

Impact of stigma on the fight against aids



**ASSIGN
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Stigma is an essential constraint in the fight against AIDS. Discuss. 1500 words.

In 2008, the World Health Organization argued that '...HIV-related stigma and discrimination are often prevalent within health services, and are critical obstacles to provision and uptake of health sector interventions. Stigma and discrimination—often pervasive at all levels of society—sustain an environment where it is difficult for health services to attract the people who most need the interventions.' (World Health Organization HIV/AIDS

Department 2008: p. 12) As the same organisation reports, every day, over 6, 800 people become infected with HIV and over 5, 700 die. This paper discusses the way in which the stigmatisation of Aids sufferers impedes understanding of their condition, and the ability of society to address the problem holistically. It argues that society has a tendency to vilify target groups over problematical and divisive health issues, and offers earlier examples of these practices . Commenting on preventative measures in South Africa, the World Health Organisation again points out that '...it is important to collect information on higher risk male-male sex, on sexual behaviour among sex workers, on both injecting behaviour and sexual behaviour among injecting drug users, and on sexual behaviours in other groups that may be at higher risk.' (World Health Organisation 2008: p. 14)

Whilst their analysis is based on positivist evidence, the identification of certain groups as most at risk introduces the parallel risk that they will be perceived - by others - as *solely* or especially responsible for the prevalence of the condition. The urge to discriminate against a range of social groups appears to be a very deep seated one in Western societies. As Rothman

points out, ' Individuals...earn prestige on the basis of their own efforts...or personal attributes (physical attractiveness, intelligence), but there is also a powerful structural dimension to prestige.' (Rothman 1993: p. 12). However, certain social groups appear particularly vulnerable to stigmatisation around issues of sexuality and disease: HIV and AIDS sufferers, it may be argued, are the latest group to suffer the re-interpretation of such prejudice. It seems fair to argue therefore that the defeat of stigmatisation is instrumental in the eradication of HIV/AIDS, and almost as important as the medical phenomenon itself. As one commentator puts it, If AIDS is to be defeated, war must be waged against poverty, ignorance, stigmatisation, violence and promiscuity.' (*The Economist* 2002).

Historically speaking, social explanations and interpretations of disease have always been mediated through cultural perceptions, and frequently manipulated for political purposes. Dirt, disease, sexuality and danger were frequently and unfavourably juxtaposed in public discussions of epidemics, whether relating to sexually transmitted diseases or not. A common theme in such discourses is a moralising view of the infected, and an inference that their behaviour was a major contributory factor in the spread of the disease to others. For example, when Cholera struck nineteenth century Britain, which had not yet developed a germ-theory of disease, its spread was attributed to ' noxious effluvias', ' poisonous vapours' and ' obnoxious atmospheres' generated in the environment of the poor and labouring classes. (Jones 1992: p. 38) It was they who were effectively stigmatised with the dissemination of the disease, despite its prevalence amongst all social groups. As Mort reports, the official response was ' ...to isolate the human

sources of infection, subjecting them to a regime of compulsory inspection and detention, combined with propaganda to educate the poor into a regime of cleanliness and morality.' (Mort 2000: p. 13) Official efforts to limit prostitution focused exclusively on female sexuality through the notorious Contagious Diseases Acts, which exposed *any* woman within certain geographical areas to arbitrary arrest, medical examination and detention.

A common theme in these scenarios, many of which were mirrored elsewhere, is the subjective location of societal health problems in the behaviour and identity of disempowered groups. In each instance - as in the case of HIV/AIDS, responsibility for wider societal ills is linked to a largely voiceless faction, who not only have poor lateral integration into society, but also less than sympathetic media representation. These behaviours and attitudes are obviously culturally mediated, and vary according to the host society: there is, however, no shortage of empirical examples. In Jamaica, otherwise respected social platforms such as evangelical churches and political parties, as well as popular music celebrities, combine the fear of AIDS with virulent homophobic attitudes. '...Dance-hall music—today's reggae—blasts across Jamaica. Its lyrics are often direct exhortations to kill gay people, or others who displease the island's gangs. Jamaica Labour Party supporters tauntingly played " Chi Chi Man", a song about killing and setting fire to gay men, at their rallies during the general election...' (*The Economist* 2004). Elsewhere, it has been shifting positions and indecision which have delayed an effective response. In Mozambique, educational programmes aimed at 14 year olds are of uncertain utility, because 40 per cent of the nation's children do not attend school, and, as *The Economist*

points out, '...their parents find it difficult to talk to them about sex. So do most public figures. Even ministers are loath to say they have taken a test. Rarely, if ever, does anyone famous admit to being HIV-positive.' (*The Economist* 2002) This situation is mirrored in South Africa, where, as Campell et al. indicate '...many parents simply refuse to acknowledge the very possibility of youth sexuality...that their children are sexually active...'. (Campbell et al. 2006: p. 132) The South African government has been engaged in a rearguard against international attitudes which, it felt, were unfairly slanted against its citizens. Recently however, it has rounded on the latter, admonishing those who it perceives as most responsible for the virulence of the disease. President Thabo Mbeki of South Africa said that '... You can't be going around having hugely promiscuous sex all over the place and hope that you won't be affected by something or the other.' (*The Economist* 2002) Campbell et al. argue that such stigmatization is a form of '..." psychological policing"', where those who break power relations of gender and generation are disciplined and punished.' (Campbell et al 2006: p. 132). In Tanzania, Haram reports it is again women who are stigmatized in this way, through images of ' defilement and displacement': '...particular concern is directed towards the displacement of young...women, who misuse their sexuality to achieve a...luxurious life , by luring wealthy...men...'. (Haram 2005: p. 5)

The overriding point here is that stigmatization, as much as mis-information and chimerical moral panics, are ultimately as damaging to those disseminating them as they are the stigmatized and abandoned victims of HIV/AIDS themselves. As Mort point out, ' Two themes have surfaced

repeatedly: competing understandings of perversion and normality and the social meanings attached to sexual acts and lifestyles.' (Mort 2000: p. xviii)

The obscuring and short-circuiting of accurate knowledge or effective counter measures merely ensures the continued presence of the infection in society, making it statistically certain that further innocent victims will fall prey to the disease. An analogy with earlier models of stigmatization illustrates this mechanism of self destruction. It was completely useless to persecute nineteenth century paupers and women as the sole sources of cholera or venereal disease, since this stood no chance of eliminating either condition. Similarly, the stigmatisation of women or the gay community cannot eliminate an HIV virus which is equally capable of infecting other social groups. In the twenty-first century, the social stigmatization of these groups overlooks the specificities of the condition, such as the growing convergence of HIV/TB epidemics.

There are notable and laudable exceptions to these patterns of behaviour: for example, in Botswana, mining companies such as Debswana have introduced educational and non-discriminatory protocols as an operational strategy, not only for health, but for commercial survival. As *The Economist* points out, the company '...reckoned that if it did nothing, its mines would go the way of Zambia's, which have to train four people for each skilled job in the knowledge that three will die. Even in 1997 the annual cost of AIDS per employee in the Botswana Diamond Valuing Company was calculated to be \$237.' (*The Economist* 2002) . As these pages were being written, the World Health Organization was attempting to polarize global attention and effort through an international AIDS effort, and focusing very much on prevention

and understanding. First and foremost, we must do a much better job of prevention. This is the only way to get ahead and ensure an adequate long-term response. We urgently need to scale up the use of proven context-specific prevention methods. We also need to expand linkages between sectors – for example, to introduce and scale up comprehensive sexuality education for young people.’ (Chan 2008). The problem is, as Haram argues, that such efforts need to be mediated through local knowledge, identifying the obstacles to behavioural change. (Haram 2005: p. 9)

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