The Implications of Stigma to Heath Communication

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Abstract

The gravity of stigma had been understated in health communication. However, healthcare practitioners and researchers have better understood its impacts to both public health and health communication. This essay summarizes Erving Goffman's seminal study of stigma, and the critiques of his work in both the Thai and English literatures. Then the implications of stigma in health communication are elucidated with a focus on how HIV/AIDS related stigma strains the world's fight against HIV/AIDS. Goffman's stigma theory is underpinned by the essentialist notion of the sources, and the analytical scope of the management, which is limited to the stigmatized individuals' interactions with strangers. To complement Goffman's theory, scholars have investigated the interplays between stigma and the pre-existing socio-cultural factors, such as power relations, gender biases, legal mechanism and mass media. Almost six decades of stigma studies has illuminated the gravity of this universal phenomenon and the challenges to health communication. Both the Thai and international literatures suggest a possibility of collective stigma management.

In 1963, American sociologist Erving Goffman's *Stigma: Notes on the Management of Spoiled Identity* was published to shed light on the implications of stigma in interpersonal interactions. For six decades after Goffman's groundbreaking work, the issue of stigma has been examined by a wide variety of academic disciplines. Goffman predominantly dealt with stigma management in impersonal contact with strangers, and pay little attention to that in recurring contacts with familiar persons (Gussow and Tracy, 1968). In addition, Goffman's studies say little about the roles of perpetuators in stigma management.

This essay first overviews Goffman's seminal study of stigma, and examines the critiques of his work in both the Thai and English language literature. After that, the implications of stigma vis-à-vis health communication, especially HIV/AIDS related stigmas both in and outside Thailand, are elucidated.

Health communication practitioners have now understood the gravity of stigma in their practices. For example, anti-Polio vaccination campaigns have been severely affected in Muslim societies, such as Northern Nigeria and Pakistan because of the distrust of the Western aids in Muslim societies. Not only did the stigma stall vaccination campaigns, but also cost the lives of local health workers and the local populations (Chen, 2004; *BBC News* 2018).

In Thailand, stigma has also been an obstacle for anti-HIV/AIDS campaigns. 'AIDS stigma' has caused various forms of discrimination, ranging from mockery to violence. It deprives people living with HIV/AIDS PLWHA of dignity and access to eligible resources and opportunities that are essential for their survival (Isarangkura Na Ayuthaya, 2006, p. 2-3). AIDS stigma prevents the patients from seeking timely diagnosis and treatment. The majority of Thai PLWHAs in fact become aware of their seropositive status only after their health conditions deteriorate (World Bank, 2000, p. 24-25). Some PLWHA even stop seeking essential services, such as treatment, counselling, free condoms, or needle exchange. In order to ensure the success of the anti-HIV/AIDS campaigns, non-discriminatory communication must be promoted at the different levels of health care. Social and cultural factors, including stigma, adversely affect the wellbeing of the public even if effective and financially viable medical treatment or preventative measures is available.

Health Communication

Health communication is often used synonymously with healthcare (du Pré, 2000, p. 10). It covers a wide range of issues in healthcare settings, such as doctor-patient interactions, public health campaigns, social responses to illnesses, leadership and teamwork within healthcare organizations, information seeking behaviors of patients in and outside the doctor's office, and the impacts of the media to public health.

At the level of doctor-patient interactions, effective communication enables doctors to better understand patients' concerns and needs, make diagnoses, and share their recommendations (du Pré, 2000, p. 10). Patients also are reported to be more satisfied with their doctors, trust diagnoses, and adhere to treatment regimens when healthcare providers try to communicate with patients (Cecil, 1998, cited in du Pré, 2000). For patients, health communication is a key indicator of successfully coping with their illness.

Effective communication is crucial at the different levels of healthcare providers. Among doctors and nurses, it is crucial to cope with work-related stress. Because they are subject to a high level of work-related stress for a prolonged period of time, effective communication can enable them to more effectively cope with emotional and physical exhaustion. It is essential for healthcare organizations to function effectively (Cecil, 1998, p. 12)

At the social level, effective use of the media can help people learn about health and minimize the influence of unhealthy and unrealistic media portrayals, such as the representations of body image in mass media. Health promoters should use effective communication skills to assess public needs, and inform then about health issues. For example, research indicate that media literate audience are less likely to behave unrealistic images of eating, drinking, using drugs, and being unnaturally thin (Cecil, 1998).

Health communication has become an essential component of healthcare system in maintaining the resources and providing the services in an efficient manner.

The Definition of Stigma

Defining stigma is an elusive task. The term 'stigma' originally referred to practices of branding undesirable individuals with epithets such as the 'mark of Cain,' which signified non-expiated murder, crime and sin. Erving Goffman (1963) expanded the original concept of stigma beyond simply physical marks in his *Stigma: notes on the management of a spoilt identity*. He analyzed the process of stigmatization and the micro strategies that individuals employ to manage stigma in face-to-face interactions.

He considered that stigmatization is established via human interactions wherein an undesirable difference is associated with a negative attribute. Goffman described the transformation of an individual in the eyes of others as follows:

> While the stranger is present before us, evidence can arise of his possessing an attribute that makes him different from others in the category of persons available for him to be, and of a less desirable kind – in the extreme, a person who is quite thoroughly bad, or dangerous, or weak. He is thus reduced in our minds from a whole and usual person to a tainted, discounted one. Such an attribute is a stigma, especially when its discrediting effect is very extensive; sometimes it is also called a failing, a shortcoming, a handicap.

Once undesirable difference is recognized, the bearer of the difference is associated with a negative category of people. The stigma limits an individual's social and economic opportunities, and renders his/her life subject to an unusual degree of scrutiny.

What kind of difference may invite stigma? Goffman (1963, p. 14) divides sources of stigma into three categories: "abominations of the body," "blemishes of individual character,"

and "tribal stigma of race, nation, and religion." The first refers to various physical deformities, such as blindness and loss of limbs. The second specifies the mental characteristics of the individual, such as weak will, domineering or unnatural passions, treacherous and rigid beliefs, and dishonesty. Goffman expanded this category to include certain behaviors and biographical profiles, such as mental disorders, imprisonment, addiction, alcoholism, homosexuality, unemployment, suicidal attempts, and radical political behavior. The last, the tribal stigma, is defined as inheritable through lineages, with the potential to contaminate all members of the group. Goffman considered that these three sources of stigma function as recognizable "marks," which attract an unusual level of scrutiny to the possessors of the difference, and separate them from the "normal."

After Goffman, other scholars have added sources of stigma. Jones *et al*. (1984, p. 24), for example, propose six factors which may have significant influence on stigma formation: the degree of the stigmatizing condition, and the probability of concealment of the condition (concealability); progression of the condition and the ultimate outcome (course); the degree of disruption to interactions (disruptiveness); the presence of aesthetically upsetting conditions (aesthetic qualities); the origin of the condition, and location of responsibility for the condition (origin); and the type and degree of danger presented by the condition (peril).

Once identified as those whose bodily and psychological conditions differ from group norms, the possessors of such differences become associated with stereotypical beliefs and are cast as stigmatized individuals. The totality of social attitude and actions towards them affects the interactions between the normal and the stigmatized. Goffman (1963, p. 15) explained the consequences of stigmatization as follows:

> By definition, of course, we believe the person with a stigma is not quite human. On this assumption we exercise varieties of discrimination, through which we effectively, if often unthinkingly, reduce his life chances. We construct a stigma theory, an ideology to explain his inferiority and account for the danger he represents, sometimes rationalizing an animosity based on other differences, such as those of social class.

Thus, stigma, forming a set of stereotypical expectations the possessors of an undesirable difference, distorts and biases our experiences at both the cognitive and affective levels. The stigmatized individuals, as a result, experience the transformation of social identity "from a whole and usual person to a tainted, discounted one" (Goffman, 1963, p. 3).

American epidemiologists Bruce G. Link and Jo C. Phelan (2001, p. 367) summarize stigmatization as five interrelated stages of social reactions: (1) people distinguish and label human differences; (2) dominant cultural beliefs link labelled persons to undesirable characteristics – to negative stereotypes; (3) labelled persons are placed in distinct categories so as to accomplish some degree of separation of 'us' from 'them;' (4) labelled persons experience status loss and discrimination that leads to unequal outcomes; and (5) stigmatization is entirely contingent upon access to social, economic, and political power that allows the abovementioned four components. Stigma is crystallized as a cognitive scheme, linking an undesirable difference and a negative attribute. When stigma is enacted, its bearers are excluded from social support (Link and Phelan, 2001, p. 365). [see Figure 1]

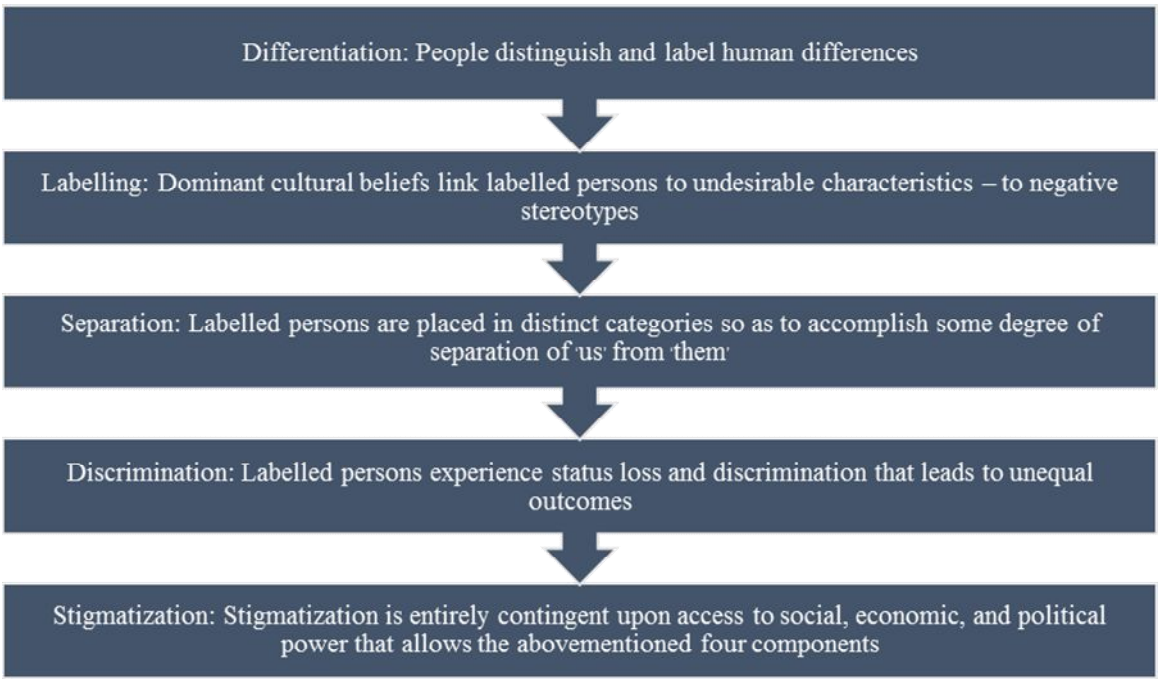

Figure 1 Five components of stigmatization (Link and Phelan, 2001, p. 367)

The discrepancy between what the stigmatized individuals wish to be and what others expect them to be wounds their self-worth, and spoils their social identities (Alonzo and Reynolds, 1995, p. 304). When the stigmatized individuals come into contact with the normal, they are uncertain about how others are thinking about him/her **(**Goffman, 1963, p. 25**)**. Austrian-American criminologist Frank Tannenbaum (1938, p. 19) describes that the stigmatized's every aspect of life becomes subject to scrutiny and question. The stigmatized become self-conscious and too uncertain about how others may regard them**.** The growing uncertainty prevents them from conducting their lives in a usual and routinized way**.** On the other hand, the normal also find their interactions with the stigmatized insecure**:** "We will feel that the stigmatized individual is either too aggressive or too shamefaced, and in either case too ready to read unintended meanings into our actions" (Goffman, 1963, p. 29). An excessive level of psychological stress, what Irwin Katz (1981, p. 7) describes as ambivalence, creates friction in social relationships. Thus, the interplay of self-consciousness and "other-consciousness" hinders smooth interactions between the two parties, and results in "the infinite regress of mutual consideration that Meadian social psychologist tells us how to begin but not how to terminate" (Goffman, 1963, p. 30). Like the monologue of a physically deformed person in front of a mirror, which Goffman detailed as an example of the "split between self-demands and self," the stigmatized may feel self-hate and self-derogation (Goffman, 1963, p. 18).

Stigmatized individuals experience isolation, rejection, prejudice and discrimination. They try to avoid situations wherein their difference may be exposed, and their interactions with others interrupted. Discrimination leads the stigmatized to develop internalized negative values and repressed anger, an outcome sometimes referred to as 'self-stigma' (Freund and McGuire 1991, cited in Alonzo and Reynolds, 1995, p. 304). Self-stigma may give rise to feelings of self-hatred and shame, and may ultimately culminate in depression and suicide.

Critiques of Goffman's Stigma Theory

Goffman continues to influence as the theoretical underpinning for the literature on stigma (Link and Phelan, 2001, p. 364). However, his theory is not free from criticism. The criticism can be divided into four types: (1) his essentialist notion of the sources of stigma, (2) the

individualistic view of stigma, or lack of insight into social factors in the process of stigma, (3) his description of stigma as static entity, and (4) strategic use of stigma.

First, Alonzo and Reynolds (1995) argue that stigmatizing differences do not exist as inherently deviant or independent of human mental activity. They argue that the 'mark' of stigma is socially constructed rather than naturally given. They argue that there is consensus that "stigma represents a construction of deviation from some ideal or expectation, whether the ideal is for 'correct' sexual orientation or to be free of a disfiguring or fatal infectious disease" (Link and Phelan, 2001, p. 304). They assert that "a given attribute that is stigmatized is not inherently pathological, immoral, or 'deviant' but derives from culturally imbedded meanings. Thus, various forms of 'deviance' are stigmatized in the context of a particular historic period and cultural context" (Link and Phelan, 2001, p. 304).

Second, critics of Goffman's stigma theory have attempted to expand the scope of analysis beyond impersonal interactions with strangers. Glaser and Strauss, for example, highlight the limitation of Goffman's theory to relatively brief face-to-face communication with the normal in unfocused gatherings (1967, p. 675). Goffman himself (1963, p. 23) acknowledged that the analytical scope of stigma is "specifically concerned with the issue of 'mixed contacts' – the moments when stigmatized and normal are…in one another's immediate physical presence, whether in a conversation-like encounter or in the mere co-presence of an unfocused gathering." Goffman's microscopic approach thus fails to investigate the social aspects of stigma. Who plays a crucial role in stigmatization? Who benefits from stigmatization? Who regulates the categories of the normal and stigmatized? In order to answer those questions, the scope of stigma theory must be expanded beyond unmediated interpersonal communication (Parker and Aggleton, 2003; Link and Phelan 2001, p. 366).

To demonstrate how the scope of stigma theory can be expanded beyond interpersonal communication, Thai anthropologist Pimpawun Predaswat (1992, p. 268) examined leprosy-related stigma in a rural Thai village vis-à-vis recurrent interactions between the stigmatized and the perpetuators, especially the role of indirect communication:

> The stigma of leprosy in the community studied was not formed through direct interactional processes. Rather it was formed through the process of indirect ongoing social contacts such as gossip and backbiting of community members in which the social meaning of being a leprosy patient was assigned to that person. The Thai practices of "politeness" and "affability" and the community and neighbourhood ties of patients and non-patients are factors inhibiting stigmatization during interactional processes.

Expressed in the stigmatized individual's absence, stigma eventually reaches them through a chain of acquaintances in a village community. Predaswat's ethnography uncovers the insider's views of stigma, which are not so directly observable, nonetheless impact the stigmatized individuals' well-beings. Her study also sheds light on the socio-cultural domains wherein stigma is socially appropriated and arouses certain emotions, such as shame and fear. Predaswat's study indicates that different analytical approaches that involve fieldwork and repeated observations, such as ethnography, may enable researchers to understand the social aspect of stigma within high-context cultures like rural Thai society.

Link and Plelan (2001, p. 375) propose that future studies of stigma should pay more attention to the power relations on which stigma rests:

> If powerful groups are motivated to discriminate against a stigmatized "them,' there are many ways in which such discrimination can be achieved. If stigmatized persons cannot

be persuaded to voluntarily accept their lower status and inferior rewards, direct discrimination can be used to accomplish the same outcome.

Predaswat's study (1992, p. 166-168) found that the power relations between the stigmatized and the perpetuators impact the stigma: who is allowed to express it, what forms it takes, when it can be expressed, and how it can be managed. She, for example, observes that local elites (e.g., wealthy farmers and community leaders) openly express their stigma towards the poor leprosy patients although explicit repulsion is considered inappropriate within the local community. Leprosy-related stigma is interrelated to pre-existing class systems in a Thai village community.

In media saturated societies, the influence of stigma is more far-reaching because it is disseminated extensively via mediated communication channels. Kasperson, Jhaveri and Kasperson (2001, p. 27) conceptualize technological stigmas as a heightened sense of risk towards application of technology and, by extension, resultant commodities and services (e.g., industrial waste and nuclear energy). They argue that media reportages of technological accidents amplify a sense of risk, and expand the impact of the accidents way beyond the immediate site. Their study indicates stigma studies can be conducted vis-à-vis the society-wide interplays between technology and mass media.

Third, Goffman's view of stigma is permanent although manageable to some extent. Parker and Aggleton (2003) regard stigma as a dynamic process, through which stigma is constantly recreated, and even challenged through social interactions. Goffman's stigma theory, like that of George H. Mead, overemphasizes the power of social structure (Treviño, 2003, p. 13)

> [F]or Goffman, the individual's very identity is controlled, even determined, by such overwhelming societal forces as institutions, roles, and social frames. In the most extreme case, the individual may undergo a mortification of self – the destruction of an individual's personhood – as a result of the total control that a social situation exerts on him or her.

Gassow and Tracy's (1964) study of leprosy patients in an American leprosarium shows that leprosy patients' collective efforts alter their stigmatized identities. They observed that the patients form a group, which binds them together long enough to develop their own subculture, norms and ideology. A group of leprosy patients can recast themselves in a more positive light by exposing fallacies and injustices levelled against the leprosy patients.

Finally, although Goffman did not explore the social and political implications of stigma, stigma can be utilized, consciously or unconsciously, as a means of social control to marginalize and exclude individuals with certain traits (Bourdieu, 1984, p. 479). In his study of systematic maintenance of social order, Pierre Bourdieu focused on the inherent ability of human beings, or separative power, which enables people to distinguish something undifferentiated, and ultimately contribute to the maintenance of social order. Applied to a certain aspect of personhood, e.g., behavior patterns and physical features, individuals are differentiated from others, and bracketed together into a stereotypical category in a given society.

Bourdieu (1984, p. 476) argues that stigma can be effectively analyzed through close examination of interests associated with membership or non-membership. He regards membership as a form of resource that can strategically be utilized to enhance one's control over another, and therefore increase his/her political power in society. Social identity derived from membership is associated with a conventionalized set of attributes, by which members of a given society are constrained. Rewards and sanctions are exerted in a hegemonic way in

order to preserve the categorical system and underlying power relations. For Bourdieu, management of a categorical system is equivalent to the struggle for consensus and one's authority over another.

In a village of Northern Thailand, during the so-called "war on drugs" campaign launched in 2003 by the Thaksin Shinawatra government, a blue flag with a royal emblem was used to distinguish a drug-free household from a "tainted" household (Isarangkura Na Ayuthaya, 2007). Several households, whose members were arrested for drug-related crimes, were not allowed to carry the flag. To villagers, the absence of the flag signified a series of associations (i.e. drug abuse, arrest, punishment and dishonor). Under the royalist discourse of the village, those who were not allowed to carry the flag could be subject to accusations of being unpatriotic and could be cast outside of the royal patronage. Apart from this symbolic punishment, households without the flag were excluded from a network of mutual support, such as the supply of water and the community funeral funds.

Separation of one group from another is considered by some to maintain the order of society. Referring to a tale of a werewolf, Giorgio Agamben (1998) shows how the expulsion of the stigmatized articulates the boundary between order and disorder, and restores the collective order of the society as a foundational victim in favor of social order. A werewolf is a mythical character imbued with both half-human and half-animal traits. Therefore, he belongs to both human society and nature. At a cognitive level, the werewolf's existence temporarily blurs the boundary between the human and the animal, or society and nature. At the affective level, his existence evokes anxiety. The tale of the werewolf ends with his murder, called "inclusive-expulsion". Thus the sense of order is restored. Agamben (1998, p. 8) argues that his protagonist embodies *homo sacer,* the person "who may be killed yet not sacrificed".

Disease-related stigma, especially that pertaining to infectious diseases, functions to socially exclude the sick from the rest of the population as a form of disease control (Bamber *et al.*, 1997). Suzan Sontag (1978) observed that "them and us" polarization takes place to (1) reduce the degree of fear and vulnerability that the diseases may affect "us", (2) separate "them" from "us" cognitively, (3) induce social exclusion, (4) induce necessary social actions to manage the perceived risk, and (5) justify the actions.

In order to control a disease, certain racial, sexual, cultural or religious groups can be systematically stigmatized, and discriminated against. For example, the studies of AIDS stigma conducted in Vietnam and India found that women are more likely to be subject to harsher judgment than children and men (Khuat, Nguyen and Ogden, 2004; Bharat and Aggleton, 1999).

Stigma Management

Goffman did not deny the possibility of challenging the social structure, and detach oneself from it by creating their own ideology. Goffman (1963) divided stigma management into two strategies according to the availability of knowledge about the stigmatizing mark of their interactants: (1) how stigmatized individuals manipulate available information in order to conceal their stigma, and (2) when they cannot conceal stigmatizing differences, how they mitigate the negative impacts of stigma.

If the stigmatized may be able to conceal stigmatizing information, they can 'pass' or pretend to be the normal. The 'discreditable' try to pass as normal by suppressing the potentially stigmatizing information.

Another strategy involves those whose stigmatizing information has become known to their interactants. If a stigmatizing characteristic is visible or revealed, the 'discredited' has to manage the resulting tension by adopting remedial strategies through psychological and/or technical adjustment. Goffman (1963, p. 19-21) referred to technical remedies, such as plastic

surgery for a physically deformed person, and eye treatment for the blind. He also alluded to victimization as a psychological strategy for the stigmatized to gain profit or sympathy as is the case with fraudulent advertisements selling products, such as speech correction and skin lighteners, which claim to correct stigmatizing traits. Goffman also noted examples of handicapped persons, who acquire the mastery of activity through personal effort, just as the blind person becomes expert at skiing and mountaineering. He described those activities as "the stigmatized individual's likely…use [of] his stigma for 'secondary gains', as an excuse for ill success that has come his way for other reasons". Goffman (1963, p. 42) argued that impression management is crucial to the 'discredited.'

Glaser and Strauss (1967, p. 675) studied the stigmatized's creative efforts to destigmatize themselves in more long-term groups, which bind them together long enough to develop their own subculture, norms and ideology (which Goffman regarded as a form of victimization). Gassow and Tracy's study of leprosy patients in an American leprosarium (1968, p. 324) showed that the stigmatized are not necessarily passive recipients of the stigma imposed on them. As 'career patients,' the stigmatized may account for their plight or strategies to avoid or minimize discrediting social attributes. They pay special attention to collective acts of recasting themselves in a more positive light by exposing fallacies and injustice against the leprosy patients.

AIDS Stigma

Since the official discovery of AIDS in 1981, the disease has been accompanied by stigma. As is the case with other sexually transmitted diseases, HIV/AIDS triggered uncontrollable fear of supposed contagiousness resulting in a call for the isolation of PLWHAs around the world. Diseases with disfiguring, debilitating and fatal effects historically fuel severe stigma and systematic discrimination against the patients (Alonzo and Reynolds, 1995; Gilman, 1988). It has had a devastating effect upon PLWHAs' lives and those similarly affected.

In many developing countries, families and communities play crucial roles in supporting and caring for sick members (Warwick *et al.*, 1998; Aggleton and Warwick, 1999; Im-em *et al.*, 2002). However, the AIDS stigma stands as an obstacle to the mobilization of families and communities to support and care for PLWHAs.

As early as 1987, the profound implications of the AIDS stigma were recognized at the international level. Jonathan Mann (1987), arguing that AIDS stigma is as central to the global challenge as the disease itself, referred to the AIDS stigma as "the third epidemic," which follows the epidemic of HIV infection and the subsequent epidemic of AIDS. It refers to all types of unfavorable reactions primarily directed at PLWHAs, ranging from beliefs to policies.

It was not until 2002 that a strategic plan to combat the AIDS stigma materialized: UNAIDS launched the 2002-2003 World AIDS Campaign*:* Live and Let Live. Parker and Aggleton (2003) urge scholars to examine the conceptual adequacy of stigma theories in relation to HIV/AIDS, and to evaluate intervention programs.

Indeed, HIV/AIDS fits the profile that invites a high level of stigmatization. Drawing on Jones et al.'s six conditions which evoke stigma, Herek (1999, p. 1109) summarizes attributes in HIV/AIDS-related stigma: close association with morally reproachable behaviors; the incurable and progressive nature of a disease; lack of understanding of the disease; and the progressively inconceivable symptoms.

First, stigma is often attached to a disease the cause of which is perceived to be the bearer's responsibility. PLWHAs are often blamed for 'inflicting HIV infection on themselves' by voluntarily engaging in behaviors which evoke social disapproval. HIV infection, therefore, "evokes anger and moralism rather than pity or empathy."

Second, HIV/AIDS is progressive and still incurable although it is treatable. Being infectious, HIV/AIDS is commonly misunderstood as 'contagious.' In addition, its fatal consequences arouse a great deal of fear, leading to avoidance of physical contact. Uncontrollable fear appropriates excessive protective measures as is the case with segregation policies which have been implemented in many countries, including Thailand.

Third, HIV/AIDS is a relatively new disease around which a number of controversies have emerged. In the early 1980s, there was considerable speculation regarding the origins of HIV and its transmission route. The ensuing lack of understanding about HIV/AIDS undoubtedly fueled a public desire to take excessive measures to ensure their safety, at drastic cost to PLWHAs' rights.

Fourth, AIDS-related symptoms are progressive and can be disturbing. When HIV infection eventually progresses to the symptomatic stage, PLWHAs can no longer conceal their HIV positive status. Thus, as their condition worsens, it becomes more difficult for PLWHAs to 'pass as normal.'

AIDS stigma can be attached not only to PLWHAs but also by extension to other affected such as PLWHAs' kin, caregivers and social groups closely associated with HIV/AIDS, such as IDUs and CSWs. Apart from the fear of supposed contagion, many have directed moral accusations at PLWHAs, claiming that HIV infection is avoidable or self-inflicted. As a result of the disproportionably high HIV prevalence rates recorded among IDUs, MSMs and CSWs in the early stages of HIV/AIDS epidemics in many countries, HIV infection has been engendered with metaphors of moral breach and punishment (Aggleton, 2000, p. 10).

Nemeroff and Rozin (1994) examine the "moral-germ conflation" as it appears in the discourse on HIV/AIDS. The scientific notion of the germ theory has been superseded by a more instinctive perception of contagion, enhanced by moral perspectives suggesting that the guilt and innocence continuum determines the likelihood of contagion. According to this logic, 'good people' have less possibility of infection than 'bad people.'

The Media and AIDS Stigma

The relationship between AIDS stigma and media reports of HIV/AIDS has been explored by a number of scholars (Lyttleton, 2000; Miller *et al*., 1998; Watney, 1987), who have tried to understand how the AIDS stigma was provoked, and possibly overlapped pre-existing stigmas. At the beginning of the HIV/AIDS epidemic, the American public tried to localize the risk of infection within 'Four Hs': hookers, Haitians, homosexuals and heroin users. Especially MSMs became symbols of AIDS, which was initially referred to as 'GRID (Gay-Related Immune Deficiency)' or 'gay cancer.' These groups were considered as reservoirs of HIV, and were brought to the fore to be targets of intervention in both the official and popular struggle with HIV/AIDS (Lyttleton, 2000, p. 63).

As HIV/AIDS epidemics matured, few were left unaffected. Any thought of separation of the abovementioned groups from the general population soon became obsolete although it dictated popular notions of who were at risk of HIV infection, and how the risk should be managed. The desire to control the epidemic often resulted in the social control of the 'high risk groups,' and denial of the "vulnerability and responsibility of the wider population" (Nelkin *et al.*, 1991, p. 5). Drastic disjunction between the risk groups and others contributed to a widespread indifference to discriminatory actions against PLWHAs and their suffering.

Laws and AIDS Stigma

Gostin and Lazzarini (1997) summarize the problematic legislations: (1) the compulsory screening and testing of groups and individuals; (2) the prohibition of PLWHAs from certain occupations and types of employment; (3) the medical examination, isolation, detention and compulsory treatment of infected persons; (4) limitations on international travel and

migration; and (5) the restriction of certain behaviors such as injecting drug use and prostitution. The AIDS stigma thus appropriated overprotective and stigmatizing measures against PLWHAs, and functioned as a form of social control (Parker and Aggleton, 2003, p. 19). These discriminatory legislations in fact served to foster the creation of a *"*misplaced sense of security among those who do not see themselves as belonging to those sections of the population*"* (Aggleton, 2000, p. 11), and drove those infected, and those most vulnerable, further underground (Gostin and Lazzarini, 1997).

AIDS Stigma in Thailand

The AIDS stigma naturalizes PLWHAs' suffering, and deprives them of dignity, autonomy, and access to eligible resources and opportunities. It causes and sustains various forms of discrimination, ranging from mockery to violence. Although comprehensive studies of the AIDS stigma in Thailand are scarce, anecdotal evidence indicates that the stigma is systematic and persistent. Because of the AIDS stigma, the public remain reluctant to participate in much needed provision of both material and moral support for PLWHAs and their kin. The AIDS stigma stands as a major obstacle to fellow-community members' co-existence with PLWHAs. In addition to acute and chronic symptoms, PLWHAs must deal with a great deal of social and economic pressure.

Despite the existence of widespread AIDS stigma and resultant discrimination in Thai society, they are often treated as a supplementary issue to HIV prevention and care for PLWHAs. Despite renowned success in the reduction of new HIV infections in the 1990s, the latest report estimates that 541,000 Thais of a total population of 65 million are living with HIV, which consists of 1.5 per cent of the entire Thai population (Thai Working Group on HIV/AIDS Projection 2001). Each year 18,200 new infections continue to occur (Thai Working Group on HIV/AIDS Projection, 2001, p. 29). With a steady improvement in the distribution of medical treatment, Thai PLWHAs' survival rate has significantly improved (*AFP*, 2006). Therefore, the AIDS stigma will become a more pressing issue vis-à-vis PLWHAs living more fulfilling lives.

The first case of AIDS was reported in Thailand in 1984, followed by four cases the following year. Three of the afflicted were foreigners, who had been infected abroad. One was a bisexual Thai man, who is believed to have contracted the disease from a foreign tourist (Thongcharoen, 1999, p. 60). In 1988, HIV/AIDS epidemics were confirmed among MSMs and IDUs, which were followed by an epidemic among female CSWs in 1989 (Im-em, 1999, p. 157; VanLandingham et al., 1993, p. 1). As a result, membership of the risk groups was expanded to include IDUs and female CSWs. The Thai public, meanwhile, remained complacent in the knowledge that the implication of HIV/AIDS was limited to those particular risk groups (Lyttleton, 2000, p. 41; Cohen, 1996, p. 328).

In 1989, the Thai government launched its first comprehensive campaign designed to alert the public to HIV/AIDS. Male clients of CSWs were included by anti-HIV/AIDS campaigners as a target group in 1990, as were housewives in 1991. The campaigns were designed to arouse fear in the public's minds to change their behaviors (Phoolcharoen *et al.,* 1999, p. 55).

Information campaigns often showed graphic images of untreated cases of AIDS-related symptoms, emphasizing fatality and absence of cure. Fear of casual contagion led to avoidance of everyday contact with PLWHAs. In time, public health specialists from the MOPH would acknowledge that the early information campaigns created fear and confusion among the public (Phoolcharoen *et al,* 1999, p. 100). Safman (1999*,* p. 3) points out that HIV/AIDS was associated with negative connotations as it was popularly called "*tai mai di*" (a bad death) and being "*sokaprok*" (dirty).

In order to contain the disease, punitive public health measures were taken in the 1980s

and the early 1990s. In May 1985, the government announced the inclusion of HIV/AIDS in its list of notifiable diseases under the Communicable Diseases Control Act "in order to detect PLWHAs and prevent further transmission of the disease" (Ministerial Announcement no. 2; Thongcharoen, 1999, p. 60). In the following year, the Ministry of the Interior included HIV/AIDS in the Immigration Act (979.3) "to prevent HIV infected aliens (excluding aliens who had permanent residency and aliens born in Thailand) from entering the Kingdom and to deport infected aliens from the kingdom" (Ministerial Announcement no.11).

In the late 1980s, the MOPH presented a draft of the so-called AIDS law. According to the draft, the authorities could force PLWHAs and those suspected of being PLWHAs to undergo testing for HIV regardless of their will to comply. Again, according to the draft, the movements of the PLWHAs would be restricted, and those who chose not to cooperate with the authorities could be detained at rehabilitation centers for up to 180 days at a time on the order of the provincial governor. At the end of August 1990, the cabinet approved the spending of 139 million baht (5.5 million dollars at that time) to build the first center in the Upper-Northern province of Lampang (*Economist,* 1990, p. 44). However, due to mounting criticism from both international and domestic AIDS activists, this law was cancelled two years later (Thongcharoen, 1999, p. 60).

At the social level, the AIDS stigma manifested itself in the form of the above mentioned discriminatory legislation in the name of protecting the Thai society from HIV/AIDS. However, after the early 1990s, the legal approach to containing HIV/AIDS was replaced with the preventative approach, which aimed to educate the public and reduce HIV infections. However, in Thailand, mandatory HIV testing is still conducted in some areas of the Thai society. For example, a person applies for a job for Buddhist ordination, and for school entrance, with or without the consent of those who are tested (AIDS NGO Coalition, 1998, p. 6). Test results are sometimes reported to their employers or heads of communities, and this can result in devastating consequences for those involved.

At the individual level, the AIDS stigma has been experienced in various ways. It is reported to be systematic but indirect, such as lack of social interaction and indifference to PLWHAs' suffering. During the 1990s, discrimination against PLWHAs was so intense that the hitherto unthinkable happened. There were a number of anecdotal cases suggesting that medical professionals refused to treat PLWHAs and that their families had abandoned them (Renard *et al.*, 2001). PLWHAs were feared even after their deaths: Buddhist monks refused to pray for them at their funerals (Sae Tang, 1993, cited in Udomithiphong). Because PLWHAs were excluded from social services and support, their condition worsened rapidly. Premature deaths and suicides were common among PLWHAs during the 1980s and 1990s (*Bangkok Post*, 1996). However, social issues, such as AIDS stigma, were treated as additional issues at state policy level, with the majority of resources being allocated to medical experiments and information campaigns for prevention.

Although social aspects of the HIV/AIDS epidemic were first recognized at the highest level of the state administrative bodies in 1992, there was no specific policy against AIDS stigma at the national level. In 2002, the national campaign was finally implemented by the MOPH in response to the UNAIDS's 2002-2004 campaign "Live and Let Live." This campaign contributed to raising public awareness of AIDS stigma. However, the AIDS stigma continues to be a cursory issue in Thai state policy.

One of the most extreme cases was the closure of the AIDS hospice in Nonthaburi province in 1996. The hospice, which had received threats from its neighbors, was eventually forced to discontinue its service of providing temporary shelter for PLWHAs after it was the target of bomb attacks (*Bangkok Post*, 1996).

The AIDS stigma deprives PLWHAs not only of their dignity but also of their autonomy and access to eligible resources and opportunities. PLWHAs are likely to hide themselves and

become inaccessible by campaigners, who only seek to offer essential information and services (e.g. testing, treatment, free condoms or needle exchange). According to a number of writers on the HIV/AIDS epidemic in Thailand, the majority of PLWHAs reported that they had avoided being tested for HIV due to fear of rejection (World Bank, 2000, p. 24-25). They became aware of their seropositivity only after their health conditions deteriorated. The delay in treatment accelerated the deterioration of their physical and mental condition. Inevitably, PLWHAs died prematurely from treatable opportunistic infections. If PLWHAs fail to take preventative measures, they risk fellow-community members' lives. Thus, the AIDS stigma damages any efforts to stem the tide of the HIV/AIDS epidemic, and contributes to its further spread. The AIDS stigma is the crucial factor that influences the possibility of taking an HIV test and the application of preventative measures against HIV infection.

The AIDS stigma poses a serious challenge to public mobilization in that the public remains less sympathetic and reluctant to participate in much needed provision of both material and moral support for those affected. For the PLWHA community-based group, AIDS stigma stands as a major obstacle to the acceptance of PLWHAs (Phongphit, 1999). It prevents families, who are considered as primary caregivers for the sick in Thai society, from supporting and caring for HIV positive members.

Discrimination, however, is not limited to PLWHAs. It affects their primary caregivers, most of whom are family members. Cha-on Suesern, the first Thai to publicly disclose his HIV status, was fired after his employer discovered his seropositivity (*Thairath,* 1989). Cha-on contracted HIV in 1986 through a blood transfusion. His three sons were also fired from their jobs. His family could not find any place to stay because nobody was willing to rent out accommodation to them (*Nation*, 1991, p.2). The principle of voluntary, anonymous, confidential counselling and testing has later been established.

AIDS Stigma Management in Upper-Northern Thailand

In Upper-Northern Thailand, village communities have proved effective in minimizing the effects of the AIDS stigma as well as provision of care for PLWHAs. The communities are portrayed as a social space wherein PLWHAs and non-PLWHAs can live together in harmony (Phongphit, 1999, p. 263). Duongsaa et al. (2001, p. 8) portrays the community-based movement in relation to a broader political movement in Thai society, i.e., "*pracha tambon*" (civil society at the sub-district level):

Community, it argues, should be a social/moral space wherein rights of the citizens, including PLWHAs, are legally protected while it is still characterised with a strong sense of solidarity. Pracha tambon movement is aimed at empowering Thai citizens through decentralization of the government and their participation in policy-making and administration.

Thai academics and NGOs supported this approach (as a later addition of the Thai government). They envisioned that rural village communities could achieve "immunity" to HIV/AIDS and other social problems (Wasi, 1999, p. iii).

Conclusion

Stigma adversely affects people's well-being as more than half a century of the research suggests. In the past, stigma had been regarded as a minor issue in the field of health communication. However, healthcare practitioners and researchers have now understood the grave impact to both public health and the management of healthcare services.

After Goffman's seminal research, the following generations of scholars have expanded the scope of stigma related research beyond the micro-interactions between the stigmatized

and the normal. Goffman's stigma research focuses on the stigmatized individuals' micro-management of their identities. As Gussow and Tracy's study on institutionalized leprosy patients, and the Thai language literature of PLWHA movements illustrates, the collective management proved to be effective in reducing stigma.

Stigma is a universal phenomenon that permeates the national and cultural boundaries. As Predaswat's study on leprosy related stigma in Thailand, and Isarangkura Na Ayutahya's study on PLWHA in Northern Thailand suggest, the expressions of stigma vary from culture to culture. In Thai society, stigma may be expressed in subtle but locally significant ways. In order to understand how stigma is expressed and managed in a given cultural context, an ethnographical study may be effective.

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