# Discrimination, Stigma and a Typology of Violence:

## Some Conceptual Reflections from HIV/AIDS Work

*-Devaki Nambiar[1]*

*...what's natural is the microbe. All the rest – health, integrity, purity (if you like) – is a product of human will, a vigilance that must never falter.*   (Camus, 1972)

## Defining Stigma

In Delhi, where I conducted my dissertation fieldwork on the stigma associated with HIV/AIDS, I found no widely used Hindi word for stigma, nor a widely accepted definition.[1] Elsewhere, there has been a great deal of academic theorizing on stigma. Among the first stigma theorists is sociologist Erving Goffman, who categorized it as an individual "attribute that is deeply discrediting" focusing his attention on the management of social interactions of a discredited "spoiled identity" (Goffman, 1963: 13). Goffman emphasized that "stigma involves not so much a set of concrete individuals who can be separated into two piles, the stigmatized and the normal, but rather as a pervasive two-role social process in which every individual participates in both roles, at least in some connexions [sic] and in some phases of life.  The normal and the stigmatized are not persons but perspectives" (Goffman, 1963:163-164). Notwithstanding Goffman's emphasis on processes and perspectives, a focus on the individual has dominated understandings of stigma and discrimination in public health as well as human rights action for

---

[1]*The following write-up is excerpted from research and analysis conducted as part of my dissertation (Nambiar, 2009) and ideas that I have been trying to build upon and think through since. The thinking here is still in ferment: apologies in advance for lapses in clarity, errors of commission and omission. Email: <devaki.nambiar@gmail.com>*

the past half century. In fact, researchers conducting HIV/AIDS-related research and interventions believe that individual-level conceptualizations of the construct in the HIV/AIDS context may in part be responsible for the limited success of efforts to reduce stigma (L. Brown, Macintyre, & Trujillo, 2003; Herek, 2002; A. P. Mahajan et al., 2008; Parker & Aggleton, 2003).

**Putting Stigma and Discrimination in Larger Context**

Recent theorizing has emphasized the structural nature of stigma and discrimination, connected to ecological processes that establish and maintain social inequality (Keusch, Wilentz, & Kleinman, 2006; Nyblade & MacQuarrie, 2006; Parker & Aggleton, 2003). In my understanding of it based on fieldwork and experience, the processes of stigma manifest in ways that are different and must be apperceived accordingly. There are the **experiential** marking processes of stigma embodied in interactions and experience, specifically separation, status loss, and discrimination. Then there are forms of stigma that are **symbolic** (marked by labels and stereotypes) and **structural** (marked as power differences within institutions). While the subjective or experiential forms of stigma are those typically studied in public health, other forms of discrimination are connected to the concepts of symbolic violence and structural violence (see Figure 1).

Stigma is manifest as **experiential violence** in the processes of separation, status loss and discrimination. The bulk of stigma research in public health to date- particularly research employing quantitative methods - falls under this category.[2] **Symbolic violence** is "a process whereby symbolic systems (words, images, and practices) promote the interests and hierarchy of dominant groups in a manner perceived to be legitimate by dominated groups" (Bourdieu, 1990:

127).  It is theorized that symbolic violence legitimizes stigma because dominated groups do not question the hegemonic words, images, and practices to which they are routinely subjected (Parker & Aggleton, 2003). In turn the symbolic forms of stigma are the basis for symbolic violence to occur: labels used to describe vulnerable groups – like people living HIV, minorities of gender, caste, or religion and the economically weaker. When dominant groups – including and sometimes especially public health institutions - normalize these labels ("high risk"), stigma becomes a form of symbolic violence (there has been some work on this in relation to targeted interventions and HIV[3]).

Experiential violence embodies and symbolic violence legitimizes **structural violence**, "preventable harm or damage... [that] emerges from the unequal distribution of power and resources or, in other words, is said to be built into the structure(s)" (Weigert, 1999: 431). Structural violence has been the subject of research in anthropological studies of stigma (Castro & Farmer, 2005; Farmer, 2004; Farmer, 2001). In this conceptualization, the distribution of power is a condition of stigma that closely relates to the workings of structural violence. Structural violence comprises social forces including racism, sexism, political violence and other social inequalities that are rooted in historical and economic processes (Castro & Farmer, 2005).[4] Critically, as these scholars note, structural violence is "not the result of accident or a *force majeure*; it is the direct or indirect consequence of human agency" (Farmer 2005: 40). The contradiction, of structural violence being intangible but at the same time social, requires that we re-socialise our understanding of stigma and violence (Castro & Farmer, 2005), which in turn links to Goffman's (1963:13) submission that to understand the construct of stigma, "a language of relationships is needed."

**Example of HIV/AIDS in India**

In my recent attempt to understand stigma and discrimination in a larger context, I found that the use of the Targeted Intervention (TI) framework for HIV/AIDS prevention and control created labels that could be easily stereotyped by NGO practitioners in order to legitimize their own role in the HIV/AIDS response (Nambiar, 2009). I saw this as a form of **adverse incorporation** where the involvement of NGOs in "peer outreach" work was endorsing the stigmatization of their peers (Nambiar &Rimal, 2012). Young people I spoke to who were unexposed to this nosology were less apt to stereotype PLWHA, suggesting that through adverse incorporation, symbolic forms of stigma were present among young people working in certain HIV/AIDS-related NGOs.

Further, I examined the HIV/AIDS response in India to see what power dependencies - structural elements of stigma - existed and how the presence of these structural elements might explain the higher stigmatization in the NGOs (Nambiar, 2011). I found disparities in the apparatus and level of funding allocated to HIV/AIDS in the late 1990s and early 2000s, relative to other diseases (with higher burden). This apparatus and funding support, almost exclusively dependent upon private donors and unchecked by the state apparatus, involved an uncritical and heavily financed endorsement of NGO participation. As a result, NGOs who already stigmatized TI groups became increasingly involved with HIV/AIDS program delivery to these populations. India's apex HIV/AIDS control agency, NACO, itself constituted rather like an NGO is structured to ignore this weakness of NGO endorsement and instead perpetuate the hegemony of the NGO complex.

This stands in contrast to NGOs with a strong political perspective – like Naz Foundation - who have been involved with the response from the beginning of the epidemic and understand the intersections and forms of stigma and violence. I raised these alternatives as "realistic utopias" for the Indian HIV/AIDS response to re-structure itself, submitting that HIV/AIDS-related stigma could be reduced and HIV/AIDS control improved as a result. Having discovered the processes and relationships of stigmatization that are embedded (and ignored) within the apparatus of public health in India, we see how a globalized response to HIV/AIDS may play a role in legitimizing HIV/AIDS-related stigma locally.

**Larger Questions**

HIV/AIDS is a central trope for understanding the notions of stigma and discrimination and indeed, the ways in which activists, researchers and public health practitioners have responded to them. It also undergirds other tensions in movements and organizing for rights and justice. As Parker (2012: 168) outlines:

> At precisely the time the global HIV/AIDS epidemic emerged, a growing neoliberal trend associated with an intensification of globalization had begun to spread across the globe, was a major step back for the principles of social justice articulated only a decade earlier in the Alma Ata Declaration(27). Indeed, this context may have led many activists, researchers and policymakers to adopt the human rights approach rather than social justice as an ethical/political rallying cry in seeking to respond to the growing HIV/AIDS epidemic. Yet, as neoliberal policies and perspectives continued to shape global public health, the focus on the need to link public health with social justice underwent a resurgence. It is interesting to note that this process was motivated by the

same concerns with the health consequences of social inequality and structural violence

that have shaped much recent thinking on stigma, prejudice and discrimination.

There is a typical tendency of public health practitioners to "confuse the things of logic for the logic of things" (Bourdieu, 2003:19) through a formulaic and axiologically neutral replication of theories and interventions on a global (ized) scale. This allows us to move forward without reflection or reflexivity - dangerously.

There are some public health practitioners who argue that "there may be circumstances when public health efforts that unavoidably or even intentionally stigmatize [like smoking] are morally defensible" (Bayer, 2008: 471). However, conceptualizing stigma asconnected to broader inequalities and power dynamics, unavoidably or intentionally stigmatizing is morally indefensible, unethical.Given the privileges of the discipline of public health and the power inherent in our role of promoting health, as Burris (2008) exhorts, the use of stigma as a tool of public health would be misuse.

Link and Phelan's framework enables a reflexive vigilance to our own processes of marking others in our use of symbols, language, our acts and relationships, as well as our structural positions and access to power. There is a need for greater sensitivity to the hegemonic, reductive, and formulaic tendencies that sometimes arise in our discipline, for indeed, stigma is connected to the ethics of public health practice. As Camus put it, this requires a vigilance that must never falter.

| Stigma | Comprises | 1) Labelling | | | | | Contingent on | 5) access to social, economic and political power |
|---|---|---|---|---|---|---|---|---|
| | | | 2) Stereotyping | | | | | |
| | | | | 3) Separation of "us" from "them" | | | | |
| | | | | | 4) **Discrimination** & Status Loss | | | |
| | | *Symbolic Violence (symbols and language)* | | | | | | |
| | | | | *Experiential Violence (acts and experiences)* | | | | |
| | | | | | *Structural Violence (structures and power)* | | | |

**Figure 1: Stigma, Discrimination and Forms of Violence**

# *Bibliography*

AFRICA: Mind your language - a short guide to HIV/AIDS slang. (2008, 18 June, 2008). *IRIN Plus News.*

Aggleton, P., Wood, K., Malcolm, A., & Parker, R. (2005).*HIV-related stigma, discrimination, and human rights violations: Case studies of successful programs*. Geneva, Switzerland: Joint United Nations Program on HIV/AIDS (UNAIDS).

Allied Chambers Hindi-Hindi-English Dictionary (Transliterated). (1993). New Delhi: Allied Chambers.

Bayer, R. (2008). Stigma and the ethics of Public Health: Not can we but should we. *Social Science & Medicine (1982), 67*(3), 463-472.

Bourdieu, P. (1990). *The logic of practice* (R. Nice Trans.). Stanford, CA: Stanford University Press.

Brown, L., Macintyre, K., & Trujillo, L. (2003). Interventions to reduce HIV/AIDS stigma: What have we learned?*AIDS EducPrev, 15*(1), 49-69.

Burris, S. (2008). Stigma, ethics and policy: A commentary on Bayer's "stigma and the ethics of public health: Not can we but should we".*Social Science & Medicine (1982), 67*(3), 473-7.

Castro, A., & Farmer, P. (2005). Understanding and addressing AIDS-related stigma: From anthropological theory to clinical practice in Haiti.*Am J Public Health, 95*(1), 53-9.

Centers for Disease Control & Prevention (CDC).(2004). *HIV/AIDS surveillance report*. Atlanta: Centers for Disease Control and Prevention.

Chakrapani, V., Newman, P. A., Shunmugam, M., McLuckie, A., &Melwin, F. (2007). Structural violence against Kothi-identified men who have sex with men in Chennai, India: A qualitative investigation. *AIDS Education and Prevention: Official Publication of the International Society for AIDS Education, 19*(4), 346-364.

Deacon, H., Stephney, I., &Prosalendis, S. (2005). *Understanding HIV/AIDS stigma: A theoretical and methodological analysis*. Cape Town, South Africa: Human Sciences Research Council.

Farmer, P. (2004). An anthropology of structural violence. *Current Anthropology, 45*(3), 305-325.

Farmer, P. (1992). *AIDS and accusation: Haiti and the geography of blame*. Berkeley: University of California Press.

Farmer, P. (2001). *Infections and Inequalities*. Berkeley: University of California Press.

Goffman, E. (1963). *Stigma: Notes on the management of spoiled identity*. Garden City, NY: Anchor Books.

Grover, J. Z. (1996). AIDS: Keywords. In D. Crimp (Ed.), *AIDS: Cultural Analysis/Cultural activism* (Fifth ed., pp. 17-30). Cambridge, MA: The MIT Press.

Herek, G. M. (1990). Illness, stigma and AIDS. In P. T. Costa Jr., & G. R. VandenBos (Eds.), *Psychological aspects of serious illness: Chronic conditions, fatal diseases, and clinical care* (pp. 103-150). Washington, DC, USA: American Psychological Association.

Herek, G. M. (2002). Thinking about AIDS and stigma: A psychologist's perspective. *J Law Med Ethics, 30*(4), 594-607.

Hong, K. (2006). Advances in the field of stigma: Vietnam. *International AIDS Conference Special Session on HIV/AIDS-related Stigma,* Toronto, Canada.

Human Rights Watch (HRW). (2003). Policy paralysis: A call for action on HIV/AIDS-related human rights abuses against women and girls in Africa. New York: Human Rights Watch.

HRW. (2004). Hated to death: Homophobia, violence and Jamaica's HIV/AIDS epidemic. New York: Human Rights Watch.

HRW.(2005). *Restrictions on AIDS activists in china*. New York: Human Rights Watch.

HRW. (2006a). Future forsaken: Abuses against children affected by HIV/AIDS in India. New York: Human Rights Watch.

HRW. (2006b). Rhetoric and risk: Human rights abuses impeding Ukraine's fight against HIV/AIDS. New York: Human Rights Watch.

Keusch, G. T., Wilentz, J., &Kleinman, A. (2006). Stigma and global health: Developing a research agenda. *The Lancet, 367*, 525-527.

Kiwia, P. (2006). Advances in the field of stigma: Tanzania. *XVI International AIDS Conference Special Session on HIV/AIDS-related Stigma,* Toronto, Canada.

Lane, S. D., Rubinstein, R. A., Keefe, R. H., Webster, N., Cibula, D. A., Rosenthal, A., et al. (2004). Structural violence and racial disparity in HIV transmission. *Journal of Health Care for the Poor and Underserved, 15*, 319-335.

Link, B. G., & Phelan, J. C. (2001). Conceptualizing stigma. *Annual Review of Sociology, 27*, 303-385.

Mahajan, M. (2008).Designing epidemics: Models, policy-making, and global foreknowledge in India's AIDS epidemic. *Science and Public Policy, 35*(8), 585-596.

Mahajan, A. P., Sayles, J. N., Patel, V. A., Remien, R. H., Sawires, S. R., Ortiz, D. J., et al. (2008). Stigma in the HIV/AIDS epidemic: A review of the literature and recommendations for the way forward.*AIDS (London, England), 22 Suppl 2*, S67-79.

McGough, L. J. (2005). HIV/AIDS stigma: Historical perspectives on sexually transmitted diseases American Medical Association.

Nambiar, D. (2009). On the experiential, symbolic, and structural forms of HIV/AIDS-related stigma: An exploratory study among multiple populations in Delhi, India. Unpublished doctoral dissertation.The Johns Hopkins University.

Nambiar, D. (2011). HIV-related stigma and NGO-isation in India: Anhistorico-empirical analysis. Sociology of Health and Illness. DOI: 10.1111/j.1467-9566.2011.01428.xPMID:22150236

Nambiar D, Rimal, R. (2012). Duty And Destiny: psychometric properties and correlates of HIV-related stigma among youth NGO workers in Delhi, India. *AIDS Care.* Jan. 2012. DOI: 10.1080/09540121.2011.648597.PMID:22292453

Nyblade, L., &MacQuarrie, K. (2006). Can we measure HIV/AIDS-related stigma and discrimination? Current knowledge about quantifying stigma in developing countries International Center for Research on Women POLICY Project.

Parker, R. (2012).Stigma, prejudice and discrimination in global public health.Cad.SaúdePública vol.28 no.1 Rio de Janeiro Jan. 2012

Parker, R., &Aggleton, P. (2003). HIV and AIDS-related stigma and discrimination: A conceptual framework and implications for action. *Social Science & Medicine (1982), 57*(1), 13-24.

Parker, R., Easton, D., & Klein, C. H. (2000). Structural barriers and facilitators in HIV prevention: A review of international research.*AIDS, 14* (Suppl 1), S22-S32.

Schiller, N. G. (1992). What's wrong with this picture? The hegemonic construction of culture in AIDS research in the United States. *Medical Anthropology Quarterly, 6*(3), 237-254.

Stockdill, B. C. (2003). Activism against AIDS: At the intersection of sexuality, race, gender, and class. Boulder, CO: Lynne Rienner.

Treichler, P. A. (1996). AIDS, homophobia, and biomedical discourse: An epidemic of signification. In D. Crimp (Ed.), *AIDS: Cultural Analysis/Cultural activism* (Fifth ed., pp. 31-70) The MIT Press.

Treichler, P. A. (1999). How to have theory in an epidemic: Cultural chronicles of AIDS. Durham: Duke University Press.

UNAIDS. (2000). HIV and AIDS-related stigmatization, discrimination and denial: forms, contexts and determinants (research studies from Uganda and India). Geneva: UNAIDS.

UNAIDS. (2001). *Stigma and HIV/AIDS in Africa: Setting the operational research agenda*. Dar-es-Salaam, Tanzania: UNAIDS Intercountry Team for East and Southern Africa Health & Development Networks Swedish International Development Agency.

Wallace, R., &Fullilove, M. T. (1991).AIDS deaths in the Bronx 1983-1988: Spatiotemporal analysis from a sociogeographic perspective. *Environ Plan A, 23*(12), 701-723.

Weigert, K. M. (1999). Structural violence.In L. Kurtz (Ed.), *Encyclopedia of violence, peace, and conflict* (). New York: Academic Press.

Whitney, W. D. (1945). In Harris Z. S. (Ed.), *The roots, verb-forms, and primary derivatives of the Sanskrit language* [The Roots, Verb-Forms, and Primary Derivatives of the Sanskrit Language]. New Haven, CT: American Oriental Society.

## *Endnotes*

[1] In my most recent of many conversations about the equivalent of "stigma" in Hindi/Sanskrit, the most recent contribution is of a renowned Sanskrit, Hindi and Tamil scholar, who feels that the best synonym is *laanchan*[1] (Jayaraman, personal communication, June 12 2009). The word derives from classical Sanskrit and is related to the Sanskrit root *laks* referring to "mark" or "sign" (Whitney, 1945). The root *laanch* means "to mark" and the suffix -*an* refers to "a process of" (Jayaraman, personal communication, June 12 2009; Whitney, 1945). Stigma in this definition, therefore, is a process of marking.

[2] If we again take the example of HIV/AIDS, stigma as separation includes fear of contagion and avoidance of casual contact with PLWHA, as a way of distancing oneself from risk (See Nambiar 2009 for extensive literature on this). Human rights researchers have documented cases of police hampering HIV prevention efforts among injection drug users in the Ukraine (Human Rights Watch (HRW), 2006b), gender-based violence and HIV infection in a number of African countries (HRW, 2003), healthcare providers' refusal to treat HIV positive children in India (HRW, 2006a), and harassment faced by AIDS activists in China (HRW, 2005) and Jamaica (HRW, 2004). Moreover, HIV/AIDS-related NGOs have reported withholding, limiting, or lowering the quality of care, services, support and education for PLWHA (Hong, 2006; Kiwia, 2006).

[3] At the beginning of the epidemic, public health authorities' initial characterization of AIDS as Gay Related Immunodeficiency Disorder (GRID) brought with it a barrage of stereotypes about homosexuals (Farmer, 1992; McGough, 2005). Following this was the 4H categorization of risk (Hemophiliacs, Heroin addicts, Homosexuals and Haitians), which encouraged collectivized perceptions of PLWHA in terms of social groups and not in terms of individuals with unique and varying histories (Herek, 1990). These epidemiologic "risk" ontologies may have been introduced as apolitical and technocratic, but were intensely political and stigmatizing (Grover, 1996; Schiller, 1992; Treichler, 1996; Treichler, 1999).

[4] Structural violence in relation to HIV has been studied using ecological models: examples include housing and community disruption and increasing AIDS deaths in the US (Wallace &Fullilove, 1991), breakdown of the local agricultural economy leading to changing sexual patterns and heightened HIV risk in Haiti (Farmer, 1992), the disproportionate vulnerability of African Americans to HIV due to incarceration, residential segregation, and limited access to sexually transmitted disease services (Lane et al., 2004), and the lower quality of service provision to homosexual populations in the United States (Stockdill, 2003) such that more AIDS deaths occur among gay and bisexual men (across all races) than in any other group (CDC, 2004). The methods used here are typically institutional and community level ethnography, policy analysis, and multi-level modeling comparing populations. A qualitative study based on in depth interviews Indian men who have sex with men connected discrimination by law enforcement and the medical establishment to broader forces of structural violence (Chakrapani, Newman, Shunmugam, McLuckie, &Melwin, 2007).