**MASIMANYANE**

**WOMEN’S RIGHTS INTERNATIONAL**

**Incorporating MASIMANYANE WOMEN’S SUPPORT CENTRE**

**Building local, national and global partnerships to eradicate violence against women**

**STIGMA AND DISCRIMINATION FOR WOMEN WITH HIV/AIDS**

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**LITERATURE REVIEW**

1.1 INTRODUCTION

Literature reviews for any scientific study are to conduct an in-depth appraisal of the existing studies that portray direct relevance to the object of study in order to relate and examine the current state of knowledge in the subject sub-field and detect inconsistencies and gaps to justify a particular object of an academic inquiry. It is a point of departure for the demarcation of problem areas for a study so as to predicate the validity and the cognition of the study with a view to provide a unique perspective of knowledge (Efretuei, 2005:75). This chapter takes an in-depth exploration of the following:

i. Definition of literature review;

ii. The necessity of review of literature for this study;

iii. Organising and writing the study’s literature review;

iv. Steps followed in literature review;

v. Literature used for the study;

vi. Sources of literature used for this study;

vii. Explanatory concepts and perspectives;

viii. Theoretical framework of the study;

ix. Literature review to gain an understanding of the topic being researched;

x. What constitutes stigma and discrimination

xi. Legislative framework governing gender and HIV/AIDS

1.2. Definition of literature review

A literature review can be defined as the selection of available documents both published and unpublished on the topic, which contain information, ideas, data and evidence written from a particular standpoint to fulfil certain aims or express certain views on the nature of the topic and how it is to be investigated, and the effective evaluation of these documents in relation to the research being proposed (Hart, 1998:13, cited in Ridley, 2008:3). The necessity of literature review is analysed hereunder.

Creswell and Clark (2010) declare that in an academic research study, a literature study needs to be engaged in for the researcher to understand different research practices in the field being studied (Creswell & Clark, 2010). This study embarked on a literature review that was aimed at contributing towards a clearer understanding of the nature and meaning of the problem that has been identified (De Vos, Strydom & Fouché, 2005:123) and to offer a thoughtful discussion of related literature that builds a logical framework for the research and sets it within a tradition of inquiry and a context of related studies (Marshall & Rossman, 1999:43).

Therefore, some background information obtained mainly from what has been published that was relevant to the research topic was done by the researcher as part of literature review for this study. In order to conceive the topic of this study, guidelines for literature review as suggested by Bless, Higson-Smith and Kagee (2009), Mark (1995, cited in De Vos et al., 2005), Marshall and Rossman (1999), Mouton (2001, cited in De Vos, et al., 2005) and Neuman (2000, cited in De Vos et al., 2005), Rubin and Babbie (2001, cited in De Vos et al., 2005) and Vital and Jansen (1997) were followed in order to:

i. Demonstrate mastery of the literature in the field (Mark, 1995:365, cited in De Vos et al., 2005:169);

ii. Discuss the proposed study in relation to the current literature (Mark, 1995:365, cited in De Vos et al., 2005:169);

iii. Display the conceptual framework of the study (Mark, 1995:365, cited in De Vos et al., 2005:169);

iv. Sharpen and deepen theoretical framework of the research (Bless et al., 2009:24; Mark, 1995:365, cited in De Vos et al., 2005:169);

v. Lay the foundation for this research (Rubin & Babbie, 2001:120, cited in De Vos et al., 2005:123);

vi. Offer a synthesis of what has already been written on the topic (Bless et al., 2009:24; Mouton, 2001:48, cited in De Vos, et al. 2005:169);

vii. Examine what has been written on the topic (Mark, 1995:365, cited in De Vos et al., 2005:169; Mouton, 2001:48, cited in De Vos, Strydom, Fouché, & Fouché, 2005:169; Rubin & Babbie, 2001:120, cited in De Vos et al., 2005:123; Vital & Jansen, 1997:14);

viii. Survey what has been written in such a way that it is conceptually or methodologically inadequate, with the goal of clarifying (Vital & Jansen, 1997:14);

ix. Avoid duplication and unnecessary repetition (Mouton, 2001:87, cited in De Vos et al., 2005:124);

x. Show that the researcher has identified some gaps in previous research and that the proposed study will fill a demonstrated need (Marshall & Rossman, 1999:43);

xi. Discover connections, contradictions or other relations between different research results by comparing various investigations (Bless et al., 2009:24);

xii. See how the researcher’s proposal addressed the gap, silence or weaknesses in the existing knowledge base (Vital & Jansen, 1997:14) or some limitations which could be uncovered by the literature review (Vital & Jansen, 1997:14); and

xiii. Familiarise the researcher with the latest developments in the area of research, particularly, acquainting with the problems and results of other researchers in order not to duplicate efforts but to widen them (Bless et al., 2009:24).

Next is the organising and writing the study’s literature review.

After exhausting the sources of the literature review and after gathering all the relevant references as suggested by De Vos et al. (2005:129), the researcher organised the information by following four of the six suggestions by Mouton (2001:91), namely:

1. By definition.

2. By theme or construct.

3. By method.

4. By the most important priority for organising and writing the literature review through organising one’s thoughts. This was done in order to address the central that this study wants to address, and then to identify any sub-themes related to the main issue. These emerged in main and subheadings, which eventually formed a framework according to which the researcher discussed the material.

The researcher used the above outline to explain what the review sets out to accomplish and to determine whether it makes sense as advised by Mark (1996, cited in De Vos et al. (2005:130).

1.2.1 Steps followed in literature review of this study

The steps suggested by De Vos et al. (2005:125) were followed by the researcher in the execution of a review of literature for this study. Only relevant sources of literature were cited and commented upon. These were grouped into different categories related to particular variables and included subheadings. Other types of background information were also presented (Bless & Higson-Smith, 2000:169).

In conducting this study’s literature review, the three broad issues were kept in mind: the purpose of the review, the literature sources, and the reviewing techniques (Bless & Hogson-Smith 2000:24). Two out of the four steps involved in conducting a literature review according to Kumar (2005:31-32) were followed. These include:

1. Searching for existing literature in your area of study.

2. Reviewing the literature selected.

Since literature review provides a theory base, a survey of published work, legislations, strategies and journals that pertain to the topic being researched (Nontshokweni, 2011), the researcher engaged in literature review in order to gain an overarching understanding of the research around the topic being researched and engaged in literature review to establish the legislation and policies governing gender and HIV/AIDS. Topics explored for this review included:

i. Literature review to gain an understanding of the topic being researched;

ii. Stigma and discrimination for HIV/AID sufferers; and

iii. Legislative framework governing HIV/AIDS.

To establish the legislation and policies governing HIV/AIDS as well as literature that is directly linked to the study, documents under review and literature published on the above topics in the past were reviewed because of the following reasons:

i. The need to gain an understanding of the topic being researched;

ii. The need to understand what constitutes gender and HIV/AIDS; and

iii. The need to base the research against legislative frameworks governing HIV/AIDS, in order to fully locate the study within the gender perspective.

1.2.2 Literature used for the study

Walliman (2006:27) is of the view that the researcher should be able to obtain the information required to complete the research. Kumar, (2005:43) strongly supports this point by clarifying that if the researcher’s topic entails collection of information from secondary sources, the researcher should ensure that data required is available in the required format before finalising the research topic. Both writers’ views were taken into consideration by the researcher before embarking on this study. This was done by collecting as much information as possible from different sources.

1.2.3 Sources of literature used for this study

Since a literature study forms the basis of all research, an in-depth inter-disciplinary literature study was undertaken. According to Mouton (2001:87), a literature review refers to a scrutiny of all relevant sources of information. However, not every source of information qualified for inclusion in the category of literature was worthy of reviewing for this study. Since the credibility of sources is important (De Vos et al., 2005), only credible sources that provided information about the research problem and about the research question that enabled the researcher to draw conclusions were used in this study (De Vos et al., 2005:127).

Mouton (2001:34-36) and Neuman (2000:445-454) recommend that most relevant sources can be reduced to the following in order of credibility and scientific verification. Taking this recommendation, the researcher’s literature review considered definitions and elaborations of learning environments because these definitions provide the basis for this study. Two sources types were used throughout this study:

1. Primary sources: Due to their reliability (Charles, 1995:27), primary sources were used in this study in order to understand legislation and background to training. The following primary sources were consulted: legislation, reports, journals and articles.

2. Secondary sources: As secondary sources are second-hand reports or interpretations of primary sources that are made by persons not originally involved with the primary sources (Charles, 1995:27), they constituted an important part of this research since they validated and analysed various aspects. Secondary sources included books, dissertations and theses, policy documents, government documents, internet, journals and articles.

The next sessions looks at the literature review to gain and understanding of the topic being researched.

1.3 LITERATURE REVIEW TO GAIN AN UNDERSTANDING OF THE TOPIC BEING RESEARCHED

There is available literature on the topic being researched, but perhaps literature listed immediately hereunder that talks particularly to stigma and discrimination for women with HIV/AIDSwill be appropriate for this chapter.

1.3.1 What constitutes stigma and discrimination

Due to tremendous stigma attached to HIV/AIDS, revelation of HIV positive sero-status of an individual has become a significant risk in communities of South Africa (Kalichman el al., 2003; Deacon et al., 2004; Kalichman et al., 2005, Simbayi et al., 2007). Several researchers have argued that HIV/AIDS stigma poses severe problems which include that it delays HIV testing; stops people living with HIV and AIDS (PLWHA) from seeking care; inhibits incorporation of prevention behaviours; increases violence against HIV-positive people; and extends beyond PLWHA to families, providers and volunteers. HIV/AIDS stigma is widespread, and it is widely accepted that it does not only reflect but also is exacerbated by co-existing stigmas related to poverty, race, gender, substance use, and sexual behaviour (Parker et al., 2002; Parker & Aggleton, 2003; Holloway, Seaton, Taylor, 2004).

1.3.1.1 Defining stigma

One way of responding to HIV/AIDS epidemic is to try to unpack the stigma attached to it as well as how it is socially defined and produced. In this regard, researchers particularly social psychologists have elucidated the ways in which people construct cognitive categories and link those categories to stereotyped beliefs. These beliefs are in turn responsible for the creation of the social process of stigmatization (Link & Phelan, 2001-2002).Moreover, the ‘social’ has been said to be an encompassing phrase and there is a need to capitalize this in this discussion to signal the understanding of HIV/AIDS stigma as a phenomenon whose complex embeddedness

in the social demands multiple points of analytical entry within this term (Kalipeni et al., 2004).

The origin of the word stigma has been traced back to the classical Greek where the term was used to describe the branding of outcast groups as a ‘permanent mark’ of their status (Parker & Aggleton, 2003). However, most discussions on stigma, particularly with respect to HIV/AIDS, have taken their point of departure the now classic work of Goffman (1963) who defines stigma as ‘an attribute that is significantly discrediting, which in the eyes of society serves to reduce the person who possesses it’ (Goffman, 1963 as cited in Parker & Aggleton, 2003: 14).

Arguably, Parker and Aggleton (2003) state that stigma need to be described as a social construction of deviation from an ideal or expectation, contributing to a powerful discrediting social label that reduces the way individuals see themselves and are viewed as persons. Visser et al., (2009) argue in this regard, that attributes that produce stigma are not inherently deviant, but deviations derive from the culturally embedded meanings of a particular historical period or ‘cultural milieu’( Visser, Makin, Vandormael, Sikkema and Forsyth, 2009:197).

However, several other authors divide stigma into felt or perceived stigma and enacted stigma (Jacoby, 1994; Scrambler and Hopkins, 1986). Felt stigma has been referred to as ‘real or imagined fear of societal attitudes and potential discrimination arising from a particular undesirable attribute, disease (such as HIV), or association with a particular group’. Enacted stigma, on the other hand, has been conceived as ‘the real experience of discrimination’ referring to lived experiences of discriminatory and abusive practice on the basis of such stigma (Brown et al., 2001: 4). A further differentiation in defining stigma is unpacked by Kretschmar (1998) who distinguishes between external stigma and internal stigma. External stigmatization, according to Kretschmar is an outcome of external oppression. Kretschmar continued to argue that this external oppression is a manifestation of perceptions, rules and laws imposed in order to discriminate against marginalized groups. Pillay (2008) stated further that this external stigma includes the ‘branding’ of those who are living with HIV and AIDS as sexually promiscuous and is reflected mostly in the way PLWHA are treated and judged as ‘deserving it’. On the other hand, internal stigma, refers to the internalization of such stigma by the person living with HIV. As Edwin Cameron explains, internal stigma is the feeling of shame that one has to live with for having contracted such a preventable disease, from an ‘intimate, expressive, hopefully loving act’ (Sunday Times, 17 April 2006:19; as cited in Pillay, 2008:22).

Pillay (2008) continues to argue that while it might be perceived that societal hostility towards infected and affected people may have declined, she asserted that AIDS stigma has not disappeared; it continues to surface in communities and it progresses differently from one community to the other. The role that cultural and socio-political factors play in creating variability in stigma will be discussed further below. At this stage, it is important to note that a number of factors including disease biology and epidemiology and societal attitudes converge to influence how and how much a disease such as HIV/AIDS, is stigmatized.

However, it has been prominently evident that Goffman’s elaborated definitions of the concept of stigma have varied considerably. Moreover, of many reasons that definitions of stigma vary, one prominent challenge to its use (Link & Phelan, 2001) is relevant to this study. This includes the fact that research on stigma has had a decidedly individualistic focus (Aggleton & Parker, 2003). Arguably, Goffman’s framework has been appropriated in much research on stigma, whether in relation to HIV/AIDS or other issues, as though stigma were a static attitude rather than a constantly changing and often resisted social process (Fife & Asch, 1988; Parker & Aggleton, 2003: 14). Aggleton et al. (2003) argue that this has seriously limited the ways in which HIV/AIDS stigma has been understood and approached. In this light, for example, Parker and Aggleton (2003) indicated that most references to stigma and stigmatization in work on HIV/AIDS rarely frame the meaning of discrimination, but indeed it is taken for granted, as though it were a given or obvious on the basis of simple common usage.

1.3.1.1.1 The function of stigma

Unlike Deacon et al., (2005) who argued that stigma needs to be understood as a problem of fear and blame, it is important to start unpacking how both HIV/AIDS as well stigma attached to it are socially constructed in different settings and to show how HIV/AIDS is linked to power and domination (Aggleton & Parker, 2003).

To put this in Parker’s words ‘stigma arises and stigmatization takes place in specific contexts of culture and power’ (Aggleton & Parker, 2003:14). Beyond this though, Aggleton et al., (2003) insists that ‘to better understand how stigma is used to reproduce social inequality, it is equally important to recognize how understanding of stigma and discrimination in these terms encourages a focus on the political economy of stigmatization and its links to social exclusion’ (Aggleton et al., 2003:16).

In this context, Gilmore & Somerville (2001) assert that stigma serves to reinforce social norms by defining deviance. ‘Dis- identification’ may strengthen and homogenize a community and its values by actually or metaphorically ridding it of unwanted or undesirable traits’ (Taylor, 2001:794). Hence, stigmatization functions as ‘an exercise of power over people’ and a means of social control by marginalizing or excluding a group from the wider community, and so reinforcing societal values’ (Gilmore & Somerville, 2001; cited in Taylor: 2001: 796).

And so, helpful in understanding how stigma functions is to investigate how in the process, it reflects and produces, as mentioned, differences and relations of power and dominance. Thus, this understanding requires one to think broadly about how for example, some individuals and groups come to be socially excluded, and about the forces that create and reinforce such exclusion in different settings (Parker & Aggleton, 2003). In this light, the role of ‘culturally constituted’ stigmatization, which Parker and Aggleton (2003) have defined as the production of negatively valued difference, need to be understood as central to the establishment and maintenance of the social order. Thus, within such framework, the construction of stigma and stigmatization involves the ‘marking of significant differences between categories of people, and through such marking, their insertion in systems or structures of power’ (Aggleton & Parker, 2003:7).

As discussed elsewhere in the empirical literature, HIV/AIDS stigma is not experienced nor directed in the same way by and towards the same category of people. Women and especially black women in general, have been found to carry the burden of HIV/AIDS disease more than any other category of people. The particularity of this phenomenon has been said to be attached to the fact that HIV/AIDS stigma is build upon pre-existing stigma attached to gender, ‘race’, sexuality, poverty and many others. To be able to illustrate this, many theorists have theorized why women especially black, poor women are ‘deviant’ and therefore the ‘other to blame’ (Schur, 1984; Shefer, 2003; Shefer, 2004; Skinner & Mfecane, 2004; Shefer, Crawford, Strebel, Simbayi, Henda, Cloete, Kaufman & Kalichman, 2008).

1.3.2 Gender, Stigma and Social Control

As illustrated before, HIV/AIDS stigma is linked to the notion of deviance and has been set up as in sub-Saharan Africa mostly women’s, and especially particularly groups of women’s deviance (such as sex-workers and women who are perceived to transgress stereotypic female norms of sexual practice). In order to be able to explore the relation of women to definitions of deviance one needs to unpack how gender stigmas operate.

As discussed before, stigma and especially gender stigmas need to be understood in relation to power and domination (Aggleton et al., 2002; Aggleton & Parker, 2002; Parker et al., 2003; Deacon et al., 2005). To be able to understand this relation, there is a need to fully comprehend how the broader gender systems operate. It has been argued in this regard, that exploring the deviance labeling of women highlights the socio-cultural connections between and among what have been treated as separate ‘problems’ or ‘private’ in some cases. It is asserted that these ‘separate problems’ are all shaped by, and constitute important parts of, an overall system of subordination and devaluation (Schur, 1984:8-9).

Diverse studies of the gender system have irrefutably shown how the subordination of women is sustained through their being socialized for, and restricted to, limited aspirations, options, roles, and rewards for women. The heavy implications of such factors, learning processes and the societal institutions that produce and perpetuate them, are unquestionable (Schur, 1984). Equally important to keep an eye on, is the role of interpersonal evaluation in ordinary life situations. In many ways, then, it is argued that societal stigmatization must be recognized as a key mechanism that ‘backs up and enforces’ many restrictions and limitations placed on women (Schur, 1984:11-12).

Following the discussion above, it is arguable that when such a level of devaluation is reached, the person becomes in the eyes of others, practically nothing but a ‘delinquent’, a ‘cripple’, a ‘homosexual’, a ‘black’, a ‘woman’ and mostly an ‘HIV positive woman’ in the case of the AIDS stigmatization process ( Schur, 1984: 30-31). Stigmatized persons, then, are little valued as persons in this instance. Society may claim authority or use this opportunity to implicitly if not explicitly treat the stigmatized individuals in exploitative and degrading ways. The logical endpoint of this process would involve treating them exclusively as ‘non persons’, the ‘other’ or simply as mere objects.

One would understand in this regard, the directions in which HIV/AIDS stigmatization processes have ended up in the ‘depersonalization’ of women and others such as gay men in some contexts which facilitated them being considered socially as ‘deviant carriers of AIDS’. Moreover, the devaluation process of women in particular has been said to be indeed substantial, and its manifestations are extremely widespread. There have been four major grounds on which basis this devaluation process of womanhood has been justified from.

The first has been the well documented existence of pronounced gender inequality within our social and economic system. A second reason to accept the claim that femaleness is devalued has to do with the widespread categorical and objectification tendencies discussed above. A third and closely related point is the pervasive devaluation of women in ‘cultural symbolism’ (Firestone, 1971; Gornick & Moran, 1972; and Gottman, 1979; Stockard & Johnson, 1980; cited in Schur, 1984: 35). The latter implies that common language usage often ‘trivializes’, ‘slights’, ‘derogates’, or unnecessarily sexualizes woman ( Lokoff, 1975; Adams & Ware, 1979; Richardson, 1981; Thorne & Henley, 1975 in Schur, 1984: 35-36).

However, the same can be applied to images of women in the mass media and advertising, especially in relation to HIV/AIDS. In this light, widespread public exposure of black African woman as the predominant image of HIV/AIDS, currently serves to further reproduce blaming and othering discourse which set up black African and poor women as responsible for HIV/AIDS.

The fourth reason to view femaleness as devalued which is perhaps most closely relevant to this study, is reflected in the central concern in this discussion, namely woman’s relation to definitions of deviance.

There have been various and a wide range of situations in which women in our society are subject to deviance labeling, these situations include the discussed earlier ones such as the objectification processes as well as the gender socialization itself. It is argued that although attempts may be made to rationalize the imposition of stigma in some of these circumstances, collectively the many stigmatizations of women demonstrate the deep-seated devaluation of femaleness itself (Schur, 1984).

Writing from a Christian spirituality perspective, Snyman (2003) recognises that about 60% of the HIV population are in Sub Saharan Africa with women being three times more likely to be infected with HIV than their male counterparts yet responses to the HIV/AIDS pandemic lack a gender focus. Some churches have not responded to the HIV/AIDS pandemic. Other Church-based responses have been isolated and simplistic in that they have concentrated on one aspect of the HIV illness. The HIV/AIDS pandemic is a growing crisis to which the Church should respond.

In linking HIV/AIDS and gender, Snyman (2003) makes mention of the reality that both empirical data and literature sources indicate that HIV/AIDS is a “women’s disease” in

Southern Africa. Underpinning the statistics and definitions, is the whether the virus is that of patriarchy which breeds in people’s minds and attitudes and is made manifest in their cultures (Okure, in Cimperman, 2005:11). To Snyman (2003), therefore, AIDS is a symptom of the patriarchal system that is sucking the life out of South African women.

According to Okure (Cited in Cimperman, 2005:11), the patriarchal virus is the reason why the situation that carries the highest risk of infection in the developing world is that of being a married woman. It is often the case that the Christian Church has given ideological and theological support to patriarchy. It is because of the patriarchal system of oppression that the prevalence of HIV/AIDS is highest among South African women. According to Dortzbach (2003:50), “AIDS rips through our families in Africa, exposing the worst of our hidden lives”. That there is a direct link between the disempowerment of women and the rate of infection among women is seen from figure 1.1. It depicts the HIV prevalence among women and men in the 15–24 year age group.

Figure 1.1 HIV prevalence among men and women 15–24 years of age

Source: UNAIDS (2005:1)

Figure 1.1 illustrates how the prevalence of HIV among women is considerably higher than among men in Southern African countries. The blue bars, which are more than double the grey bars, indicate the prevalence of HIV among women while the grey bars suggest the prevalence of HIV among men. South Africa, third from the right, has one of the highest prevalence rates of HIV in Sub-Saharan Africa. The rate of infection among women is cause for deep concern, especially when combined with the workload that women have in terms of caring for AIDS patients and their own families (UNAIDS, UNFPA, UNIFEM 2004:7).

Sub-Saharan Africa is the only place in the world where infection is greater among women than among men (Phiri, 2003:8). Cockerham (1992:32), an American medical sociologist, comments that in Africa, HIV is transmitted through “conventional (sic) sexual intercourse among heterosexuals”. Married women appear to be at high risk for HIV/AIDS in Sub-Saharan Africa where 60-68 percent of women who are HIV-positive reported having had sex with only their husbands (UNAIDS, UNFPA, UNIFEM 2004:16). However, according to an UNAIDS report, Sub-Saharan young women are withstanding the worst of the AIDS epidemic, with 36 women between the ages of 15-24 being affected for every 10 men (UNAIDS update 2004/11). This is comparable with an anonymous population based survey conducted in KwaZulu-Natal that demonstrates that HIV is four times more common in young women compared to men, especially women between the ages of 15-24 (Karim, 1998:15-33).

HIV/AIDS is increasingly infecting monogamous women in South Africa (Karim, 1998:19). This is due, in part, to the migrant labour system in this country. Cockerham (1992:32) references research by Charles Hunt who explains that the migrant labour system is a significant contributing factor to the high rate of transmission in Southern Africa. Typically, rural African women will remain in the villages to work and care for the family while their husbands seek employment on commercial farms and in the mines. This labour system causes family disturbances and an increased number of sexual partners because of long absences from home. These factors have resulted in a sector of the population that suffers from a wide range of sexually transmitted diseases, which increases susceptibility to HIV/AIDS. The pattern of transmission is different in Europe and America where HIV is transmitted primarily through drug users and homosexual and bisexual men (Cockerham, 1992:32).

Women’s vulnerability to HIV/AIDS is a result of several factors. Feminised poverty and the social disempowerment of woman are two factors contributing to the high rate of infection among women. Other factors include, cultural traditions, socio-economic factors, a lack of education and physiological factors. However, at the heart of the AIDS epidemic is the strong indication that it is a crisis of gender inequality with women having less control over their bodies and lives (UNAIDS, UNFPA, UNIFEM 2004:7). Different writers (Fiorenza, 1993, 1995, 2001; Oduyoye, 1986, 1995, 2001 & Ruether, 1983) acknowledge that in most societies there are unequal power relations between men and women and that this is illustrated by fewer legal rights protecting women, less access to information, health services and education for them and less negotiation around how and when they engage in sexual intercourse (Commonwealth Secretariat 2002:xi). Gender disparities are further linked to the lack of access to financial resources that characterises the lives of many women, making them more susceptible to abuses of power (UNAIDS, UNFPA, UNIFEM 2004:7). A number of the factors that make women more vulnerable to contract HIV/AIDS are feminised poverty, social disempowerment, cultural traditions, socio-economic factors, lack of education and physiological factors.

1.3.3 Stigma and discrimination: the causes

It is important to understand the causes of HIV/AIDS stigma in order to reveal what stigma is. PLWHA are perceived as a threat to those who are HIV/AIDS negative because of the threat they present of catching an incurable and terminal disease. The fear of contracting the virus and fear of the potentially terminal nature of HIV/AIDS is referred to as instrumental stigma (Herek & Capitanio, 1999; Stein, 2003). This fear of contracting the virus often leads people to labelling PLWHA as being a threat to the community at large. This results in HIV/AIDS stigma and discrimination in the form of isolation of those infected or suspected of being infected with the virus (International Centre for Research on Woman, 2006).

HIV/AIDS stigma is closely linked to sexual stigma, mainly because the virus is most commonly spread through sexual interaction. As a result, HIV/AIDS stigma has reinforced pre-existing sexual stigma associated with sexually transmitted diseases, homosexuality, promiscuity and prostitution (Stein, 2003). For example, homosexuals are commonly stigmatised to be at blame for the spread of the virus or the only group at risk of infection. Infected women are commonly accused of promiscuous sexual behaviour and the cause of the spread of the virus among heterosexuals. HIV/AIDS stigma is strongly fuelled by beliefs of moral integrity and the immoral values of PLWHA (International Centre for Research on Woman, 2006).

There is a tendency for people to associate HIV/AIDS with moral impropriety. This moral component of HIV/AIDS stigma is referred to as symbolic stigma (Stein, 2003). Symbolic stigma is based on judgemental attitudes towards individuals who have put themselves at risk of infection through immoral or irresponsible behaviours.

Symbolic stigma serves the purpose of distancing the individual or group from the fear of contracting the virus. The individual or group distance themselves from infection by denying that they can also be at risk of contracting the virus. Therefore, symbolic stigma responds to the pending threat by controlling anxiety. However, this form of protection from HIV/AIDS infection is counter productive as it gives one a false sense of protection (Stein, 2003). Its goal is to protect one from fear and not infection.

According to Stein (2003:9), literature highlights that “people always underestimate their own risk of misfortune in comparison to others”. This is referred to as optimistic bias. Yet, blame and stigma play a specific function, to make an individual feel safe or less vulnerable to misfortune because he/she has not done anything to deserve it. Thus, the individual reduces anxiety without the discomfort of altering his/her behaviour.

Another function of symbolic stigma is to maintain social order. According to Stein (2003:9) a UNAIDS report reveals that, “stigma is a powerful means of social control applied by marginalising, excluding and exercising power over individuals who display certain traits”. The moral component associated with HIV/AIDS serves to strengthen and reinforce social norms around fidelity and family. Due to the sexual transmission of HIV/AIDS, the virus is identified as a symbol of promiscuity and deviant sexual practices that threaten to disrupt family life through decreased social cohesion, fatherless children and women in poverty.

HIV/AIDS stigma plays a role in all key axes of inequality, for example, class, gender, sexual orientation, age, race and ethnicity. PLWHA’s are often thought to have deserved their illness because they have engaged in wrongful behaviour (Aggleton et al., 2003). More often these wrongful behaviours are linked to sexual activities or socially frowned-upon activities such as injecting drug use.

The International Centre for Research on Woman (2006) notes that women generally experience more HIV/AIDS related stigma than men. This is because women are expected to uphold moral traditions but when they are infected communities tend to label them as not upholding traditional moral values. This indicates gross double standards as men are often expected to engage in reckless sexual practices and therefore more likely to be exposed to HIV/AIDS and sexually transmitted diseases while women are expected to be sexually faithful and chaste (International Centre for Research on Woman, 2006).

1.3.4 Understanding the relationship between HIV/AIDS stigma and discrimination

Stigma can be harmful to an individual as it leads to feelings of shame, guilt and isolation, but it also has a larger societal impact (Aggleton, Parker, & Maluwa, 2003). Discrimination is defined as the “acts or omissions in which the content of the stigma is applied, either at an individual or social/community level” (Skinner & Mfecane, 2004:158). Discrimination occurs when there is a difference in someone else that results in him/her being treated unfairly or unjustly based solely on his/her belonging or being perceived as belonging to a particular group (Aggleton et al., 2003).

The association of stigma and discrimination with a disease is not a new phenomenon. History has documented stigma and discrimination attached to various epidemics and the social groups linked to them, which has often led to the hampering of treatment and prevention. Such illnesses include people with mental illnesses, physical disorders, cancer, TB and STD’s. HIV/AIDS stigma therefore follows the footsteps of past epidemics (Herek & Mitnick, 1996; Skinner & Mfecane, 2004).

Since the early days of diagnosing the virus, people infected with HIV/AIDS have been subject to social ostracism, discrimination and even violence (Campbell, Nair, Maimane, & Subiya, 2005; Herek et al., 2002; Herek & Mitnick, 1996). HIV/AIDS stigma can manifest in the following forms, physical and social isolation, verbal stigma (for example gossip and insult), loss of role (for example, loss of religious rites and loss of respect), loss of resources (for example, loss of job, customers, housing or being given poor quality or no medical assistance) (Cao, Sullivan, Wu & Xu, 2006; Miller & Forehand, 2007).

It is therefore understandable that PLWHA may be afraid or hesitant to disclose their HIV/AIDS status. This fear will undoubtedly have a profound impact on HIV/AIDS prevention, care and treatment programmes, as PLWHA may be afraid to access the services provided. According to International Centre for Research on Woman (2006), qualitative studies have revealed that people are afraid of being tested for HIV/AIDS due to the social repercussions that they will be faced with if found to be HIV/AIDS positive. In addition, people who do get tested fear going back for their test results because being seen at the clinic could create suspicions with regards to their health. Research has also highlighted that people are less willing to disclose their HIV/AIDS positive status to their spouses, for fear of physical violence (in the case of women) and abandonment (International Centre for Research on Woman, 2006).

As a result of HIV/AIDS discrimination, the rights of PLWHA are usually violated. This gross violation of an individual’s right increases the negative impact of the virus at various levels. At the individual level, undue anxiety and distress is elevated and these factors can contribute to ill health. At the level of the community whole families and groups bear the shame. Families attempt to conceal their association with the epidemic in order to receive a positive social response (Cao et al., 2006; Miller & Forehand, 2007).

HIV/AIDS stigma creates a significant amount of stress for many people living with the virus. PLWHA might fear disclosing their status with family, friends and co-workers as this might place undue strain on their relationships. Revealing their status might also make it difficult for them to maintain a normal life. In addition, HIV/AIDS stigma can undermine their livelihood and quality of life as PLWHA lose their jobs or are denied employment due to their HIV/AIDS status. The above inaccurate beliefs make it acceptable to ostracise, blame and shame PLWHA (Cao et al., 2006; Miller & Forehand, 2007).

In an attempt to avoid HIV/AIDS stigma and discrimination, many PLWHA have opted to conceal their status (Cao et al., 2006; Miller & Forehand, 2007). They have decided to deny their positive status to family, friends, employers and even physicians. However, by concealing their status they forfeit social support, as well as medical and social services that could assist in improving their health and longevity (Cao et al., 2006).

1.3.5 Stigmatisation of people living with HIV/AIDS

Several writers (Abrahams, 2006; Abrahams, 2010; Adewumi, 2013; Airhihenbuwa, BeLue, Brown, 2010; Barradas, 2005; Bashe, 2012; Bekker, Mall, Mark, Middelkoop, Wood, 2003; Bhattacharya, 2003; Brown, Macintyre & Trujillo, 2011;Cain, Eaton, Kalichman, Pieterse, Pitpitan, Sikkema, Skinner, Watt, 2012; Campbell, Maimane, Nair & Sibiya, 2005; Chavula, Choko, Chunda, Corbett, Desmond, MacPherson, Makombe, Mavedzenge, Squire & Webb, 2011; Chirwa, Cuca, Dlamini, Greeff, Holzemer, Kohi, Makoae, Naidoo, Phetlhu, Stewart & Uys, 2007; Cloete, Ginindza, Kalichman, Mkhonta, Mthembu, Simbayi, 2009; Curtisb, Mishrac & Sambisaa, 2010; dos Santos, Kruger, Mellors, van der Ryst & Wolvaardt, 2014; Forsyth, Makin, Sikkema, Vandormae, Visser, 2009; Gilbert & Walker, 2010; Govender, 2005; Greeff & Phetlhu, 2007; Hartwig, Hartwig & Kissioki, 2006; Holzemer, 2003; Jugdeo, 2009;

Kayonga, 2009; Lesko, 2005; Letamo, 2002; Luthuli, 2004; Materu, 2011; Maughan-Brown, 2008; Mdlalose, 2006; Mlobeli, 2007; Mokwatlo, 2006; Mshubeki, 2007; Mukasa, 2012; Nyblade & MacQuarrie, 2006; Padayachy, 2011; Ragimana, 2006; Roberts, 2005; Roman, 2006; Skinner & Mfecane, 2004; Stein, 2003; Stephenson, 2009; Stewart, 2012; Zamberia, 2011) have written about the topic of stigma and discrimination for people living with HIV/AIDS. However, not all these writers have focused on stigma and discrimination with regard to women living with HIV/AIDS.

Kayonga’s (2009) study was aimed at understanding whether HIV/AIDS as a social construct and those living with HIV/AIDS are understood and responded to differently by males and females and those previously classified by the apartheid divisive policy as African and Coloured participants in the context of their daily encounters. Kayonga’s (2009) study therefore investigated whether there is a relationship between race, gender and HIV/AIDS stigma among participants and whether this relationship is mediated by age, educational level, and participants’ household situation. In addition, the study explored whether gendered stigmatization is subscribed to by participants, while it further sought to assess the extent to which participants were exposed to HIV and AIDS; and whether there were gender and racial differences with respect to participants’ perceptions about PLWHA. Finally, the study scrutinized participants’ perceived levels where they believe interventions to eliminate stigma could be prioritized.

This study utilized a survey questionnaire drawn up on the basis of qualitative findings in earlier studies on stigma and HIV/AIDS in both ‘African’ and ‘coloured’ communities. Two hundred participants were recruited through a convenience sampling method in the Mitchell’s Plain area of Cape Town, South Africa. The sample was stratified by ‘race’ and gender with the majority between the age of 35 and 49 years; 50.3 % of the respondents in the sample were males, while 49.7 % were females. The majority of the respondents were Africans of Xhosa speaking descent (49.2 %) and coloureds (48.2 %) with a small proportion of whites (2.5 %).

According to Kayonga’s (2009) study, gendered constructions of stigma, while impacting on both men and women (since both appear to be stigmatized differently), are clearly still salient and it is recommended that efforts be continually made to raise the way in which gender, class, racialised and other differences of power are being played in community responses to HIV and those living with HIV/AIDS.

Research by Jugdeo (2009) explored HIV/AIDS stigma in the workplace, with a special focus on the stigmatised. An analysis of the data revealed that the majority of the participants were shunned by family, friends and partners. Others were too ashamed or afraid to reveal their positive status. The majority of the participants did not feel comfortable revealing their positive status to their line managers and to their co-workers. All participants felt that others viewed people living with HIV/AIDS as dirty and unclean and many had been exposed to stigmatising behaviours towards them due to their HIV/AIDS positive status. As a coping mechanism, most participants noted that they would walk away if stigmatised against.

An interesting study by Maughan-Brown (2008) arose out of a concern that previous South African national surveys may have underestimated the levels of HIV-related stigma because of limitations in the questions employed. It thus provides a more comprehensive evaluation of the extent and nature of HIV-related stigma through the measurement of several different dimensions of stigma (and regression analysis is used to conduct an exploratory examination of the factors associated with each dimension). It also presents the first assessment in South Africa of changes in stigmatising attitudes and behaviours towards people living with HIV/AIDS (PLWHA) over time.

Multi-item stigma modules from seven surveys were used to measure stigma from the perspective of both the general population and PLWHA on highly active antiretroviral therapy (HAART). Within the general population, instrumental, symbolic, resourcebased, and perceived stigma, andehavioural intentions towards PLWHA were measured. Among PLWHA, experienced, perceived, and internalised stigma were evaluated. Results show that the extent of stigma varied between the different dimensions and that the kinds of questions typically adopted by national surveys fail to capture subtle but important aspects of the problem.

Behavioural intentions towards PLWHA were demonstrably more positive towards family/friends than strangers. Within the general population, instrumental and symbolic stigma was more frequently reported than negative behavioural intentions or resource-based stigma. Among young adults, despite the roll-out of HAART, stigma increased between 2003 and 2006. Although relatively few PLWHA reported many experiences of stigma, most indicated some experienced stigma. Consistent with qualitative research in Cape Town, experienced stigma was more commonly subtle (e.g. gossip) than overt (e.g. losing friends). Importantly, most people perceived PLWHA to live in a highly stigmatising environment.

This study highlights the importance of a multidimensional approach in the measurement of HIV-related stigma, which captures the perspective of both the general population and PLWHA. The increase in stigma measured among young adults shows that stigma may change in unexpected ways and needs to be monitored over time. Finally, regression results indicate that different factors are associated with different dimensions of stigma and hence analyses of stigma, and efforts to reduce stigma, should take cognisance of such variation.

A study by Bhattacharya (2003) shows that South Africa has the dubious distinction of having stepped into the new millennium with the highest population of people living with HIV and AIDS. 4.7 million people, i.e. 1 in every 9 men, women and children in South Africa directly live with the virus in their body. In terms of percentage, this is approximately 10% of the world population of people living with HIV and AIDS. With an estimated 500 infections everyday, the country is beset with a galloping HIV and AIDS epidemic (Barrett-Grant et al., 2001:11-12).

According to Bhattacharya (2003), these accelerating numbers make it impossible to ignore people living with the virus, as they will inevitably form a more and more significant part of the workforce. While the civil society, along with various institutions of governance, is attempting to address the multiple facets of this epidemic, one of the singular aspects of this phenomenon that needs dedicated attention is the issue of the stigmatisation of people living with HIV and AIDS in the workplace. The extreme attitude towards PLWHA can be summed up in the following table:

Table 1: Attitude towards people living with AIDS (%)

Response Lebowa % Soweto % Natal %

Should be killed 23.0 6.5 22.3

Should be isolated 45.0 55.1 65.3

Should be cared for 9.0 31.8 89.1

Source: Webb (1997:166)

HIV-related stigma remains poorly understood, particularly in developing countries (Nylablade et al., 2003:4). A review of Bhattacharya’s (2003) list of sources as well as the bibliographies of the authors named in his study, demonstrates that studies investigating stigma are more voluminous in the West. However, the focus of most of the studies is directed towards being able to list the different types of stigma and discrimination, as a practical base to recommend remedial action. Useful as that is, Bhattacharya (2003) believes that (for a more intimate and sensitive understanding of the subject), it is necessary to undertake studies that view the issue from the perspective of PLWHA.

Bashe’s (2012) researched on the perceptions of HIV/AIDS-related stigma among employees in the Parliament of the Republic of South Africa. The purpose of this study was to explore employee perceptions of HIV/AIDS stigma in the Parliament of the Republic of South Africa in order to inform improved anti-stigma strategies and interventions.

The main themes were: the actual acts of discrimination (enacted stigma), concerns related to disclosure, assumptions and preconceptions about causes and signs of HIV infection, concerns about psychological impact and lack of knowledge and education. Discrimination was generally described as being treated differently, as well as prejudice and negative attitude to a person with HIV/AIDS. More specifically, it was understood as labelling those who are HIV positive negatively and ostracizing them. Gossip and lack of confidentiality were the main barriers to disclosure and testing while weight loss and long term sick leave were interpreted as classic signs of a person who is HIV positive in Parliament. Fear played a major role in these respondents’ accounts of HIV/AIDS related stigma, while the perceived widespread ignorance was attributed to lack of information, knowledge and education.

In Ragimana’s study (2006) which explored factors contributing to the stigma associated with HIV/AIDS in Mamelodi and Atteridgeville, 30 fieldworkers interviewed a convenient sample of 1077 respondents from different ethnic groups, gender, educational level, marital status and age groups and found that respondents tend to stigmatise persons with HIV/AIDS.

The level of personal stigma attached to HIV/AIDS was found to be lower than the level of stigma perceived in the community. This indicates that people perceive a collective stigma in the community that is negative, blaming, judging and restrictive towards interaction with people with HIV/AIDS. The perception of highly stigmatising attitudes in the community was shared by all sub-groups in the study. Only 22% of people surveyed would be scared or felt uncomfortable sending their child to school with children living with AIDS. Almost 42% of respondents believe that people who were exposed to AIDS through sex got what they deserved. In general, research shows that knowledge of HIV is quite high (95%).

Writing from the perspective of journals, (Airhihenbuwa, BeLue, Brown, 2010; Cain, Eaton, Kalichman, Pieterse, Pitpitan, Sikkema, Skinner, Watt, 2012: Chirwa, Cuca, Dlamini, Greeff, Holzemer, Kohi, Makoae, Naidoo, Phetlhu, Stewart, Cloete, Ginindza, Kalichman, Mkhonta, Mthembu, Simbayi, 2009; dos Santos, Kruger, Mahajan, Mawar, Pandit, Sahay, 2005; Mellors, van der Ryst & Wolvaardt, 2014; Gilbert & Walker, 2010; Greeff & Phetlhu,2007; Forsyth, Makin, Sikkema, Vandormael, Visser, 2009; Skinner & Mfecane, 2004; Stein, 2006; Stephenson, 2009; Uys, 2006; Zamberia, 2011), have written about stigma about stigma for PLWHA.

In a study conducted by Shefer, Crawford, Strebel, Simbayi, Henda, Cloete , Kaufman & Kalichman (2008), data were collected through confidential surveys administered in three cities/countries; Cape Town South Africa, 422 HIV-positive men and 646 HIV positive women recruited from antiretroviral (ARV)/ infectious disease clinics and support groups; nationally in Swaziland (from the City of Manzini and the regions of Hhohho, Lubombo and Shiselweni), 359 HIV-positive men and 728 HIV-positive women recruited from HIV-related medical centers; and Atlanta Georgia USA, 171 men and 48 HIV-positive women recruited from community support and HIV treatment services. The South Africa sample was racially diverse, as would be expected in Cape Town, with 68% (714) African, 15% (156) mixed race or colored, 12% (127) Indian and 5% (47) white. In Swaziland, all of the participants were indigenous Africans and in the USA 92% were African American and 8% white.

According to this study, respondents who did not disclose their HIV/AIDS status out of fear are as follows:

• Cape Town (414)

• Swaziland (422)

• Atlanta (77)

Coming to differences in Internalized AIDS Stigma Scale scores among persons who have not and who have experienced two AIDS-related discrimination events, in Cape Town, 751 did not experience, in Swaziland, 877 did not experience and in Atlanta, 134 did not experience. Zamberira’s (2011) study conducted in Swaziland described the way HIV-related stigma and other contextual factors can hinder access to health care services for people living with HIV. Interview and focus group discussion data show how stigma mediates peoples’ attitudes and behaviours towards people who are HIV-positive and their activities. Findings from this study show that lack of social support from the family and the community makes it difficult for them to access health care and sustain continuity of care, for fear of stigmatisation and other people’s ignorance about the disease. The data indicate that people lack sufficient knowledge about AIDS and critical information on how to care for those infected with HIV. This finding corroborates the findings of previous studies which have found that stigma is a serious problem, especially in rural areas where knowledge about HIV is limited (Ji et al., 2007).

Consistent with findings from previous investigations, HIV-related stigma was found to be a major drawback to accessing ARV therapy services for a number of reasons. Firstly, it constitutes a serious barrier as fear of stigmatisation keeps the sick away from health care facilities. Secondly, the fear of stigmatisation makes some families and community members wary of providing social support to people living with HIV because they are afraid of getting infected or being associated with people suffering from AIDS. Studies focusing on the roll-out of ARV therapy in resource-limited settings have reported similar findings highlighting stigma as a major stumbling block in the successful implementation of ARV programmes (see Mshana et al., 2006; Wolfe et al., 2006).Chesney and Smith (1999) have noted that stigmatisation can result in HIV-positive individuals foregoing valuable social support and medical treatment that could improve their longevity and quality of life.

The study found that the major hindrance to accessing health services is the prevailing stigma and discrimination. People living with HIV are not adequately integrated into the community because of the stigma associated with being HIV-positive. This stigmatisation extends to their family members, and affects the economic activities that they engage in. Accounts by these people described how the attitude of the community makes it difficult for them to collect medication or donated food packages. Furthermore, even when they attempt to uplift their economic well-being through small-scale income generating ventures, the community does not always sufficiently support these projects.

This analysis brought to light the intertwined nature of the factors that perpetuate HIV-related stigma in Swaziland, and explored how inadequate understanding of the AIDS epidemic tends to reinforce stigmatising and discriminatory attitudes towards people living with HIV. In explaining how these factors determine access, the analysis was cast in terms of the particular concatenation of social and economic forces at the familial and community levels focusing on how the interplay between these factors shapes access to health care services. On the whole, the findings demonstrate that it is not sufficient to simply have service agencies and personnel closer to those who need care; it is also essential to take cognisance of social factors, specifically stigmatisation of people living with HIV, when designing service delivery systems.

Still in South Afria, Gibert and Walker’s study (2010) took place in a public-sector HIV/AIDS clinic in Johannesburg, South Africa. Gibert and Walker’s qualitative study (2010) randomly selected sample of 44 patients who attended the HIV/AIDS clinic. The findings from this study suggest that the fear of stigma plays a significant role in patients’ experiences of the disease from the early stages of testing and disclosure, to the initiation of, and commitment to, ART. It also impacts on their relationships with their families and on their intimate sexual experiences.

Still on stigmatisation of PLWHA outside of South Africa, Stephenson’s (2009) study focused on Community factors shaping HIV-related stigma among young people in Zambia, Burkina Faso and Ghana. In the study, it is revealed that despite the high prevalence of HIV/AIDS that exists in many sub-Saharan African countries, very little is known of the prevalence and context of HIV-related stigma in these settings. Stephenson’s (2009) study sought to understand the community-level factors associated with HIV-related stigma among young people in three culturally contrasting Burkina Faso, Ghana and Zambia. Using nationally representative data on young people (15-24) from Burkina Faso, Ghana and Zambia, the analysis examines the economic, demographic and behavioural dimensions of community environments that shape HIV-related stigma among young people. The results demonstrate a clear influence of the community environment on shaping HIV-related stigma among young people. The elements of the community that were significantly associated with HIV-related stigma were the economic and behavioural aspects of the community environment, and there was no evidence of relationships between demographic patterns and HIV-related stigma. Behavioural change interventions must address HIV-related stigma in order to encourage behaviour change, and must take into account the social, economic and cultural environments in which young people exist. The weakness in Stephenson’s (2009) study is that, unlike Zamberira’s (2011), it does not show readers the genders of the respondents, which is the core element of this study.

1.3.5.1 Stigmatisation of women

So far, literature has revealed stigmatisation for PLWHA but has not focused on women per se. What follows hereunder is a literature review to gain an understanding of the topic being discussed with particular reference to women and gender.

A study on the socio-demographic influence on HIV and AIDS-related stigma (HARS) shows that gender plays a major role in both susceptibility to HIV infection and stigmatisation of PLWHA (Morrison, 2006; De Bruyn, 2002). Gender is defined by Morrison (2006) as a combination of symbolic, social, political, economic, legal, and cultural attributes assigned to a person as a result of his or her sex. Generally speaking, the significance of gender to health is revealed in differences and inequalities in women’s and men’s susceptibility to illness, health status, access to preventive and curative measures, burdens of ill-health and quality of care. This is true of HIV/AIDS as studies have shown that women who are HIV positive are much more stigmatised than men (Cloete, Strebel, Simbayi, vanWyk, Henda & Nqeketo, 2010; Leclerc-Madlala, 2002).

Aggleton and Warwick (1999) argue that the impact of HARS on women reinforce pre-existing economic, educational, cultural, and social disadvantages and unequal access to resources, information, power and services. Furthermore, in most cultures, women are expected to uphold and preserve the moral values of their communities hence a woman that is HIV infected is perceived as having failed to execute their social duties since those cultures closely associate HIV with sex and moral indecency. In a number of societies, women are erroneously perceived as the main transmitters of STIs, which they erroneously referred to as “women’s diseases” (de Bruyn, 1992; Baden, 1992; Verdonk, Benschop, de Haes & Lagro-Janssen, 2009). Cloete et al. (2010) discovered that women who disclosed their status to spouses and family members could face divorce, being ejected from their home, or even subjected to violence. Levin (2008) noted that despite the significant advances in HIV care to ensure safer pregnancy, fetal development, and delivery of uninfected children by HIV-positive women through PMTCT.

Over the past decade, the social stigma surrounding pregnancy and childbearing in HIV-positive women still remains strong. In a study on the community attitudes towards sexual activity and childbearing by HIV-positive people in South Africa, Myer et al. (2006) found out that 77% of the participants felt HIV infected people should not have children. Mbwambo, et al. (2004) posits that sanction may be taken by relatives against PLWHA if they bear children in contrary to their counsel in Tanzania. Report also have it that more than half (59%) of HIV-positive women experience societal pressure to forego childbearing in USA (Squires, Hodder, Feinberg, Bridge, Abrams, Storfer, 2011).

In a Serithi study by Mdlalose (2006), the focus was on three 375 HIV positive women from disadvantaged locations of Tshwane. In this study, the focus was on women’s experiences of an HIV positive diagnosis and the stigma associated with HIV and their level of disclosure. An analysis was made to whom they disclose, why they choose to disclose and the reaction of the people disclosed to, as well as reasons some people decided not to disclose.

It was established from the research results that upon diagnosis, most women experience negative emotions and thoughts including shock, fear of death, sadness, anger, self-blame and denial. These reactions, however, over time seem to fluctuate and positive reactions such as acceptance of the HIV positive diagnosis and positive thinking come to the fore.

HIV related stigma was assessed through three different types of stigma, namely;

• Experienced personal stigma (expectations of stigmatised individuals of how others will react to their condition;

• Perceived community stigma (how the respondents think most people in the community feel and react towards HIV); and

• Enacted stigma (the actual experiences of discriminatory acts due to their HIV positive status).

From these assessments, it was established that respondents perceive community stigma to be the most prevalent and more negative than felt or personal stigma and enacted stigma, which was the least negative.

Correlations between the various measures of stigma and disclosure showed that the women’s decision to disclose their HIV status is not only related to their stigma scores. Levels of personal stigma only played a role in disclosure to family members and friends and not in disclosure to partners. Perceived community stigma, which was high, did not have an impact on the level of disclosure. Therefore, the decision to disclose ones HIV status is not totally influenced or dependent on HIV related stigma because other variables such as the quality of relationships also play a role. This raises the opportunity for further research as to what other aspects may have an impact on the issue of disclosure of one’s HIV positive status.

Still on the stigmatisation of women, a study by Romans (2006) explores the stigma experienced by a group of women who are living with HIV/AIDS and focuses on how negative responses have impacted on these women.

The study employs feminist qualitative research methods. The data was collected through six focus group discussions, which were held with a total number of 36 women who are living in Guguletu and Mitchells Plain, two suburbs in Cape Town. One of these suburbs is historically African and one historically coloured and both are still predominantly low-income, disadvantaged areas.

The findings reveal that women who are living with HIV experience widespread stigmatisation. Although stigmatising attitudes are not always expressed in words, they are nevertheless obvious to those who are living with HIV. The participants of this study reflected that they are treated differently; are frequently avoided; and spoken about in their absence. Even in the health sector, the very place that one would expect to find expertise, confidentiality and to be met without prejudice, there are reports of HIV positive patients experiencing some form of victimisation. This study reveals the thoughts and experiences of a group of women living with HIV/AIDS, and includes both their negative experiences and aspects of their lives that have facilitated more positive experiences such as support groups. In response to the need to reflect upon related stigma, the findings have implications for effective intervention to care for and assist women who are living with HIV/AIDS.

Robert’s (2005) study demonstrates how poor black women are particularly vulnerable as a result of HIV/AIDS (Lawson 1999; Bujra 2000; Becker 2001:1; Crothers 2001:13; LeClerc-Madlala 2001; Walker and Gilbert 2001). HIV further marginalises women who have already been made vulnerable by their economic position, gender and race. Poor black women face particular challenges when it comes to HIV infection. They have a high risk of infection, have limited chances to protect themselves from infection and bear most of the care responsibilities, as their families get sick. These challenges are compounded by stigma (Haram 2001; LeClerc-Madlala 2001; Nyblade et al. 2003).

Poor black women are likely to suffer stigma to a much greater extent and the stigma may translate to abuse by a partner or family member(s). They may lose access to resources as their partners abandon them. Women may also have a lack of autonomy over what happens to their own bodies. Poor women have very few resources to defend or protect themselves.

Black women are most at risk for HIV, and HIV increases their social vulnerability. Walker and Gilbert note (2001:3):

It is these (young African) women who are most susceptible to infection, have the highest rate of infection, get the most inadequate and inferior access to treatment, take most of the responsibility for caring for the sick and dying and have the shortest survival rate.

Social and gender inequalities are the core problems that lead to the spreading of HIV/AIDS. This is due to the socio-economic inequalities where women rely on men for their access to necessary resources (Bujra 2000; Becker 2001:1; Walker and Gilbert 2001). Women, more especially black women, are generally less educated, which further limits their access to economic empowerment (Walker and Gilbert 2001:9). Additional factors relate to women’s lack of sexual decision-making power, experience pressures to form sexual relationships at a young age, and to accept violence in relationships as normal (LeClerc-Madlala 2001:41). Poverty, in particular, is linked with sexually risky behaviour for women, as they need to survive (Ogden and Nyblade 2005:14). In addition to this, women face increased challenges once they have children, as they may become sole caregivers and financial providers (Sewpaul and Mahlalela 1998:36).

HIV stigma further increases their social vulnerability. Krabbendam et al. (1998:2) clarify how stigma affects women at all stages of HIV infection:

Women...receive less support than men if they are ill and they have to take care of the ill, husband and the children. An HIV-infected woman is more vulnerable to financial problems than an HIV-infected man... [and] might be abandoned by her husband or her family.

LeClerc-Madlala (2001) and Haram (2001) also note how women are blamed for AIDS and that female sexuality and promiscuity are ‘demonised’ as the cause of AIDS, while males are portrayed as innocent victims. This double standard is intimately linked to others, such as where men are allowed promiscuity and women not, and where women who attempt to assert their independence and choose not to marry, are portrayed as the source of moral corruption that is AIDS (LeClerc-Madlala 2001:41).

Fox (2003:15) reports that ‘the stigma attached to HIV/AIDS affects women in particularly adverse ways. Fear of violence, stigmatisation, exclusion and destitution dominates the lives of many women in South Africa.’ Women may be the victims of violence from their partners, if their status is known. In an already abusive relationship, disclosure of HIV status poses a real threat of death or desertion (Fox, 2003:15). Abuse may be inescapable as women are often financially dependent on men (Fox, 2003:17). Public disclosure may result in mob violence, as in the case of the murder of Gugu Dlamini (UNAIDS, 2003:37). Women remain vulnerable to HIV stigma and the violence that may accompany it.

An exploration was made of literary evidence demonstrating that women’s suffering is greatly increased by the stigma associated with the AIDS epidemic. Not only are women more likely to get HIV/AIDS, they are more likely to lose access to income as a result of the infection, thus further increasing their vulnerability to opportunistic diseases and stigma. Women’s options are limited due to four interrelated factors. These are race, class, gender and finally, seropositivity. Options to evade HIV include getting an education, delaying the sexual debut and avoiding abuse, all of which are limited by poor socio-economic conditions. The chances for poor black women to avoid being infected with HIV are smaller than for other groups. Similarly, once positive, black women are more likely to be subject to severe stigma. The stigma experienced by PLHAs comes to a head when they are diagnosed HIV positive.Several studies done in various parts of the globe revealed that significant gender differential exists in terms of nature of HARS perceptions with women having less stigmatising attitudes compared to men. For instance, studies done in South Africa to determine the factors related to HARS showed that males blame PLWHA more for their condition than what females do (Forsyth, Vandormael, Kershaw & Grobbelaar, 2008; Ragimana, 2006). A study in South Africa by Visser, Makin and Lehobye (2006) on stigmatising attitudes of the community towards PLWHA reports race, knowing someone with HIV, living area, gender and age as the most important variables in explaining the level of personal stigma.

In Mshubeki’s (2007) study, mention is made of the reality that HIV/AIDS has historically been associated with homosexuality and promiscuity (especially among blacks), evoking blame and stigma. The implication of sex in the spread of HIV and AIDS complicates matters as traditional ideas of pollution and contamination are evoked. These attitudes translate into a lack of support for people infected with and affected by HIV and AIDS. Moreover, such attitudes result in the stigmatisation of those people, leaving them with a poor self-image. Stigmatisation also leads to secrecy and non-disclosure of the disease allowing it to spread rapidly. This thesis deals with the issue of stigmatisation due to HIV and AIDS, looking specifically at the two congregations of the Evangelical Lutheran Church in Southern Africa (ELCSA) in KwaZulu-Natal province.

Still on church level, Mshubeki’s (2007) study looks at the stigmatisation of black South African women regarding HIV and AIDS during the period 1996-2005, using the Machibisa and the Esibusisweni Lutheran congregations as a case study. Through this period (1995-2006) HIV and AIDS became visible as a pandemic in South Africa and South Africans became increasingly aware of the disease. The Machibisa congregation is part of the Pietermaritzburg-South Lutheran Parish in Pietermaritzburg, and the Esibusisweni congregation is part of the Ntuzuma Lutheran Parish, in Durban, both in KwaZulu-Natal province. Most members of these two congregations are Zulu. The two congregations fall under the South Eastern Diocese (SED), which is part of the Evangelical Lutheran Church in Southern Africa (ELCSA).

The first objective of the study was to throw more light on the issue of the HIV and AIDS-related stigma in the Christian church in general, by examining the issue of stigmatisation in the two specific congregations. The second objective was to look at some of the practical demonstrations of stigmatisation of women in the two congregations.

The research question of this study is whether the Lutheran church, in the Machibisa and Esibusisweni congregations, has been able to reduce the stigmatisation of women infected by HIV and AIDS. To answer this question, the research was guided by the following questions: What is the level of stigmatisation in Machibisa and Esibusisweni Lutheran congregations? What have been the initiatives of the two congregations in the last ten years to reduce stigma? How successful have the two congregations been in bringing about gender-based de-stigmatisation? On the other hand, in what ways have the teachings of the two congregations contributed to gender-based stigmatisation? Are there any insights that can be drawn from the involvement of other faith-based organisations in the area of gender-based de-stigmatisation, which can be applied to these two congregations?

The hypothesis of this study is that the teachings of the two congregations on HIV and AIDS have not been gender-sensitive and that women are more stigmatised than men. The hypothesis of the study is based on Kanyoro's theoretical framework on feminist cultural hermeneutics within African Women's Theology, which she describes as a key to African women's liberation. It offers an opportunity to scrutinize culture and theologically discuss oppressive practices for the well-being of women.

1.3.6 Stigma in the SADC region

Beginning with the assumption that HIV and AIDS is a “gendered pandemic,” and that the church is central to the lives of many people in Africa, particularly Tanzania, Materu’s (2011) study sought to assess the HIV and AIDS intervention programmes of the church. The study used the HIV and AIDS programmes and policy of the Northern Diocese of the Evangelical Lutheran Church in Tanzania as a case study, and the central question of this study was: “To what extent have the theological beliefs which under-gird the HIV and AIDS policy and programmes encouraged these programmes to adequately respond to the gender challenges posed by the pandemic?” The hypothesis of Materu’s study was that the HIV and AIDS programmes of the ELCT Northern Diocese have not responded adequately to the gender challenges posed by the pandemic among its church members, and that therefore a more gender-sensitive theological response is needed. As such the objectives of this study were to investigate whether the HIV and AIDS programmes are gender sensitive, to examine to what extent the theological beliefs under-girding the HIV and AIDS programmes and policy encourage gender sensitivity in these programmes and to develop theologies that encourage a more gender sensitive response to HIV and AIDS.

The gap in Materu’s study is that it does not resonate well with the topic being study in this study in that it does not cover issues that deal with stigma and discrimination.

Still on the SADC region, a study by Barradas (2005) in Maputo reveals some anecdotal descriptions of employees that have died of Aids although they were entitled to free HIV and Aids treatment in their companies. Fear of social isolation and ridicule is what discourages workers from disclosing their sero-status and using workplace HIV and Aids services (Williams et al., 2004).

In fact, ‘finger-pointing’ moralistic attitudes, compounded by ignorance, create a hostile environment and act as a strong disincentive for employees to claim their rights. People living with HIV and Aids (PLWHAs) have become targets for blame and punishment. This heightens their vulnerability to HIV and Aids and pushes them into a vicious cycle of stigmatisation and discrimination.

When asked if a woman infected with HIV is treated better, the same, or worse than an infected man, 39.1% (25/64) of the respondents said they are treated the same (Table 2).

Table 2: “Is a woman infected with HIV treated better, the same, or worse than an infected man?”- Respondents’ opinions, by gender.

Is a woman infected with HIV treated better same, or worse than an infected man?

Male Female Total

n % n % n %

Better 7 13.7 0 0 7 10.9

The same 21 41.2 4 30.9 25 39.1

Worse 8 15.6 8 61.5 16 25

Don’t know 15 29.5 1 7.6 16 25

Total 51 100 13 100 64 100

Source: Barradas (2005)

Considering those who think a woman infected with HIV is treated worse, a highly significant statistical difference was found: 61.5% of the female respondents (8/13) did think so, while only 15.6% of the male respondents (8/51) did (p = 0.005). This remarkable disparity is probably the result of the gender inequities so common within the conservative Mozambican society. This finding ought to be born in mind whenever designing stigma mitigation strategies for the company.

Twenty five percent of the respondents (15 men and one woman) said they did not know if a woman infected with HIV is treated better, same, or worse than an infected man. Only 10.9% (7/64) said a woman is treated better, and these were all male. This seems to reinforce the above-mentioned disparity.

Using the 2005-2006 Zimbabwe Demographic and Health Survey, Curtisb, Mishrac and Sambisaa (2010) investigated the prevalence of HIV testing uptake within a sample of women (6839) and men (5315), and identified the independent effects of AIDS stigma on testing uptake, with particular emphasis on three pathways to testing: voluntary testing, testing when offered, and testing when required. The prevalence of self-reported HIV testing was higher among women (31%) than men (22%). For women, the main pathway to testing uptake was to accept testing when it is offered (46%), whereas for men it was voluntary testing (53%). In the logistic regression models, they found that social rejection stigma was inversely associated with uptake across all pathways of testing for women, but not men. As regards observed enacted stigma, respondents who both knew someone with HIV and had observed discrimination against someone with HIV were more likely to test for HIV through all pathways, while those who knew someone with HIV but had not observed stigma were more likely to test voluntarily. Individual characteristics important to the adoption of testing included high educational attainment, religion, exposure to mass media, and ever use of condoms; while being never married and self-perceived risk were barriers to testing. Programmatic strategies aimed at increasing HIV testing uptake should consider reducing stigma toward people living with HIV/AIDS and also addressing the role of agency and structure in individual’s decision to be tested for HIV.

Still on the SADC region, the primary goal of Letamo’s (2001) study is to examine and determine factors influencing stigmatisation and discrimination among adolescents towards people living with HIV/AIDS in Botswana. HIV/AIDS-related stigma and discrimination result from fear, ignorance, and denial. There exists little or no research in Botswana dealing with how people living with HIV/AIDS or suspected of having HIV/AIDS are perceived and treated. Data analysed in this paper are taken from the Botswana AIDS Impact Survey conducted in the year 2001. Both descriptive and multivariate logistic regression models are used to analyse the data. The results show that many of the adolescents expressed negative attitudes towards people living with HIV/AIDS.

Logistic regression analysis shows that misconceptions about HIV transmission often encourage stigmatisation and discrimination of people living with HIV/AIDS. Interestingly, although the majority of the adolescents stigmatise and discriminate against PLWA, many of them are willing to care for a family member who has HIV/AIDS. There is need to address issues of stigma and discrimination as part of prevention of further spread of HIV/AIDS in Botswana.

HIV/AIDS-related stigma and discrimination are a serious public health problem not only in Botswana but also internationally. The purpose of this study was to examine the factors influencing stigma and discrimination related to HIV/AIDS among adolescents and to suggest ways of mitigating the impact created by such practices. The results clearly showed that HIV/AIDS-related stigma and discrimination are rampant in Botswana. One important finding is that although many of the respondents stigmatise and discriminate against HIV/AIDS patients (a teacher or shopkeeper who is sick with HIV/AIDS), a substantial proportion of them are willing to care for a family member sick with HIV/AIDS. This probably reflects that no matter how stigmatised the disease is, people are willing to make sacrifice in order to care for their close relatives. It is possible that the hypothetical teacher or shopkeeper who is sick with HIV/AIDS is not imagined to be a family member but a distant person. One may conclude that people are more likely to discriminate against HIV/AIDS patients who are not close relatives.

Misconceptions about how HIV infection may be transmitted tend to promote negative attitudes towards PLWA. Consistently, respondents who believed that HIV infection can be transmitted through witchcraft or sharing a meal with a PLWA were significantly more likely to stigmatise and discriminate against PLWA than other people. This might be indicative of the fact that negative response and attitudes towards PLWA are strongly linked to general levels of knowledge about HIV and AIDS and, in particular, to the causes of AIDS and routes of HIV transmission (Bharat, Aggleton and Tyrer 2001). In other words, the perception of how HIV/AIDS was acquired is critically important on how people will treat a PLWA. The results also show that regardless of intensive public campaigns relating to various aspects of HIV/AIDS, including its transmission, the messages have not quite reached a large majority of people in the country.

1.3.7 Discrimination

The topic of discrimination of PLWHA has been covered by Mukasa (2012), Padayachy (2011), Rangoato (2013) and Roman (2006). Writing from a legal perspective, Rangoato’s (2013) study aims at analyzing the rights of employees more particularly those living with HIV/AIDS in the workplace. The study illustrates the need to eliminate unfair discrimination in the workplace permanently and makes some recommendations which must be considered for the development of workplace HIV/AIDS policy and programmes. Rangoato (2013) hoped that the study will contribute to a better understanding of the need to encourage employers and trade unions on how they should both respond to HIV/AIDS discrimination in the workplace. It will benefit law students for a better understanding on HIV/AIDS discrimination and disability issues.

Although the study by Rangoato (2013) was about discrimination for people with HIV/AIDS in the workplace, there was no special emphasis on women and HIV/AIDS, which is a central point of this research.

Still on workplace discrimination, Padayachy’s (2011) research has sought to critically discuss and analyse how the introduction of a HIV and AIDS policy in the workplace reduces stigma and discrimination within the workplace, increases VCT and reduces the risk of infection. This research, sought to further discuss and analyse how the ideas, beliefs and values embedded within a HIV and AIDS policy can be further extended into the community. This research focused on the literature of key theorists such as Donnely, S. (2002). A New Form of Discrimination in the Workplace (www.iol.co.za April 29th 2002), Hereck, G.M. (1990). Illness Stigma and AIDS. Psychological Aspects of Serious Illness. Washington D.C.: American Psychological Association. Goffman, E. (1963). Stigma: Noted on the Management of Spoiled Identity. New Jersey: Prentice Hall as a means of validating the research. This research has further made use of both qualitative and quantitative methods through the use of biographical questionnaires and structured one-on-one interviews. In so doing the research has found that the implementation of a HIV and AIDS workplace policy would assist in eradicating stigma and discrimination in the workplace.

Mukasa’s (2012) comparative study of discrimination against PLWHA in Uganda and South Africa reveals that despite HIV and AIDS knowledge and attitude change programmes, workplace HIV and AIDS-related discrimination persists in workplaces in many sectors, including the education sector. Mukasa’s (2012) study investigates why the phenomenon of workplace HIV and AIDS-related discrimination persists. It also predicts which factors were responsible and how they related to HIV and AIDS-related discrimination in the workplace.

Mukasa (2012) discovered that attitudes were the second strongest predictor; and only HIV and AIDS-legal knowledge could predict discrimination but not biomedical HIV and AIDS knowledge. In the in-depth interview, incidents of discrimination were reported, possible reasons for HIV and AIDS-related discrimination were reported; and it was found that workers varied in ways of keeping secrets regarding sensitive information such as colleagues’ HIV-positive status, and cited reasons for revealing such information which included malice, jealousy, moral responsibility, anger and loose talks. There are implications for reducing workplace HIV and AIDS-related discrimination which include: Integrating HIV and AIDS-legal knowledge with biomedical HIV and AIDS knowledge, more efforts should be spent in designing and imparting information to reduce traditional beliefs, develop and evaluate instruments to measure traditional beliefs and HIV and AIDS-legal knowledge; and to study more about secret keeping, particularly in regard to workplace HIV and AIDS-related discrimination.

In Mukasa’s (2012) study, mention is made of the reality that South Africa and Uganda are facing a catastrophic AIDS epidemic. HIV prevalence in South Africa is measured by actuarial extrapolations of tests carried out in state antenatal clinics on an annual basis. Because of the necessary assumptions required to generate a model representing the entire population, there is room for uncertainty over the exact levels of HIV infection. The most recent release shows that 22% of South African adults are HIV-infected, that is more than 6.2 million people (Department of Health, June 2005). However, UNAIDS (2009) estimated that 5.6 million South Africans were infected with HIV at the end of 2009. In Uganda, there has been some positive change in terms of reduction in infection rate from about 15% in 1991 to about 6% in 2007 (UNAIDS 2008), but the impact of HIV and AIDS is still great. The Human Sciences Research Council, a South African institution, estimates 10.9% of all South Africans are infected with HIV and AIDS.

Southern Africa remains the world’s most affected region, with epidemics that have grown rapidly. There is no single explanation for why the epidemic is so rampant in Southern Africa. A combination of factors, often working in concert, seem to be responsible, including: poverty and social instability that result in family disruption; high levels of other sexually transmitted infections; the low status of women; sexual violence; high mobility, which is largely linked to migratory labour systems; and ineffective leadership during critical periods in the epidemic's spread (Crush, Frayne & Grant, 2006; Halperim & Epsein 2006).

Discrimination against those infected with HIV and AIDS is rife in the workplace. The general consensus is that teachers in Africa living with AIDS are seriously discriminated against by school principals/managers, teaching colleagues and students (Bennell, Hyde & Swainson, 2002:86). Researchers reveal that the level of denial and secrecy, that is, not wanting to be identified that one carries the virus that causes AIDS is high among teachers in schools. Given the stigma, educators are not prepared to reveal their HIV status.

Like Rangoato (2013) and Padayachy’s (2011) studies on discrimination for people with HIV/AIDS in the workplace, in Mukasa’s (2012) study, there was no special emphasis on women and HIV/AIDS.

Govender’s (2005) study that was conducted in the Chatsworth area in Kwazulu-Natal examined the experiences of four Indian women living with HIV/AIDS. The data collected in this study reveals that all four participants have had negative experiences. The following themes emerge: (1) stigma, secrecy and HIV related prejudice (2) poverty (3) family and community support in the face of HIV/AIDS and (4) gender inequality and disempowerment.

In terms of stigma, secrecy and other related prejudices, the findings of Govender’s (2005) study support what the literature (O'Sullivan, 2000; Mthembu, 1998; Karim, 1998; Tallis, 1997; Francis, 2003 & Webb, 1997) have to say about people living with HIV/ AIDS. All the participants in Govender’s (2005) study shared experiences of living in isolation and secrecy where stigma is pervasive. Evidence from the literature supports Govender’s (2005) research study in that all four participants still see HIV/AIDS as 'that thing called AIDS'. Throughout the research study, all the participant s did not refer directly to HIV/AIDS but to 'that sickness'. This is supported in other literature by Aggleton (2001), Francis (2003; 2004), 0'Sullivan (2000) and Mthembu (1998), where it was reported that stigma and associated misconceptions regarding HIV/AIDS such as: "that only promiscuous and immoral people get HIV/AIDS" has prevented many women who are HIV positive from seeking treatment and support (Mail and Guardian, 2nd December 2003). All four women in Govender’s (2005) study maintained that they would never disclose their status to anyone but their immediate family.

What emerges from the interviews with the four participants is that even two decades after the first known case of HIV/ AIDS, in the Chatsworth community, HIV/AIDS is still thought of as someone else's disease. To put it more bluntly, Indians, especially those in Chatsworth, feel it is a Black man's disease (Sunday Times, 6th December 2003). Throughout the interviews with the women in the study, the word HIV/AIDS was never used, unless prompted by the researcher. The words "that sickness" and "that thing" was used emphasizing denial.

Contrary to the literature available where interviewees have spoken openly about their experiences living with HIV/AIDS and where some have even disclosed their serostatus (Mthembu 1998), for the four participants, it is still something that is cloaked in secrecy. All the participants mentioned that they would never disclose their HIV status. They would rather pass it off as Tuberculosis or cancer. There are many reasonss for this secrecy. Pre-existing local practices and beliefs are the major determinants for HIV/ AIDS-related discrimination, stigmatization and denial. These beliefs frequently establish categories of person or types of behaviour that are likely to be stigmatized (e.g. sexually 'promiscuous' individuals, sex workers, drug users). This in turn has an important role in 'policing' the behaviour of people living with HIV/AIDS, causing some to deny their serostatus, others to conceal it, and all to experience anxiety about telling others and seeking care (UNICEF 2000).

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