HIV-RELATED STIGMA AND DISCRIMINATION IN ASIA:

A REVIEW OF HUMAN DEVELOPMENT CONSEQUENCES

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A REVIEW OF HUMAN DEVELOPMENT CONSEQUENCES

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1. INTRODUCTION

> *"In the course of socially constructing an illness, symptoms are identified, and the disease is named… Responsibility and blame often are assigned. Those who contract the disease come to be regarded as victims or patients, guilty or innocent, dangerous or benign, heroic or pitiable."*
>
> *(Herek, 2003)*

Although there have been many notable successes in both the prevention and treatment of HIV, stigma and discrimination have been intractable problems associated with the AIDS epidemic throughout the world. Stigma certainly has well-established individual consequences: it has been shown to delay HIV testing, restrict utilization of preventative programs, and hinder the adoption of preventative behaviours like condom use and HIV status disclosure (Brooks et al., 2005). Stigma may also have consequences for individual economic well-being as well as broader socioeconomic development (beyond the impact of HIV disease alone). In Asia, where the epidemic arrived relatively late, HIV is spreading with rapid speed. In 2005, the number of AIDS cases in Asia topped 8 million; this is compared to approximately 3 million people just 10 years prior (UNAIDS, 2006). Determinants and consequences of stigma and discrimination on socioeconomic development in Asia have yet to be empirically assessed.

In this context, this review is aimed at generating informed discussion among key stakeholders including academia, policy makers, governments, donors and people living with HIV on the phenomenon of stigma and discrimination, with a particular focus on its human development context and impact. The paper also seeks to set a research agenda to foster compelling and disaggregated enquiries into stigma and discrimination.

This review takes an ecological perspective to examine the human development consequences of HIV-related stigma and discrimination in Asia. A report from the US Institute of Medicine (2002) has called for an ecological approach to research and health promotion (Institute of Medicine, 2002). Ecological Systems Theory (Bronfenbrenner, 1989) emphasizes the dynamic relationship between an individual and the social environment. Each domain may affect other domains, thereby influencing outcomes in indirect and/or reciprocal ways. While many studies have explored determinants of stigma, very few have taken an explicitly ecological perspective. Most studies included factors within the individual domain (e.g., sexual orientation, risk behavior), with scant attention to the family, institutional and structural/policy domains. The Ecological Model has been used in a process evaluation of an AIDS intervention in Zimbabwe (Laver, Van den Borne, Kok, & Woelk, 1996), a support program for pregnant women in Latin America (Langer et al., 1993), and maternal and child health programs in NY (Newes-Adeyi, Helitzer, Caulfield, & Bronner, 2000) and NC (Margolis et al., 2001).

In this paper, we first review stigma and discrimination using an ecological approach: at the level of the individual, family, institution and structure/society. The ecological approach views stigma and discrimination as a social phenomenon and helps examine the pathways, with a view to find effective and sustainable solutions. This particular approach is highly applicable in the context of stigma and discrimination because while the impact of stigma appears to be evident at the individual level, the nature, context and severity is influenced by the social environment.

The individual is seen within the context of the family, the community and the larger society. The existing norms and values within families and communities; prejudices based on race, ethnicity, caste and gender; and the socio-economic and political contexts, including that of power, play a significant role in the way stigma manifests.

TABLE 1. "INFLUENCE MATRIX":
Stigma and Human Development, Examples of Multiple Levels of Influence

STIGMA		INDIVIDUAL	FAMILY
	INDIVIDUAL	• Self-perceived stigma restricting choices regarding work/school • Depression, anxiety; potential for disease progression/decline	• Early entry into workforce among children and youth, restricting educational opportunities • Reluctance to seek care in formal sector drains family resources for home care
	FAMILY (affected individual)	• Loss of primary income • Push deeper into poverty • Lack of resources • Orphans & vulnerable children	• Withdrawal from economic activity for caretaking or secondary stigma • Differential treatment of orphans by family - forced into economic activity, internal migration rather than education
	INSTITUTION	• Prohibited access to schools, jobs, health care, insurance through compulsory testing/notification • Client discrimination by AIDS Service Organizations (e.g., CSW, drug users) • Absenteeism due to illness • Health care costs, if provided by the institution • Interpersonal relationships (trust, morale)	• No/limited access to micro-credit or market–level resources (e.g., farmers unable to sell food products at the market due to stigma) • Religious institutions denying socioeconomic support/ educational opportunities to affected families • Absenteeism due to caretaking, with further implications for stigma