STIGMA AND SUFFERING:
A THEOLOGICAL REFLECTION WITHIN THE HIV/AIDS PANDEMIC FROM THE PERSPECTIVE OF A *THEOLOGIA RESURRECTIONIS*

by

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DECLARATION

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ABSTRACT

Stigma is a social-identity devaluation due to a characteristic mark or feature. It imposes a discredited status, resulting in personal/social rejection and suffering. As a psychosocial construction, stigma reflects a systemic influence, as determined by the history and characteristics of the individual's psychological and social environment.

This study explores the nature, variations, development, functions, processes, and justification of stigma and stigmatisation. It reflects on the experiential context of HIV/AIDS stigma/stigmatisation from the perspective of both the stigmatiser and stigmatised. Accounting for HIV/AIDS stigma are factors such as concealability, the unpredictability of infection, its terminal nature, and visible manifestations. The result is the multi-faceted suffering of internalised and external stigma, manifested by the prejudice, rejection, ostracism, discrimination, and condemnation of people infected and affected by HIV/AIDS.

An assessment of HIV/AIDS destigmatisation found that it represents a recent development in the struggle against the pandemic. Destigmatisation interventions have been mostly ineffective because they lack a systems approach. Destigmatisation interventions must be developed with cognisance of the societal context, cultural impediments, major causes and problems of the pandemic.

It was argued and concluded that theology can play a major role in combating HIV/AIDS stigma and stigmatisation. Scripture provides both knowledge and existential direction to inform HIV/AIDS destigmatisation. Stigmatisation is sin because it robs the human being - as created in the image of God, reconciled, and redeemed through the cross and resurrection - from his God-endowed dignity and worth. A theology of HIV/AIDS, including a theology of affirmation and an inhabitational theology, is required to adequately address HIV/AIDS stigmatisation and destigmatisation. A theology of affirmation is appropriate because it confirms the eschatological ontology of the human being as a new creation, with a new, stigma-freed identity and status. An inhabitational theology reflects triumph over stigma through the empowerment of the indwelling Spirit. It was concluded that both a theology of the cross (reflecting the passion and compassion

of God) and a theology of the resurrection is needed. A theology of the cross reveals our human condition of sin, guilt and guilt feelings, but also God's grace, our salvation, forgiveness and reconciliation. A *theologia resurrectionis* emphasises the power of God over sin, results in the transformation of the believer, which enables empowerment through the Spirit - who infuses the believer with courage, meaning, purpose, dignity and self-worth. Stigmatisation has made way for self-worth, victory, and charisma.

The study concluded that the church has a major role to play in the destigmatisation of HIV/AIDS stigma. The church should contribute to the deconstruction of power and counter systemic injustices. Its should follow a holistic, systems approach, involving the proclamation of a theology of life, practicing pastoral care, participate in the *missio Dei*, and exhibiting a normative basis regarding destigmatisation interventions - especially with regard to marriage, gender and sex education. It should fulfil its calling of service, participate in the home-based care of the HIV/AIDS infected and affected (including children), and demonstrate the resurrection identity of hope and empowerment, as enabled by the Holy Spirit.

OPSOMMING

Stigma is 'n sosiale-identiteits devaluering, gebaseer op 'n karakteristieke merk of eienskap. Dit bring oneer mee wat persoonlike en sosiale verwerping veroorsaak, met gepaardgaande lyding. Stigma as 'n psigies-sosiale konstruksie word bepaal deur die geskiedenis en eienskappe van 'n persoon se sielkundige en sosiale omgewing.

Hierdie studie ondersoek die aard, variasies, ontwikkeling, funksionering, proses, en regverdiging van stigma en stigmatisering. Dit ondersoek die eksperiënsiële konteks van MIV/VIGS stigma/stigmatisering vanuit die perspektief van beide die stigmatiseerder en gestigmatiseerde. Daar word gewys op verdoeselbaarheid, die onvoorspelbaarheid van infeksie, die terminale aard, en sigbare manifestasies as oorsake van MIV/VIGS stigma.
Die gevolg is die veelvoudige lyding van geïnternaliseerde en uitwendige stigma, soos geopenbaar deur die vooroordeel, verwerping, diskriminasie, en veroordeling van diegene wat deur MIV/VIGS geïnfekteer en geaffekteer is.

'n Evaluering van MIV/VIGS destigmatisering het aan die lig gebring dat dit 'n onlangse ontwikkeling is in die stryd teen die pandemie. Destigmatiserings intervensies is meestal oneffektief omrede die afwesigheid van 'n sistemiese benadering. Destigmatiserings intervensie moet ontwikkel word wat rekening hou met die sosiale konteks, kulturele hindernisse, en die vernaamste oorsake en probleme van die pandemie.

Daar is tot die slotsom gekom dat teologie 'n belangrike rol kan speel in die bekamping van MIV/VIGS stigma en stigmatisering. Stigmatisering is sonde omdat dit die mens - wat in die beeld van God geskape is, versoen deur die kruis en opstanding - ontneem van sy God-gegewe waardigheid en waarde. 'n Teologie van MIV/VIGS - wat 'n teologie van bevestiging (affirmation) en beliggaaming (inhabitational theology) insluit - word vereis om MIV/VIGS stigmatisering en destigmatisering aan te spreek. 'n Teologie van bevestiging onderstreep die eskatologiese ontologie van die mens as 'n nuwe skepping met 'n nuwe, stigma-vrye identiteit en status. 'n Teologie van beliggaaming dui op die oorwinning oor stigma deur die werking van die Gees. Beide 'n teologie van die kruis en opstanding word benodig om die pandemie aan te spreek. 'n Teologie van die kruis weerspieël die menslike lot van sonde, skuld en skuldgevoelens, én God se genade,

verlossing, vergifnis en versoening. 'n *Theologia resurrectionis* beklemtoon die mag van God oor sonde, die gevolglike transformasie van die gelowige, soos bekragtig deur die Gees - waardeur die gelowige bemoedig word en sin, doel, waardigheid en eiewaarde verkry. Stigmatisering het dus plek gemaak vir eiewaarde, oorwinning en *charisma.*

Die studie het tot die gevolgtrekking gekom dat die kerk 'n vername rol kan speel in die destigmatisering van MIV/VIGS. Die kerk moet bydra tot die dekonstruksie van mag en sistemiese ongeregtigheid teenstaan. Dit behoort 'n holistiese, sistemiese benadering te volg wat die verkondiging van 'n teologie van lewe, pastorale sorg, deelname in die *missio Dei*, en 'n normatiewe grondslag t.o.v. die huwelik, geslag en seks onderrig behels. Die kerk moet sy roeping tot diens vervul, deelneem aan tuissorg van MIV positiewe persone en familie, en die opstandingsidentiteit van hoop en bemagtiging - soos deur die Gees bewerkstellig - demonstreer.

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CHAPTER 1

INTRODUCTION

1. BACKGROUND

This study originated from the context of post-apartheid South Africa. It is an effort to reflect theologically on stigma, stigma-related suffering, and destigmatisation, in the context of the HIV pandemic, against the background of massive unemployment, widespread poverty, and the pervasive and alarming incidence of violence and crime.

Since the HI virus was first detected in human beings in 1981, AIDS has claimed the lives of an estimated twenty five million people worldwide (UNAIDS, 2008:31). Over 14 million children have been left orphans, every day more than 14,000 new HIV infections occur and more than 8,000 people die - the greater majority in the two-thirds world (UNAIDS, cited by ERT, 2005: 131). More than two-thirds of these infections and deaths are in sub-Saharan Africa, with some of the highest infections rates found in Southern Africa. About 2% of the world population resides in Southern Africa, yet it contains more than 30% of the world's PLHA (*people/person living with HIV/AIDS*)(Van Dyk, 2005:7). HIV incidence in Africa varies between 1% (Mauritania) and more than 40% (Botswana and Swaziland), with areas in South Africa exceeding 30% (Van Dyk, 2005:7).

The sheer magnitude of this health catastrophe moved Tomkins (cited by ERT, 2005) to declare that:

> The global HIV epidemic is the greatest threat to health, family life and economic survival that the world has ever known (2005:132).

Connor & Klingman's assessment (cited by Van Wyngaard, 2006) reflect the disease's resistance to epidemiological efforts to retard its advance:

> We could not have designed a more frightening disease if we had tried. If we could play at being Satan for the day, charged with the task of designating an epidemic to undermine both the developed and underdeveloped countries of the world . . . then the blueprint for the design would incorporate many of the features of AIDS. (2006:265).

The prevalence of stigma in the HIV/AIDS context has propelled this phenomenon to the forefront of the struggle against the pandemic. Peter Piot, the executive director of UNAIDS, - in an address to the agency's Programme Coordinating Board in December 2000 - identified "a renewed effort to combat stigma" as the number one challenge of the five "most pressing items on this agenda for the world community" (Piot, cited by Parker and Aggleton, 2003:14). Reflecting the urgency of Piot's assessment, the theme for the 2002-3 World AIDS Campaign was HIV and AIDS-related stigma and discrimination,

> "highlighting the continuing pertinence of these concerns both conceptually and programmatically" (Parker & Aggleton, 2003:14).

A UNAIDS-supported Theological Workshop Focusing on HIV negative and Aids-related stigma (2005) states that:

> . . . the most powerful obstacle to effective prevention, treatment and care is proving to be the stigmatization of people living with HIV and AIDS (UNAIDS, 2005).

Enjoining this assessment, Ackermann (2005) states that:

> "The complexity of the Human Immunodeficiency Virus (HIV) pales in comparison to the complexity of the social forces involved in the production and reproduction of stigma in relation to HIV and Aids" (2005:385-95).

Stigma is not only related to the HIV/AIDS pandemic in the current South African context. As represented by the apartheid era - when the majority of the population was stigmatised in various ways as inferior - stigmatisation is a major characteristic of South African history (Ackermann, 2005:389-90). Because of apartheid, the advent of democracy resulted in reverse stigmatisation: the South African white population now lives under the stigma-shadow of past racial injustice and discrimination. Since stigma is a common phenomenon in South Africa, it features as one of the major challenges of the post-apartheid era.

Theology played an important role in the development and justification of apartheid and as such was a major determinant in the development of racial stigma. However, theology is not only linked to the racial stigmatisation of the past, but also to the stigmatisation of HIV/AIDS through its initial reflection on the causes of the pandemic (Hoffman and Grenz, cited by Louw, 2006:101). By assessing that the pandemic reflects God's

punishment, theology not only contributed to the stigmatisation of HIV/AIDS, it also became stigmatised and discredited. It is thus imperative that theology in South Africa strives to be part of the challenge to engage constructively the search for constructive approaches to the pandemic. Through such an effort, theology can engage the task of destigmatisation - of itself as an academic discipline, and of the HIV/AIDS pandemic.

The hope is that a theological exploration will contribute to a better understanding of stigma, the relationship between stigma and suffering and, in particular, HIV/AIDS stigma and suffering. The study also aims to develop a theologically-informed destigmatisation agenda that the church can employ to reduce HIV/AIDS-related suffering.

2. LITERATURE REVIEW

The researcher will first briefly review the fields of research and scholarly interest closest related to the topic of research, that of a *social-psychological* study of stigma, and a *theological reflection* on stigma, stigma-related suffering, and HIV/AIDS-related stigma and suffering.

Stigma is a topic of interest to various scientific fields, e.g. social psychology, sociology, and anthropology. It is a psycho-social phenomenon: human beings notice differences among fellow human beings and then proceed to make certain devaluing character inferences based on the perceived differences. The study of stigma has located various types of stigma (the devaluating "marks"), and indications of how it originates, develops, varies, functions, and how it is justified (Heatherton, Kleck, Hebl, & Hull; [2000] 2003; Abram, Hogg & Marques, 2005; Stangor, 2000; and Schneider, 2004). Social psychology has also looked at responses to stigma and the process of stigmatisation, which includes the dimension of suffering (Heatherton et. al., [2000] 2003; Abram, Hogg & Marques, 2005). A literature review has found an extensive body of research on stigma as a psycho-social phenomenon, allowing one to reflect theologically on this research.

Theological research and literature on the topic of *suffering* abounds (cp. Hall, 1986, 2003; Thornton, 2002; Inbody, 1997; Louw, 2000; Depoortere, 1995; Gerstenberger & Schrage, 1977). The body of literature on suffering represents various points of view on

the origin and purposes of suffering. In general, it links suffering to various assessments of the nature of God and evil, the theodicy question, and an assessment of suffering in the light of the Scriptures. The issue of suffering is inherently an issue of theology, as Luther's theology of the cross and the long history of the issue of theodicy indicates. The issue of suffering can be traced back tot the wisdom literature of the Old Testament.

Whereas research and literature on *theology and suffering* abounds, a theological perspective on *stigma*, and the *relationship between suffering and stigma,* has mostly eluded scholarly interest here in South Africa. Theological literature on *stigma, or stigma-related suffering*, refers to the context of HIV/AIDS and poverty (Clifford, 2004; UNAIDS, 2005; van Wyngaard, 2005; Ackermann, 2005, Louw, 2006, 2008) as part of a more encompassing theological view on the pandemic, e.g. as part of a theology of HIV/AIDS (Wyngaard, 2005; Conradie, 2004; Ndungane, 2004).

A literature search found a few efforts on a *theology of HIV/AIDS (*Marshall, 2005; Conradie, 2004; Clifford, 2004; UNAIDS, 2005; Van Wyngaard, 2005). T*heology of HIV/AIDS* studies endeavour to view the pandemic from a comprehensive theological position. In some cases these efforts include references to stigma or suffering or both (Ackermann, 2005; Clifford, 2004; van Wyngaard, 2005; and Conradie, 2004).

Theological reflection on HIV/AIDS-related stigma varies in terms of their scope. There are a few articles that only address this concern, e.g. the UNAIDS Theological Workshop on HIV/AIDS-related stigma (UNAIDS, 2005; Clifford, 2004; Ackermann, 2005). There are various scholarly articles on the *role of the church in terms of HIV/AIDS*, with some articles referring to HIV/AIDS-related stigma (Hood, 2006; Krakauer and Newbery, 2007).

Efforts to locate scholarly work on a *theological perspective on HIV/AIDS-related stigma and suffering* were, with the exception of one article, unrewarded. The only closely related theological study on stigma, within the domain of HIV/AIDS, is an article by Louw (2006:100-114), entitled "The HIV pandemic from the perspective of a *theologia resurrectionis*: resurrection hope as a theological critique on the punishment and stigma paradigm".

In conclusion, the theological investigation of the phenomenon of *suffering* abounds, and some attention has been given to a *theology of HIV/AIDS*. However, theological investigations of *stigma* and the *relationship between stigma and suffering* is limited, and theological exploration of the relationship *between HIV/AIDS-related stigma and suffering* is almost non-existent.

The study topic relates to these areas of scholarly concern. The topic involves various dimensions: (1) a social-psychological assessment of stigma and stigma-related suffering, (2) HIV/AIDS-related stigma and the resulting suffering, (3) a theological reflection on stigma and stigma-related suffering, (4) a socio-psychological and theological assessment of destigmatisation, and (5) the role of the church in terms of HIV/AIDS destigmatisation.

The lack of an appropriate theological perspective on stigma, stigma-related suffering, and the relationship between theology and HIV/AIDS-related stigma and suffering, has steered this study in an exploratory direction that will, hopefully, create some significant questions, answers, and avenues for further investigation.

3. RESEARCH OBJECTIVES

The research objectives are to (1) provide a theological perspective on stigma and suffering in the context of HIV/AIDS and, (2) to develop a theologically-informed destigmatisation agenda for church participation in HIV/AIDS destigmatisation.

As starting point, the researcher will delineate what is "stigma". What is *stigma,* how does it develop, varies, functions, and how is it justified? What is the nature of HIV/AIDS stigma and stigmatisation from the perspective of the stigmatiser and the stigmatised, and how does stigmatisation take place? Secondly, what is the nature of stigma-related suffering? How does HIV/AIDS stigmatisation result in suffering, and what is the character of such suffering?

Finally, what entails a theological approach to stigma and destigmatisation intervention? In general, within the theological debate, the phenomenon of stigma is connected to the cross (the suffering of Christ and his stigmata). The question at stake is whether such an

approach suffices? Is the connection between sin/punishment and the cross not so close so that the issue of judgement immediately surfaces? Should destigmatisation in theology not depart from the resurrection than merely from the cross? Is an emphasis on a *theologia resurrectionis* a possible solution to those experiencing HIV/AIDS stigmatisation and its suffering? How can the church contribute to destigmatisation interventions?

The researcher will apply theology's hermeneutic (interpretation) model to investigate the phenomena of stigma and suffering. The theological, hermeneutical paradigm is in essence:

> "an experiential structure which transcends the theoretical and methodological truth of the formal sciences" (Louw, 1998:14).

This statement is founded on the assumption that understanding is a basic characteristic of being human. Louw (1998:16) points out that theology sets out to discover - a discovery of understanding. A theological-hermeneutical perspective occurs against the background of faith, and involves reciprocity between faith and reason. It is:

> "a conceptual and systematized process of understanding in the light of the content of the Christian faith" (Louw, 1998:18).

A theological interpretation involves an interpretation of the message of the Gospel in terms of the human context, in order to contribute to life as a meaningful and qualitative endeavour (Louw, 2000:1). The researcher therefore approaches this research project from a theological-hermeneutical point of view. This paradigm means that the researcher will critically reflect on, and analyse, the units of analysis, based on an understanding and interpretation that is informed by theology.

The research objective is both descriptive and exploratory. On the one hand - through a literature study - the researcher will describe scholarly positions on stigma and suffering, HIV/AIDS stigma and stigma-related suffering, and scholarly views on destigmatisation. However, due to the largely uncharted territory of a theological reflection on the relationship between stigma and suffering, HIV/AIDS stigma, and destigmatisation, this research project will be exploratory.

4. RESEARCH DESIGN

4.1 Conceptualisation

The important constructs in this proposed study are stigma, stigma-related suffering, HIV/AIDS, theology, *theologia resurrectionis*, and destigmatisation.

Stigma refers to "a mark of disgrace associated with a particular circumstance, quality or person" (South African Concise Oxford Dictionary, 1999 & 2002). Heatherton et al. [2000] (2000:3) defines stigma as "a social construction that involves at least two fundamental components: (1) the recognition of difference based on some distinguishing characteristic, or 'mark'; and (2) a consequent devaluation of the person".

Suffering is an experience of something that is perceived as painful or unpleasant (South African Concise Oxford Dictionary, 1999 & 2002). In defining suffering as a "complex, multi-faceted issue", Louw (1998:9-12) distinguishes between various aspects of the concept of suffering. It is a universal phenomenon, involving a cosmic-, cultural-, structural-, physiological/biological-, psychological-, existential- and religious dimension. This research project will assess this concept from a socio-psychological and theological point of view.

Theology/theological represents the epistemological and hermeneutical view of the study topic. This view occurs against the background of faith, and involves reciprocity between faith and reason. It is "a conceptual and systematized process of understanding in the light of the content of the Christian faith"(Louw, 1998:18). *Theological* is a co-determining concept - with the concept of theology - of the theoretical and interpretative position from which this research projects is approached and executed. *Theological* denotes an interpretation of the message of the Gospel in terms of the human context, in order to contribute to life as a meaningful and qualitative endeavour (Louw, 2000:1).

Theologia resurrectionis, a theology of the resurrection, is an understanding of the human identity in the light of the resurrection of Christ. As such, it views the human being as

recipients of the hope of the victory of Christ over death, suffering, and stigmatisation (Louw, 2006:104).

HIV is an acronym for the human immunodeficiency virus. *Immuno* refers to immunity, the body's immune system, which defends it against foreign substances that enters the body. The Merriam-Webster's Dictionary (Merriam-Webster, 1996, c1993) defines HIV as "any of a group of retroviruses and especially HIV-1 that infect and destroy helper T cells of the immune system, causing the marked reduction in their numbers that is diagnostic of AIDS".

AIDS refers to the later stages of HIV infection. It is an acronym for *A*cquired *I*mmune *D*eficiency *S*yndrome. "Acquired" indicates the opposite of "inherited", and "Deficiency" indicates an immune system that has been compromised so that it cannot optimally defend the body against infections. "Syndrome" is a "medical term for a collection of specific signs and symptoms that occur together and that are characteristic of a particular condition" (Van Dyk, 2005:3).

Destigmatisation refers to various interventions to counters the stigmatisation of PLHA. These interventions are mostly developed and executed by government agencies, as informed by socio-psychological research findings. For the purposes of this study, such interventions include all efforts to stem the tide of stigmatisation and HIV/AIDS-related stigmatisation.

4.2 Research Design and Methodology

The researcher conducted a literature study to execute this research project within the qualitative research paradigm. Babbie and Mouton (2001:646) define qualitative research as:

> "the non-numerical examination and interpretation of observations for the purpose of discovering the underlying meanings and patterns of relationships".

According to Mason (1996:4) qualitative research lends itself to an hermeneutic approach since it deals with interpretations of the functioning of the social world. Louw (1998:5) states that qualitative research is more inductive and less deductive, and include

hermeneutics through which texts are analyzed, as well as "the role of prejudices, and previous horizons of understanding" (Louw, 1998:5).

Secondary data (documents, texts, books) will be analyzed to reflect on the research questions/objectives. The mode of reasoning will be predominantly hermeneutical, to critically reflect and analyse texts - to advance from an investigation of texts to an understanding of concepts and relationships between concepts. The researcher will also employ deductive reasoning to make conclusions regarding HIV/AIDS from a theological-normative framework.

The units of analysis will be references to stigma and stigma-related suffering within social-psychological and theological contexts - within and outside the context of HIV/AIDS - located in social-psychological and theological sources, as mentioned above.

It is necessary to acknowledge the foreseen limitations of this study. To a large extend the researcher aims to explore, organize and integrate the existing literature on the above research elements, and to arrive at interpretive insights. Such insights need to be subjected to further research, and can only be regarded as exploratory and indicative of future research possibilities.

4.3 Data collection and Analysis

The data for this study will consist of references to stigma, stigma-, and HIV/AIDS-related suffering, and HIV/AIDS stigma-related destigmatisation interventions - within the scholarly disciplines of social psychology, HIV/AIDS research, and theology - within and outside of the context of HIV/AIDS. Such references in scholarly articles, books, and theses were located. The researcher searched electronically for such references in articles, and supplemented the search results with a library catalogue search to locate hard copy articles and books in the local theology and general university libraries. Such a catalogue search for books were done according to the search key-words "stigma", "suffering", "HIV/AIDS".

An electronic search was conducted to locate appropriate sources through various key-word search combinations in various social sciences databases i.e. theology+suffering; theology+stigma; theology+stigma+HIV/AIDS; stigma+HIV/AIDS; and theology+stigma+church+HIV/AIDS.

It must be acknowledged that the process of data collection and analysis will be subjective, thus limited by the researcher's biases and limitations (Louw, 1998:4). All the sources will be read and categorized according to certain categories, e.g. "stigma", "suffering", "stigma-related suffering", "the social psychology of stigma", "HIV/AIDS-related stigma", HIV/AIDS stigma and related suffering" "theology and stigma-related suffering", "theology and stigma", "HIV/AIDS destigmatisation", and "HIV/AIDS destigmatisation and the church".

In processing the data, the researcher will be guided by the research objectives. It will act as measuring and analysis criteria, functioning to both delineate and categorise the sources, as well as setting the interpretation parameters. These measures will help to systematise the research process and arrive at conclusions.

The research process is hermeneutical, and as such will serve to report on the exploratory and descriptive dimensions of the study. The analysis will endeavour to describe and integrate the current scholarly body of research regarding the research topic, which is in accordance to Louw's criterion (1998:11): that logic should determine - through content and critical analysis - acceptable conclusions.

4.4 Operationalisation

Operationalisation deals with the measurement techniques used to measure the variables or concepts. It is what links the research problem to phenomena to be studied. The researcher discussed and elaborated on the research problems through various questions/objectives. These questions/objectives will function as operationalising devices to delineate the research scope. The researcher will limit himself to the above research questions/objectives as the guidelines for the literature study and theological-theological hermeneutic.

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CHAPTER 2

THE PHENOMENON OF STIGMA: A DESCRIPTIVE PERSPECTIVE

One of the major concerns of this study is the phenomena of stigma and stigma-related suffering. First, the concept of "stigma". What is the nature of stigma, how does it vary, and how does it develop? What are the individual and social functions of stigma and stigmatisation, how does it develop as a process, and how is it justified?

This chapter will consist of three parts. Part one (sections 1-6) will reflect the social psychology literature on stigma and stigmatisation. Part two (sections 7-7.2) will be a review of the HIV/AIDS stigma and stigmatisation literature, and part three (section 7.3) will be a comparison between these two scientific fields.

1. THE NATURE OF STIGMA

Stigma is a social construction and not a personal idiosyncrasy (Dovidio, Major & Crocker, [2000] 2003:3). It is the result of a social identity devaluation of a person (the *stigmatised*) by other persons (the *stigmatisers*), due to some distinguishing feature or "mark" of the stigmatised. This difference between the stigmatised and the stigmatiser is one of two fundamental aspects of stigma (Dovidio et al [2000] 2003:3). The second aspect is the resulting devaluation of the stigmatised person.

Major and Eccleston (2005:64) define stigma as "a mark or sign of disgrace or discredit". This "mark or sign" represents a deviation from the social norm, which indicates some discrediting dispositions (Jones et al., cited by Major & Eccleston, 2005: 64). This mark can be *physical* (e.g. disfigurement, dismemberment, paralysis, racial features, gender or age), or it can be some character manifestation (e.g. homosexuality, criminality). The Greeks physically branded a criminal or traitor to openly display his/her devalued status. These marks were called "stigmas". In our times, stigmatisation is a psychological process through which individuals are cognitively branded to indicate that the identified deficiencies ("marks") are so discrediting that it negates other characteristics of the individual (Neuberg, Smith & Asher, [2000] 2003:31). The authors note that individuals

can also be positively assessed (e.g. a hero), attributing added value and an enhanced identity, which is the opposite of stigmatisation (Neuberg et al [2000] 2003:31). Such "positive stigmatisation" thus indicates more of a stereotypical response.

Because stigma is inherently a social phenomenon it varies across time and context, and with regard to the psychological effects of stigmatisation (Dovidio et al [2000] 2003:3). Stigma is therefore the product of history and culture. It is an interpersonal and social process, where the individual-, social- and situational context of the stigmatiser and stigmatised plays a determining role, impacting on stigmatiser-stigmatised interaction, and its personal- and social affective, cognitive and behavioural effects (Dovidio et al [2000] 2003:3).

Reactions to stigmatised individuals differ in intensity and quality, from dissociation (cognitive, affective and behavioural) to hate, and even genocide. Such feelings may be ambivalent (combining sympathy with unease) although it usually involves disdain and avoidance (Neuberg et al [2000] 2003:32). A stigmatising definition of an individual includes a devaluation that is in accordance with the stigmatising label (Crocker, Major & Steele, cited by Neuberg et al [2000] 2003:31). Schneider (2004:474) define stigma as:

> "an attribute or characteristic that convey a social identity that is devalued in a particular context".

He adds that the greater majority of people in a particular society or culture share this devaluation (Schneider, 2004:474). What really accounts for the negativity of stigmatisation is not so much the physical ramifications of the stigma but its psychological and social effects (Biernat & Dovidio, [2000] 2003:88).

There are a variety of stigmatised groups in Western society, including alcoholics, the blind, those diagnosed with cancer, the physically scarred and disabled, homosexuals, the obese, stutterers, and females (Hebl et al [2000] 2003:276-77). Because stigmatised individuals are ostracised, they are often found in positions of low status and social power.

1.1 Stigma and societal-systems factors

Parker and Aggleton (2003) argue that:

> Stigma plays a key role in producing and reproducing relations of power and control. It causes some groups to be devalued and others to feel that they are superior in some way. Ultimately, therefore, stigma is linked to the workings of *social inequality* (sic) and to properly understand issues of stigmatization and discrimination, whether in relation to HIV and AIDS or any other issue, requires us to think more broadly about how some individuals and groups come to be socially excluded, and about the forces that create and reinforce exclusion in different settings (2003:16).

Paterson (UNAIDS, 2005:39) states that stigma relates directly to social, economic and political power:

> . . . it was the power of the white apartheid state that allowed the systemic stigmatisation and discrimination suffered by black South African." (UNAIDS, 2005:39).

Paterson relates Link & Phelan's illustration (UNAIDS, 2005:39) of mental patients that label their staff according to their behaviour. The patients may stigmatise their staff in various ways, representing every component of stigma in the process, yet the staff would not become a stigmatised group, simply because the patients do not have the power to relate their "stigmatisation" to discriminatory action or to broader societal participation:

> Consider further that scenarios similar to the one just described exists for all sorts of circumstances in which relatively powerless groups create labels and stereotypes about more powerful groups and treat members of the more powerful group in accordance with these stereotypes. This clarifies why the definition of stigma must involve reference to power differences . . . Stigma is dependent on power (Link & Phelan, cited by UNAIDS, 2005:39).

The relationship between power and social inequality involves the dynamic of historical forces (Ackermann, 2005:389). In the South African context this necessitates accounting for the prominent role that apartheid has played in the history of stigmatisation in South Africa. To counter the "total onslaught" and ensure survival, the black majority was

stigmatised as the "swart gevaar" (black danger), and denigrated and devalued in various ways to justify and legitimise their multifaceted and multilevel subjugation. The South African context is therefore an excellent case study of the development and reinforcement of social inequality through stigma and stigmatisation (Ackermann, 2005:389).

1.2 Stigma and other forms of personal devaluation

1.2.1 STIGMA AND DEVIANCE

Stigma can be similar to, or different from, other forms of personal devaluation, e.g. deviance, ostracism, prejudice, and stereotyping. Stigma is similar to the concept of "marginality" or "deviance", yet also distinctive (Dovidio et al [2000] 2003: 4). Deviance is:

> "a perceived behaviour or condition that is thought to involve an undesirable departure in a compelling way from a putative standard" (Archer, as cited by Dovidio et al [2000] 2003:4).

Numerical appearance does not affect stigma, whereas deviance is affected. As an example, Archer (cited by Major & Eccleston, 2005:65) refers to the phenomenon of premarital sex, which was contrary to seventeenth century norms, but became accepted in the eighteen century. Numerical presence does not affect stigma as, for example, the stigmatisation of obesity indicates (Major & Eccleston, 2005:65).

Both Dovidio et al [2000] (2003:4) and Major & Eccleston (2005:65) point out that deviance can be the result of positive factors (e.g. superior intellectual capacity), whereas stigma is always a negative departure from the accepted societal norm. This departure is quite severe, resulting in people been seen as less than human (Goffman, cited by Major & Eccleston, 2005:65). Furthermore, deviance as a negative phenomenon may not include stigmatisation if it does not involve some measure of personal devaluation. Stigma thus includes, but also exceeds deviance.

1.2.2 STIGMA AND PREJUDICE

Stigma invariably involves *prejudice*. Prejudice is a negative, biased and erroneous generalisation about a group of individuals (Dovidio et al [2000] 2003:4). Stigma involves prejudice because it is based on societal norms and ideologies about group worth and identity. As is the case with deviance and low social status, stigma includes, yet exceeds, prejudice.

In their chapter, "Stigma and social exclusion", Major & Eccleston (2005:63-87) identify exclusion as a characteristic of stigma. This relationship is so fundamental that social exclusion measurements are used to reveal stigma-based prejudice. The authors state that stigma-based exclusion differs from other forms of social exclusion such as non-stigmatised rejection. It is, in the first place, consensual, based upon socio-cultural consent, rather than idiosyncratic attitudes. Stigmatised persons will thus be more socially excluded than other rejected individuals (e.g. the very wealthy by the lower social classes of society). Secondly, stigma-based exclusion is a function of social identity, not merely personal identity. This is typical of "tribal stigmas" (i.e. race and religion), where interpersonal differences are very pronounced. A third difference between stigma-based exclusion and idiosyncratic exclusion is so-called "moral exclusion" (Opotow, cited by Major & Eccleston, 2005:66). This refers to the cultural agreement in society that stigma-based exclusion is morally justified.

1.2.3 STIGMA AND STEREOTYPING

Stigma involves *stereotyping*. According to Stangor (2000:1) *stereotypes* are:

> "beliefs about the characteristics of groups of individuals . . ." (2000:1),

And *stereotyping:*

> "is the application of these stereotypes when we interact with people from a given social group" (2000:1).

Stereotypes are beliefs about the characteristics of people that are unjustified because of erroneous cognitive processes (over-generalisations), factual errancy, rigidity and attribution patterns (Biernat & Dovidio, [2000] 2003:88). Schneider states that a dislike of a certain group of individuals requires some rationalisation, which is provided through

stereotyping. Such a rationalisation becomes culturally warranted, shared, and reserved for the groups in society that are most despised. What stigmatising and stereotyping have in common is:

> "the process of generalizing from observable physical characteristics to a set of assumed character traits . . ." (Biernat & Dovidio, [2000] 2003:88).

Stigmatising stereotyping contains the most negative evaluations of people (Schneider, 2004:474). In addition, not only are negative evaluations involved in stigmatisation stereotypes, but stigmatisers believe that certain characteristics are typical of the stigmatised, i.e. the stigma identifies a social identity (Biernat & Dovidio, [2000] 20030:89). Both stereotyping and stigmatisation attribute group or category membership according to some distinguishing mark. Stereotyping is instrumental in the development and perpetuation of stigmatisation, and creates associated convictions that determine information processing and attributions (Biernat & Dovidio, [2000] 2003:107).

Although stereotyping involves stigmatisation and vice versa, each phenomenon may occur without the other (Biernat & Dovidio, [2000] 2003:108). The basic difference between the two constructs is that stereotyping can be a positive evaluation (without any stigmatisation), whereas stigmatisation is negative, devaluative, and may function without any stereotypes. Stereotypes may serve to exacerbate stigmatisation, as it supplies a more elaborate and systematic set of stigmatising beliefs, effecting more negative experiences and outcomes for the stigmatised (Biernat & Dovidio, [2000] 2003:112).

2. VARIATIONS IN STIGMA

If it can be determined how stigma varies, then a typology of stigmas may be developed to aid in understanding the range of reactions that stigmatised individuals manifest (Schneider, 2004:475). Such a need for categorisation has resulted in various suggestions of certain dimensions that would account for the variations in stigma.

Goffman (cited by Major & Eccleston, 2005:64) categorised stigma according to three stigmatising conditions: "blemishes of individual character", "abominations of the body", and "tribal stigmas". The first category involves stigmas due to some form of aberrant behaviour (e.g. homosexual, criminal behaviour, unemployment, addictions, mental

disorders) (cf. Dovidio et al [2000] (2003:6). "Abominations of the body" are stigmas that result from physical disfigurement or physical variations from what is considered as the norm in a particular society. A common example of this category of stigmas is obesity. "Tribal stigmas" indicate the characteristics of particular racial, ethnic and religious groups. These characteristics can be inherited (e.g. skin colour) or membership indications (e.g. membership dress code).

Jones and colleagues (cited by Schneider, 2004:474-479) suggest six dimensions to account for variations in stigma. The most salient is *concealability.*

2.1 Concealability

Concealability is the degree to which a stigmatising feature is noticeable. Schneider (2004) points out that concealability has a major effect on stigmatisation, because the sooner a stigmatised mark is identified the sooner a stigmatised person is devalued and avoided. Such early discovery of the stigmatising "mark" consequently means that the stigmatiser would not have much opportunity to get to know the stigmatised person, leaving the stigmatiser's stereotype of the stigmatised individual unaffected. If the stigmatised mark is more concealed (e.g. homosexuality), then more knowledge of a stigmatised person is obtained through interaction before discovering the concealed stigma. The result would then be that such stigma might not have much of a bearing on the evaluation of such a person. Such evaluation might then be equivalent to a non-stigmatised evaluation. Crocker and colleagues (cited by Dovidio et al [2000] 2003:6) state that the *concealability/visibility* of a stigma determines (1) the framework through which others evaluate them, and (2) the degree to which a stigmatised person is aware of his stigmatised status (Kleck & Strenta, cited by Dovidio et al [2000] 2003:6).

2.2 Time Course

The second of Jones and colleagues' six dimensions is *time course* (Schneider, 2004:475). This refers to the extent to which the stigmatising "mark" may worsen or improve over time. A person might be born with a stigma (e.g. mental retardation), or a stigma may

appear gradually (HIV/AIDS) or suddenly (the result of an accident). Intervention (e.g. drugs, therapy or surgery) may or may not relieve stigmas.

2.3 Aesthetic value

Aesthetic value is the third dimension. This dimension refers to how much the stigma renders individuals unattractive. Schneider (2004) points out that physical unattractiveness is itself a stigma, and therefore a reason for social exclusion.

2.4 Stigma origin

Stigma origins plays an important role in stigmatisation since it has a greater capacity to influence the devaluation of individuals (Schneider, 2004). Persons who are perceived as being "responsible" for their "mark" are more likely to be devalued (e.g. obesity) than those who are not (e.g. paraplegics). Stigma origin or controllability identifies the stigmatised person's involvement in having the stigma, and his/her responsibility in terms of adhering or removing the stigma (Dovidio et al [2000] 2003:7). Individuals who are seen as choosing their stigmatised behaviour are most severely stigmatised (e.g. those who attracted HIV through sexual promiscuity are generally more severely stigmatised than an unsuspecting spouse, infected unknowingly by her/his husband/wife). The authors point out that societal assessment of stigmatised person's responsibility for their stigma varies cognitively, emotionally, and behaviourally (Dovidio et al [2000] 2003:7).

Stigma origin or controllability also affects stigmatised persons. It plays a role in the development and functioning of their frame of reference, and the state of their self-image.

2.5 Danger

The dimension of *peril* or *danger* indicates the extent to which a person feels threatened by a stigmatised person. Stigmatised people could be a real threat (e.g. criminals) or a perceived threat (e.g. mentally handicapped individuals or homosexuals). A perceived threat can be imagined, simply because of a fear for the unknown or uncertainty how to interact with a stigmatised person (e.g. people living with HIV/AIDS). A stigma might

also confront us with our vulnerability, for example, contact with a person who has cancer. One can become stigmatised simply by associating with stigmatised individuals ("courtesy stigma"), e.g. family members of a PLHA. Another example of such "courtesy stigmas" is when a HIV negative person who organises and conduct support group meetings for PLHA becomes stigmatised. The real or perceived threat that stigmas present or conjure up is a major reason for the devaluation and exclusion of stigmatised individuals.

2.6 Disruptiveness

Disruptiveness is Jones and colleagues' (cited by Schneider, 2004:477-479) sixth stigma dimension. Disruptiveness refers to the extent to which a stigma impedes personal interaction. Concealed stigmas are less disruptive than non-concealable stigmas (e.g. severe physical disfigurement). There are various reasons for the disrupting effect of stigma. A stigma creates awkwardness because of the non-stigmatised individuals' uncertainty of how to behave towards the stigmatised individual. This awkwardness results in strained interaction, as the non-stigmatised person tries to be careful not to offend the stigmatised person. Physical stigmas can contribute to this awkwardness because of the effort of non-stigmatised observers not to stare at the stigma. If the particular observer tries too hard to avoid looking at the stigma then it may actually reinforce the awkwardness through the greater unease it may create in the stigmatised person. The result of the disruptiveness dimension is greater social exclusion, which reinforces, rather than adjusts, stereotypes through interaction, and an increased knowledge about the stigma.

2.7 Mental versus physical stigmas

Schneider (2004) adds *mental versus physical stigmas* as an additional dimension to explain variations in stigmas. Mentally-stigmatised persons (mental illness, homosexuality) are more negatively devalued than physical-stigmatised individuals, probably because it involves a greater measure of blame. Mental stigmas involve a greater threat, perceived or real, and result in a greater degree of social exclusion (Schneider, 2004:480).

3. THE DEVELOPMENT OF STIGMA

3.1 The origins of Stigma

How does stigma originate? Is there a basic theory of the origins of stigma? According to Stangor & Crandall [2000] (2003:62) both questions have received inadequate attention in social psychology literature. They suggest that a universally-present instinct to avoid danger is the basic origin of stigmatisation. Threatening situations are avoided, ensuring both survival and optimal functioning of the individual and his/her ingroup (Stangor & Crandall, [2000] (2003:67). Outgroups are thus initially stigmatised because they are perceived as threatening. Self-interest also motivate people, when they observe ingroup and outgroup members, to develop associated stereotypes and prejudices about these groups, i.e. social categories (Stangor & Crandall, [2000] (2003:67). Examples of such social categories are simplified social perception, and increased self-esteem.

These are the tenets of a *functional approach* to stigma development. The primary significance of such an approach is that it suggests an impetus for stigma development:

> In this sense, stigmas may be assumed to have their origins because they provide appropriate meaning about the environment, because they provide support for the individual perceiver's self concept, and (perhaps particularly) because they provide cues about the potential of danger for the perceiver" (Stangor & Crandall, [2000] 2003:68).

3.1.1 PERCEPTUAL THEORIES

The second category of stereotype and prejudice development theories that may shed some light on the development of stigma is *perceptual theories* (Stangor & Crandall, [2000] 2003:68). There are two types of perceptual theories: *belief creation*- and *accentuation theories*. According to the illusory correlation approach within *belief creation* theories, people credit minority groups with negative characteristics because they inaccurately relate group characteristics to group size. Negative behaviour and minority groups thus became distinctive because they occur infrequently, therefore becoming wrongly associated. It appears to be characteristic of stigma development, as stigmas are

also seen as unusual, and as such associated with negative beliefs. A second approach within *belief creation theories* is the *ecological approach*. This approach posits that personal characteristics indicate fairly accurately personality characteristics. This approach is parallel to stigmatisation since stigmas contain such a "kernel of truth" which is consequently emphasised and overgeneralised (Stangor & Crandall, [2000] 2003:69).

Accentuation theories suggest that real or perceived differences in terms of group behaviour are cognitively exaggerated and biased (Stangor & Crandall, [2000] 2003:69). Stigmatisation includes such exaggerated perceptions to provide meaning in differences and to distinguish the ingroup from the outgroup. Differences between ingroup and outgroup members are exaggerated, resulting in ingroup favouritism.

3.1.2 CONSENSUS THEORIES

The third category of stereotype and prejudice development theories that may assist in understanding stigma development is *consensus theories* (Stangor & Crandall, [2000] 2003:69-73). Whereas functional theories propose to account for the initial development of stigmas, consensus theories may explain their subsequent reinforcement (Stangor & Crandall, [2000] 2003:69). *Consensus theories* entail *social exchange and communication theories*, which may provide an answer to the question as to how stigmas became consensual. The basic assumption in this regard is that (1) as is the case with stereotype beliefs, stigmatising beliefs became shared by members of a society through a process of communication, and that (2) people conform to the beliefs of others in their cultures, thus agreeing among one another as to the prevailing social opinions.

Pettigrew's (cited by Stangor & Crandall, [2000] 2003:70) investigation of anti-Black and pro-apartheid beliefs of White South Africans is a case in point. He concluded that stigmatising beliefs were not the product of individual constructs like authoritarianism, but the result of:

> "cultural norms about the acceptability of prejudice towards Blacks, and individual conformity to those norms." (Pettigrew, cited by Stangor & Crandall, [2000] 2003:70).

Stigmatisation was thus a social and not personal phenomenon because it was the South African society, and not the individual per se, that was responsible for the development and sustenance of the stigmatising attitudes and beliefs (Pettigrew, cited by Stangor & Crandall, [2000] 2003:70).

Although shared social stigma beliefs developed though outgroup contact, they are then reinforced and consensualised through contact with ingroup members (Stangor & Crandall, [2000] 2003:70). An individual's interaction with a stigmatised person is therefore shaped by the perception of the ingroup 's normative beliefs about the specific stigma. As the above research case demonstrates, such cultural normative beliefs exert a strong sense of acceptability. Another possible parallel between prejudice and stigmatisation is that individual differences in prejudice seems more likely to indicate differences in personal conformity to observed group norms, rather than a desire for personal gain (Stangor & Crandall, [2000] 2003:71).

3.1.3 THE COMMUNICATION OF SOCIAL BELIEFS

Social beliefs are communicated *passively or actively* (Stangor & Crandall, [2000] 2003:71). An individual may internalise such beliefs during routine interactions. The mass media contribute to the passive spreading of stigmatising beliefs through stereotyped portrayal, including depicting stigmatising as humour. Assisting the *active communication* of stigmatising beliefs is the finding (Stasser & colleagues, cited by Stangor & Crandall, [2000] 2003:72) that shared information is more likely to be discussed by group members than information that is not available to all group members.

An important assumption underlying the dissemination and general acceptance of beliefs is that individuals are indeed motivated to share their beliefs (Stangor & Crandall, [2000] 2003:72). The reason for this assumption is the social nature of human beings: people have a need to be included in groups. To be included requires acceptance, and the sharing of beliefs is one mechanism to acquire acceptance.

The consensus requirement of shared beliefs is also a function of stigmatiser-stigmatised interaction (Stangor & Crandall, [2000] 2003:72). According to the authors both

stigmatiser and stigmatised agree through interaction that the stigma is justified as a devaluative attribute. Stangor & Crandall [2000] (2003:72) conclude that the stigma and stigmatisation process is socially constructed, even if it involves only two, local, individuals. As is the case with the initial impetus to stigma development, reactions to stigmatised individuals are the product of social learning and social interaction.

3.1.4 FUNCTION, OBSERVATION AND SOCIAL SHARING

Stangor & Crandall [2000] (2003:73-79) suggest that a theory of stigma origins would have to include three components: function, observation, and social sharing. They propose such a theory, which consists of three stages: (1) an initial functional stimulation, which is the observation of a real or perceived threat for the individual or society, (2) perceived distortions that amplify group differences, and (3) the consensual sharing of threats and perceptions (Stangor & Crandall, [2000] 2003:73).

In terms of *stage one*, a real threat is "instrumental" since it endangers some material or concrete object, e.g. health, safety, wealth, or social position (Stangor & Crandall, [2000] 2003:74). Perceived threats involve endangered beliefs, values, norms, ideologies and worldviews. In some cases stigmas can be the result of both real and perceived threats, e.g. AIDS (Stangor & Crandall, [2000] 2003:74).

Intergroup conflict influences stigmatisation. Social categories involves threat when associated with intergroup conflict (Stangor & Crandall, [2000] 2003:74). Threatening outgroup s (and ingroup rebels) are thus stigmatised.

A second example of *perceived or real threats* is *health threats*. An experiment by Crandall & Moriarty (cited by Stangor & Crandall, [2000] 2003:75) suggests that two aspects of a stigma result in stigmatisation: if it is the severe, contagious and sexually transmitted, and if blame can be ascribed. Personal responsibility also correlated with contiguousness and sexual transmission. These two reasons have been demonstrated as applicable in terms of other stigmas (Weiner, Perry & Magnusson, cited by Stangor, & Crandall, [2000] 2003:76). The more threatening the stigma and the more blame is ascribed the more severe the stigmatisation may be.

Stangor & Crandall [2000] (2003:77) discuss another type of threat, *belief in a just world*. Advantaged individuals or groups tend to stigmatise disadvantaged persons or groups so that the latter's lot can be justified (Lerner, cited by Stangor & Crandall, [2000] 2003:77). An example of this mechanism of stigmatisation is the view that AIDS is punishment for homosexual behaviour (Furnham & Gunter, cited by Stangor & Crandall, [2000] 2003:77). Lerner (cited by Stangor & Crandall, [2000] 2003:77) suggests that a belief in a just and fair world is a very common motivation. This phenomenon seems so deep-seated that evidence to the contrary will be rejected to defend this belief in basic justice! To illustrate: Crandall, Brit & Glor (cited by Stangor & Crandall, [2000] 2003:78) reported that in a series of studies, belief in a just world was actually elevated after the presentation of a case where a young boy became infected with the HI virus through a blood transfusion. This paradoxical reaction seems to indicate an inconsistent reaction when a stigmatised condition is presented as unjustly acquired. The inconsistency is revealed through cognitive efforts to reaffirm justice and fairness in an effort to also reaffirm the justification of the stigmatisation.

Moral threat represents another kind of threat (Stangor & Crandall, [2000] 2003:78). A society holds to some shared ideology that supports its values and norms, and punishing violations of such a moral ideology. These values are core values or basic principles that reflect a particular society's essence, its basic philosophy. These values or principles also sharply delineate the ingroup-outgroup boundary. Violation of this boundary will result in severe stigmatisation, because of the perception that they present a threat to the well-being of the society (e.g. the perceived "threat" that Black Americans do not honor the traditional American principles of individualism). This form of stigmatisation can be explained as a matter of psychological balance: ingroup members are perceived as "good", with "good" values, whereas those with different values are branded as deviant or "bad".

To summarise: what most likely causes initial stigmatisation is a perceived or real threat. Subsequent cognitive and social processes expand the perceived or real threat beliefs and they became communicated throughout the group/society, followed by consensual acceptance. Stangor & Crandall [2000] (2003:79-80) argue that threat as the initial impetus for stigmatisation is true even when different threat cues occur simultaneously,

because *any* potential threat is sufficient to trigger stigmatisation. The authors discount other proposed triggers of stigmatisation, i.e. deviance or social norm violations, because *they may not always be the source of stigmatisation* (positive deviations and normative unusualness are not usually stigmatised) (Stangor & Crandall, [2000] 2003:80). According to their theory, it is only those deviations and violations of social norms that are perceived as a symbolic or real threat that result in stigmatisation.

Stangor & Crandall [2000] (2003:80) does mention one possible exception to their theoretical approach, the so-called "*anarchic stigmatisation*". This phenomenon refers to stigmatisation as a random phenomenon (Stangor & Crandall, [2000] 2003:80). They illustrate this type of stigmatisation with the "dumb Swede" jokes of the 1950s in the U.S.A. which became "dumb Polish", and later "dumb blonde" jokes. The authors could not identify any event or events that could have influenced those changes. They conclude, therefore, that some types of stigma and changes in stigmas appears to be random, unaccounted for and unpredictable (Stangor & Crandall, [2000] 2003:80).

In their conclusion, the authors distinguish between their *social approach* to the origins of stigmatisation and *individual causation approaches* (Stangor & Crandall, [2000] 2003:80-81). Stigmatisation, according to them, starts with a real or perceived threat. This threat is then exaggerated, distorted and enhanced, followed by an eventual negotiation of shared understanding on all levels of interaction. The result is stigmatisation (Stangor & Crandall, [2000] 2003:81). The authors do recognise that *individual dynamics* play a role in the development of stigmatisation (Stangor & Crandall, [2000] 2003:81). Variations in individual propensities to stigmatise and destigmatise must be sought in individual stigmatisation dynamics. Such a dimension to the development and change of stigmatisation inevitably includes a consideration of *context*. The context within which stigmatisation originates and changes introduces a variety of variables that influences both the individual and social dimensions of stigmatisation.

It is within this systemic perspective that stigmatisation combine individual perceptions and beliefs with group sharing of those cognitive constructions:

> "Stigmatization can be the result of threat, but it requires social communication and sharing on the one hand, and individual distortions and enhancements on the other" (Stangor & Crandall, [2000] 2003:81).

Whereas the preceding section dealt with the nature, variations and development of stigma and stigmatisation, the next section investigate the functionality of stigmas and stigmatisation in an effort to find an answer to the question of *why?*

4. THE FUNCTIONS OF STIGMA

This section of the stigma literature review deals with the question as to why people, on an individual level, stigmatise. A basic and fundamental observation is that stigma is a *universal* phenomenon. It is this characteristic which has prompted social psychologists to ask whether stigmatisation fulfill some basic personal or societal need (Crocker & colleagues, cited by Dovidio et al [2000] 2003: 7). In terms of the psychology of the stigmatiser, various approaches have identified several *reasons for stigmatisation*, e.g. the enhancement of self/group-esteem and control; to ameliorating anxiety (Dovidio et al [2000] 2003:7), and to assist in interpreting people (Fiske & Neuberg, cited by Neuberg et al [2000] 2003:32). Comparing oneself to those less well endowed than oneself increases one's sense of self-worth and control. Such functional approaches represent individual psychological explanations for stigmatisation, which propose that it has a meaningful purpose for the stigmatiser.

Stigmas create interpersonal tension because of its *real of perceived threat* to non-stigmatised individuals. Stigmatisation can thus relieve such tension or anxiety by increasing the stigmatiser's real or perceived measure of control through various modes of avoidance behaviour. The stigmatised person is excluded and stereotyped, since stereotypes provide a more encompassing rationale for such stigma-based exclusion, further increasing the stigmatiser's sense of control. Certain stigmas may impact the stigmatiser through a threatening awareness of his/her *vulnerability and mortality* (Dovidio et al [2000] 2003:8). Such existential anxiety is more common in the case of physical stigmas, i.e. cancer or accidental dismemberment/disfigurement. It results in a strengthening of the cultural worldview, employing norms or values to justify the

exclusion or devaluation of the stigmatised person. Such a cultural (shared) worldview results in the branding of individuals who falls outside of the boundaries of such a worldview. Such "rebels" are prone to stigmatisation and exclusion.

Favorable group comparisons may prompt stigmatisation (Dovidio et al [2000] 2003:8). Such a comparison also enhances self-esteem, especially when a stigma represents a primary category of people (e.g. racial or gender group), delineating social identities. The above authors refer to *social identity theory tenets* - that people distinguish between out- and ingroups to create and increase a sense of belonging and distinctiveness (Dovidio et al [2000] 2003:8). That may be one explanation of why prejudice, discrimination, stereotyping and social exclusion is an inextricable part of the process of stigmatisation: by identifying ingroup characteristics that makes the ingroup preferable (and superior) than those of the outgroup (the stigmatised group) stigmatisation can be justified. The preference of one's owns group to other groups thus strengthens one's group sense and identity, enhancing personal and group self-worth (Dovidio et al [2000] 2003: 8).

4.1 Social functions of stigma

4.1.1 THE EVOLUTIONARY APPROACH

Evolutionary perspectives argue that the *survival of their members* is the purpose of society. However, the social group both improves and threatens the chances of such survival. Through reproduction and cooperation, sociality increases the prospects of survival. On the other hand, features of group living such as competition and conflict threatens survival. This conflicting process determines when individuals choose to be social and when not. According to Kurzban and Leary (cited by Major & Eccleston, 2005:69) stigmatisation serves the purpose of separating those deemed unfit from those desired for enhancing one's reproductive security. They argue that stigma is the result of cognitive adjustments to solve *three problems*. The first are adjustments to exclude from interaction those deemed "poor partners for social exchange" (Major & Eccleston, 2005:69). Such individuals include those seen as unpredictable (e.g. the mentally handicapped), those violating social norms (e.g. homosexuals), those considered as rebels (e.g. criminals) and those who cannot contribute to reproductive fitness (e.g. the elderly).

A second adjustment is to prevent excluded individuals form benefiting from ingroup membership, and to exploit such persons. This argument is to explain the competition and conflict dilemma: outgroup s are stigmatised and excluded to optimise the ingroup 's economic and social benefits, to protect against outgroup exploitation (e.g. racial and religious groups) (Major & Eccleston, 2005:69). The third adjustment is to ensure physical survival by avoiding individuals who may carry a life-threatening disease (PLHA). The authors observed that these three cognitive adjustments, which explain stigma across cultures and time, are reminiscent of Goffman's (cited by Major & Eccleston, 2005) typology of stigmas.

Neuberg and colleagues (cited by Major & Eccleston, 2005:69-70) argue that *sharing* is the prime benefit of group living. However, sharing can only contribute to group living if everyone participates. Those who are identified as non-contributing are therefore stigmatised (e.g. the physically handicapped). Other non-cooperative group members prone to stigmatisation are those who exploit group members (criminals), and those who violate norms and socialisation, i.e. homosexuals (Neuberg and colleagues, cited by Major & Eccleston, 2005:70).

Major and Eccleston (2005:70) noted that while these evolutionary perspectives contribute to understanding shared features of stigmatisation across culture and time, they do not account for variations within, and across, cultures and time. These perspectives also fail to address the variety in context, and its contribution to stigmatisation. Neuberg et al [2000] (2003:31-61) propose a framework to account for these factors, namely the biocultural approach.

4.1.2 THE BIOCULTURAL APPROACH

These authors criticise the individual-level psychological approach to stigmatisation for being insufficient (Neuberg et al [2000] (2003:33). For instance, resorting to stigmatisation to enhance self-worth does not explain why some individuals are stigmatised while others not. An individual-psychological approach also fails to explain the qualitative variations in stigmatisation:

> why some such individuals are avoided; others are ridiculed; others are viewed with ambivalence; yet other are quarantined, exiled, imprisoned, or executed (Neuberg et al [2000] 2003:33).

Stigmatisation can also be non-psychological, intended as a way to communicate social denigration, e.g. the apartheid era requirement that blacks carry passbooks, and the Nazi requirement that Jews wear Stars of David (Neuberg et al [2000] 2003:33). In complimenting above evolutionary perspectives, the authors argue that stigmatisation is the result of the biological-determined need *to optimise group living*. Such an approach augments individual-psychological reasons for stigmatisation (e.g. enhanced self-esteem) by providing a larger, biocultural, context through which the individual processes are better interpreted and integrated. Their basic assumption, in addressing the question as to why people stigmatise, is that because of the crucial necessity for group living, group members will stigmatise those members who are perceived as threatening or harming the effective functioning of the group (Neuberg et al [2000] 2003:36).

The human being has an innate tendency towards both prosociality and exploitation (Batson; Caporeal et. al, cited by Neuberg et al [2000] 2003:36). Such exploitation tendencies result in mechanisms to identify such individuals, and to apply some form of sanction or sanctions. It is suggested that stigmatisation is one of those mechanisms or sanctions to restore and safeguard group requirements of reciprocity, honesty, trust, a common group identity, socialisation and well-being (Neuberg et al [2000] 2003:36-37). The authors use various examples to illustrate how violations of, or threats to, effective group functioning result in stigmatisation (2003:37-46). Although the biocultural approach applies to threats from within a group, the authors argue that it can be applied in the case of outgroup stigmatisation threats as well (Neuberg et al [2000] 2003:47-51).

Stigmatising members of an outgroup is a logical consequence of the evolutionary and biocultural approaches. Since every group is geared towards survival and efficiency, the presence of other groups usually results in competition for scarce resources, to ensure optimal reproductivity and efficiency. As ingroup members who obstruct group-efficiency are stigmatised, so are outgroup members who threaten the group in the same way.

An important aspect of stigmatisation is the flexibility of multiple group membership, and its effect on stigmatisation (Neuberg et al [2000] 2003:49-51). Distinguishing "we" from "them" varies according to whichever group membership is at stake. On the level of "we" versus "them", stigmatisation targets the outgroup simply because it poses some threat to the survival or successful functioning of the ingroup. As the real or perceived threat that the outgroup poses diminishes, so does the stigmatisation of the outgroup.

Stigmatisation is, therefore, not some fashionable, temporary, arbitrary phenomenon. It changes as the threat to the well-being of the ingroup changes An outgroup can over time be integrated into the ingroup due to historical, circumstantial or situational changes (Neuberg et al [2000] 2003:50), with a resulting disappearance of stigmatisation. What determines changes in stigmatisation are changes in the real and perceived threat of the outgroup, through which the ingroup-outgroup boundaries are redrawn. These shifting boundaries are the inevitable effect of historical, contextual and other cultural changes.

The biocultural framework allows for *predictions across cultures, time and even species* about which kind of behaviour and characteristics are prone to stigmatisation (Neuberg et al [2000] 2003:51-53). The authors explain that although the stigmatisation of categories of people is biologically determined, the particular character of stigmatisation is influenced by context-specific and cultural factors.

Another advantage of the biocultural framework is that it explains "positive stigmatisation" (Neuberg et al [2000] 2003:53). The authors illustrate this strength with the example of a hero, who contributes par excellence to the group's survival and optimal efficiency. Instead of being devalued and shunned, such an individual is highly valued and sought after as role model. The framework is also capable to bridge the research gap between "process" in the fields of social cognition (the *how* dimension of social observation) and "content" (the *what* dimension of social observation) - what people are thinking during the social observation process.

Specifically appropriate to the South African context is another function of stigmatisation, the *defense of the status quo* (Dovidio et al [2000] 2003:9). This purpose or function of stigmatisation was institutionalised during the apartheid era to justify and maintain the

ideology of racial inferiority, separate development, and racial denigration. Blacks were stigmatised as racially inferior, rationalising White hegemony, in order to maintain the status quo. This form of stigmatisation involved systemic discrimination and societal separation. Apart from maintaining control over the black population, stigmatisation of blacks also benefited whites individually, reserving the best employment and living opportunities for this minority population group. Such a form of stigmatisation was possible because race is a social construction that allows for group domination, exclusion, and discrimination. Stigmatisation thus served the interests and purposes of the dominant white population group. What this systems function of stigmatisation fails to explain though is why certain groups are stigmatised and excluded across cultural and temporal boundaries (Major & Eccleston, 2005:68).

5. THE PROCESS OF STIGMATISATION

A review of scholarly material on stigma indicates that stigmatisation is a process. Stigmatisation as a process involves the dual dimensions of stigmatisation from the perspective of the stigmatiser, and stigmatisation from the perspective of the stigmatised.

Dovidio et al [2000] (2003:1-28) provide a brief overview of the research history regarding the process of stigmatisation. Stigmatisation was first interpreted in terms of individual idiosyncrasies, as reflected by different personality types of the stigmatiser, causing personality distortions in the stigmatised person. During the past fifty years this consensus has changed from deficient personality traits as the cause of stigmatisation to:

> a normal (if undesirable) consequence of people's cognitive abilities and limitations, and of the social information and experiences to which they are exposed (Dovidio et al [2000] 2003:2).

This change was accompanied by a changed consensus of how the stigmatised react to stigmatisation. Instead of inevitable psychological trauma, stigmatised persons are now believed to cope with stigmatisation as non-stigmatised people do with their psychological challenges. Because stigmatisation results in coping behaviour instead of psychological damage, significant differences are found within stigmatised groups, as is the case with non-stigmatised groups:

> Thus current views of stigma, from the perspectives of both the stigmatizer and the stigmatized person, consider the processes of stigmatisation to be highly situationally specific, dynamic, complex and non-pathological (Dovidio et al [2000] 2003:2).

The above authors point out that not all non-stigmatised individuals engage in stigmatisation, and not all stigmatised persons react negatively to stigmatisation. (Dovidio et al [2000] 2003:2-3). Stigmas are thus both negatively and positively evaluated by non-stigmatised individuals (e.g. sympathy and acceptance), and we find stigmatised individuals who have a positive and resilient self-esteem, despite being stigmatised.

The process of stigma, as pointed out above, is *contextual* (Dovidio et al [2000] 2003:2). The reason for this characteristic is the fact that stigmatisation is not individually determined but socially. The example of how premarital sex was stigmatised during the seventeenth century, but de-stigmatised during the eighteenth century confirms both the social construction and context-dependent character of stigmas. *Context* also determines how stigmatised individuals react to stigmatisation. What was stigmatised during the apartheid era might not be so now, more than ten years after its demise. Furthermore, what may be stigmatised among one group of the population is not necessarily the case among another population group. It thus follows that stigma as a social construction is unavoidably a cultural construct. This variability of stigma within a two-thirds world context may distinguish the process and characteristics of stigma from a one-third, Western world, stigma model. Dovidio et al [2000] (2003:3) emphasise the importance of the social and situational context on both the stigmatiser and stigmatised, the interaction between them, and the totality of social and personal consequences of such interaction. They are also cognisant of the larger cultural context that frames the interpersonal process of stigmatisation as it materialises in stereotypes, values, ideologies, and the situational characteristics that determine the situational meaning within which stigmatisation as interpersonal process occurs.

5.1 A conceptual framework

To explain the process of stigmatisation, Dovidio et al [2000] (2003:9-15) propose a *conceptual framework* that consists of three dimensions: the *perceiver-target*, *personal-group-based identity* and *affective-cognitive-behavioural* dimensions.

5.1.1 PERCEIVER-TARGET DIMENSION

The *perceiver* and *target* refer to the stigmatiser and stigmatised respectively. This distinction reaffirms the distinction between stigmatisation from the perspectives of the stigmatiser and stigmatised. Dovidio et al [2000] (2003:10) identifies this aspect as "one of the most basic issues in understanding stigma and stigmatization . . . ". The difference between the *perceiver* and *target* involves needs, goals and motivations, as well as situational and dispositional attributions for the same behaviours. The different perspectives between stigmatisers and the stigmatised affect their social roles, and how they function in those roles influence the development of their identities. It thus stands to reason that the best assessment of stigma and stigmatisation would entail knowledge about the interaction between the two groups. Unfortunately, this important issue has eluded scholarly attention. Whereas stigma also involves a cultural and collective dimension, it has been researched and offers important information on the process of stigmatisation.

5.1.2 PERSONAL-GROUP-BASED DIMENSION

The *personal-group-based* dimension is the second dimension of the Dovidio et al [2000] (2003:12-13) conceptual framework. This dimension distinguishes between personal and social identity, in particular between interpersonal and intergroup processes. Understanding these processes would pave the way for understanding the cognitive, affective and evaluative processing dynamics involved in stigmatisation. It is proposed (Fiske & Neuberg, cited by Dovidio et al [2000] 2003:12) that the perceiver (stigmatiser) forms impressions through various processes, which reflect a continuum from *category-based processes* to *individuating processes*. *Category-based processes* are social processes, where group membership dictate impressions. *Individuating processes*

determine impressions of individual characteristics, excluding group membership impressions. Brewer (cited by Dovidio et al [2000] 2003:12) suggests that *category-based processing* is "top-down" in nature, from global to specific, while person-based processing (*individuating processes*) is "bottom up", from detailed concrete to abstract information. Fiske & Neuberg, and Brewer (cited by Dovidio et al [2000] 2003:12) agrees that, in terms of stigmatisation, *category-based processing* takes precedence over *person-based processing*, because social information is usually processed through social categories.

Dovidio et al [2000] (2003:12-13) emphasise the importance of distinguishing between *personal and social identity*. This distinction applies to both the perceiver (the stigmatiser) and the target (the stigmatised). Personal and social identity represents two poles on a continuum, according to self-categorisation theory. One's position on this continuum determines one's responses: when the personal identity position is prominent then personal dynamics will dominate behaviour, and vice versa. Whatever identity position is dominant at any time will determine how a person perceives, evaluates, and behaves. These dimensions to information-processing is important because stigma is both a interpersonal and intergroup phenomenon. As such, it necessitates knowledge of personal and collective processing, reactions, and identity.

5.1.3 AFFECTIVE-COGNITIVE-BEHAVIOURAL DIMENSION

The last dimension of the Dovidio et al [2000] (2003:13-15) conceptual framework is the *affective-cognitive-behavioural* dimension. They posit that stigmatisation involves a mixture of these three components of general and intergroup attitudes. The functions of these components in terms of stigmatisation are primarily determined by the nature of the particular stigma, its context, and differences between the people involved. *Affective* (negative) reactions are more likely in the case of physical stigmas, followed by behavioural aversion. This *affective-behavioural* pattern is spontaneous and intense, and occurs across cultures and species. *Cognitive* amelioration (e.g. sympathy) of this affective-avoidance reaction can happen, which render attitudes towards physically-handicapped people ambivalent. Ambivalence is also characteristic of reactions towards "tribal stigmas" - i.e. race, gender, age.

Whereas *affective reactions* are characteristic of physical, individual stigmas, *cognitive reactions* more typifies reactions to collective stigmas. Collective stigmas are usually connected to consensual stereotypes, activating stereotype schemas which determine to a large extend the cognitive reaction to the stigma. Although personal-group-based identity may be linked to affective-cognitive reactions, they may not explain reactions to stigmas. Dovidio, Major & Crocker, (2003, c2000:15) refers to the example where an affective reaction to a person with AIDS may be determined cognitively, based on attributions about the cause of disease. In the case of "personal blemishes" stigmas, reactions may be both affective and cognitive, where a cognitive evaluation may determine the extent of the affective reaction. (e.g. what was the cause of a criminal's conviction?). Again, stereotypes may play a role in terms of this category of stigmas. The authors suggest that whatever reaction occurs first (affective, cognitive, or behavioural) and whichever reaction may influence the initial reaction, the first response depends on the type of stigma, its context, and individual differences in terms of experience, beliefs, values, goals and roles (Dovidio et al [2000] 2003:15).

The authors acknowledge that the implication that stigma is a by-product of social interaction is *a limitation of the conceptual framework* (Dovidio et al [2000] 2003:16). As stated above, stigma is both an interpersonal, as well as collective and cultural phenomenon. Crocker (cited by Dovidio et al [2000] 2003:16-17) has suggested that stigmatisation is determined by the interaction between collective cognitive content and the nature of the stigmatising situation, rather than the interaction between perceiver and target. Cultural portrayals involves stereotypes and culture-specific ethical convictions that are well known, shared and propagated through the mass media, irrespective of their general acceptance or not. Stigmatised individuals realise that their social identity is being devalued, and the reasons for it. Such knowledge of the negative stereotypes of one's stigmatised group may result in vulnerability. Such vulnerability presents a "self-threat" when the negative stereotype is prominent and directly relevant to the stigmatised person's behaviour or attributes in a particular situation (Dovidio et al [2000] 2003:17). The negative effects of stigma thus prevail beyond stigmatiser-stigmatised interaction or the mere presence of a stigmatiser.

A *second limitation* acknowledged by the authors (Dovidio et al [2000] 2003:17) is that the separate levels of the dimensions do not suggest differences but "a blend of reactions" (2003, c2000:17).

6. THE JUSTIFICATION OF STIGMATISATION

6.1 Justification ideologies

Another aspect of stigmatisation as a process is the role of ideologies to defend stigmas and stigmatisation. This dimension involves the justification of stigmatisation. Crandall states that:

> " . . . people, in the process of stigmatizing others, believe that the rejection, avoidance, and inferior treatment they dole out to stigmatized others are fair, appropriate, judicious-in other words, *justified* (sic). This justification includes moral, ethical, legal, social, natural, and logical bases-even requirements-for their rejection (Crandall, [2003] 2003:126).

Justification theories include, according to Crandall [2000] (2003:127), a particular worldview, as well as attached moral standards that develop moral value distinctions, i.e. ideologies. Ideologies are rigid belief systems that are socially learned, very resistant to scrutiny, and protected by the overall value and norm system of a specific worldview. Such justification ideologies provide both private and public "cover" for stigmatisation, prejudice and discrimination that would otherwise be deemed unacceptable (Crandall, [2000] 2003:128). The author argues that the processes of justifying stigmatisation is indeed the same whether it results in stigmatisation, prejudice, discrimination or other negative, biased and devaluing behaviour. Justification ideologies serve to justify prejudice, discrimination, and the rejection of stigmatised individuals (Crandall, [2000] 2003:128).

How do individuals justify their stigmatising behaviour? Crandall [2000] (2003:128) proposes three types of justification beliefs that account for the devalued treatment meted out to the stigmatised: (1) *attributional*, (2) *hierarchical*, and (3) *attributional-hierarchical combination* beliefs. The first entails the processes whereby assessments of

responsibility, causality and blame justifies stigmatisation, and the second accounts for the positive view of social classes or hierarchies, justifying differential, hierarchical treatments for different hierarchies.

6.1.1 ATTRIBUTIONAL JUSTIFICATION BELIEFS

I have touched upon *belief in a just world* in a preceding section (the origins of stigma). Crandall [2000] (2003:129) is of the opinion that this aspect is a prominent stigma-justifying dynamic, and an example of an attributional justification approach or ideology. The conviction that a universal, basic justice ensure that people are recompensed for their behaviour is so pervasive that stigmatisers will not only select and distort evidence pointing to the "guilt" of stigmatisers, they will even create such "evidence" (Lerner, cited by Crandall, [2000] 2003:129-130).

Another dimension of stigmatisation already referred to is the issue of responsibility (see *variations in stigma*). According to Crandall, [2000] (2003:13), perceived responsibility for stigma (by the stigmatiser) accounts for more than variations in stigmatisation - it also supports justification attributions. Weiner, Perry & Magnusson (cited by Crandall, [2000] 2003:131) found that responsibility for a variety of stigmas (including HIV infection) evoked anger and an unwillingness to assist the stigmatised. The opposite was also found as true: in cases were no blame could be attributed unstigmatised individuals reacted more positively, and expressed a willingness to improve their situation.

An interesting attributional dimension of the justification of stigmas is the Protestant work ethic (PWE). According to Crandall [2000] (2003:131-132), psychologically, the PWE includes two aspects: (1) a denial of the self as a measure of self-control and resulting anxiety about failures to deny the self (e.g. through pleasure and materialism), and (2) the attribution that self-control, together with hard work and determination, equals success. The attributional aspect of the PWE value system, according to Crandall [2000] (2003:132), is that success is self-determined. This PWE value paves the way for various prejudices, including stigmatisation (Crandall, [2000] 2003:132).

This concludes the first type of justification approach, *attributional* justification for stigmatisation. The second justification belief category is the *hierarchical* approach.

6.1.2 HIERARCHICAL JUSTIFICATION BELIEFS

Various theories propose that people both observe and bolster social hierarchies. It follows that as people differ according to their social class (based on their level of education, job status, wealth, and community standing) so they differ in terms of what is expected to be due them. The wealthy deserves more privileges and opportunities than the less wealthy, and so on, down the social class/status hierarchy, to the very poor. Crandall [2000] (2003:133-136) discusses the phenomena of Social Darwinism, social dominance, and system justification as explanations for the development of hierarchical philosophy and social hierarchies. Stereotypes are an inherent characteristic of social hierarchical thinking and social hierarchies, because as ideological props they defend the exploitation necessary to maintain social class differences. As stereotypes thus serve to legitimise class differences, they also bolster stigmatisation beliefs and practices.

6.1.3 ATTRIBUTIONAL-HIERARCHICAL JUSTIFICATION BELIEFS

The third justification belief category is a combination of the above two approaches: an *attributional-hierarchical* justification of stigmatisation. Crandall [2000] (2003:136) states that this type of justification emerges in "more complex social perception and intergroup relations". There are two types of this blended justification process: (1) *political orientation*, and (2) *principled racism*. *Political orientation* involves political ideology, and it plays a significant role in the justification of stigmatisation. Research has indicated that political conservatism goes hand-in-hand with attributions of responsibility for outcomes (Lane, Thomas, & Weiner, cited by Crandall, [2000] 2003:136-7). Because of this association, political socialisation and political identification can result in the justification of stigmatisation:

> "by creating consistent and persistent political ideological styles of attribution, and the endorsement of hierarchical structure in society" (Crandall, [2000] 2003:137).

The basis for the correlation between political conservatism and the stigmatisation of various social groups in the United States is political conservatism's ideology, and not

racial antipathy (Crandall, [2000] 2003:137). This ideological stance is called "*principled racism*".

Dovidio et al [2000] (2003:19) point out that the attributional-hierarchical distinction resembles the personal-group-based distinction they presented in their three-dimensional framework. The authors interpret attributions as explanatory for individual-level behaviour, whereas hierarchical ideologies account for the social status quo (Dovidio et al [2000] 2003:19). They add that attributional and hierarchical justifications colour affective, cognitive and behavioural responses to the stigmatised (Dovidio et al [2000] 2003:19).

6.2 The suppression of stigmatising sentiments

Crandall [2000] (2003:138) mentions that an important development in social psychology the past two decades has been the scholarly attention to the suppression of feelings and beliefs towards stigmatised individuals. McConahay, Hardy & Bates (cited by Crandall, [2000] 2003:140) believe that the suppression of racism actually contributes to racism. The suppression of racism renders it unnoticeable, as if it does not exist. However, such suppressed racist prejudice may still exert itself, albeit in ambiguous ways (Crandall, [2000] 2003:140). Such pseudo-prejudice results in pseudo-justification: the particular individual believes that he/she is not prejudiced or stigmatising towards others. In fact, such an individual can continue to act prejudicial and stigmatising (Monin & Miller, cited by Crandall, [2000] 2003:141).

6.3 The consequences of justification ideologies

Crandall [2000] (2003:142-143) lists various consequences of justification ideologies, that the researcher will briefly mention. As can be expected, justification ideologies normalise the prejudice, discrimination, rejection, and exclusion of the stigmatised. Stigmatisation becomes accepted and entrenched. Secondly, justification ideologies infiltrate and influence public policy. The chances that a conservative government will extend a helping hand to the needy, if they are viewed as responsible for their

predicament, is much more limited than that of a liberal administration (Skitka & Tetlock, cited by Crandall, [2000] 2003:142).

Hierarchical justification ideologies support the status quo, including its negative consequences. Hierarchical-based ideologies tend to excuse stigmatisation because it serves to reinforce social class distinctions. Such distinctions are often viewed as superior-inferior distinctions, as Crandall's example of the role of affirmative action in the United States illustrates [2000] (2003:143). Another example of public policy hierarchical perceptions is the issue of equal educational opportunity. Unequal educational funding amongst the American states entrench the education quality disparities, reinforcing the rich-poor, Black/Hispanic-White/Asian, divide between and within states (Kozol, cited by Crandall, [2000] 2003:144). Such and other justification, ideological-dominated public policies amply demonstrate how prevalent prejudice, discrimination, stigmatisation, and other forms of individual maltreatment is:

> "Justification ideologies proscribe and prescribe rough treatment of the stigmatized, and they even serve to define what is and what is not a stigma". (Pfuhl & Henry, cited by Crandall, [2000] 2003:144).

This concludes the review of the social psychology literature on stigma and stigmatisation. The purpose of this review was, first, to ascertain what stigma is, how it develops, how it varies, what purposes it serves, how it functions as a process, and how it is justified. Second, to assist in the development of a theological perspective on stigma and stigmatisation, as well as the relationship between stigma and suffering. Next, to compliment the above literature the researcher will review the literature on HIV/AIDS stigma and stigmatisation.

7. HIV/AIDS STIGMA AND STIGMATISATION

What is the nature of HIV/AIDS stigma and stigmatisation from the perspective of the stigmatiser and stigmatised? Central to answering this question will be the South African Human Sciences Research Council (Human Sciences Research Council and Harriet Deacon, 2005 = HSRC & Harriet Deacon, 2005) joint study by its Research Programmes on Social Cohesion and Identity, and The Social Aspects of HIV/AIDS and Health

(HSRC & Harriet Deacon, 2005). The reason for the centrality of this study is because it consists of a recent and comprehensive theoretical and methodological assessment of HIV/AIDS stigma research.

7.1. FROM THE PERSPECTIVE OF THE STIGMATISER

7.1.1 Introduction

This study (HSRC & Harriet Deacon, 2005) approaches HIV/AIDS stigma from a systems perspective: stigma must be considered within its societal (social, economic and cultural) as well as behavioural context[1]. Research on the failure of educational campaigns to eradicate individual ignorance as the psychologically-perceived cause of stigma has indicated that:

> Stigma is instead a complex social process linked to competition for power and tied to the existing social mechanisms of exclusion and dominance. (HSRC & Harriet Deacon, 2005:ix).

According to Parker & Aggleton (cited by Ackermann, 2006:229) AIDS-related stigma is a product of class divisions (HIV/AIDS as a disease of the poor), gender divisions (HIV/AIDS as caused by women or men), race divisions (HIV/AIDS as a black disease), and sexual divisions (HIV/AIDS as a homosexual disease).

HIV/AIDS as a disease of the poor points to the context of *poverty*. Poverty is the home of HIV/AIDS in the two-thirds world. It provides the optimal social "temperature" and environment for HIV/AIDS to thrive (Pienaar, cited by Louw, 2008:393). It does so in various ways: it dehumanises people by depriving them from material and spiritual resources, leaving them physically and spiritually vulnerable and debilitated (cf. Louw, 2008:393). The poor's physical debilitation results in a lack of nutrition, which compromises the body's immune system, making it more susceptible to contracting diseases. The suffering and debilitation of poverty makes the poor vulnerable and susceptible to HIV/AIDS risk behaviour such as prostitution, intravenous drug abuse, rape, sexual infidelity and multiple sex partners. Poverty also hampers the

[1] See section 1.1: Stigma and societal-systems factors

epidemiological management of HIV/AIDS such as prevention and treatment. The poor are less likely to be HIV/AIDS-informed and to seek and adhere to treatment, because of a lack of resources, illiteracy and ignorance. Poverty condemns people to a life of desperation, in which existence becomes a daily preoccupation with staying alive. For these and other reason, HIV/AIDS find itself very much at home in the "home" that poverty provides.

Other fissures in the two-thirds world social landscape that contributes to the advance of HIV/AIDS and HIV/AIDS stigmatisation are *culture-specific factors* like migrant labour, women's lack of sexual bargaining power, and prostitution (Louw, 2008:392-394; Van Wyngaard, 2006:274-281). Campbell portrays the stigmatisation phenomenon in terms of the individual-society dialectic:

> If health and sexuality are indeed shaped by society, culture and history in ways that cannot be apprehended by biomedical or behavioural understandings, we need to develop understandings of the complex dialectic of individual and society which shapes these phenomena." (cited by HSRC & Harriet Deacon, 2005:4).

A case in point may be Louw's (2008:394) remarks about the role culture can play in the advance of HIV/AIDS. He states that one of the reasons for the excellent fit between HIV/AIDS and the African context is polygamy and concubinage (Louw, 2008:394). Sexual promiscuity - against the background of this cultural practice - would not be disapproved of, even if it were connected to the threat of HIV/AIDS (Mokhobo, cited by Louw, 2008:394).

The use of condoms presents an example of the clash between two-thirds world culture and Western medicine's prevention model. Louw (2008) reports the finding by Mokhobo, that:

> Many blacks perceive contraceptive advice as a political manoeuvre supporting White engineered intentions (Mokhobo, cited by Louw, 2008:394).

Stigma has been a characteristic dimension of various diseases (e.g. cancer, leprosy), and it has adversely effected all aspects of the HIV/AIDS pandemic. According to McGrath, Black & Miles, Bond et al.

> It has been identified as a key reason for reluctance by PLHA to disclose their condition, or come forward for voluntary counseling and testing (VCT) and healthcare; it is also identified as a significant cause of non-adherence to treatments . . . It has also been used to explain negative attitudes and discrimination against PLHA (quoted by HSRC & Harriet Deacon, 2005:1):

7.1.2 HIV/AIDS stigma and discrimination

Parker and Aggleton (2003:19) suggest that HIV/AIDS-related stigmatisation and discrimination should be interpreted against the background of the relations between a particular culture, power dynamics and differential stigmatisation (Parker and Aggleton, 2003:19).

Parker & Aggleton (2003:14) suggest a re-assessment of the theoretical frameworks that is used to grapple with the problem of HIV/AIDS stigmatisation. A re-oriented conceptual framework should take cognisance of the dominant research focus on the relation between perception (of stigmatising individuals) and stigmatisation. It should also broaden the dominant socio-cognitive focus and individualistic emphasis to include stigmatisation and discrimination as social processes within the social sphere of power and domination (Parker & Aggleton, 2003:15-6). The authors criticise the narrow focus on stigma as a static attitude (instead of a constantly changing social process), regarding its emotional-cognitive nature and its preoccupation with the stigmatisers (Parker & Aggleton, 2003:15-16).

Stigma should be distinguished from discrimination, because stigmatisation is not always discriminatory (HSRC & Harriet Deacon, 2005:ix). The HSRC study states that HIV/AIDS stigma is:

> an ideology that identifies and links the presence of a biological disease agent (or any physical signs of a disease) to negatively-defined behaviours or groups in society (HSRC & Harriet Deacon, 2005:ix-x).

Not all negative beliefs about HIV/AIDS are or should be considered as stigma. Only beliefs that are part of a process of stigmatisation that involves social process dynamics like fear and blame qualify as stigmatisation (HSRC & Harriet Deacon, 2005:x).

It is therefore important not to define stigma in terms of its effects (e.g. discrimination), because stigma does not always result in some form of direct stigmatisation action (HSRC & Harriet Deacon, 2005:37). Stigmatisation may result in negative effects (e.g. increasing self-stigmatisation) without involving stigmatisation *action*, e.g. discrimination (HSRC & Harriet Deacon, 2005:37). Furthermore, public health measures that place limitations on PLHA to combat the pandemic do not qualify as discrimination but as differential treatment.

7.1.2.1 DISCRIMINATION VIS-À-VIS DIFFERENTIAL TREATMENT

One thus has to distinguish between discrimination and differential treatment. First, there can be a cause-effect relationship between stigmatisation and discrimination. Second, discrimination of the stigmatised can be due to reasons other than stigmatisation (e.g. gender, racism). HSRC & Harriet Deacon (2005:37-8) list four categories of differential treatment. These categories are *redress, preventing infection, social distancing,* and *balancing social contributions.*

Redress treatment aims to offset disadvantages imposed on a category of people (in this case PLHA). Disability grants are an example of a redress measure. HSRC & Harriet Deacon point out that a redress measure can contribute to the disadvantage being redressed: disability grants in the context of severe poverty becomes a disservice because it is an incentive to remain ill, and even to become sick (Nattrass, cited by HSRC & Harriet Deacon, 2005:37).

The refusal to allow blood donations from PLHA is an example of differential treatment to *prevent infection* (HSRC & Harriet Deacon, 2005:37). However, differential treatment to prevent infection can be discriminatory if they ignore scientifically-validated methods of HIV transmission (HSRC & Harriet Deacon, 2005:37).

An example of differential treatment that qualifies as stigmatisation is *social distancing*. Such distancing, or social exclusion, can be the result of symbolic stigmatisation. This occurs when PLHA are morally devalued (e.g. as promiscuous), resulting in an

experience of status loss, discrimination and religious ostracism, e.g. (HSRC & Harriet Deacon, 2005:38).

HSRC & Harriet Deacon's (2005:38) fourth category of differential treatment is *balancing social contributions*. This involves discrimination to justify the diminished contributions and increased costs to society of PLHA (e.g. refusal of medical aid and pensions). Such discrimination violates the human rights of PLHA.

The issue that these categories of differential treatment raise is the distinction between differential treatment and discrimination. HIV infection necessitates differential treatment, for instance, the use of condoms to prevent transmission. Differential treatment justified by a prevention of infection must be scientifically validated, and not based on spurious motives or an overestimation of the potential risk (HSRC & Harriet Deacon, 2005:38). To discern when differential treatment is discriminatory and when not, one has to distinguish between the public and private discourses on HIV/AIDS (HSRC & Harriet Deacon, 2005:38). The study cautions that discrimination can be disguised as warranted differential treatment (HSRC & Harriet Deacon, 2005:38).

It is justified in *private discourses* to differentiate in order to protect one's health (e.g. the decision to use a condom during sexual intercourse). However, one will behave discriminatory when you differentiate on the basis of a false justification, for example, believing promiscuity caused an HIV positive person to contract the disease (HSRC & Harriet Deacon, 2005:38).

In *public discourses* on HIV/AIDS there can be no differentiation between HIV/AIDS and other diseases, because it will contribute to HIV/AIDS stigma. Whereas an individual can differentiate by refusing to have sex with a HIV positive person (with or without a condom), the public health stance is to use a condom every time you have sex (HSRC & Harriet Deacon, 2005:39).

The study points out that the line between justified differential treat and discrimination can be a very fine one (HSRC & Harriet Deacon, 2005:39). The public health prevention message to be faithful/abstain (i.e. the "ABC" campaign: to abstain, be faithful,

condomise) can be interpreted as stigmatisation: do not be promiscuous (and, by implication, HIV positive individuals *are* promiscuous) (HSRC & Harriet Deacon, 2005:39). Condoms as a prevention measure has also contributed to HIV/AIDS stigma and stigmatisation, as did anti-prevention and treatment measures, for instance, formula milk and ARV clinics. An interesting example of these "markers" of HIV/AIDS and their acquired status of stigma-by-association[2] is the "AIDS-porridge" case, reported by HSRC & Harriet Deacon (2005:26): a school feeding scheme hit a snag when learners identified the cereal as "Aids-porridge", a common cereal used by the community's AIDS patients, and refused to eat it.

A final aspect of differential treatment is a troublesome one. This form of differential treatment qualifies as discrimination, and involves a private, household example of *balancing social contributions (*the fourth category of differential treatment). As hospitals prioritise treatment for patients likely to recover (called "triage"), so we find the same happening in households (HSRC & Harriet Deacon, 2005:40). This occurs in very poor households where the decision-maker(s) has to calculate the cost of sustenance and treatment, for e.g. a PLHA, in terms of household income. According to research in the South African context, such sustenance discrimination occurs often (Le Marcis, cited by HSRC & Harriet Deacon, 2005:40).

We can conclude that the difference between discrimination and differential treatment is that discrimination involves differential treatment that is based on biased and prejudicial grounds, whereas differential treatment is based on unbiased, non-prejudicial, medically-sound grounds. Stigmatisation involves, but also exceeds, discrimination because it does not merely involve discrimination as biased and prejudicial attitudes and behaviour, it also involves a social identity devaluation and a disgraced and discredited status as a cognitive construction.

7.1.2.2 STIGMA AND DISCRIMINATION

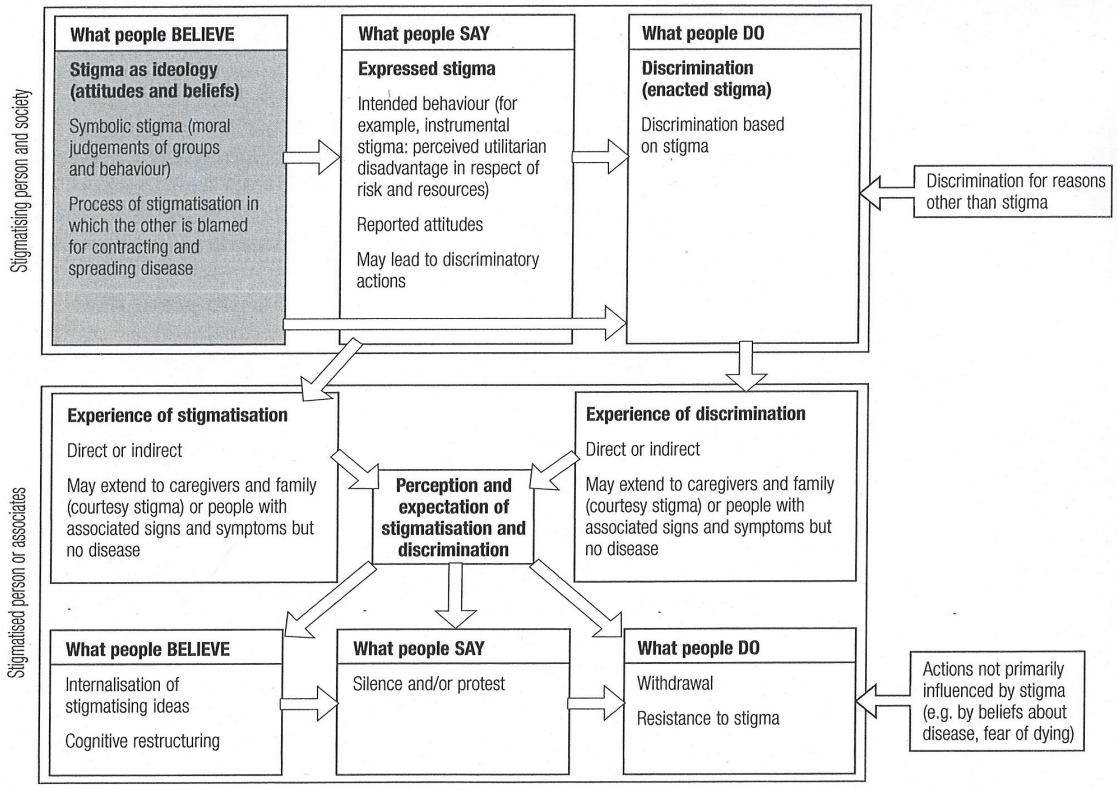
The study (HSRC & Harriet Deacon, 2005) proposes the following definition of disease stigma:

[2] See "courtesy stigmas": section 2.5.

Disease stigma can be defined as an ideology that claims that people with a specific disease are different from 'normal' society, more than simply through their infection with a disease agent. This ideology links the presence of a biological disease agent (or any physical signs of a disease) to negatively-defined behaviours or groups in society. Disease stigma is thus negative social 'baggage' associated with a disease." (Figure 1) (2005:19).

Figure 1 (HSRC & Harriet Deacon, 2005:20) points to the contrast between the study's definition and the socio-psychological approach to the relationship between stigma and discrimination. The first (shaded) column (what people believe) represents *social stigmas* (stigma as ideology). The third column (what people do) indicates the possibilities of discrimination, withdrawal, and activism. The second column represents verbal, *expressed stigma*. As the accompanying note to Figure 1 indicates, the definition only defines the cognitions of the "stigmatising person and society" (HSRC & Harriet Deacon, 2005:20). The rows (the two horizontal sections) distinguish between the stigmatising and stigmatised parties.

Figure 1: How different kinds of stigma and discrimination relate to each other



Note: The shaded section represents the aspects of stigma covered by the proposed definition. Arrows represent lines of influence or causality

The study's argument (HSRC & Harriet Deacon, 2005:20) is that one has to distinguish between what both stigmatising and stigmatised individuals believe (stigma cognitions/ideologies), say (expressed stigma), and what these individuals actually do (measured as discrimination, withdrawal, or activism - based on stigma ideologies). Second, above definition thus conceptualises stigma according to the upper left section (shaded section), as stigma ideology. Third, additional to stigma ideology (not covered by the definition) is expressed stigma (column two) which provides a measure of inferring stigmatising beliefs. The differentiation between expressed and enacted stigma (discrimination) is vital, to distinguish between expressed but unacted stigmatising beliefs, and intended but unacted stigmatising beliefs. What stigmatising individuals thus report as acts of stigma (enacted stigma) the study conceptualises as discrimination (HSRC & Harriet Deacon, 2005:20).

The value of this diagram is its distinction between stigmatising cognitions, stigmatising expressions and stigmatising actions. Thus, the diagram deviates from the social psychology literature by questioning the assumed inevitable linear progression from stigmatising beliefs to stigmatising expressions to enacted stigma. Secondly, it distinguishes between discrimination as enacted stigma and discrimination resulting from other sources.

7.1.3 Prejudice and HIV/AIDS stigmatisation

As indicated above, stigma involves prejudice. *Prejudice* is a negative, biased and erroneous generalisation about a group of individuals (Dovidio et al [2000] 2003:4). Stigma involves prejudice because it is based on societal norms and ideologies about group worth and identity.

The study (HSRC & Harriet Deacon, 2005:11) points out that HIV/AIDS stigma acquired more stigmatisation when it corresponds to membership of an already-stigmatised community or group. Such societal prejudice results in differential stigmatisation according to the different ways of contracting HIV, e.g. the stigma attached to an unfaithful husband who contracted the disease, compared to the stigma of his HIV positive wife, whom he infected.

As previously mentioned, stigmatisation involves the association of certain behaviours or personality traits with certain diseases. HSRC & Harriet Deacon, (2005:25) point out that the opposite is also true: current negatively-perceived groups are stigmatised as disease carriers. Stigma, as pointed out above, taps into current societal prejudice and inequalities, thus blaming marginalised groups for certain diseases, e.g. HIV/AIDS. Social inequalities can contribute to the incidence of a disease, placing more stress on marginalised groups to find treatment, further reinforcing the association between such groups and the blame accorded them (HSRC & Harriet Deacon, 2005:25). Disease stigmatisation thus reserves certain outgroup s (marginalised groups) as disease-bearers because of their negative personality traits or behaviours, exempting all other individuals with the same disease from stigmatisation (HSRC & Harriet Deacon, 2005:25).

The study (HSRC & Harriet Deacon, 2005:7) conceptualises stigma in relation to diseases as "disease stigma". They argue that HIV/AIDS stigma develops from the "social landscape of prejudice" (HSRC & Harriet Deacon, 2005:7). The researcher has attended to the factor of *blame* as a dynamic of prejudice earlier in this chapter. Such blame involves the perceived (symbolic) or real threat attached to an outgroup. Blaming an outgroup for being at risk of some disease, e.g. HIV/AIDS, provides an illusion of control over such disease (HSRC & Harriet Deacon, 2005:7). People thus differentiate their ingroup from an outgroup (s), whereby the ingroup is supposedly low in risk factors, while the outgroup is high on such factors. The outgroup is then blamed and characterised as being high-risk. HSRC & Harriet Deacon (2005:7) argue that this "blame" model is characteristic of "modern society": good health became an indicator of social-moral wellbeing, and ill health became associated and stigmatised with social and moral decay.

In blaming the "other", disease stigmatisation uses the stigmatisation content of a *variety of other forms of prejudice*, and adheres to existing social patterns of inequality and prejudice (HSRC & Harriet Deacon, 2005:8). Similarities in the stigmatisation of various diseases can be explained by the close relationship between disease stigmas. However, social inequality, prejudice, and the strength and ideological content of stigmas vary significantly between diseases (HSRC & Harriet Deacon). The study is of the opinion that biological factors, e.g. the progression of the disease and the state of the pandemic, could explain this variability (HSRC & Harriet Deacon, 2005:8). Other biological factors

include Jones et al's dimensions (as reviewed earlier) of concealability, time course, stigma origins, aesthetic value, danger and disruptiveness (Jones, et al., quoted by HSRC & Harriet Deacon, 2005:8). Chapman (quoted by HSRC & Harriet Deacon) is among researchers that have concluded that:

> The particularly strong stigma attached to HIV/AIDS in the West is driven by its concealability, the unpredictability of illness onset, its terminal nature, the development of visible and unaesthetic skin conditions such as Kaposi Sarcoma, and its early associations with the gay community and with Africa. (2005:8).

The study (HSRC & Harriet Deacon, 2005:9) cautions that disease stigma is not the result of biological factors, but that such factors impact on the social meaning that a disease develops. The biology of a disease manifests itself through its individual and social impact, furnishing the disease with its social evaluation.

7.1.4 HIV/AIDS stigmatisation as a process

The HSRC study suggests that the above definition (section. 7.1.2.2) should be augmented with a process model to explain the cause-effect dynamics of stigmatisation, its functions, as well as variations in stigma content (HSRC & Harriet Deacon, 2005:21).

Gilmore and Somerville (quoted by HSRC & Harriet Deacon, 2005:21) suggest four characteristics of stigmatisation: (1) the problem, (2) the identification of the stigmatised individual/group, (3) the act of stigmatisation, and (4) how a reaction to the stigmatised person/group develops. Link & Phelan (quoted by HSRC & Harriet Deacon, 2005:21) argues that stigmatisation is the convergence of four processes: (1) the distinction and labelling of individuals, (2) the identification of such individuals with certain undesirable personality traits, (3) the categorisation of such "marked" individuals to separate 'them' from 'us', and (4) the resulting experience by the stigmatised of status loss, resulting in unequal outcomes.

The blaming model of stigmatisation serves to reduce anxiety. People distinguish between good and bad to counter the anxiety of HIV/AIDS infection, and then reject the negative through projecting it onto an outgroup. The outgroup is then identified as having certain

characteristics that would increase the risk of contracting the disease, placing blame on the outgroup (s) for possessing those characteristics, which is then identified as the reason for having and/or spreading the disease (HSRC & Harriet Deacon, 2005:22). This perspective of the "blame" model of stigmatisation substantiates the study's proposed process model:

> Disease stigmatisation can be defended as a social process by which people use shared social representations to distance themselves and their ingroup from the risk of contracting a disease by: (a) constructing it as preventable or controllable; (b) identifying 'immoral' behaviours causing the disease; (c) associating these behaviours with 'carriers' of the disease in other groups; and (d) thus blaming certain people for their own infection and justifying punitive action against them. (HSRC & Harriet Deacon, 2005:23).

7.1.5 HIV/AIDS stigma content and variations

HIV/AIDS stigma content displays both universal and local characteristics (HSRC & Harriet Deacon, 2005:26). Local variations in HIV/AIDS stigma are due to local societal factors, e.g. cultural, political, historical and social determinants (HSRC & Harriet Deacon, 2005:26).

Patient and Orr (quoted by HSRC & Harriet Deacon) identified shared beliefs that are fundamental to HIV/AIDS stigmatisation in Southern Africa:

(1) "If you have HIV you're going to die, so I won't invest resources in you" (AIDS=death).
(2) "HIV/AIDS is a punishment for sin" (AIDS=sex=sin).
(3) "We cannot change the way we do things" - for example, condoms challenge cultural norms about procreation, and culture and tradition cannot be challenged (AIDS=condoms=contraception=cultural taboo) (2005:26).

Certain "instrumental stigma" beliefs like "HIV infection could result in higher susceptibility to disease like TB", or "HIV is easily transmitted by shaking hands" do not qualify as stigma, because they do not accord differentiation and blame to PLHA (HSRC & Harriet Deacon, 2005:25). However, *secondary stigmatisation* (or "courtesy"

stigmatisation) does exist. Examples of this kind of stigmatisation is the HIV/AIDS-TB link, the use of formula feeding for HIV positive mothers, and the use of condoms to prevent infection (HSRC & Harriet Deacon, 2005:26).

One possible reason for the variation in stigma has been changes in the strength of the stigmatising ideologies of various diseases (HSRC & Harriet Deacon, 2005:27). The study identified various factors that influence the strength and content of HIV/AIDS stigmatisation (HSRC & Harriet Deacon, 2005:27). These are: definitions of the other, other cultural associations, individual responsibility, disease biology (biological characteristics of the disease), course of the epidemic, medical knowledge, situational context, the social acceptability of expressing stigmatising beliefs towards a specific group, the legal and regulatory environment, and socio-economic context.

One of these factors, the biology of the disease is, according to the study, a "vital" factor in variations of stigma strength and content (HSRC & Harriet Deacon, 2005:28). The study quotes Alonzo and Reynolds (HSRC & Harriet Deacon, 2005:28), that HIV/AIDS stigmatisation changes according to the stages of the disease. This "stigma trajectory" involves four stages:

> (1) at risk: pre-stigma and the worried well; (2) diagnosis: confronting an altered identity; (3) latent: living between illness and health; and (4) manifest: passage to social and physical death (Alonzo and Reynolds, quoted by HSRC & Harriet Deacon, 2005:28).

The effect of anti-retroviral treatment (ARV) on HIV/AIDS stigmatisation seems to be unclear at this stage. A study in the Netherlands has indicated reduced stigmatisation of HIV/AIDS in this context (Bos, Kok and Dijker, quoted by HSRC & Harriet Deacon, 2005:28). The government rollout of ARV's occurred after this study, which leave us in the dark as to its effect on HIV/AIDS stigmatisation in South Africa. Judged by a study among South African mineworkers (Day, quoted by HSRC & Harriet Deacon, 2005:28-9) ARV's may alter the public perception of HIV/AIDS as "a killer disease'" in those areas where ARV's are available (2005:28-9).

7.2. FROM THE PERSPECTIVE OF THE STIGMATISED

7.2.1 Responses to HIV/AIDS stigmatisation

7.2.1.1 SELF-STIGMATISATION

How do people react to HIV/AIDS stigmatisation, and how do their reactions influence the impact of such stigmatisation? HSRC & Harriet Deacon (2005:31) suggest that the search for answers to this question should consider the everyday experiences of PLHA. The study distinguishes between two major responses to stigmatisation: *internal (self-stigmatisation*) and *external stigmatisation* (HSRC & Harriet Deacon, 2005:31). Internal stigmatisation involves *self-stigmatisation* (internalised stigmatisation), which results in "preventative" behaviour: individuals avoid settings perceived as discriminatory, inflicting some kind of disadvantage onto themselves in the process. This implies an acceptance of their social-devalued identity, resulting in a compromised self-esteem, which weaken the individual's resistance to stigmatisation (HSRC & Harriet Deacon, 2005:34). Other ramifications of such self-stigmatisation are the likelihood of discouraging testing, disclosure and treatment-seeking (HSRC & Harriet Deacon, 2005:34). Hiding a stigma is considered a manifestation of self-stigmatisation. Whether a stigma is concealed or made visible later cause greater stress than acknowledging an existing stigma (HSRC & Harriet Deacon, 2005:34). According to Link and Phelan (cited by HSRC & Harriet Deacon, 2005:34) self-stigmatisation may be the result of a prior internalisation of stereotypes regarding the particular disease.

The study apply research on coping with stressors to responses to stigmatisation (HSRC & Harriet Deacon, 2005:32) Citing Miller and Kaiser, a transactional, process-oriented model explain why people differentiate in their responses to stigmatisation, and how feedback from a response influences other reactions (HSRC & Harriet Deacon, 2005:32). *Figure three* (below) suggests that individuals can respond voluntarily or involuntarily to, and engage or disengage stigmatisation.

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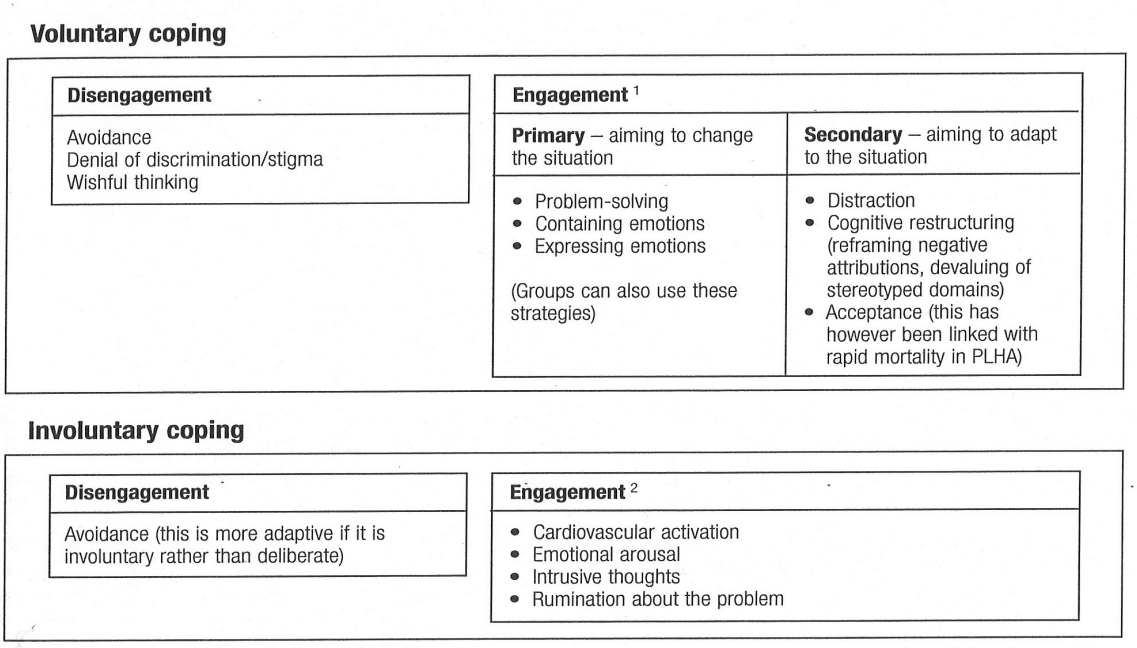
Stigmatisation reaction can be adaptive or maladaptive (HSRC & Harriet Deacon, 2005:32). There are instances when avoidance reaction to stigmatisation is adaptive, e.g. non-disclosure and a refusal to accept negative HIV views, since it represents an effort to repudiate stigmatising connotations (Deacon, Stephney, & Prosalendis, 2005:32). Non-disclosure may be maladaptive if it is an effort to shirk the realities of the disease by maintaining risk behaviour.

Figure 3: Responses to stigma



Source: Derived from the theoretical review in Miller & Kaiser 2001

Notes
1. Some responses to stigma, such as seeking social support, can serve a number of these functions at the same time (for example, problem solving, expression of emotion, cognitive restructuring).
2. Thinking about negative stereotypes may lead to depression and psychological distress, but emotional and physiological arousal, as a result of prejudice or discrimination, may alert and motivate better coping responses. Immediate reactions, such as exclamations, may serve as a kind of protest.

The literature on responses to stigmatisation indicates that stigmatisation prompts people to negotiate their identity, with implications for their behaviour (HSRC & Harriet Deacon, 2005:34). PLHA may project an overly positive identity onto them, which amounts to a form of denial. For example:

> HIV-positive women . . . cultivated a positive identity that emphasised their wellness and 'projected contagion and irresponsibility, key elements of a stigmatised HIV identity' onto other people: those who did not know their HIV status (Soskolne, Stein & Gibson, cited by HSRC & Harriet Deacon, 2005:34).

Both the need to alleviate anxiety as well as social factors, e.g. society's negativity, influences such projected positive identity (HSRC & Harriet Deacon, 2005:34-5). The study states that such an overly strong, projected, positive identity is an effort to project an image of independence. The denial character of such a strong, overly positive, identity functions to isolate such an HIV positive individual from the realities of the disease. It pressures the person to appear healthy even when they do not feel healthy, creating anxiety, and bar the person from speaking about the effects of the disease (Soskolne et al., cited by HSRC & Harriet Deacon, 2005:35).

7.2.1.2 EXPECTED STIGMATISATION

A second response to stigmatisation is *expected stigma and discrimination*. How stigmatised individuals perceive their membership to a stigmatised group and their stigmatisers influence their perceptions of stigmatisation (HSRC & Harriet Deacon, 2005:35). In addition, their past stigmatisation and discrimination, and information about their stigmatisation act as clues for how they perceive they will be stigmatised in the future (HSRC & Harriet Deacon, 2005:35). Expected stigmatisation exerts a negative influence on the impact of HIV/AIDS, the willingness to seek voluntary counseling and testing (VCT) and seems to exaggerate existing stigmatisation (Green; Green and Rademan, cited by HSRC & Harriet Deacon, 2005:35). Visser (cited by HSRC & Harriet Deacon, 2005:35) reported that expected stigmatisation contributed more to HIV positive women's experience of their community stigmatisation than real stigmatisation.

A crucial dimension of stigmatisation, from the perspective of the stigmatised, is that:

> It is very difficult to measure the amount of likely stigma and discrimination in the public sphere. The mismatch between perceived and reported stigma could instead indicate that the general public significantly under-reports stigma against PLHA . . . (HSRC & Harriet Deacon, 2005:36).

Another caveat is that the impact of stigmatisation cannot be determine only according to what HIV negative people *say* about, or *propose* to do regarding PLHA (HSRC & Harriet Deacon, 2005:36). Experienced stigmatisation, coupled by what the stigmatised hear and read about HIV/AIDS stigmatisation, can create such powerful expected stigmatisation

that such expected stigmatisation itself can be a greater barrier to seeking treatment and support than real, experienced stigmatisation or discrimination (HSRC & Harriet Deacon, 2005:36).

This review of the comprehensive theoretical and methodological assessment of HIV/AIDS stigma research by The South African Human Sciences Research Council's (HSRC) Research Programmes on Social Cohesion and Identity, and The Social Aspects of HIV/AIDS and Health (HSRC & Harriet Deacon, 2005) shed more light on the phenomenon of stigma and stigmatisation within the existential context of HIV/AIDS. The purpose of this review was to compliment the social psychology literature on stigma and stigmatisation with recent research on HIV/AIDS stigma/stigmatisation.

7.3 STIGMA/STIGMATISATION: A COMPARISON BETWEEN THE SOCIAL PSYCHOLOGY AND HIV/AIDS LITERATURE

7.3.1 Stigma and discrimination

The reviewed social psychology literature on stigma and stigmatisation indicated that stigma and stigmatisation is linked to discrimination. Discrimination is the result of justifying stigmatisation: it reflects the process whereby ingroup characteristics that makes the ingroup preferable (and superior) to those of the outgroup (the stigmatised group) justify discrimination (Dovidio et al [2000] 2003: 8). Discrimination also serves to defend the status quo, as in the case of White discrimination against Blacks during the apartheid era. This can be done through using ideologies to defend stigma and stigmatisation. Such justification ideologies provide both private and public "cover" for stigmatisation, prejudice, and discrimination that would otherwise be deemed unacceptable (Crandall, [2000] 2003:128).

In the case of HIV/AIDS research, it was also found that stigmatisation is linked to discrimination. Stigma should also be distinguished from discrimination because stigmatisation is not always discriminatory (HSRC & Harriet Deacon, 2005:ix). Disease stigma should distinguish stigmatising cognitions from discriminatory actions and stigma from its effects (Jennings et. al., 2002:9-10 and Miles, cited by HSRC & Harriet Deacon,

2005:18-19). The authors argue that it cannot be assumed that stigmatising cognitions necessarily results in discrimination against PLHA. Discrimination towards the stigmatised can also be due to reasons other than stigmatisation (e.g. gender, racism).

One also has to distinguish between discrimination and differential treatment in terms of HIV/AIDS. HIV infection necessitates differential treatment, for instance, the use of condoms to prevent transmission. However, HSRC & Harriet Deacon (2005:38) cautions that discrimination can be disguised as warranted differential treatment. Discrimination as such involves differential treatment that is based on biased and prejudicial grounds, whereas differential treatment is based on unbiased, non-prejudicial, medically-sound grounds.

HSRC & Harriet Deacon (2005:20) differs from the social-psychological approach as to the relationship between stigma and discrimination (see fig. 1). The former (HSRC & Harriet Deacon, 2005:20) argues that one has to distinguish between what both stigmatising and stigmatised individuals believe (stigma cognitions/ideologies), say (expressed stigma), and what these individuals actually do (measured as discrimination, withdrawal, or activism based on stigma ideologies). Thus, the HSRC & Harriet Deacon (2005:20) (*figure 1*) deviates from the social psychology literature by questioning the assumed inevitable linear progression from stigmatising beliefs to stigmatising expressions, to enacted stigma. Secondly, it distinguishes between discrimination as enacted stigma and discrimination resulting from other sources. This suggestion the researcher found helpful, although the problem is how to distinguish between these two sources when measuring stigma-based discrimination (enacted stigma). The researcher agrees that the concept of "enacted stigma" should be re-conceptualised as discrimination, reserving the concept of "stigma" to cognitions and expressed stigma. The researcher therefore appropriates these qualifications, as illustrated by Figure 1 (section 7.1.2.2).

7.3.2 Stigma and prejudice

The social psychology and HIV/AIDS stigma literature agrees as to the contributing role of prejudice to stigma and stigmatisation. The study (HSRC & Harriet Deacon, 2005:7) argues that HIV/AIDS stigma develops from the "social landscape of prejudice". HSRC

& Harriet Deacon (2005:7) argue that good health became an indicator of social-moral wellbeing, and ill-health became associated and stigmatised with social and moral decay. In blaming the "other", disease stigmatisation uses the stigmatisation content of a variety of other forms of prejudice and adheres to existing social patterns of inequality and prejudice (HSRC & Harriet Deacon, 2005:8). Similarities in the stigmatisation of various diseases can be explained by the close relationship between disease stigmas. However, social inequality, prejudice, and the strength and ideological content of stigmas vary significantly between diseases (HSRC & Harriet Deacon).

7.3.3 The processes of stigma

Stigmatisation, according to the social psychology literature, is an inevitable product of people's cognitions, social information and experiences (Dovidio et al [2000] 2003:2). Because stigma and stigmatisation is culturally determined, stigmatisation is regarded as "situationally specific, dynamic, complex and non-pathological" (Dovidio et al [2000] 2003:2).

The HIV/AIDS literature confirms this particularistic dimension of stigma/stigmatisation. According to the HIV/AIDS literature, HIV/AIDS stigmatisation involves a cause-and-effect dynamic. This cause-and-effect process involves certain steps through which the stigmatiser stigmatises the stigmatised, and the experience and reaction to stigmatisation by the stigmatised. HSRC & Harriet Deacon (2005:21-23) report on the specifics of HIV/AIDS stigmatisation.

One could ask whether the HIV/AIDS literature would agree with the social psychological position, that stigmatisation is non-pathological, because the disease stigma definition suggested by HSRC & Harriet Deacon (2005:19) conceptualises disease stigma as "social baggage". Above HIV/AIDS findings may suggest that stigmatisation as the biased, negative devaluation of individuals - accompanied by the associated phenomena of discrimination and prejudice - is a pathological phenomenon[3].

[3] See prior reference to the non-pathology of stigmatisation at section 5.

7.3.4 Variations in stigma

The social psychology literature on stigma refers to scholarly efforts to typologise stigma, e.g. Goffmann's classical categorisation of stigma. According to HSRC & Harriet Deacon (2005:26), HIV/AIDS stigma content in South Africa involves both universal and local characteristics, Examples of these culturally-specific characteristics are definitions of the other, other cultural associations, shared beliefs, individual responsibility, socio-economic context, and disease biology (biological characteristics of the disease). Disease biology - HIV/AIDS stigmatisation changes according to the stages of the disease - is in the South African context a "vital" factor in variations of stigma strength and content (HSRC & Harriet Deacon, 2005:28). Variations in the stigma attached to specific diseases might be a factor in the variations of HIV/AIDS stigma.

To conclude: in this chapter the researcher ascertained what stigma is, how it develops, how it varies, what purposes it serve, how it functions as a process, how it is justified, as well as an existential dimension of stigma and stigmatisation, i.e. HIV/AIDS stigma and stigmatisation. Next, the researcher will look at the relationship between stigma and suffering. What is suffering, and, specifically, the suffering of stigmatisation? How does the HIV/AIDS stigmatised suffer?

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CHAPTER 3

STIGMATISATION AND SUFFERING

1. THE PHENOMENON OF SUFFERING

One of the assumptions of this study is that suffering is an inevitable consequence of stigmatisation. The researcher will first look at suffering as a universal phenomenon. Suffering is universal in the sense that all human beings experience suffering. Louw (2000:9) argues that suffering is a "complex, multi-faceted issue". He identifies five dimensions of suffering; the cosmic-, cultural/structural- physiological/biological-, psychological-, and existential/religious dimension (Louw, 2000:9-11).

- The *cosmic* dimension of suffering denotes the human being's subjection to, and experience of, natural disasters and events over which there is no human control.

- The *cultural and structural* dimension of suffering denotes suffering as the by-product of human living. Technology, science, development and other cultural characteristics of Western society exact a cost in human suffering because it produce negative factors such as stress, pollution, technocracy, and materialism.

- The *physiological/biological* dimension of suffering is the physical manifestation of suffering e.g. sickness and bodily injury. This form of suffering manifests through physical pain, which flags physical malfunctions or disturbances in the body, whether it is sickness or injury. Suffering as pain depends on the effective working of the neurological system, which detects physical pain, and alerts the body through sensory stimulation.

- Louw refers to the *psychological* dimension of pain as: "One's most acute suffering" (2000:10). This dimension reflects any kind of psychological malfunction or imbalance (Louw, 2000:10). This kind of suffering involves both the suffering of the particular psychological dysfunction (e.g. the emotional roller coaster of the bipolar

disorder), as well as interpersonal suffering that results from the specific psychological disorder (e.g. rejection, stigmatisation, and exclusion).

- The last dimension of suffering, according to Louw (2000:11), is *existential* and *religious* suffering. It is the inevitable reaction to the human being's struggle to deal with the exigencies of life. It involves one's total response to the happenstances of life, influenced by one's level of responsibility, norms, values, and search for security (Louw, 2000:11). Existential suffering refers to one's psychic, spiritual-systemic reaction to the challenges of life, as determined by, inter alia, the maturity of one's attitudes, aptitudes, character, and moral ethic. This mode of suffering includes guilt, anxiety, despair, and helplessness, and self-contempt.

People usually experience suffering as negative, painful, unwanted, and thus to be avoided. However, suffering does not always result in avoidance. Suffering can also be accepted. Self-inflicted suffering is a fact of live, just as involuntary suffering characterises our human existence. Striving for personal betterment goals, for example, involves self-inflicted suffering, as do other priority decisions to attain something deemed worthwhile.

Another dimension of accepted suffering is when suffering results in spiritual and personal growth. To be certain, more often than not, one experiences such suffering as negative and unwanted. Examples of such personal/spiritual growth are self-sacrifice, patience, endurance, and becoming other-focused vis-à-vis being self-focused (Louw, 2000:11). Louw states that the result of such "identity" growth is greater maturity, more purposeful meaning in life, and the purification of character and behaviour (2000:11).

Suffering thus has the capacity to effect fundamental changes in one's motivation for, and orientation to, life. Suffering can be life-changing. The researcher will use Louw's typology of suffering (2000:9-11) to explore the multi-faceted suffering of stigmatisation.

2. THE SUFFERING OF STIGMATISATION

2.1 Experiential suffering: the spiritual dimension of suffering

The suffering that results from stigmatisation is of an experiential nature (Louw's fifth category). Experiential suffering is the result of the happenstances of life, of which stigmatisation is one example. The suffering of stigmatisation is the suffering of being devalued, ostracised, rejected, ignored, and denigrated, to be assessed as less of a human being. It involves the struggles to cope with stigmatisation, as influences by one's worldview, norms, values, self-image, and maturity, i.e. by the totality of one's being functions, one's individual and social identity.

Louw (2000) connects suffering to the issue of identity. In times of suffering one inevitably turns inward and probes for answers as to the reasons for such suffering. This inward search for understanding might be more likely in the case of experiential suffering. Suffering in this context results in an inner wrestling for meaning, where the search for reasons meet the particular individual's state of being. Where purpose and destiny, significance, and hopes combine with the pain of suffering to reveal the deepest, inner, qualities of character. This cauldron of the burning search for meaning centers, according to Louw (2000:16-20) around four questions that are put to God: *Why?, How?, Where?, When?,* and *for what purpose?*

The question of w*hy?* results in an inevitable surfacing of the sufferer's God-image(s). In the search for reasons and meaning through this question, the sufferer tries to reconcile God's identity with the sufferer's explanation of the reason(s) for his suffering. The question as to *why God*? is connected to the theodicy issue, why a good God could allow such suffering. This question involves the sufferer's interpretation of his/her suffering through an explanation and understanding of such suffering.

The question as to h*ow?* points to God's involvement. This question represents the struggle regarding God's identity and the revelation of that identity amidst suffering. It probes tot the verification of such identity through ways in which God demonstrates his caring:

The w*here?* question indicates the sufferer's need to verify God's presence, and behind this presence the need for God's providence and will. This question reveals the sufferer's need to secure control, the search for reassurance that God is in control and the security that such reassurance brings.

The *When?* question indicates the toll that the duration of suffering has had on the sufferer. It signifies the culmination of the stress of the suffering in the question as to how long the suffering will still last?

The last question that Louw (2000:16) propose as being part of the spiritual dimension of suffering is the question *for what purpose?* This question probes to the meaning of suffering, in the sense that it is the search for purpose and destiny, for the connection between the reason for suffering and self-identity. Next, the researcher will reflect on the suffering of stigma-based exclusion.

2.2 The suffering of social exclusion

2.2.1 EXPERIENTIAL SUFFERING

Major & Eccleston (2005:70-80) discuss the psychological consequences of stigma-based exclusion and responses to the threat of stigma-based exclusion. Their discussion indicates to a significant extent the suffering involved in social exclusion, which is a fundamental characteristic of stigmatisation.

The psychological suffering of rejection and exclusion becomes apparent when one realises how contrary it is to the personal well-being needs of being included and valued (Major & Eccleston (2005:70). Stigmatisation results in the oppression of one's personality and particularly one's self-image, because group evaluation plays an important role in self-image (Cartwright, (cited by Major & Eccleston, 2005:70). Cartwright (cited by Major & Eccleston, 2005:70) found that being identified with a devalued group results in self-hatred and feelings of worthlessness. Stigma-based suffering is also the consequence of socio-economic exclusion, e.g. a lack of education, employment, occupational well-being, housing and medical care (Major & Eccleston, 2005:70-71).

Such systemic stigmatisation endangers and effects both physical and emotional health, more so if it is well-entrenched. It is a form of psychological violence, which is the lot of the stigmatised (Herek, cited by Major & Eccleston, 2005:71).

2.2.2 DIFFERENTIATED SUFFERING

The authors mention research findings, that stigmatisation do not uniformly result in negative affective, cognitive and physical conditions (Crocker & Major, cited by Major & Eccleston, 2005:71). Stigmatised individuals often report self-esteem levels similar or better than non-stigmatised individuals. They argue that such variability in exposure to stigmatisation reflect how the stigmatised process stigmatisation, how they assess such stigmatisation (as exclusion), and how they cope with stigmatisation that is experienced as stressful (Major & Eccleston, 2005:71).

How stigmatised individuals respond to stigma-based exclusion thus reflect the suffering inflicted by such stigma-based exclusion. This is an important disclaimer, because it qualifies stigma-based suffering as non-uniform: some individuals suffer because of stigmatisation, others suffer less, and some may not suffer at all, albeit that this scenario varies from one social and individuals context to another.

I will briefly mention some of the responses to the threat of stigma-based exclusion to indicate the extent and variations in the suffering attached to the effects of stigmatisation (Major & Eccleston's, 2005:72-80). One indication of this varying degree of stigma-based suffering is Allport's extropunitive versus intropunitive defenses (Allport, cited by Major & Eccleston, 2005:72). According to this distinction, those with an extropunitive defense discredit the stigmatiser, while those with an intropunitive defense blame themselves for their rejection and exclusion. People suffer when they feel powerless to change or remove their stigmas. On the other hand, when stigmatised individuals are capable to alleviate or remove their stigma, suffering is reduced (e.g. losing weight to reduce/remove obesity-based stigmatisation).

2.2.3 THE SUFFERING WITHIN RELATIONSHIPS

One of the major areas of stigma-based suffering entails the repercussions of a stigma on *relationships*. HIV infection is a good example, where non-disclosure prevents the trauma of broken relationships and a subsequent loss of fellowship and support. However, it seems that suffering in such a case is not really alleviated, but exchanged (Major & Eccleston, 2005:72). The suffering that results from the disclosure of a stigma (particularly a threatening stigma like HIV/AIDS) is substituted for a "suffering of silence", the psychological burden of having to cope without any support with all aspects, present and future, of a stigma. PLHA often strike some compromise: they keep their infection/disease secret from those individuals/relationships whom they fear would result in the greatest trauma (such as spouses, children and family members), but disclose to very close friends or family members, whom they are confident will support and accept them (Major et.al.., cited by Major & Eccleston, 2005:74). Such a compromise may alleviate suffering from one area of relationships (those disclosed to) but may entrench the suffering of nondisclosure (e.g. anxiety). Fear of discovery and fear of rejection, in case of discovery of a concealed stigma, is some of the kinds of suffering that result from non-disclosure. Anxiety is likely, both in terms of one's immediate environment, as well as non-stigmatised individuals in private and public life. Such anxiety may not only result in affective, cognitive and physical stress, but may also exacerbate the stigma condition (Pennebaker, cited by Major & Eccleston, 2005:74). An appropriate example is the worsening of an HIV infection because of nondisclosure (Cole, Kemeny & Taylor, cited by Major & Eccleston, 2005:74). Nondisclosure also results in the suffering of bearing it alone - being without self-validation, social support, and the advantages of ingroup social comparisons (Major & Eccleston, 2005:74). Research has confirmed that disclosure of a stigma to close family or friends who reacted with rejection is very painful (Major et. al., cited by Major & Eccleston, 2005:74). Non-disclosure is common amongst homosexuals (Franke & Leary, cited by Major & Eccleston, 2005:73), those who suffers from mental illness (Wahl, cited by major & Eccleston, 2005:73), those had an abortion (Major et. al., cited by Major & Eccleston, 2005:73), and PLHA. Jones et al (cited by Major & Eccleston, 2005:74) found that the suffering of disclosure is so consequential that people who non-disclosed suffer less.

The stress, anxiety, and other forms of suffering which results from *overcompensation* is another dimension of stigma-based suffering. Overcompensating occurs when a stigmatised individual tries to overcome the effect of a stigma (e.g. rejection, exclusion, and discrimination) in various social relationships (Miller & Myers, cited by Major & Eccleston, 2005:74).

2.2.4 THE SUFFERING OF WITHDRAWAL

Major & Eccleston (2005:75-76) discuss withdrawal as another reaction to stigma-based exclusion. Withdrawal as a reaction to stigma/stigmatisation is a social-oriented withdrawal, including relationships and all other social contexts where exclusion is expected. In situations where such physical withdrawal is not possible (e.g. at the workplace or school) stigmatised individuals withdraw psychologically (Major & Eccleston, 2005:75). This involves a "disengagement of the self-esteem" from situation where they expect or have to endure the effects of stigmatisation (Major & Eccleston, 2005:75). This reduces the suffering of exclusion, rejection, devaluation and the stress and anxiety that accompanies it. Major & Eccleston (2005:75) observe that a negative consequence of psychological withdrawal is that it robs such individuals from the motivation to overcome the stigmatisation threat of those social environments. This may jeopardise vital development requirements such as school and career development. Withdrawal may backfire if stigmatisers also withdraw to justify stigmatisation, blaming those who withdraw for not being interested or able to be responsible performers.

Distancing oneself from one's stigmatised group through either avoidance or concealing one's stigma reduces stigma-based suffering (Major & Eccleston, 2005:73). Fear of stigmatisation motivates this and other forms of suffering-avoidance behaviour (Pennebaker, cited by Major & Eccleston, 2005:73).

2.2.5 SUFFERING AND INGROUP AFFILIATION

Another reaction to the suffering of stigmatisation is to search for ingroup affiliation that will replace exclusion and other effects of stigmatisation with inclusion, value, respect and other self-esteem enhancing mechanisms (Major & Eccleston, 2005:76-78). Such

affiliation provides acceptance and support, and may redefine and enhance ingroup identity. Such identity enhancement emphasises ingroup distinguishing features (that are stigmatised) as acceptable (Tajfel & Turner, cited by Major & Eccleston, 2005:76). By facilitating ingroup comparison, such ingroup affiliation may help to shift social comparison from outgroup characteristics to ingroup features. Ingroup comparison protects self-worth against the stigma-based suffering of outgroup comparison. These mechanisms for greater acceptance may lessen the suffering of stigmatisation, because they shift the focus from an outgroup to the ingroup.

It follows that the visibility of a stigma influences the extent to which one can acquire ingroup affiliation (Major & Eccleston, 2005:76-77). The positive effect of affiliation is evident in the light of findings that those with invisible stigmas suffer more from lower self-esteem, anxiety and depression than those with visible stigmas as well as non-stigmatised people (Major & Eccleston, 2005:77). These individuals include homosexuals and PLHA. Because they lack the strengthening effect of ingroup affiliation, they are more prone to suffer from stigmatisation.

These mechanisms of alternative forms of inclusion may not result in the expected lessening of stigma-based suffering (Major & Eccleston, 2005:77). The authors state that:

> . . . strong identification with a stigmatized group may increase one's vulnerability to rejection and exclusion of the group (2005:77).

The reason for this phenomenon is that the suffering of exclusion still occurs in ingroup affiliation, and being overly affiliated may increase, instead of decrease, vulnerability to rejection. Inclusion with a stigmatised group may result in more exclusion by an outgroup, because the outgroup may perceive it as purposefully exclusionary (Major & Eccleston, 2005:77). In fact, such behaviour may be perceived as reverse discrimination, resulting in increased exclusion and animosity (Major & Eccleston, 2005:78).

I have now reviewed three responses to the threat of stigma-based exclusion, as presented by Major & Eccleston (2005:72-78), identifying stigma-based suffering inherent to these responses. The last response presented by the authors is to "attribute exclusion to discrimination" (Major & Eccleston, 2005:78-80).

2.2.6 THE ATTRIBUTION OF DISCRIMINATION

This coping method involves blaming stigma-based exclusion on the prejudice of the stigmatiser towards the stigmatised group (Major & Eccleston, 2005:78-80). Such projections serve to protect self-esteem relative to blaming oneself for such exclusion. As with the above three responses, stigmatised individuals find it difficult to avoid stigma-based exclusion and, therefore, stigma-based suffering. Such blaming of the stigmatiser only lessens stigma-based exclusion if the stigmatised individual is not strongly affiliated with the stigmatised group (Major & Eccleston, 2005:78). This is also the case if such prejudice is blatant instead of ambiguous.

The prevalence of group identity effects stigma-based exclusion, and thus suffering. Major & Eccleston (2005:79) argue that stigmatised individuals who belong to a group with a less defined collective identity may be more vulnerable to stigma-based exclusion than those belonging to a easily-recognised group. The authors estimate that this phenomenon may explain why AIDS support groups are successful:

> They provide not only opportunities for social support, but also a mechanism for forming a collective identity and group-level attributions (Major & Eccleston, 2005:79).

Stigmatised individuals believe that stigma-based exclusion is discriminatory when such exclusion is believed to be unjust or illegitimate (Major & Eccleston, 2005:79).

2.2.7 BEING "RESPONSIBLE" FOR STIGMA

Stigmatised individuals may (correctly or incorrectly) identify themselves as the cause for stigma-based exclusion (Major & Eccleston, 2005:79-80). Such self-blame may result in a variety of stigma-based forms of suffering. Self-blame is more likely when some moral indiscretion is judged responsible for a particular stigma, which is the case with stigmas judged as controllable. The stigmatised individual is then branded as responsible for his/her stigma, because of the moral "character blemish", justifying rejection and exclusion, even by fellow stigmatised individuals (e.g. promiscuity being "identified" as a categorical reason for women's HIV positive status) (Crandall; Rodin et al; cited by Major & Eccleston, 2005:79). Such "responsibility" for a stigma results in more severe

stigmatisation: individuals face the suffering of being branded as responsible and blameworthy, and have to deal with its affective, cognitive and behavioural effects. Responsibility-based stigmatisation attributions are so prevalent that it even negatively reflects on stigmas seen as non-controllable (Brickman et al., cited by Major & Eccleston, 2005:80). This phenomenon prompts the question whether someone seen as not responsible for contracting HIV/AIDS (e.g. infection through blood transfusion) may be seen as responsible for overcoming the effects of such infection. A finding by Major & Eccleston (2005) may confirm the question that "'abominations of the body":

> even though not perceived as controllable, are also often seen as reflecting some moral imperfection of the person" (, 2005:80)

It is therefore not surprising that individuals suffering from stigmas perceived as controllable are more prone to stigmatisation than those whose stigmas are not seen as controllable (Major & Eccleston, 2005:80). The authors surmise that such individuals are less likely to seek affiliation as a "group" than those who believe their stigmas to be uncontrollable. The former individuals thus suffers more from rejection and exclusion on an individual level, than as a group (Major & Eccleston, 2005:80).

3. HIV/AIDS STIGMA/STIGMATISATION AND SUFFERING

> Stigma has become the silent killer - it decimates families, who cannot speak to each other about the illness in their midst. It brings fear of alienation and rejection (Ndungane, 2005:379).

The suffering of HIV/AIDS involves physical-, emotional-, relational-, and spiritual suffering (Marshall, 2005:142). The suffering of stigmatisation includes the suffering of ostracism, rejection, prejudice, discrimination, and condemnation. Condemnation involves the prejudice of labelling a PLHA as responsible for the disease, as deserving it (because of promiscuity), and thus as being judged by God (cf. Marshall, 2005:142).

Stigmatisation is a form of violence. It devalues and demeans human beings as less than fully human beings, destroying their capacity for being fully human and their prospect for becoming fully human. Paterson (UNAIDS, 2005) states it succinctly:

> If we can persuade ourselves that 'the other' is less than human, then we don't have to worry about treating them like animals (2005:36).

HIV/AIDS exact a mental, emotional, and social toll (Van Dyk, 2005:214). The psycho-social, socio-economic and spiritual problems of HIV positive individuals include fear, loss, grief, anger, denial, guilt, anxiety, low self-esteem, depression, suicidal thoughts/behaviour, obsessive conditions, spiritual anxiety, and socio-economic challenges (Van Dyk, 2005:216-8). These dimensions of suffering are intertwined with the suffering caused by HIV/AIDS stigma and stigmatisation.

Probably the most challenging is the effect of HIV/AIDS on the victims' sense of purpose and destiny. The task of finding spiritual equilibrium after a HIV positive diagnosis is daunting, often involving a prolonged process of mental and emotional anguish. The search for meaning amidst the finality of a HIV positive diagnosis may involve self-mourning and destructive behaviour of the self and others, as the person grieves the loss of his/her pre-HIV positive status. The process of grief also includes a variety of fears about an uncertain and impaired future (Van Dyk, 2005:238-243).

Van Dyk (2005) asserts that:

> Aids-related stigma and discrimination remain the greatest obstacles to people living with HIV infection or Aids. Stigma and discrimination increase people's vulnerability, isolate them, deprive them of their basic human rights, care and support, and worsen the impact of infection" (2005:100).

Culture has a major impact on the suffering of HIV/AIDS stigmatisation. Shame and silence are two of the dimensions of the suffering caused by HIV/AIDS-related stigma. Clifford (2004:8) states that "Silence has always been a consequence of stigma" (cf. Ndungane, 2005:379). Duffy (2005) reports a village health worker in Zimbabwe as saying that PLHA are

> ill-treated . . . Nobody likes to associate or share anything with an Aids patient . . . they are considered repugnant or repulsive (2005:5)

Duffy (2005) reports the effects of stigmatisation in the Zimbabwean context:

> They are given separate eating utensils . . . and people tend to clap hands when greeting instead of the very important handshaking that is the norm in this culture (2005:5).

She mentions the assessment of a nurse in one of the villages, that there is a strong perceived relationship between HIV and promiscuity:

> They are treated differently, they isolate them . . . Serves you right, why did you acquire it? (Duffy, 2005:5).

Isolation is rejection, which is another manifestation of stigmatisation. In this cultural setting, as in other cultural contexts, fear of isolation strongly discourages disclosure. Such isolation is so pervasive that it bears no resemblance to the actual risk of infection posed to others. In this case study, women suffered more from HIV/AIDS stigma than men (Duffy, 2005:6). They are the one's to blame when a husband and wife both become HIV positive, a function of the greater tolerance of male promiscuity than that of women (Duffy, 2005:6). It is women who are ostracised or sent away, even when they are infected by their husbands (Duffy, 2005:6).

Duffy (2005:9) reports that stigmatisation and suffering present a "vicious circle**".** Stigmatisation causes greater suffering, which result in silence (to avoid the suffering of stigmatisation), adding further impetus to stigmatisation. Such suffering adds to the suffering of social inequality. Because the prevalence of HIV/AIDS coincides with the marginalised and lower classes in society, stigmatisation of HIV/AIDS reinforces the already-present social exclusion, prejudice and discrimination. Duffy (2005) suggests that the stigmatisation of HIV/AIDS, and the suffering it causes, may well reflect the divide between rich and poor:

> Are stigma and resulting discrimination the reasons why so little seems to be done about finding a vaccine, about funding antiretrovirals for developing countries . . . (2005:10)

Above examples of stigma-related suffering in the Zimbabwean context reflect stigma-related suffering in other cultural contexts, as the review of the relationship between stigma and suffering indicates. Many of the facets of HIV/AIDS suffering, e.g. fear, loss, grief, anger, guilt, anxiety, low self-esteem, depression, suicidal thoughts, and obsessive

behaviour are characteristic of HIV/AIDS stigma-related suffering. Being devalued, ostracised, discriminated against, and other effects of stigmatisation interacts with other mental-emotional suffering caused by being HIV positive, exacerbating the legacy of HIV/AIDS suffering.

4. CONCLUSION

It has become clear in this chapter that the suffering caused by stigmatisation is multifaceted. It is *existential suffering*, suffering on the level of identity and meaning. It involves an inner wrestling for meaning. This mode of suffering includes guilt, anxiety, despair, helplessness, and even self-contempt. It is the suffering of being devalued, ostracised, rejected, ignored, and denigrated, i.e. to be assessed as less of a human being, destroying the capacity for being fully human. The suffering of stigmatisation involves *social exclusion*, resulting in the "suffering of silence", the psychological burden of having to cope without any support with all aspects (present and future) of a stigma. *HIV/AIDS stigmatisation* is an example of this form of suffering. It wrecks havoc with relationships: the stress of non-disclosure and the ramifications of disclosure both exacts a heavy psychological toll. Another manifestation of the suffering of stigmatisation is *withdrawal*: social-oriented withdrawal from relationships and all other social contexts where exclusion is expected, and psychological withdrawal in situations where physical withdrawal is not possible. Stigmatised individuals may even identify themselves (correctly or incorrectly) as the cause for stigma-based exclusion. Such *self-blame* may result in a variety of stigma-based forms of suffering. *Culture* has a major impact on the suffering of HIV/AIDS stigmatisation. It involves shame, adding to the suffering of social inequality. Because the prevalence of HIV/AIDS coincides with the marginalised and lower classes in society, stigmatisation of HIV/AIDS reinforces the already-present social exclusion, prejudice and discrimination.

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CHAPTER 4

TOWARDS DESTIGMATISATION:
A SOCIO-PSYCHOLOGICAL AND THEOLOGICAL PERSPECTIVE

A basic assumption of this study is that stigmatisation needs to be countered by effective destigmatisation intervention. First, the researcher will present a review of the literature on destigmatisation interventions, and second, explore how theology and the church can contribute to HIV/AIDS destigmatisation. This approach is motivated by the assumption that a holistic, systems, approach would best delineate the parameters of destigmatisation, and addresses the real-life (existential) reality of the PLHA.

1. A SOCIO-CULTURAL PERSPECTIVE

The HSRC study (HSRC & Harriet Deacon, 2005:1) points out that destigmatisation only came in focus in the recent history of the pandemic, after the initial struggle to understand the operation of the disease resulted in a focus on medical interventions. Stigmatisation acquired greater prominence as a priority in combating the disease because of its prevalence, and the realisation that stigmatisation impedes the prevention and treatment of the disease.

The study found that only a *small amount of research* has been done on destigmatisation interventions, compared to research on HIV/AIDS stigma (HSRC & Harriet Deacon, 2005:xii). Furthermore, assessments of destigmatisation interventions indicate that such interventions are not effective, because they lack a systemic approach (HSRC & Harriet Deacon, 2005:3). A more holistic intervention, for instance, integrating educational campaigns with counseling, coping, self-empowerment, involvement with PLHA, and community involvement is needed (Brown et al.; Bollinger; Visser; cited by HSRC & Harriet Deacon, 2005:3).

Parker & Aggleton (2003:14) add that the inadequate effect of HIV/AIDS destigmatisation interventions on stigmatisation, discrimination and denial, is related to *limitations of theory and methodology*. Parker & Aggleton (2003:16) state that the

preponderance of destigmatisation interventions developed to combat HIV/AIDS stigmatisation and discrimination has been aimed at efforts to (1) *"convert" stigmatisers* to be more accepting towards the stigmatised, and (2) to *aid the stigmatised to better deal with stigmatisation and stigma-related discrimination* (Parker & Aggleton, 2003:16).

To further complicate the challenge for successful destigmatisation interventions, Paterson (UNAIDS, 2005:33) criticises the *narrow psycho-social focus* on stigma and stigmatisation. She asserts that the weakness of the medical approach is that (1) the "systemic implications" of stigma is ignored, and (2) it does not recognise the way stigma:

> . . . is embedded in the hearts both of the stigmatizers and their victims (UNAIDS, 2005:33).

She argues that scientific paradigms for disease is not sufficient in terms of HIV/AIDS stigma, illustrating her point with Arbuckle's (cited by Paterson, UNAIDS, 2005:33) distinction between *disease* as a scientific construct, and *illness* denoting the experiential dimension of disease (cf. Louw, 2008:36-46).

2. DESTIGMATISATION: A SYSTEMS APPROACH

HIV/AIDS stigmatisation and accompanying discrimination is part of the *political dynamic of social exclusion* that determines and influences the contexts and functions of HIV/AIDS-related stigma. These characteristics and dynamics of HIV/AIDS-related stigmatisation and -discrimination should be critical in informing destigmatisation interventions.

There appears to be a shift in the assessment of HIV/AIDS stigmatisation and stigma-related discrimination during the past few years: stigma and stigmatisation being addressed as both an individualistic, social-psychological phenomenon, yet operating in the *context of social forces* such as prejudice, power, social inequality and social exclusion. The HSRC study's review of destigmatisation interventions reflect a more holistic, systems-oriented assessment of HIV/AIDS stigmatisation and stigma-related discrimination (HSRC & Harriet Deacon, 2005).

HSRC & Harriet Deacon (2005:8-9) add that disease stigma usually reflect the stigmatisation involved in other prejudices and in the social inequalities in society. Destigmatisation intervention must, therefore, perceive HIV/AIDS stigmatisation as part of the broader *societal prejudices and inequalities*, and the stigmatisation involved in those systemic characteristics. In addition, because stigmatisation ideologies varies in strength and content, destigmatisation interventions must reckon with the cultural, regional, historical and social differentiation in stigmatisation (HSRC & Harriet Deacon, 2005:8).

Patient and Orr (cited by HSRC & Harriet Deacon, 2005:76) suggests countering stigmatisation beliefs in their societal context. Link & Phelan (cited by HSRC & Harriet Deacon, 2005:76) propose a *top-down approach*: to counter the stigmatising attitudes of the stigmatisers, and oppose opportunities for entrenching stigmatising attitudes in society.

Van Dyk (2005) refers to *cultural impediments to HIV/AIDS prevention campaigns*, e.g. the Rwandan belief that the fluids involved in sexual intercourse amounts to an exchange of the "gift of self" that is perceived as necessary for fertility and the prevention of disease (Taylor, cited by Van Dyk, 2005:123). Rwandan women fear that condoms may irretrievably be stuck in the vagina, resulting in women becoming "blocked beings" (Taylor, cited by Van Dyk, 2005:123). It is clear that these and other cultural impediments to HIV/AIDS prevention campaigns must be resolved to retard the advance of the pandemic and increase the efficiency of destigmatisation interventions.

HIV/AIDS epidemiology in many two-thirds world countries is the story of *cultural conflict.* For instance, the Western-oriented and dominated medical epidemiological management of the pandemic calls for the use of condoms, whilst two-thirds world culture opposes it due to a fear of physical non-wellness, as the above Rwandan finding so aptly demonstrates. South Africa has witnessed numerous rounds of the tug-of-war between representatives of Western medicine (campaigning for scientific HIV/AIDS prevention and treatment) and the two-third world dominated government, highlighting the diametric differences on the pandemic. Western medicine identifies the cause of the pandemic as the entry of the HI virus into the bloodstream through personal action; two-

thirds world culture look for magic or witchcraft as the "personal or ultimate" cause (Van Dyk, 2005:117-8). Two-thirds world culture provides other reasons for illness such as HIV/AIDS, e.g. a neglect to perform traditional purification rituals - which is supposed to cure an HIV positive spouse after her husband died of AIDS - and the natural presence of 'germs', seen as causing e.g. colds and sexually transmitted diseases (Van Dyk, 2005:120).

These and various other cultural conflicts directly impact on HIV/AIDS, as Van Dyk explains (2005):

> Unfortunately, the connection between STI's (*sexually transmitted infection)*, Aids and sexual behaviour change is often not made in Africa. People often cannot understand why they have to change their sexual practices to prevent HIV infection, because HIV attacks everything accept their sexual organs (2005:120).

The tragic result of this and other clashes between Western medicine and two-thirds world culture is that Western medicine-designed prevention campaigns fail because they do not address these and other conflicts between Western medicine and two-thirds world culture.

A crucial aspect of destigmatisation interventions is that they should be both "*multifaceted*" (addressing various social determinants of disadvantages impacting stigmatisation and discrimination), *and "multilevel*" (including both individual and structural discrimination) (Link & Phelan, cited by HSRC & Harriet Deacon, 2005:76). This dual approach involves a confrontation of the basic cause of stigma, i.e. (1) the entrenched attitudes and beliefs of dominant groups that causes the devaluing effects of stigmatisation (e.g. prejudice, ostracism, discrimination), and (2) changing the power of the dominant groups to establish their stigmatising beliefs circumstances.

Certainly, the direct and *major causes* for HIV/AIDS stigma and stigmatisation (i.e. its concealability, unpredictable onset, terminal nature, and association with certain population groups) *must be countered* for destigmatisation interventions to be effective. New *advocacy and social change models* need to be developed, seen against the background of the success of community mobilisation against stigmatisation and discrimination (Parker & Aggleton, 2003:21). In addition, such models need to be part of

a *"multi-dimensional' intervention strategy*: interventions must be locally-oriented and complimented with structural/environmental interventions, with the purpose of transforming the stigmatising context of both stigmatiser and stigmatised (Parker & Aggleton, 2003:21).

2.1 Destigmatisation interventions

HSRC & Harriet Deacon, (2005) state that destigmatisation interventions should *target the major HIV/AIDS problems*:

> barriers to prevention, treatment and care; discrimination against people living with HIV/AIDS; and the difficulties (and occasional opportunities) posed by living with HIV/AIDS in a stigmatising, and increasingly poor and divided, society (2005:xii).

These priorities must be assessed within the larger public context so that they can be integrated efficiently with the influence of factors such as employment, housing, the functioning of health care services, and educational input. Other such destigmatisation priorities include promoting disclosure and protecting confidentiality, developing and enforcing a rights-based approach, educational interventions, community projects and adapting public health messages (HSRC & Harriet Deacon, 2005:77-83; Parker & Aggleton, 2003:22).

Destigmatisation must also be *cognisant of the HIV/AIDS body of research* on destigmatisation interventions, so that destigmatisation strategies that have been proven inefficient can be avoided (HSRC & Harriet Deacon, 2005:4).

An important point of the HSRC study (HSRC & Harriet Deacon, 2005:13) is that one must *distinguish between stigma-based discrimination and "differential treatment based on rational assessment of risk***"**. In other words, because of the nature of the disease, limitations on behaviour must be introduced to combat the spread of the disease, for instance, to introduce certain qualifications for anti-retroviral treatment candidacy. However, such limitations or differential treatment of PLHA must not be stigmatising in any way.

It is necessary that not only *the general public (as stigmatisers) but also health-workers and the families of PLHA* must be the target of destigmatisation interventions, because those two parties are part of the problem of HIV/AIDS stigma and stigmatisation (Bond et al., cited by HSRC & Harriet Deacon, 2005:75).

Another conclusion is that *neither educational materials nor educational programmes have been successful* in eliminating stigma and stigmatisation (HSRC & Harriet Deacon, 2005:75). The study refers to the experience of the Treatment Action Campaign (TAC), confirmed by research in the United States, of:

> . . . the important role that developing group identity, self-esteem, rights based legal and policy frameworks and political activism can play in challenging stigma (HSRC & Harriet Deacon, 2005:75).

According to the stigma literature, both the *development of group identities and group work* can efficiently challenge stigma and stigmatisation (HSRC & Harriet Deacon, 2005:79). Group work can assists PLHA to counter stigma and stigmatisation attitudes, counter self-stigmatisation, and increase self-esteem. PLHA can thus be introduced to various AIDS ideologies, and they can receive social support and develop a positive group identity.

Confirming the HSRC study's destigmatisation review is *Skinner's list of destigmatisation interventions in South Africa* (cited by HSRC & Harriet Deacon, 2005, 75): education, demystification of threat, positive contact and exposure to PLHA and their empowerment, the development of a resistance ethic among PLHA, and structural interventions.

The prevalence of HIV/AIDS - indicated by the number of HIV positive cases, as well as HIV/AIDS-related deaths - has already undermined *promiscuity* as the perceived cause of the disease (HSRC & Harriet Deacon, 2005:76). Destigmatisation interventions should be designed and continually evaluated and adapted in the light of *changes in the disease's social character.*

The HSRC study proposes some *specific interventions* to reduce the impact of stigmatisation *on PLHA* (HSRC & Harriet Deacon, 2005:78-80). These interventions are

identified as a neglected area of intervention, as interventions have targeted HIV negative individuals. The benefits of addressing HIV positive individuals could be safer sex behaviour and improving exposure to testing, through limiting the effects of stigmatisation and discrimination.

Expected stigmatisation and discrimination need to be reduced by confronting those stigmas and stigmatisation/discrimination most prominent to PLHA. Parker & Aggleton (cited by HSRC & Harriet Deacon, 2005:79), emphasise localised interventions, through community mobilisation and social change. This may mean that PLHA are to join in social activism against stigmatisation. The study suggests a combination of HIV positive and HIV negative activists participating in destigmatisation intervention efforts as the most effective intervention against stigma and stigmatisation (HSRC & Harriet Deacon 2005:79).

We will be amiss if we interpret all discrimination in terms of stigma-related behaviour (HSRC & Harriet Deacon, 2005:33). According to the POLICY project (cited by HSRC & Harriet Deacon, 2005:33) PLHA are adamant that their identities and behaviour are not only determined by HIV/AIDS.

In conclusion, destigmatisation must be based on a holistic, systems approach. Although stigma and stigmatisation is a social-psychological phenomenon it operates within a socio-political context, characterised by prejudice, power issues, social inequality, and social exclusion. Stigma, in particular disease stigma, thus highlights other societal stigmatisation, which results from prejudice and social inequalities. Destigmatisation intervention must, therefore, engage HIV/AIDS stigmatisation as part of the broader societal prejudices and inequalities. Destigmatisation must be context-specific and aimed at the stigmatiser as the primary source of stigma and stigmatisation. Destigmatisation interventions must be multifaceted as well as multilevel to effectively retard this primary source of stigma and stigmatisation. Apart from targeting the primary stigma sources, destigmatisation interventions should also target the major HIV/AIDS problems. Destigmatisation must be cognisant of the HIV/AIDS body of research on destigmatisation interventions, and current destigmatisation interventions, so that destigmatisation strategies that have been proven inefficient can be avoided. In particular,

educational interventions must be re-assessed as to their effectiveness. Next, the researcher will present a theological approach to destigmatisation interventions.

3. TOWARDS A THEOLOGICAL PERSPECTIVE

3.1 Introduction

The researcher will now reflect on HIV/AIDS stigmatisation and destigmatisation from a theological perspective. How appropriate is Scripture, as a combination of theory and praxis, to the HIV/AIDS scenario? What is theology's perspective on the human being involved in both stigmatising and responding to stigmatisation? And, how can a theology of HIV/AIDS guide us in terms of HIV/AIDS stigma, destigmatisation and the role of the church in destigmatisation interventions?

3.2 Theology: theory and praxis

"Theology" involves both a theoretical and practical dimension. As theory, theology indicates both the message of Scripture and content of the faith-tradition of the Church. As practice, theology indicates the application of Scriptural truth as praxis, as applicable, and applied to an existential context. Scripture, as the revelation of God in His involvement with life on earth, involves both knowledge/principle and existential direction. The New Testament is a revelation of God's love in Christ, through his incarnation, suffering, crucifixion and resurrection. Scripture thus presents us with (1) God's guidelines for ethical, righteous, and godly living, and (2) with examples of applying those precepts. It explains, informs, directs and aids the human condition in existential context: how to live virtuously, according to the kingdom values and norms of Christ, according to a transformed identity, which Christ enabled through his redeeming, atoning and salvific work on the cross, as confirmed by his resurrection.

The researcher is, therefore, confident that theology can inform HIV/AIDS stigmatisation and destigmatisation. It can do so because HIV/AIDS stigmatisation is part of the domain of the human condition, part of the reality of being human, for which Christ-incarnate gave himself to reconcile man to God. The reconciliation of God and man eclipsed all

contexts of time, and culture, thereby including all manifestations of the human condition, including HIV/AIDS.

3.3 Stigmatisation as sin

A theological workshop on HIV/AIDS-related stigma (UNAIDS, 2005), concludes that:

> Understandings of sin, therefore, constitute an essential component of Hiv- and AIDS-related stigma" (2005:13).

The workshop report points out that stigmatisation is not only a sin against one's fellow human being, but also against God (Gen. 3:1-8; Matt. 24:4-14), because all human beings were created in the image of God (UNAIDS, 2005:13; Ackermann, 2005:391; Marshall, 2005:137). This rebellion exceeds beyond God to include the dehumanisation of human beings through the processes of stigmatisation (Ackermann, 2005:391). God is love, and love enhances and elevates, bestows meaning, purpose and worth, whilst stigmatisation represents the opposite of these characteristics (cf. Ackermann, 2005:391).

The effect of sin is destruction of individual and social life. Stigmatisation as sin involves *denying the stigmatised his God-given identity as a worthy and valued human being,* a value which is testified by Christ's death on the cross. Jesus himself denounced the attitudes of "pride, self-righteousness, exclusivity, hypocrisy, and the misuse of power" that is central to stigma-related processes of prejudice, social exclusion and discrimination (UNAIDS, 2005:14).

Stigmatisation is the sin of human beings' *misplaced appropriation of God's role as judge* (Marshall, 2005:137; Ackermann, 2005:391). Not only is the prohibition against judging someone else one of the kingdom values Jesus proclaimed, but judging others has ramifications (Matt. 7:1,2; cf. Ackermann, 2005:391). Of course, as indicated above, judging others is completely contrary to love, and love is a fundamental characteristic of a transformed (Christian) identity. Stigmatisation is sin because, as an act of judgement it dehumanises by stripping human beings of their dignity, en thus denying the love of God towards that person.

Judging others reveals perpetrators' *misappropriated God-images*. Two such God-images in terms of HIV/AIDS are God as judge and God as tyrant (Wohlk, cited by Louw, 2008:401). Whereas an appropriate understanding of God as judge serves to guide behaviour through the corrective of guilt and guilt feelings, a misunderstanding and misappropriation of such image(s) serves only to condemn, in the case of HIV/AIDS stigmatisation to devalue and degrade. What these and other negative images of God have in common is the absence of love. It is the church' task to rectify negative, inappropriate God-images in connection to HIV/AIDS and HIV/AIDS-related stigma (Louw, 2008:427-428).

Apart from the sin of stigmatisation is the sin of HIV infection as the result of *sinful behaviour and sin-warped social structures* (cp. Marshall, 2005:137). Marshall adds that human refusal to accept God's right to delineate human behaviour hampers destigmatisation and epidemiological efforts to combat a disease that is actually preventable (2005:137). A thorough diagnosis of the scope of HIV/AIDS necessitates recognition of the impact of sin on HIV/AIDS (Conradie, 2007:12). He (Conradie, 2007:12) comes to an important conclusion:

> There is a crucial fallacy in many AIDS-awareness campaigns that the major problem is one of ignorance and that conveying the correct information about the pandemic would result in appropriate action (2007:12).

Stigmatisation as sin taints not only individual character but also social identity. It damages relationships and subject human community to the suffering of injustice and prejudice (cf. Ackermann, 2005:391). It is the injustice of the lie, countering the image and work of God. Contrary to the lie is the truth, and the mission of the Holy Spirit on earth is to guide us in truth (Joh. 16:12; Ackermann, 2005:392).

3.4 The need for a theology of HIV/AIDS

For the purpose of this study the researcher will only reflect on a theology of HIV/AIDS insofar as it impacts on the issue of HIV/AIDS stigma, stigmatisation, destigmatisation interventions, as well as the role of the church in such interventions.

Louw (2008:426) highlights the importance of theology in terms of HIV/AIDS. In a negative sense, he identifies the contribution that theology can make (and did contribute) to the development of stigma. *Theology contributes to stigma* through attaching an anthropological assessment to a particular stigma, thereby validating such assessment as a "fixed perception" (Louw, 2008:426). Theology thus can reinforce and legitimise prejudice, and when such prejudice becomes validated by a God-image we find stigmatisation as "legitimised" by both God and the church (Louw, 2008:426).

In this context, various scholars has emphasised *the importance of a theology on HIV/AIDS* (Clifford, 2004:1; Marshall, 2005:134; Van Wyngaard, 2006:267; Conradie, 2007:1). The effort of church leaders to counter the disastrous proclamations in the 1980's by some churches in the U.S., that HIV/AIDS presents the "punishment of God" (Clifford, 2004:1; Louw, 2008:428), is one reason for such a need. Ndungane (2005:378) referred to those proclamations as a "destructive theology" that has been responsible for erroneous links between sin, guilt and punishment, which is thus indirectly to blame for the stigma and spread of HIV/AIDS (cited by Clifford, 2004:9, cf. Louw, 2008:429-432). Another, obvious, reason is to establish theological grounds for responding to the pandemic (Clifford, 2004:2; Van Wyngaard, 2006:267). A third justification for a theology on HIV/AIDS is to counter the discriminated disservice to HIV infected Christian who were forced to remain silent about their HIV positive status (Clifford, 2004:3).

Van Wyngaard (2006:268) remarked that, contrary to the Roman Catholic Church's advocacy of a theology of HIV/AIDS in the early nineties, *the Reformed Church still lacks a comprehensive theology on HIV/AIDS*. Conradie (2007:1) identifies various ways in which theologians have already assisted their churches' response to HIV/AIDS, e.g. liturgical and resource material, leadership training, and pastoral care and counseling. What *is* lacking, though, is that Christian theologians still need to apprehend the "critical challenges" of HIV/AIDS to Christian theology (Conradie, 2007:1).

Conradie discusses some of *the challenges of HIV/AIDS to Christian theology* (2007:10-14). Illustrating his argument with a reference to Bonhoeffer's plea for responsibility, Conradie argues that Christian faith should impact the HIV/AIDS world with the

contribution of our faith in God. Christian theology must account for God's transcendence in such a way that it will have a salvific, healing and liberative impact. (Conradie, 2007:11).

A theology of affirmation is appropriate to the issue of HIV/AIDS stigma/stigmatisation and destigmatisation, because it addresses the ontology of the human being, i.e. his identity and status (Louw, 2008:30). This identity and status is determined by eschatology as:

> An ontological category that defines our being human in terms of the events of the cross and resurrection (Louw, 2008:30).

Eschatology thus identifies the human being in the light of Christ's death and resurrection, and not in the light of the culmination of history. A theology of affirmation identifies the human being as significant, worthy, purposeful, and dignified. Added to this ontological reality is the confirmation of this new identity and status by baptism, the Eucharist, and the fruit of the Spirit, as demonstration of the new pneumatological reality (cf. Louw, 2008:30). As such, a theology of affirmation confirms the necessity of an inhabitational theology: God that indwells the believer through the Spirit. Lastly, a theology of affirmation identifies the human being in terms of the "ontology of salvation" (Louw, 2008:28), which is manifested in our corporate identity as transformed children of God (Louw, 2008:28).

3.5 The cross and resurrection: a paradigm for human identity

Louw (2006:100) has remarked that:

> "Most of the theological responses to the HIV pandemic take the notions of creation and incarnation as the starting point for a reflection on the pandemic".

He argues for a balanced theological assessment of the HIV/AIDS pandemic, involving *both a theology of the cross and a theology of the resurrection*:

> "A *theologia crucis* reveals the passion and compassion of a suffering God . . . A *theologia resurrectionis* reveals the overwhelming and victorious power of a living and faithful God" (Louw, 2006:113).

Through the cross, a compassionate God, who suffers with human beings, identified himself with our suffering and predicament in the suffering of Christ. However, it is only

part of God's identification with humankind: the resurrection, through which God in Christ demonstrated his victory over death, hell and the grave, confirms the work of the cross. Guthrie (1994:272) concurs, stating that Christians experiences both the grace of God's forgiveness and the grace of God's empowerment out of sin.

The total “baggage” of our sin was nailed to cross, including our stigma and stigmatisation. The cross is the location where we died with Christ, in the totality of our sin-warped “old” nature. The cross is the monument of God’s grace and love: it displays the depth of His identification with the sin and suffering of mankind, suffering for us and suffering with us. God's identification with mankind's suffering, as represented by the work of Christ through the cross, is indeed appropriate in terms of the suffering of stigmatisation.

What is *the message of the cross for HIV/AIDS*? The cross represents the theopaschitic paradigm: it emphasises God's compassion and identification with the HIV/AIDS sufferer (Louw, 2008:430). It is the comfort that God is present as a compassionate and suffering God. The HIV/AIDS infected and affected can rest assured that God is in, and through, Christ God-with-us (Louw, 2008:430).

Although the cross reveals God grace, it does not ignore the predicament of sin and guilt. HIV/AIDS infection because of promiscuous behaviour reminds us that the cross also addresses punishment and sin. Just as vital as the cross' message of compassion is to convey the love and care of God just as vital is it to remember the other dimension of God's involvement in this world-of-suffering: his power to transform suffering and guilt into freedom from the suffering and guilt of stigma.

However, is it enough that God identifies with the suffering of the pandemic, and comforts through his compassion? How does one deal with the existential effects of HIV/AIDS stigmatisation, which opposes the reality of God's identification with, and presence in, the suffering caused by HIV/AIDS? *Is the cross the last word on HIV/AIDS and its stigma and stigmatisation?:*

> Is God not indeed almighty and powerful and able to transform the reality of our suffering and guilt and to change the quality of our life despite the virus? What about hope, victory and meaning? (Louw, 2006:104).

Louw (2006:106-7) cites various sources to illustrate the *central importance of the resurrection* in New Testament theology (Goppelt; Guthrie; Jonker; and Barth; cited by Louw, 2006:106). Guthrie (1994) states that:

> If it could be said that the whole of the Christian faith stands or falls with any one claim, the claim that God raised the crucified Jesus from the dead is that claim. Without faith in a risen and living Christ there would be no Christianity (1994:271).

Furthermore, the cross and the resurrection are so inherently connected that they are actually one work (Louw, 2006:107). The resurrection imparts a significant meaning to suffering, it not only draws eschatologically from the cross (cf. Moltmann, cited by Louw, 2006:108). Guthrie (1994:272) states that the believer expects not only God's presence in our struggles and pain, but also the renewal of transformation: to effect righteousness, justice and self-worth, as the kingdom of God advances towards its eschatological destiny. The resurrection is both hope and faith: the empty grave is the historical demonstration of the end of all forms of death, including those processes that impinge on our dignity, future, and identity, e.g. stigmatisation (cf. Louw, 2006:108). In commenting on the function of the resurrection of Christ within Christian theology McGrath (2001:404) states that it verifies Christian hope, both eschatological (verifying the hope of eternal life) and soteriologically (understanding the death of Christ on the cross in the light of the resurrection as the victory over death).

Louw (2006:104) identifies a theology of *the resurrection as God's answer to the human predicament.* The reason is that the resurrection addresses the human need for a life of significance and purpose. Excluding both extremes of pessimism (human beings confined to sin) and optimism (human beings as completely self-sufficient), Louw argues that a theology of the resurrection is crucial to a theological anthropology, i.e. to determine the essence of our identity (2006:104). Gal. 2:20 states that the life of the believer is in reality the life of Christ who "lives in me" (New King James Version). Second Corinthians 5:17 confirms that:

> Therefore, if anyone is in Christ, he is a new creation; old things have passed away; behold, all things have become new (New King James Version).

This inner transformation, wrought about by the redemption, reconciliation and salvation of Christ, is a radical transformation, as we have been "born again" of "incorruptible seed" (1 Pet. 1:23) This transformation, therefore, bestowed upon the believer a new identity, making him "special", "royal", "chosen" and "holy" (1 Pet. 2:9). In addition, the believer is now incapable to continue, through prejudice, discrimination, ostracism, and denigration, to stigmatise others, because he is now "dead" to the sin of stigmatisation (Rom. 6:22). Furthermore, the believer's identity does not accept stigmatisation: because he/she is a new being in Christ, purchased by the blood of Christ, endowed with the down-payment seal of the Holy Spirit (2 Cor. 1:22). The believer cannot be devalued, excluded, ostracised, and discriminated against (Rom. 8:33). The believer cannot be stigmatised, ontologically speaking, because he has already been exalted and elevated as God's elect.

Resurrection hope, based on the transformed human identity as effected by salvation, is a source of inspiration, affirmation and validation, encouraging and empowering PLHA to live life to the full. Resurrection hope, as confirmed by a theology of affirmation, contributes to the destigmatisation of the PLHA (Louw, 2008:31). This means that the resurrection resulted in our transformation into a new ontological state, that of the eschatological new being in Christ. The result of this new identity is the indwelling strength of the Spirit, who endows us with courage and hope. As such, Scripture identifies this quality of strength/courage as *parrhesia*: it is courage/strength as confirmation of the functioning of the Spirit, and not as a human quality or achievement.

Louw (2006:110) aptly warns against the artificial optimism of a *theologia gloria,* which borders on denial and escapism. Hope is the assurance of what God has promised and worked through Christ, however it does deny or ignore the reality of suffering. The resurrection is a source of encouragement and purpose *amidst* the suffering of HIV/AIDS (Louw, 2006:110). The resurrection as a message of hope contradicts our suffering: it is hope in spite of suffering, because it represents the victory of God over suffering (Louw, 2006:109). The resurrection:

> Confirm the veracity of God's faithfulness and the truth of the eschatological victory within this creaturely reality (Louw, 2006:109).

Resurrection hope transforms the PLHA *within* his suffering, instead of offering a false hope that suffering will be ameliorated (cf. Inbody, 1997:180). Transformation is a function of resurrection hope, an indication of a new reality within the realm of suffering (Louw, 2006:111). It is the power of the resurrection, endowed by the Spirit to counter a return of the "old" identity, so that our lives can demonstrate the fruit of the Spirit and not our past "baggage" of sin (Louw, 2006:112).

The resurrection is the acclamation that "It is finished" (Joh. 19:30). It is the demonstration of the all-encompassing power of God over death, hell, and the grave (cf. Louw, 2006:113). In addition, it confirms that the promises of God-in-Christ, which provide the experiential foundation for the believer, are true, valid and reliable. In terms of HIV/AIDS stigma and stigmatisation, the resurrection bestows and confirms the believers' new identity in Christ, which is antithetical to any devaluation, including that of stigmatisation (cf. Louw, 2006:113). The resurrected Christ embodied physically the stigma of the cross (Louw, 2008:81). The cross as curse (Gal. 3:13) was overcome by the power and glorification of the resurrection. The pierced hands and feet of Christ, which was a symbol of the stigma of the cross, lost their stigmatisation through the resurrection, instead becoming the symbols of the resurrection (Louw, 2008:81).

What does the resurrection mean to PLHA? Louw (2008:439-441; 2006:110) identifies certain theological indicators that can assist the PLHA to understand his/her suffering, from the perspective of the resurrection. Firstly, the *transformation of the believer* as the new eschatological reality, which determines an ontology of *charisma*, and not stigma. It enables the PLHA to appropriate the righteousness of Christ as an imputed righteousness, freeing their identity from stigma.

Secondly, *liberation.* Because the resurrection witnesses to the completion of our salvation, forgiveness is final and real. We have been reconciled to God, our past has been obliterated, and we now live free from our sins and our past, in the domain of God's grace. The power of Christ translates as the power of the PLHA. The power of the resurrection translates as the empowerment of the PLHA to transcend the previous

unsurpassable. It is victory over the powerlessness of defeat, of surrendering to the effects of the pandemic. The resurrection proves God's complete victory over all forms of sin, including stigma and stigmatisation. Stigma is replaced by *charisma* as the fruit of the Spirit (Louw, 2006:110). The resurrection also negates stigma its stigmatisation: visible stigma no longer defines the PLHA as devalued and discredited (Louw, 2008:410). Victory over death is assured by the resurrection, fixing our hope in a God-inspired purpose for life. The resurrection re-opens the door to the heartbeat of life (*geborgenheid),* to again partake of life in all its dimensions. The resurrection transforms the PLHA to live victorious (1 Cor. 15:15), contagiously infecting the PLHA with *parrhesia* courage and a zeal for life (Louw, 2008:413). Louw (2006) states that:

> Resurrection hope is about the death of death, about the fact that every form of rejection, stigmatisation and isolation has been finally deleted by God. People suffering from HIV *should* (italics added) therefore be empowered to start to live life despite the reality of the virus (2006:104).

Thirdly, the resurrection hope acquired *vision, imagination, and a new future* for the PLHA. He/she now has new, healed expectations and anticipations. Fourthly, *his/her witness is now to demonstrate,* through the fruit of the Spirit, the reality of the resurrected Christ. The resurrection proved God's faithfulness, notwithstanding our suffering. Our trust in God is secured.

The resurrection also *brought about effective koinonia*: within the fellowship of believers the PLHA can be edified, because this fellowship is not determined by "phenomenological and perceptions (stigma)", but the Lordship of Christ (Louw, 2008:440). The PLHA are also comforted, because his/her future is not dependent on achievements but by his/her new identity in Christ. They are comforted because of the courage to life live to the full, as enabled by the Spirit. Lastly, the resurrection contains the truth of "*divine confirmation, affirmation, and a guarantee and promise for life*" (Louw, 2008:440).

4. DESTIGMATISATION AND THE CHURCH

> Political systems come and go, politicians, businesses and UN organizations come and go, but *the long-term perspective, the memory and the future is with faith-based organizations and religions* (italics added) . . . (Ecumenical News … , cited by Ndungane, 2005:384).

These words by Peter Piot, the executive director of UNAids, indicate the *vital role and responsibility of the church*.

The church, according to Marshall (2005:133), has been *minimally involved* in the struggle against HIV/AIDS in the two-thirds world. HIV/AIDS is not an ecclesiastical or political priority, and in many two-thirds world countries both the government and church ignore the pandemic (Marshall, 2005:133). Louw (2008:425) identifies apathy, smugness, hypocrisy, and prejudice as implied causes for the church's lack of involvement, and suggests that these factors pose a "great danger" to the church's response to the pandemic.

Conradie (2007:1) assesses that the church in South Africa has, to the contrary, *contributed "significantly at various levels"* to the struggle against the pandemic. He continues:

> . . . it remains a question whether the contributions from the church have fathomed the uniqueness of what Christianity may offer in this regard . . . In my view the Christian faith has far more to offer than many Christians may realise . . .(Conradie, 2007:1).

As an example of the challenge to the church, Conradie (2007:13) refers to his visit to Malawi in 1997, where he was told that the HIV infection is as low as 1% in some areas, due to the moral leadership of village chiefs in those areas. This, according to Conradie, is an unambiguous demonstration of the church's potential to have a major impact on the disease's advance (2007:13).

Instead of constructive engagement, the *involvement of churches in the condemnation of PLHA* has contributed to HIV/AIDS stigmatisation and other forms of suffering (Marshall, 2005:144; Van Wyngaard, 2006:266; Conradie, 2007:13; Ndungane, 2005:378). Marshall (2005:138) identifies Christian prejudice towards PLHA as a

contributing factor to the spread of HIV/AIDS. Such prejudice has resulted in the stigmatisation of PLHA and their caretakers, demonstrating the absence of the grace of God:

> Like the priest and the Levite, we have chosen to pass by a fellow human being in need of God's grace . . . (2005:138).

Avoiding the PLHA testifies that *the church contributes to society's exclusion of PLHA* (cf. Louw, 2008:400). Like the priest's excessive emphasis on the exterior, Christian have clothed themselves with the cloak of self-righteousness by ostracising those effected and affected by the pandemic (cf. Louw, 2008:400). Ndungane (2005:378) states that in its contribution to the stigmatisation of HIV/AIDS, the church has aided and abetted the "fear, denial and silence" so characteristic of HIV/AIDS-related stigma and stigmatisation.

To "pass by on the other side" like the priest and the Levite (Luk. 10:31,32) not only contributes to the stigmatisation of PLHA, it signifies *a judging attitude* and expose the church to the danger of being judged themselves (Ndungane):

> The church must not allow people to be marked out, labelled, categorised and judged, whether because of their own HIV infection, or the infection of family members, or poverty, or blindness or anything else (2005:379).

The challenge of destigmatisation thus involves church identity. How one understands one's own group determines one's association with one's ingroup, and how one distinguish between your ingroup and an outgroup. In- and outgroup categorisation involves some kind of identity standard according to which in- or outgroup membership is measured. Such a body of identity-characterising features or principles functions as the group prototype (Hogg, 1995:559).

In terms of the church, one has to identify this identity prototype and determine how it effects the development and implementation of effective destigmatisation interventions. The crucial question is thus whether the church's self-understanding of its identity and purpose - determined by its identity prototype- hinders or promotes the development and implementation of destigmatisation interventions. For example, Hendriks (2004:46-47)

assesses the Reformed "proclamation" church model as characterised by the proclamation of the Word, the centrality of Christ, and salvation through grace alone:

> The test of the true church is . . . where the Word is rightfully proclaimed according to Scripture, where the sacraments are ministered in accordance with Scripture and where the church law and discipline maintain the integrity of the Word (Hendriks, 2004:47).

In his evaluation of this church model Hendriks (2004) states that:

> The limitation of the model is that the emphasis on proclaiming the Word often results in less emphasis on the incarnational side, i.e. living the Word (2004:47).

The church will, thus, be ineffective in developing and implementing destigmatisation interventions if its prototype allows for stigmatisation. Its prototype first needs to be adjusted so that the self-understanding of its identity is changed, to reject stigmatisation and commit to destigmatisation. The necessity of such change is demonstrated by the early condemnation and exclusion of PLHA.

The *role of the church in HIV/AIDS destigmatisation* is multifaceted. The researcher will, next, discuss the contribution that the church can make to effective HIV/AIDS destigmatisation intervention. Firstly, the *deconstruction of power*: as Christians, we must be cognisant of the fact that our salvation requires our divestment of power (UNAIDS, 2005:44). Christ's self-emptying (k*enosis)* set the example for us: to take the form of a servant so that we can be stripped of our power to stigmatise, and of the pride that separate us from the world of the stigmatised (UNAIDS, 2005:45).

Secondly, the *social dimension*. The church must be the champion for systemic justice, otherwise it risks being the enemy of destigmatisation. Paterson (UNAIDS, 2005:36-7) points out that because the characteristics of the Christian community, e.g. strong cohesion and protective boundaries, are differentiating in character, the church can easily reinforce existing social inequalities. The implication is that the church has to expose the societal prejudice, discrimination and power politics so that it does not, unwittingly, reinforce systemic stigma and injustices. The church, especially in South Africa, must be "actively" involved in an ongoing campaign to guard against sustaining the social order (Patterson, 2005:37). As supportive as the Afrikaner church was in justifying and supporting apartheid, so it must continually guard against contributing to institutionalise a

societal order that is still marked by gross inequality. Paterson points out that Christianity in the Indian sub-continent has focused on the stigmatised, thereby succeeding in aiding the social infrastructure of the area's countries (Paterson, 2005: 37).

It would be a matter of gross irresponsibility by the church not to reverse its stained record and restore its damaged reputation (cf. Van Wyngaard, 2006:267.) It is the task of the church, according to Van Wyngaard (2006:281) to develop answers to the pressing social injustices that contribute to HIV/AIDS and its stigmatisation. Conradie (2007:12) remarks that a continuing lack of church reaction to the pandemic would signify that the gospel is not appropriate to the disease. The World Council of Churches declared 11 years ago :

> The church's response to the challenge of HIV/AIDS comes from its deepest theological convictions about the nature of creation, the unshakeable fidelity of God's love, the nature of the body of Christ and the reality of Christian hope (cited by Clifford, 2004:4).

As the *Kairos* document represents the repentance of the Afrikaner churches regarding the sin of apartheid, so we as Christians must not hesitate to counter other forms of societal sin and evil. This includes those structural elements that discriminate and stigmatise PLHA. Is it not time for the institutional church to proclaim a *kairos* moment to repent for its continuing apathy to HIV/AIDS stigma and stigmatisation?

Ndungane (2005:379) cites the oppression of women with regard to HIV/AIDS as an example of the church's "spiritual blindness". He points out that about three-quarters of those infected in the 15-24 year-old age group in sub-Saharan Africa are women. Furthermore, in some countries those highest at risk for contracting the disease are married women (Ndungane, 2005:379). Van Wyngaard (2006:276) adds that, according to UNAIDS, in some countries 10% more married women are HIV positive than sexually active unmarried women. Married women in traditional societies are expected to strictly adhere to their husband's headship, even if that means running the risk of HIV infection. They are also discriminated against as unfaithful when contracting the disease from their husbands/partners. In addition, even when the husband was unfaithful, his transgression is seen as excusable, whereas the women who were unfaithful are condemned and

ostracised. These statistics highlight both the church's impotency in countering societal injustice and the challenge and opportunity to be a force for justice.

The discrimination against women focuses on this effect of HIV/AIDS stigma and stigmatisation. Discrimination is so prevalent in HIV/AIDS stigmatisation that Van Wyngaard (2006:283) refers to it as a "second epidemic" besides HIV/AIDS. The combination of discrimination and stigmatisation provides the dynamic to fuel silence and denial, effectively hindering epidemiological and social efforts to curb the disease, reinforcing the marginalisation of the marginalised (Van Wyngaard, 2006:283). This phenomenon presents the church with the task of being "light" in the dark world of stigmatisation and discrimination. The Sermon on the Mount provides the Scriptural backing for prioritising the stigmatised: it reversed the Law's prohibition of physical impurity or imperfection participating in the temple ritual (Lev. 21: 17-21; UNAIDS, 2005:38).

Thirdly, the necessity of *a holistic approach.* Louw (2008) points out that both in the context of pastoral counseling and church ministry, response to HIV/AIDS requires a holistic, systems approach:

> The challenge is for a total new understanding of our being the church within the pandemic (2008:394).

This "new understanding" challenges the doctrine, convictions, integrity, identity, and sincerity of the church (cf. Louw, 2008:399). These and other considerations of the character of the church can be encapsulated within the question as to how unconditional is the love of the Christian church (Louw, 2008:399). This question not only addresses the question as to the status of the HIV positive church member (Louw, 2008:399), but also the PLHA outside the church walls.

Fourthly, the importance of *a theology of life*. The researcher agrees with the assessment by the Theological Workshop on HIV/AIDS-related stigma, that the primary motivation for church involvement in the HIV/AIDS pandemic is the "lived experience of Christ" (UNAIDS, 2005:22). Jesus' association with the outcasts and the marginalised is paradigmatic for the church's involvement in the world (cf. Marshall, 2005:143; Ndungane, 2005:378). When condemned by the religious establishment for transgressing their laws he replied:

> Those who are well do not need a physician, but those who are sick (Luk. 5:31, New King James Version).

Fifthly, *the church's pastoral care role*. Jesus commanded his disciples to care for the less fortunate, for the hungry, naked, sick and imprisoned (Matt. 25:31-46; cf. UNAIDS, 2005:23). Are we not to visit those "imprisoned" by the ravages of HIV/AIDS, including its stigmatisation? Compassion is the opposite of stigmatisation, because one cannot "look down" on those towards whom you have compassion (cf. Ndungane, 2005:382). Furthermore, Christian "hope" is a certainty and not an effort to expect what may not be realised. Hope is related to faith and love (1 Cor. 13:13), and in essence it is the certainty of all that we believe that we are, and that we will be, and that should translate in a caring church.

Sixth, *the church as part of the missio Dei.* Jesus' care and non-stigmatisation example (e.g. the woman caught in adultery) is paradigmatic for the church's mission to effect the physical, emotional, relational and spiritual healing of PLHA (Marshall, 2005:143). However, we must acknowledge that in imitating Jesus' compassion we are to rely on the power of the Holy Spirit to effect such healing from shame, guilt and other manifestations of HIV/AIDS stigma and stigma-related suffering (cf. Marshall, 2005:143). Exposing stigmatisation as sin opens avenues for individual and communal healing (Ackermann, 2005:393). We must be sensitive in our healing ministry not to add to the suffering of HIV/AIDS stigmatisation through word or deed. We must be mindful of our language, so that we not, unintentionally, reinforce HIV/AIDS stigma.

Church ministry to the HIV/AIDS stigmatised includes proclaiming "the hope that is in us" (cf. Marshall, 2005:143-4; 1 Pet. 3:15). Sharing our transformation from the power of sin to a life of liberty and purpose is not a function of evangelisation, but a spontaneous witness of a new identity. In fact, the power of our Christian identity is not derived from our proclamation as much as it is derived from our self-sacrificing, love-prompting actions. To be salt and light requires believers to demonstrate a sacrificial love, a love that exacts a cost from us. It is a love that does not shirk from the risks involved in caring for PLHA. We are well served by the reminder that the power of the sacrificial offering of

believers for the care and wellbeing of the unbeliever is what propelled Christianity from an obscure sect to the official religion of the Roman Empire.

Seventh, the *normative dimension*. Communities of believers has the task to appropriate God's norms for behaviour, e.g. faithfulness in marriage, loving families, sexual integrity, care for one's neighbour, and doing to others as you want them to behave towards you, as a fundamental dimension of destigmatisation interventions (cp. Marshall, 2005:136). This statement needs to be accompanied by a caveat: Christian ethics should not degenerate in simplistic approaches and solutions, and moralising prescriptions. Christian ethics are embodied ethics: the power of Christian morality lies in its demonstration, not its proclamation - as argued above.

Marshall (2005:133) refers to the designation of AIDS as "a disease of broken relationships", because it reflects the moral breakdown that results when God's plan for mankind is disregarded. This moral decay is indicated by HIV/AIDS dynamics such as stigma, discrimination, oppression, and a lack of access to knowledge and resources (Marshall, 2005:133). Louw (2008:398) points to the relationship between stigmatisation and moral imperfection. To devalue an individual as discredited necessitates a moral judgement and interpretation (Louw, 2008:398).

The church has the cardinal task to infuse its community with the non-stigmatised virtues of the gospel. It is heart-breaking to hear the plight of a married/unmarried woman involved in a marriage/relationship where her husband/partner's sexual adventures present a real risk of HIV infection, yet she is powerless to prevent it. For her to discuss condom-use with her husband/partner in such a case is to invite physical abuse. On the other hand, to leave the husband/partner is in many cases (e.g. because of children's sustenance) not only economically unfeasible, but also impossible. This is where Peter Piot's words ring true and urgent: that *the long-term perspective, the memory and the future is with faith-based organizations and religions*.

The church should be involved in teaching and demonstrating truth. The truth about stigmatisation should accompany truth about HIV/AIDS to refute the lies of HIV/AIDS and its stigmatisation, and to effectively destroy the connection between lies, silence and

denial (Ackermann, 2005:392). It should also address the power dynamics behind stigmatisation, and its social inequality dimension. This would be an effective action against the prevalence of denial and silence in HIV/AIDS stigmatisation and suffering. Van Wyngaard (2006:282) points out that denial is not only part of HIV/AIDS stigma and stigmatisation. Denial exists at three levels: at (1) individuals and groups outside of the HIV/AIDS arena (e.g. the church), (2) governments, and (3) those affected by the disease. The result is a vicious circle: stigmatisation leads to denial, which again reinforces stigmatisation (Van Wyngaard, 2006:282).

The Christian sacraments of baptism and the eucharist serves as regular reminders that believers have been cleansed of all stigmatisation (Conradie, 2007:13). However, believers must be careful, as Conradie points out, that these sacraments do not attain a moral gate-keeping function to exclude the unwanted (Conradie, 2007:13).

In the eight place, the church and *diakonia.* The church should be the one who welcomes and reach out to the stigmatised. Those who are HIV positive should be seen as a resource, not a burden (UNAIDS, 2005:17). Hearing from those who suffer from stigmatisation is a way to disarm the underlying stereotypes and prejudice to stigmatisation. A PLHA surrounded by a loving church can be aided immensely to realise his/her freedom from stigmatisation. The Theological workshop in HIV/AIDS-related stigma, states that:

> We believe that our Scriptures encourage us to move beyond the stigmatisation and exclusion of the crucifixion towards resurrection, hope and redemption (UNAIDS, 2005:17).

The church can also play an important role in *home-based care.* One form of reaching out is to join hands with secular organisations in the home-based care of PLHA, included the care of children bereaved by AIDS. Louw (2008:420) points out that the church is organisationally excellently equipped to participate in home-based care. Not only does it possess the network, resources, and community support to physically reach out, it is also positioned to co-ordinate and optimises home-based care. This can be done as an in-house ministry, or in cooperation with other home-based care organisations.

How can the church participate in destigmatisation interventions regarding the aspects of *marriage and gender*? The marriage and family roles of men, especially in HIV/AIDS-stricken contexts, needs urgent adjustment, and the church is excellently positioned to proclaim Christian gender and marital ethics. Ndungane states that the church is guilty of:

> . . . sustaining the patriarchal dominance of men and the subjugation of women in terms of politics, economics, culture, society and the family as well as within the institutional church (2005:379)

Marshall (2005:138-139) is of the opinion that:

> Headship as a widely accepted view of the divine ordering of male-female relationships has commonly been corrupted into male domination over women, resulting in female subservience and abuse in diverse forms (2005:139).

Christian married men are to love their wives as Christ loves the church (Eph. 5:25). The church is, therefore, in a position par excellence to de-abuse male behaviour towards women by distinguishing between male dominance and its accompanying abuse and oppression, and male care, support, and responsibility.

Another area of the church's moral responsibility that has been found wanting is its contribution to the *sexual education* of its teenagers (cf. Ndungane, 2005:380). This is a vital concern, not only to prepare our teenagers for their roles in marriage, but also to deny HIV/AIDS its major infection propellant. Louw (2008:425) discusses, in this regard, the transformation of the domain of sexuality from the private to the public sphere.

The contrast and moral *conflict between the cultures of sexuality of the Western and two-thirds world* is one of the indications of this fundamental challenge to the church. For instance, polygamy and concubinage are pitted against the Judeo-Christian ethic of monogamy and abstinence outside of wedlock. Marshall (2005) points out that:

> The equating of sexual activity with sexuality, and the separation of sexual activity from marriage . . . have contributed to the spread of HIV . . . attempts to deal with HIV by countering 'unsafe sex' and 'gender equality' have largely failed, in part because of lack of understanding of the complexity of human sexuality and the pervasiveness of sin (2005:139).

Marshall (2005:140) argues that sexual fidelity (in marriage) and abstinence (outside of marriage) is the best way to counter the spread of HIV. He refers to Uganda's success

with encouraging marital sex and later sexual debut, in combating the spread of HIV infection. These sexual norms act as a "social vaccine", and forms part of the Christian ethic on virtuous relationships and ethical behaviour. The fact is that the majority of married women contract HIV/AIDS from their partners, which is a characteristic feature of this disease in the two-thirds world. Getting the message at a young age that sexual behaviour cannot be divested from its overall role responsibilities may retard the pandemic more than any other prevention measure. Such sexual socialisation and an internalisation of the role of sex in marriage may greatly contribute to the ABC prevention campaign already in action. However, community mobilisation and other supportive measures, combined with sufficient sexual education, is crucial to effect a significant reduction in infection rates.

What may probably be the greatest challenge HIV/AIDS pose to the church is *the plight of HIV/AIDS-affected children*. Ndungane (2005:381) quotes statistics from Worldvision-that more than 14 million children have lost a parent to the pandemic, 95% of which lives in Africa. The Old Testament prescriptions regarding the widow, the fatherless and the stranger captivates the predicament of the most marginalised of marginalised. The church does not need another sermon, or wait until a comprehensive theology of HIV/AIDS have seen the light. They only need to act, in the spirit of care for one's neighbour, sufficiently informed by the content and context of Scripture's prescriptions for these marginalised of society.

How are we as Christians to help destigmatise our fellow believer? Ackermann (2005:393) reminds us that, as the body of Christ, we are such a close union that if one member suffers the other members suffer too (1 Cor. 14:26). The church not only suffers because those gifts imparted to the Christian PLHA are hindered or absent, we also suffer as a community because we cannot be built up as God intended.

The church needs to proclaim the message of *the destigmatisation of the resurrection* (se pp.90-91). The theological indicators of the resurrection can be instrumental in the realisation of the identity change that the resurrection wrought, and the meaning in life that it secured. Such identity and meaning is the message of the hope of the resurrection. How can the church infuse hope into the HIV pandemic arena? Oliver (2005:98) states

that there needs to be a meeting between people's private and national hope, on the one hand, and HIV/AIDS, on the other hand. The church needs to re-orient themselves towards HIV/AIDS, perceiving it as a challenge, rather than "a calamity or threat" (Oliver, 2005:99).

By demonstrating the "hope that is in us" we are to let our witness of Christ include *God's perspective on life and death*. Ndungane (2005:382) states that death is an ambiguous issue to secular and secularised society. The Christian not only accepts death as integral to life, but is also committed to a "good death" (Ndungane, 2005:382). The church in this context should be the bearer of God's peace, for to die in peace is a most fitting entry to eternal life. The researcher is reminded of the words of Ps. 116:15:

> Precious in the sight of the Lord is the death of his saints (New King James Version)

However, as much as dying in peace is the proper farewell to this world, and appropriate entrance to the eternity, Marshall (2005) balances the temporary with the eternal:

> There is something worse than dying with AIDS, as terrible as that is-and that is dying without Christ (2005:145).

Of course, this does not mean that the disease or its variegated suffering is belittled or ignored. Neither does it sanction an insensitive, uncaring, fundamentalist-like evangelisation of PLHA to "save" a "lost sinner". It is a sensitive, loving, encouragement that Jesus' death and resurrection opened the door to eternal glory, and that the death of the believer is precious in the sight of God, because he/she can cross over the suffering of this world into a non-suffering world of everlasting bliss (cf. Rom. 8:18). Although the prospect of eternal damnation is real and something we all must confront, it does not portray an image of God as having already found the PLHA guilty, poised to strike his judicial gavel the moment he/she breathes his/her last breath.

To conclude, a few remarks on the *ecclesiology* represented by the preceding discussion on the role and contribution of the church regarding the HIV/AIDS stigmatisation crisis. The church should contribute to the destigmatisation and prevention of HIV/AIDS as a function of its identity. As the Body of Christ the church represents a united front, a co-ordinated and interdependent action involving all its members according to their particular unique contributions. As Family of God, the church represents a network of

loving relationships to sustain its effort and to infuse its contribution with a spiritual healing dimension. As the Temple of God, the church stands in relationship to God, and as such it conveys its holiness through its actions and service in the world. Rather than being one-dimensional, it is required of the church to be holistically involved in the HIV/AIDS crisis, and specifically HIV/AIDS stigma and stigmatisation. This requires an integration of the clerical-, koinonial-, and pastoral paradigms of the church. The church needs to be church, to be faithful to itself in all aspects of its God-given identity.

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CHAPTER 5

SUMMARY AND CONCLUSIONS

1. STIGMA AND SUFFERING

Stigma is a complex phenomenon. It involves two actors in a perpetrator-victim relationship, displaying two constituent parts: (1) a psychological, and (2) a social element. It is a psychosocial construct, which reflects a systemic influence and nature, as determined by the influences of an individual's psychological and social environment, history, context, and location.

Stigma is a social identity devaluation (ideology) of a particular (*stigmatised)* individual or group, by another (*stigmatiser)* individual and group, because of a characteristic mark or feature (physical or personality trait). This characteristic feature evokes a variety of negative identity devaluations of the bearer of the mark/feature, negating all other characteristics of the bearer, imposing a disgraced, discredited and "abnormal" status upon the bearer. This disgraced identity devaluation results in personal and social rejection, ostracism, dissociation, disdain, avoidance, hate - and even genocide. This devaluation process becomes shared among members of a particular group (*the stigmatising outgroup)* in a particular context and time in history, who possesses the social power to enforce their devaluation on the stigmatised group as an acceptable practice. This process of stigmatisation causes suffering due to its psychological and social impact.

Stigma appears to originate as an universal, individual-social reaction to perceived or real danger. This danger involves any perception of threat, from threat to self-perception to the threat of survival. Stigma involves a distinction between those who presents the perceived or real threat (the outgroup) and those who feel threatened (ingroup). Stigma "circle the wagons" to exclude what is threatening and undesirable, and to include what is not threatening and desirable. This distorted ("social baggage") inclusion-exclusion reaction reverberates socially through communication and sharing, becoming a consensualised phenomenon. Stigma then becomes supported by the ingroup 's norms and values, and attain the status of an ideology. The process of stigmatisation provides an experience of

equilibrium to the stigmatiser, as the perceived or real threat is successfully countered. It relieves anxiety, enhances self-esteem and control, as it provides a resolution of the (distorted) threatening perception. These distorted perceptions may change over time as the real or perceived threat changes.

The extent of stigmatisation differs according to a variety of factors such as the visibility of the stigma, its changes over time, how much it blemishes the bearer, whether the bearer was responsible for his stigma or not, if the stigma poses a danger to the non-stigmatised, and how much it disrupt personal interaction.

These dimensions and characteristics of stigmatisation represent stigmatisation as a perpetrated phenomenon, as an action by the stigmatiser. From the perspective of the victim of stigmatisation, the stigmatised, stigmatisation results in differential suffering. It is existential suffering, suffering as a reaction to the distorted, unjust and severe social identity devaluation, resulting in being assessed and treated as less than a human being. Stigmatisation results in suffering because it results in the oppression of one's personality and particularly one's self-image, which is contrary to the personal well-being needs of being included and valued.

Responses to stigmatisation differ in intensity of suffering because of the differential in coping with the effects of stigmatisation. Stigmatisation results in stigma-avoidant behaviour. A person can withdraw (physically or psychologically), seek greater ingroup affiliation that will replace exclusion and other effects of stigmatisation with inclusion, value, respect and other enhancing self-esteem mechanisms, or attribute stigmatisation to unjust discrimination.

2. HIV/AIDS STIGMA AND STIGMATISATION

HIV/AIDS stigma is the existential demonstration of the characteristics of stigma and stigmatisation. One has to distinguish between non-discriminatory stigmatisation, stigma-related discrimination and differential treatment to epidemiologically combat the disease. HIV/AIDS stigma develops from the "social landscape of prejudice", reflecting historical and current societal prejudice and inequality. Biological factors are a prominent reason

for the variability of HIV/AIDS stigma, to which factors like concealability, the unpredictability of its infection, terminal nature, and visible manifestations contribute.

HIV/AIDS stigma involves the social process of communicated and shared beliefs, through which people distance themselves from those perceived as posing a risk to infection. HIV/AIDS becomes portrayed as preventable, as caused by immoral behaviour, identifying infected members of other groups as responsible for such behaviour, blaming those individuals as responsible for their infection, and justifying punitive action against them (HSRC & Harriet Deacon, 2005:23)

How do people react to HIV/AIDS stigmatisation, and how do their reactions influence the impact of such stigmatisation? The two major responses to stigmatisation are self-stigmatisation and external stigma. *Self-stigmatisation* results in "preventative" behaviour, resulting in stigmatised individuals appropriating their social-devalued identity. This discourages testing, disclosure and seeking treatment. *Expected stigmatisation* draws on past stigmatisation, discrimination and information to provide clues for how PLHA perceive they will be stigmatised in the future. Expected stigmatisation exerts a negative influence on the impact of HIV/AIDS, i.e. on the willingness to seek voluntary counseling and testing (VCT), and it exaggerates existing stigma.

The suffering of HIV/AIDS involves the physical-, emotional-, relational-, and spiritual suffering of ostracism, rejection, prejudice, discrimination, and condemnation. The disease also effects significant others. It forces friends and family members to come to grips with their prejudices and fears, and to re-orient themselves towards a new, demanding situation. Probably the most challenging is the effect of HIV/AIDS on the victims' sense of purpose and destiny. The task of finding spiritual equilibrium after a HIV positive diagnosis is daunting, often involving a prolonged process of mental and emotional anguish.

3. DESTIGMATISATION

Destigmatisation only came in focus in the recent history of the pandemic, after the initial struggle to understand the operation of the disease necessitated a focus on medical

interventions. Destigmatisation acquired greater prominence as a priority in combating the disease because of the prevalence of stigmatisation and the realisation that stigmatisation impedes the prevention and treatment of the disease.

There appears to be a welcome shift in the assessment of HIV/AIDS stigmatisation and stigma-related discrimination during the past few years: stigma and stigmatisation being addressed as both an individualistic, social-psychological phenomenon, yet operating in the context of social forces such as prejudice, power, social inequality and social exclusion. Destigmatisation interventions must, therefore, perceive HIV/AIDS stigmatisation as part of broader societal prejudices and inequalities, and the stigmatisation involved in those systemic characteristics. In addition, because stigmatisation ideologies vary in strength and content, destigmatisation interventions must reckon with the cultural, regional, historical and social differentiation in stigmatisation.

Destigmatisation interventions face the daunting task of confronting and dismantling the systemic-structural foundation of stigma and stigmatisation. What insitutionalises stigma and stigmatisation are the social, economic and political power bases of society. Those institutions possess the power and control to create and reinforce social exclusion, as their past role in the creation and sustenance of social inequality indicates. The systemic stigmatisation and discrimination suffered by blacks during the apartheid era is a good illustration of the systemic role in the creation and maintenance of stigma and stigmatisation. The researcher thus concludes that paradigms (belief systems) play an important role and suggest a process of deconstruction, in which a theology of the resurrection should play an instrumental role.

The historical effects of apartheid-based stigma must not only be considered as a crucial, historical, determinant of apartheid, but also as a formidable, current influence on HIV/AIDS stigma. A population group already devalued as less of a human being now also face the burden of HIV/AIDS stigma and stigmatisation, which may have the effect of "confirming" their apartheid-devalued status. Against the history of the severe stigmatisation of apartheid, destigmatisation must involve and prioritise the underlying, systemic causes of stigma and stigmatisation. A re-orientation of stigmatisation and stigma-related discrimination away from individual and social psychology to aspects of

power, inequality and social exclusion will move destigmatisation away from a narrow focus on behaviour change to community mobilisation and societal transformation.

Assessments of destigmatisation interventions indicate that such interventions are not effective, because they lack a systemic approach. The preponderance of destigmatisation interventions developed to combat HIV/AIDS stigmatisation and discrimination has been aimed at efforts to (1) "convert" stigmatisers to be more accepting towards the stigmatised, and (2) to aid the stigmatised to better deal with stigmatisation and stigma-related discrimination.

Contributing to the systemic determination and contribution to stigma and stigmatisation are social ills such as poverty and the conflict between Western medicine's epidemiological struggle against the pandemic and two-third world culture. Poverty is the home of HIV/AIDS in the two-thirds world. It provides the optimal social "temperature" for the pandemic to thrive. Because health and sexuality are the product of society, culture and history, which exceeds biomedical or behavioural understanding, we need to address the dialectic dynamic between individual and society that determines society's health and sexuality (HSRC & Harriet Deacon, 2005:4). Contributing to the cultural opposition to HIV/AIDS prevention in Africa are the phenomena of migrant labour, women's lack of sexual bargaining power, prostitution, and cultural beliefs. It is clear that these and other cultural impediments to HIV/AIDS prevention campaigns must be resolved to retard the advance of the pandemic and increase the efficiency of destigmatisation interventions.

HIV/AIDS has succeeded in transforming sexuality from the private to the public domain. This social change has highlighted the contrast and conflict between the cultures of sexuality and epidemiology of the Western and two-thirds world. This epidemiological and sexuality clash need to be resolved so that progress can be made in the effective prevention, treatment, and destigmatisation of the pandemic.

The researcher's experience last year as an intern counselor in a Brown and a Black neighbourhood was instrumental in the realisation of the vast differences between Western- and African South Africa. The researcher found that these cultural differences

hamper efforts towards counseling and pastoral care, as well as voluntary counseling and testing (VCT). Not only does the African's positioning in terms of illness and suffering differs greatly from that of the Western approach, such differences (against the background of two different and contrary cultures) necessitates a dual cultural approach to HIV/AIDS destigmatisation. The individual-approach frameworks of destigmatisation interventions are alien to the African cultural-context in which they are applied. Furthermore, destigmatisation interventions must recognise the lack of resources in South Africa**.**

A crucial aspect of destigmatisation interventions is that they should be both "multifaceted" (various social determinants of disadvantages impacting stigmatisation and discrimination), and "multilevel", addressing direct and major causes for HIV/AIDS stigma and stigmatisation. Destigmatisation interventions should target the major HIV/AIDS problems like barriers to prevention, treatment and care; discrimination against PLHA; the difficulties posed by living with HIV/AIDS in a stigmatising, and social handicapped society (HSRC & Harriet Deacon, 2005:xii).

Destigmatisation interventions must be a joint, multidisciplinary effort, combining the contributions of the medical science, psycho-sociological input, anthropology, sociology, politics, economic and theology (cf. Marshall, 2005:146). The dynamics of HIV/AIDS, and specifically HIV/AIDS stigma and stigmatisation, is too complex to be the domain and speciality of any single scientific endeavour. Only a holistic approach, representing the broadest societal context in which the disease features, will be sufficient.

The researcher believes that the prominence of HIV/AIDS stigma and stigmatisation may indicate a shift in the sociological assessment of the disease, from its early association with homosexuality as a "sinner's disease" to a "victim's disease". The prevalence of HIV/AIDS among married, and young, unmarried women, as well as the over 14 million AIDS-orphans has changed HIV/AIDS as a disease characterised by the plight of the vulnerable and marginalised, the victims of society.

4. HIV/AIDS STIGMA AND THEOLOGY

A sober conclusion of this study is that the absence of a theological perspective in addressing HIV/AIDS stigma and stigmatisation may be a contributing factor to the general and pervasive inability to destigmatise the disease. The researcher concluded that paradigms (belief systems) play an important role in stigmatisation, and suggest a process of deconstruction, in which a theology of the resurrection should play an instrumental role.

The researcher is confident that theology can inform the phenomenon of HIV/AIDS stigmatisation, as well as destigmatisation, because theology reflects Scriptural precept (principle of truth) as well as praxis (existential guidance) for the human existential condition. Stigmatisation is sin because the fallen nature of mankind results in negative and unrighteous behaviour towards our fellow human being, including stigmatisation. Stigmatisation as sin involves a misappropriation and corruption of the image of God as judge, whereby stigmatisers appoint themselves as judge to condemn, devalue and denigrate other human beings. Such stigmatising judgement not only reveals distorted God-images, it opposes love that enhances and elevates, bestows meaning, purpose and worth. It is the injustice of the lie, countering the image and work of God. Stigmatisation taints not only individual character but also social identity.

A theology on HIV/AIDS is necessary for various reasons: (1) to counter the disastrous proclamations in the 1980's by some churches, that HIV/AIDS presents the "punishment of God", (2) to establish theological grounds for responding to the pandemic, (3) to counter the initial disservice to HIV infected Christian who were forced to remain silent about their HIV positive status and, (4) to provide a new ontological basis for the identity of the stigmatised. Without a stigmatiser there would be no stigmatisation. The extent, therefore, to which theology can contribute to reduce or eliminate stigmatisation by the stigmatiser, is the extent to which theology can contribute to destigmatisation interventions.

Scripture acknowledges stigma and stigmatisation as existential phenomena, however, does it also point the way to destigmatisation? The answer to this question must be sought

in the life, death, and resurrection of Jesus Christ, because he represents God's answer to the totality of the human predicament. The crucifixion and resurrection of Christ resulted in a reversal of the effects of the Fall. In Christ's death and resurrection mankind is redeemed, atonement for, saved and thus restored to full fellowship with God. There is no more stigmatisation, because all stigmas have been removed. The Stigmatised One gave his life for the world's stigmatised, because we *were* all stigmatised, "blemished" in character. The stigmatised One became the Destigmitised and Destigmatising One.

The cross represents the identification of God-in-Christ with the suffering and predicament of mankind. The total “baggage” of our sin was nailed to cross, including our stigma and stigmatisation. Louw (2006:104) identifies a theology of the resurrection as God's answer to the human predicament, as crucial to a theological anthropology. The spiritual dimension is an important aspect in this regard, specifically the role of an eschatological perspective. Finding meaning in the suffering of HIV/AIDS stigmatisation is to find the hope of a *theologia resurrectionis* (Louw, 2000:458-459). The identity change of being a new creation in Christ means that the stigmatised HIV/AIDS believer not only lives the reality of the Christian hope, but also experiences the new ontological status of being in Christ, being empowered by the Spirit, living as a sign of Christ's *incoming*.

Firstly, the resurrection as a message of hope contradicts our suffering: it is hope *in spite* of suffering, because it represents the victory of God *over* suffering. The resurrection enables the PLHA to appropriate the righteousness of Christ as an imputed righteousness, freeing his/her identity from stigma. Secondly, the power of Christ translates as the power of PLHA. Thirdly, the resurrection proves God’s complete victory over all forms of sin, including stigma and stigmatisation. Stigma is replaced by charisma as the fruit of the Spirit (Louw, 2006:110). Victory over death is assured by the resurrection, fixing our hope in a God-inspired purpose for life. Finally, the resurrection re-opens the door to the heartbeat of life (*geborgenheid)* to again partake of life in all its dimensions. Resurrection hope transforms the PLHA *within* his suffering, instead of offering a false hope that suffering will be ameliorated. The gospel of Christ announced an identity transformation of the Christian that transforms stigmatisation to destigmatisation.

5. DESTIGMATISATION AND THE CHURCH

> Political systems come and go, politicians, businesses and UN organizations come and go, but *the long-term perspective, the memory and the future is with faith-based organizations and religions* (italics added) . . . (Ecumenical News … , cited by Ndungane, 2005:384).

These words by Peter Piot, the executive director of UNAids, indicate the vital role and responsibility of the church. The church has been minimally involved in HIV/AIDS in the two-thirds world. Instead of constructive engagement, the involvement of the church in the condemnation of PLHA has contributed to HIV/AIDS stigmatisation and its suffering.

Theory determines praxis. Archbishop Ndungane (2005:379) equates the church's stigmatisation with "spiritual blindness" that "denies the full humanity of every being", which is a sin. The researcher believes that such "spiritual blindness" is indicative of the prevalence of the church's lack of sound theological and scriptural proclamation, as well as an experiential Christian identity.

The church, especially in South Africa, must be actively involved in an ongoing campaign to guard against sustaining the social order, so that the church can be a champion for destigmatisation, and not its enemy. As supportive as the Afrikaner church was in justifying and supporting apartheid, so it must continually guard against contributing to a societal order that is still marked by gross inequality.

The pandemic requires a "total new understanding of our being the church" (Louw,, 2008:394). This "new understanding" starts with the "lived experience of Christ" as the primary motivation for church involvement in the HIV/AIDS pandemic. Jesus' care and non-stigmatisation actions are paradigmatic for the church's mission to effect physical, emotional, relational and spiritual healing of PLHA. Church ministry to the HIV/AIDS stigmatised includes proclaiming "the hope that is in us" (1 Pet. 3:15). Sharing our transformation from the power of sin to a life of liberty and purpose is not a function of evangelisation, but a spontaneous witness of a new identity.

Communities of believers has the task to appropriate God's norms for behaviour, e.g. faithfulness in marriage, loving families, sexual integrity, care for one's neighbour, and doing to others as you want them to behave towards you as a fundamental dimension of destigmatisation interventions.

The church should be involved in teaching and demonstrating truth. The truth about stigmatisation should accompany truth about HIV/AIDS, to refute the lies of HIV/AIDS and its stigmatisation, and to effectively destroy the connection between lies, silence and denial. The church should be the one who welcomes and reach out to the stigmatised. Those who are HIV positive should be seen as a resource, not a burden.

The PLHA can channel his suffering to result in spiritual and personal growth. Examples of such personal/spiritual growth are self-sacrifice, patience, endurance, and becoming other-focused vis-à-vis being self-focused. Louw states that the result of such "identity" growth is greater maturity, more purposeful meaning in life, and purification of character and behaviour (2000:11). Suffering thus has the capacity to effect fundamental changes in one's motivation for, and orientation to life. Suffering can be life-changing. Such life-changing transformation of HIV/AIDS-related suffering is a wonderful instrument for destigmatisation intervention

The marriage and family roles of men, especially in HIV/AIDS-stricken contexts, needs urgent adjustment, and the church is excellently positioned to proclaim Christian marital ethics. Another area of the church's moral responsibility that has been found wanting is its contribution to the sexual education of its teenagers (cf. Ndungane, 2005:380). This is a vital concern, not only to prepare our teenagers for their roles in marriage, but also to deny HIV/AIDS its major infection propellant and to counter the stigma and stigmatisation of HIV/AIDS.

6. FURTHER STUDY

Through this exploration some further research possibilities have been indicated. Firstly, theological research on stigma, and the relationship between stigma and suffering, would be encouraging because of the current lack of such research. Secondly, further research on

the issues explored in this study could contribute to a multidisciplinary approach to stigmatisation and destigmatisation. Such a contribution could assist the church, especially in the HIV/AIDS context, to contribute to destigmatisation intervention and overall struggle against the pandemic.

Thirdly, research into stigmatisation, the experience of stigmatisation, and destigmatisation in an African community would be a welcome addition to the scientific study of these phenomena. As mentioned during this study, the researcher's brief exposure to a multi-racial neighbourhood suggested considerable differences between the African and Western contexts within a multi-racial and multi-cultural country such as South Africa. These differences indicate a need for a dual cultural approach to HIV/AIDS stigmatisation and destigmatisation intervention.

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