you face?

…………………………………………………………………………………………
…………………………………………………………………………………………
…………………………………………………………………………………………

45. What are your suggestions to improve your living condition?

…………………………………………………………………………………………
…………………………………………………………………………………………
…………………………………………………………………………………………

46. What do you need in the future?

…………………………………………………………………………………………
…………………………………………………………………………………………
…………………………………………………………………………………………

Thank you

APPENDIX 2: Key Formants Questionnaires Survey Form

No____________

Key formant Questionnaires Survey Form

"Stigma, discrimination experience, and coping mechanism: A case study of people living with HIV/AIDS in urban and in rural of Cambodia"

By

MATH Srales

Public Health Management (PHM)
School of Health, Environment, and Life Science
Ritsumeikan Asia Pacific University (APU),Japan

Introduction

Hello! My name is MATH Srales, who is a graduate student at Ritsumeikan Asia Pacific University in Japan. I am pursuing my master degree in the field of International Cooperation Policy (Public Health Management).

Now, I am doing survey on the comparison of stigma, discrimination and coping to response among people living with HIV/AIDS between urban and rural of Cambodia. This survey requires for the completion of Master's degree; therefore, I would like to confirm that all your information will be kept in privacy and confidentiality while it only needs to analyze for my academic purpose, so your contribution is vitally important for my future academic achievement.

Thank you for your cooperation.

Name of respondent:____________________ Date:____________________

Institution's Name: ____________________

Key formant Interview

1. In your opinion, currently, what are the main general problems of people living with HIV/AIDS?

2. Regarding to stigma and discrimination issue, how do People living with HIV/AIDS face stigma and discrimination?

3. In your opinion, for urban and rural areas of Cambodia, which one is the higher case of stigma and discrimination happening? Why?

4. According to your opinion, Please tick (✓) the following each item for current environment of stigma and discrimination

From	Very low	Low	Average	High	Very high	Reason
A/. Community environment						
B/.Family Environment						
C/.Health Care environment						
D/.Work place Environment						
E/. Other…						

5. What are the main solutions to cope to response against stigma and discrimination among PLHIV?

6. What kind of social supports which is the most important need for people living with HIV/AIDS?

7. What kind of health supports which is the most important need for people living with HIV/AIDS?

8. Do your NGOs have a policy or strategy to address the stigma and discrimination among PLHIVs?

   ☐ Yes, ☐ No (if no skip to 11)

9. If yes, please tick (✓) of the following of policy implementation

1	2	3	4	5
Very poor	Poor	Average	Good	Very good

10. What are the roles of NGOs in reducing stigma and discrimination?

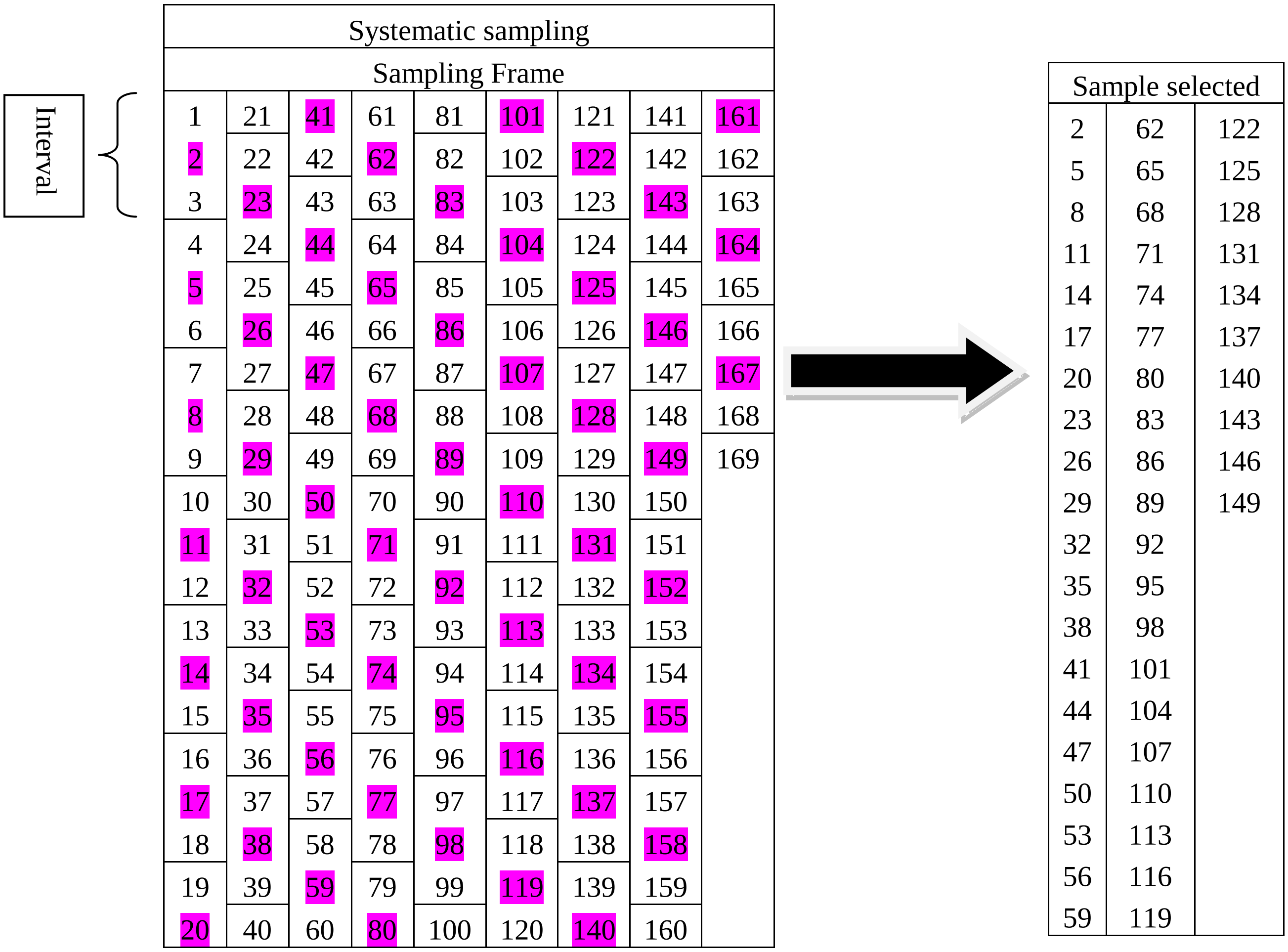
12. In your opinion, what have been the main challenges during working with PLHIV?

13. What are your suggestions to reduce stigma and discrimination in the future?

Thank you for cooperation.

APPENDIX 3: Research sampling method

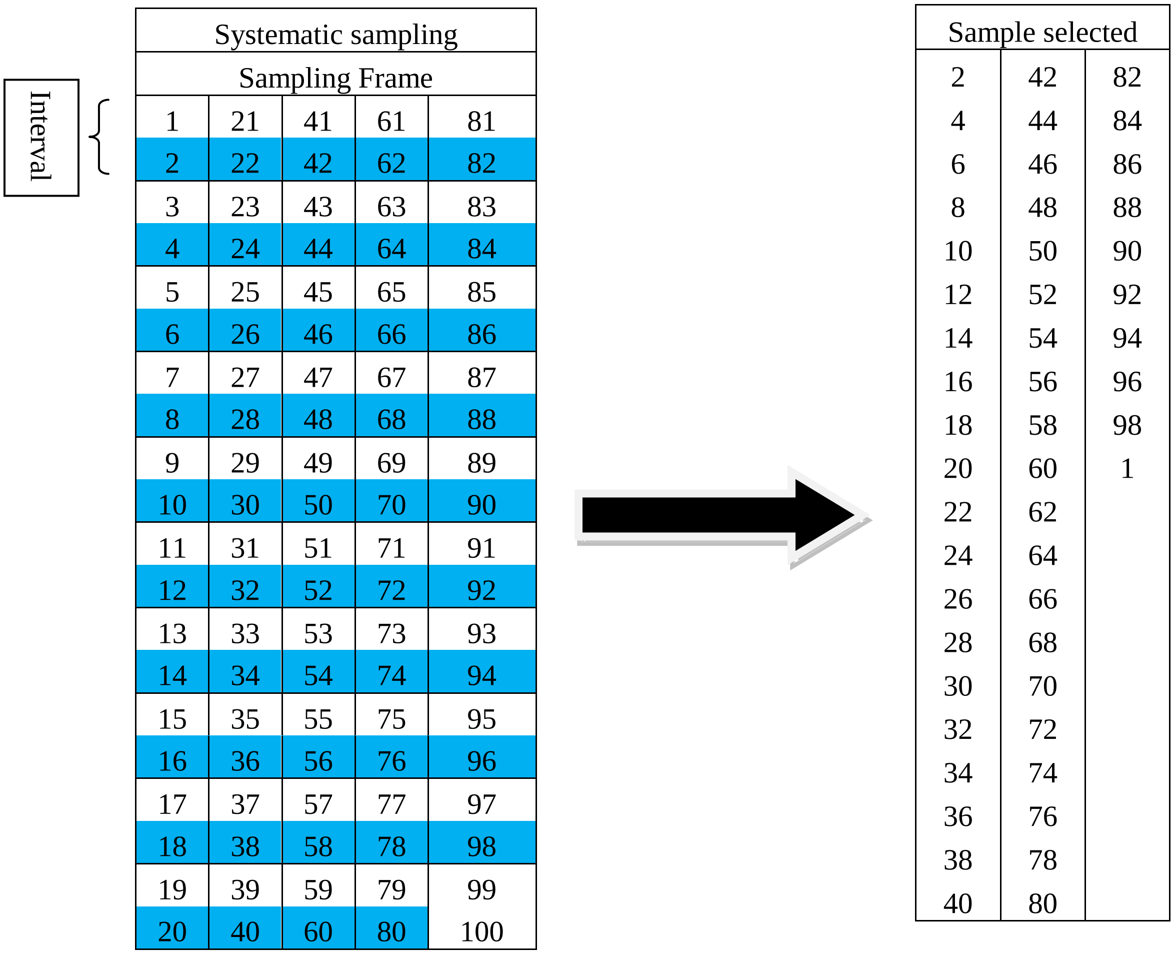
3.1 Number of PLHIV in Kean Svay District



Systematic sampling								
Sampling Frame								
1	21	41	61	81	101	121	141	161
2	22	42	62	82	102	122	142	162
3	23	43	63	83	103	123	143	163
4	24	44	64	84	104	124	144	164
5	25	45	65	85	105	125	145	165
6	26	46	66	86	106	126	146	166
7	27	47	67	87	107	127	147	167
8	28	48	68	88	108	128	148	168
9	29	49	69	89	109	129	149	169
10	30	50	70	90	110	130	150	
11	31	51	71	91	111	131	151	
12	32	52	72	92	112	132	152	
13	33	53	73	93	113	133	153	
14	34	54	74	94	114	134	154	
15	35	55	75	95	115	135	155	
16	36	56	76	96	116	136	156	
17	37	57	77	97	117	137	157	
18	38	58	78	98	118	138	158	
19	39	59	79	99	119	139	159	
20	40	60	80	100	120	140	160	

Sample selected		
2	62	122
5	65	125
8	68	128
11	71	131
14	74	134
17	77	137
20	80	140
23	83	143
26	86	146
29	89	149
32	92	
35	95	
38	98	
41	101	
44	104	
47	107	
50	110	
53	113	
56	116	
59	119	

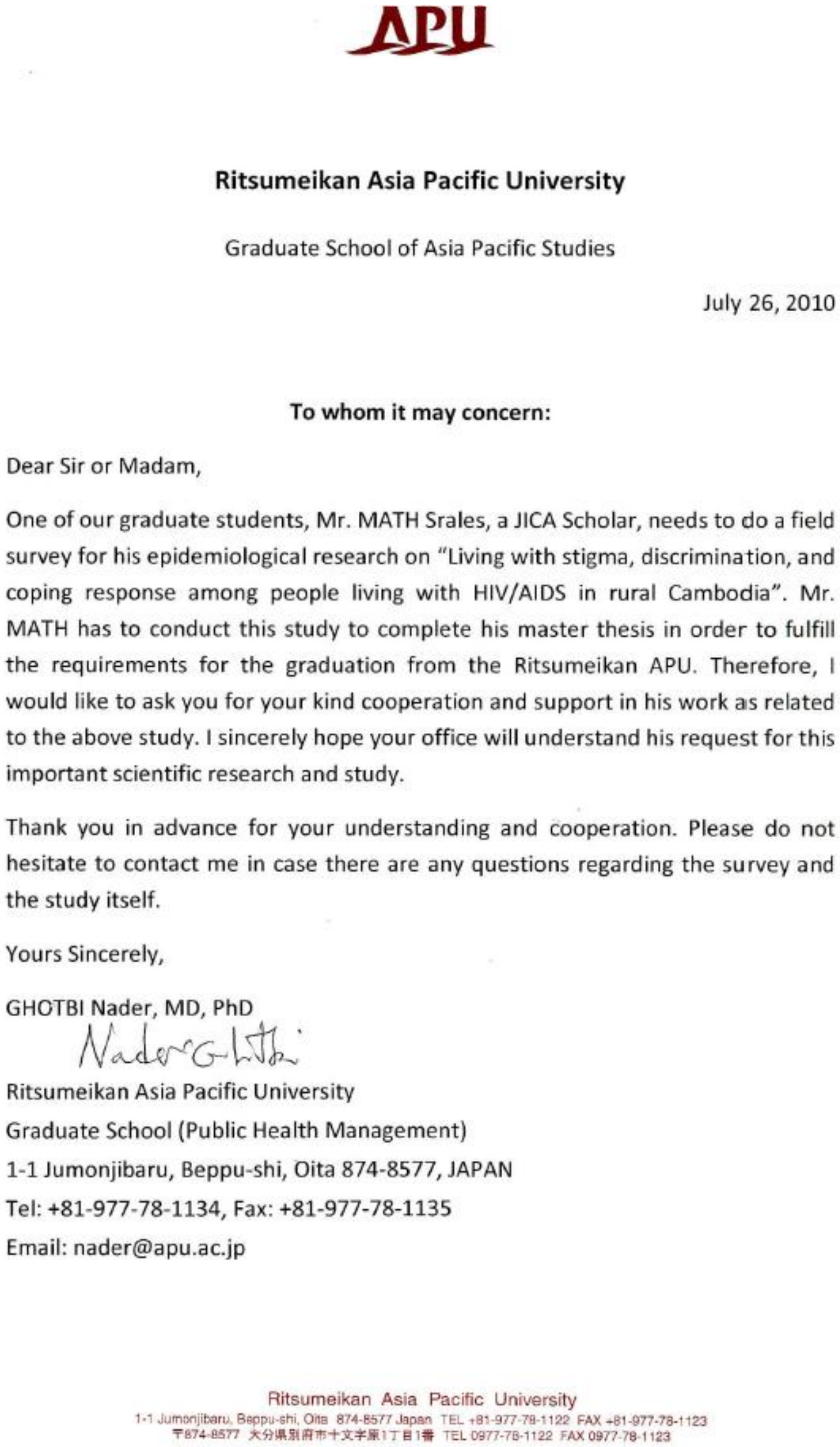
3.2 Number of PLHIV in Kampong Tralach District



Systematic sampling				
Sampling Frame				
1	21	41	61	81
2	22	42	62	82
3	23	43	63	83
4	24	44	64	84
5	25	45	65	85
6	26	46	66	86
7	27	47	67	87
8	28	48	68	88
9	29	49	69	89
10	30	50	70	90
11	31	51	71	91
12	32	52	72	92
13	33	53	73	93
14	34	54	74	94
15	35	55	75	95
16	36	56	76	96
17	37	57	77	97
18	38	58	78	98
19	39	59	79	99
20	40	60	80	100

Sample selected		
2	42	82
4	44	84
6	46	86
8	48	88
10	50	90
12	52	92
14	54	94
16	56	96
18	58	98
20	60	1
22	62	
24	64	
26	66	
28	68	
30	70	
32	72	
34	74	
36	76	
38	78	
40	80	

APPENDIX 4: Requesting letter from APU



APU

Ritsumeikan Asia Pacific University

Graduate School of Asia Pacific Studies

July 26, 2010

To whom it may concern:

Dear Sir or Madam,

One of our graduate students, Mr. MATH Srales, a JICA Scholar, needs to do a field survey for his epidemiological research on "Living with stigma, discrimination, and coping response among people living with HIV/AIDS in rural Cambodia". Mr. MATH has to conduct this study to complete his master thesis in order to fulfill the requirements for the graduation from the Ritsumeikan APU. Therefore, I would like to ask you for your kind cooperation and support in his work as related to the above study. I sincerely hope your office will understand his request for this important scientific research and study.

Thank you in advance for your understanding and cooperation. Please do not hesitate to contact me in case there are any questions regarding the survey and the study itself.

Yours Sincerely,

GHOTBI Nader, MD, PhD
Nader Ghotbi
Ritsumeikan Asia Pacific University
Graduate School (Public Health Management)
1-1 Jumonjibaru, Beppu-shi, Oita 874-8577, JAPAN
Tel: +81-977-78-1134, Fax: +81-977-78-1135
Email: nader@apu.ac.jp

Ritsumeikan Asia Pacific University
1-1 Jumonjibaru, Beppu-shi, Oita 874-8577 Japan TEL +81-977-78-1122 FAX +81-977-78-1123
〒874-8577 大分県別府市十文字原1丁目1番 TEL 0977-78-1122 FAX 0977-78-1123