

Title: The impact of HIV stigma in accessing Sexual Health Services among black sub-Saharan African woman and gay men: A Systematic Literature Review.

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Abstract

For many years HIV related stigma and denial has characterized the pandemic and presented a major challenge to the uptake of HIV testing, prevention and normalization among black sub-Saharan African (BSSA) women and gay men. The challenges have had a ripple effect on the access to sexual health services and resources within the communities in question. This article reviews literature on the types of HIV stigma and its impact in accessing sexual health services and resources by the aforesaid communities. Furthermore the article will review literature on attempts made to demystify HIV stigma in order to increase its uptake among the groups in question. The findings from the literature suggest that HIV stigma remains a big challenge to the uptake of HIV testing and access to sexual health services including resources among different social groups under consideration in this article. Despite the efforts to normalize HIV testing, including access to sexual health services and resources, HIV stigma has tended to take a new complex dimension and has proved hard to disappear. In addition to the current efforts to end HIV stigma there is need to understand more about the forms, contexts and social construction of HIV stigma and sexual health seeking behavior in different communities, if we are to succeed in our endeavor to control the epidemic.

Keywords: Stigma, HIV stigma, African women and gay men.

Introduction

Stigma refers to any characteristic or reference real or perceived that gives a negative social identity (UNAIDS, 2013; Crocker, Major and Steel 1998; Goffman, 1963). Therefore HIV stigma refers to prejudice, negative attitudes including maltreatment aimed at people living with HIV and Aids (Avert, 2013; UNAIDS, 2009). This negative attitude and treatment is driven by the fact that the individuals are believed or perceived to be suffering from HIV because of their own fault. Logie et al (2012) further define HIV stigma as a process of devaluing, labeling and stereotyping individuals because they are HIV positive resulting in the individuals loss of status. In the light of the above assertions HIV stigma in this paper shall be viewed as prejudice and devaluing of an individual's social status based on the fact that they are they are HIV positive or are perceived to be HIV positive.

There has been persistence of negative attitudes towards people living with HIV since the break out of the epidemic. Despite massive sexual health promotion, equal rights legislation enactment and educational programmes aimed at communities, stigma has continued to be wide spread (Centre for Aids Prevention Studies (CAPS) 2006). HIV stigma and discrimination (S&D) has been instrumental in impeding prevention care and treatment of HIV across communities (Pulerwitz et al, 2008). Stigma and discrimination has been recognized as an

obstacle to prevention interventions and uptake of HIV testing among communities across the globe (Bharat et al, 2001, Campbell et al 2005, Liber et al 2006 and Plummer et al, 2006). From the above empirical confirmations it has now been widely asserted that stigma and discrimination(S&D) deter many communities from seeking HIV information, services and support.HIV stigma and discrimination (S&D) can be experienced in different environments across the social divide ranging from families, communities to inter-communities and services(Venable,2006).

Since the primary mode of HIV transmission in sub-Sahara Africa is heterosexual, there is very limited research focusing on the sexual health behavior of men who have sex with men (Cloete et al, 2008). Currently there is limited information on the number of people living with HIV among BSSA men who have sex with men and very little is known about the extent of stigma this social group experiences (Ibanez et al, 2005). There is evidence of inter and intra HIV stigma being experienced by this social group. As for the BSSA women there is evidence of blame for spreading the infection from their male partners (Benson et al, 2010). These power dynamics and associated silences around HIV in BSSA communities have effectively affected the sexual health outcomes of BSSA women including their ability to use their rights in accessing HIV and sexual health services. In view of cultural sensitivity and the fragile nature of HIV stigma and sexual health very few researchers have tried to engage with the subject (Sidibe et al, 2014). In the light of this background there is need explore further the impact of HIV stigma on the two social groups in question.

Search Methods

An extensive search was undertaken to identify peer reviewed articles using the search terms AIDS, HIV, Stigma, Discrimination and Isolation for the period 1985 to 2014 inclusive. Key words and phrases including gay community, gay men, black sub-Sahara African women, HIV stigma, serosorting and disclosure were used to refine and filter the search. Using CINAHL, Cochrane library and the worldwide web to search information, a total of 500 articles were generated and reviewed for relevancy to be included in the article in question.

Results

Stigma and HIV testing

HIV Stigma has been conceptualized as both public and personal (Janni, et al 2007). The public conceptualization involves attitudes or reactions held by members of the public towards people who are affected and infected by HIV (Reif, 2005). The personal dimension has to do with the internalization of the negative responses of the surrounding individuals resulting in perceived feelings of being stigmatized (Venable, 2006).

Reif (2007) asserts that fear of stigma has deterred individuals and communities from taking up HIV tests and from disclosing their seropositive status to sexual partners, family and the community at large. In the light of this assertion high levels of perceived stigma has been strongly linked to more depressive and HIV associated symptoms including lower levels of antiretroviral therapy adherence(Smedly,2002). While Stigma in clinical settings discourages HIV positive individuals from accessing treatment and care, the same perceived stigma is also responsible for low uptake of HIV testing among communities with potential high prevalence rates like the BSSA communities (Cloete et al, 2010). Subsequently this affected prevention programs across communities especially the BSSA communities (Janni et al 2007). Many studies have focused on public and personal stigmatization, there has been very little research on health care providers as a source of stigma (Janni, et al 2007). The available limited evidence analyzing the interaction between HIV positive individuals and health care providers has shown significant perceived discrimination and confirmation of stigma as experienced in communities (Rhon, 2006). However there seem to be little known about the prospective relationship between

perceived stigma from health care providers and overall access to care (UNAIDS 2013). Perceptions of stigma from health care providers have the possibility to affect a host of services ranging from medical outpatients to treatment rooms (Williams, 2007).

In 2009 the United Nations global programme on HIV (UNAIDS) estimated that 370 000 children were affected by HIV and an estimated 42 000 to 60 000 pregnant women died of HIV related causes with the majority being in BSSA communities (UNAIDS, 2011). This situation has continued despite massive developments in anti-retroviral treatment (ART). In the light of the above assertion the global community has set two important goals which include the virtual elimination of vertical HIV transmission and a 50% reduction in HIV related maternal mortality by 2015 (UNAIDS 2011). This has resulted in some marked improvement globally in terms of HIV prevention of mother to child transmission and between sexual partners (WHO, 2011; UNAIDS, 2011). However there is ample evidence pointing to the effect that there are serious challenges such as low uptake of HIV testing and adherence to treatment regimes especially in high HIV prevalence communities like the BSSA communities (Lehman, John, Steward et al, 2009; Spensely et al 2007; Stringer Ekouevi et al, 2010). While there is a compelling case to expand the supply of services, mounting evidence demonstrate an urgent need to respond to demand side barriers that affect people to use sexual health services such as stigma and discrimination(Ekouevi,2010).

One key factor that limits the successful prevention and treatment of HIV is the persistent HIV stigma and discrimination that has engulfed communities over the years. Many people have opted out of testing and treatment programmes for fear of facing disclosure difficulties and associated consequences (Bukusi et al, 2011). There is evidence that many people living with HIV have suffered different types of stigma which include anticipated stigma, perceived stigma, enacted stigma and self stigma which has adversely affected their lives(Steward Herek et al 2008,Earnshaw and Choudoir,2009;Holzemer,Humal et al 2009). Furthermore there is a suggestion that HIV stigma and discrimination perpetrated by close people or relatives have a bigger impact compared to common stigma from the wider community (Brickely.Le Dung Hanh et al 2009; Brown Belue et la, 2010; Turan,Bukus et al,2011) HIV related fears and extreme experiences of stigma can lead to loss of confidence and other psycho-social effects which in turn lead to behavioral consequences such as lack of disclosure and low uptake of sexual health services(Turan,Bukusi et al 2011). This will automatically result in poor sexual health outcomes for communities.

Stigma among BSSA women and Access to HIV Services

Many women have opted not to disclose their HIV status due to fear of being stigmatized (Bond Chase et al, 2002; Turan, Miller et al, 2008). Their predicament may be compounded by the social order of communities including complex relationships and values held by communities (Sandelowski, Lambe et al, 2004; Streble, Crawford, 2006). HIV positive women usually struggle with multiple stigmas (Le Dung Hanh et al, 2009). This may include the stigma of being HIV positive and childless in a community that values fertility like the BSSA communities or stigma of being a pregnant unmarried women in a community that values marriage(Brown, Belue, 2010; Barnes and Murphy, 2009; Upton and Dolan, 2011).

There are so many settings where HIV positive women experience stigma and discrimination these may include families, communities, and work places and in health care services (Simbayi et al, 2007; Klichman and simbayi, 2009; Rohangdale Bandur et al, 2010). There are different circumstances in which pregnant women or different individuals might be affected by stigma and avoid using services. Many pregnant BSSA women have avoided the use of antenatal services for fear of being tested for HIV (Laher Cescon, 2011). For example a focus group participant in Soweto South Africa had this to say “I didn’t book at an antenatal clinic because I was afraid that they would test me for HIV ,so I avoided it as I told myself that I might be found

to have this disease”(Laher, Cescon,2011). Angleton and Warwick (1999) linked stigma to gender especially in heterosexual communities like BSSA communities where females are blamed for the spread of the condition. More so there have been some suggested links between race and HIV where epidemiological statistics have shaped beliefs that certain races and ethnic groups are prone to HIV and may be responsible for the epidemic (Piot, 2000; Serrant-Green, 2010).

Some pregnant women are avoiding the use of HIV related services or even terminate treatment because of HIV stigma. For example in a study of 28 women participants in Malawi half of them dropped out citing “involuntary HIV disclosure and negative community reactions, unequal gender relations, difficulties in accessing care and treatment including lack of support from husbands(Chikonde,Sunby et al 2009). This perception again calls on scholars to interrogate the social order in so as to identify hidden issues around unequal gender relations and other marginalized views responsible for exacerbating HIV stigma (Serrant-Green, 2010).

There is evidence that women who blame themselves and internalize negative perceptions about living with HIV are less likely to utilize HIV care and treatment services leading to depression and isolation. For example among HIV positive women In Cape town South Africa “self-stigma was in many instances derived from moral judgments of oneself for failing to satisfy traditional gender roles of wife and mother(Rahangdale,Bandur,2010;Titilayo et al, 2012). These social views held by communities have a negative effect on marginalized social groups and may play a pivotal role in disenfranchising communities.

Some women wishing to become pregnant who disclosed their status either advertently or inadvertently has suffered physical or verbal abuse including being socially isolated(Brown,2007). For example in a research in South Africa a young women narrated the following experience the doctor said to me “How can you think about getting pregnant knowing that you will kill your child because you are positive”. He threatened not to see me again if I got pregnant. He told me that I was irresponsible a bad mother and that I was certainly running around infecting other people (Kendall, 2009). This again is a pre judgmental and well-orchestrated designed assumption by communities and health services on what is expected of a women who is HIV positive.

HIV Stigma and discrimination among gay communities

There is strong evidence to support that the BSSA gay community is also exposed to stigma and discrimination (Cloete et al, 2008, Dowshen, Binns and Garofalo, 2009). Gay men who are HIV positive are more likely to withdraw from their social circles and risks isolation (Botnick, 2000; UNAIDS, 2013) This polarization is likely going to impact on the testing behavior and accessing of other sexual health services of the group in question (WHO, 2011; Botnick, 2000; UNIAIDS 2009).These effects coupled with the fact that the prevalence of HIV among gay men is high, shows the need for more robust interventions to counter stigmatization. Attitudes of stigma towards gay men is extensive and wide ranging (Brown, 2007). In a research involving 667 gay men 79.5% reported one or more forms of stigma from the communities that they were living in (Kelly et al, 2009). The stigma involved discrimination and rejection by other HIV negative men. Duncan and Franks (2000) believe that HIV negative gay men are of the opinion that HIV positive gay men threatened the existence of the gay community which is already experiencing phobia and discrimination from other social groups and communities.

Gomez and Diaz (2006) pointed out that many gay HIV negative men were blaming HIV positive gay men for their HIV infections and thought that they were more promiscuous than them. Some HIV positive gay men find it difficult to trust the general population as they perceive them to be stigmatizing (Courtenay Quick et al, 2006). Many HIV positive gay men over the age of 50

felt that they were undervalued compared to young HIV positive gay men and received less empathy and compassion than young HIV positive gay men (Dodds, and Keogh, 2006 and Siegel, 2003). Conversely young HIV positive gay men have reported anti-empathy from older ones (Dodds and Keogh, 2006). The young HIV Positive men are resented and are accused of being dependent on the state social benefits (Monvoisin et al 2008). This slant of discrimination segmentation and stigmatization among gay communities on each other makes it complicated and difficult to craft and develop everlasting interventions to deal with HIV stigma. Changes in body shape caused by HIV or its treatment are viewed as unattractive and a strong reminder of the person's HIV status (Presson, 2005).

There is also evidence of well documented HIV stigma running through lines of race and ethnic differences within the gay communities (Raymond and Macfarland, 2009). There is a strong perception that black gay men are more likely to be HIV positive compared to other ethnicities which may lead to men of other groups to avoid black men as partners (Pence, 2009) Further evidence suggest that the social set up in gay venues and social networks can separate black gay men from their peers resulting in self-stigmatization (Glick and Golden, 2010). This internalized homophobia can cause black gay men not to undertake HIV tests and present late at treatment centers (Eaton et al 2009).

There is also strong evidence linking stigma to mental health among black gay men as a result of increased levels of anxiety, loneliness and depressive symptoms (Courtenay Quirk et al 2006 and Grove et al, 2010). Further more physical evidence of HIV (assumed or real) has a severe negative psychological and emotional impact on the gay community (Pence, 2009). It has now been established that gay men especially those who are HIV positive are more likely to suffer from mental health problems compared to general population at large (King et al ,2008). HIV positive black gay men with major depressive disorder (MDD) are usually associated with denial, isolation, poor coping strategies and less social support (Mao et al 2009).

Sero-sorting is common among gay men and men who have sex with men (MSM) where association is based on the same HIV status (Keogh, 2004). This also extends to individual relationships in communities where HIV negative and positive gay men screen prospective social or sexual partners for concordance in HIV status before a sexual or a social association (Eaton et al, 2009). There are some studies linking sero-sorting to reduction of HIV transmission among high risk negative gay men (Wilson et al 2010 and Buchbinder, 2010).

Eaton (2009) believe that HIV negative men who have sex with men who sero-sort sometimes put themselves at risk for HIV through low testing ,lack HIV status disclosure and acute HIV infection. Therefore true sero-sorting may only be possible for HIV positive men outside the clinical settings (Cains et al, 2007). There is a belief that HIV positive and negative gay men may be practicing sero-sorting selection based on perceived rather than the true HIV status (Zablotska, 2009).

Interviews carried out in Australia with positive gay men linked the presence of lipodystrophy with feelings of isolation (Persson, 2005). The participants reported loss of intimacy including avoidance of particular social space as they felt uneasy with their appearance. They also reported fear of rejection based on how they appeared and perceived interpretation of their situation. In addition people with perceived HIV manifestations may be prone to risk taking behavior and other potentially health compromising acts associated with poor confidence (Collins, Wargner and Walmsely, 2000; Duran et al 2001).

Recent studies have shown a strong link between HIV related stigma and poor rates of counseling and testing among gay men. Furthermore this has been associated with poor knowledge about transmission and reluctance to disclose their HIV status and test results (Pulerwitz Machaelis, Wess Brown and Mahendra, 2010). Some gay men are reluctant to take an

HIV test through fear of the negative consequences of stigma and discrimination (S&D) associated with a positive test result (CAPS, 2006, Fengwu and Detels, 2010 Nannin et al, 2009).

Non disclosure of HIV status led to stigmatization and isolation among gay men communities. Conversely even those who chose to disclose their status to the community suffered isolation (Courtenay Quirk, 2006). This strongly reinforced the reason why many people from the gay community did not want to disclose to people outside their support network. However there is also some growing evidence to support that disclosing one's status in carefully chosen settings may act as a coping strategy against stigma especially in situations where the individual felt disclosure might encourage social support or reduce gossip and rumors (Makoae, 2008). Pointdexter and Shippy (2010) identified three themes relating to HIV disclosure which include a) Hiding or selective disclosing (Stigma management) b) Partial disclosure to help control spread of information c) Wide spread or complete disclosure i.e. stigma resistance. This can mitigate against forced disclosure where physical manifestations of HIV are present (National Centre for HIV Research, 2003 and Persson, 2005).

In UK a series of studies confirmed that the bulk of gay men felt that they will be rejected if they disclose their status to their partners or potential partners (Bourne, Dodds, Keogh, Whetherburn and Hammond, 2009). This in many cases resulted in drop of esteem and self confidence. Gay communities also felt that being associated with HIV positive sexual spaces on line or offline would compound stigma directed towards them (Kelvin and Aziza, 2001). Many HIV positive gay men reported rejection and lack of empathy from HIV negative friends or partners (Maxwell 1998). In UK similar situations have been confirmed where HIV positive gay men have reported rejection and violence by potential partners upon disclosure of their HIV status (Whetherburn et al, 2009).

HIV positive gay men sometimes participate in high risk behaviors like use of hard drugs and unprotected anal sex as a means of coping with living with HIV (Kelly, Bimbi, izienicki and persons, 2009). This group tend to report increased stigma, gay related stress self blame related copying and substance misuse (Kelly et al 2009 and Radcliffe et al, 2010). Some gay men who are HIV positive have reported community rejection as reason to indulge in unprotected sex (Sheon and Cosby, 2004). The effectiveness of antiretroviral drugs has also been cited as a reason for increased unprotected sex (Abynew, Deribew and Deribe, 2011) there are no conclusive studies to link stigma and alcohol. Conversely Courtenay-Quirk (2006) reported that young HIV positive gay men experiencing stigma were likely to use hard drugs than their counter parts who experienced less stigma. Individuals who experienced high levels of stigma were likely to skip their HIV medication (Sayles et al, 2009).

Gay men experience multiple layers of stigmatization and discrimination from other HIV negative and positive men (UNAIDS 2008). The result for this is wide ranging and can have a long term impact on the life of these men. There are increased reports of the association of being HIV positive in gay communities and risk taking behaviour. HIV stigma has been noted in many researches as divisive and hampering HIV prevention and treatment among many communities including the gay community (Dodds, et al, 2009).

Condom use seems to be dropping due to serosorting and individual assessments (Prestege et al, 2009). This has also taken a knock on the sexual health seeking behavior and has been associated with increased stigma in gay communities' (Imre and McDonalds, 2009). Gay men tend to be more comfortable in relationships with men of the same status due to HIV related stigma (Eaton, 2009).

In some countries infecting someone with HIV may be deemed a criminal offence punishable by imprisonment (UNAIDS, 2013). This has however been viewed as a contentious issue in the fight against stigma as it may influence high levels of stigma (Dodds et al, 2009). This is viewed as

worsening the already existing stigma and misinformation about HIV thereby hindering testing and prevention work (McDonald, 2013).

Parker and Galvao (1996) assert that HIV stigma and discrimination has tended to be centered on population whose sexual practices or identities hugely depart from the “norm”. This belief has reinforced pre-existing sexual stigma that has always been associated with sexually transmitted diseases, homosexuality, promiscuity, prostitution and social deviation (Gagman and Simon, 1973). This belief has also tended to support the notion that HIV is a disease for homosexuals and those who are promiscuous (Parker et al 2000).

Castells (1998) believe that rapid globalization and growing polarization between rich and poor has also exacerbated HIV stigma and discrimination in communities across the World. HIV stigma may therefore be a result of the interaction between diverse pre-existing sources of HIV stigma and fear of contagion and disease among others. However what seems to be absent from the statements presented above is how the mentioned factors have been socially constructed and reinforced in to full blown HIV stigma in specific communities as opposed to the general presented perception. This has limited the ability of scholars to develop an effective and everlasting solution to the problem of HIV stigma including its effect on the sexual health seeking behavior among communities. This again has created a vicious circle where other communities are blamed for the epidemic and vice versa.

Disclosure is regarded as an important facet in supporting HIV positive members of the community and delivering an effective treatment and care system (Foley, 2005). However there is evidence to support that disclosure rates are based on ethnicity signifying that disclosures are lower among ethnic groups compared with the white Caucasian community. In UK the lowest disclosure rates are among black Africans and Asians (Pettrak et al 2001). In New Zealand Sub-Saharan Africans never disclosed to anyone in their communities and only very few disclosed to family members (Worth et al, 2001). A major barrier to disclosure among ethnic minorities is the fear of being a burden and subsequent stigma which may follow (Worth et al, 2001; Anderson and Doyal, 2005). The stigma comes with many effects for example social exclusion from other Africans (Foley, 2005). Fear of being rejected on moral grounds for being gay and being HIV positive is causing many gay Africans not to disclose their sexuality and seropositive status. (Dodds et al, 2004; Keogh et al, 2004; Kennamer et al, 2000). Because of stigma disclosure poses a real threat to HIV positive individuals. Some women who disclosed their seropositive experienced a backlash of violence from husbands and partners. (Anderson and Doyal, 2004). Disclosure victims are affected by hard feelings of guilt, shame and dilemma (UNAIDS, 2013; Crawford et al, 1997).

Understanding the lived experiences of specific ethnic minority groups on their perception of stigma is crucial for planning and implementation of appropriate health and social care (WHO, 2013; Anderson and Doyal, 2005). In order to deliver a sound sexual health service, there is need to eradicate stigma, therefore more information is needed on the social construction of HIV stigma and sexual health seeking behavior in specific ethnic minority communities. Studies need to challenge the current cultural status quo with regards to HIV stigma in these communities while articulating the marginalized views of less considered social groups. This is meant to present a new dimension in understanding HIV stigma and sexual health seeking behaviors among ethnic minority groups. It is also important to evaluate and interrogate the relationship between ethnic minority groups and types of sexual health services available with intent to project

A gap for Research and Intervention.

There is need to reconsider the way in which research and interventions to address HIV stigma is being carried out. There is need for a more robust and broader approach in which the current

conceptual framework and intervention models that focuses on the individual are complimented by:

- Modern approaches to researching ways of understanding the social construction of HIV stigma taking into consideration the social,cultural,political and economic aspects of the phenomenon.
- New approaches to programming and interventions focussing on ways of responding to HIV stigma that actively engage societies, communities and the victims of HIV stigma

Research is therefore required to:

- Identify the environmental and structural sources that support the social construction of HIV stigma and the ways in which they are manifested through case studies and qualitative community research.
- Identify and develop robust concepts and understanding that amalgamates the social, cultural, political and economic determinants and consequences of HIV stigma within specific communities as opposed to general presentations..
- Review the adequacy and appropriateness of concepts over time in the light of changing needs, priorities, culture and circumstances that have an impact on HIV stigma in specific communities.
- Contribute to understanding of the process of change, social movements and cultural transformation in response to HIV stigma.
- Investigate social processes in a range of multiple contexts to enable comparisons to be made and develop an understanding of the aspects of HIV stigma.

Concluding Comments

The discussion above has demonstrated that HIV stigma is linked to the actions and attitudes of families, communities and societies. In many circumstances stigma has been viewed as a static feature or characteristic. This has limited the analysis of the underlying picture and effective responses to HIV stigma. There is need to move beyond the current philosophy and think towards a new dimension that is based on an understanding that HIV stigma and sexual health seeking behaviour are social processes that can be resisted and challenged by social action.

Social and political theories are key in understanding that HIV stigma is not an isolated phenomenon or an expression of individual attitudes but rather a collective social process used to create and maintain social control and produce inequalities. Stigma is used to create order in society through the effect of inferiority complex by comparing the normal and the abnormal characters “deviant” and “non deviant” (Gretz,1983).Concepts of symbolic violence and hegemony highlight the place of stigmatization in the establishment of social order and control and singles out part of the struggle for power (Bourdieu,1977). Symbolic violence images and practices promote the interest of dominant groups (Passeron, 1977). Hegemony is realised through the use of political, social and cultural forces to promote dominant meanings and values that legitimizes unequal structures (Foucault 1977 and 1978).

In line with the notion that stigmatization involves identifying differences between groups of people and using the differences to determine where groups fit into structures of power lays the idea that stigma is used to create social inequality. Stigmatization perpetuates inequalities and concepts of symbolic violence and hegemony helps us to understand how the oppressed accept and internalize the stigma to which they are subjected. This is because the violence and the hegemony convince the dominated to accept the status quo and this may persist for generations if it is not challenged.

Understanding stigmatization as a political and social process helps us to reconsider responses to HIV stigma. Identity theory asserts that those who are stigmatized can take action to resist the powers that discriminate against them (Castells, 1997; Hall 1990). The marginalized usually generate “resistance identities” and use them to build a new dispensation that redefines their position in the society i.e. seeking to transform the overall social structure.

The discussed ideas offer crucial insights for reconceptualising HIV stigma within the broader social, cultural, political and economic framework rather than as an individual processes. It offers a framework to understand HIV stigma as a social process that is used to create a social hierarchy by differentiating between the stigmatized and the none stigmatized. This also improves the ability to analyse the social construction of HIV stigma and ways in which it interacts with pre-existing HIV stigma and social exclusion. Consequently a better understanding of the processes that produces HIV stigma would enable us to develop more comprehensive and effective responses to HIV stigma.

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