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CHAPTER IV

REVIEW OF LITERATURE

4.1 Introduction

HIV/AIDS is as much about social phenomena as it is about biological and medical concerns. Across the world, the global pandemic of HIV/AIDS has shown itself capable of triggering responses of compassion, solidarity and support, bringing out the best in people, their families and communities. But the disease is also associated with stigma, ostracism, repression and discrimination, as individuals affected by HIV have been rejected by their families, their loved ones and their communities. This rejection holds as true in the rich countries of the west, the literate state of Kerala as well as it does in the poorer and developing countries elsewhere. Any number of studies can be quoted on the social issues of this disease. The society is many a time held responsible for many evils that lead to this infection. At the same time, many communities have reacted to this epidemic as if it is an intrusion into the cultural values. This dichotomy is experienced in all studies pertaining to the social aspects of many undesirable events in the evolution of a culture, be it economic regression, educational backwardness, improper handling
of environmental health and ecology or manipulation for menial needs of individuals. AIDS is no exception here too. The reactions as analysed by many experts from across the globe, as well as from different parts of our region are summarized in this chapter.

4.2 Global realities

All over the world, ignorance, lack of knowledge, fear and denial have engendered serious and often tragic consequences, denying people living with HIV/AIDS access to treatments, services and support, as well as making it hard for prevention work to take place. The epidemic of fear, stigmatization and discrimination first described by Jonathan Mann (1987)\(^1\) has undermined the ability of individuals, families and societies to protect themselves and provide support and reassurance to those infected (Merson, 1993)\(^2\).

The London Declaration on AIDS Prevention following the World Summit of Ministers of Health on Programmes for HIV Prevention in January 1988 was one of the first international statements to recognize that “Discrimination against and stigmatization of HIV-infected people and people with AIDS and population groups undermine public health and must be avoided.”
In 1988, the 41st World Health Assembly (WHA) urged Member States to foster a spirit of understanding and compassion for HIV-infected people and those suffering with AIDS. In addition, WHA recommended Member States to protect the human rights and dignity of affected individuals and population groups so as to discourage discrimination and stigmatization in the provision of services, employment and travel.  

In 1989, the United Nations Centre for Human Rights organized the first international consultation on HIV/AIDS and human rights. This forum reaffirmed the public health rationale for the prevention of HIV/AIDS-related discrimination and the promotion and protection of human rights in the context of HIV/AIDS – a view reaffirmed in United Nations General Assembly resolutions in 1990 and 1991. In late 1996, the second international consultation on HIV/AIDS and human rights was convened jointly by UNAIDS and the Office of the High Commissioner for Human Rights. Twelve international guidelines on HIV/AIDS and human rights were drafted at this meeting, the majority of which emphasized, once again, the need to avoid HIV/AIDS-related discrimination and
to ensure the promotion and protection of the human rights of people living with and affected by HIV/AIDS.\(^5\)

International human rights law seeks to guarantee freedom from discrimination on many grounds including sex, race, language, religion, political opinion, birth or other status. In 1995 and 1996, the UN Commission on Human Rights confirmed that the phrase “other status” is to be interpreted as incorporating health status, including HIV/AIDS. This means that discrimination against people living with HIV/AIDS – or those perceived to be at higher risk of infection – is legally prohibited.

Resolution 49/1999 of the UN Commission on Human Rights reaffirms that

"**Discrimination on the basis of HIV or AIDS status, actual or presumed, is prohibited by existing international human rights standards, and that the term, ‘or other status’ in non-discrimination provisions in international human rights texts should be interpreted to cover health status, including HIV/AIDS.**"
Visibility and openness about HIV/AIDS are prerequisites for the successful mobilization of government and community resources to respond to the epidemic. Because they fear stigma and discrimination, people living with HIV/AIDS may be deterred from being open about their serostatus. This enables governments and others to deny that there is a problem. Consultations and meetings have already taken place designed specifically to review experiences and progress in combating the kinds of stigmatization and discrimination that are serious obstacles to prevention and care. Objectives also include sharing best practices with respect to existing codes and legislative frameworks, and to further contribute to international efforts ensuring that HIV/AIDS-related discrimination is reduced and its effects ameliorated.

4.3 Stigma and Discrimination in HIV/AIDS

"Stigma is a dynamic process of devaluation, whose qualities are quite arbitrary, arising from the perception that there has been a violation of a shared set of shared attitudes, beliefs or values. It is linked to power and domination throughout societies, creating and reinforcing inequality where some groups are made to feel superior and others devalued (especially where gender, sexuality or race are
concerned). This process can therefore lead to prejudicial thoughts, behaviours and actions by individuals, governments, communities, health care providers, friends or families. Stigma is socially constructed and therefore needs societal based interventions to combat it, aimed at changing attitudes and behaviours.

Discrimination is an action that occurs when a distinction is made against a person. This results in his or her being treated unfairly and unjustly, on the basis of their belonging to a particular group. Combating discrimination requires providing a supportive legal environment.

In a classic statement, the sociologist Erving Goffman (1963) defined *stigma* as a “significantly discrediting” attribute possessed by a person with an “undesired difference”. Stigma is a powerful means of social control applied by marginalizing, excluding and exercising power over individuals who display certain traits. It is a common response to perceived threat when escape from, or the destruction of, this threat is impossible.

While the societal rejection of certain social groups (e.g. “homosexuals”, injecting drug users, sex workers and migrants) may predate HIV/AIDS, the disease has, in many cases, reinforced this
stigmatization. By attributing blame to specific individuals and groups, society can absolve itself from the responsibility of caring for and looking after such populations (McGrath, 1993). This is seen not only in the manner in which “non resident” groups are blamed for having brought HIV into a country, state or neighbourhood, but also in how such groups are subsequently denied access to the services and treatment they need.

Gilmore & Somerville (1994) have described what they see as the four main features of any stigmatizing response:

1. the problem that initiates the reaction;
2. the identification of the group or individual to be targeted;
3. the assignment of stigma to this individual or group; and
4. the development of the stigmatizing response.

Other authors have found it helpful to distinguish between felt and enacted stigma. Felt stigma is more prevalent – feelings that individuals harbour about their condition and the likely reactions of others. Enacted stigma refers to actual experiences of stigmatization and discrimination (Scambler & Hopkins 1986).
Felt stigma often precedes enacted stigma and may limit the extent to which the latter is experienced. For example, some people living with HIV, aware that many people with HIV/AIDS have been treated badly by others, may conceal their serostatus. To the extent that they are successful in “passing” as non-infected, such individuals may limit the amount of enacted stigma prevalent in a society or community – at least in the short term. (Jacoby, 1994)\textsuperscript{11}

4.3.1 Sources of HIV/AIDS-related stigmatization, discrimination and denial

A historical and socio-cultural perspective may be helpful in understanding the negative reactions triggered by HIV/AIDS. In previous epidemics, the real or supposed contagiousness of disease has resulted in the isolation and exclusion of infected people (Volinn, 1989\textsuperscript{12}; Gilmore & Somerville, 1994\textsuperscript{13}). Sexually transmitted diseases in particular are notorious for triggering such socially divisive responses and reactions (Carrara, 1994\textsuperscript{14}; Goldin, 1994\textsuperscript{15}). From early in the AIDS epidemic, a series of powerful metaphors were mobilized which serve to reinforce and legitimate stigmatization. These include HIV/AIDS as \textit{death} (e.g. through imagery such as the Grim Reaper); HIV/AIDS as \textit{punishment} (e.g. for immoral behaviour); HIV/AIDS as
a crime (e.g. in relation to innocent and guilty victims); HIV/AIDS as war (e.g. in relation to a virus which needs to be fought); HIV/AIDS as horror (in which infected people are demonized and feared); and HIV/AIDS as “otherness” (in which the disease is an affliction of those set apart). Together with the widespread belief that HIV/AIDS is shameful (Orangi, 1997\textsuperscript{15}), these metaphors constitute a series of “ready-made” but highly inaccurate explanations that provide a powerful basis for both stigmatizing and discriminatory responses. These stereotypes also enable some people to deny that they personally are likely to be infected or affected.

People living with HIV/AIDS are seen as ignominious in many societies. Where the infection is associated with minority groups and behaviours (for example, homosexuality), HIV/AIDS may be linked to “perversion” and those infected punished (Mejia, 1988\textsuperscript{16}). In individualistic societies, HIV/AIDS may be seen as the result of personal irresponsibility (Kegeles et al., 1989\textsuperscript{17}). In yet other circumstances, HIV/AIDS is seen as bringing shame upon the family and community (Panos, 1990\textsuperscript{18}; Warwick et al., 1998\textsuperscript{19}).

The manner in which people respond to HIV/AIDS therefore varies with the ideas and resources that society makes available to
them. While negative responses to HIV/AIDS are by no means inevitable, they not infrequently feed upon and reinforce dominant ideologies of good and bad with respect to sex and illness, and proper and improper behaviours (Warwick et al., 1998).

De Bruyn (1999a) has identified five factors as contributing to HIV/AIDS-related stigma:

- *The fact that HIV/AIDS is a life-threatening disease;*
- *The fact that people are afraid of contracting HIV;*
- *The disease's association with behaviours (such as sex between men and injecting drug use) that are already stigmatized in many societies;*
- *The fact that people living with HIV/AIDS are often thought of as being responsible for having contracted the disease;*
- *Religious or moral beliefs that lead some people to conclude that having HIV/AIDS is the result of a moral fault (such as promiscuity or "deviant" sex) that deserves punishment.*

HIV/AIDS-related stigmatization causes resources essential to preventing infection to be displaced. People are victimized and blamed, social divisions are reinforced and reproduced, and new infections continue to emerge as long as people misread the nature of the epidemic and its causes. More importantly, while negative
responses of stigmatization and discrimination seemingly give cohesion to societies and communities, they lead to greater instability in the long term. The social categories and barriers that have been constructed around it cannot contain HIV/AIDS. It requires a more effective means of prevention than this.

4.3.2 Forms of HIV/AIDS-related stigmatization, discrimination and denial

There are several levels at which HIV/AIDS-related discrimination, stigmatization and denial may be experienced and felt. These include societal and community levels, in addition to the experience of individuals.

4.3.2 a. Societal and community levels

At the level of society, laws, rules, policies and procedures may result in the stigmatization of people living with HIV/AIDS. A significant number of countries have enacted legislation with a view to controlling the actions of HIV/AIDS-affected individuals and groups (Tomasevski et al., 1992). These laws include legislation for:

- the compulsory screening and testing of groups & individuals;
- the prohibition of people living with HIV/AIDS from certain occupations and types of employment;
• the medical examination, isolation, detention and compulsory treatment of infected persons;
• limitations on international travel and migration;
• the restriction of certain behaviours such as injecting drug use and prostitution (Gostin & Lazzarini, 1997).

International experience now shows that such measures serve only to increase and reinforce the stigmatization of people living with HIV/AIDS and those at greatest risk of contracting the virus. In many countries, discriminatory practices such as the compulsory screening of certain populations or “risk groups” cause both the further stigmatization of such groups and a misplaced sense of security among those who do not see themselves as belonging to these sections of the population. A recent review has, moreover, pointed to the gaps between more liberal national policies and the application of these policies and principles in practice (Gruskin, Hendricks & Tomasevski, 1996). Even where supportive legislation exists, its application may be partial, uneven or ignored.

Restrictive and coercive measures – frequently enacted to “protect” society from infection – discriminate against, or exclude, those who are already infected. Laws that insist on the compulsory
notification of HIV/AIDS cases and the restriction of a person’s right to anonymity and confidentiality, as well as the right to movement of those infected, have been justified on the grounds that the disease constitutes a public health emergency (Manuel et al., 1990). While with other infectious diseases such responses may be justifiable, in the case of an already highly stigmatized condition such as HIV/AIDS disease they result in punitive measures that further discriminate against people living with HIV/AIDS and may drive those infected, and those most vulnerable, further underground (Gostin & Lazzarini, 1997).

Consequently numerous countries have now enacted legislation to protect the rights and freedoms of people living with HIV/AIDS and to safeguard them from discrimination (Mann, Tarantola & Netter, 1992; Mann, Tarantola & Netter, 1996). Much of this legislation has sought to ensure the right to employment, education, privacy and confidentiality, as well as the right to information access, treatment and support. However, the failure of governments to protect people living with HIV/AIDS from discrimination, through legislation or through the active enforcement of such legislation, is a violation of their human rights. The apathy of
some governments in providing effective systems of prevention, treatment and care may also arise from more deep-seated stigmatization at a societal level.

Governments and national authorities contribute to HIV/AIDS-related stigmatization in other ways. They may, for example, cover up and conceal cases or fail to maintain reliable and transparent reporting systems (Milner, 1991\textsuperscript{27}; Whiteside, 1993\textsuperscript{38}). Ignoring the existence of HIV/AIDS, neglecting to respond to the needs of those living with HIV infection, and failing to acknowledge burgeoning epidemics in the belief that HIV/AIDS "can never happen to us" are some of the most widely reported responses of denial (Daniel, 1991\textsuperscript{29}; Milner, 1991\textsuperscript{27}). This denial fuels stigmatization by making those few individuals acknowledged to have HIV/AIDS appear abnormal and exceptional. They do little to enable people to develop a more realistic appreciation of individual vulnerability, and contribute to a vulnerability to the epidemic (Mann, Tarantola & Netter, 1996\textsuperscript{26}; UNAIDS, 1997\textsuperscript{3b}).

Stigma and discrimination, both real and perceived, may also arise from a variety of community-level responses to HIV/AIDS. The harassing and scapegoating of individuals suspected of being
infected or of belonging to a particular group has been widely reported. It is often stimulated by the need to blame and punish and can, in extreme circumstances, extend to acts of violence and murder (Nardi & Bolton, 1991). Attacks on men who are presumed gay have increased in many parts of the world, and have been associated with the growing HIV/AIDS epidemic. Sex workers and street children in Mumbai have likewise been singled out for violence and abuse. HIV/AIDS-related murders have been reported in countries as diverse as Brazil, Colombia, Ethiopia, India, South Africa and Thailand (Panos 1990; AFAO, 1997). In December 1998, Gugu Dhlamini was stoned and beaten to death by neighbours in her township near Durban, South Africa, after speaking out openly on World AIDS Day about her HIV status. A similar incident of stone pelting of a lady to death has happened in Cuppum in Andhra Pradesh.

4.3.2.b. Individual experience

People’s experience of HIV/AIDS-related stigmatization and discrimination is affected by commonly held beliefs, forms of societal stigmatization, and factors such as the extent to which individuals are able to access supportive networks of peers, family and kin. It may
also be influenced by the stage of the epidemic and whether individuals feel they can be open about their serostatus, age, gender, sexuality and social status – among a host of other variables.

Overall, the negative depiction of people living with HIV/AIDS – reinforced by the language and metaphors used to talk and think about the disease – has reconfirmed fear, avoidance and the isolation of affected individuals and, in some cases, friends and families. In a highly stigmatizing environment, people may withdraw from society as a means of self-preservation. This isolation can extend to exclusion from social and sexual relationships and – in extreme circumstances – has led to premature death through suicide or euthanasia (Gilmore & Somerville, 1994\(^8\); Hasan et al., 1994\(^4\)).

More often, however, stigmatization causes a kind of social death in which individuals no longer feel part of civil society, and are no longer able to access the services and support they need (Daniel & Parker, 1990\(^5\)).

Who to tell, how and when, can be a potential source of fear and anxiety among many people living with HIV/AIDS and may prevent individuals from accessing treatment and care (Moynihan et al., 1995\(^6\); Omang, 1997\(^1\)). Even where laws have been enacted to
protect the rights and confidentiality of people living with HIV/AIDS, few people are prepared to litigate in case their identity will become widely known. Those who are identified as belonging to marginalized and/or minority groups may also worry about the reactions of others, regardless of their serostatus. Fear of telling family members about their homosexuality has recently been cited by some Mexican men as equal to the fear of revealing their serostatus (Castro et al., 1998).

The impact of HIV/AIDS on women is particularly acute. In many developing countries, women are already economically, culturally and socially disadvantaged and lack equal access to treatment, financial support and education. Being outside the structures of power and decision-making, they may be denied the opportunity to participate equally within the community and may be subject to punitive laws, norms and practices exercising control over their bodies and sexual relations. In a number of societies, women are erroneously perceived as the main transmitters of sexually transmitted infections (STIs), which may be referred to as “women’s diseases” (de Bruyn, 1992). Together with traditional beliefs about sex, blood and other kinds of disease transmission, these perceptions provide a
fertile basis for the further stigmatization of women within the context of HIV/AIDS (Ingstad, 1990\textsuperscript{39}; Peterson, 1990\textsuperscript{40}; Mushingeh, Chana & Mulikelela, 1991\textsuperscript{41}; Thant, 1993\textsuperscript{42}). There is clear evidence from recent UNAIDS-supported studies of household and community responses to HIV/AIDS in developing countries (Warwick et al., 1998\textsuperscript{39}; Aggleton & Warwick, 1999\textsuperscript{43}) that seropositive women are likely to be treated very differently from men. Whereas men are likely to be "excused" for the behaviour that resulted in their infection, women are not. In India, for example, the husbands who infected them may abandon women living with HIV/AIDS. Rejection by wider family members has also been reported as common (Bharat & Aggleton, 1999\textsuperscript{44}). In some African countries, women whose husbands have died from AIDS-related infections have been blamed for the death. Remaining relatives may also evict the surviving spouse from her home (Henry, 1990\textsuperscript{45}). Fearful of such situations, some women may prefer to remain ignorant of their serostatus or may keep it a secret.

As a result of such a thought process, individual denial of risk and vulnerability is not an uncommon response to the epidemic. Such denial may manifest itself in self-distancing from the problem and, in
extreme cases, can result in people misperceiving their vulnerability. Denial can also discourage voluntary testing among many people, particularly among members of especially vulnerable groups. This, in turn, may increase the potential risk of HIV transmission within the community (Lie & Biswalo, 1996). Such action undermines prevention, care and support.

4.3.3 Contexts of HIV/AIDS-related stigmatization, discrimination and denial

HIV-related stigmatization, discrimination and denial may appear in a variety of contexts. Central among those are the family and local community, employment and the workplace, and the health care system.

4.3.3 a. The family and community

In the majority of developing countries, families are the primary care-givers to sick members. There is clear evidence of the important role that the family can play in providing support and care for people living with HIV/AIDS (World Bank, 1997; Warwick et al., 1998; Aggleton & Warwick, 1999). However, not all family response is positive. Infected and affected family members may still be stigmatized and discriminated against within the home. There is
also mounting evidence that women (Bharat & Aggleton, 1999[^44]) and homosexual family members (Castro et al., 1998a[^48]; 1998b[^37]) are more likely to be badly treated than children and men.

The family’s efforts to “manage” stigmatization within the wider community also have consequences for quality of care. Families may shield affected members from the wider community by keeping them within the house or by protecting them from questioning (Lwihula et al., 1993[^49]). The extent to which such strategies are successful may depend upon the wealth of the household concerned and its capacity to provide care without calling upon other community members for support. Fear of rejection and stigmatization within the home and local community may prevent people living with HIV/AIDS revealing their serostatus to family members (McGrath et al., 1993[^5]). Families may reject seropositive members not only because of the stigma associated with HIV/AIDS, but also because of the connotations of promiscuity, homosexuality and drug use that HIV/AIDS carries (Panos, 1990[^18]; Misra, 1999[^50]; Mujeeb, 1999[^5]).
4.3.3 b. Employment and the workplace

While HIV is not readily transmitted in the majority of workplace settings, the supposed risk of transmission has been used by numerous employers to terminate or refuse employment (Gostin, 1992\textsuperscript{53}; Panos, 1992\textsuperscript{53}; Shisam, 1993\textsuperscript{54}; Hasan et al., 1994\textsuperscript{54}; Ongani, 1997\textsuperscript{15}). There is also evidence that where people living with HIV/AIDS are open about their serostatus at work they are likely to experience stigmatization and ostracism by others (Panos, 1990\textsuperscript{18}; Gostin, 1992\textsuperscript{52}; Gostin & Lazzarini, 1997\textsuperscript{25}).

Pre-employment screening takes place in many industries – particularly in countries where the resources for testing are readily available and affordable. In poorer countries screening has also been reported as taking place, especially in industries where health benefits are available to employees (Parker, 1991\textsuperscript{55}; Jackson & Pitts, 1991\textsuperscript{56}). Employer-sponsored insurance schemes providing medical assistance and pensions for employees have come under increasing pressure in countries that have been seriously affected by HIV/AIDS. Some employers have used this pressure to deny employment to people living with HIV/AIDS (Whiteside, 1993\textsuperscript{28}; Williams & Ray, 1993\textsuperscript{57}). Only very few companies in developing countries appear to have developed strategies to combat fear, stigma and discrimination in the
workplace (Hughes, 1988\textsuperscript{58}), and an equally small number have begun to define the responsibilities of employers towards employees with HIV/AIDS (Jackson & Pitts, 1991\textsuperscript{56}; Bezmalinovic, 1996\textsuperscript{55}).

A study of seven large Mumbai-based businesses revealed that none had a policy on AIDS and that mid-level management have adopted a “wait and see” attitude – waiting to see how many workers became infected and whether this had an impact on productivity (Hira, Gupta & Godwin, 1998\textsuperscript{63}). At the same time, anecdotal evidence of employment-related discrimination and stigmatization has begun to emerge. Individual cases of job loss, emotional isolation, and denial of employment on the basis of HIV status have been reported in the media, to NGO workers and social counselors, and to medical practitioners. An industrial body with a specialized role in coordinating industry-based initiatives on the epidemic, the Industrial Response to AIDS (IRTA), has produced a booklet on corporate policy and HIV/AIDS (Nangia, 1998\textsuperscript{64}).

4.3.3.3 c. The health care system

Many reports reveal the extent to which individuals are stigmatized and discriminated against by the health care system. Numerous accounts including those from different parts of India and
Kerala also proliferate of withheld treatment (AIDS Bhedbhan Virdhi Andolan, 1993\textsuperscript{62}; Carvalho et al., 1993\textsuperscript{63}; Panebianco et al., 1994\textsuperscript{64}); non-attendance of hospital staff to patients left lying in their beds (Daniel\&Parker, 1990\textsuperscript{15}; Ogola, 1990\textsuperscript{65}; Masini \& Mwampeta, 1993\textsuperscript{66}); HIV testing without consent, breaches of confidentiality, and denial of hospital facilities and medications (Panebianco et al., 1994\textsuperscript{64}).

Contributing to such responses are ignorance and lack of knowledge about HIV/AIDS transmission (Kegeles et al., 1989\textsuperscript{67}; Herek \& Capitano, 1993\textsuperscript{68}; Herek et al., 1998\textsuperscript{69}); fear (Blendon \& Donelan, 1988\textsuperscript{70}; Tesch, Simpson \& Kirby, 1990\textsuperscript{71}); moralistic assumptions of guilt (Cole, Zhang \& Chen, 1993\textsuperscript{72}; Masini \& Mwampeta, 1993\textsuperscript{66}); and the perceived incurability of HIV/AIDS. All of these conspire to make it appear pointless to offer good-quality care. Lack of confidentiality has been repeatedly cited as a particular problem in health care settings. Wide variations in practice exist between countries, and between health care facilities within countries. In some settings signs have been placed near people living with HIV/AIDS with words such as "HIV-positive" and "AIDS" written on them. Elsewhere, registers of HIV-positive people have been
compiled and their names released to media and police without permission (Panos, 1990\textsuperscript{18}, Singh, 1991\textsuperscript{75}).

Principles of confidentiality also vary between countries and cultures. In some places, for example, confidentiality may be less an individual issue than a community and collective concern. The term “shared confidentiality” describes a situation where family and community members feel they have the right to know the serostatus of family members, neighbours and friends (Campbell et al., 1997\textsuperscript{74}).

4.4 Implications for enquiry

The above are not the only settings in which HIV/AIDS-related stigmatization and discrimination take place. It should be clear that responses in one setting (e.g. the hospital and health care setting) may have consequences for the way in which people react in others (e.g. at work or at home). It is observed in many studies that heirship issues and ownership of property are major issues that come up. Especially when these patients are being subjected to costly tests and treatments, the expenditure on health increases and the family, relatives and friends play a role in deciding the source of money for these. There have been instances where families which can afford these have refused to accept the offer, labeling it as “wasteful
expenditure". Similar attitudes are raised and nurtured even by administrators and policy makers at various discussions. To deny or delay treatment is also a form of discrimination. In the context of providing drugs too, many governments (including Govt. of India and Kerala) decides on many occasions to restrict drug delivery to certain categories only, even ignoring scientific guidelines. The usage of Nevirapine prophylaxis in preventing mother to child transmission, in the place of more effective Zidovudine prophylaxis is a classic example of this type of a discrimination in administrative machinery. We need to examine more closely the fields in which stigmatization occurs, the forms that HIV/AIDS-related discrimination takes, individual, social and institutional determinants, and the responses to which stigmatization gives rise. Only by understanding more about such processes will it be possible to develop the kinds of programmes and interventions that will be successful in preventing HIV/AIDS-related stigma and the negative consequences to which it gives rise.
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CHAPTER V

KERALA SCENARIO

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